

HEALTHCARE-ASSOCIATED INFECTIONS ADVISORY COMMITTEE

**December 17, 2014
1:00 pm to 3:00 pm**

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

MEMBERS PRESENT: Carlton Brown
Paul Cieslak, MD
Kelli Coelho, RN, CNOR
Julia Fontanilla, RN, MN (phone)
Jon Furuno, PhD (phone)
Jamie Grebosky, MD (phone)
Joan Maca, RN
Csaba Mera, MD
Nancy O'Connor, RN, BSN, MBA, CIC
Rachel Plotinsky, MD
Pat Preston, MS
Dana Selover, MD, MPH
Mary Shanks, RN, MSN, CIC
Diane Waldo, MBA, BSN, RN, CPHQ, CPHRM, LNCC
Bethany Walmsley, CPHQ, CPPS

MEMBERS EXCUSED: Jill Freeman
Laurie Murray-Snyder
Dee Dee Vallier

STAFF PRESENT: Kate Ellingson, PhD, Healthcare-Associated Infections Reporting 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 June and September Meeting Minutes
 - 2013-2014 Healthcare Worker Influenza Vaccination Report
 - 2012 CLABSI Validation Project: Results and Discussion
 - 2013 CDI Validation Project: Overview and Discussion
 - OAR Updates

- **Overview of OAR-Mandated Surveys to be Distributed in January 2015**
- **Making the 2014 HAI Annual Report More Actionable: Interactive Session on Proposed Metrics & Organization**
- **Standing Agenda: Committee Member Updates**
- **Integrating Reporting and Prevention**
- **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 June 25, 2014 and September 24, 2014 meetings were unanimously approved.	
2013-2014 Healthcare Worker Influenza Vaccination Report OHA Staff	<p>The 2013-2014 Healthcare Worker Influenza Vaccination Rates report, available on the Healthcare-Associated Infections Program website, examines hospital, long-term care facility (LTCF), and ambulatory surgery center (ASC) vaccination rates for workers that receive a paycheck directly from the facility, licensed independent practitioners, and unpaid workers (i.e., volunteers and students). For the employee category, while vaccination rates have increased across all facility types during the last four influenza seasons, long-term care facilities and ambulatory surgery centers will need to intensify efforts to meet the 75% vaccination rate goal set for 2015 by the U.S. Department of Health and Human Services Healthy People program. Only 49% of ambulatory surgery centers and 29% of LTCFs achieved the 2015 target. In contrast, employee immunization rates at hospitals surpassed the goal for the past two flu seasons. Moreover, vaccination rates for hospital employee rates rose from 77% last flu season to 82% this flu season; 30% of hospitals have already attained the 2020 Healthy People benchmark of a 90% vaccination rate. There is large variation in healthcare worker vaccination, exemplified by ambulatory surgery centers and long-term care facilities, whose vaccination rates range from 0% to 100%.</p> <p>Although most facilities offered no-cost immunization during the 2013-2014, some smaller</p>	

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	<p>long-term care facilities and ambulatory surgery centers did not offer vaccination to staff. Other delivery methods included mobile carts, vaccination in congregate areas, and peer vaccination. The top three reasons given by workers for declining a vaccination were:</p> <ul style="list-style-type: none"> • Other – 39% • Philosophical or religious beliefs – 21% • I am concerned about the side effects – 14% <p>OHA will begin sending congratulatory letters and certificates to organizations who achieved the 2020 HHS goal to commend their achievement. OHA is also considering distributing information, recently received from APIC, about a CDC toolkit that contains ideas and materials designed to increase vaccinations at long-term care facilities. To augment OHA’S efforts, attendees proposed:</p> <ul style="list-style-type: none"> • Prominently display immunization rates for all facilities to incentivize organizations to improve vaccination rates. (A link directly to facility vaccination rates has since been added to the HAI website.) • Find and publicize available studies that examine the relationship between healthcare worker influenza vaccination and nosocomial infection rates. • Use resources, such as newsletters and websites, of organizations represented by committee members to support OHA’s immunization campaign. 	
<p>2012 CLABSI Validation Project: Results and Discussion OHA Staff</p>	<p>HAI Program staff used CDC’s toolkit to validate 2012 Oregon hospital ICU central line-associated blood stream infections (CLABSIs) reported to the National Healthcare Safety Network (NHSN).The validation included examining hospital methods for collecting denominator data (patient and central line days). OHA selected 23 facilities, including 19 targeted and 4 randomly selected hospitals. Targeted facilities were selected by sampling hospitals with the highest expected number of 2012 CLABSIs.OHA staff requested a list of positive blood cultures from each participating hospital; a subset of pathogenic organisms was selected for medical review. The selection targeted organisms with an increased CLABSI-associated risk, including <i>Candida spp.</i>, <i>Escherichia coli</i>, <i>Staphylococcus aureus</i>, and</p>	

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	<p>coagulase-negative <i>Staphylococcus</i>. Cases were reviewed to verify correct application of the NHSN CLABSI definition, other NHSN definitions, and to assure complete case ascertainment.</p> <p>From patient medical record reviews, OHA identified 53 CLABSIs and facilities reported 44 CLABSIs. OHA and hospital infection preventionists reviewed, discussed, and agreed on correct ascertainment for all outstanding discrepancies in follow-up conference calls. After the adjudication process, OHA determined that 23% of CLABSIs were under-reported, which is consistent with a previous validation performed by OHA on 2009 reported CLABSI events. Common reasons for discrepancies included:</p> <ul style="list-style-type: none"> • Complicated gastrointestinal infections complicating CLABSI determination. • Incorrect hospital location attributed to CLABSI. <p>Interviews with hospital infection preventionists to obtain information about how denominator data is collected revealed:</p> <ul style="list-style-type: none"> • Most hospitals gather central-line day denominator data manually; patient days are usually provided by the accounting department. • One-third of hospitals do not verify electronic/manually collected data. • Counting port access, particularly for electronic systems, presents a challenge due to complexity of inclusion criteria: only 38% of facilities correctly tallied port access. <p>OHA concluded that:</p> <ul style="list-style-type: none"> • CLABSI surveillance has led hospitals to focus on generalized HAI related infection prevention efforts, since many of those efforts overlap. Oregon hospital ICU CLABSI rates per 1,000 central line days decreased from 1.54 per 1,000 central line days in 2009 to an estimated 1.25 (95% CI 0.97–1.60) per 1,000 central line days in 2012, despite relatively consistent central line usage in both periods. *Following the meeting, we offer this corrected statement: Because of the targeted sampling 	

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	<p>method used, it is not statistically appropriate to extrapolate beyond the sample of charts reviewed. Instead, comparing reported vs. validated CLABSIs, the rate of adult ICU CLABSIs from the sampled hospitals increased from 0.53 per 1,000 central line days to 0.74 per 1,000 central line days.</p> <ul style="list-style-type: none"> • Validation of reported CLABSIs is important for obtaining accurate infection data due to underreporting of events. From the blood cultures selected for review, OHA calculated a sensitivity of 77.4%, which is consistent with the 70-80% range reported by previous validation efforts. • Recommendations were offered to CDC regarding surveillance definitions, validation methods, and concern that states and facilities that do validate their data might be penalized for correctly reporting infections to NHSN. 	
<p>2013 CDI Validation Project: Overview and Discussion</p> <p>OHA Staff</p>	<p>In 2015, OHA will be performing a validation of 2013 facility-wide <i>Clostridium difficile</i> infection (CDI) NHSN data. Data for the project will be gathered from a random sample of patients from 19 hospitals in 5 counties. Corroboration of reported CDI is crucial because rates obtained from NHSN for CMS and Oregon published reports should accurately reflect actual incidence of hospital-onset CDI. Published statistics are used by consumers to decide where to receive healthcare and can incentivize facilities to reduce healthcare-associated infections.</p> <p>The validation project will investigate potential sources of systematic bias in categorization of CDI LabID events and in calculation of CDI rates:</p> <ol style="list-style-type: none"> 1. <u>Misclassification of LabID events</u> - Reviewers will confirm NHSN data by following the same CDC procedures used by hospital infection preventionists to identify and report CDI LabID events. NHSN defines LabID events as non-duplicate <i>C. difficile</i> toxin-positive lab results; duplicate events are CDI lab tests from the same patient and same location within 14 days. NHSN classifies recorded LabID events by healthcare association. The Oregon HAI report only includes incident healthcare facility-onset (HO) events. To be considered an incident hospital onset event, the specimen reported as a CDI LabID event must meet two criteria: 	

Item	Discussion	Follow-Up
	<ul style="list-style-type: none"> ○ Collected >3 days after hospital admission; specimens obtained on days 1-3 of hospital stay are classified as community-onset CDI ○ First specimen or collected >8 weeks after a previous CDI LabID event <p>2. <u>Exclusion of data from outside facilities</u> - OHA will identify community-onset (CO) CDI by reviewing patient medical records at 3 hospitals, surrounding long-term care facilities, and outpatient clinics. Reviewers will verify and document whether CDI status was communicated when patients transferred between facilities. Reviewers will compare rates/SIRs of validated data with NHSN data to establish whether NHSN-determined HO LabID events were biased by lack of information from surrounding facilities.</p> <p>3. <u>Inclusion of all patient days in denominator data</u>—inclusion of all patient days in the denominator of CDI rates and in the calculation of SIR denominators may distort results since patients are only at risk during specified times of their hospital stay. Positive CDI specimens for LabID events defined as hospital-onset incident must be collected more than three days after admission or more than 8 weeks following any prior CDI events. Consequently, usage of overall patient days rather than patient-days-at-risk may cause higher CDI rates/SIRS for hospitals with longer lengths-of-stay. To assess the impact of these variables, reviewers will compare CDI rates/SIRs calculated with patient days against rates/SIRS calculated with patient-days-at-risk. Patient discharge data will be used to approximate patient-days-at-risk. Patient-days-at-risk are considered day 3 of admission to discharge.</p>	
<p>OAR Updates</p> <p>OHA Staff</p>	<p>To align Oregon Administrative Rules (OARs) with current CMS mandates, OHA will be submitting a proposal to the state legislature next year requesting two modifications to OARs reporting requirements:</p> <ul style="list-style-type: none"> ● Elimination of 4 out of 6 Surgical Care Improvement Project (SCIP) measures(not reportable to CMS since 2011) 	

Item	Discussion	Follow-Up
	<ul style="list-style-type: none"> • Addition of rule mandating inpatient psychiatric facilities to report healthcare worker influenza vaccination numbers(required by CMS since October 2014) 	
<p>Overview of OAR-Mandated Surveys to be Distributed in January 2015</p> <p>OHA Staff</p>	<p>Posters containing information about an upcoming web-based survey are being distributed to facilities this month (pages 56-58 of meeting materials). The HAI program will mail instructions and a link to the questionnaire to hospital infection preventionists, laboratories performing bacteriology, and skilled nursing facilities in January 2015. The survey, which is mandatory for nursing facilities and optional for hospitals and labs, is due within 30 days of receipt. Responses from facilities will enable OHA to better understand how healthcare-facilities prevent and manage HAIs. Topics covered in the survey will include cabapenem-resistant <i>Enterobacteriaceae</i> (CRE), <i>Clostridium difficile</i> infections (CDI), and general resource questions.</p>	
<p>Making the 2014 HAI Annual Report More Actionable: Interactive Session on Proposed Metrics & Organization</p> <p>OHA Staff</p>	<p>OHA asked for feedback for methods to design the 2014 annual report to be more actionable, readable, and useful. This objective is challenging because Oregon mandates the reporting of a substantial amount of HAI data, which is increasing every year. Examples of new reporting requirements include:</p> <ul style="list-style-type: none"> • 2014 - MRSA bacteremia in inpatient units and CAUTI in hospital adult/pediatric ICUs. • 2015 - CAUTI in inpatient rehabilitation facilities and CLABSI in hospital wards. <p>To improve the report, OHA asked members to consider topics ranging from the scope of material to the type of graphics:</p> <ul style="list-style-type: none"> • <u>Scope</u>- should the information be comprehensive—include every reportable infection type and a variety of metrics – or should findings be summarized in an executive-style summary report and readers be directed to the OHA online interactive map and CMS Hospital Compare website for detailed data evaluation? To meet the needs of a diverse audience and to fulfill the objective of the report, the committee concluded that both a summary and an all-inclusive detail section are necessary. 	<p>OHA will present ideas for content and design of annual report at next meeting.</p>

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	<ul style="list-style-type: none"> • <u>Organization</u> - should separate reports be created for various settings, infections, and audiences? Attendees replied that information ought to be presented in multiple ways for different readers. Suggestions included: <ul style="list-style-type: none"> ○ Hospital audience - graphs stratified by bed size for each infection type to allow comparisons of infection rates, such as the number of <i>Clostridium difficile</i> infections per 10,000 patient days among similar facilities. ○ Varied audience - material ranging from short, simple explanations accompanied by illustrations to complex detailed information incorporating multiple statistical measures. • <u>Visual display</u> – how should data be presented? In the most recent annual report, HAI information is displayed in a variety of ways: data is sorted by facility name or SIR rank; directional arrows, forest plots, and bar charts show each organization’s SIR in relation to the national baseline; and line and bar graphs illustrate aggregate facility SIRs over time. OHA referred the committee to a 2-page summary of Oregon’s 2013 HAIs published by the CDC (pages 72-73 of meeting materials) as an example of an alternative approach. In the CDC report, percentages coupled with color-coded arrows are used to convey how a state’s SIR for each infection type compares to the national experience. Due to the simplicity of the charts and use of percentages, OHA proposed a similar format to summarize each hospital’s data for future reports. Opinions about these charts varied among members: <ul style="list-style-type: none"> ○ Would be instructive for hospital personnel but may not be appropriate for the public; ○ Might be a good option for readers favoring a simple graphic display of each facility’s infection rates. <p>OHA also presented CMS Hospital Compare and Tennessee’s SIRs and confidence intervals formatting (pages 74-78 of meeting materials). Format preferences differed among members, so no consensus was reached.</p> 	

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	<ul style="list-style-type: none"> • <u>Metrics</u> – which statistical measures should be used in the annual report and how should they be applied? <ul style="list-style-type: none"> ○ SIR –is the observed number of infections/predicted number of infections. Predicted infections are derived from computations comprised of 3 components formulated specifically for each infection type: (1)the amount of exposure (e.g., number of procedures and device days), (2) the national baseline rate, and (3) adjustments for risk factors (e.g., facility bed size and patient age). Although calculations for each infection type take into account key differences between hospitals and patient populations, SIRs are best used for evaluating facility progress over time, rather than hospital comparisons. Nonetheless, facilities are ranked by SIR in the 2013 Oregon annual report thereby encouraging readers to compare hospitals. Should ordering by SIR be continued in the next report? If so, should context be provided to help readers interpret this data? Would promoting intra-facility comparisons over time be preferable? No decisions were reached by committee members regarding these questions. ○ Confidence intervals (CIs) –CIs are the range around the SIR estimate used to convey the level of confidence in the precision of an SIR estimate. OHA queried the usefulness of this metric. Committee responded affirmatively: while confidence intervals may not be of interest to most readers, they may be beneficial to healthcare professionals. ○ Cumulative attributable difference (CAD) –is the observed number of infections minus the predicted number of infections. CAD was introduced by the CDC as a way to assess a facility’s burden of infection, in other words, the number of preventable infections. Outcomes calculated with CAD show a different picture than SIR. For example, in 2013, one Oregon hospital with a high SIR of 3.38 could have a relatively low CAD of 5.6 whereas another facility with a moderate SIR of 1.35 could have a high CAD of 70.5. CAD offers 	

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	<p>an effective tool for setting HAI prevention goals, reporting facility achievements relative to HHS targets, ranking hospitals to spotlight low and high performers, and targeting facilities that would most benefit from guidance on how to reduce infections. Meeting attendees agreed, but noted that intervention efforts are beyond the purview of the committee. Nonetheless, CAD and other measures would be valuable when making recommendations to partner organizations involved with establishing programs aimed at lowering HAIs, such as the Oregon Patient Safety Commission.</p> <ul style="list-style-type: none"> • <u>Miscellaneous information</u> <ul style="list-style-type: none"> ○ Should these topics remain in the annual report? <ul style="list-style-type: none"> ▪ Surgical Care Improvement Project (SCIP) measures—committee decided these metrics could be eliminated because adherence to recommended care standards is high and hospital personnel, cognizant of their facility’s compliance rates, do not require this information. ▪ Summary of healthcare worker influenza vaccination report – no decision reached. ○ Should these topics be added to the annual report? (Proposed by OHA but no further discussion.) <ul style="list-style-type: none"> ▪ Overview of NHSN data validation efforts and findings. ▪ Acknowledgement of hospitals performing better than expected. 	
Standing Agenda: Committee Member Updates	There were no committee member updates.	

Item	Discussion	Follow-Up
Integrating Reporting and Prevention OHA Staff	Integrating reporting and prevention was briefly discussed during overview of CAD metric (see Making 2014 HAI Annual Report More Actionable item above).	
Public Comment / Adjourn	No public comments.	

Next meeting will be March 25, 2015, 1:00 pm to 3:00 pm, at the Portland State Office Building, Room 1B.

Submitted By: Diane Roy

Reviewed By: Kate Ellingson
Zintars Beldavs
Genevieve Buser

EXHIBIT SUMMARY

A – Agenda

B – September 24, 2014 Minutes

C – June 25, 2014 Minutes

D – 2013-2014 Healthcare Worker Influenza Vaccination Rates

E – Validation of NHSN-Reported Central Line-Associated Blood Stream Infections – Oregon, 2014

G – 2013 *C. difficile* Validation Project Overview & Discussion

H – 2015 Healthcare-Associated Infection Surveys

G – Feedback & Planning for Oregon’s 2014 Annual HAI Report: Scope, Organization, and Metrics

G – Cumulative Attributable Difference (CAD)



Task Force on the Future of Public Health Services: Recommendations to Modernize Oregon's Public Health System

WHAT: The Task Force on Future of Public Health Services was created by House Bill 2348 (2013) with the directive of providing recommendations for the future of public health in Oregon that:

- Create a public health system for the future.
- Explore the creation of regional structures.
- Enhance efficiency and effectiveness of public health services.
- Promote partnerships with local health care providers and community organizations.
- Consider cultural and historical appropriateness.
- Are supported by best practices.

WHY: With the advent of health care transformation there is increased awareness about the need to address health issues before they begin – to focus on prevention of illness. The role of public health is to promote interventions for the entire population that are prevention focused. These interventions address the underlying causes of death and disease. Preventing disease before it happens will result in significant cost savings to the health care delivery system.

The current situation for public health in Oregon is inhibiting the ability of public health agencies to achieve a population-wide focus on prevention. Some of the issues are:

- Large disparity in level of county funding resulting in limited capacity in many areas
- A focus on individual service delivery at the cost of providing community wide interventions
- Reliance on Federal categorical funding which dictates what programs need to be provided, regardless of community need
- Limited state funding for foundational public health capacities and programs

HOW: To address these problems and establish a modern Public Health System in Oregon, the Task Force made the following recommendations:

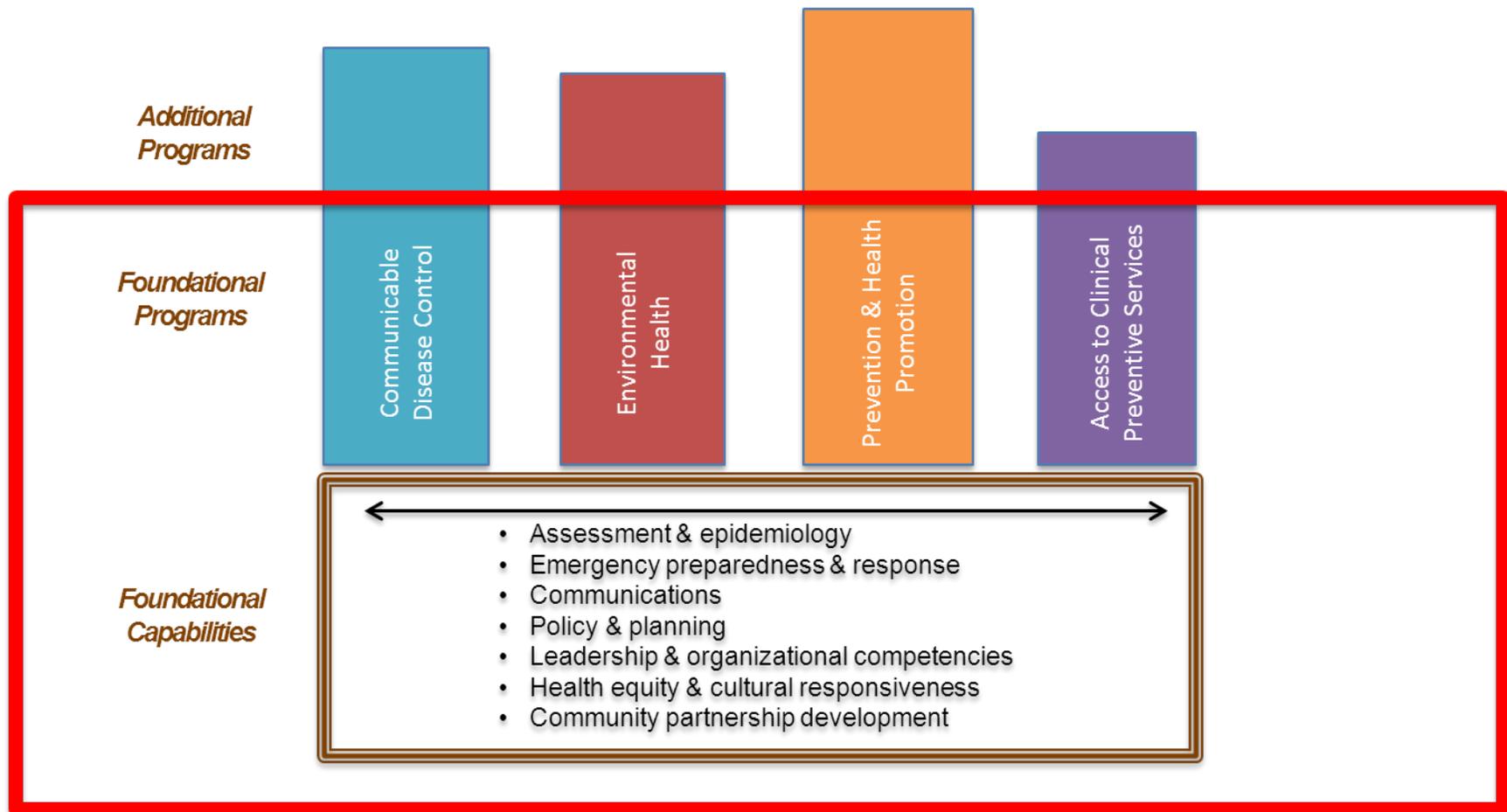
- A defined set of Foundational Capabilities & Programs be adopted in all public health agencies in order for the public health system to function efficiently and effectively.
- Significant and sustained state funding for the governmental public health system be identified and allocated for proper operationalization of the Foundational Capabilities and Programs.
- Statewide implementation of the Foundational Capabilities & Programs occur in waves.
- Local jurisdictions will have flexibility when operationalizing Foundational Capabilities & Programs.
- Improvements and changes in the governmental public health system be structured around state and local metrics. These metrics will be established and evaluated by the Public Health Advisory Board, which will report to the Oregon Health Policy Board.

Implementation of these recommendations will result in:

- Better integration of governmental public health with a transforming health care system.
- Improved coordination and clarity of roles between local and state.
- Basic public health assurances in place for everyone in Oregon.

For additional information contact: publichealth.policy@state.or.us
Complete Task Force details can be found at: healthoregon.org/taskforce

Conceptual Framework for Governmental Public Health Services



□ = Present @ every Health Dept.

Modernizing Oregon's Public Health System

*Findings from the Future of Public Health
Task Force*

Oregon
Health
Authority

What Does the Public Health System Do?

Three main public health functions are:

- Assessment and monitoring of the health of communities to identify health problems and priorities.
- Formulation of public policies designed to solve identified local and national health problems.
- To assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.

-World Health Organization, 2014

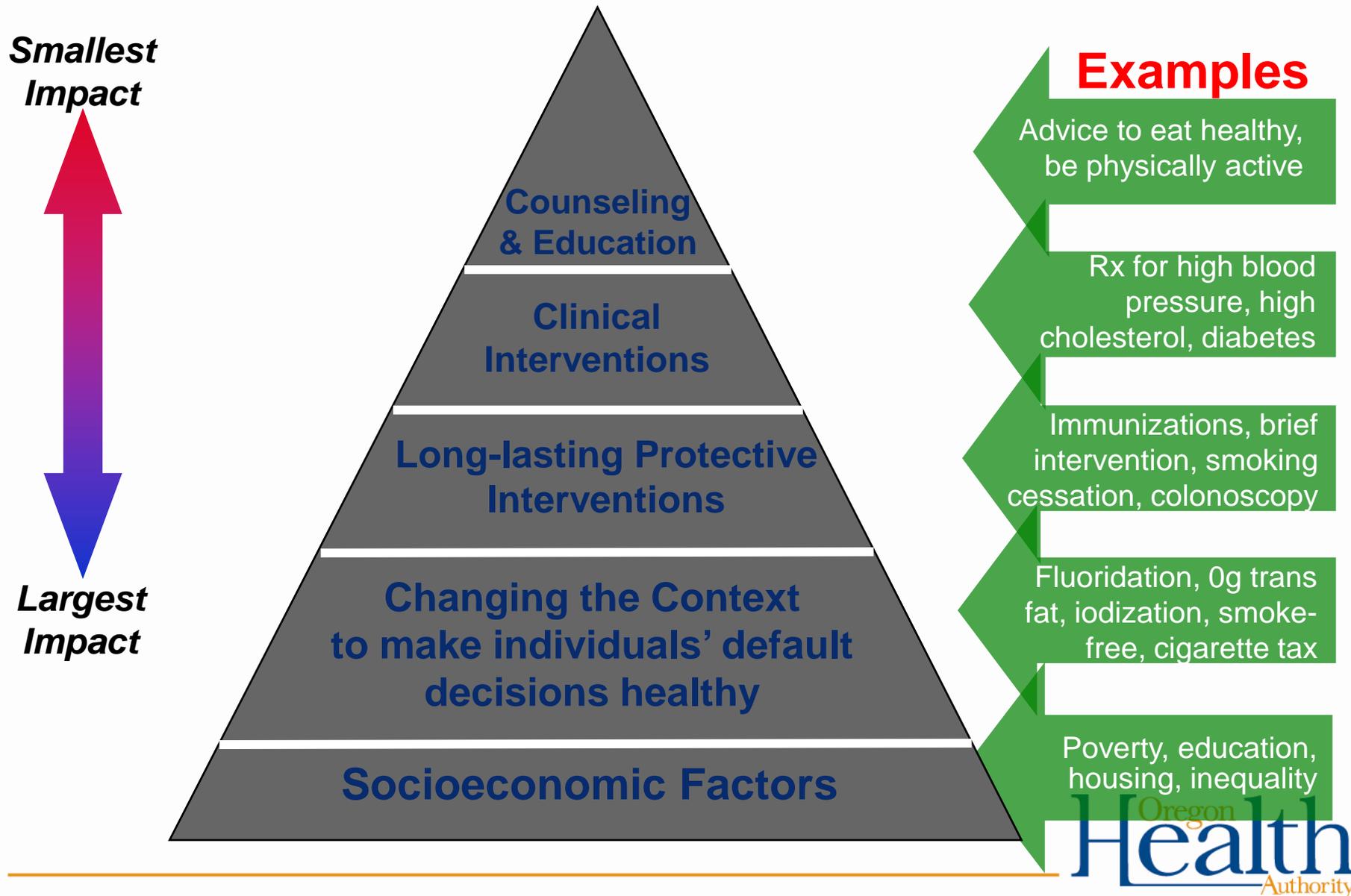
Public Health in the Community

- Public health monitors **diseases** and **health behaviors** of the entire population.
 - Vital records: Birth and Death Data
 - Reportable diseases
 - Population-based surveys
 - Clinical service delivery data
- Public health has a role in protecting the health of everyone in Oregon.
 - Food and water safety
 - Health care facility licensing
 - Smoke free laws
 - Water fluoridation
 - Health Impact Assessments

Current Situation for Public Health in Oregon

- Large disparity in level of county funding resulting in limited capacity in many areas
- A focus on individual service delivery at the cost of providing community wide interventions
- Reliance on Federal categorical funding which dictates what programs need to be provided, regardless of community need
- Limited state funding for core public health capacities and programs

Factors that Affect Health



Task Force on the Future of Public Health Services:

HB 2348 (2013)

Focused on recommendations that:

- Create a public health system for the future
- Consider the creation of regional structures
- Enhance efficiency and effectiveness
- Allow for appropriate partnerships with regional health care service providers and community organizations
- Consider cultural and historical appropriateness
- Are supported by best practices

Task Force Membership

- Tammy Baney (Chair), Deschutes County Commissioner
- Liz Baxter (Vice Chair), Oregon Public Health Institute
- Carrie Brogoitti, Union County Public Health
- Carlos Crespo, Portland State University
- Charlie Fautin, Benton County Public Health
- Nicole Maher, Northwest Health Foundation
- John Sattenspiel, Trillium Community Health Plan CCO
- Jennifer Mead, Department of Human Services
- Gary Oxman, Multnomah County
- Alejandro Queral, United Way of the Columbia-Willamette
- Eva Rippeteau, AFSCME Council 75
- Rep. Jason Conger (R-Bend)
- Rep. Mitch Greenlick (D-Portland)
- Sen. Bill Hansell (R-Pendleton)
- Sen. Laurie Monnes Anderson (D-Gresham)

HB 2348 (2013): Task Force Report
Future of Public Health Services

Modernizing Oregon's Public Health System

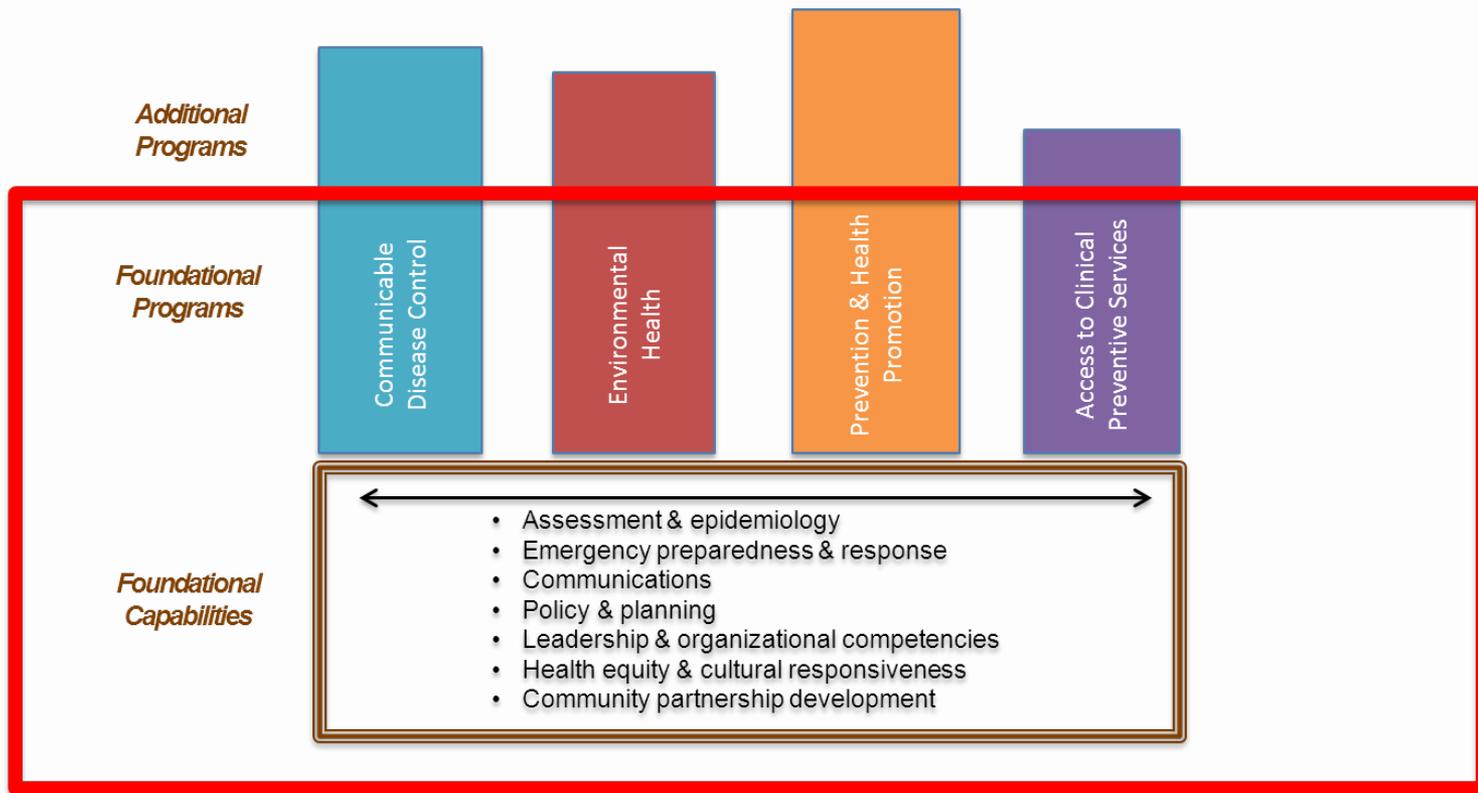
Executive Summary

September 2014

Oregon
Health
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Conceptual Framework for Governmental Public Health Services



☐ = Present @ every Health Dept.

Recommendations

1. The Foundational Capabilities and Programs should be adopted in order for Oregon's public health system to function efficiently and effectively
2. Significant and sustained state funding be identified and allocated for proper operationalization of the Foundational Capabilities and Programs
3. Statewide implementation of the Foundational Capabilities and Programs will occur in waves over a timeline to be determined

Recommendations

(con't)

4. Local public health will have the flexibility to operationalize the Foundational Capabilities and Programs through a single county structure; a single county with shared services; or a multi-county jurisdiction
5. Improvements and changes in the governmental public health system be structured around state and local metrics established and evaluated by the Public Health Advisory Board, which will report to the Oregon Health Policy Board

Recommendation #1

The Foundational Capabilities and Programs should be adopted in order for Oregon's public health system to function efficiently and effectively

Foundational Capabilities

- Critical knowledge, skills and abilities necessary to carry out public health activities efficiently and effectively
- Needed to identify and analyze public health problems, & to address these problems through public health programs and policies
- Key to protecting and improving the community's health, and achieving effective and equitable health outcomes

For Oregon's public health system to function well, these foundational capabilities need to be broadly present in our state and local health departments: they are the essential capacities

Foundational Capabilities:

Assessment & Epidemiology

Example: Collect and maintain vital records

Emergency preparedness & response

Example: Activate emergency response personnel and communications systems during a public health emergency

Communications

Example: Develop and implement proactive health education/health prevention strategies

Policy & planning

Example: Using science & best practices, develop policies to protect & improve population health

Leadership & organizational competencies

Example: Financial management, contract and procurement services

Health equity & cultural responsiveness

Example: Commitment to supporting policies to promote health equity

Community partnership development

Example: Convene and sustain strategic relationships with traditional and non-traditional partners and stakeholders to collectively advance health

Foundational Programs

- Basic areas of public health expertise and activity essential to assess, protect and improve the community's health
- Benefits must be available to everyone in Oregon
- These programs are considered the baseline services of the governmental public health system
 - Communicable Disease Control
 - Environmental Health
 - Prevention and Health Promotion
 - Access to Clinical Preventive Services

Additional Programs

- Public health programs and activities implemented in addition to foundational programs to address specific identified community public health problems or needs.
- Additional programs are of two fundamental types:
 - Enhancement or expansion of a foundational program
 - A new program to address a need not addressed by a foundational program

Recommendation #2

Significant and sustained state funding be identified and allocated for proper operationalization of the Foundational Capabilities and Programs

Public Health in Oregon: Funding

OHA Public Health Division

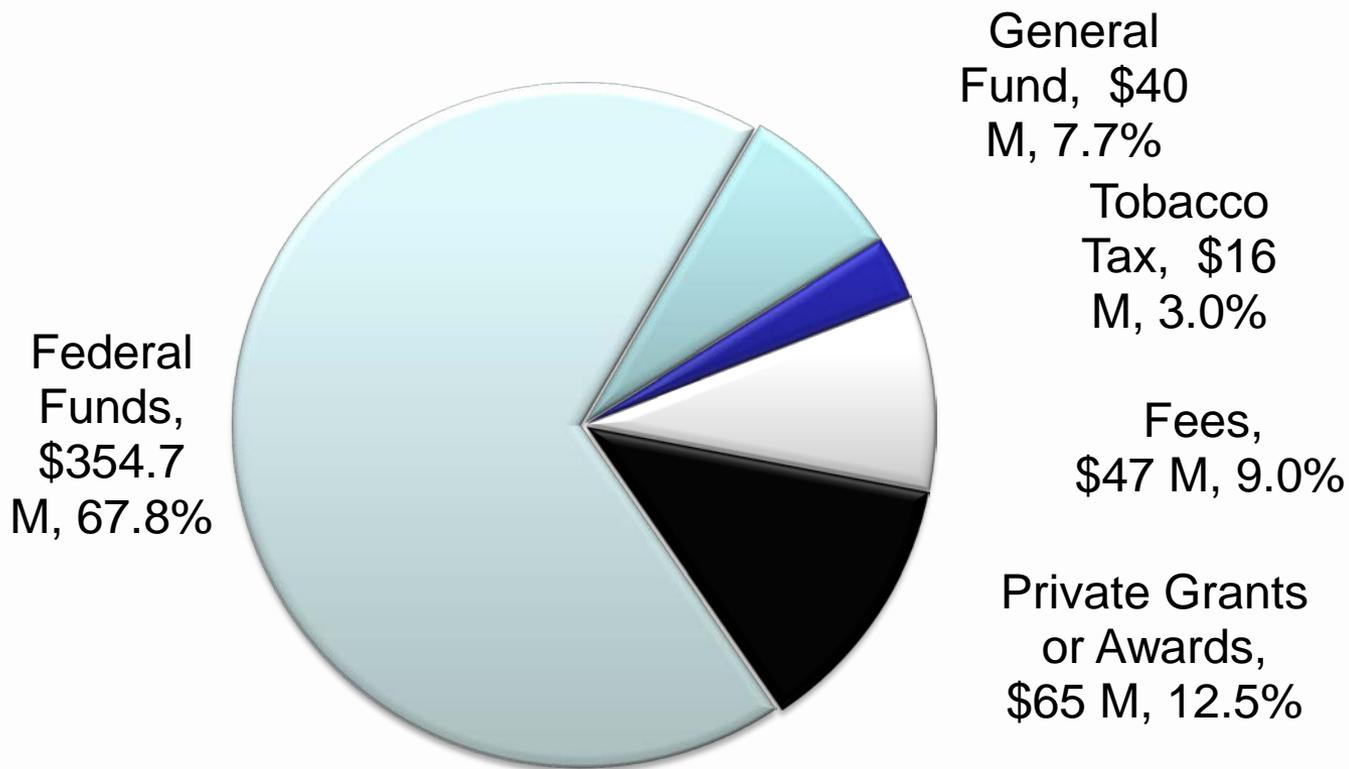
- Federal grants
- Private grants
- Fees
- Tobacco tax
- State General fund

Local Public Health Authorities

- Medicaid reimbursement
- County general funds
- Pass-through federal grants
- Fees and donations

State Public Health Budget by Fund Type

Total budget \$523,079,350



State Public Health Budgets			
State	FY 2011-2012	FY 11-12 Per Capita	Per Capita Ranking
Hawaii ²	\$215,793,131	\$154.99	1
D. C.	\$65,927,000	\$104.26	2
Idaho	\$143,890,100	\$90.17	3
West Virginia	\$160,589,232	\$86.55	4
Alaska ²	\$59,261,100	\$81.02	5
New York	\$1,468,595,515	\$75.04	6
Alabama	\$358,728,139	\$74.39	7
California	\$2,512,158,000	\$66.04	8
Wyoming	\$33,852,718	\$58.73	9
Massachusetts	\$361,079,843	\$54.33	10
Arkansas	\$150,180,308	\$50.92	11
North Dakota ³	\$34,013,780	\$48.62	12
Rhode Island	\$49,390,630	\$47.03	13
New Mexico	\$97,144,500	\$46.58	14
Kentucky	\$191,695,800	\$43.76	15
Tennessee	\$275,073,200	\$42.61	16
Washington ³	\$289,049,500	\$41.91	17
Vermont	\$26,084,071	\$41.67	18
Delaware ²	\$38,153,700	\$41.60	19
Nebraska	\$72,690,976	\$39.18	20
Oklahoma ¹	\$148,623,000	\$38.96	21
Virginia ³	\$299,156,071	\$36.55	22
Colorado	\$180,719,799	\$34.84	23
Maryland ²	\$175,461,490	\$29.82	24
South Dakota ⁴	\$23,735,633	\$28.48	25
MEDIAN \$27.40			
Utah	\$78,246,700	\$27.40	26
New Jersey	\$229,203,000	\$25.86	27
Connecticut ²	\$88,191,904	\$24.56	28
Illinois	\$297,253,500	\$23.09	29
Maine ²	\$29,708,338	\$22.35	30
Florida ²	\$382,052,729	\$19.78	31
Montana	\$19,552,494	\$19.45	32
South Carolina	\$90,947,879	\$19.25	33
Texas	\$478,338,289	\$18.36	34
Iowa	\$53,688,501	\$17.46	35
Indiana	\$113,929,495	\$17.43	36
Michigan ³	\$172,041,800	\$17.41	37
Georgia	\$168,715,698	\$17.01	38
Louisiana	\$70,778,560	\$15.38	39
Minnesota ^{2,4}	\$77,456,000	\$14.40	40
Ohio	\$166,257,009	\$14.40	40
Kansas ⁴	\$41,479,143	\$14.37	42
Pennsylvania ²	\$181,961,000	\$14.26	43
North Carolina ²	\$138,126,056	\$14.16	44
New Hampshire	\$17,794,601	\$13.47	45
Oregon	\$52,141,850	\$13.37	46
Wisconsin	\$75,042,700	\$13.10	47
Mississippi ²	\$26,521,920	\$8.89	48
Arizona	\$49,756,500	\$7.59	49
Missouri	\$36,592,175	\$6.08	50
Nevada	\$9,042,262	\$3.28	51



Notes:

1 May contain some social service programs, but not Medicaid or CHIP.

2 General funds only.

3 Budget data taken from appropriations legislation.

4 State did not respond to the data check TFAH coordinated with ASTHO that was sent out October 26, 2012. States were given until November 16, 2012 to confirm or correct the information. The states that did not reply by that date were assumed to be in accordance with the findings.

Recommendations #3 & 4

- Statewide implementation of the Foundational Capabilities & Programs will occur in waves over a timeline to be determined
- Local public health will have the flexibility to operationalize Foundational Capabilities and Programs through a single county structure; a single county with shared services; or a multi-county jurisdiction

Public Health in Oregon

- Decentralized public health structure
- State public health
 - OHA Public Health Division
- Local public health
 - 34 local public health authorities (one three-county health district)
 - Local public health authorities may delegate public health authority to another entity (nonprofit organization, etc.)

Recommendation #5

Improvements and changes in the governmental public health system be structured around state and local metrics established and evaluated by the Public Health Advisory Board, which will report to the Oregon Health Policy Board

What This Means for the Future of Public Health

- Better integration of governmental public health with a transforming health care system.
- Improved coordination and clarity of roles between local and state.
- Basic public health assurances in place for everyone in Oregon.
- Local flexibility in determining additional public health service.
- Improved sustainability for governmental public health services over time.

The full report in addition to task force meeting minutes and materials can be found online:

www.healthoregon/taskforce



Oregon  Association
of Hospitals and Health Systems

HOSPITAL TRANSFORMATION PERFORMANCE PROGRAM

March 25, 2015

HPPP Description

- CMS incentive program for DRG hospitals
- Allows OHA to make payments to participating DRG hospitals for implementing and reporting on health system reform initiatives to improve quality and access of care
- Measures developed by OHA-led Hospital Performance Metrics Advisory Committee
- First phase approved through June 30, 2016
- Funded by Oregon's Medicaid hospital provider tax

Hospital metrics committee

Authority

In 2013, Oregon House Bill 2216, Section 1, established the nine-member hospital performance metrics advisory committee appointed by the Director of the Oregon Health Authority.

Membership

The members of the committee include:

- Four members who represent hospitals;
- Three individuals with expertise in measuring health outcomes; and
- Two representatives of coordinated care organizations.

Eligibility

- Diagnostic-Related Group (DRG) hospitals that are assessed the provider tax are eligible
- 28 Oregon hospitals are considered DRG hospitals

Domains and Measures

Focus Area	Domains	Measures
Hospital focus	1. Readmissions	1. Hospital-Wide All-Cause Readmission
	2. Medication Safety	2. Hypoglycemia in inpatients receiving insulin
		3. Excessive anticoagulation with Warfarin
		4. Adverse Drug Events due to opioids
	3. Patient Experience	5. HCAHPS, Staff always explained medicines (NQF 0166)
		6. HCAHPS, Staff gave patient discharge information (NQF 0166)
	4. Healthcare-Associated Infections	7. CLABSI in all tracked units (adapted from NQF 0139)
		8. CAUTI in all tracked units (adapted from NQF 00754)
Hospital-CCO Coordination focus	6. Emergency Department (ED) visit information	9. Hospitals sharing ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits
	7. Behavioral Health	10. Follow-up after hospitalization for mental illness (adapted from NQF 0576)
		11. Screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT) in the Emergency Department

Payment Allocation

- Phase 1: Floor Allocation
- Phase 2: Allocation per Measure Achieved

Phase 2: Allocation per Measure Achieved

- **Step 1:** Determine hospital performance against each measure
- **Step 2:** Calculate amount each measure is worth (“base amount”)
- **Step 3:** Allocate base amount to hospitals according to hospital size (adjustment factor)

Phase 2, Step 2: Measure Worth

Domains	Measures	Share of Funds	
		YR 1	YR 2
Readmissions	1. Hospital-Wide All-Cause Readmission	18.75%	18.75%
Medication Safety	2. Hypoglycemia in inpatients receiving insulin	6.25%	6.25%
	3. Excessive anticoagulation with Warfarin	6.25%	6.25%
	4. Adverse Drug Events due to opioids	6.25%	6.25%
Patient Experience	5. HCAHPS, Staff always explained medicines (NQF 0166)	9.38%	9.38%
	6. HCAHPS, Staff gave patient discharge information (NQF 0166)	9.38%	9.38%
Healthcare-Associated Infections	7. CLABSI in all tracked units (modified NQF 0139)	9.38%	9.38%
	8. CAUTI in all tracked units (modified NQF 00754)	9.38%	9.38%
ED visit information	9. Hospitals share ED visit information with primary care providers and other hospitals to reduce unnecessary ED visits	12.50%	12.50%
Behavioral Health	10. Follow-up after hospitalization for mental illness (modified NQF 0576)	6.25%	6.25%
	11. Screening for alcohol and drug misuse, brief intervention, and referral to treatment (SBIRT) in the Emergency Department	6.25%	6.25%

Phase 2, Step 3: Adjust Base Amount by Hospital Size

- After base amount is calculated, it is adjusted and allocated to hospitals achieving the measure based on **hospital size**:
 - 50% based on hospital's share of total Medicaid discharges
 - 50% based on hospital's share of total Medicaid inpatient days
- Note hospital size calculation is based on discharge data as reported to COMPDATA for the period October 1, 2011 – September 30, 2012 for payments in both Year 1 and Year 2. This ensures hospitals are not penalized for reducing Medicaid discharges or inpatient days.

Data Collection and Reporting Mechanism

- OAHHS/Apprise
 - Key intermediary for HTPP data collection and reporting
 - Launched a secure, web-enabled reporting platform for data submission
 - Working with hospitals to ensure timely reporting
 - Check submitted data for validity
 - Submit final data to OHA for CMS reporting and payment calculations

Data Collection and Reporting Mechanism

OHA

- Working with hospitals on data submission for follow-up after hospitalization for mental illness measure
- Review submitted data to determine whether it meets thresholds and requirements for payment
- Perform payment calculations
- Distribute payments

WHAT COMES NEXT?

- First reports (baseline data) have been reviewed by hospital
- On April 17, 2015, OHA will send notification to DRG hospitals of payment amounts for baseline year; to be issued on April 30th

<http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx>

QUESTIONS?



Thank you.

Diane Waldo
503.479.6016

Diane.waldo@oahhs.org

2014 HAI Annual Report March Update

Kate Ellingson, PhD
Healthcare-Associated Infections Program
Oregon Health Authority
March 25, 2015



(Enter) DEPARTMENT (ALL CAPS)
(Enter) Division or Office (Mixed Case)

March Update: HAI Report

- Timeline
- Report format(s): consumers & providers
- Data displays
- Facility-specific report cards
- Forums for publication & promotion

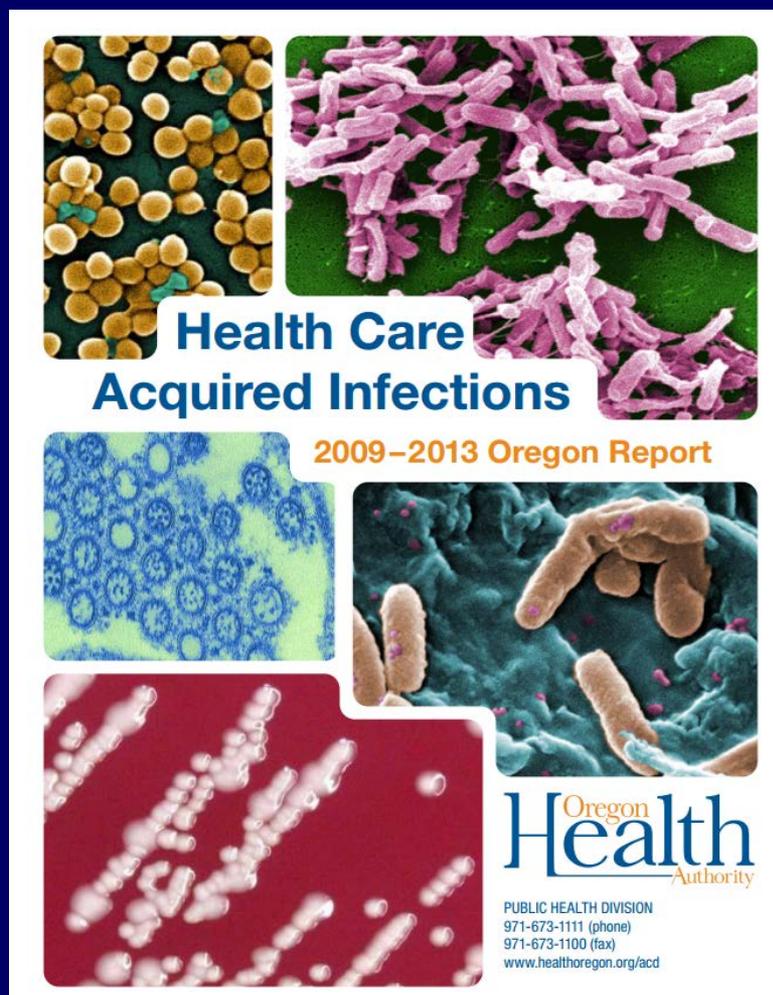
Big Picture: Mandatory Reporting, Hospitals

Infections/Metrics	2009	2010	2011	2012	2013	2014	2015
CLABSI – Adult ICUs	✓	✓	✓	✓	✓	✓	✓
CLABSI -- NICUs			✓	✓	✓	✓	✓
CLABSI Wards							✓
CAUTI– Adult/Ped ICUs						✓	✓
CAUTI – Wards							✓
SSI, CABG/CBGB	✓	✓	✓	✓	✓	✓	✓
SSI, COLO			✓	✓	✓	✓	✓
SSI, Abd. HYST			✓	✓	✓	✓	✓
SSI, KPRO	✓	✓	✓	✓	✓	✓	✓
SSI, HPRO			✓	✓	✓	✓	✓
SSI, Laminectomy			✓	✓	✓	✓	✓
<i>C. Difficile</i> LabID Events					✓	✓	✓
MRSA Bacteremia LabID						✓	✓
SCIP Measure Adherence	✓	✓ (+)	✓ (+)	✓ (+)	✓	✓ (-)	✓ (?)
HCW Influenza Vaccination	✓	✓	✓	✓	✓	✓	✓

Big Picture: Mandatory Reporting, Non-Hospitals

Infections/Metrics	2009	2010	2011	2012	2013	2014	2015
DIALYSIS							
Dialysis event					✓	✓	✓
HCW Influenza Vaccination							✓
LONG-TERM CARE FACILITIES							
HCW Influenza Vaccination		✓	✓	✓	✓	✓	✓
AMBULATORY SURGICAL CENTERS							
HCW Influenza Vaccination			✓	✓	✓	✓	✓

Publication Schedule



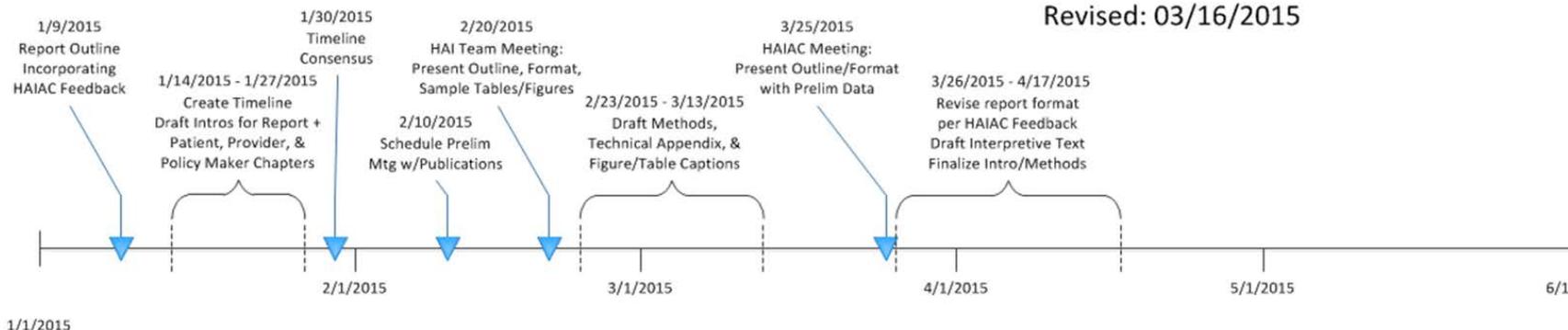
- 2013 report published Summer, 2014
- Target publication date for 2014 HAI Report:
July 31, 2015

Timeline: January – April

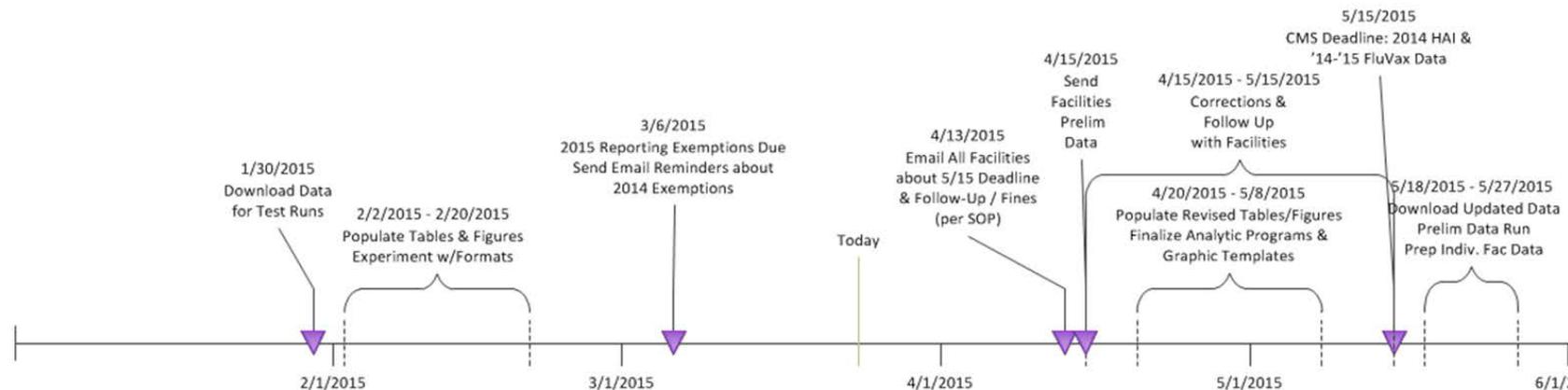
Report Creation & Publication

2014 HAI Annual Report Timeline

Revised: 03/16/2015



Data Collection & Analysis

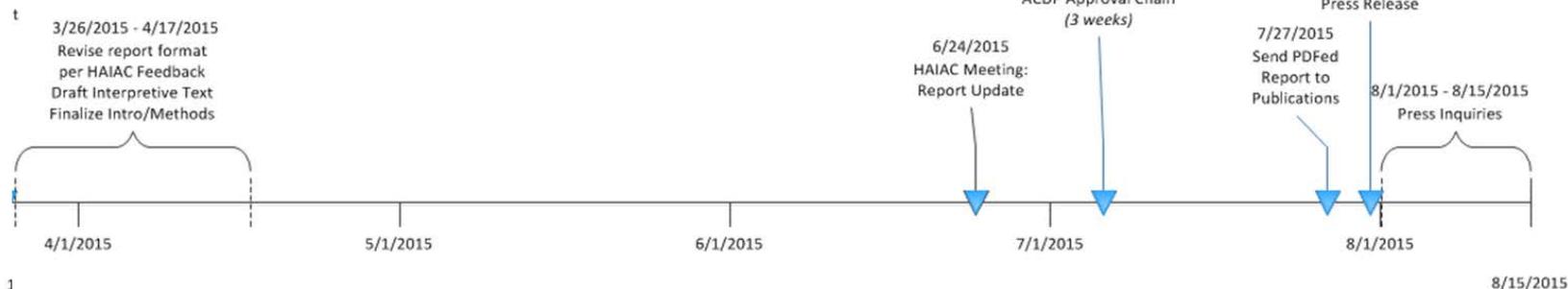


Timeline: April – July

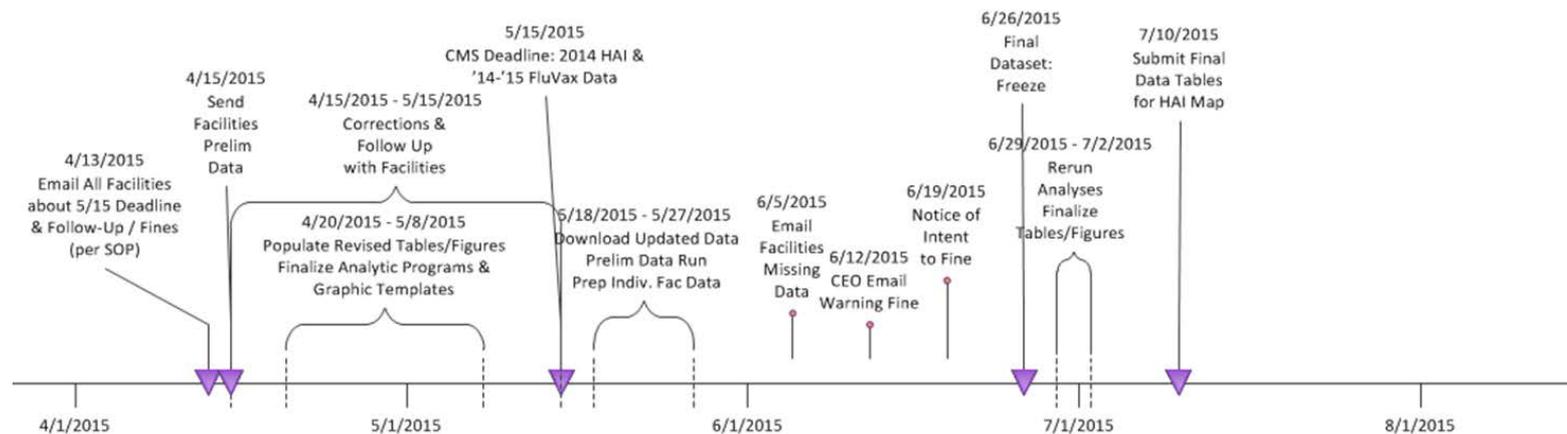
Report Creation & Publication

2014 HAI Annual Report Timeline

Revised: 03/16/2015



Data Collection & Analysis



Committee Recommendations (Dec.)

- Present data in “complexity layers”
 - Clear summary presentation for consumers
 - More detailed & complex data for providers
 - Allow everyone access to granular data
- Modifications/additions to data elements
 - Display rates in addition to SIRs
 - Publish aggregate SIRs/rates by hospital size
 - Display color-coded confidence intervals for providers
- Tight executive summary

Based on Your Recommendations...

- OHA will produce two annual reports
 - Shorter, simpler report for consumer
 - Longer technical report for providers or interested consumers
- Executive summary will include graphic with overall HAI picture in Oregon
- SIRs, color-coded CIs, and rates in technical report + SIRs/rates by size

CDC Workgroup Consensus on Format for Consumer Report

Legend							
	Fewer infections (better) than predicted based on the national experience.*	=	About the same number of infections as predicted based on the national experience.*		More infections (worse) than predicted based on the national experience.*	No Conclusion	When the number of predicted infections is less than 1, no conclusion can be made.
*National experience contains data from 2006 – 2008 for CLABSI and SSI, 2009 for CAUTI, and 2010-2011 for MRSA and C.difficile Laboratory-Identified Events.							

Sample Report Title: [STATE] Central Line-Associated Bloodstream Infection (CLABSI) Acute Care Hospital Report, 2013

Facility Name	Unit Type	Observed Infections	Predicted Infections	How Does This Facility Compare to the National Experience?
Clean Memorial	Adult/pediatric intensive care units (ICU)	1	2.8	 Better
Clean Memorial	Inpatient Wards	3	4.1	= Same
Town Surgical Hospital	Adult/pediatric intensive care units (ICU)	0	0.6	No Conclusion
Vine Medical Center	Adult/pediatric intensive care units (ICU)	3	3.2	= Same

CDC Workgroup Consensus on Format for Consumer Report

Report Title: [STATE] Surgical Site Infections following Abdominal Hysterectomy Procedures Acute Care Hospital Report, 2013

Facility Name	Procedure Type	Number of Procedures	Observed Infections	Predicted Infections	How Does This Facility Compare to the National Experience?
Clean Memorial	Abdominal Hysterectomy	78	5	3.0	✗ Worse
Town Surgical Hospital	Abdominal Hysterectomy	200	5	6.8	= Same
Vine Medical Center	Abdominal Hysterectomy	107	6	5.6	= Same

Sample Report Title: [STATE] *Clostridium difficile* (*C. difficile*) Hospital-Onset Laboratory-Identified Event Report, 2013

Facility Name	Observed Events	Predicted Events	How Does This Facility Compare to the National Experience?
Clean Memorial	3	6.5	★ Better
Town Surgical Hospital	5	4.1	= Same
Vine Medical Center	7	5.1	✗ Worse

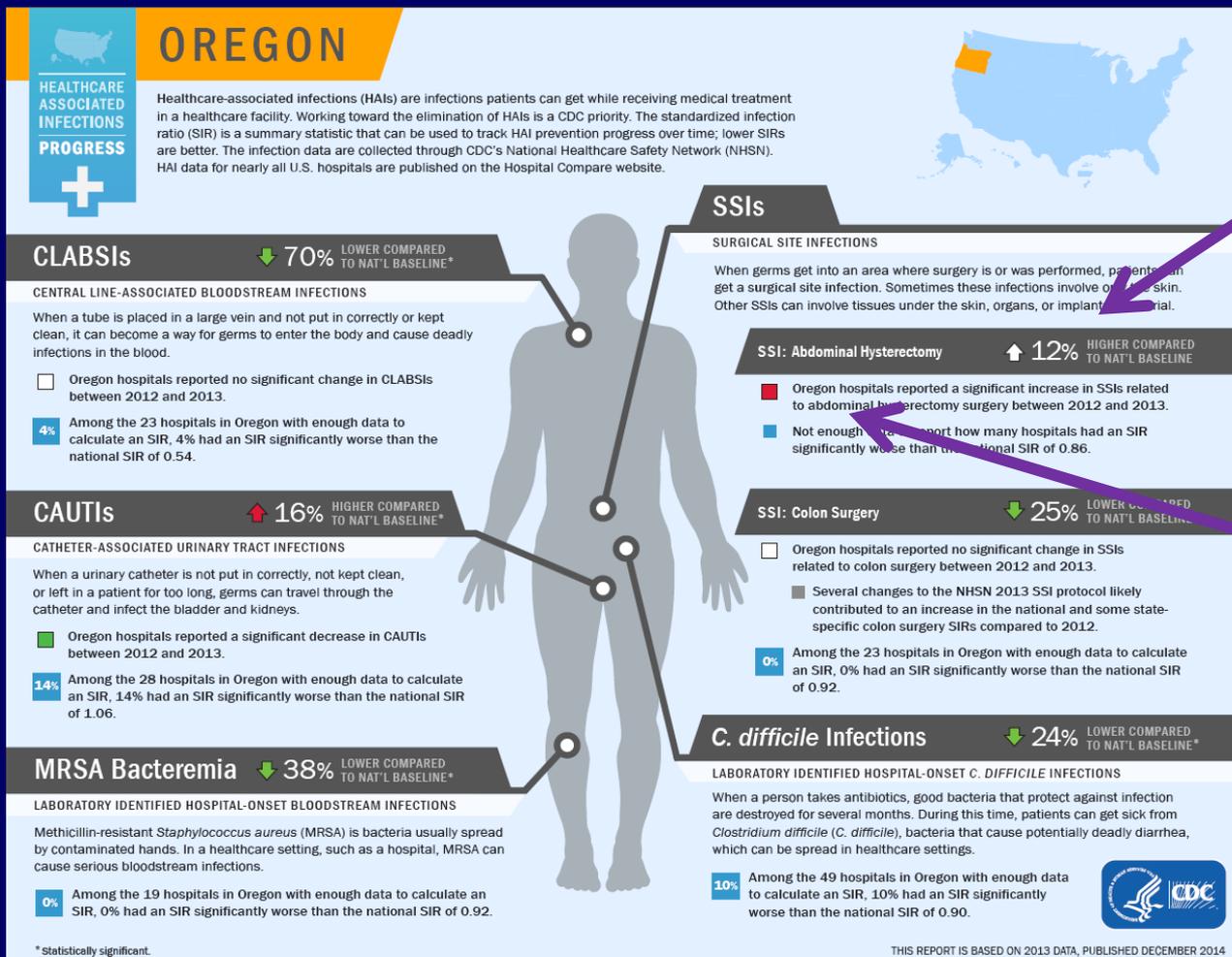
Technical Report for Providers

- Executive summary w/graphic for all OR
- Detailed methods section
- For each facility & infection type:
 - # observed infections
 - # patient/catheter/line days or # procedures
 - Rate per (appropriate denominator)
 - # expected infections
 - SIR with color-coded confidence interval
 - % change in 2014 vs. 2013 SIR

Technical Report for Providers

Hospital	Obs	Pt Days	Rate	Expected	SIR	95% CI	% change since 2013
A	1	8508	1.18	5.1	0.2		15% ↓
B	6	20739	2.89	14.5	0.4		35% ↓
C	15	41213	3.64	30.7	0.5		78% ↑
D	1	2715	3.68	1.2	0.8		12% ↑
E	17	41929	4.05	29.6	0.6		6% ↓
F	5	12939	3.86	8.2	0.6		23% ↓

Following CDC Example for Graphic Executive Summary:



Compares to national baseline

Compares to previous year in Oregon

* Statistically significant.

THIS REPORT IS BASED ON 2013 DATA, PUBLISHED DECEMBER 2014



Other Potential Forums for Data

- Facility Report Cards
 - 1 or 2 page summary of all infections
 - Could integrate flu vax and annual report data
- HAI Map
 - Update maps with 2014 data
 - Standardize graphics/formatting with report
- Others?

Questions? Thoughts? Go for it!



Healthcare Personnel Influenza Vaccination: A Closer Look at NHSN vs. Oregon-Specific Data Elements

Context:

In 2014 OHA required hospitals, ASCs, and LTCFs to report healthcare worker influenza vaccination data. To fulfill OHA requirements, facilities submitted NHSN-required elements AND Oregon-specific elements. Requiring Oregon-specific questions requires submission of data to two reporting forums (NHSN and Survey Monkey), which burdens facilities. Nowhere in OARs or Oregon Statute are the Oregon-specific questions required; they were added at the request of OHA immunization and HAI programs in 2010. In February, 2015, OHA officials decided to remove Oregon-specific questions from the reporting requirements for all facilities reporting influenza vaccination data. All reporting facilities – hospitals, long-term care facilities, ambulatory surgical centers, and dialysis facilities – will report NHSN required elements only beginning with the 2014-15 influenza season.

Questions for the Committee:

- How might we use the Oregon-specific data (on promotion/delivery strategies) already collected?
- Concerns about removal of questions? Should we ask promotion/delivery questions as part of other questionnaires since no longer part of the Mandatory HAI Reporting program?

NHSN Data Elements:

- # employees, licensed independent practitioners, students/trainees/volunteers, and other contract personnel
- # vaccinated, stratified by HCW type (categories above)
- # w/contraindication, stratified by HCW type
- # declined vaccine, stratified by HCW type
- # with unknown vaccination status, stratified by HCW type

Oregon-Specific Elements:

- Which of the following methods did you use during the influenza season to deliver vaccine to your HCWs?
 - No cost vaccines
 - Mobile carts
 - Centralized Mass Vaccination Campaigns
 - Peer Vaccinators
 - Provided Vaccine in Congregate Areas
 - Other (specify)
- Which of the following strategies did you use to promote/enhance HCW influenza vax at your facility?
 - No formal promotional activities were conducted
 - Incentives
 - Reminders by mail, email, or pager
 - Coordination of vaccination w/other annual programs
 - Required receipt of vaccination for credentialing
 - Campaign including posters, flyers, buttons, and fact sheets
 - Required vaccination or wearing of mask during influenza season
 - Required declination form
- For declinations other than for medical contraindications input the following counts for all HCW:
 - I believe I will get the flu if I get the shot
 - I don't like needles
 - I never get the flu
 - My philosophical or religious beliefs prohibit vaccination
 - I am concerned about side effects
 - Other (free text)

Table 1. Vaccination Rates (stratified by Facility Type) by promotional strategy for the 2013-2014 Influenza Season

Delivery Method/Strategy	Hospitals Only (n=61) Overall Vax Rate: 76%				ASCs Only (n=88) Overall Vax Rate: 68%				LTCFs Only (n=139) Overall Vax Rate: 59%			
	% Yes (using strategy)	Vax Rate Yes	Vax Rate No	p-value	% Yes (using strategy)	Vax Rate Yes	Vax Rate No	p-value	% Yes (using strategy)	Vax Rate Yes	Vax Rate No	p-value
No Cost Vaccine	90%	76%	79%	0.56	85%	71%	50%	0.0026	90%	60%	50%	0.09
Mobile Carts	84%	77%	73%	0.47	15%	79%	66%	0.0004	17%	64%	58%	0.21
Centralized Mass Vax Fairs	87%	77%	75%	0.78	12%	83%	66%	<0.0001	40%	61%	58%	0.48
Peer Vaccinators	80%	78%	72%	0.09	50%	73%	63%	0.054	57%	55%	65%	0.01*
Provided Congregate Areas	87%	77%	75%	0.61	30%	72%	66%	0.29	55%	59%	59%	0.92
Provided in Occ Health Clinic	67%	77%	76%	0.82	5%	69%	50%	0.5	6%	59%	59%	0.96
Incentives	49%	75%	78%	0.32	8%	63%	68%	0.57	21%	67%	57%	0.023
Reminders	98%	62%	77%	0.18	53%	69%	67%	0.73	42%	61%	58%	0.56
Coordination w/Annual Programs	41%	79%	75%	0.24	8%	81%	67%	0.0006	19%	68%	57%	0.018
Receipt of Vax for Credentialing	8%	74%	77%	0.62	2%	61%	68%	0.69	4%	57%	59%	0.77
Campaign	90%	76%	77%	0.97	36%	71%	66%	0.42	60%	62%	56%	0.14
Vax or Wear Mask	31%	85%	72%	<0.0001	7%	87%	66%	0.04	11%	69%	58%	0.06
Required Declination Form	93%	77%	62%	0.0082	64%	69%	65%	0.47	57%	64%	53%	0.004
No Formal Promotion	3%	84%	76%	0.34	28%	61%	70%	0.1	14%	50%	61%	0.03

*Significant but in wrong direction (relative to expected outcome)

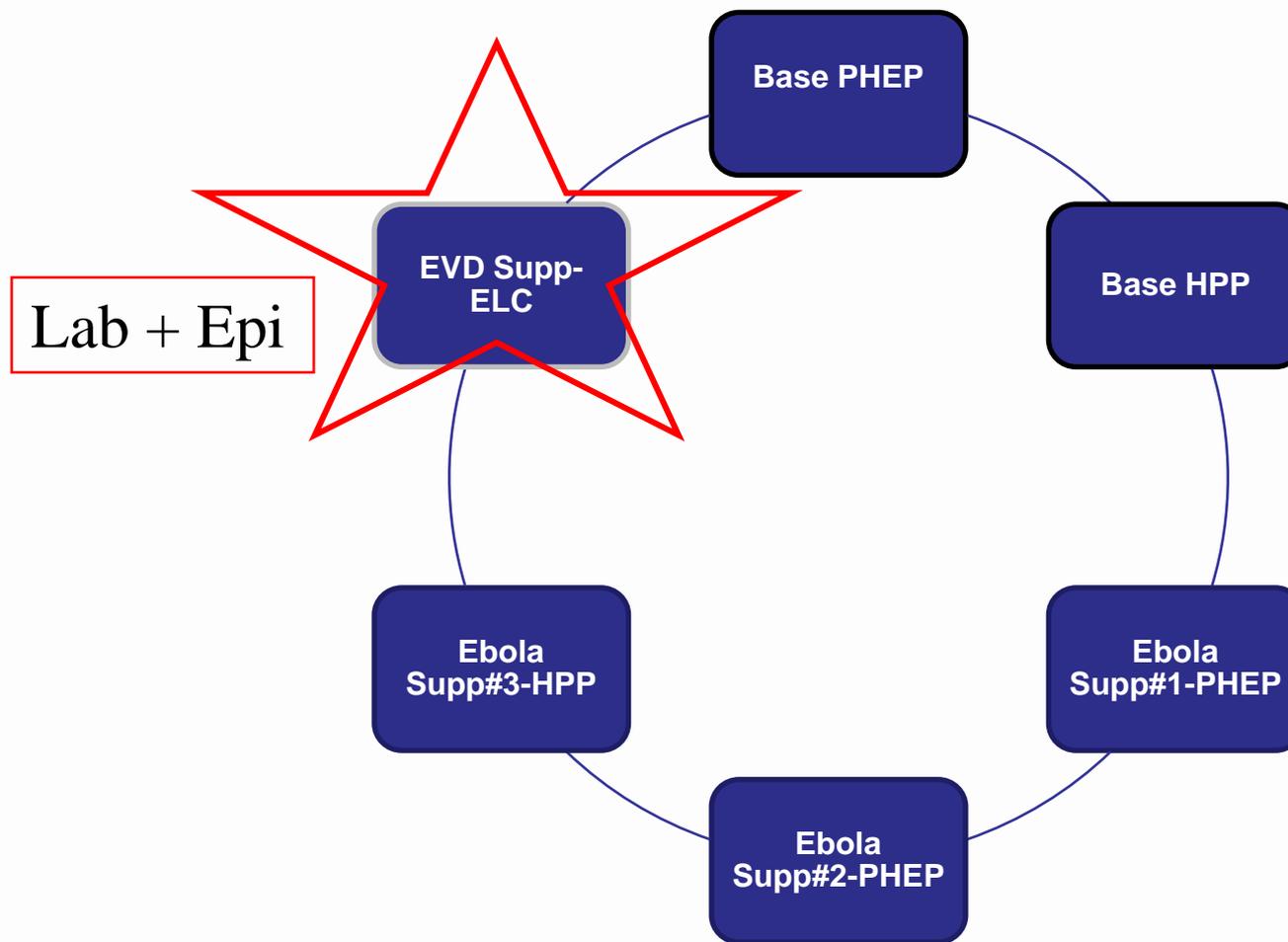
Take home from preliminary association study:

- Impact of delivery and promotion methods appears to vary across settings
- For hospitals, asking HCWs who have declined vaccine to wear a mask is associated with higher rates of vaccination (only about 1/3 of hospitals do this)
- For ASCs, access to vaccine through no cost, mobile carts, and vax fairs is associated with higher rates, as is coordination w/annual programs & mask req
- For LTCFs, coordination with other annual programs and requiring a declination form are methods associated w/higher rates (mask req=borderline sig)



ELC GRANT

“Ebola” Grants Overview



Ebola ELC Competitive Grant

Epidemiology and Laboratory Capacity

- Separate from direct HPP and PHEP supplemental Ebola funding
- ELC Epi Grant has two-part focus on building statewide capacity and education
 1. Consultative, non-regulatory assessments of Oregon Ebola Tier 2 Assessment Hospitals (Year 1)
 2. Develop statewide infection control capacity to prevent HAIs (Years 2 & 3)
 3. Expand biosafety capacity at Public Health Laboratory
- Key partnership links:
 - Healthcare Facilities
 - Oregon State Public Health Laboratory
 - HAI Advisory Committee, Infection Control & Assessment Program (ICAP)
 - Patient Safety Commission
 - APIC
 - CDC
 - EMS—parallel assessments for out-of-hospital transport

HAI Advisory Committee: ICAP program

- Infection Control Assessment and Promotion program
 - Sub-committee of HAI AC
 - Expand surveillance-only to “epi for action” to guide prevention activities
 - New plan
 - New partners
 - Health Security, Preparedness and Response (HSPR)
 - HPP Liaisons
 - Office of Licensing and Regulatory Oversight (OLRO)
 - Emergency Medical Services

Ebola Assessment Hospitals Verification

If ELC Epi Grant is funded....

- Tentative project start date is April 2015
- Finalize CDC Draft Ebola Hospital Assessment Tool with stakeholder input
- Share tool with hospitals
- ACDP Epi Team will coordinate:
 - Identifying team to conduct assessment of Oregon Ebola Tier 2 Assessment Hospitals
- Conduct verification visits
- Prepare and share gap analysis
- Follow up at 6 months and 1 year
- De-identified, aggregate summary report to share strengths and learning

Ebola Assessment Hospital Capabilities

Source: CDC, Hospital Preparedness: A Tiered Approach (February 20, 2015)
<http://www.cdc.gov/vhf/ebola/healthcare-us/preparing/assessment-hospitals.html>

- Facility Infrastructure: Patient rooms
- Patient Transport
- Laboratory
- Staffing
- Training
- PPE
- Waste Management
- Worker Safety
- Environmental Services
- Clinical Management
- Operations Coordination

Increasing Capacity and Education

- Healthcare-Associated Infection Outbreaks
 - Inventory healthcare system facilities
 - Inventory outbreak tools and resources
 - Build more HAI outbreak tools, expand website
 - Align statutes and regulations
- State-wide Infection Control and Emerging Infections Capacity
 - Over 3 year project
 - Develop tools for assessment
 - Visit regions and assess capacity for infection control and communication between facilities

CDI INITIATIVE



Oregon HAI Program Surveys, 2015

- Hospitals, Skilled Nursing Facilities, Laboratories
 - Infection Control support, staff time, and activities
 - Practices for MDRO screening, precautions
 - Carbapenem-resistant *Enterobacteriaceae*
 - *C. difficile*
 - Surveillance, testing, response, housekeeping
 - Inter- and intra-facility communication of MDROs & precautions
 - Interfacility communication rule, “flags”
 - Policies and monitoring of practice adherence
 - Education for staff, patients, and infection control staff
 - Antibiotic stewardship
 - Adequacy of response & facility support; facility priorities
 - Laboratory technology, standards, and capacity

***3. How many full-time equivalent (FTE) employees are currently dedicated to your facility's infection control program?**

***8. How does your facility typically identify MDROs on or prior to patient admission?**

***13. How does your facility communicate with other facilities about patients with colonization or infection with MDROs and *C. difficile* at the time of transfer?**

***28. If Contact Precautions (gown and gloves) are started for a patient with *C. difficile* infection (CDI), how long are they continued?**

***29. Select the response that best describes how often the following actions are taken for patients with *C. difficile* infection (CDI):**

***38. How does your facility monitor correct environmental cleaning?**

***41. Does your facility have a specific person (or people) responsible for reviewing antibiotic utilization?**

Select all that apply.

- Not applicable, review of antibiotic utilization is not performed.
- Pharmacist
- Infectious Diseases MD
- Non-Infectious Diseases MD
- Director of Nursing
- Other (please specify)

CDI Epidemiology & Response

