Acute Care & Outpatient Settings Webinar Series

June 11, 2025

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DEPT. OF HEALTH AND HUMAN SERVICES

NE ICAP

NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM

Presenters & Panelists & Moderator

Presenters today:

Juan Teran Plasencia, MD — jteranplasencia@unmc.edu

Panelists today:

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Moderator today:

Margaret Deacy — mdeacy@nebraskamed.com

Questions & Answer Session

- Please use the Q&A box in the webinar platform to type a question to be read aloud.
  - If your question is not answered during the webinar, please call (402) 552-2881 Monday – Friday 8:00 am – 4:00 pm CST to speak with one of our Infection Preventionists or e-mail your question to nebraskaicap@nebraskamed.com

Slides & Webinar Recordings Available

- During this webinar, slides are available on the NE ICAP Acute Care webpage
  - After the webinar, slides and a recording will be posted on the NE ICAP Past Webinars and Slides webpage

Continuing Education Disclosures

- 1.0 Nursing Contact Hour is awarded for the LIVE viewing of this webinar.
- Nebraska Infection Control Assessment and Promotion Program is approved as a provider of nursing continuing professional development by the Midwest Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.
- To obtain nursing contact hours, you must attend the entire live activity and complete the post-course survey form.
- No relevant financial relationships were identified for any member of the planning committee or any presenter/author of the program content.

Nebraska Pathogen Watch

Juan Teran, MD
Medical Director, NE ICAP

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Key Points

- Measles cases are increasing nationwide. First case identified in Nebraska
- Influenza and COVID activity is minimal

Measles Cases in US: Update as of 6/5/25

- As of June 5, 2025, a total of **1,168** confirmed* measles cases were reported by 34 jurisdictions+

- There have been 17 outbreaks (defined as 3 or more related cases) reported in 2025, and 89% of confirmed cases (961 of 1,046) are outbreak-associated.

  - *For comparison, 16 outbreaks were reported during 2024 and 69% of cases (198 of 285) were outbreak-associated.*

https://www.cdc.gov/measles/data-research/index.html

+ Alaska, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New Jersey, New Mexico, New York City, New York State, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia, and Washington

Measles Cases in US: Update as of 6/5/25

U.S. Cases in 2025

Total cases

1168

Age
Under 5 years: **339 (29%)**
5-19 years: **439 (38%)**
20+ years: **381 (33%)**
Age unknown: **9 (1%)**

Vaccination Status
Unvaccinated or Unknown: **95%**
One MMR dose: **2%**
Two MMR doses: **3%**

U.S. Hospitalizations in 2025

12%

12% of cases hospitalized (137 of 1168).

Percent of Age Group Hospitalized
Under 5 years: **21% (71 of 339)**
5-19 years: **8% (34 of 439)**
20+ years: **8% (31 of 381)**
Age unknown: **11% (1 of 9)**

U.S. Deaths in 2025

3

There have been 3 confirmed deaths from measles.

https://www.cdc.gov/measles/data-research/index.html

Cases in Texas and Kansas

Total	742

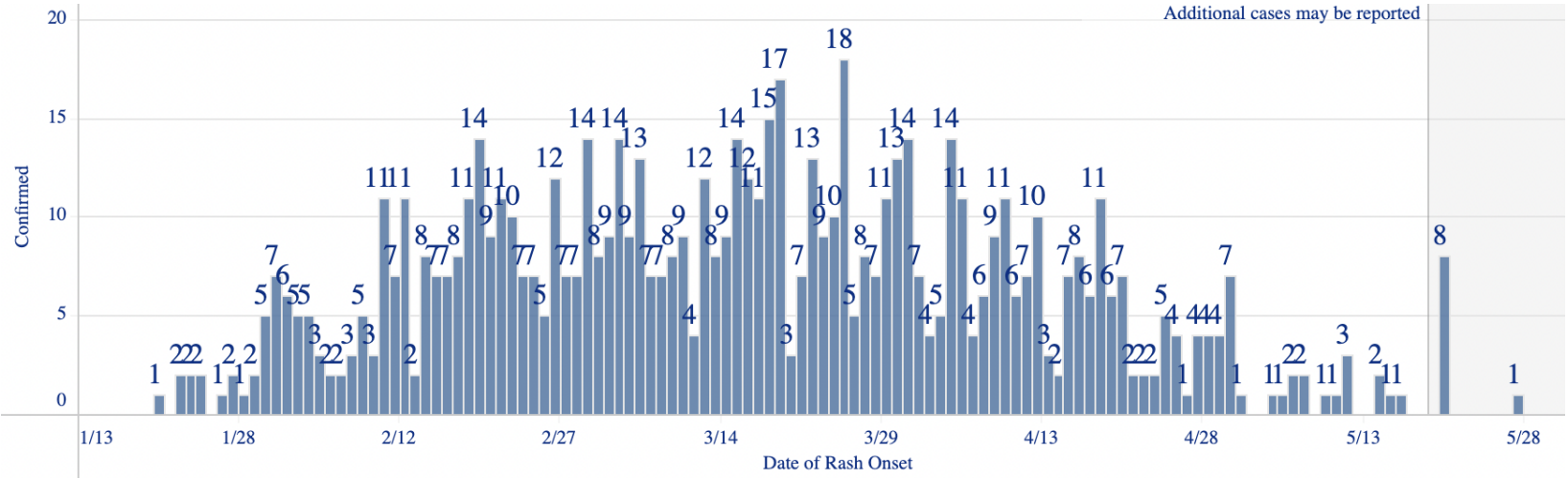
Outbreak Cases by Age

Age Group	Confirmed
0-4 Yrs	218
5-17 Yrs	281
18+ Yrs	239
Pending	4

Outbreak Cases by Vaccination Status

Vaccination Status	Confirmed
Unknown/Unvaccinated*	705
Vaccinated: 1 dose	18
Vaccinated: 2+ doses	19

*The unvaccinated/unknown category includes people with no documented doses of measles vaccine more than 14 days before symptom onset.



https://www.dshs.texas.gov/news-alerts/measles-outbreak-2025

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Nebraska Department of Health and Human Services

Health Alert Network

Update

June 4, 2025

Measles Detected in Nebraska

Summary

On May 27, 2025, the Nebraska Department of Health and Human Services reported the first measles case in Nebraska since 2017. Panhandle Public Health District identified a confirmed case of measles in an age-appropriately vaccinated child that had not had any recent out-of-state travel history, indicating potential spread within the community. Locations of potential public measles exposure can be found here. The symptom monitoring period for most contacts of this case will end June 11, 2025.

https://dhhs.ne.gov/han%20Documents/UPDATE06042025.pdf

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MEASLES

IDENTIFICATION, TESTING, AND MANAGEMENT OF SUSPECTED CASES

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Triage febrile rash illnesses by phone, or immediately upon arrival, assess the need for control measures

PATIENT MUST MEET BOTH CRITERIA

- Prodrome: fever (100.4*F or higher) / cough / runny nose (coryza) / red, watery eyes (conjunctivitis)
- Followed in 2-4 days by: generalized descending maculopapular rash beginning at hairline / face lasting for usually 5-6 days
  Koplik spots inside cheeks (may / may not be present prior to rash)

AND

- Risk factors for measles (history of international travel, contact with travelers or links to known outbreak or case), or no/unknown immunity status

No to any of the criteria

Consider other viral/bacterial differential diagnoses and manage as clinically indicated.

https://dhhs.ne.gov/Pages/Measles-Provider-Guidance.aspx

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YES to BOTH Criteria

MINIMIZE RISK OF TRANSMISSION AS SOON AS POSSIBLE

- Measles is highly airborne infectious: Identify febrile rash illnesses prior to, or immediately upon arrival to expedite evaluation in a negative pressure room, when possible, or a private room to minimize congregate exposures
  - *Conduct exam in room that can be left vacant with the door closed for at least 2 hours after patient departure*
- Avoid waiting room (use side / back entrance)
- Staff evaluating patient should have presumptive evidence of measles immunity and should wear N-95 masks
- Contact infection control preventionist, if available
- Request patient wear surgical mask

IMMEDIATELY CALL (24/7) upon suspicion for public health reporting and follow-up guidance

Your Local Health Department

https://dhhs.ne.gov/Documents/Measles-ID-TESTING-MGMT-OF-SUS-CASES-MAY-2025.pdf

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Testing

PREFERRED SPECIMENS to be collected **as soon as possible**

- *Within 3 days of Rash Onset*- Nasopharyngeal (NP) or throat swab in universal viral transport media **and** Urine in a sterile cup, (if able to self void), for RT-PCR
- *Within 4-10 days of Rash Onset*- Urine in sterile cup (*catheterize, if necessary*) for RT-PCR; ideally with a Nasopharyngeal (NP) or throat swab in universal viral transport media for RT-PCR

[OPTIONAL] SERUM SPECIMENS consider collecting if **> 72 hours AFTER rash onset**

- Measles specific IgM (*Caution: clinical interpretation of IgM*)

***Measles IgG testing should only be considered when testing for PRIOR measles immunity (natural or vaccination) and should NOT be used for active infection**

Measles RT-PCR available at certain commercial labs or through NE Public Health Laboratory after prior authorization by NE-DHHS Public Health

Suspect Case Management:

- Isolate patient immediately
- Exclude from childcare/school/workforce for at least 4 days after rash onset
- Reassess isolation based on diagnosis and provide supportive treatment

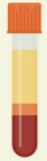
If POSITIVE: Measles PCR test OR High Suspicion for ACTIVE INFECTION (after Public Health consultation)

- Notify receiving facilities of diagnosis
- Identify patients/visitors/staff that shared congregate space exposure and review measles immunity status
- Exclude all health care staff without immunity evidence from day 5 through day 21 following exposure
- Recommend vaccine within 3 days, or immunoglobulin within 6 days of exposure as indicated
- Clean surfaces that may be contaminated with an EPA-registered disinfectant for health care settings

https://dhhs.ne.gov/Pages/Measles-Provider-Guidance.aspx

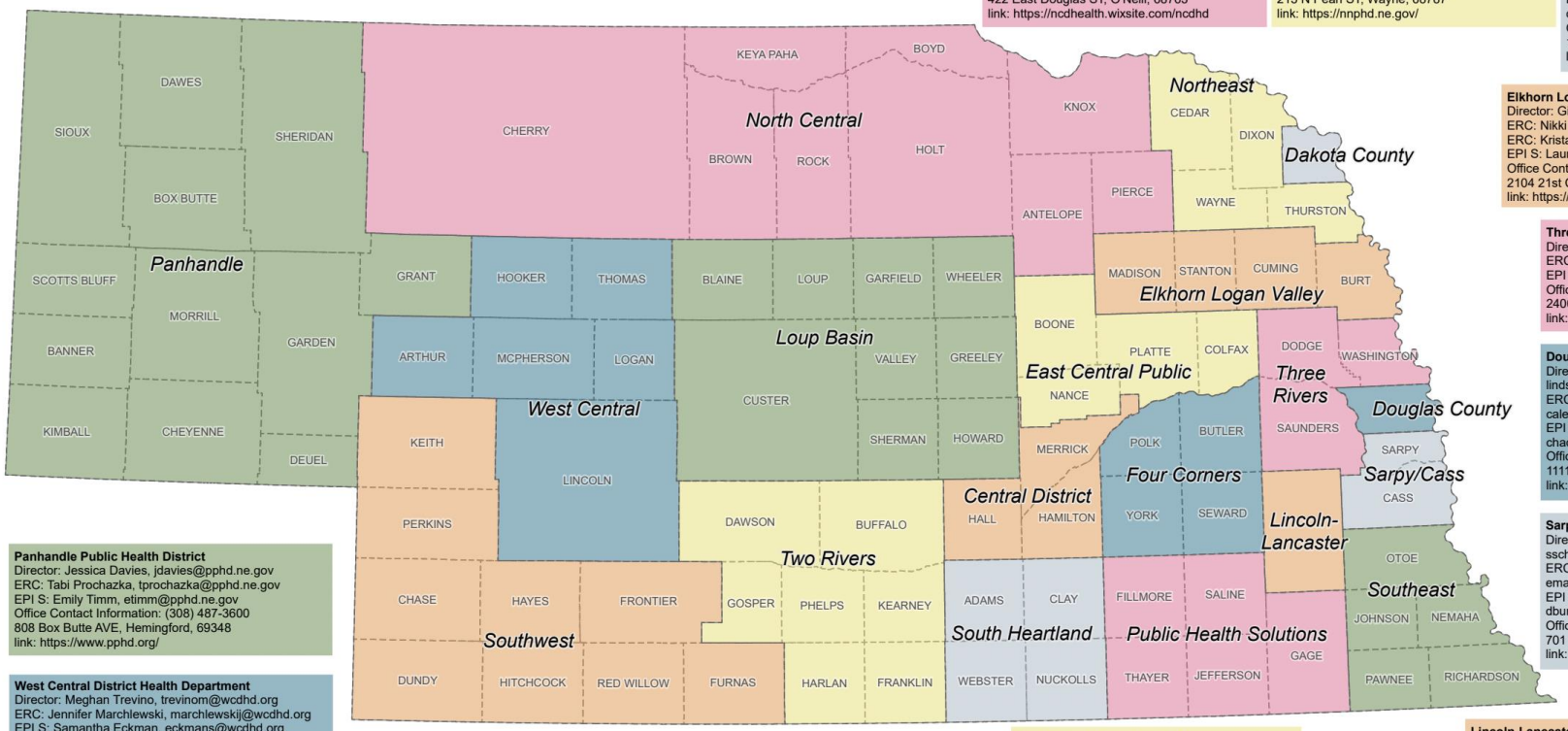
Measles Tests

When to Collect?

Acute Disease	PCR	Nasopharyngeal (NP) or Throat (OP) Swab 	As soon as possible upon suspicion of measles: ideally **3** days after rash onset and within **4-10 days.**
Acute Disease	PCR	Urine 	**Within 10 days of rash onset.** *Collecting a urine specimen along with an NP/OP swab may improve test sensitivity, especially if at the end of the PCR detection window.
Acute Disease	IgM	Serum 	**OPTIONAL:** Collect with specimen for PCR. Can be negative up to 3 days after rash onset. IgM **can be detected for 6-8 weeks after acute measles.**
Immunity	IgG	Serum 	IgG testing is used when assessing evidence of immunity, can be detected **~2 weeks** after MMR vaccination.

https://dhhs.ne.gov/Documents/Measles-ID-TESTING-MGMT-OF-SUS-CASES-MAY-2025.pdf

Local Health Department Contacts



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link: https://www.sedhd.org/

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Last update: May 13, 2025.
For the most current information and links visit: https://arcg.is/0a4jXi or scan the QR code.
Email DHHS.GIS@nebraska.gov with updates.

https://dhhs.ne.gov/CHPM%20Maps/LHDcontactMaster.pdf

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MEASLES ALERT

If you've got a **FEVER** and any of the following:

AND have recently traveled to:

_____

Or, been in contact with someone known or suspected to have measles in the past 21 days

Please call this number so can ensure a room is ready, bring you a mask:

_____

သမူးဖိတ်ဆေါ်တ်ဟုဉ်ပလိၢ်

နမ့်ဒီးနှ်ဘဉ် တ်လိၢ်ကိုဉ် **3** တ်လၢလာ်သ့ဉ်တဖဉ်အံၤတမံၤမံၤ

3 တယံာ်ဒီးဘဉ်အခါလဲၤကှၤဘဉ်တ့ာ်ဝဲဒဉ်ဆူ

_____

မ့တမ့ၢ်, ဘဉ်ထွဲလိာ်သးဒီး ပှၤတဂၤဂၤလၢ တ်သ့ဉ်ညါဘဉ် မ့တမ့ၢ် တ်သးဒ့ဒီအိဉ်ဝဲဒဉ် လၢအအိဉ်ဒီးသမူးဖိတ်ဆေါ် ဖဲအပူၤကွံာ် 21 သိ

ဝံသးစူၤကိးဘဉ် နိဉ်ဂံၢ်အံၤ ဒ်သိးဃကမၤလိ တ်အိဉ်ကတာ်ကတိၤဟ်စၢၤ ဒၢးတဖျၫ်ဉ်အဂီ ဟဲစိာ်နှ်နှၤ တ်ကးဘၢမဲာ်တခါ ကသ့အဂိၢ်နှ်

_____

ALERTA SARAMPIÓN

Si tiene FIEBRE **MÁS** alguno de los siguientes síntomas:

Y ha viajado recientemente a:

_____

O ha estado en contacto con alguien que se sabe o se sospecha que tuvo sarampión en los últimos 21 días

Por favor, llame a este número para que podamos asegurarnos de que haya una habitación disponible y le llevaremos una mascarilla:

_____

_____

ALERTE ROUGE À LA ROUGEOLE

Si vous avez de la FIÈVRE **et** présentez l'une des symptômes suivants :

ET si vous avez récemment voyagé en :

_____

Ou si vous avez été en contact avec une personne atteinte ou suspectée d'être atteinte de la rougeole au cours des 21 derniers jours

Veuillez appeler ce numéro afin que nous puissions nous assurer qu'une chambre est disponible et vous fournir un masque :

_____

تنبيه بشأن الحصبة

إذا كنت مصابًا بالحمى **وأي** مما يلي:

وقد سافرت مؤخرًا إلى:

_____

أو خالطت شخص معروف أنه مصاب بالحصبة أو مُشتبه بإصابته بها خلال آخر 21 يومًا

فيرجى الاتصال على هذا الرقم حتى نتمكن من التأكد من وجود غرفة جاهزة، وإحضار قناع لك:

_____

https://icap.nebraskamed.com/pathogens-of-interest/measles/

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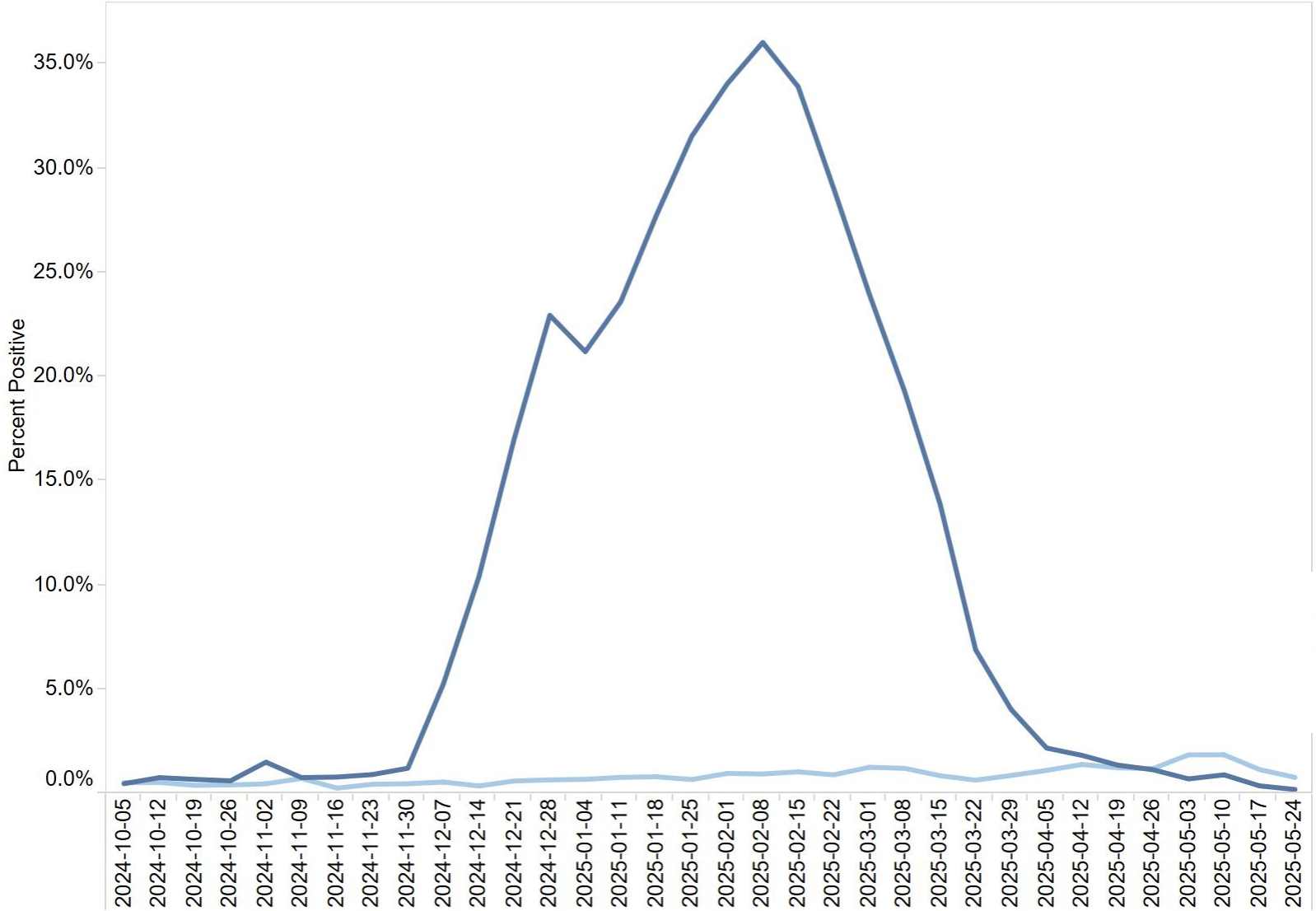
Influenza NE DHHS Report



Influenza Type: **Influenza B**
MMWR Week: **21**
Week Ending Date: **2025-05-24**
Percent Positive: **0.8%**

Influenza Type: **Influenza A**
MMWR Week: **21**
Week Ending Date: **2025-05-24**
Percent Positive: **0.2%**

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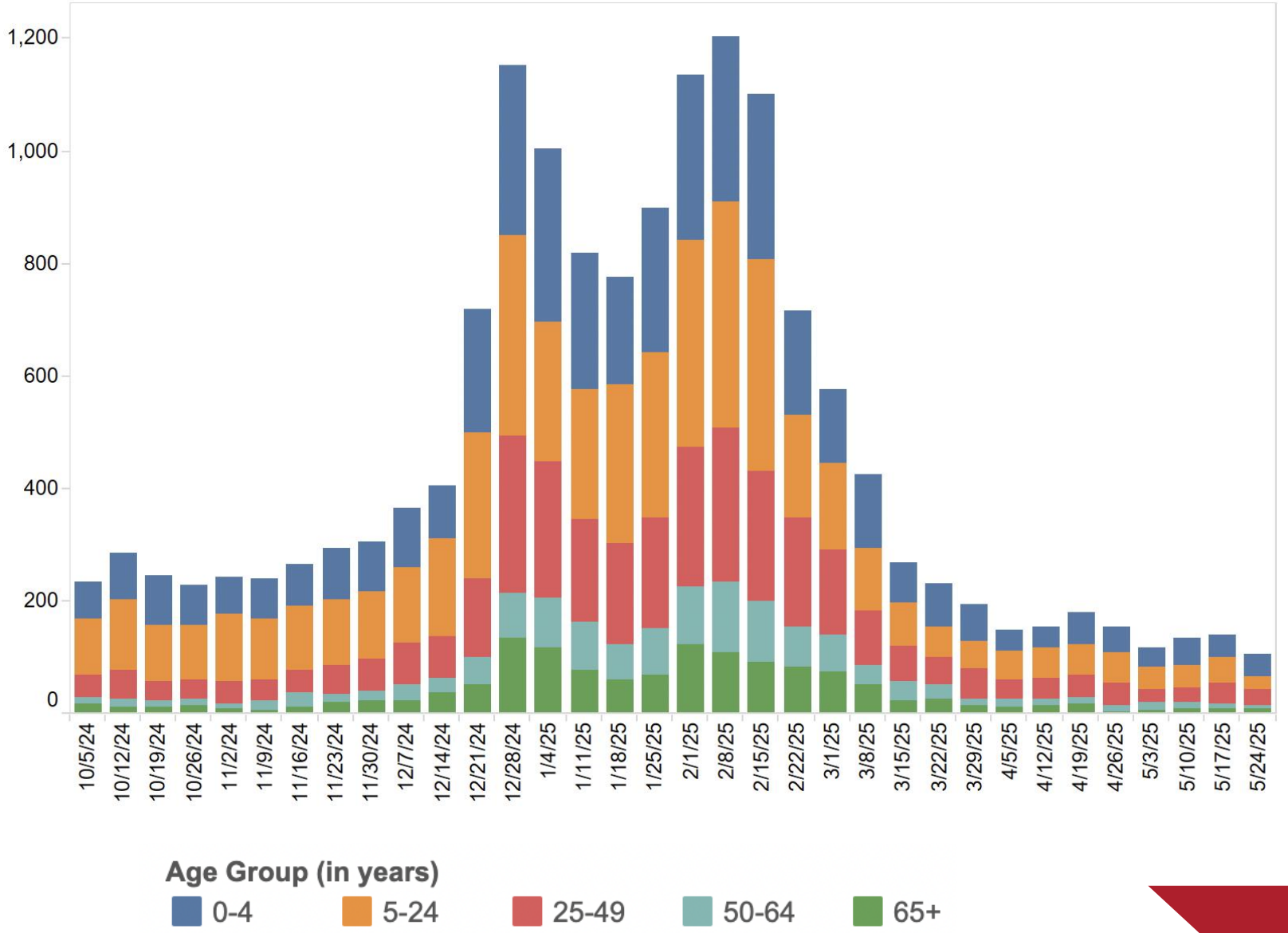
Influenza-like Illness ED Visits



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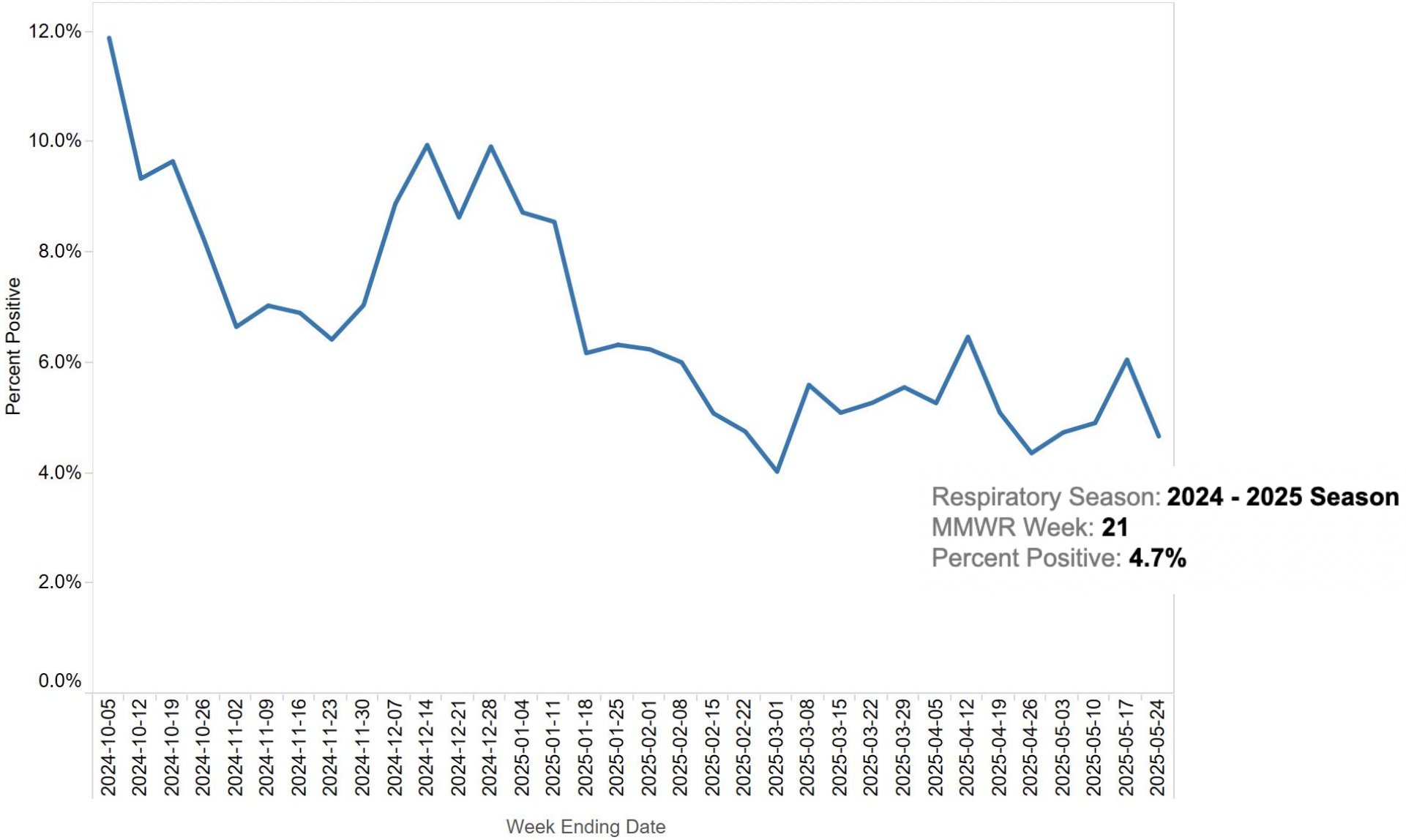
Covid-19 NE DHHS Report



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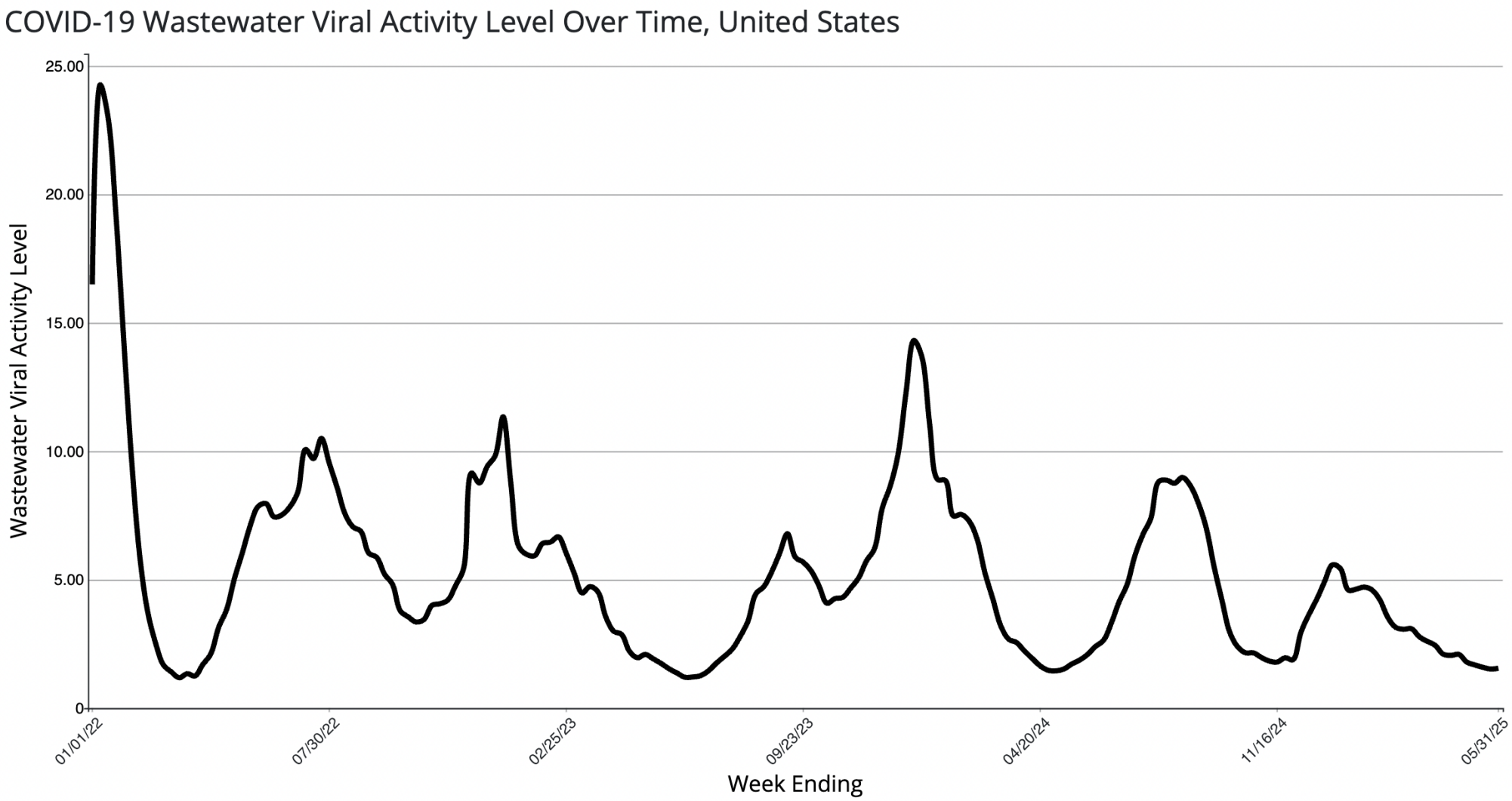
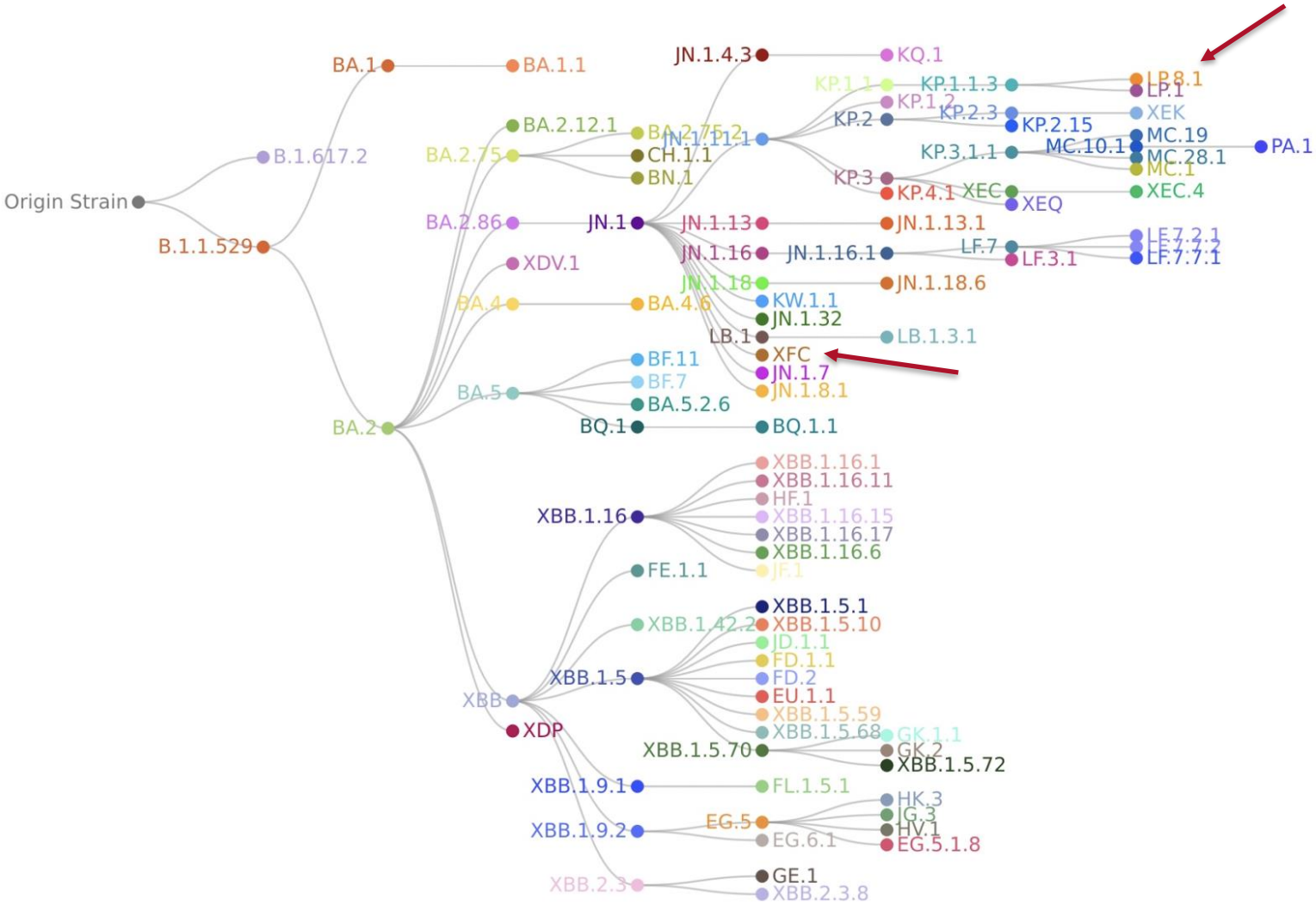
Covid Wastewater Data



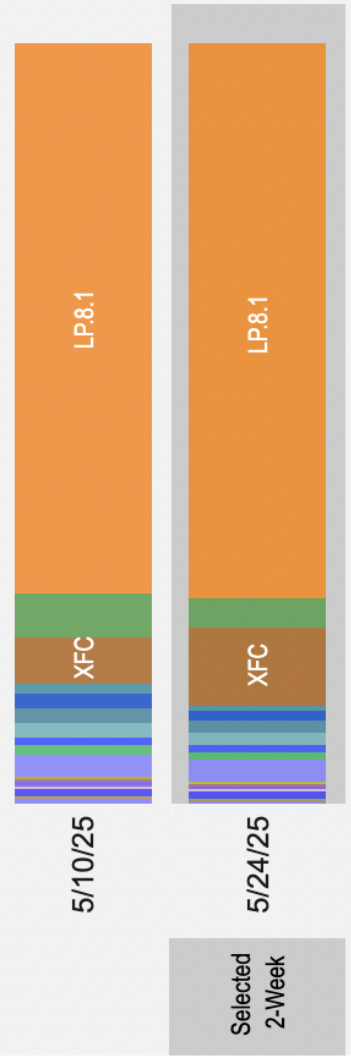
COVID Data Tracker

CDC

ICAP



Nowcast:** Model-based projected estimates of variant proportions



COVID Data Tracker

CDC

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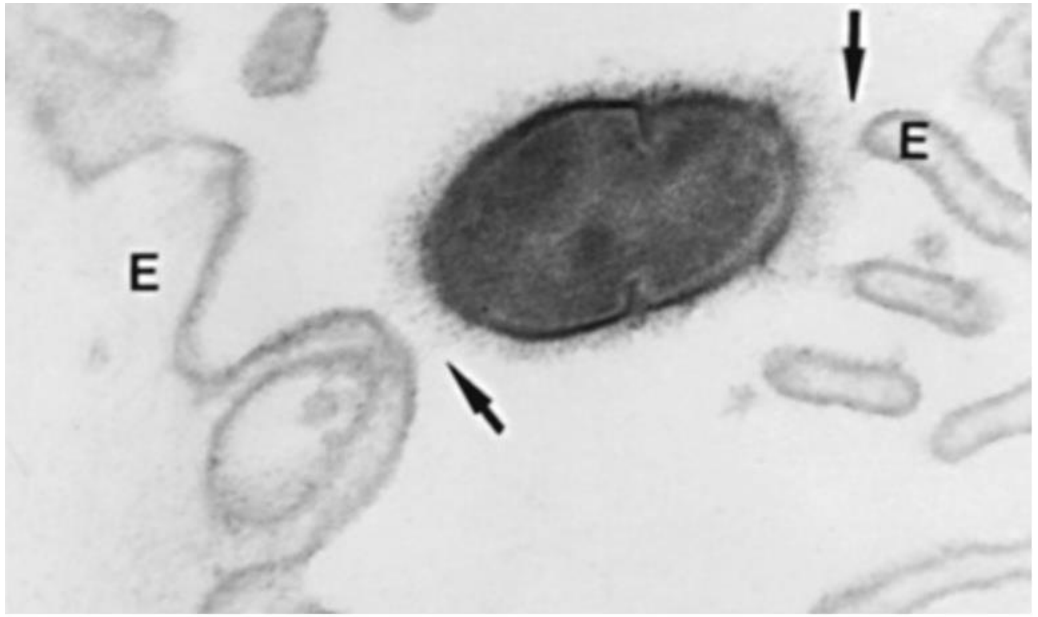
Group A Streptococcal Infections

Juan Teran, MD
Medical Director, NE ICAP

NE ICAP

Streptococcus



Beachey EH, Ofek I. Epithelial cell binding of group A streptococci by lipoteichoic acid on fimbriae denuded of M protein. *J Exp Med*. 1976;143:759–771.)

MANDELL, DOUGLAS, AND BENNETT'S PRINCIPLES AND PRACTICE OF INFECTIOUS DISEASES, NINTH EDITION

Group A Strep Spectrum of Disease

- Streptococcal Pharyngitis
- Scarlet Fever
- Streptococcal pyoderma
- Erysipelas
- Cellulitis
- Necrotizing Fasciitis/Myositis
- Streptococcal Toxic Shock Syndrome

Examples

https://www.cdc.gov/group-a-strep/hcp/clinical-guidance/cellulitis.html

MANDELL, DOUGLAS, AND BENNETT'S PRINCIPLES AND PRACTICE OF INFECTIOUS DISEASES, NINTH EDITION

Reportable Condition

Nebraska Reportable Diseases Title 173 Regulations

Updated 5/3/2017 Condition	Labs- automated ELR			Labs reporting manually			Healthcare providers		
	immediate	within 7 days	monthly	immediate	within 7 days	monthly	immediate	within 7 days	monthly
Streptococcal disease (all invasive disease caused by Groups A and B *Streptococci*)		x			x			x	

https://dhhs.ne.gov/epi%20docs/ReportableDiseaseChart.pdf

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Invasive Disease Definition

Isolation of GAS from a normally sterile site (e.g., Blood, CSF, Synovial Fluid, Pericardial Fluid)

Isolation of GAS from a non-sterile site AND presence of necrotizing fasciitis OR Streptococcal Toxic Shock Syndrome STSS

Definition of STSS

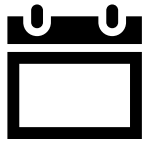
1. **Hypotension** Systolic <= 90 mm Hg for adults or < 5th percentile by age for children aged less than 16 years.
2. **Multi-organ involvement** characterized by **two or more** of the following:
   - Renal impairment: Creatinine >= 2 mg/dL for adults or >= upper limit of normal for age. Twofold elevation over the baseline level for those with preexisting renal disease.
   - Coagulopathy: Platelets <= 100,000/mm^3 or disseminated intravascular coagulation
   - Liver involvement: ALT, AST, or total bilirubin levels greater than or equal to twice the upper limit of normal for the patient's age. In patients with preexisting liver disease, a greater than twofold increase over the baseline level.
   - Acute respiratory distress syndrome
   - A generalized erythematous macular rash that may desquamate.
   - Soft-tissue necrosis, including necrotizing fasciitis or myositis, or gangrene.

Confirmed: Clinical Criteria AND Isolation of GAS from a sterile site

Probable: Clinical Criteria AND Isolation of GAS from a non-sterile site and absence of other etiology

https://ndc.services.cdc.gov/case-definitions/streptococcal-toxic-shock-syndrome-2010/

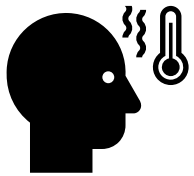
Invasive Group A Strep: National Data



Jan 2013 – Dec 2022

Demographic and Clinical information were extracted from medical records

10 States with Active Bacterial Core Surveillance (ABCs) Sites

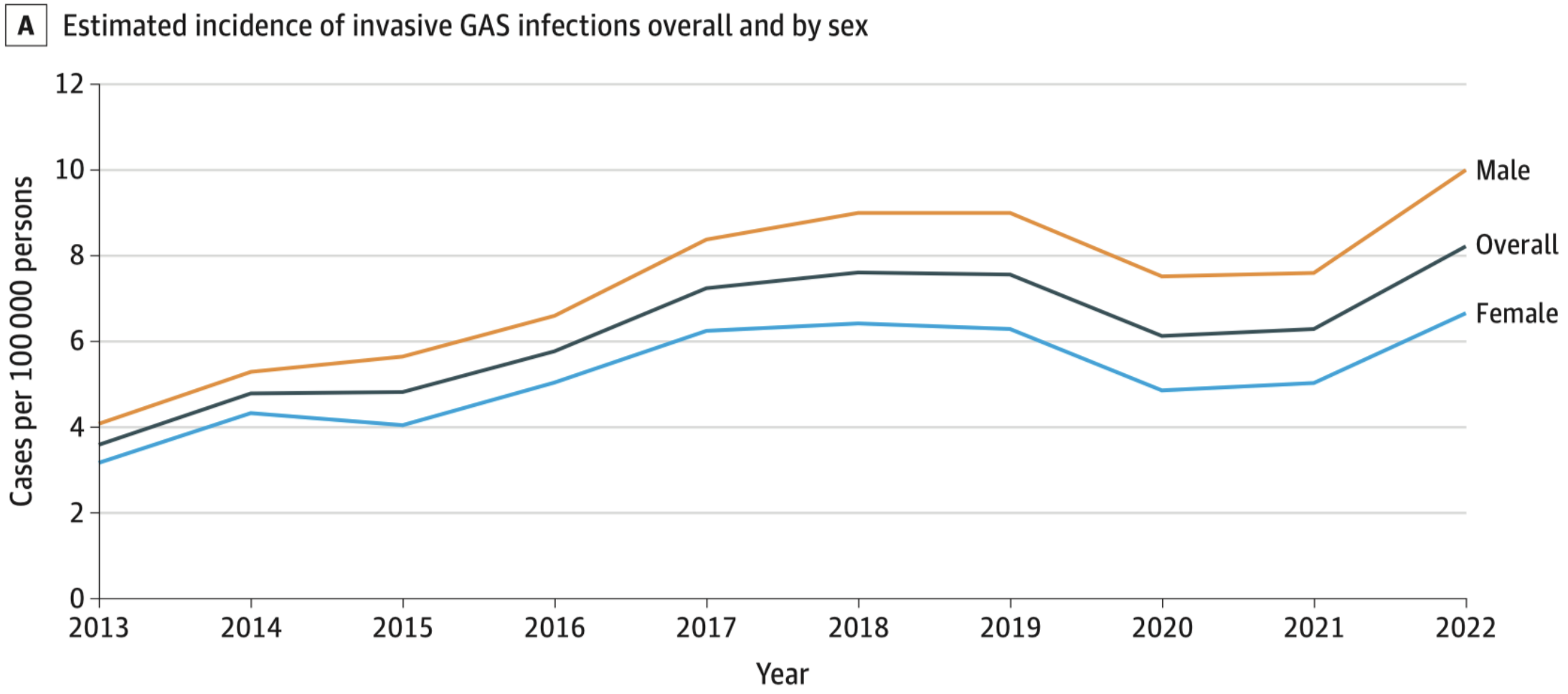


Invasive Disease

21,312 cases of Invasive GAS
95% were hospitalized
57% were male
30% were 65 or older
39.6% were admitted to ICU
9.1% died

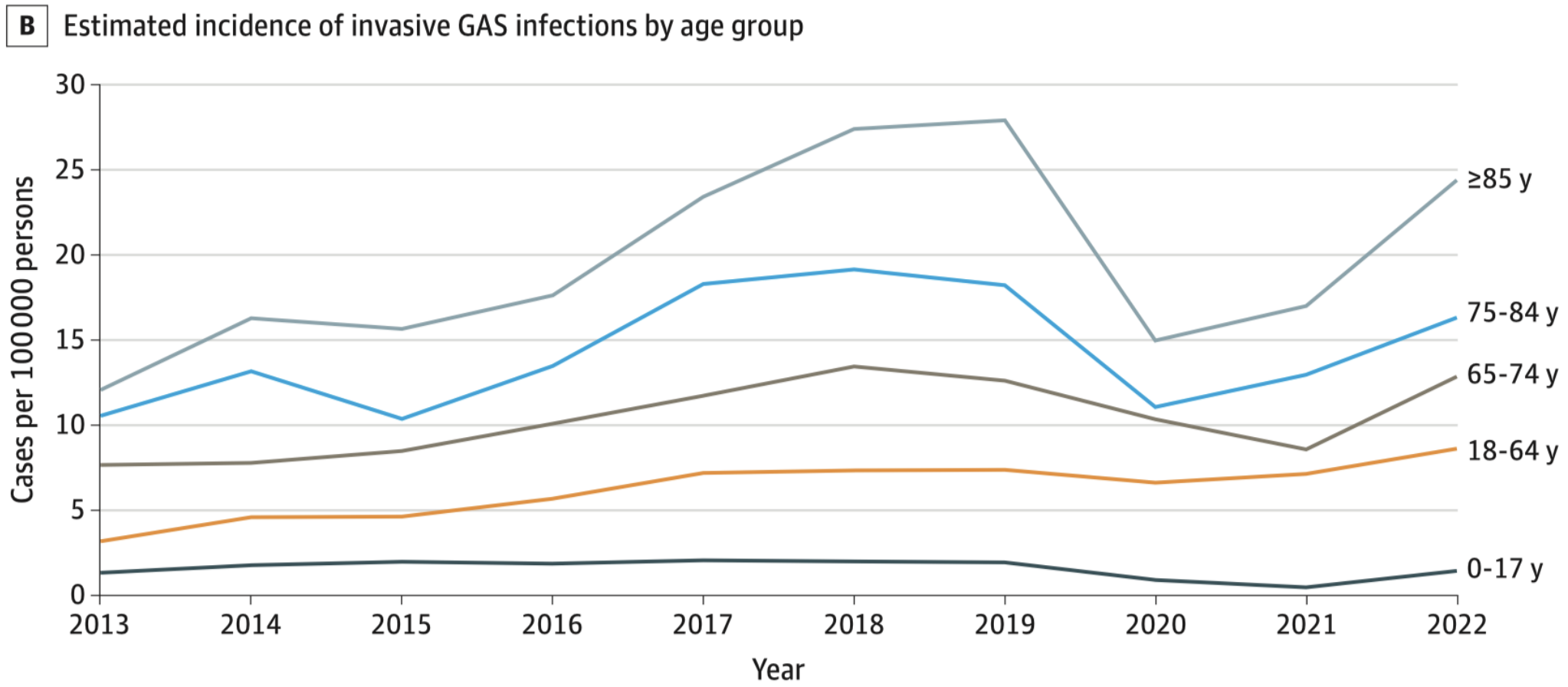
Gregory et al. Invasive Group A Streptococcal Infections in 10 US States. *JAMA.* 2025;333(17):1498–1507.

Trends



Gregory et al. Invasive Group A Streptococcal Infections in 10 US States. *JAMA.* 2025;333(17):1498–1507.

Older Population is at Higher Risk



Gregory et al. Invasive Group A Streptococcal Infections in 10 US States. *JAMA.* 2025;333(17):1498–1507.

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Known Risk Factors

Long Term Care Resident:

- 6.5% were residents in LTC
- The incidence rate was 101.1 per 100 000 in 2018 and 75.4 per 100 000 in 2020

People Experiencing Homelessness:

- Increased from 52 in 2013 to 493 in 2022
- Incidence rate increased from 85.0 per 100 000 in 2013 to 806.7 per 100 000 in 2022

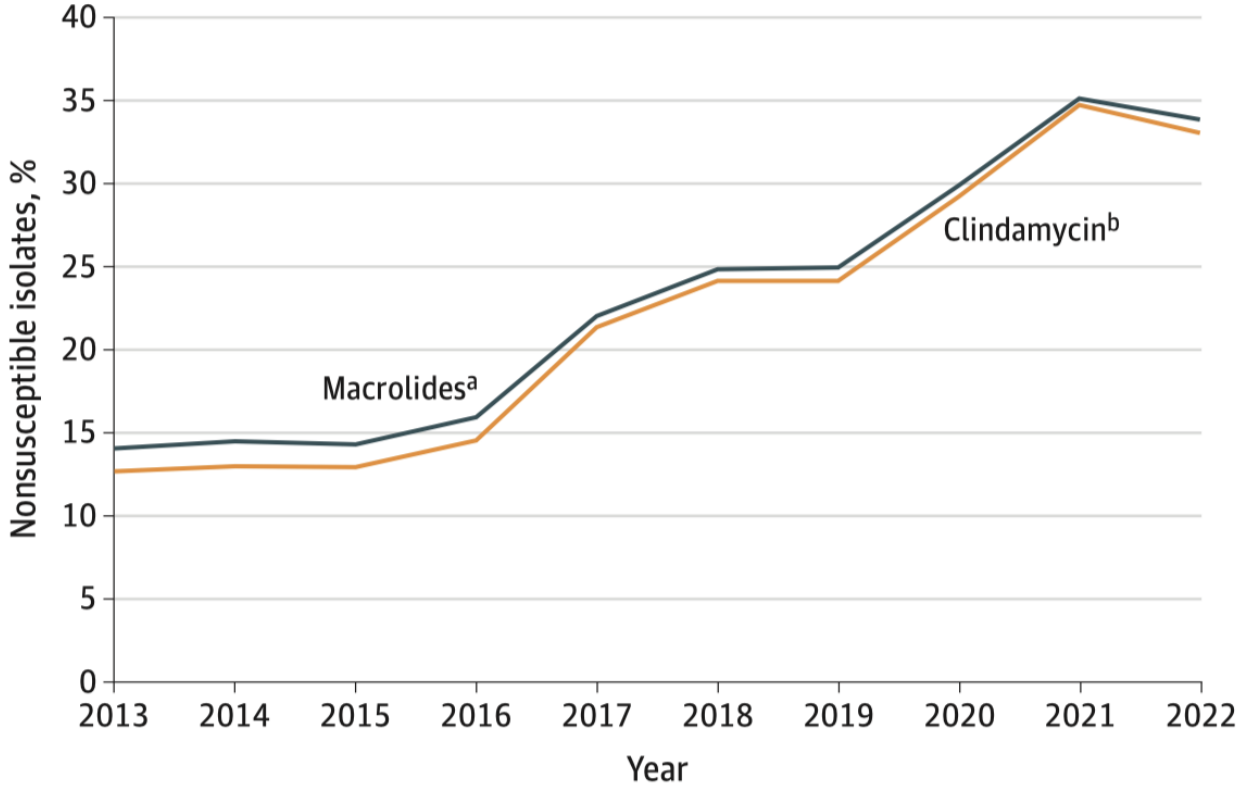
Substance use:

- Increased from 59 in 2013 to 515 in 2022
- Rate of invasive GAS among people 18 years or older who inject drugs was 97.0 per 100 000 in 2018

Gregory et al. Invasive Group A Streptococcal Infections in 10 US States. *JAMA.* 2025;333(17):1498–1507.

Resistance is Increasing

Figure 3. Percentage of Group A *Streptococcus* Isolates Nonsusceptible to Macrolides and Clindamycin, 2013-2022



No. of isolates tested

2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
944	1260	1403	1735	2202	2304	2337	1817	1833	2457

Gregory et al. Invasive Group A Streptococcal Infections in 10 US States. *JAMA.* 2025;333(17):1498–1507.

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Precautions

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Streptococcal disease (group A *Streptococcus*) Skin, wound, or burn Major	Contact + Droplet + Standard	Until 24 hours after initiation of effective therapy	Until drainage stops or can be contained by dressing.
Streptococcal disease (group A *Streptococcus*) Skin, wound, or burn Minor or limited	Standard		If dressing covers and contains drainage.
Streptococcal disease (group A *Streptococcus*) Serious invasive disease	Droplet + Standard	Until 24 hours after initiation of effective therapy	Outbreaks of serious invasive disease have occurred secondary to transmission among patients and healthcare personnel [162, 972, 1096-1098]. Contact Precautions for draining wound as above; follow recommendations for antimicrobial prophylaxis in selected conditions [160].

Risk for Household Members

Epidemiological feature	Canadian study [6]	US study[a]
Surveillance area	Ontario, Canada	CT, MN, and counties in CA and OR
Period of observation	Jan 1992–Jun 1995	Jan 1997–May 1999
Surveillance population, millions of persons	10.7	12.1
Sporadic cases detected, no.	732[b]	1064
Incidence of sporadic disease, cases/100,000 population per year	2.4[b]	3.5
Household contacts of index patients, no.	1360	1514
Subsequent cases detected, no.[c]	4	1
Syndromes observed in each index patient/subsequent case patient pair	Bacteremia (index), pneumonia (subsequent); bursitis (both); soft-tissue infection (both); necrotizing fasciitis (both)	Bacteremia (index), necrotizing fasciitis (subsequent)
Attack rate, cases/100,000 population (95% CI)	294 (80–750)	66 (2–367)
Proportion of subsequent cases, % of all invasive GAS cases	0.6	0.1

[a] K. Robinson, personal communication.
[b] Figures listed differ from data published in the reference. Revised figures are based on follow-up surveillance data (A. McGeer, personal communication).
[c] Within 30 days after a culture form the index patient was positive for group A streptococci.

Table 1 Summary of 2 studies of the risk of subsequent invasive group A streptococcal (GAS) disease among household ...

The Prevention of Invasive Group A Streptococcal Infections Workshop Participants, Prevention of Invasive Group A Streptococcal Disease among Household Contacts of Case Patients and among Postpartum and Postsurgical Patients: Recommendations from the Centers for Disease Control and Prevention, *Clinical Infectious Diseases*, Volume 35, Issue 8, 15 October 2002, Pages 950–959, https://doi.org/10.1086/342692

Postpartum Risk – ~220 cases of Invasive GAS per year

Disease or condition	No. (%) of patients (n = 87)
Bacteremia without focus	40 (46)
Endometritis	24 (28)
Peritonitis	7 (8)
Septic abortion	6 (7)
Cellulitis	3 (3)
Septic arthritis	3 (3)
Necrotizing fasciitis	3 (3)
Streptococcal toxic shock syndrome	3 (3)
Chorioamnionitis	3 (3)
Pneumonia	1 (1)
Abscesses	0 (0)
Other[a]	3 (3)

[a] Meningitis, pelvic thrombophlebitis, and septic emboli.

Table 1 Diseases and conditions seen among patients with postpartum group A streptococcus infection, Active Bacterial ...

Period of observation, months[a]	No. of hospitals with ≥2 cases during 24 months	No. of case pairs at all hospitals during 24 months	No. (%) of case pairs with *emm* typing data available for both cases	No. (%) of case pairs with identical *emm* types	Shared *emm* type (no. of case pairs)
6	8	11	9 (82)	1 (11)	28 (1)
12	13	23	20 (87)	3 (15)	28 (2), 11 (1)
24	16	36	31 (86)	5 (16)	28 (2), 11 (2), 13 (1)

NOTE. An average of 204 hospitals (range, 169–255 hospitals) were included in the ABCs GAS surveillance each year.

[a] The period of observation during which ≥2 cases were noted. The pairs of cases in the 12-month period include those from the 6-month period, and the pairs of cases in the 24-month period include those from the 6-month and the 12-month periods.

Table 2 Frequency and congruence of emm types of group A streptococcus (GAS) isolated from cases of invasive ...

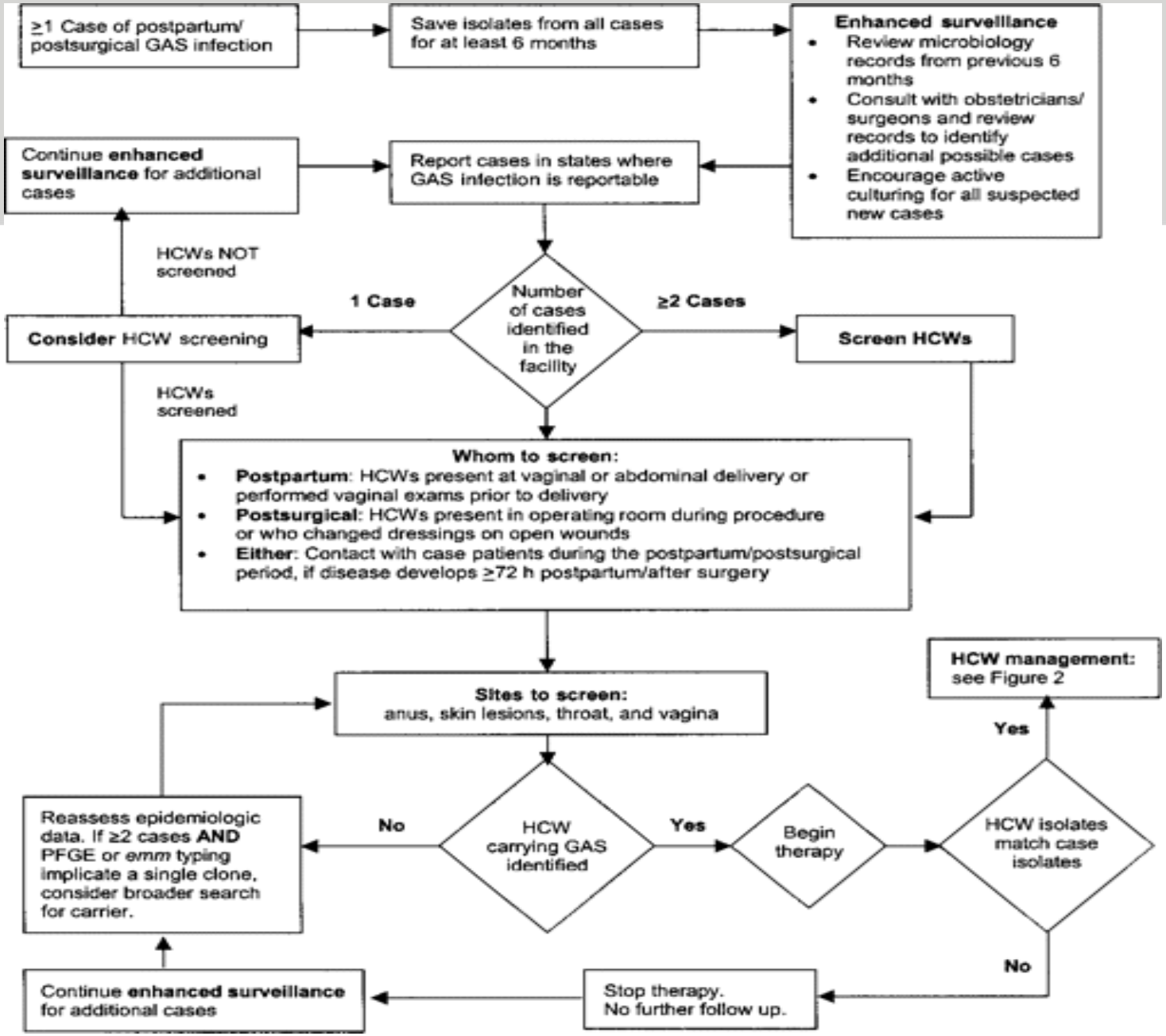
Clin Infect Dis, Volume 35, Issue 6, 15 September 2002, Pages 665–670, https://doi.org/10.1086/342062

Post-Surgical Risk

In 2000, 1.5% of cases of invasive disease were classified as post-surgical (within 7 days of a surgical intervention)

Based on national census, an estimated 135 surgical cases occur in the US annually

The Prevention of Invasive Group A Streptococcal Infections Workshop Participants, Prevention of Invasive Group A Streptococcal Disease among Household Contacts of Case Patients and among Postpartum and Postsurgical Patients: Recommendations from the Centers for Disease Control and Prevention, *Clinical Infectious Diseases*, Volume 35, Issue 8, 15 October 2002, Pages 950–959, https://doi.org/10.1086/342692



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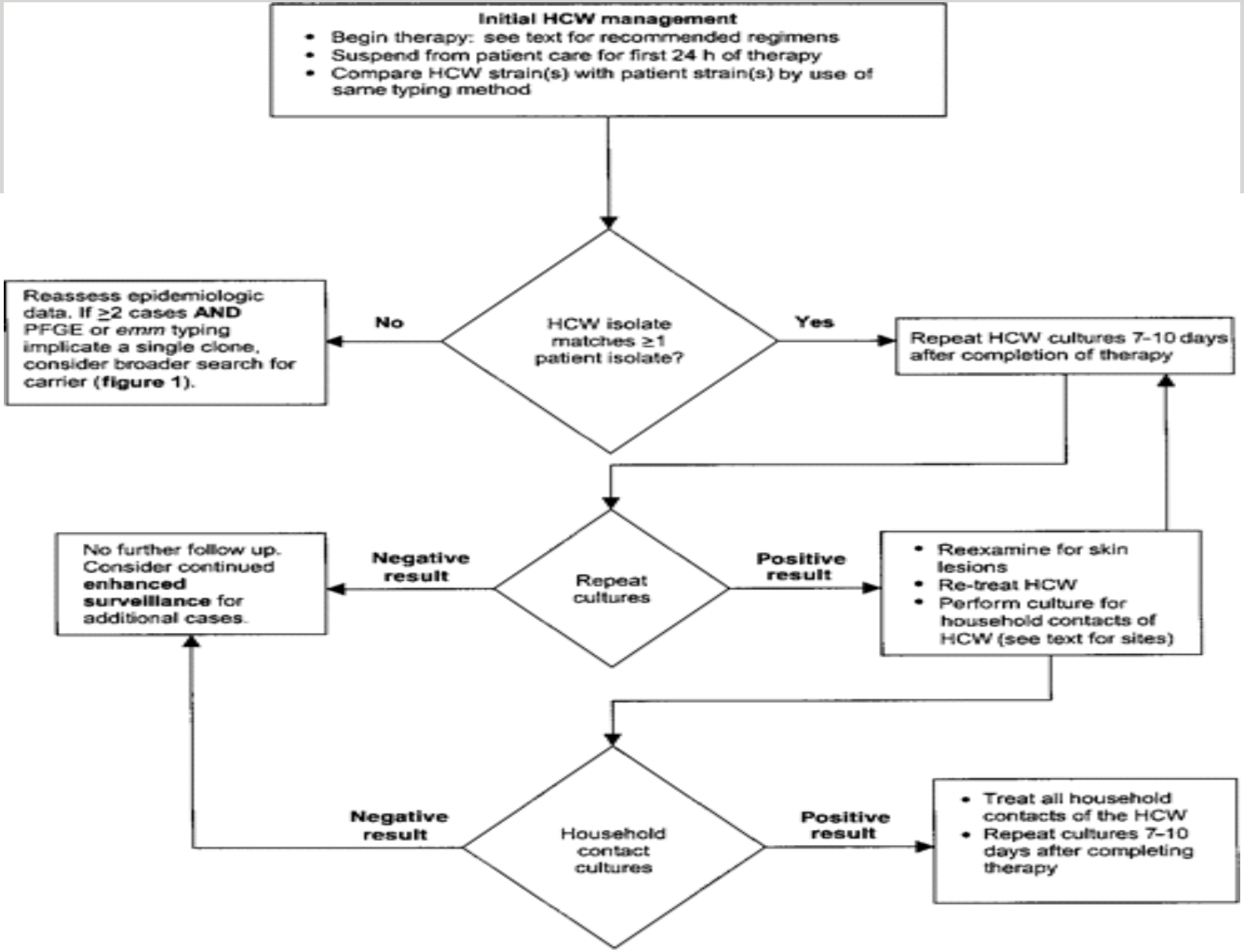


Clin Infect Dis, Volume 35, Issue 6, 15 September 2002, Pages 665–670, https://doi.org/10.1086/342062

Cases not linked to outbreaks or investigations

Infection Control in Healthcare Personnel:
Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients

Group A *Streptococcus*

Recommendations

1. Postexposure prophylaxis and work restrictions are not necessary for healthcare personnel who have an exposure to group A *Streptococcus*.
2. For healthcare personnel with known or suspected group A *Streptococcus* infection, obtain a sample from the infected site, if possible, for group A *Streptococcus* and exclude from work until group A *Streptococcus* infection is ruled out, or until 24 hours after the start of effective antimicrobial therapy, provided that any draining skin lesions can be adequately contained and covered.
    - For draining skin lesions that cannot be adequately contained or covered (e.g., on the face, neck, hands, wrists), exclude from work until the lesions are no longer draining.
3. Work restrictions are not necessary for healthcare personnel with known or suspected group A *Streptococcus* colonization, unless they are epidemiologically linked to transmission of the organism in the healthcare setting.

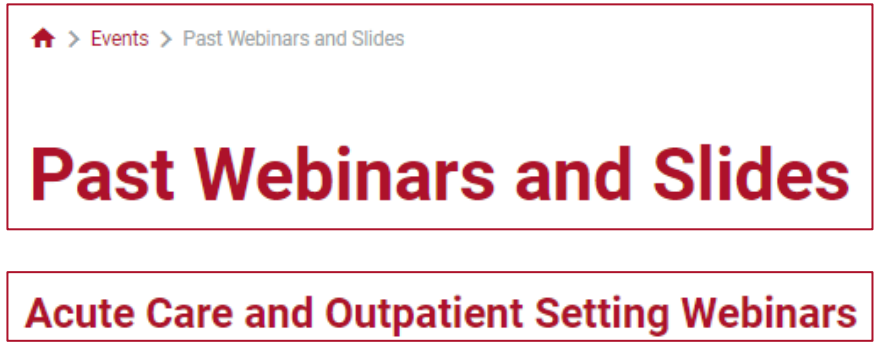
https://www.cdc.gov/infection-control/media/pdfs/Guideline-IC-HCP-H.pdf

Questions & Answer Session

- Please use the Q&A box in the webinar platform to type a question to be read aloud.
  - If your question is not answered during the webinar, please call (402) 552-2881 Monday – Friday 8:00 am – 4:00 pm CST to speak with one of our Infection Preventionists or e-mail your question to nebraskaicap@nebraskamed.com

Slides & Webinar Recordings Available

- During this webinar, slides are available on the NE ICAP Acute Care webpage
  - After the webinar, slides and a recording will be posted on the NE ICAP Past Webinars and Slides webpage



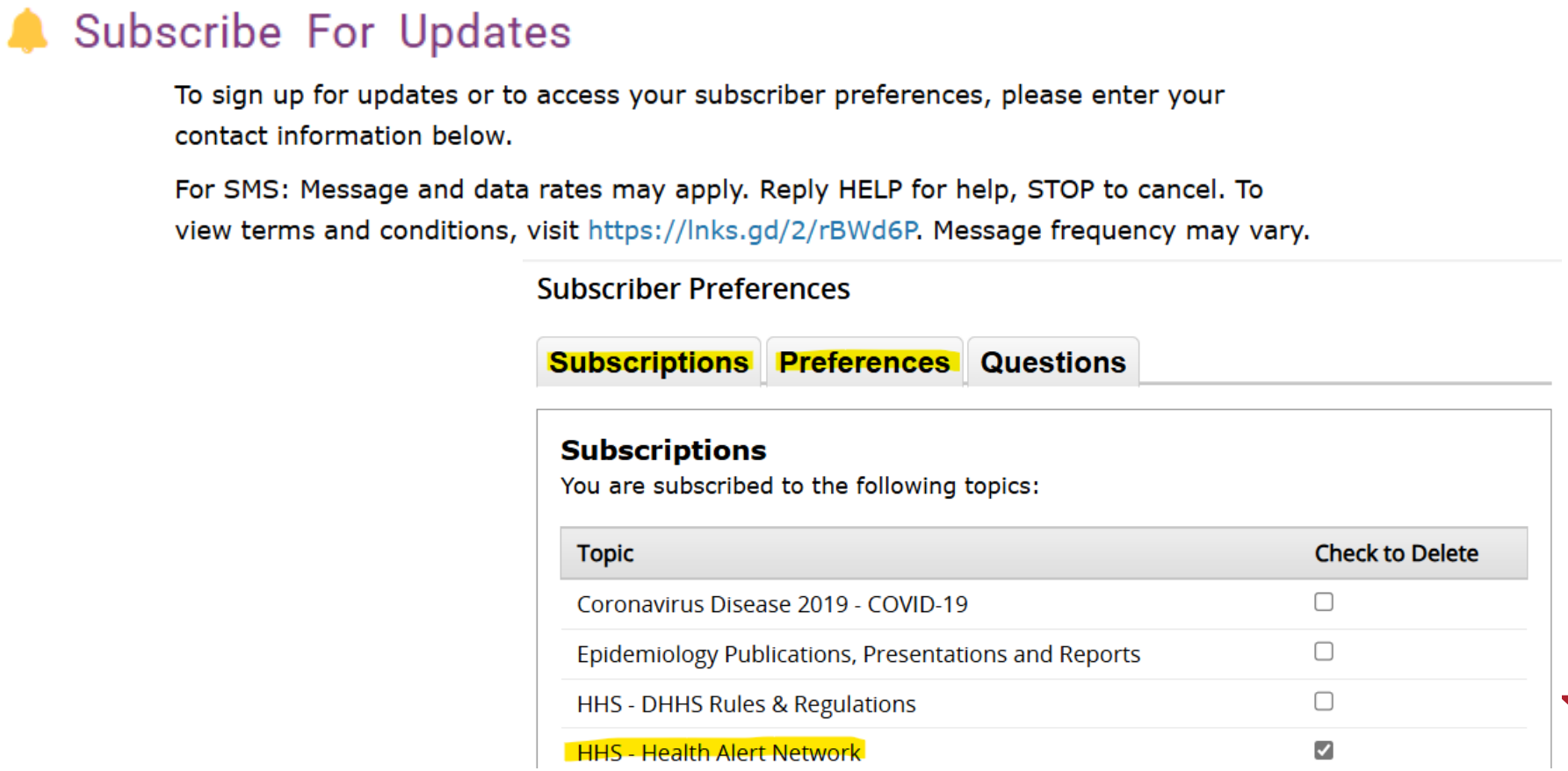
Misc. Updates & Upcoming Educational Opportunities

Rebecca Martinez, BSN, BA, RN, CIC
Infection Preventionist, NE ICAP

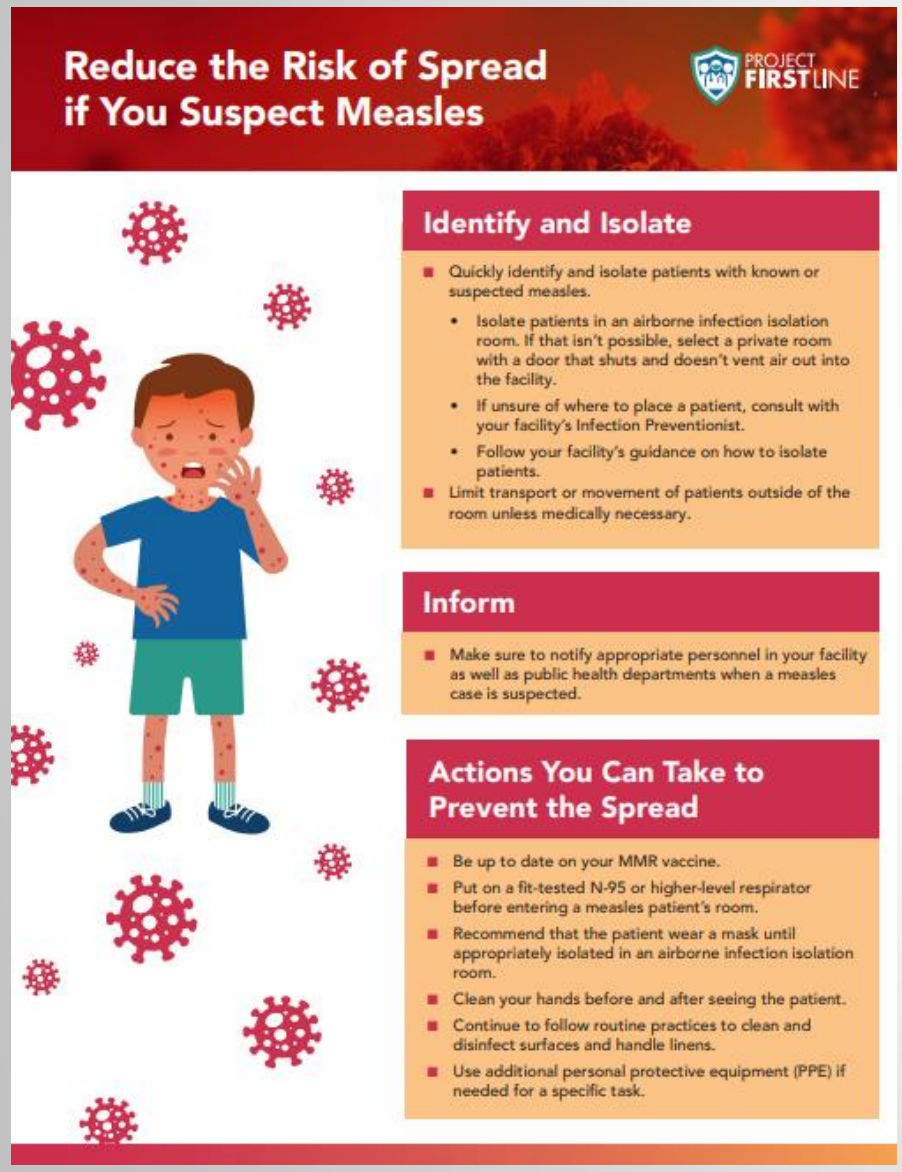
NE ICAP

Options for Nebraska Health Alert Network (HAN) Communications

- When subscribing to the Nebraska HAN, select type (e.g. email, text) and daily frequency.
- https://dhhs.ne.gov/Pages/Health-Alert-Network.aspx



Measles Micro-Learn by CDC's Project Firstline



- **Do staff at your healthcare setting know what they should do when they suspect measles so they can reduce the risk of spread to others?**
  - Use this Project Firstline micro-learn to educate your team on what to do when they suspect a measles case.
    - The micro-learns are a series of guided discussions that connect infection control concepts to immediate, practical value, so healthcare workers can recognize risks and stop the spread of germs.

https://www.cdc.gov/project-firstline/media/pdfs/PFL-MeaslesMicroLearn.pdf

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Upcoming NHSN Patient Safety Component (PSC) Annual Training Summer Series

- Details are in the weekly email from the CDC NHSN PSC Annual Training Team but key points are:
  - Tuesdays and Thursdays starting June 10th through July 17th
  - For training, click the link of the presentation you want to join that was sent in the weekly email
    - No registration needed
    - Times are approximate
    - No recordings of training

Thursday, June 12
To join click, June 12 Annual Training Session to access Teams at 12:00 Noon Eastern (ET).

Title	Duration	Time
Welcome	30 minutes	12:00 Noon ET
AT - NHSN Organism Browser	30 minutes	12:05 Noon ET
AT - LABID - Locking in on LabID Event Reporting	75 minutes	12:35 PM ET
AT - Rebaseline CDI	60 minutes	1:50 PM ET
AT - Cracking the Code: Your Guide to Chapter 2 NHSN Definitions for Reporting Success	60 minutes	2:50 PM ET

- To join the New Annual Training Community in Service Now, register once for access

Infectious Diseases of Public Health Concern (IDPHC) – *Voluntary Reporting to NHSN PSC Module*

Overview

The Infectious Diseases of Public Health Concern (IDPHC) form can be used by hospitals and public health officials to support potential preparedness and response efforts to high consequence infectious diseases and to better understand their impact on patients and the healthcare system. The intent of this data collection is to provide situational awareness of these diseases in facilities and which facilities and/or geographic regions may need additional infection prevention and control support, as well as inform which patient populations are affected.

The form will be available for optional reporting of incidence and prevalence data for prioritized infectious diseases affecting patients in Acute Care Hospitals (ACHs). The data are stratified between confirmed and unconfirmed disease, as well as by patient population (adult patients and pediatric patients).

Reporting of this form does not replace regulatory reporting requirements.

The following diseases and conditions are available for reporting:

- Crimean-Congo Hemorrhagic Fever (CCHF)
- Dengue
- Ebola
- Lassa
- Measles
- Mpox
- Nipah
- Toxigenic Vibrio cholerae

Protocol

Infectious Diseases of Public Health Concern Protocol [PDF – 494 KB]

Data Collection Forms and Instructions

Pathogens of High Consequence (Infectious Diseases of Public Health Concern) Form (57.130) [PDF – 231 KB]

Table of Instructions [PDF – 232 KB]

Training

How to Report IDPHC [PDF – 631 KB]

https://www.cdc.gov/nhsn/psc/Infectious-Diseases.html

Updated Multisociety Guidance for Sterilization and High-Level Disinfection

- What is it?
  - A free key multi-society infection prevention guidance document for individuals and organizations that engage in sterilization or high-level disinfection (HLD).
- Who developed it?
  - SHEA, in partnership with ASGE, APIC, AAMI, AORN, HSPA, IDSA, SGNA, and The Joint Commission.
- Why is it important?
  - "Facilities without appropriate expertise and resources are not able to implement sterilization and HLD safely and effectively."
  - Failure to effectively sterilize or HLD is unsafe and can lead to direct transmission of pathogens causing infections and outbreaks.

https://tdoi.org/10.1017/ice.2025.41

Preferred Future Topic Regarding Tuberculosis – *Prior Webinar Poll Results*

- Discussion of typical and atypical patient case scenarios and investigations (e.g. pulmonary TB, extra-pulmonary TB, M. bovis)
- Guidance on what are next steps when a HCP screens positive on a TB screening test
- Current recommendations for TB screening of HCP
- Learning how a tuberculosis-related investigation at your facility might be done?
- Other Topic - C. difficle / Measles / Hep B / Hep A

Join Us - Upcoming NE ICAP Webinars

- July 9, 2025
  - 12:00 – 1:00 PM (CST)
    - Endoscope Reprocessing – Reducing Gaps & Validating Practices
      - Rebecca Martinez, BSN, BA, RN, CIC

- August 13, 2025
  - 12:00 – 1:00 PM (CST)
    - Review of HCP recommendations for tuberculosis (TB) screening
    - Typical and atypical patient case scenarios and investigations (e.g. pulmonary TB, extra-pulmonary TB, *M. bovis*)

APIC NEBRASKA

Nebraska Infection Control Network

NEBRASKA METHODIST COLLEGE
THE JOSIE HARPER CAMPUS
PROFESSIONAL DEVELOPMENT

Agenda

Time CST	Topic/Title/Speaker/Contact Hours Awarded
7:00 am – 8:15 am	Registration/Breakfast
8:15 am – 8:30 am	Welcome: Dr. Richard Starlin (0.25 CH)
8:30 am – 9:15 am	Future of Infection Prevention: Dr. Gonzalo Bearman (0.75 CH)
9:15 am – 10:00 am	Leadership Development & Influencing Change: Dr. Hilary Babcock (0.75 CH)
10:00 am – 10:30 am	Break/Vendors
10:30 am – 11:30 am	Vaccination Promotion: Dr. Peter Hotez (presenting remotely 0.0 CH)
11:30 am – 12:30 pm	Lunch (Provided) and Vendors
12:30 pm – 1:30 pm	Track 1: TBD: LTC Guideline Updates (1.0 CH)
12:30 pm – 1:30 pm	Track 2: Vascular Access Related Infection Prevention and Management/Preventative Technology: Barb Nickel (1.0 CH)
1:30 pm – 2:00 pm	Break/Vendors
2:00 pm – 2:45 pm	MDRO in Animals: Stephen Cole (0.75 CH)
2:45 pm – 3:30 pm	How to Interact with Media and Art of Communication: Cathy Wyatt (0.75 CH)
3:30 pm – 3:45 pm	Closing (0.25 CH)

Join NICN and APIC NE for their 45th anniversary symposium. Join us for an engaging and informative workshop dedicated to infection prevention and control in all healthcare settings. This workshop will feature expert speakers and interactive discussion on infection prevention strategies, leadership development, vaccination promotion, and media interaction skills.

- Friday, August 29, 2025
- 8:00 AM to 3:15 PM
- The Holland Center, Omaha, NE 68102

NICN APIC Nebraska Symposium Registration

ICAP Contact Information

Call 402-552-2881

Office Hours are Monday – Friday

8:00 AM - 4:00 PM Central Time

Weekends and Holidays 10:00-4:00 (CST)

On-call hours are available for emergencies only

Scan the QR Code to be taken to our NE ICAP Contact Form.
You can request to be connected to an Infection Preventionist that specializes in your area, get added to our setting specific communication list for webinar and training invites, sign up for newsletters and reminders, or request an ICAR review for your facility.

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Webinar CE Process

- **1 Nursing Contact Hour is awarded by Nebraska ICAP**
  - Nebraska Infection Control Assessment and Promotion Program is approved as a provider of nursing continuing professional development by the Midwest Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

- **CNE Nursing Contact Hours:**
  - Completion of survey is required.
  - The survey must be specific to the individual obtaining credit; (i.e., 2 people cannot be listed on the same survey).
  - Survey functionality is lost on mobile devices.
  - One certificate is issued quarterly for all webinars attended.
  - Certificate comes directly from ICAP via email.