SYNERGY: COMBINING EFFORTS FOR HAI PREVENTION

Nov-Dec 2011

News from the Virginia Department of Health's Healthcare-Associated Infections (HAI) Program

Volume 2, Issue 11

Edited by: Andrea Alvarez

Notes from VDH

2011Q3 (July 1-Sept 30) central line-associated bloodstream infection data are posted. Fifty-eight infections were reported, with a state rate of 1.26 infections per 1,000 central line days. For the full report, please go to: **http://www.vdh.virginia.gov/Epidemiology/Surveillance/HAI/haireport.htm**

We are pleased to share that a new and improved HAI website will be debuted in the coming weeks with resources for acute care, long-term care, as well as ambulatory care settings. Stay tuned!

Lastly, the VDH HAI Team wishes all of you a safe and happy holiday season. Although the "ARRA" of infection prevention is coming to a close, the HAI Program looks forward to continuing to collaborate with facilities across the continuum of care to prevent healthcare-associated infections!

VDH/APIC-VA Conference - November 10, 2011

The November 10th conference, "The Epidemic of Infection Prevention: Pass it On" was a success both in terms of attendance and feedback from the evaluations.

Out of the nearly 200 people in attendance, approximately half were from acute care hospitals while the other half were from long-term care facilities with a few participants from the health department, partner organizations, or ambulatory care settings. While most attendees were infection prevention staff, there were also nurses, administrators, quality improvement staff, clinical educators, staff development coordinators, and physicians.

Andrea Alvarez, VDH HAI Program Coordinator, kicked off the conference, followed by two information-packed panel sessions. The first session explored infection prevention collaborative experiences from a variety of perspectives. The second session demonstrated the importance of bridging the information gap across the continuum of care from both the health department perspective in outbreak situations and the healthcare facility perspective.

The session on building a business case for infection prevention was especially helpful for hospital infection preventionists, and may be useful to other settings in the future.

The afternoon breakout sessions were very well received. Acute care sessions focused on surgical site infection reporting via NHSN and uploading methods. Long-term care facilities engaged in discussions around practical surveillance techniques and best practices/lessons learned from the urinary tract infection prevention collaborative, past trainings, and facility experiences.

Thank you to APIC-VA, the speakers, and the attendees for making the conference such a positive environment to share questions, comments, and tips. The more we are able to share the information to spread the epidemic of infection prevention, the safer and healthier Virginia's residents will be.

In this issue:

Section	Page
Notes from VDH	1
VDH/APIC-VA Conference 11/10/11	1
Outpatient Dialysis Facilities and NHSN	2
VDH/NHSN Q&A	2
Comment Opportunity	3
Recognition Opportunity	3
UTI Panel 11/2/11	3
Immunization Updates	4
All About Antibiotics	5
Outbreak Corner	5
Region III Collaborative Meeting 11/9/11	5

Upcoming Events:

Dec 20 - Dialysis webinar (1-2:30 PM)

Jan 1 - SSI and CAUTI reporting begins for acute care hospital participating in CMS IPPS

Contact:
Andrea Alvarez,
HAI Program Coordinator
with questions / comments:
804-864-8097

Outpatient Dialysis Facilities and NHSN Reporting

As a result of a CMS Final Rule published November 10th, starting in 2012, outpatient dialysis facilities will be required to report dialysis events to NHSN for at least 3 consecutive months per year to obtain incentives outlined in the End Stage Renal Disease (ESRD) Quality Incentive Program (QIP). The data specific to the rule include positive blood cultures, intravenous antimicrobial starts, and signs of vascular access infection. Facilities must begin reporting no later than October 1, 2012 but are encouraged to start as early as possible and before July 2012. E-mail ESRDQIP@cms.hhs.gov with QIP questions.

Upcoming training opportunity (free webinar):
December 20 (1pm - 2:30pm ET)
Dialysis Event (DE) Surveillance and Reporting
Register at: **http://webinars.apic.org/session.php?id=8055**

For other training materials, enrollment instructions, event forms, and updates, refer to the NHSN Dialysis website: **http://www.cdc.gov/nhsn/psc_da_de.html**.

In order to be in compliance:

1. Complete required training
2. Complete all enrollment steps (may take 4-6 weeks)
    - Enroll in NHSN individually [i.e., each dialysis facility or dialysis unit within a hospital needs a unique NHSN organization identification number (org ID)]
    - Enroll in NHSN as an 'AMB-HEMO – Hemodialysis Center' facility type and complete enrollment survey
    - Input a correct CMS Certification Number (CCN) into NHSN
3. Report data following the NHSN protocol

Facilities needing to modify their enrollment status (for example, if there is an outpatient dialysis component of an acute care hospital) can do so using their current digital certificate by requesting NHSN Enrollment rights through the NHSN Helpdesk (nhsn@cdc.gov).

VDH/NHSN Q&A

Q. Since there is no CLABSI rate benchmark for combining adult ICUs and the new SIR is able to summarize CLABSI data by more than a single location by adjusting for differences in the incidence of infection among the location types, has VDH considered using SIRs for the VDH quarterly report?

A. The VDH HAI team is very interested in updating the VDH CLABSI quarterly report in a number of ways. We want this process to be inclusive of other parties, including the APIC-VA Mandatory Reporting Committee and the HAI Advisory Committee to come to a consensus about how to effectively report our data. If you have ideas or concerns, please contact Eve Giannetta (egc6x@virginia.edu) or Dana Burshell (Dana.Burshell@vdh.virginia.gov).

Q. Is VDH requiring IPs to go back and check the new "Report No Events" box for 2011 data?

A. Checking the new "No event" box is important for VDH to ensure complete data and is required for 2011 and beyond. Starting in 2012, NHSN will require facilities to indicate zero infection events by checking the "Report No Events" box. It makes the distinction of no events for that month versus that no events were entered but one or more was meant to be entered.

How to check the "Report No Events" box:

- On the navigation bar, go to Summary Data —> Add or Find (to edit an existing record).
- If zero is entered for a summary data field, the "Report No Events" box is automatically checked.
- If your facility has not identified a given event for that month, check the "Report No Events" box and click "Save".
- If an infection event occurs and is added after the "Report No Events box" is checked, NHSN will automatically uncheck the "Report No Events" box on the summary data screen.
- When reporting no events for the procedure-associated module, check the appropriate "Report No Event box(es)" in the Alerts section (instructions on page 9 of the NHSN ALERTS, October 2011).

Data quality checks using NHSN Alerts: http://www.cdc.gov/nhsn/PDFs/pscManual/NHSN-Alerts_6_5.pdf.

- Alerts —> Missing events —> Alert type "Summary but no events"
- Alerts —> Missing PA events —> Report no events
- To remove alert, either enter the missing event or report no events.

Comment Opportunity

CDC is requesting Office of Management and Budget approval to make several reporting changes to NHSN. Overall, CDC is seeking to delete four current forms and add five new ones. The total reporting burden is expected to be reduced by 1.26 million hours. The public is invited to comment on these changes, which include:

- Updating assurance of confidentiality language
- Expanding dialysis surveillance among outpatient dialysis centers
- Expanding the patient safety component to include long-term care facilities in HAI surveillance
- Adding a new form to facilitate summary reporting of influenza vaccination in health care workers
- Transitioning the antimicrobial use and resistance module from manual web entry to electronic data upload to reduce the reporting burden

Comments due by **December 30th**. More information, including how to comment is available at: **http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/html/2011-30832.htm**

Recognition Opportunity

The U.S. Department of Health and Human Services and the Critical Care Societies Collaborative annually recognize teams of critical care professionals and healthcare institutions that achieve excellence and notable, sustained improvements in preventing healthcare-associated infections (with emphasis on eliminating central line-associated bloodstream infections and ventilator-associated pneumonia). Applications are due by **December 19th**.

Send your questions to the American Association of Critical-Care Nurses (AACN) Recognition Team: 800.394.5995 Ext 507 or 371, awards@aacn.org.

For more information, visit: **http://www.hhs.gov/ash/initiatives/hai/projects/index.html**.

Urinary Tract Infection (UTI) Educational Panel - November 2, 2011

The VDH HAI Program in partnership with the Virginia Health Care Association (VHCA) recently facilitated an educational panel targeting urinary tract infection (UTI) prevention in nursing homes.

The November 2nd program held in Virginia Beach at Beth Sholom Village offered presentations from a panel of experts including:

- Robert M. Palmer, MD, MPH - John Franklin Chair of Geriatrics, Professor of Medicine and Director of the Glennan Center for Geriatrics and Gerontology, Eastern Virginia Medical School
- Edward C. Oldfield, III, MD - Professor of Medicine, Microbiology and Molecular Cell Biology, Director of Infectious Disease Division, Eastern Virginia Medical School
- Edna Garcia, BSN, RN-BC - Director of Clinical Education, Riverside Lifelong Health and Aging Related Services

This opportunity aligned with a prevention collaborative in 12 nursing homes in the Eastern region of Virginia focusing on the development of best practices for the reduction of UTI events in the long-term care population.

Representatives from the collaborative facilities and healthcare providers who care for residents of those facilities were among the nearly 100 attendees. The panel presentations addressed the most current information regarding UTI prevention, assessment, and treatment in this population.

As result of the UTI prevention collaborative efforts, a toolkit was developed entitled *Successful Strategies for the Prevention of Urinary Tract Infections in Long-Term Care*. The toolkit contains infection prevention presentations, resources, and tools that have been adapted for long-term care facilities to promote strategies to improve resident care including the judicious use of antimicrobials in UTI treatment. This resource will be shared with long-term care facilities throughout Virginia, district health directors, and other long-term care partners; one copy will be mailed to each facility/local health department/stakeholder in late December and all toolkit materials will be posted to the VDH HAI website.

Immunization Updates

On November 25th, the Centers for Disease Control and Prevention (CDC) released a report in *Morbidity and Mortality Weekly Report (MMWR)* summarizing the Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinating health-care personnel (HCP). This report updates and replaces the recommendations from 1997 and does not contain any new recommendations or policies that have not previously been published.

The summary of recommendations for vaccinating HCP can assist healthcare providers in developing and updating their infection prevention programs and practices. Based on documented healthcare transmission, HCP are considered to be at substantial risk for acquiring or transmitting hepatitis B, influenza, measles, mumps, rubella, pertussis, and varicella.

The table below summarizes the key changes from the 1997 recommendations. The complete report can be found by visiting: **http://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf**.

BOX. Summary of main changes* from 1997 Advisory Committee on Immunization Practices/Hospital (now Healthcare) Infection Control Practices Advisory Committee recommendations for immunization of health-care personnel (HCP)

Hepatitis B

- HCP and trainees in certain populations at high risk for chronic hepatitis B (e.g., those born in countries with high and intermediate endemicity) should be tested for HBsAg and anti-HBc/anti-HBs to determine infection status.

Influenza

- Emphasis that all HCP, not just those with direct patient care duties, should receive an annual influenza vaccination
- Comprehensive programs to increase vaccine coverage among HCP are needed; influenza vaccination rates among HCP within facilities should be measured and reported regularly.

Measles, mumps, and rubella (MMR)

- History of disease is no longer considered adequate presumptive evidence of measles or mumps immunity for HCP; laboratory confirmation of disease was added as acceptable presumptive evidence of immunity. History of disease has never been considered adequate evidence of immunity for rubella.
- The footnotes have been changed regarding the recommendations for personnel born before 1957 in routine and outbreak contexts. Specifically, guidance is provided for 2 doses of MMR for measles and mumps protection and 1 dose of MMR for rubella protection.

Pertussis

- HCP, regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap.
- The minimal interval was removed, and Tdap can now be administered regardless of interval since the last tetanus or diphtheria-containing vaccine.
- Hospitals and ambulatory-care facilities should provide Tdap for HCP and use approaches that maximize vaccination rates.

Varicella

Criteria for evidence of immunity to varicella were established. For HCP they include

- written documentation with 2 doses of vaccine,
- laboratory evidence of immunity or laboratory confirmation of disease,
- diagnosis of history of varicella disease by health-care provider, or diagnosis of history of herpes zoster by health-care provider.

Meningococcal

- HCP with anatomic or functional asplenia or persistent complement component deficiencies should now receive a 2-dose series of meningococcal conjugate vaccine. HCP with HIV infection who are vaccinated should also receive a 2 dose series.
- Those HCP who remain in groups at high risk are recommended to be revaccinated every 5 years.

Abbreviations: HBsAg = Hepatitis B surface antigen; anti-HBc = hepatitis B core antibody; anti-HBs = hepatitis B surface antibody; Tdap = tetanus toxoid, reduced diptheria toxoid and acellular pertussis vaccine; HIV = human immunodeficiency virus.

* Updated recommendations made since publication of the 1997 summary of recommendations (CDC Immunization of health-care workers: recommendations of the Advisory Committee on Immunization Practices [ACIP] and the Hospital Infection Control Practices Advisory Committee [HICPAC]. MMWR 1997;46[No. RR-18]).

Additional news this fall from the ACIP includes the **strong recommendation for the hepatitis B vaccine for diabetes patients under age 60 who have not previously received full vaccination**. The recommendation is based on the finding that patients with diabetes face an increased risk of hepatitis B virus (HBV) infection. It was reported from the CDC announcement that data indicates that patients younger than 60 years have nearly twice the risk of being infected with HBV than people without diabetes. The ACIP recommends that clinical discretion be used for diabetic patients older than 60, assessing those at increased risk of exposure from assisted glucose monitoring practices and most likely to respond to vaccination.

All About Antibiotics

November 14-20th was "Get Smart About Antibiotics Week", a national campaign to highlight the efforts of CDC, state, and local partners to educate people about the importance of using antibiotics wisely in community and healthcare settings. This year, the campaign focused on appropriate antibiotic use in nursing homes and long-term care facilities.

To learn more about the national Get Smart campaign and download additional materials and fact sheets, go to:

- **http://www.cdc.gov/getsmart/index.html**
- **http://www.cdc.gov/getsmart/specific-groups/hcp/inpatient.html** (for inpatient healthcare providers)

To learn more about Virginia's Get Smart campaign (run by the Medical Society of Virginia Foundation in partnership with VDH), go to: **http://foundation.msv.org/Foundation/AntibioticResistance.aspx**

In addition, CDC launched a new antibiotic tracking system within NHSN. The Medication-Associated (MA) module (**www.cdc.gov/nhsn/psc_ma.html**) currently allows facilities to track antimicrobial use using electronic data capture and will soon be updated to accept antimicrobial resistance data as well.

Outbreak Corner

The October 28th edition of *Morbidity and Mortality Weekly Report* (MMWR) had two relevant articles about outbreaks in long-term care settings.

The first article described an investigation of invasive group A *Streptococcus* (GAS) infections among residents of a Pennsylvania skilled nursing facility specializing in neurologic and pulmonary care. Ten residents had noninvasive GAS infection and 13 had invasive GAS infection. Poor hygiene practices among staff members, improper wound care practices, and other infection prevention deficiencies were noted. Having two or more wounds was the most significant risk factor for GAS infection, after adjusting for length of stay and receiving physical therapy. The authors recommend that long-term care facilities should investigate single cases of invasive GAS because of the possibility of unrecognized GAS transmission among staff members and residents.

The second article described rotavirus outbreaks among elderly adults in two retirement communities in Illinois. In both communities, illness likely was transmitted person-to-person via contaminated hands or fomites (e.g., environmental surfaces). Although many people think of rotavirus as a cause of gastrointestinal illness in young children, it can also affect adults. Prevalence of rotavirus in the adult population is not well known because rotavirus testing is not often performed during outbreak investigations of diarrheal disease among elderly adults in residential facilities and rotavirus outbreaks are not nationally reportable. The authors recommend that health professionals who care for elderly persons in residential facilities or who investigate outbreaks of gastrointestinal illness consider rotavirus as a possible cause of acute diarrhea, especially during the months when rotavirus circulates (usually January to June).

To access the articles directly, go to: **http://www.cdc.gov/mmwr/PDF/wk/mm6042.pdf**

Region III HAI Prevention Collaborative Meeting - November 9, 2011

State health department HAI program staff and a group of HAI advisors from the states in Health and Human Services (HHS) Region III (DC, DE, MD, PA, VA, WV) met in Philadelphia on November 9th. This meeting was part of a one-year HAI prevention collaborative to promote interstate discussions about how to work together to identify and address HAI surveillance and prevention challenges across the region. Following this meeting, the group will continue to meet via conference call to further focus its collaborative efforts.

Each jurisdiction gave an overview of its HAI reporting requirements and the current state of its HAI program, including successes, challenges, and potential solutions.

Attendees discussed the importance of good data collection to build the evidence base and a desire to explore ways to develop a common set of reporting standards across the region. Workforce recruitment and training needs to support HAI initiatives were also identified as a common gap.