Oregon Health Authority

# Healthcare-Associated Infections Advisory Committee
September 28, 2016

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Speaker: **** Snyder at ****

Next Speaker: Hi LaRay.

Next Speaker: Laurie Murray-Snyder, from Health Insight.

Next Speaker: Can we turn it up a bit?

Next Speaker: That's okay.

Next Speaker: ****

Next Speaker: Anyone else?

Next Speaker: Hi, it's Judy Guzman

Next Speaker: Okay.

Next Speaker: Judy. Okay, hi, Judy.

Next Speaker: Hi. How are you?

Next Speaker: I'm good.

Next Speaker: Good.

Next Speaker: Hello, this is Jamie Grebosky.

Next Speaker: Hi Jamie.

Next Speaker: ****

Next Speaker: Okay then. Uh, can we start introducing ourselves around the room so **** are here? You can start over there.

Next Speaker: You two ladies –

Next Speaker: Can we –

Next Speaker: **** introduce yourselves.

Next Speaker: Oh, I'm Tina Meyer. I'm the, um, HAI office specialist.

Next Speaker: Uh, I'm Diane Roy, HAI research analyst.

Next Speaker: Uh, ****

Next Speaker: ****

Next Speaker: I don't have an official title, I don't think. ****

Next Speaker: **** and I'm with the **** association.

Next Speaker: I'm Barbara Wade, from the Oregon Association of Hospitals and Health Systems.

Next Speaker: I'm Monika Samper. I'm ****

Next Speaker: I'm Lisa Sakiugi. I'm ****

Next Speaker: I am Leslie **** I'm an HI, HAI ****

Next Speaker: I'm **** I'm **** section manager for **** disease, and also the HAI program manager.

Next Speaker: I'm Mary Shanks. I, uh, am **** at Kaiser **** and I chair this committee at the moment.

Next Speaker: I'm Mary Post, director of infection prevention at the Patient Safety Commission.

Next Speaker: Okay. So we've had our little roll call. Has everybody had a chance to look at the minutes from our, um, June meeting?

Next Speaker: Yes.

Next Speaker: Okay, okay. Does anybody have any objections to approving them? If not, then do we have, uh, a move to approve?

Next Speaker: ****

Next Speaker: And do we have a second?

Next Speaker: So moves.

Next Speaker: Okay. Minutes are approved.

Next Speaker: Okay. There's also the March minutes ****

Next Speaker: Oh, the March minutes as well? Okay.

Next Speaker: Do we have –

Next Speaker: Do you want to take a minute to look at, do we have a form?

Next Speaker: I believe so. One, two, three, yes, I think we do.

Next Speaker: Good.

Next Speaker: Don't we need seven?

Next Speaker: ****

Next Speaker: Okay. So take a look at the March minutes and, again, if anybody has any objections or changes, please, um, speak up. We'll just take a minute.

Next Speaker: ****

Next Speaker: Yes. **** report out ****

Next Speaker: **** the minutes

Next Speaker: ****

Next Speaker: Okay. March minutes are approved. So moving onto our first agenda item, uh, healthcare work influenza vaccination report update from Monica.

Next Speaker: Actually, we're gonna' switch. I'm sorry. We bumped Judy up in front of me and moved me to the end.

Next Speaker: Okay.

Next Speaker: You must have gotten my initial agenda ****

Next Speaker: **** yes.

Next Speaker: Sorry, sorry.

Next Speaker: I got my new updated agenda ****

Next Speaker: That's all right.

Next Speaker: So now, Judy, are you ready to roll with the, um, Ebola assessment update?

Next Speaker: Yeah, sure. Are my slides up for everybody there from, at the meeting?

Next Speaker: They are.

Next Speaker: Yes.

Next Speaker: Okay, great. So I'll just, yeah, I'll just let you guys know when I need them to be, um, to be forwarded. So this is Judy Guzman. Sorry I'm not there, um, in person today to join you for the **** meeting. Um, I'm, uh, I gave a presentation about 15 months ago, um, which is when, um, I joined, um, the HAI group as the medical lead for the, um, Eb, Ebola preparedness for the six Ebola assessment hospitals in Oregon. As a reminder, for those of you who weren't at that meeting at the time, um, next slide, please. Um, at the time in, in summer of 2000, um, 15, uh, we had six self-identified hospitals throughout the State of Oregon that agreed, that agreed to be Ebola assessment hospitals, meaning that if there was a patient who was identified either at the time through, um, screening, um, a returning child who was from West Africa, or from the healthcare provider at the front line, if they identified, um, an individual or a group of people who identified to be possible, um, to possibly have Ebola infection, they were, um, the plan was for them to cooperate with the, um, health department to be admitted to one of these six hospitals here listed on the slide, as assessment hospitals. These hospitals, um, agreed, um, to be able to have the capacity to admit the patient and basically, be able to do a rule in or rule out evaluation of the person under investigation for Ebola, and to be able to do that safely and effectively. So starting in July of 2015, um, our team, um, of, um, our Ebola consultation team, which was myself, Mary Post is the infection preventionist, um, Rob Niccola, which has now, um, um, for the, uh, laboratory expertise, that is now, um, he's passed **** to Tina Ramos, um, a bio safety officer with the, um, Oregon State Public Health Lab, and Dan Kane, who is an industrial hygienist, who is looking at healthcare worker safety, PPE, those types of things. And then we also, always had a, um, public health physician, first Genevie Buser, and since she's moved on, um, we've had, um, um, uh, sorry, Richard Leeman has joined us, um, with, um, a few rounds of our visits. So we've, um, visited all six hospitals, and through the grant work, um, we had, um, we, uh, the Ebola ELC grant, we did baseline studies, basically, baseline visits, um, all of last summer. And then we did 6-month visits, um, just to see where, um, where the hospitals were, what their level of preparedness, based on a template that was made by the CDC, specific to Ebola assessment hospitals. And then we're now actually just scheduling our final, um, third visit, uh, 1-year visits. Um, and as you can see here on the list, these are the hospitals. We have one hospital, um, in, uh, Southern Oregon, Asante Ashland Community Hospital, and we have three hospitals in the Portland Tri County area, Kaiser Westside Hospital, Legacy Good Samaritan Hospital and Providence Milwaukee. And then, um, just south of here we have Lebanon Community Hospital. In central Oregon, Saint Charles Redmond Medical Center was, um, also an Ebola assessment hospital. I've indicated that one, um, in parenthesis because when we did our, um, our most recent visit, um, after long discussion from the Health Department and

leadership of Saint Charles Healthcare System and Redmond Hospital, specifically, we realized that, um, the **** for the Saint Charles Healthcare System is huge, in terms of geographic areas, um, for Oregon. And if, um, based on the experience from other assessment hospitals and treatment hospitals across the country, that if an, a patient with possible Ebola, not even confirmed, but possible Ebola was admitted to, um, Saint Charles Redmond, there was concern that it would decrease their capacity to be able to continue providing routine healthcare and emergency healthcare beyond Ebola, um, if they did have a patient. So based on that, um, we, um, mutually decided to, um, to take Saint Charles Redmond Medical Center off of the list for Ebola assessment hospitals. Next slide. So as I already mentioned, um, just a reminder for those of you who haven't been going to these meetings like we have and talking about it a lot, even though no one really seems to care much about Ebola anymore, there are no more PUMs, which is a person under monitoring. Back when the Ebola, um, outbreak was continuing in, in Western Africa, um, the State and local health departments, um, and, um, uh, airlines, especially the, the airplanes, the, um, airports that have the biggest influx of, of immigrants and international travelers, were keeping tabs on people who were, had any risk and had been traveling to any of those areas and doing, um, monitoring, um, in collaboration with the local and State health departments. Um, so we've done away with the active monitoring of people, so there are no more PUMs, or people under monitoring. So what do we do now? It doesn't mean that Ebola is gone. Um, there is, um, so what we've, what we're relying now is continued triage screening for all hospitals, and most importantly, we still want to work with the six assessment hospitals, um, or with the five assessment hospitals and Saint Charles, so that all of these hospitals will be able to rapidly identify, isolate and notify, um, if there's a patient that has an acute illness, recent international travel that may be, um, where Ebola is on the differential diagnosis. Um, um, when we last, uh, touched base with the CDC, um, there is still a desire to continue an active list of these Ebola assessment hospitals, so this designation continues. And our team at the HAI program, we, um, we, routinely update our list of the, um, hospitals and we submit that to the CDC so that if a person was identified and, um, required healthcare or evaluation in Oregon, we'd be able to quickly, with the CDC, look at that list of the active hospitals, and really look at where they are with their level of preparedness. So with the Ebola outbreak over and, um, with us wrapping up with our third visits of the hospitals between now and, and November, um, our team has been, um, trying to, um, figure out and collaborate with the hospitals how we continue collaborating with these six hospitals to continue just general infection pre, or improvement, and really, continue the preparedness for not only Ebola, but for the next emerging pathogens. Next slide. So after a lot of brainstorming of, you know, really, uh, cute acronyms and all sorts of things, we were trying to come up with a, how we could newly designate these hospitals. Um, we came up with Oregon ICAR Centers of Excellence. Now, ICAR is a terminology you probably have heard from Mary Post or others on our team already. ICAR is a term from, um, the CDC, which stands for infection control, assessment and response. And Mary has been, um, you know, keeping the, the HAI committee up to date on the type of ICAR general infection prevention visits and consultations that she's been doing throughout Oregon over the past year or so. We use that same term, terminology, and we added Centers of Excellence. And so what our goal now here is to continue to keep these six hospitals, including Saint Charles, who is longer, technically, an Ebola assessment hospital, but to keep them engaged to become centers of excellence and to continue the, to basically, not throw away all of the great work, preparedness, and frankly, um, you know, financial resources that the hospitals and healthcare systems have, have put into, when they were planning for Ebola. So we wanted them to be continuing to kind

of be at that continued state of readiness, as the joint commission likes to say. Next slide. So what is an ICAR Centers of Excellence? So it's, uh, initially our collaboration with those self-identified assessment hospitals, and we're gonna' continue active engrave, engagement, um, with us and the infection prevention teams, and really their Ebola assessment teams, or the Ebola preparedness teams that they all created when they were getting prepared for a possible Ebola PUI. Um, we, we, um, used as a template the CDC document that they, that had created a, basically, a checklist, for preparedness for Ebola, and we kind of broadened the lens, if you will, and we created our own new template or checklist with different domains or different types of, um, categories that we want the hospitals to be thinking about. Which category do we feel like we need to work on most to strengthen our general infection prevention preparedness and really, preparedness for the next emerging pathogen that may be Ebola or may be something else. Um, we, um, are periodically following up with these hospitals by email, by phone calls. We still have one more webinar that we've, um, Ebola webinar was what they started off, but now we're just calling them ICAR webinars and talking about various different, um, topics. For example, our last Ebola/ICAR webinar 2 week, 2 months ago, we actually invited, um, a subject matter expert from Salem to talk about, um, airborne isolation, um, uh, rooms, and what the hospitals should be doing in terms of minimal requirements for, for maintenance and for, um, making sure that people are checking to make sure that **** is corrected, working the way you want it to when you have a patient admitted who requires negative pressure isolation. Next slide. So as I mentioned, we repr, repurposed the CDC assessment hospital document. I wanna' stress to the HAI committee that this, um, the, the document that we created and disseminated to the six hospitals are not expectations. These are kind of best case scenario, like, where we think the hospitals could really achieve, in terms of their able, their ability to safely and effectively take care of a patient with any type of, um, emerging pathogen that may be, um, uh, transmitted through airborne contact, droplet, whatever you may be. Um, and it's really just a way to also **** these hospitals, continue to work with them, um, and to highlight their commitment to strengthening Oregon's infection prevention infrastructure. Next slide. Um, I just wanted to highlight just a few, um, with the last few minutes, um, a few of the kind of things that we are highlighting in this document we created. Um, one of the, one of the categories was in fa, in facility infrastructure. And for Ebola, it was basically, do you have a designated room, with **** area, do you have a toilet that has a lid, those type of things. Now we're looking at general infrastructure. So we're asking the hospitals have you done a critical review of your hand hygiene projects, product placement throughout your hospital, the **** placement, so that, you know, the only time you don't have gowns, gloves and mask is when you have a patient who's in isolation, because we should be doing standard precautions with every single patient encounter. And a lot of times I've been in healthcare, um, environments where you walk in to see a patient, and the patient suddenly starts coughing. But since the patient's not in isolation yet, you can't find a mask anywhere. So we're trying to make, um, standard precautions something that really, truly can happen with every patient. And then as I already mentioned, looking at airborne isolation, um, ventilation capacity, so the hospitals know on any given day within their hospital and across their hospital system, how many rooms they have and who is taking, who is doing the safety checks to make sure that the, um, negative pressure is truly negative. Next slide. Another example with patient transportation, of course, with Ebola and con, and with any emerging pathogen, there has to be a lot of collaboration between the hospital and their EMS partners who are gonna' be transporting these patients from facility to facility. And also, we're gonna' work with the hospitals to improve their notification of the MDRO transfer rule, so if a patient, um,

has a MDRO or requires isolation precautions, to ensure that an accepting hospital or facility where the patient's being transferred to, is appropriately notified before the patient arrives, and documentation would be good too. Next slide. Um, I mentioned the laboratory folks who are a part of our team. So they're helping with their lab leaders at the hospitals to make sure that they're maintaining the appropriate point of care testing, central lab area testing, based on the differential diagnosis. And we're really trying to cultivate our relationship between the lab, O, **** and the clinical lab to say, you know, how else can we help you in terms of training your staff to be able to do things safely, packaging, those type of things, but also we're seeking clinician advice for how can we make things easier for you, for example, Zika virus testing. So we need that clinic, clinical liaison to be able to make sure that it's, um, it's the most efficient system possible. Next slide. Next slide is staffing. Staffing, I think, is one of the hardest things for the hospitals that are still being Ebola assessment hospitals. We're asking them to be able to maintain a staff of, um, of, of trained, uh, healthcare providers, nurses, physicians, some RTs to be able to support 96 hours of care if they do have an Ebola, um, person under investigation admitted to the hospital. And that's a tall order to have a long list of healthcare providers, especially nurses. Nurses come and go. They move to different units, etcetera, and it costs money to take the staff away from the bedside. So we're trying to figure out creative plans for them to be able to keep that staffing, um, up to date and keep those staff trained. Next slide is worker safety. So, um, we're kind of looking, again, beyond Ebola, but other things that I know come up in the HAI committee frequently, of how we need to improve patient safety. So looking at, um, **** protection programs, needle stick prevention, making sure employees' exposures to things like TD, measles, varicella, blood body fluids are, that they have good plans and policies in place, making sure that immunizations are provided to healthcare providers, and making sure that the hospitals have, um, good **** provider policies that are easy to, um, follow. Next slide is clinical planning. We're working with some of the hospitals, um, like, one hospital, Asante Ashland, said, you know, we'd just like to kind of go down the list of all of the bugs that come in here, influenza, measles, um, whooping cough, varicella, and make sure we have organism specific, um, post-exposure manage, management plans, um, isolation plans and prophylaxis plans. So that's what I'm working with on them. Next slide is my last slide. Um, so again, if anybody on the committee has any ideas of, um, you know, kind of from whatever realm that you are representing, of anything else that we can work on with the hospitals, in terms of emerging preparedness, emerging pathogen preparedness, um, please let anybody, um, on our team know. I know Mary is there in person and I'm here, and you can always email or call me. So any comments, suggestions or questions, I'm, I'm happy to answer. Thanks for the time for the update.

Next Speaker: Well, thank you, Judy. This is a very nice overview. So if there's no questions then, um, our next agenda item is the HAI annual report update from Lisa.

Next Speaker: ****

Next Speaker: Okay. So hello everyone. I'm Lisa Lisa Sakiugi. Um, um, so **** talking about **** um, that Kate, um, had worked on this report before she left. Um, I'm, I'm sure she mentioned this year we're **** the main summary report kind of separate from the **** available online on data.oregon.gov. Um, and so **** have going over the **** summary findings for each **** included in the report. Um, then also I'm hoping that we can kind of look

at data.oregon.gov together and show the features, um, on, online. Um, and as you'll note on the slides, I have a draft **** watermark. Um, so we are **** to release the report soon, but apparently, um, it's still unpublished data. So that's why the draft watermark is on these slides. So what is included in this year's report? Um, so this year we have hospital data and **** facility data. Um, similar to last year's report, we have, um, **** for **** infections, catheter associated urinary tract infections, **** after the six different procedure types, um, hospital **** and **** And then for the office facilities, we have **** infection and then at the facility, **** infections. Um, so this year, um, **** the reporting **** to include a medical, surgical and medical/surgical ****. Um, and then in the report, we have **** that we can compare our data to. So this is the, uh, **** national **** developed by the Department of Health and Human Services or HHS. Um, and then we also have, uh, the percentile compared to the 2014 national SIR distribution. And we used 2014 because this is the most recent year that CDC has released their national report. Okay, so I'm gonna' go, um, through each HAI types, starting with, um, central line associated blood stream infection. So this year we have the **** hospitals reporting. Um, you can see that there was 151,000 central line **** with 118 infections, um, with an SIR of 0.43, which means you have 57 percent for infections **** and this **** So **** look at this broken down by different location types. Um, so this is looking at ICUs, um, **** and then neonatal ICU. Um, we can see that the SIR for ICUs is at 0.35, um, which met the target. But for **** 0.53 and for, um, NICU it was 0.75, which does not meet **** reduction target. Um, the graphs on the slide are what's included in the summary report. You can see that, um, this SIR is over the years, on the left, is at their **** ICU location. And then on the right is the SIRs for the NICU location. Um, and then on the graphs we have three, um, dotted lines that show what the national baseline is. That's basically an SIR 1. Um, and then the two ****, so that's 713 target ****, um, which is 0.5 for ****. And then the, um, **** national SIR. Okay, so next is, um, catheter associated urinary tract infections, or CAUTIs where we had 57 hospitals reporting **** 191,000 catheter **** and 188 infections, um, with an SIR of 0.54, meaning 46 percent **** infections **** And this again, means our 25 percent target **** Um, when we look at it by location types **** pediatric, **** which is an SIR of 0.7 and, um, **** with an SIR of 0.4. Um, these both meet the target **** 0.75. Um, and this graph shows the SIR is for ICU locations. Um, next is the hospital onset **** So we had 61 hospitals reporting with around 1.4 million patient days, and 909 hospital onset infections. Um, the SIR here is 0.88, which translates to 12 percent **** infections than expect, expected. Um, this does not meet our reduction target of 30 percent. And, um, I do point out that when we look at this graph, um, **** this is the highest, um, SIR reported in our State.

Next Speaker: Can I ask a question? And, and remind me where the target of the 30 percent reduction came from.

Next Speaker: This was developed by the Health and Human Services.

Next Speaker: ****

Next Speaker: So ****

Next Speaker: This is a poll for **** based on **** data.

Next Speaker: And that, **** specifically that 30 percent, do you know if that was, ****

Next Speaker: They, you know, they had a stakeholders –

Next Speaker: ****

Next Speaker: – meeting where they looked at data in metrics, and I think just ****

Next Speaker: ****

Next Speaker: **** came up with that. They looked at, you know, prior data.

Next Speaker: Yeah.

Next Speaker: Yeah.

Next Speaker: So.

Next Speaker: Yeah, and it seems like there's a, I will mention this later, but there is some proposed targets, you know, for 2020, and it seems like they're, um, **** public comment, so I think they take into account **** and also, like, um, **** as well, so ****

Next Speaker: I just wonder how realistic 30 percent reduction and, um, and **** which seems to be on the increase rather than on the decrease.

Next Speaker: I think at the time, they had very little surveillance data, because ****

Next Speaker: ****

Next Speaker: **** had not been required to be publicly reported.

Next Speaker: Yeah.

Next Speaker: And I think, um, you know, as you were saying, I think improvement efforts have really just been undertaken **** the last couple years. And so tryin' to work on evidenced based practices and really understanding the basic epidemiology I think –

Next Speaker: Right.

Next Speaker: Mm hmm.

Next Speaker: Because, you know, it's one of those that's really hard to pin down, because there's so many of the current cases coming in. And if they're not captured within a certain time, they fall back into the hospital's prior docket, when it's really a current situation.

Next Speaker: So moving on to, um, the **** we had 61 hospitals reporting, with around 1.5 **** days and 51 hospital onset dissections reported. This translates into an SIR of 0.59, meaning 41 percent **** Um, and this does meet the **** target goal of 25 percent reduction. Um, this is the graph that shows, um, the SIR **** Um, and then next we have surgical site infections. So this slide shows the aggregate of all, from all the **** procedures **** reported. Um, so there was around 36,000 procedures reported, with 216 complex surgical site infections, um, with an SIR of 0.62, translating to 38 percent **** infections **** 25 percent reduction. If we look at this by infection sites, starting with the coronary artery bypass graph, and we see that, um, we had around 2,000 procedures with five SSIs, um, with an SIR of 0.19, um, which does meet our 25 percent reduction goal. And you can see the trends, um, in the graph. Um, next is laminectomies. Um, so we had around 8,000 procedures reported, with 29, um, SSIs, with an SIR of 0.57. Again, um, this does meet our 25 percent reduction goal. Um, next is abdominal hysterectomies, with around 3,000 procedures reported, and 13, um, SSIs, with an SIR of 0.49, which, again, meets the reduction target goal. And then colon surgeries, um, we had around 4,000 procedures reported, with **** um, SSIs, an SIR of 0.66, um, which, uh, meets the reduction goal. Um, hip replacement surgeries, we had around 8,000 procedures reported, with 41, um, surgical site infections, with an SIR of 0.62, uh, which meets the target goal. And then lastly, um, knee replacement surgeries, we had around 10,000 procedures reported, with 51 SSIs. The SIR here is 0.83, um, so this, this one does not meet our reduction target goal. Um, so moving onto the office facilities, um, we had, we re, we report **** infections as well as **** So either part has rates. Uh, for **** we had 0.43 per 100 patient ****, which is 50 percent **** in the national average. Uh, and then for office related **** infections, we had 0.30 infections per 100 patient ****, which is 58 percent **** the national average. Okay, so that's the main, the main **** the main findings that are included on the report. And as I mentioned, the facility specific data will be available online on data.oregon.gov. This is **** showing, um, what the data will kind of look like. Um, and I'm hoping I can go in and show it to you, um, **** way. Um, and this is also screenshots of the maps that we have, um, for, for hospital performance.

Next Speaker: We are, um, I mean, I failed a couple questions. Do, do we have a way to do, uh, interactive ****

Next Speaker: ****

Next Speaker: I think we do.

Next Speaker: Is the computer ****

Next Speaker: ****

Next Speaker: Yeah.

Next Speaker: Huh. I don't know if we're set up.

Next Speaker: Does it have ****

Next Speaker: I guess you could walk over there –

Next Speaker: Yeah.

Next Speaker: ****

Next Speaker: Um, I mean, I think this might be more just for the group in general in terms, it looks like **** we're doin' pretty good. And I'm wondering if anyone has any sense of what might have changed in the last, um, year or two, because it did seem like there's a pretty big drop. And I don't know if anyone's aware of any specific efforts that might be in place.

Next Speaker: There's been a lot of focus on proactive bathing and increasing the quantity and quality of the bathing and all of the patients taking their uh, their chlorhexidine baths at home proactively as well as to decolonization **** and of uh, the skin, uh in the prep area. A lot of hospitals are now doing a sage, which is a CHD cloth wipe down immediately before surgery. Those, I know that there's been a lot of focus in the hospitals that don't do that.

Next Speaker: Um, the other question I had, in terms of C. Diff I think that, yeah we're seeing an increase there and that's a hard one to deal with but I think it is, it's a state priority and I think appropriately so. I think it's also related to antimicrobial use and some went on to amnia rose which are all these different things that we're really focused on. So are there any ideas for what more we might be able to do?

Next Speaker: I think from, based on what we were seeing last year and the increased numbers was due to, a lot of that was driven by testing. And um a lot of places, including Kaiser were over testing. Testing anybody who had any kind of loose stool. So instead of applying some parameters such as you know, signs and symptoms of infection you know rather than having just completed a GI prep. So, we were most likely collecting a lot of colonized patients and not infected patients. Um, so, I think that people are starting to become a little more discriminating in terms of their testing for C. Diff in terms of looking at uh, risk factors plus symptoms and then testing. So, I know in my, uh, in my own hospital I can tell you that our rates are much lower this year. Even though we are still doing a considerable number of tests we have significantly reduced our testing. But the tests that we are sending down are much more focused on symptoms.

Next Speaker: Do you guys have a criteria?

Next Speaker: Yes. We call it Steps to C. Diff testing. So it's primarily, it's like the IHI has actually had a bundle for that but it's primarily looking at um, patients with um, recent antibiotic exposure. Patients who have had recent hospitalizations or stays in a healthcare facilities, people with cancer. Uh, so there's a list of risk factors that one should, if somebody's having diarrhea and the stool should be watery and frequent, meaning more than one. So, if somebody's having two or three watery stools in a day and they have risk factors one should test. And we have a little best practice alert that pops up whenever that is documented on the flow sheet, diarrhea or loose stools. So I think that you know, we're trying to capture 'em, we certainly do not want somebody undiagnosed on a floor. Um, and I think another thing is a lot of hospitals are going

with uh, sporicidal disinfectants and uh, with UV disinfection it really stepped up their EVS, their high touch surface decontamination so I think there's a lot of work going on in healthcare.

Next Speaker: I just wanted to put a plug in. I know, everybody here is very supportive of these efforts. We do have a multiregional multi-facility collaborative that we'll be rolling out. And uh, much of the goals are to improve the partnership between hospitals and all facilities that aids including nursing homes, so there'll be a great opportunity to really um, try and build on best practices and get everybody on the same page as far as, um, antibiotic stewardship and urinary tract infection prevention, CDI prevention and inter facility transfer communication.

Next Speaker: I think that's, that is very promising, especially with MDROs and making sure everybody understands what's needed.

Next Speaker: Right.

Next Speaker: Because there are sometimes a lot of confusion um, is a lot of confusion going on between can we take this patient, the patient came to us with this MDRO, so yeah, you can take the patient. So, cause a lot of facilities are a little nervous about it. Especially some of the more resistant organisms we're starting to see. And I don't know if I'll, I can tell you from a hospital perspective we are seeing a lot more ESDLs.

Next Speaker: Um, I was just going to comment on dialysis as well. Um, our data looks great when we compare nationally and much of the reason is that Northwest for a long time has done a really great job of trying to move the patients to permanent access versus central lines. And so I think that's why we tend to perform much much better than other regions. Plus, they've done improvement efforts is still the first.

Next Speaker: I think a couple people may have joined since the beginning. Are you guys able to introduce yourselves?

Next Speaker: Sure. Uh, Genevieve Deeser from Providence.

Next Speaker: Hi. Jennifer Graham, I'm the health security for Various Intersquad Program. I'll pretty much be coming to the meeting instead of Akeko Saigo from now on. I think she sent –

Next Speaker: Yeah.

Next Speaker: – someone an email about getting me permanently –

Next Speaker: I saw it, I was copied on something about it.

Next Speaker: – okay. Yeah. So, you should see more of me ****

Next Speaker: So, I'm sorry, what's your role?

Next Speaker: Um, I am the medical counter measures coordinator for Hisper so, I focus on post exposure prophylaxis and um, emergency based medication and supplies.

Next Speaker: Oh, okay. Great. Thank you.

Next Speaker: Sure.

Next Speaker: Okay. So, are we ready to roll on? Oh, you're going to do the directive?

Next Speaker: Yeah, I still have one more slide. But I'll go through those and then I'll pull up the online data. Okay. So, um, as we were talking about, we're using data.oregon.gov which is a new feature for us but we think, you know, we encourage people to try and use it. We think it's easy to access and use. Um, it's customizable. People can filter by different things, um, export the data if they want to. They can visualize the data in different formats. So, we have it as tables and maps but there's also options to create charts or graphs if you're interested in that. And ideally with this database we hope we can publish information faster. So, um, the fine timeline that we have set is this week, um the week of the twenty-sixth, we sent an email out to healthcare facilities with a link to data.oregon.gov to preview their facility specific data. And then next week, the week of the third, um, we plan to post the summary report as well as the data.oregon.gov link on our um, HAI website. So next, um, I do also want to mention that um, if you're not aware yet, um **** a re-baseline of their data based on 2015 um and they're planning to release the new version of **** in December. And the new SARs will be available for 2015 data.org. So if you're interested or want to learn more about this, next week there will be a webinar, that I posted a link to if you are interested. Um, and kind of in line with this, um, as you mentioned there will be new 20/20 um, target reduction goals. These are currently in drafts mode but I am told that they should be released soon. So, as you can note, all of the **** goals are going to be based on the 2015 baseline. And that's all I have, so.

Next Speaker: So, in a nutshell, we're over basically on Peak's CLABSIs, right? Neonatal and Peaks in general?

Next Speaker: Yes.

Next Speaker: CDI and PayPros.

Next Speaker: PayPros, correct.

Next Speaker: Okay, so, we need to be thinking about programs that will target those.

Next Speaker: You know, just, uh, speaking out for the hospitals, um, we are doing such a great job at getting catheters out in a timely manner that our catheter dates are shrinking. So, it's, it kind of, um, sometimes predisposes us to higher rates simply because our denominator's smaller. Just FYI and with all these rate reduction targets. You know if you're taking that into consideration.

Next Speaker: Well we did okay as a state with CAUTIs. So that's good news.

Next Speaker: Yes.

Next Speaker: Yeah. We hit target. So hopefully with the readjustment of 2015 they'll take into account the smaller catheter days, catheter utilizations ****

Next Speaker: This is Genevieve, but also Skyping **** point of view, it seems like, you know, CDI has this, **** has a different objective than for CLABSIs.

Next Speaker: Right.

Next Speaker: Because people bring, can often be bringing that in and so **** that's exposed. What we're really concerned about is preventing those transition events or that as soon as they're identified that they're going onto contact isolation like that. So it's a little bit of a different outcome. So just as something that when they're looking at these as we maybe test less, uh, one thing that crossed my mind is maybe we don't find those colonized people, maybe that leads to silent transmission or you know that could be some unintentional –

Next Speaker: That's why you need the, um, for silent disinfectants.

Next Speaker: Right. That's used for –

Next Speaker: As your backup.

Next Speaker: – right, exactly. So, just, um, I just wanted to point out that the CDI surveillance is a different beast than the others because I think the objectives are different because it's a somewhat naturally overflow occurring presence **** so anyway. But keeping that end and whether that helps us look at our data or how we might categorize it differently or if there's any deep dives that are done to understand that. So probably preventing transmission, that kind of thing. So.

Next Speaker: **** the **** you mentioned, is it already going?

Next Speaker: No.

Next Speaker: When is it starting?

Next Speaker: We just got funded.

Next Speaker: Oh.

Next Speaker: Um, you know, our timeline was to start around November but again, we're still working on agreements and recruiting, things like that. So, if it doesn't start November it'll probably start um, January. And we have had some informing recruiting discussions and seems to, we seem to already have lined up some very interested nursing facilities and a couple hospitals have um, expressed a lot of interest because of especially the readmission. You know,

prevention of readmissions potential and they really wanted to be working on building their partnerships with the nursing homes anyway. So, um, I think the timing's good.

Next Speaker: Yeah. That's good.

Next Speaker: Yeah. And we anticipate even though um, we will be communicating a shorter timeline, because the funding we, you know, have available is only until um, August 1 essentially. We're hoping that there will be subsequent years of funding as well so we can actually treat it as a longer term project. It's hard to get everybody up and moving in a short span of time. And um, part of this is to get the um, nursing homes enrolled in um, the NHSN long-term care mission modules. So not only for the Clostridium difficile infection module but also for the urinary tract infection prevention module.

Next Speaker: This is Jamie from Providence. For the pediatric side, the NICU CLABSIs also noted that that's high. I'm just curious how, I don't know if there's any particular NICU CLAB **** hospitals that might take a deeper dive and understand why that's happening. Is it a product change? Um, the hospitals are different but the providers are actually can sometimes be the same because they work for pediatrics or, you know, so, is there some way that to kind of look a little bit more closely at that **** and understand that maybe that might give some clues to why things are going up. Testing practices or I know they just introduced a new, uh, **** that thing.

Next Speaker: ****

Next Speaker: Yeah, or like the way that they, you know, **** the umbilical catheters or things like that, so I don't know. Just wanted to throw that out there ****

Next Speaker: No, I think that's a good point. I think there's been some dialog with you know, one facility in particular, but I think a statewide dialog –

Next Speaker: It's actually like very much the same. A lot of providers that work **** the thing NICUs ****

Next Speaker: Right. Yeah, yeah.

Next Speaker: Just as a suggestion.

Next Speaker: Thanks.

Next Speaker: And I think they have some kind of a collaborative.

Next Speaker: They did.

Next Speaker: NICU.

Next Speaker: There's the **** which was does look at many different things including CLABSI. And so there's already a nice form –

Next Speaker: Yeah, cause when I was at St. Bea's, the St. Bea's nurses are hooked up with OHSU or hooked up with, cause they do talk to each other.

Next Speaker: I think there's only what, seven NICUs in the city?

Next Speaker: Yeah. And then they take the two major pediatric unit hospitals that more units.

Next Speaker: Yeah. And they work, there's also, that kind of the Von Collaborative also includes Southwest Washington NICU, so just **** order **** to them. FYI. Yeah.

Next Speaker: ****

Next Speaker: Are you ready Lisa?

Next Speaker: Yeah. I'm ready.

Next Speaker: Okay.

Next Speaker: So I pulled up, this is near the oregon.gov, this is the link that we have, shows all the results um, for each, for all the **** tables and maps that will have with the report. And you can see that um, **** with it. So, um, I put the first table which is **** um and this is what it looked like. So, the data is um, categorized alphabetically um, with the facility name, this is all **** is on top but as you go down you'll see all the facilities with the new data. And then the next column will be the hospital location. So we report by ward and ICU and um, also have an aggregate and a combine row as well. Um, we have data for centralized days ****, **** perceptions, the SIR with **** and then we have an interpretation of what that **** means along with a simple **** report. We also show whether or not it met the target, um and we also have **** facility reported zero exceptions. So you'll get, a facility has one checkmark if they met the target or a zero **** they have two checkmarks if they did both. And then the next column shows the percentile range of compared to the national **** 14 distribution. And then the next column you have like the geographic information. This is helpful for potentially county or regional efforts and for the map. And so you can see you have the county, the **** region and the facility address. Any questions? And then I also pulled up the map here. Um, and this is **** pediatric ICU wards. And so, um, if we zoom in a little bit, you can see uh, that **** records represented here either by the icon arrow or a word **** facilities is encrypted by blue dots. And what you can do with this map is you can click on a facility, or you can click on an icon, I'm sorry. And it will open up information about that facility that's based on what is reported in the table. And you can look at that for different facility **** different facilities **** here. That's what it'll look like. Any questions?

Next Speaker: **** available in the future or now?

Next Speaker: Uh, ask ****

Next Speaker: Okay. Thank you. Sorry.

Next Speaker: It's really cool.

Next Speaker: So, I have a question kind of for the group. Uh, Lisa came and presented this data to our **** healthcare preparedness program liaisons which is how we got that HEP region added into the data. But she came and presented to them, Lisa, was it in August? A couple of months ago and basically Kinko had initially been trying to figure out how we can get the preparedness liaisons who work very closely with the hospital coalitions and some of the other healthcare facilities in their regions to utilize this data to help them um, you know, do better long-term planning around preparedness and so I just, I'm wondering if you all have any thoughts about the best way for us to, cause Lisa's given me access to the data so that I can create some things through the HEP region or if they request specific maps of hospitals or hospital systems so we can give them that information? Um, in addition to what they can access here, like we can play around with it a little bit more, but what do you all think would be the most useful for them as far as like a coalition level for that region? Do you have any thoughts? Cause we got a lot of wide eyes during that presentation and I don't think they really, they were like, okay, what are we supposed to do with this? This is a little out there, so. And you all can think more on it. **** broad question.

Next Speaker: It's Genevieve for those of us on. I was just curious if part of the APP **** involves patient safety and I kind of see that as one, one obvious kind of parallel.

Next Speaker: Well, it's gonna involved everything for sure and patient safety's gonna be included. Worker safety is included in that and um, I'm even, you're reiterating the type of cleaner that's being used. If you think about a, an emergency where you've got a medical surge, where they're already at capacity, some of those things start dropping off. And then if you don't have the same supplies. I mean, so we've tried to think about all of those different pieces, um, which I think is maybe making it harder to fit this in because it's, it's pretty, it's nebulous to a lot of those things. So, yeah, I'm not sure, it would be ****. Worker safety, patient safety would be relevant. I'm just not sure how to –

Next Speaker: Yeah, maybe that's the way to start is sort of what, what do they do. Maybe we understand like what their role is and oh yeah, sorry, then that might help us make those connections, so whether that's afterwards or something, but ****

Next Speaker: I was just gonna add, you know, I think knowledge about things like influenza vaccination rates and areas where maybe uh, you know, they can help encourage higher vaccination rates or maybe assist with vaccination programs and I think again just helping improve inner facility transfer communication knowing CDI levels in the communities, uh, and again, be more aware of risk factors for you know, helping to train EMS and others who may be involved with transport between facilities prevention measures.

Next Speaker: Yeah, cause I can see all of those as Genevieve began. I can see all those having parallels to noninfectious subjects that would be under their purview. But I mean, I'm sure they deal with communication between hospitals and so making sure that infection piece is part of it

or that if there was another bad H1N1 year knowing very quickly what their workers' workforce susceptibility is, you know, help you vaccinate, help me earn ****

Next Speaker: So the next ****

Next Speaker: So this will be, the vaccine data will be a separate report that Monica's working on but we will have that in a similar **** data ****.

Next Speaker: Okay. So –

Next Speaker: I'm gonna talk about it later today.

Next Speaker: Okay. Perfect. Well this is a start and I'll get more –

Next Speaker: We've already had an employee with the flu.

Next Speaker: Oh no.

Next Speaker: And a patient.

Next Speaker: Flu A, B?

Next Speaker: A.

Next Speaker: Okay. I am next, I'm just gonna give a update about outbreaks that have been reported to us since June of this year. Um, the summer months are always kind of fun because we don't get the normal just norovirus and just flu outbreaks and so, um, there's a variety of outbreak pathogens as you can see on this table. So all in all we've had 62 reported outbreaks. Um, 28 were confirmed norovirus outbreaks, we had 3 salmonellas, 2 E. Coli and 1 **** and astrovirus, cryptosporidium, Hepatitis A, **** hemalyticus. You notice a lot of them are actually foodborne, uh, and we do see increases in foodborne outbreaks in the summer months. But we see a lot of GI still that are unknown, so 17 of them are unknown and then some respiratories. We've had 3 pertussis outbreaks, 1 parainfluenza, 3 outbreak in a long-term care facility, um 1 that's, uh, the pathogen is unknown and a couple of other various outbreaks, so rash, it's scabies and hand-foot-mouth and then the other one I will have that in a second. Um, so the outbreaks, or the settings that are in bold are healthcare facilities. So this next slide, um, summarizes that. So 60 percent of the outbreaks between oh, that should say June and September, um, were in healthcare associated settings. And the most common etiology was neuro or neuro-like. And so you can see 22 of those outbreaks occurred, 22 of those healthcare associated outbreaks occurred, were, had norovirus as a pathogen, 11 were unknown but of GI source. And so then the other ones, 1 that **** memory care facility was the scabies outbreak and the other in the hospital was, this was a, something knew for me. It was TASS which is toxic anterior segment syndrome and there's a cluster of 6 patients that had um, has post cataract surgery.

Next Speaker: Oh wow.

Next Speaker: Yeah. All in one hospital. Um, one surgeon. And so the hospital's doing a review. I have no additional updates as of right now but that was a new one. Um, it's, has to do with ****

Next Speaker: If you guys need help with that let me know cause I've dealt with a few.

Next Speaker: Oh, you have. Okay, good to know. Yeah, we, um, the hospital called us and was like we have six of these, we've only seen one this year and all of a sudden we've had six.

Next Speaker: Yeah, something's wrong.

Next Speaker: Yeah. So that was pretty interesting. And I also wanted to pull out some other interesting outbreaks that happened this summer. We had an E. coli 0157 that was associated with a fair. This, we've, we have every year you know, a handful of E. coli and salmonella **** cases that are associated with the fair but this one was associated, we had three cases that all attended the same fair. Um, 2 out of the 3 of these cases **** age range was between 3 and 15, so all young. Uh, and so this is pretty interesting. The, uh, so, and their routine **** which is a long hypothesis generated questionnaire that we perform with all ****. By seven cases they noticed that uh, these cases went to the same fair. And so we, our two EIS officers which is Epidemiological Intelligence Service officers actually went out to this fair and swabbed everything. Unfortunately none of it was positive, um, but through a narrowed down questionnaire, a, more specific, fair specific questionnaire they were able to narrow down exposure to sheep and goat exhibits. And so this E. coli 0157 pattern is a common pattern that has been linked in the past to petting zoos and raw milk exposures and so this is, uh, we see this quite often. It's just a nice plug to wash your hands after playing with those petting things.

Next Speaker: Have we gone a year without one?

Next Speaker: No. It's a dumb, I mean, yeah, let's just leave it at that. You know, we see, we see this a lot and, um, we always try and ask that the fairgrounds and petting zoo exhibits have handwashing stations and this fair actually did have one, um, but the parents of these children were having an issue with getting the water to work. Yeah, it's pretty important, handwashing. Um, the second interesting foodborne outbreak was 8 Salmonella Newports that was associated with a single restaurant and so this was a Friday, I know this really well cause I was on call this day. It was Friday at like 4:00 and our lab called because they found 8 Salmonella Newports that all had the same pulse field, that all match for the pulse field **** ultraphoresis. And so, um, in questioning these cases they realized that a lot of these cases, I think it was like 5 of the original 8, all ate at the same restaurant. Um, and at the same restaurant location. The restaurant is a chain. And so um there were 5 additional cases reported that met this um, that matched by PFGE and so, again we went out and we swabbed the restaurants. There was nothing positive which is great, um, and environmental health did go out and did find some violations but nothing too major and so a specific food or vehicle couldn't be implicated but given that so many people, 9 cases ate at the same restaurant, the same location in the span of 25 days, we kinda think that the restaurant is the likely, likely source. Now lastly I wanted to talk about a Mycobacterium chimaera case that was reported in Oregon. And so this was pretty interesting. So this case was

reported to us because um, a culture, a tissue culture came back as growing Mycobacterium chimaera but um, so this happened in late August. The patient sought care because it had a cubic history of a red mass and swelling near his sternum um, and he, a year prior had had um, an aortic valve replacement and other open heart surgery at an **** hospital. And so the samples taken during the surgery here and the Oregon hospital were positive for M. chimaera and so uh, this is, you know, bringing it back. That CDC recently this year, sent out a report that says that heater-cooler units during cardiac surgery have been linked to Mycobacterium chimaera infections and they uh, did this really nice study. I don't know if anyone has read this but there's videos of the study that they did and so, um, they are suggesting that everyone points, positions their heater-cooler units away from the surgical field. They did some really cool experiments with smoke and you can see like the smoke drifting over the sterile field. So, this was **** so. Questions?

Next Speaker: Do we know how many hospitals in Oregon use that? Cause I think it's a very specific –

Next Speaker: It's a very specific one, there's basically, it's the Soren Freetee, it's the basically only heater-cooler unit on the market. I would assume almost all the hospitals use it just cause there's no real other options.

Next Speaker: They are doing a lot more off pump procedures.

Next Speaker: This patient did use our Oregon hospital's heater-cooler unit but they asked the, Soren to come in and help clean, so.

Next Speaker: You mean off pump they don't need to use the heater-cooler?

Next Speaker: No.

Next Speaker: Okay.

Next Speaker: All right. Thank you very much for that. **** Okay, we have a 5-minute break so stretch your legs.

Next Speaker: So, um, I'm gonna change things up a little bit. There's about an 8-minute video I'd like to play for everybody that we've been working on so I'm gonna move quickly through the dialysis slides since we have them as a handout. But some of these I wanted to include for those who've never been **** for the presentation for the first time but they are repeats. So I'm gonna go over them really quickly at high level. So, um, much of the work **** is actually funded by a grant from the Centers for Disease Control as a result of Ebola. And you can see uh, as Judy talked about it, it not only funds our Ebola assessment hospital work but it's also funding a lot of general infection prevention practices to really help build the general infection prevention infrastructure in the state. Um, we tried creating a regional approach working with our emergency preparedness liasions as well. We're really trying to build partnerships. Um, so often people may be talking on the phone and we're trying to get them in the room so they know each other and if they have problems or issues with transfer communication or an infection is admitted

that they know who to call. So much of what we'll be doing over this next year is again, continuing to try and build those partnerships. The first year we did 25 um, actually completed 24 consultations. Um, the second and third year of this grant we're actually trying to get 35 done. They are consultations across **** of care so it includes hospitals, dialysis facilities, long-term care facilities including nursing homes and ****, memory care, we've done some consults for, um and then ambulatory surgery centers as well have some medical clinics and we additionally did a dental clinic as well. Um, we're really trying to loop in the local health departments on these consults and if possible involve local APIC members as well so they can kind of learn more about the other, um, facility settings across the health continuum. And you can see the regions. The first year we really tried to target partner hospitals and facilities in these specific regions. The CDC has four different tools that we use. Each tool has different domains and requirements. We've created template agendas for each setting that vary. And um, I've really learned that it's much better to get the information by doing um, observations, audits and staff interviews instead of sitting in a conference room and asking questions with people. It's just much more meaningful and you can collect a lot more information. So, um, today's report is on dialysis. This is the last of the four reports we've given and what we found the first year. You can see the domains that we query and look at through the tool. It does include dialyzer reuse and reprocessing. We did do, we had a consult in one facility that still does dialysis for use. So we were able to work with them on that. Um, for all the tools, again, it's very much structured on ensuring you have observational competencies, annual competencies with observations, periodic performance feedback audits which means it's not just walking through the hall. It's actually collecting data and recording data, performing, providing performance feedback to staff as well. So, um, in all the **** elements it'll ask questions about that. Most facilities are getting zeroes because if you don't do it all, you do nothing, you get a zero for it and all the elements. So um, I think for instance, hospitals are really good and performing hand hygiene observation competencies but when it comes to like environmental services observational competencies and you know, competencies for catheter, you know Foley catheter insertion and things like that that are observational, most facilities don't do it. Okay? So again, this is, this is sort of a new era, I think we will be pushing for more observational competencies. I think some of the discussion of course is when is it reasonable? If you've worked with a hospital who's gone two years without a CLABSI and there's a lot of competition to get that annual competency time that's dedicated for staff, is it reasonable to do it for CLABSIs if you haven't had any for two years versus maybe something associated with you know, permitting patient falls, you know. So I think again, you know, there's still going to be some discussion about the right approach to take. Um, and again I just want to emphasize the zero is not really indicative of quality. It's just more an indication whether or not they have all those observational competency components in place. So, in terms of dialysis, we did three consultations for dialysis facilities. The 66 percent had designated IPs in place with specific training. Two-thirds participated in the egg shape eye, QI project. Two-thirds had a contact precautions protocol. All provided a lot of education to patients on risk for vascular site infections and other types of infections ****. Um, I will tell you that um, they've really gone electronic in their documentation and unfortunately the space requirements between the dialysis chairs and the computer stations was not met in most cases. They just weren't designed for that spatial separation. Yes.

Next Speaker: Is there a minimum FTE for a dedicated IV?

Next Speaker: No.  In fact, um, the dialysis rates right now don't really require that.

Next Speaker: So if –

Next Speaker: At all.

Next Speaker: – they do .1, then that would meet the –

Next Speaker: It, you know, in Oregon we mostly have two, large dialysis organis, organizations, there's another one.  I can tell you one of them has done a great job by requiring each facility to have an onsite infection preventionist, someone who's designated for the role. And that individual has to have regional training and sometimes it's attending like our 3-day course as well.  So I think it's starting to happen and hope we will continue working to really develop that onsite presence.

Next Speaker: But like I have a lot of like, you know, similar ****.  But these people tend to wear multiple hats.  Um, are they you know, are they a good quality person to enter into the –

Next Speaker: Yeah, yeah, yeah.  Um, I think designated time is gonna be an issue.

Next Speaker: – mm hmm.

Next Speaker: The model I've seen a lot of times is it's somebody who's a staff nurse who also is in charge at times.

Next Speaker: Which might be fine, I just didn't know if there was an expectation for a minimum M.D.

Next Speaker: Yeah, they don't, they don't have it.  Not at this point.

Next Speaker: And just a quick, **** are dialysis units included in that or no?

Next Speaker: They're totally different.  **** participating.

Next Speaker: Totally different, okay.  So they're not included ****

Next Speaker: But the snips haven’t been released yet, right?

Next Speaker: No, no, no.

Next Speaker: I'm only asking because I've heard it will be released before the end of this month.

Next Speaker: Yeah, right.

Next Speaker: Which is pretty short.

Next Speaker: But in the new law that's under consideration does not include dialysis.

Next Speaker: I'm sorry?

Next Speaker: So for the new CMS regulations do not include, that are under consideration, do not include dialysis.

Next Speaker: Right.

Next Speaker: So it's specific to the long-term care setting, the nursing homes and snips site?

Next Speaker: So each setting has specific sets of rules for condition of participation.

Next Speaker: So the ones that have been released, you all are waiting for a different, different set?

Next Speaker: We're waiting for um, Senates for Medicaid came out with their first rule revisions for nursing homes and snips that they have in I think it was like 20 years or something, 17 years.

Next Speaker: Right.

Next Speaker: So very drastic changes. They did in the draft recommend a full-time infection preventionist who's dedicated to infection prevention and can spend some time in like quality. They also um, they had a lot of other requirements like medical evaluations I want to say within like 24 hours.

Next Speaker: And this is the, the rules that came out this month?

Next Speaker: They were draft rules. No, they were draft rules.

Next Speaker: They're drafts?

Next Speaker: They were draft rules that were published, um, I forget, I think nine months ago or something, a year ago.

Next Speaker: Last July 2015, yeah.

Next Speaker: Mm hmm. Okay.

Next Speaker: But um, I actually had a conversation with a colleague Saturday who's been involved with the rule making.

Next Speaker: Gotcha.

Next Speaker: And the person who's involved with the Federal Register said they're still on the docket to be published, the final rules by the end of the month.

Next Speaker: Okay. So the ones that I'm thinking of are totally different.

Next Speaker: So we'll see.

Next Speaker: Cause we just saw some be released like a couple of weeks ago.

Next Speaker: Yeah, no, not yet. Those are something different, yeah.

Next Speaker: Not those.

Next Speaker: Um, okay. All of our dialysis facilities do have a specific Hepatitis B exhalation room but none have a special room designated for other infectious diseases, so they just kind of make space within ****. All facilities do have specific job training and observational competency, 60 percent have it annually. All have standardized tools for education and practice assessments. Two facilities met all domain requirements under um, under personal healthcare. Um, most had follow-up and of blood and body fluid exposures and tried to improve or prevent all screened Hepatitis patients for Hepatitis C. All offered influenza vaccination to staff and I have to say they had some very high rates at some of their facilities. All screen staff for TB and all are required to report illness to staff. And two-thirds felt their policies did not feel ****. In terms of surveillance, all enter bloodstream data into NISA. All have a list of reportables required to go to the county. And only one facility had a system for inner-facility transfer communication. So again that's an opportunity that I think we still have. Um, in terms of respiratory etiquette, most had programs and space in place and had signage. I will say only one had designated space for sick patients in the waiting area, um, and only one had the ability to separate symptomatic patients by at least six feet from the other patients in the unit, the actual treatment unit. In terms of PPE all did a great job and met all requirements. Environmental cleaning is a place where we have a lot of opportunity. In dialysis facilities they have come out with new guidelines for cleaning the stations and an actual checklist for it. And in doing observations, nobody, no facility did it at all, correctly. And most of the time what's happening is they are required not to begin the actual disinfection of the station until the patient has left the dialysis chair and they don't do that. They begin disinfection while the patient is often holding the access site to prevent bleeding. And so, um, that's just something that again, they're gonna really have to work on. Um, they've you know kept clear the **** of Hepatitis C transmission from the environment in dialysis facilities, so it's a huge issue and concern and I think one is definitely the center of attention nationally. I want to include the health and alert network that again emphasized what I just talked about, we just need to really focus on disinfection of the dialysis station. So again it's very timely that we've been able to do these audits and collect a little bit of data, what's actually happened in our facilities here in Oregon. Um, in terms of hand hygiene, they actually had incredibly high rate. You know this is an open unit. I'm there for, I was there for you know, 4 to 8 hours sometimes. I'm there for a long day, open unit, I can gather data and observe really quickly and well, 85 to 95 percent. And mostly because, remember they have those computer stations? They have gloves attached them and they have hand sanitizers. So they're right there, very easy access and I think that was the secret to their stellar hand

hygiene. Uh, we had some issues with injection safety. Um, only one had an actual medication administration room. Everybody else was administering meds in the clinical, immediate clinical area which again, a lot of times it's at a nursing station with the chairs you know, not far away. So, uh, that again was a **** issue for them. There was multidose vials that were being shared in the area and they also were not always being labeled appropriately for immediate use medication. So we have some education improvement opportunities there. Again, they really did a good job in terms of observational competencies for vascular access, cannulation, de-cannulation, psyche care. So they're doing in terms of observational competencies pretty well, in comparison to other sites. Um, again, immediate use medications and labeling is an issue, um blood glucose devices you don't see a lot used most of the time. They do venous pressure. I did find some glucose devices but they really were being used more for patient education. They more often would use the patient's own device and there wasn't a glucometer sharing. Again we had to choose in terms of reminding them about our inner facility transfer written communication requirements and their hand hygiene was stellar. They actually do a pretty good job of mixing any disinfectants appropriately. They use a lot of bleach concentrations for, and they have some pretty stringent guidelines and marked all the bends and everything that they need to do. I think it's, as I mentioned the infrastructure's really training, uh changing, they are putting infection preventionists in roles at the facilities and again, I want to you know, acknowledge that because of NHSN, um, some of the large LDOs, Large Dialysis Organizations, have actually hired regional infection preventionists. So they've had additional training and they're really doing a lot of their surveillance and um, helping analyze that data. So again I think that's something that we're seeing, quite frankly as a result of the requirement for public reporting. Uh, I think it's important again to have these observational competencies, it really helps hardwire the staff and hardwire the practices that need to be there. Again, rural areas have a very difficult time recruiting and training and personnel. So good educational orientation programs are really important. Practices will drift unless they're not reinforced. Um, and we found cases where people left their employment and then with the processes that were in place were no longer in effect. And again I think just having the presence and feedback is really important for infection prevention. So next steps we have our infection prevention fundamentals training course which is scheduled from November 1 to the third. I looked at our numbers and sadly we peaked the month before we're already at 70. And so um, we're starting a waitlist and we'll kind of talk to I think a couple of people about **** again that everybody's gonna attend. But it's a high demand course. So, we also have some other training courses. I'm hoping sometime around the start of the year we'll roll out a training course for environmental service managers. Um, we also have wanted to do one for hands-on instrument reprocessing and um, I think we maybe have a solution to actually having a setting that we can do it in. And then I really think there's a need for a medical clinic tool kit and some training. So I'm hoping that that will be something that we will be able to also roll out this next year. And then I wanted to show you we've been working on a cleaning video, environmental service cleaning video. And it's ready but it's getting close **** or actually is posted to YouTube so this will be available.

Next Speaker: Can you?

Next Speaker: While she's working on that can I ask one question?

Next Speaker: Yes.

Next Speaker: About the domains. Did you look at medication storage? Like if they have anything that needs to be refrigerated or?

Next Speaker: Um, it's not on the um, assessment, but I do look at it. I look at what is in the medication refrigerator and I, because I am looking at labeling and I'm looking to ensure people are rubbing you know the, or swabbing the rubber septum when they open medications and other safe injection practices. I do kinda eyeball and I'm certain you know that if they are required to be refrigerated they are.

Next Speaker: Okay.

Next Speaker: And I check to be certain they're taking temperatures too. Which is not on the sheet, but.

Next Speaker: Right.

Next Speaker: Ready? Okay.

Next Speaker: So, uh, this is a training video that we developed based on a lot of the common things like ****

Next Speaker: **** training program on best practices to use when cleaning and disinfecting patient rooms. Cleaning and disinfecting can help your facility ****

Next Speaker: Can everybody hear okay?

Next Speaker: **** hospitals limit long-term and ****

Next Speaker: Turn it up a little bit.

Next Speaker: Turn it up a little.

Next Speaker: – **** requires environmental service workers to have specialized training. Individuals with specialized training may have ****

Next Speaker: ****

Next Speaker: **** admissions, EVS workers or housekeepers. In addition to specialized training the healthcare EVS workers should be able to demonstrate competency. This means being able to show your supervisor or trainer that you can perform the practices correctly after being trained. Healthcare facilities are different than other kinds of businesses when it comes to cleaning and disinfecting. The reasons for this include bad germs in these kinds of places are more common, the germs are often difficult to remove or kill, the germs are invisible which makes it very hard to know if you have been successful in cleaning practices. Patients and residents who stay in hospitals and other healthcare facilities are often ill, elderly and debilitated.

This makes them more likely to catch infection. Patients also have many more chances to be exposed to the germs that are found in their surroundings since they have frequent contact with healthcare workers. One fact that you need to know is the hands of healthcare workers are the most common way that germs can travel around medical facilities. Meet our friend Anna. She is an EVS worker. Some people may think of her as a maid or a janitor. Although those jobs are important the healthcare EVS worker is there for the both of us. It is her job to clean, disinfect and prepare the environment in the facility so that it's safe for patient, visitors and staff members. Anna has been trained by her supervisor how to properly clean and disinfect patient rooms. Anna had to demonstrate the proper techniques she learned before she was allowed to work independently. Anna is ready to clean the patient room. The patient was sent home today so now she needs to make sure that the patient's room is properly cleaned so that it's safe for the next patient. This will prevent the transfer of any germs left behind from the first patient to the next new patient who will be occupying this room soon. Anna will begin by making sure her EVS cart is properly supplied and neatly organized. Clean things are physically separated from dirty items such as trash or used cleaning cloths. After her cart setup is complete she performs hand hygiene, applies her disposable gloves and goes into the room to remove the trash and soiled linen. Next she removes her gloves, cleans her hands and applies fresh new gloves. Then she begins to clean making sure she is going from top to bottom, cleanest to dirtiest areas, then she moves in a clockwise, counter-clockwise fashion around the room. This helps her to clean all items that need cleaning and also to prevent her from cross-contaminating areas and items in the room. Anna folds and refolds her microfiber cleaning cloth that is dampened with the approved disinfectant as she moves around the room cleaning. This process also helps prevent cross-contamination by making sure the cleanest portion of the cloth is used as she cleans. Use of microfiber cleaning cloths is considered a gold standard in healthcare environmental cleaning by infection control. The technology of microfiber cloth greatly increases the germ removal ability over non-microfiber rags. Anna changes her cloth frequently when needed and never touches a dirty area of the room with the same cloth that she will use to clean a less dirty area. She will clean the bathroom last since it is considered the dirtiest area of the patient room. In the bathroom she begins with high to low cleaning and then moves from the cleanest area. For example, that includes the sink toward the dirtiest one which is the toilet. The last thing she will do after cleaning and disinfecting the toilet is to mop the floor with a disinfectant. Anna has a very specific routine when she cleans which was taught to her by her trainer. This routine will help assure that she doesn't miss areas or contaminate areas when she's cleaning. Remember, the germs that Anna is working to kill are invisible so it is important that she follows the facility policies and doesn't miss any steps in performing her cleaning duties. Some of the main things to remember when cleaning and disinfecting include the following: you should use an EPA registered hospital disinfectant when cleaning in healthcare. Follow the manufacturer's directions **** labeling and expiration date. This includes when filling your pails, bottles and other containers. Often these directions include the use of chemical mixing stations or specialized **** pump models located in EVS work closets. For your safety always be sure to wear the proper PPE such as gloves and eye protection when filling your containers with cleaning solution. Never top off cleaning disinfectants. Instead, only add new cleaning disinfection solution to the empty clean containers as this is considered best practice for infection control reasons. And last but not least you should know the name of the product and the **** time required for the disinfectant to do its job. This is found on the product label. When you perform surface cleaning and disinfection take care not to apply too much liquid to the surface

being disinfected. The excess moisture can promote the growth of a lot of organisms including mold. And the excess of it can be destructive to the surfaces being cleaned. Make sure that your cleaning equipment is cleaned daily when you finish and it's in good working order. You should clean and disinfect mopping pails and similar equipment at the end of each work shift as well as when exiting from patient isolation rooms. Worn out equipment should not be used. You must remember that dust is not a friend in healthcare. Dust carries germs through the air in the air current and can increase the risk for infection. Our goal is to prevent dust movement during the cleaning processes. You should never use dry methods such as feather dusters or other dry high reach types of equipment to clean **** in healthcare. Instead, use a damp dust muffin. To do this, the cleaning cloth, microfiber mop or microfiber duster is dampened with the approved disinfectant and then the surface is damp wiped clean. Remember to damp and not saturate. Also don't forget to use friction when cleaning as this is very important in the germ removal process of cleaning in healthcare. Other approved methods of dust removal in the patient care areas include the use of Hepa filter vacuum equipment. And don't forget, a very important reminder, once you have finished your cleaning task, you should remove your disposable gloves and perform hand hygiene every time. Often healthcare workers forget to clean their hands after removing their gloves. Those responsible for cleaning the healthcare environment are the foundation of the facility's infection prevention and control program. Thank you for what you do as a healthcare worker to make the environment where you work a safer place. Remember that by following these best practice instructions you can make your patient and resident care areas cleaner and safer for **** as well as the visitors and staff working at the facility.

Next Speaker: Thank you. Now let's um, Deb Hurst and her sister did the bulk of the work on that video and it's really – it can't serve as the only training that's done for environmental service workers but I think it is a good film that especially hits on the high points of things you need to cover when you are training somebody and it's a good review for like staff meetings and things like that. So it will be posted on the Commission's website and we can have a link with the OHA website as well and it will be available for free for all facilities to use.

Next Speaker: Well thank you Mary. That was very nice. So we're ready to move on to Debra, you have a report for the role of Oregon's Office of Licensing and Regulatory Oversight?

Next Speaker: Deb are you on the line?

Next Speaker: I think so.

Next Speaker: Yes, can you hear me?

Next Speaker: Yes.

Next Speaker: Yes.

Next Speaker: Okay, perfect. All right, so, this is going to be pretty brief, I'm just going to kind of let you know where we're at. There's basically three things that we're trying to do: rule revision, serving prompt and um, increased communication with our setting through **** hours. So right now we're, I'm working on recommended rule revisions for both nursing homes, assisted

living and adult foster homes to address several items. So, some of the language will identify who needs to be notified because there's some confusion when it says notify the state so we're going to spell it out. Should be both the local health department and our office around reportable diseases and communicable outbreaks. Um, responsibilities around the MDRO forms. Beefed up language, this is a really big one. Beefed up language around training to include all staff for hand hygiene and respiratory etiquette. All staff providing resident care, um, requires standard precaution training. Laundry staff with additional training around contaminated laundry. Kitchen staff with additional training around food handling. And what we want is this not only at hire, we have very general language that says at hire, but I'm recommending at hire and annually. Um, and then we're also putting language in to refer for **** facilities is putting language in there to remind them that they also have responsibilities under OSHA regulations around infection control. What I put in for language around PPP says outside of gloves I think a lot of the facilities are pretty clear about gloves whether they use them or not, they're aware of it. It's the other items that they may need to have that really is overlooked many times. Outside of their **** setting. Um, we're going to add some language around maintaining standard precautions specific to a resident's condition. We're also gonna spell out that if the local health department or the health division gives the facility different sets of protocol based on individual circumstances that they are obligated to follow those recommendations. Um, we also have a bit of an issue around proper disposal of sharps and so we're going to add some additional language around that. Um, I hope to have the draft wording to them by October 12 and then once I, he take a look at it, or you know, whoever he sends it to, for comments then I will refer it on to the different programs for them to incorporate in their next rule revision. I will say that when I gave a report around some of the stuff Mary was doing in their surveillance um, efforts around a variety of things in infection control, they were pretty stunned at some of the low numbers of about what facilities are or are not doing. So I think that there's a lot of support to move most of this forward. So we currently have new **** for the nursing home, the assisted living and pretty routinely I address some, some issue around infection control, whether it's a reminder, letting them know about new tools or training. So I will continue to do that. In 2017 they'll be adding a new **** for adult foster homes. So I will do the same path with them as well cause what we want to do is keep infection control a very active concept. Now, even though a lot of these things are not in the rules yet, the training cert that I already do, I already incorporate all of these requirements in that training. So they're already hearing those messages. Um, let's see, oh, I'm also developing some survey and license **** for the assist living and foster home settings on what to be looking for around different infection control concepts. Nursing homes have a pretty well defined one that's prescribed by CMS. I'll share what I'm doing for the others with the manager of the nursing home program. However, they may already have met most of those but I will pass that information on. So right now that's kind of my efforts with our agency to support what you all folks are trying to accomplish.

Next Speaker: Well, thanks, though I do have a question. With um, the sharp disposal, what kind of problems are you having? Are they saying?

Next Speaker: Well, first of all they're around so that residents can get into them. They're not always the sharp-approved container so that you can remove the like so you know, that's not cool. And then we have found out, and this is mostly with foster homes, that some were just throwing it in the regular garbage. Um, so we're trying to get all that stuff, make sure that's clear.

We've actually been teaching to it for quite some time but not, oh I know, that's one of the things that we're recommending for foster homes that we add infection control as one of the annual mandatory trainings. Because it's difficult a lot of times to you know, once they've taken the training, if it's not required routinely, then keeping them up to date has been a big challenge.

Next Speaker: Right.

Next Speaker: Well we applaud your efforts.

Next Speaker: Very much so. And I know that sharp disposal, especially diabetic supplies is an ongoing issue and outside of healthcare settings.

Next Speaker: Well, and it sounds like, especially for foster homes who don't have any kind of natural relationship with hospitals or other big organizations that dispose of things. Sometimes I mean, they're being charged in some counties some pretty outrageous prices. You know, around $35.00, $40.00 per container.

Next Speaker: Wow.

Next Speaker: So, you know, we don't really have any control over that. And what we tell them that is a part of doing business. Um, but that doesn't really help.

Next Speaker: Um, to back up one question for you.

Next Speaker: Sure. Is this Mary?

Next Speaker: Yes, it is.

Next Speaker: Okay.

Next Speaker: Did I hear you at the start say you're changing the rules so that if there is an outbreak or a reportable infection they are required to report them not only to the health authority but also to your regulatory agencies?

Next Speaker: Well, they were supposed to always report to us. We're referring to the health division website that gives the information on what needs to be recorded and when. And so we're just going to make that really clear that you know, you have to make reports as directed by this website. And then in addition to, all communicable outbreaks, because you know we often deal with things like dead bugs and scabies, etc. But they have to be reporting to our office. Cause what our office is um, we take a look at the circumstances and determine there's a concern that maybe they weren't doing things to prevent or minimize the outbreak. Some settings it's just a general challenge because of the population they serve, like, for example, if they serve a lot of homeless then they tend to have more problems with things like lice, bedbugs, you know, that kind of stuff.

Next Speaker: I guess, the reason I asked the question is um, it's not something we require other healthcare facilities that OHA, you know the HCRQI site to report.

Next Speaker: Yeah. It's actually always been required to report to us.

Next Speaker: Yeah.

Next Speaker: That's just part of the responsibility.

Next Speaker: I guess my question is, I mean, I certainly can understand for some things but I'm somebody who never wants to, I don't want to prevent reporting. I think that sometimes people fell there is a regulatory impact or potential decline, they're very hesitant to report and so I, you know, personally am always supportive of kind of a safe table for reporting, knowing that they can call and get the help and expertise they need to address the problems. But that that not necessarily mean you know, unless it's something egregious that they would have um, a regulatory survey or penalty as a result.

Next Speaker: It doesn't generate a survey. But there's a whole laundry list of things they're required to report to us. Not just a **** infection. So it's been part of their doing business for as long as I know. Um, and it doesn't necessarily mean a survey is generated.

Next Speaker: Hey, Mary and Deb, this is Dana from the HCRQI from before.

Next Speaker: Hi Dana.

Next Speaker: Hey there. Um, I have been silently listening but I heard you mention it and I just want to clarify that the difference between long-term care and non-long-term care is exactly that, what Deb was talking about, is it's just um, you know, enormously more kind of closely regulated and the reporting like Deb said, they have degobs of things that they report including the, you know, 40-page MDS. But um, for every patient every time something changes. So they have a lot of reporting. And um, as you well know, none of our facilities have to self-report except for to the Patient Safety Commission of course if they have something going on. So, um, and if they're um, if they find a reporting agreement. So it's just sort of the nature of how long-term care started in a different place and how it's just been more tightly managed and is it kind of a different model than the other types of facilities and I will. And from a licensing perspective we also have nothing that requires them to report. Although if we do hear about it, um, it probably would, you know if there were some sort of serious infection and someone you know claims that there was a condition or participation violated, especially infection control. We would go out and do an investigation, likely a federal one.

Next Speaker: And the process of this clarification actually will save them. Because what will happen is if they don't report to us then they, depending on other things, they may get a citation. Um, and what we find is that they have this perception many times, and it can go both ways, that if they report it to the local health department then the local health department reported to us. Or sometimes it's the other way around. They assume that if they report it to us we report it to local.

So this is just really to clarify that when they need to do it to what agencies. So for them really it's business as usual.

Next Speaker: Okay, well, thank you very much. That was very interesting. So, Monica, can we uh –

Next Speaker: Do we know ****? I will be really really quick.

Next Speaker: Okay, we have like five slides or so.

Next Speaker: On the healthcare worker influenza vaccination report. And the slides that you're gonna see in here today are, um, which button am I needing to push? There we go. Is also new data but I was not astute enough to put draft on it like my coworker was. And it has yet to be released. But this is a copy of last year's report. This year's report is going to be very similar, that's why I put this up. We have very limited amount of writing and it's really heavy on graphs and figures. And this again is the link where you'll be able to find this year's report. So here's some new data. From 2011-2012 is our first reporting year. Actually it was 2010-11 but there were only two facilities reporting at that time. Hospitals and snips. So now, uh, 2015 and 16 you can see we added dialysis facilities and like Mary Post alluded to earlier they had phenomenal rate of healthcare worker vaccination. They almost meet the healthy people 2020 goal of 90 percent. And you can see we have a pretty gradual incline for most facilities for whatever reason. Hospitals dropped 1 percent this year, um, also, um, it's hard to see but ambulatory surgical centers dropped too a little bit and then snips took a pretty big jump for the first time in quite a while. So, that's new data and that's kind of cool. Hospitals for the third year in a row, met, or for the third year, yeah, met, health people 2015 goal of 75 percent. Um, oops, okay, this was a page taking out of last year's report, I duplicated this page again in this year's report and this will give us line by line, each facility. Again, we covered hospitals, long-term care or snips, ambulatory surgery centers and again, dialysis facilities are new this year. We included again like he did last year, in her HAI report, although we're not doing them together this year, my report will be separate. Um, the number of healthcare workers eligible to receive vaccine, the rate of vaccine per eligible healthcare workers. And by definition eligible healthcare worker just means those without a medical contraindication. Uh, the rate of declination for eligible healthcare workers which I'm gonna talk about at the end of this slide. The rate of unknown vaccination and then the change in vaccination rates since the previous season which I think is always interesting. Whether they met the 2015 or 2020 target and again, another cool number I think is the number of healthcare workers that they needed to vaccinate additionally in order to meet the 2020 goal. So that puts it in hard numbers, oh, if only we'd only vaccinated five more people we would've met this goal. Um, this is last year's map actually but this year's map I put it up because in this year's map which we already saw that Lisa showed us, I wanted to show that again. We're gonna have a legend, we're gonna have, facilities will be represented by a dark green dot if they had a greater than 90 percent vaccination rate, a light green dot if they're 75 to almost 90 percent vaccination. And there's a typo on here. It should say 60 percent to 75 percent vaccinated is the light red and then dark red is if they're below 60 percent. And again, we'll be able to do the same things with this data, click on a specific site, see the exact numbers, it'll be really user friendly. This is again a brief synopsis of our data this year which has yet to be shared with anybody. It shows again that the hospitals had a 78 percent vaccination rate, ASCs

are 68, snips 63 and dialysis, phenomenal 88 percent. And again a reminder of our healthy people goals.

Next Speaker: This is a draft, right?

Next Speaker: This is all draft. Yeah. This hasn't been shared yet. And this is the site that I was referring to earlier which I think is really an interesting slide and I think there's a lot of takeaway discussion on this slide. They, the rates that I'm mainly interested in is that unknown status. You know if you look at hospitals have a 13 percent unknown vaccination status, that simply means if they were able to track down these people, were you vaccinated somewhere else? Were you vaccinated, did you go to Rite-Aid one weekend? I mean, their vaccination rates could be 13 percent higher if they simply knew the vaccination rates of all their people. And you have that situation both in hospitals and in snips. And then again you know, in snips why are 19 percent declining vaccination? Why are an ASCs 22 percent declining vaccination? I mean, these are interesting things that you know, would be good to know the answers to. Maybe then the rates could be even higher. I mean 22 percent, that's that's really high. You can have you know a 90 percent vaccination rate of ASCs if you could just convince these people. And then, I said I'd be quick. Any questions?

Next Speaker: No.

Next Speaker: Um, this is Jamie Grebosky.

Next Speaker: Yes.

Next Speaker: What are the barriers of that won't allow us to pass legislation that'll allow hospitals to require healthcare workers to get a flu immunization as part of employment?

Next Speaker: There's a lot of barriers. We have, we've discussed this actually at our last meeting too I believe.

Next Speaker: Mm hmm.

Next Speaker: Um, there's legislation and pushback that you just can't force people to get vaccinated.

Next Speaker: Yeah, Oregon has some of the lowest vaccination rates in the country. And it's because there is a sizable anti-vaccine voice. Um, another thing is unions are on, at the forefront too to say that you cannot enforce vaccination, employers can't. So we did think about taking this to um, the legislature to see about getting uh –

Next Speaker: And we being our APIC group.

Next Speaker: – our APIC group. Yes. And we've, uh you know, basically there are groups that would be difficult to fight and we said –

Next Speaker: Yeah, I just don't think that's a valid rationale not to have tried to move this forward. I think what I heard was unions and community resistance. I do think we're only one of two states in the nation that don't have legislation like that. And I do think it would significantly improve our community health if we were to move it forward.

Next Speaker: You can mandate vaccine. Yeah, but um, that is a law that needs to change and we do need to get champions in the house of the senate to write the bill. So I think we could get support. It might be worth taking another try and who has the time, that would be great.

Next Speaker: The other side of the coin too that could, you know, be up for discussion is the punitive side of people calling in sick when they have the flu. I mean that's the other side of it. There have been several articles written recently as far as you know, we have ill people showing up to work when these flu people should be staying home. And you know, maybe that's where we should be focusing our efforts is educating employers that these people need to stay home. Yeah, we could vaccinate them. The vaccine though isn't 100 percent effective but when you've got a sick person you didn't need them there making everybody else sick too. There's been a lot of push in that regard as well and I've seen several articles and blogs discussing that too.

Next Speaker: States that have legislation like that have significantly higher immunization rates than we do.

Next Speaker: I know.

Next Speaker: Um, are hospitals taking any extra precautions since the flu mist is not available?

Next Speaker: I haven't seen –

Next Speaker: You're not offering flu mist?

Next Speaker: No.

Next Speaker: Right. So any extra precautions to, since you'll probably see additional – do you think you'll see additional decreases in rights? I know we've been talking about the **** in another –

Next Speaker: Well I know that you know, you can only receive flu mist up until the age of 50 anyway, and um, I didn't even, I mean, I don't know if we'll see a decrease in rates or not. That's a good question. I hope we come out with something.

Next Speaker: Yeah.

Next Speaker: For those who are needle phobic.

Next Speaker: Are needle phobic.

Next Speaker: Yeah.

Next Speaker: And then the age is expanded as well.

Next Speaker: Exactly.

Next Speaker: Yeah.

Next Speaker: Cause you don't just stop being needle phobic at age 50.

Next Speaker: Exactly.

Next Speaker: Well thank you guys, I appreciate the input.

Next Speaker: Yeah.

Next Speaker: Well thank you, Monica. And thank you, um –

Next Speaker: Jamie.

Next Speaker: – Jamie. I think your comments are um, important and I think we'll bring it back to APIC. I don't know if there's any other um, group that would support publically looking at vaccination law.

Next Speaker: Oregon ****

Next Speaker: I think it will –

Next Speaker: I think they ****

Next Speaker: It will take probably the hospital association, the medical association, um, you know, again, a large coalition of partners if it's really going to happen. Has to be more than just APIC. So, could you leverage in any way the whole modernization piece? By like using that as emergency preparedness is one of the main ones that's being focused on so I don't know if there would be a way to leverage that since it's got so much attention already. I don't know.

Next Speaker: Yeah, that's an interesting thought.

Next Speaker: Barbara, this is Jamie again. I would ask that the Oregon hospital and healthcare association quality committee consider this question at our next meeting.

Next Speaker: I will take it forward. Thank you.

Next Speaker: Thank you, Barbara.

Next Speaker: Yeah, this is Genevieve from Providence. I think this came up at a recent tri-county meeting around preparing for this flu season. And that was brought up as the piece of

interest. And there were many members on that ****, on the, what is it called, the care committee you just mentioned, so there's definitely some ****

Next Speaker: Do you belong to the IVSA Oregon?

Next Speaker: I do not personally.

Next Speaker: It will take a strong coalition.

Next Speaker: It will.

Next Speaker: Yeah, because I guess the legislative rep I spoke to said that immediately this school teachers, our mothers of school children will feel that this has impact and bearing on them so they will be **** reactivated to propose.

Next Speaker: Right. Thank you.

Next Speaker: All right then, uh, does anybody have any comments or further ideas for discussions and things for upcoming meetings? Barbara maybe can you get back to us after you have a discussion with your board?

Next Speaker: Yeah. They meet again I believe in November, so timing wise –

Next Speaker: Perfect. Our next meeting is December 14.

Next Speaker: You definitely should come and let us know what the feelers were.

Next Speaker: I mean it doesn't have to be something huge, just ****

Next Speaker: Something I'm thinking about, I mean there's the whole rise in C. Diff and whatnot and the other thing is I don't know if anyone saw this but the United Nations declared **** organisms the biggest problem in the world or something like that. Some kind of the biggest global challenge currently. And so I think this potentially having some kind of a meeting at some point that's themed or is specifically on MDROs, C. Diff, antimicrobial resistant stewardship, etcetera. And how we can all help to work on that might be helpful.

Next Speaker: I think maybe discussion of um, the grant projects and because other people, you know, like Health Insight has some work that's going on. And Care Oregon has some grant funding and so I think if we can maybe have a discussion of the different projects and possible alignment potentials.

Next Speaker: That's good.

Next Speaker: This is Jenny from Providence. I've heard Judy, Dr. Guzman's presentation coming in and one of the keys I wanted to mention was talking about, she mentioned how there's the triage screening that's going on and is that something you can talk about maybe some

standardization as a state so there's expectations with in case she goes to any **** that you know, certain questions will be asked about that. So, kind of on that same line as well as MDRO, the patient comes in a healthcare facility in Oregon, it's found out that they were just hospitalized in India for two weeks, six weeks ago, like, that there's something that goes into motion about should they be screening. And just maybe sharing some of the EPI that you guys have learned about where the cases are coming from and that might drive any sort of best practices for healthcare, Oregon healthcare facilities. That came up even in a pediatric patient we found that he has **** and recently admitted while in India. And just like a month prior to being admitted here, so it's definitely very real.

Next Speaker: Yeah, yeah. We've had that.

Next Speaker: Risk factor that we can do something about.

Next Speaker: Well, then, thank you everybody, the meeting is adjourned until our December meeting. So thank you.