

## Sanofi Pasteur Dinner sets Tone for Conference

Infection preventionists enjoyed dinner and received valuable updates on two important vaccines on the eve of the state APIC conference in April.

Sanofi Pasteur representatives hosted the event with Gregory Huhn, MD, speaking about the Tdap and high-dose influenza vaccines. Thirty-one states, including Wisconsin, now require middle school students to receive the Tdap booster licensed in the US since 2005.

Studies that may lead to recommendations for more than one Tdap booster will be reviewed at the October meeting of the Advisory Committee on Immunization Practices (ACIP).



Conference Chairman Paul Thomas, Saint Clare's Hospital of Weston, shares his passion for infection prevention with Cheryl Jahns and Cindy Hurlbert at the Wednesday evening dinner hosted by Sanofi Pasteur.

Fluzone™ high-dose influenza vaccine was developed to help boost the immune response to influenza vaccine in adults age 65 and over. Phase III clinical trials conducted in this age group resulted in higher seroconversion rates for the high-dose influenza vaccine compared with standard-dose vaccine. However, ACIP has not recommended the use of the high-dose vaccine because there are no current data to indicate differences in rates of influenza prevention or complications when comparing high-dose to standard-dose Fluzone™ influenza vaccine.

## First Statewide HAI Report Released

The Wisconsin Division of Public Health Healthcare-Associated Infections (HAIs) Prevention Project announces the release of the first annual report on rates of central line-associated bloodstream infections (CLABSIs) among hospitals reporting data to the CDC National Patient Safety Network (NHSN).

Major findings include an increase in the number of reporting hospitals since the project began in September, 2009 and significant reductions—33% in 2009 and 26% in 2010—in CLABSI occurrence among the reporting hospitals compared to the national baseline CLABSI occurrence from 2006-2008. The reductions among Wisconsin hospitals reporting to NHSN are similar to the national reduction in CLABSI occurrence for the same time period.

### 2009 Wisconsin CLABSI Data Summary

In 2009, 11 Wisconsin hospitals reported CLABSI data



from 34 inpatient units (excluding neonatal intensive care units) to NHSN and conferred rights to these data to DPH. All 11 facilities are general acute care hospitals, and 17 (50%) of the 34 reporting units are critical care units. Of 408 possible reporting months, 343 (84%) months of data were submitted.

One (3%) of 34 reporting units had a mean CLABSI incidence density (number of CLABSI per 1,000 patient days) that was lower than the 2009 national pooled mean for similar units (0.0 vs. 1.3,  $p = 0.044$ ). This rate was based on 12 months of data collected from a medical/surgical intensive care unit.

The remaining 33 reporting units had CLABSI rates that were not statistically different from the national pooled mean ranging from 0 to 1.8 CLABSI per 1,000 patient days, depending on the type of unit.

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## WMS Fellow Joins DPH

Adam Hofer, a second-year medical student at the University of Wisconsin-Madison School of Medicine and Public Health, is spending the summer working with the Division of Public Health through a Wisconsin Medical Society Fellowship.



As part of a collaborative project between the UW and the DPH, Adam is developing a survey to examine the prevalence of adoption and implementation of practices for the prevention and control of *Clostridium difficile* infections (CDI) in Wisconsin healthcare

facilities. The goal of the project is to identify factors that impede or facilitate the use of such practices and to develop interventions to strengthen adoption of evidence-based prevention practices in healthcare facilities throughout the state.

Adam is a graduate of UW-Madison, where he earned his B.S. in medical microbiology and immunology. After spending a year working as a research assistant, he attended the University of Minnesota School of Public Health where he completed his MPH in public health administration and policy in 2010.

Aside from his studies, Adam is a member of the AMA-Medical Student Section Executive Board and he volunteers at free clinics in the Madison area through the MEDiC program. Outside of school he has many interests including running, cycling, golfing, skiing, and cooking.

However, whenever there is a break in the academic year, his favorite activity is making the trip home to the Twin Cities and Eau Claire to spend time with family and friends.

## First Statewide HAI Report Released... (continued from Page 1)

CLABSI occurrence in 2009 among these 34 units can be compared to national data using a standardized infection ratio (SIR), which is calculated by dividing the number of CLABSIs reported (54) by the number of CLABSIs expected (80). The expected number is based on the national pooled mean CLABSI rate from 2006-2008.

The 2009 SIR for the 34 reporting units is 0.67 ( $p < 0.001$  CL 0.50-0.87), meaning the CLABSI occurrence among these units was 33% less than the national baseline CLABSI occurrence from 2006-2008.

### 2010 Wisconsin CLABSI Data Summary

In 2010, 40 Wisconsin hospitals reported CLABSI data from 156 inpatient units (excluding neonatal intensive care units) to NHSN and conferred rights to these data to DPH. Of the 40 facilities, 34 (85%) are general acute care hospitals and 6 (15%) are critical access hospitals. Critical care units comprise 48 (31%) of the 156 reporting units. Of 1,872 possible reporting months, 909 (49%) months of data were submitted.

One (< 1%) of 156 reporting units had a mean CLABSI incidence density that was lower than the 2009 national pooled mean for similar units (0.0 vs. 1.1,  $p = 0.043$ ). This rate was based on 6 months of data collected from a surgical ward. Two (1%) of 156 reporting units had a mean CLABSI incidence density higher than the 2009 national

pooled mean for similar units (5.7 vs. 1.4,  $p = 0.009$ ; 10.3 vs. 1.1,  $p = .005$ ). Each of these rates represents 6 months of data, one from a medical ward and one from a medical/surgical intensive care unit.

The remaining 153 reporting units had CLABSI rates that were not statistically different from the national pooled mean ranging from 0 to 2.6 CLABSI per 1,000 patient days, depending on the type of unit.

The 2010 SIR for the 156 reporting units is 0.74 ( $p < 0.001$  CL 0.60-0.89), meaning the CLABSI occurrence among these units was 26% less than the national CLABSI occurrence for the same time period, and this difference was statistically significant.

### Summary

Although there was an increase in the CLABSI SIR from 2009 (0.67) to 2010 (0.74), the increase is not statistically significant ( $p = 0.57$ ). There is also no difference between the Wisconsin CLABSI SIRs and the 2009 national CLABSI SIR of 0.83 ( $p = 0.12$  for 2009 and  $p = 0.27$  for 2010).

This means that CLABSI occurrence in Wisconsin has been significantly reduced from 2009-2010 compared to the baseline time period of 2006-2008, and the reductions are similar to the national reduction during the same time period.

# CSTE Recognizes APIC for H1N1 Response

Members of The Council of State and Territorial Epidemiologists (CSTE) at its 2010 Annual Conference voted to officially recognize APIC as a public health partner and to thank infection preventionists for their response to the 2009 H1N1 influenza pandemic.

A position statement co-authored by Thomas Haupt, Wisconsin Division of Public Health Respiratory Diseases Surveillance Coordinator, acknowledged that "...it became apparent very early in the response that clinical data from patients hospitalized with pandemic influenza A (H1N1) infection was a critical component in the national response plan...this data collection became a substantial burden for hospital infection preventionists who had other important obligations both for ongoing infection and special issues specific to the pandemic."

"Despite the overwhelming demands of data collection and infection prevention activities, infection preventionists successfully collected these data, contributing importantly to the successful response to this pandemic."



**Thomas Haupt with the four Wisconsin APIC Chapter Presidents: Melinda Reppen (Badger), Debbie Briggs (Southeastern), Brenda Ehlert (Northeastern), Terri Dums (North Central).**

Haupt arranged for plaques to be made for each of the four Wisconsin APIC chapters and presented them to the chapter presidents at the State APIC Conference in April. The citation on the

plaques reads, "In recognition of the contributions of APIC during the 2009 influenza A H1N1 pandemic, and of the long-standing public health partnership between APIC and CSTE."

## Conference Another Big Success

Credit for the success of the 2011 State APIC Conference goes to the hard-working members of the conference planning committee.

Committee members are pictured at right.

Front row: Connie Nowakowski, Teresa Hosterman and Bridget Pfaff.

Middle row: Brenda Ehlert, Chairman Paul Thomas, Marilyn Michels and Wanda Lowrey.

Back row: Kayla Ericksen, Debbie Wesolowski, Mary Luzinski, Anna Hutchings, Nancy Moskal, Jean Druckenmiller, Kathy Kaiser, Linda McKinley and Gayle Land.



# Infection Prevention Resources Review

- The International Scientific Forum on Home Hygiene has prepared a fact sheet on preventing transmission of *Escherichia coli* 0157 infections in the home. <http://www.ifh-homehygiene.org/IntegratedCRD.nsf/9c1b88071913b860802575070007d2f3/105fd84284cd34048025752400561557?OpenDocument>. The December 2007 issue of the *American Journal of Infection Control* also provides information on hand hygiene in home and community settings (Bloomfield SF, Aiello AE, Cookson B, O'Boyle C, Larson EL. The effectiveness of hand hygiene procedures in reducing the risks of infections in home and community settings including handwashing and alcohol-based hand sanitizers. *AJIC* 2007; 10: Supplement 1).
- Centers for Disease Control and Prevention. Interim results: State-specific influenza vaccination coverage, US, August, 2010-February, 2011. *Morb Mort Wkly Rep* 2011; 60 (22): 737-743.
- Huskins WC, Huckabee CM, O'Grady NP, et al. Interventions to reduce transmission of resistant bacteria in intensive care. *N Engl J Med* 2011; 364: 1407-1418.
- Jain RJ, Kralovic SM, Evans ME, et al. Veterans Affairs initiative to prevent methicillin-resistant *Staphylococcus aureus* infections. *N Eng J Med* 2011; 364: 1419-1430.
- Horsburgh CR, Rubin EJ. Latent tuberculosis infection in the United States. *N Eng J Med* 2011; 364: 1441-1448.
- Platt R. Time for a culture change? *N Eng J Med* 2011; 364: 1464-1465.
- DeVries AS, Harper J, Murray A, et al. Vaccine-derived poliomyelitis 12 years after infection in Minnesota. *N Eng J Med* 2011; 364: 2316-2323.
- View the "Crying Baby Symphony" video on the Immunization Action Coalition website at: <http://www.immunize.org/votw/may11.asp> This one-minute clip features

babies crying at the beginning and ends with happy babies after receiving lifesaving vaccines.

- The US Food and Drug Administration has posted draft guidance on "Processing/Reprocessing Medical Devices in Health Care Settings: Validation Methods and Labeling," <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm252999.htm> These are in draft form and posted for comment only; when finalized they will replace the April 1996 document, "Labeling Reusable Medical Devices for Reprocessing in Health Care Facilities: FDA Reviewer Guidance." Comments may be submitted for up to 90 days after the initial posting date of May 2.
- Centers for Disease Control and Prevention. Guide to infection prevention in outpatient settings: minimum expectations for safe care. Access at: <http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html>
- "Partnering to Heal" is a computer-based, video-simulation training program on infection control practices for clinicians, health professional students, and patient advocates. It was developed by the US Department of Health and Human Services. Viewers may assume the identity of several characters and make decisions that affect the storyline. <http://www.hhs.gov/ash/initiatives/hai/training/>.
- CDC and the Association of Public Health Laboratories have released competency guidelines for biosafety laboratories. They are intended for laboratorians working with hazardous biologic agents, obtained from either samples or specimens that are maintained and manipulated in clinical, environmental, public health, academic, and research laboratories. Access at: [http://www.cdc.gov/mmwr/preview/mmwrhtml/su6002a1.htm?s\\_cid=su6002a1\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/su6002a1.htm?s_cid=su6002a1_w)
- The Wisconsin Division of Quality Assurance has opened a new listserv called, "DQA Construction," to provide subscribers with notices of DQA physical plant memos, CMS Life Safety program letters, questions and answers, and interpretation. To subscribe, go to [http://www.dhs.wisconsin.gov/rl\\_DSL/Listserv/signup.HTM](http://www.dhs.wisconsin.gov/rl_DSL/Listserv/signup.HTM).
- APIC, ASHE, and SHEA have formed a coalition to respond to conflicting studies about use of electronic faucets in healthcare settings. A joint [statement](#) released by the three organizations describes planned activities to address the issues raised by these studies.



# Project Update

## Collaboration between Quality and Infection Prevention Highlighted at Learning Session

*Ashlie Dowdell*

Marilyn Hanchett, RN, MA, CPHQ, CIC, Senior Director of Clinical Innovation for the Association for Professionals in Infection Control and Epidemiology (APIC), kicked off the June 2 “On the Path to Zero” learning session hosted by MetaStar, the Wisconsin Hospital Association (WHA), and the Division of Public Health.

The day-long session included team members from hospitals participating in the central line-associated bloodstream infection (CLABSI), methicillin-resistant *Staphylococcus aureus* (MRSA) and surgical site infection (SSI) prevention collaboratives led by MetaStar and WHA.

Ms. Hanchett’s presentation described

the evolution of the relationship between quality and infection prevention in eliminating healthcare-associated infections (HAI) and national trends in HAI elimination. She detailed three examples of how quality staff and infection preventionists (IPs) can collaborate to impact HAI rates in this time of competing priorities:

- Work to improve the quality of HAI data;
- Improve case finding, investigation, and data analysis; and,
- Be a change leader.

HAI data to measure the national HAI elimination goals are mainly taken from the National Healthcare Safety Network (NHSN), but there are other sources (e.g., SCIP, AHRQ, etc.) in use as well.

A key takeaway from an analysis of whether these data are on track nationally to meet the five-year goals outlined by the U.S. Department of Health and Human Services is that four of the nine measures are listed as “data not yet available”. This underscores the need for continued data collection and analysis, as well as validation of the data that are available. Ms. Hanchett discussed the importance of hospitals self-validating their data, as well as having more formal, external audits. She described the importance of using both rates and standardized infection ratios (SIRs) in performing data analyses, both of which can be pulled directly from NHSN.

Ms. Hanchett advised participants to be cognizant of the many complexities in health care, cautioning them from oversimplifying root causes or jumping to conclusions with their data. She reminded the group that getting to zero infections is an ongoing campaign. Once a hospital hits zero, it does not mean that the hospital will never have another infection. It is important to keep performing surveillance, reviewing data, and making process changes as necessary to maintain that irreducible number of infections.

Ms. Hanchett cautioned that leadership in the journey toward zero cannot be confined to a title or job description.

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## Ambulatory Surgery Centers Undergo Needs Assessment

*Emma Gelman*

Staff from the Wisconsin Division of Public Health Healthcare-Associated Infections (HAI) Project recently distributed a needs assessment to all ambulatory surgery centers (ASCs) in Wisconsin.

The main purposes of the assessment are to collect information about infection control programs and contact information for the individual primarily

responsible for infection control activities in each facility.

The assessment will also evaluate facility interest in serving on a work group to develop best practices for surgical site infection surveillance and joining the CDC National Healthcare Safety Network.

Responses will remain confidential and DPH will share findings with all ASCs. Please share this information with

your colleagues from ASCs. The assessment was mailed to ASCs, however, the survey can also be completed electronically by visiting the following link: <http://4.selectsurvey.net/dhs/TakeSurvey.aspxSurveyID=92M2n9IK>

Please contact Emma Gelman at [emma.gelman@wi.gov](mailto:emma.gelman@wi.gov) or 608-267-7321 if you have any questions about the survey.

## Collaboration between Quality and Infection Prevention

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Everyone will need to help lead the way and a strong collaboration between quality staff and IPs will be an important part of this leadership. An effective collaboration will need to be based on a culture of mutual respect. It is important to evaluate whether that culture is present in an organization.

As part of her presentation, Ms. Hanchett made APIC members aware that they will see a survey later this summer as part of a study led by Massachusetts General Hospital in Boston about MRSA contact precautions. The researchers are studying whether patients testing positive for MRSA should be considered positive for life or if there is an appropriate timeframe/process for discontinuing contact precautions.

The topics of collaboration and the importance of data were a great way to kick off a day devoted to learning more about using NHSN consistently, pulling data from NHSN, digging into events using root cause analysis, and learning from the bumps along the road from other collaborative participants.

### NHSN Analysis Workshop

CDC epidemiologists Maggie Dudeck, MPH, CPH, and Paul Malpiedi, MPH, led a session on pulling data from NHSN using the built-in analytic features. Session participants were one of the first groups to use the new NHSN test database that will soon be released for all NHSN users to use for training and practice.

After a brief tour of the layout of the analysis section, participants worked in small groups on an exercise packet that included scenarios where they created data reports like those they might be asked for by their own

infection control committees or stakeholders. The exercises allowed them to use many of the different output formats available in NHSN including line lists, rate tables, frequency tables, pie charts and SIRs. Topics covered in the reports included:

- Running CDC pre-configured reports;
- Modifying and filtering reports;
- Adding variables to the display and sorting;
- Checking for data quality and missing data;
- Interpreting data results; and,
- Testing for statistical significance.

The CDC epidemiologists and Ashlie Dowdell from the Wisconsin Division of Public Health HAI Prevention Project team were available to answer questions throughout the two-hour session. Feedback from the session was very positive and most participants expressed interest in similar follow up sessions so time could be devoted to practicing accessing reports while having someone available in real time to answer questions.

Planning for additional sessions is in the early stages and more details will be announced as they become available. In the meantime, hospitals interested in practicing the analysis module in NHSN can access the exercises and answer guide from the CDC session at <http://metastar.com/Web/Default.aspx?tabid=486>.

### NHSN Case Study Analysis

Kathy Allen-Bridson, RN, BSN, CIC, Nurse Consultant with CDC, offered participants another hands-on NHSN learning opportunity as she presented case studies of varying difficulty to practice using the NHSN definitions for the CLABSI, SSI and MDRO modules. The case studies represented some of the types of cases

sent to the NHSN Help Desk for clarification. The majority of the session was spent walking through case studies and allowing for group discussion to better understand the intricacies of the NHSN criteria for the modules most commonly used by hospitals in Wisconsin.

A key takeaway from the session is that consistency in using the NHSN definitions is essential, stressing that clinical and surveillance definitions may not always match, but it is important to the integrity of NHSN that all participating hospitals are using the NHSN definitions and applying them the same way. Given the new attention being paid to the NHSN definitions with the upcoming pay-for-performance program for CMS, HICPAC is currently working on revisions to the CLABSI criteria and will look at the SSI criteria next. There is also a pediatric group looking at the CLABSI criteria for neonatal ICUs and it is anticipated that hospitals will not need to collect umbilical line days in the future.

Ms. Allen-Bridson prepared 12 case studies for the group, but neither session worked through all of them due to the time needed for questions and discussion. A copy of her slideset with the case study information and associated answers is available at <http://metastar.com/Web/Default.aspx?tabid=486> for those interested in working through the examples.

### Materials Availability

Materials for all of the June 2 Learning Session presentations, including handouts and a video recording of each, are available for any hospital to access at <http://metastar.com/Web/Default.aspx?tabid=486>.

Stay tuned for information about additional NHSN training sessions and a learning session in the fall that will be open to all Wisconsin hospitals.