Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

June 19, 2019
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:

- Joshua Bardfield, Supply Chain Services Manager, The Oregon Clinic, P.C. (phone)
- Genevieve Buser, MD, Pediatric Infectious Disease Physician, Providence St. Vincent Medical Center
- Paul Cieslak, MD, Medical Director, Oregon Public Health Division, Oregon Health Authority
- Pamela Cortez, MBA, BSN, RN, CNE, BC, Director of Patient Safety and Clinical Support, Salem Health (phone)
- Dennis Drapiza, MPH, BSN, RN, CIC, Regional Director - Northwest Infection Prevention and Control, Kaiser Permanente Northwest
- 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

- Kirsten Schutte, MD, Infectious Disease and Medical Director of Infection Prevention and Control, Asante (phone)

MEMBERS EXCUSED:

- Deborah Cateora, BSN, RN, Healthcare EDU/Training Coordinator and RN Consultant, Safety, Oversight and Quality Unit (SOQ Unit), Oregon Department of Human Services
- Kelli Coelho, RN, CASC, MBA, Executive Director, RiverBend Ambulatory Surgery Center
- 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
- Lisa Freeman, Executive Director, Connecticut Center for Patient Safety
- 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

OTHER PARTICIPANTS PRESENT:

- Jackson Baures, Public Health Division Manager, Jackson County (phone)
- Joyce Caramella, RN, CPHQ, CHC, Project Manager, HealthInsight Oregon
- Kari Coe, RN, BSN, IP Nurse, Communicable Disease Program, Deschutes County Health Services (phone)
- Sydney Edlund, MS, Director of Analytics and Research, Oregon Patient Safety Commission (phone)
- Mesa Greenfield, BSN, RN, CWOCN, Infection Prevention/Employee Health Nurse, Lake District Hospital (phone)

- Ryan Grimm, Director of Surgical Services, Ambulatory Surgery Centers, The Portland Clinic (phone)
- Stacey Karvoski, RN, BSN, Infection Control/Employee Health/Outpatient Therapy Manager, Wallowa Memorial Hospital (phone)
- Jesse Kennedy, RN, Nurse Practice Consultant, Oregon Nurses Association (phone)
- Karen Keuneke, RN, MSN, Supervisor of Infection Prevention, Good Samaritan Regional Medical Center (phone)
- Chitra Kanchagar, pharmacy student, OSU/OHSU
- Gretchen Koch, MSN, RN, Policy Analyst, Nursing Practice and Evaluation, Oregon State Board of Nursing (phone)
- Julie Koch, RN, MSN, BSN, CIC, Manager Infection Prevention, Salem Health Hospitals and Clinics
- L Dianne Long, Med/Surg Supervisor, St. Alphonsus Baker City (phone)
- Lauren Ogden, MPH, CIC, Infection Preventionist, Oregon Health and Science University
- Mary Post, RN, MS, CNS, CIC, Infection Prevention/Employee Health Coordinator, Shriners Hospitals for Children – Portland (phone)
- Kristine B. Rabii, MSc., Infection Preventionist, Tuality Healthcare (phone)
- Jessica Symank, RN, MPH, Senior Director, Patient Safety and Quality Partnerships, Washington State Hospital Association

OHA STAFF PRESENT:

- Zintars Beldavs, MS, ACDP Section Manager
- Alyssa McClean, AWARE Coordinator
- Valerie Ocampo, RN, MIPH, HAI Public Health Nurse
- Diane Roy, HAI Data and Logistics Coordinator
- Monika Samper, RN, Flu Vax Coordinator and Clinical Reviewer

- Lisa Takeuchi, MPH, HAI/AR Monitoring & Prevention Epidemiolgist
- Roza Tammer, MPH, CIC, HAI Reporting Epidemiologist
- Dat Tran, MD, HAI Outbreak Response Physician/Interim HAI & EIP Program Manager
- Alexia Zhang, MPH, HAI EIP Epidemiologist

ISSUES HEARD:

- Call to order and roll call
- Logistics update
- Approve March 2019 minutes
- Oregon Health Authority (OHA) National Healthcare Safety Network (NHSN) reporting requirements
- 2018 OHA NHSN reporting
- Injection practices and needle use in Jackson County
- 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)	8 members (53 percent) and 17 participants present.	No action items

Logistics Update Roza Tammer, Oregon Health Authority	HAIAC membership updates: • Labor Representative position open; Jordan Ferris, Oregon Nursing Association, transitioning from role. • Health Insurer Representative position still vacant.	No action items
Approve March 2019 Minutes All Committee Members	March 2019 meeting minutes were approved by 53 percent of members.	No action items
OHA NHSN Reporting Requirements Roza Tammer, Oregon Health Authority (See pages 19-28 of meeting materials)	➢ OHA mandates hospitals report HAI outcome measures listed below to NHSN as specified in Oregon Administrative Rules (OARs): • 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) • Surgical site infections (SSIs) resulting from following procedures: ○ Coronary artery bypass graft (CBGB) ○ Knee prosthesis (KPRO) ○ Colon surgery (COLO) ○ Hip prosthesis (HPRO) ○ Abdominal hysterectomy (HYST) ○ Laminectomy (LAM)	Send questions and comments regarding reporting requirements to Roza Tammer.

	➢ Standardized infection ratios (SIRs) calculated using 2015 baseline data reveal Oregon hospitals need to improve on five metrics (SIR greater than one): • CLABSIs in critical access hospitals (CAHs) • MRSA BSIs in CAHs • KPRO SSIs • HPRO SSIs • HYST SSIs ➢ National 2017 acute care hospital (ACH) SSI data show infections are higher than predicted for a many adult and/or pediatric procedures including: craniotomy, cesarean section, open reduction of fracture, and kidney transplant. ➢ HAIAC members/participants proposed changes to current reporting requirements. • Hospitals: o Remove laminectomy o Add Non-Ventilator-Associated Pneumonia (PNEU) o Add Antibiotic Use/Antibiotic Resistance • Add SSI reporting for ambulatory surgery centers: o Hernia o Breast o Cholecystectomy o Cataract and other eye procedures o Joint procedures (e.g., hip, knee) o Laminectomy	

	Question ➢ Paul Cieslak: What is the baseline for SIR? Roza Tammer: Baseline is 2015 national HAI data. SIR is observed number of infections divided by predicted number of infections. Predicted infections are estimated based on risk-adjusted national baseline data for each HAI metric and facility type. Question ➢ Roza Tammer: Comments on proposed changes to mandated reporting or additional ideas? Monika Samper: ASCs should report SSIs because of high volume and increasing complexity of cases. Julie Koch: Laminectomies mostly performed in outpatient setting. Risk is mainly when spinal fusion is done with laminectomy so recommend only reporting fusions. Paul Cieslak: SIR is a relative rate so does not indicate absolute rate. Less impressed by an SIR that increased since 2015 than a rise in absolute rate of an infection. Favor eliminating laminectomies without fusion. Believe infection rates from breast and routine hernia surgeries are low. Should focus on surgeries with more infections and greater mobidity such as open reduction internal fixation of fracture (ORIF) regardless of whether inpatient or outpatient setting. Kristen Schutte: Agree, need to target procedures with high morbidity and poor outcomes, including fusions in ASCs as well as inpatient settings. Tracking ORIF would be	

	interesting, but situations that put patients at risk are complicated. If ORIF used to treat open fracture, might be difficult to determine amount of risk reducible through proper antibiotic use or better infection prevention practices. <u>Question</u> ➢ Roza Tammer: Are proposed procedures high-volume and high-risk in ASCs? Dennis Drapiza: Our ASCs perform surgeries previously done in inpatient settings: laminectomy, breast, and hernia procedures. Also, do high volume of cataract surgeries. ASCs recommended starting with reporting a few SSIs rather than all seven at once. Genevieve Buser: Perhaps begin with highest morbidity or frequency like joint procedures previously done in inpatient locations. Julie Koch: Some of our ASCs will be providing two-night stays. Already considering moving inpatient joint procedures to these ASCs. Joint procedures are my highest level of concern based on inpatient outcomes. Dennis Drapiza: Would be helpful to know type and number of procedures being done in ASCs, how we're doing, and ways to improve outcomes. <u>Question</u> ➢ Genevieve Buser: Do hospital outpatient units currently fall under NHSN inpatient reporting?	

	Julie Koch: Outpatient units are not required to report data. Genevieve Buser: So ambulatory surgery center reporting would not encompass outpatient hospital settings? Roza Tammer: Would only include procedures done in licensed ASCs, regardless of duration of stay. Hospitals only required to report HAIs for inpatient procedures. Inpatient defined as patient is admitted and discharged on different calendar days. <u>Comment</u> ➢ Roza Tammer: Reporting requirements could be expanded to include outpatient hospital procedures. Julie Koch: Need to restrict reporting to essential HAIs because IP resources limited. Ryan Grimm: To understand outpatient procedure infection rates, need to look at hospital outpatient departments as well as outpatient industry. However, staffing is a big issue so need to effectively analyze and tailor reporting requirements. Proposed reporting not highly burdensome, but we're bigger than most independent ASCs. On board with reporting proposals, but not all procedures at once. <u>Question</u> ➢ Genevieve Buser: Any procedures you are concerned about due to frequency or morbidity? Ryan Grimm: Infection rates low at our multi-specialty surgery centers. Perform large number of cataract surgeries.	

	Only remember one hernia and no breast procedure infections. Ortho surgeries might have more infections but possibly volume dependent. Paul Cieslak: Most interested in ASCs reporting joint procedures due to incidence of infection. <u>Question</u> ➢ Dat Tran: Any significant differences in type and frequency of procedures performed in ASCs versus hospital outpatient units? Should know if we're going to mandate reporting for both facility types. Lauren Ogden: Would need to look at actual data. <u>Question</u> ➢ Julie Koch: What about antibiotic use? Lisa Takeuchi: 21 Oregon hospitals currently report antibiotic use (AU); fewer report antibiotic resistance (AR). Nationwide only Missouri and Tennessee have mandated select hospitals report AU data. Tennessee first requiring AU data from larger acute care hospitals, followed by smaller acute care hospitals, and eventually critical access hospitals. Challenge is purchase of expensive software or development of homegrown system to enable AU reporting. Lauren Ogden: We proposed AU reporting requirement to committee to help justify purchase of necessary software to hospital administration.	

	Dennis Drapiza: Agree, would like AU module to support our antimicrobial stewardship program. Roza Tammer: What about initially requiring hospitals with larger bed size to report AU data and then periodically expand mandate to smaller hospitals? Dennis Drapiza: Great idea. Kirsten Schutte: Agree with comments. However, need to improve how we benchmark and use this information. Complicated in terms of defining when antibiotic should be prescribed and which drug is appropriate. How would data be employed to improve outcomes and quality of care? <u>Question</u> ➢ Dat Tran: Do facilities have opinion about AU versus AR reporting? Julie Koch: Would suggest AU because AR much more complicated. State could help facilities with benchmarking. Dat Tran: Oregon Antimicrobial Stewardship Network (ORASN) collaborative tasked with developing benchmarks. All facilities reporting AU will have a voice in determining standards. Paul Cieslak: Perhaps best to delay implementation of AU reporting until committee has determined how data will be used.	

	Genevieve Buser: Recommend selecting well-defined area, such as sepsis, with nationally developed guidelines on appropriate antibiotic use.	
2018 OHA NHSN Reporting Lisa Takeuchi, Oregon Health Authority (See pages 29-45 of meeting materials)	<u>Review of HAI Data</u> ➢ CDC's 2017 report compares Oregon data to national data for acute care hospitals on six HAIs reportable to CMS. Report reveals: • Oregon SIR significantly higher than national SIR for CAUTI. • Difference between Oregon SIR and national SIR statistically insignificant for: ○ CLABSI ○ HYST SSI ○ COLO SSI ○ MRSA BSI ○ CDI ➢ Oregon's 2018 data show: • Acute care and critical access hospitals – Oregon's observed infections compared to predicted infections for all HAI categories either statistically insignificant or statistically lower. • Dialysis facilities – Oregon 2018 SIR significantly lower than national 2017 SIR for BSIs. <u>Considerations for 2018 HAI Report</u> ➢ Goal for annual report is to provide clear and concise information that allows:	

	• Patients to make healthcare choices • Healthcare facilities to improve patient safety ➢ Content of report: • Online report published annually contains executive summary, aggregate data, and facility-specific data. • Formal report published about every three to five years includes trend data. What topics should be included? ○ NHSN annual survey data such as facility characteristics or antimicrobial stewardship metrics? ○ Recommendations for providers and patients on how to minimize HAI risks like 2016 report? ○ Overview of how HAI Program uses data to inform and prioritize projects and activities? ○ Other topics? <u>Responses:</u> Dennis Drapiza: Recommendations are important, especially since report is meant for public. Zintars Beldavs: Can statistics be obtained on how public is using online report? Information would help OHA improve outreach. Jon Furuno: Important to know how report being utilized: some may view it to inform healthcare decisions while others interested in how data is used. However, utilization statistics will not capture missing data/topics sought by users; what information should be included is fairly intuitive. Also, need	

	to consider whether a topic should be incorporated in report or placed elsewhere on website. Genevieve Buser: Offering aggregate NHSN data from annual survey (perhaps separate from report) would be useful. Advantage of posting information online independent of report is that it can be updated in real time rather than when report produced. Zintars Beldavs: Maybe include HAI Program activities and HAI prevention efforts of hospitals and collaboratives. ➢ Should OHA censor data of facilities who perform relatively few procedures? • Concern about patient identification when numbers small? • Useful to present small numbers? • Data not censored in previous OHA reports or Center for Medicare and Medicaid Services' (CMS) Hospital Compare online reports. <u>Responses:</u> Julie Koch: Don't think it's an issue. Lauren Ogden: Problem if, for example, a hospital had 50 central line days and reported 10 CLABSIs. When I scanned data, did not find any issues. Lisa Takeuchi: Based on responses, will not censor data. ➢ How often should formal HAI report be produced?	

	Responses: Jon Furuno: Frequency should be based on indications such as marked changes in trend data, modifications to HAI definitions, new HAI categories, and addition of facility types. Lisa Takeuchi: So, will revisit question yearly. This year, OHA will generate formal report with trend data so reader can see how facilities doing. ➢ Provide printer-friendly PDF or web-based report? Latter would permit tracking report usage. Responses: Julie Koch: We utilize both. Use web-based at my desk but give chief officers paper copy in monthly public reporting meetings. Lauren Ogden: Online is fine. Receive many calls from public asking for general information. Could place links to OHA recommendations on hospital website.	
Injection Practices and Needle Use in Jackson County Roza Tammer, Oregon Health Authority	➢ 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. ➢ Mailed or emailed surveys three times to Jackson County licensed providers, businesses, and facilities providing health-related services.	OHA asked attendees to review Injection and Needle Safety Toolkit and provide feedback.

(See pages 46-66 of meeting materials)	• 9% response rate • 272 surveys have sufficient data for analysis ➢ Analysis of surveys reveal diverse respondents, services, and practices. • Providers and services: ○ Business/facility types encompassed: 47.8% inpatient, 50% outpatient, and 2.2% acupuncture. ○ Common provider types included: CNA, RN, NP, MD, and LAc. ○ Common needle-based or injection services included: biopsy, dialysis, blood draw/phlebotomy, surgery, and acupuncture. • Injection and needle-based practices: ○ Injectable medications/treatments administered in 97% inpatient and 25% outpatient settings. ○ Medication vials “never” used on more than one patient in majority of inpatient and outpatient locations. ○ Safety syringes used by 76% inpatient and 46% outpatient facilities. ○ Needle-based treatment without injection provided in: 9% inpatient, 5% outpatient, and 50% acupuncture settings. • Medication practices: ○ Mix/reconstitute injectable medications less than one hour before administration: 47% inpatient, 34% outpatient, and 17% acupuncture.	

	○ Draw up injectable medications/treatments less than one hour before administration: 54% inpatient, 51% outpatient, and 17% acupuncture. • Education: ○ Most inpatient and outpatient settings provide education on needle use/injection practices once per year. ○ Majority of acupuncture clinics do not offer instruction. ○ Inpatient respondents more interested in educational topics listed in survey than outpatient respondents. ➢ Conclusions: • Outpatient settings less likely to adhere to best practices. • Facilities/businesses/providers need ongoing education. ➢ Next steps: • Perform additional analyses and publish final report. • Continue to review, update, and expand information and resources in online toolkit. • Continue to offer in-person and remote education/training. • Ask licensing boards to promote education to lend legitimacy and impetus to efforts.	

	<u>Question</u> ➢ Genevieve Buser: Will survey results be sent to respondents? Roza Tammer: Great idea.	
Discussion: Topics for Future Meetings and Reports All attendees	➢ Kirsten Schutte: • Presentation on how to screen for measles; statewide guidelines would be helpful. • Guidance from state on pandemics; unable to generate alerts within health system when cases reach U.S. ➢ Julie Koch: Review Pandemic and All Hazards Preparedness Act (PAHPA) and discuss how facilities managing recommendations.	No action items
Public Comment	No public comment	No action items
Adjourn		

Next meeting will be September 18, 2019, 1:00 pm - 3:00 pm, at Portland State Office Building, Room 1B

Submitted by: Diane Roy
Reviewed by: Roza Tammer