NEVADA HEALTHCARE-ASSOCIATED INFECTION (HAI) TASK FORCE MINUTES

October 6, 2017
10:30 a.m.

Place of Meeting:
Division of Public and Behavioral Health
3811 W. Charleston Blvd.
Suite 205
Las Vegas, Nevada 89102

Video Conferenced to:
Division of Public and Behavioral Health
4126 Technology Way
2nd Floor Conference Room
Carson City, Nevada 89706

Teleconference Line:
Dial-In Toll Free Number 1-888-557-8511
Conference Code #7845036

TASK FORCE MEMBERS PRESENT:
Kimisha Causey, HAI Coordinator, Health Program Specialist II, Office of Public Health Informatics and Epidemiology (OPHIE)
Donna Thorson, HealthInsight
Dustin Boothe, Carson City Health and Human Services (CCHHS)
Ihsan Azzam, Medical Epidemiologist, (OPHIE)
Kathy Johnson, University Medical Center Hospital (UMC)
Marissa Brown, Nevada Hospital Association (NHA)
Zuwen Qiu-Shultz, Southern Nevada Health District Office of Epidemiology (SNHD)

TASK FORCE MEMBERS ABSENT:
Elena Mnatsakanyan, Northern Nevada Medical Center (NNMC)
Heather Holmstadt, Washoe County Health Department (WCHD)
Joan Hall, Nevada Rural Hospital Partners (NRHP)

NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH PRESENT:
Adrian Forero, Health Facilities Inspector III, (OPHIE)
Chidinma Njoku, Health Facilities Inspector I, (OPHIE)
David Schmitt-Culp, Health Facilities Inspector I, (OPHIE)
Jared Fitch, Health Facilities Inspector, (OPHIE)
Jessica Conner, Health Facilities Inspector II, (OPHIE)
Laura Erskine, Sentinel Event Registrar & Interstate Communication Control Records Coordinator, (OPHIE)

OTHERS PRESENT:
Becky Bailey, Nevada Rural Hospital Partners (NRHP)
David Woodard, University of Nevada, Las Vegas (UNLV)
Diane Rhee, Roseman University of Health Sciences (UHS)
Norman Wright, Kindred Hospitals Las Vegas – Flamingo Campus
Paul Shubert, Health Care Quality and Compliance (HCQC)

1. CALL TO ORDER

Ms. Kimisha Causey called the Nevada Healthcare Associated Infection (HAI) Task Force meeting to order at **10:30 a.m.** This meeting was video conferenced from the Nevada Division of Public and Behavioral Health, Las Vegas to the Nevada Division of Public and Behavioral Health in Carson City. This was a public meeting and the public was invited to make comments. In accordance with the Nevada Open Meeting Law NRS 241.020 & NRS 232.2175 this meeting agenda was posted at the following

locations: Health Care Quality and Compliance (HCQC), Las Vegas; Nevada Department Health and Human Services (NDHHS), Carson City; NDPBH, Las Vegas; NDPBH, Carson City; Nevada State Library Archives, Carson City; Legislative Council Bureau, Carson City; Grant Sawyer Building, Las Vegas; WCHD, Reno; Elko County Library, Elko; the NVHAI web site at http://dpbh.nv.gov/Programs/HAI/dta/HAI_Advisory_Group/ ; and the public notice web site at notice.nv.gov.

2. INTRODUCTIONS/ROLL CALL – CONFIRMATION OF QUORUM

Introductions were made at all locations/teleconference line and quorum was met.

3. FIRST PUBLIC COMMENT

Ms. Causey announced the First Public Comment Session and invited members of the public to speak. Hearing no comments, Ms. Causey moved to the next agenda item.

4. REVIEW AND APPROVAL OF MEETING MINUTES – MAY 5, 2017

Ms. Causey asked for approval of the May 5, 2017 meeting minutes. The following changes/edits were suggested and will be made to the minutes:

- Zuwen Qiu-Shultz last name needs to be corrected
- Donna Thorson has a title change; Sr. Project Manager, Donna's new title will be reflected on next meeting minutes
- HealthInsight is all one word with the "I' being capitalized

Ms. Causey asked for approval of the May 5, 2017 meeting minutes with the corrections being made.

MOTION: **Ms. Causey motioned to approve the meeting minutes**
SECOND: **Ms. Johnson seconded the motion**
PASSED: **All were in favor and the motion carried unanimously**

5. CARBAPENEMASE PRODUCING ORGANISM MANDATORY STATE REPORTING

On July 5th the DPBH was notified of an Acinetobacter *baumaniiin* cluster. A cluster was identified by WCHD. There were eight cases of Acinetobacter identified from one Long Term Acute Care (LTAC.) Further investigation into these cases by OPHIE determine that there were additional cases at an additional location for the same LTAC. From July 11th through July 19th, OPHIE preformed chart reviews, there were thirteen cases with Carbapenem Resistant Acinetobacter (CRA) identified. On July 12th the Centers for Disease Control and Prevention (CDC) HAI outbreak team was contacted, the CDC recommended pulsed-field gel electrophoresis (PFGE) testing for all the isolates. The outbreak team made an unannounced visit to both LTAC locations to observe cleaning practices, Personal Protective Equipment (PPE) use and to conduct additional chart reviews. An inspection was also completed by (HCQC.) August 3rd; the OPHIE outbreak response team returned to both LTAC locations and one additional Skilled Nursing Facility (SNF), suspected to be involved based on the chart reviews. Thirteen patients with Acinetobacter *baumanniii* were found during the investigation, the specimen collection dates range from January 12th through July 1st, four of the isolates were Carbapenemase resistant and they were as follows: nine sputum 1 surgical-bone and three wound and three of those isolates are known to be pan resistance. Outbreak was isolated to two LTAC locations and one SNF, a potential index case was also identified. The possible source of the outbreak was determined to be contributed to, improper PPE use; sharing of staff between the two LTAC facilities; improper cleaning and disinfection of

environmental surfaces; improper isolation of the infected patients; no dedicated equipment for wound care patients on infection control precautions and a lack of training for wound care staff. The OPHIE outbreak response team will continue to monitor for CRA through surveillance for the next few months. HCQC issued a formal statement of deficiencies to the facilities. The OPHIE outbreak response team will ensure that all facilities and labs will know to send in CRA organisms to the state lab in Washoe County where reporting is required for Carbapenem Producing Organisms; and remind healthcare facilities to use the transfer form when they transfer patients. Initial notification to the state was delayed, state was notified by a local health authority. There is a need to make Carbapenemase-Producing Organism's (CPO) and Carbapenem-Resistant Organism's (CRO) reportable conditions in Nevada. PFGE results show twelve of the thirteen cases were linked.

6. INFECTION CONTROL RISK ASSESSMENT UPDATE

HAITF had selected sixty three facilities for infection control assessments in 2015, fifty have been completed and they need seven more facilities to participate. CDC has requested that they continue to reach out to more facilities that were not selected to participate so the goal can be met. Follow up letters went out to facilities that were assessed; which included most of the mitigation strategies that were developed together; including the hand hygiene training and antimicrobial stewardship toolkit. Some of the facilities that report Central Line Associated Bloodstream Infections (CLABSI) data into the National Healthcare Safety Network (NHSN), received Targeted Assessment for Prevention (TAP) reports along with the follow up letters. TAP reports outline infection counts, facility Standardized Infection Ratio (SIR) by location and the Cumulative Attributable Difference (CAD), which gives each facility a location, a quantifiable number of infections needing to be reduced in order to meet the standardized SIR goal. Tap reports were limited to facilities that had NHSN data. We will continue to work until the grant period ends March 31, 2018, we will continue to follow up with this assessment; in two weeks a CLABSI data validation project will begin. With the same facilities reporting CLABSI data into NHSN, we will be visiting each facility with a contactor from Connecticut to help review positive line listings and blood cultures and comparing those results to NHSN data, there are ten facilities in Las Vegas and five facilities in Reno. We are going to follow up again with the original Infection Control Assessment and Response (ICAR) facilities with the TAP assessment. The data that is reported into those assessment tools is then reported back to the CDC, deficiency or gap reports are then generated, and TAP reports are created.

7. REVIEW AND MAKE RECOMMENDATIONS CONCERNING INFECTION PREVENTIONIST MANUAL PEER REVIEW

Majority of the chapters have been reviewed and edited by subject matter experts. Ms. Causey asked for volunteers to review the chapters. The microbiology chapter is being worked on by Pat Armor, and David Woodard will follow up with Pat. Dr. Rhea is working on the anti-microbiology stewardship chapter and will return when it is completed. The following chapters need to be reviewed; Environmental Services, Laboratory, Antimicrobial Stewardship, Emergency Preparedness, Infection Preventionists Job Description, Authority of Infection Preventionists, Committee Leadership and Membership, Surveillance, Outbreak Management, Microbiology Construction and Renovation, Quality Assurance and Performance Improvement, Regulatory Compliance, Infection Control and Standard Precautions. Ms. Johnson volunteered to review chapter Environmental Services, Mr. Woodard volunteered to review chapter Laboratory, Mr. Wright and Mr. Schmitt-Culp volunteered to review chapter Antimicrobial Stewardship, Ms. Qiu-Shultz volunteered to review chapter Surveillance, Ms. Thorson volunteered to review chapter Quality Assurance and Performance Improvement.

8. REVIEW AND MAKE RECOMMENDATIONS CONCERING PRIORITY PREVENTION TARGETS FOR SURVEILLANCE

Ms. Causey stated Central Line-Associated Bloodstream Infection (CLABSI), Clostridium Difficile (CDIFF) and Catheter-associated Urinary Tract Infections (CAUTI) were selected for priority prevention targets for surveillance and prevention, target date for implementation was July 2015 and it was missed. A message will be sent to the hospitals to confirm rights to the state as we already have access so we can analyzed the data to determine what type of education is needed. TAP reports can be generated to see what areas need improvement on CLABSI and we can start working toward prevention. Ms. Johnson stated that seventy percent of the hospitals that the joint commission surveyed lack in environmental disinfection. If you were to run a state report through HealthInsight for 2016 that CAUTI's are no longer one of the leading infections in the state, it would probably be more Methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile infection (CDI) and then CLABSI. Mr. Woodard stated that pan resistant organisms is another area and he believes that the commission needs to revisit this topic. The whole dynamic of infection prevention has changed and to serve the folks in the state best, it would be very helpful to them. Ms. Johnson inquired are we able to change the priorities of this HAI task force at this time, I think that CAUTI is defiantly something that has been dealt with, with the definition change. MRSA and CDI are like a yo-yo they go up and go down, there is still room for improvements for CLABSI in the state but I believe that is on its way for reduction too. Ms. Causey inquired to Ms. Thorson if that data was available, Ms. Thorson stated she would have to request the data. Mr. Schmitt-Culp stated that the TAP assessment tools will take a deeper dive into CDI, CAUTI and CLABSI's to see where our efforts need to be focused on now and in the future. Ms. Causey inquired should we remove CAUTI all together. Ms. Johnson stated you should contact HealthInsight for the most recent state data, which is probable a year old. Mr. Woodard inquired you review these every meeting. Ms. Causey stated the targets are reviewed as needed. Ms. Causey stated she would work with Ms. Thorson and then we will look at what infections need to be targeted.

9. FUTURE MEETING DATES

Ms. Causey stated the next meeting will be Friday, January 12, 2018 at 10:30am to 12:30pm.

10. SECOND PUBLIC COMMENT

Ms. Causey announced the First Public Comment Session and invited members of the public to speak. Hearing no comments, Ms. Causey moved to adjourn the meeting.

11. ADJOURMENT

Ms. Causey adjourned the meeting at **11:35 a.m.**