



UNIVERSITY OF
Nebraska
Medical Center

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

Welcome to Session 38



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
- All the session presentation are available on our [website](#)
- 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

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 - Erica Stohs, MD, MPH
 - Kelly Cawcutt, MD, MS
- Jonathan Ryder, MD

Quality Improvement Team

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CE Disclosures



UNMC ID Health Equity and Quality Improvement ECHO Project

Topics:

IPC: Implications of this ECHO for Infection Prevention and Control

Free Live ECHO Project

May 17, 2023

CID 57619

TARGET AUDIENCE

This accredited continuing education 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:

- Recognize how our understanding of effective infection prevention and control (IPC) has changed since the onset of the COVID-19 pandemic.
- Discuss how IPC content from this ECHO has been applied to organizational improvements.
- Associate core principles of IPC from this ECHO with improvements to organizational preparation for future pandemics and outbreaks.

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. Regulatory boards are the final authority on courses accepted for continuing education credit. Social workers completing this course receive 1.5 general continuing education credits. **Social work level of content: Advanced.**



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: I00055117 Approval Number: 230001567

To claim these CEs, log into your CCMC Dashboard at www.ccmcertification.org.



DISCLOSURE DECLARATION

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.

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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

The below faculty have nothing to disclose:

M. Salman Ashraf, MBBS*

Merck & Co, Inc: Industry funded research/investigator

Kelly Cawcutt, MD, MS

CloroxPro: Medical writer

*faculty and planning committee member



Disclosures

PLANNING COMMITTEE

Erica Stohs, MD, MPH

ReViral Ltd.: Industry funded research/investigator

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www.unmc.edu/cce

POLL



Achieving Equitable Health Outcomes in Nebraska

An ECHO Project Funded by Nebraska DHHS through a CDC grant

June 2023 - May 2024

- Focus on applying QI tools to achieve equitable health outcomes In Nebraska
- Monthly 60-minute sessions every 3rd Wednesday at 12:00 pm CT starting June 21
- Opportunity for additional/continued QI coaching and funding
- Open to continuing and new participants in NE



Achieving Equitable Health Outcomes in Nebraska

Sessions 1-3

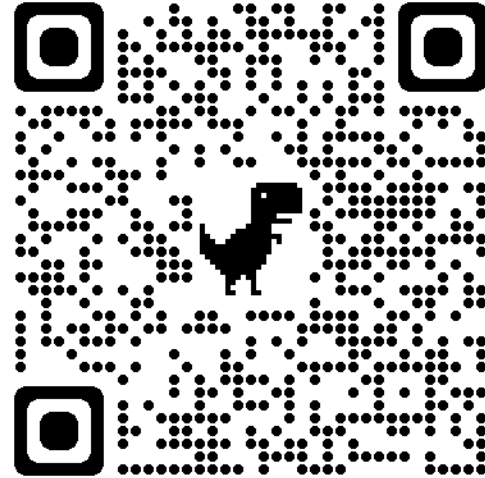
- **Session 1 (June 21):** Implementing Quality Improvement to Meet the Joint Commission's Requirements for Health Equity
- **Session 2 (July 19):** Getting Leadership Buy-in for Health Equity Improvements
- **Session 3 (August 16):** Scoping QI Projects for Health Equity



Participant Interviews

- 30-45 minutes each
- Focused on how you hope to apply what you are learning to your work
- Helps us improve program content

Schedule an interview:



Poll Results



Phase 1 Final Evaluation Survey



<https://redcap.nebraskamed.com/surveys/?s=CKPRPWTLKMMWFAA8>



Infection Prevention and Control: Implications of this ECHO for Infection Prevention and Control

Presenter: Dr. M. Salman Ashraf



Objectives

1. Recognize how our understanding of effective infection prevention and control (IPC) has changed since the onset of the COVID-19 pandemic.
2. Discuss how IPC content from this ECHO has been applied to organizational improvements.
3. Associate core principles of IPC from this ECHO with improvements to organizational preparation for future pandemics and outbreaks.



Reflecting on What We Discussed About IPC Program Infrastructure



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

^aGoals 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

IPC Program Domains

Applicable to all 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
- Antibiotic Stewardship

Setting specific domains

- 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
- Device Reprocessing
- Sterilization of Reusable Devices
- High-level disinfection of reusable Devices



Source: [CDC Infection Control Assessment Tools](#)

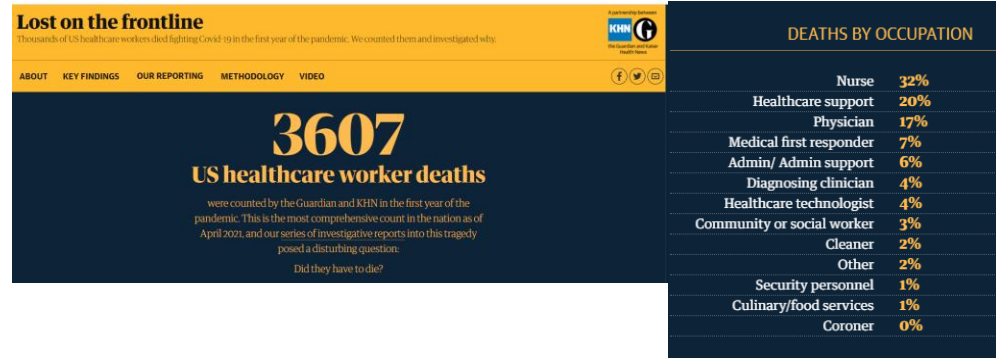


What Lessons We Learned from COVID-19 Pandemic Relevant to Infection Prevention and Control Programs in Healthcare Settings?



COVID-19 Burden on Healthcare Workers

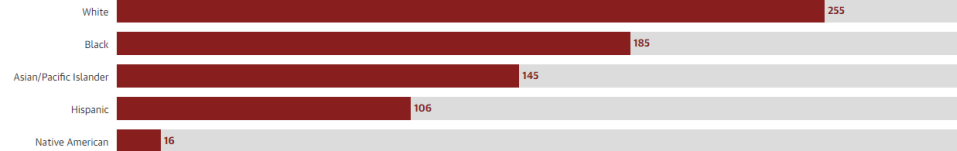
- Guardian and Kaiser Health News reported over 3600 deaths of healthcare workers from 3/2020 to 4/2021 with majority under the age of 60.
- A majority of deceased healthcare workers identified as people of color
- Over 50% worked in nursing/residential facilities
- Many of those who died were worried about not having enough PPE.



A majority of deceased healthcare workers identified as people of color

Although non-Hispanic white Americans account for about 60% of the US population, and Black Americans account for 13% of the population, we found that white healthcare workers died at a lower rate.

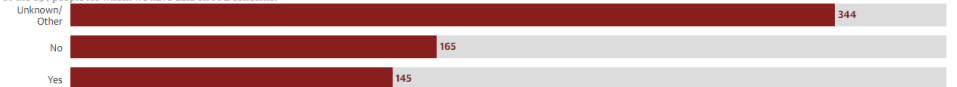
Of the 862 people for whom we have race data,



Many of the cases involved concerns over inadequate PPE

We learned that a large number of those who died were worried about not having enough personal protective equipment (PPE). (We only possess information about PPE concerns for a smaller subset of cases, based on interviews with family members, friends and colleagues, as well as text messages or online messages some victims sent before they died.)

Of the 654 people for whom we have data on PPE concerns,



Select Outcome

- ☒ Deaths
☐ Cases

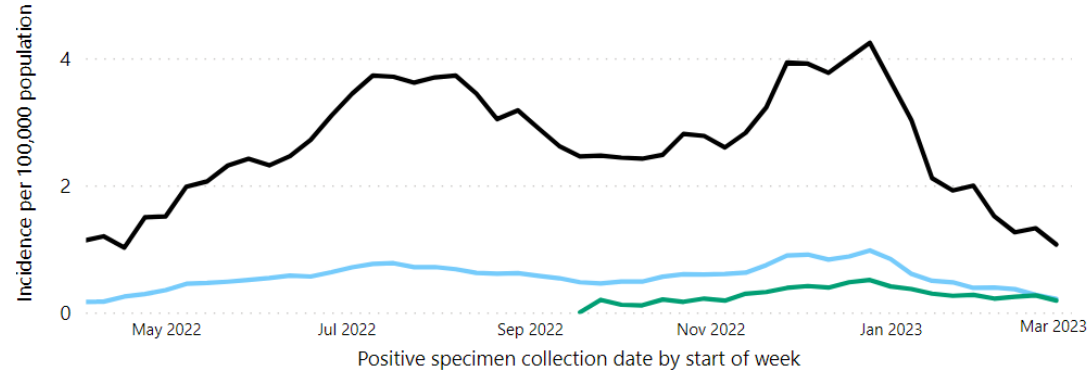
Date

4/3/2022 2/26/2023

Rates of COVID-19 Deaths by Vaccination Status in Ages 18 and Older

April 03, 2022–March 04, 2023 (25 U.S. jurisdictions)

● Unvaccinated ● Vaccinated without updated booster ● Vaccinated with updated booster



In February 2023, people ages 18 years and older and vaccinated with an updated (bivalent) booster had:

6X

lower risk of dying from COVID-19

compared to unvaccinated people, and

1.4X

lower risk of dying from COVID-19

compared to people vaccinated without the updated (bivalent) booster.



<https://covid.cdc.gov/covid-data-tracker/#rates-by-vaccine-status>



Association of NH Staff Vaccination Rate with COVID-19 Outcomes

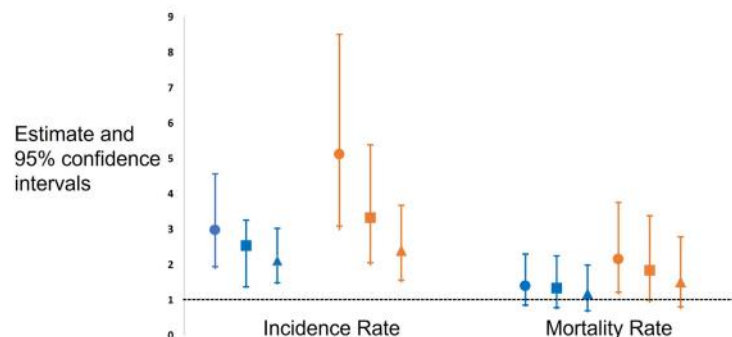
Figure 1. Unadjusted Associations Between Staff Vaccination Rates and COVID-19 Outcomes in Nursing Homes



A, Nursing homes (NHs) with a high proportion of vaccinated staff were in the top quartile (highest 25%) of staff vaccination rates; NHs with a low proportion of vaccinated staff were in the bottom quartile (lowest 25%) of staff vaccination rates. B, Quartiles of staff vaccination rates are calculated for each week and thereby vary for each week. C and D, Data represent facility-weeks between May 30 and December 5, 2021.



COVID-19 Outbreaks in California Skilled Nursing Facilities



- Model 1 = Adjusts for number of certified beds, facility average age, proportion of residents on Medi-Cal, activities daily living score, overall facility rating, operating margin, and employee turnover.
- Model 2 = Model 1 + Healthy places index score, and proportion of neighborhood Black or Hispanic/Latinx.
- ▲ Model 3 = Model 2 + County COVID-19 incidence.

FIGURE 1 Association of racially and ethnically mixed SNFs (blue) & SNFs with $\geq 32\%$ Black or Hispanic/Latinx residents (orange) compared to majority White SNFs with COVID-19 outcomes

Key points

- Skilled nursing facilities with mixed resident racial and ethnic composition and those with $\geq 32\%$ Black or Hispanic/Latinx residents had higher COVID-19 incidence rates compared to SNFs with majority White residents even after adjusting for facility-, neighborhood-, and county-level factors.
- Skilled nursing facilities with the worst financial performances and those located in neighborhoods with the lowest socioeconomic status and in communities of color exacerbated resident COVID-19 disparities.

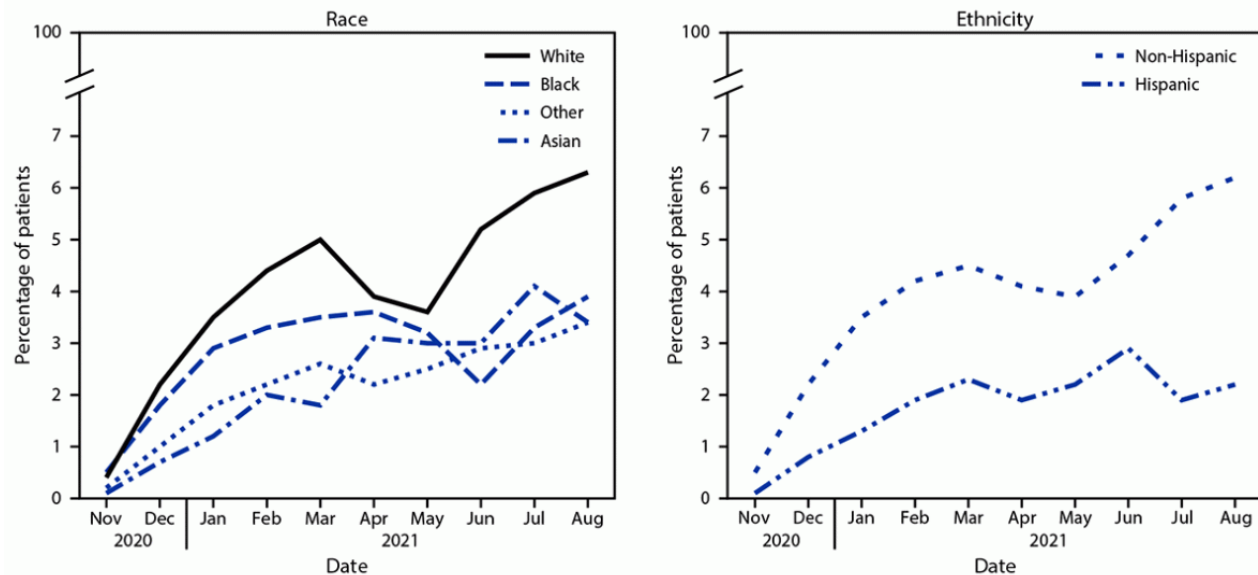
Racial and Ethnic Disparities in Receipt of Medications for Treatment of COVID-19 — United States, March 2020–August 2021

Weekly / January 21, 2022 / 71(3);96–102

On January 14, 2022, this report was posted online as an MMWR Early Release.

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FIGURE. Monthly* percentage of COVID-19 patients (n = 805,276) receiving monoclonal antibody treatment,[†] by race[§] and ethnicity[¶] — 41 health care systems in the National Patient-Centered Clinical Research Network — United States, November 2020–August 2021



Black: 22.4% less often
Asian: 48.3% less often
Other: 46.5% less often

Hispanic: 57.7% less often than non-Hispanic

Some of the Key Lessons to Focus Moving Forward

- Need for improvement in surveillance for healthcare associated infections
- Having preparedness plans in place for emerging infections and highly communicable pathogens
- Better engineering and administrative controls to prevent healthcare associated infections
- Making appropriate PPE available and have proper plans in place to use them (e.g. having a respiratory protection program)
- Finding new strategies to increase vaccination rates for recommended vaccines in both patients and staff
- Developing plans for reducing health disparities that are contributing to healthcare-associated infections



COVID-19 has highlighted the need for infection prevention and control program to focus on addressing health disparities although evidence of disparities in healthcare-associated infections has been noted prior to COVID-19 pandemic



Previous Studies Highlighting Disparities in Healthcare-associated Infections

HAI	Identified disparities	References
CAUTI	Asian and Hispanic patients experienced significantly higher rates than non-Hispanic White patients (5.0% and 4.6% vs. 3.2%)	Infect Control Hosp Epidemiol. 2016;35:S10–6
Hospital-onset MRSA infection	Black patients had higher incidence rates of hospital-onset MRSA infection than White patients (6.21 per 100,000 vs. 2.94 per 100,000)	Clin Infect Dis. 2018;67:1175–81
CDI	When analyzing 1.7 million discharges following CDI, Black patients had significantly higher mortality rates (7.4% vs. 7.2%) and increased incidence of severe CDI (24% vs. 19%) compared to White patients, despite overall CDI being significantly higher among White patients (7.7 per 1,000 vs. 4.9 per 1,000 discharges)	BMC Infect Dis. 2016;16:454
Hospital-acquired BSI	Non-Hispanic Black patients had greater risk of hospital-acquired bloodstream infections than non-Hispanic White patients after adjusting for sociodemographic factors including age, sex, distance to the hospital, and month and year of discharge (hazard ratio 1.31, 95% CI 1.02–1.69). (However, these differences were no longer significant after controlling for other covariates including comorbidities, primary payer, and admission through the emergency department)	Am J Infect Control. 2014;42:1296–302

Health Disparities in HAIs Among Patients Hospitalized with Acute Cardiovascular Disease, Pneumonia, and Major Surgery – 2009 to 2011

Bakullari et al. Infect Control Hosp Epidemiol. 2014 Oct;35 Suppl 3:S10-6

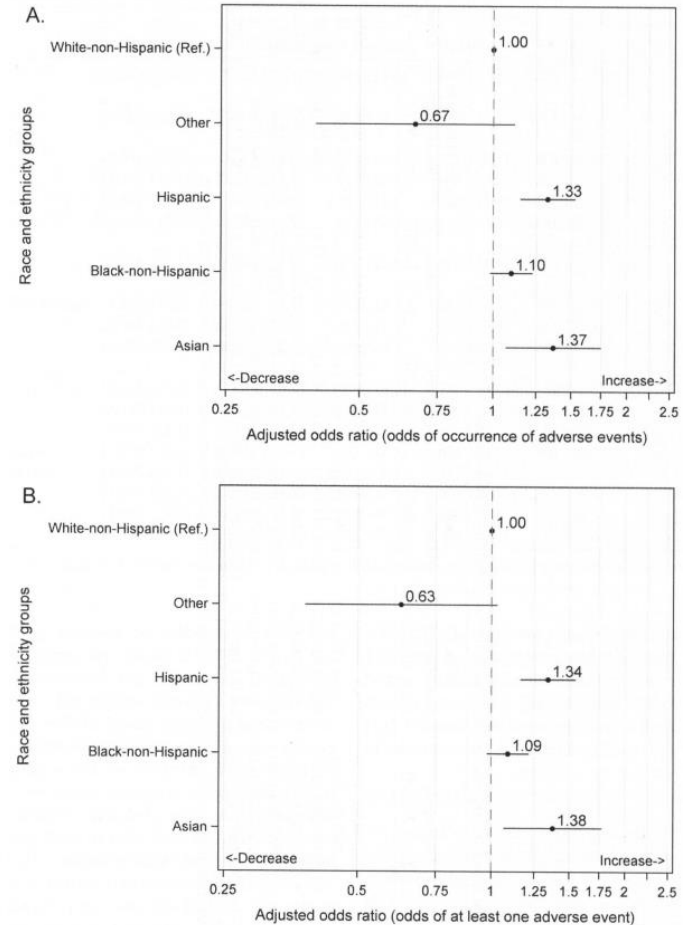


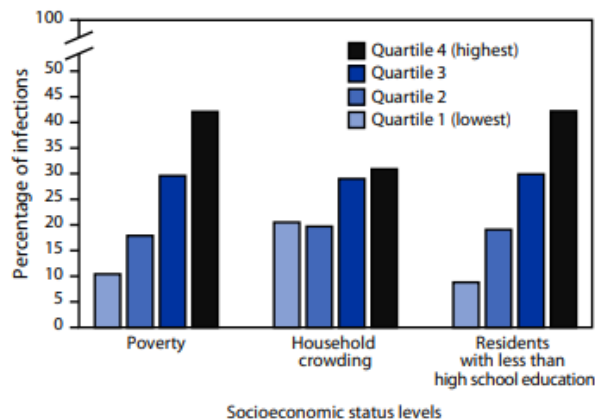
FIGURE 1. Adjusted odds ratios for the occurrence of healthcare-associated infections (A) and at least 1 healthcare-associated infection (B) by race and ethnicity.

Disparities in Hemodialysis-Associated *S. aureus* Infections

TABLE 2. *Staphylococcus aureus* bloodstream infections associated with hemodialysis — Emerging Infections Program,* United States, 2017–2020

Characteristic	Univariate analysis			Multivariable analysis	
	No. of <i>S. aureus</i> bloodstream infections	No. of patient-years	Unadjusted rate [†]	aRR [§] (95% CI)	p-value
Race and ethnicity^{††}					
Black, non-Hispanic	1,509	31,762	4,751	1.1 (0.9–1.2)	0.40
Hispanic	321	7,122	4,500	1.4 (1.2–1.7)	<0.001
White, non-Hispanic	687	17,764	3,866	Ref	—
Other, non-Hispanic	284	9,270	3,061	1.0 (0.8–1.2)	0.92

FIGURE 1. Percentage distribution of *Staphylococcus aureus* hemodialysis bloodstream infections among adult hemodialysis patients, by socioeconomic status levels of U.S. Census Bureau tracts of residence — Emerging Infections Program, United States, 2017–2020



Rha B et al. MMWR Morb Mortal Wkly Rep 2023;72:153–159.



Health Disparities Related to Antibiotic Resistance

<https://www.cdc.gov/drugresistance/pdf/health-equity-antibiotic-resistance-fs-508.pdf>

Antibiotic Resistance and Health Disparities

Health disparities related to AR may occur through a variety of avenues, including variance in risk of exposure or transmission, disparities associated with susceptibility to infection, or treatment received. Examples of known disparities for AR threats include:



CAMPYLOBACTER

Campylobacter infections with decreased susceptibility are more common in low- and middle-income countries, putting travelers at risk for infections that may be harder to treat (CDC, 2019).



ENTEROBACTERIALES BACTERIA

Community-associated ESBL-Enterobacteriales have higher incidence rates in certain geographic areas with lower median incomes, lower high school education rates, higher percentages of persons without health insurance, and limited English proficiency (CDC, 2019).



GROUP B STREPTOCOCCUS (GBS)

Disproportionately impacts infants, pregnant women, older adults, the Black population (regardless of age), and people with certain medical conditions, such as diabetes (CDC, 2019; CDC, 2019).



NEISSERIA GONORRHOEAE (GONORRHEA)

The estimated rate of reported cases among men who have sex with men is 42 times the rate for men who have sex with women only (CDC, 2019).



STAPHYLOCOCCUS AUREUS (S.AUREUS)

Community-associated methicillin-resistant *S. aureus* (MRSA) rates are higher among Black populations when compared to White populations.

Differences in rates of community-associated MRSA may be attributable to socioeconomic factors, including income, housing, education, and health (CID, 2017).



SALMONELLA

Children younger than five and older adults living in higher-poverty census tracts have higher incidence rates of *Salmonella*. Additionally, a higher incidence of *Salmonella* is associated with increasing census tract poverty (JID, 2020).



CANDIDA SPECIES

Candidemia rates are approximately twice as high in Black persons as in non-Black persons, which could be related to differences in underlying medical conditions, socioeconomic status, healthcare access and availability, or other factors (CDC, 2021).



CLOSTRIDIODES DIFFICILE (C. DIFF)

Communities with low-income, foreign-born populations, those who speak less English at home, or with crowding in homes have higher incidences of community-associated *C. diff* infections (CID, 2021).



GROUP A STREPTOCOCCUS (GAS)

American Indian and Alaska Native persons have substantially higher population rates of all invasive GAS disease (EID, 2020). Erythromycin-nonsusceptible invasive GAS disproportionately impacts persons residing in long-term facilities, experiencing homelessness, who are incarcerated, or who inject drugs (CID, 2021).



MYCOBACTERIUM TUBERCULOSIS (TB)

In 2020, the majority of U.S. TB cases occurred among minorities- Asian, Hispanic and Black populations (CDC, 2020).



SHIGELLA

Disproportionately impacts individuals living in poverty or in close contact (homeless shelters) and is higher among children under 5 (OFID, 2020). *Shigella* is especially prevalent among children living in poverty, regardless of sex, race/ethnicity, or geographic location (CDC, 2021).



STREPTOCOCCUS PNEUMONIAE*

The only AR bacterial threat with an effective vaccine, overall rates of invasive pneumococcal disease (IPD) for the Black population have remained higher than the White population with the remaining disparities mainly due to serotypes not covered by the vaccine (2007-2018, CDC).

*Active Bacterial Core Surveillance 2007-2018. Unpublished data. This data demonstrated that IPD rates have remained higher for Black adults than White adults aged 19-64 and 65 and older from 2007 to 2018.

Conceptual Framework to Mitigate Inequities in HAIs

Potential Drivers of Racial/Ethnic Inequities in Healthcare-associated Infections, and Proposed Actions to Mitigate Them

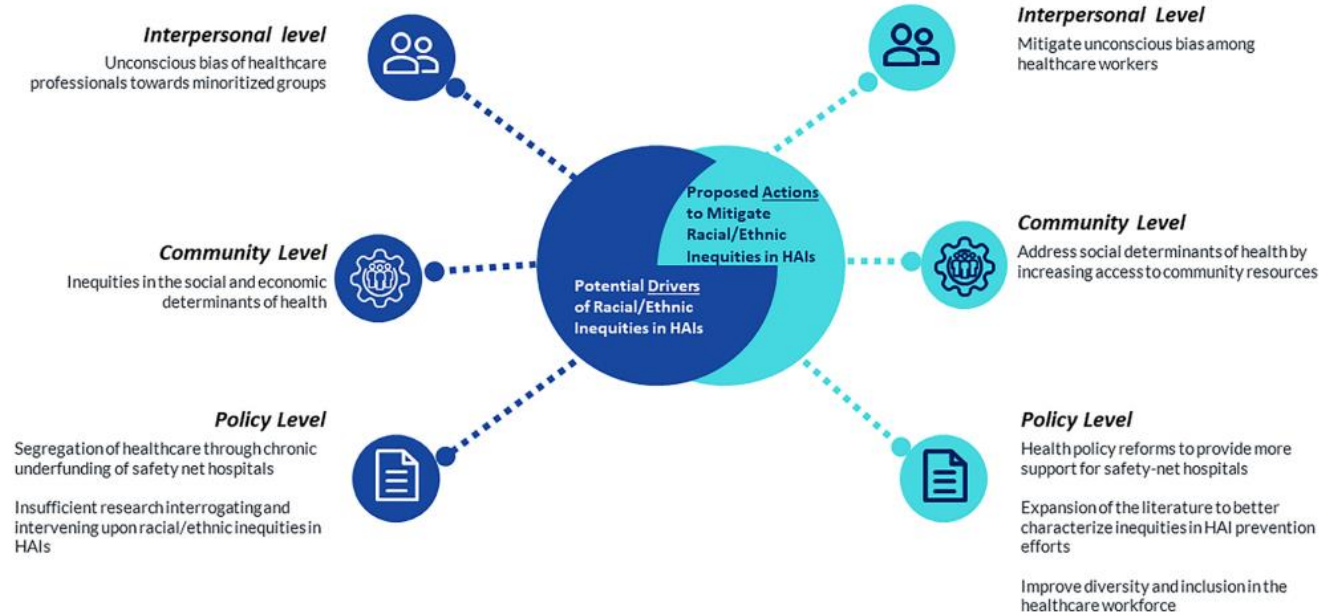


Fig. 1 Conceptual framework



Recommendations from APIC health inequalities and disparities task force to APIC Board of Directors

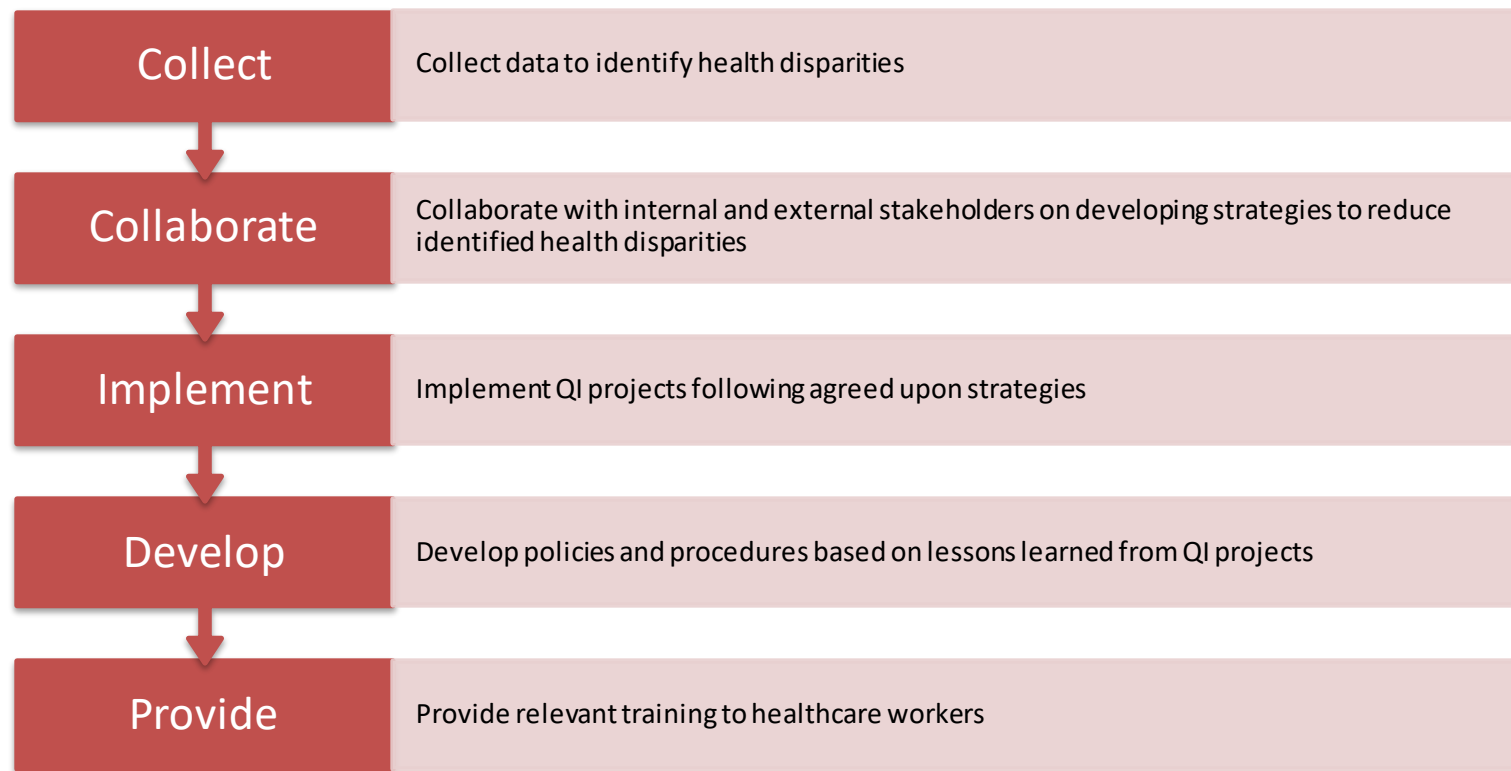
Table 1

Actionable recommendations, challenges, and biopsychosocial influences

Recommendation	Opportunities	Challenges	Biopsychosocial influences
NHSN Data	<ul style="list-style-type: none"> • Begin by making Ethnicity and Race required fields in NHSN 	<ul style="list-style-type: none"> • VA not included • Establishment of data definitions to ensure alignment and prevent misreporting • Data categories offered may not be fully representative • Staff entering data elements with limited bandwidth - additional time required for increased reporting measures 	<ul style="list-style-type: none"> • Biological • Psychological • Social
National organizational partnerships	<ul style="list-style-type: none"> • Consider partnership with SHEA to request implementation of recommendations and data extraction for analysis to NHSN and other initiatives • Other partnerships could include AHA, AMA, ANA, APHA, CDC, IDSA, and IHI to facilitate data obtainment, literature generation, standards of care evaluation, resource development and allocation, quality assessment, and other projects related to HI&D 	<ul style="list-style-type: none"> • Establishing partnership and collaborating on shared priorities 	<ul style="list-style-type: none"> • Psychological • Social
Research	<ul style="list-style-type: none"> • Create HI&D research grant(s) provided to APIC membership • Establish funding for organizations and/or community groups to undertake research and initiatives (external grant) 	<ul style="list-style-type: none"> • Allocation of resources to establish grants • Communicating availability of external grants 	<ul style="list-style-type: none"> • Biological • Psychological • Social
Policy	<ul style="list-style-type: none"> • Partner with CMS and accrediting bodies to incorporate an assessment of inequalities and disparities related to patient safety (process and outcome measures) • Mandate implicit bias training for healthcare professionals • Assess the need for additional educational opportunities related to HI&D • Ensure an appropriate institutional corrective action plan exists when events related HI&D are identified 	<ul style="list-style-type: none"> • Time to implementation may be lengthy 	<ul style="list-style-type: none"> • Psychological • Social
Community involvement	<ul style="list-style-type: none"> • <i>Aforementioned external grants</i> • Creation of easily accessible, multilingual, and multimodal educational materials for patients • Creation of community forum in collaboration with health departments to identify community-specific needs 	<ul style="list-style-type: none"> • Ensuring solutions for resource-poor geographical areas to prevent the creation of disparate situations 	<ul style="list-style-type: none"> • Biological • Psychological • Social
IP Training	<ul style="list-style-type: none"> • Collaborate with CBIC to make HI&D a competency domain • Add HI&D component to requirements for APIC's Program of Distinction • Create APIC training opportunities to help IPs identify and reduce disparities in practice in collaboration with Education Committee 	<ul style="list-style-type: none"> • Creation of a meaningful and effective assessment for HI&D competency • Time to CBIC competency implementation • Identifying IP educational needs and effective strategies to address needs 	<ul style="list-style-type: none"> • Psychological • Social



Steps IPC Programs Can Take to Address HAI Disparities



Case Discussion



Today's Topic

Managing Resistance to Change and Change Fatigue



Case Discussion

- Central line associated bloodstream infections (CLABSIs) in your hospital have increased since the arrival of COVID-19.
- COVID-19 disproportionately impacted historically underserved patient groups, therefore:
 - Increases in CLABSIs have disproportionately impacted populations that were already experiencing health disparities.
 - Current data support the translation to higher rates of CLABSIs in these patient groups.



Highly Adoptable Improvement Model

- **Developed by:** Chris Hayes, MD, Chief Health Information Officer, Trillium Health Partners (Ontario, Canada)
- **Hypothesis:** High perceived value + no additional workload = greater likelihood of adoption and sustainable outcomes
- **Sources:**
 - [Highly Adoptable Improvement Website](#)
 - Hayes CW, Batalden PB, Goldmann D. “A ‘work smarter, not harder’ approach to improving healthcare quality.” BMJ Qual Saf 2015; 24:100–102.



Highly Adoptable Improvement Model

Includes 6 elements that most strongly influence QI adoption

Intervention design (What are you asking people to do?)

1. End-User Participation - Are end-user staff/physicians involved in the change?
2. Alignment & Planning - Does the change initiative align with the organization's and/or team's values and goals and has the rollout been planned effectively?
3. Resource Availability - Are the required resources (training, equipment, time, personnel) for the implementation of the change initiative known and will they be made available?

Source: [Highly Adoptable Improvement Website](#)



Highly Adoptable Improvement Model

Includes 6 elements that most strongly influence QI adoption

Implementation strategy (How are you asking people to do it?)

- | | |
|----|--|
| 4. | Workload - How much workload (cognitive, physical, time) is associated with the intervention? |
| 5. | Complexity - How complex is the change intervention? |
| 6. | Efficacy - What degree of evidence and belief is there that this intervention will lead to the intended outcome? |



Source: [Highly Adoptable Improvement Website](#)



Breakout Exercise

The same qualities that make a change adoptable can help to make a change adaptable and sustainable. Revisit the six elements of adoptability in the context of CLABSI rates:

1. End-User Participation
2. Alignment & Planning
3. Resource Availability
4. Workload
5. Complexity
6. Efficacy



Breakout Room Questions

Revisit the six elements of adoptability in the context of CLABSI rates:

1. What has changed over the past 3+ years? This could include both changes that have persisted and changes that have impacted habits.
2. Did social determinants of health play a role in the fact that CLABSIs occurred at a higher rate in minority populations?
3. Which of these changes do you think are most likely to impact the reliability of infection control processes for CLABSIs?



[Miro Board](#)



Case Discussion

**Breakout
Room 1**

**Breakout
Room 2**

15 mins

**General Discussion
& Take-Home Points**

30 mins

Ground Rules

1. Be present & turn on your videos
2. Make Space, Take Space
3. ELMO: Enough Let's Move On
4. Take the lessons, leave the details
5. Assume positive intent
6. Be open to learning
7. Building, not selling
8. Yes/and, both/and



Revisit the six elements of adoptability in the context of CLABSI rates

	Breakout Room 1	Breakout Room 2
1. What has changed over the past 3+ years? This could include both changes that have persisted and changes that have impacted habits.	<ul style="list-style-type: none"> 1. Higher use of non-local providers 2. Different levels/types of training 3. Constant guidance changes 4. Staffing changing; worker burnout 5. Folks think IPC practices were only due to pandemic and assume we can stop now 6. Remote nursing increased during pandemic to avoid close contact, and as workers adjust back to in-person, there is forgetfulness of proper IPC procedures 7. Priorities constantly changing 8. Sustained supply chain issues 	<ul style="list-style-type: none"> 1. Resource availability - fewer expected products, fewer people 2. EUP: Staffing turnover and changes 3. EUP: Increased temp staff - investment and buy-in 4. Competency training - knowledge of BPs in IPC policies and procedures 5. Policies we moved away from and then came back to 6. Increases in personnel costs and impact on budget 7. Burnout negatively impacts IPC adherence
2. Did social determinants of health play a role in the fact that CLABSIs occurred at a higher rate in minority populations?	<ul style="list-style-type: none"> 1. Potentially, <u>take a look</u> at data. check-in with providers on their observations too. 2. Do a drill down to investigate potential role of SDOH in higher rates. Be sure to incorporate SDOH. 3. <u>Previous</u> to hospital encounter, what was the impact of SDOH? It may be pre-hospitalization. 4. Geographic location - resources limited in rural setting can impact. 	<ul style="list-style-type: none"> 1. Access to care, timeliness of diagnosis and treatment 2. Built environment 3. Preexisting health disparities became increased disparities during COVID 4. Acceptance/fear of COVID vaccination, negative historical experiences with the HC system, 5. Lack of trust in gov't/HC 6. Working environments that encourage COVID spread (ex: packing plants)
3. Which of these changes do you think are most likely to impact the reliability of infection control processes for CLABSIs?	<ul style="list-style-type: none"> 1. Staff turnover 2. Insufficient time/not taking shortcuts 3. Education of workforce on this skill 4. Lack of experience with central line placement 	<ul style="list-style-type: none"> 1. Resources: Are products meeting expectations? 2. P&P: Are competencies there across staff? 3. Reinforcing basics and predictability 4. Workload: How are we creating a new normal instead of trying to recreate the old normal?

General Discussion

Some changes that our faculty have seen impact CLABSI rates:

1. Focus on the adoption and maintenance of COVID-19 IPC practices took attention away from existing practices
2. Increased patient loads for nurses due to staffing shortages
3. Less time for routine education and feedback due to increased patient loads
4. Longer average patient stays in the ICU due to COVID-19 infections
5. Less frequent direct observation of patients in isolation due to COVID-19 infection



References

- Dramatically higher CLABSI rates in patients with COVID-19 vs. patients without COVID-19. (Source: [Haroun et. al. 2021](#))
- Differences in HAI occurrences by race and ethnicity in a network of community hospitals. (Source: [Getler et. al. 2022](#))
- Higher CLABSI rates for Black patients vs general patient population, with the disparity growing during the pandemic. (Source: [Getler et. al. 2022](#))



Current State of COVID-19 in Nebraska

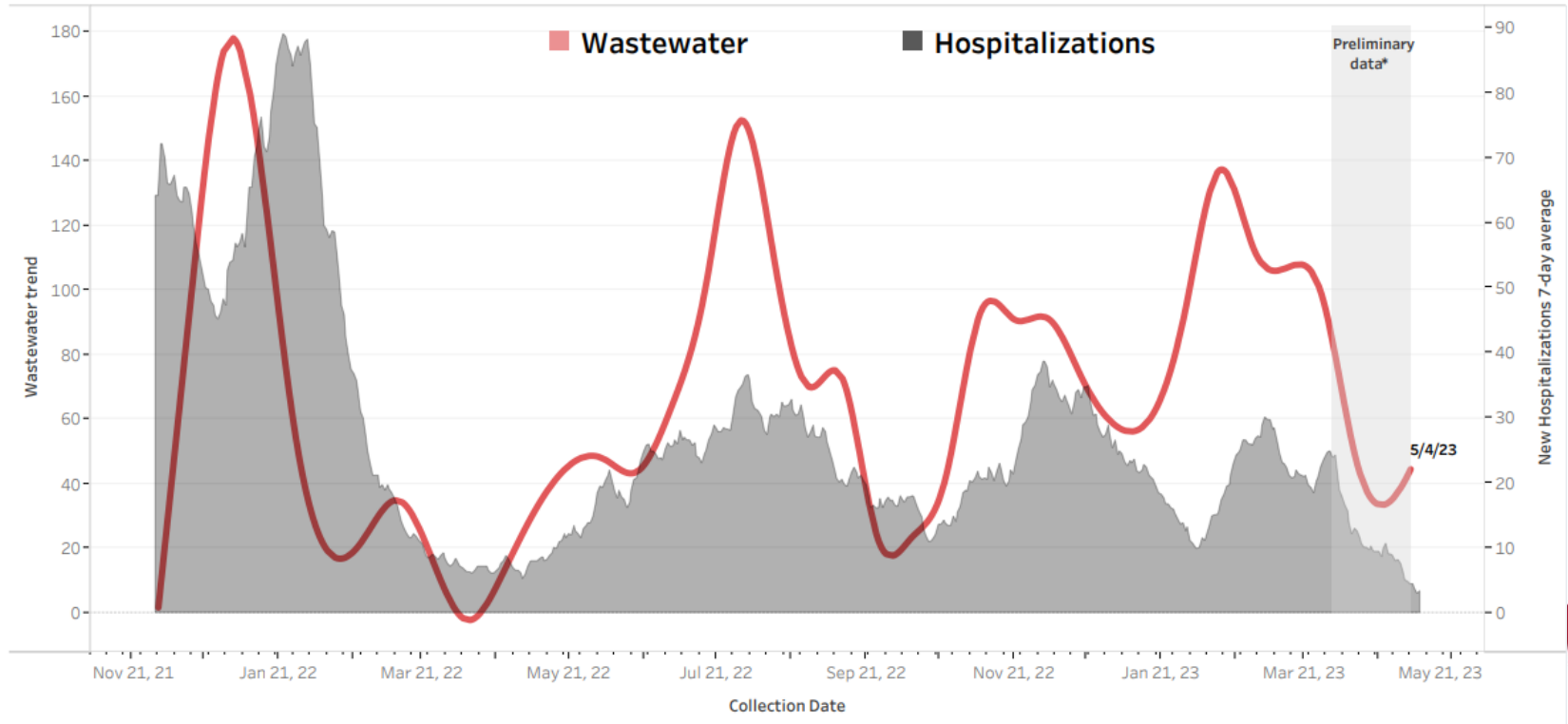


Nebraska COVID-19 Statistics

Nebraska SARS-CoV-2 Wastewater Surveillance Report

Nebraska Statewide SARS-CoV-2 Wastewater Levels and COVID-19 Hospitalizations

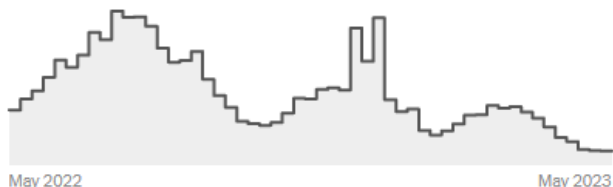
Updated 5/10/2023



Nebraska COVID-19 Statistics

Weekly cases

May 4 to 10
373
14-day change
-10%



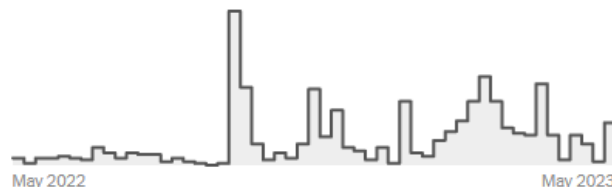
Test positivity rate

Avg. on May 11
8.0%
14-day change
+11%





Weekly deaths

May 4 to 10
24
14-day change
+100%

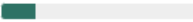


Primary series vaccination rate

67% 
Total population
[About this data](#)

95% 
Ages 65 and up

Bivalent booster rate

18% 
Total population

48% 
Ages 65 and up

A bivalent booster [is recommended](#) for adults and most children if it has been at least two months since their last dose.



Nebraska COVID-19 Statistics

Stay Up to Date with COVID-19 Vaccines

Updated May 11, 2023

[Español](#) | [Other Languages](#)

[Print](#)

What You Need to Know

- [Everyone aged 6 years and older](#) should get **1 updated Pfizer-BioNTech or Moderna COVID-19 vaccine** to be [up to date](#).
- [People aged 65 years and older](#) may get a 2nd dose of updated Pfizer-BioNTech or Moderna COVID-19 vaccine.
- [People who are moderately or severely immunocompromised](#) may get additional doses of updated Pfizer-BioNTech or Moderna COVID-19 vaccine.
- [Children aged 6 months–5 years](#) may need multiple doses of COVID-19 vaccine to be [up to date](#), including at least 1 dose of updated Pfizer-BioNTech or Moderna COVID-19 vaccine, depending on the number of doses they've previously received and their age.
- COVID-19 vaccine recommendations will be updated as needed.

Nebraska COVID-19 Statistics

Week	Weekly Cases per 100k	Weekly Admits per 100k	% COVID-19 Hospitalizations
4/19/23	38.0	4.3	3.2
5/3/23	21.8	2.4	2.0
5/17/23	19.3	2.2	1.4



<https://covidactnow.org/us/nebraska-ne/?s=46443393>



POLL



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. Phase 2, **Session 1 on June 21st:**
 - ***Review the Joint Commission's Health Equity new requirements for health care organizations (effective July 1, 2023)***
 - ***Discuss examples of quality improvement (QI) projects which align with the Joint Commission's requirements***
 - ***Recognize the ways in which different roles can contribute to QI projects to promote health equity***



[Registration](#)



Phase 1 Final Evaluation Survey



<https://redcap.nebraskamed.com/surveys/?s=CKPRPWTLKMMWFAA8>



Poll Results



Thanks

