DRAFT

Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

December 11, 2018
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.

MEMBERS PRESENT:

- Genevieve Buser, MD, Pediatric Infectious Disease Physician, Providence St. Vincent Medical Center
- Kelli Coelho, RN, CASC, MBA, Executive Director, RiverBend Ambulatory Surgery Center (phone)
- Pamela Cortez, MBA, BSN, RN, CNE, BC, Director of Patient Safety and Clinical Support, Salem Health
- Lisa Freeman, Executive Director, Connecticut Center for Patient Safety (phone)
- Jon Furuno, PhD, Associate Professor, Department of Pharmacy Practice, Oregon State University/College of Pharmacy, Oregon Health and Science University
- Vicki Nordby, RN, BSN, Nurse Consultant, Marquis Companies, Inc

MEMBERS EXCUSED:

- Joshua L. Bardfield, Supply Chain Services Manager, The Oregon Clinic, P.C.

- Deborah Cateora, BSN, RN, Healthcare EDU/Training Coordinator and RN Consultant, Safety, Oversight and Quality Unit (SOQ Unit), Oregon Department of Human Services
- Paul Cieslak, MD, Medical Director, Oregon Public Health Division, Oregon Health Authority
- Wendy L. Edwards, RN, BSN, Patient Safety Surveyor, Health Facility Licensing and Certification, Oregon Public Health Division, Oregon Health Authority
- Jordan Ferris, BSN, RN, CMSRN, Nursing Practice Consultant, Oregon Nurses Association
- Laurie Polneau, RN, MHA, CPHRM, Director, Quality/Risk Management/Infection Control, Vibra Specialty Hospital Portland
- Pat Preston, MS, Executive Director, Center for Geriatric Infection Control
- Kirsten Schutte, MD, Infectious Disease and Medical Director of Infection Prevention and Control, Asante
- Amy Jo Walter, Infection Preventionist, Southern Coos Hospital

OTHER PARTICIPANTS PRESENT:

- DeAnza Britton, RN, Friendship Health Center
- Nicole Cantu, RN, BSN, CMSRN, Nursing Practice Consultant, Oregon Nurses Association (phone)
- Dennis Drapiza, MPH, BSN, RN, CIC, Regional Director - Northwest Infection Prevention and Control, Kaiser Permanente Northwest (phone)
- Sydney Edlund, MS, Director of Analytics and Research, Oregon Patient Safety Commission
- Ryan Grimm, Director of Surgical Services, Ambulatory Surgery Centers, The Portland Clinic (phone)

- Judy Guzman-Cottrill, DO, Pediatric Infectious Disease Physician, Oregon Health and Science University and Oregon Health Authority
- Thomas Jeanne, Deputy State Health Officer, Oregon Health Authority
- Kirstin King, RN, Director of Nursing Services, Marquis Silver Gardens
- Renee Kozlowski, student, Jesuit High School
- Julie Koch, RN, MSN, BSN, CIC, Manager Infection Prevention, Salem Health Hospitals and Clinics
- Jenny Krein, Representative, ALK (phone)
- Shanna Middaugh, MLS, BHA, CIC, Samaritan North Lincoln Hospital (phone)
- Mary Post, RN, MS, CNS, CIC, Infection Prevention/Employee Health Coordinator, Shriners Hospitals for Children – Portland (phone)
- Kristine Rabii, MSc, Infection Preventionist, Tuality Healthcare (phone)
- Rachel Ruehl, Clinical Pharmacist, ALK (phone)
- Michele Shields, Staff Development Specialist, Holgate Community
- Rachel Steele (phone)
- Dee Dee Vallier, Consumer Advocate (phone)
- Diane Zhitlovsky, Clinical Specialist, Thrombolytics, Genentech

OHA STAFF PRESENT:

- Zintars Beldavs, MS, Acute and Communicable Disease Prevention (ACDP) Section Manager
- Tara Buehring, MPH, Healthcare-Associated Infections (HAI) Office Specialist
- Alyssa McClean, AWARE Program Coordinator
- Valerie Ocampo, RN, MIPH, HAI Public Health Nurse
- Rebecca Pierce, PhD, HAI & Emerging Infections Program (EIP) Program Manager
- Diane Roy, HAI Data and Logistics Coordinator
- Monika Samper, RN, Flu Vax Coordinator and Clinical Reviewer

- Roza Tammer, MPH, CIC, HAI Reporting Epidemiologist
- Dat Tran, MD, HAI Outbreak Response Physician
- Nicole West, MPH, Influenza Epidemiologist
- Alexia Zhang, MPH, HAI EIP Epidemiologist

ISSUES HEARD:

- Call to order and roll call
- Logistics update
- Approve September 2018 minutes
- Outbreaks update
- NHSN data
- Jackson County Pilot Project
- Panel: HCP influenza vaccination programs and policies in LTCFs
- Discussion: Topics for future meetings and reports
- 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, Providence St. Vincent (Chair)	40 percent of members present.	No action items

Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

Logistics Update Tara Buehring, Oregon Health Authority	➢ Membership status • Health Insurer Representative position is still vacant. • Application for Consumer Representative was submitted; OHA is reviewing. • All other HAIAC members have been approved. ➢ Introduction of webinar • Meetings may now be attended remotely through GoToWebinar. • Short survey will be sent to determine effectiveness of webinar and use of microphones.	OHA will send survey to participants who attended meeting remotely to determine effectiveness of webinar and microphones.
Approve September 2018 Minutes All Committee Members	September 2018 meeting minutes were approved by 40 percent of members.	No action items
Outbreaks Update Dat Tran, Oregon Health Authority (See pages 27-30 of meeting materials)	➢ 70 outbreaks were reported between 9/1/18 and 12/6/18. • 48 gastroenteritis • 11 respiratory • 11 other ➢ Healthcare-associated infections accounted for 70% (49/70) of outbreaks. • Majority occurred in long-term care facilities (n=45; 64%). • Most common etiology was norovirus (n=30; 43%).	No action items
NHSN Data	**OHA's 2017 HAI Report**	OHA will include an agenda item to review HAI

Roza Tammer, Oregon Health Authority (See pages 31-48 of meeting materials)	➢ Oregon 2017 HAI report and supporting documents were published in October 2018 on OHA's website (see page 32 of meeting materials). • Report: ○ Evaluates progress of Oregon facilities in reducing HAIs compared to the U.S. overall and to national goals ○ Accessible through interactive tables and maps • Supporting documents: ○ 2017 Oregon HAI Data Summary – synopsis of how well Oregon hospitals performed against national benchmarks ○ About the Data – describes methods, data presentation and usage, and data interpretation for tables and maps ➢ Report and HAI Data Summary examine infections reportable to OHA through the National Healthcare Safety Network (NHSN). • Hospitals: ○ Central line-associated bloodstream infections (CLABSIs) ○ Catheter-associated urinary tract infections (CAUTIs) ○ Laboratory-identified methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections (BSIs)	reporting requirements in 2019 HAIAC meetings.

	○ Laboratory-identified *Clostridioides difficile* (*C. difficile*) infections ○ Surgical site infections (SSIs) resulting from these procedures: abdominal hysterectomy, colon surgery, coronary artery bypass graft, hip replacement, knee replacement, and laminectomy • Dialysis facilities: dialysis bloodstream infections (BSIs) – not evaluated in Data Summary report ➢ Metrics used to evaluate facility and statewide performance include: • Tables/maps: ○ Standard Infection Ratio (SIR) - calculated by dividing number of observed infections by number of predicted infections ○ Number of predicted infections – estimate based on risk adjusted 2015 national HAI aggregate data • HAI Data Summary report: ○ 2015 national baseline data – 2015 risk adjusted national HAI aggregate data ○ U.S. Department of Health and Human Services (HHS) 2020 targets ➢ HAI Data Summary report contains aggregate data for acute care hospitals (ACHs) and critical access hospitals (CAHs).	

	• Device-associated and laboratory-identified infections are reported separately for ACHs and CAHs. • Adult SSIs are combined for ACHs and CAHs. ➢ Summary report reveals Oregon generally performed well compared to 2015 national baseline, but only met a few 2020 HHS targets. • ACHs: ○ Lower than national baseline for: ▪ CLABSIs ▪ MRSA BSIs ▪ *C. difficile* infections ○ Higher than national baseline for CAUTIs** ○ Met 2020 HHS target for CLABSIs in neonatal intensive care units (NICUs) • CAHs: ○ Lower than national baseline for: ▪ MRSA BSIs ▪ *C. difficile* infections ▪ CAUTIs ○ Met 2020 HHS target for CAUTIs ○ Insufficient data to assess CLABSIs • ACH and CAH adult SSIs: ○ Lower than national baseline for: ▪ Coronary artery bypass graft ▪ Laminectomy ▪ Colon surgery ○ Higher than national baseline for:	

	▪ Abdominal hysterectomy** ▪ Hip replacement** ▪ Knee replacement o Met 2020 HHS target for: ▪ Coronary artery bypass graft ▪ Laminectomy (**Although higher than 2015 national baseline, not statistically significant.) **<u>Centers for Disease Control and Prevention's (CDC) 2016 National and State HAI Progress Report</u>** ➢ CDC's 2016 National and State HAI Progress Report can be viewed on CDCs website (see page 41 of meeting materials). ➢ HAI Progress Report offers: • Executive summary • Simple interactive progress report • Detailed technical data tables ➢ Data is stratified by facility type: • Acute care hospitals (ACHs) • Critical Access Hospitals (CAHs) – data tables only • Inpatient rehabilitation facilities (IRFs) • Long-term acute care hospitals (LTACHs) ➢ HAI data are provided for: • Central line-associated bloodstream infections (CLABSIs)	

	• Catheter-associated urinary tract infections (CAUTIs) • Ventilator-associated events (VAEs) – except IRFs • Surgical site infections (SSIs) – ACHs only • *Clostridioides difficile (C. difficile*) infections • Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia ➢ Report shows Oregon percentage of HAIs declined more than national percentages between 2015 and 2016 in most cases. • ACHs: ○ Oregon percentage of decrease greater than national decrease: ▪ CLABSIs ▪ Abdominal hysterectomy SSIs ▪ Colon surgery SSIs ▪ MRSA bacteremia ○ Oregon percentage increased but national percentage decreased: ▪ CAUTIs** ▪ *C. difficile* infections** ○ Oregon percentage remained the same but national percentage decreased: VAEs • IRFs: ○ Oregon percentage of increase greater than national increase: CAUTIs**	

	○ Oregon percentage of decrease greater than national decrease: *C. difficile* infections (**Although Oregon percentage increased, number of infections not statistically significant compared to 2015 national baseline.) **Exemptions to OHA Reporting Mandates** ➢ Elimination of exemptions beginning in 2019 will expand reporting requirements for some hospitals. • CLABSIs must be reported for specified patient care locations regardless of annual number of central line days. • SSIs must be reported for specified procedures regardless of annual number of procedures. ➢ Recorded webinars and technical assistance is available (see page 47 of meeting materials for details). **Comments and Questions** Question ➢ Zintars Beldavs: What has caused dramatic decreases in some SSIs? Roza Tammer: CMS requires reporting of SSIs so facilities probably monitoring these infections more closely. Julie Koch: coding issues, coding changes over time, and a shift in surgical settings. Patients are not staying overnight as often so fewer patients meeting surveillance definition.	

	Rebecca Pierce: Relatively few number of SSIs in Oregon makes interpreting percentage differences tricky <u>Question</u> ➢ Roza Tammer: Is mapping of CPT or ICD-10 billing codes to procedures being routinely checked to ensure infections identified as SSIs meet NHSN SSI surveillance definition? Julie Koch: We've found coding errors that had to be sent back to specialist for recoding. Specifics of procedure—for example, how a hysterectomy is performed—are not always captured correctly resulting in coding inaccuracies. <u>Question</u> ➢ Genevieve Buser: Does it matter whether patients admitted to day surgery unit leave the same day? Roza Tammer: Patient must be admitted and discharged on different calendar days to be considered an inpatient by NHSN. <u>Questions</u> ➢ Zintars Beldavs: Any insights into factors causing differences in outcomes, for example, decrease in MRSA bacteremia and increase in CAUTIs in Oregon? What initiatives and practices have been successful or could/should be implemented to decrease infections? ➢ Genevieve Buser: How do long-term care facilities think recently established initiatives are going? Is there message	

	fatigue or are initiatives progressing well? Have they been incorporated into routine practice? Vicki Nordby: Marquis companies have decreased CAUTIs by reducing catheter usage, have lowered *C. difficile* infections through antibiotic stewardship, and have few CLABSIs due to low number of central lines. Rebecca Pierce: Small numbers coupled with confines of CDC statistics make interpretation of HAI data difficult from year to year. Trend data would be helpful in future reports. Over last few years, *C. difficile* has been stagnant, although made substantial progress this year, CAUTI has fluctuated, and CLABSI has been steadily declining. <u>Question</u> ➢ Genevieve Buser: How does NHSN deal with and adjust to new realities of healthcare as more surgeries are performed in ambulatory surgery centers or as day surgeries in hospitals? Ultimate goal is patient safety regardless of setting. Roza Tammer: Believe NHSN has been working to bolster this part of their application. Some states currently require ASCs to report SSIs. Sense that additional states will follow suit as more procedures are being performed in this setting; a large portion of surgeries are being missed by only focusing on hospitals.	

	Julie Koch: ASCs potential move toward 2-night stay would likely lead to more procedures. Committee might consider requiring ASCs to report SSI measures. Roza Tammer: Plan to have committee discussion about Oregon reporting requirements in 2019.	
Jackson County Pilot Project Roza Tammer, Oregon Health Authority (See pages 49-70 of meeting materials)	➢ OHA developed and implemented project to improve safety of injections and needle use in healthcare facilities using funds from CDC's One and Only Campaign. • Created survey to assess needle use and injection practices to inform educational activities. • Devised online toolkit for public and health professionals. ○ Approximately 4,000 surveys were mailed to providers, businesses, and facilities providing health-related services. • 73 surveys currently have been received. • 70 surveys have sufficient data for analysis. ➢ Analysis of surveys revealed a wide range of respondents, services, and practices. • Providers and services: ○ Business/facility types encompassed: 21.4% inpatient, 70% outpatient, 8.6% acupuncture. ○ Common licensed provider types included: CNA, RN, NP, MD, and LAc. ○ Common needle-based or injection services included: biopsy, dialysis, blood draw/phlebotomy, surgery, and acupuncture. • Injections:	OHA encouraged committee to review and evaluate online toolkit (see page 74 of meeting materials)

	○ Majority of respondents administered injectable medications/treatments. ○ Facilities most commonly injected medications/treatments intramuscularly, intravenously, and subcutaneously. ○ Safety syringes used by 80% inpatient facilities and 45% outpatient facilities. ○ Injections involving blood/body fluids performed by 53% of inpatient facilities and 6% of outpatient facilities. • Medication practices: ○ Injectable medications/treatments mixed/reconstituted less than one hour before administration: inpatient – 75%; outpatient – 60%; acupuncture – 17%. ○ Injectable medications/treatments drawn up or added to bags less than one hour before administration: inpatient – 75%; outpatient – 90%; acupuncture - 17%. ○ Injectable medications/treatments checked using 2-step process: inpatient – 67%; outpatient – 37%; acupuncture – 0%. ○ Majority of inpatient and outpatient facilities "never" use medication vials on more than one patient. • Education:	

	○ Most inpatient and outpatient facilities provide education once per year on needle use/injection practices. ○ Majority of acupuncture settings do not offer instruction. • Disease notifications: 67% inpatient, 41% outpatient, and 0% acupuncture businesses/facilities receive information about disease clusters, outbreaks, or injection/needle related patient/client notifications. **<u>Comments and Questions</u>** <u>Question</u> ➢ Roza Tammer: What should our priorities be for education, outreach, and engagement? How can we ensure our toolkit gets into the right hands? Julie Koch: Were surveys sent to tattoo parlors? There was a recent outbreak in Florida related to contaminated tattoo ink. Roza Tammer: Data would be interesting to see, but tattoo parlors were excluded because funding is for healthcare settings. Nonetheless, route of disease transmission in tattoo parlors and other non-healthcare settings using needles/performing injections is similar. Rebecca Pierce: Information was not obtained from tattoo parlors, but data collected from Jackson County project,	

	such as trends and data from alternative clinics, could be used to develop similar training materials for tattoo parlors.	
Panel: HCP influenza vaccination programs and policies in LTCFs Kristin King, Marquis Silver Gardens; Michele Shields, Holgate Community (See pages 71-86 of meeting materials.)	**<u>Presentation by Kristin King</u>** ➢ Facility attained 100% healthcare personnel influenza vaccination rate in 2018. ➢ Flu vaccination and infection control are promoted through a variety of methods. • Surgical masks: ○ Personnel asked to wear surgical mask during September staff meeting; few able to tolerate mask for entire 90-minute meeting. ○ New policy requires staff who decline flu vaccination to wear surgical mask during influenza season. • Comprehensive education: ○ Present facts on effectiveness and safety of flu vaccine ○ Explain common signs and symptoms of flu ○ Describe ways to prevent spread of flu • Vaccination incentives: ○ Offer monetary rewards, such as $100 Visa gift card raffle ○ Give stickers to vaccinated employees to wear on badge • Flu prevention resources: ○ Flu posters displayed in key areas	No action items

	○ Hand sanitizers strategically placed throughout facility **Comments and Questions** Question ➢ Dat Tran: Was initiative specific to your facility or was it enterprise wide? Kristin King: It was done facility wide. Question ➢ Dat Tran: How did other facilities within enterprise perform? Vicki Nordby: 8 out of 18 facilities have over 90% vaccination rate so far. The one facility that did not require masks to be worn during September staff meeting has 27% vaccination rate. Monika Samper: Requiring staff to wear a mask for even a short period of time is a phenomenal idea—it can be miserable breathing through a mask. Question ➢ Zintars Beldavs: How effective are incentives like a $100 gift card? How often do other facilities use this strategy? Monika Samper: OHA in past surveys asked facilities about types of incentives used to promote flu vaccinations. Results showed incentives were used frequently but generally were not effective.	

	Kirsten King: Gift cards and the offer of a TV one year are significant incentives to CNAs that generate a very positive reaction. Small incentives like pizza parties have also worked. **<u>Presentation by Michele Shields</u>** ➢ Successful strategies utilized to improve vaccination rates: • Established masking policy effective as of 2018-2019 influenza season • Arranged for Alexia Zhang, OHA epidemiologist, to provide influenza education • Offer one-on-one training to staff whose second language is English • Give stickers to vaccinated employees to display on badge • Promote flu vaccinations at every opportunity ➢ Lessons learned: • Immunize all staff at same time; delaying vaccinations for some personnel can contribute to flu outbreaks • Follow up with vendors to ensure flu vaccine order received • Use simple flu vaccination stickers to avoid wasting money • Masking policy works: during recent flu outbreak, “mask on” policy increased vaccinations by 22%	

	Comments and Questions Question ➢ Roza Tammer: Any difference in misperceptions or reasons for hesitancy between healthcare personnel, which you educate about flu vaccine, and the general public? Michele Shields: we don't vaccinate general public, so unknown. Staff appear to have fewer excuses or reasons this year for refusing flu vaccine, such as it will make me sick. Common justification for declinations is religious beliefs. Regardless of reason, unvaccinated staff must wear a mask until active cases resolved. Question ➢ Rebecca Pierce: Has more hesitancy been observed following a flu season where vaccine was less effective, like last year? Kirsten King: yes, biggest issue this year. Marquis Silver Gardens responded by distributing educational materials, upholding masking policy (most successful intervention), and reasoning with staff—e.g., partially effective vaccine better than no vaccine. Michele Shields: Counteracted hesitancy by providing substantial education. Explained last year's vaccine was less effective because it was obtained from Southern hemisphere where flu was prevalent. Staff were instructed flu shot is still best bet for protecting themselves and residents.	

	Kirsten King: also emphasized to staff that vaccine decreases severity of illness and reduces ICU stays.	
Discussion: Topics for future meetings and reports All members	➢ HAI reporting requirements, particularly for ambulatory surgery centers ➢ Mapping of hospital units to CDC locations in NHSN	No action items
Public comment	No public comment	No action items
Adjourn		

Next meeting will be March 20, 2018 1:00 pm - 3:00 pm, at Portland State Office Building, Room 1B

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