CT HAI Multidisciplinary Group Meeting
May 6, 2015

HAI Advisory members in attendance: Dale Cunningham, Louise Dembry, Wendy Furniss, Brenda Grant, Jean Rexford, Jack Ross

Present via Telephone: Ray Andrews, Laurie Brentlinger, Deb Quetti

HAI Advisory Members Excused: Allison Hong, Carl Schiessel, Jacqueline Murillo, Lynne Garner

Liaison Members present: Lauren Backman, Harry Byrne, Tracy Creatore, Kathryn Cusano, Carol Dietz, Nancy Dupont, Lori Dutko, Shelli Eason, Mary Emerling, Brenda Grant, Traci Greenspar, Alessandra Litro, Richard Melchreit, Donna Morris, Julie Petrellis

Agenda Item	Presenter	Discussion	Action Item	Responsible Person(s)	Due Date
Welcome and Call to Order	L. Backman, CT DPH HAI Program	The meeting was called to order at 9:05 am. A motion was made to accept the minutes from the 02/04/2015 meeting. The minutes were accepted as is.			
HAI Program Updates	L. Backman, CT DPH HAI Program	L. Backman provided an update on HAI program activities. They included: the new ELC Ebola grant for the Healthcare Infection Control Assessment and Response of CT Healthcare facilities; 2015 CT IP survey; and 2015 changes to NHSN surveillance definitions.			
ELC Ebola Grant	L. Backman CT DPH HAI Program	L. Backman provided a slide presentation on the new funding award that DPH HAI program received from the CDC Epidemiology & Laboratory Capacity (ELC) Ebola supplemental funding. The purpose of the funding is to develop and implement a state plan for the Healthcare Infection Control Assessment and Response of CT Healthcare facilities. Elements of the state plan that are required for the grant are as follows:	See action steps below for each plan element.	L. Backman	

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ELC Ebola Grant	L. Backman CT DPH HAI Program	1. Expand current HAI advisory group to include additional partners, specifically hospital preparedness (through representatives from hospital/healthcare coalitions funded through the ASPR Hospital Preparedness Program); additional representation from state and/or regional hospital associations, Quality Improvement Networks/Organizations, and accrediting and/or licensing agency with surveyor authority is ideal.	1. Expand current HAI Advisory group by inviting Liaison members to join the HAI Advisory Committee.	L. Backman/R. Melchreit	1. July 1, 2015
		2. Actively involve State HAI/Infection Control advisory group (e.g., be a resource, provide guidance, etc.) with the health department's developing and implementing the state's plan which includes: a) updating the state's HAI plan; b) interpreting findings from infection control assessments (e.g., gap analysis); and c) developing mitigation strategies for addressing identified gaps.	2. Provide/present Ebola grant activity progress reports at HAI Advisory committee meetings	L. Backman/R. Melchreit	2. Ongoing
		3. Create an inventory of all healthcare settings (acute care, non-acute care, ambulatory) in the state (list must include at least one infection control point of contact at the facility and indication of what (if any) HAI-related data is available to recipient. This inventory should be sustainable and updated, as needed, to reflect changes.	3. Create an inventory of all CT healthcare facilities beginning with acute care hospitals then expanding the list to other facilities.	L. Backman & HAI team	3. August 1, 2015
		4. Identify current regulatory/licensing oversight authorities for each healthcare facility.	4. Inventory of CT healthcare facilities will include current regulatory/licensing oversight authorities	L. Backman & HAI team	4. August 1, 2015
		5. Explore, pilot and implement ways to expand oversight (e.g., licensing and credentialing) to include infection control capacity or competence as a requirement for operations	5. Explore, pilot & implement ways to expand oversight to include infection control capacity or competence	L. Backman & HAI team	5. April 1, 2016

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ELC Ebola Grant	L. Backman CT DPH HAI Program	6. Using CDC readiness assessment tool, conduct on-site infection control assessments of, at a minimum, all Ebola-designated assessment hospitals, and selected Ebola Treatment Centers as appropriate. This should include an onsite assessment by state health department staff or contractors.	6. Conduct on-site infection control assessments using CDC tool	L. Backman/R. Melchreit	6. Sept 29, 2015
		7. Determine gaps in infection control readiness within the Facilities.	7. Using CDC tool, determine gaps in infection control	L. Backman & HAI team	7. Ongoing
		8. Address gaps by providing general infection control consultation and/or training to assessment hospitals using CDC-based resources, working with the hospital to develop and implement a plan to mitigate identified gaps. State/City Program should identify opportunities to use and coordinate facility-specific pathways for Ebola assessment hospitals and Treatment Centers to reach preparedness through resources linked to either CDC's Public Health Emergency Preparedness Program and/or ASPR's Hospital Preparedness Program linked training resources for Ebola Treatment Facilities.	8. Develop gap mitigation plan	L. Backman & HAI team	8. Ongoing
		9. Follow up assessments performed to confirm mitigation of gaps in infection control at the facilities previously evaluated.	9. Perform follow-up assessments	L. Backman & HAI team	9. 2016-2017

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ELC Ebola Grant	L. Backman CT DPH HAI Program	10. Using a standardized outbreak assessment tool (CDC can provide technical assistance on this approach), assess capacity of healthcare facilities to detect, report, and respond to potential outbreaks and emerging threats	10. Using CDC tool, assess capacity of healthcare facilities to detect, report & respond to potential outbreaks & emerging threats.	L. Backman & Team	10. Sept 29, 2015
		11. Determine gaps in outbreak reporting	11. Determine gaps in outbreak Reporting	L. Backman & Team	11. Ongoing
		12. Determine gaps in outbreak response in all healthcare Settings.	12. Determine gaps in outbreak Response	L. Backman & HAI team	12. Ongoing
		13. Address gaps in outbreak investigative capacity by working with healthcare partners to develop a plan (and infrastructure) to improve outbreak reporting and response	13. Develop a plan to mitigate Gaps	L. Backman & HAI team	13. Ongoing
		14. Track healthcare associated infections outbreak response and outcome	14. Track HAI outbreak response & outcome	L. Backman & HAI team	14. Ongoing

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New England QIN-QIO/Qualidigm: 2015 CMS Update	Carol Dietz, RN, MBA, CPHQ QI Consultant New England QIN-QIO/Qualidigm	Carol Dietz provided a slide presentation on the CMS reporting requirements in NHSN and the Medicare Quality Reporting Programs. The following programs were discussed in detail: • Hospital Inpatient Quality Reporting, • Hospital Outpatient Reporting, • Readmissions Reduction program, • HAC reduction program and • Hospital Value based Purchasing. The December 2014 table of Healthcare facility HAI reporting requirements to CMS via NHSN was distributed to those present. The first quality reporting program for acute care hospitals was the Inpatient Quality Reporting Program (IQR) which started with only clinical measures; now this program includes all the HAI measures: CLABSI, CAUTI, SSI, MRSA and CDI LabID events, and Healthcare Personnel Influenza Vaccination Summary data. Hospitals participating in this program must report their performance on all of the measures before each deadline period; there are no extensions. If they do not submit their data on time their facility could lose up to 2 percent of their Annual Payment Update (APU). CMS also has a Hospital Outpatient Reporting Program (OQR) which is a data reporting program where hospitals report data using standardized measures of care to receive the full annual update to their Outpatient Prospective Payment System (OPPS) payment rate. The only outpatient data that is submitted into NHSN is the Healthcare Personnel Influenza Vaccination Summary data.	None		

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New England QIN-QIO/Qualidigm: 2015 CMS Update	Carol Dietz, RN, MBA, CPHQ QI Consultant New England QIN-QIO/Qualidigm	Another program CMS has implemented is the Hospital Acquired Condition (HAC) Reduction Program which will allow CMS to reduce hospital payments by 1 percent for hospitals that rank among the lowest- performing 25 percent with regard to HACs. For FY 2015 only CLABSI and CAUTI SIRs were part of Domain 2 while Domain 1 was the Patient Safety Indicator (PSI) composite measure. For FY 2016 Domain 2 will include: CLABSI, CAUTI, and SSI SIRs. Domain 1 has not changed. CMS has a Hospital Readmission reduction program to incentivize hospitals to reduce admissions to an IPPS Acute Care hospital within 30 days of discharge from the same or another acute care hospital. Hospital Value-Based Purchasing (VBP) is Medicare's change to a quality-based system from a quantity-based system to improve healthcare. There are 4 domains that are reported on in this program and the HAI measures are within the Safety Domain. For FY 2017 the HAI measures include: CLABSI, CAUTI, SSI, MRSA and CDI LabID events.	None		

New England QIN-QIO/Qualidigm: NHSN: Targeted Assessment for Prevention Reports (TAP)	Carol Dietz, RN, MBA, CPHQ QI Consultant New England QIN-QIO/Qualidigm	Carol Dietz provided a slide presentation on the new Targeted Assessment for Prevention (TAP) reports implemented in NHSN. The TAP strategy is a method developed by the Centers for Disease Control and Prevention (CDC) to target facilities and units with excessive HAIs, then assess their current practices to find gaps with best practices, then implement these best practices to prevent further HAIs. The TAP strategy allows for the ranking of facilities (or units) in order to identify and target those areas with the greatest need for improvement. The TAP report uses a metric called the cumulative attributable difference (CAD). The CAD is the number of infections that must be prevented to achieve a SIR goal and is calculated by subtracting the predicted number of HAIs for that specific facility (or unit) times the SIR target goal from an observed number of HAIs. The TAP report allows for the ranking of facilities, or locations within individual facilities, by the CAD to prioritize prevention efforts where they will have their greatest impact. TAP reports are currently available in NHSN for CLABSI, CAUTI, and CDI. More enhancements to the TAP report will be made in the summer 2015.	None		

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Data and Statistics	L. Backman	Due to Ebola grant activities, no HAI data was presented.	None		
CSTE Position Statement	R. Melchreit	The Council of State and Territorial Epidemiologists (CSTE) adopts position statements each year at the CSTE Annual Meeting. This science and policy documents are important ways to influence policy to align them better with public health practice and the logistics of healthcare surveillance. CSTE is planning on assessing the use and usefulness of the Position Statements as a policy tool for states. Richard Melchreit introduced this issue, and it will be discussed in more detail at a follow-up meeting with Committee members.	None		
Other	R. Melchreit	The Committee discusses the critical need for adequate resources for healthcare IP programs. The programs have experienced a dramatic increase in responsibilities without apparent increases in needed resources. During the discussion, it was suggested the advocacy community consider and address this issue.	Ongoing	R. Melchreit	
Attachments		1. DPH HAI Program Updates (Powerpoint) 2. Medicare Hospital Quality Reporting Programs Using NHSN Data (Powerpoint) 3. CDC's Targeted Assessment for Prevention (TAP) Strategy to Reduce Harmful HAIS (Powerpoint)			

Ongoing 2015-2016 Initiatives to be Discussed and Finalized 2015-2016 Actual Date of Completion

1. 2010-2014 & updated 2015-2019 CT HAI State Plan
2. 2015 CT Infection Prevention Survey
3 Assessing hospitals for Ebola readiness
4. Mapping and Inventory Initiative of CT healthcare facilities
5. CT DPH Healthcare Quality & Safety (Regulations & Facility Licensing) State Surveys for IC gaps