



Nebraska Healthcare-Associated Infections and Antimicrobial Resistance (HAI/AR) Program Update

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Disclosure

- Merck & Co. Inc – Principal Investigator for an investigator-initiated research grant focused on training consultant pharmacist in antibiotic stewardship implementation in LTCF

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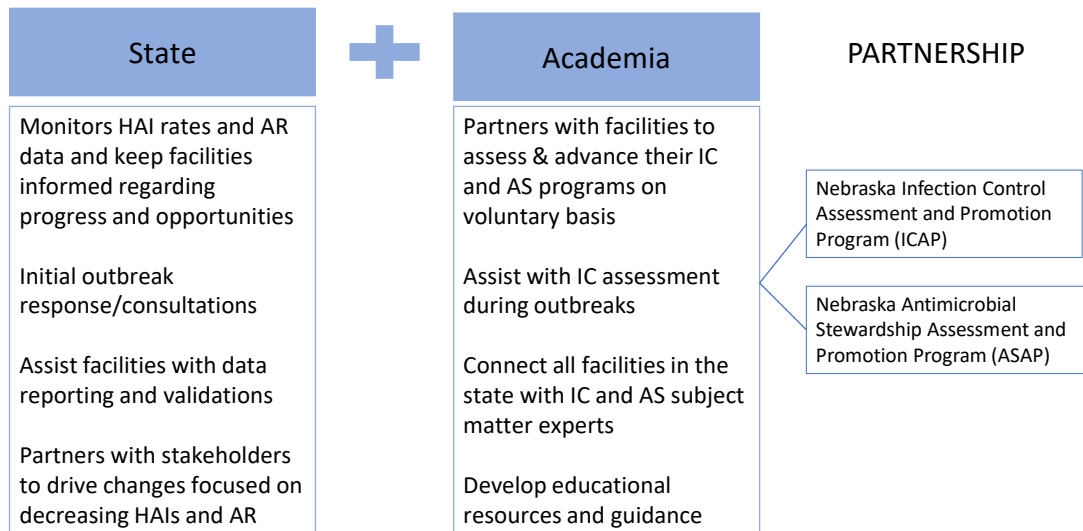
Objectives

- Review trends in healthcare-associated infections and antimicrobial resistance (HAI/AR) in Nebraska
- Identify opportunities for improvement related to infection prevention and control (IPC) and antimicrobial stewardship (AS) programs
- Discuss upcoming and ongoing projects focused on strengthening IPC and AS programs in healthcare facilities and decreasing HAI/AR

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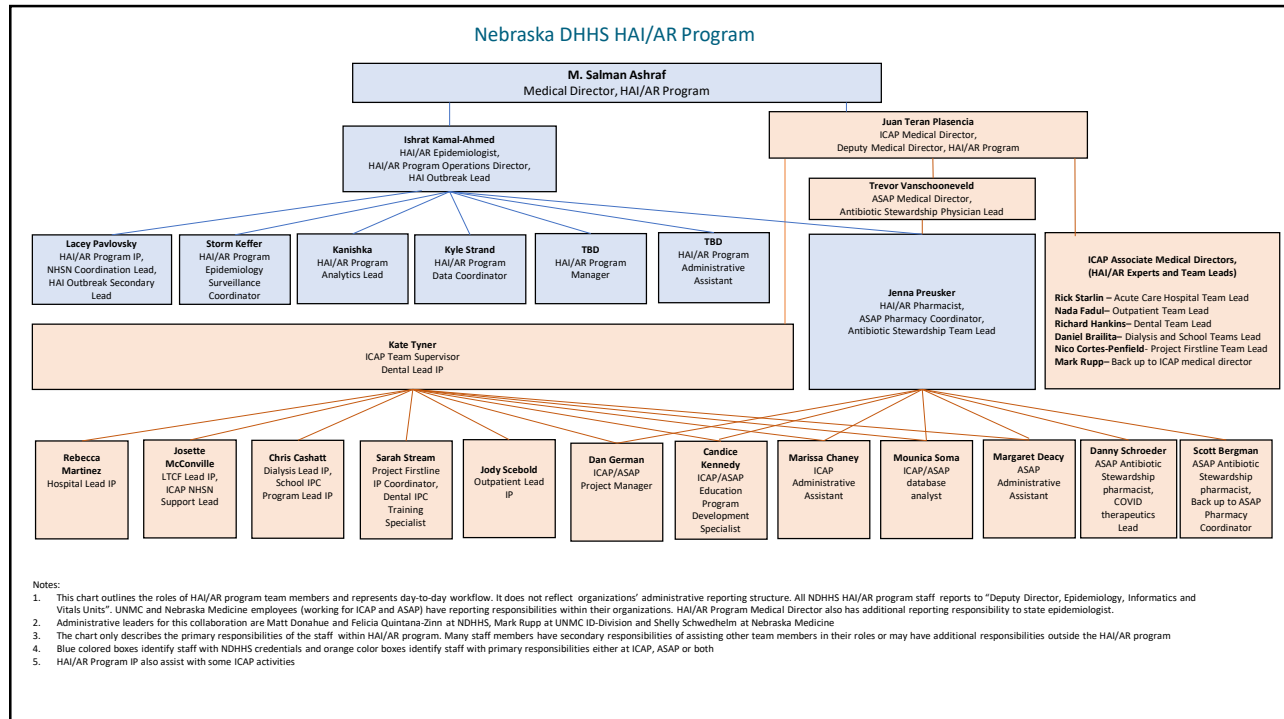
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Nebraska DHHS HAI/AR Program



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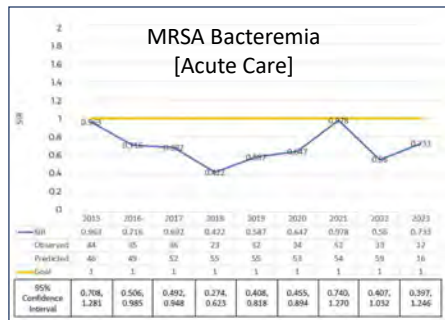
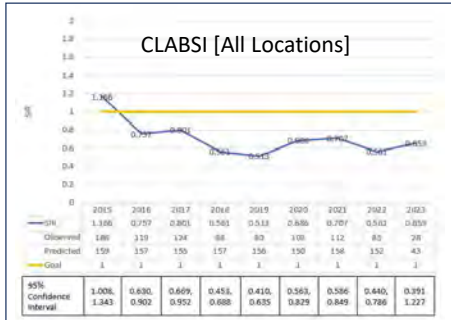
Updates to be Discussed

- Trends in healthcare-associated infections (CAUTI, CLABSI, MRSA bloodstream infection, CDI, SSI)
- Promoting NHSN AUR module uptake in the hospitals
- Trends in multidrug resistant organisms (CRE/CP-CRE, CRPA, *C. auris*)
- CDC's updated guidance to prevention and response to MDROs
- Nebraska DHHS protocol for tracking targeted MDROs and keeping facilities informed
- Supporting LTCF with infection prevention and control and antimicrobial stewardship efforts
- Healthcare-associated legionnaires' disease

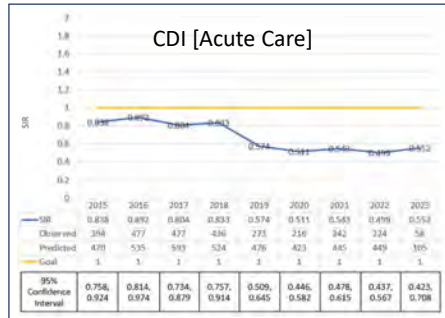
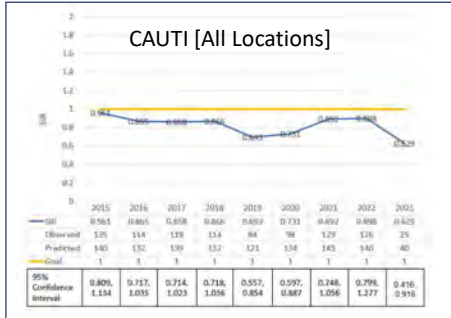
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Healthcare-Associated Infections – Nebraska 2015-2023



*2023 Data is for January 2023- April 2023

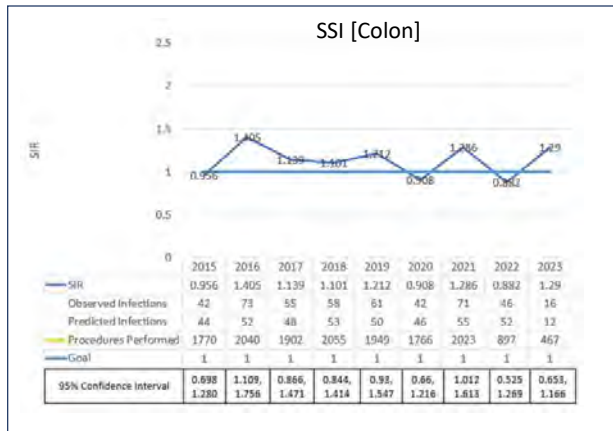
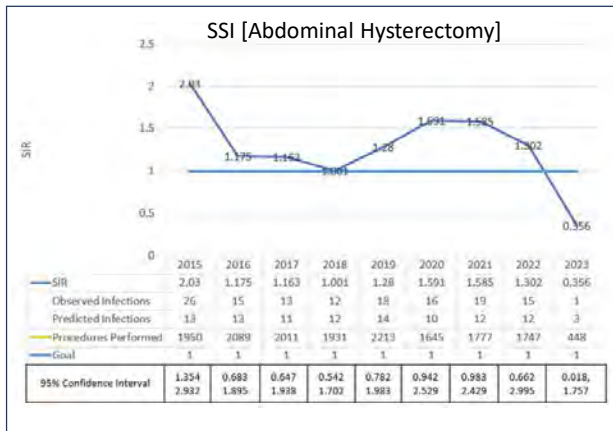


Data Source: NHSN – Include acute care hospitals conferring rights to DHHS



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Healthcare-Associated Infections – Nebraska 2015-2023



*2023 Data is for January 2023- April 2023

Data Source: NHSN – Include acute care hospitals conferring rights to DHHS

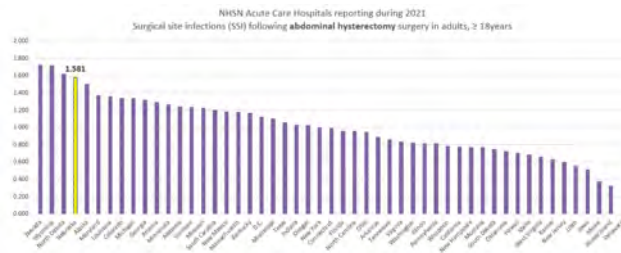
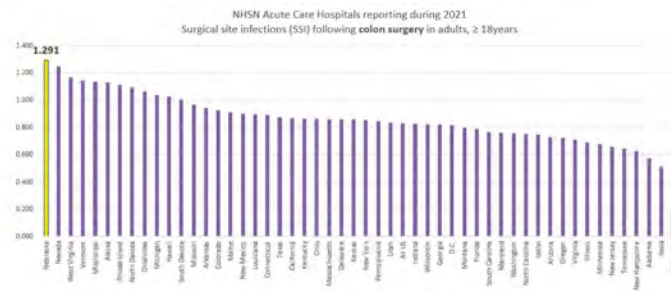


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2021 SIR Comparison for SSI Among All States

Nebraska has the **highest SIR** for Surgical Site Infections following Colon Surgeries



Nebraska has the **fourth highest SIR** for Surgical Site Infections following Abdominal Hysterectomies

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<https://www.cdc.gov/hai/data/portal/progress-report.html>

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Collaborative Efforts to Decrease SSI

- Development of SSI subcommittee of HAI/AR Advisory Council
 - Representative of xx hospitals participating in the subcommittee
 - Includes ID physicians, surgeons, IPs and quality program leaders
- Subcommittee developed and conducted statewide survey of hospitals
 - >50% of hospitals responded to survey
- Survey results will be used by the committee to develop guidance for best practices
- One-on-one outreach and assistance, as needed, is also available

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Preliminary Findings From SSI Survey

Some noticeable variations in practice existed including (but not limited to) the following areas:

- Auditing of aseptic technique practices prior to and during surgical procedures
- Monitoring compliance with best practice recommendations for the OR (compliance with surgical attire, minimizing OR traffic etc.)
- Standardizing and monitoring antimicrobial prophylaxis practices
- Changing gloves and using a separate sterile field set-up for closing for colon and abdominal hysterectomy cases
- Pre-operative mechanical bowel preparation regimen for colon surgeries
- Vaginal preparation/cleansing prior to hysterectomies
- Use of an alcohol-based agent for skin preparation
- Perioperative screening and treatment for bacterial vaginosis

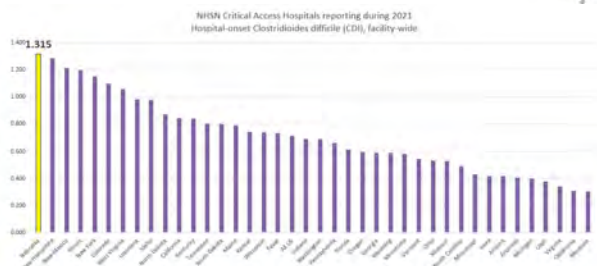
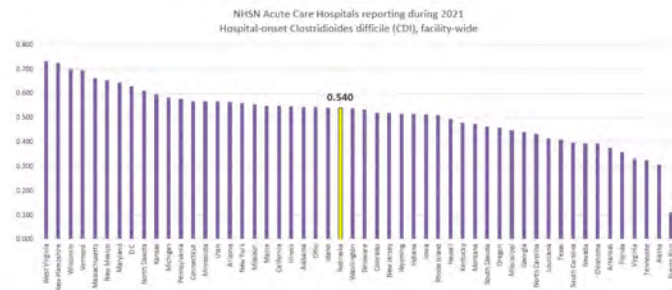
Further analyses of survey data will be conducted by the subcommittee and recommendations will be made and shared with all hospitals

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Digging Deeper into Hospital- Onset *C. difficile* Infections

Nebraska acute care hospitals (excluding critical access hospitals) **ranked 26th for lowest SIR** for *C. difficile* Infections among all 50 states in the US in 2021 (with 28 facilities contributing to this report)



Nebraska critical access hospitals have **the highest SIR** for *C. difficile* Infections among all 50 states in the US in 2021 (with 36 facilities contributing to this report)

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Supporting Critical Access Hospitals with High CDI SIR

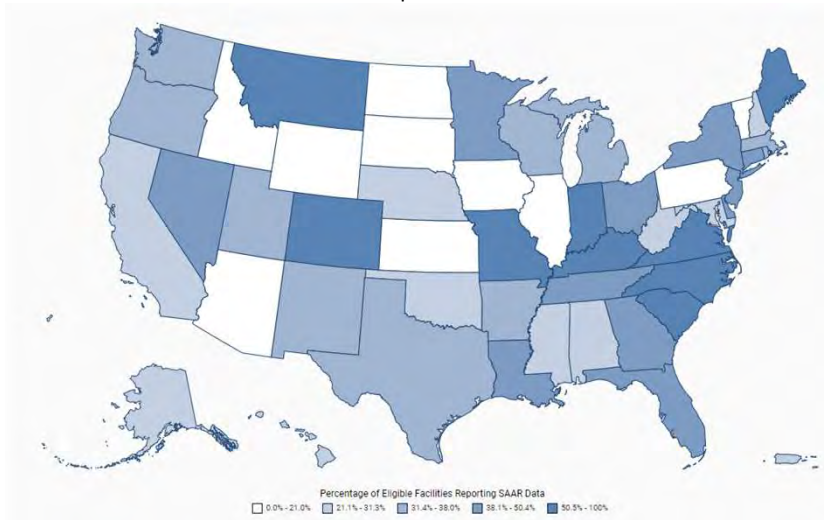
- Nebraska hospitals utilizes NHSN's group function to share data with Nebraska DHHS
 - Requires multi-step process for the facilities to initiate data sharing and serves as a barrier to reporting
- DHHS only have access to less than 15% of Critical Access Hospital CDI data in NHSN limiting outreach efforts for support currently
- Establishing a **"Data Use Agreement"** with the CDC that will automatically report the NHSN data on behalf of the facilities unless they opt out
- Many hospitals also lack the ability to report to NHSN AUR module which is an additional limitation on providing technical support

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NHSN Antibiotic Use Module

Percentage of active NHSN acute care facilities reporting at least one month of data to the AU Option as of 2021



Nebraska:

Number of facilities reporting: 13
Number of facilities eligible to report SAARs: 54
Percentage: 24.1%

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<https://arpsp.cdc.gov/profile/inpatient-antibiotic-use/all>

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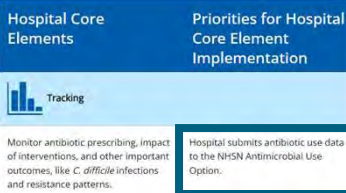
Benefits of AUR Reporting

Insights and Data Benefits

- Benchmarks for antimicrobial stewardship
- Benchmarks for antimicrobial quality improvement activities
- Compare with antimicrobial use trends across the nation (SAAR)
- Identify problem areas within a facility to target interventions
- Antibiotic Stewardship guidance from Nebraska ASAP

Regulatory and Payment Benefits

- Meet the CMS Promoting Interoperability requirement added for CY 2024
- Satisfy the Joint Commission's antimicrobial stewardship standard for tracking and reporting
- Added to the CDC Priorities for Hospital Antibiotic Stewardship Core Element Implementation in 2022
 - [Priorities for Hospital Core Element Implementation | Antibiotic Use | CDC](#)



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<https://www.cdc.gov/antibiotic-use/core-elements/hospital/priorities.html>

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NHSN AUR Implementation in Nebraska – Funding Assistance

- **Nebraska DHHS HAI/AR program has made funding available to dedicate towards assisting hospitals with implementing NHSN AUR module**
- Funding distributed by **reimbursing** at least part of their expenses for program implementation incurred **between February 2022 – July 2024**
- Facilities meeting all requirements for funding may request reimbursement for related eligible expenses up to the maximum amount allowed for their facility based on licensed bed size as follows:
 - Facilities with <100 licensed beds can request a maximum of \$10,000 in reimbursement
 - Facilities with 101-200 licensed beds can request a maximum of \$15,000 in reimbursement
 - Facilities with ≥201 licensed beds can request a maximum of \$20,000 in reimbursement

Nebraska National Healthcare Safety Network Antibiotic Use and Resistance (NHSN AUR) Module Support Project - Expenses Reimbursement Requirements

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Purpose: The purpose of this application is to reimburse expenses associated with implementation of reporting data to the National Healthcare Safety Network (NHSN) Antibiotic Use (AU) and/or Antibiotic Resistance (AR) modules to Nebraska hospitals. Individual staff are not eligible for reimbursement.

Who is eligible for reimbursement?

Licensed acute care inpatient facilities in Nebraska are eligible if the following criteria are met:

1. The facility must be enrolled in NHSN and eligible to report to the NHSN Patient Safety Component AUR Module as defined by NHSN below.
 - a. Inpatient facilities eligible to report to the NHSN Patient Safety Component AUR Module include facilities enrolled as general hospitals, critical access hospitals, children's hospitals, long term acute care hospitals, pediatric long term acute care hospitals, military and veterans' hospitals, oncology hospitals, orthopedic hospitals, psychiatric hospitals, rehabilitation hospitals, surgical hospitals, women's hospitals, women's and children's hospitals, government and non-government hospitals for public health emergencies.

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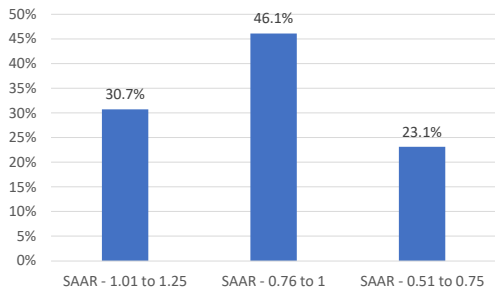
<https://dhhs.ne.gov/pages/Healthcare-Associated-Infections.aspx>

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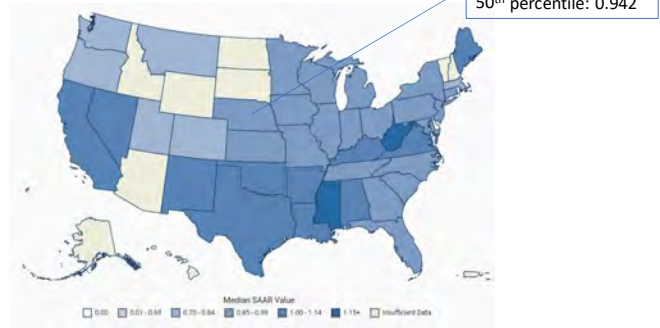
NHSN AUR: Nebraska All Antimicrobial Usage by Facility

Nebraska Acute Care Hospitals Reporting Antibiotic Use to NHSN AUR module in **2022** (N=13)



Data Source: NHSN

Median SAAR values for Hospitals in **2021**

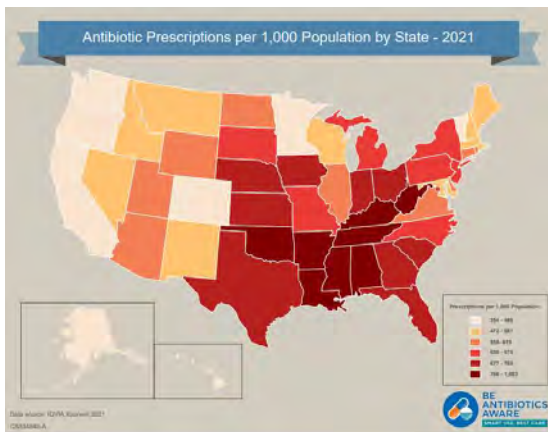


<https://arpsp.cdc.gov/profile/inpatient-antibiotic-use/all>

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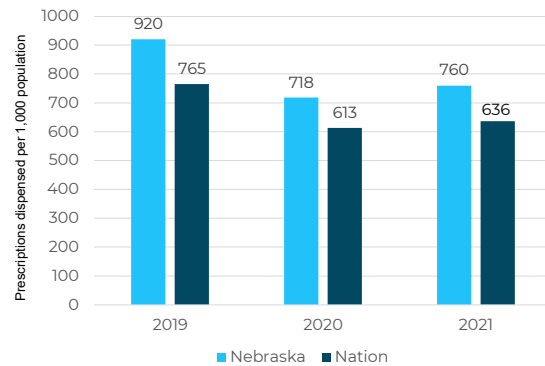
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Community Antibiotic Prescribing in Nebraska



<https://www.cdc.gov/antibiotic-use/data/report-2021.html>

Changes over time in outpatient antibiotic prescription rates



<https://arpsp.cdc.gov/profile/geography/nebraska>

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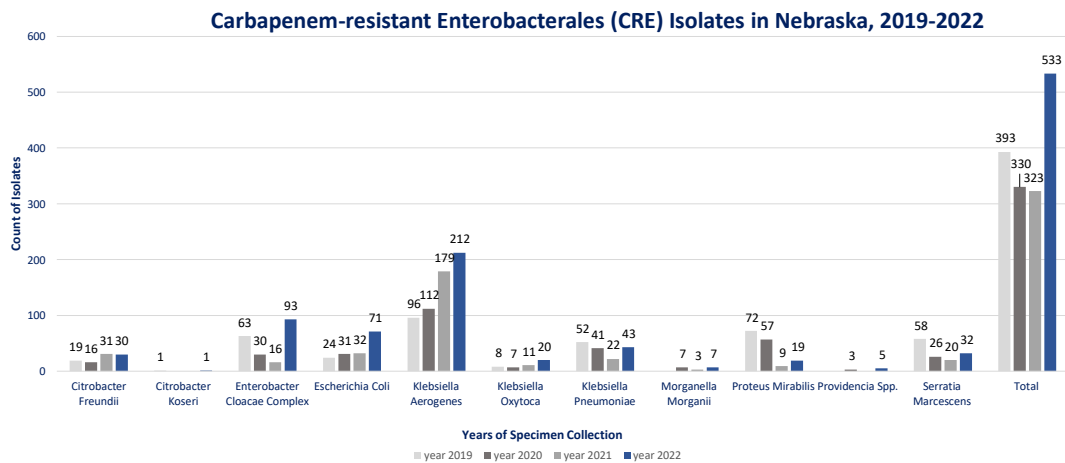
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Plans for Promoting Outpatient Antibiotic Stewardship

- Increase outreach to hospital systems with associated clinics and other outpatient networks
- Exploring collaborative opportunities with insurance providers for targeted education
- Expanding engagement with primary care providers and professional societies

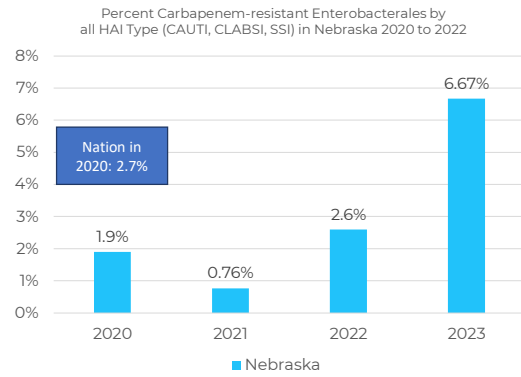
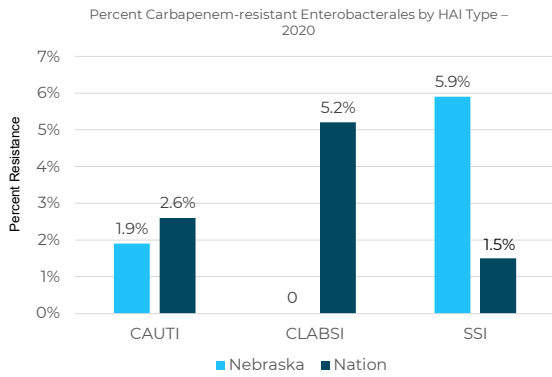
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Carbapenem-Resistant Enterobacterales in Nebraska



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CRE Trends Related to HAIs



Source: NHSN Data

<https://arpsp.cdc.gov/profile/antibiotic-resistance/carbapenem-resistant-enterobacteriales>
<https://arpsp.cdc.gov/profile/geography/nebraska>

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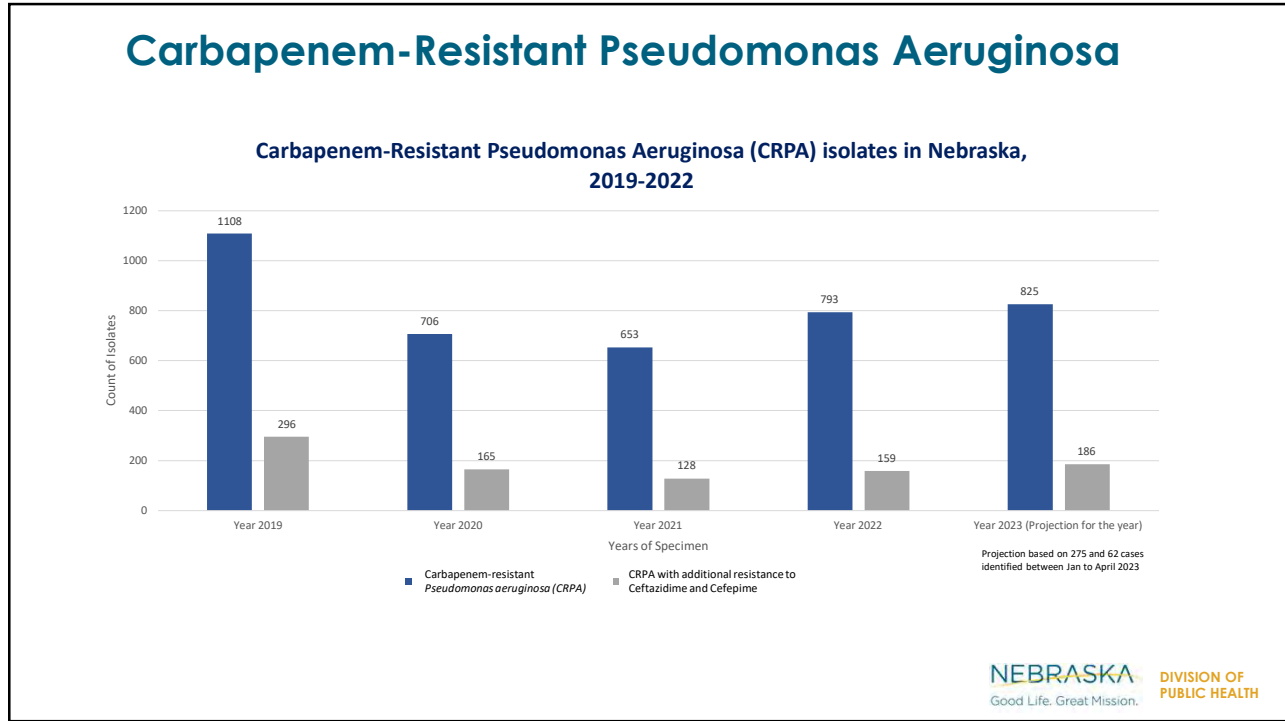
Carbapenemase Genes Identified in Enterobacteriales Isolates, Nebraska 2019-2023

Year	KPC	NDM	OXA-181	OXA-48	VIM	Total
2019	18	9	3	0	0	30
2020	8	0	0	1	0	9
2021	3	0	0	1	0	4
2022	8	3	0	1	1	13
2023 to date	2	3	0	2	0	7

In 2023, 1 case each of Carbapenemase producing *Pseudomonas aeruginosa* and *Acenitobacter baumannii* has also been isolated

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Candida auris

Annals of Internal Medicine

ORIGINAL RESEARCH

Worsening Spread of *Candida auris* in the United States, 2019 to 2021

Hughan Lyman, MD; Kaitlin Forsberg, MPH; D. Joseph Sexton, PhD; Nancy A. Chow, PhD, MS; Shawn R. Lockhart, PhD; Brendan R. Jackson, MD, MPH; and Tom Chiller, MD, MPH/MTM

Background: *Candida auris* is an emerging fungal threat that has been spreading in the United States since it was first reported in 2016.

Objective: To describe recent changes in the U.S. epidemiology of *C. auris* occurring from 2019 to 2021.

Design: Description of national surveillance data.

Setting: United States.

Patients: Persons with any specimen that was positive for *C. auris*.

Measurements: Case counts reported to the Centers for Disease Control and Prevention by health departments, volume of colonization screening, and antifungal susceptibility results were aggregated and compared over time and by geographic region.

Results: A total of 3270 clinical cases and 7413 screening cases of *C. auris* were reported in the United States through 31 December 2021. The percentage increase in clinical cases grew each year, from a 44% increase in 2019 to a 95% increase in 2021. Colonization screening volume and screening cases increased in 2021 by more than 80% and more than 200%, respectively. From 2019 to 2021, 17 states identified their first *C. auris* case. The number of *C. auris* cases that were resistant to echinocandins in 2021 was about 3 times that in each of the previous 2 years.

Limitations: Identification of screening cases depends on screening that is done on the basis of need and available resources. Screening is not conducted uniformly across the United States, so the true burden of *C. auris* cases may be underestimated.

Conclusion: *C. auris* cases and transmission have risen in recent years, with a dramatic increase in 2021. The rise in echinocandin-resistant cases and evidence of transmission is particularly concerning because echinocandins are first-line therapy for invasive *Candida* infections, including *C. auris*. These findings highlight the need for improved detection and infection control practices to prevent spread of *C. auris*.

Primary Funding Source: None.

Ann Intern Med. 2023;176(4):489-495. doi:10.1093/ajph/2023.176.489-495. For author, article, and disclosure information, see end of text. This article was published at Annals.org on 21 March 2023.

Most Recent 12 Months

Number of *C. auris* clinical cases through December 31, 2022

In the most recent 12 months, there were 2,377 clinical cases and 5,754 screening cases (January 2022 - December 2022).

- 0 clinical cases and at least 1 screening case
- 1 to 10
- 11 to 50
- 51 to 100
- 101 to 500
- 501 to 1000
- 1001 or more

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Lyman M et al. Ann Intern Med. 2023 Apr;176(4):489-495. <https://www.cdc.gov/fungal/candida-auris/tracking-c-auris.html>

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Candida auris Surveillance Efforts in Nebraska

- Education has been done by NPHL to make labs aware of CDC recommendation regarding all yeast isolates from normal sterile site need to be identified to the species level along with potential of misidentification
- NPHL has the ability to assist other labs with *C. auris* identification and has communicated to send potential isolates when they are unable to perform identification or are suspecting misidentification
- Labs are also advised to report any *C. auris* case and send the isolate to NPHL
- Nebraska DHHS team and NPHL are also exploring launching wastewater surveillance for *C. auris* and some other MDROs.

Identification Method	Database/Software, if applicable	<i>C. auris</i> is confirmed if initial identification is <i>C. auris</i> .	<i>C. auris</i> is possible if the following initial identifications are given. Further work-up is needed to determine if the isolate is <i>C. auris</i> .
Bruker Biotyper MALDI-TOF	RUO libraries (Versions 2014 [5627] and more recent)	<i>C. auris</i>	n/a
	CA System library (Version Claim 4)	<i>C. auris</i>	n/a
bioMérieux VITEK MS MALDI-TDF	RUO library (with Saramis Version 4.14 database and Saccharomycetaceae update)	<i>C. auris</i>	n/a
	IVD library (v3.2)	<i>C. auris</i>	n/a
	Older IVD libraries	n/a	<i>C. haemulonii</i> <i>C. lusitanae</i> No identification
VITEK 2 YST	Software version 8.01*	<i>C. auris</i>	<i>C. haemulonii</i> <i>C. duobushaemulonii</i> <i>Candida</i> spp. not identified
	Older versions	n/a	<i>C. haemulonii</i> <i>C. duobushaemulonii</i> <i>Candida</i> spp. not identified
API 20C		n/a	<i>Rhodotorula glutinis</i> (without characteristic red color) <i>C. sake</i> <i>Candida</i> spp. not identified
API ID 32C		n/a	<i>C. intermedia</i> <i>C. sake</i> <i>Saccharomyces kluyveri</i>
BD Phoenix		n/a	<i>C. catenulata</i> <i>C. haemulonii</i> <i>Candida</i> spp. not identified
MicroScan		n/a	<i>C. lusitanae</i> ** <i>C. guilliermondii</i> ** <i>C. parapsilosis</i> ** <i>C. famata</i>
		n/a	<i>Candida</i> spp. not identified
RapID Yeast Plus		n/a	<i>C. parapsilosis</i> ** <i>Candida</i> spp. not identified
GenMark ePlex BCID-PP Panel		<i>C. auris</i>	n/a

* There have been reports of *C. auris* being misidentified as *C. lusitanae* and *C. famata* on VITEK 2. A confirmatory test such as conreal agar may be warranted for these species.
 ** *C. guilliermondii*, *C. lusitanae*, and *C. parapsilosis* generally make hyphae or pseudohyphae on conreal agar. If hyphae or pseudohyphae are not present on conreal agar, the isolate should raise suspicions of being *C. auris* as *C. auris* typically does not make hyphae or pseudohyphae. However, some *C. auris* isolates have formed hyphae or pseudohyphae. Therefore, it would be prudent to consider any *C. guilliermondii*, *C. lusitanae*, and *C. parapsilosis* isolates identified on MicroScan and any *C. parapsilosis* isolates identified on RapID Yeast Plus as possible *C. auris* isolates and further work-up should be considered.

If *C. auris* is confirmed: Place patient in transmission-based precautions, report to CDC (candidaauris@cdc.gov), and notify state and local health departments.
 If *C. auris* is possible: Further work-up is needed to determine if actually *C. auris*. Send isolates to a reference lab, a state public health lab, a regional lab, or CDC for further identification. Place patient in transmission-based precautions and notify state and local health departments and CDC (candidaauris@cdc.gov).

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<https://www.cdc.gov/fungal/candida-auris/identification.html>
https://www.cdc.gov/fungal/candida-auris/pdf/Testing-algorithm_by-Method_508.pdf



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Updated Guidance for Prevention and Response to MDROs

Strategies for Prevention and Response to Novel & Targeted Multidrug-Resistant Organisms (MDROs)

[Print](#)

Overview

Multidrug-resistant organisms (MDROs) are continuing to develop and spread in healthcare settings throughout the United States. Because of this, efforts to prevent MDRO transmission are still needed. In the past, MDROs were identified after lab confirmation, however, research has found that these organisms can spread long before being detected. A prevention approach that incorporates multiple healthcare facilities can potentially limit spread more effectively than response strategies alone.

CDC has developed two guides and FAQs for healthcare facilities, state, local, and territorial health departments to limit the spread of novel or targeted (e.g., *Candida auris*, carbapenemase-producing CRE) MDROs, FAQs, and a graphic (Figure 1) showing the relationship between prevention and response activities.



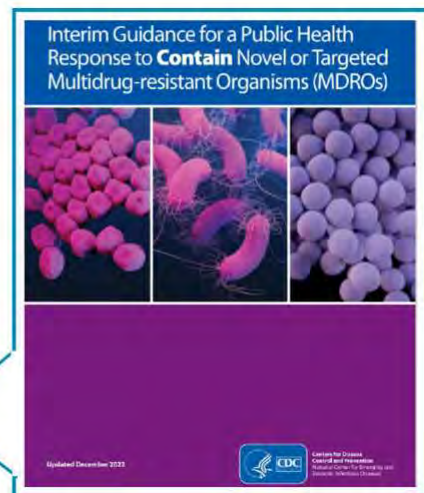
Prevention Strategies
To prevent the spread of novel and targeted MDROs across healthcare facilities



Containment Strategy
To address the initial response to novel and targeted MDROs

On This Page

- Comparison of Strategies
- FAQs
- Lab Resources
- Investigation Guides
- Colonization Screenings
- Inter-facility Transfer Forms
- MDRO Resources



<https://www.cdc.gov/hai/mdro-guides/index.html>



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Tier Definitions and Examples

Tier	Definition of Included Organisms and Mechanisms	Examples (not all inclusive) of organisms/mechanisms for Nebraska
Tier 1	Never (or very rarely) been identified in the United States and for which experience is extremely limited	Novel Carbapenamases
Tier 2	<ol style="list-style-type: none"> Primarily associated with healthcare settings and are not commonly identified in the region (i.e., not been previously identified in the region or have been limited to sporadic cases or small outbreaks), corresponding to “not detected” or “limited to moderate spread” epidemiologic stages. No current treatment options exist (pan-not susceptible) and potential to spread more widely 	<i>C. auris</i> Carbapenamases (e.g. KPC, NDM, OXA-48, VIM, IMP) <ul style="list-style-type: none"> Enterobacterales <i>Pseudomonas aeruginosa</i> <i>Acinetobacter baumannii</i>
Tier 3	Include MDROs targeted by the facility or region for epidemiologic importance that have been identified frequently across a region, indicating advanced spread, but are not considered endemic	
Tier 4	Endemic in a region and have been targeted by public health for their clinical significance and potential to spread rapidly	MRSA, VRE, Organisms producing extended spectrum beta lactamases

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Containment Response Elements Upon Identification of Targeted MDROs

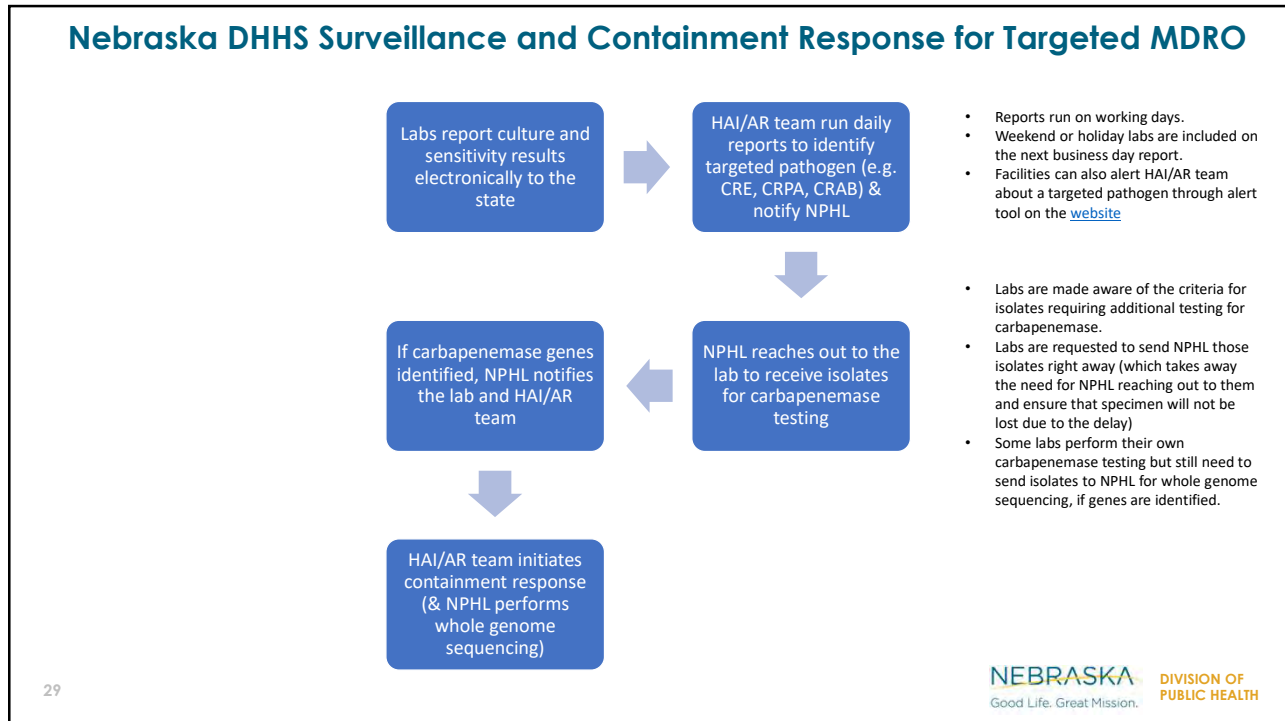
Response Elements

Elements	Tier 1	Tier 2	Tier 3	Tier 4
Healthcare Investigation¹				
Review the patient's healthcare exposures prior to and after the positive culture ²	ALWAYS <small>Typical review period: 30 days prior to culture collection to present</small>	ALWAYS <small>Typical review period: 30 days prior to culture collection to present</small>	ALWAYS <small>Typical review period: Current admission and sometimes immediately prior admission</small>	Prioritize prevention; containment principles generally do not apply.
Contact Investigation³				
Screening of healthcare contacts (i.e., residents and patients) ⁴	ALWAYS	ALWAYS	USUALLY	Prioritize prevention; containment principles generally do not apply.
Household contact screening	USUALLY	RARELY	RARELY	
Healthcare personnel screening	USUALLY	RARELY	RARELY	
Additional Actions if Transmission Identified in Healthcare				
Recurring response-driven point prevalence surveys ⁵	ALWAYS	ALWAYS	RARELY	
Evaluate potential spread to healthcare facilities that regularly share patients with the index healthcare facility ⁶	USUALLY	USUALLY	RARELY	Prioritize prevention; containment principles generally do not apply.

Elements	Tier 1	Tier 2	Tier 3	Tier 4
Clinical Laboratory Surveillance				
Retrospective lab surveillance ⁷	ALWAYS	ALWAYS	RARELY	Prioritize prevention; containment principles generally do not apply.
Prospective lab surveillance ⁸	ALWAYS	ALWAYS	ALWAYS	
Environmental Cultures				
Environmental sampling	SOMETIMES	RARELY	RARELY	Prioritize prevention; containment principles generally do not apply.
Infection Control Measures				
Notify healthcare providers; promptly implement appropriate transmission-based precautions	ALWAYS	ALWAYS	ALWAYS	
Infection control assessment with observations of practice	ALWAYS	ALWAYS	SOMETIMES	Prioritize prevention; containment principles generally do not apply.
Clear communication of patient status with transferring facilities	ALWAYS	ALWAYS	ALWAYS	

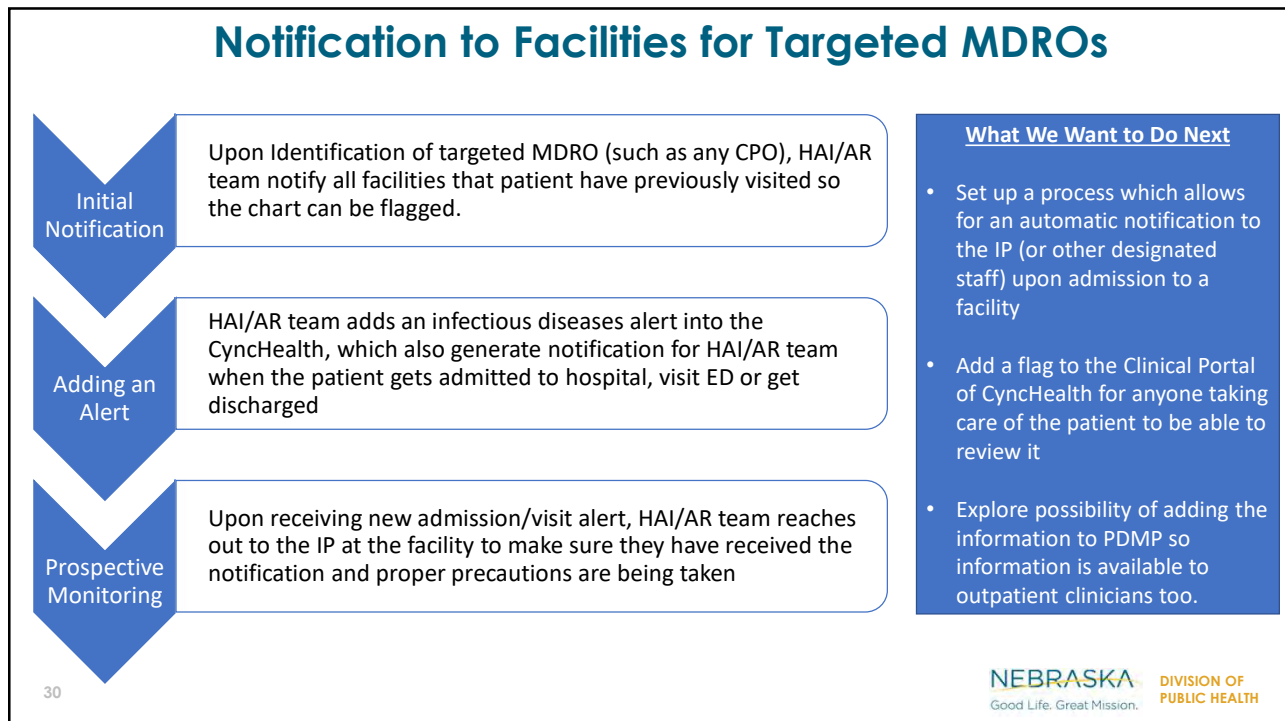
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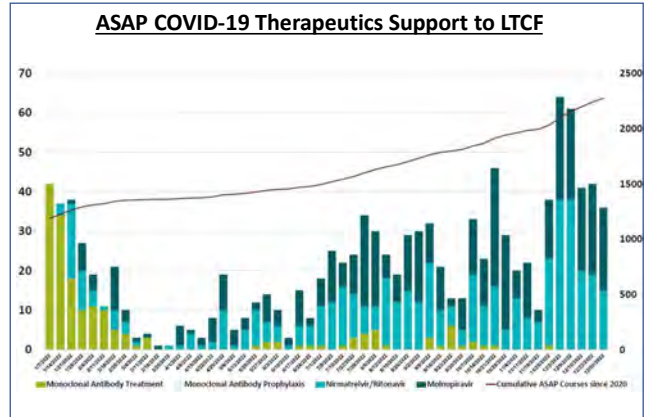
HAI/AR Program LTCF Support

ICAP Infection Prevention and Control Support to LTCF

Metrics	2020	2021	2022	2023	2020-2023
COVID outbreaks	804	1,239	1,528	426	3,997
Outbreak assistance	804	1,239	1,164	187	3,394
% Outbreak assistance	100%	100%	76.2%	43.9%	84.9%
No. of LTCF assisted	309	359	373	176	405
Structured IPC assessments	309	442	457	55	1,180
IPC consultations	Not tracked	2,644	4,571	483	5,054

Notes:

- Some of the metrics were not being systematically tracked in 2020 and 2021 and had to be estimated based on the experience that ICAP was offering assistance for every outbreak and had performed a structured IPC assessments for each facility that had an outbreak at least once.
- Outbreak has been defined as any case of LTCF staff or resident in a facility (facility remains in outbreak status until no new case for 14 days)
- 2023 Data is updated as of 5/22/23



Other ICAP and ASAP Services to all healthcare facilities (including LTCF) include: Onsite IPC assessments and feedback; ASP assessments and feedback; Dedicated webinars; Mentorship opportunities for new IPs; Consultations on any IPC/ASP topics; Basic IPC education to frontline healthcare workers through Project Firstline; Availability of various tools, templates and guidance through the website

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2023-2024 Initiative to Support LTCF (LTCF Strike Team Project)

- Assist LTCF with implementing Respiratory Protection Program
- Train additional staff in LTCF who can step in as IP for the facility
- Promote training of frontline staff in LTCF to serve as infection control champions
- Strengthen infrastructure at LHD to coordinate LTCF HAI/AR prevention and containment efforts with Nebraska DHHS HAI/AR Program

<https://dhhs.ne.gov/pages/Healthcare-Associated-Infections.aspx>

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Nebraska Long-Term Care Facilities Strike Team Related Educational and Fit-Testing Expenses Reimbursement Guidelines



Purpose: The purpose of this application is to reimburse infection prevention and control (IPC) educational and N-95 fit testing expenses to Nebraska long-term care facilities that participate in the long-term care facility (LTCF) strike team project. Individual staff are not eligible for reimbursement.

Who is eligible for reimbursement?

1. Skilled Nursing facilities, and Assisted Living Facilities meeting the following criteria:

How much and what do the grants fund?

1. The grant provides funding for reimbursement of expenses related to IPC training and N-95 fit testing of the staff.
2. Reimbursements are dependent on availability of funding.
3. Facilities that meet all criteria for reimbursements may request reimbursement for any eligible educational program or N-95 fit-testing related expenses up to the maximum amount allowed for their facility based on the facility type and size as follows:
 - a. Skilled Nursing Facilities maximum reimbursement will be based on the number of licensed beds as follows:
 - i. Facilities with ≥ 175 licensed beds can request a maximum of \$11,800 in reimbursement
 - ii. Facilities with 125-174 licensed beds can request a maximum of \$10,500 in reimbursement
 - iii. Facilities with 75-124 licensed beds can request a maximum of \$8,800 in reimbursement
 - iv. Facilities with 50-74 licensed beds can request a maximum of \$7,500 in reimbursement
 - v. Facilities with <50 licensed beds can request a maximum of \$6,200 in reimbursement
 - b. Assisted Living Facilities maximum reimbursement will be based on the number of licensed beds as follows:
 - i. Facilities with ≥ 200 licensed beds can request a maximum of \$9,000 in reimbursement
 - ii. Facilities with 150-199 licensed beds can request a maximum of \$7,300 in reimbursement
 - iii. Facilities with 75-149 licensed beds can request a maximum of \$6,000 in reimbursement
 - iv. Facilities with <75 licensed beds can request a maximum of \$4,700 in reimbursement

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LTCF Strike Team Project Progress

- Local health departments have received “Train-the-Trainer” trainings for N-95 fit testing
- LHDs have assigned a HAI/AR liaison to collaborate efforts with DHHS HAI/AR team
- 83 LTCF have confirmed their interest to participate so far
- 54 LTCF are not sure at this point but have not declined
- 31 LTCF have already received fit-testing support from the LHD

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Healthcare-Associated Legionnaires' Disease

- Since 2022, five cases of healthcare-associated legionnaires' disease has been identified in four different healthcare facilities across the state
- Legionella has also been identified in surveillance cultures as part of the water management program in a few other facilities
- In response, DHHS HAI/AR team has:
 - Enhanced surveillance effort
 - Increased focus on providing education for developing and implementing water management plan
 - Exploring possibility of grant funding to enhance capacity of water testing for Legionella through Public Health Environmental lab (at least during outbreak in a healthcare facility)
- Challenge:
 - Many cities across the state do not chlorinate water which makes mitigation effort harder for facilities

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In Summary.....

- Nebraska hospitals are doing better in preventing most healthcare-associated infection, but opportunities exist in some areas to improve
- Even though total counts for some of the targeted multidrug resistant organisms remain low the upward trend in numbers are concerning.
- Most of our larger hospital systems are doing an excellent job in keeping antimicrobial use low but additional efforts are needed to promote optimal antibiotic use in all healthcare settings.
- Existing partnerships and collaborative relationships of healthcare facilities with public health in Nebraska has allowed us to make meaningful progress in strengthening infection prevention and control/ antimicrobial stewardship program infrastructure in many facilities across the state.
- HAI/AR program will continue to expand collaboration with healthcare facilities, local health departments, professional organizations and other stakeholders to coordinate patient safety initiatives

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A hand is shown placing a wooden block with a yellow lightbulb icon on top of a stack of wooden blocks. The stack consists of three layers: the bottom layer has three blocks with red question marks, the middle layer has two blocks with red question marks, and the top block has a yellow lightbulb icon and a red question mark. The background is a plain, light-colored surface.

QUESTIONS?

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THANK YOU

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