Healthcare-Associated Infections Advisory Committee
March 15, 2017

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Speaker: Okay, are we ready to call the meeting to order?

Next Speaker: I think so. Can everyone on the phone hear us okay?

Next Speaker: Mm hmm.

Next Speaker: Yes.

Next Speaker: Great, okay, so if we could, um, maybe hear from the people on the phone as to who's calling in.

Next Speaker: Debra Tora.

Next Speaker: Oh.

Next Speaker: Rachel Plotinsky

Next Speaker: Hi Rachel.

Next Speaker: Hi.

Next Speaker: ****.

Next Speaker: Hi Jamie.

Next Speaker: Hi.

Next Speaker: This is Kristen **** director of the National Prevention ****.

Next Speaker: You got that?

Next Speaker: Hi, this is Rebecca **** with the Oregon Association of Hospitals and ****.

Next Speaker: Hello. Anybody else? Okay, let's just go around the room quickly and introduce ourselves, so they all know who we are.

Next Speaker: Uh, this is Lexie Jones from HAIFB **** here at ACDP.

Next Speaker: This is Rosalie Tamera, the HAI reporting ****, also with the HAI program in ACDP.

Next Speaker: Um, Lisa Cafucci, also A, AGIF **** at the Oregon ACDP program.

Next Speaker: Hi, and I'm Richard Leman. I'm chief medical officer for Health Security Preparedness and Response here at the Public Health Division.

Next Speaker: Hi, my, I'm Dak Tran. I'm the Public Health Division for the HAI program at ****.

Next Speaker: Uh, Mary Close, the director of infection prevention **** and **** with the OHA program.

Next Speaker: I'm JJ Furuno. I'm an **** professor at Oregon State ****.

Next Speaker: Paul Cieslak, medical director for communicable disease Oregon Health Authority.

Next Speaker: Monika Samper, uh, **** coordinator and clinical reviewer with the Oregon Health Authority.

Next Speaker: Tina Meyer, um, officer **** OAJ.

Next Speaker: Debbie Hurst, infection prevention consultant.

Next Speaker: Kelli Coelho, Oregon, I work at day surgery and I represent surgery centers.

Next Speaker: Melissa Parkerton, interim executive director with the Oregon Patient Safety Commission.

Next Speaker: Mary Shanks, infectious control at Kaiser Westside and acting chair.

Next Speaker: Hi, I'm Melissa Graham. I'm the medical **** coordinator with Health Security Preparedness and Response at OHA.

Next Speaker: **** health educator with **** program.

Next Speaker: Uh, Diane Roy, OHA, um, I'm a research analyst.

Next Speaker: Well, welcome everybody. What's that?

Next Speaker: Did someone else join the line? I heard a beep.

Next Speaker: Mm hmm, anonymous. Okay, so, uh, thank you everybody for, uh, calling in and, uh, coming in, so we'd like to continue on with, uh, approval of the minutes from the last two meetings. We

have September and December minutes to go through. They were in the packets that were mailed out, so has everybody had a chance to look at them?

Next Speaker: Yes.

Next Speaker: Are there any objections to any of the minutes, any changes? Can we have approval for the minutes for the past two meetings? Motion to approve or you need some time to review?

Next Speaker: ****.

Next Speaker: I motion to approve.

Next Speaker: ****.

Next Speaker: You'd like to approve?

Next Speaker: Yes.

Next Speaker: Okay, let's approve, okay, a second?

Next Speaker: Second.

Next Speaker: Approved, okay, the minutes are approved. Okay, Alexa, you're next.

Next Speaker: Okay.

Next Speaker: ****.

Next Speaker: Um, so I'm Alexia. I am one of the epidemiologists here at the HAI **** Acute and Communicable Disease Prevention program. I apologize if you guys are on the last **** webinar because, uh, these, these are the same slides. Uh, my slides were due at the same time, so they are out of date because I put them together last week. Um, so I'm gonna give you a brief overview of outbreaks that have been reported to the Safe ****, um, the ACDP Acute and Communicable Disease Prevention program since the beginning of this year. It's been pretty busy for us here at ACDP since the beginning of the year with a total of 190 outbreaks reported. Again, um, we've had more outbreaks reported since last Tuesday when I put these slides together. Um, 33 of these outbreaks occur, uh, were Norovirus, um, and 28 of those 33 occurred in long term care facilities. We also had a whole bunch of other GI type outbreaks, um, that were reported to ACDP. We had a couple of salmonellas, a couple of E Coli O157s, a couple of Rotaviruses, one of which was in a long-term care facility, and 27 unknown GI outbreaks that were reported. Seventeen of those 27 unknown GI outbreaks occurred in a long-term care facility. The majority of the outbreaks that were reported to us since the beginning of the year, um, to probably no one's surprise has been respiratory outbreaks and the majority of which were influenza, so 101 influenza outbreaks were reported to the state public health department since the beginning of this year, 97 of which were, um, occurred in a long-term care facility and 1 that occurred in a hospital. Um, I will touch base on influenza strains in the next slide, but, uh, we've been super busy with influenza-like illnesses. We have, they have a **** outbreaks reported to us that both occurred in schools. Um, there

has – in the new community wide mumps average, which I will also touch base on, and then we also had 16 unknown etiologies for respiratory outbreaks, 13 of which were in long term care facilities, so that, um, is a total of 190 outbreaks.

Next Speaker: Just for a little perspective.

Next Speaker: Whew.

Next Speaker: This is nuts. Um, our typical annual total had, in recent years has been 250 to 300 a year, so to have 190 by the Ides of March is sort of off the charts and, uh, it's common to have that many Norovirus outbreaks, so what is really different is the influenza outbreaks. They, they have just been, um, you know, historically high.

Next Speaker: And, um, the majority of the outbreaks did occur in, were what we consider healthcare associated, uh, meaning that they occurred in some sort of healthcare facility. Eighty-one percent of the 190 outbreaks occurred in a long-term care facility or a hospital. Usually this number is closer to 50 percent, 50 to 60 percent, so we're seeing a lot more in long term care facilities. Uh, the most etiology that we saw for influenza and respiratory outbreaks was Influenza A, um, and the strain type that was predominant, um, predominant this season was AH3. U, AH3 is one, the AH3 is known to disprop, disproportionally affect those that are older than 65, so, um, maybe that's why we see, we saw, or still seeing, um, lots more outbreaks in the long-term care facilities and that's why we might be seeing more influenza-like outbreaks or influenza outbreaks in long term care facilities. Um, let me –

Next Speaker: Could I, could I just mention, Lexie –

Next Speaker: Yes.

Next Speaker: – uh, some of this may also be, some of it, a small amount may be surveillance artifact because, uh, a number of counties had made it a point to reach out to long term care facilities and to encourage them to report in the first place and to report early, so, uh, that, that may mean that we're hearing about a few more than we might have heard about; otherwise, that we may be hearing about some of them a little bit earlier, that does not explain the, uh, the mammoth number of, uh, ILI, uh, influenza-like illness outbreaks.

Next Speaker: But I would say that things have started to go back to normal and as of like the very – we've seen more Norovirus type outbreaks, which, um, **** calm, I guess, I don't know. Um, so the table on this slide is breaking down the long-term care facility types. Uh, the outbreaks reported in long term care facilities by type of facility and also by etiology, and so you can see, um, actually the vast majority of outbreaks did occur in assisted living facilities, but we did see outbreaks in all different types of long term care facilities, ranging from, uh, memory care units, uh, to retirement communities **** facilities, but again, the majority of, uh, outbreaks, uh, were influenza, but we are seeing more Norovirus and more nor, uh, unknown GI outbreaks than we have. So I did want to touch base on two outbreaks of interest that, uh, uh, we at ACDP have been working on. Uh, first one is this mumps among wrestlers. Um, the U.S. in general has seen an uptick in mumps outbreaks, um, last year and this year. The last updated number that I had gotten was, and Paul correct me if I'm wrong, but there's over 6,000 U.S. cases since late last year.

Next Speaker: I think there were 5,000 total last year and there might be another 1,000 this year so far.

Next Speaker: Right, and, um, one of the outbreaks that I have been working on would just cross my fingers almost over, is the mumps outbreaks, um, among high school wrestlers, and so for the last case out there – there was 13 cases from 6 counties with an age range of 10 to 54 years of age and the majority of, of 'em are male, and we found out about this outbreak when there – we got a call from a provider, um, who had seen a family, um, that all presented with mumps like symptoms, and two of the cases were high school wrestlers. Well, um, as we, as I dug into this further I realized that one of these patients actually wrestled at a very large wrestling tournament here in Oregon while communicable, um, so they did lots of trace back for that, uh, that exposure. And then about a week later I found out that there is another wrestler that wrestled while communicable, but at a smaller tournament, so the most recent case that we've had, um, and that's associated with wrestling and with mumps, um, happened in February, so I'm crossing my fingers that we don't see any more cases. Uh, the OSAA, the Oregon State Athletic Association, uh, wrestling championships were March, or sorry, February 23rd through like the 25th, and so I'm going to wait until the incubation period is over, um, from that day and see if it's over.

Next Speaker: **** any data on vaccination rates on those afflicted?

Next Speaker: Yes, um, in this outbreak in particular all or at least the vast majority **** like 90 percent or more the cases were vaccinated, so.

Next Speaker: Um, I think the outbreak would be much worse. That it would have spread to many more people if we didn't have these vaccination rates. CDC reports that a single dose of mumps vaccine is about 78 percent effective and 2 doses are 88 percent effective. Uh, we know there's waning over time and most kids who are in high school would have gotten their second dose at 4 to 6 years of age, so they're, they're hittin', you know, 12, 13, 14 years since their most recent shot, and, you know, I think that explains –

Next Speaker: It could have waned a bit.

Next Speaker: –a certain amount of susceptibility. Right.

Next Speaker: Um, so if you guys do see, any more mumps case, report 'em. Um, the other outbreak that I wanted to mention was the E Coli O157 outbreak related to I Am Healthy brand soy nut products. Um, so as of last week there were 16 people from 9 states that were affected, um, and we had two cases here in Oregon. Uh, this is now revised. Can I share this information? I think I can. We now have four cases that match this pattern that are associated with this soy nut butter product.

Next Speaker: ****.

Next Speaker: Um, last week when CDC was interviewing cases they had interviewed nine cases and all nine have reported eating I Am Healthy brand soy nut butter in the week prior to on, onset, so, uh, the soy nut butter, soy not brother, soy nut butter company – it's really hard to say, uh, has put a voluntary recall in place **** stuff on your shelves, just don't eat it. So that's actually all I had, and if you guys have any questions, let me know.

Next Speaker: You've been busy.

Next Speaker: Yeah, yeah.

Next Speaker: Thank you very much, Lexie.

Next Speaker: Thank you.

Next Speaker: All right, we're up next to talk about, um, something that really, um, follows, uh, what Lexie was saying and during the peak influenza season we had a bed crisis in the city, and, um, it got to the point where most of the emergency rooms in the city were on divert, ICUs were full, beds were full. I had people calling us from Springfield regarding how to, um, manage their patients, um, so, and they had no beds left, so we really were down to the nubs in terms of that availability in the city during the height of this, um, - and it wasn't just influenza. There was a lot of, um, snow related problems with trips and falls and fractures, and other reasons that brought people into the hospital, and, um, Dr. Cieslak did send out a, um, recommendation for, um, how we handle patients and these, uh, high, um high rate of times and it gave some direction in terms of how to manage, uh, the transfer of patients that are still potentially infectious, going into, um, skilled facilities or other, uh, levels of care that may not be quite used to handling patients that are infections, uh, so, um, I thought I would love to discuss with this group a way of perhaps formalizing communication lines so that, you know, infection control is brought in and maybe, uh, we have, um, a way to detect when we're getting like up to 90 percent full, uh, capacity bed wise during, uh, outbreak season, so I'd like to open up that, that discussion, and Dr. Leman do you have something you'd like to add?

Next Speaker: Sure, uh, thank you, um, Mary, and I, I was also kind of interested since presumably we have folks, uh, either on the phone or present who may be in other parts of this state, this certainly was not, uh, uh, Frank County area did not corner the market on, um, on this issue either in the way of, uh, of freezing rain and ice or for that matter, influenza activity and I think there were several parts of this state that we were hearing from, uh, who were describing issues of having a very high census, having quite a few people who would otherwise have been ready to go home, uh, ready to be discharged, but they could not be discharged either because of the weather or, uh, um, or because there was no place. There was no placement, um, for them, and, um, there also was the issue that, uh, in a number of areas of the state, uh, weather was so bad that it was difficult for staff to come in and so there were more people who needed to be, uh, taken care of in the hospital, a census well above the usual 100 percent, and fewer people to handle care, and so I think Mary and I are interested in just hearing if any of you had experienced that, what your experience was during this and, uh, and what your thoughts were, so I'm just gonna shut up for a little while and see, uh, see what people's thoughts are.

Next Speaker: And Dr. Plotinsky how was it over in Providence?

Next Speaker: Um, it was pretty rough. I mean, well, I mean, personally, I was on the east side and trying to get to the west side, which was challenging. Um, I mean, you know, the hospital really stepped out. They had shuttles going from the train to the hospital, back and forth, getting people back and forth, and there were people who were driving, so, um, you know, we did the best we could, but it was definitely challenging in the hospital.

Next Speaker: How was your bed availability?

Next Speaker: ****.

Next Speaker: What was your bed availability like 'cause I, I do believe you were on divert?

Next Speaker: Yeah, we were on divert. I, you know, I don't know the details of that because I don't really deal much with that department.

Next Speaker: Right.

Next Speaker: Um, but I know, I mean all of the hospitals were, I mean we had a patient up here from Eugene. I mean it was just, it was **** patients were **** divert.

Next Speaker: I talked to my colleagues at our APIC meeting and, uh, privately afterwards, um, and all of the systems, um, Legacy, as well as Providence were, um, to full to capacity and really had difficulty moving patients, and a lot of the nursing homes, because of influenza outbreaks, were not receiving patients, so we couldn't move patients out. Um, and we have our usual standard in the hospitals about how long we keep patients in isolation and it's usually 7 days is the recommendation from CDC, 7 days post onset of symptoms, and they have to be afebrile at least 24 hours without, um, antipheretics, so generally at that point the, the facilities will receive them back, so with this kind of a, a backlog we needed to kind of move them fast, faster than that, and I do believe your letter helped us with that with how we can, um, get people to cohort, um, in the skilled facilities as much as possible. I mean there are difficulties. Pat Preston is not available to join us today. He would have been an excellent person to address the situation in long term care facilities, um, but my question is how do we identify when we're getting to the point where we need to convene or we need to enact special conversations?

Next Speaker: ****, uh, monitor on an ongoing basis or is that just something that we called in when there's like an emergency.

Next Speaker: Yeah, there, there is, uh, Class Cap is a, uh, system that we have here at the Public Health Division, which allows us to track bed availability and several other aspect of healthcare surge, and typically there are folks at each facility who try to update that daily, and it, and the updated, can be updated more often than that. Uh, we did put out a specific request to, uh, to get folks to, to do updates on a regular basis so that we could track that, uh, and that's potentially a, a useful, uh, resource not everybody, every, on a regular schedule update ****, so sometimes you have to sort of ping people to, uh, to get ****.

Next Speaker: Uh, you know, I think the first place that you feel it in a, in an acute care center is the emergency room because you start seeing the inflow of, of ILI or patients from facilities requiring admission. Um, is there a way that we monitor that, the, the emergency room?

Next Speaker: ****.

Next Speaker: The what?

Next Speaker: The clinics as well. Emergency department clinics is where you'll see that increase in volume ****.

Next Speaker: And, yeah, and at the state there is a system called Essence, which, uh, automatically uploads encounter data from all 60 emergency departments in the state, and then analyzes that to look for spikes that are above, uh, statistically above what would be expected, um, given, given baseline, and we do regularly track at least influenza-like illness. There's more of a delay before you can say whether or not it's influenza. I think it's interesting though that the – well, I'll, I'll go on in a sec, but I just wanted to see, is there somebody from the Asante system on the line down in, in, uh, Jackson and Josephine because as I remember it you folks had, uh, had a few issues with this as well and I just wanted to make sure you had a chance to chime in if you're, uh, if you're there and interested.

Next Speaker: Yeah, ****. You know, we had quite a few challenges, um, you know, we're, um, for, for many different reasons. Um, you know, we had employees out sick, uh, **** employees out sick **** availability. Um, we were actually **** from several facilities, um, in, uh, Sacramento and San Francisco reason, **** presentations. So it was really kind of an unusual scenario.

Next Speaker: Yeah. Well, I thought it was interesting as well, not in all cases was the, uh, the surge due to influenza. I mean, there were influenza cases goin' on, but we had situations, uh, where folks were, for instances, on psychiatric holds, and there was no place for those folks to go. So they had to be sittin' there in the emergency department or someplace else. Uh, and then that was, there were also folks who did not necessarily have influenza, but they were otherwise ready to go home, and because, uh, long-term care facilities were experiencing influenza-like outbreaks, they couldn't go out, and they were not ready to go home to, to their actual dwelling. They needed to have rehabilitation or they needed other services. So, uh, it was really a multifaceted, uh, perfect storm –

Next Speaker: Mm hmm.

Next Speaker: Yes.

Next Speaker: – that, that led to the situation. And I, I just wanted to, wanted to ask, uh, I know a number of you are familiar with the Oregon Crisis Care Guidance, um, which basically is a, a, an ethically grounded, uh, framework for providing the most effective care possible in the setting of a, a surge. It's more designed for, uh, for more severe, uh, levels of surge where, uh, the demand on healthcare is, uh, is very severe and is sustained and is pervasive. So there's no safety valve. There's no, no other place that, uh, uh, you can send people, either because of damage to roads from an earthquake or because everybody else is experiencing the same thing. I do see the parallels, though, in, in this situation. Uh, and I think it's notable that because people couldn't send folks to other places because of the weather down in Jackson County, and the Dells experienced this and **** experienced this and the tri-county area and the Salem area experienced this. Um, you couldn't send people to other places, and your staff was having a tough time coming in because of weather as well. And so, um, a number of healthcare facilities used, strategies that are outlined in the Oregon Crisis Care Guidance that don't require a declaration of emergency, they don't require any special waivers from, uh, Center for Medicare and Medicaid Service, but they were simple things that made sense in terms of dealing with the situation. And, uh, um, so I think that's wonderful that people were able to do that, and that just kinda

shows how, uh, how innovative people can be when they have to be. Uh, I do wonder whether it might have been a bit less stressful, uh, and a bit easier if people had already identified those strategies upfront, incorporated them into their emergency response plans and practiced them so that we weren't having to kind of make it up on the fly when we were presented with the situation.

Next Speaker: Well this is Jamie again. Uh, for a particular weather event, we, uh, implemented our, um, uh, incident command center and **** staff over, um, for a period of time 'til we were sure that we could have, have other staff come on in to the facility. Um, interestingly, I thought this was really happening, we did not have one elective surgical case that was canceled. 100 percent. **** I think. 100 percent of our elective surgical cases showed up.

Next Speaker: Wow.

Next Speaker: We had **** people from the coast who showed up, and that's a significant drive. I mean, **** but, you know, uh, our staff and patients really went to, uh, great lengths to make sure they had access to care ****.

Next Speaker: Now what you're saying resonates with me 'cause my wife works at an amb, uh, actually three ambulatory surgery centers and, and she said yeah, the patients show up without fail. It's the staff that ****. Yeah, the patients are waiting for their surgery for some time, and maybe it's the end of the year. It's in December and they've got to spend down their, you know, their deductible is already taken care of and they wanna get, you know, the surgery in before the end of the year, so they show up. It's the, it's the staff who had trouble.

Next Speaker: We had the same experience. All our patients showed up.

Next Speaker: This is Irene and, um, I was just gonna say that I think hospitals have become pretty adept. I mean, they are staffed so tightly, most of them, um, especially critical care, and they frequently are, are on ****. So I think it's, it's common for them to kinda do the drill of trying to identify who can be discharged, etcetera. They don't wanna cancel elective surgeries. That's a revenue generator for them. And, and I found myself, I was consulted several times during this by hospitals, and if I reflect on what they were looking for, they were asking me questions about ****. Can I possibly pair this patient with this patient? Kinda picking my brains, um, some options there. So maybe that's where we can do a little bit more development or maybe education. **** some of these were experienced IPs. Um, the other thing that, um, I was frequently asked again, um, relates to almost a concern that the long-term care facilities aren't taking some of these patients. And I think as Marion mentioned, kinda really good criteria about whether somebody's infectious, um, you know, the kind of treatment they would need would be helpful to have. I think there needs to be some understanding for acute care for really the regulatory requirements that they are under, where if they do have more than two cases identified, they're not to accept patients, you know, in admission. So –

Next Speaker: Is that a law?

Next Speaker: – um, you know, I will double check. That CVC, um, you know, definitely spells that out.

Next Speaker: So if a patient is medically stable but they're still a little **** –

Next Speaker: Yeah, they –

Next Speaker: – and they've completed maybe, or are most of the way through ****.

Next Speaker: So when you said, I, I was talking about when they're, quote, having an outbreak, they're not to accept patients –

Next Speaker: Oh okay.

Next Speaker: – in admissions. That's what I was talking about. The criteria for what an infection is. They can take infected patients, but what happens for them is again, if you think about the nature of the business, they're into restorative health, they're into helping people go to PT/OT, and they are not about keeping patients in the room. You know, most, they, they really are trying to get them out of their rooms, which is different from where we deliver care in acute care, which is pretty, most of it's either in a different department or at the bedside. Um, and, you know, so they're **** a lot of contact, isolation, but they can do it. Um, to keep patients in their room, they have to charge more for it. And again, there's been, um, you know, they've been held under the gun by regulatory agencies not to over isolate. So again, you're dealing with a different environment, different priorities. And I ****.

Next Speaker: You know, what I can tell you is that all of the patients were elderly and often from these facilities.

Next Speaker: And they couldn't take them back.

Next Speaker: In rehab.

Next Speaker: And I think the people here at the state can really attest to the severity of outbreaks –

Next Speaker: Yeah.

Next Speaker: – in long-term care, where there have been eight influenza deaths, um, sometimes as a result of an outbreak. So again, I think we, we need to appreciate the hesitancy and identify, just as we are, have a dialogue about how can we educate, how can we define more clearly some of the guidance and criteria ****.

Next Speaker: And, you know, I guess under normal circumstances, no problem. We keep 'em until they're –

Next Speaker: Yeah.

Next Speaker: – they meet the criteria. But in a situation where you have people stacking up in the emergency room –

Next Speaker: Right.

Next Speaker: – you need to move.

Next Speaker: Yeah, and I ****.

Next Speaker: ****.

Next Speaker: One of the other things from the hospital perspective too, I think it's, you know, we're together on this.

Next Speaker: Yes.

Next Speaker: We're trying to figure out how we can provide care across the continuum. Um, and you meet the sickest patients' needs. But, um, I think the other thing is, um, when you're trying to create beds, when you're trying to co-port, it may be helpful to have a little bit more guidance from the state or regulators about when can we do one of those procedural areas for maybe more of an observation care timeframe and –

Next Speaker: You're talking keeping the patients in acute care in a procedural area such as a, a recovery room?

Next Speaker: A GI lab, recovery room, etcetera.

Next Speaker: So that means you need the staff to do that.

Next Speaker: Was there someone on the phone that had a comment? I heard a very soft –

Next Speaker: Yeah, this is Deborah Troy Jackson. I heard a **** comment about the issue of, uh, treating rooms in long-term care that they have to charge from them ****.

Next Speaker: Um, that's what I've been told Deborah that, um, to actually charge for additional isolation means they have to have, I think the term is called the **** or something. So –

Next Speaker: No, no. ****. No. No, they, they, **** recommendation **** isolate or even a ****, um, they're not supposed to be charging for them, charging them. And the **** a copy of that, but that, that really should not be **** whenever we're talking about transferring ****, um, admissions or any, uh, **** norovirus or whatever the situation might be.

Next Speaker: Okay. Deborah, did you have any other, uh, thoughts about, uh, this from the, the long-term care facility side of things?

Next Speaker: Um, no. I mean, I, I think that that's it. I know **** everybody else that I got the impression **** facilities were trying pretty hard to ****. **** I don't think that's not really true. Um, but I think that, uh, the information **** gets out to them on help. Um, it may be that that's something that we **** before, um, flu season, um, and as a way just to remind people.

Next Speaker: Yeah, and thank you very much for working with us on that. It was, it was great to, uh, to have your perspective and, and get the language right.

Next Speaker: Well, I appreciate working with you on it.

Next Speaker: I think it was a good, a great example of pulling teams together and coming up with some interim guidance that was greatly appreciated.

Next Speaker: Yeah.

Next Speaker: But the communication that went out, um, **** that you sent out, um –

Next Speaker: That Richard drafted.

Next Speaker: That's right.

Next Speaker: – it didn't come to us. I got it from our care manager because, you know, she needs some assistance with some of the discharges and, and the admissions. But I think this is a great little guideline to use and, um, if we could get this, you know, distributed more widely, um –

Next Speaker: Yeah, and, and you know, we, we have some limitations. We have the, the, uh, uh, the HAN, or Health Alert Network, and unfortunately, we're not very good at having, having clinicians. I thought we were pretty good about getting it to, uh, preventionists, and I'm, I'm sorry and kind of appalled –

Next Speaker: Sorry.

Next Speaker: – if we didn't get to it ****.

Next Speaker: Well, and we, and I have to say we identified kind of a system glitch –

Next Speaker: Mm hmm.

Next Speaker: – with like our **** doctor, where there used to be a welcome letter that had instructions on how you sign up for HAN, and Rosa, at one of our meetings, um, we talked about this, and she followed up instructions for, um, IPs –

Next Speaker: Yeah.

Next Speaker: – and how to do that.

Next Speaker: For HAN and for Essence as well. So all of our members of our local chapter of APIC got that, should have gotten that email with those instructions. But if there's anyone here in the room or on the call that would like those instructions as well, and I'll just say Flu Bites is another helpful resource, so if anyone wants any of that, feel free to let me know now or send me an email or give me a call and we'll make sure to get that information out.

Next Speaker: Yeah, and, and Mary, getting back to your issue around communication, if we can make it so that we can effectively reach out to preventionists like **** everywhere through the Health Alert Network, that might be a very good way to make sure that we can tie things in and, and also, we wanna hear from you. If, you know, we can be looking at Essence, and we can be looking at Class Cap and that tells us a certain something, but what we really need to hear is what –

Next Speaker: Hospitals.

Next Speaker: – hospitals and health systems are experiencing. And, and, uh, uh, yeah, Dr. Grebosky, that goes for you to. We gotta, we've gotta hear from hear from you folks so that we know what's going on.

Next Speaker: ****. Yeah, that make sense. You know, and another partner that we really do need to have dialogue with are our long-term care, um, facilities, the ones that we interact with, um, the, the give and take, to and from, um, to make sure that when things are rough, that they can, um, cohort under these kinds of circumstances, unusual but, um, can they do it? Will they do it, whether it's norovirus or influenza.

Next Speaker: I think it's –

Next Speaker: I think too, you know, when you think surge, it's nice if you can identify some plans for facility settings to take more patients. So do we in the city have like some long-term care facilities that maybe aren't using some space, that in a situation like this could easily be converted and supported and taking some of these patients? And the other thing too, so if you've got a separate unit for concerns about transmission in those settings, you've got, you know, more barriers and more protection to that. They have the staff, like all ****.

Next Speaker: And that's always an issue is the staffing.

Next Speaker: Yeah.

Next Speaker: ****.

Next Speaker: And Deborah, this is another place we could certainly benefit from guidance from you, not on this call necessarily, but at some point, because, uh, you know, if it's a skilled nursing facility, they probably can do droplet precautions. But I think if you're talking an assisted living facility or a retirement home, and we just lightly say oh yeah, you need to do droplet precautions, then I, yeah, I, I mean, that's what we say. I do, I think we don't always think about how easy or difficult that's going to be for an assisted living, uh, center to do.

Next Speaker: Or memory care.

Next Speaker: Yeah, and **** 'cause I think that there's some way to maybe not fully implement droplet precautions, but **** to improve it. Um, and we've actually even had those conversations in years past where there's been issues in foster homes, which is even more of a challenge.

Next Speaker: Yeah.

Next Speaker: Where we come up with the, um, you know, alternative to, to try to minimize, um, you know, the, uh, the threat.

Next Speaker: Something we were talk –

Next Speaker: ****.

Next Speaker: – something we've been talking about is during our September meetings possibly kind of focusing in on flu, and we could also have sort of a focus on long-term care. But it's nice, it's September, it's right before flu season starts, it's very timely, so perhaps there's an opportunity to discuss some of this more in depth at that time.

Next Speaker: Yeah, and I like the idea of raising awareness about, uh, HAN for the infection prevention team, APIC, uh, and when to notify Public Health if, if we're seeing that capacity being, um, tight due to influenza or other things.

Next Speaker: The one thing about HAN and our APIC chapter, as well as not all IPs belong to APIC, and I know that's part of the grant work that's been going on is to have an inventory with the IPs, and I think because of the reporting, Rosa, with the reporting requirements here in Oregon, do you have a list of all, at least the acute care IPs? Probably it's a moving thing that's changing, evolving all the time.

Next Speaker: Um, I know that we have a number of different sources of contact information for our facilities. I don't know if there is, I, I don't, I don't know.

Next Speaker: Maybe, maybe we can go offline. Maybe what we can do is look at what we have and maybe the solution is just to simply have a column that we add that says HAN, yes, no, and maybe those that aren't hooked up to HAN we reach out to and try and get them to sign up.

Next Speaker: And how do we get the long-term care, um, people engaged?

Next Speaker: Um, I think Deb's on the line, especially taken this long-term care answers.

Next Speaker: Maybe this is something that we can possibly, uh, have, have a discussion offline about some strategies. I know that a number of different people are working with, on, you know, how to contact our long-term care facilities, so this is something that we have to talk about –

Next Speaker: **** supplies even more efficiently, don't you think, because of the, um –

Next Speaker: They can, they can help with communication.

Next Speaker: Right.

Next Speaker: Again, those are traits so not everybody's ****.

Next Speaker: No, I mean –

Next Speaker: There's licensing, so licensing is gonna get nursing homes and sniffs, and Debbie, you have a list of, like, how some memory care, right?

Next Speaker: Yeah. Yes, we do have a list of all of our facilities.

Next Speaker: So at least there's a licensure list.

Next Speaker: At least what we have is **** accurate as far as contacting them and, um, actually their fact find, uh, because they, they have to use those for med orders and that kind of stuff, and so they're less likely to be a lot of changes in the ****.

Next Speaker: Um, one, one thing that is different though is again, they're not required at this point to have a designated infection preventionist. There's a requirement for us to have a program.

Next Speaker: Yeah, but they have a director of nursing.

Next Speaker: But a lot of times it's the DNS, yeah. Okay, great.

Next Speaker: Thank you for the conversation. I think it's an interesting topic.

Next Speaker: Well, Mary, thank you for, uh, thank you for coming up with that topic. That's –

Next Speaker: Well, you know, thanks for drafting this ****.

Next Speaker: Yeah.

Next Speaker: It was helpful. Okay, shall we take a little break here until, uh, 1:50? It is, no, let's break until, uh, 5 to 1.

Next Speaker: ****.

Next Speaker: Um, everyone has a printout in their packet or their emailed materials. That's the little two-pager that's from NHSN. Um, so those of us who have been working with NHSN for some time will already know that this is a complex application, and every time they release a new version there are bumps in the road, so some of you, like, had experienced these sort of glitches, um, so we have a couple of minutes and anyone has information to share about their experiences with any of these issues, that might be helpful for the group to hear, um, so there was an email that went out from NHSN to NHSN users on 2/24, um, and that included this sheet as an attachment, but we just wanted to provide it again to everyone, um, essentially just saying that they have pretty much resolved all of the issues that thing, that they knew were going on. Um, the email did say, you know, just please check incomplete events alert in NHSN, regenerate data sets prior to running, you know, your analysis reports, etc. Um, also as a disclaimer, you know, this is not an exhaustive list of all the things that went awry during that time, and there may be some new things that are going, uh, I don't want to say wrong, differently. Um, I don't

want to get too focused on all of these specifics here but just wanted to provide this as a resource for you in case anyone had been encountering these issues and then as a reminder to please consider generating, regenerating your data and trying again if you've been running into these problems. Um, many of these may require to, you to regenerate your data in NHSN for the patches or fixes to be, um, incorporated –

Next Speaker: Mm hmm.

Next Speaker: – into your, into your account, so anyone has any thoughts about this, anything to share, anything that is still ongoing that has not been resolved? Great.

Next Speaker: I haven't had any.

Next Speaker: Okay. Well, I think it's always, you know, something I've been trying to get them to do for years now is to post their known bugs somewhere on the application so we can actually, you know, see there's something that went wrong. Is it a known issue? What's the resolution? What's the work around? And, um, I don't know if that's ever gonna happen, but we can definitely talk about those things during these meetings where you can mention them to me, and we can always communicate amongst ourselves to try to do some information sharing, uh, so, you know. Okay. So now I'm just going to jump into this, uh, presentation on the annual HAI report for 2016 data, um, and to clarify, this report is going to include our data from the calendar year of 2016 but of course will be published in 2017, and I just want to thank Lisa, who helped me put together some of these slides. Um, and I think everyone got an email, um, maybe a few weeks back kind of with a link to the report, and those of us in the room have the paper report available to us, um, so to give a little bit of context here, we made some changes to the way we had presented our 2014 data when we rolled out our 2015 data, um, and I want to mention some of those changes, so while the 2014 data were presented in two separate reports, one for consumers and one for technical audiences, we were advised to go back to the method we had previously used to present it all together in one report, so our 2015 data did look that way, um, and we have a PDF report available on our web site, um, and that shows data for all of our facilities aggregated together or pooled together, and we also provided facility-specific data in the form of tables and maps online. Another change was that the data for device-associated infectious, CLABSI and CAUTI, were, uh, stratified and presented by hospital location type, and then we provided benchmarks for both the aggregate data and the location type. And then a change was also made to the, the display of the aggregate data so the PDF report, um, the graphic used in the executive summary felt sort of busy to some people, and the table was a little bit confusing, so that graphic was split into two pages, and we went ahead and just removed the **** wall, and I say we euphemistically, not me but others who worked very hard, so thank you. So with that, um, post historical contactors a number of major changes, many of which relate to the re-baselining efforts going on at NHSN, um, that we need to consider as we begin to make some decisions for what our 2016 report is gonna look like, and those major changes are sort of separate from the routine content edits that we would always make every year, like, you know, if the numbers change, whatever. So there's three major data elements, um, to think about, and those are the new SIRs are now available. We have new national HHS HAI reduction targets, and then we have new national SIRs, and there are two other issues I'll discuss later that aren't about data specifically, which are prevention activities and patient advocate review. So the first and really most extensive of these changes is, uh, the new SIRs, so SIRs are now available using the 2015 baseline. Um, new SIRs can be calculated for 2015 data forward. Old can be calculated for 2016 data and backward. CDC's national progress report, um, which will be presenting 2015 data, um, and will hopefully be published in 2017, fingers crossed, will

present the baseline SIRs, so this report is gonna look quite different from how it's looked in the past because we, they are not gonna be able to show any trend data. Um, there is a new SIR output option for dialysis event. We're gonna be looking at our surgical site infection SIRs being stratified into adult and pediatric outputs, and then we're gonna be seeing CLABSI, CAUTI, MRSA, and CDI SIRs stratified by facility category. Um, so these are all some new things happening within the application. For, we can, we also have access to these old models and the old outputs, but this is what the new baseline, re-baseline SIRs are going to be looking like for us. And I just want to dive a little bit deeper here, um, and I should say current SIRs in this table is the new SIRs, um, based on the new baseline, and while currently, sort of currently, so using the old baseline, there's one SIR per each surgical procedure. The re-baseline SIRs again are stratified into adult and pediatric events, um, which cannot be aggregated together, so if I, let's see, yes, okay, and then secondly, CLABSI and CAUTI data and then also CDI, um, and MRSA lab I.D. data are stratified by facility category. I just kind of wanted to present this way. It really illustrates what we might potentially be looking at depending on how we want to display our data, so you'll see CDI and MRSA very similar to CAUTI and CLABSI. And the last point I want to highlight is that, um, you know, going, if we were to sort of want to present at, you know, at some point we will want to present these new SIRs, so we may want to show, um, what, when we're looking at CDI, MRSA, CLABSI and CAUTI, now that they're kind of broken down by facility category, we do have one LTAC that reports to SBIA and HSN, so this kind of raises the question that if we're going to be presenting our SIRs in our aggregate data report, and if we cannot aggregate these SIRs together, we're gonna be looking at presenting our one LTAC all on its lonesome, which we probably don't really wanna do, but just an interesting point. So, closely related to these newly re-baselined SIRs that are now available to us, we also have new HHS HAI reduction targets, and that's coming down from the federal level, um, and the important thing to remember here is that these new reduction targets are SIRs and that they are based on the new 2015 baseline. And then the last data element, um, that will impact how we report out on our 2016 data is that CDC, who does produce that national progress report every year, um, is going to show 2015 data. Hopefully will be published sometime this calendar year, and they do plan again to present that 2015 data using the new 2015 baseline. Um, in past years we have shown that national SIR in our report, um, because it helps to sort of situate our data at the state level, uh, but we really don't know kind of what this will look like if we were to incorporate it in our report if we wanted to incorporate it in our report, um, and our understanding is that because 2015 national SIRs are the 2015 baseline they would be about one, or very close to one, as far as we can tell, so that may not be necessarily a super-informative element for us to include in our report, um, but something to think about, and another important take-home message here is that any SIRs calculated under the new baseline, including national SIRs, right, cannot be compared to any SIRs calculated under the old baseline because the denominators are different. So now that we've covered these three sort of major data issues that may impact the way we want to report out on our 2016 data, I wanna get into how we will be working with them, and I'll discuss some ideas on how we might approach these in this slide, in this slide set. Um, but this was a quote from Rick Steves, so those of you who have an APIC meeting heard my little joke, but I'm a very bad packer. I always wanna bring everything that I can, so a quote that I read from Rick Steves was, "You can't travel heavy, happy, and cheap. Pick two." So, um, while we have our goals here, clarity, brevity, and utility, we may sometimes have to kind of weigh them out against each other and see, you know, what's really going to be the best kind of combo for our purposes. Um, so just this delicate balance between these goals of being clear, being brief, and really allowing our patients and our health care facilities to use our data for action. I'd just like to all have these things in mind as we think about these options, because there are so many permutations of how we can address these changes in our report. Um, this will not be an exhaustive list of all of them, but we're gonna be

presenting two, probably, hopefully good options that can also be kind of, um, you know, tailored based on the group's feedback.

Next Speaker: ****.

Next Speaker: Okay, so before we jump into the proposals, birds-eye view, one, all three of these elements are related to each other, so how we decide to show our SIRs will determine how we should show our HHS targets and vice versa. Secondly, many places we can consider incorporating these elements, both in the aggregate data, the facility-specific data, or in the narrative component of our report, and then one last note is we don't have to adopt all the pieces of each of these proposals. We can mix and match, so anyway. Okay, so the first proposal I'll present, and I feel like this could be a good happy medium, is to roll out these changes over 2 years, and what this would mean is that aggregate, uh, 2016 data report would include the original SIR and HHS targets in the graphs and that we may reference the new SIRs and HHS targets in the narrative portion of the report, so we can sort of introduce that concept in the front matter and the introduction and then kind of weave in a little bit of it just in the narrative kind of paragraphs in each measure-specific section, and then something we could also potentially do is present the actual new data, um, in the measure-specific sections again in the narrative but not include it in the visual element of the report, and then our facility-specific data, the tables could include both of the new and the old SIRs and HHS targets, and then in 2017, uh, for 2017 data, I should say, which will be published in 2018, that would be a fresh start, so we would include data from 2015, '16, and '17 bearing in mind, all using the new SIRs and new HHS target, bearing in mind we can't compare any of those numbers with the old numbers, but we could also mention the original SIRs and HHS targets, again in the narrative section, so that we feel like that might kind of tie the two together. So what might this look like? Um, I won't read through all the content on this slide, but you guys can kind of get a summary of what it might look like, so circling back to our goals of clarity, brevity, and utility, how does this stack up? And some thoughts about this approach might be that it would allow us to sort of ease into this new information. Um, it wouldn't display the new data visually, so it would kind of keep things, um, you know, simple, which is good, but we would include, you know, that information in the text, and we could in, also include it in the facility-specific data tables, um, so a slow introduction could be a positive thing for clarity, and it would allow us to keep our PDF report about the same length, and we believe that is the strength of our report. Right? No, no one wants to sit, well some of us may, but many of us may not want to sit and read, you know, a hundred-page report. It may be a little bit out of our reach, right? So having this report kind of staying around maybe 40 pages or so is probably a, a good thing. Um, and then the tables online would expand very substantially, so maybe brief discussion on this? Anyone have thoughts about this proposal?

Next Speaker: Well, for the public, um, who would be using this, I think we need to be very clear what, what is old and what is new and what the SIR is, 'cause most of them are not gonna have a clue what re-baseline means. It just, you know, they need to understand that as we're improving, the target's getting, you know, the bar's being higher, raised higher so that we are expecting the SIRs to be potentially higher, if you compare the old versus the new. Just so they understand that.

Next Speaker: Right.

Next Speaker: Theoretically, the public's not gonna be doing year-to-year comparisons, right? I mean, I need my surgery. I'm gonna –

Next Speaker: Yeah.

Next Speaker: – go in and look at the hospitals for, like, how they –

Next Speaker: But if we're putting, if we're putting this SIR and that SIR next to each other, they see one's lower than the other –

Next Speaker: Yeah.

Next Speaker: – at least they understand what the one in parentheses means. Maybe that's the new one.

Next Speaker: So we would never display them next to each other.

Next Speaker: Okay.

Next Speaker: Because they cannot be, uh, compared to each other because the, again, denominators are different from each other, so what we would wanna do is include, like you're saying, which is a great point, you know, in our introduction, what does the re-baseline mean. We don't even have to use a term re-baseline. We can say, you know, we're starting fresh in 2015 measuring nationally, you know, to account for the great progress that we've made, you know, in all of our facilities nationwide, and we're going to be, and then kind of work it in that way.

Next Speaker: Make it ****.

Next Speaker: And I feel like, you know, covering it in the narrative component, again, kind of discourages the comparisons of what's seen in the graph with what's written in the text, hopefully. The tables might be a little bit trickier, but we would make sure, kind of put, put all the variables in, um, the same order for the old and the new so the SIRs would never end up, like, right next to each other.

Next Speaker: Okay.

Next Speaker: Any other thoughts about this proposal? Definitely it's a challenge to be presenting old and new in the same reports, so it may not be a great idea too.

Next Speaker: So we're publishing the 2016 data using the old benchmark.

Next Speaker: Well, that's the proposal, right?

Next Speaker: Mm hmm.

Next Speaker: So, you know –

Next Speaker: It's a proposal.

Next Speaker: Yes. The proposal would be to incorporate individual elements, in the graphs that we have, only the old, which allows us to compare, you know.

Next Speaker: Mm hmm.

Next Speaker: Then we would still be able to see our trends.

Next Speaker: Right.

Next Speaker: But then in the narrative –

Next Speaker: Explain.

Next Speaker: – possibly we could include new data, and then in the tables that are facility-specific we could possibly include.

Next Speaker: I think that makes a lot of sense to do that, and especially to wait until next year to incorporate the new SIR baselines, because then you'll have 3 years of data to look at.

Next Speaker: Right.

Next Speaker: You know?

Next Speaker: Right, I agree.

Next Speaker: If you try to incorporate the new SIR this year, you'll only have the 2 years of data and what good does that do?

Next Speaker: Nothing. Yeah, I agree.

Next Speaker: So.

Next Speaker: Yeah.

Next Speaker: How do people feel about including all of these new, um, columns in our facility-specific data? So currently we have our tables for facility-specific data, and we have columns for SIR, the confidence interval, the interpretation of the SIR. There's an icon for the SIR. We have the old HHS targets, an icon for the benchmark, and a percentile on the 2014 national distribution, so we would basically be having all of those and then adding a whole, doubling it with all of the new. Does that feel like a good idea or?

Next Speaker: I don't think so. That's too much.

Next Speaker: It's too much. I feel like I'm asking leading questions, um, but I'm not trying to. Does it feel like, does anyone want to reflect on this?

Next Speaker: I like these. From, from myself, when I look at it, I do like seeing the SIR. I like seeing the confidence intervals, because then the significance, um, I think **** had a check mark or something if it was significantly different, higher or lower. I think that was clear and easy to understand. Um, so I like that part. If we deleted the confidence intervals and put, you know, a check mark if it's significant, maybe that could take the place of that information.

Next Speaker: I think we're plan, I think we want to continue keeping what we have in place but, but maybe, you know, maybe there's an opportunity to kind of come back to that if we, you know, if in the next year, I mean, we could, we could definitely restructure it, but –

Next Speaker: So keeping with **** and doubling it, is, is that –

Next Speaker: That would be what this would look like. Now, we could also include a whole new set of tables that are just including the new data, but that feels maybe confusing if people kind of just end up there. It doesn't match what's in the report.

Next Speaker: Maybe the new data could be put, like, as an appendix for people who are interested and not necessarily, you know, in with the report itself.

Next Speaker: But when, when, you know, health care consumers want to see most recent data on, you know, I, I would think that in the facility-specific report where we imagine that some people might be going to see, you know, the quality of care at a given facility that we would want the most recent data, and I don't think they're gonna bother, I don't think they're gonna say, "Well, golly, this number's higher than it was last year." I think they're gonna be comparing this year's number at this hospital to this year's number at a previous hospital, and we can, you know, in, in the aggregate report, who I envision is more for, you know, policymakers, the legislators who committed this committee, um, you know, to look at how we're doing in Oregon and where do we need work, and it could be more of a broad overview that might include things like trends where you would need to explain this difference, but for the consumer I think it would just be, you know, I, I like putting all the confidence limits and everything else in there, and we could make really prominent the, the data that we think is the most, you know, uh, prominent or most important and sort of highlight that in the data table and then in the small print have all the confidence limits and all the caveats and everything, but that's ****.

Next Speaker: Okay.

Next Speaker: I, I will say, I found it really great to hear when this was, discussion was presented at the APIC chapter meeting, how many facilities are actually looking at the report, using it, sharing it with their administrators, etcetera. So that was reassuring to me to hear that again, people are using it so, um.

Next Speaker: So, another option might be, so I think if we're gonna be presenting the old SIRs in our, in our aggregate report that we would want to have our facility specific data available in using the old SIRs. We could also have them available using the new SIRs to provide the most recent data for consumers in a whole set of separate tables that live in a separate place on the web site so, you know, you can find all the tables for facility specific data using the old baseline, and the new baseline, but they wouldn't be in the same place. Right? So, does that make sense?

Next Speaker: I was just, I was just kinda thinking **** right? **** you post it online, you know, you're going through the same work effort.

Next Speaker: A little double, right?

Next Speaker: The table.

Next Speaker: Right. But you save when it comes to printing and distribution, you save money if you're, if you're more focused. So maybe, you know, maybe the middle ground might be go, go full blown online.

Next Speaker: So this –

Next Speaker: **** printed ****.

Next Speaker: **** it adds a whole, it, like, doubles the, the facility specific data. The aggregate data would still be the same. So it's essentially doubling the work for what we only post online but the work for the aggregate is the same. But that's not really a major concern here. It's just, like, isn't clear if there's, you know, here's the tables using the old baseline. Here's the tables using the new baseline instead of having the tables using the old and the new **** table encouraging that comparison.

Next Speaker: Right.

Next Speaker: Which is not appropriate statistically.

Next Speaker: So how are you promoting this to consumers?

Next Speaker: I mean, is it being promoted to consumers?

Next Speaker: I would like to talk more about that and we do have, like, a little slide on that too. So thank you for bringing that point.

Next Speaker: I'm just, I'm just thinking what consumers are actually gonna find this data in the first place, to some extent too, unless we're specifically promoting it to them.

Next Speaker: That's a great question.

Next Speaker: Thank you.

Next Speaker: I, I don't know how many are looking it up. We can look at our **** and try to see who –

Next Speaker: I've been trying, Paul.

Next Speaker: Oh really?

Next Speaker: Yes, Alyssa and I have been working on that.

Next Speaker: I, I, I doubt that there's, you know, hoards of patients –

Next Speaker: I think it's facilities and healthcare workers lookin' at it right now.

Next Speaker: I think so too.

Next Speaker: **** consumers.

Next Speaker: Okay.

Next Speaker: But I think, you know, I'm interested in for the aggregate report. I think we wanna be interested in something that's short and sweet that we can, you know, give to legislatures and whatever and say here's what we found.

Next Speaker: Right.

Next Speaker: Okay. So the alternative proposal would be that we don't roll out any of the new data at this time, um, you know, that would look like leaving both the aggregate report and the facility specific data that's just on the web the same and that we would just sort of generally reference this, there's a baseline in the introduction of the report we would still have to grapple with all of this when we get around to presenting 2017 data but, you know, that's true of everything no matter what. Um, so again, circling back to the goals, um, this would be very familiar to our readers. **** the strength and **** would stay the same length. No additional tables because again, we're not presenting any of the most recent data but, you know, this is the question that I have, which kinda circles back around nicely to what we talked about is, this has been, this was not be the most recent current data. So we're not making that available to our consumers and providers. So, kinda with this counterpoint –

Next Speaker: I guess I'm confused.

Next Speaker: Yes.

Next Speaker: You're, you're presenting the most recent data you're just not using the most recent baseline.

Next Speaker: Correct.

Next Speaker: Okay.

Next Speaker: Thank you.

Next Speaker: I, myself like to see both but what I'm more interested in is how we'd look with the new baseline. Because that's gonna be worse. That's where it really, that's why I think everybody's a little nervous because obviously its going to ****. But I think if you're, if you are going to look at where you need to focus your attention that would be a good selling point.

Next Speaker: Yeah, I just, I, I grew so weary at looking at the **** baseline 'cause everybody dropped, you know, since the first baseline. It's kinda like, Lake Woebegone, right? We're all above average ****.

Next Speaker: There's a comfort in that.

Next Speaker: Okay, well I think this is really helpful, you know, I think that what I'm hearing is we wanna discourage people from looking at them side by side but we do wanna be able to, we wanna things short and sweet but we also want people to have access to the data that they need which may involve data under the new baselines. And we, at the program level, wanna always be supporting our facilities in terms of, you know, actually reporting the data out because we know that's useful. So, I think we have some stuff to chew on here. Um, any last thoughts about the data specifically before we, anything in the report **** had thoughts about? Maybe wanting to change. I think that, you know, kinda going back to this idea of maybe eliminating columns, Mary, that you had mentioned. I think, because we do have to roll out new stuff this year we're tryin' to sort of minimize –

Next Speaker: Well when you said doubling it I thought you were putting it side by side.

Next Speaker: Well and that was my proposal but I feel like that's maybe not the best way to do is. So to have a whole separate set of tables.

Next Speaker: Right.

Next Speaker: Do people think that's better?

Next Speaker: Yes.

Next Speaker: Does anyone think that would be not good?

Next Speaker: Okay.

Next Speaker: **** 'cause it's, you know, I mean, **** it's really tedious detail-oriented work to do ****. So, um, you know, I'm all, I, I kinda like the web based options **** but again, I think you still put in the same amount of work to get there.

Next Speaker: It's a lot of work.

Next Speaker: It's a lot of work.

Next Speaker: So you as a facility **** this new baseline, how long have you been hearing that the baseline is coming?

Next Speaker: For probably about a year and a half or so. And all of our facilities, I should mention, have the capacity to obtain all of these data on their own.

Next Speaker: Oh yeah.

Next Speaker: But, but, not every facility has the time and capacity to do that and so –

Next Speaker: Well, your –

Next Speaker: What you really wanna know is how you're doing in relation to others. Even though you have a national it's, it's nice to see locally how you're doing.

Next Speaker: Well, and the numbers for the facilities because they're SIRs they incorporate the national picture too. So when you're looking at our tables on our web site you can see how they all kinda stack up against each other. So you can see what, what a facility's SIR looks like in comparison to another facility's SIR. But you can also see what that facility's performance is in comparison to the national perspective because it's actually built into the analysis.

Next Speaker: Is there, so do we think that the ****?

Next Speaker: It will definitely not be published.

Next Speaker: I don't think so, no.

Next Speaker: So we don't have the 2015 percentiles?

Next Speaker: I, you know, maybe. Maybe, I don't know. Maybe it will. Maybe I'm being, um, pessimistic.

Next Speaker: Do you know how **** is going to present their annual report?

Next Speaker: Yeah, so they're gonna be presenting the 2015 data using the 2015 baseline. So all of the SARs may very well be one, I don't know. And, is that useful information? Not alone for us to include in our table, our charts.

Next Speaker: Yeah.

Next Speaker: Okay. So I'm gonna just move onto the other pieces of this, but this is super helpful. Thank you for your feedback and, ah, if anyone has other thoughts about this, I know it's a lot to kinda chew **** so if anyone has other thoughts about this please feel free to let us know. So the other piece, so there were two, um, sort of non-data elements we wanted to talk about, potential changes in our report. Um, first, we do have information regarding our prevention activities on our web site but we wanted to know if we should include some of that in our report. Um, and this could look a number of different ways. You know, we could include a link. We could build out our web site to include more information. We could include actual content on that in our report. Um, other options. Some of the feedback that we've gotten is that the best way is just to simply include a link to this part of our web site in our report. And just say, you know, our prevention activities are covered on our web site. So, thoughts on that.

Next Speaker: Always use your web site to ****.

Next Speaker: Someone else should answer that question.

Next Speaker: I think it's pretty easy.

Next Speaker: So this would be, like, a hyperlink anyways, so. And I think we have some friendly links.

Next Speaker: Well, I mean, okay. **** try and find something. It can be extremely difficult to find what you're looking for. So to just have one link saying to cc.gov to find information on ****. You know, you know what I'm saying?

Next Speaker: Yeah.

Next Speaker: So its, would they be able to get to a section of the report and **** activities and easily find it from one link on our web site.

Next Speaker: So I'm hearing a link to that specific part of our web page. Not in general.

Next Speaker: Possibly because if they, if they get there. We just, in my pervious job we did some, um, basically focus testing and people got through but clicks in, um, and if they couldn't find it in three clicks they **** so you know what I mean? Just thinking about that. If they can't get to it quickly they're probably just gonna probably not bother.

Next Speaker: So we can bring them straight here.

Next Speaker: Yeah.

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

Next Speaker: I know, yeah, I mean.

Next Speaker: Yeah.

Next Speaker: So, Rosa, some of this kinda goes into, I think future work for this group. Um, it's my understanding that this group is set to sunset in 2018 by state statute?

Next Speaker: February 1st 2018.

Next Speaker: Okay.

Next Speaker: So, I don't know –

Next Speaker: Really this is the last year.

Next Speaker: Well, it doesn't have to be but again what, you know, to me we need to be talking about the future and I think there's been a vision of, you know, be it the HIA grants, the EOC grants to, um, you know, really have this, like, I guess the best term I could say **** for the state. You know, so, so not only it was formed really to make decisions about public reporting but now maybe the capacity of this group can be to look at the data that's coming in to –

Next Speaker: You know, Mary, I think that's –

Next Speaker: – area of improvements and –

Next Speaker: You know, I think that we need to make some of this stuff actionable. Because what I do, and I look at it and I look at the top performers in my problem area, it's like these three or four hospitals are doing ace work so we put on a webinar pulling the brains and the practices from those hospitals through our **** Hospital Association. We did a series of SSI **** webinars, ah, for spinal surgery, for, um, total joints and, um, colons.

Next Speaker: Mm hmm.

Next Speaker: And, um, we took the top performers. So we used this report to, to look at that, the number of cases that we wanted people to **** large, um, denominators and small enumerators. And that's who we asked to join the webinars and share their opinion, their practices. So I think there is an opportunity to, to use the data that is collected statewide, identify the top performers and find out what are their practices? You know, what are they doing?

Next Speaker: And I, and I think to beyond the **** I think there's outbreak investigations that are going on where this group can say okay, what are the actions that are being taken. You know, what recommendations do we have to improve outcomes or to double tools and resources. There's a lot of grant work going on. There's work going on with **** and other stakeholders to try and improve the quality for HAI so again, they can, you know, this group may kinda be the reporting mechanism hearing what activities are happening and making recommendations for, um, improvements, future priorities for the state, etcetera.

Next Speaker: I think what you guys are saying is very much in line with what we at the program want, the direction we wanna move, you know, we know that we can report this data out of these data out as many times as we want but unless they're really being used, you know again by both our consumers, our healthcare consumers and our providers to improve outcomes. You know?

Next Speaker: I just wonder how much freedom the average consumer has in choosing their facility.

Next Speaker: Yeah, not much.

Next Speaker: Well, I think this **** really nicely into the last piece that I wanted to cover and Jennifer you brought this up so very timely, thank you. So, one of the goals we've been talking about is utility and we really do want healthcare consumers, to the extent that they have any freedom to make these decisions about their healthcare, to be able to use the data to make good decisions. Um, so we would just, in general, want more frequent input from **** regarding our content and our report structure.

Um, and we don't have separate reports that are targeted to that audience. Um, which is, you know, something that we tired and maybe wasn't quite as successful as we had hoped. Um, so we think more reviewing from patients and consumers and advocates would help us to make these reports more kind of accessible. So wondering if anyone in the room has ideas, um, that might give us some thoughts about how to engage reviewers in this way. Or anyone on the phone, I should say. I'm sorry.

Next Speaker: Well, Dee Dee's on the phone.

Next Speaker: Any of our participants of the meeting today.

Next Speaker: So, we're hoping, you know, that some of you may be able to give us some feedback. Again, this is a lot to kind of chew on right here in the room but things to keep in mind. And some of the suggestions we've heard would be reaching out to individual boards or looking at, um, hospital consumer assessment healthcare providers, systems data. I'm not totally clear on who we might leverage those data sources yet. Or what the data available to us through those, you know, organizations might look like. But, um, any of your thoughts would really help.

Next Speaker: **** probably scary thought for **** facilities since they don't have a lot of, since those patients don't really have a lot of choices of where they're going. You could use a consumer-based report to turn patients into advocates for infection prevention so, um, if you're wanting to give them this data obviously in the simplest way possible. But then the focus of the report **** on these are the infection projection processes that we expect to see in the facilities and then kind of give them that awareness so that when they are patients in a hospital or whatever that they don't just, like, have nurses coming into rooms without using their gloves and they feel like they have enough say to, to ask them to, to follow the appropriate infection prevention practices. Does that make sense? So, not necessarily getting them to, to use the data 'cause I don't think that's gonna happen.

Next Speaker: That's not a new thought. That's not a new thought and, um, I can tell you most patients, um, will be too shy to ask their providers to wash their hands, right? We rely on other methods of, um, monitoring hygiene compliance. Um, but, and I was involved with this at Providence as well. Um, with, ah, engaging patients to advocate for hygiene and very few patients are willing to ask especially physicians coming into the room. They don't want to, um, make them angry. So that may not be the most reliable way to ensure, um, best practices. But, um, I do agree that, um, education to patients and families and visitors regarding h and hygiene's important and that often gets missed.

Next Speaker: Yeah, that's true.

Next Speaker: I think there are a lot of hospitals listed on there that have patient-family advisory councils. And it might be interesting to share this report with those councils and let them at each facility kinda **** with how to get this information out and share it.

Next Speaker: Thank you.

Next Speaker: There's no way to pull from the data in any way, shape or form what might have been contributed by, like, visiting family or the patient themselves or the provider.

Next Speaker: Right. Like, they don't get down to the level of, like, facility practices in, like, waiting rooms or anything like that, right?

Next Speaker: So for some measures there are, so for, yeah, so for, so for surgical site infection, this isn't quite what you're referring to but for surgical site infection it's, like, they have been, you know, updating these protocols year after year. Every year they update the protocols. And I think every year they try to kind of get at some of the things you're talking about. So, um, there are some interesting examples for, you know, for surgical site infections it's actually a great example. So, for a very long time even if that person presented at the facility with the infection, there was nothing in the protocol to preclude that infection from being categorized as a surgical site infection. So now there's, ah, um, um, present at time of surgery field that can be marked and I want to say those are being excluded from the new SIR models. Anyone ****, yeah? Okay. I think so. So there's other, there's another, um, for centralized associated blood stream infections, there's documented tampering, I think there's also a field for that.

Next Speaker: Yes, yes.

Next Speaker: Um, where they're interesting kind of examples of **** talk about that. Um, offline where if patients are, you know, sort of known to be doing something –

Next Speaker: These are out long term –

Next Speaker: **** exclusionary.

Next Speaker: Yeah.

Next Speaker: Long-term antibiotics.

Next Speaker: **** from an ****.

Next Speaker: Right

Next Speaker: But these are not, um, these data are not intended to be linked to specific deficiencies. Even where there are process measures and outcome measures that kind of go together in the application, they aren't really, they're not, we're not able to say they're causative. Does that sort of answer your question?

Next Speaker: Was your question about, like, um, the **** data 'cause that's a lot of data that is, you know, consumers, patients' families are asked to comment –

Next Speaker: Patient satisfaction.

Next Speaker: On that experience and their satisfaction. So is that kind of what you're getting at?

Next Speaker: 'Cause that's where they provide input and –

Next Speaker: I don't know, I don't know what, how useful patient satisfaction necessary.

Next Speaker: Yeah.

Next Speaker: I don't know.

Next Speaker: There's a lot of questions about **** your medications to you, you know, ****.

Next Speaker: Was your room clean? Was your ****.

Next Speaker: Quiet at night.

Next Speaker: I don't believe there was a question about did you observe staff washing their hands. So –

Next Speaker: I guess they could start including that.

Next Speaker: Yeah.

Next Speaker: I don't, I don't think it gets into that **** detail.

Next Speaker: Do anyone on the phone have any comments? I just wanna make sure everyone has an opportunity to –

Next Speaker: ****.

Next Speaker: Hi, or you're okay. Okay. I thought you had something, sorry.

Next Speaker: No official comment.

Next Speaker: Okay. Well this has been super, super helpful, um, you know, as you think of things please do let me know. Um, and then just tentative report process, this is our, you know, timeline that we do expect to publish it at the end of August. That our process will look very similar to past years. That we'll be doing internal validation and providing those reports on last year's data to our facilities on April 10th with a two-week review period and of course, we're available for technical assistance during that time. Final data will be sent out on April 24th with an opportunity for comments. And then we will be sharing the facility specific data about, ah, one week prior to the public release. And we will also have, you know, talking points available and things of that nature as well.

Next Speaker: Okay, um, I think in the interest of time we'll just move forward and then sorry for, you don't have to listen to my voice for so long here. Um, the last thing I wanted to talk about is really our membership. Um, so, some of you may have noticed new names, new faces and voices during this meeting. So, there are a number of committee members whose terms have recently expired. Um, you know, it's a two-year term that everyone kind of signed up for. So I've been sort of reaching out to all of our members, um, to identify those of you who wanna continue on to serve on our advisory committee. Of course, we would love to have you all continuing on. And some of you may be finding that it's time for you to transition away from that role, um, so I have heard from most of you by now. There are a

couple people who I haven't heard, um, an answer from yet so I may giving a friendly reminder just as a head's up. And then in order for us all to put our appointment paperwork in place, um, for everyone's new terms I think most of you are also aware that we do need a copy of your CV to include the paperwork. So again, I think every, almost everyone has provided me with a CV. There's a couple that, um, are still waiting on so if you're not sure if you've provided your CV to me **** to tell you the answer to that question. Or I guess maybe a friendly reminder about that as well. Um, along with these changes our chair, Mary Shanks, um, will still be continually, continually, continuing on in her role on our advisory committee but her appointment as chair has ended so this is her last meeting as chair and I just wanna give her a huge thank you so much.

Next Speaker: Thank you.

Next Speaker: Do you wanna say a few words?

Next Speaker: No, it's just been a learning experience and, um, it, obviously it's a different slice of the pie, you know, than I see in my day-to-day work. So this has been very interesting, ah, two plus years.

Next Speaker: ****.

Next Speaker: So thank you for the opportunity. It's been wonderful.

Next Speaker: Thank you.

Next Speaker: So, what this means is that we do need a new chair person and I'm wondering if anyone has any nominations for chair, phone or in person?

Next Speaker: You can nominate yourself if you want.

Next Speaker: ****.

Next Speaker: So we may, you know, reach out to some of you to see if you're willing to serve as chair, um, because we do need a chair person.

Next Speaker: And if I put it out to ****, um, it's, I know they're **** is that just it?

Next Speaker: I think they need to be a member, isn't that correct?

Next Speaker: Oh, okay, it has to come from, yeah.

Next Speaker: Yes.

Next Speaker: So ****.

Next Speaker: What do you need to be, um, infection prevention members:

Next Speaker: So, that, that ties really well in another one of my little points on this agenda item, was that we do have four vacancies on our **** Committee at this time. So, the four vacancies that we have are, hospital, and these are the names of these positions from the statue. So, a health insurer representative, a representative of the Department of Human Services, a healthcare purchasing representative and a hospital administrator with expertise in infection control at a facility with fewer than 100 beds. So, we are definitely actively wanting to fill these vacancies, so, the chair could certainly come from someone **** was to fill these vacancies, or from whatever already through members of our committee. So, with that in mind, again, any nominations for chair? And I'm sure Mary would make herself available to explain what level of, you know, commitment is required.

Next Speaker: It's minimal, minimal. You just show up. You read, read the agenda and read the minutes before the meeting and that you just, you know, start the meeting up, and that's it. So, I'd like to nominate Mary Post.

Next Speaker: I'm, I'm not an official member.

Next Speaker: You're not ****.

Next Speaker: Mary, Mary is not **** our rules in the statute.

Next Speaker: Well, thank you.

Next Speaker: Okay.

Next Speaker: Yes.

Next Speaker: Well, is any in, interested?

Next Speaker: And if you are not sure if you would know one of the rules in the statute, you can also ask me and I can give you that information as well.

Next Speaker: ****, um, moving forward, at this point, maybe sending out a list of who the **** members are. Reminding us where we have vacancies, what those vacancies are **** committee give more thought to it. And then just a request for nominations for potential chairs.

Next Speaker: That's a great idea. And, going back to those four vacancies, um, you know, I definitely, um, will send out an email with those four position titles, because we would like to really recruit and make sure that we have a fully staffed up advisory committee as well. Um, unless anyone has any ideas about who I might reach out to to fill those vacancies. Does anyone want me to read those positions again?

Next Speaker: Just send them out.

Next Speaker: I, I, yeah, we may, if you send it out, we may ****.

Next Speaker: **** I didn't even know this was ****.

Next Speaker: Well, we had that number one time and I recruited it by phone calling. And, when I first started here, yeah.

Next Speaker: If we need somebody from a hospital with fewer than 100 beds, I would ask our, our, uh, telephone audience, uh, Dr. Propensky and Rosti whether, you know, anything ****, whether you might be able to scrounge up somebody from one of the smaller hospitals in your systems.

Next Speaker: And this could be someone that has administrative roles at multiple facilities, including a facility with fewer than 100 beds.

Next Speaker: Uh, **** who would, um, uh, uh, consider a **** position on that committee at that point.

Next Speaker: Sweet.

Next Speaker: Yay.

Next Speaker: 'Kay. Well, I will send out that email, so, um, the just of all this is that there's gonna be some, you know, there are changes that are happening currently, people transitioning in their roles, changes for our membership and so, we'll be updating our current roster and distributing it during the June meeting and Tina will be reaching out to you to verify everyone's contact information and credentials and all of that good stuff to make sure that our roster is really totally up to date and has all of our most recent information and I think that we'll wait until June to do more formal introductions so everyone knows who each other are, as well, and find out **** more settled into place. Okay. Thank you.

Next Speaker: You don't have to eat it.

Next Speaker: I ****, right?

Next Speaker: Yeah, so, right, so thank you, uh, Rosa. I think we pretty much made it through the agenda. So, public comment on any of the dialogue for this meeting? Okay. We do have some objectives, um, for the coming year. Um –

Next Speaker: So, we just mentioned the sun's setting, by statute **** it seems to me that, um, we either have to work with the legislature, um –

Next Speaker: Yeah, so –

Next Speaker: – use statute or –

Next Speaker: – so, we, we have, uh, called, called to the legislature's attention, huh, the fact that the committee will sunset by ****, uh, as of January 1st, unless they decide to amend the statute. So, when they put it in place, you know, uh, I guess in some sense, it's kinda' nice that they have a sunset clause. Let's try it for 10 years and see what happens. Uh, Mitch Greenlick, Representative Greenlick was the

mover and the shaker **** in the first place and he remains as a chair of the, uh, house, house, house **** subsidy, I think.

Next Speaker: Yeah.

Next Speaker: I can't remember the formal name of it, um, so, uh, we're, we've, we've called it to their attention and we'll see whether he, you know, puts anything forward to, uh, delete that little clause and let us continue. Uh, we also, um, suggested some language around the annual report which, um, substantially, anyway, we're seeing this duplicative of data that you can get from, uh, CMS. Uh, so, anyway, requesting permission not to have to duplicate what CMS is producing already. Uh, but also indicating that we see value in, in, uh, going forward with the information we have in an effort to, uh, improve things. In other words, **** just recording, but taking the next step and trying to use the data that we've collected in order to make things better. So, in, in short and sweet fashion, we, um, put some stuff forward to, to **** call it to their attention and we'll just have to see what they say.

Next Speaker: When will they be talking about it? To make a decision?

Next Speaker: Uh, you know, I don't know. Um, I think some of the language was put forward as part of what we call our, uh, Oregon Health Authority Housekeeping Bill, you know, uh, which is usually, uh, just a potpourri of not very consequential stuff, including **** here and there that turns out to be updated and whatnot. And, uh, yeah, I, I don't know exactly when they would be considering it. They, you know, they're, they're current concern, I think, is a lot of budgetary stuff, and that's what's gonna be weighing heavily on their minds. I think where our stuff will fall in their priority list. But it, you know, uh, I think it's going to be considered because, you know, the Housekeeping Bill has been ****. I mean, it's, it's, **** it's a bill, and so, there will be a discussion at some point, but I don't know when.

Next Speaker: So, we'll make sure to give that update when we have some new information to share at this meeting.

Next Speaker: All right then. So, um, since there's nothing else that anybody wants to discuss or share, then, shall we adjourn?

Next Speaker: I so move.

Next Speaker: Okay. The meeting is adjourned.