Healthcare-Associated Infections Advisory Committee (HAIAC) Meeting

March 11, 2020
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 (phone)
- Deborah Cateora, BSN, RN, Healthcare Education/Training Coordinator and Nurse Consultant, Safety, Oversight and Quality Unit (SOQ Unit), Oregon Department of Human Services (phone)
- Paul Cieslak, MD, ACDP & Immunizations Medical Director, Oregon Public Health Division, Oregon Health Authority
- Jon Furuno, PhD, Associate Professor, Department of Pharmacy Practice, Oregon State University/College of Pharmacy, Oregon Health and Science University (phone)
- Wendy L. Edwards, RN, BSN, Patient Safety Surveyor, Health Facility Licensing and Certification, Oregon Public Health Division, Oregon Health Authority

- Jesse Kennedy, RN, Nurse Practice Consultant, Oregon Nurses Association (phone)
- Vicki Nordby, RN, BSN, Nurse Consultant, Marquis Companies, Inc. (phone)

MEMBERS EXCUSED:

- Pamela Cortez, MBA, BSN, RN, CNE, BC, Director of Patient Safety and Clinical Support, Salem Health
- Dennis Drapiza, MPH, BSN, RN, CIC, Regional Director - Northwest Infection Prevention and Control, Kaiser Permanente Northwest
- Kelli Coelho, RN, CASC, MBA, Executive Director, RiverBend Ambulatory Surgery Center
- Pat Preston, MS, Executive Director, Center for Geriatric Infection Control
- Kirsten Schutte, MD, Infectious Disease and Medical Director of Infection Prevention and Control, Asante

OTHER PARTICIPANTS PRESENT:

- Sandra Assasnik, Director, Safety and Quality, Washington State Hospital Association (phone)
- Tara Buehring, MPH, Infection Preventionist, Vibra Specialty Hospital of Portland (phone)
- Melissa Davis, Facility Administrator, DaVita Inc. (phone)
- Ryan Grimm, Director of Surgical Services, Ambulatory Surgery Centers, The Portland Clinic (phone)
- Elizabeth Hickerson, MLS/ASCP, Clinical Laboratory Manager/Infection Prevention Officer, Pioneer Memorial Hospital (phone)
- Martha Jaworski, MS, RN, CIC, Senior Quality Advisor, Comagine Health (phone)

- Dennis Kan, Program Manager - Infection Prevention and Control, Kaiser Sunnyside Medical Center (phone)
- Karen Keuneke, RN, MSN, Supervisor of Infection Prevention, Good Samaritan Regional Medical Center (phone)
- Gretchen Koch, MS, 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 (phone)
- Karen Larson, Regional Quality Manager, Fresenius Kidney Care (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)
- Yolanda Ryckman, Infection Prevention/Employee Health/Quality Improvement, Harney District Hospital (phone)
- Jason Scott, Clinical Specialist, US Renal Care (phone)
- Kristen Van Allen, DaVita Inc. (phone)
- Aisha Hedden, Abbott
- Brian St. Cyr, Abbott

OREGON HEALTH AUTHORITY (OHA) STAFF PRESENT:

- Zintars Beldavs, Section Manager, Acute and Communicable Disease Prevention
- Maureen Cassidy, MPH, Multi-Drug Resistant Organisms (MDRO) Epidemiologist
- Lisa Iguchi, MPH, Healthcare-associated infection (HAI)/Antimicrobial Resistance (AR) Monitoring & Prevention Epidemiologist
- Laura LaLonde, MPH, HAI Office Specialist

- Valerie Ocampo, HAI Public Health Nurse (phone)
- Ama Owusu-Dommey, Viral Pathogens Epidemiologist
- Steven Rekant, Epidemic Intelligence Service (EIS) Officer
- Diane Roy, HAI Data and Logistics Coordinator
- Monika Samper, RN, Influenza Vaccination Coordinator and Clinical Reviewer
- Roza Tammer, MPH, CIC, HAI Reporting Epidemiologist
- Dat Tran, MD, HAI Outbreak Response Physician

ISSUES HEARD:

- Call to order and roll call
- Logistics update
- Approve December 2019 minutes
- State HAI Plan
- High impact pathogen update
- Evaluation and validation of National Healthcare Safety Network (NHSN) Dialysis Event reporting
- Oregon dialysis data overview
- Panel: Infection prevention in the dialysis setting
- Discussion: Topics for future meetings and reports
- Public comment
- Final roll call and adjourn

Item	Discussion	Action Item
Call to order and roll call Roza Tammer, OHA	Eight members (62 percent) and seventeen participants present.	No action items
Logistics update Roza Tammer, OHA	➢ HAIAC membership updates: • Four vacancies: • Hospital Administrator with Expertise in Infection Control in a Facility with Fewer than 100 Beds. • Consumer and Patient Representative. • Health Insurer Representative. • Oregon Patient Safety Commission Representative. o Opportunity for current member to serve as Chairperson. ➢ Remote attendees will remain unmuted for meeting; reminder to unmute yourself to speak. Guidance for using webinar included in meeting minutes.	Please share "Bring your voice to the table" one-pager with your networks and email Roza if interested
Approve December 2019 minutes All Committee Members	December 2019 meeting minutes were approved by 62 percent of members.	No action items

State HAI Plan Roza Tammer, OHA (See pages 16-22 of meeting materials)	➢ State HAI Plan: • Create a standardized way to evaluate statewide and facility-specific data and identify data-driven priorities: o Performance based on a target threshold (percent met). o Level of concern (One = high, Two = moderate). • Use to inform HAIAC membership and attendees and annual updates to State HAI Plan. • Data matrix tool used to organize and assess data that includes many actionable metrics. <u>Question</u> ➢ Roza Tammer: What is your level of concern (high or moderate) for the hospital measures (see pages 19-20 of meeting minutes), for example healthcare worker (HCW) influenza vaccination rates? Various: High concern. Roza Tammer: The next two measures are about essential elements of antimicrobial stewardship programs in healthcare facilities and hospitals. Are these a high or moderate concern? Sandra Assasnik: High concern. Roza Tammer: Would a SurveyMonkey be useful? Sandra Assasnik: Yes, with definitions of each measure. Paul Cieslak: I care about HCW influenza vaccination rates, antibiotic stewardship, and *Clostridioides difficile*. I	Please respond to survey once distributed.

	don't care much about catheter-associated urinary tract infections. Genevieve Buser: Should there be a low concern group? Roza Tammer: We're hesitant to create a low concern group because we do not feel we collect low-priority data, and we would not want to characterize our concern about an infection that has real impact on patients and families as "low." It's the same reason why we've moved from "expected" infections to "predicted" infections in this work. Dat Tran: In addition to that, having only two categories for level of concern allows us to create a plot that is easier to use to identify our priorities. Roza Tammer: I will distribute a survey. Please let us know if we are missing collecting important data elements. Skilled nursing facility (SNF) data will be going through a similar process and review will be done by email.	
High-impact pathogen update Maureen Cassidy and Paul Cieslak, OHA	➢ *Candida auris*: • Infection colonization or isolation in a laboratory will be a reportable condition beginning April 6, 2020. o OHA can facilitate screening done at the regional Antibiotic Resistance Laboratory Network (ARLN). o Contact the HAI Program or Maureen Cassidy. • Screen new admissions to your facility if hospitalized or in a SNF in areas of extensive transmission:	No action items

	○ Include New York, New Jersey, Illinois, Florida, and California in the United States and India, parts of Africa, and Venezuela. ○ Are on the Centers for Disease Control and Prevention (CDC) website. ➢ COVID-19: • Currently 15 cases in Oregon: eight in Washington County, two in Jackson, one in Multnomah, one in Marion, one in Douglas, one in Umatilla, and one in Klamath. • Cases include people: ○ With a travel history. ○ Seriously ill with viral pneumonia with no cause identified before testing. ○ Mildly symptomatic who were close contacts of identified cases. • Currently testing people who are symptomatic after arrival from five countries that CDC has designated as having high-level travel warnings (China, Iran, Italy, Japan, and South Korea) or those that are hospitalized with viral pneumonia and have no other cause identified. • OHA has offered guidance related to personal protective equipment (PPE): ○ Currently droplet precautions unless administering an aerosol-generating procedure like intubation.	

	○ Face shields or masks with aerosol-generating procedures. • The state public health lab currently has the capacity to test about 80 specimens a day; currently testing one specimen per patient. • Order of preference for specimens is: ○ Lower respiratory tract specimens like bronchoalveolar lavage fluid or endotracheal aspirate. ○ Sputum. ○ Nasopharyngeal (NP) swab or oropharyngeal swab. • University of Washington Virology Lab, LabCorp and Quest provide commercial testing; Providence, Legacy, Kaiser, Oregon Health and Science University (OHSU) and BioFire Diagnostics are working on a test. • The focus is protecting the most vulnerable. <u>Comment</u> ➢ Brian St. Cyr: Abbott is working on a rapid coronavirus test as well.	
Evaluation and validation of NHSN Dialysis	➢ Dialysis event reporting in Oregon: • People who receive dialysis already have reduced health status.	No action items

Event reporting
Lisa Iguchi, OHA
(See pages 23-45 of meeting materials)
	• Reporting is used to track infections, monitor trends and facility performance, and inform prevention efforts.
	• Thirty-seven thousand bloodstream infections (BSI) per year at $28,000 per BSI costs over $1 billion per year.
	• The goal of the evaluation was to identify knowledge gaps and the potential for reporting errors.
	• Seventy percent of all data reported from dialysis facilities in NHSN is through automated processes rather than through manual data entry.
	• Challenges:
	  ○ Knowledge gaps can cause systematic errors.
	  ○ Errors in clinical document architecture file preparation can cause systematic errors.
	  ○ Some data need more examination.
	  ○ Reporting delays limit timeliness.
	
	➢ NHSN external data validation of dialysis events:
	• Currently 64 facilities reporting in Oregon.
	• Reporting of Dialysis Events mandated by OHA since 2013: intravenous (IV) antimicrobial starts, positive blood cultures (PBC), and pus, redness, or increased swelling (PRS) at the vascular access site.
	• Goals of external validation:
	  ○ Assess and improve the quality of reporting.
	  ○ Evaluate current surveillance practices and knowledge of facility staff.	

	○ Provide guidance to dialysis facilities. ○ Provide feedback to CDC on implementation guidance. • Scope of validation: ○ Facilities limited to Portland tri-county area. ○ Facilities randomly selected until 14 recruited. ○ Study period between July – December 2017. • Patient selection and survey assessment: ○ Five line lists requested from each facility for patients in the study period who: • Received one or more in-center hemodialysis treatment. • Had any PBCs. • Received any intravenous antimicrobials. • Had any PRS at the vascular access site. • Were hospitalized. ○ Selected up to 30 patients per facility. ○ Online survey to assess facility staff on NHSN surveillance practices and knowledge. • On-site visits: ○ One-day visit with two to three validators. ○ Review records and survey. ○ Perform exit interview. • Validation findings: ○ 385 charts reviewed. ○ Eleven-minute average time per record review.	

	○ Thirteen out of 14 facilities had one or more reporting discrepancies. • PBC reporting: ○ Only NHSN dialysis event included in annual reports. ○ Main reason for under-reported events was data collection outside of facility: • Records not received and reviewed. • Information not documented to allow for automated reporting. • PBC: Twenty found in chart, 20 correctly reported to NHSN, ten underreported, three overreported. • Survey highlights: ○ Ninety-three percent completed NHSN training. ○ Seventy-one percent have access to NHSN. ○ Sixty-four percent do NHSN data entry. • Common themes: ○ Ninety-three percent of validated facilities use automated imports for reporting: • IV antimicrobial start events are captured accurately. • PBC events collected at the facility are captured accurately. • PRS events lack standard field for documentation.	

	○ Large dialysis organizations have corporate/regional staff responsible for NHSN reporting. ○ Difficult to access hospital records to accurately identify all PBCs. • Conclusions and future steps: ○ On-site visits and outreach to regional partners helped us better understand workflow processes and strengthened relationship with dialysis facilities. ○ We are developing an internal validation guidance document informed by external validation efforts. ○ We will be providing additional training on NHSN reporting and analysis. <u>Question</u> ➢ Dat Tran: Will facilities be able to access hospital records electronically? Lisa Iguchi: There was an end-stage renal disease (ESRD) project that was trying to help facilities to get hospital electronic access. Jason Scott: Do you foresee the automated process that some of companies are working towards for reporting NHSN data will resolve some of these discrepancy issues? Lisa Iguchi: Potential to resolve some of the issues. It's a conversation for the national or corporate level.	

Oregon dialysis data overview Lisa Iguchi, OHA (See pages 46-54 of meeting materials)	➢ BSI in dialysis facilities decreased from 0.72 to 0.55 between 2015 and 2018. ➢ IV antimicrobial start rates (events per 100 patient-months): • Decreased from 3.31 to 2.78 between 2015 and 2018. • Stable between 2016 and 2018. ➢ Local access site infections (LASI) are defined as PRS events without an accompanying PBC (events per 100 patient-months): • Decreased from 0.79 to 0.54 between 2015 and 2018. • Higher than NHSN pooled mean rate. ➢ Facility results for NHSN 2019 Annual Survey, which focused on infection prevention: • Seventy-two percent participate in infection prevention initiatives. • All conduct hand hygiene staff audits. • Almost all (97 percent) observe staff Veterans Affairs (VA) care and central venous catheter accessing practices. • All conduct staff competency assessments for VA care and catheter access. • All follow CDC Core Interventions to prevent BSI; 46 percent follow them sometimes rather than always. ➢ OHA resources and announcements:	No action items

	• Developing dialysis internal validation guidance document intended to assist facility staff in reviewing annual NHSN data reports from OHA.
	• Upcoming: HAI Lunch and Learn Webinar:
	  ○ Provide guidance to NHSN users on dialysis event reporting.
	  ○ Review reporting and analysis functions.
	• Visit our website to learn more: www.healthoregon.org/hai
	
	<u>Question</u>
	➢ Zintars Beldavs: Do you trust the standardized infection ratio (SIR) results based on the validation findings?
	Lisa Iguchi: With new reports, I want to add a quick check or data quality report and do more active outreach to facilities.
	Roza Tammer: Internal validation is a great tool for that. We have been asking facilities to check data and providing guidance on how to check and resolve data quality issues. A similar process could work for dialysis facilities.
	Paul Cieslak: Have you looked into All Payer All Claims data as a secondary source?
	Lisa Iguchi: I would need access.
	Paul Cieslak: All Payer All Claims data may be able to pull together data when dialysis is happening at one place and the blood culture is happening at another place.	

Panel: Infection prevention in the dialysis setting **Karen Larson, Fresenius Medical Care** **Kristen Van Allen and Nancy Welder, DaVita Kidney Care** (See pages 55-73 of meeting materials)	<u>Infection prevention and control in dialysis settings, Karen Larson:</u> ➢ National burden of dialysis infections: • In the US, about 370,000 people rely on hemodialysis. • About 75,000 people receive hemodialysis through a central line. • Central lines have a higher risk of infection than a fistula or graft. • CDC estimates 37,000 central line-associated BSI may have occurred in U.S. hemodialysis patients in 2008. ➢ Patients who undergo hemodialysis have a higher risk of infection due to: • Frequent use of catheters or insertion of needles to access bloodstream. • Weakened immune systems. • Frequent hospital stays and surgery. ➢ Barriers to infection control in dialysis facilities: • Difficulty in isolating contagious patients. • Patient-to-patient contact is common. • Over 200 individual workflow steps in a single dialysis treatment and over 25 percent carry risk of contamination. ➢ Staff engagement:	No action items

	• Mission of the team is to optimize infection prevention strategies to reduce devastating impact of infections on patients. • CDC has developed specific recommendations tailored for hemodialysis HCW to decrease infections. • Spread existing knowledge and best demonstrated practices for infection prevention. • Organize knowledge in ways that staff at the point of care are engaged in reaching goal of zero infections. • Participate in validation processes. ➢ Patient and family engagement: • Partnerships to engage in care and share baseline information. ➢ Healthcare partner engagement: • Partner with OHA and NHSN for education and data collection. ➢ Quality assessment and improvement program oversight: • Patient representation at meetings. • Continuous quality improvement principles. • Data-driven root cause analysis and action planning. • Turn process into quality. <u>DaVita: infection management overview, Kristen Van Allen:</u> • Infections are second leading cause of death in ESRD patients.	

	• Infections are number-one cause of hospitalizations in ESRD patients.
	• HCW transmit infection.
	• Most infections are preventable.
	• In-center hemodialysis (ICHD) environment:
	  ○ Multiple opportunities for person-to-person transmission directly or indirectly via:
	  • Contaminated devices.
	  • Equipment and supplies.
	  • Environmental surfaces.
	  • Hands of personnel.
	• Surveillance:
	  ○ Infection Preventionists (IPs) considered experts on NHSN reporting including the 21-day rule; reporting is consistent across our 2,000+ facilities.
	  ○ NHSN reporting now automated with exception of external blood cultures (EBCs).
	  ○ Algorithm developed with automated notification sent to facilities when an opportunity to capture an EBC exists; IP enters the reportable cultures into the EBC tool.
	  ○ With automation of surveillance, focus shifts to prevention.
	• Driving improvement remotely.
	• Dashboard:	

	○ Infection prevention management (IPM) tool for ICHD and peritoneal dialysis provides trended data to guide improvement efforts: • Bloodstream infection and peritonitis rates by group, stratified by access type. • Includes organism data as well, allowing for further analysis by IPM. • Antibiotic stewardship tab allows review of antibiotic starts, highlighting deviation from protocol. ○ Manager of Clinical Services (MCS) Team – boots on the ground/“eyes and ears”: • MCS Team alerts IPM as needed. • IPM alert local teams as needed – i.e., surveillance patterns/trends. • Process for deeper dives and oversight initiated as needed. Question: ➢ Roza Tammer: Are there specific initiatives you've been able to work on with patients and families? Kristen Van Allen: Social workers involved in group (empowering patients and change) for department specific efforts to empower patients and change. Currently developing patient education from our department. Maureen Cassidy: Do you send cultures to a central lab that's associated with your dialysis system or do you use local or regional laboratories?	

	Kristen Van Allen: DaVita has a central lab that is utilized 90 percent of the time. Certain areas have Kaiser facilities, in which case, cultures are sent to a regional lab. Karen Larson: Fresenius Medical Care uses a central lab unless on rare occasion it is not feasible and then uses a local lab. Maureen Cassidy: If you have an organism that is reportable to a state, are you reporting it? Karen Larson and Kristen Van Allen: Yes, the lab does. Occasionally the facility. Roza Tammer: Any thoughts about the communication of PBC from external labs or that were collected at different facilities? Karen Van Allen: It's obtaining the information from visits to the hospitals in required timeframe for reporting. We have pretty good mechanisms for follow-up. There is room for improvement and a work in progress. The external sources and the sharing of information can be challenging. Lisa Iguchi: Are you following the CDC guidelines for core element of antimicrobial stewardship implementation in outpatient settings or internal DaVita or Fresenius guidance? Karen Larson: We have an internal protocol. It is hard to follow up on disconnects between actual care and protocol recommendation. Kristen Van Allen: We have an internal protocol.	

Discussion: Topics for future meetings and reports All attendees	Future topics: Please email Roza Tammer.	Email Roza any other ideas or topics for 2020
Public comment	<u>Comment</u> ➢ Jesse Kennedy: Recommendations state patients with COVID-19 should be placed on droplet precautions unless doing an aerosolized procedure. What is the best guidance when there is variance related to PPE guidance? Should we follow the World Health Organization (WHO) and CDC recommendations to use a respirator, or the OHA recommendations? Roza Tammer: Continue to follow the OHA recommendations. There are limited supplies of PPE and shortages in supplies for facilities and local health departments. Genevieve Buser: There are public health calls. On the public health call today we were supportive of the enhanced droplet contact with eye protection for non-aerosol-generating procedures with patients in Oregon, which follows WHO and Washington guidelines. Currently considered special droplet contact. Most important thing is masking the patient and hand hygiene. There's probably more specific information for dialysis units.	No action items

	Roza Tammer: If providers, health departments, and healthcare facilities do have questions, please call the on-call epidemiologist at 971-673-1111. <u>Question</u> ➢ Joshua Bardfield: For N95 masks, will Occupational Safety and Health Administration (OSHA) waive the fit test requirement? Roza Tammer: Sounds unlikely. Waiving the requirement might encourage more people in the community to be wearing and purchasing these masks. We want to keep supplies available for those who need them most. Genevieve Buser: Check with the Oregon Chapter for OSHA.	
Final role call and adjourn		

Next meeting will be June 10, 2020, 1:00 pm - 3:00 pm, at Portland State Office Building, Room 1E

Submitted by: Laura LaLonde
Reviewed by: Roza Tammer
Diane Roy