Healthcare-Associated Infections Multidisciplinary Group
Wednesday, November 02, 2016, 9-11 am
Connecticut Hospital Association (CHA)
110 Barnes Road, Wallingford, CT 06492

DRAFT

Voting Members Present: Dale Cunningham, Louise-Marie Dembry, Alison Hong, Wendy Furniss, Jack Ross, Jacqueline Murillo, Lynne Garner, Jean Rexford

Present via Telephone: Ellen Edge, Jaya Bhargava

Members Excused: Carl Schiessl

Liaison Members present: Lauren Backman, David Banach, Johnathan Best, Bianca Cartagena, Evelyn Carusillo, Diane D'Addabbo, Carol Dietz, Diane Dumigan, Patricia Gannon, Paul Gentile, William Gerrish, Meghan Maloney, Richard Melchreit, Kathryn Cusano, Brenda Nurse, Julie Petrellis, Roza Tammer, Jana Lohrova, Acacia F. Ransom

New To Meeting: Theresa Kennedy, Doreen Beattie, and Cynthia Hayle, Anjali Poudyal

Issues Heard:

- Call to Order and Roll Call
- Approval of August 03, 2016 HAI Meeting Minutes
- Update on CT "Frontline Hospital" Ebola/SID Infection Control Site Visits
- Update on expanding Infection Control & Response (ICAR) site visits to Long Term Care
- Report on IPRO- Dialysis ICAR Assessments
- Update on 2016 Qualidigm- QIO LTC NHSN LabID C. difficile Project
- Understanding the CAD (Cumulative Attributable Difference) in NHSN
- A quality improvement approach to internal validation of healthcare facility-reported HAI data
- Update on CT Antimicrobial Resistance/Antimicrobial Stewardship Initiative
- CRE Reporting in CT: Data from 2014-2016

Agenda Item	Presenter	Discussion	Action Item	Responsible Person(s)	Due Date
Welcome and Call to Order	R. Melchreit CT DPH HAI Program Coordinator	The meeting was called to order at 9:00 am by Dr. Rich Melchreit. Minutes for August 03, 2016 meeting were unanimously approved as written. Roll call was heard including members who were in attendance, via telephone.		R. Melchreit	
New Member Welcome	CT DPH HAI Program	Welcome Acacia Finlayson Ransom; IPRO	Informational only	R. Melchreit DPH HAI Staff	Ongoing
ELC Ebola Grant	**Presenter**	**Discussion**	**Action Item**		
CT ELC Ebola-funded (ICAR) Site Visits	L. Backman CT DPH HAI Program	**CDC Ebola Supplemental Funding to ELC (Epidemiology & Laboratory Capacity)** L. Backman gave a brief over view of the Ebola Supplemental Funding from the CDC's Infection Control Assessment and Response (ICAR) Program received by the CT DPH HAI Program. The purpose of the funding is to augment the state's HAI plan, create a facility inventory of all CT health care settings and facilities, and identify infection control readiness, and mitigate infection control gaps that are identified. State Plan to develop and implement Healthcare Infection Control Assessment and Response (ICAR)	State Plan Developed and submitted 10/ 1/2015 ELC- EBOLA Funding May 2015	L. Backman DPH HAI staff	Ongoing

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New Business	L. Backman, CT DPH HAI Program	L. Backman provided a slide presentation updating the committee on **CDC- CT DPH Plan: "Healthcare Infection Control Assessment and Response (ICAR)"** In response to concerns the Ebola crisis raised about infection prevention, the Center for Disease Control (CDC) launched a nationwide, effort to assess and improve the quality of infection control at all types of health facilities. As part of the Infection Control Assessment and Response (ICAR) activities, the CT DPH HAI program were asked to assess acute care hospitals (ACHs) to identify infection control readiness to Ebola/Serious Infectious Disease Patients using CDC Ebola Readiness Assessment (ERA) tool. This tool was developed to assess whether a hospital has appropriate infection prevention policies, procedures, and supplies in place to allow healthcare personnel (HCP) to provide safe care during the assessment and treatment of patients with suspected or confirmed Ebola virus disease (Ebola). The CT DPH HAI program Acute Care Hospital site visit assessment infrastructure was reviewed and covered the following 12 Domains:, Pre Hospital Transport/EMS/ED preparedness., Facility Infrastructure/ Patient Placement, Patient Transportation, Laboratory Safety and Capacity, Staffing of Patient Care Team, Training, PPE, Waste Management, Worker Safety, Environmental Services, Communications, Special Populations/ Management of Deceased. In completing the ICAR Tool, ACH Infection Preventionists consult with the ACH manger related to the domain. **Updates on CT Acute Care Hospital Site visit Assessments for Ebola funded - Infection Control Assessment and Response-**The current status of the 29 CT acute care hospital (ACHs) assessments were reviewed. 3 ACH had CDC Ebola readiness site visits (with CDC team). On April 20, 2016 the CT DPH HAI team began site visits to assess Infection Control readiness in 26 "Frontline" hospitals. As of September 07, 2016 the team has completed 25 of 26 hospital visits, and 1 Long Term Acute Care (LTAC) as of September 19, 2016. These site visits so far have been a great success and although these site visits are not mandatory, not one hospital has refused. In January of 2016 CDC introduced the ICAR Tool as an ELC Grant deliverable. So far there have been 24 Acute Care Hospitals (ACH) that completed the ICAR Tool. This assessment data is submitted to CDC and is de-identified and aggregated by CDC for CT DPH HAI.	Assessment Time frame: 08/2016-04/2018 ICAR Tool Data Submitted to CDC on 10/28/16	L. Backman D. Dumigan E. Carusillo D. D'Addabbo P. Gannon	Completed: 09/01/15 -- 3 ACH Ebola ERA Assessment Visits April 2018

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	L. Backman CT DPH HAI Program	**Updates on expanding ICAR Assessments to Long Term Care (Nursing homes).** The CT DPH HAI program with guidance from the HAI-AC have expanded the infection control assessments beyond the prioritized Ebola designated facilities. The decision was made to target Long Term Acute Care Facilities such as Hospital for Special Care, etc. in September of 2016 and Long Term Care (Nursing Homes) in October/November 2016. CT DPH HAI will start to enroll LTC Nursing Homes by sending a one-page document via fax. This document describes the project overview, background, objectives, project team, structure of the visit, length of visit, and what to expect after the visit. These site visits are voluntary, non-regulatory, no-cost, collaborative and educational. LTC facility (DON/IP) willing to participate will be asked to contact CT DPH HAI program to scheduled site visits. (November start date) After the site visit dates have been confirmed an introductory letter with site visit documents (agenda & ICAR tool) will be sent to LTC administrator. LTC IP will be asked to submit completed ICAR tool to DPH before visit. The ICAR Tool for Long Term Care Facilities is intended to assist in the assessment of infection control programs and practices in nursing homes and other long-term care facilities. Each tool is designed with specific ICAR Tool for ACH that has 12 domains, this tool has only 9 domains. • Infection Control Assessment Tool (Long Term Care Nursing Homes) • Infection Control Program and Infrastructure, Healthcare Personnel and Resident Safety • Surveillance and Disease Reporting • Hand Hygiene (HH) • Personal Protective Equipment (PPE) • Respiratory/ Cough Etiquette • Antibiotic Stewardship • Injection safety and Point of Care Testing • Environmental Cleaning	Assessment Time frame: 08/2016-04/2018 1 LTAC Completed 09/19/16	L. Backman D. Dumigan E. Carusillo D'Addabbo P. Gannon	April 2018 Ongoing

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Report on IPRO – Dialysis ICAR Assessments	A. Ransom	**Report on IPRO – Dialysis ICAR Assessments** A. Ransom updated the committee on the ICAR assessments for Outpatient hemodialysis centers and the NHSN Dialysis Training Module. Patients who undergo hemodialysis have an increased risk of getting a HAIs. The understanding and implementation of basic infection control in routine practice is imperative to reducing HAIs in the hemodialysis setting. Dialysis facilities that report to NHSN complete an Outpatient Dialysis Center Practices Survey each year in February. The elements included in the ICAR assessment tool are intended to complement the NHSN survey. These site visits have enabled the facility to showcase their Infection Prevention plan and update it with recommendations from the IPRO Dialysis Team. Recently, the Centers for Medicare and Medicaid Services (CMS) published a final rule encouraging all end stage renal disease (ESRD) facilities to track quality indicators through NHSN by following the Dialysis Event Protocol. Facilities must comply with the rule to receive full payment through the CMS Prospective Payment System (PPS) ESRD Quality Incentive Program (QI). Monthly Reporting Plans to indicate what surveillance the facility is doing according to NHSN protocol(s). Training the trainer is an educational component of the ICAR assessment activities. Outpatient Dialysis facilities have the option to participate in both the Dialysis component and the Healthcare Personnel safety Components. CDC has created a new continuing education course "Infection Prevention in Dialysis Settings" for outpatient hemodialysis healthcare workers, including technicians and nurses. The 1-hour self-guided training course features a flash-based slide presentation and audio narration. The course reviews the following topic areas: Infections that patients can get from dialysis, Infection control recommendations for outpatient hemodialysis healthcare workers, and Educating your patients and their caregivers. These modules are used as educational tools in hemodialysis facilities for new staff or annual in-service training.		D. Dumigan L. Backman	

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	C. Dietz F. Johnson	**Update on 2016 Qualidigm- QIO LTC C. difficile Project** Carol Dietz gave a brief update on Qualidigm C. difficile Project. Regional based (6 states) quality improvement organizations covering New England with representative from each state working on CLABSI, CAUTI, CDI, and VAE. Helping ACHs to reduce infection rates, hospitals volunteer to be part of the project. Currently working with 9 CT hospitals. NHSN antimicrobial use measure to compare hospital antibiotic prescribing to national benchmark may become final rule in August. Nursing Home reporting for CMS: QIO will be required to have 15% of nursing homes enrolled. Nursing Homes will be required to report C-diff cases to NHSN in the near future.	Informational Only:	C. Dietz C. Hayle F. Johnson	
Agenda Item	**Presenter**	**Discussion**	**Action Item**	**Responsible Person(s)**	**Due Date**
A quality improvement approach to internal validation of HCF-reported HAI data	R. Tammer	**"A quality improvement approach to internal validation of HCF-reported HAI data"** R. Tammer provided the committee with a presentation on the Quality improvement approach to internal validation of healthcare facility-reported HAI data. The CT DPH HAIs program collects HAI data via the National Healthcare Safety Network (NHSN) from four healthcare facility (HCF) categories: Acute care hospitals (ACH) which began reporting CLABSI, CAUTI, SSI, and LABID Event- in 2008, Long-term acute care hospitals (LTACH) began reporting CLABSI, CAUTI, and LabID Events in 2013, Inpatient rehabilitation facilities (IRF) began reporting CAUTI and LabID Events in 2013 and Hemodialysis facilities began reporting Dialysis Events in 2013. HAI data reported into NHSN should be checked to ensure data quality, one approach is known as internal validation. The Quality improvement approach includes a three Plan-Do-Study-Act (PDSA) cycles. **Plan**- Define the goal, why it is needed and how it will be carried out? **Do**- Implement plan and document what occurs. **Study**- Analyze data and summarize what is learned, and **Act**- Decision-making based on study phase (adapt & re-test, adopt, abandon) **PDSA Cycles 1 and 2** Our team designed reports covering HAI data for 2014 (Cycle 1) and 2015 (Cycle 2), Distributed reports and accompanying guidance to HCF reporting partners, Quantified changes made to data following a two-week review period (Round 1 vs. Round 2)		R. Tammer	Ongoing

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A quality improvement approach to internal validation of HCF-reported HAI data	R. Tammer	**Results PDSA Cycle 1** Aggregate SIR and 95% CI for all ACH, by measure and round (2014 data) 32 ACH, 3 LTACH, and 8 IRF reported 2014 HAI data to CT DPH. We found no unresolved alerts during Round 1, no changes made by LTACH or IRF and 4/32 ACH (12.5%) accounted for 100% of changes made. The Few changes made to data, posing challenges for assessment of statistical significance were: New voluntary processes require time for uptake, Implementing new processes is burdensome, Emailed reports may not always be received, Centers for Medicaid and Medicare Services (CMS) deadlines had long since passed, and HCFs may have already executed their own validation efforts on these data **Processed Improvements: for Cycles 1 and 2** PDSA Cycle 2 attempted to address several limitations of the process implemented during PDSA Cycle 1, New voluntary processes require time for uptake this was Intrinsically addressed by Cycle 2. Emailed reports may not always be received, we developed a contact sheet and currently undergoing validation. The Centers for Medicaid and Medicare Services (CMS) deadlines had long since passed, and HCFs may have already executed their own validation efforts on these data. The 2015 data was exported and distributed in April-May 2016, two weeks prior to the annual deadline. We found delay between deadline and reports much shorter **Results PDSA Cycle 2:** 32 ACH, 3 LTACH, and 8 IRF reported 2015 HAI data to CT DPH, 10 unresolved alerts during Round 1 (resolved in Round 2), No changes made by any LTACH; 1 IRF made a change, 6/32 ACH (18.8%) and 1/8 IRF (12.5%) accounted for 100% of changes made. **Process improvements:** Need to gain understanding of the following to improve value of this process to customers: New contact sheet likely improved completeness, timeliness of distribution and receipt. Are our HCF reporting partners aware of these reports? Not many changes made during either PDSA cycle, Are our reporting partners using these reports? If so, how? Implementing new processes is burdensome, What part(s) of this process are useful for HCF? What are our opportunities for improvement?	PDSA Cycle 1 –Feb 2016 PSDA Cycle 2 –Apr 2016 PDSA Cycle 3 –Jun 2016	R. Tammer UCONN MPH practicum students Andrea Borondy Kitts, MS Genevieve Caron Judith Bennett, RN, BSN	

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<tr><th>Agenda Item</th><th>Presenter</th><th>Discussion</th><th>Action Item</th><th>Responsible Person(s)</th><th>Due Date</th></tr>
<tr><td>A quality improvement approach to internal validation of HCF-reported HAI data</td><td>R. Tammer</td><td>
PDSA Cycle 3
Designed and distributed web-based survey assessing if and how these reports were being used as well as opportunities for improvement and analyzed responses.
Results PDSA Cycle 3
Response rate of 8.7% (N=15, of 173 unique email address)
<table>
<tr><td></td><td>Yes (n, %)</td><td>No (n, %)</td></tr>
<tr><td>Aware of internal validation reports? (n=15)</td><td>13 (86.7)</td><td>2(13.3)</td></tr>
<tr><td>Became aware after an email from the HAI Program (n=13)</td><td>8 (61.5)</td><td>5 (38.5)</td></tr>
<tr><td>Became aware after a meeting or phone call (n=13)</td><td>5 (38.5)</td><td>8 (61.5)</td></tr>
<tr><td></td><td>Yes (n, %)</td><td>No (n, %)</td></tr>
<tr><td>Reviewed 2014 report (n=13)</td><td>12 (92.3)</td><td>1 (7.7)</td></tr>
<tr><td>Made changes to 2014 data (n=13)</td><td>1 (7.7)</td><td>12 (92.3)</td></tr>
<tr><td>Made changes as a result of report (n=1)</td><td>1 (100)</td><td>0 (0)</td></tr>
<tr><td></td><td>Yes (n, %)</td><td>No (n, %)</td></tr>
<tr><td>Reviewed 2015 report (n=13)</td><td>12 (92.3)</td><td>1 (7.7)</td></tr>
<tr><td>Made changes to 2015 data (n=12)</td><td>0 (0)</td><td>12 (100)</td></tr>
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What about the internal validation reports work well? (n=12)
(n=9) reported that having an internal validation report was helpful (positive)
And stated that it was nice to have all data summarized in one place to review, missing months were highlighted and it’s a good reminder to double check items.
(n=2) reported that they felt the report had no impact in the IP program. Since the data reported had already been reported, reviewed, and discussed with our infection control committee.
(n=1) reported negatively and felt that it is just another time that they have to redo the same data again and again.
Suggestions on how to improve internal the internal validation reports and what the HAI Program can do to improve were reviewed and some respondents had suggestions on formatting changes, lack of utility, and timing of the reports.
Process Improvements Suggestions:
Improve contact sheet (validate & collaborate with other units), Publicize report, Consider changes to format, timing, and guidance, Clarify goals, use and requirements relating to reports.
</td><td></td><td>R. Tammer

UCONN MPH practicum students Andrea Borondy Kitts, MS

Genevieve Caron

Judith Bennett, RN, BSN</td><td></td></tr>
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A quality improvement approach to internal validation of HCF-reported HAI data	R. Tammer	Our Goal is to ensure that each facility has the opportunity to review [HAI] data as well as identify and resolve discrepancies to make certain that the data in the legislative report are of the highest quality. Our team will read guidance and locate your facility's data, review and resolve alerts, review data (numerator/denominator, months, comments, highlighted fields), cross-reference data in reports with data reported in to NHSN by your facility, Identify discrepancies and resolve internally or ask HAI Program for technical assistance. There is no requirement to notify the DPH HAI Program of discrepancies or changes to these data **Conclusions** Though statistically significant changes were not achieved, data outcomes with practical significance were observed. Providing data reports and guidance to facilities is an efficient and systematic process for internal validation. This process encourages communication between HCF and the HAI program, analysis of their own data, compliance with legislation, Due Diligence for future publication of HCF-specific data		R. Tammer UCONN MPH practicum students Andrea Borondy Kitts, MS Genevieve Caron Judith Bennett, RN, BSN	

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Antimicrobial resistance-AMS	M. Maloney	**Antimicrobial Resistance/ Antimicrobial Stewardship Update** M. Maloney presented the committee with updates on some of the activities the Antimicrobial Resistance/Antimicrobial Stewardship Multidisciplinary Technical Advisory Group. First meeting was held in September 2016. Opening Key factors discussed at the meeting, Consensus on the desire to expand AR reporting to include carbapenem-resistant Acinetobacter baumannii (CRAB) and the development of the DPH laboratory CRE testing paradigm with planned implementation, both items to beginning January 2017. HAI Program AR/AMS Activity post Advisory meeting were reviewed and include, Submission of Reportable Disease Committee proposals to require submission of CRE isolates, addition of CRAB reporting. Collaboration with DPH laboratory to refine plans for CRE testing implementation. Participation in CDC training on Antimicrobial Resistance Lab Network (ARLN) outbreak support, CRE laboratory test protocol development. Presentation of 2014-2015 CT CRE data at the Northeast Epidemiology Conference. Providing technical assistance on CRE reporting to several jurisdictions.	CRE reporting-01/2017 ARLN Presentation to CT IPs-11/02/2016	M. Maloney EIP Staff	Ongoing

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	M. Maloney	M. Maloney also shared her travel to Massachusetts to explore logistics of transition of CRE data to CTEDSS (aka Maven) this was the first step towards the development of XDRO registry, which will allow different Healthcare facility access to CRE case information. She also stated that MA discussed their current implementation of statewide antibiograms and potential future strategies. Some of the AR/AMS activities anticipated in the near future will include, A presentation of ARLN CRE surveillance culture guidance to the CT IP community. CDC/DPH social media campaign in support of Get Smart week (Nov 14-21), DPH HAI staff will be using social media sites like Facebook, Twitter, and Instagram. Collaboration with DPH Laboratory to support development of reporting tools for enhanced CRE laboratory panel and the development of CRAB database/data collection tools/clinical laboratory reporting support materials. (CRE Tool kit) **Emerging Infections Program HAIC Activities** Sepsis and Septic Shock Epidemiology study has been approved by DPH HIC as non-research! The reason(s) being that recent changes have been made to clinical guidance on the definition of "sepsis" "sever sepsis" and "septic shock". There have been discrepancy in the application of these terms. The first step in understanding a public health problem is to develop a means to define it, CT will aim to identify 3-4 hospitals to participate. CHIME data will be used to identify patients with a discharge diagnosis of "sepsis" or "septic shock" between Oct 1, 2014-Sept 30, 2015 (ICD-9) Our goal is to identify and review charts for 100 adult and 100 pediatric cases. Nursing Home HAI Prevalence and Antimicrobial Use Study: This EIP Nursing Home Survey gathers data on all types of HAIs in nursing homes. For this survey, the use of an alternate set of surveillance definitions for infections in Long-Term Care Facilities will be used. Nursing homes will be randomly selected for participation. Nursing home participation is voluntary. The goal is to recruit up to 20 nursing homes from the Hartford and New Haven counties. Each nursing home will selected a single survey day between April and September 2017. Resident's medical records will be reviewed to collected demographic data, and for evidence of HAIs and antimicrobial use. Medical record reviews will be performed by EIP staff members, and in some cases with assistance from nursing home staff members.	Social media Campaign-Get Smart week (Nov 14-21)	M. Maloney	Spring 2017

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CRE Reporting in CT: Data from 2014-2016	M. Maloney	M Maloney presented CRE reporting data for 2014-2015 on behalf Noelisa Montero, MPH CDC/CSTE Applied Epidemiology Fellow. In Connecticut, CRE has been laboratory reportable since January 2014. All genus and species of Enterobacteriaceae from all sterile sites, sputum and urine should be reported to the Department of Public Health. A patient with multiple specimen collections of the same genus/species and carbapenem resistance profile, should be reported as an incident case ONLY, once every 30 days. However, if a different genus/species or a more-resistant profile is identified in a patient within the 30-day window, this should be reported as a separate incident case. The HAI program followed up on all reported cases and used a data collection form for chart reviews of hospitals inpatients. In this form, we look for patient, laboratory and clinical information, risk factors: healthcare exposures and infection control practices, and any antibiotic therapy that the patient had while hospitalized and in the previous 60 days. The information is then entered and stored in an Access database and analyzed using SAS 9.4. We had 296 reports and completed about 77% of the charts. 37% were from non-hospitalized patients. These were excluded from the analysis due to the limited information on their medical records. Non-cases were also excluded. We classified a case AS SUSPECT if they met the genus and clinical source components of the case definition but there was insufficient data available to evaluate the antibiogram requirements. Identified cases for data analysis were 138. For the demographics assessment, we excluded 12 duplicate forms to represent unique individuals. Females and males were nearly equally distributed. However, for females, most isolates were from urine. For males, the type of isolate was equally distributed between urine and all other isolates. We found that females presented more urinary tract infections than males (total urinary tract infections N=62, 58% for females and 42% for males). Confirmed/Suspected Hospitalized CRE Cases= 3 quarters of reported cases were 60 years of age or older and the distribution of race and ethnicity was representative of the population in Connecticut. July 2015 census: White: 80.8%, Hispanic: 15.4%, Black: 11.6%, Asian: 4.6%.		M. Maloney N. Montero Meghan Maloney, MPH Richard Melchreit, MD Lynn Sosa, MD HAI Program at DPH Medical Records Department s & staff	

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CRE Reporting in CT: Data from 2014-2016	M. Maloney	**Type of Organism** found during follow-up, 90% of our cases, for both, hospitalized and non-hospitalized individuals, are one of the "big 3 Enterobacteriaceae": Klebsiella pneumoniae, and klebsiella oxytoca, E coli, and Enterobacter species. Reporting of all Enterobacteriaceae will continue in order to be able to detect clusters and novel resistance mechanisms. There is no explanation as to why Enterobacter is less likely in non-hospitalized CRE cases. In hospitalized cases, 87% of the specimens were from urine and the respiratory tract. However, about 93% were from urine ONLY for non-hospitalized cases. Perhaps they had higher urine colonization. More than one infection type could be selected in the form. Urinary tract infection, pneumonia, and sepsis were the most common infections among hospitalized cases (with about 3 quarters). 35% of infections in non-hospitalized cases were from the urinary tract and 55% were unknown, as expected, since the information for them was limited. The hospital stay ranged from 2 days to about 6 months with 14 median days. We calculated the number of antimicrobial days as the sum of treatment days for each drug; and we had 17 median days of antimicrobial therapy in total. 32% of cases had additional positive cultures within 30 days of report. We noted that most cases survived during the hospitalization. Three-quarter of cultures were collected in the emergency room and in the ICU. For those collected in the ED, about 60% came from a private residence and about 35% from a long term care facility. This information highlights the important role of inter-facility communication and communication between facilities in infection prevention and control practices, especially for transfer patients In future analysis, we would like to have a control for co-morbidities and age to see if results change or remain the same. Other exposures could be interventional radiology, surgery / operating room, and observational unit. In 2014: 19.4 died after discharge. 2015: 14.8 died after discharge. Mortality during hospitalization is statistically different according to isolate type. Exposure during collection period, about 41% of cases had culture collection 3 days after admission; this serves as a proxy to measure a hospital acquired infection. 78% had antibiotic therapy in the previous 60 days and nearly half of the cases had an ICU stay during hospitalization. 2/3 cases had one or more MDROs.			

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CRE Reporting in CT: Data from 2014-2016	M. Maloney	Nearly 77% of cases had 1 or more invasive devices during hospitalization. Being indwelling urinary catheter, central line, and enteral feeding tube, the majority of them. Overall, the majority of cases had one or more exposures during their information collection period. In the past year we have seen that most cases had an acute care hospitalization (84%), surgery or an invasive procedure (68.1%). DPH receives lab reports on CRE cases. However, after performing the chart reviews, we noted that about a quarter of cases didn't have CRE diagnosis specifically noted in the medical record or in the lab report within the medical record. In contrast, for nearly 48% of cases, CRE diagnosis was specifically mentioned in both the medical record and the lab report within the medical record. Having the CRE diagnosis specifically mentioned could help increase awareness of CRE cases within a facility. 24.6% (34/138) of cases did not have diagnosis of CRE specifically noted in the medical records or in the lab report within the medical record No MR and no Lab report. In reviewing the Infection prevention practices, hospitals placed the cases in contact precautions in a median of one and a half days BEFORE the positive culture result date. The range went from 22 days before the positive result (indicating that the patient may have been placed in contact precautions for reasons other than the CRE) to 13 days after (and we want to see a lower number for this as a way to decrease the risk of transmission within the facility). CRE cases showed some risks for transmission, 60% were incontinent of urine and had open and/or draining wounds during the admission; and nearly 50% were incontinent of stool and had diarrhea. **Limitations found during CRE follow-up cases:** Very limited outpatient information → No completion of the data collection tool, 37% of reports were from non-hospitalized patients, CRE cases reported with no antibiogram were classified as "suspect" pending antibiogram information collection, Medical record review strategies changed according to facility, Different medical record storage systems, History of international travel and international hospitalization were difficult to obtain from the medical records, CRE case report is dependent on laboratory reports only			

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CRE Reporting in CT: Data from 2014-2016	M. Maloney	**Next Steps:** CT DPH HAI team would like to move toward "real-time" case follow-ups for 2017, Develop a data collection protocol for non-hospitalized patients, Isolate submission to the state lab for follow-up testing beginning in Jan 2017, expand reporting of Carbapenem-resistant Acinetobacter baumanii (CRAB) beginning in Jan. 2017. Develop XDRO patient registry that will help transition the CRE Access database to the Surveillance System platform in CT. The registry will be accessible to Infection Control Preventionists in acute care hospitals for reporting of inpatients hospitalized within own facility and link CRE to a common grouping accessible across facilities. Finally, it is important to educate facilities that don't specifically indicate CRE in their medical record and/or the lab report within the medical record (24.6%) as a way to promote the inter-facility communication.			
		2017 Quarterly Meeting Dates:			
2017 HAI Committee Meeting Dates	R. Melchreit, CT DPH Program	Meetings will be held from 9-11 am at CHA Wallingford, CT • February 8, 2017 • May 3, 2017 • August 2, 2017 • November 1, 2017 – (Location TBD)	Informational Only	R. Melchreit	
Adjournment		- Due to time restrictions some agenda items were not reviewed and will be discussed at next HAI-AC meeting. Motion was made to adjourn, all members accepted.			
Attachments		1. DPH Advisory Committee Meeting: November 2, 2016 (Power Point)- L. Backman 2. CT HAI Advisory Committee August 3, 2016 meeting minutes. 3. Presentation on "A quality improvement approach to internal validation of healthcare facility-reported HAI data" (Power point)- R. Tammer 4. CT Antimicrobial Resistance/Antimicrobial Stewardship Initiative (Power Point)- M. Maloney 5. CRE Reporting in CT: Data from 2014-2016 (Power Point) M. Maloney (N. Montero)			

Ongoing 2015-2016 Initiatives to be Discussed and Finalized 2015-2016	Actual Date of Completion
1. Assessing hospitals for Ebola readiness	September 2016
2. Facility inventory of CT healthcare facilities	Ongoing
3. CT DPH Healthcare Quality & Safety (Regulations & Facility Licensing) State Surveys for IC gaps.	Completed for ACH: 9/15/15 75% Completed for LTC (nursing home): 11/01/15
4. CT DPH HAI Outbreak Reporting Plan	Ongoing