

**HEALTHCARE-ASSOCIATED INFECTIONS ADVISORY COMMITTEE**

**December 18, 2013  
1:00 pm to 3:00 pm**

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

**MEMBERS PRESENT:** Kelli Coelho, RN, CNOR (phone)  
Jill Freeman  
Jon Furuno, PhD  
Tara Gregory, MS, FNP  
Joan Maca  
Csaba Mera, MD  
Laurie Murray-Snyder  
Pat Preston, MS  
Dana Selover, MD, MPH  
Janet Sullivan, RN  
Dee Dee Vallier (phone)  
Diane Waldo, MBA, BSN, RN, CPHQ, CPHRM, LNCC  
Bethany Walmsley, CPHQ, CPPS

**MEMBERS EXCUSED:** Paul Cieslak, MD  
Jamie Grebosky, MD  
Nancy O'Connor, RN, BSN, MBA, CIC  
Rachel Plotinsky, MD

**STAFF PRESENT:** Dianna Appelgate, MS, MPH, CIC, CPHQ, Clinical Epidemiologist  
Zintars Beldavs, MS, Healthcare-Associated Infections Program Manager  
Monika Samper, RN, Healthcare-Associated Infections Reporting Coordinator  
Ann Thomas, MD, MPH, Acute and Communicable Disease Medical Epidemiologist

**ISSUES HEARD:**

- **Call to Order**
- **Introduce New OHA and Committee Members**
- **Approval of Minutes**
- **HAI Annual Report Changes/Ideas**
- **Standing Agenda: Oregon Patient Safety Commission**
- **Standing Agenda: Long Term Care Facilities**



Item	Discussion	Follow-Up
	<p>beds, has resigned from the committee. The Oregon Health Authority is asking for suggestions for a replacement from members.</p> <ul style="list-style-type: none"> <li>• OHA recently hired Dianna Appelgate as a clinical epidemiologist to assume much of Monika Samper’s role as an HAI reporting coordinator. Ms. Appelgate offers a strong statistical background and has many new ideas for the HAI annual report.</li> </ul>	
Approval of Minutes	The minutes for June 26, 2013 and September 25, 2013 meetings were unanimously approved.	
<p>HAI Annual Report Changes/Ideas</p> <p>OHA Staff</p>	<p>In the September meeting, members proposed ideas for the next HAI annual report such as improve readability, include gross numbers, and consider reducing the volume of the report. Taking these suggestions into account, examples of possible formats for the report are provided in the meeting materials:</p> <ul style="list-style-type: none"> <li>• 2009 central line-associated blood stream infections (CLABSI) and 2012 colon surgeries (COLO) SIRs for Oregon Hospitals are illustrated through a horizontal bar chart incorporating 3 different colors (page 28 and 30 respectively): <ul style="list-style-type: none"> <li>○ Green bar indicates that the number of observed infections was lower than expected and was statistically significant (SIR is less than 1).</li> <li>○ Red bar signifies that the number of observed infections was higher than expected and statistically significant (SIR is greater than 1).</li> <li>○ Blue bar denotes that the number of observed infections was not significantly different from the expected number.</li> <li>○ An asterisk symbolizes that an SIR could not be calculated because the hospital did not report any CLABSIs.</li> </ul> </li> <li>• CLABSI SIRs displayed in a forest graph for each institution are represented by dots and the 95% confidence intervals are illustrated through bars that transverse the dots (page 32). If the confidence interval crosses the dashed line —extends below and above the SIR value of 1 -- the interval is not statistically significant.</li> <li>• Simulated 2009 COLO data is displayed through a forest chart (page 33). To</li> </ul>	

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	<p>address consumer desire for gross numbers, total COLOs and surgical site infections, as well as the SIR, are shown to the left of the chart.</p> <ul style="list-style-type: none"> <li>• COLO 2012 SIRs with color-coded results are depicted in a vertical bar chart (page 34): green bars represent statistically significant positive results (less infections observed than expected), red bars signal statistically negative results (more infections observed than expected), and the black line marks an SIR of 1.</li> <li>• COLO SIR aggregate monthly data throughout 2009 for all Oregon hospitals is displayed in a line graph that utilizes vertical bars to portray confidence intervals (green – significantly better than the national average; gray – not significantly different from the national average (page 35).</li> <li>• Simulated 2012 aggregate catheter-associated urinary tract infections (CAUTI) rates by hospital unit are compared, using a bar chart, with the national SIR (page 36).</li> </ul> <p>Comments from committee members about the graphs included:</p> <ol style="list-style-type: none"> <li>1. Attendees liked the 2012 COLO and CAUTI charts (on pages 34 and 36 respectively) and proposed including additional charts, formatted the same as the graph on page 36, to compare each hospital's data with the Oregon and national rates.</li> <li>2. Terms such as SIR, statistical significance, and confidence intervals that readers may not be acquainted with, need to be explained at a 6<sup>th</sup> grade level to accommodate a diverse audience. Statistical appendices might be a good location for these definitions.</li> <li>3. Employ both narratives with basic examples and color-coded graphs with simple terms such as good, better, and best to address different learning styles.</li> <li>4. Include bar charts, in addition to line charts with confidence intervals, because consumers are familiar with them.</li> <li>5. Replace large detailed HAI annual report with a clear and concise synopsis focused on user needs.</li> <li>6. Exclusion of some of the charts in the HAI annual report may be possible due to the upcoming implementation of an online interactive map (refer to HAI Map presentation below for more information.)</li> </ol>	

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<p data-bbox="195 277 510 342">Standing Agenda: Oregon Patient Safety Commission</p> <p data-bbox="239 415 466 444">Bethany Walmsley</p>	<p data-bbox="541 277 1535 342">Bethany Walmsley provided an overview of the Oregon Patient Safety commission's current activities aimed at reducing HAIs:</p> <ul data-bbox="573 358 1577 1252" style="list-style-type: none"> <li data-bbox="573 358 1577 496">• OPSC has been working with The Northwest Dialysis Blood Stream Infection Prevention Collaborative for about a year and a half. Out of the original 33 facilities, 25 are still engaged in the collaborative. Analysis of the collected data will be finished in the spring of 2014.</li> <li data-bbox="573 500 1577 638">• OPSC has been involved with The Oregon Antimicrobial Stewardship Collaborative for the last 18 months. The collaborative, which held its final learning session in November, is anxious to examine the data that is still being gathered.</li> <li data-bbox="573 641 1577 886">• For over two years, OPSC has been offering infection training and educational programs, funded by the Healthcare Regulation Quality Improvement grant, to help facilities achieve their goals for survey results. All classes are listed on their website on the events page for public viewing. Upcoming events include webinars focused on Norovirus for long-term care facilities in January and infection prevention training for ambulatory surgery centers on February 7, 2014.</li> <li data-bbox="573 889 1577 1252">• On August 1, 2013, OPSC began a MDRO Prevention Collaborative, comprised of three different groups: north coast region targets the Astoria area, Linn-Benton region encompasses the Corvallis area, and south coast region covers the Bay area. These collaboratives were established not only to reduce infections, but also to provide a forum for different types of organizations to work together and learn from each other. OPSC supports these efforts through a collaborative model, which incorporates evidence-based resources, targeted learning sessions, and site visits. Preliminary results show that the groups have been very successful, and tangible data for the committee is expected to be available in the spring.</li> </ul> <p data-bbox="541 1268 1535 1408">Due to the importance of their work, meeting attendees deliberated about the best method for disseminating information about these collaboratives. Although all published materials are available to the public through each group's website, some members questioned whether a more direct method such as email/mailings to the</p>	

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	<p>target audience, utilizing databases maintained by various organizations, might be more effective. One member explained that they either partner with or rely on other organizations to forward messages/material to appropriate contacts in their mailing lists. Another option would be to channel information through the local the Association for Professionals in Infection Control and Epidemiology (APIC) chapter.</p>	
<p>Standing Agenda: Long Term Care Facilities</p> <p>Joan Maca</p>	<p>Healthcare professionals at long-term care facilities (LTCF) encounter multiple obstacles in their struggle to control infections and adhere to CMS and state reporting rules. To begin with, access to basic Information regarding reporting requisites is often lacking. Although OHCA and other organizations send notices of CMS mandates to LTCF administrators, information may not trickle down to directors of nursing or nurses who are tasked with reporting and controlling infections. As a result, pertinent staff may have no idea of what to report, how to define their infections, or even aware that data needs to be collected. This disconnect is particularly evident in assisted living facilities where tracking tools and reporting guidelines are often unavailable. Limited clinically-trained personnel serve to compound the problem in all types of LTCFs. Infection control nurses in skilled nursing facilities are typically charged with multiple responsibilities within the constraints of part-time hours, leaving non-clinical staff to perform the majority of reporting activities. Assisted living facilities often do not have healthcare professionals on staff and certainly do not hire infection control nurses. Therefore, unlike the published government regulations distributed to healthcare administrators, any guidelines provided to staff must be at a level all personnel are able to understand. In an effort to fill the gap, Yamhill county offered its first workshop last week to educate LTCFs about CMS requisites for mandatory reporting of HAI data.</p> <p>To improve communication, committee members recommended partnering with the Oregon Health Care Association (OHCA), Leading Age, and APIC as an effective means of reaching directors of nursing (contact lists would need to be evaluated for completeness) regarding administrator alerts, reporting requisites, and important upcoming events. LTCF administrators, on the other hand, would benefit from communications sent by the Public Health Division and the Patient Safety Commission because these government agencies are tied to the Office of Licensing and Regulatory Oversight (OLRO), a state arm of CMS, who is responsible for issuing citations to</p>	

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	<p>facilities found to have violated federal regulations during inspections. Consequently, administrators are more likely to carefully read and forward information from these organizations to staff tasked with reporting and controlling infections.</p> <p>As with reporting mandates, lack of proper training and skilled nursing staff is probably the cause of continued infections. One solution might be for LTCFs to work more closely with hospitals as an opportunity to connect with experts or to have hospitals serve a central point for coordinating efforts and resources. However, collaborating with corporate-owned facilities, with their inherently complicated hierarchical infrastructure, is difficult because all relevant parties—such as corporate leadership, corporate nurses, and facility nurses—must be involved for tasks to be accomplished. Another option, which the industry might be more responsive to, would be to broach education about federal regulations as a means to avoid F Tags/CMS citations and to reduce infections thereby increasing profits.</p> <p>LTCFs are not cited for infections, an inevitable outcome in healthcare organizations, but for not following their own policies including failure to: implement established policies, identify infections in a timely manner, or closely adhere to protocols. The most common citation given by CMS is F Tag 441, which focuses on preventing and controlling the spread of infections through such measures as hand hygiene, laundry management, and employee work restrictions.</p> <p>Committee members expressed the need for CMS input in order to proceed with training for nursing homes (the statute does not apply to assisted living facilities). Consequently, OHA will contact the Manager of the Nursing Facilities Licensing Unit at the DHS Office of Licensing &amp; Regulatory Oversight to determine the best resource for advising the committee.</p>	

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<p data-bbox="201 277 506 378">Standing Agenda: Oregon Association of Hospital &amp; Health Systems (OAHHS)</p> <p data-bbox="275 451 432 477">Diane Waldo</p>	<p data-bbox="541 277 1583 662">For the last two years, OAHHS has been partnering with the American Hospital Association (AHA) and the Health Research and Education trust (HRET), the quality arm of the AHA, on the CMS Partnership for Patients (PfP) initiative to reduce hospital-acquired conditions in ten target areas including: central line-associated blood stream infections (CLABSI), catheter-acquired urinary tract infections (CAUTI), surgical site infections (SSI), ventilator-associated pneumonia (VAP), preventable readmissions and pressure ulcers. The national HRET Hospital Engagement Network (HEN) is comprised of 31 states with over 1600 hospitals. In Oregon there are four HENs: Intermountain Healthcare Network, Premier Network, Washington State Hospital Association Network, and the OAHHS-HRET Network. 31 hospitals, which is over half of the acute care facilities in Oregon, belong to the latter network.</p> <p data-bbox="541 686 1583 857">As a result of hard work over the last two years, hospitals in the OAHHS-HRET Network have achieved the difficult milestone of at least a 40% reduction in five of the ten target areas: CAUTI, CLABSI, early elective deliver, VAP, and SSI. This achievement has led Oregon to become the top performer of all states participating in the national HEN based on recent results.</p> <p data-bbox="541 881 1583 1052">In 2014, adverse drug events and surgical cases, two of the ten PfP areas of focus, will be expanded slightly and the emphasis will be somewhat different. For example, instead of SSIs associated with hip and knee procedures, infection data already being reported by hospitals--such as spinal operations, hysterectomies, and other types of surgeries--will be analyzed in order to share more surgical outcomes with the public.</p>	
<p data-bbox="243 1065 459 1123">Standing Agenda: Acumentra Health</p> <p data-bbox="222 1203 480 1229">Laurie Murray-Snyder</p>	<p data-bbox="541 1065 1583 1235">Acumentra Health, the Medicare Quality Improvement Organization (QIO) for Oregon, is working with hospitals and other stakeholders to encourage antimicrobial stewardship and to reduce <i>Clostridium difficile</i> (CDI), catheter-associated urinary tract infections (CAUTI), and surgical site infections (SSI) related to knee and hip surgeries. These efforts include:</p> <ul data-bbox="573 1260 1583 1408" style="list-style-type: none"> <li data-bbox="573 1260 1583 1318">• Collaborating with the Oregon Hospital Engagement Networks to assist hospitals participating in the Partnership for Patient’s safety and quality initiative.</li> <li data-bbox="573 1343 1583 1408">• Working through the Oregon HAI Prevention Coalition with selected hospitals to improve patient outcomes: 8 hospitals are focusing on CAUTIs, 11 hospitals are</li> </ul>	

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	<p>targeting SSIs (knees and hips), and 6 hospitals are striving to reduce CDIs.</p> <p>During the CMS measurement period, which ended August 31, 2013, CAUTI rates of participating hospitals varied widely, particularly during the last 6 months, leading Acumentra Health to wonder whether facilities would meet benchmarks. In addition, CDI rates were also high. Fortunately, hospitals passed with SIRs of 0.9 for CAUTI and 0.8 for CDI and with a SDUR--the device utilization rate--of 1.0 (an SDUR equal to or less than 1.0 was required to pass).</p> <p>To celebrate the completion of the PfP CAUTI initiative and to learn about the National ED Improvement Intervention program aimed at reducing catheter utilization and decreasing overall CAUTI rates, Acumentra Health will be hosting a meeting in February. Dr. Mohamad Fakih, a national expert on healthcare-acquired infections, will be the featured speaker.</p> <p>Acumentra Health will be able to proceed with efforts to reduce HAIs as a result of a new 5-year contract with CMS. Staff will continue to work on CAUTIs--hospital units will be expanded from ICUs to multiple units—CDI, and antimicrobial stewardship, but SSIs will be eliminated from their program.</p>	
<p>Standing Agenda – Public Health Division</p> <p>OHA Staff</p>	<p><u>Healthcare Acquired Infections Reporting Poster</u></p> <p>The HAI poster, with information listed by facility type, will allow healthcare professionals to easily identify both Oregon and CMS reporting requirements pertaining to their organization (page 37 of meeting materials). Included in the hospital category is Vibra Specialty Hospital of Portland, a long-term acute care facility licensed as a hospital.</p> <p>Committee members discovered an error in the poster. CAUTIs are listed as reportable for long-term care facilities; however, only hospitals are obligated to inform CMS and the State of these infections. Corrections will be made prior to the publication of the poster.</p> <p><u>HAI Annual Report</u></p> <p>Although Oregon Revised Statutes (ORS) mandate the publication of the HAI annual report no later than April 30th of each year, the deadline is impossible to meet.</p>	<p>Zints Beldavs will research process for altering ORS and present findings at next meeting.</p>

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	<p>Facilities have until April 15th to enter their infection data into the National Healthcare Safety Network (NHSN) and then have 30 days to review reports created by OHA from finalized NHSN data. Due to the onerous process involved with modifying ORS, OHA has not pursued changing the statute, but staff will investigate further and report findings at the next meeting.</p> <p><u>OARs 333-019-0052</u></p> <p>OHA staff has been collaborating with stakeholders to develop policies to encourage better inter-facility communication during the transfer/discharge of patients. The resulting policies have been incorporated into the new Oregon Administrative Rule (OAR) 333-019-0052 that will become effective January 1, 2014 (refer to page 39 in meeting materials). To summarize the rule, when a referring facility transfers or discharges a patient who is infected or colonized with a multidrug-resistant organism (MDRO) that warrants transmission-based precautions, a written notification --readily accessible to all parties involved with the transfer (e.g., medical transport personnel)—must be included in the transfer documents to the receiving facility. The OARs focus on communicable pathogens rather than conditions requiring contact precautions because infection prevention policies differ between long-term and acute care facilities. In support of the new rule, a standard inter-facility communication form to accompany patients during transfer/discharge is being developed by a work group led by OHA. MDROs applicable to the rule include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)</li> <li>• Vancomycin-resistant <i>Enterococcus</i> (VRE)</li> <li>• Carbapenem-resistant Enterobacteriaceae (CRE)</li> <li>• Multidrug-resistant <i>Acinetobacter baumannii</i></li> <li>• Multidrug-resistant <i>Pseudomonas aeruginosa</i></li> <li>• Drug-resistant <i>Streptococcus pneumoniae</i></li> <li>• Other gram-negative bacteria producing extended-spectrum beta-lactamases (ESBL)</li> <li>• Toxin-producing <i>Clostridium difficile</i></li> </ul>	

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	<p>Facilities obligated to abide by the new Oregon Administrative Rule encompass organizations that provide 24-hour patient care including adult foster homes, residential care, and mental health agencies. These organizations only need to communicate MDRO infections during patient transfers; the rule does not require any specific action with the exception of laboratory-confirmed carbapenemase-producing Enterobacteriaceae (CPE). In this case, the referring facility must notify the local health department (LHD) within one working day after the patient is transferred or discharged. Initially, due to limited resources, OHA will only investigate violations to the new MDRO communication rule when a complaint is received. OHA will also most likely be enforcing the reporting of lab-confirmed CPE to LHDs.</p> <p>Although all licensed facilities should have received the complete text of the new Oregon Administrative Rule, OHA will also be offering instructional webinars to explicate crucial elements. OHA is also working on developing materials to better educate the healthcare community about MDROs, particularly carbapenemase-producing CRE. As communication about patients' health status improves, facilities lacking knowledge of the risks associated with each MDRO, may reject patients solely based on fear.</p>	
<p>HAI Map</p> <p>OHA Staff</p>	<p>In response to the need for a user-friendly data abstraction tool, Magdalena Scott Kendall developed an interactive state map that will provide consumers with a number of options to easily view HAI data extracted from NHSN's tracking system for Oregon hospitals (refer to meeting material for the semi-final version beginning on page 44). When initiated, the software will display an Oregon map with all hospitals represented by red pins. From this screen, utilizing an array of tools, consumers will be able to:</p> <ul style="list-style-type: none"> <li>• Examine a listing of an individual hospital's statistics for all reportable HAIs--such as the incidence of <i>clostridium difficile</i> or the percentage of laminectomies resulting in a surgical site infection--for a specific year.</li> <li>• Scrutinize a hospital's infection trends illustrated through a line graph for a particular HAI over multiple years.</li> <li>• Compare data of multiple hospitals displayed in a bar chart for a single HAI and year.</li> <li>• Create, sort, and export a table containing all reportable HAIs for individual or</li> </ul>	

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	<p>multiple hospitals in a given year.</p> <p>A software tool developed by a different company, InstantAtlas, is also under consideration. An example of the initial screen this software might display for CLABSI data shows a US map and a table--similar to those in our annual report—with SIR, count, predicted infections, and total by state. OHA liked this report and has forwarded data in response to Instant Atlas’ offer to produce additional sample reports for free.</p> <p>Due to the simplicity, report options, and ease-of use, committee members discussed replacing the detailed data given for each hospital in the HAI annual report with an online interactive map. Several meeting attendees, impressed with the maps, would like to investigate providing access to them on insurance websites, where consumers are making decisions about their healthcare options, through transparent linking software tools. The mapping software is expected to be available on OHA’s website by the time the 2013-2014 HAI Annual Report is published.</p>	
<p>2012-2013 Healthcare Working Influenza Vaccination Survey Annual Report</p> <p>OHA Staff</p>	<p>More healthcare workers are being vaccinated for influenza every year in Oregon facilities (refer to report beginning on page 49 of meeting materials). Based on benchmarks established by U.S. Department of Health and Human Services (HHS) for vaccination rates—60% for 2010, 75% for 2015, and 90% for 2020—Oregon hospitals are doing well. Since the 2011-2012 reporting period, hospital have improved by 8% and, for the first time, met the 2015 benchmark by vaccinating 77% of their personnel. In addition, 52% of hospitals, 27% of long-term care facilities, and 41% of ambulatory surgery centers have fulfilled the 2015 Healthy People Targets for vaccination rates set by HHS.</p> <p>Some especially noteworthy results gathered from the survey include:</p> <ul style="list-style-type: none"> <li>• The most common reason given by healthcare workers for declining a vaccination in 2012-2013 was, “other” whereas the most frequent response in the previous reporting year was, “I decline to provide a reason”. This variance can be attributed to the elimination of the latter reason--an attempt to encourage workers to provide a more informative answer-- leading respondents to chose the “other” category instead.</li> </ul>	

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	<ul style="list-style-type: none"> <li>• A high percentage of facilities offered vaccinations at no cost to employees: 100% of hospitals, 93% of long-term care facilities, and 73% of ambulatory surgery centers.</li> <li>• Delivery methods for vaccinations varied between the three types of facilities: 85% of hospitals employed mobile carts and provided vaccinations in congregate areas; ambulatory surgery centers favored peer-administered vaccinations; and long-term care facilities chose to primarily offer vaccinations in congregate areas.</li> <li>• The percentage of hospitals providing formal education on influenza vaccination dropped from 62% to 48% in the last year for unknown reasons; in contrast, the percentage of long-term care facilities and ambulatory surgery centers offering instruction increased.</li> </ul>	
Public Comment / Adjourn	No public comments	

**Next meeting will be March 26, 2:00 pm to 4:00 pm, at the Portland State Office Building, Room 1E.**

Submitted By: Diane Roy

Reviewed By: Dianna Appelgate  
Zintars Beldavs

***EXHIBIT SUMMARY***

- A – Agenda**
- B – June 26, 2013 Minutes**
- C – September 25, 2013 Minutes**
- D – HAI Annual Report Changes/Ideas**
- E – HAI Reporting Poster**
- F – New OAR 333-019**
- G – HAI Map Examples**
- H – Healthcare Worker Influenza Vaccination Rates 2012-2013 Season**