Acute Care & Outpatient Settings Webinar Series

August 13, 2025

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NEBRASKA INFECTION CONTROL ASSESSMENT AND PROMOTION PROGRAM

Presenters & Panelists & Moderator

Presenters today:

Juan Teran Plasencia, MD	jteranplasencia@unmc.edu
Kristin Bertrang, RN, MSN	kristin.bertrang@nebraska.gov

Panelists today:

Kate Tyner, BSN, RN, CIC	ltyner@nebraskamed.com
Chris Cashatt, BSN, RN, CIC	ccashatt@nebraskamed.com
Josette McConville, BSN, RN, CIC	jmcconville@nebraskamed.com
Lacey Pavlovsky, MSN, RN, CIC, LTC-CIP, FAPIC	lacey.pavlovsky@nebraska.gov
Rebecca Martinez, BSN, BA, RN, CIC	remartinez@nebraskamed.com

Moderator today:

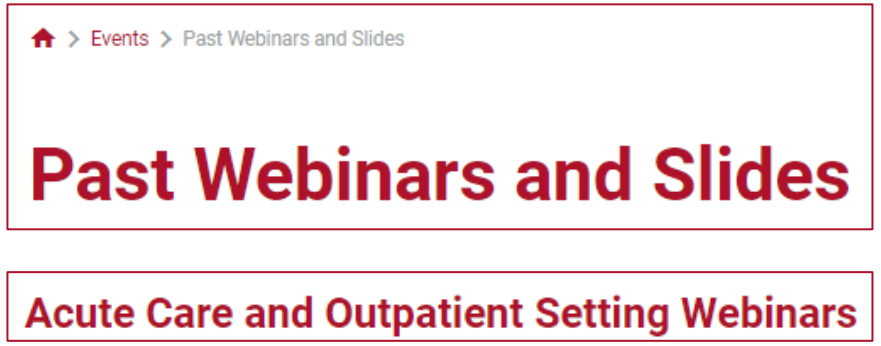
Margaret Deacy	mdeacy@nebraskamed.com

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

NE ICAP

Key Points

- Measles cases are increasing nationwide.
- COVID activity is increasing

Measles Cases in US: Update as of 8/6/25

- As of August 6, 2025, a total of **1,356** confirmed* measles cases were reported by 41 jurisdictions+

- There have been 32 outbreaks (defined as 3 or more related cases) reported in 2025, and 87% of confirmed cases (1,177 of 1,356) 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, Arizona, 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 Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming

Measles Cases in US: Update as of 8/6/25

U.S. Cases in 2025

Total cases

1356

Age
Under 5 years: **386 (28%)**
5-19 years: **501 (37%)**
20+ years: **462 (34%)**
Age unknown: **7 (1%)**

Vaccination Status
Unvaccinated or Unknown: **92%**
One MMR dose: **4%**
Two MMR doses: **4%**

U.S. Hospitalizations in 2025

13%

13% of cases hospitalized (171 of 1356).

Percent of Age Group Hospitalized
Under 5 years: **21% (82 of 386)**
5-19 years: **8% (40 of 501)**
20+ years: **11% (49 of 462)**
Age unknown: **0% (0 of 7)**

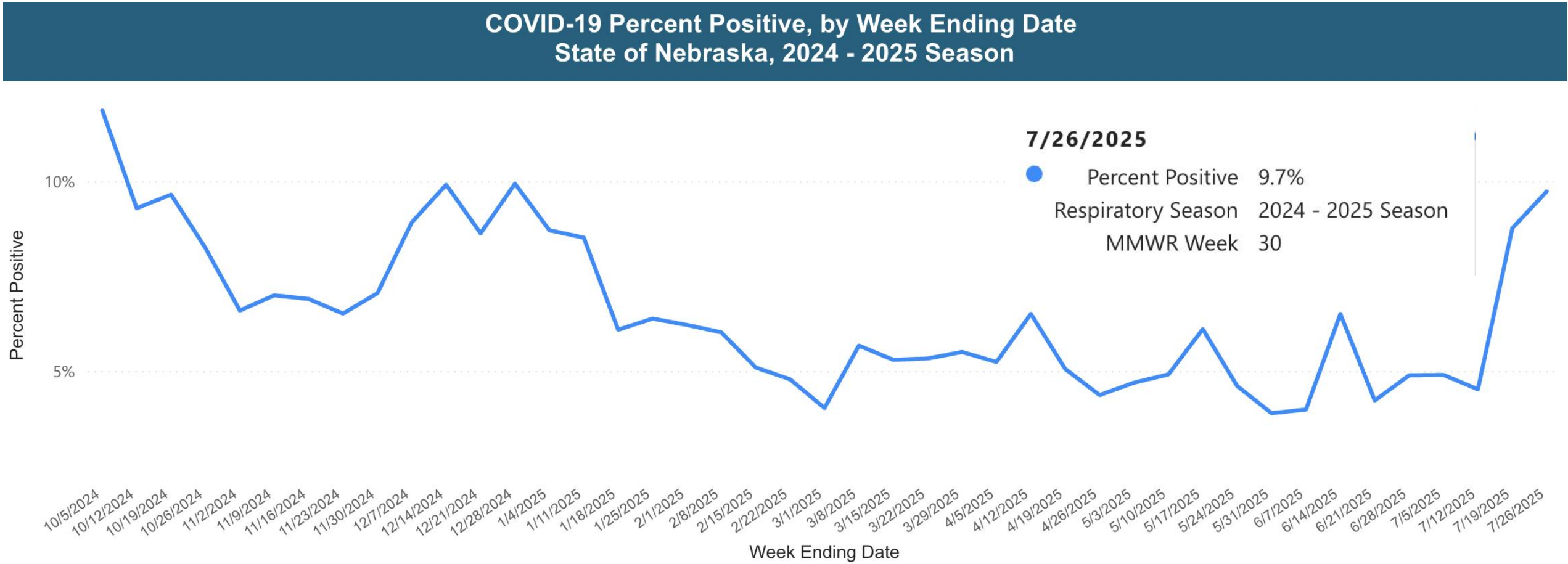
U.S. Deaths in 2025

3

There have been 3 confirmed deaths from measles.

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

Covid-19 NE DHHS Report



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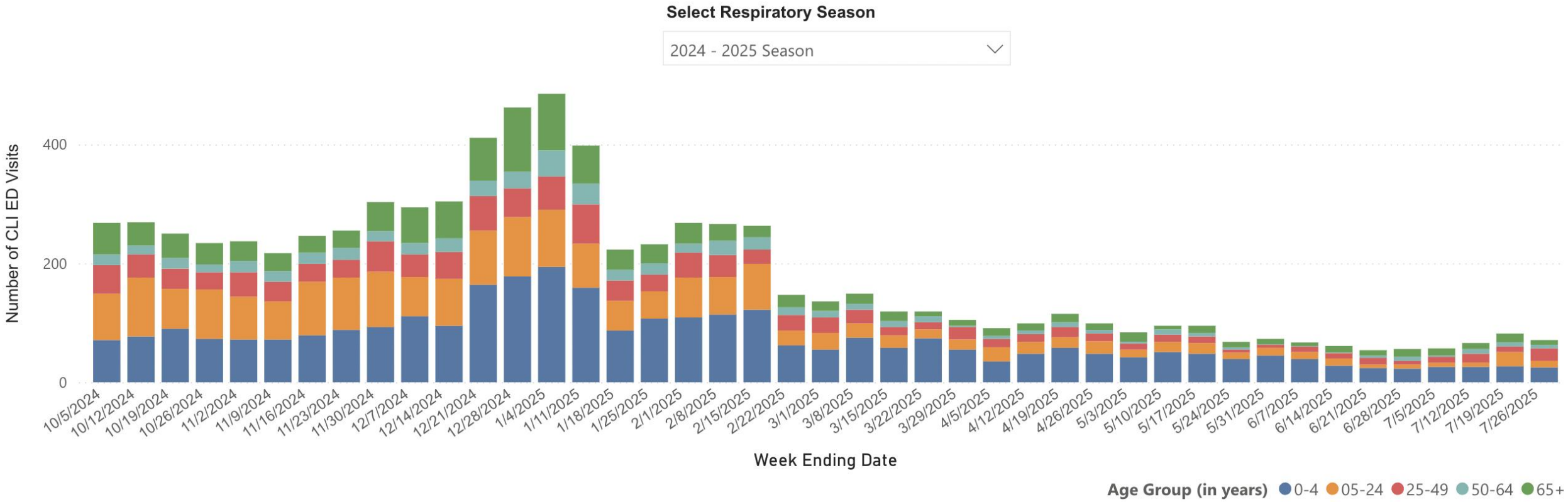
Covid-19 NE DHHS Report

Number of Influenza-like Illness (ILI) Emergency Department (ED) Visits by Age Group, by Week Ending Date, State of Nebrasksa, 2024 - 2025 Season



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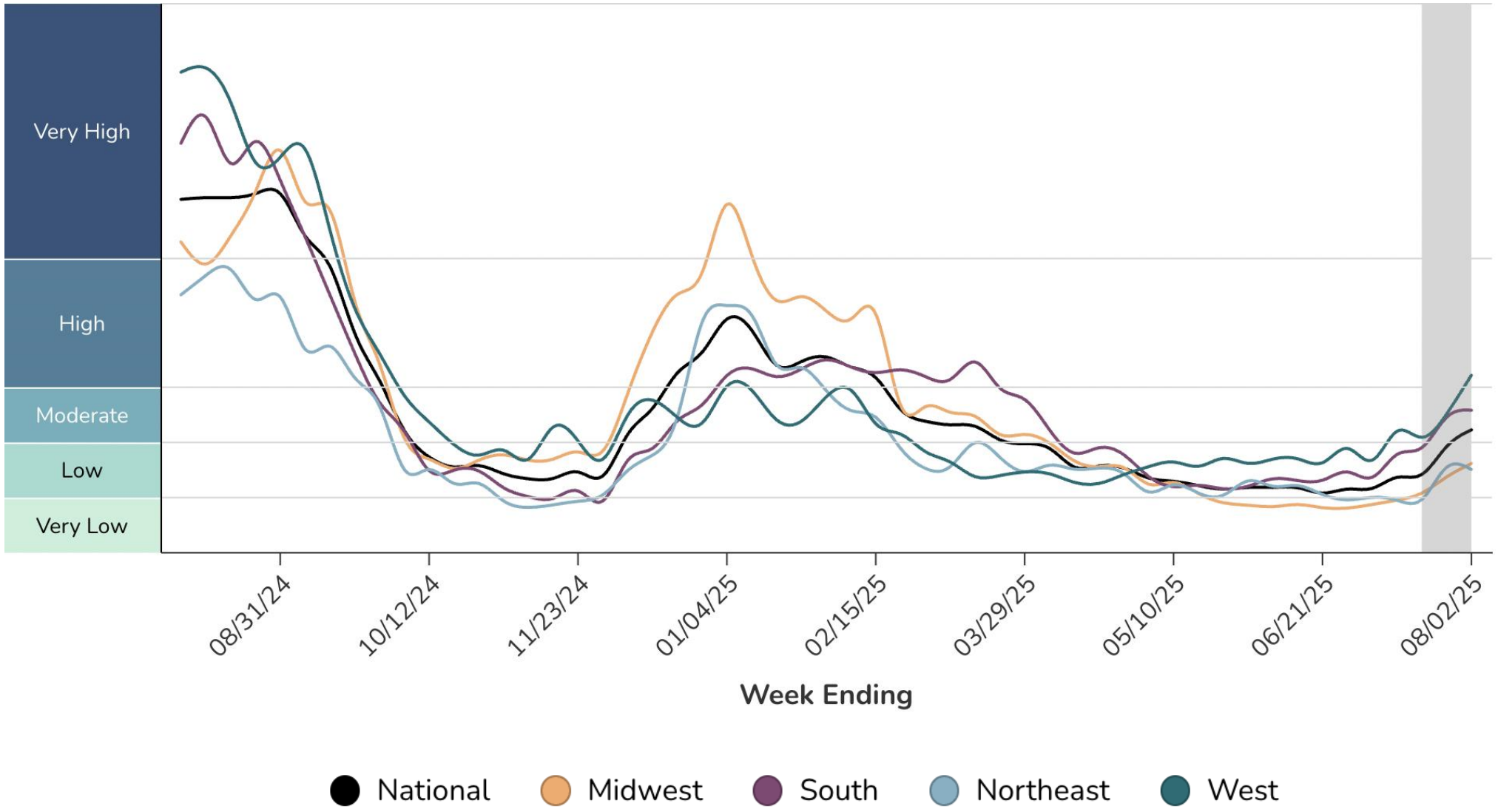
Covid Wastewater Data



COVID Data Tracker

CDC

NE ICAP

Typical and atypical patient case scenarios and investigations

Juan Teran, MD
Medical Director, NE ICAP

NE ICAP

Clinical case

- You are the IP at a small hospital in rural Nebraska. In addition to your infection prevention and control (IPC) responsibilities, you also manage aspects of employee health and contribute to the development of the annual IPC training.

- During the onboarding of a new nurse aide, they ask about the risk of developing tuberculosis as a healthcare worker. Specifically, they want to know how often you see latent and active tuberculosis in healthcare workers.

- **Select the correct answer:**
  A. The risk is similar to that of the general population
  B. The odds of latent tuberculosis are 5 times higher among healthcare workers than in the general population
  C. The odds of developing latent tuberculosis are 70% higher than in the general population
  D. There are no cases of active tuberculosis among healthcare workers

Risk among healthcare workers

Meta analysis
8 studies Asia, 5 Africa, 4 Europe, 3 South America

21 Studies
12 Latent TB
8 Active TB
1 Both

4 Studies investigated HCW with high exposure to TB

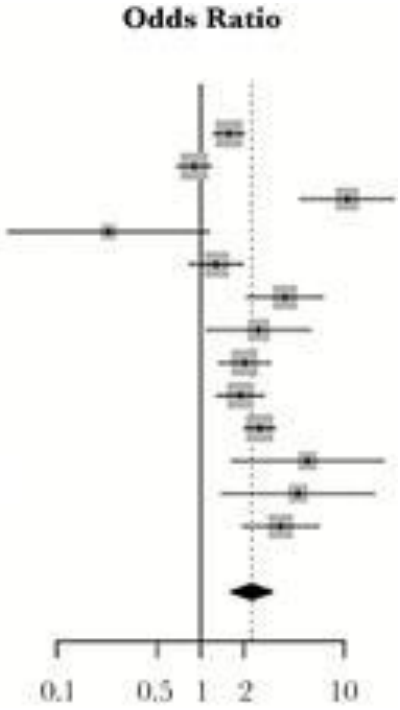
Controls included school workers, nonmedical students, administrative employees, and general population data

Uden et al., Risk of Tuberculosis Infection and Disease for Health Care Workers: An Updated Meta-Analysis, *Open Forum Infectious Diseases*, Volume 4, Issue 3, Summer 2017, ofx137

Latent TB

Study	HCWs Events	HCWs Total	Control Events	Control Total	W(random)	OR	95% CI
Agaya et al 2015	534	898	160	332	10.1%	1.58	[1.22–2.03]
Corbett et al 2007	183	342	248	443	10.0%	0.90	[0.68–1.20]
Drobniewski et al 2007	107	262	8	130	7.1%	10.53	[4.94–22.43]
Durando et al 2013	3	585	3	136	3.2%	0.23	[0.05–1.14]
Franco et al 2006	101	169	88	164	9.2%	1.28	[0.83–1.98]
Maciel et al 2007	114	619	12	218	8.0%	3.88	[2.09–7.18]
Sawhney et al 2015	20	100	9	100	6.5%	2.53	[1.09–5.87]
Nikokar et al 2010	113	185	79	181	9.3%	2.03	[1.34–3.07]
Powell et al 2011	380	956	40	155	9.5%	1.90	[1.29–2.78]
Rutanga et al 2015	635	1023	135	348	10.2%	2.58	[2.01–3.32]
Storla et al 2009	42	155	3	48	4.5%	5.58	[1.64–18.91]
Zu et al 2014	6	20	7	85	4.5%	4.78	[1.40–16.34]
van Rie et al 2013	68	120	21	79	8.0%	3.61	[1.95–6.69]
Random effects model		5434		2419	100%	2.27	[1.61–3.20]

Heterogeneity: I-squared=84.8%, tau-squared=0.2849, p<0.0001



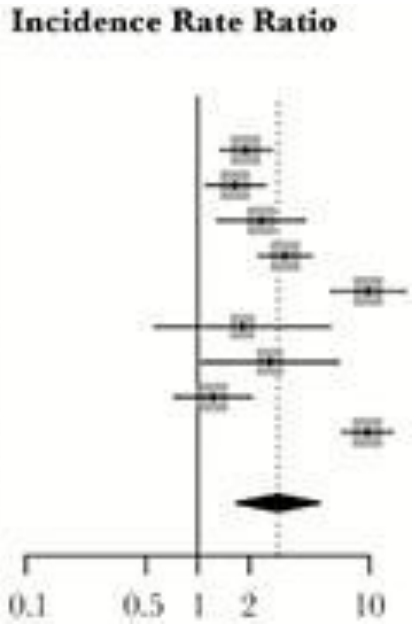
- Pooled prevalence was 37%
- Estimates ranged from 0.5 - 62%
- OR: 2.27 for high TB burden countries
- OR: 1.74 for low TB burden countries

Uden et al., Risk of Tuberculosis Infection and Disease for Health Care Workers: An Updated Meta-Analysis, *Open Forum Infectious Diseases*, Volume 4, Issue 3, Summer 2017, ofx137

Active TB

Study	HCWs Events	HCWs Time	Control Events	Control Time	W(random)	IRR	95% CI
Chen et al, 2014	142	181724	41	100000	12.1%	1.91	[1.35–2.70]
Chu et al, 2014	62	101505	37	100000	11.9%	1.65	[1.10–2.48]
Claassens et al, 2010	11	250	1875	100000	11.1%	2.35	[1.30–4.24]
Corbett et al, 2007	30	155	6000	100000	12.1%	3.23	[2.25–4.62]
Klimuk et al, 2014	23	5445	43	100000	11.5%	9.82	[5.92–16.30]
Pan et al, 2015	3	4980	33	100000	8.2%	1.83	[0.56–5.95]
Pazin-Filho et al, 2008	5	4520	42	100000	9.5%	2.63	[1.04–6.66]
Skodric-Trifuno et al, 2009	24	57279	34	100000	11.5%	1.23	[0.73–2.08]
Sotgiu et al, 2008	50	5303	97	100000	12.1%	9.72	[6.91–13.67]
Random effects model					**100%**	**2.94**	**[1.67–5.19]**

Heterogeneity: I-squared=92.1%, tau-squared=0.6629, p<0.0001



- Pooled incidence is 97/100,000 person-year
- Range is 42 – 4,393/100,000 py
- IRR: 2.09 for LMICs
- OR: 1.66 for non-LMICs

Uden et al., Risk of Tuberculosis Infection and Disease for Health Care Workers: An Updated Meta-Analysis, *Open Forum Infectious Diseases*, Volume 4, Issue 3, Summer 2017, ofx137

Clinical Case

- You begin an investigation after a patient is diagnosed with tuberculosis.

- The patient is a 48-year-old woman who was admitted with pneumonia. She was initially treated for community-acquired pneumonia, but on hospital day 6, a CT scan revealed a cavitary lesion in the right upper lobe. Further history revealed she had lived in the Marshall Islands for five years. Sputum testing was positive for *M. tuberculosis* by smear and culture.

- One of your floor nurses is identified as a close contact. She is immunocompetent, US-born, and has no symptoms of active TB. Her chest X-ray is normal. She undergoes a tuberculin skin test (TST) showing 6 mm of induration. Her baseline TST at hire two years ago showed 0 mm induration.

- **How should you interpret this TST result?**
  A. Negative: she is immunocompetent and US-born
  B. Negative: there is < 10 mm increase from her baseline TST
  C. Positive: any increase in TST induration is positive
  D. Positive: she is a close contact to a TB patient

Heartland National Tuberculosis Center, Case Studies in Tuberculosis: Nurse Case Management Training Tools for Patient Success

 **5 or more millimeters**	 **10 or more millimeters**	 **15 or more millimeters**
An induration of **5 or more millimeters** is considered positive for • People living with HIV • Recent contacts of people with infectious TB disease • People who have fibrotic changes on a chest radiograph • Patients with organ transplants • Other immunosuppressed patients (e.g., patients on prolonged therapy with corticosteroids equivalent to/ greater than 15 mg per day of prednisone or those taking TNF-α antagonists)	An induration of **10 or more millimeters** is considered positive for • People born in countries where TB disease is common, including Mexico, the Philippines, Vietnam, India, China, Haiti, and Guatemala • People who abuse drugs or alcohol • Mycobacteriology laboratory workers • People who live or work in high-risk congregate settings (e.g., nursing homes, homeless shelters, or correctional facilities) • People with certain medical conditions that place them at high risk for TB (e.g., silicosis, diabetes mellitus, severe kidney disease, certain types of cancer, or certain intestinal conditions) • People with a low body weight (<90% of ideal body weight) • Children younger than 5 years of age • Infants, children, and adolescents exposed to adults in high-risk categories	An induration of 1**5 or more millimeters** is considered positive for • People with no known risk factors for TB

Test Choice

TB blood tests are the preferred method of testing for:

- Groups of people who might be less likely to return for TST reading and interpretation (e.g., homeless persons or drug users).
- People who have received the bacille Calmette-Guérin (BCG) vaccine.
- People who are likely to be infected with M. tuberculosis and are at a low to intermediate risk of progression to TB disease.
- People who are unlikely to be infected with M. tuberculosis (note: persons who are unlikely to be infected generally should not be tested for TB; a confirmatory test is recommended if the initial test is positive in those unlikely to be infected).

https://www.cdc.gov/tb/media/Core_Curriculum_TB_eBook.pdf

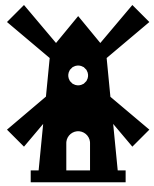
Clinical Case

- A 58-year-old man from Pakistan who recently immigrated to the US is admitted to your hospital. He has experienced 25 lbs of unintentional weight loss, night sweats, fatigue, and a nonproductive cough. Chest X-ray shows fibrotic changes in the apices. Six months ago, he started infliximab (Remicade) for rheumatoid arthritis. He has a 40-pack-year smoking history.

- The primary team calls requesting to discontinue airborne precautions after three sputum samples are negative for *AFB* by smear.

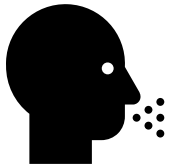
- **Question:**
  What is the most appropriate next step?
- A. Remove the patient from airborne precautions: three AFB smears are negative.
  B. Remove the patient from airborne precautions: most likely lung cancer.
  C. Continue airborne precautions: clinical suspicion for TB remains high.

Smear-negative TB



Study from the Netherlands
All culture-confirmed TB cases from 1996 -2004

M. Tuberculosis isolates that had 100% identical DNA fingerprints were clustered



13,067 Patients with TB

7,438 matched database

3,696 patients in a cluster of >=2

1,285 cases in 394 clusters that started after 1996

Tostmann et al., Tuberculosis Transmission by Patients with Smear-Negative Pulmonary Tuberculosis in a Large Cohort in The Netherlands, *Clinical Infectious Diseases*, Volume 47, Issue 9, 1 November 2008, Pages 1135–1142

Results

- Patients with smear-negative pulmonary TB cause 12.6% of the TB transmission in the Netherlands

- Smear-negative TB had a relative transmission rate of 0.24 (95% CI, 0.20–0.30). This means that patients with smear-negative pulmonary TB were only 0.24 times as likely to spread TB as patients with smear-positive pulmonary TB

- Secondary cases in clusters with an index patient with smear-negative TB were more likely to have smear-negative TB (OR, 1.86; 95% CI, 1.18–2.93) and were more frequently >55 years of age (OR, 1.87; 95% CI, 1.16–3.00)

Tostmann et al., Tuberculosis Transmission by Patients with Smear-Negative Pulmonary Tuberculosis in a Large Cohort in The Netherlands, *Clinical Infectious Diseases*, Volume 47, Issue 9, 1 November 2008, Pages 1135–1142

Clinical case

- A 78-year-old woman born in Fremont, Nebraska, with no history of travel, is admitted to your hospital. She has severe reflux, weighs 110 lbs (BMI 17), and is a never-smoker. She reports a chronic productive cough, malaise, and 20 lbs of unintentional weight loss over the past year. Previously an avid hiker, she now develops shortness of breath after walking two blocks. CT scan shows multiple nodules and some cavitary lesions.

- The primary team is concerned for tuberculosis. Three sputum samples were sent: two were AFB smear-positive, cultures are pending, and MTB/RIF Xpert is negative. She is currently in airborne isolation.

- **Question:**
  What is the most appropriate recommendation for isolation?

A. Continue isolation until the patient has received at least 10 days of anti-tuberculosis medication
B. Continue isolation since cultures are pending
C. Remove isolation precautions since the patient is US-born
D. Remove isolation precautions since the organism is unlikely to be contagious

Non-tuberculous mycobacteria

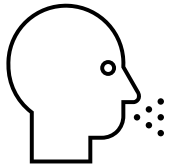
Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Mycobacteria, nontuberculosis (atypical)		Not transmitted person-to-person.	
Mycobacteria, nontuberculosis (atypical)	Pulmonary	Standard	
Mycobacteria, nontuberculosis (atypical)	Wound	Standard	

https://www.cdc.gov/infection-control/hcp/isolation-precautions/appendix-a-type-duration.html

PCR testing

27 Studies with 9557 participants

59% from LMICs



As an initial test to replace smear:
Sensitivity: 89% Specificity: 99%

If smear negative:
Sensitivity: 67% Specificity: 99%

If smear positive:
Sensitivity: 98% Specificity: 99%

Steingart et al., Xpert® MTB/RIF assay for pulmonary tuberculosis and rifampicin resistance in adults. *The Cochrane database of systematic reviews*, *2014*(1), CD009593

Clinical case

A 17-year-old Latino male emigrated from El Salvador to the U.S. in 2020. He presents to your hospital with malaise, fever, cough, shortness of breath, and a chest X-ray showing apical lesions. He works on a cattle ranch and occasionally drinks unpasteurized milk. Outpatient workup revealed a sputum culture positive for Mycobacterium tuberculosis complex, susceptible to isoniazid and rifampin but resistant to pyrazinamide.

Your astute laboratory director suspects Mycobacterium bovis.

- **Question:**
  What is the most appropriate recommendation for infection control?

A. Continue isolation since the culture showed M. tuberculosis
B. Remove isolation since Mycobacterium bovis is not transmissible from person to person
C. Continue isolation, as Mycobacterium bovis behaves identically to M. tuberculosis
D. Remove isolation, given that CDC Appendix A says no isolation is needed for non-tuberculous mycobacteria

Mycobacterium bovis

Possible Airborne Person-to-Person Transmission of *Mycobacterium bovis* — Nebraska 2014–2015

Weekly / March 4, 2016 / 65(8);197–201

Print

Bryan F. Buss, DVM[1,2]; Alison Keyser-Metobo, MPH[2]; Julie Rother[3]; Laura Holtz[4]; Kristin Gall, MSN[2]; John Jereb, MD[5]; Caitlin N. Murphy, PhD[6]; Peter C. Iwen, PhD[6,7]; Suelee Robbe-Austerman, DVM[8]; Melissa A. Holcomb, DVM[2]; Pat Infield[2] (VIEW AUTHOR AFFILIATIONS)

https://www.cdc.gov/mmwr/volumes/65/wr/mm6508a1.htm

Tuberculosis (TB) Screening, Testing and Treatment of U.S. Health Care Personnel

Kristin Bertrang, RN, MSN
DHHS Tuberculosis Program
August 13, 2025

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Nebraska TB Updates

- 41 cases (2024)
- Kansas City, Kansas TB outbreak
- U.S reported 10,347 cases (3.0) cases per 100,000
    - Increase 8% case counts from 2023-2024

Two dead, dozens sickened in Kansas tuberculosis outbreak

By Jacqueline Howard, CNN

4 min read · Updated 6:46 PM EST, Tue January 28, 2025

Provisional 2024 Tuberculosis Data, United States. Centers for Disease Control and Prevention. Accessed from Provisional 2024 Tuberculosis Data, United States | Tuberculosis Data | CDC on August 4, 2025.

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Baseline (preplacement screening and testing)

- All U.S. health care workers baseline TB screening
  - Includes individual risk assessment (new)
  - Symptom evaluation
  - Test (TST or IGRA)

Tuberculosis Screening, Testing and Treatment of U.S. Health Care Personnel: Recommendations form the National Tuberculosis Controllers Association and CDC, 2019. U.S Department of Health and Human Services/Centers for Disease Control and Prevention. MMWR. May 17, 2019. Vol 68. No.19

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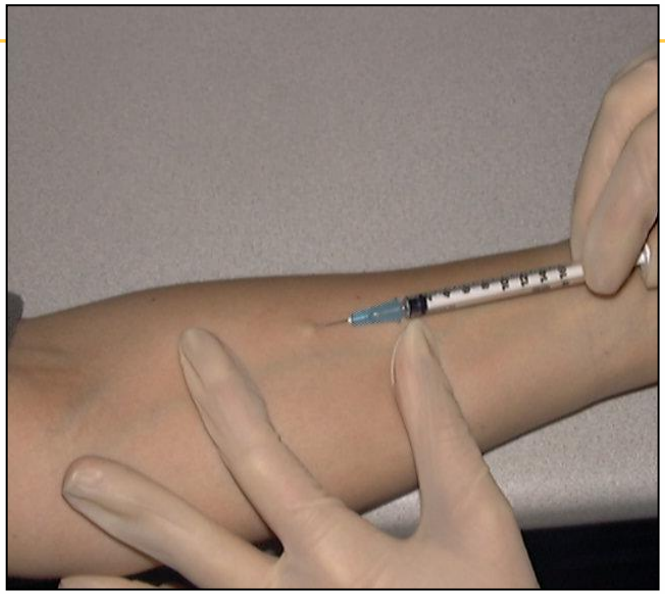
Tuberculin Skin Testing

- Inexpensive
- Anergy
- BCG vaccine
- Subjective
- Recent infection
- Improper storage, administration
- Repeat visit
- Boosting



Testing for Latent Tuberculosis. Mayo Center for TB Excellence, 2025.

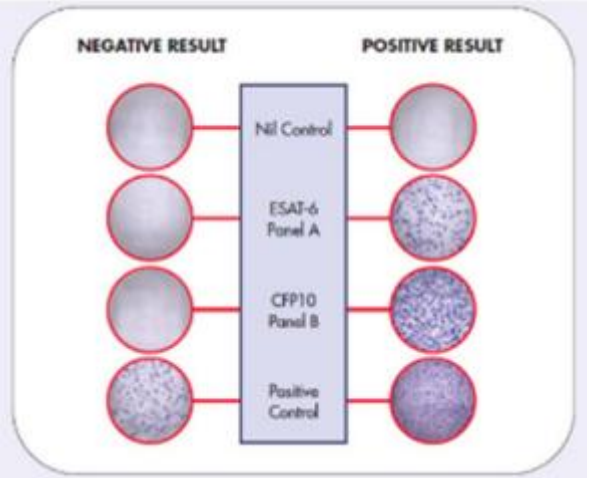
Interferon Gamma Release Assays (IGRAs)

Mitogen – Positive Control
Low response may indicate inability to generate IFN-γ

Nil – Negative Control
Adjusts for background IFN-γ

TB1 – Primarily detects CD4 T cell response

TB2 – Optimized for detection of CD4 and CD8 T cell responses



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IGRA Testing

Advantages

- Cost
- Quantitative result
- Greater sensitivity and specificity (not affected by BCG or most nontuberculous mycobacteria)
- Usually reported within 36-48 hours
- No boosting

Disadvantages

- Cost?
- Timely processing
- Indeterminates and borderline results
- Live Virus Vaccines

Testing for Latent Tuberculosis. Mayo Center for TB Excellence, 2025.

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Individual Risk Assessment

- Temporary or permanent residency (for greater than one month) in a country with a high TB rate (i.e. any country other than Australia, Canda, New Zealand, the United States, and those in western or northern Europe)

Or

- Current or planned immunosuppression, including human immunodeficiency virus infection, recipient of an organ transplant, treatment with a TNF alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids or other immunosuppressive medication

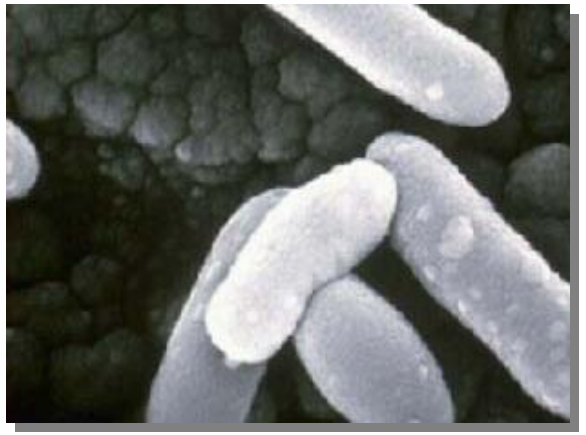
Or

- Close contact with someone who has had infectious TB disease since the last TB test

Tuberculosis Screening, Testing and Treatment of U.S. Health Care Personnel: Recommendations form the National Tuberculosis Controllers Association and CDC, 2019. U.S Department of Health and Human Services/Centers for Disease Control and Prevention. MMWR. May 17, 2019. Vol 68. No.19

Postexposure Screening and Testing

- Symptom evaluation for all health care workers when an exposure occurs
- Test following last exposure
- Repeat 8-10 weeks post exposure
- Local Public Health Department partnership



Tuberculosis Screening, Testing and Treatment of U.S. Health Care Personnel: Recommendations form the National Tuberculosis Controllers Association and CDC, 2019. U.S Department of Health and Human Services/Centers for Disease Control and Prevention. MMWR. May 17, 2019. Vol 68. No.19

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Serial Screening and testing

- Not routinely recommended except for selected health care workers
- Annual TB education for all health care workers, including TB exposure risks
    - Emphasis on exposure risks
- Treatment is encouraged for all health care workers with untreated LTBI, unless medically contraindicated.

Tuberculosis Screening, Testing and Treatment of U.S. Health Care Personnel: Recommendations form the National Tuberculosis Controllers Association and CDC, 2019. U.S. Department of Health and Human Services/Centers for Disease Control and Prevention. MMWR. May 17, 2019. Vol 68. No.19

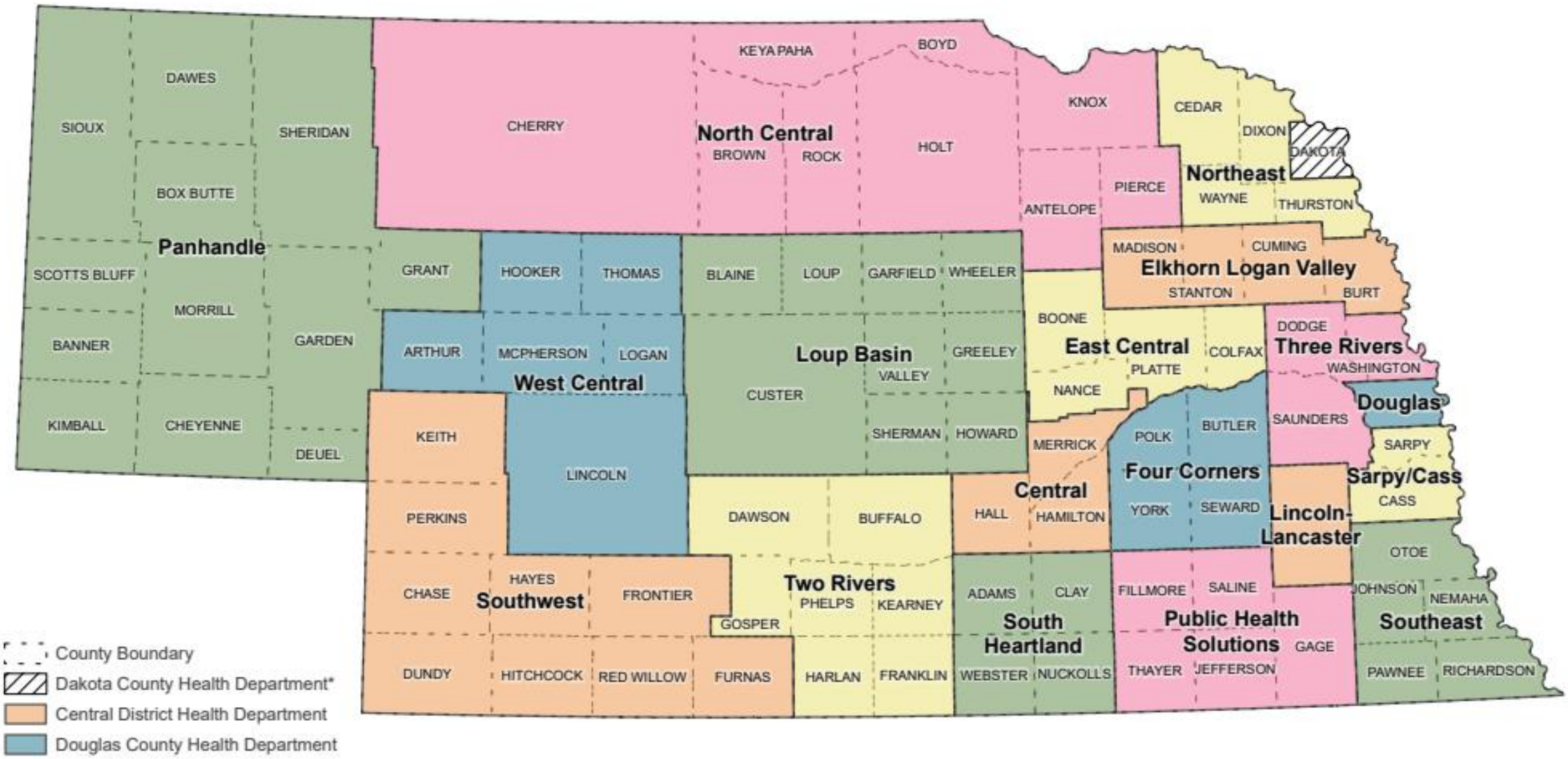
Health Care Personnel with newly Positive Results

- Symptom evaluation
- Chest radiograph to assess for disease
- Additional workup based upon findings
- Health care workers with prior positive TB test and documented normal chest radiograph do not require repeat radiograph unless
    - Symptomatic
    - Starting LTBI treatment

    *notify Local Public Health Department immediately if TB disease suspected

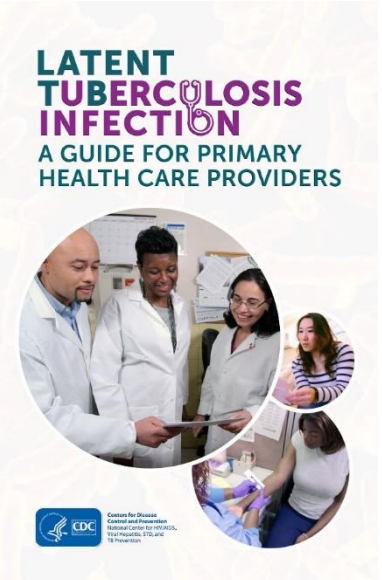
Tuberculosis Screening, Testing and Treatment of U.S. Health Care Personnel: Recommendations form the National Tuberculosis Controllers Association and CDC, 2019. U.S Department of Health and Human Services/Centers for Disease Control and Prevention. MMWR. May 17, 2019. Vol 68. No.19

Nebraska Local Health Departments



Treatment Options

- Health care workers with LTBI and no prior treatment should be offered and encouraged to complete
- Health care workers who do not complete LTBI treatment should be monitored with annual symptom evaluation and reevaluate risk and benefits of LTBI treatment



Tuberculosis Screening, Testing and Treatment of U.S. Health Care Personnel: Recommendations form the National Tuberculosis Controllers Association and CDC, 2019. U.S Department of Health and Human Services/Centers for Disease Control and Prevention. MMWR. May 17, 2019. Vol 68. No.19

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LTBI Medication Options

- Isoniazid and Rifapentine
- Rifampin
- Isoniazid and Rifampin
- Isoniazid (6 months or 9 months)
- Cost Issues

Latent Tuberculosis Infection: A Guide for Primary Health Care Providers. Centers for Disease Control and Prevention. Accessed https://www.cdc.gov/tb/media/pdfs/Latent-TB-Infection-A-Guide-for-Primary-Health-Care-Providers.pdf on August 5, 2025.

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Kristin Bertrang, RN, MSN

DHHS Program Specialist RN

kristin.bertrang@nebraska.gov

402-471-6441

Nebraska Department of Health and Human Services

Nebraska DHHS

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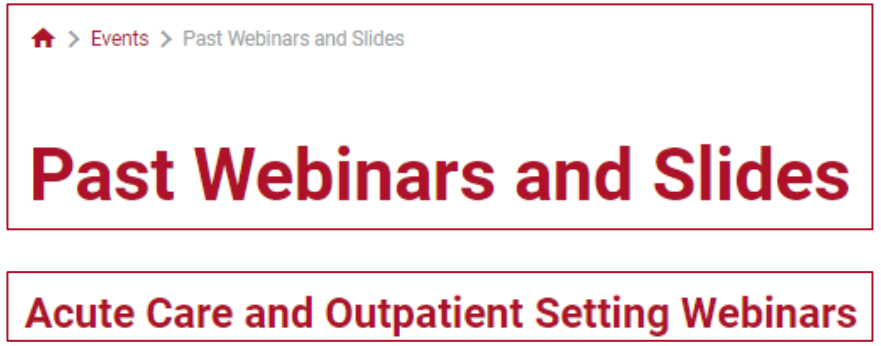
Helping People Live Better Lives.

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

The NICN and APIC NE Symposium: 45 Years of Progress: Advancing Infection Prevention and Control Together

APIC NEBRASKA

Nebraska Infection Control Network

NEBRASKA METHODIST COLLEGE
THE JOSIE HARPER CAMPUS
PROFESSIONAL DEVELOPMENT

Friday, August 29, 2025

8:00 AM to 3:15 PM

The Holland Center, Omaha, NE 68102

NICN APIC Nebraska Symposium Registration

- ❑ Future of Infection Prevention: Dr. Gonzalo Bearman
- ❑ Leadership Development & Influencing Change: Dr. Hilary Babcock
- ❑ Vaccination Promotion: Dr. Peter Hotez (presenting remotely)
- ❑ Track 1: Infection Prevention and Control Updates for the Post-Acute and Long-Term Care Settings: Dr. M. Salman Ashraf
- ❑ Track 2: Vascular Access Related Infection Prevention and Management/Preventative Technology: Barb Nickel
- ❑ MDRO in Animals: Stephen Cole
- ❑ How to Interact with the Media and Art of Communication: Cathy Wyatt

Engaging and informative workshop dedicated to IPC in all healthcare settings.

Featuring expert speakers and interactive discussion on infection prevention strategies, leadership development, vaccination promotion, and media interaction skills.

Dental Infection Control Summit

Friday, October 10, 2025

8:00 AM to 3:00 PM
Lied Lodge at Arbor Day Farms
Great Plains Rooms (2nd Level)
2700 Sylvan Rd
Nebraska City, NE 68410

6 CE Hours

MORNING: Basic Infection Control in the Dental Setting:
Introduction to essential infection control practices in the dental setting including standard and transmission-based precautions, environmental cleaning and disinfection, sharps safety, instrument reprocessing, and dental unit water lines.

AFTERNOON OPTION A: Employee Safety in Dentistry and Antibiotic Prescribing in the Dental Setting:
Introduction to OSHA's employee safety requirements and antibiotic prescribing guidelines surrounding pain and swelling and antibiotic prophylaxis in the dental setting.

AFTERNOON OPTION B: Sterile Technique in the Dental Setting (interactive):
Learn how to identify when a sterile field is necessary in addition to managing the sterile field to ensure patient safety.

NE ICAP

Nebraska Infection Control Network
985400 Nebraska Medical Center
Omaha NE 68198-5400
Phone: (402) 559-8668

UNMC COLLEGE OF DENTISTRY

Registration Link

NE ICAP

2 Newer Items Added to the NE ICAP / ASAP Learning Center

Learning Center

ICAP/ ASAP Education on Your Own Time

Designed for front-line HCP. Has quiz & certificate.

Courses

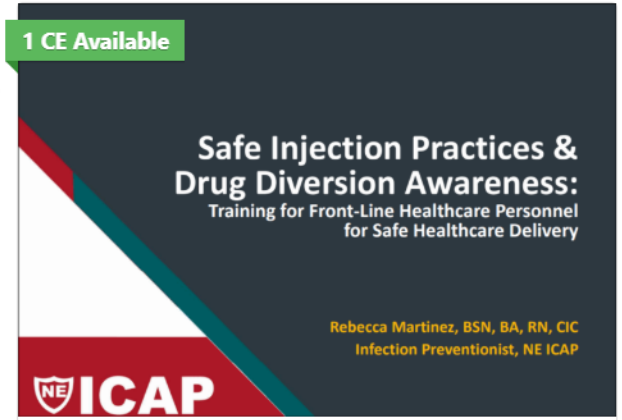
Thank you for exploring the courses Nebraska ICAP/ ASAP have to offer. All users must be registered to take a course with Nebraska ICAP/ ASAP.

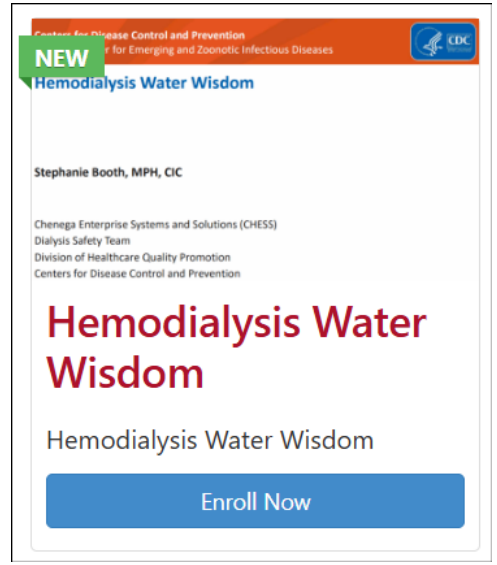
New users: Please click on the "Registration" tab at the top of the page to create an account.

Registered users: Login below or you will be asked to login when you select a course.

Login

https://icapasaplearning.nebraskamed.com/

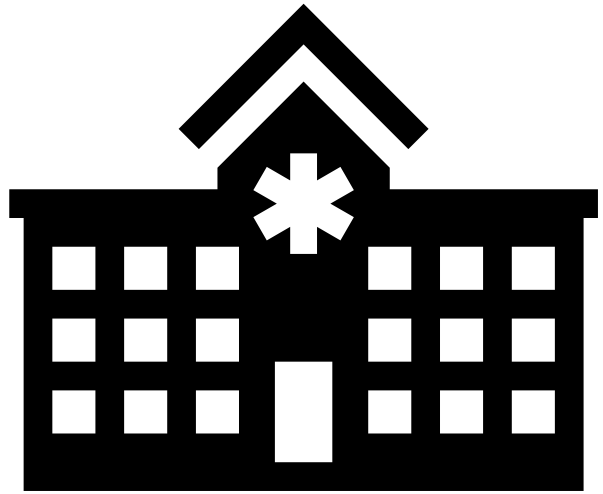




ICAP

Infection Control Assessment & Response (ICAR) Visits

- On-site infection control assessment and response visits are available. Can be general or focused including the following:
  - Surgical Site Infection (SSI) Prevention
  - Device Reprocessing
  - Water Management Program
  - Among other domains, it will be tailored to your facility



CDC's Project Firstline: Resource Highlight

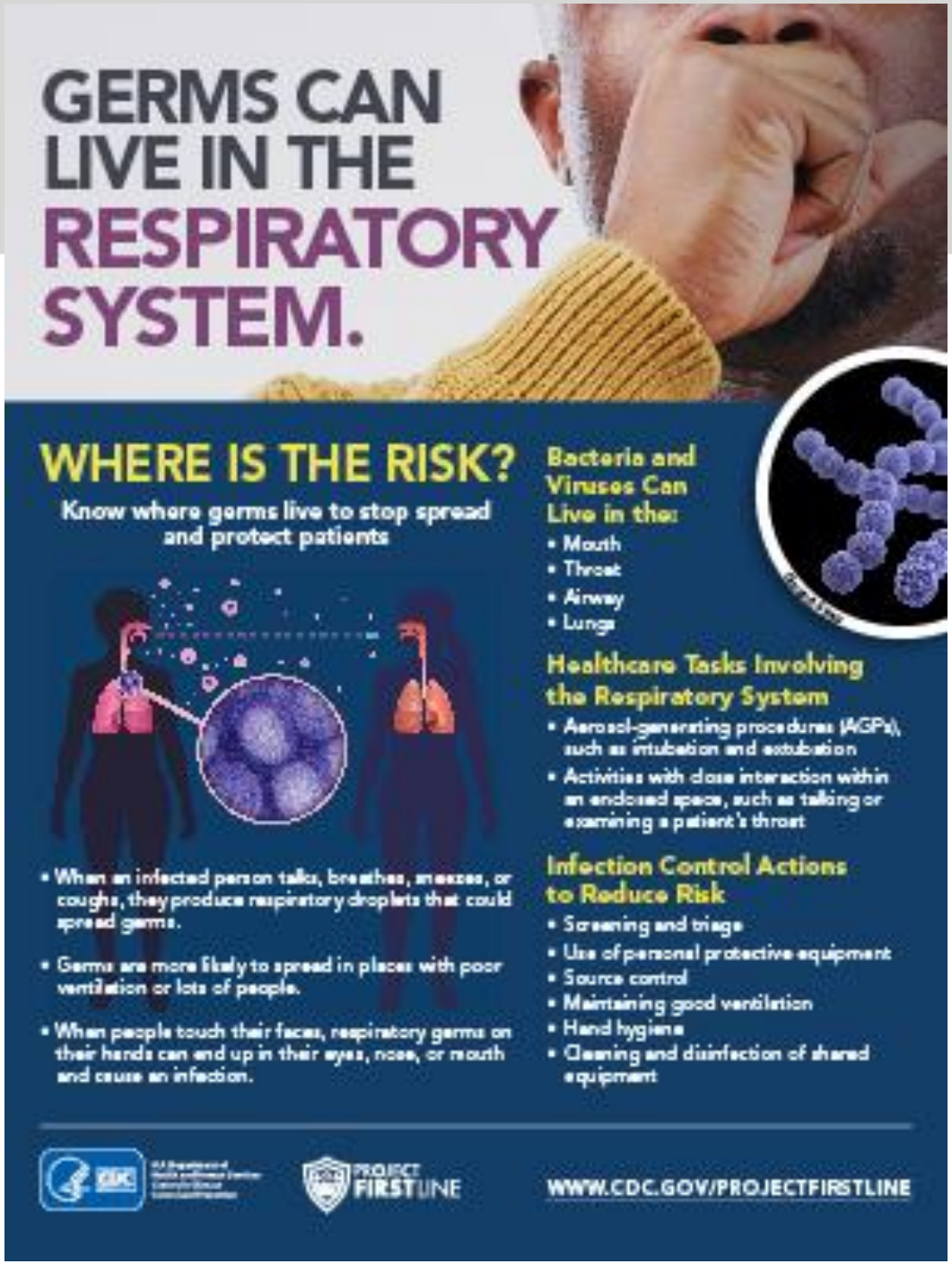


Image Courtesy of CDC

CDC Project Firstline - Respiratory System

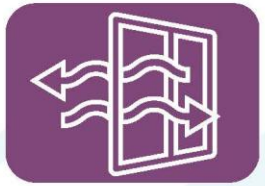
ICAP

CDC's Project Firstline: Resource Highlight

VENTILATION IN HEALTHCARE SETTINGS

In healthcare settings, ventilation is important because it helps remove things from the air that we don't want to breathe in – like small virus particles. Good ventilation improves air quality and reduces the risk of germs spreading.

WHAT TO KNOW



Understand what an air change is and why recommended air changes per hour are important in healthcare.

- An air change means the air in a room is replaced with new air.
- Air changes are usually measured by the hour – air changes per hour (ACH).
- In healthcare facilities, nearly every type of room has a recommended number of ACHs to help reduce the risk of germs spreading among patients and staff.

Respect wait times to allow the air in rooms to clear.

- The infection prevention or clinical leaders in your area, like your nurse manager, will use the ACH to figure out how long a room should sit empty after a patient with a possible or confirmed respiratory infection has left.
- It is okay to enter a room before the air is completely cleared, including while the patient is still there, if you use the recommended personal protective equipment (PPE).

Ask before making changes to the ventilation in a room.

- Rooms are often connected in healthcare facilities.
- Making a change to the ventilation in one room – like opening a window or closing vents to adjust temperature – can change the ventilation in other places, too.
- **That's why it's important to talk to the person or team at your facility that is responsible for maintaining air filtration and ventilation if you have concerns about the ventilation in a room.**

Make sure vents are not blocked.

- A blocked vent could prevent the ventilation system from functioning like it is supposed to.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

PROJECT FIRSTLINE

cdc.gov/ProjectFirstline

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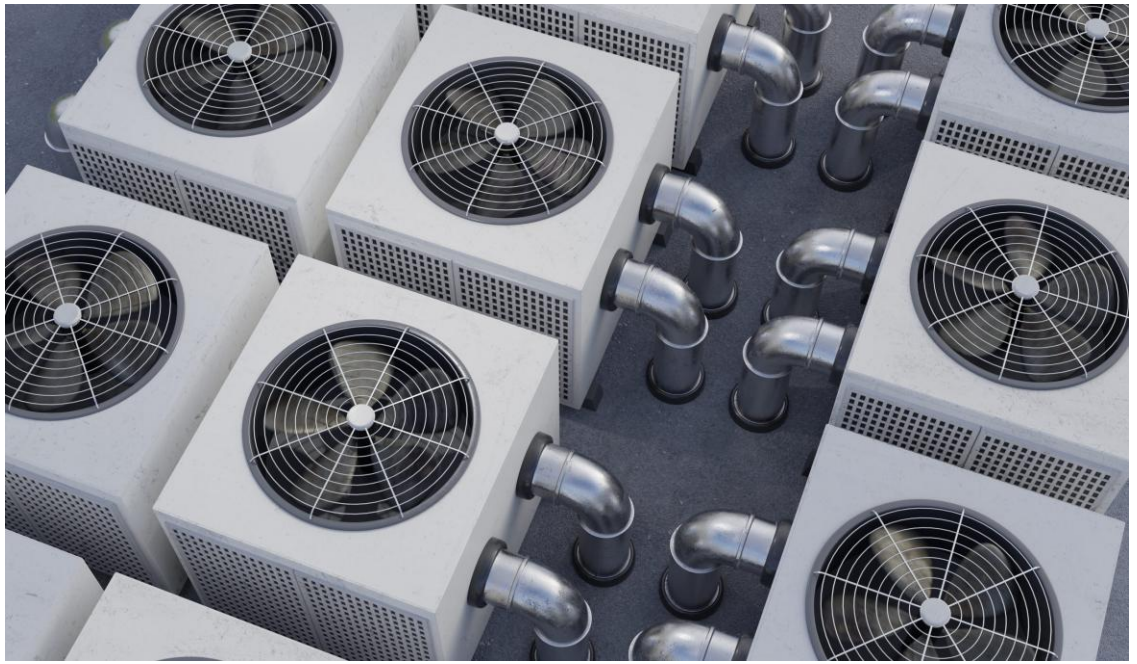

[CDC Project Firstline Ventilation in Healthcare Settings Factsheet]

[Image Courtesy of CDC]

[CDC Project Firstline - Ventilation Factsheet]

NE ICAP

Join Us - Upcoming NE ICAP Webinars

- September 10, 2025
  - 12:00 – 1:00 PM (CST)
    - Dietary Services & Food Safety: Key Points for Infection Preventionists in Healthcare Settings

- October 8, 2025
  - 12:00 – 1:00 PM (CST)
    - Antibiotic Awareness

BE ANTIBIOTICS AWARE
SMART USE, BEST CARE

ICAP Contact Information

Call 402-552-2881

Business Hours are Monday – Friday
8:00 AM - 4:00 PM Central Time

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.

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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.