

State-Level Partners Collaborating to Eliminate Healthcare-Associated Infections: Meeting Summary

September 15 – 16, 2011

Dallas/Fort Worth, TX

*Organized by:
Office of Healthcare Quality
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services*

The State-Level Partners Collaborating to Eliminate Healthcare-Associated Infections Meeting, hereafter the State-Level Partners Meeting, was held September 15-16, 2011 at the Hyatt Regency Dallas/Fort Worth, TX. The Office of Healthcare Quality (OHQ), Office of the Assistant Secretary for Health (OASH), U.S. Department of Health & Human Services (HHS), hosted the meeting, led by Don Wright, MD, MPH, Assistant Secretary for Healthcare Quality. Although OHQ hosted the meeting, it could not have happened without the help of an interagency committee made up of the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), and the Agency for Healthcare Research and Quality (AHRQ).

Meeting objectives and key questions posed to participants were as follows:

Objectives:

1. To promote collaboration and strategic alignment of programs and resources across state-level entities with HAI prevention-related activities (e.g., state health departments, state hospital associations, QIOs, PSOs, healthcare systems, payers, consumer organizations, professional organizations, the federal government, and other stakeholders).
2. To share and discuss information regarding current and pending federal legislation/initiatives that may impact state-level prevention efforts (e.g., Partnership for Patients (PfP), Affordable Care Act (ACA), Meaningful Use of Health Information Technology).
3. To share and discuss information regarding current and pending state-level legislation/initiatives that may impact national-level prevention efforts (e.g., state reporting mandates).
4. To identify tools needed, specifically at the state-level and in an era of limited funding, to achieve HAI reduction targets in the national and state action plans.

Key Questions:

1. How can state-level partners improve HAI rates using current funding or resources?
2. What has already worked in your state to improve HAI rates and how can that be shared with others?
3. What are the barriers to improving HAI rates in your state?

Meeting participants included

- 318 individuals
- Representatives from every state, the District of Columbia, Puerto Rico and the Virgin Islands
- Greatest participation from Region VI (Arkansas, Louisiana, New Mexico, Oklahoma and Texas)- 56 participants; followed by Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) -54 participants; followed by Region III (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia)- 52 participants.
- QIOs and State HAI Coordinators were a significant proportion of participants.

- Representation from multiple sectors, including healthcare systems, state health departments, state hospital associations, quality improvement organizations, patient safety organizations, consumer organizations, professional organizations, payers, and multiple HHS offices.

The meeting consisted of five plenary sessions, one open space session, networking lunch, recap from the focus group “Essential Components of a Healthcare-Associated Infection Program”, and an update on the Regional HAI Projects. Each day started with a welcome to the meeting that outlined the objectives and goals of that day’s program. The welcome from the second day of the meeting came from Marjorie Petty, JD, Region VI Regional Administrator.

Plenary Session 1: Broad Federal Patient Safety Initiatives

Plenary Session 1 discussed the various broad federal patient safety initiatives taking place in HHS. The following speakers gave presentations on their subject areas of expertise:

Partnership for Patients – John O’Brien, PharmD, MPH, CMS

Dr. O’Brien gave a brief review of the Partnership for Patients (PfP), a \$1 billion investment, and discussed how it relates to reducing and eliminating HAIs. Of the ten of the healthcare-acquired conditions (HACs) that PfP is focusing on, four are HAIs: Ventilator-Associated Pneumonia (VAP), Central Line Associated Bloodstream Infections (CLABSI), Catheter-Associated Urinary Tract Infections (CAUTI) and Surgical Site Infections (SSI).

Dr. O’Brien also provided information on how CMS wanted to use PfP to develop a national learning platform that would engage systems and hospitals, and where successful hospitals would serve as mentors to other hospitals.

The partnership for patients has two main goals:

- A 40-percent reduction in preventable harm in hospitals would mean 1.8 million fewer injuries and the potential to save 60,000 lives.
- A 20-percent reduction in readmissions means that 1.6 million fewer patients would suffer harm that sends them back to the hospital within 30 days. This could save \$35 billion.

Centers for Medicare & Medicaid Services (CMS) Quality Update – Jean Moody-Williams, RN, MPP, CMS

A CMS Quality update discussed the various initiatives through which CMS is working to reduce and ultimately eliminate HAIs and other HACs. A great deal of emphasis was placed on Learning and Action Networks (LAN) and how they can be used to reduce and eliminate HAIs in the 10th Scope of Work (SOW) whose aims are to create better patient care, better population health, and lower health care costs.

Financial incentives will play a large role in reaching CMSs goals. Value-based purchasing is one type of financial incentive tool that is used to help align payment incentives with infection prevention goals, and

the shift is from volume to value, outcome and innovation. Value-based payment is one incentive that really draws attention to the C-Suite, chief executive officers (CEO), chief financial officers (CFO), etc.

Plenary Session II – Healthcare-Associated Infection (HAI) Activities at the National Level

Plenary Session II discussed HAI Activities at the National Level. The following speakers gave presentations on their subject areas of expertise:

Action Plan Phase II and III Workgroups

Phase II

Ambulatory Surgical Center (ASC), Amber Taylor, Health Policy Analyst, HHS, OASH, OHQ

End-Stage Renal Disease (ESRD Facilities), Marjory Cannon, MD, Medical Officer, Office of Clinical Standards and Quality Improvement Group, CMS

Increasing Influenza (Flu) Vaccination Coverage of Healthcare Personnel, Alexandra Stewart, JD, Assistant Professor, George Washington University, School of Public Health and Health Services

Phase III

Long Term Care (LTC) Facilities, Ian Kramer, HHS, OASH, OHQ

The Phase II (ASC, ESRD and Influenza) Work Groups (WG) and Phase III (LTC) all provided updates on WG activities, as well as HAI activities within the HHS offices represented by work group members. All groups recently updated their chapters in the AP and are working on HAI projects with funds provided by OHQ. Information on the projects is available at

http://www.hhs.gov/ash/initiatives/hai/projects/index.html#regional_projects.

In particular, Professor Stewart spoke about “Influenza Vaccination of the Healthcare Workforce: Developing a Model State Law”. The work is funded by the influenza WG. The project’s goals are to:

- analyze state laws that address mandatory influenza vaccination of healthcare workers (HCWs),
- develop recommendations and model language for state laws that will decrease transmission of flu from HCWs to patients, and
- collaborate with states to create a legal environment that encourages flu vaccination of all HCWs.

One of the main findings is that mandatory policies are more effective and produce more reliable results than any voluntary measure.

Implementation Science/Overview of the Comprehensive Unit-Based Safety Program (CUSP) and Lessons Learned, James Battles, PhD, Social Science Analyst, Center for Quality Improvement and Patient Safety, AHRQ.

A brief overview was given of CUSP and its current progress. There are five basic CUSP components: educate on the science of safety, identify defects, assign executive to adopt unit, learn from defects, and implement teamwork and communication tools. The guiding principle for the project is that infection prevention efforts must engage all frontline professionals and focus on change where the action is; change is not just the responsibility of the infection preventionist.

CUSP is expanding to other HAI focus areas. CUSP Catheter-Associated Urinary Tract Infections (CAUTI) just completed the pilot phase and is being expanded to all 50 states. The Surgical Unit-Based Safety Program (SUSP) began September 1, 2011 and ventilator-associated pneumonia (VAP) will have a three-state pilot and scheduled for a national rollout in FY2013.

Lessons Learned from the American Reinvestment and Recovery Act (ARRA) HAI CDC Program Action Plan Update, Arjun Srinivasan, MD, FSHEA, CAPT, USPHS, Associate Director Healthcare-Associated Infection Prevention Programs, CDC

In 2009 \$40 million ARRA funds were designated for states to develop HAI programs. States could apply for the funding in three activity areas: (A) Developing or supporting HAI infrastructure, (B) Monitoring HAIs, and (C) Preventing HAIs. ARRA funding has allowed enhanced infrastructure, supported infection control training and new prevention collaborative, all of which served to result in fewer infections.

Lessons learned from this effort include the importance, as well as the limits, of funding. Infrastructure is crucial for maintaining this public health intervention. Ongoing priorities include measuring outcomes, including steps toward larger goals; verifying adequate progress and communication; eliciting future support; and ensuring that efforts are coordinated but not duplicated. He concluded by saying that sustainability is a challenge given limited resources, but that sustaining the effort is crucial

Plenary Session #3: State HAI Program Examples

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This session focused on three state HAI programs at various levels of implementation: established, intermediate, and new. Before the three selected states gave their presentations, Kate Ellingson, PhD, Division of Healthcare Quality and Promotion (DHQP), CDC, gave a brief presentation on states' HAI activities in which she stated that all grantees were able to hire an HAI coordinator, although turnover in personnel due to the temporary state of funding proved to be a big barrier to developing infrastructure. She also noted a dramatic increase in NHSN participation since the distribution of ARRA funding, and noted that activities such as ARRA-funded NHSN training and validation projects supported data quality during the enrollment surge.

Established: Pennsylvania – Stephen Ostroff, MD, Director of Pennsylvania Department of Health's Bureau of Epidemiology and Kim Buffington, Director, HAI Prevention

Intermediate: North Carolina - Constance Jones, RN, CIC, HAI Coordinator

New: Texas -- Wes Hodgson, MPH, State Plan Project Coordinator and Ron Gernsbacher, LCSW, HAI Program Coordinator

All states gave presentations on how their programs started and progress since then. A common theme in each of the presentations is that collaboration is key, and that states must be creative in how they conduct training (e.g., webinars) to deal with time, money and distance when training individuals either in the use of NHSN and/or basic infection control prevention information. Having a supportive advisory committee also is important to a successful program.

Open Space Session

Open Space is a meeting technique for problem-solving, sharing important knowledge/information that would otherwise be lost, gaining clarification/insight, and being in action [unclear?], and making offers and requests of one another in real time. In the philosophy of Open Space, the answer is always in the room.

An open space session allows attendees to give five-word topics that they would like to discuss. For this conference a predetermined number of twenty-five sessions were allowed; ultimately, there were nineteen open space sessions. Each topic was reported-out at the end of the session. The topics included:

1. Minimize NHSN data collection burden
2. What patients want: Let's talk
3. Models for prevention collaboratives
4. Coordinating various patient safety initiatives
5. Sparking and spreading learning networks
6. CUSPed: Cleansing unhelpful physician's mindsets
7. Designing model PSOs
8. Lab to HIE culture reporting
9. Promoting CAH participation in HAI
10. Finding patients to tell stories
11. PSOs as partners
12. NHSN for QI, not surveillance
13. Hemodialysis: CLABSI/rehospitalization collaboration strategies
14. Non-mandatory approaches to HCW fluVACs
15. Credible data validation protocols
16. Post-discharge surveillance and SSI reporting
17. EHRs: Prevention and data opportunities
18. Creating patient safety culture
19. Long-term care

Although each session had a different title, some were quite similar, and common themes emerged: streamlined data collection and validation tools are needed, electronic reporting should be improved, collaboration is important, and use of the C-Suite requires staff buy-in.

HHS Regional Projects Program Update

CAPT Zachary Taylor, MD, MS, HHS Region VIII Regional Health Administrator

This session was moderated by Rani Jeeva, HAI Team Leader, OHQ, and OASH

An overview was given of the ten HHS Regional Offices and the role of the Regional Health Administrator (RHA). OHQ has sponsored several projects in the regions for FY2010 and FY2011. Those projects can be found on the OHQ website.

http://www.hhs.gov/ash/initiatives/hai/projects/index.html#regional_projects. CAPT Taylor also reviewed the Region VII and VIII projects, including a project whereby, for FY2011, Regions VII and VIII combined forces to develop a training method for critical access hospitals (CAHs), a productive partnership since both regions encompass large geographic areas with sparse populations.

Day 2 – Friday, September 16, 2011

Plenary Session #4: State-Level Public/Private Collaborations – Success Stories, What Works

This session highlighted three states public-private collaborations and how they were successful in working together to implement a comprehensive program to reduce HAI in their states.

Louisiana: Quality Improvement Led Collaboration

Erica Washington, MPH, State HAI Coordinator, Debra Rushing, RN, MBC/HCM, CPE Executive Director, EQHealth Solutions Louisiana and Raoult Ratard, MD, MS, MPH, State Epidemiologist

Tennessee: State Health Department Led Collaboration

Marion Kainer, MD, MPH, Director, HAI and Antibiotic Resistance Program, TN State Health Department and Chris Clarke, RN, BSN, Senior Vice President Clinical and Professional Practices, Tennessee Hospital Association

Michigan: State Hospital Association Led Collaboration

Sam Watson, MSA, MT (ASCP), Senior Vice President Patient Safety and Quality, Michigan Hospital Association and Lawrence Ramunno, MD, MPH, CDE, Chief Quality Officer, Northeast Healthcare Quality Foundation (spoke in absentia for originally scheduled speaker, Gregory Pawlson, MD, MPH, FACP, Executive Director for Quality Innovations, Blue Cross Blue Shield Association)

The states that presented began with introduction to their state program beginnings, followed by descriptions of their specific collaboration efforts. Each state stressed that their advisory committee was a big part of their success and that getting buy-in for the C-suite was very important in driving collaborations and, ultimately, in reducing rates. Transparency was also a big motivating factor in the collaborations.

Recap of the Focus Group: Essential Components of State Healthcare-Associated Infection Efforts

Focus Group Facilitators: **Rachel Stricof, MPH, CIC, Consultant, CSTE**

Katherine Kahn, MD, Senior Natural Scientist, Rand Corporation

The half-day focus group, held the day before the State-Level Partners Meeting, consisted of participants from two vastly different state HAI programs, South Carolina and Michigan, representatives from CDC, AHRQ, CMS, consumers, and OHQ staff. Focus Group participants were asked to give their opinion as to what they saw as the top priorities for a state HAI program and who should lead those priorities.

During the State-Level Partners Meeting, participants used an audience response system (ARS) to identify their top priorities and see whether they matched those of the focus group. Once the highest priority component was identified, it was removed from the list and attendees voted for the second priority component. There was a high-level of agreement between the state-level partner participants and focus group participants. However, priority #3 was slightly different. The state-level partner participants voted for priority #3 to be, “Culture of safety, health and learning” and the focus group participants voted for priority #3 to be, “Implementation Dissemination Evaluation Assessment (IDEA)”, which does have learning included but does not address the culture of safety. The objectives, goals, and key questions of the focus group were:

Objective:

To outline and prioritize the essential components of a state program to achieve HAI reduction targets – within the context of lean resources and the *National Action Plan to Prevent Healthcare-Associated Infections: Roadmap to Elimination* – and define the resources, infrastructure and support needed to effectively implement the programs.

Goals:

- Identify and prioritize thematic components of comprehensive baseline state HAI program
- Identify lead stakeholders for each component
- Identify required resources & infrastructure
- Describe federal and regional support
- Build upon existing foundation
 - Partnership for Patients, “National Action Plan to Prevent HAIs: Roadmap to Elimination”
 - ASTHO/CDC Eliminating HAI State Policy Options
 - CMS Quality Improvement Organizations (QIO)

- CDC Recovery Act Funded State Program
- AHRQ Comprehensive Unit-based Safety Program (CUSP)
- AHRQ Patient Safety Organizations (PSO)

Key Questions:

- What are the essential thematic components required for a state program?
- Of these essential components, which are priority components?
- Which stakeholder is best suited to take the lead for each component?
- What resources and infrastructure are required and how can the federal government and regional entities best support these programs?

The top four ARS responses are below: For more in-depth responses, please click [here](#).

Priorities (in descending order) and Lead Agency (in parentheses)

1. Collaboration, collaboration and integration (State and Local Health Departments)
2. Surveillance, validation, analysis and reporting (State and Local Health Departments)
3. Culture of safety, health and learning (QIO)
4. Quality improvement/best practices (QIO)

Participants were asked to give feedback on priorities that may have been missed. Some responses were:

- Universities should be looked at as potentially valuable partners in prevention efforts.
- Bring physicians to the table.
- Outbreaks should be reported in real time.
- Patient education should occur more frequently, both on the prevention of HAIs, but understanding the publicly available data [meaning unclear?]

Plenary Session #5: Moving Forward: Focus on Sustainability

California Department of Public Health

John Rosenberg, MD, Chief, HAI Program and Lynn Janssen, MS, CIC, Coordinator, HAI Liaison Program

Illinois Department of Public Health

Lauren Gallagher, MPH, CPH, CIC, HAI Prevention coordinator and Barbara Fischer, RN, BA, Public service Administrator

Both California (CA) and Illinois (IL) began their presentations with how their program started and then discussed their sustainability techniques. For both states, collaboration proved to be a big help in sustaining their programs, especially partnerships with the CDC Prevention Epi Centers, APIC and other infectious disease-related organizations in their state. In CA, licensing fees helped to raise \$3 million for the HAI program. IL has been able to supplement ARRA-funded efforts with a CDC-sponsored Public Health Prevention Service (PHPS) fellow, and has utilized a non-HAI Council of State and Territorial Epidemiologists (CSTE) fellow and Epidemic Intelligence Service (EIS) Officers (through the Epi-Aid mechanism) for special projects. While ARRA funding has been very helpful in sustaining the program, the uncertainty of future funds can make it difficult to retain skilled and dedicated talent.

HAI prevention professionals were encouraged to think beyond public reporting and look ahead to how they can help individual facilities, as well as to remember that data will help to identify needs and can serve as a basis for action.

Next Steps

We hope to capitalize on the State Level Partners Meeting and continue to document the partnerships and tools that states are using in their HAI programs and to ensure that they are easily and readily accessible to those who wish to use them. We also hope to take the information gleaned from the Open Space Session and the ARS and use it for future innovations and policy. In addition, we hope to ensure that and make sure that participants voices are heard to reduce the data burden, we develop consumer-friendly HAI data websites continue to increase HAI training to public health workers, three of the top responses on what participants would like to have happen as a result of the meeting.

Conclusion

Whereas this meeting highlighted many issues that remain to be addressed in the effort to prevent HAIs, we can celebrate considerable success during the past few years. Among those successes, standouts are the ever-evolving NHSN, which now has over 4000 users, and the CUSP program, which has expanded to 1055 hospitals and, for those that participate, produced a 33-percent reduction in CLABSIs. In addition, multiple training tools have been developed and shared from both the federal and state-levels.

Moving forward, the information taken from this meeting holds promise to produce further, future successes in the effort to prevent and reduce HAIs in all the states of the nation.

ARS Responses to the Essential Components of a State HAI Program

What are the top four priorities for a state HAI program?

Priority 1	Responses	
Coordination, collaboration, and integration	95	44.60%
Surveillance, validation, analysis and report...	37	17.37%
Culture of safety, health and learning	26	12.21%
Quality improvement/best practices	24	11.27%
Legislation, regulations and quality assurance...	10	4.69%
Workforce development and technical expertise...	9	4.23%
Reimbursement strategies	7	3.29%
Outbreak investigation and control	5	2.35%
Advocacy	0	0%
Totals	213	100%



Figure 1

Priority 2	Responses	
Surveillance, validation, analysis and report...	97	44.09%
Culture of safety, health and learning	64	29.09%
Quality improvement/best practices	27	12.27%
Workforce development and technical expertise...	9	4.09%
Reimbursement strategies	8	3.64%
Legislation, regulations and quality assurance...	7	3.18%
Outbreak investigation and control	6	2.73%
Advocacy	2	0.91%
Totals	220	100%



Figure 2

Priority 3	Responses	
Culture of safety, health and learning	113	50%
Quality improvement/best practices	41	18.14%
Workforce development and technical expertise...	27	11.95%
Legislation, regulations and quality assurance...	22	9.73%
Outbreak investigation and control	14	6.19%
Reimbursement strategies	7	3.10%
Advocacy	2	0.88%
Totals	226	100%



Figure 3

Priority 4	Responses	
Quality improvement/best practices	116	50.22%
Workforce development and technical expertise...	57	24.68%
Legislation, regulations and quality assurance...	27	11.69%
Outbreak investigation and control	18	7.79%
Reimbursement strategies	10	4.33%
Advocacy	3	1.30%
Totals	231	100%



Figure 4

Who should be the lead for the top four priorities?

Priority 1: Coordination, collaboration, and integration	Responses	
State and Local Departments of Health	97	48.02%
QIO	48	23.76%
State Hospital Association	30	14.85%
Other	6	2.97%
PSOs	6	2.97%

Consumer Organizations	5	2.48%
State Survey Agencies	4	1.98%
Professional organizations	3	1.49%
State Medicaid Offices and/or Private Payers	3	1.49%
Totals	202	100%

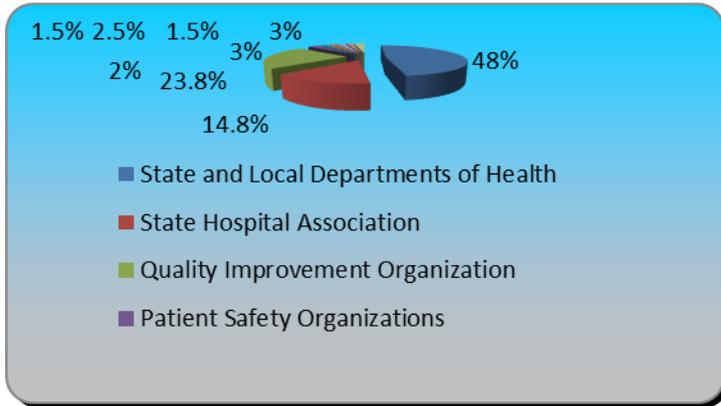


Figure 5

Priority 2 – Surveillance, validation, analysis, and reporting

	Responses	
State and Local Departments of Health	131	63.29%
QIO	39	18.84%
State Hospital Association	18	8.70%
PSOs	6	2.90%
State Survey Agencies	6	2.90%
Professional organizations	3	1.45%
Consumer Organizations	2	0.97%
Other	2	0.97%
State Medicaid Offices and/or Private Payers	0	0%
Totals	207	100%



Figure 6

Priority 3 – Culture of safety, health, and learning	Responses	
QIO	106	48.85%
State Hospital Association	56	25.81%
PSOs	22	10.14%
State and Local Departments of Health	14	6.45%
Professional organizations	11	5.07%
State Survey Agencies	3	1.38%
Other	2	0.92%
Consumer Organizations	2	0.92%
State Medicaid Offices and/or Private Payers	1	0.46%
Totals	217	100%



Figure 7

Priority 4 – Quality improvement/best practices	Responses	
QIO	140	61.40%
State Hospital Association	42	18.42%
Professional organizations	21	9.21%
State and Local Departments of Health	11	4.82%
State Survey Agencies	7	3.07%
PSOs	6	2.63%
Consumer Organizations	1	0.44%
State Medicaid Offices and/or Private Payers	0	0%
Other	0	0%
Totals	228	100%



Figure 8