HEALTHCARE-ASSOCIATED INFECTIONS ADVISORY COMMITTEE

June 26, 2013
1:00 pm to 3:00 pm

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

MEMBERS PRESENT: Bruce Bayley, PhD
Paul Cieslak, MD
Tara Gregory, MS, FNP
Laurie Murray-Snyder (phone – in place of Stacy Moritz, RN, MBA)
Kecia Norling, RN
Pat Preston, MS
Angel Wynia

MEMBERS EXCUSED: Susan Mullaney
Nancy O'Connor, RN, BSN, MBA, CIC
Dana Selover, MD, MPH
Dee Dee Vallier
Diane Waldo, MBA, BSN, RN, CPHQ, CPHRM, LNCC
Bethany Walmsley, CPHQ, CPPS

STAFF PRESENT: 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
- Approval of Minutes
- Review Oregon HAI Prevention Plan
- Standing Agenda: OPSC
- Standing Agenda: ASCs
- Standing Agenda: LTCFs
- Standing Agenda: Dialysis Centers
- Standing Agenda: Birthing Centers
- Update from Hospital Association
- Standing Agenda: Acumentra
- Standing Agenda: Public Health
- Discussion on Areas of Potential Collaboration

- **Frequency of Meetings**
- **Public Comment / Adjourn**

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

Item	Discussion	Follow-Up
Call to Order	The meeting was called to order at approximately 1:00 pm. There was a quorum.	
Approval of Minutes	The minutes for February 27, 2013 and April 24, 2013 meetings were unanimously approved.	
Review Oregon HAI Prevention Plan Staff	To gain a better understanding of the role of the committee, members at the April meeting requested for Oregon Public Health Division (OHPD) staff to review the Oregon HAI Prevention Plan at the next meeting. So, Monika Samper presented a synopsis of the plan and discussed obstacles preventing the committee from reaching some of the goals. The original document, dated December 2009, was developed by the Oregon Public Health Division, Oregon Health Policy and Research (OHPR), and the Oregon Patient Safety Commission. Derived from a federal grant application template, consisting of a list of choices and blank lines for selecting/filling in statewide objectives, the plan is very basic. Of particular interest is section 1, which details infrastructure planning for HAI surveillance, prevention, and control. Although most of the items under this section have been completed, implementation of some of the objectives has not been possible because the National Healthcare Safety Network (NHSN) system lacks the necessary functionality. The items that are incomplete include: • Integrate laboratory activities with HAI surveillance, prevention, and control efforts (page 4, Level I, item 3) – The CDC is gradually working toward upgrading NHSN, but this software application does not currently support outbreak investigations, provide health level 7 (HL7) messaging of lab results, or offer other related functions. However, OPHD has addressed the coordination of lab testing with HAI reduction endeavors in a recently published toolkit that provides guidance to labs and healthcare personnel for controlling CRE, a reportable HAI pathogen.	Monika Samper will summarize the status of items in the HAI Prevention Plan and compose a list of future goals for the next meeting.

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	Note: Level I plans encompasses state activities that are being funded by the federal government. • Facilitate use of standards-based formats by healthcare facilities for purposes of electronic reporting of HAI data (Level II ,item 5) Although some of the larger electronic medical record (EMR) vendors are working with NHSN to integrate laboratory activities through the electronic transfer of hospital EMR data directly into the NHSN system, currently infection preventionists must manually enter all information. It's not known whether EPIC, a healthcare software company with an EMR system used by most Oregon facilities, is collaborating with NHSN at this time. Therefore, OHPD is making an effort to establish a relationship with EPIC to encourage and facilitate the development of an interface with NHSN. The Oregon Public Health Division is investigating electronic laboratory reporting for multi-drug resistant organisms (MDROs). Creating a computerized method to identify MDROs and transmit the information to NHSN, though, is not an easy task. First, the transfer of data will be difficult because the structure of the database and content/format of fields will differ between the EMR and NHSN. Second, unlike many reportable infections, identifying an MDRO involves complex program code to select the correct organism. For example, CRE encompasses: 38 kinds of bacteria from the *Enterobacteriaceae* family that are non-susceptible to any carbapenem, resistant to 3rd generation cephalosportins, possess a gene sequence specific for cabapenemase, test positive for cabapenemase production, etc. After reviewing the State Plan, members decided that the document needed to be rewritten and reformatted to improve readability. A summary of the accomplishments and outstanding items for each goal would facilitate the development of future goals. A revised plan and a list of proposed objectives will be presented by the HAI program at the next meeting scheduled in September.	
Standing Agenda : OPSC Bethany Walmsley	Bethany Walmsley from the Oregon Patient Safety Commission was unable to attend the meeting today.	

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Standing Agenda: ASCs Kecia Norling	The approximately 100 ambulatory surgery centers (ASCs) in Oregon, of which about 83 are Medicare certified, have been ramping up their infection control and reporting efforts: • Oregon, Colorado, South Carolina, and some United Surgical Partners International centers are part of the first phase of the Agency for Healthcare Research and Quality's (AHRQ) initiative to promote a culture of safety in ambulatory surgery centers through the implementation of AHRQ's surgical safety checklist. In addition to a focus on safety, the AHRQ program for ASCs also entails an HAI component, including training on evidence-based infections and reporting of surgical site infections. The surgical procedures that ASCs will gather infection data for have not yet been determined because HAI reporting is part of the pilot project and identifying appropriate procedures in a surgery setting is difficult. • The national Ambulatory Surgery Center Association (ASCA), which Ms. Norling is a board member of, just approved the funding for a registry, indicating a commitment at the national level. The association already has 6 quality measures sanctioned by the National Quality Forum that many centers are reporting online. Consequently, ASCA is now ready to fund the national registry and to truly begin data collection. • ASCs are now reporting data to CMS, including quality data G-codes on five outcome measures. On July 1, 2013, ASCs will begin submitting data for additional measures: o ASC-6 – Does/did your facility use a safe surgery checklist based on accepted standards of practice during the designated period? o ASC-7 – What was the aggregate count of selected surgical procedures per category? • Centers will most likely report data to CDC via NHSN, once the ASC component is available. The Oregon Patient Safety Commission just released the 2012 ASC Annual Summary (available on their website), which provides an aggregate overview of reported adverse events. This document reveals a nice increase in reporting: the commission received 177 reports that included 180 events. Healthcare-associated infections (HAIs), totaling 31 or 17%, were the second most frequently reported adverse event type in 2012. Out	

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	of the 31 HAIs, 16 were considered serious events (e.g., required a return to surgery, an admission to a hospital, etc.)--a detail not included in the report. Nonetheless, 31 HAIs is not a huge number. In particular, surgical site infections (SSIs) have been very low because historically the top three procedures--cataract extraction, upper GI endoscopy/biopsy, and colonoscopy—rarely have infections. While the data is favorable, the number of facilities not reporting to OPSC is unknown because participation is voluntary; only the fee is mandatory. Oregon is being swept up in national CMS reporting more quickly due to the efforts of OPSC. Willing to take on more than other states, Oregon ASCs are pushing for CMS to allow total joint replacements, a definitely reportable SSI, to be performed on Medicare patients in the ASC setting. This serious step demonstrates that Oregon is not afraid of providing data. The National Association is pressing for reporting from all states and Oregon is willing to comply.	
Standing Agenda: LTCFs Pat Preston	In the past 18 months, the long-term care industry has been very active: • Long-term care facilities (LTCFs) are partnering with two trade organizations that represent all nursing homes: the Oregon Healthcare Association and Leading Age. These organizations sponsored a daylong workshop, incorporating HAI materials, in 2012 and will offer another workshop on September 11, 2013. • The Oregon Patient Safety Commission developed an all-day workshop—scheduled in five cities from October 2012 through October 2013--for long-term care focused on HAIs and vaccination. • Payless, a long-term care pharmacy under the ownership of Moda Health (formerly ODS), presents all-day workshops with an HAI educational component. • The Oregon Public Health Division is working with corporations to identify outbreaks, not just transmission and colonization, but also clinically defined HAIs within a nursing home. As a result of one investigation, a corporate training webinar was produced on *Acinetobacter*. • CMS' latest release of the "National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination" on April 13, 2013 includes a new section specific to infection reduction in LTCFs. The three organisms that LTCFs routinely contend with are MRSA, *Clostridium difficile*	

Item	Discussion	Follow-Up
	(C. diff), and *Acinetobacter. C. diff,* a much more prevalent and transmissible organism than MRSA, is the biggest issue followed by *Acinetobacter*, an easily spread organism as evidenced by a small outbreak in Oregon. As a result of continually increasing high levels of morbidity, mortality and dollar cost, *C. diff*, and *Acinetobacter* should be targeted if the committee considers mandating the reporting of additional HAIs. If not deemed mandatory, LTCFs will be reluctant to disclose these cases. On the other hand, if punitive measures are employed when a facility reports an outbreak, a backlash may occur. In the case of norovirus outbreaks, local county health departments are now required to answer inquiries from news outlets and to contact the Oregon Health Authority, which leads to the public, family members, and state officials notifying CMS and OSHA. These agencies may then stop admissions and fine facilities. If carried over to HAIs, these disciplinary actions may cause reporting to diminish. Nevertheless, the role of the committee is to reduce HAIs by promoting transparency and mandating reporting, so members wondered how this problem might be solved. A staff member offered that Tom Eversole, the Administrator for the Center for Public Health Practice, would like to create a statewide work group, comprised of representatives from public health and long-term care facilities, to develop a plan to reduce the burden on nursing homes, patients, and public health agencies. An easy way for the committee to help, Pat Preston offered, would be to encourage inter-facility communication between hospitals and long-term care about any identified active infections or colonization of disease-producing organisms on discharge of a patient. LTCFs still admit patients with *C. diff*, MRSA, and other MDROs without any knowledge that the patient had been in isolation during their hospital stay. A statewide needs assessment survey sent to labs, hospital infection preventionists (IPs), and LTCFs by OHPD revealed that only 55% of IPs are aware of MDRO status on admission. To improve communication, Pat Preston would like the committee to endorse and drive the inter-facility transfer form published recently in the DROP-CRE toolkit by the Oregon Health Authority. Currently, hospitals and independent corporations are creating and using their own forms. One committee member liked the idea and agreed that a universal form was a worthwhile endeavor, but questioned whether it was within the purview of the committee. Perhaps, the committee might lend its voice or the	

Item	Discussion	Follow-Up
	endeavor might be incorporated into the Patient Safety Commission's activities to reduce healthcare-acquired conditions.	
Standing Agenda: Dialysis Centers	The Northwest Dialysis Blood Stream Infection Prevention Collaborative, comprised of staff from The Oregon Patient Safety Commission, Northwest Renal Network, and Washington State Department of Health, are currently providing learning sessions to 28 dialysis centers in Oregon and Southwest Washington in an effort to reduce blood stream infections. After the last session in July, analysis of outcome data will hopefully offer definitive answers regarding the progress of the collaborative. An application has been submitted to extend the grant money received from the CDC to enable the collaborative to continue their endeavor through December 2013.	
Standing Agenda: Birthing Centers	Kecia Norling, a new board member of the Oregon Patient Safety Commission, informed the committee that the commission will not likely require birthing centers to report infections in 2014.	
Update from Hospital Association Diane Waldo	Diane Waldo was unable to attend the meeting, so Bruce Bayley offered an update on the Oregon Association of Hospitals and Health Systems' (OAHHS) recent activities. The association continues to be involved with the national Centers for Medicare and Medicaid Services (CMS) Partnership for Patients (PfP) initiative. To assist hospitals with improving safety, OAHHS has been providing statewide lean training, utilizing tools designed to increase efficiency and improve processes, to optimize healthcare delivery. Hospitals have been excited about participating in this training. In addition, Ms. Waldo has set up quarterly meetings for the 4 statewide healthcare engagement networks — HRET/ OAHHS, Intermountain Healthcare, Premier, and Washington State Hospital Association—to furnish hospitals with a forum to discuss their activities and goals and to provide a means to sustain the group and their efforts.	
Standing Agenda: Acumentra Laurie Murray-Snyder	Acumentra is working with CMS on 3 healthcare-associated infections—catheter-associated urinary tract infections (CAUTI), surgical site infections (SSI), and *Clostridium difficile (C. diff)* infections—and antimicrobial stewardship. • CAUTIs – Data from eight hospitals currently reporting CAUTIs reveals a 7% relative improvement in infection rates in the first quarter of 2013 compared to the fourth quarter of 2012. However, this improvement is not necessarily indicative of a trend because rates fluctuate across quarters. Both nationally and in Oregon, CAUTI and device utilization	

Item	Discussion	Follow-Up
	rates have remained about the same for the last three quarters. Oregon's catheter days, though, have been 12.5% lower than national rates. Although overall rates have been steady, CMS is asking for a relative improvement rate of 25% for CAUTIs and 10% for catheter days by the end of July 2014. • *C. difficile* – Rates, of the six Oregon hospitals reporting *C. diff* data, have increased 4.2% from the fourth quarter of 2012 to the first quarter of 2013. CMS is requesting an 8% relative improvement rate by the end of July 2014 and Acumentra is asking for a 10% improvement (which was the original goal set by CMS, but 3 months ago the center reduced the improvement rate to 8% possibly because CMS did not perceive 10% as an achievable goal; Acumentra kept the 10% goal to provide an incentive for hospitals to improve infection rates). • SSIs – While CMS does not have an official goal, Acumentra is asking the 11 hospitals they're working with for a relative improvement rate of 25% by the end of July 2014.	
Standing Agenda: Public Health Staff	<u>State Report</u> The Public Health Division has submitted the first rough draft of the state report of 2009-2012 reportable HAI infections to the publications department. The first 34 pages include an executive summary, the history of HAI reporting, the rationale for producing the report, and a summary of each individual mandated reporting measure. In the subsequent pages, infection statistics for each hospital will be presented in graph format; these are currently not available because the publications department has not yet finalized the data. New to the report, as discussed in previous committee meetings, is the use of the CDC standardized infection ratio (SIR). To accommodate the general public, on page 10, an explanation of the SIR—what the ratio means and how to interpret it--is explained in layman's terms. The mandated measures section of the report show some interesting trends:	

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	• Adult ICU CLABSIs (central line-associated blood stream infections) have continued to decrease. However, only CLABSIs reported by hospitals for 2009 have been validated by OHPD, so the actual number of infections may be slightly higher. The percentage of facilities that reported no infections remained the same from 2011 to 2012, but is still higher than figures reported in 2009 and 2010. • CLABSIs in neonatal ICUs have increased from 9 in 2011 to 11 in 2012, but the number of hospitals reporting no infections almost doubled. Nonetheless, 2012 CLABSIs for Oregon NICUs are 42% lower than the national expected number of infections. • Abdominal hysterectomy SSIs (surgical site infections) SIRs have dropped 4.5% from 2011 to 2012, and hospitals reporting no infections decreased 10% during the same time period. This improvement may be due to a reduction in number of abdominal hysterectomies performed: 3,694 in 2011 and 3,502 in 2012. • Colon SSIs have remained relatively stable during the two-year data period. • CBGB (coronary artery bypass graft) SSIs counts since 2009 have gradually decreased, and the percentage of facilities with no reported infections has gradually increased. • Hip replacement infection data from 2011 to 2012 indicate that the number of SSIs fell slightly and the percentage of facilities reporting no infections rose. • Knee replacement standardized infection ratios, which incorporate the number of procedures as part of the calculation, have been consistent during 2009-2012, but infection counts have increased somewhat with the growth in the number of knee replacements being performed. • Laminectomy SSIs counts were similar for the 2 years of reported data: 67 infections in 2011 and 63 infections in 2012, but the percentage of facilities reporting no infections remained the same, 36%.	

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	• *Clostridium difficile* infection measures are new this year consequently no comparative data is available. In 2012, hospitals reported 646 cases of *C. difficile*, which is 27% lower than the expected number based on the calculated SIR. On page 23, a chart shows a comparison between the rates of healthcare facility onset infections and community-onset healthcare facility-associated infections of *C. diff* per 1,000 patient days. Corrections and suggested modifications to the mandated measures section of the report included: • Page 17, figure 6 – change title from abdominal hysterectomy to colon • Page 20, knee replacement SSIs – add comment that the increase in infection counts is due to a growth in the number of procedures • Page 24 – remove SCIP-Inf-6 from list of Surgical Care Improvement Project measures tracked by Oregon • Page 25 - change graph heading from *Clostridium difficile* infections to Surgical Care Improvement Project • Page 26, figure 20 – Y axis headings and labels for chart symbols incorrectly specify infection counts and facilities reporting no infections. In actuality, the bars illustrate the percentage of healthcare workers vaccinated and the hexagon shapes represent the percentage of hospitals meeting or exceeding the 70% goal of vaccinated healthcare workers by 2015. • For each procedure, include the number of hospitals performing the procedure, total number of procedures, and the percentage of procedures resulting in an SSI. When reviewing the state report, the reader should be aware of two significant limitations: the data is self-reported by facilities and hospitals vary in their ability to detect HAI cases. For example, Kaiser, a closed system with both an inpatient and outpatient EMR, is able to obtain almost all of post-discharge	

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	surveillance of surgical procedures. In contrast, other hospitals may be limited to searching through inpatient readmission records for SSIs and asking surgeons to report SSIs treated in an outpatient setting. Nonetheless, a committee member commented, hospitals need to employ the highest standards of auditing to ensure quality data, and the committee needs to reinforce this message. Accurate and complete reporting is encouraged by the Oregon Public Health Division through audits of hospital medical records. A statewide validation of all 58 Hospitals required to report CLABSIs in 2009 was done in 2011 and a validation of all 14 hospitals required to report 2009-2010 CABG-associated SSI events was performed in 2012. Results from the CLABSI audit have been published, and data from the SSI audit will be made available once analysis has been completed. While good surveillance is desirable, reputations of healthcare facilities must be protected. Larger hospitals, particularly OHSU with the only burn unit in the state, treat patients at a higher risk for infections due to the nature, severity, and complexity of their conditions. The committee needs to advocate for these facilities by enumerating the variables that may affect the number of HAIs reported by a hospital. <u>CRE Toolkit</u> OHPD recently published the "Guidance for Control of Carbapenem-resistant Enterobacteriaceae (CRE)" toolkit. A meeting scheduled in September will focus on realistic and workable methods for encouraging healthcare facilities to follow these guidelines. One option, already implemented by one state, might be to mandate the transfer of information to appropriate healthcare and public health personnel	
Discussion on Areas of Potential Collaboration Staff	To facilitate further discussions regarding the objectives of the committee, OHPD will compile a list of suggestions for future goals, to be incorporated in the state plan, for September's meeting. A finalized plan will provide a framework for members to work collaboratively toward the reaching objectives.	
Frequency of Meetings	In the last meeting, the committee discussed changing back to quarterly	

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Staff	meetings, but no decision was reached. So, the change was put to a vote, and members approved quarterly meetings. The next meeting scheduled in August will be moved to September 25, 2013 from 1:00 pm to 3:00 pm.	
Public Comment / Adjourn	No public comments	

Next meeting will be September 25, 2013, 1:00 pm to 3:00 pm, at the Portland State Office Building, Room 1C.

Submitted By: Diane Roy

Reviewed By: Monika Samper
Zintars Beldavs

EXHIBIT SUMMARY

A – Agenda
B – February 27, 2013 Minutes
C – April 24, 2013 Minutes
D – Oregon HAI Prevention Plan
E - Draft of Healthcare Acquired Infections 2009-2012 Oregon Report