

HEALTH CARE ACQUIRED INFECTIONS ADVISORY COMMITTEE

**December 3, 2012
2:00 pm to 4:00 pm**

**Portland State Office Building, Room 1A
800 NE Oregon Street
Portland, OR 97232**

MEMBERS PRESENT: Bruce Bayley, PhD (phone)
Paul Cieslak, MD
Tara Gregory, MS, FNP
Stacy Moritz, RN, MBA
Nancy O'Connor, RN, BSN, MBA, CIC
Pat Preston, MS
Kecia Rardin, RN (phone)
Dana Selover, MD, MPH
Marjorie Underwood, RN, BSN, CIC
Dee Dee Vallier (phone)
Diane Waldo, MBA, BSN, RN, CPHQ, CPHRM, LNCC
Bethany Walmsley, CPHQ, CPPS

MEMBERS EXCUSED: Eric Chang, MD
Sue Davidson, PhD, RN, CNS
Susan Mullaney
Rodger Slevin, MD
Angel Wynia

STAFF PRESENT: Zintars Beldavs, MS, Healthcare-Associated Infections Program Manager
Margaret Cunningham, MPH, Healthcare-Associated Infections Epidemiologist
Russell Voth, Health System Research & Data Manager

ISSUES HEARD:

- Call to Order
- Approval of Minutes
- HAI Reporting Transition
- New CMS Requirements
- HAI Partnership for Patient Prevention Targets

- **Healthcare Worker Influenza Vaccination**
- **Antimicrobial Stewardship and Dialysis BSI Prevention Collaboratives**
- ***C. difficile* and CAUTI Learning and Action Networks**
- **MDRO Surveillance and Response Network**
- **Next Steps**
- **Public Comment/Adjourn**

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

Item	Discussion
Call to Order	The meeting was called to order at approximately 2:00 pm. There was a quorum.
Approval of Minutes	No minutes were available from the last meeting to approve.
<p>HAI Reporting Transition</p> <p>Zintars Beldavs</p>	<p>Reporting of healthcare-associated infections (HAI) has until recently been centered at the Office for Oregon Health Policy and Research (OHPR). However, due to the recent resignation of the OHPR HAI analyst, the Public Health Division, the only other state-level HAI agency, has agreed to take over HAI reporting. State funds dedicated to HAI do not exist, but limited federal money is available for 1 position focused on HAI reporting. Currently, the Public Health Division is in the process of hiring an HAI Reporting Coordinator to replace the OHPR analyst and hope to have the coordinator on board soon.</p> <p>The HAI Advisory Committee has not met since April, so the purpose of the current meeting is to get reoriented and obtain up-to-date information on HAI in Oregon. The next meeting, which will probably be held in February, will highlight decision making including:</p> <ul style="list-style-type: none"> • determining the frequency and content of meetings • obtaining recommendations for HAI reporting requirements and for the next annual HAI report due in March, a deadline the HAI Program is aiming to meet.
<p>New CMS Requirements</p> <p>Chair</p>	<p>Nancy O'Connor provided a brief overview of the new 2013 hospital reporting requirements to CMS via NHSN (National Healthcare Safety Network). Nancy offered to present additional information at the next meeting.</p> <ul style="list-style-type: none"> • Beginning January 13th, MRSA bacteremia—any positive blood culture that grows MRSA regardless of whether a line is in place-- must be reported as a lab ID event for all units (not just ICUs) except pediatric units.

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	<ul style="list-style-type: none"> • As of January ^{1st}, the following items must be reported: <ul style="list-style-type: none"> ○ <i>C. difficile</i> lab ID event (Hospitals have already been entering this event for the past year.) ○ Healthcare worker influenza vaccinations; reporting October-December 2012 vaccination data is optional. ○ SSIs with implants will be reportable for up to 30 days; previously, the reporting time span had been 1 year. • VAPs (ventilator-associated pneumonia) will change to a ventilator- associated event (VAE), resulting in a more clear and objective classification. The new criterion recognizes baseline ventilation stability before initiating a VAE.
<p>HAI Partnership for Patient Prevention Targets</p> <p>Diane Waldo</p>	<p>The Partnership for Patients (PfP) initiative is a CMS (Centers for Medicare and Medicaid Services) national project**. Almost every state in the country is rallying around the initiative’s 2 main goals: Reduce hospital-acquired conditions by 40% and hospital readmissions by 20% by the end of 2013. These goals are being addressed through 10 target hospital-acquired conditions including: CAUTI (catheter-acquired urinary tract infections), CLABSI (central line-associated blood stream infections), and avoidable readmissions.</p> <p>Through the Oregon Association of Hospitals and Health Systems (OAHHS), 31 hospitals--half of which are critical access hospitals--have been recruited to participate in the PfP initiative through the OAHHS-HRET Hospital Engagement Network (HEN). There are 3 other networks in the state: Intermountain Healthcare Network, Premier Network, and Washington State Hospital Association (WSHA) Network.</p> <p>To begin the project, hospitals were asked to take on 1-2 targets based on a needs assessment. However, a couple of weeks ago, CMS requested adoption of at least 6 of the 10 targets for all hospitals in the HRET collaborative by the end of January. So, hospitals are busy hunting for and gathering data, which has been made easier by CMS recently declaring universally available claims data as acceptable. Hospitals enter data into the National Healthcare Safety Network (NHSN) and confer rights to allow the Health Engagement Network to capture their information. OAHHS is concerned because hospitals may work very hard on 1 or 2 strategies to reduce harm, but reporting on multiple data areas may not show improvement since the original focus was on 1-2 areas. However, not every hospital has to demonstrate more than 20% improvement. The program is voluntary and therefore hospitals are directed to prioritize their efforts.</p> <p>Apprise Health Insights, the data portion of OAHHS, collects potentially preventable readmission (PPR) data through DataGen of New York. Not all causes of readmission are collected because the Oregon PfP is focusing on areas that hospitals have control over and therefore can show improvement. Currently, 100% of the data for avoidable readmissions for all hospitals is available.</p> <p>** The CMS PfP initiative is being implemented by OAHHS (Oregon Association of Hospitals and Health</p>

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	Systems) in collaboration with AHA (American Hospital Association) and HRET (Health Research and Education Trust), an affiliate of AHA.
<p data-bbox="218 303 564 363">Healthcare Worker Influenza Vaccination</p> <p data-bbox="317 407 466 435">Russell Voth</p>	<p data-bbox="627 303 1881 472">Oregon healthcare worker (HCW) influenza vaccination rates for the 2011-2012 flu season were collected from hospitals, skilled nursing facilities and, for the first time, ambulatory surgery centers. For this study, Healthcare workers are defined as personnel who worked at the facility between July 1, 2011 and March 31, 2012 for at least 30 working days. In addition, HCWs were divided into 3 categories: employees, credentialed non-employees, and other non-employees.</p> <p data-bbox="617 496 1902 737">The vaccination rate calculation included those who: received a vaccination, were offered a vaccination but declined, or were categorized as unknown (because vaccination status was unknown or documentation of vaccination by employee/outside facility was not provided). HWCs in the unknown category, consisting of a large number of individuals in some facilities, were reported as unvaccinated, thereby lowering vaccination rates. HCWS that declined a vaccination due to a medical contraindication were not included in the rate calculation. The formula for calculating the vaccination rate is the number of vaccinated healthcare workers divided by the total number of healthcare workers (excluding those with medical contraindications).</p> <p data-bbox="617 761 1398 789">To summarize findings obtained during the 2011-2012 flu season:</p> <ul data-bbox="669 800 1890 1398" style="list-style-type: none"> <li data-bbox="669 800 1772 828">• Vaccination rates were highest for hospitals and for employees regardless of facility type. <li data-bbox="669 837 1881 932">• Percentage of HCWs receiving a vaccination has increased for hospitals and remained stable for long-term care facilities. No comparison is available for ambulatory surgery centers because 2011-2012 is the first year they reported data. <li data-bbox="669 941 1881 1040">• Reporting ability--the percentage of facilities able to report data for all 3 categories of HCWs—was lowest for long-term care facilities due to the small number of HCWs in the non-employee categories. <li data-bbox="669 1050 1881 1256">• Goals set by the US department of Health and Human Services, through the Healthy People program, for flu vaccinations rates are: 60% for 2010, 70% for 2015, and 90% by 2020. Based on these goals, success rates for the employee category varied across facilities: <ul data-bbox="764 1159 1881 1256" style="list-style-type: none"> <li data-bbox="764 1159 1881 1187">○ Hospitals have exceeded benchmarks for 2010 and are very close to reaching 2015 targets. <li data-bbox="764 1196 1415 1224">○ Long-term care facilities are below all benchmarks. <li data-bbox="764 1234 1835 1256">○ Ambulatory surgery centers are approximately halfway between 2010 and 2015 goals. <li data-bbox="669 1266 1818 1365">• Two main reasons for HCWs declining a vaccination were: “I decline to provide a reason” and “other”. These responses made it difficult to draw conclusions about why HCWs refused vaccinations. <li data-bbox="669 1375 1318 1398">• Most common vaccination delivery methods were:

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	<ul style="list-style-type: none"> ○ mobile carts in hospitals ○ peer vaccinations in hospitals and ambulatory surgery centers ○ vaccinations in congregate areas in long-term care facilities ● Most popular vaccination promotional methods were: <ul style="list-style-type: none"> ○ reminders by mail, email, or pager in hospitals and ambulatory surgery centers ○ campaign posters, flyers, and buttons in hospitals and long-term care facilities ● Limitations of the study included: <ul style="list-style-type: none"> ○ Data is self-reported by facility ○ Surveillance methods and resources vary across facilities ○ Inability to determine length of service - Zintars Beldavs noted that the exact length of service needed to assess whether HCWs met the minimal requirement (30 working days) was sometimes unavailable. Nancy O'Connor added that some facilities did not have the length of service for credentialed non-employees and so included all of these HCWs in their analysis.
<p>Antimicrobial Stewardship and Dialysis BSI Prevention Collaboratives</p> <p>Melissa Parkerton</p>	<p>Both the Antimicrobial Stewardship and Dialysis BSI Prevention Collaboratives follow basically the same model developed by the Institute for Healthcare Improvement. Core components of the model are: face-to-face learning sessions, conference calls, webinars, site visits, monthly data submission, and data feedback to foster collaboration and communication among participants.</p> <p><u>Dialysis BSI Prevention</u></p> <p>A seven-month pilot for the dialysis collaborative was performed in 2011. The pilot was small and limited to Northwest Oregon, within a 90 minute radius of Portland, to allow as much support as necessary. Accomplishments were minimal: the majority of the dialysis centers did not complete the pilot and most of the time was spent getting facilities set up in NHSN.</p> <p>Based on the pilot, a new 10-month dialysis collaborative was launched on October 25, 2012 with 31 facilities in Oregon and Washington. The collaborative, which is partnering very closely with the Northwest Renal Network and the Oregon Health Authority, is focusing on blood stream infections and on vascular access technique to reduce site infections. Emphasis is being placed on developing a culture of safety in dialysis centers including fostering hand hygiene.</p> <p>A 10-month period will allow much more to be accomplished because the majority of dialysis facilities have already been set up on NHSN and will soon start reporting. Data is entered into NHSN at the facility or corporate level. The latter method, adopted by DaVita who owns approximately half of the 31 facilities, is concerning because the quality of the data entered on behalf of centers may be compromised and facilities</p>

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	<p>will not be familiar with their statistics. To counteract ignorance about data, the collaborative is providing monthly dashboards to each of the dialysis centers.</p> <p><u>Antimicrobial Stewardship</u></p> <p>Funded by the Department of Justice from money obtained through a settlement with Pfizer, 13 hospitals launched the antimicrobial stewardship program last Thursday, November 29, 2012. Prior to the launch, a baseline practices assessment of all Oregon hospitals was performed in August, which showed that about half of the hospitals have some type of antimicrobial stewardship program. The goal after 12 months is to have functioning antimicrobial stewardship programs in all 13 hospitals. Currently, the hospital programs are either too new to see results or are very much in need of resources.</p> <p>Key components of the project are:</p> <ol style="list-style-type: none"> 1. Participants confer rights to <i>Clostridium difficile</i> data in NHSN. 2. Hospitals send antimicrobial usage data each month. This data is monitored by OHA for changes in antimicrobial usage practices: quantity of drugs, IV (intravenous) versus PO (oral) drug administration, and amount of high-risk antimicrobial and broad-spectrum agents. 3. Hospitals maintain a logbook of pharmacist recommendations and whether they are accepted by physicians. This data is also submitted each month to measure the acceptance of the antimicrobial stewardship project.
<p><i>C. difficile</i> and CAUTI Learning and Action Networks</p> <p>Stacy Moritz</p>	<p>Acumentra Health , the Medicare Quality Improvement Organization for Oregon, reached out to the four Oregon Hospital Engagement Networks (HENs) to recruit hospitals to join the Oregon HAI Prevention Coalition (OHPC) ** in an their effort to reduce <i>C. difficile</i>, surgical site, and catheter-associated urinary tract infections. The Oregon Association of Hospitals and Health Systems’ HEN agreed to participate. However, the other three HENs have not been so forthcoming in partnering with the Coalition.</p> <p><u>CAUTI (catheter-associated urinary tract infections)</u></p> <p>The CAUTI project began in August of 2011 with a subset of the hospitals that already had a program in place. Once the project was well established, the remaining hospitals, with no existing CAUTI program, were asked to join, thereby allowing them to learn from the experienced facilities. This model for disseminating knowledge is called “all teach all learn” because it allows everyone to learn from each other.</p> <p>Data gathered through September 2012 indicates the coalition’s efforts have been successful. CAUTIs are going down and catheter rates are steadily decreasing.</p> <p><u><i>C. difficile</i></u></p> <p>Both the Oregon Patient Safety Commission and the Oregon HAI Prevention Coalition are pooling resources</p>

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	<p>for the <i>C. difficile</i> initiative. Currently, hospitals that meet eligibility criteria for participation are being identified and recruited. Once they join the program, hospitals must confer rights to NHSN to enable the Coalition to analyze their data.</p> <p><u>Antimicrobial Stewardship</u> In partnership with the Oregon Patient Safety Commission, the Oregon HAI Prevention Coalition will work with hospitals to develop an antimicrobial stewardship program or expand an existing program.</p> <p><u>SSIs (surgical site infections)</u> OHPC is collaborating with the Institute for Healthcare Improvement and promoting participation in IHI's Project JOINTS (Joining Organizations in Tackling SSIs).</p> <p><u>MDRO (multi-drug resistant organisms)</u> OHPC, in partnership with the Oregon Association of Hospitals and Health Systems, is working with the Office of Rural Health to put on a conference in May on MDROs. With money from the Rural Health Office, critical-care hospitals and anyone who is in Melissa Parkerton's antimicrobial stewardship collaborative or other related collaborative will be able to attend the conference for the cost of food. **The Oregon HAI Prevention Coalition is a learning and action network (LAN) focused on spreading information on best practices including improvement methods and successful interventions.</p>
<p>MDRO Surveillance and Response Network</p> <p>Zintars Beldavs</p>	<p>The latest MDRO project is aimed at reducing carbapenem-resistant <i>Enterbacteriaceae</i> (CRE), a large family of gram-negative bacteria, such as <i>E. Coli</i> and <i>Klebsiella</i>, common in gut flora. Although rare, these organisms are very difficult to treat because they are highly resistant to the carbapenem class of antibiotics that are often considered the last line of defense. Implicated in many healthcare-associated infections such as urinary tract and wound infections, CRE infections have a death rate of up to 40%, a rate much higher than MRSA and <i>C. difficile</i>. First identified in 2001 in North Carolina, CRE is rapidly becoming more common on the East Coast and is quickly spreading West.</p> <p>Two different resistance mechanism exist for CRE:</p> <ol style="list-style-type: none"> 1. porin mutations – do not transfer rapidly between organisms 2. carbapenemase producers – genetic element where resistance easily transfers between organisms <p>Carbapenemase producers are obviously the most concerning. So far, Oregon only has 3 reported cases of carbapenemase-producing CRE out of less than 30 total CRE cases. All 3 of these cases had recent out-of-state travel to areas where carbapenemase-producing CRE is endemic. Due to the low CRE incidence, Oregon is in a great position to possibly prevent the growth and spread of these organisms. To meet this goal, the DROP-CRE Network (Drug-Resistant Organism Prevention and Coordinated Regional Epidemiology</p>

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	<p>Network)—a statewide effort spearheaded by the Oregon Health Authority, VA, OHSU, OSU, and CDC-- was established to develop the capacity to rapidly detect and contain every case of CRE.</p> <p>The DROP-CRE Network is establishing guidelines for infection control and developing an educational outreach program. A needs assessment will be sent to infection preventionists, laboratories, and long-term care facilities to determine their level of knowledge and ability to deal with CRE.</p>
<p>Next Steps</p> <p>Chair</p>	<p>Zintars Beldavs asked for agenda items for the February HAIAC meeting. Committee members suggested:</p> <ul style="list-style-type: none"> • reporting requirements for healthcare-associated infections • content and format of the annual report • frequency and content of meetings • structure of Committee including composition and length of term served by members • appropriate usage of SIRs (CDC standardized infection ratio, based 2008 baseline data) • support for facilities with new MRSA bacteremia and expanded <i>C. difficile</i> reporting requirements
<p>Public Comment / Adjourn</p>	<p>No public comments</p>

Next meeting will be February 27, 2013, 1:00 pm to 3:00 pm, at the Portland State Office Building, Room 1D.

Submitted By: Diane Roy

Reviewed By: Zintars Beldavs

EXHIBIT SUMMARY

- A – Agenda**
- B – Transition for HAI Reporting**
- C – Oregon Healthcare Worker Influenza Vaccination Rates for 2011-2012 Season**
- D – Oregon Antimicrobial Stewardship Collaborative**
- E – Oregon Antimicrobial Stewardship Initiative**
- F – Oregon HAI Prevention Coalition – Action Plan**
- G – DROP-CRE Network**