

Michael Bell, MD, on how Project Firstline provides infection control training

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Featured topic and speakers

In today's COVID-19 update, AMA Chief Experience Officer Todd Unger speaks with Michael Bell, MD, deputy director of CDC's Division of Healthcare Quality Promotion and lead physician on Project Firstline. Project Firstline provides front line health care workers and members of the public health workforce the infection control training they need to protect the nation from infectious disease threats, including COVID-19.

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Speakers

- Michael Bell, MD, deputy director, Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention (CDC)

Transcript

Unger: Hello. This the American Medical Association's COVID-19 update. Today we're discussing Project Firstline, a new initiative launched by the Centers for Disease Control and Prevention. The focus is on infection control. My guest today is Dr. Michael Bell, the deputy director of CDC's division of Health Care Quality Promotion, and the lead physician on Project Firstline in Atlanta. I'm Todd Unger, AMA's chief experience officer in Chicago. Dr. Bell, can you begin by giving us a short explanation of what Project Firstline is?

Dr. Bell: Sure. Thanks Todd. Project Firstline is a new training initiative that is intended to go beyond the much more high-level focused efforts that we've made to date and actually reach all front line health care providers across the country.

Unger: So infection control has always been critical, but probably never more important than right now. Can you tell us why you started Project Firstline at this very moment in time?

Dr. Bell: Yes. Project Firstline was created to address the fact that even though we spent 20 or 30 years training many people in infection control most of that training has gone to infection control professionals, hospital epidemiologists, others who are experts in the field, who are then expected to reach everyone else.

In reality our health system has become so broad and so complex that reaching everybody is not the simple effort that it used to be. I think back when most care happened in an acute care hospital it was much easier to reach all of the staff in a systematic way, but with our disbursed health care delivery system, with a lot of caring nursing homes, rehab facilities, outpatient facilities, we need to do a better job of reaching people.

So now, with the clear crisis of COVID-19 combined with the impending flu season, we want to make sure that we've done everything we can to get the word out to people who need to know.

Unger: What is your vision for this project?

Dr. Bell: There's a good example from injection safety that I like to use. This is maybe 10 years ago that a clinician was noticed by his receptionist to have reused syringes to give a vaccine. It was the receptionist who said, "Look, I think I've read in the paper that you're not supposed to do that. We need to call the Health Department." Sure enough, they had to do a big investigation. Fortunately, nobody caught hepatitis, but it was that broad understanding of what's not okay.

Another good example is smoking. If we walk into any hospital in the country right now and light up a cigarette people will jump on us immediately, and not just the health care professionals in the facility. Even patients and allied health staff would say, "No, no, no, no, no, you can't do that."

I want the same kind of broad understanding for infection control practices to be present in all of the places where we deliver care.

Unger: So, you also have, obviously, a new set of tools at your disposal and a new kind of virtual world that we're existing in. How do you use those to increase the understanding of transmission dynamics and not take for granted things like you just talked about?

Dr. Bell: I have to say that trying to reach literally millions of people at a time when we're not allowed

to actually go see those people is a crazy challenge. We estimate that there are upwards of six to 10 million health care professionals that we need to reach. This is all nurses, nursing assistants, receptionists, technicians, radiology techs, dialysis techs, infusionists, you name it.

The vast number of people who we need reach is one of the complicating factors. The other is how these people tend to work. If you think about those of us who are physicians and related professionals, we often have time set aside for us to do continuing education, to sit in on webinars, that kind of thing. Unfortunately, that's not the case if you're a nursing assistant in a long term care facility.

Added to that the fact that after a 10 hour shift the likelihood of somebody wanting to sit down for 45 minutes and view a webinar is pretty slim. So acknowledging that and understanding that people need to be able to learn wherever they are, we have devised new modules that are portable, using platforms including things like YouTube videos, so that people can look at eight to 10 minute clips on their smartphone, in the carpool, everybody else gets to listen or while waiting for transportation.

These are things that are intended to fit the lifestyles of the people we're trying to reach in a much broader way than the traditional professional education process.

Unger: You mentioned a couple of anecdotes up front, but talk a little bit more about how the CDC identified the need for a training collaborative like this.

Dr. Bell: One thing that's special, well, there are several things that are special, but one thing that I think is very important about Project Firstline is that it's not just CDC sending material out to the world. Probably the most important pillar of Project Firstline is our partnerships. We have engaged a wide range of partner organizations.

I won't go through the list, but a very broad range, addressing not only a variety of professional types, but also community locations, sort of linguistic subgroups, realizing that whether you're on the west coast or the east coast will to a large extent determine what the language capabilities of many of your staff are.

It's extremely different across the country that work everywhere--not everywhere, but in all of the regions more or less, and the extent to which Spanish is important in some places, Tagalog and so on are important elsewhere. The mix is both wonderful, but also challenging, so having partners that can help us reach different groups and also help us understand different realities.

We have tribal health colleagues that are helping us understand what the differences and variations are from region to region for different populations who come from tribal orientations. So that rich blend of partnerships is another important factor in what we're doing, and that's what has informed a lot of what we're working on.

We've done a lot of listening sessions, and across the country during the summer, heard from a range of health professionals and partners, understanding what they find both important or confusing, so that we can provide clarity and also target the areas that they're most concerned about.

Unger: We here at the AMA are excited to be one of those partners. This afternoon at 1:00 p.m. Eastern Time you can see a Project Firstline webinar and learn more about that, and subsequently you can look at that on our AMA YouTube channel.

Unger: Dr. Bell, tell us why is now the right time to launch this initiative?

Dr. Bell: I've already mentioned COVID-19 and the flu season. I'll share another pithy quote that I received from a gardening friend, who said, "The best time to plant a tree is 20 years ago. The second-best time is today." This is a large endeavor that I think has a lot of value built into it. The sooner we get started, the better off we'll be.

I think we have a very important opportunity right now, thanks to the willingness of AMA and other partners, that will allow us to reach the range of individuals that we really want to support. Our health care staff across the spectrum of health care are one of the most valuable resources we have in this country. These are people who are willing to accept terrible schedules, all night of work, being in the presence of infectious diseases like COVID, but many other infectious diseases as well, and they deserve to know how to protect themselves to the best extent possible.

There should not be mystery behind what we're doing or what we're asking people to do. I think getting to the point where everyone understands not only the what of what you're supposed to do, but the why you're supposed to do it. The rationale behind recommendations is critical.

If we look back, we've done a lot of training that focuses on these are the protective equipment that you're supposed to wear, or these are the five rules of this or that, and that's okay, but understanding the reasoning behind that is what creates longevity of understanding and the ability to push that forward.

Unger: Let's dig in a little bit more on that. I think you are talking about, you know, you're going beyond that type of hypothetical and insuring that the training is really relevant to daily activities in real life. Can you talk about some more details of the training in that regard?

Dr. Bell: Sure. If we look at some of the early modules, there are basic things like source control. It's been in the press, and people are using masks in public, but I don't think there's been a lot of attention on how this works and the extent to which it works, having people understand what the rationale is for keeping the mask on not only when you're with patients, but also when you're with colleagues.

COVID-19 modules are designed to accommodate the current needs of this pandemic, and as we look at transmission dynamics in health care facilities, we're seeing that there are asymptomatic carriers that can spread infection to their coworkers. This can happen in break rooms and cafeterias, so making sure that people understand that it's not just when you're with a patient that you need to be practicing source control, but that you need to be doing it all the time so that just in case you're infectious you don't spread it to your coworkers, and similarly they don't spread it to you.

Unger: I know it probably took years for kind of hand hygiene to become part and parcel of everyday physician practices, so there's a lot more to learn. What kind of tools are you providing to insure that there is kind of ongoing training of existing and new people in these offices?

Dr. Bell: The tools that most people immediately recognize will be the web based or other portable video-type training materials. There will be ancillary materials, including training guides for trainers, annotated resources for the individuals who are responsible for training programs within facilities and so on.

The other piece of this is related to interactive sessions, again leveraging our array of partners. The label "tool" might be a little bit counter-intuitive, but I look at it as an incredibly important process for generating understanding. We will be working closely with partners and relying on that extensive network to engage in a back and forth with front line health care personnel who can have questions discussed in live form, who can bring concerns that they have or that they're hearing about to us to have an open discussion and discuss why the approaches that we recommend are taken, again, what the rationale is behind that, and ways that you can maybe tailor those things to best fit the environment that you're working in.

Unger: If our webinar is any indication, physicians have a lot of questions, so we're excited to be able to address some of those in the webinar this afternoon. Can you talk a little bit about your plans and overall goals for the project? What does success look like for you?

Dr. Bell: Success gets back to that vision of having a community across the spectrum of practice that truly understands the basics. I'm not asking people to become world experts at infection control and infectious diseases, but I do want everyone to understand the basics.

Unfortunately, we're at a point where a lot of the basics of microbiology that used to be part of medical

education have been shortened or abbreviated almost out of the business, right? There used to be about three months of medical microbiology in med school curricula, and that is no longer the case.

Similarly, for nurses, aseptic technique and similar topics were at the core of training and now, unfortunately, the amount of stuff everyone needs to know has grown so much that some of those basics have been kind of squeezed out the sides. So, getting us back to a point where everyone understands what unacceptable looks like, and that everyone can perceive risk in a similar way.

I want people to be able to walk into a setting, a patient room, an exam room, a waiting area and immediately notice if something is wrong, if there is a risk that needs to be addressed. I don't want it to be just the infection control professional or the practice manager who gets it. I want everyone to be able to say, "Oh, that person is coughing. They shouldn't be sitting there in the waiting room with everyone else. Let's get them into a room right now."

Very common sense stuff, nothing terribly surprising, but having that consistency of understanding, so that whether it's the environmental services staff who can point out that that sharp implement should not be left there on the counter, why don't I deal with that, or our emergency services providers who need to be able to do a hand-off in a way that is safe for them, but also safe for the facility.

Having everyone be on the same page and understand what the expectations are I think is a very important factor. It's amplified by the fact that, as I mentioned earlier, we are providing care in so many different locations, and the type of care we're providing is rapidly escalating. What used to be pretty much intensive care unit-based medicine is now often taking place on the wards. We've gotten better at it. The wards don't tend to be as well staffed as the ICU, so that creates a little bit of risk.

Some of what used to take place in the wards is now happening in long term care facilities. Long term care facilities often don't have the infection control resources or infrastructure that we would like to see. Take ambulatory surgery. Surgical procedures are growing in number in our country, but the number in acute care hospitals is actually going down, so these are mostly outpatient ambulatory procedures.

If you're lucky enough to be in a place that's attached to a major hospital then you might have those infrastructure pieces, but if you're a free-standing ambulatory surgery center, you might not, so it's all the more important now that everyone in that kind of facility has the basic understanding that they need to keep patients safe and protect themselves.



Unger: So many things and so many reasons to pay attention to this with our lives and the lives of our health care workers on the line. Thank you so much for all of the work on this. Please tune in today to the webinar, where we'll discuss Project Firstline. You can register for that webinar on the AMA site or catch that on demand on our YouTube channel. Thanks so much, Dr. Bell, for being here today and sharing your perspective.

That's it for this COVID-19 update. We'll be back with another segment soon. For additional information on COVID-19 visit ama-assn.org/COVID-19. Thanks for being with us and please take care.

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