Working together to improve health care quality, outcomes, affordability, and equity in Washington State

Outpatient Infection Control

2022

Bree Collaborative Outpatient Infection Control Guidelines
Updated: June 29, 2022

Executive Summary

Many patients receive health services in outpatient settings, also known as ambulatory settings, where they do not need to be admitted to the hospital. Outpatient services can increase accessibility and affordability of clinical care and are often well-received by patients. Despite these benefits, outpatient settings vary greatly in their resources and infection control capability. Over the past few years, infection control guidance rapidly evolved in response to the COVID-19 pandemic. More work is needed to align guidance for

The Bree Collaborative elected to develop recommendations for outpatient infection control activities in 2021 and convened a workgroup of subject matter experts from January to September 2022. This guideline is meant to be applicable to all outpatient (ambulatory) care centers, regardless of specialty. This guideline is meant to supplement existing guidelines from federal, state, and local public health organizations and provide a path forward for outpatient facilities to prioritize infection control activities. Specific focus areas discussed in this guideline include **prevention, surveillance, minimizing exposure, environment of care, sterilization and high-level disinfection,** and **community spread.** Recommendations are directed toward:

- Outpatient health delivery systems
- Health insurance plans
- Employer health care purchasers
- Public health agencies
- Those receiving care (patients/consumers)

This report is meant to complement existing regulations and guidelines. Consult with your local public health jurisdiction, review federal and state guidance, and follow requirements from any applicable regulatory agencies as well. Our aim is to not be overly prescriptive in our recommendations in a way that inhibits providers and outpatient settings from providing the best care for patients.

We summarize available evidence and guidelines for infection control activities through a review of evidence from the Centers for Disease Control and Prevention, the Washington State Department of Health, Washington State Labor and Industries, other public health agencies outside of Washington, and available articles on infection control practices.

We hope this guideline is useful to our health care ecosystem and people being served as we navigate the opportunities for care improvement.

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Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 *"…to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State."* The Bree Collaborative was named in memory of Dr. Robert Bree, a leader in the imaging field and a key member of previous health care quality improvement collaborative projects.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying health care services annually with substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State's largest health care purchasers, Medicaid, and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

Bree Collaborative members identified telehealth as a priority improvement area and convened a workgroup to develop evidence-informed standards. The workgroup met from January to September 2022.

See **Appendix B** for the workgroup charter and a list of members.

Background

Over the past few decades, healthcare delivery has largely moved from acute inpatient facilities to outpatient and community-based settings.[1] More than three quarters of all operations in the United States are performed outside of a hospital[2] and each year more than one million Americans receive

outpatient chemotherapy, radiation therapy, or both.[3] Proper infection control practices are essential to reduce the risk of healthcare-acquired infections.[4] Outpatient settings often lack infrastructure or resources for infection control.[5,6] The Centers for Disease Control developed minimum expectations for outpatient infection control in 2016,[7] but emerging pathogens and the COVID-19 pandemic have highlighted the need for more robust procedures.

As of April 2022, almost 1.5 million Washingtonians have contracted COVID-19 with more than 60,000 COVID-19 patients requiring hospitalization.[8] Many best practices for COVID-19 involved basic infectious control measures such as mask wearing, eye protection, hand sanitizer availability, rapid testing, and vaccination.[9] The increase of these measures appears to have reduced the prevalence of RSV, acute bronchitis, common cold, and flu, although confounding factors may have played a role.[10,11]

As the COVID-19 pandemic evolves and fluctuates, there are concerns that loosening infection control practices may lead to increased spread of disease, unwanted hospitalization, and deaths especially among vulnerable populations. Additionally, many best practices during the pandemic targeted long-term care or inpatient facilities or were subject to variability depending on local, state, and federal jurisdictions.

This guideline focuses on infection control measures for outpatient healthcare settings. Recommendations are meant to be generalizable to healthcare delivered outside of inpatient hospital settings. While these recommendations provide a general outline to improve infection control practices, each site must adhere to applicable regulations from the Centers for Disease Prevention and Control, Department of Health, and their local health jurisdiction as needed. A summary of additional resources and checklists to guide outpatient infection control programs can be found in **Appendix C.** The Bree recommendation focus areas are organized around the point of care for infection control measures as shown in **Table 1**. To identify focus areas, the workgroup relied on existing guidelines from federal and state agencies, available evidence, and expert opinion.

Table 1: Bree Collaborative Outpatient Infection Control Focus Areas

Focus Areas	Clinical Goal(s)
Preventative Measures	• Enact proper precautions and procedures for infection prevention • Use of proper PPE and physical distancing as needed • Encouraging vaccines as a preventative measure • Protect and educate patients and staff
Monitoring/Surveillance	• Collect and report data on notifiable conditions • Provide information on circulating infectious diseases to patients and staff • Improve surveillance capacity
Minimizing Exposure	• Prevent infection from spreading once a positive case is identified

	• Develop clinical workflows for patients based on their risk or infection status
Environment of Care	• Ensure clinical environment is regularly clean and facilitates infection control
Sterilization and High-Level Disinfection	• Practice proper routine device sterilization according to manufacturer instructions • Practice proper high-level disinfection of all devices
Community Spread	• Partner with patients and communities to mitigate the spread of disease • Educate patients and communities about their risk of disease and what they can do to prevent illness

Recommendations

A. Outpatient Health System

Outpatient health systems are clinics and health delivery sites outside of inpatient hospitals. These recommendations are meant to be generalizable to most outpatient settings.

Prevention

Providers, Staff and Patients

- Inform patients on risk of infection and educate patients on how to mitigate risk
- Enact proper standard, contact, and droplet precautions for healthcare providers and staff (DOH) and airborne precautions (AIIR)
- Educate staff on all infection control procedures, including hand hygiene, injection safety, and standard precautions.
- Educate and encourage appropriate vaccination for patients, staff and providers based on the CDC Immunization Schedule and ACIP Vaccine Recommendations. Consider motivational interviewing to address vaccine hesitancy.
- Vaccinate staff and providers based on CDC recommended vaccines for healthcare providers and maintain records of exemptions (required for clinics receiving funding from CMS)
- Staff, providers and patient practice proper hand hygiene, respiratory hygiene/cough etiquette, and mask guidance, injection safety practices
- Staff and providers practice proper injection safety practices
- Treat high-risk populations prophylactically (eg using antivirals such as Tamiflu, monoclonal antibodies, Evusheld) based on current evidence and guidelines.

Administration

- Assign at least one individual trained in infection prevention to coordinate the outpatient setting's infection control program.
- Provide proper PPE based on standard and transmission-based precautions according to the CDC (Standard Precautions and Transmission-Based Precautions)
- Ensure physical environment is optimized in consideration of infection prevention and control, including placement, and spacing of furniture and ability to clean furniture and other shared items.
- Ensure infection control training and competency for staff (CDC)
- Manage the risk of staff infections according to current guidelines (DOH)
- Provide appropriate time off for infectious disease considering potential incubation period and infectious period (in alignment with DOH recommendations for staff exposure risk and staff shortage requirements)

Monitoring/Disease Surveillance

- Provide information to patients about the prevalence of circulating communicable diseases as available from local public health jurisdictions, Washington state Department of Health, the Centers for Disease Control, and other sources.
- Coordinate with appropriate level of public health for reportable infectious diseases. (Notifiable conditions for Washington state can be found here.)
- Consider providing point-of-care testing for patients and staff members or offer resources regarding where testing is available if unavailable in the outpatient setting.

Minimizing Exposure

Currently Infected Patients (Identified as having a communicable or highly infectious disease)

- In Office Visit
    - Notify arrival prior to entry of building
    - Encourage online check in
    - Take a home test if available to confirm disease
    - Patient to wear appropriate PPE including mask (surgical vs N95) type according to current guidelines
    - Wash hands and limit contact with objects
    - Room immediately upon arrival
        - Use an EPA-registered healthcare disinfectant with consideration of pathogens that are a high-risk according to manufacturer's instructions with focus on high-touch areas.
    - Exit separately if plausible
- Telehealth
    - Offer phone or virtual visit if triage for visit appropriate
    - Follow Bree Collaborative Telehealth guidelines

- Referral
    - Refer to Urgent Care or ER if appropriate and necessary for higher level of care or if infection prevention and control requirements exceed that of the facility.

High Risk Patients (during periods of high prevalence of disease of interest)

- Educate patients who are high risk
    - Have signs in office for this risk group
    - Coordinate with local public health for public outreach
- In Office visit
    - Notify arrival prior to entry of building
    - Encourage online check in
    - Patient to wear mask (surgical vs N95) type depends on latest evidence
    - Wash hands and limit contact with objects
    - Room immediately upon arrival
        - Use an EPA-registered healthcare disinfectant with consideration of pathogens that are a high-risk according to manufacturer's instructions with focus on high-touch areas.
    - Exit separately if plausible
- Telehealth
    - Offer phone or virtual visit if triage for visit appropriate
    - Follow Bree Collaborative Telehealth guidelines
- Referral
    - Refer to Urgent Care or ER if appropriate and necessary for higher level of care or if infection prevention and control requirements exceed that of the facility.

Low Risk Patients (screened negative for disease, low risk for contracting disease)

- Follow standard in office registration and rooming procedures
- Follow standard precautions (such as using proper PPE for aerosolizing procedures, practicing proper masking/cough etiquette)

<u>Environment of Care</u>

- Maintain ventilation systems
- Provide easily accessible masks, hand sanitizer, and garbage cans
- Ensure all surfaces are cleanable
- Ensure clear separation between clean and dirty storage
- Appropriate storage of supplies and regular review expiration dates of medications and equipment
- Ensure physical environment is optimized in consideration of infection prevention and control, including placement, and spacing of furniture and ability to clean furniture and other shared items.

<u>Sterilization and High-Level Disinfection</u>

- Develop plans for routine device sterilization and environmental cleaning
- Practice proper reprocessing and sterilization of reusable devices
- Follow nationally recognized and evidence-based guidelines and follow manufacturer's
- instructions for use (MIFUs)

Community Spread

- Participate in community health meetings and establish relationships prior to an outbreak
- Participate in infection control meetings convened by local public health
- Partner with community leaders and media for information campaigns
- Provide educational material about preventative measures and treatments

B. Employers

Prevention

- Provide incentives for testing
- Provide incentives for vaccination as a preventative measure. Educate and encourage appropriate vaccination based on the CDC Immunization Schedule and ACIP Vaccine Recommendations. Provide educational sessions with experts and trusted community leaders to address vaccine hesitancy and misinformation.
- Provide workers with face coverings and surgical masks as appropriate as well as PPE required by the position.
- Provide appropriate paid time off for infectious disease based off transmission time and/or current physical symptoms.
- Follow current guidelines for quarantine or isolation procedures for infected and/or exposed employees and create policy for management and staff.
- Provide appropriate PPE and spacing if deemed necessary for infectious control.
- Implement protections from retaliation for employees who report failures to comply.
- Follow any other applicable mandatory Washington State Labor and Industries and OSHA standards for workplace disease prevention.

Monitoring/Disease Surveillance

- Record and report reportable infections and deaths to the appropriate authority, usually OSHA, WA Labor and Industries, or the Department of Health

Minimizing Exposure

- If a symptomatic employee does need to come to work, consider minimizing exposures through PPE, proper hand hygiene, and encouraging alternative work structures
- Follow other applicable mandatory Washington state Labor and Industry and OSHA standards to minimize workplace exposures.

Environment

- Perform routine cleaning and disinfection
- Improve infrastructure for infection control such as spacing and barriers
- Create workflows to minimize exposure during times of high community spread using virtual meetings, work from home and physical distancing as necessary

Sterilization/High-Level Disinfection

- Use EPA approved disinfectants (for low and intermediate level)
- Follow nationally recognized and evidence-based guidelines and follow manufacturer's
- instructions for use (MIFUs)

Community Spread

- Educate workers on Infectious Disease policies and procedures in accessible formats

C. Insurers

Prevention

- Cover at-home and in-person testing for circulating illness
- Provide incentives for vaccination as a prevention measure. Educate and encourage appropriate vaccination based on the CDC Immunization Schedule and ACIP Vaccine Recommendations.
- Cover cost of vaccination and administration
- Cover PPE costs as medical equipment for infected clients
- Consider increase physician payment for patient infectious disease control measures, and vaccine education including addressing hesitancy.
- Consider continuing telehealth reimbursements
- Consider infection control targets/measures in value-based purchasing

Monitoring/Disease Surveillance

- Assist disease reporting to Public Health officials using charge data

Minimizing Exposure

- Cover prophylactic treatments for high-risk populations
- Work with infected patients in a declared pandemic to remove financial barriers to treatment such as waiving copays, reducing deductibles, or identifying qualified charity care.

Environment of Care

- Increase infected patient payments to cover additional environmental costs

Sterilization/High-Level Disinfection

Community Spread

- Participate in educational campaigns to support current preventive measures and treatments

D. Public Health

Prevention

- Communicate up-to-date preventative guidelines to other public health agencies, health delivery systems, providers, and patients as appropriate.
- Expand access to vaccines and ensure efficient roll-out of vaccine programs.
- Align/coordinate communication efforts between state- and local- public health
- Consider hiring staff to maintain communication and coordination efforts including alignment with other public health agencies and providing information to the public
- Include local voices from patients and physicians when developing guidelines and revise guidance based on community input.

Monitoring/Disease Surveillance

- Develop and maintain accessible dashboards for communicable diseases
- Maintain accessible registries of immunization records

Staffing/Administration

- Provide technical assistance and education in a non-regulatory process to outpatient health facilities (ICAR)

Environment/Sterilization

- Train/educate outpatient health facilities on sterilization and high-level disinfection

Community Spread

- Provide public communication campaigns on infection control and community spread of infectious diseases

E. Patients

Prevention

- Keep appropriate preventative goods at home, including hand sanitizer and masks
- Get appropriate vaccinations per ACIP schedule

Monitoring/Disease Surveillance

- Have appropriate home tests available and use if you develop relevant symptoms or are
- in close contact with a confirmed case per testing guidelines

- Stay current on the prevalence of disease in your community using local and national web tools or other available sources.
- Discuss your personal health risk for community infectious diseases with a trusted healthcare provider
- Report your disease status to the appropriate authorities to assist with disease prevalence data if you test positive

Minimizing Exposure

- Follow CDC mask guidelines, or your local county's guidelines if applicable
- Stay home or contact your healthcare provider if you have a fever or are contagious within 24 hours before a scheduled appointment.

Community Spread

- Maintain physical distance from others during periods of high transmission of communicable diseases

Review of Evidence

The workgroup conducted an evidence review of existing guidelines from state and local public health agencies as well as published evidence on infection control measures, especially recent measures in response to the COVID-19 pandemic. Additional resources to guide outpatient infection control programs can be found in **Appendix C.**

Preventative Measures

The Centers for Disease Control and Prevention (CDC) and the Washington State Department of Health (DOH) provide healthcare infection control resource centers, as well as infection control guidance for outpatient settings.

The CDC's 2016 Guide to Infection Prevention for Outpatient Settings[12] recommends minimum expectations for safer care, including:

- Dedicate administrative resources to infection prevention
- Educate and train healthcare personnel
- Monitor and report healthcare-associated infections
- Adhere to standard precautions (hand hygiene, personal protective equipment, safe injection practices, safe handling of potentially contaminated equipment, and respiratory hygiene)

Additional standard precautions for infection recommended by the CDC include appropriate patient placement, proper handling of needles and other sharp material, and proper sterilization/disinfection.[13]

The Washington state Department of Health offers additional resources to improve infection control programs, including the Infection Control Assessment and Response (ICAR) program. The ICAR program is a non-regulatory, free program that offers healthcare facilities the opportunity to participate in a consultation and review of their infection prevention practices.[14]

In addition to minimum expectations for safe care, this workgroup examined emerging guidance for prevention during the COVID-19 pandemic, including the personal masks, physical distancing, and vaccination. As of the publication of this report, the CDC maintains a COVID-19 webpage for resources to manage the spread of COVID-19[15] and the Washington DOH offers interim recommendations for SARS-CoV-2 infection prevention.[16]

During the COVID-19 pandemic masks or face coverings were recommended as a potential infection control measure for source control and personal protection.[17] Reviewing the literature on using medical/surgical masks to prevent infection often provides mixed results. Several controlled trials conducted prior to COVID-19 demonstrated little benefit to preventing influenza but may be hampered by adherence to masking best practices.[18] Other meta-analyses of observational studies have demonstrated a significant reduction in infections for practices using face masks, up to a 70% decrease in infection.[19,20,21] In accordance with the evidence and existing guidance from federal and state public health departments, this workgroup recommends using face masks as a preventative measure in times of high community spread of respiratory infectious disease or for high-risk or infected patients visiting the facility. More information about masks and face coverings can be found on the Washington DOH website.[22]

Physical distance (also called social distancing) or maintaining a distance of six feet from others while in public spaces, is another recommendation for infection control introduced during the COVID-19 pandemic. A Lancet meta-analysis of 172 observational studies across 16 countries showed that transmission of viruses was lower with physical distancing of 1 meter or more and increased as distance was lengthened or when implemented in combination with face masks.[23] In accordance with the literature and public health guidance, this workgroup recommends implementing physical distancing in times of high community spread, or for infected or high-risk patients.

The COVID-19 pandemic also brought increased attention to the use of vaccines as a preventative measure. The CDC maintains a webpage detailing the safety and efficacy of vaccines, which can be especially useful while discussing vaccine decisions with patients.[24] Additionally, studies have found that the COVID-19 vaccine is safe and effective.[25] Many providers and practices still encounter vaccine hesitancy as a factor limiting vaccine uptake, and should work to counter vaccine misinformation through motivational interviewing and patient engagement.[26] Given the overwhelming evidence in support of vaccines, this workgroup recommends following the CDC's Advisory Committee on Immunization Practices recommended schedule for vaccines.[27]

Monitoring and Surveillance

Monitoring infections and reporting them to the applicable authority is a cornerstone of the CDC's minimum expectations for outpatient infection control. Technology and automated surveillance practices allow practices to collect and aggregate data to respond effectively.[28] During the COVID-19 pandemic, surveillance of COVID-19 cases was vital for monitoring case counts, vaccine distribution, and screening activities.[29]

In Washington, the Department of Health is the primary organization that monitors notifiable conditions. The DOH maintains a webpage with more resources on notifiable conditions and how to report them.[30] In addition to the DOH, employers should familiarize themselves with required documentation and reporting for occupational diseases from Washington Labor and Industries.[31]

Minimizing Exposure

Beyond standard precautions for prevention, the CDC recommends transmission-based precautions to minimize exposure when treating patients who may be infected or who may need additional protection due to their risk status.[32] General transmission-based precautions include contact, droplet, and airborne precautions. In addition to standard and transmission-based precautions, other activities to minimize exposure when treating currently infected or at-risk patients include screening, isolation, and telehealth alternatives.

Screening for infectious disease is an important practice to prevent the spread of potentially contagious diseases to staff or other patients. Screening patients before they arrive on-site can also help practices triage patients or adequately prepare for currently infected or high-risk patients. The COVID-19 pandemic highlighted the importance of diagnostic screening, but also exposed challenges with large-scale communication and implementation of national testing programs.[33,34] Despite their challenges, tests that can quickly identify many infectious individuals are widely acknowledged to limit the spread of infection and help prevent large outbreaks as consumers and providers can understand their infection status and plan accordingly.[35] This workgroup recommends screening for circulating infectious diseases as able in order to minimize exposure and limit the spread of disease.

If an individual is positive or at high-risk for infectious disease, they may prefer a telehealth alternative to visiting the outpatient facility, if possible. The Bree Collaborative developed recommendations for telehealth in 2021 that focus on appropriateness, person centered interactions, and measurement and follow-up. Those recommendations can be found here.

Environment of Care

The environment of care can play an important role in facilitating infection prevention and control. The CDC provides recommendations for environmental infection control in healthcare facilities that include:

- Air (ventilation, air quality, aerosol hazards)
- Water (waterborne microorganisms, water systems)
- Environmental services (cleaning and disinfecting strategies, cleaning spills, pest control)
- Laundry and bedding (handling contaminated laundry, bedding)
- Animals in healthcare facilities
- Regulated medical waste

The design of the physical space can impact the spread of infectious disease. When coupled with the other infection control practices described in this report, physical barriers can act as a component of exposure control and block infectious respiratory droplets.[36,37]

Sterilization and High-Level Disinfection

Standard environmental cleaning procedures are not always sufficient to prevent the spread of outbreaks, especially when it comes to medical device use. The CDC provides recommendations for disinfection and sterilization for healthcare facilities that include:

- Occupational health exposure
- Cleaning patient-care devices
- Sterilization vs. high-level vs low-level disinfection
- Selection of disinfectants

The level of disinfection or sterilization depends on the use of the object, but failure to properly disinfect devices can lead to outbreak.[38] When planning sterilization or high-level disinfection, use an EPA-registered disinfectant according to the manufacturer's instructions for use where applicable.

Community Spread

Addressing the community spread of infectious diseases is essential to combat spread of infection and requires cross-sector partnerships between public and private health organizations. Public health agencies are responsible for coordinating guidance between federal, state, and local jurisdictions. In Washington state, local public health jurisdictions have the final say in infection control regulations. You can find your local public health jurisdiction through the DOH website here.

Although public health agencies work to coordinate efforts and prevent community spread, healthcare facilities should play an active role in mitigating community spread. Outpatient healthcare providers must communicate effectively with patients about their risk status and preventative measures like vaccination. The CDC provides additional communication strategies for providers to communicate with patients.[39]

Appendix A: Bree Collaborative Members

Member	Title	Organization
Susie Dade, MS	Patient Advocate	
David Dugdale, MD, MS	Medical Director, Value Based Care	University of Washington Medicine
Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
Stuart Freed, MD	Chief Medical Officer	Confluence Health
Mark Haugen, MD	Family Medicine	Walla Walla Clinic
Darcy Jaffe, MN, ARNP, NE-BC, FACHE	Senior Vice President, Safety & Quality	Washington State Hospital Association
Sharon Eloranta	Medical Director, Performance Measurement and Care Transformation	Washington Health Alliance
Norifumi Kamo, MD, MPP	Internal Medicine	Virginia Mason Franciscan Health
Angie Sparks, MD	Chief Medical Officer, Community Plan	UnitedHealthcare
Wm. Richard Ludwig, MD	Chief Medical Officer, Accountable Care Organization	Providence Health and Services
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Kimberly Moore, MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
Drew Oliveira, MD	Executive Medical Director	Regence BlueShield
Mary Kay O'Neill, MD, MBA	Partner	Mercer
Kevin Pieper, MD	Chief Medical Officer	Kadlac Medical Center
Susanne Quistgaard, MD	Medical Director, Provider Strategies	Premera Blue Cross
John Robinson, MD, SM	Chief Medical Officer	First Choice Health
Jeanne Rupert, DO, PhD	Provider	The Everett Clinic
Hugh Straley, MD (Chair)	Retired	Medical Director, Group Health Cooperative; President, Group Health Physicians
Shawn West, MD	Medical Director	Embright, LLC
Judy Zerzan, MD, MPH	Chief Medical Officer	Washington State Health Care Authority

Appendix B: Outpatient Infection Control Charter and Roster

The Bree Collaborative

Bree Collaborative Outpatient Infection Control Guidelines
Updated: June 29, 2022

Infection Control Charter and Roster

Problem Statement

The past several decades have seen a significant shift in healthcare delivery from inpatient to outpatient settings, yet outpatient settings often lack the infrastructure or resources to support infection prevention and surveillance activities.[40] The COVID-19 pandemic has demonstrated the importance of infection control measures and as of December 2021 over 800,000 Washingtonians have been infected.[41] At the same time, strong infection control policies and procedures introduced during the COVID-19 pandemic like physical distancing and masking have disrupted the circulation of other respiratory viruses and infectious dieseases.[42]

Aim

To help standardize infection control practices in the outpatient setting in order to mitigate the spread of prevalent infectious diseases.

Purpose

To propose evidence-informed recommendations to the full Bree Collaborative on practical and evidence-based methods for implementation of infection control in the outpatient setting, including:

- Outpatient transmission-based protocols, sterilization and disinfectant protocols.
- Accessing appropriate testing, PPE, and other needed resources.
- Surveillance of infectious disease transmissibility.
- Developing clinical workflows for high-risk/crisis situations.
- Partnering with patients to provide education about disease risk.
- Engaging community leaders to mitigate community spread.
- Designing benefits and incentives to help encourage behavior change.
- Applying existing infection control guidelines to the varied resources available in outpatient settings.

Duties & Functions

The workgroup will:

- Research evidence-informed and expert-opinion informed guidelines and best practices (emerging and established).
- Identify current barriers and future opportunities for implementing interventions.
- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.
- Maintain an equity lens throughout the guideline development process.
- Align recommendations with federal, state, local, and manufacturer guidance when possible.
- Meet for approximately nine months, as needed.
- Provide updates at Bree Collaborative meetings.
- Post draft report(s) on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
- Present findings and recommendations in a report.

- Recommend data-driven and practical implementation strategies including metrics or a process for measurement.
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Revise this charter as necessary based on scope of work.

Structure

The workgroup will consist of individuals confirmed by Bree Collaborative members or appointed by the chair of the Bree Collaborative. The Bree Collaborative director and program coordinator will staff and provide management and support services for the workgroup.

Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative.

Meetings

The workgroup will hold meetings as necessary. Bree Collaborative staff will conduct meetings, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members may be added at the discretion of the Bree Collaborative director.

Name	Title	Organization
Mark Haugen, MD (chair)	Family Medicine Physician	Walla Walla Clinic & Surgery Center
Anne Sumner, BSN, MBA	VP Head of Operations	Baker Boyer Bank
Andrea DeLong, ARNP	Public Health Manager	Walla Walla County Department of Community Health
Cathy Carrol		WA Health Care Authority
Daniel Kaminsky, MD	Public Health Officer and Medical Director	Walla Walla County Department of Community Health
Faiza Zafar, DO, FACOI	Medical Director	Community Health Plan of Washington
Larissa Lewis, MPH, CIC	Nurse Consultant	WA Labor and Industries
Lisa Hannah, RN, CIC	Infection Prevention Team Supervisor	WA Department of Health
Lisa Waldowski,DNP, CIC	Regional Director, Infection Prevention and Control	Kaiser Permanente
Rebecca Brown, MD		Walla Walla Clinic & Surgical Center
Rhonda Bowen, CIC, CPPS, CPHQ	Senior Improvement Advisor, Patient Safety	Comagine Health
Stephanie Jaross, BSN, RN	ASC Director	Proliance Center for Outpatient Spine and Joint Surgery
Sierra Bertolone-Smith	Medical Student	Pacific Northwest University of Health Sciences

Appendix C: Additional Outpatient Infection Control Resources

Federal Resources

Centers for Disease Control and Prevention (CDC)

a) Infection Control Resource Center
b) Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care
c) Infection Control Self-Assessment Tools
d) Respiratory Infection Control Measures
e) Hand Hygiene in Healthcare
f) Guidance for COVID-19

Occupational Safety and Health Administration (OSHA)

a) Infectious Disease and Healthcare Workers
b) COVID-19 Control and Prevention

Washington State Resources

Washington State Department of Health

a) COVID-19 Infection Prevention in Healthcare Settings
b) Donning and Doffing PPE
c) Infection Control Assessment and Response Program (ICAR)
d) Notifiable Conditions
e) Washington State Local Public Health Jurisdictions

Washington State Labor and Industries

a) Biological Safety and Health Topics
b) COVID-19 (Coronavirus) Resources

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[1] Centers for Disease Control and Prevention. (September 2016). Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care. https://www.cdc.gov/infectioncontrol/pdf/outpatient/guide.pdf
[2] Barie PS. Infection Control Practices in Ambulatory Surgical Centers. JAMA. 2010;303:2295-2297.
[3] Halpern MT, Yabroff KR. Prevalence of Outpatient Cancer Treatment in the United States: Estimates from the Medical Panel Expenditures Survey (MEPS). Cancer Investigation. 2008;26:647-651.
[4] Centers for Disease Control and Prevention. Preventing Healthcare-Associated Infections. Accessed April 26, 2022. https://www.cdc.gov/hai/prevent/prevention.html
[5] Maki DG, Crnich CJ. History Forgotten is History Relived: Nosocomial Infection Control is also Essential in the Outpatient Setting. Arch Int Med. 2005;165:2565-2567
[6] Jarvis WR. Infection control and changing health-care delivery systems. Emerg Infect Dis 2001;7:17-173.

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[7] Centers for Disease Control and Prevention. (September 2016). Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care. https://www.cdc.gov/infectioncontrol/pdf/outpatient/guide.pdf
[8] Washington State Department of Health. COVID-19 Data Dashboard – Disease Activity and Testing. Accessed April 26, 2022. https://doh.wa.gov/emergencies/covid-19/data-dashboard
[9] Centers for Disease Control and Prevention. Preventing the Spread of COVID-19 in a Variety of Settings Throughout Your Community. Accessed April 26, 2022. https://www.cdc.gov/coronavirus/2019-ncov/php/infection-control.html
[10] Dadras, Omid et. al. Effects of COVID-19 prevention procedures on other common infections: a systematic review. *European Journal of Medical Research.* (2021) 26:67. https://doi.org/10.1186/s40001-021-00539-1
[11] Itaya, T. et al. Does COVID-19 infection impact on the trend of seasonal flu infection? 11 countries and regions, from 2014 to 2020. *International Journal of Infectious Disease.* https://doi.org/10.1016/j.ijid.2020.05.088
[12] Centers for Disease Control and Prevention. (September 2016). Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care. https://www.cdc.gov/infectioncontrol/pdf/outpatient/guide.pdf
[13] Centers for Disease Control and Prevention. (2016). Infection Control: Standard Precautions for All Patient Care. https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html. Accessed June 2022.
[14] WA Department of Health. (2022). Infection Control Assessment and Response. https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/healthcare-associated-infections/infection-control-assessment-and-response. Accessed June 2022.
[15] Centers for Disease Control and Prevention (2022). COVID-19. https://www.cdc.gov/coronavirus/2019-nCoV/index.html. Accessed June 2022
[16] Washington State Department of Health. (2022). Interim Recommendations for SARS-CoV-2 Infection Prevention and Control in Healthcare Settings. DOH. https://doh.wa.gov/sites/default/files/2022-06/420-391-HealthcareIPCCOVID.pdf
[17] Czypionka T, Greenhalgh T, Bassler D, & Bryant M. (2020) Masks and Face Coverings for the Lay Public: A Narrative Update. Annals of Internal Medicine. doi:10.7326/M20-6625
[18] Jefferson T, Del Mar CB, Dooley L, Ferroni E, Al-Ansary LA, Bawazeer GA, van Driel ML, Jones MA, Thorning S, Beller EM, Clark J, Hoffmann TC, Glasziou PP, Conly JM. (2020). Physical interventions to interrupt or reduce the spread of respiratory viruses. Cochrane Database of Systematic Reviews. 2020(11).DOI:10.1002/14651858.CD006207.pub5.
[19] Tabatabeaizadeh, S. (2021) Airborne transmission of COVID-19 and the role of face mask to prevent it: A systematic review and meta-analysis. European Journal of Medical Research. 2021(26):1. https://doi.org/10.1186/s40001-020-00475-6
[20] Li Y, Liang M, Gao L, Ahmed M, Uy J, Cheng C, Zhou Q, & Sun C. (2020). Face masks to prevent transmission of COVID-19: A systematic review and meta-analysis. American Journal of Infection Control. 2020(49) https://doi.org/10.1016/j.ajic.2020.12.007
[21] Alberta Health Services. (2020) COVID-19 Scientific Advisory Group Rapid Response Report. AHS COVID-19 Scientific Advisory Group. https://www.google.com/search?client=safari&rls=en&q=COVID-19+Scientific+Advisory+Group+Rapid+Response+Report.&ie=UTF-8&oe=UTF-8 Accessed June 2022
[22] Washington State Department of Health. (2020). Masks and Face Coverings. https://doh.wa.gov/emergencies/covid-19/masks-and-face-coverings Accessed June 2022
[23] Chu D, Akl E, Duda S, Solo K, Yaacoub S, & Schunemann H. (2020) Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: A systematic review and meta-analysis. Lancet. 395(10242): 1973-1987 doi: 10.1016/S0140-6736(20)31142-9: 10.1016/S0140-6736(20)31142-9
[24] Centers for Disease Control and Prevention. (2019). Questions about Vaccines. https://www.cdc.gov/vaccines/parents/FAQs.html. Accessed June 2022
[25] Barda N, Daga N, Ben-Shlomo Y, Kepten E, Waxman J, Ohana R, Hernan M, Lipstich M, Kohane I, Netzer D, Reis B, and Balicer R. (2021). Safety of the BNT162b2 mRNA COVID-19 Vaccine in a Nationwide Setting. New England Journal of Medicine. 385:1078-1090 DOI: 10.1056/NEJMoa2110475
[26] Geoghegan S, O'Callaghan K, & Offit P. (2020) Vaccine Safety: Myths and Misinformation. Frontiers in Microbiology. 11(372). doi: 10.3389/fmicb.2020.00372

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[27] Centers for Disease Prevention and Control. 2022. Vaccine Recommendations and Guidelines of the ACIP. Advisory Committee on Immunization Practices. https://www.cdc.gov/vaccines/hcp/acip-recs/index.html. Accessed June 2022
[28] Wright M. (2007). Automated surveillance and infection control: Toward a better tomorrow. American Journal of Infection Control. 36(3):S1-S6. https://doi.org/10.1016/j.ajic.2007.09.003
[29] Ibrahim K. (2020) Epidemiologic surveillance for controlling COVID-19 pandemic: types, challenges, and complications. Journal of Infection and Public Health. 13(11):1630-1638. https://doi.org/10.1016/j.jiph.2020.07.019
[30] Washington State Department of Health. (2022). List of Notifiable Conditions. https://doh.wa.gov/public-health-healthcare-providers/notifiable-conditions/list-notifiable-conditions. Accessed June 2022
[31] Washington State Labor and Industries. (2022). Documentation and Reporting. https://lni.wa.gov/claims/for-medical-providers/documentation-reporting. Accessed June 2022
[32] Centers for Disease Control and Prevention. 2016. Transmission-Based Precautions. https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html. Accessed June 2022.
[33] Martindale A, Pilbeam C, Mableson H, Tonkin-Crine S, Atkinson P, Borek A, Lant S, Gobat N, Solomon T, & Sheard S. (2021) Perspectives on COVID-19 testing policies and practices: A qualitative study with scientific advisors and NHS health care workers in England. BMC Public Health. 21(1216). https://doi.org/10.1186/s12889-021-11285-8
[34] Mina M & Andersen K. (2020). COVID-19 testing: One size does not fit all. Science. 371(6525):126-127. https://doi.org/10.1186/s12889-021-11285-8
[35] Manabe Y, Sharfstein J, Armstrong K. (2020). The Need for More and Better Testing for COVID-19. JAMA. 324(21):2153-2154. doi:10.1001/jama.2020.21694
[36] Ren C, Xi C, Wang J, Feng Z, Nasiri F, Cao S, & Haghighat F. (2021). Mitigating COVID-19 infection disease transmission in indoor environment using physical barriers. Sustainable Cities and Society. https://doi.org/10.1016/j.scs.2021.103175
[37] University of Washington Environmental Health and Safety. (2020). UW Guidance for Plexiglass Barriers in Support of COVID-19 Prevention Efforts. https://www.ehs.washington.edu/system/files/resources/COVID-19-plexiglass-barriers-workplace.pdf Accessed June 2022
[38] Rutala W, & Weber D. (2016). Disinfection and Sterilization in Health Care Facilities: An Overview and Current Issues. Infectious Disease Clinics of North America. 30(2016) 609-637
[39] Centers for Disease Control and Prevention. (2022). Communication Strategies. https://www.cdc.gov/healthliteracy/researchevaluate/comm-strategies.html. Accessed June 2022.
[40] Centers for Disease Control and Prevention. (September 2016). Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care. https://www.cdc.gov/infectioncontrol/pdf/outpatient/guide.pdf
[41] WA Department of Health. (December 2021) COVID-19 Data Dashboard. https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard
[42] Centers for Disease Control and Prevention. (July 2021) Changes in Influenza and Other Respiratory Virus Activity During the COVID-19 Pandemic. https://www.cdc.gov/mmwr/volumes/70/wr/mm7029a1.htm