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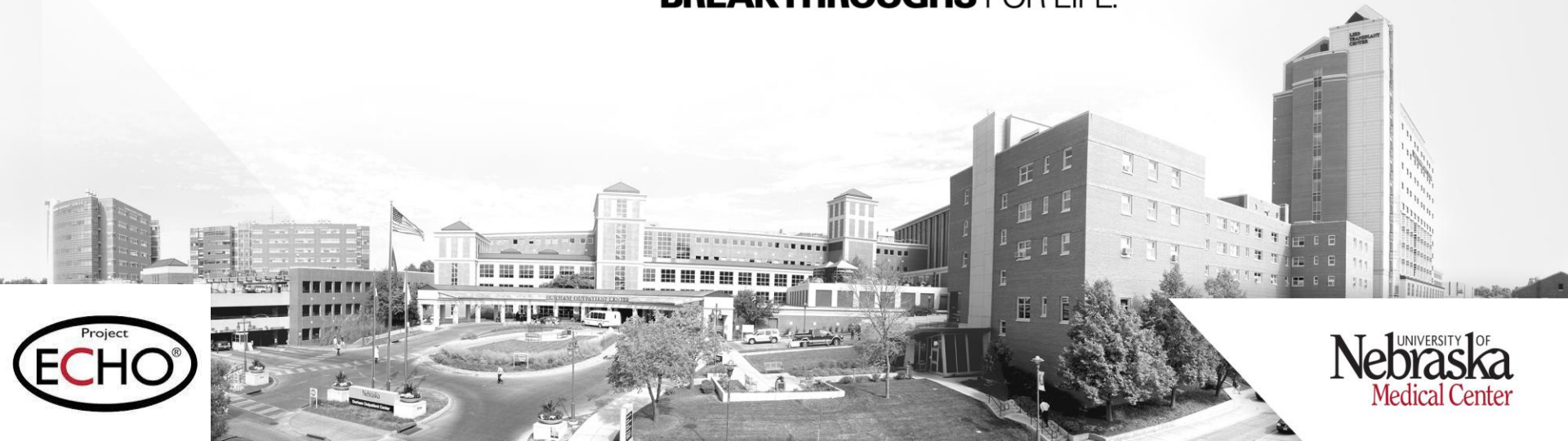
BREAKTHROUGHS FOR LIFE.®



Project ECHO®

University of Nebraska Medical Center

UNMC ID ECHO Project to Reduce COVID-19 Health Disparities Through Quality Improvement

Welcome to Session 2

Project Funded by Nebraska DHHS through a CDC grant

Housekeeping Reminders

- Discussion makes sessions work best!
- Please stay muted unless you are speaking
- We love to see your face!
- Sessions will be recorded and available upon request
- Attendance is taken by filling the survey in the chat

- Reminder: Project ECHO collects registration, participation, questions and answers, chat comments, and poll responses for some ECHO programs. Your individual data will be kept confidential. This data may be used for reports, maps, communications, surveys, quality assurance, evaluation, research, and to create new initiatives.

Subject Matter Experts

Infectious Diseases Team

- M. Salman Ashraf, MBBS
- Nada Fadul, MD
- Erica Stohs, MD, MPH
- Anum Abbas, MD
- Kelly Cawcutt, MD, MS

Quality Improvement Team

- Jeff Wetherhold, QI Consultant
- Gale Etherton, MD
- Mahliqha Qasimyar, MD
- Ardis Reed, State QIN/QIO Representative

Health Equity & Cultural Sensitivity Team

- Mahelet Kebede, HE & CS Consultant
- Shirley Delair, MD
- Jasmine Marcelin, MD
- Precious Davis, Case Manager
- Andrea Jones, MD
- Samantha Jones, Program Manager

CE Disclosures

Project ECHO®

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UNMC ID Health Equity and Quality Improvement ECHO Project

Topics: Cultural Sensitivity- Foundational Awareness and Understanding the Basics of Infection Control Infrastructure

Free Live ECHO Project
November 17, 2021
CID 53866

University of Nebraska Medical Center

TARGET AUDIENCE

This live activity is intended for physicians, APPs, nurses, social workers, case managers, and anyone else interested in learning about health equity in underserved populations.

ACTIVITY DESCRIPTION

Achieving health equity, addressing COVID-19 disparities, and improving the health of all Nebraskans using a quality improvement approach are the goals for our newly launched educational initiative. This COVID-19-focused health equity and quality improvement educational series will use the ECHO model for training healthcare workers.

The course is being offered through the University of Nebraska Medical Center (UNMC) infectious diseases (ID) ECHO program and is funded by the Nebraska Department of Health and Human Services (DHHS) via a CDC grant.

EDUCATIONAL OBJECTIVES

At the conclusion of this live activity, the participants should be better able to:

- Describe the cultural sensitivity spectrum.
- Define cultural sensitivity.
- Describe the ways in which facility-level policies and procedures can support COVID-19 infection prevention and control.
- Identify changes to facility-level policies and procedures which can improve COVID-19 infection prevention and control for patients who are at higher risk and historically underserved.

REQUIREMENTS FOR SUCCESSFUL COMPLETION

In order to receive continuing education credit/credits, you must:

1. Participate in the live activity via ZOOM. Your attendance will be tracked by the course facilitator.
2. Complete the overall evaluation
    a. Instructions on how to access the overall evaluation will be provided on a quarterly basis.
    b. Continuing education credits will be issued for activities you attended.

For questions regarding evaluation and attendance, please contact Nuha Mirghani, MD, MBA, HCM at nmirghani@unmc.edu

ACCREDITED CONTINUING EDUCATION

In support of improving patient care, University of Nebraska Medical Center is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

PHYSICIANS/PHYSICIAN ASSISTANTS

The University of Nebraska Medical Center designates this live activity for a maximum of 1.5 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NURSES/NURSE PRACTITIONERS

The University of Nebraska Medical Center designates this activity for 1.5 ANCC contact hour(s). Nurses should only claim credit for the actual time spent participating in the activity.

ACCREDITED CONTINUING EDUCATION

As a Jointly Accredited Organization, University of Nebraska Medical Center is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. University of Nebraska Medical Center maintains responsibility for this course. Social workers completing this live activity receive 1.5 interactive continuing education credits. Social work level of content: Intermediate

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers.
The course is approved for 1.5 CE contact hour(s).
Activity code: I00048418 Approval Number: 210003785
To claim these CEs, log into your CCMC Dashboard at www.ccmcertification.org.

DISCLOSURE INFORMATION

As a jointly accredited provider, the University of Nebraska Medical Center (UNMC) ensures accuracy, balance, objectivity, independence, and scientific rigor in its educational activities and is committed to protecting learners from promotion, marketing, and commercial bias. Faculty (authors, presenters, speakers) are encouraged to provide a balanced view of therapeutic options by utilizing either generic names or other options available when utilizing trade names to ensure impartiality.

All faculty, planners, and others in a position to control continuing education content participating in a UNMC accredited activity are required to disclose all financial relationships with ineligible companies. As defined by the Standards for Integrity and Independence in Accredited Continuing Education, ineligible companies are organizations whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients. The accredited provider is responsible for mitigating relevant financial relationships in accredited continuing education. Disclosure of these commitments and/or relationships is included in these activity materials so that participants may formulate their own judgments in interpreting its content and evaluating its recommendations.
This activity may include presentations in which faculty may discuss off-label and/or investigational use of pharmaceuticals or instruments not yet FDA-approved. Participants should note that the use of products outside currently FDA-approved labeling should be considered experimental and are advised to consult current prescribing information for FDA-approved indications.

All materials are included with the permission of the faculty. The opinions expressed are those of the faculty and are not to be construed as those of UNMC.

Disclosures

The accredited provider has mitigated and is disclosing identified relevant financial relationships for the following faculty, planners, and others in control of content prior to assuming their roles:

FACULTY

M. Salman Ashraf, MBBS*
Merck & Co, Inc: Industry funded research/investigator

The below faculty have nothing to disclose:

- Anum Abbas, MBBS
- Shirley Delair, MD, MPH
- Gale Etherton, MD, FACP
- Mahelet Kebede, MPH*

**Indicates on the planning committee*

Disclosures

PLANNING COMMITTEE

Nada Fadul, MD
ViiV Healthcare: Advisory Committee/Board

Erica Stohs, MD, MPH
ReViral Ltd.: Industry funded research/investigator

The below planning committee members have nothing to disclose:

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- Samantha Jones, CSW
- Nuha Mirghani, MD, MBA, HCM
- Renee Paulin, MSN, RN, CWOCN
- Jeff Wetherhold, M.Ed
- Bailey Wrenn, MA

www.unmc.edu/cce

Current State of COVID-19 in Nebraska

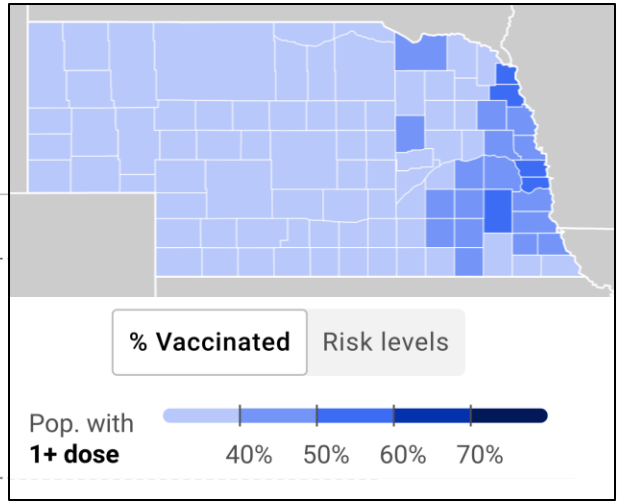
Nebraska Statistics

Cases

DAILY NEW CASES
• **44.0** PER 100K

INFECTION RATE
• **1.15**

POSITIVE TEST RATE
• **14.8%**



Accessed 11/15/21. https://covidactnow.org/us/nebraska-ne/?s=24951410

Nebraska Statistics

Week	Daily New Cases/ 100K	Infection Rate	Positive Test Rate	ICU Capacity Used	*Vaccinated 1+
11/01/21	29.6	1.03	12.8%	80%	61%
11/15/21	44.0	1.15	14.8%	86%	62%

*Percent of the entire state population vaccinated, regardless of eligibility/age.

https://covidactnow.org/us/nebraska-ne/?s=24951410

Nebraska Statistics

Nebraska Hospital Capacity & Respiratory Illness Dashboard | Nebraska DHHS https://datanexus-dhhs.ne.gov/views/Covid/1_DailyCharts?%3AisGuestRedirectFromVizportal=y&%3Aembed=y Data updated through: 11/14/2021

COVID-19 Cases

Total Positive Cases
297,214

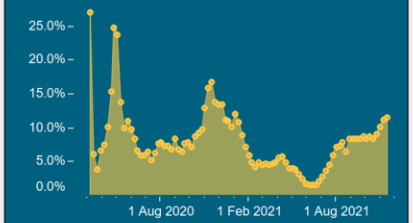
Total Tests
4,059,919

Active Hospitalizations
455

Deaths
2,561

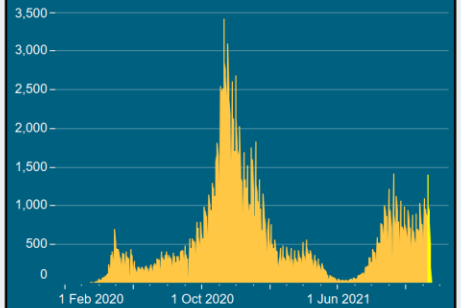
Weekly % Positive by Specimen Date

Non-Null Values Only



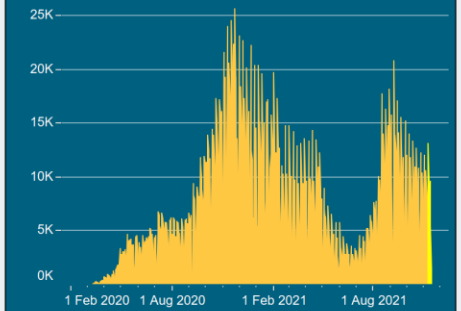
Positive Cases by Specimen Date

Non-Null Values Only



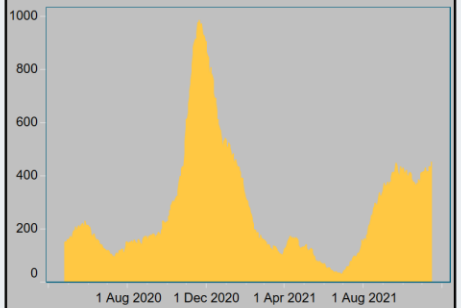
Test by Specimen Date

Non-Null Values Only



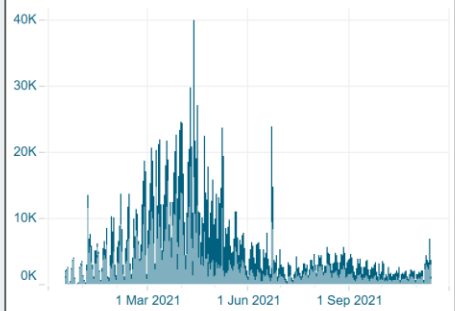
COVID-19 Active Hospitalizations

Non-Null Values Only



Daily New Vaccinations Administered

Non-Null Values Only



COVID-19 Vaccinations

Total Allocations
2,834,975

Total Administered
2,203,879

People

Fully Vaccinated
1,091,345

Partially Vaccinated
96,941

% Fully Vaccinated
69.31%

% Partially Vaccinated
6.16%

1.57 M People Ages 12+

Hospital Capacity | LHD Statistics Map | COVID-19 | County Statistics Map | Age & Gender | Race & Ethnicity | Influenza | RSV | About the Data

Nebraska Statistics

Nebraska Hospital Capacity & Respiratory Illness Dashboard | Nebraska DHHS https://datanexus-dhhs.ne.gov/views/Covid/1_DailyCharts?%3AisGuestRedirectFromVizportal=y&%3Aembed=y Data updated through: 11/14/2021

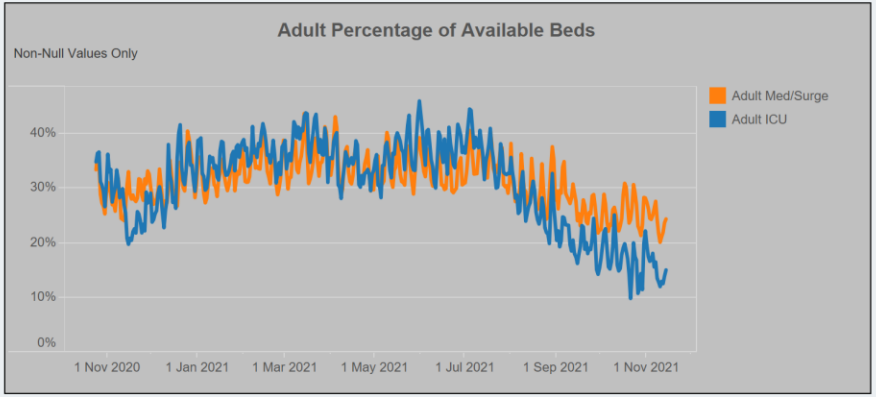
Nebraska Hospital Capacity

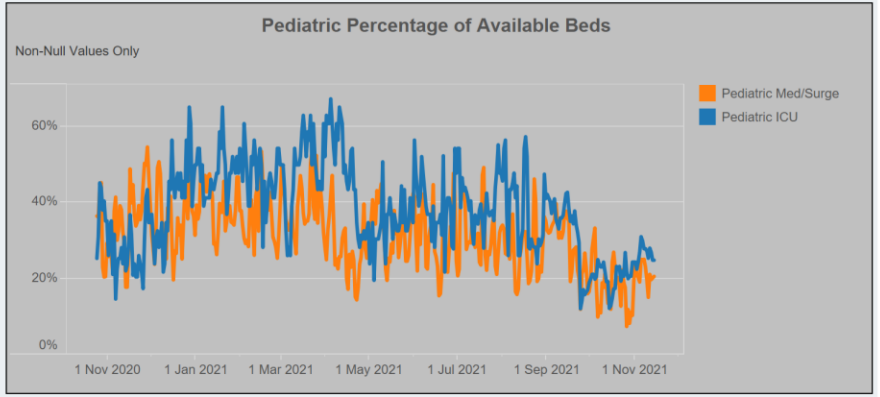
Prior Day Adult

Medical / Surg		ICU	
Staffed	% Available Staffed	Staffed	% Available Staffed
3,215	24%	471	15%
COVID Occupied	Non COVID Occupied	COVID Occupied	Non COVID Occupied
332	2,098	116	284
% COVID Staffed	% Non COVID Staffed	% COVID Staffed	% Non COVID Staffed
10%	65%	25%	60%

Prior Day Pediatric

Medical / Surg		ICU	
Staffed	% Available Staffed	Staffed	% Available Staffed
233	21%	189	25%
COVID Occupied	Non COVID Occupied	COVID Occupied	Non COVID Occupied
7	178	0	142
% COVID Staffed	% Non COVID Staffed	% COVID Staffed	% Non COVID Staffed
3%	76%	0%	75%





Hospital Capacity | LHD Statistics Map | COVID-19 | County Statistics Map | Age & Gender | Race & Ethnicity | Influenza | RSV | About the Data

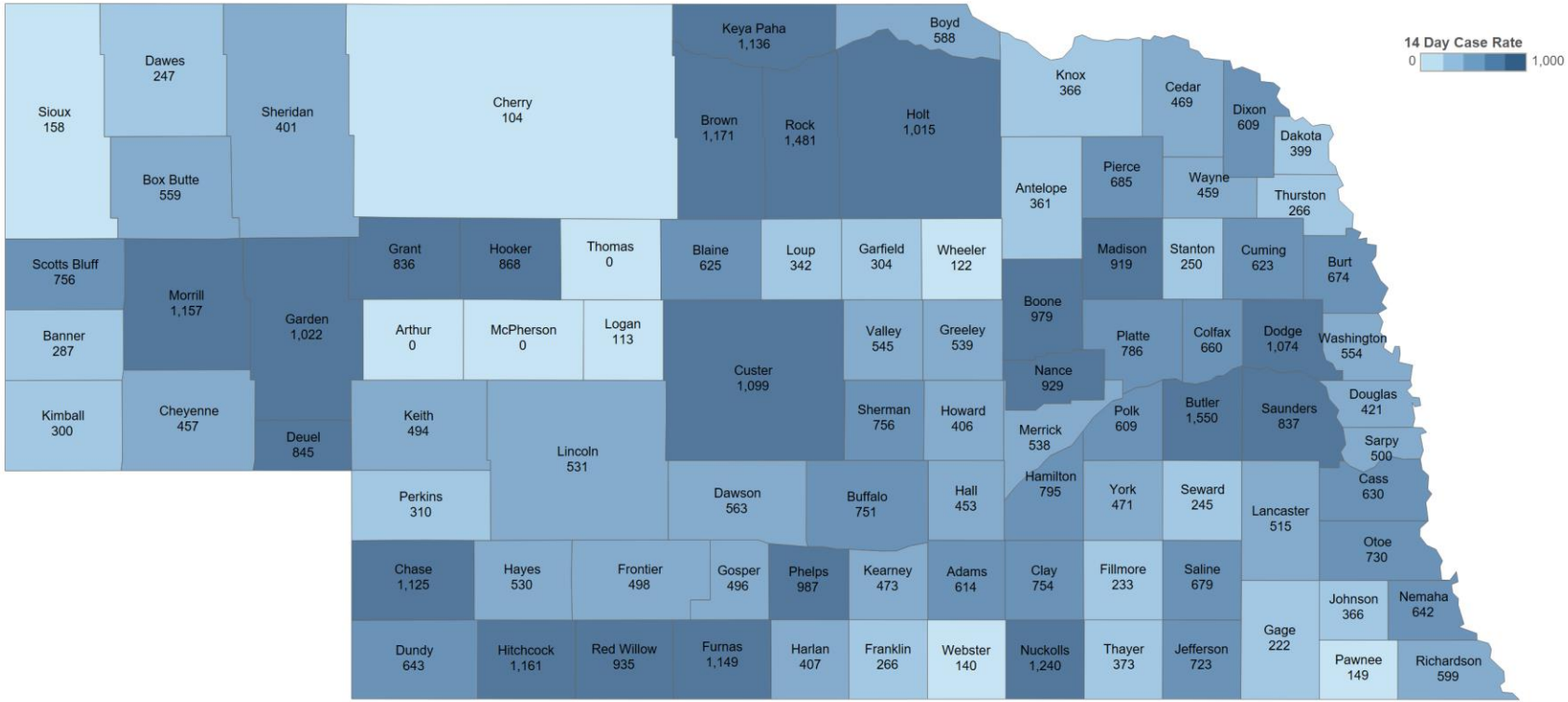
Nebraska Hospital Capacity Dashboard | Nebraska DHHS

Data updated through: 11/14/2021

COVID-19 Case Rate Last 14 Days

Hover over a county in the map to receive additional details pertaining to COVID-19 Cases and Vaccinations

https://datanexus-dhhs.ne.gov/views/Covid/1_DailyCharts?%3AisGuestRedirectFromVizportal=y&%3Aembed=y



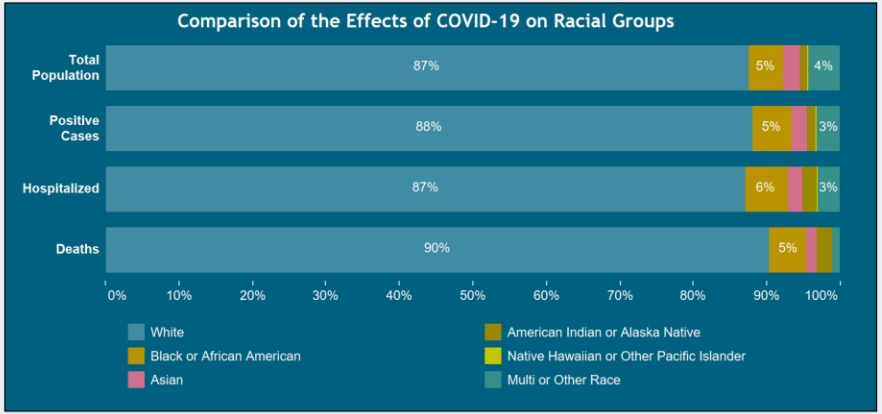
Hospital Capacity | LHD Statistics Map | COVID-19 | County Statistics Map | Age & Gender | Race & Ethnicity | Influenza | RSV | About the Data

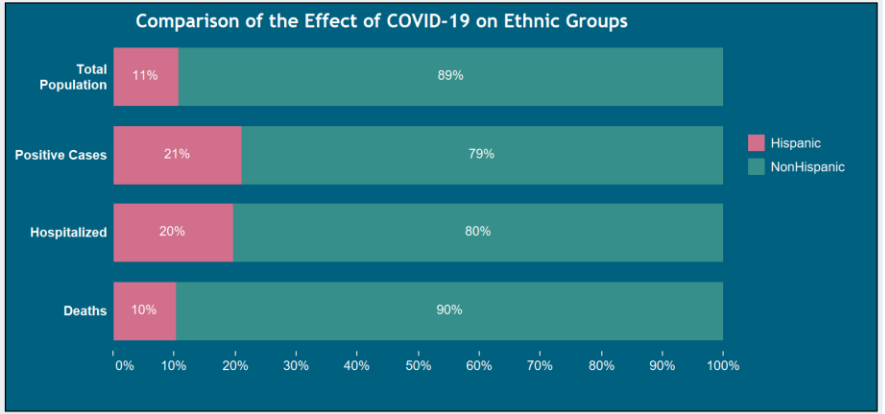
Nebraska Statistics

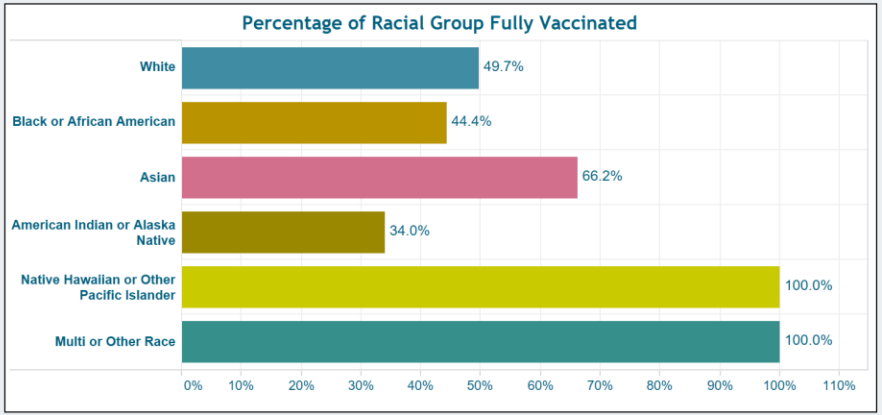
Nebraska Hospital Capacity Dashboard | Nebraska DHHS

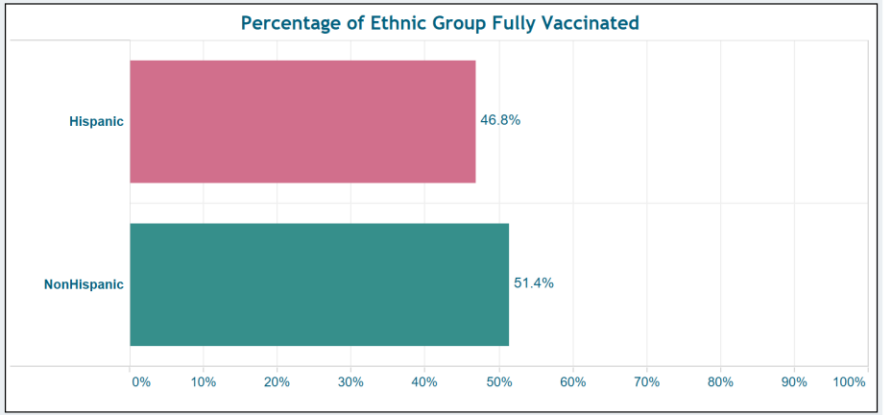
https://datanexus-dhhs.ne.gov/views/Covid/1_DailyCharts?%3AisGuestRedirectFromVizportal=y&%3Aembed=y

Data updated through: 11/14/2021









Hospital Capacity | LHD Statistics Map | COVID-19 | County Statistics Map | Age & Gender | **Race & Ethnicity** | Influenza | RSV | About the Data

Nebraska Statistics

Nebraska Hospital Capacity Dashboard | Nebraska DHHS

https://datanexus-dhhs.ne.gov/views/Covid/1_DailyCharts?%3AisGuestRedirectFromVizportal=y&%3Aembed=y

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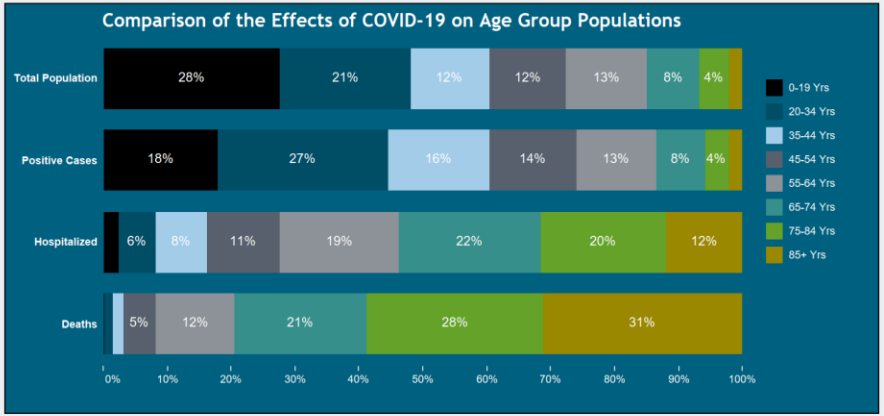

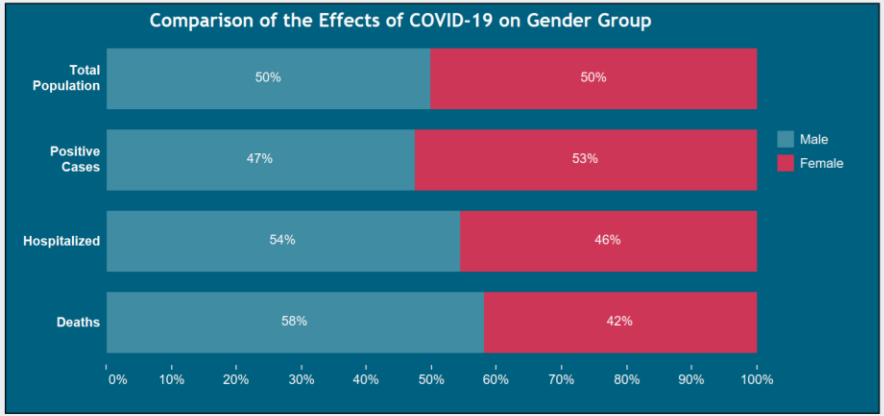

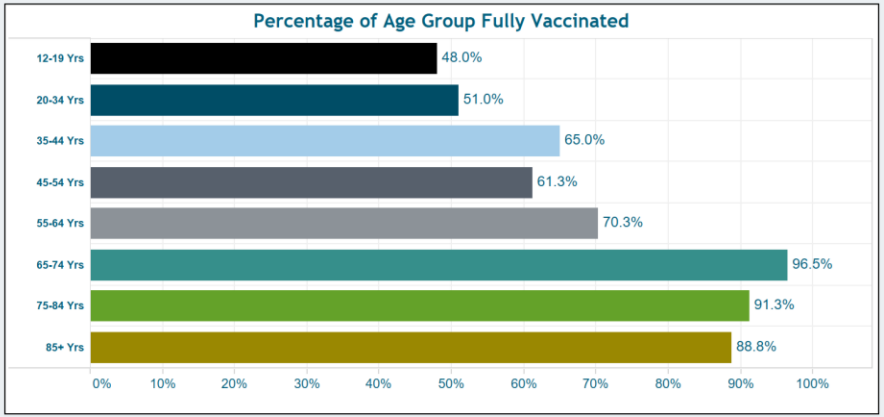

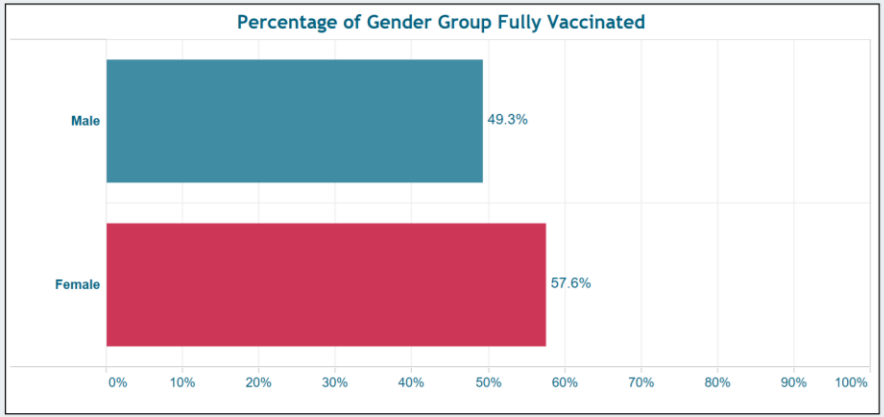

Debrief

For our previous session:

What have you done, or do you hope to do, with this content?

For today's session:

Do you have questions or concerns that we can address?

Case Discussion

75-year-old male resident of an assisted living facility who has multiple comorbidities, including a recent diagnosis of metastatic lung cancer, is arriving at the clinic for an end-of-life discussion.

What IPC policies/protocols need to be in place for a safe visit? How might these be adapted in response to different cultures?

Basic Infrastructure for Infection Prevention and Control

Project ECHO

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Objectives

1. Describe the ways in which facility-level policies and procedures can support COVID-19 infection prevention and control (IPC).

2. Identify changes to facility-level policies and procedures which can improve COVID-19 infection prevention and control for patients who are at higher risk and historically underserved."

IPC Program Goals

Comprehensive IPC programs can:

- Reduce healthcare associated infections
- Minimize the spread of multi-drug resistant organisms
- Address emerging infections and pathogens
- Improve patient safety overall

TABLE 1. Goals for Infection Prevention and Control/Healthcare Epidemiology Programs in 2016 and Beyond

1. Protect the patient[a]
2. Protect healthcare personnel, visitors, and others[a]
3. Meet accreditation and regulatory mandates
4. Accomplish goals above in as cost-effective manner as possible[a]

[a]Goals cited in 1998.

Source: Bryant K et al. *Infection Control & Hospital Epidemiology, 37*(4), 371-380.

IPC Program Activities

Core Activities

- Surveillance
- Reporting
- Acute event/Outbreak response
- Performance Improvement
- Education and Training

Adjunct Activities

- Collaboration with Employee Health Services
- Antibiotic Stewardship
- Participation in Regional and National Collaboratives

Source: Bryant K et al. *Infection Control & Hospital Epidemiology, 37*(4), 371-380.

IPC Program Domains

Outpatient Settings

- IPC Program and infrastructure
- IPC training and competency
- Healthcare Personnel Safety
- Surveillance and Disease Reporting
- Hand Hygiene
- Personal Protective Equipment
- Injection Safety
- Respiratory Hygiene/Cough Etiquette
- Point-of-Care Testing
- Environmental Cleaning
- Device Reprocessing
- Sterilization of Reusable Devices
- High-level disinfection of reusable Devices

Acute Care Settings

- Prevention of CAUTI
- Prevention of CLABSI
- Prevention of VAE
- Prevention of SSI
- Prevention of CDI
- Systems to Detect, Prevent and Respond to HAIs and MDROs

Related

- IPC programs play a role in Antibiotic Stewardship

Source: CDC Infection Control Assessment Tools

Resource:

CDC Infection Control Assessment Tools

Source: CDC Website

Healthcare-associated Infections (HAI)

- HAI Data
- Types of Infections
- Diseases and Organisms
- **Preventing HAIs**
  - Staph BSI Prevention Strategies
  - CDI Prevention Strategies
  - Urine Culture Stewardship
  - Targeted Assessment for Prevention (TAP)
  - Prevention Toolkits
  - Basic Infection Control and Prevention Plan for Outpatient Oncology Settings
  - Outpatient Care Guide
  - Tools for Protecting Healthcare Personnel
  - **Infection Control Assessment Tools**
  - Environmental Cleaning in

Infection Control Assessment Tools

The basic elements of an infection prevention program are designed to prevent the spread of infection in healthcare settings. When these elements are present and practiced consistently, the risk of infection among patients and healthcare personnel is reduced.

The Infection Control Assessment Tools were developed by CDC to assist health departments in assessing infection prevention practices and guide quality improvement activities (e.g., by addressing identified gaps). These tools may also be used by healthcare facilities to conduct internal quality improvement audits.

Assessment Tool by Setting

English

- Infection Control Assessment Tool for Acute Care Hospitals [PDF – 433 KB] (including hospitals and long-term acute care hospitals)
- Infection Control Assessment Tool for Long-term Care Facilities [PDF – 104 KB]
- Infection Control Assessment Tool for Outpatient Settings [PDF – 337 KB]
- Infection Control Assessment Tool for Hemodialysis Facilities [PDF – 278 KB]

Spanish

- Herramienta de evaluación de las prácticas de control y prevención de infecciones en hospitales para enfermedades agudas [PDF – 31 paginas]

Acronyms & Definitions

ICAR: Infection Control Assessment and Response Program

IP: Infection Prevention

Healthcare Personnel IP Competency: The proven ability to apply essential knowledge, skills, and abilities to prevent the transmission of pathogens during the provision of care.

Healthcare Personnel IP Competency-Based Training: The provision of job-specific education, training, and assessment to ensure that healthcare personnel possess IP competency.

Competency Assessment: The verification of IP competency through the use of knowledge-based testing and direct observation. If direct observation is not included as part of a competency assessment, an alternative method to ensure that healthcare personnel possess essential knowledge, skills, and abilities should be used.

IPC Infrastructure Needs

- Policies and procedures, reassessed annually and as needed
- Annual risk assessment
- Priorities for interventions based on risk assessment
- Surveillance resources
- Staff trained in IPC with dedicated time for the work
- Leadership commitment to provide multidisciplinary support to these staff

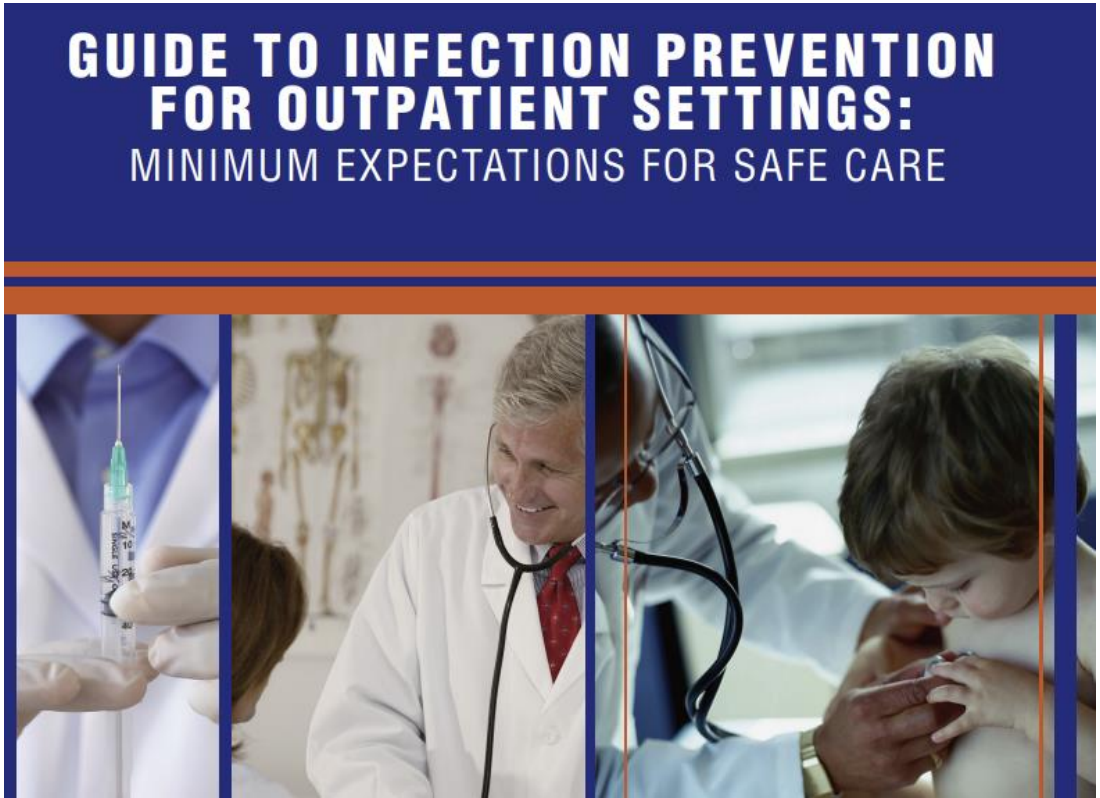
Sources:

- Bryant K et al. *Infection Control & Hospital Epidemiology, 37*(4), 371-380.
- CDC Infection Control Assessment Tools

Resource:

Source: CDC Website

CDC Guide to Infection Prevention for Outpatient Settings



Core Elements for Occupational Health

- Leadership and management
- Communication and collaboration
- Assessment and reduction of risks for infection among HCP populations
- Medical evaluations
- Occupational IPC education and training
- Immunization programs
- Management of potentially infectious exposures and illnesses
- Management of HCP health records

Accessible version: https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/index.html

Infection Control in Healthcare Personnel: Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services

Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases
Division of Healthcare Quality Promotion

Updated: October 25, 2019

David T. Kuhar, MD[a]; Ruth Carrico, PhD[b]; Kendra Cox, MA[c]; Marie A. de Perio, MD[d]; Kathleen L. Irwin, MD, MPH[e]; Tammy Lundstrom, MD, JD[f]; Amanda D. Overholt, MPH[g]; Kristin Tansil Roberts, MSW[c]; Mark Russi, MD, MPH[h]; Connie Steed, RN, MSN[i]; Srila Sen, MA[c]; Thomas R. Talbot III, MD, MPH[j]; David J. Weber, MD, MPH[k]; Hilary Babcock, MD, MPH[l]; and the Healthcare Infection Control Practices Advisory Committee[m]

Source: CDC Infection Control in Healthcare Personnel

IPC Programs and Health Disparities

Table 2. Comparison of the Disparity in Health Care–Associated Infection Rates Between Safety-Net and Non–Safety-Net Hospitals Before and After VBIP Implementation

	Pre-VBIP[a] disparity		Post-VBIP[a] disparity		Post- vs pre-VBIP comparison	
Outcome	Mean IRR or OR (95% CI)[b]	*P* value	Mean IRR or OR (95% CI)	*P* value	ROR (95% CI)	*P* value
CLABSI per 1000 central line-days	1.23 (1.07-1.42)	.004	1.15 (1.00-1.32)	.046	0.93 (0.77-1.13)	.48
CAUTI per 1000 catheter-days	1.38 (1.16-1.64)	<.001	1.24 (1.05-1.47)	.01	0.90 (0.73-1.10)	.31
SSI per 100 colon surgical procedures	1.26 (1.06-1.50)	.009	1.22 (1.03-1.43)	.02	0.96 (0.78-1.20)	.75
SSI per 100 abdominal hysterectomy procedures	1.13 (0.91-1.40)	.27	1.43 (1.11-1.83)	.006	1.20 (0.91-1.59)	.20

Abbreviations: CAUTI, catheter-associated urinary tract infection; CLABSI, central line–associated bloodstream infection; IRR, incident rate ratio; OR, odds ratio; ROR, ratio of ratios; SSI, surgical site infection; VBIP, value-based incentive program.

[a] The pre-VBIP implementation period included data from January 1, 2013, through December 31, 2013. The post-VBIP period included data from July 1, 2017, through June 30, 2018.

[b] IRRs are reported for CLABSI and CAUTI rates. ORs are reported for the SSIs.

Source: Hsu HE et al. *JAMA Netw Open*. 2020;3(7):e209700.

What elements of IPC are frequently impacted by health disparities?

- Vaccination
- Testing
- Personal Protective Equipment (PPE)

What else should we add?

Cultural Sensitivity: Foundational Understanding

Presenters: Dr. Nada Fadul and Mahelet Kebede, MPH

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Objectives

1. Define cultural sensitivity.

2. Describe the cultural sensitivity spectrum.

Chat box: What is the first word that comes to mind when you think of “culture?”

Definitions

Culture

The shared beliefs, practices, and material objects of a group of people.

- **Material culture**: The objects or belongings of a group of people.
- **Non-material culture**: Consists of the ideas, attitudes, and beliefs of a society.

POLL: What type of culture is this an example of?

POLL: What type of culture is this an example of?

Definitions

Values

A culture's standard for discerning what is good and just in society.

Beliefs

Tenets or convictions that people hold to be true.

Ideal vs Real

Values often suggest how people should behave, but they don't accurately reflect how people actually behave.

Ideal culture: the standards a society would like to embrace and live up to

Real culture: the way society really is based on what actually occurs and exists

Reflection

Ideal vs Real Values

What examples can you think of? Enter them into the chat box.

Definition

Cultural Sensitivity

a. Being aware that cultural differences and similarities between people exist without assigning them a value – positive or negative, better or worse, right or wrong.

b. Being aware that cultural differences and similarities between people exist and have an effect on values, learning, and behavior.

c. A set of skills that allows you to understand and learn about people whose cultural background is not the same as your own.

Cultural Sensitivity Spectrum

Framework to understand various stages of cultural sensitivity

Case Study

Case Discussion

75-year-old male resident of an assisted living facility who has multiple comorbidities, including a recent diagnosis of metastatic lung cancer, is arriving at the clinic for an end-of-life discussion.

What IPC policies/protocols need to be in place for a safe visit? How might these be adapted in response to different cultures?

IPC Protocols to Consider

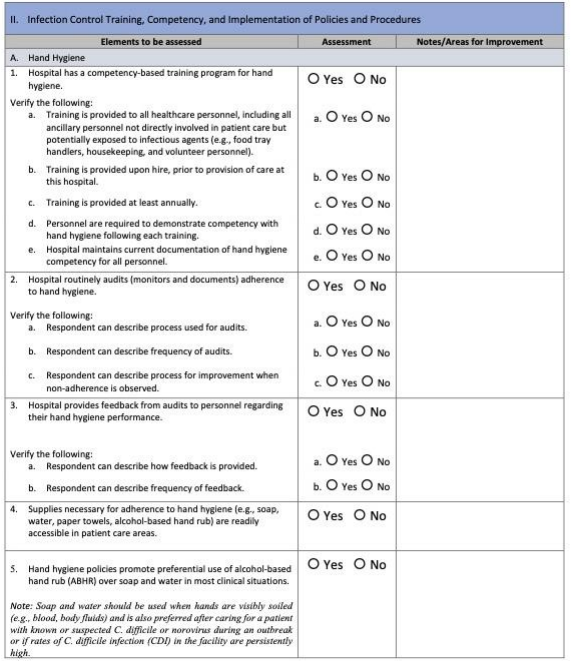
1. Screening before arrival for any isolation needs
2. Screening upon arrival for symptoms and exposures
3. Source control/masking
4. Hand hygiene
5. Respiratory etiquette protocols/ signage
6. Isolation precautions after arrival (if necessary)
7. PPE use protocols (also think of respiratory protection program)
8. Injection safety protocols (if applicable)
9. Point-of-care testing protocols (if applicable)
10. Cleaning and disinfection for reusable medical equipment
11. Environmental cleaning and disinfection
12. Accompanying visitors/ Visitation

Health Equity and Cultural Sensitivity Principles to Consider

1. Availability of interpreters
2. Posted instructions in multiple languages for patients and staff
3. Developing procedural instructions/signage for staff based on staff diversity (language, educational level etc.)
4. Providing needed IPC education, training and oversight regardless of work shift
5. Non-penalizing sick leave policies
6. Making simple resources available (masks, hand sanitizers etc.) for community use of staff and patients who may be in need for that support
7. Offering variety of options for certain services (e.g., testing, vaccination)
8. Incorporating shared decision-making process when making IPC plans with the patient (e.g., planning safe outpatient use of central line)
9. Introducing processes that consider accommodating cultural beliefs and practices by providing reasonable alternatives and exceptions

What can you do in the next 2 weeks?

1. Review your current IPC policies and procedures in core areas
2. Identify a change opportunity that could reduce health disparities or incorporate cultural sensitivity principles



II. Infection Control Training, Competency, and Implementation of Policies and Procedures		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
A. Hand Hygiene		
1. Hospital has a competency-based training program for hand hygiene. Verify the following: a. Training is provided to all healthcare personnel, including all ancillary personnel not directly involved in patient care but potentially exposed to infectious agents (e.g., food tray handlers, housekeeping, and volunteer personnel). b. Training is provided upon hire, prior to provision of care at this hospital. c. Training is provided at least annually. d. Personnel are required to demonstrate competency with hand hygiene following each training. e. Hospital maintains current documentation of hand hygiene competency for all personnel.	O Yes O No a. O Yes O No b. O Yes O No c. O Yes O No d. O Yes O No e. O Yes O No	
2. Hospital routinely audits (monitors and documents) adherence to hand hygiene. Verify the following: a. Respondent can describe process used for audits. b. Respondent can describe frequency of audits. c. Respondent can describe process for improvement when non-adherence is observed.	O Yes O No a. O Yes O No b. O Yes O No c. O Yes O No	
3. Hospital provides feedback from audits to personnel regarding their hand hygiene performance. Verify the following: a. Respondent can describe how feedback is provided. b. Respondent can describe frequency of feedback.	O Yes O No a. O Yes O No b. O Yes O No	
4. Supplies necessary for adherence to hand hygiene (e.g., soap, water, paper towels, alcohol-based hand rub) are readily accessible in patient care areas.	O Yes O No	
5. Hand hygiene policies promote preferential use of alcohol-based hand rub (ABHR) over soap and water in most clinical situations. *Note: Soap and water should be used when hands are visibly soiled (e.g., blood, body fluids) and is also preferred after caring for a patient with known or suspected C. difficile or norovirus during an outbreak or if rates of C. difficile infection (CDI) in the facility are persistently high.*	O Yes O No	

Source: CDC Infection Control Assessment Tools

Wrap-Up

1. You will receive today's presentation, in addition to a one-page key-takeaways document and next session's agenda through email.
2. Next session will be on December 1st on ***"Improved Access & Vaccination; Cultural Values & Attitudes"***.
3. If you'd like to share a case with us, kindly send it by Monday, November 29th.
4. Please complete the pre-assessment survey if you haven't done so already.

Thank You