

Presentation Type:

Poster Presentation

Infection Prevention and Control Policies and Staffing: A**National Survey of Home Health Agencies in the United States**

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Background: Infection prevention and control (IPC) is a national priority in all healthcare settings, and IPC staffing characteristics have been linked to patient safety outcomes. However, there is a lack of knowledge about IPC in home healthcare (HHC), the fastest growing healthcare sector. Our aim was to better understand the current state of IPC in HHC, as well as the HHC staff involved with IPC policy implementation. **Methods:** A national survey was conducted between October 2018 and November 2019. The participants included (1) agencies recruited from a national HHC conference and (2) a national random sample of 1,501 agencies stratified by census region, ownership status, and rural or urban location. Survey items included staff influenza vaccination policies, antibiotic stewardship, infection surveillance, and IPC staffing. Descriptive statistics were computed, and differences by ownership were calculated using χ^2 and Student *t* tests.

Results: Of the 535 HHC agencies that responded to the survey (response rate, 33%), 64% were for-profit agencies. Overall, 30.8% of the agencies (17.9% for-profit, 57.6% nonprofit; $P < .01$) required staff influenza vaccination. Most nonprofit agencies (84.1%) and about half of the for-profit agencies (48.1%) offered free influenza vaccinations to staff ($P < .01$). During the past influenza season, 62.6% of agencies (81.5% nonprofit vs 51.6% for-profit; $P < .01$) had $\geq 75\%$ of their employees vaccinated for influenza, and 9.3% (2% nonprofit vs 13.5% for-profit; $P < .01$) reported that they did not track this data. Only 17.9% of HHC agencies used antibiotic prescribing guidelines, and 33.3% reported that they reviewed cases to assess the appropriateness of antibiotic administration and/or indication. Most HHC agencies (86%) reported collecting and reviewing infection data to identify trends, which was often done quarterly or more frequently. Almost every responding agency reported that the staff member in charge of IPC had other responsibilities including administrative, education/training, or quality improvement, and 33.5% of those personnel had received no specific IPC training. Also, ~6% of agencies (12.5% of government-owned agencies) reported that they currently did not have a staff member in charge of IPC. **Conclusions:** This is the first national study of IPC in HHC, which can be used as a benchmark for quality improvement initiatives in the home care environment. Compared to other healthcare settings, HHC agencies have substantial challenges related to IPC. Most HHC agencies do not have a staff member exclusively dedicated to IPC, and staff training is inadequate. Furthermore, a significant number of agencies have no staff influenza vaccination or antibiotic stewardship policies in place. The situation is worse at for-profit agencies, which dominate the current US HHC industry.

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Infection Prevention and Control Practices Implemented for Congenital Measles in an Extremely Low Birth Weight Infant

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Background: Measles can cause miscarriages and preterm birth in nonimmune pregnant women. During the 2018–2019 measles outbreak in New York, a woman with measles delivered an extremely low birth weight preterm infant at our Women and Children's Hospital. We describe our measles preparedness strategies and infection prevention and control (IPC) management relevant to congenital measles. **Methods:** Because of the measles outbreak, in Q4 2018, IPC verified measles immunity in all obstetric and pediatric staff, per state regulations, and recommended determining the measles immune status of all pregnant women. To prevent measles exposure, visitor restrictions for the neonatal intensive care unit (NICU) were implemented (May 2019); only 3 visitors were permitted for each infant, including parents. All visitors had to provide written documentation of immunity to measles, regardless of epidemiologic risk factors or receive an MMR vaccine prior to visiting. New York state and New York City health departments performed measles diagnostic testing for maternal and infant specimens. **Results:** Our hospital was informed of the imminent transfer of a woman in preterm labor with suspected measles. To avoid any exposure, the mother was masked in the ambulance bay and taken by commandeered elevator to the obstetrical operating room suite, which was cleared of other patients. She delivered by C-section and was transferred to an airborne infection isolation (AII) room. The 25-week-gestation infant was transported by isolette to the NICU and was placed on AII. Testing confirmed measles in the mother (measles PCR- and IgM-positive) and congenital measles in the infant (Table 1). The mother was allowed to visit the NICU when her respiratory symptoms and rash resolved, as confirmed by her provider, ~10 days after discharge. The infant never developed a rash, pneumonia, or neurologic findings. AII was discontinued on day of life 61 in consultation with the health departments. The infant was discharged at ~36 weeks gestation. No secondary cases of measles occurred among patients, visitors, or

Table 1. Measles Diagnostic Testing in Infant with Congenital Measles

Day of life	Serum IgM	OP/NP PCR	NP/OP Culture	Urine PCR	Urine Culture	Placenta Culture
0	Positive	Positive	Positive	Positive	Positive	Positive
36	NA	NA	NA	Positive	Negative	NA
46	Negative	Negative	NA	NA	NA	NA
60	NA	Negative	NA	Negative	NA	NA

OP = oropharyngeal, NP = nasopharyngeal, NA = not available