

Draft

Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

June 28, 2017
1:00 - 3:00 pm

PSOB – Room 1B
800 NE Oregon St.
Portland, OR 97232

Agenda, materials, minutes, recordings, and transcriptions for meetings are available at:
<http://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/HAI/Prevention/Pages/Meetings.aspx>.

**NOMINATED
MEMBERS
PRESENT:**

- Genevieve Buser, MD, Pediatric Infectious Disease Physician, Providence St. Vincent Medical Center
- Deborah Cateora, BSN, RN, Healthcare EDU/Training Coordinator and RN Consultant, Safety, Oversight and Quality Unit (SOQ Unit), Oregon Department of Human Services (phone)
- Paul Cieslak, MD, Medical Director, Acute and Communicable Disease Prevention, Oregon Health Authority
- Kelli Coelho, RN, CASC, MBA, Executive Director, RiverBend Ambulatory Surgery Center (phone)
- Vicki Nordby, RN, BSN, Nurse Consultant, Marquis Companies, Inc. (phone)
- Rebecca Pawlak, MPH, Director of Public Policy, Oregon Association of Hospital and Health Systems
- Pat Preston, MS, Executive Director, Center for Geriatric Infection Control (phone)
- Kirsten M. Schutte, MD, Infectious Disease and Medical Director of Infection Prevention and Control, Asante (phone)

NOMINATED
MEMBERS
EXCUSED:

- Tom Stuebner, MSPH, Executive Director, Oregon Patient Safety Commission
- Wendy L. Edwards, RN, BSN, Patient Safety Surveyor, Health Facility Licensing and Certification, Oregon Health Authority
- Jon Furuno, PhD, Associate Professor, Department of Pharmacy Practice, Oregon State University/College of Pharmacy, Oregon Health and Science University
- Mary Shanks, RN, MSN, CIC, Infection Preventionist, Kaiser Westside Medical Center
- Dee Dee Vallier, Consumer Advocate

OTHER
PARTICIPANTS
PRESENT:

- Larlene Dunsmuir, DNP, FNP, ANP-C, Assistant Executive Director of Professional Services, Oregon Nurses Association
- Jennifer Graham, MPH, Medical Countermeasures Coordinator/CHEMPACK State Coordinator, Health Security, Preparedness, and Response (HSPR), Oregon Health Authority (phone)
- Judy Guzman-Cottrill, DO, Pediatric Infectious Disease Physician, Oregon Health and Science University/Oregon Health Authority
- Gretchen Koch, MSN, RN, Policy Analyst, Nursing Practice and Evaluation, Oregon State Board of Nursing (phone)
- Laurie Murray-Snyder, Hospital Improvement Innovation Network Project Lead, HealthInsight Oregon
- Paola Montes, MPH, MT, CHES, CIC, Infection Preventionist, Samaritan Pacific Communities Hospital (phone)
- Mary Post, RN, MS, CNS, CIC, Director, Infection Prevention, Oregon Patient Safety Commission/Oregon Health Authority

- Gina Ramoz, Operations and Policy Analyst and Biosafety Officer, Oregon State Public Health Laboratory (OSPHL)

OHA STAFF
PRESENT:

- Zintars Beldavs, MS, ACDP Section Manager
- Monika Samper, RN, HAI Reporting Coordinator
- Roza Tammer, MPH, CIC, HAI Reporting Epidemiologist
- Dat Tran, MD, Public Health Physician
- Alexia Zhang, MPH, HAI Epidemiologist

ISSUES HEARD:

- Call to order and roll call
- Introductions and membership updates
- Approve March 2017 minutes
- Outbreaks update 2017
- Infection Control Assessment and Response (ICAR) update
- Annual CDC report
- Annual Healthcare-associated Infections (HAI) Program report
- NICU collaborative update
- Multi-Drug Resistant Organism (MDRO) Toolkit
- SHEA/CDC Outbreak Response Training Program (ORTP)
- Discussion: themes and topics for future 2017 meetings
- 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	Action Item
Call to Order and Roll Call Genevieve Buser, Chair	Quorum met. Sixty-nine percent of members present.	No action items
Introductions and Membership Updates Roza Tammer	<ul style="list-style-type: none"> • HAI Advisory Committee is seeking to fill four vacancies: <ul style="list-style-type: none"> ○ Hospital administrator with expertise in infection control at a facility with fewer than 100 beds ○ Healthcare purchasing representative ○ Department of Human Services representative ○ Health insurer representative • Committee is also searching for additional consumer and patient advocates/representatives. • Contact OHA if you are interested in an opening, can promote positions amongst contacts, or have suggestions for potential candidates. 	Committee will continue to work on filling open positions.
Approve March 2017 Minutes All Committee Members (Pages 2-8 of meeting materials)	March 15, 2017 meeting minutes were approved.	No action items
Outbreaks Update 2017 Alexia Zhang (Pages 9-14 of meeting materials)	<ul style="list-style-type: none"> • 112 outbreaks were reported between 3/1/2017-6/21/2017: <ul style="list-style-type: none"> ○ 46 norovirus, 1 <i>Salmonella</i> and norovirus, 4 <i>Salmonella</i>, 2 E. coli O157, 2 rotavirus, and 27 gastroenteritis with etiology unknown. ○ 6 influenza, 4 pertussis, 2 RSV, 1 mumps, and 7 unknown respiratory illness with etiology unknown. 	No action items

Item	Discussion	Action Item
	<ul style="list-style-type: none"> • Of the 112 outbreaks, 57 (41%) occurred in a healthcare facility. <ul style="list-style-type: none"> ○ Most common healthcare facility was assisted living facilities, followed by skilled nursing facilities. ○ Most common etiology in healthcare facilities was norovirus. • 2 outbreaks are of interest: <ul style="list-style-type: none"> ○ Hepatitis A in food handlers: <ul style="list-style-type: none"> ▪ 2 confirmed Hepatitis A cases in food handlers at same restaurant. ▪ 2 additional symptomatic food handlers but did not meet case definition. ▪ Multnomah county organized immunization efforts. ▪ No additional reported cases. ○ <i>Salmonella</i> and live poultry: <ul style="list-style-type: none"> ▪ CDC working with multiple states to investigate multiple clusters of <i>Salmonella</i>. ▪ Cases reporting exposure to live poultry. ▪ Currently 10 different <i>Salmonella</i> serotypes and 18 different pulse field gel electrophoresis (PFGE) patterns. ▪ Currently 8 Oregon cases. <p><u>Comment</u> Availability of a report containing outbreak data categorized by healthcare setting would facilitate identification of best methods</p>	

Item	Discussion	Action Item
	<p>for controlling infections and enable OHA to offer recognition to successful facilities. Data might include:</p> <ul style="list-style-type: none"> • Relative number of outbreak cases • Elapsed time before outbreak identified • Duration of outbreak 	
<p>ICAR Update Mary Post (Pages 15-39 of meeting materials)</p>	<p><u>ICAR Onsite Consultations</u> Common findings from 35 (out of 95) completed consultations:</p> <ul style="list-style-type: none"> • Hand hygiene: <ul style="list-style-type: none"> ○ Long-term Care Facilities (LTCF's) have increased use of hand sanitizers. ○ Dialysis audits show 90% hand hygiene compliance. ○ Staff often forget to wash hands after glove removal. • Personal protective equipment (PPE) should include more use of gowns as part of standard precautions. • Respiratory/cough etiquette signage, educational materials, and supplies need to be available year round. • Antibiotic Stewardship Programs (ASP): <ul style="list-style-type: none"> ○ Most hospitals have begun to implement ASP. ○ Dialysis, ASCs, and clinics have started initiatives, but have not yet implemented facility-wide ASP strategies. ○ LTCF's have begun to institute ASP policies and some are involving consultant pharmacists. • Injection safety and point-of-care devices: <ul style="list-style-type: none"> ○ Issues: <ul style="list-style-type: none"> ▪ Multi-dose vials are used in common patient care areas. 	<p>No action items</p>

Item	Discussion	Action Item
	<ul style="list-style-type: none"> ▪ Vial rubber septums and IV hubs are not always disinfected/scrubbed prior to access. ▪ Approved disinfectants are not used or not applied for recommended contact time. ▪ Glucometers, not approved for multi-patient use, are shared among patients. ○ Successes: use of lancets, insulin pens, and multi-dose vials are restricted to one patient. • Inter-facility transfer communication: need to improve intake and transfer information for patients/residents with MDROs and special precautions. • Operating Room: <ul style="list-style-type: none"> ○ CHG skin antiseptic instructions are not consistently followed. ○ Best practice observed – at start of suite turnover, wipe/cloth is placed on top of equipment to designate it needs cleaning. • Device Reprocessing: <ul style="list-style-type: none"> ○ High-level disinfectant solution QC checks are not always documented. ○ Sterile processing is not always employing correct-sized brush nor properly disinfecting or disposing of brushes after use. • Other findings <ul style="list-style-type: none"> ○ Many hats are worn by individual(s) overseeing infection control program. ○ Environmental services need additional training. 	

Item	Discussion	Action Item
	<p><u>Training, Workgroups, and Collaborative Efforts</u></p> <ul style="list-style-type: none"> • Five statewide environmental services training courses are offered in late June and July 2017. • 23 infection prevention videos, scheduled to be completed by end of July, are being produced by OPSC and OHA; videos will posted on OPSC YouTube Channel: http://bit.ly/2sctBxC. • Four webinars on <i>Clostridium difficile</i> were presented between May and June 2017 in partnership with HealthInsight and OAHHS. • Three webinars on NHSN Tap Reports were led by the OHA HAI program and presented in partnership with HealthInsight, OAHHS, and OPSC. • MDRO Toolkit is being developed for use in all facility settings. • Dialysis Activities: <ul style="list-style-type: none"> ○ Participated in End Stage Renal Disease National Coordinating Center Learning Action Network (LAN) Workgroup. ○ Faculty member of Dialysis Training Workshop offered at National APIC conference. • Multi-regional Oregon Infection Prevention Partnership Collaborative launched in April 2017. <ul style="list-style-type: none"> ○ Seven LTCF's and three hospitals are currently participating. ○ Objectives include: 	

Item	Discussion	Action Item
	<ul style="list-style-type: none"> ▪ Implementing infection prevention and antimicrobial stewardship program strategies across the continuum of healthcare. ▪ Creating partnerships between hospitals and LTCF's. ▪ Standardizing best practices for preventing urinary tract infections (UTI), <i>clostridium difficile</i> infections (CDI), multidrug resistant organism (MDRO) infections, and hospital readmissions. <p><u>Comment</u> Development of videos to educate patients and families about topics such as hand hygiene, wound care, toileting, and glucose monitoring would be valuable; some topics would also be applicable to school, camp, and health fair settings.</p>	
Annual CDC Report Roza Tammer (Pages 40-42 of meeting materials)	CDC will publish 2015 data aggregated by facility type on Hospital Compare website. <ul style="list-style-type: none"> • SIRs will be calculated using 2015 baseline rather than original baseline. • 2015 SIRs will not be compared to SIRs from previous year to show trends due to re-baselining. 	No action items
Annual HAI Program Report Roza Tammer (Pages 43-56 of meeting materials)	Current status of activities related to 2016 HAI annual report: <ul style="list-style-type: none"> • Completed: <ul style="list-style-type: none"> ○ Previous year's report was reviewed to identify changes needed to 2016 report. 	OHA will solicit feedback from committee on how to improve process employed

Item	Discussion	Action Item
	<ul style="list-style-type: none"> ○ Internal validation - facilities were asked to examine NHSN reports provided by OHA and revise incorrect data in NHSN. ○ Facility comments were solicited for inclusion in report. • In progress: <ul style="list-style-type: none"> ○ Analyses – aggregate SIRs will use original baseline whereas facility-specific SIRs will use both 2015 and original baselines. ○ Quality assurance. ○ Report preparation – summary report will be available in hardcopy and on website; facility-specific data will only be available through website link to tables and maps. • Prior to publication: <ul style="list-style-type: none"> ○ Facilities will be able to view facility-specific data. ○ OHA will provide talking points. • Publication: aiming for late August publication date and to present data at September HAIAC meeting. • Ongoing: OHA is evaluating internal validation process and will be soliciting further input from HAIAC. <p><u>Comment</u> Attendee comment: Critical access hospitals (CAH) and acute care hospitals (ACH) have different characteristics, yet data has traditionally been combined in computation of original NHSN baseline used to derive SIRs.</p>	to validate facility data.

Item	Discussion	Action Item
	<p>OHA response:</p> <ul style="list-style-type: none"> • New NHSN release provides separate SIRs for CAHs and ACHs, computed with new baselines, beginning with 2015 data. • CAH SIRs calculated with new baselines cannot be compared to SIRs derived using original baseline due to incompatibility of data. • OHA will publish facility-specific comparative data for critical access hospitals using new baseline once CDC has fixed risk-adjustment models. 	
<p>NICU Collaborative Update Judy Guzman-Cottrill (Pages 57-69 of meeting materials)</p>	<p>Vermont Oxford Network (VON) and CDC Antibiotic Stewardship Collaborative:</p> <ul style="list-style-type: none"> • VON is a network of NICUs engaged in several quality improvement (QI) projects. • VON and CDC partnered in 2016-2017 to create a NICU-specific antibiotic stewardship QI collaborative. <ul style="list-style-type: none"> ◦ Goal is to decrease antibiotic use by 25%. ◦ Currently 169 NICUs are actively participating, including all 11 Oregon and SW Washington NICUs. • Oregon and SW Washington NICUs have created a statewide group called NW IPAS (NW Improvement Priority: Antibiotic Stewardship). <ul style="list-style-type: none"> ◦ NICUs have demonstrated excellence in stewardship in NW IPAS collaborative. ◦ Oregon hospitals can look to local NICUs as a pilot unit for focused, successful unit-based stewardship programs. 	<p>No action items</p>

Item	Discussion	Action Item
	<ul style="list-style-type: none"> OHA has partnered with NW IPAS to provide: <ul style="list-style-type: none"> Support when analyzing antimicrobial use (AU) in NICUs. Incentive funds to both Asante and Legacy Healthcare systems, who had prioritized AU reporting to NHSN, to begin AU reporting by spring 2017. Currently 13 acute care facilities actively report AU to NHSN (263 total facilities in the US). 	
MDRO Toolkit Judy Guzman-Cottrill (Pages 70-77 of meeting materials)	<ul style="list-style-type: none"> First-ever state-wide hospital epidemiologist/medical director meeting was held 4/24/2017 to discuss MDRO toolkit. Attendees concluded: <ul style="list-style-type: none"> DROP-CRE team will focus on MRSA first. MRSA isolation/de-isolation/screening protocols are very heterogeneous. Team will review recent MRSA literature and make recommendations. Next state-wide meeting scheduled for 7/24/2017. Over following months, recommendations for each topic in toolkit will be completed, formatted into a new public document, and disseminated to healthcare facilities. <ul style="list-style-type: none"> Toolkit will cover topics such as MRSA, ESBL CRE, CDI, and resistant Pseudomonas. Recommendations will encompass continuum of care, including acute care hospitals, long-term care facilities (LTCFs), and skilled nursing facilities (SNFs). <p><u>Comment</u></p>	No action items

Item	Discussion	Action Item
	MCR-2 and candida should be added to list of topics covered in toolkit (see slide labeled “Planned Toolkit Sections” on page 73 of meeting materials); Dr. Guzman agreed.	
SHEA/CDC Outbreak Response Training Program (ORTP) Judy Guzman-Cottrill (Pages 78-84 of meeting materials)	Society for Healthcare Epidemiology of America (SHEA) received a contract from CDC to create a training program for Hospital Epidemiologists. <ul style="list-style-type: none"> • Training is specifically for managing outbreaks. • Instruction includes new Expert Guidance Document, webinars, in-person workshops, and on-line simulations. • More information is available at http://ortp.shea-online.org. 	No action items
Discussion: Themes and Topics for Future 2017 Meetings All members	Meeting attendees proposed these themes and topics for future 2017 meetings: <ul style="list-style-type: none"> • Legislative update on HAI annual report mandate • NHSN data issues specific to critical access hospitals • Effective use of NHSN data; reliance on reported numbers can lead facilities to overlook key issues/root causes. 	OHA will follow-up on proposed topics/themes.
Public Comment	No public comment	No action items
Adjourn		

Next meeting will be December 13, 2017, 1:00 pm - 3:00 pm, at Portland State Office building, Room 1B

Submitted by: Diane Roy
Reviewed by: Roza Tammer
Rebecca Pierce

EXHIBIT SUMMARY

- A – Agenda
- B – March 15, 2017 meeting minutes
- C – Outbreaks
- D – Ebola Grant (ICAR) Updates
- E – Data Explanation for 2015 HAI Data Report
- F – NHSN v8.7 (June 17, 2017) Release Notes
- G – Annual HAI Program Report
- H – HAIAC Updates

HAIAC

Alexia Zhang, MPH

Healthcare-Associated Infections Epidemiologist
Acute and Communicable Disease Prevention Program

Wednesday, Sept 27th, 2017

The logo for the Oregon Health Authority. It features the word "Oregon" in a small, white, serif font, positioned above the word "Health". The word "Health" is in a large, white, serif font. Below "Health" is the word "Authority" in a smaller, white, serif font. A thin white horizontal line is positioned between "Health" and "Authority". The entire logo is set against a dark blue background with a lighter blue curved shape behind it.

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Outbreaks since 6/15/2017

Etiology	Count	Setting
Norovirus	11	LTCF (4) , DCC (2), Camp (2), School (1), Restaurant (1), Other (1)
Gastroenteritis		
Campylobacter	1	Other (1)
<i>Clostridium difficile</i>	1	LTCF (1)
<i>Salmonella</i>	4	Other (2), Restaurant (2)
Sapovirus	1	LTCF (1)
Rotavirus	2	LTCF (1)
Shigella	1	Other (1)
unknown	15	LTCF (8) , Camp (2), DCC (2), School (1), Restaurant (1), Hospital (1)
Respiratory		
Influenza B	6	LTCF (1)
Pertussis	3	School (2), other (1)
Strep Pyogenes	1	DCC (1)
Unknown	2	LTCF (1), Hospital (1)
Rash	2	LTCF (1) , DCC (1)
Total	45	

Healthcare associated outbreaks, 6/15/2017-9/18/2017

- Healthcare associated infections account for 44% (n=20) of all outbreaks from June to September
- Most common etiology was norovirus or noro-like outbreaks

Facility type	Norovirus	unknown-GI	Influenza	C. Diff	Rotavirus	Sapovirus	Total
Memory Care	1	0	0	0	0	0	1
Assisted Living Facility	4	7	0	1	0	0	12
Skilled Nursing Facility	0	1	0	0	0	1	2
Mixed (e.g., both ALF and SNF)	0	1	1	0	1	0	3
Total	5	9	1	1	1	1	18

Outbreak of Interest

- *Salmonella* Paratyphi B
 - 19 cases in OR and WA
 - Multiple cases mention sushi in their exposure period
 - Environmental Health visited restaurants
 - Fish samples collected and sent for testing
 - Serotype associated with tuna outbreak in 2015 (tuna scrape)

Norovirus nomenclature

- CDC updated nomenclature for norovirus genotypes on 7/17/2017
- All prior GII.4 Untypeable outbreaks are now typed as GII.4 Sydney

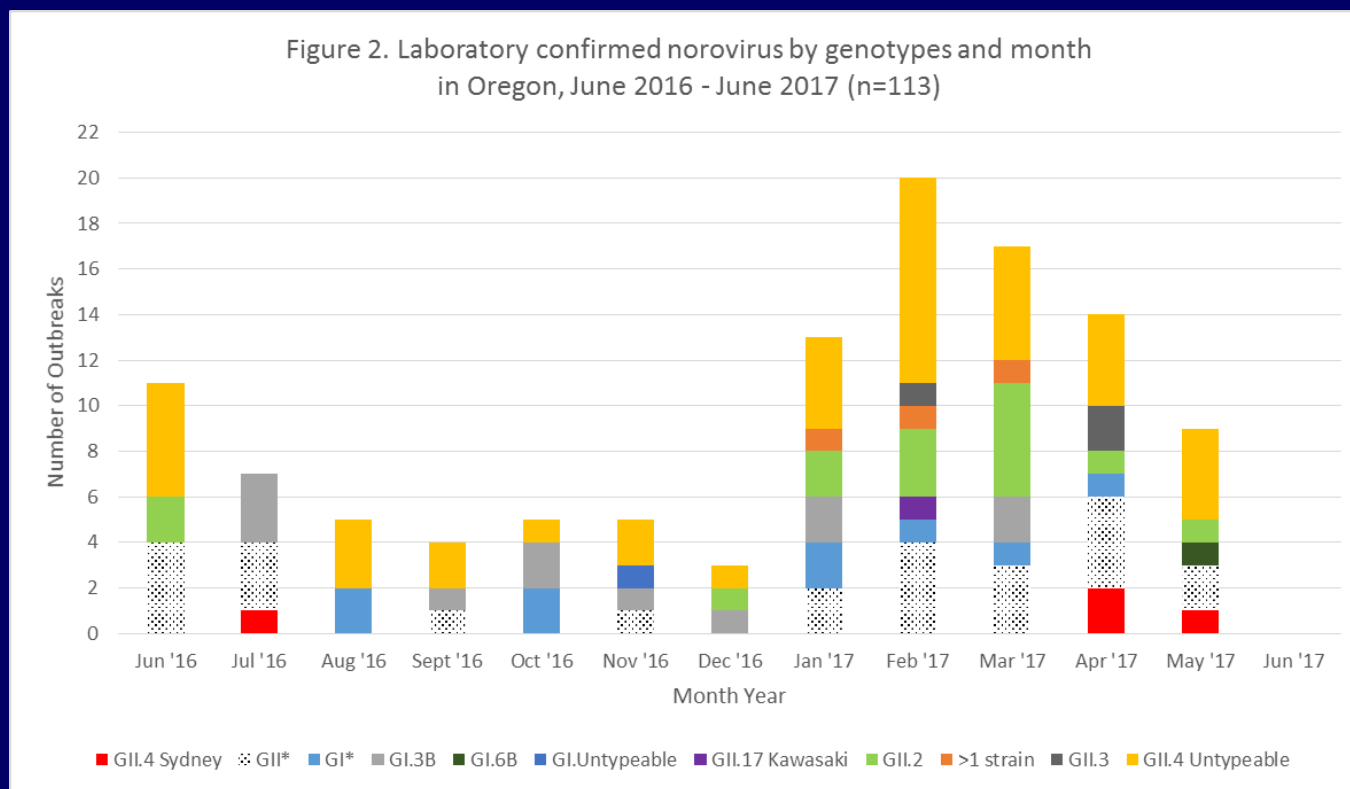
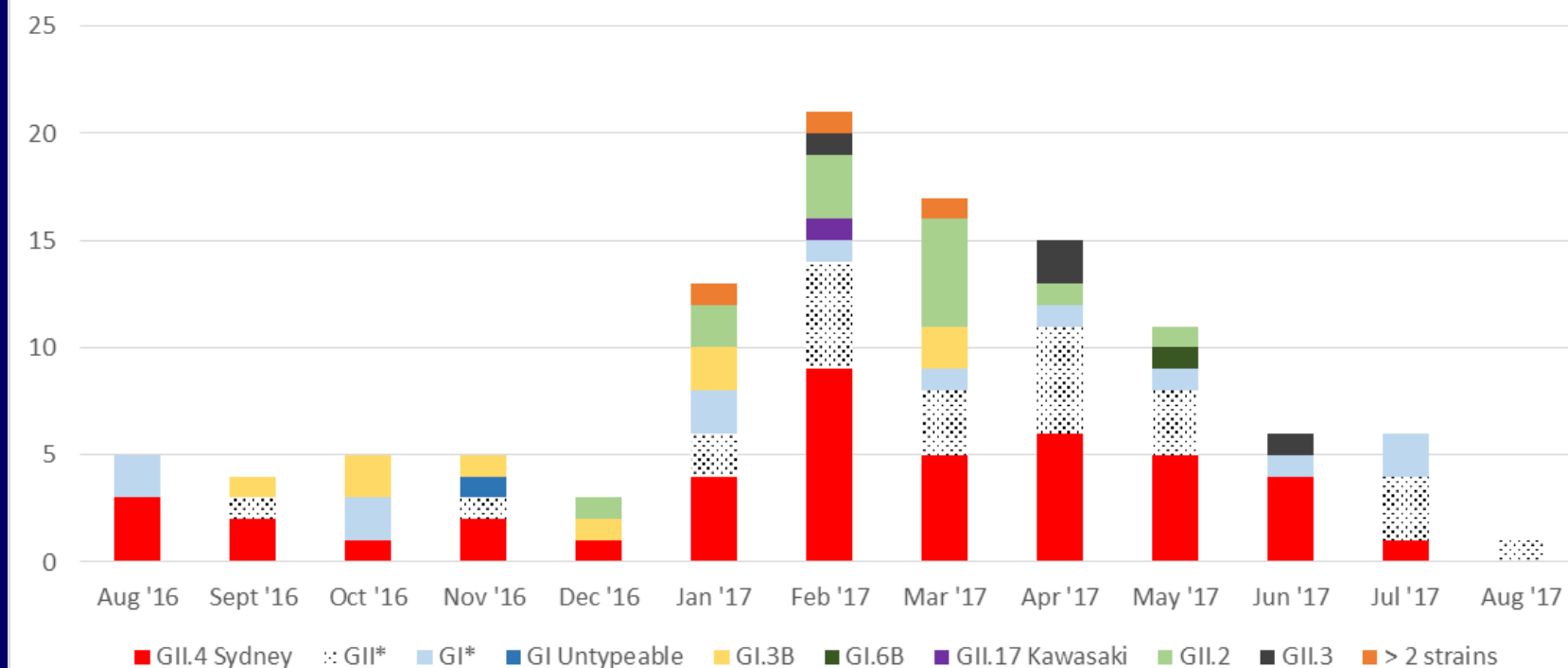


Figure 2. Laboratory confirmed norovirus by genotypes and month in Oregon, August 2016 - August 2017 (n=112)



Thank You

<http://public.health.oregon.gov>

alexia.y.zhang@state.or.us

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One and Only Campaign

OHA ▾ Programs and Services ▾ Oregon Health Plan ▾ Health System Reform ▾ Licenses and Certificates ▾ Public Health ▾

Safe Injections: One and Only Campaign

Healthcare-Associated Infections

Learn about HAIs

For the Public

For Health Professionals

For Health Care Facilities

Long Term Care Facility HAI Toolkit

HAI Reporting

HAI Prevention

DROP-CRE Network

HAI Advisory Committee

Preventing Clostridium difficile infection

Interfacility Transfer Communication

Oregon Patient Safety Commission Collaborative

Safe Injections: One and Only Campaign

Lunch and Learn

HAI Surveillance

Oregon Health Authority has joined the "One & Only" Campaign

The "One & Only" campaign is a public health campaign, led by the Centers for Disease Control and Prevention (CDC) and the Safe Injection Practices Coalition (SIPC), to raise awareness among patients and healthcare providers about safe injection practices. The campaign aims to eradicate outbreaks resulting from unsafe injection practices.

Most healthcare providers practice safe injections, but unsafe practices do occur and can cause serious harm. Since 2001, more than 150,000 patients in the U.S. have been notified of potential exposure to viral hepatitis and HIV due to lapses in injection safety. Unsafe injection practices put patients and healthcare providers at risk of adverse events and have been associated with a wide variety of procedures and settings.

Do your part to make healthcare safe. Raising awareness among healthcare providers and patients is critical to eliminating preventable infections caused by unsafe injections.



For Providers

Campaign resources

- Healthcare provider information
- Healthcare provider toolkit
- What are safe injection practices and why follow them?
- Infographic: Single-dose or multi-dose vials
- Poster: Standards of care for pain clinics (pdf)

CDC information

- Clinical Reminder: Insulin Pens (pdf)
- Injection safety website

For Patients

- Patient brochure on safe injections (pdf)
- What to ask healthcare providers

Partners

[Lunch and Learn](#)[HAI Surveillance](#)[HAI Validation](#)[Publications and Map](#)[Infection Control Resources](#)[Contact Us](#)

Partners in our Prevention Efforts

- [HealthInsight Oregon](#) (formerly Acumentra Health) is committed to improving patient safety, health, and health care through community partnerships and the practical application of science, resulting in quality health solutions
- [Leading Age](#) is a charitable organization that aims to expand the possibilities for aging by education, advocacy, and applied research.
- [Centers for Disease Control and Prevention](#) HAI Program highlights their work with state health departments to improve HAI tracking and prevention by implementing successful prevention strategies in the entire and state and tracking the impact of that strategy across all hospitals.

Long Term Care Facility (LTCF) HAI Toolkit

Healthcare-Associated Infections

Oregon Public Health Division

Diseases and Conditions > Communicable Disease > Healthcare-Associated Infections > Long Term Care Facility HAI Toolkit

Long Term Care Facility HAI Toolkit

Healthcare-Associated Infections

Learn about HAIs

For the Public

For Health Professionals

For Health Care Facilities

Long Term Care Facility HAI Toolkit

HAI Reporting

Mandatory Reporting of HAIs

Guidelines for Investigating HAI Outbreaks

Healthcare Worker Influenza Vaccination Reporting

HAI Prevention

DROP-CRE Network

On this page:

Infection Control Resources

- Antimicrobial stewardship
- Handwashing and environmental cleaning
- Rules
 - Interfacility transfer rule
 - HAI reporting
- General training and resources

Organism Specific Resources

- Multidrug resistant organisms
- Norovirus
- Respiratory conditions
- Urinary tract infections/ Catheter associated urinary tract infections

Infection Control Resources

LTCF HAI Toolkit continued

HAI Advisory Committee

Preventing *Clostridium difficile* infection

Interfacility Transfer Communication

Oregon Patient Safety Commission Collaborative

Safe Injections: One and Only Campaign

Lunch and Learn

HAI Surveillance

HAI Validation

Publications and Map

Infection Control Resources

Contact Us

Antimicrobial Stewardship

- [CDC's Core Elements of Antibiotic Stewardship for Nursing Homes](#)

Guidance: Nursing homes are encouraged to work in a step-wise fashion, implementing one or two activities to start and gradually adding new strategies from each element over time. Any action taken to improve antibiotic use is expected to reduce adverse events, prevent emergence of resistance, and lead to better outcomes for residents in this setting.

- [Antibiotic Stewardship Assessment Checklist \(pdf\)](#)

Process and practice checklist: Examine nursing home processes and staff practices for improving antibiotic use to decrease residents' risk of *C. difficile* infection.

Hand Hygiene and Environmental Cleaning

Hand Hygiene

- [CDC's Hand hygiene in health care settings](#)

Online training: Review key concepts of hand hygiene and standard precautions

- [Assessment of Current CDI Prevention Activities - Hand Hygiene \(pdf\)](#)

Check list: Assess knowledge and competency, infection prevention and infrastructure and monitoring practices related to hand hygiene

- [WHO: Hand hygiene: Why, How and When \(pdf\)](#)

Educational tool: Info-graphic rich guide to the 'Why, How and When' of hand hygiene, including the WHO '5 Moments.'

- [Guidelines for Hand Hygiene in Healthcare Settings \(pdf\)](#)

Guidance: 2002 CDC Morbidity and Mortality Weekly Report on hand hygiene guidelines for health care settings.

- [WHO: "Clean Care is Safer Care"](#)

Toolkit: Support health-care facilities in improving hand hygiene practices among health-care workers

Environmental Cleaning

- [EPA's Registered Antimicrobial Products Effective Against *Clostridium difficile* Spores](#)

Cleaning product list: These products carry an EPA label as being effective at removing *C. difficile* spores

- [CDC's Options for evaluation Environmental Cleaning](#)

Evaluation tool: Website on processes for assessing cleaning practices

- [Oregon Patient Safety Commission's Norovirus: Training for environmental cleaning staff](#)

Online training video: Walk through important information about norovirus, how it spreads, and how to prevent the spread of the virus by swiftly implementing best-practice infection prevention measures

LTCF HAI Toolkit continued

- [CDC's Environmental Cleaning and Disinfecting for MRSA](#)

Information and resources: All you need to know about cleaning and disinfecting for MRSA

Rules

- [Interfacility transfer communication](#)

Information and resources: As part of best practice during patient transfers, information about a patient's medical status, including colonization or infection with a multidrug-resistant organism, should travel with a patient and be readily available to medical providers

- [Healthcare Acquired Infection Reporting](#)

Information and resources: The Oregon Health Authority (OHA) provides oversight and support for mandatory HAI reporting activities in Oregon hospitals.

Oregon hospitals report HAIs using the [National Healthcare Safety Network \(NHSN\)](#) reporting tool. This includes the reporting of CLABSI, certain kinds of SSIs, and several healthcare facility process measures designed to ensure quality and to reduce HAIs.

General Training and Resources

- [Tracking Infections for Long-term Care Facilities](#)

Resources and toolkits: CDC's National Healthcare Safety Network provides long-term care facilities with a customized system to track infections in a streamlined and systematic way

- [Working together to prevent infections brochure \(pdf\)](#)

Family educational tool: This family brochure can be modified to include your nursing home's contact information. Show that you promote Community Immunity™ (CI): it takes everyone to prevent infections and promote good health for all. Community Immunity is a trademark of Kimberly-Clark

- [Early Identification/Containment Assessment Checklist \(pdf\)](#)

Process and practice checklist: Assess nursing home processes and staff practices for identification and diagnosis of CDI and implementation of appropriate precautions to limit spread of *C. difficile*

- [AHRQ Improving Patient Safety in Long-term Care Facilities](#)

Training module: Help nursing home staff detect and communicate changes in resident conditions

- [Nursing Homes and Assisted Living Facilities](#)

Facility resources: CDC resources for LTCFs

CME/CE opportunities

- [Infection Prevention in Long-Term Care Settings \(1 Contact Hour\)](#)

LTCF HAI Toolkit continued

- QIS: Infection Prevention and Control (for Administrators) (1.25 Contact Hours)

Organism Specific Resources

Multidrug Resistant Organisms

MDRO stands for multidrug-resistant organism. An MDRO causes human disease which has acquired antibiotic resistance, as listed and defined by the Centers for Disease Control and Prevention (CDC) in [Antibiotic Resistance Threats in the United States, 2013 \(pdf\)](#).

[View a list of selected MDRO definitions \(pdf\)](#).

Carbapenem-resistant *Enterobacteriaceae* (CRE)

- [Carbapenem-resistant *Enterobacteriaceae* \(CRE\)](#)
Recommendations and information: A brief overview of CRE from OHA.
- [Guidance for Control of Carbapenem-resistant *Enterobacteriaceae* \(CRE\) 2016 Oregon Tool Kit](#)
Toolkit: Page 16-23 of the offers specific recommendations for skilled nursing facilities.

Clostridium difficile

- [Clostridium difficile](#)
Recommendations and information: A brief overview of *Clostridium difficile* from OHA.
- [CDC's *C. difficile*](#)
Information and resources: Broad overview of *C. difficile* from the CDC with information for patients, providers, and healthcare facilities.
- [Advancing Excellence *C. difficile* Infection Prevention Assessment Checklists](#)
Checklist: CDC resource for preventing and containing *C. difficile*.
- [Early Identification/Containment Assessment Checklist \(pdf\)](#)
Checklist: Assess nursing home processes and staff practices for identification and diagnosis of CDI and implementation of appropriate precautions to limit spread of *C. difficile*.

Methicillin Resistant *Staphylococcus aureus* (MRSA)

- [Methicillin Resistant *Staphylococcus aureus* \(MRSA\)](#)
Recommendations and information: A brief overview of MRSA from OHA.
- [CDC's General Information About MRSA in Healthcare Settings](#)
General Information: Risk factors, causes, and prevention
- [CDC's Environmental Cleaning and Disinfecting for MRSA](#)

LTCF HAI Toolkit continued

Information and Resources: All you need to know about cleaning and disinfecting for MRSA

- [APIC's Guide to the Elimination of Methicillin- Resistant *Staphylococcus aureus* \(MRSA\) in the Long-Term Care Facility \(pdf\)](#)

Vancomycin Resistant *Enterococci* (VRE)

- [Vancomycin Resistant *Enterococci* \(VRE\)](#)

Recommendations and information: A brief overview of VRE from OHA.

- [VRE infection control guidelines](#)

Guidelines from New York State Department of Health: Care of patients colonized or infected with VRE in hospitals, long-term care facilities and home health care.

Norovirus

- [CDC's Norovirus in Healthcare Settings](#)

Toolkit: Symptoms, transmission and prevention of Norovirus and a list of resources.

- [Oregon Patient Safety Commission's Norovirus: Training for environmental cleaning staff](#)

Online training video: Walk through important information about norovirus, how it spreads, and how to prevent the spread of the virus by swiftly implementing best-practice infection prevention measures.

- [Norovirus in long-term care facilities](#)

Information: Oregon Public Health Division annotated report of stakeholder meeting and interviews.

Respiratory Conditions

- [Healthcare Provider Influenza Vaccination Tool Kit](#)

Toolkit: Oregon Health Authority toolkit specifically for long term care facilities.

CDC resources

- [Influenza Toolkit for Long-Term Care Employers](#)
- [Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities](#)
- [Summary Guidance for Flu Outbreak Management in LTCF \(pdf\)](#)

Outbreaks in long-term care facilities (LTCF)

- [Facility Control Measure Report for Flu Outbreaks \(pdf\)](#)
Tool: Influenza outbreak control measure report for LTCFs
- [Influenza Outbreak Control in Long Term Care Facilities \(pdf\)](#)

LTCF HAI Toolkit continued

Educational tool: Cheat sheet for flu outbreaks

- [Managing gastroenteritis outbreaks and infection control in long-term care facilities \(LTCFs\)](#)

Toolkit: How to manage a gastroenteritis outbreak in a LTCF

Sample letters / Alerts

- [Letter of notification for residents of independent or LTCF advising prophylaxis \(.doc\)](#)
- [Letter of notification and request for providers to use prophylaxis \(.doc\)](#)
- [Sample provider alert \(.doc\)](#)

Urinary Tract Infections/Catheter Associated Urinary Tract Infections

- [CDC's CAUTI Prevention Guidance and Resources](#)

Toolkit Implementation Guide: [Links to Example Resources](#)

- [AHRQ Toolkit: Determine Whether it is Necessary to Treat a Potential Infection with Antibiotics](#)

Toolkit: [Medical care referral form](#)

- [CDC's Urinary Tract Infection \(UTI\) Event for Long-term Care Facilities](#)

Guidelines and Treatment Algorithms: [How to track, report and manage UTIs in a LTCF.](#)

HAI Reporting

HAI Reporting

seases and Conditions > Communicable Disease > Healthcare-Associated Infections > HAI Reporting > Mandatory Reporting of HAIs

Mandatory Reporting of HAIs

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On this page:

- [Reporting Forms and Information](#)
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Reporting Forms and Information

- [Healthcare worker influenza vaccination](#)
- [HAI Disease Reporting Poster \(pdf\)](#)
- [CRE Disease Reporting Poster \(pdf\)](#)

Reporting Requirements

View Oregon Administrative Rules related to disease reporting: [OAR 333-018](#).

Mandatory healthcare-associated infections reporting to State of Oregon includes:

- Central line-associated bloodstream infections (CLABSIs)
- Catheter-associated urinary tract infections (CAUTIs)
- Laboratory-identified methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections (BSIs)
- Laboratory-identified *Clostridium difficile* infections (CDI)

And surgical site infections (SSIs) resulting from the following procedures:

- Coronary artery bypass graft (CBGB)
- Knee prosthesis (KPRO)
- Colon surgery (COLO)

HAI Reporting continued

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- Hip prosthesis (HPRO)
- Abdominal hysterectomy (HYST)
- Laminectomy (LAM)

For additional information about reporting requirements, see our [HAI Disease Reporting Poster](#).

Exemptions to Reporting Requirements

A hospital may request an exemption to mandatory reporting in some circumstances. Examples of these are:

- Facilities which perform less than 20 specific surgical procedures (i.e. laminectomy) may request an exemption from reporting that surgical site infection (SSI).
- Facilities which have less than 50 central line (CL) days per year may request an exemption from reporting CL-associated blood stream infections (CLABSI).

Exemptions are determined prospectively based on data reported to the HAI program via web-based survey.

About the HAI Reporting Program and the HAIAC

In 2007, the Oregon State Legislature passed House Bill 2524 with the intent of creating a mandatory healthcare-associated infection (HAI) reporting program. This program's activities are directed by [OARS: Hospital Reporting: Health Care Acquired Infection Reporting and Public Disclosure](#) and [Oregon Revised Statute 442.851](#). (Scroll to 442.990) (Temporary provisions relating to healthcare-acquired infections are compiled as Notes following ORS 442.851.)

OHA established the [Oregon Healthcare-Associated Infections Advisory Committee \(HAIAC\)](#), a diverse group of stakeholders, to inform policy for reporting HAIs. On July 1, 2008, based on determinations by the Oregon HAIAC, the OHA published rules for HAI reportability and chose NHSN as the reporting system to be used for inpatient HAI outcome measures.

About the National Healthcare Safety Network

NHSN, which is a secure, internet-based surveillance system, is the primary tool used for collecting hospital HAI data in most U.S. states and territories. The Oregon Public Health Division uses NHSN data to estimate the burden of HAIs in Oregon and provides data to measure the impact of Oregon surveillance and prevention programs. Additionally, to ensure accuracy of occurrences and data reported, [validation of NHSN data](#) is independently audited by state employees.

[Learn more about NHSN.](#)

HAI Surveillance

IA ▾ Programs and Services ▾ Oregon Health Plan ▾ Health System Reform ▾ Licenses and Certificates ▾ Public Health ▾

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Oregon Patient Safety Commission Collaborative

Safe Injections: One and Only Campaign

HAI Surveillance Activities through Oregon EIP

- Candidemia Surveillance
- MuGSI Surveillance
- *Clostridium difficile* Surveillance
- HAI Special Studies



Note: Along with Oregon's state healthcare-associated infection (HAI) activities, there are a number of HAI surveillance and prevention activities that are part of Oregon's Emerging Infections Program (EIP). Our partners in the EIP Program include California, Colorado, Connecticut, Georgia, Maryland, Minnesota, New Mexico, New York, and Tennessee. For more information, visit the [CDC's EIP website](#).

Candidemia Surveillance

What is candidemia?

Candida is a type of yeast commonly found in the gastrointestinal and female genital tracts, but can sometimes cause disease. Most infections can be easily treated. Healthy individuals are at a low risk of invasive disease due to *Candida*.

Immunocompromised patients (e.g., cancer patients) and patients with central venous catheters (CVCs), are at increased risk of invasive *Candida* bloodstream infections, called candidemia. Candidemia is most often acquired in the healthcare setting and can be deadly.

Why do we care?

Candida species are the fourth most common cause of healthcare-associated bloodstream infections in the U.S. Invasive disease caused by *Candida* is deadly. In Oregon nearly one quarter of cases die.

What is Oregon doing about it?

- Estimating the incidence of candidemia by conducting active, population-based surveillance in the Portland tricity-area
- Estimating the prevalence of antifungal drug resistance in *Candida* species
- Exploring candidemia's regional patterns and trends over time
- Providing data on risk factors and clinical outcomes of patients with candidemia in order to target prevention efforts

EIP partners in the candidemia project include Georgia, Maryland, Oregon, and Tennessee. For more information, visit the [CDC's EIP website](#).

Reports

- View the most recent [Candidemia Surveillance Report \(pdf\)](#)

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- [2011-2012 Biennial Report \(pdf\)](#)
- [CD Summary - Candidemia: Central Line and Main Line, January 28, 2014 \(pdf\)](#)

For more information

- [Candida species](#) (Diseases A-Z)

Multidrug-Resistant Gram-Negative Bacilli (MuGSI) Surveillance

What is Multidrug-Resistant Gram-Negative Bacilli?

Gram-negative bacilli (GNB) are bacteria that frequently cause infections in both healthcare and community settings. Infections with multidrug-resistant GNB (MDR GNB) have been identified in people who are hospitalized or immunocompromised; these infections may not be treatable with available antibiotics, or they may be treatable only with antibiotics that can cause kidney and nerve damage. MDR GNB are easily transmitted and are a serious challenge for healthcare facilities.

Why do we care?

The emergence of antimicrobial resistance has raised the importance of these organisms as a public health problem, as new classes of antibiotics are not expected to be available for many years. Oregon has joined four other EIP sites in an active, laboratory-based surveillance project, in order to increase our understanding of this emerging problem, to define the population at risk, and to inform prevention efforts.

What is Oregon doing about it?

- Evaluating the population-based incidence of carbapenem-nonsusceptibility among common strains of *Enterobacteriaceae* and *Acinetobacter baumannii*, and describing how incidence changes over time
- Characterizing carbapenem-nonsusceptible strains in order to improve prevention efforts
- Describing known resistance mechanisms among certain carbapenem-nonsusceptible *Enterobacteriaceae*

EIP partners in the MuGSI project include Colorado, Georgia, Maryland, Minnesota, and Oregon. For more information, visit the [CDC's EIP website](#).

For more information

- [Acinetobacter baumannii](#) (Diseases A-Z)
- [Carbapenem-Resistant Enterobacteriaceae \(CRE\)](#) (Diseases A-Z)

Clostridium difficile Surveillance

What is C. difficile?

Clostridium difficile (*C. diff*) is a bacterium that produces toxins that cause diarrhea and more serious intestinal conditions.

C. diff infections are almost always linked to medical care; people who take antibiotics and also receive medical care are most at risk. States have reported increased rates of *C. diff* infection, noting more severe disease and an increase in mortality. Death rates due to *C. diff* are highest in the elderly, however, almost half of infections occur in people younger than 65 years. These changes may be largely due to the emergence of a stronger *C. diff* strain that appears more virulent and is more resistant to the antibiotics traditionally used to treat *C. diff*.

HAI Surveillance continued

Why do we care?

C. diff infections are a leading cause of patient harm in the U.S. medical system, and are responsible for 337,000 infections and 14,000 deaths every year. Data from this project will help inform future policy and prevention strategies to reduce *C. diff* disease.

What is Oregon doing about it?

- Determining the population-based incidence of community– and healthcare–associated *C. diff* infection
- Characterizing *C. diff* strains that are responsible for infections, with a focus on strains infecting community–associated cases
- Describing the epidemiology of community– and healthcare–associated *C. diff* infection and generating hypotheses for future research

EIP partners in the *C. difficile* project include California, Colorado, Connecticut, Georgia, Maryland, Minnesota, New Mexico, New York, Oregon, and Tennessee. For more information, visit the [CDC's EIP website](#).

Reports

- [View the most recent *C. difficile* Surveillance Report \(pdf\)](#)

For more information

- [Clostridium difficile](#) (Diseases A-Z)

HAI Validation

Healthcare-Associated Infections

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[DROP-CRE Network](#)

[HAI Advisory Committee](#)

CLABSI and SSI Infection Validation Studies

The Oregon Public Health Division performs independent validation of hospital results to ensure Oregon healthcare-associated infection data is accurately and completely reported.

Validation studies allow us to:

- Monitor accuracy of data submitted by hospitals to the National Healthcare Safety Network (NHSN)
- Assess hospital surveillance systems and their use of NHSN definitions
- Ensure that hospitals are reporting infections in a consistent fashion

On this page:

- [CLABSI Validation](#)
- [SSI Validation](#)

Central Line-Associated Bloodstream Infection (CLABSI) Validation

A central line-associated bloodstream infection is a serious infection that occurs when bacteria enter the bloodstream through a central line. A central line is a catheter (tube) that healthcare providers place in a large vein in the neck, chest, or arm to provide fluids, blood, or medications. Commonly found in an intensive care unit (ICU) setting, central lines are different from short-term intravenous catheter's (IVs) because they terminate in major veins close to the heart. They can remain in place for weeks or even months, and are much more likely to cause a serious infection.

CLABSIs result in thousands of deaths each year and billions of dollars in added costs to the U.S. healthcare system, yet these infections are preventable. According to the U.S. Centers for Disease Control and Prevention (CDC), an estimated 250,000 CLABSI cases occur each year in U.S. hospitals, resulting in a range of 30,000 to 62,000 deaths. It is estimated that U.S. hospitals spend up to

HAI Validation continued

[Preventing Clostridium difficile infection](#)

[Interfacility Transfer Communication](#)

[Oregon Patient Safety Commission Collaborative](#)

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2.68 billion dollars annually to manage CLABSI cases.

2014 Validation Study

Currently, Oregon Public Health Division is performing a statewide validation of ICU CLABSI and denominator data during 2012 using a targeted sample of 23 Oregon hospitals. Study results will be reported in late 2014.

- [2012 National Healthcare Safety Network \(NHSN\) Validation Guidance and Toolkit \(pdf\)](#)
- Study protocol of 2012 data: [CLABSI Validation Protocol, 2012 \(pdf\)](#)
- 2012 study data: Buser et al. [Optimizing validation of CLABSIs - Oregon \(pdf\)](#). 2015 CSTE poster presentation

2011 Validation Study

During 2011, the Oregon Public Health Division completed a statewide validation of ICU CLABSI data reported by 44 hospitals during 2009 to determine the accuracy of data submitted by hospitals to NHSN during the first reporting year. Validation focused on assessing hospital surveillance systems and their use of NHSN definitions. Such validation projects ensure that hospital surveillance systems consistently apply NHSN CLABSI definitions.

- Study protocol of 2009 data: [CLABSI Validation Protocol, 2009 \(pdf\)](#)
- 2009 study data: Oh et al. [ICHE 2012;33:439–445: Statewide Validation of Hospital-Reported Central Line-Associated Bloodstream Infections: Oregon, 2009 \(pdf\)](#)

Surgical Site Infection (SSI) Validation

The Oregon Public Health Division is conducting a data validation study of coronary artery bypass graft (CABG) and surgical site infections occurring with patients hospitalized in Oregon due to procedures performed in 2009 and 2010. This procedure and time frame is chosen to establish a baseline for comprehensive validation of Oregon's reportable healthcare-associated infection data for SSIs.

A surgical site infection (SSI) is an infection that occurs after surgery in the part of the body where the surgery took place. Though SSIs can sometimes be superficial infections, involving only the skin, other times SSIs can be deeper and involve tissues beneath the skin in organs, or implanted material. Validation of SSI data is necessary to ensure accurate hospital reporting.

Oregon's SSI data validation efforts will monitor the accuracy of data submitted by 14 hospitals that reported CABG SSI data during 2009 and 2010 to the NHSN, assess hospital surveillance systems, and evaluate the use of NHSN definitions. The validation will occur between September 2011 and June 2012. The findings of this validation project will provide guidance to hospital staff on their use of surveillance definitions, reporting methods, and the NHSN.

- 2009-2010 study data: Ocampo et al. [Validation of SSIs after CABG surgery \(pdf\)](#). 2015 SHEA poster presentation.

HAI Program Staff

Staff

Search:

Name	Role	Department
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Oregon Patient Safety Commission's Infection Prevention Video Resources

Videos Available On YouTube

An infection prevention video series is now available on the Oregon Patient Safety Commission (OPSC) YouTube channel (<http://bit.ly/2wctBxC>). This educational series includes 12 videos, available in both English and Spanish*, covering a wide range of topics. From general environmental cleaning for food and laundry services to specific methods used to address outbreaks caused by flu, norovirus, *Clostridium difficile* and other infections, you'll find the right educational video to support your healthcare organization's infection prevention needs. This series includes:

- Environmental Hygiene: Best Practices to Use When Cleaning and Disinfecting Patient Rooms
- *Clostridium Difficile* Training for Environmental Cleaning Staff
- Environmental Cleaning Basics for Perioperative Areas (2 videos)
- Managing Influenza Outbreaks in Long-Term Care Facilities *
- Environmental Cleaning and Disinfection: Dialysis
- Infection Control for Healthcare Food Service (2 videos)
- Infection Control for Healthcare Laundry Services (2 videos)
- Preventing Infection during Blood Glucose Monitoring and Insulin Administration
- Norovirus Training for Environmental Cleaning Staff



Access the Complete Series
on OPSC's YouTube Channel

<http://bit.ly/2wctBxC>



* No Spanish translation is currently available for *Managing Influenza Outbreaks in Long-Term Care Facilities*.

This video series was made possible in part by a grant from the Center for Disease Control and Prevention (CDC) and in partnership with the Oregon Health Authority.

333-018-0130 Proposed Changes**HAI Public Disclosure**

- ~~(1) The Authority shall disclose to the public facility level and state level HAI outcomes quarterly.~~
- (2) The Authority may disclose state-level and facility-level HAI data, including but not limited to observed frequencies, expected frequencies, proportions, and ratios.
- ~~(3) The Authority shall summarize HAI data by facilities subject to this reporting in an annual report. The Authority shall publish the annual report no later than April 30 of each calendar year.~~
- ~~(4) The Authority shall disclose data and accompanying explanatory documentation to facilities and the general public.~~
- (5) The Authority may use statistically valid methods to make comparisons by facility, and to state, regional, and national statistics.
- (6) The Authority shall provide a maximum of 30 calendar days for facilities to review facility-reported data prior to public release of data.
- ~~(7) The Authority shall provide facilities the opportunity to submit written comments and may include any submitted information in the annual report.~~
- (8) Pending recommendations from the committee, the Authority may publish additional reports intended to serve the public's interest.

Statement of need for the revisions:

The proposed revisions and repeals would remove the requirement for public reporting of quarterly and annual HAI data for the state of Oregon. We provide the following justifications:

- 1) Changes align rules with current statutory requirements.
- 2) The annual report is an extensive effort than is largely duplicative of Centers for Medicare & Medicaid Services (CMS) Hospital Compare.
- 3) The HAI program will continue to obtain reportable HAI data from sites and will utilize data to inform public health action to reduce healthcare-associated infections in the state of Oregon.
- 4) This change does not alter the HAI Program's role in collecting HAI data for the state of Oregon and does not preclude us from continuing to communicate findings in a non-redundant manner.

Documents Relied Upon, and where they are available:

Oregon Revised Statutes (http://sos.oregon.gov/archives/Pages/oregon_administrative_rules.aspx)

Oregon Administrative Rules (https://www.oregonlaws.org/oregon_revised_statutes)

Hospital Compare-Centers for Medicare & Medicaid Services
(<https://www.medicare.gov/hospitalcompare/search.html>)

Fiscal and Economic Impact:

Oregon Public Health Division estimates fiscal and economic impact to be negligible. FTE costs related to report development and publication would be avoided.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)): Reduction in staffing cost to develop, edit, and publish the report.
2. Cost of compliance effect on small business (ORS 183.336): ORS 183.310(10) defines small business as "a corporation, partnership, sole proprietorship or other legal entity formed for the purpose of making a profit, which is independently owned and operated from all other businesses and which has 50 or fewer employees."
 - a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule: none

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services: none

c. Equipment, supplies, labor and increased administration required for compliance: none