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HEALTHCARE-ASSOCIATED INFECTIONS ADVISORY COMMITTEE

**June 25, 2014
1:00 pm to 3:00 pm**

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

MEMBERS PRESENT: Paul Cieslak, MD
Kelli Coelho, RN, CNOR (phone)
Julia Fontanilla, RN, MN (phone)
Jon Furuno, PhD
Jamie Grebosky, MD (phone)
Tara Gregory, MS, FNP
Joan Maca
Rachel Plotinsky, MD (phone)
Pat Preston, MS (phone)
Dana Selover, MD, MPH
Dee Dee Vallier (phone)

MEMBERS EXCUSED: Jill Freeman
Csaba Mera, MD
Laurie Murray-Snyder
Nancy O'Connor, RN, BSN, MBA, CIC
Janet Sullivan, RN
Diane Waldo, MBA, BSN, RN, CPHQ, CPHRM, LNCC
Bethany Walmsley, CPHQ, CPPS

STAFF PRESENT: Dianna Appelgate, MS, MPH, CIC, CPHQ, Clinical Epidemiologist
Zintars Beldavs, MS, Healthcare-Associated Infections Program Manager
Monika Samper, RN, Healthcare-Associated Infections Reporting Coordinator
Ann Thomas, MD, MPH, Acute and Communicable Disease Medical Epidemiologist

ISSUES HEARD:

- Call to Order
- Approval of Minutes
- Update: Follow-up Items (HO/CO-HCFA CDI)
- Annual HAI Report

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- **Standing Agenda: Oregon Patient Safety Commission**
- **Standing Agenda: Ambulatory Surgery Centers**
- **Standing Agenda: Long Term Care Facilities**
- **Standing Agenda: Oregon Association of Hospital & Health Systems**
- **Standing Agenda: Acumentra**
- **Inpatient/Outpatient SSI Reporting**
- **Update on Status of OAR 333-018**
- **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	Follow-Up
Call to Order	The meeting was called to order at approximately 1:00 pm. There was a quorum.	
Approval of Minutes	Minutes for the March 26, 2014 meeting were unanimously approved (see pages 1-7 of meeting materials).	
Update: Follow-up items (HO/CO-HCFA CDI) OHA Staff	Committee members at the March 26, 2014 meeting suggested adding information about healthcare facility-associated (HCFA) community onset <i>Clostridium difficile</i> infections (CDI) to the HAI annual report (refer to page 8 of meeting materials). According to data extracted from the National Healthcare Safety Network (NHSN), 68% of reported HCFA <i>C. difficile</i> LabID events are hospital onset (other types of healthcare facilities are not currently required to report CDI cases) while only 32% are community onset. However, OHA questions the completeness of this data and meeting attendees concurred. Experts believe that most reoccurrence of CDI presents in the outpatient setting, but clinics are not required to report these cases. Therefore, accurate measurement of HCFA community onset events is not possible at this time.	

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<p>Annual HAI Report</p> <p>OHA Staff</p>	<p>A high-level overview of the recently published Health Care Acquired Infections 2009-2013 Oregon Report was provided by OHA (see pages 11-25 of meeting materials):</p> <p><u>Outcome Measures</u></p> <ul style="list-style-type: none"> • Central line-associated blood stream infections (CLABSIs) in adult ICUs - rates are dropping, leading Oregon to report 71% fewer CLABSIs in 2013 than the national baseline. • Central line-associated blood stream infections in NICUs - Oregon is well below the national SIR baseline of 1. • Coronary artery bypass graft (CBGB) surgical site Infections (SSIs) - except for a dip in 2012, rates have been relatively constant, indicating little improvement. • Colon surgery (COLO) SSIs - small variance in rates between years. • Hip prosthesis (HPRO) SSIs - after being above an SIR of 1 for 2011-2012, rates dropped to 0.67 in 2013. • Abdominal hysterectomy (HYST) SSIs - slight rise in 2013 (may be the result of a decrease in supracervical hysterectomies due to FDA concerns over the spread of undiagnosed cancer). • Knee prosthesis (KPRO) SSIs - lowest in 5 years after a moderate rise in 2012 • Laminectomy (LAM) SSIs - minor increase • Hospital onset CDI LabID - infection rates have grown by 10% (may be due to some hospitals changing over to a more sensitive lab test). • Dialysis events, which include both blood stream and access-related blood stream infections - both types of infections are below the NHSN pooled mean for fistula, graft, and tunneled and non-tunneled central line access methods. 	<p>OHA will send information on the logistic regression model used to calculate SIRs to committee members.</p>

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	<p>In summary, although many outcome measures show improvement, SIRs for some procedures have either increased or remained relatively flat. Therefore, data needs to be employed for not only surveillance, but to develop an action plan for effective HAI prevention. The action plan might include:</p> <ul style="list-style-type: none"> • Determine methods hospitals with low SIRs are utilizing to lower infections. • Establish standardized procedures to reduce HAIs based on research findings. • Offer assistance to hospitals with high SIRs. • Enlist CMS surveyors already in the field to watch for improper patient care, as defined by the committee, and share the citations and plan of correction given to healthcare facilities with OHA. <p><u>Process Measures</u></p> <ul style="list-style-type: none"> • Healthcare worker influenza vaccination rates - increased by 8% for all surveyed healthcare organizations, including hospitals, free-standing ambulatory surgery centers, and long-term care facilities. • Surgical Care Improvement Project (SCIP) measures – compliance rates for all measures are above 95%. 	
<p>Standing Agenda: Oregon Patient Safety Commission</p> <p>Mary Post</p>	<p>Improvement activities with free-standing licensed dialysis facilities ceased in late February, and OPSC is in the process of evaluating the data. Although a final report is not yet available, data indicate that efforts were extremely effective in prevention of dialysis catheter-associated blood stream infections.</p> <p>OPSC is also engaged in several grant-sponsored projects:</p> <ul style="list-style-type: none"> • Offer training programs for long-term care facilities, which approximately 50% of LTCFs are attending. • Wrapping up multidrug-resistant organisms (MDROs) prevention collaborative comprised of three different Oregon regions: north coast, 	

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	<p>Linn/Benton County, and south coast. The collaborative brings together a diverse community, including hospitals, nursing homes, and assisted living facilities, to work together and provide a forum for members to learn from each other. OPSC also provides on-site support to facilities experiencing problems/concerns with MDROs.</p>	
<p>Standing Agenda: Ambulatory Surgery Centers</p> <p>Kelli Coelho</p>	<p>No updates.</p>	
<p>Standing Agenda: Long- Term Care Facilities</p> <p>OHA</p>	<p>Oregon Administrative Rules (OARs) 333-018 now mandate that long-term care facilities (LTCFs) submit an annual Infection Prevention Program Survey to OHA beginning in 2015. To develop ideas for the content of this survey, OHA has been researching existing tools. In the meeting materials, are:</p> <ul style="list-style-type: none"> • A copy of the NHSN Annual Facility Survey (page 26-27 of meeting materials) • A list of additional items deemed important by OHA that were not included in the NHSN survey (page 9 of meeting materials). Items were gleaned from: <ul style="list-style-type: none"> ○ OPSC Infection Prevention Program Survey ○ CDC LTCF Baseline Prevention Practices Assessment Tool ○ Oregon MDRO Surveillance and Response Network LTCF Needs Assessment. <p>OHA asked for recommendations from the committee on what items should be included in the questionnaire in order to assess LTCFs ability to implement and maintain infection prevention practices. Members responded with an inquiry as to whether CMS surveyors were already gathering this information from some, if not all, LTCFs. OHA will investigate further and present a more formalized</p>	

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	version of the survey at the next meeting.	
Standing Agenda: Oregon Association of Hospital & Health Systems Diane Waldo	No updates.	
Standing Agenda: Acumentra Laurie Murray-Snyder	No updates.	
Inpatient/Outpatient SSI Reporting Jennifer Zeck	<p>Currently, the HAI annual report only furnishes data for inpatient procedures, but hysterectomies, laminectomies, and total joint replacements are increasingly being performed in an outpatient setting. This can potentially skew infection data because inpatient surgeries are more likely to be performed on patients at a greater risk of acquiring an infection due to comorbidities coupled with a longer exposure to the healthcare environment. To illustrate this point, Ms. Zeck presented Good Samaritan Regional Medical Center’s 2013 data for inpatient and outpatient laminectomy cases (see pages 28-29 of meeting materials):</p> <ul style="list-style-type: none"> • Almost half of the laminectomies took place in an outpatient setting: 209 outpatient surgeries compared to 231 inpatient surgeries. • SIRs for inpatient laminectomies were substantially higher: 1.218 for inpatient surgeries versus 0.566 for outpatient surgeries. <p>Consumers therefore need both inpatient and outpatient rates to be accurately informed of each hospital’s incidence of infection for a particular procedure. Perhaps outpatient cases reported by some hospitals through NHSN could be incorporated into the HAI annual report. Members, however, expressed a concern that presenting inconsistent data—inpatient statistics for some hospitals and both inpatient and outpatient data for other facilities—might be confusing to readers. Another option might be to mandate the reporting of outpatient procedures. As a starting point, OHA would like to present this idea at an APIC meeting for feedback. If a favorable response is received, OHA would potentially survey all facilities to ascertain the viability of</p>	Present idea of mandating reporting of outpatient procedures at APIC meeting and present feedback to committee.

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	hospitals supplying outpatient data.	
Standing Agenda: Update on Status of OAR 333-018 OHA Staff	Changes to Oregon Administrative Rules 333-018 discussed at the March meeting have been finalized and are available online.	
Public Comment / Adjourn	No public comments	

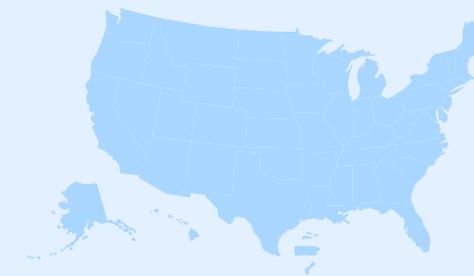
Next meeting will be September 24, 1:00 pm to 3:00 pm, at the Portland State Office Building, Room 1A.

Submitted By: Diane Roy

Reviewed By: Zintars Beldavs

EXHIBIT SUMMARY

- A – Agenda**
- B – March 26, 2014 Minutes**
- C – Follow-up and New Items**
- D – Oregon Annual HAI Report - 2013**
- E – Long Term Care Facility Component—Annual Facility Survey**
- F – MDRO Nursing Home Qualitative Questions**
- G – FSRMC 2013 LAM Comparison**



Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.

CLABSIs

↓ 19% LOWER^X COMPARED TO NAT'L BASELINE

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a way for germs to enter the body and cause deadly infections in the blood.

▣ <<State>> hospitals reported a significant decrease in CLABSIs between 2012 and 2013.

11% Among the 100 hospitals in <<State>> with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 0.56.

CAUTIs

↓ 3% LOWER^X COMPARED TO NAT'L BASELINE

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

▣ <<State>> hospitals reported a significant decrease in CAUTIs between 2012 and 2013.

11% Among the 100 hospitals in <<State>> with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 1.03.

^XStatistically significant; see table for additional information.

MRSA Bacteremia

↓ 39% LOWER COMPARED TO NAT'L BASELINE

LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is a type of staph bacteria usually spread by direct contact with an infected wound or from contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

11% Among the 100 hospitals in <<State>> with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 0.56.

SSIs

SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

SSI: ABDOMINAL HYSTERECTOMY ↓ 13% LOWER COMPARED TO NAT'L BASELINE

▣ <<State>> hospitals reported a significant decrease in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.

11% Among the 100 hospitals in <<State>> with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 0.89.

SSI: COLON SURGERY ↓ 25% LOWER COMPARED TO NAT'L BASELINE

▣ <<State>> hospitals reported a significant decrease in SSIs related to colon surgery between 2012 and 2013.

▣ Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.

11% Among the 100 hospitals in <<State>> with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 0.80.

C. difficile Infections ↓ 17% LOWER COMPARED TO NAT'L BASELINE

LABORATORY IDENTIFIED HOSPITAL-ONSET *C. DIFFICILE* INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea. *C. difficile* is usually spread by contact with contaminated surfaces or contaminated hands.

11% Among the 100 hospitals in <<State>> with enough data to calculate an SIR, 11% had an SIR significantly worse than the national SIR of 1.03.

- 2013 HAI Progress Report: www.cdc.gov/hai/progress-report/
- NHSN: www.cdc.gov/nhsn
- HAIs and prevention activities in <<State>>: www.state.org/hai



HEALTHCARE-ASSOCIATED INFECTION (HAI) DATA give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

LEGEND ▼

 2013 state SIR is significantly lower (better) than comparison group in column header

 or  No significant change in 2013 state SIR compared to group in column header

 2013 state SIR is significantly higher (worse) than comparison group in column header

 2013 state SIR cannot be calculated

HAI TYPE	# OF <<STATE>> HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013 Total Hospitals in State: 118*	2013 STATE SIR vs. 2012 State SIR [†]	2013 STATE SIR vs. 2013 Nat'l SIR	2013 STATE SIR vs. Nat'l Baseline [‡]	2013 STATE SIR	2013 NAT'L SIR
CLABSI Nat'l Baseline: 2008	76	 10%	 40%	 19%	0.81	0.56
CAUTI Nat'l Baseline: 2009	90	 12%		 3%	0.97	1.03
SSI, Abdominal Hysterectomy Nat'l Baseline: 2008	64	 23%	 8%	 13%	0.87	0.80
SSI, Colon Nat'l Baseline: 2008	74	 5%		 25%	0.75	0.89
MRSA Bacteremia Nat'l Baseline: 2011	76	2012 SIR not available	 5%	 39%	0.61	0.56
C. difficile Infections Nat'l Baseline: 2011	90	2012 SIR not available	 15%	 17%	0.83	1.03

*Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.
[†]The state's 2012 SIR can be found in the technical tables of this report: www.2013SIR.com.
[‡]Nat'l baseline time period varies by infection type. See first column of this table for specifics.

WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

WHAT IS <<STATE>> DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

<<State>> has a state mandate to publicly report at least one HAI to NHSN. <<State>> is one of 10 state health departments participating in CDC's Emerging Infections Program, which allows for extra surveillance and research of HAIs.

<<State>> has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections
- *C. difficile*, deadly diarrheal infections
- MRSA infections