SYNERGY: COMBINING EFFORTS FOR HAI PREVENTION

February 2012

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

Volume 3, Issue 2

Edited by: Andrea Alvarez

Notes from VDH

Our HAI website (**www.vdh.virginia.gov/epidemiology/surveillance/hai**) is now live and updated with resources for healthcare facilities across the continuum of care and the general public! Visitors to the site will find electronic versions of the two toolkits (urinary tract infection prevention for long-term care facilities and general infection prevention for nursing homes and assisted living facilities), presentations from past trainings, surveillance tools, prevention strategies, and much more.

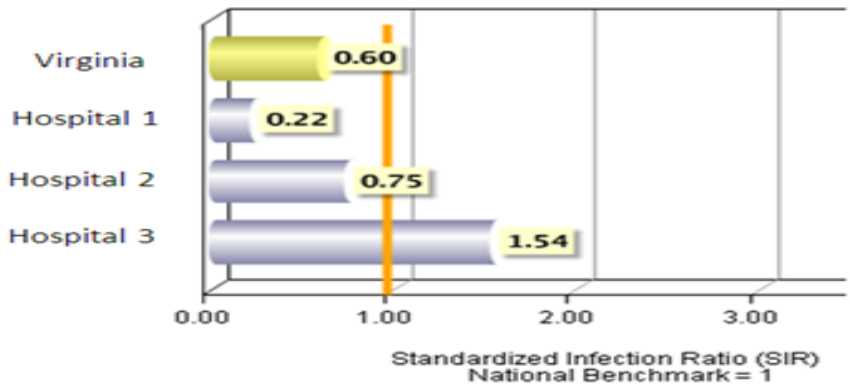
The link to the central line-associated bloodstream infection reports has changed to **www.vdh.virginia.gov/epidemiology/surveillance/hai/CLABSI_reporting.htm**. The most recent quarterly report (Oct-Dec 2011) is now posted and shows a decline in the number of infections and CLABSI rate in adult intensive care units—great job, hospitals!

CMS Hospital Compare Publishes HAI Patient Safety Measure

In late January, central line-associated bloodstream infection (CLABSI) data from 2011 (January to March) became available on Hospital Compare, an online resource from the Centers for Medicare and Medicaid Services (CMS) intended to be used by patients to choose a hospital based on performance on selected quality and patient safety measures. CLABSI data from adult, pediatric, and neonatal intensive care units are reported by hospitals participating in the Inpatient Prospective Payment System (IPPS) incentive program.

CMS chose to report the CLABSI data using the standardized infection ratio (SIR) as recommended by the Centers for Disease Control and Prevention (CDC). A hospital SIR (purple) can be seen next to the state SIR (yellow) and up to two other hospitals at a time. While the SIR point estimate is displayed, there is no reference to statistical significance.

To access Hospital Compare, visit:: **http://www.hospitalcompare.hhs.gov/**.



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Upcoming Events:

Early March: anticipated release of CDC 2010 state-specific and national SIR report

March 4 -10: Patient Safety Awareness Week

March 21—12 PM: VDH webinar for LTC facilities on the use of the UTI toolkit

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

CLABSI Surveillance Summary—2009 to 2011

On Tuesday, January 24th, an e-mail was sent to IPs and NHSN contacts explaining facility reporting expectations to meet the VDH mandate for HAIs, which currently includes CLABSIs in acute care adult intensive care units. Thank you to all participating facilities for ensuring that data were available to VDH for the 2011Q4 quarterly report that can be viewed at **http://www.vdh.virginia.gov/epidemiology/surveillance/hai/CLABSI_Reporting.htm**.

Beginning with the VDH 2012Q1 quarterly report, VDH will be replacing the CLABSI rate with the CLABSI SIR in its published reports. This is because the CLABSI SIR is a more appropriate measure to use at the hospital level and because it is being used by CDC for national reports and by CMS in Hospital Compare. The tables below show the annual CLABSI rates and SIRs for the past three years and the quarterly rates and SIRs for 2011. In 2011 as a whole, Virginia hospitals observed 36% fewer CLABSIs than predicted. For the most recent quarter (2011Q4), Virginia hospitals observed 50% fewer CLABSIs than predicted, which is the lowest SIR to date and is statistically significant.

Year	CLABSIs	Central line days	State rate
2009	275	190,179	1.45
2010	232	190,858	1.22
2011	233	194,644	1.20

Year	CLABSIs	CLABSIs predicted	SIR	SIR 95% CI
2009	275	352.33	0.78	0.69, 0.88
2010	232	359.74	0.65	0.57, 0.73
2011	233	366.33	0.64	0.56, 0.72

Quarter	CLABSIs	Central line days	State rate
2011 Q1	65	51,966	1.25
2011 Q2	63	48,771	1.29
2011 Q3	60	46,059	1.30
2011 Q4	45	47,848	0.94

Quarter	CLABSIs	CLABSIs predicted	SIR	SIR 95% CI
2011 Q1	65	98.09	0.66	0.51, 0.85
2011 Q2	63	91.49	0.69	0.53, 0.88
2011 Q3	60	87.32	0.69	0.52, 0.88
2011 Q4	45	89.42	0.50	0.37, 0.67

Are Postdischarge SSI Surveillance Practices Consistent?

A Washington state hospital survey regarding postdischarge surveillance for surgical site infections concluded that there is "little to no consistency among hospitals, sometimes even within the same hospital system." The article, published in the January issue of *Infection Control and Hospital Epidemiology*, states the need to know how each hospital performs postdischarge surveillance and how it may impact the hospital's SSI rates to ensure fair representation. It also stresses the importance of standardizing postdischarge surveillance practices.

Of the hospital respondents, 95% conducted postdischarge surveillance. Of those that conducted SSI postdischarge surveillance, nearly all hospitals used more than one method: the majority of hospitals monitored readmissions (95%), and 63% exchanged patient lists with surgeons.

Most hospitals (83%) with computer information resources used electronic data sources for postdischarge surveillance. While nearly all hospitals reported using the National Healthcare Safety Network criteria to define postdischarge surveillance, nearly half of outpatient clinics did not use NHSN criteria when reporting SSIs to hospital infection control.

While postdischarge methods may have some challenges such as low response rates, low interobserver agreement, and possible overdiagnosis, 82% of hospitals found cases via postdischarge surveillance that otherwise would not have been detected. *Every* hospital found a case using postdischarge surveillance.

In conclusion, the need for standardized definitions and practices applies also to postdischarge surveillance in order to produce comparable data.

Hand Hygiene Resources

For those of you interested in some new hand hygiene activities and promotional campaigns, the "Wellness Room" website from Georgia-Pacific Professional contains a variety of resources (**http://gppro.com/wellnessroom**).

- ◊ Spread Wellness – initiative that includes reminders about washing hands to promote wellness (**www.spread-wellness.com**)
- ◊ Didya? – campaign that reminds people to wash and dry their hands
- ◊ The Art of Washing Hands – innovative resource to educate children about hand hygiene (**www.theartofwashinghands.com**)
- ◊ Watching Hands – exhibit of artists who interpret the act of hand washing in interesting ways

Other information on hand hygiene can be found on the VDH HAI hand hygiene page (**www.vdh.virginia.gov/epidemiology/surveillance/hai/handhygiene.htm**).

NHSN Q&A

Q. Can NHSN tell me if my facility or unit in my facility qualifies as an inpatient rehabilitation facility (IRF) or a long-term acute care facility (LTAC)?

A. NHSN response: Unfortunately, CDC relies mainly on the individual facilities to know their own CMS licensure status and enroll correctly within NHSN. There is nothing within the NHSN system that validates a facility's or unit's type. Therefore, please contact CMS for further clarification on facility licensure. They will be able to tell the individual facility which licenses it has and therefore which reporting it qualifies for (IRF, LTAC, and/or dialysis).

Dialysis questions: ESRDQIP@cms.hhs.gov

IRF/LTAC questions: LTCH-IRF-Hospice-Quality-ReportingComments@cms.hhs.gov

Q. If my facility conducts hysterectomies and I recorded that in our February monthly reporting plan, what do I do if we had no hysterectomies in February? Do I take it out of my reporting plan?

A. If your facility conducts surgeries and you are following NHSN definitions and meet NHSN in-plan requirements, you should always keep it in your monthly reporting plan. However, you must also indicate that there were no procedures and no events so NHSN can be certain that the data are not missing. You can do this by logging into the NHSN patient safety module > clicking on "Procedure" on the navigation bar, and then clicking "Incomplete". The alerts tabbed menu will appear and you should address the tabs, "Missing PA Events" and "Missing Procedures". Check the appropriate boxes for "No Procedures Performed" and/or "Report No Events". For more information see **http://www.cdc.gov/nhsn/PDFs/pscManual/NHSN-Alerts_6_5.pdf**.

NHSN Updates for v6.6

NHSN updates from version 6.6 (February release) addressing CLABSI, CAUTI, and SSI

- ◊ CLABSI and CAUTI SIRs will now include those months where denominator data were entered, but 0 device days were reported. In addition, a table has been added to these SIR output options so that facilities and groups can identify the months and locations in which 0 device days were reported. To view these variables, navigate to Analysis > Advanced > Plan Data > CDC Defined Output > Line Listing-Patient Safety Plans > Modify and use the "Export Analysis Data Set" button.
- ◊ Variables for "Report No Procedures" and "Report No SSI Events" for a given month have been added to NHSN analysis datasets.
- ◊ Months where there were no events but the "Report No Events" check boxes were not activated will not be included in the SIR output analysis.
- ◊ SSIs detected on readmission must now be reported as "RF" (readmission to facility in which the original procedure was performed) or "RO" (readmission to a facility other than the one in which the original procedure was performed).
- ◊ ICD9-CM codes have been incorporated into v6.6.
- ◊ Rate tables have been updated to use national comparative rates from 2010 as published in the December 2011 issue of *AJIC* available at http://www.cdc.gov/nhsn/dataStat.html.
- ◊ Long-Term Acute Care (LTAC)— new facility surveys and new locations have been added. LTACs should enroll now.
- ◊ Dialysis Event Protocol has been revised and expanded.

HAI Advisory Committee Meeting Summary—Feb 23, 2012

On February 23rd, a multidisciplinary group representing consumers, infection preventionists, quality improvement professionals, physicians, providers in healthcare settings across the continuum of care (acute care, long-term care, ambulatory surgery, dialysis facilities), and organizations [VDH, VHQC, the Virginia Hospital and Healthcare Association (VHHA), APIC-VA, Mid-Atlantic Renal Coalition, Virginia Ambulatory Surgery Association] met to discuss the current state of HAI surveillance and prevention activities and opportunities for collaboration.

The event was organized by VDH and VHQC and led by Dr. Cook from VHQC. The first item on the agenda allowed each organization to describe its role in HAI prevention and outline some of its current activities and future plans. This included Dr. Keri Hall from VHHA introducing the new Hospital Engagement Network (HEN) and its goals to reduce hospital-acquired conditions and readmissions by the end of 2013. Conversations were also focused on organizations working together more closely to ensure deduplication of effort by infection prevention and quality improvement staff. This engaging discussion also touched on challenges with transitions of care and inter-facility communication.

Dana Burshell from VDH led a discussion of a draft report that shares central line-associated bloodstream infection (CLABSI) data using the standardized infection ratio rather than CLABSI rates as they are published currently. The new version of this report is planned for release in the spring of 2012 after additional review and input by other stakeholder groups including hospital epidemiologists and consumers.

Andrea Alvarez from VDH introduced the new HAI website (mentioned on page 1 of the newsletter) and highlighted some of the resources it contains for healthcare facilities and the general public. The Advisory Committee members were encouraged to share the website link with their organizations to publicize the site and make the resources available.

Jennifer Reece from VHQC shared drafts of two fact sheets that addressed central lines and hand hygiene for use by patients in acute care hospitals.

The Advisory Group plans to continue to meet on a quarterly basis and promote synergy among the various organizational efforts to accelerate statewide progress in preventing HAIs.

C. difficile Infection and Proton Pump Inhibitors: FDA Drug Safety Announcement

In early February, the Food and Drug Administration (FDA) posted a drug safety announcement that the use of proton pump inhibitors (PPIs) may be associated with an increased risk of *Clostridium difficile*-associated diarrhea (CDAD). Efforts are underway with the FDA and manufacturers to educate and include this risk information within the drug labeling. PPIs are marketed as prescription or over-the-counter products and function to reduce the amount of acid in the stomach. They are used to treat a range of conditions such as stomach ulcers, gastroesophageal reflux disease (GERD), and esophageal inflammation.

The FDA advises healthcare professionals that patients who take PPIs and develop diarrhea that does not resolve should be considered for a CDAD diagnosis. Patients should use the lowest dose and shortest duration of PPI therapy appropriate to the condition being treated. Adverse events or side effects related to the use of these products may be reported to the FDA's MedWatch Safety Information and Adverse Event Reporting Program (**www.fda.gov/MedWatch/report.htm**).

For the complete safety announcement, please go to: **http://www.fda.gov/Drugs/DrugSafety/ucm290510.htm.**