

**Georgia HAI Advisory Committee Meeting (GHAIAC)  
October 24th, 2012  
Georgia Hospital Association**

**Attending HAI Advisory members:** Jeanne Negley, Robert Jerris, Cindy Prosnak, Lynn Reynolds, Susan Ray, Craig Smith, James Steinberg, Kate Arnold, Renee Watson, Armando Nahum, Peggy McGee

**Present via Teleconference:** Denise Leaptrot, Marcia Delk, Donna Matthews (for Mary Key), Connie Smith (for Ryan Deal), Nimale Stone

**Not present HAI Advisory members:** Robert Thornton, Beth Morrow, Jesse Jacob, Susan Fuller

**Public Health Adhoc members present:** Lauren Lorentzson, Matthew Crist

**Committee meeting guest:** n/a

Agenda Item	Presenter	Discussion	Action Item	Responsible Person(s)	Due Date
Welcome and Call to Order	Jeanne Negley	Called to order at 9:10 a.m.			
Clostridium <i>difficile</i> Laboratory Methods Survey	Robert Jerris	<p>A draft survey for Clostridium <i>difficile</i> laboratory testing methods was presented based on the EIP's CDI laboratory methods survey. The purpose of the survey would be to summarize statewide data and to determine if the GHAIAC would like to make recommendations regarding laboratory methods.</p> <p>Members provided comments, which included distinguishing between labs performed in- and out-of-house, obtaining the name of lab director, and asking if the facility had revised its lab method in the last year.</p> <p>It was decided that IPs should be sent the survey to encourage communication with laboratory managers and to learn the methods used in their facility. Also, this would likely increase the response rate. The survey will be distributed to IPs using a link to an online survey sent via email.</p> <p>Members decided that the survey would be sent to acute care facilities first, and that a LTC survey would be tabled until further review.</p>	<p>Final design for CDI laboratory survey – to be sent to Jeanne Negley to distribute</p> <p><u>Response:</u> Jeanne distributed the revised tool to committee members during the first week of November, and the tool is finalized. On 11/19/2012, Jeanne learned NHSN is revising its C. <i>difficile</i> questions in its annual survey, and she has submitted the survey to CDC to see if the GHAIAC survey questions can be incorporated.</p>	Robert Jerris	

Roll Call and Minutes	Lauren Lorentzson	Minutes from the previous meeting were approved without revisions.			
Validation of HAI Data	Kathryn Arnold	<p>The role of the infection preventionist was emphasized in performing internal NHSN data validation. Internal validation of data can help facilities with HAI tracking, planning, and prevention. The Infection preventionist as a validator is a coordinator role working with a team that should include administrative staff.</p> <p>NHSN will send out a tool next year to assist with mapping. The Committee discussed EMR difficulties. One member reported that it took a year with many improvement cycles to bring central line data errors down in his EMRs, but that it was worth it because the datasets become incredibly rich. Once an EMR is tested, updated, and corrected to provide accurate data, there is a lot of potential for research.</p> <p>Validation guidance for ICU CLABSIs is under development, and a validation tool is being tested by Committee members at GDPH, partnered with a metro hospital and the EIP. The tool will be prescriptive, with detailed instructions that will facilitate objective validation.</p> <p>One member pointed out that there is a great deal of emphasis placed on IPs doing all of this work. It was noted that IPs have a new role in their organization with the advent of value based purchasing and the Quality Improvement Program. IPs are encouraged to talk to CEOs.</p> <p>Committee members discussed it is unclear if the number of IPs has increased to match the increasing demands of CMS reporting requirements. It was noted once we have NHSN data, we can evaluate IP FTE vs. bed size.</p>	<p>Distribution of validation tools to GHAIAC  <u>Response:</u> We have distributed the tools via a web site connection, so all IPs in the state can have access to them.</p> <p>Follow-up with Katie re: CDC contact for software vendors/provide this information to the Committee</p> <p><u>Response:</u> CDC has a support program for facilities that are having challenges using CDA (<a href="mailto:nhsncda@cdc.gov">nhsncda@cdc.gov</a>). Facilities are also encouraged to have vendors use this support program when facilities have questions vendors cannot address. As suggested by CDC, Jeanne is also following up with Alabama to learn how their IPs have used MedMined for reporting.</p>	Jeanne Negley	Jeanne Negley

Public Health Update / Validation in a Resource-Efficient Manner	Matthew Crist	<p>The role of the state in validation was highlighted in a presentation on CLABSI validation by the Tennessee Department of Health. Tennessee developed a targeted validation method, which included validating facilities with the highest and lowest CLABSI rates, requiring all facilities to submit positive culture lists, and targeting infections known to have a higher probability of being misreported.</p> <p>Since the results in Tennessee showed around a 10% difference between what is reported and what is found on validation, there seems to be little evidence of systematic under-reporting in the hospitals surveyed in Tennessee.</p> <p>It was noted that there are still facilities in Georgia that use paper medical records and lab reports, so it could be difficult to get line lists from them when validation is performed here.</p>			
HEN and NICU Affinity Group Update	Denise Flook	<p>Denise Flook presented on NHSN CLABSI data available to the HEN. Overall, a trend toward lower rates has been observed.</p> <p>The current goals of the HEN are:</p> <ul style="list-style-type: none"> <li>• to reduce HACs by 40% (that is, a CLABSI HAC rate of 0.67/1,000 discharges)</li> <li>• &lt; 1 CLABSIs per 1,000 central line days</li> </ul> <p>The HHS HAI Action Plan goals for 2013 are:</p> <ul style="list-style-type: none"> <li>• CLABSI SIRs &lt; 0.5</li> <li>• 25% reduction in CAUTI rates</li> </ul> <p>The accuracy of the HEN data was questioned, and it was noted that falling rates were noted nationally, including states with validated data. It is believed CMS penalties have increased focus on HAIs in facilities and rates have dropped.</p> <p>One member noted that NHSN does not monitor “appropriateness” in regards to catheter and other device utilization. Only the device’s presence is monitored. It is up to the staff to determine appropriateness at the patient</p>			

		<p>level.</p> <p>GHA's HEN is changing with CMS' shift to an "All Cause Harm" model and will include all Georgia hospitals in the future.</p>			
10 <sup>th</sup> Scope of Work Update	Cindy Prosnak	<p>All seven facilities that missed the deadline for reporting first quarter data won their cases on appeal, and will receive full reimbursement. Second quarter data are due November 15<sup>th</sup>, 2012. Recruiting is still ongoing for <i>Clostridium difficile</i> Lab ID Event reporting; 13 have committed and the total may reach 15 or 16. Clarification from CMS is needed as to whether the QIO can work with any facility that wants to join, or if there are restrictions by CDI rate.</p> <p>There is some concern that many member facilities cannot lower their rates beyond their current levels. They are already complying with Appropriate Use. Having started with 25, there are now 22 members. Two that left dropped out to work with the HEN. Denise Flook said that all hospitals in Georgia besides 1 are in some kind of HEN.</p> <p>GIPN went very well. Attendees reported that it was helpful for IPs not familiar with NHSN. An upcoming GHA webinar will address mapping issues for <i>C. difficile</i>.</p> <p>It was noted that one facility required daily re-orders for foley catheters – the same process facilities use for restraints – and their utilization has lowered dramatically. That facility will be presenting on their process and progress soon.</p>			
Fungal Meningitis Outbreak Update	Matthew Crist	<p>The Georgia Department of Public Health has worked closely with the one facility in the state that received the potentially contaminated lots methylprednisolone injections from the New England Compounding Company (NECC) compounding pharmacy. One case has been found to meet the fungal meningitis case definition in Georgia. When the FDA expanded the recall of NECC products, GDPH contacted all affected facilities in the state.</p>	<p>Follow-up regarding notification of patients exposed to NECC products</p> <p><u>Response:</u> For those who received high risk medication (i.e.,</p>	Matthew Crist	

			the initial lots), after six weeks, the risk is less than 1%.		
Adjournment	Jeanne Negley	Meeting adjourned at 12:45 p.m.			

**Georgia HAI Advisory Committee Meeting (GHAIAC)**  
**August 29<sup>th</sup>, 2012**  
**Georgia Medical Care Foundation**

**Attending HAI Advisory members:** Marcia Delk, Denise Flook, Jesse Jacob, Robert Jerris, Mary Key, Denise Leaptrot, Armando Nahum, Cindy Prosnak, Susan Ray, Lynn Reynolds, Craig Smith, James Steinberg, Nimalie Stone, Beth Morrow, Peggy McGee, Connie Smith, Susan Fuller  
**Public Health Adhoc members present:** Jeanne Negley, Lauren Lorentzson, Matthew Crist, Ashley Moore  
**Committee meeting guests:** Alice Guh, Delmar Little

Agenda Item	Presenter	Discussion	Recommendation	Responsible Person(s)	Date for completion or Update
Welcome and Call to order	Matthew Crist	Called to order at 9:10 a.m.			
Roll Call and Minutes	Lauren Lorentzson	Correction to minutes: Denise Flook was in attendance for our conference call meeting on July 25 <sup>th</sup> . Minutes approved.			
CRE and CDC Toolkit	Alice Guh	<p>Guest speaker Alice Guh from CDC presented on Carbapenem-resistant Enterobacteriaceae (CRE) epidemiology and prevention. Klebsiella Pneumoniae Carbapenemase (KPC) was emphasized. KPCs are of concern because they are plasmid-based, can transfer resistance, are extremely drug resistant, and are becoming widespread.</p> <p>Robert Jerris noted that there was a change in the breakpoints in 2010, and that some systems use different standards for determining resistance. Alice Guh presented data that had been entered into the NHSN device and procedure-associated module from 2007-2010.</p> <p>Craig Smith discussed the problem of LTCFs refusing to accept patients that are colonized with CRE. He recommended that CDC send out more educational materials.</p>			
MuGSI Surveillance	Jesse Jacob	<p>Jesse Jacob presented on CRE epidemiology in Georgia. CRE data is gathered by the EIP Multi-Site Resistant Gram Negative Bacilli Surveillance (MuGSI) program.</p> <p>Members' suggestions for control of CRE included hand-hygiene education and increased environmental vigilance. Craig Smith emphasizes removal of aerators on sink faucets.</p> <p>Alice Guh and Jesse Jacob explained that the carbapenemase gene can move from one species to another, although it is rare. MuGSI</p>	Further evaluate EIP methodologies and determine applicability to Georgia Outside Atlanta (GOA)	Jeanne Negley	

		<p>surveillance is assessing this, and has found that it spreads primarily through cloning.</p> <p>Nimalie Stone asked for recommendations for regular CRE surveillance. Alice Guh said that using a 6 month to 1 year timeframe would be a good starting point. Not all labs use the same breakpoints. A surveillance definition would need to be created based upon a stated goal. States can write evaluation protocols according to their purposes.</p> <p>Facilities in metro areas may have higher rates than rural facilities, and be reluctant to report if located in a high prevalence area. But even a ‘quick and dirty’ survey could help with evaluation of need, establishment of a rough baseline, and an opportunity to intervene. A strategy for getting cleaner data could follow. Not only would we like to know where the burden is greatest, but <i>how</i> labs are detecting CRE.</p> <p>Jesse Jacob informed the committee that communication should be improved between IPs and labs. Often IPs are not notified of a CRE or other MDRO, especially when the labs are off-site.</p> <p>Craig Smith emphasized the importance of keeping precautions simple. Since precaution guidelines are the same or similar for all MDROs, then using universal MDRO precaution guidelines is easier for nurses and other healthcare providers to understand and remember.</p> <p>Beth Morrow asked if CRE was being added to the NHSN facility survey under the MDRO module. Nimalie Stone said that the survey catches a lot, but does not ask about specific organisms. A layer of complexity would have to be added.</p> <p>Robert Jerris pointed out that labs are not using the systems, panels, and breakpoints to properly detect MDROs. A definition is needed in the labs. The extent of the problem is unknown. The definitions are good now, but standardization is needed. He requested that the committee use him for education on labs. Jesse Jacob said that lowering breakpoints makes detection easier and more sensitive for detecting resistance. The FDA decides the panels, and CLSI has broader, better standards.</p> <p>It is not recommended that there be public reporting of CRE at this time. The problem of CREs is emerging and the uniformity of laboratories is not known.</p>			
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		<p>Matt Crist said that eliminating the Hodge test helped to simplify detection. The public health perspective would be that casting a wider net would be better. It is unknown what mechanism is at work – ESBLs with porin versus plasmid mediated. Jesse Jacob said that while this is interesting, it is of more academic interest than practical. It is usually transmitted via hand-spread of the same organism.</p> <p>Craig Smith said that CRE is a good organism for new initiatives.</p> <p>James Steinberg wants to send out a recommendation against using carbapenems for surgery prophylaxis.</p>			
H3N2 Influenza	Delmar Little	<p>With ‘state fair season’ approaching, it is of some concern that H3N2 influenza virus infections will increase. This virus is not as severe as others in the past.</p> <p>Signs are being sent out to be put next to pig displays to inform fair-goers that they should not get too close to swine. Brochures and flyers are also being sent out. The virus has only been seen in the US so far. Regular seasonal flu is showing typical off-season numbers.</p> <p>Denise Leaptrot offered to send out Delmar Little’s materials to all her hospital IPs. Cindy Prosnak offered to send out the materials through the GIPN listserve.</p> <p>Labs are having meetings on their detection panels. The public health side, medical side, and agricultural side are coordinating.</p>	Send out H3N2 educational materials	Denise Leaptrot; Cindy Prosnak	October 2012
QIO 10 <sup>th</sup> Scope of Work	Cindy Prosnak	<p>CLABSI reports from 2011 were due in August, as well as CAUTIs in ICUs, and SSIs for COLOs and HYSTs since January 2012. There are hospitals that have not reported before because they do not have ICUs. Some realized two weeks before the due date for SSIs that they had to report.</p> <p>Cindy Prosnak has done NHSN training and ensured all hospitals had reported by August 15<sup>th</sup>.</p> <p>Seven hospitals are under CLABSI appeal for data not sent to CMS – no results yet.</p> <p>In January of 2013, facility-wide in-patient C. diff and MRSA bacteremia lab ID events and HCW influenza vaccination data will</p>	<p>Influenza vaccination training</p> <p>Attend NHSN training conference</p>	Matthew Crist, Jeanne Negley	October 2012

		<p>be reportable to CMS.</p> <p>There is a 3-day NHSN training in Atlanta that conflicts with the 3-day GIPN conference in Savannah. Both are October 2-4<sup>th</sup>, 2012.</p> <p>The NHSN training course is full, and many hospitals in Georgia are waitlisted for registration. However, materials will be archived on the internet this year.</p> <p>Cindy Prosnak updated the committee on the QIO C. diff initiative that began with July reporting. Thirteen hospitals agreed to report on C. diff. After baseline data are collected from July through December 2012, CMS will require that facilities have a rate of 6/10,000 or higher to continue to work in this initiative, and that the data will have to be reported to CMS.</p> <p>Jeanne Negley gave a presentation to this initiative featuring a screen-by-screen orientation to C. diff data entry into NHSN. This presentation was very informative and helpful according to the facilities.</p> <p>CAUTI numbers are low in the data so far. Cindy Prosnak is focusing on device utilization, instructing facilities that not all patients in ICUs need Foley catheters. There has been some pushback, but it is improving.</p> <p>Jay Steinberg asked about testing for inter-rater reliability (kappa score) by the States. Although there will be validation by CMS through TelGen (26 Georgia hospitals have been selected for validation in May 2013), inter-rater reliability is not being assessed that the committee is aware of.</p> <p>CMS validation will consist of reviews of three medical charts per hospital for a sample of hospitals.</p> <p>Hospital-wide CLABSI reporting is not in the new federal register, only ICU CLABSIs.</p> <p>Jeanne Negley urged the committee to convince facilities to begin reporting on flu vaccination of healthcare workers now. Required reporting begins in January 2013, but by that time flu season will be well under way and many workers will already have their vaccines. Vaccine tracking beginning now will help facilities to be prepared for mandatory reporting later. Denise Flook would</p>			
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		like Jeanne Negley to provide a training webinar as soon as possible.			
HEN and NICU Affinity Group Update	Denise Flook	<p>Denise Flook holds HEN conference calls emphasizing an attitude of “all causes, all preventions,” and making infection control processes more reliable and sustainable. She is encouraging workers to ask each other questions about all risks and device use during rounding.</p> <p>Goals continue to change. The denominator for SIR calculations will be updated by CMS and will roll forward. The SIR for her collaborative is .77, but the State not having access to NHSN data hampers understanding of change over time.</p> <p>Hospitals are finding CLABSI rates outside of ICUs are pushing SIRs above 1. Insertion guidelines are often being followed, and the focus should turn to maintenance and dressing changes. Maintenance guidelines are not currently standardized.</p> <p>Armando Nahum described a project he is working on with CMS to make the best practices of champion hospitals widely available on the internet. The champion hospitals don’t have time to spread the word, they are working hard on maintaining standards. Dissemination of information via conference calls with collaboratives is somewhat slow and repetitive when the goal is to spread the highest quality models nationally and worldwide. He plans to speak with Jay Steinberg about Emory Hospital’s excellent VAPs work.</p>			
Update on HAIs becoming Notifiable	Matthew Crist	All signatures have been obtained for approval to make HAIs Notifiable Diseases in Georgia, except the Commissioner’s, which is expected soon. The data reported would be protected, and soon facilities will be encouraged to confer NHSN rights to the State.	Get hospitals to join the State NHSN user’s group, and confer rights to the State	Jeanne Negley, Denise Flook	
Review of Mission and Vision and Discussion of Committee Priorities	Jeanne Negley; Craig Smith	<p>Brainstorming was done for updating the Action Plan. Craig Smith emphasized pushing recommendations and communicating with hospitals.</p> <p>Many hospitals are not aware of the GHAIAC, and although they are already doing well with NHSN help, there is a need for recommendations across the continuum of care.</p> <p>There are many sources of information and an overwhelming amount of recommendations and requirements. The GHAIAC can</p>	Update the GHAIAC Action Plan	HAI Plan Subcommittee	

		<p>emphasize the best ones. New education does not need to be created, it already exists. Smaller hospitals may not be aware of all the programs available and how to prioritize them. There is a heavy focus on NHSN as facilities struggle to keep up with reporting requirements, so focus may have shifted away from the bigger picture.</p> <p>There is a trend in downsizing in infection control professionals. Infection prevention may be seen as a clerical position by hospital administrators. The IP industry is changing as facility-experienced IP nurses are retiring and young, relatively inexperienced academically-trained personnel move into those positions. High turnover exacerbates the problem as younger nurses do not want IP jobs since they fear being laid off not long after being hired. Craig Smith is concerned that when the rates appear to be low the administrators think there is no need for IPs, but the numbers are actually low because there aren't enough IPs to work on finding all cases and producing good data. Cindy Prosnak says that some facilities report to the QIO as few as 0.2 FTEs will be dedicated to doing infection control work. Beth Morrow reports that IP vacancies remain open for a long time.</p> <p>It is important to educate administrators that infection control is a separate, important job. Many IPs dedicate only a portion of their time to infection control because they are expected to do other jobs as well. NHSN reporting requirements may be a mechanism for improvement. Denise Flook is telling personnel that if they "do the right thing the numbers will follow."</p> <p>She noted that the advantage for the State is that it represents a neutral body that all types of healthcare providers can trust for recommendations; the reach is broader than for the GHA. Once the State has access to data and can disseminate it to facilities they will see the utility of reporting.</p> <p>Jeanne Negley wants to set 5-year goals once data can be accessed to assess a baseline. Craig Smith wants staff to present on processes at APIC meetings and at GIPN.</p> <p>Nimalie Stone asked what can be done to emphasize infection control resource needs to administrations – to motivate administrations to support their IP staff. Since greater resources need to be budgeted for IP, Jay Steinberg suggested a study to assess if there is a correlation between resource allocation and lower rates. Denise Flook says that analysis can be done, and that</p>			
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		<p>money lost on readmissions should also be brought to administrator's attention. (Beth Morrow and Nimalie Stone say that readmission rates for HAIs are not available at this time, however.) HAC data cannot be used to describe the relationship between resources and outcomes because it is not risk-adjusted.</p> <p>Jay Steinberg suggested offering a certification in infection control to MPH students, with multiple courses and training in statistics. Lauren Lorentzson suggested having a course of NHSN training for nursing students.</p> <p>Cindy Prosnak suggests that the State needs to make recommendations to lawmakers that IPs have minimum levels of education, since this is done for other positions. Infrastructure development to support this plan and enforce it would be needed, and the GHAIAC does not have the power to set up infrastructure, although creating the requirement may lead to infrastructure development. Beth Morrow would like to see more attention given toward support for IPs that are already on the job if infection control is going to improve quickly.</p>			
Closeout	Matthew Crist	The next date for a GHAIAC meeting was set for October 24 <sup>th</sup> .			
Notes:		The West Nile Virus presentation to be given by Melissa Ivey was tabled.			

**Georgia HAI Advisory Committee (GHAIAC) Meeting  
July 25th, 2012  
Conference Call**

**Attending HAI Advisory members:** Jeanne Negley, Marcia Delk, Robert Jerris, Cindy Prosnak, Lynn Reynolds, Craig Smith, James Steinberg, Kate Arnold, Robert Thornton, Peggy McGee, Susan Fuller, Ryan Deal, Denise Leaptrot, Denise Flook

**Not present HAI Advisory members:** Beth Morrow, Cyndra Bystrom, Mary Key, Victoria Nahum, Nimalie Stone, Jesse Jacob, Susan Ray, Renee Watson

**Public Health Adhoc members present:** Matthew Crist, Ashley Moore, Cherie Drenzek, Lauren Lorentzson

**Committee meeting guest:** Abby Berns

Agenda Item	Presenter	Discussion	Recommendation	Responsible Person(s)	Date for completion or Update
Welcome and Call to order	Matthew Crist	Called to order at 10 a.m. Changes to the committee roster announced.  1.) Jeanne Negley is the new HAI Coordinator at GDPH, and co-chair of the GHAIAC 2.) Craig Smith has agreed to be the new co-chair 3.) Henrietta Smith has withdrawn her membership	None	None	None
Minutes	Lauren Lorentzson	Minutes approved without revisions. Roll called.	No corrections requested	None	None
10 <sup>th</sup> Scope of Work	Cindy Prosnak	QIO CAUTI work is continuing with 25 acute care hospitals in GA using a “trigger tool” to review the necessity for catheters, and to get unnecessary urinary catheters removed. Most are doing well, some are having challenges with updating their electronic medical records.  Recruitment for lab identified C. difficile infections (CDI) efforts is starting, recruiting from the pool of 25 hospitals referred to above. Not all of them are participating yet. They have been asked to enter data into NHSN starting now. Facilities have to have a CDI rate of 6 per 10,000 or higher. This may pose a challenge. It will be important to assess what the rates are at present. Claims data were used to estimate a baseline, but some	Determine if CDI data are corrected for EIA vs. PCR labs  Send GHAIAC members the HAI planner for LTCFs that is out for comment  Assist facilities with CDI reporting  Continue work with the QIO	Cindy Prosnak  Cindy Prosnak  Jeanne Negley  Cindy Prosnak	October 2012  By the next in-person meeting  Ongoing  Ongoing

	<p>facilities report that their internal tracking shows different numbers from the claims data. Hospitals can be dropped later if their rates do not meet the requirement.</p> <p>The C. difficile cases are determined by lab ID, not by method. It is unknown if there is any correction for EIA vs. PCR.</p> <p>The CLABSI validation tool is due on August 1<sup>st</sup> 2012 for eligible hospitals. Approximately 800 hospitals turned in data using a template. Any patient that spent time in the ICU that had a positive blood culture had to be listed.</p> <p>TelGen is the company working on validation.</p> <p>Based on 1st Quarter reporting, 7 hospitals have been denied their payments (APU). Appeals are due by Friday (7-27-2012), and are being developed with help from the GHA and QIO. The 7 hospitals that were denied had not mapped their data to the ICU, and therefore the data did not transmit to CMS. It is hoped that CMS will accept the appeals while mapping issues are further addressed.</p> <p>Similar mapping issues were addressed in October and November of 2011.</p> <p>In addition, Denise Flook reports that in April 2012 CMS was not receiving data from hospitals that were submitting. There was a glitch preventing data entered into NHSN from getting to CMS. The QIOs sent reports to hospitals, indicating that the data had been entered.</p> <p>Jeanne Negley has experience with training facilities in Oregon to report CDI. She offered her help.</p> <p>All hospitals with ICUs have to have 1<sup>st</sup> Quarter data from this year submitted by August 15<sup>th</sup> to NHSN to be sent on to CMS.</p> <ol style="list-style-type: none"><li>1.) Procedure data for hysterectomies and colons</li><li>2.) CLABSIs</li><li>3.) CAUTIs</li></ol>			
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		<p>Several hospitals have been reporting CLABSIs, but not CAUTIs or procedure data. Their personnel didn't know how. Cindy has been going to facilities and giving instruction. Some hospitals don't have an ICU, but do procedures that have to be reported. They are being introduced to NHSN for the first time.</p> <p>In October, LTAC and inpatient dialysis clinics have to enter CAUTI data into NHSN.</p> <p>A plan for HAIs LTC facilities came out for comment. Cindy will send the committee the link to the planner. It is out for comment. It seems that a goal will be set for 5% of nursing homes to use NHSN. No nursing homes are using NHSN at present.</p>			
HEN HAI Collaboration and NICU Affinity Group	Denise Flook	<p>Hospitals are receiving information, some only listening in on conference calls.</p> <p>36 facilities have conferred rights to Denise Flook on NHSN so that she can see their data.</p> <p>National HEN CAUTI SIR data were made available, and Georgia's HEN's SIR was higher (1.4-0.8) than the national SIR (0.6). The national data include approximately 4,000 hospitals. The goal is 1 case per 1,000 catheter days. The high was in Quarter 2 in 2010, and many hospitals have improved since 2011. Approximately 120 Georgia hospitals are in a HEN. Denise Leaptrot asked if there were any plans to change the data once validation is done, and Cindy Prosnak stated that she was unaware of any plans to correct the data.</p> <p>SIR data from 2010 indicated that Georgia's NICUs have a higher than 1 ratio, so started a 'NICU Affinity Group' in May of 2012. 17 hospitals participate. Both local and national NICUs have given webinar presentations. Last month's call featured an excellent presentation from California collaborative member Janet Pedit.</p> <p>Denise Flook emphasized that work has to go beyond bundles and checklists.</p> <p>1.) Accountability</p>	<p>Continue working with the HEN HAI Collaborative to bring down CAUTI and CLABSI SIRs</p> <p>Continue to work with the NICU Affinity Group to lower the NICU CLABSI SIR</p>	<p>Denise Flook, Collaborative members</p> <p>Denise Flook, Matt Crist, Affinity Group members</p>	<p>Ongoing</p> <p>Ongoing</p>

		<p>2.) Ownership 3.) Involvement of senior leadership 4.) Involvement of all staff 5.) Empowerment</p> <p>Focus has been shifting away from insertion practices to line maintenance in adults this year, looking beyond the ICUs to also cover general floor PICC lines. Insertion practices have improved greatly, but line maintenance has been lacking.</p> <p>On the monthly collaborative call, a change to unit-level responsibility was encouraged.</p> <p>Denise will be emphasizing best practices with the CLABSI collaborative in September 2012. Her goal is to do more site visits and one-on-one work. She will be working with Johns Hopkins University on SSI and VAP programs that will begin in January 2013.</p>			
HAI Reporting Progress	Matthew Crist	<p>Matthew Crist met with Sid Barrett, the General Counsel at the GDPH, and learned that the commissioner has the power to declare data confidential, so there is now a method in place to protect the data. After meeting with Sid Barrett and getting suggestions for edits, a formal notice was written, and converted into a 'notice from the commissioner.' It is under review starting today, so it should be in place and go into effect in January 1<sup>st</sup> 2013. This will allow the State access to HAI data being reported to CMS, and will follow the CMS schedule. Matt Crist credited Katie Arnold with the idea and thanked her.</p> <p>Katie Arnold asked if voluntary reporting of HAIs to the State from hospitals will be protected with the same level of confidentiality. Cherie Drenzek said she would talk to Sid about this.</p>	<p>Complete the process for making HAIs Notifiable</p> <p>Ask the GDPH legal team if hospitals reporting data voluntarily will be protected with the same level of confidentiality as other facilities</p>	Matthew Crist  Cherie Drenzek, Matthew Crist	<p>January 2013</p> <p>By the next in-person meeting</p>
Renewal of Mission and Vision	Matthew Crist	<p>The mission and vision statements were sent to the GHAIAC before the call for members to review.</p> <p>The GHAIAC was originally created to provide guidance on how</p>	<p>Re-write the Mission and Vision statements and provide them to the GHAIAC</p>	Matthew Crist	By the next in-person meeting

		<p>to best use NHSN data for prevention, and since those data will soon be accessible, an update to the mission and vision may be necessary.</p> <p>Various members of the committee offered suggestions for changes in wording, and Katie Arnold encouraged the group to choose priorities. The GHAIAC is meant to consider Georgia's situation and focus attention on actions that will have the highest yields in terms of improvement.</p>			
Necrotizing Fasciitis Update	Jay Steinberg	<p>Jay Steinberg gave a case report on a woman that had suffered post-partum Group A Streptococcus necrotizing fasciitis. Her case was complex because she was a resident of another state, and had a natural birth of twins with several attending doulas. In addition, the case caught the attention of the press.</p> <p>During the investigation, another case of post-partum GAS was identified from three months prior. This second case triggered an outbreak protocol, and all medical staff with any contact with the patient were swabbed. Seventy-four staff members had had contact with the patient, with 14-15 having had intimate contact (i.e. performance of a vaginal exam). Intimate contacts had up to five sites swabbed. All 74 were swabbed, and all swabs were negative.</p> <p>Due to ongoing EIP surveillance of GAS in Georgia, the isolate from the previous case was still available and was tested. It was not the same strain type as this case.</p> <p>Hand hygiene compliance was emphasized at the facility.</p> <p>Whether one or two cases of GAS should trigger an outbreak investigation was discussed. The CDC guidelines and literature on how to respond to cases of GAS were reviewed. At the moment the guideline is two cases.</p>	None	None	None
Invasive Group A Streptococcus Outbreak Investigation	Matthew Crist	<p>An invasive Group A Streptococcus outbreak at a skilled nursing facility beginning in April of 2009 and being thoroughly investigated by GDPH and CDC in November of 2011 was still ongoing. Despite the extensive intervention at that time, four new</p>			

		<p>cases were identified this year.</p> <p>Healthcare Facility Regulation and Quality were alerted, and after discussions with GDPH, CDC, and the skilled nursing facility senior leadership, the decision was made to give antibiotic prophylaxis to all residents and staff.</p> <p>Approximately two-thirds of the residents received penicillin/rifampin, and a third received Keflex. Swabs were taken on positive cases and any residents with wounds before administration of antibiotics. Any staff member who refused antibiotics was swabbed and furloughed until confirmed to be negative.</p> <p>Ashley Moore has drafted a letter to be sent out to any facility with one or more invasive GAS cases that are either at a LTCF or are post-partum. Queries of invasive GAS data entered into SendSS are done monthly to ensure that cases are found and facilities notified.</p>			
Final Comments	Matthew Crist	An in-person meeting is to be scheduled for late August or early September, since there is so much work ongoing and the new HAI Coordinator and co-chair is finally here.	Schedule an in-person meeting	Matthew Crist	August 2012
Adjournment	Matthew Crist	Meeting adjourned at 11:33 a.m.	None	None	None

**Georgia HAI Advisory Committee Meeting (GHAIAC)**  
**April 25<sup>th</sup>, 2012**  
**Georgia Medical Care Foundation, Dunwoody, GA**

**Attending HAI Advisory members:** Dawn M. Sievert, Denise Flook (via teleconference), Jesse Jacob, Susan Ray, Marcia Delk, Craig Smith, Suleima Salgado, Armando Nahum, Renee Watson, L. Clifford McDonald, Cindy Prosnak, Lynn Reynolds, Donna Matthew (via teleconference), Peggy McGee (via teleconference)  
**Not present HAI Advisory members:** Beth Morrow, Cyndra Bystrom, Marcia Delk, Nancy White, Henrietta Smith, Robert Jerris, Mary Key, Denise Leaptrot (via teleconference), Victoria Nahum, Nimalie Stone, Robert Thornton, Katie Arnold  
**Public Health Adhoc members present:** Lauren Lorentzson, Matthew Crist, Ashley Moore, Melissa Tobin-D'Angelo  
**Committee meeting guest:** none

Agenda Item	Presenter	Discussion	Recommendation	Responsible Person(s)	Date for completion or Update
Welcome and Call to order	Matthew Crist	Called to order at 9 a.m. Introduction of new members made.	None	None	None
Minutes		Minutes approved without revisions. Sign-in sheet distributed.	No corrections requested		
<i>Clostridium difficile</i> Vital Signs	L. Clifford McDonald	<p>Vital Signs is a monthly release from CDC with facts, announcements, and calls to action pertaining to a particular health issue. The first Making Healthcare Safer release was March 2011 with a focus on blood stream infections, and the second was released March 2012, with a focus on <i>Clostridium difficile</i> infections (CDI).</p> <p>A summary of the current rates, recommendations, prevention methods, and data was presented. It was noted that NHSN collects laboratory identified events, and if the CDI event was healthcare or community associated. CDC is working on preventing penalization for large numbers of CDI because good diagnosis and reporting is needed.</p> <p>The importance of including environmental health personnel in developing cleaning policies within facilities to prevent spread of CDI was emphasized, and it was suggested that patients with viral URI be given cold packs to avoid a demand for antibiotics.</p> <p>CDC puts instructional videos on Youtube.com, which cannot be watched in many hospitals due to restrictions on internet use.</p>	Consider gaining access to CDI data in NHSN	Matt Crist	None

		QI0 is considering CDI for the 10 <sup>th</sup> Scope of Work.			
EIP Update	Susan Ray	Phase III activities have concluded and results are heading toward publication.	Publication of results	Susan Ray	None
SafeCare Update	Armando Nahum	Armando Nahum brought to our attention the release of a new free 2012 SAFE CARE Patient Safety Education Program at <a href="http://www.safecarecampaign.org/poster/welcome.html">http://www.safecarecampaign.org/poster/welcome.html</a> , where 11x17" posters are available for download with QR codes that link to instructional videos for patients, patient advocates, and other consumers to learn precautions to help prevent infection while receiving care. The primary poster is free. There is a library of videos, and the poster can be customized for a fee.	Make healthcare providers aware of the availability of the QR  Send out link, discuss on conference calls	All members  Denise Flook	Ongoing
New Business, Membership Discussion	Matt Crist	We are seeking a new co-chair. Craig Smith fits the requirements, and expressed interest in the position.  Two new members have been added to the committee. Ryan Deal from GDPH will serve as the communications representative and Peggy McGee from Liberty Regional will represent critical access hospitals.  Members were asked to consider if they would like to add an IP who primarily works in an LTAC or if the current representation in the committee that cover LTACs as part of their role is adequate representation.  The job description and announcement for the position of HAI Coordinator at DPH, formerly Teresa Fox's position, are now up on the relevant websites, and applicants, are expressing interest. It is anticipated that the position may be filled in mid-June.	Assume responsibilities of new posts  Consider LTAC representative	Craig Smith, Matthew Crist, Peggy McGee, Ryan Deal  All members	By next meeting, July 25 <sup>th</sup> 2012
GHA Collaboratives – HEN, NICU, CUSP	Denise Flook	Barriers to compliance were discussed, such as getting everyone on board and believing that it is possible to prevent all infections.  A facility has reported going 5 years without a CLABSI.  Johns Hopkins got another grant – Pronovost – for Surgical Care	Continue with supportive conference calls  Continue working with Georgia hospitals in	Denise Flook	Ongoing

		<p>Safety – SUSP (Surgical Unit-based Safety Program). It includes using the Surgical Care Checklist to improve surgical care safety and reduce SSIs. A SUSP collaborative to reduce surgical complications including SSI begins in Fall 2012.</p> <p>Conference calls are the 2<sup>nd</sup> Wednesday of every month:  NICU 10-11 am  CUSP 11-12:30 pm</p> <p>GHA is now a CMS Hospital Engagement Network (HEN) with 121 Georgia hospitals. National goals by 2013 are to reduce HACs by 40% and reduce readmissions by 20%. Emphasis is on culture change and evidence-based practices.</p> <p>A NICU CLABSI Affinity Group began in April.</p> <p>VAPs to be addressed.</p> <p>HAI collaborative work continues to evolve.</p>	collaboratives		
NHSN Update	Dawn Sievert	<p>We were informed that adjusted SIRs can't be done for at least another year.</p> <p>SIRs are not using confidence intervals yet.</p> <p>Denise told the committee that the PPS rule for CMS was just put up on AHA and was accepted.</p> <p>NHSN major changes:  Release 6.6.1 on April 28<sup>th</sup>, 2012  Release 7.0 in late August of 2012  Release 7.1 in January 2013</p>	None	None	None
State Activities Update	Matthew Crist	<p>CMS now requires reporting of HAIs to NHSN to receive 2% reimbursement. Numbers are posted on <a href="http://hospitalcompare.hhs.gov">hospitalcompare.hhs.gov</a> each Quarter, approximately 1 year after submission. The first 2011 Quarter was posted February 2012.</p> <p>2011 first Quarter data refers to CLABSI data for acute care facility ICUs. 36 Georgia hospitals submitted enough data to</p>	<p>Develop a method for obtaining HAI data from Georgia facilities</p> <p>Provide education on prevention, NHSN enrollment, and case</p>	Matthew Crist, Lauren Lorentzson	Ongoing

		<p>compute SIRs. [172 acute care facilities currently in Georgia]</p> <p>Validation is performed on 3 charts from each facility per quarter, approximately 800 hospitals.</p> <p>The NHSN State Specific Report to be released publically 4/19/12. (Deidentified data were released to individual state HAI Coordinators last month for review.)</p> <p>Georgia has an overall SIR of 0.55, 8 hospitals with SIR of 0 (zero), and 29 hospitals <math>\leq</math> 1.0. SIRs have significantly decreased since 2009.</p> <p>-----</p> <p>Georgia has no reporting mandate due to open records laws and hospital concerns about confidentiality and accuracy of data. Potential solutions include: 1.) reporting mandate (law), 2.) data Use Agreement (DUA), 3.) addition of HAIs to the notifiable diseases list. The latter option would allow GDPH HAIs section to be added as an NHSN users group. Resources for validation are scarce.</p> <p>It is hoped that GDPH can obtain data reported to NHSN in accordance with CMS requirements so that data can be used to direct public health interventions. We want to be able to assist with validation if we are going to have a mandate.</p> <p>Dawn Sievert told the committee that NHSN are working to fix the DUA problem (3 month delay in obtaining data, etc.).</p> <p>Renee Watson reminded the committee that dealing with public reporting was part of the reason for the formation of GHAIAC in the first place. She discussed the importance of remembering our charter and mission and vision.</p> <p>It was discussed that while reporting would be a tool for improvement, the hospitals would have to do the work to fix the problems. (The reporting and data can be used to empower healthcare workers to convince colleagues to use best practices.)</p>	<p>determinations</p> <p>Consider small-scale voluntary validation</p> <p>Continue to work with collaboratives and partners (CUSP, NHSN, etc.)</p> <p>Continue to reevaluate the situation as personnel and funding situation changes</p> <p>Review and potentially update mission and vision</p>		
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10 <sup>th</sup> Scope of Work	Cindy Prosnak	Postponed due to time constraints.	None	None	None
Adjournment	Matthew Crist	Meeting adjourned at around 2:00 pm.	None	None	None

**Georgia HAI Advisory Committee Meeting (HAIAC)  
January 25th, 2012  
Department of Public Health Teleconference**

**Attending HAI Advisory members:** Cindy Prosnak, Mary Key, James Steinberg, Kate Arnold, Jesse Jacob, Craig Smith, Robert Thornton, Susan Ray, Lynn Reynolds, Denise Leaptrot, Amando Nahnum, Robert Jerris, Beth Morrow

**Not present HAI Advisory members:** Denise Flook, Nancy White, Henrietta Smith, Nimalie Stone, Marcia Delk, Renee Watson, Cyndra Bystrom, Steve Marlowe

**Public Health Adhoc members present:** Teresa Fox, Lauren Lorentzson, Melissa Tobin-D'Angelo, Cherie Drenzek, Matthew Crist,

**Committee meeting guests:** None

Agenda Item	Presenter	Discussion	Recommendation	Responsible Person(s)	Date for completion or Update
Welcome and Call to order	Teresa Fox	Called to order at 1:03 pm	None		
Minutes	Teresa Fox	Explanation that a conference call was utilized for this meeting to save time and reduce travel burden, and because there are fewer updates than usual. Minutes presented and approved as presented.	None		
Roll Call	Lauren Lorentzson	18 members were present via telephone for call; attendees listed above	None		
On the CUSP: HAI Initiative and CMS Update	Denise Flook	Denise was unable to attend and will provide a written update to be added to the minutes.	Update committee as needed	Denise Flook	Ongoing
EIP/NHSN Update	Nancy White	Nancy was unable to attend and will provide a written update to be added to minutes.	Update committee as needed	Nancy White Susan Ray	Ongoing
GIPN Conference Update	Cindy Prosnak	A retreat is beginning this weekend for the purpose of working on planning the next GIPN conference scheduled for October 2012. This year the conference will be held in Savannah. Anyone with suggestions for the agenda should email Cindy Prosnak so she can pass them on to the program chair. They want to serve the needs of all members.	Update committee as needed	Cindy Prosnak	Ongoing

QIO 10 <sup>th</sup> Scope of Work	Cindy Prosnak	<p>The QIO has been working to recruit hospitals to work on issues with SSIs, CAUTIs, and C. diff. So far there are 27 hospitals involved. There were two successful kickoff meetings in December 2011, one in Tifton and one in Atlanta, with a webinar for hospitals that could not attend. The hospitals were trained in CUSP methodology for CAUTI. There was a support call yesterday (Jan 24<sup>th</sup>, 2012), with 26 of the 27 hospitals in attendance. The call offered a forum for sharing ideas and discussing dealing with various aspects of CAUTI. The program is off to a great start.</p> <p>Ann Hernandez wanted to bring to our attention to the need for an advisory committee for this work, and wanted our input. It was decided, with many members concurring, that GHAIAC could function as the advisory committee for the QIO 10<sup>th</sup> Scope of Work.</p>	Continue to work with GHA and PH to decrease HAIs; update committee as needed	Cindy Prosnak Anne Hernandez	Ongoing
NHSN Enrollment	Teresa Fox	PH and GHA determined that 172 facilities should be reporting to NHSN, and this number was submitted to CDC for use in the 2009-2010 SIR report that the committee will be reviewing at today's meeting.	Continue to recruit for NHSN and G-SNUG	Matt Crist Lauren Lorentzson Nancy White Denise Flook	Ongoing
HAIAC Charter	Teresa Fox	After completing suggested revisions, the HAIAC Charter was emailed to committee members for final approval. No other comments or revisions were requested.	None		Completed December 2011
HAI Plan Revision Subgroup	Melissa Tobin-D'Angelo	No updates since the last meeting. Their work will be concentrating on surveillance activities, and work cannot move forward until a decision is made in regards to a data use agreement (DUA) and it is known how surveillance will work in Georgia.	Continue revisions to plan via subgroups and update full committee at next meeting	Melissa Tobin-D'Angelo Matthew Crist Lauren Lorentzson	April , 2012
CDC-GA Data Use Agreement Update	Melissa Tobin-D'Angelo	<p>Sub-group members met with the Georgia Department of Public Health legal team and the Georgia Hospital Association legal team to discuss utilizing a data use agreement for disease reporting and any legislative issues that may come up during this session.</p> <p>Some of the legal staff have expressed that they have heard from Georgia representatives that there may be something coming up that will affect disease reporting.</p> <p>There are issues with the need to update disease reporting rules since DPH became a separate entity from DCH. CDC will need</p>	Updates will be emailed to committee members as available	Matthew Crist Lauren Lorentzson Melissa Tobin-D'Angelo	Ongoing

		those updates before they can approve the DUA.			
SIR Report Discussion	Matthew Crist	<p>Prior to the call, the committee was provided via email a copy of the 2012 State-specific SIR report to be released in mid-February. The portions of the report to be released publicly are: Tables 1a-c, Tables 3a-d, Table 6, and Table 7.</p> <p>The structure of the report, i.e. the order that the tables are presented, is based on precedent, according to Katie Arnold. The data will be made public via website. The data can be put in an executive summary, and developing a communication plan for orienting the public to the data is the purpose of our receiving this draft report ahead of time</p> <p><b><u>Key Points for Georgia</u></b></p> <ol style="list-style-type: none"> <li>1. Georgia's CLABSI rates are showing significant improvement from 2009 to 2010.</li> <li>2. We still have a lot of work to do, particularly in NICUs. The ideal goal is 0, but we are working to eliminate as many of the preventable CLABSIs as possible through our partnerships with GHA, the QIO, GIPN to provide education to promote evidence based practices shown to reduce CLABSIs.</li> <li>3. We are working on a collaboration to help reduce CLABSIs in NICUs.</li> <li>4. This data is based on a somewhat small sample of the hospitals in Georgia, and we know that by the beginning of 2011 there were already 94 facilities reporting to NHSN.</li> <li>5. There has not been any external validation performed on this data.</li> </ol> <p><b>Discussion</b></p> <p>Tables 1a-c list the facilities reporting for each state for CLABSIs, CAUTIs, and SSIs respectively. In 2010, 37 (21.5%)</p>	Continue to monitor and update committee as needed	Matthew Crist	Ongoing

		<p>of 172 hospitals in Georgia reported CLABSI data to NHSN, so this is still a fairly small percentage of the hospitals. It is expected that these are the larger hospitals, so it may represent considerably more than 21% of the central line days in the state but we don't really know. These 37 hospitals reported data on 154 units and 67.4% of the total months that could have been reported were reported. With the CMS requirements going into place in 2011 a much higher percentage of facilities to be reporting.</p> <p>Tables 3a-d are the key part of the report that will be made public. They show the CLABSI SIRs and 95% CIs for all locations (a); adult/pediatric ICUs (b); non-critical care wards (c); and NICUs (d) separately. The SIR is an observed/expected ratio with 2006-2008 NHSN data used to predict the expected number of infections based on type of units and number of central line days in a facility (or entire state). Georgia's overall SIR is 0.806 (0.713-0.907), so the observed infections are significantly less than the predicted number of infections predicted from the reference data. However Georgia is significantly above the national SIR of 0.684 (0.673-0.696).</p> <p>Table 3b looks at adult/pediatric ICUs and divides them up by states with and without reporting mandates. There doesn't appear to be a glaring difference between mandate and non-mandate states as there was with the validation and non-validation states on the 2009 report. This is the area where Georgia seems to be doing best, with an SIR of 0.645 (0.539-0.765), significantly less than 1 and slightly better than the national avg. of 0.654 (0.639-0.669).</p> <p>Table 3c shows that of 15 facilities that reported on ward location our SIR of 0.948 (0.763-1.164) is slightly below 1, though not significantly so, and is worse than the national average of 0.728 (0.708-0.748). Prevention efforts have largely been focused on ICUs as the baseline rates were considerably lower, and there are fewer controllable variables in the wards, so it's not surprising that there has not been a dramatic change nationwide compared to the 2006-2008 data.</p> <p>Table 3d is expected to raise questions from the public. For the 10 facilities reporting NICU data, Georgia's SIR is 1.275 (0.952-1.672). Though not statistically significantly higher than 1, the number attracts attention. In Tennessee the NICUs had</p>			
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		<p>significant improvement prior to public reporting due to the Tennessee Initiative for Perinatal Quality Care, which is like a QIO for infants. They led more of a grass roots campaign that got a lot of frontline staff to champion the cause, and the SIR dropped from over 1 to less than 0.5. Teresa Fox has been in contact with Seema Csukas in maternal/child health at DPH, who said Georgia does not have an equivalent organization, but they are working to establish one. They are going to meet soon to talk about how the GHAIAC could be involved with and partnered with them on CLABSI reduction in NICUs. This should get a lot of bang for our effort, and hopefully significantly reduce CLABSIs in NICUs. The committee was unsure how many NICUs are presently providing care in Georgia. DPH will try to find out how many NICUs there are in GA.</p> <p>Table 6 compares our overall CLABSI SIR in 2010 to the SIR in 2009 (15 facilities reported in 2009) and shows a significant decrease from 0.982 to 0.806 (P=0.027). This emphasizes that Georgia is improving. Comparing the 15 facilities that reported both years, the improvement was also statistically significant (P=0.044).</p> <p>Table 7 shows the national reductions for CLABSIs and various SSIs from 2009 to 2010.</p> <p>These data are not meant for state-to-state comparison. Katie Arnold discussed that the purpose of the data will be to allow for states to compare their SIRs serially across time. They are not meant to be compared across states because they are so different depending on mandates, validation, and number and types of facilities.</p> <p>Without the ability to mandate we don't know the quality of the data. The data cannot be properly interpreted without validation. Matt Crist pointed out that there tends to be underreporting if there are no validations being performed. Lynn Reynolds comes from Virginia, and they validate their data. She reports that in Virginia the interpretations of the CDC definitions were not consistent, and the definitions were often being modified. She emphasized the importance of ensuring that facilities are using the CDC definitions verbatim. It was discussed that determining if an infection – particularly a secondary infection – fulfills the definition can be very difficult with certain patients and cases, such as trauma patients. It was emphasized that at the moment</p>	<p>Contact Medicaid Office to see they have the number of NICUs in GA</p>	<p>Teresa Fox Lauren Lorentzson</p>	<p>April 2012</p>
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		we should work to provide the best education possible and reinforce, and that there is a great benefit to validation despite the cost and time consumption. It provides a check to the pressure to keep the reported numbers low, and ensures that the definitions are being applied as accurately as possible.			
Open Discussion	Teresa Fox	Teresa announced her resignation and informed the group that she will begin working in Alabama next month. She expressed her best wishes for the progress and continuation of a great program in Georgia. Teresa was thanked by many members of the group and wished good luck.	None		Resignation effective February 2, 2012
Next Meeting	Teresa Fox	Meetings are planned for:  <b>April 25</b> <b>July 25</b> <b>Oct 24</b>  Please mark your calendars. The meeting location is the Georgia Hospital Association If the situation should arise that another meeting is needed before the scheduled April meeting, a notice will be emailed at least 2 weeks prior to the called meeting.	Reminders, agenda will be sent prior to meeting	Matthew Crist Lauren Lorentzson	
Adjournment	Teresa Fox	Meeting was adjourned at 1:59 pm.			

**Georgia HAI Advisory Committee Meeting (HAIAC)  
October 26th, 2011  
Children's Healthcare of Atlanta, Atlanta, GA**

**Attending HAI Advisory members:** Denise Flook, Cindy Prosnak, Mary Key, Nancy White, James Steinberg, Kate Arnold, Jesse Jacob, John McGowan, Craig Smith, Robert Thornton, Susan Ray

**Not present HAI Advisory members:** Henrietta Smith, Nimalie Stone, Robert Jerris, Marcia Delk, Renee Watson, Cyndra Bystrom, Steve Marlowe, Lynn Reynolds, Denise Leaptrot, Amando and Victoria Nahnum

**Public Health Adhoc members present:** Teresa Fox, Lauren Lorentzson, Melissa Tobin-D' Angelo, Cherie Drenzek, Matthew Crist,

**Committee meeting guests:** Heather Bond, Russell Crutchfield

Agenda Item	Presenter	Discussion	Recommendation	Responsible Person(s)	Date for completion or Update
Welcome and Call to order	Teresa Fox	Called to order at 9:17 am	None		
Minutes	Teresa Fox	Minutes presented and approved as presented.	None		
Introductions	Melissa Tobin-D' Angelo	New Member: Matthew Crist (HAI Medical Epidemiologist); Lauren Lorentzson (HAI Epidemiologist), Cherie Drenzek (State Epidemiologist); Robert Thornton (Representative for local and district PH)	None		
On the CUSP: HAI Initiative and CMS Update	Denise Flook	It was noted that CLABSI rates have gone down according to the national data. (CMS writes regulations every year.) It was suggested that work be done with manufacturers to address issues with equipment, for example problems with the adherence of dressings.  It was emphasized that culture change is the most important and effective assurance of compliance with regulations. Work will be done with hospital boards, CEOs, and other managerial leadership. Monthly CUSP coaching calls will continue as a resource to support staff and to offer feedback. Techniques for increasing compliance with policies and regulations include putting emphasis on getting back to core values of patient safety and peer-to-peer accountability.	Update committee as needed	Denise Flook	Ongoing
QIO 10 <sup>th</sup> Scope of Work	Cindy Prosnak	It was found that 82% of hospitals had an SIR of <1.0. The goal is to work with 22 CAUTI hospitals, and 21 have been recruited with 2 more to be added soon. (It was noted that the hospitals	Continue to work with GHA and PH to decrease HAIs; update committee	Cindy Prosnak	Ongoing

		working with GHA are not eligible for working with the QIO) The national goal for HACs is 40% reduction. A culture of non-punitive accountability was emphasized.	as needed		
EIP Update	Susan Ray	<p>The GA EIP is currently working on four projects:</p> <ol style="list-style-type: none"> <li>1) HAI Surveillance (denominator simplification project and multi-drug resistant use and HAI prevalence survey). The simplification project is working to evaluate the feasibility and accuracy of using a less resource intense method (sample of one day per week) for determining denominator (device-days) used for calculating device HAI rates instead of the current method of daily collection of data. The project is about 75% complete, and the preliminary results show that the sampling method is valid and feasible. The HAI and antimicrobial use prevalence survey team recruited 25 facilities to participate in this project. The team reviewed the charts of all patients on antimicrobials during a defined timeframe. The team recorded antimicrobial specifics, clinician's reason for antimicrobial use, and identified the HAI currently being treated. 1400 patients were included (including 225 children). Phase II of the project is nearing completion. The preliminary results showed that 48% of patients were on at least one antimicrobial agent. The challenges of standardization of definitions, documentation, and reporting were discussed. An evaluation team for Phase III is needed.</li> <li>2) MUGSI (multi-drug resistant gram negatives). The objectives are: 1) to evaluate the incidence of carbapenem-nonsusceptible infections, 2) to characterize cabapenem-non-susceptible strains to guide prevention efforts, 3) describe know resistance mechanisms among certain species of cabapenem-nonsusceptible <i>Enterobacteriaceae</i></li> <li>3) Invasive MRSA. Surveillance and hospital-acquired community-onset case-control study. The project reviewed MRSA isolated from invasive sites utilizing sterile technique. Based on epidemiologic criteria, cases were classified as healthcare-associated healthcare-onset, healthcare-associated community-onset, or community-associated.</li> <li>4) Candidemia surveillance. The project began March 2008 and includes surveillance for <i>Candida</i> blood</li> </ol>	Update as needed	Susan Ray Nancy White	

		stream infections in GA District 3, with all ages included. Presently 1783 cases have been reported and 95% of the reported cases have been reviewed. Literature review indicates community-onset <i>Candida</i> BSIs appears to be increasing worldwide.			
NHSN Enrollment	Teresa Fox	NHSN enrollment continues to increase. Presently, NHSN enrollment stands at 126. The total number of facilities reporting to NHSN for CLABSI is 106. The total number of hospitals in GA was discussed. Based on the data received from American Hospital Association there are 186 facilities. The Georgia Hospital Association (GHA) shows 156 members. Teresa is to contact NHSN and request a list of participating facilities. The recruitment for G-SNUG continues to be very low at 3.	Continue to recruit for NHSN and G-SNUG  PH and GHA are to work together to determine the correct number of facilities and, if possible, the number of critical access facilities.	Teresa Fox Nancy White  Teresa Fox Denise Flook	Ongoing  January, 2012
GIPN Annual Educational Conference	Cindy Prosnak	The Annual GIPN Educational Conference was held Oct 5-7. There were 134 attendees. Attendee breakdown: acute care - 93; long term care - 8; public health - 9; public health students - 1; long term acute care - 1; consultant - 4; clinic - 2; ASC - 3; drug rehab - 1; mental health - 2; retired - 2. Conference presentation topics included NHSN definitions, NHSN validation process, use of standardized infection ratios (SIR), sterilization, and other infection prevention and control topics.	None		
HAIAC Charter	John McGowan	Input from the subcommittee lead to the current draft of the charter. There was a change in the wording. Nancy White suggested using the same acronym for the committee throughout, as well as a consistent title for Teresa Fox. Teresa has two titles, HAI Coordinator and HAI Surveillance Program Director. HAI Surveillance Program Director was decided on as the title to use in the charter. HAIAC was decided on as the official acronym of the committee. It was requested that facilitating communication be added to the guiding principles because we are a forum for collaboration. The group was instructed to go back to constituents and communicate to them what we are working on. It was noted that our minutes are posted on the website.	After completing the requested revisions, the charter will be emailed to committee members for final approval	Teresa Fox	December, 2011
Data Use Agreement	Kate Arnold	Because state and local public health are responsible for assuring the health of their constituents, CSTE proposed that CDC find a way to share NHSN data that is not otherwise required by mandate with states, for public health purposes. A Data Use	PH will continue to investigate options to access state HAI data	Teresa Fox Melissa Tobin- D' Angelo Matthew Crist	January, 2012

		<p>Agreement (DUA) template has been developed to make this possible. Unless a state mandate specifically requires public reporting, individual and facility-level NHSN data must be protected from disclosure by the state under the DUA. If the state can document sufficient protections for this "covered data," a DUA can be negotiated with NHSN/CDC staff. Under the DUA, there are potential sanctions and penalties for misuse or inappropriate disclosure.</p> <p>Georgia will be discussing entering into a DUA with NHSN later this month. This approach is favored by the Department of Public Health because assuring the quality of publicly reported data would require investment for data validation and additional staffing that is not currently available or likely. Momentum for a public reporting law has also been building, and may also eventually lead to a mandate through legislation. Present at the meeting was the DPH attorney and the DPH legislative representative to answer questions for members.</p>		Lauren Lorentzson	
HAI Plan Revision Subgroup	Melissa Tobin-D'Angelo	Subcommittees are meeting and revising. The plan is to be distributed to all members for review before the website is updated. It was suggested that the surveillance section should be updated or deleted. Additional sources for stakeholder members were discussed. It was noted that the purpose of reporting was not outbreak surveillance, and that outbreaks would be detected by other means. Alignment of our surveillance with CMS requirements would be beneficial, and reduction of overlap of reporting demands from DPH and QIO, etc., was emphasized. It was decided that our official acronym will be HAIAC.	Continue revisions to plan via subgroups and update full committee at next meeting	Teresa Fox Melissa Tobin-D'Angelo Matthew Crist	January, 2012
Open Discussion	Teresa Fox	None			
Next Meeting	Teresa Fox	Next meeting is to be scheduled.	Proposed 2012 meeting schedule to be sent with minutes	Teresa Fox	November, 2011
Adjournment	Teresa Fox	Meeting was adjourned at 1:20 PM.			

**Georgia HAI Advisory Committee Meeting (GHAIAC)**  
**April 27th, 2011**  
**Children’s Healthcare of Atlanta, Atlanta, GA**

**Attending HAI Advisory members,** Renee Watson, Denise Flook, Cyndra Bystrom, Cindy Prosnak, Mary Key, Nancy White, Steven Marlowe, Denise Leaptrot, James Steinberg, Lynn Reynolds, Kate Arnold, Jesse Jacob, Armando Nahum

**Not present HAI Advisory members:** Henrietta Smith, Susan Ray, Nimalie Stone, Robert Jerris, Marcia Delk, John McGowan, Craig Smith

**Public Health Adhoc members present:** Teresa Fox, Lauren Lorentzson, Melissa Tobin-D’Angelo

**Committee meeting guest:** Beth Morrow (representing Marcia Delk)

Agenda Item	Presenter	Discussion	Recommendation	Responsible Person(s)	Date for completion or Update
Welcome and Call to order	Melissa Tobin-D’Angelo	Called to order at 9:20 am			
Minutes	Teresa Fox	Minutes presented and approved without corrections	None		
Introductions	Melissa Tobin-D’Angelo	New Member representing patient consumer, Armando Nahum. Ariane Reeves, Margaret Cousart, Cherie Drenzek and Mike Brown resigned due to resignations and/or retirement.	Members to submit names with bios to committee for consideration	Melissa Tobin-D’Angelo Teresa Fox	July 2011
On the CUSP: HAI Initiative	Denise Flook	Discussed the national collaboratives to reduce BSIs and CAUTIs and culture of safety, a major component of the collaboratives. The first BSI cohort will end in Sept. GHA will oversee the existing cohorts. It will work with the QIO to recruit new hospitals into Stop BSI as part of the 10th Scope of Work. The first cohort CAUTI is enrolling (32 hospitals enrolled). Much interest has been exhibited by facilities. The targeted audience is small, rural facilities; however any hospital may join. GHA will be focusing in their next scope of work on “Eliminating Preventable Harm”. New state goals will be established and 6 collaboratives will be forming, two of which are Stop BSI and Stop CAUTI.  GHA, Public Health and the QIO will be working very closely in present and future collaboratives. Hospital trustee education on patient safety has been provided and will continue through the GHA Trustee Education program. Participation in CUSP varies by state. Georgia is in the top 5 of the participating 30 states. Georgia rate has been decreased within the collaborative by 50%. GHA is to co-author an article about the Georgia experience with Dr. Provonost. Consumer representative commented that educating the public is essential to reducing HAIs. Education should be provided to community and orient family and patients	Update committee as needed	Denise Flook	Ongoing

		on admission on how to prevent infections.			
LTC Collaborative	Cindy Prosnak	Three 2-day LTC infection prevention trainings have been conducted. A LTC needs assessment was conducted prior to training sessions. To evaluate instruction effectiveness, a pre and post-test was administered. Significant changes between pre- and post-test scores were observed, with the greatest change occurring in the third session.	Continue to assess the needs and training opportunities for this LTC project	Nimalie Stone Teresa Fox Cindy Prosnak Melissa Tobin- D'Angelo	Ongoing
NHSN Enrollment	Teresa Fox	NHSN enrollment continues to increase. Presently, the NHSN enrollment stands at 112. The recruitment for G-SNUG continues to be very low at 3. Anonymous participation is now available.	Continue to recruit for NHSN and G-SNUG	Teresa Fox Nancy White	Ongoing
Funding for HAI Activities	Melissa Tobin- D'Angelo	Briefly outlined submitted HAI funding for sustaining program	Submitted to CDC	Teresa Fox Melissa Tobin- D'Angelo	July, 2011
QIO 10 <sup>th</sup> Scope of Work CMS	Cindy Prosnak	This scope of work (SOW) will begin in August 2011 and continue over the next three years. The 10th SOW will have a greater HAI focus on acute care facilities; however some LTC activities are also addressed. The QIO will be recruiting hospitals that have BSIs rates of 1.5 or greater. The QIO cannot presently identify facilities for resource focus due to lack of available data. Facility individual rates/SIRs are not currently available to the state or the QIO. Facility recruitment is not to overlap with the CUSP project currently underway by GHA, although the QIO can continue the work with those facilities after the GHA CUSP project is completed. Cindy Prosnak will be sending a short questionnaire asking hospital-based GIPN members to voluntarily provide information about their facilities' CLABSI rates and reporting format. As part of the 10th SOW, learning and action networks in communities across the state will be created.	Administer questionnaire and provide results in aggregate form to the committee	Cindy Prosnak	July, 2011
Committee Membership and Structures	Melissa Tobin- D'Angelo	Discussed committee membership and structure including adding local Public Health and Facility Regulation representatives. Discussed the need for a mission statement, charter, guidelines and by-laws for making decisions. Discussed creation of a co-chairperson position outside of Public Health to provide leadership and help drive the content of meetings.	To form sub-committee to review and make recommendations for committee membership, terms, charter, co-chairperson and process for representative replacements	Melissa Tobin- D'Angelo  Teresa Fox	July, 2011
CDC Validation of CLABSI Reporting	Kate Arnold	Longitudinal surveillance data are important to show trends. For example, BSI rates were decreasing prior to mandatory reporting, and continue to decrease; but the longitudinal data shows that mandatory reporting is only one factor contributing to the falling	Update CSTE proposal status	Katie Arnold	July, 2011

		<p>rates. Over 4500 hospitals are now reporting CLABSIs to NHSN, compared to less than 500 in 2006. This rapid change in reporting, with many inexperienced reporters, is one of several factors that could affect NHSN data quality, and data validation is needed to ensure continued high quality .Another example is potential error associated with electronic capture of denominator data, making it advisable to compare electronic and manual data before relying on electronic data. In addition, there may be under-or over-reporting of infections due to misunderstanding or inappropriate application of NHSN definitions. Unfortunately, external validation of NHSN data by the SHD is not possible in GA at this time because the SHD does not have access to NHSN data (few facilities have joined GSNUG and conferred rights to CLABSI data, even though this will largely be public through CMS "hospital compare"), and ARRA funding was not provided to GA for this purpose. Other states have been conducting validation projects and helping facilities to improve their performance. Facilities can conduct a form of "internal validation" by running NHSN reports on a monthly basis to look for missing, inconsistent, or implausible data reported to NHSN. In addition, CMS will be validating CLABSI data among hospitals participating in the IPPS system, along with other quality indicators but CLABSI data will not be validated until beginning January 2012. CMS will validate 800 preselected hospitals (nationwide) per year, by requesting line lists of positive blood cultures from ICUs, and requesting a select number of charts for review based on these lists. It is unclear whether our inability to validate reporting will increase problems for GA hospitals under IPPS. The Point-prevalence survey being conducted by the GA EIP may be one opportunity for hospitals to self-validate. Nineteen facilities are now enrolled, 25 are needed. EIP will continue to recruit for project within the Atlanta Metro Area. Data collected by this project will provide an opportunity for participating hospitals to see how their reporting compares with findings of the EIP team, in a non-punitive situation.</p> <p>The Council of State and Territorial Epidemiologists (CSTE) will vote on a proposal this summer to make CLABSIs in ICUs nationally notifiable via NHSN. The proposal will be presented to the CSTE membership during the 2011 CSTE Annual Conference for a vote. Most states will adopt what CSTE votes for, but GA is not obligated to do so.</p>	Update validation as needed		
State Health and Human Services legislative Committee	Teresa Fox	List of legislators were provided to committee for review. Discussed inviting legislator as a non-voting or one-time visitor to relevant meeting.	Consult with PH legal office about inviting a legislator	Melissa Tobin-D'Angelo	July, 2011

Open Discussion	Melissa Tobin-D'Angelo	Discussed inviting GMCF, GHA and DCH legal services to our next meeting. Discussed possible program funding opportunities including fees and fines. Discussed program successes, NHSN enrollment, needs assessments, training and the building of collaboratives. Identified gaps that need to be addressed: lack of epidemiology support to facilities, lack of access to HAI data and need for epidemiology training for districts to help with outbreak investigations. Discussed state supporting the formation of IP network, including local public health to help facilities reduce HAIs. A recommendation was made to review and revise state HAI Plan as needed.	Form sub-committee to review and make recommendations for updates to the state's HAI Plan  Contact PH legal	Melissa Tobin-D'Angelo  Teresa Fox	July, 2011
Next Meeting C	Teresa Fox	Next meeting is July 27 <sup>th</sup>			
Adjournment	Teresa Fox	Meeting was adjourned at 1:20 PM.			

**Georgia HAI Advisory Committee Meeting (GHAIAC)  
January 26th, 2011  
Children’s Healthcare of Atlanta, Atlanta, GA**

**Attending HAI Advisory members,** Renee Watson, Susan Ray, Denise Flook, Cyndra Bystrom, Cindy Prosnak, Mary Key, Nancy White, Steven Marlowe, Denise Leaptrot, Nimalie Stone, James Steinberg, Lynn Reynolds, Robert Jerris, John McGowan, Mike Brown, Marcia Delk, Kate Arnold

**Not present HAI Advisory members:** Margaret Cousart, Jesse Jacob, Victoria Nahum, Henrietta Smith,

**Public Health Adhoc members present:** Teresa Fox, Lauren Lorentzson, Cherie Drenzek, Melissa Tobin-D’Angelo

**Committee meeting guest:** Wendy Vance

Agenda Item	Presenter	Discussion	Recommendation	Responsible Person(s)	Date for completion or Update
Welcome and Call to order	Teresa Fox	Called to order at 9:20 am			
Minutes	Teresa Fox	Minutes presented and approved without corrections	None		
Introductions	Teresa Fox	New member, Dr. Melissa Tobin-D’Angelo introduced. Behazad Razavi resigned from the committee due to relocation.	None		
FY 2011 IPPS Final Rules (RHQDAPU) Updates	Denise Flook	Presented the CMS (IPPS) ruling. Discussed the impact of ruling on the reporting of HAIs in Georgia. Members were directed to the website <a href="http://hospitalcare.hhs.gov">hospitalcare.hhs.gov</a> . A flowchart was passed out illustrating how Total Performance Scores will be calculated. This is a budget neutral initiative – hospitals that perform poorly will pay fines that will then be rewarded to hospitals with better scores.	Update committee as needed	Denise Flook	Ongoing
HAI Reporting Law Update	Kate Arnold	Discussed using the current Notifiable Disease Law for reporting HAIs to the state. The positive and negative issues were discussed in using this method for HAI reporting. A statutory authority that would protect data is necessary. A law would allow GSNUG to be explicit about what hospitals can expect when they join; would allow annual reports as necessary; and will allow us to say ‘no’ to the news media if hospital infection rate data is demanded. States vary in their ability to protect data, depending on interpretation of the law. Hospital Compare publishes rates. Questions were raised concerning funding through legislation and should funding be tied to a direct resource. The state’s program is presently funded by ARRA.	Investigate funding and legislative actions for sustaining program beyond Dec. 2011	Melissa Tobin-D’Angelo Teresa Fox	Update April 2011

NHSN Reporting Update	Nancy White	Presented an update on HAI projects that are underway. Reviewed the impact of CMS ruling on IPPS facilities needing to report CLABSI data via NHSN and how it has driven the increase in NHSN enrollment for GA facilities. Updated the attendees on the GA facilities participation with the CDC dominator simplification and validation project and the upcoming 2011 HAI and Antimicrobial Use Prevalence Survey to be conducted in the 20 metro county Greater Atlanta area this summer.	Continue to promote NHSN, coordinate activities related to the HAI and Antimicrobial Use Prevalence Survey and the Denominator Simplification and Validation projects	Nancy White Susan Ray	Update April, 2011
LTC Collaborative	Nimalie Stone	Discussed planned LTC training for infection preventionists across the state. The project is a collaborative supported by CDC, the Georgia QIO (Georgia Medical Care Foundation), state and federal facility regulatory agencies, and DCH. The training sessions are to begin in February, 2011. There are 3 training sessions planned in geographically different locations across the state.	Continue to assess the needs and training opportunities for this LTC project	Nimalie Stone Teresa Fox Cindy Prosnak Melissa Tobin- D' Angelo	Update April, 2011
NHSN Enrollment	Teresa Fox	NHSN enrollment continues to increase. Presently, the NHSN enrollment stands at 102. The enrollment includes 2 children's, 6 LTAC, 2 military, 1 surgical, 1 women and 90 general hospitals. The recruitment for G-SNUG continues to be very low at 2. Anonymous participation is now available.	Continue to recruit for NHSN and G-SNUG	Teresa Fox Nancy White	Update April, 2011
ELC Funding for HAI Activities	Cherie Drenzek	Approximately 250,000 and 500,000 until 12/1/11 (ARRA and State funds). Funding requests from EIP and ELC. \$ 40,000 was proposed for a new HAI Epidemiologist 1 at the State.	Hire Epi 1 and Continue to explore resources for state HAI program	Teresa Fox Melissa Tobin- D' Angelo	Update April, 2011
Collaborative I CLABSIs – CUSP	Denise Flook	The CUSP Collaborative was described. Four cohorts in Georgia. Each unit's workers are responsible for their own rates, rather than being told their rates by a QI or ICP. MHA (Michigan Hospital Association) collects the data. It was emphasized that it is possible to have zero CLABSIs, and that in fact four hospitals in Georgia reported none for 12 months. The next initiative is to start CAUTIs, and there will be conference calls on February 3 <sup>rd</sup> and March 2 <sup>nd</sup> . Members were referred to the website <a href="http://ontheCUSPHAI.org">ontheCUSPHAI.org</a> . A challenge will be issued to Georgia hospitals to eliminate preventable harm. It was emphasized that risk adjustment is vital.	To continue to recruit and apply national guidelines and checklists CLABSI and CAUTIs	Denise Flook	Update April, 2011
Collaborative III CDI	Mike Brown Marcia Delk	NHSN surveillance definitions were reviewed. The collaborative's preliminary meetings were convened on 1 <sup>st</sup> , December 20 <sup>th</sup> of 010. Inaugural meetings to be held February 7 <sup>th</sup> with 12 representatives from nursing homes and Wellstar. Goals include a common definition and surveillance method for LTC facilities; follow-ups	Update on collaborative at next meeting	Marica Delk Mike Brown	Ongoing

		to be reported to the HAI committee; to go statewide. Concern was expressed over problems with C. diff being created in hospitals and transferred to nursing homes. The need to educate physicians, nurses, nursing homes was discussed, including the possibility of creating a PDF that can be downloaded at bedside. Problems with C. diff diagnosis and slacking MRSA education were discussed. It was suggested that groups share the protocols they are using – a sample of 2 or 3. The possibility of forming a ‘care transitions group’ was discussed, with lessons learned throughout the state disseminated and validations made on strategies that work. The “Tactical Toolkit” was described. ASM guidelines refined diagnosis. It was suggested that all patients with diarrhea be immediately isolated. An EIP C. diff project is ongoing. Improperly cleaned equipment is often taken from one patient’s room to another as needed, and this can be prevented with a strategy called “Wipe Your WOW,” ‘workstation on wheels.’			
GIPN Mentoring Program	Henrietta Smith	Tabled			Update April, 2011
Public Health Website	Teresa Fox	Presented new DCH HAI website improvements. Discussed proposed communication project with the CDC	Continue to work with CDC communication project	Melissa Tobin-D’Angelo Teresa Fox	April 2011
New Business	Teresa Fox	A recommendation was made that the committee consider inviting a legislator that serves on the Health and Human Services committee. It was suggested that we solicit the local GIPN and APIC Chapters to get involved in contacting their representatives. Investigate methods to promote our group to the legislative and community. Should we increase the consumer presence on the community? Investigate method of producing a state-wide antibiogram. Discussed mechanism to fill a member's position if they needed to give up their responsibility for any reason, and if the membership should be rotating or stable? Discussed formalizing the structure of the committee ---would it include chairperson. Membership and committee structure discussion to be continued at next meeting	List of state healthcare legislator committee  GIPN and APIC involvement  2011-2012 Discussion of committee members  Membership and committee structure  Explore statewide antibiogram	Teresa Fox  Cindy Prosnak Teresa Fox  Melissa Tobin-D’Angelo Teresa Fox  All members  Teresa Fox Melissa Tobin-D’Angelo	April, 2011  April, 2011  April, 2011  April, 2011  April, 2011
2011 Meeting	Teresa Fox	Next meeting is April 27 <sup>th</sup> at Children’s Healthcare of Atlanta			

Calendar		Office Park.			
Adjournment	Teresa Fox	Meeting was adjourned at 2:30 PM.			

## **Brief Summary of September 22, 2010 HAI Advisory Committee Meeting**

At the second quarterly Advisory meeting, the committee discussed the impact of the CMS (IPPS) ruling on the reporting of HAIs in Georgia. The previously selected HAI 5-year targets were discussed and the committee decided to keep the CLABSIs target as stated and to revisit the SSIs targets when the CMS selected surgical procedures are determined. The committee decided to mirror the Georgia's targets to the required elements by CMS. Based upon the CMS "de facto" public reporting ruling, the committee tabled the possible transparency legislation until the impact of this ruling is determined. The committee expressed concern that the infection prevention resources within the state were limited and the new CMS reporting requirements will exceed the resources. (The committee had previously requested a needs assessment be conducted to measure the resources and impact of public reporting.) Thus, two Infection Prevention Needs Assessments were presented, discussed and approved for distribution. The assessments will be used in resource development. Georgia's Advisory Committee continues to support statewide HAI reduction collaboratives, including the long term care infection prevention training (GMCF, state and federal facility regulatory agencies, and CDC), Georgia Infection Prevention Network (GIPN) mentoring program, the Team STEPPS MRSA Reduction (GMCF), and the **ON THE CUSP: Stop BSI and UTI** (GHA).

**Georgia HAI Advisory Committee Meeting (GHAIAC)**  
**June 30<sup>th</sup>, 2010**  
**Georgia Hospital Association Educational Center, Marietta, GA**

**Attending HAI Advisory members:** George Chastain (Margaret Cousart), Renee Watson, Susan Ray, Denise Flook, Craig Smith, Cyndra Bystrom, Cindy Prosnak, Marcia Delk, Mary Key, Victoria Nahum, Nancy White, Henrietta Hardnett, Jesse Jacob, Steven Marlowe, Denise Leaprot, Nimalie Stone, James Steinberg, Lynn Reynolds (via teleconference)

**Not present HAI Advisory members:** John McGowan, Behzad Razavi

**Public Health Adhoc members present:** Kate Arnold, Arianne Reeves, Jessica Garcia, Teresa Fox

**Committee meeting guest:** Sophia Henlon

Agenda Item	Presenter	Discussion	Recommendation	Responsible Person(s)	Date for completion or Update
Welcome and Call to order	Kate Arnold	Inaugural meeting of the GHAIAC called to order at 9:15 am			
Minutes		Stakeholder's meeting minutes (12/2/09) distributed prior to meeting	No corrections requested		
Introductions and Ice Breaker	Teresa Fox	Committee member introductions. Draft bio-sketches and contact information distributed. Plan is to post bio-sketches on DCH website, unless member requests otherwise.	Each member to read and provide corrections to bio-sketch as needed, to Teresa	Members	7/22/10
			After updates, bio-sketch will be emailed to each member for final approval	Teresa Fox	8/6/10
Background: Surveillance and Reporting of HAI	Kate Arnold	Highlights: <ul style="list-style-type: none"> <li>• Definition, scope, and major types of HAIs.</li> <li>• Changing paradigms in HAI prevention and control with federal and state initiatives and advent of public reporting laws.</li> <li>• Overview of Georgia HAI Prevention Plan (<a href="http://health.state.ga.us/pdfs/epi/hai/HAI%20Plan_GA_final%20122209.pdf">http://health.state.ga.us/pdfs/epi/hai/HAI%20Plan_GA_final%20122209.pdf</a>)               <ul style="list-style-type: none"> <li>○ Use of CDC's National Healthcare Safety Network (NHSN) surveillance system</li> <li>○ Chosen initial HHS metrics and targets for GA:</li> </ul> </li> </ul>	Forward copies of slide presentation to all members of committee	Teresa Fox	7/8/2010  Completed

		<ul style="list-style-type: none"> <li>▪ CLABSI (NHSN)</li> <li>▪ Selected SSIs (NHSN)</li> <li>○ Existing prevention collaboratives <ul style="list-style-type: none"> <li>▪ GA Hospital Assn: “CUSP:Stop BSI” for the prevention of CLABSIs</li> <li>▪ GA Medical Care Foundation: “Team STEPPS” for the prevention of MRSA</li> </ul> </li> <li>• Draft CMS Rule: for FY 2013, CMS hospital performance scores will include HAI rates. Medicare payments to hospitals will be based on reporting to NHSN of CLABSIs in ICUs, beginning Jan 2011. It is anticipated that reporting of SSIs will be added the following year. <ul style="list-style-type: none"> <li>○ This creates a “fiscal mandate” for HAI reporting in GA</li> </ul> </li> <li>• Advisors expressed a desire to harmonize any state requirements with other reporting requirements such as the CMS rule</li> </ul>			
Georgia HAI Plan/ CDC Technical Review  Georgia HAI	Kate Arnold & Teresa Fox	<p>Georgia HAI Plan written following December 2009 Stakeholders’ Meeting and submitted to CDC before January 2010. Four sections:</p> <ul style="list-style-type: none"> <li>• Develop/enhance HAI program infrastructure <ul style="list-style-type: none"> <li>○ <i>Establish leadership (GHAIAC)</i>; a 21 member multidisciplinary group of healthcare providers, healthcare consumers, physicians, epidemiologists, and Infection Preventionists from across the state of GA. Included with the group is representation from professional infectious diseases physicians, infection prevention organization, healthcare purchasing, GA QIO and GHA, consumer and CDC.</li> </ul> </li> <li>• Surveillance, detection, reporting and outbreak response <ul style="list-style-type: none"> <li>○ <i>Prevention targets chosen at stakeholders’ meeting reviewed</i> (CLABSI: GHAIAC advisors voiced preference for CLABSI in ICUs only; selected SSIs (hip and knee prosthesis and abdominal hysterectomies).</li> <li>○ Discussion of Spinal fusion and cardiac procedures in order to accommodate pediatric facilities and additional acute care facilities. Committee will review SSI procedure inclusions after CMS rule clarifies required SSI reports for 2012, to allow</li> </ul> </li> </ul>	<p>Plan submitted January, 2010</p> <p>Plan provided to advisors via email prior to meeting</p> <p>Multidisciplinary membership has been Completed. (Attached membership roster)</p> <p>Hire experienced ICP as the state’s HAI Program Director</p> <p>Review SSI procedures selection at next meeting.</p>	<p>Kate Arnold &amp; Teresa Fox</p> <p>State</p> <p>Full membership</p>	<p>Plan accepted by CDC</p> <p>Completed April, 2010</p> <p>March, 2010</p> <p>September, 2010</p>

		<p>harmonized reporting requirements</p> <ul style="list-style-type: none"> <li>○ Transparency in SSI reporting must include provisions for standardized definitions and post-discharge surveillance criteria, standardized risk adjustment</li> <li>○ ICP training and workforce development issues were discussed.</li> <li>○ <i>Improve outbreak investigation and reporting</i>, HAI Surveillance Training for district and local public health departments will be provided to encourage involvement in HAI reduction activities. HAI Surveillance Program Director is working in conjunction with GMCF, State Regulation and CDC to design educational conferences to assist healthcare providers, regulators and public health staff with basic infection control and prevention activities to be conducted via WebEx and on-site presentations</li> <li>○ NHSN and G-SNUG Training will be available during the GIPN Annual Conference in October, 2010</li> </ul> <ul style="list-style-type: none"> <li>• <i>Prevention</i>: No ARRA funding was made available for new prevention collaboratives, but state is exploring potential for C.diff community collaborative if resources become available AND collaborating to train LTCFs in prevention <ul style="list-style-type: none"> <li>○ Continue GHA and GMCF collaboratives to prevent CLABSI and MRSA</li> </ul> </li> <li>• <i>Evaluation, oversight and communication</i>: CDC Technical Review, strengths and recommendations were presented, and generally positive.</li> </ul>	<p>Request work group to recommend appropriate risk-adjustment of rates.</p> <p>Design, develop and implement training activities presently for LTCF and state public health workforce staffers</p> <p>Design, develop and provided educational opportunities involving NHSN and G-SNUG to ICPs at conference</p>	<p>Teresa Fox</p> <p>Teresa Fox Kate Arnold Nimalie Stone Cindy Prosnak</p> <p>Teresa Fox Ariane Reeves Katie Arnold Nancy White Gloria Morrell (CDC)</p>	<p>September, 2010</p> <p>Ongoing</p> <p>October, 2010</p>
NHSN Reporting Update	Teresa Fox	<p>2010 Goals Update:</p> <ol style="list-style-type: none"> <li>1. To double NHSN enrollment and reporting of central line-associated bloodstream infections (CLABSIs) among GA hospitals (from 14 hospitals to 28 or more) by 2011. <ol style="list-style-type: none"> <li>a. Between January and June 2010, active reporting to NHSN had grown from 8 to 44 GA facilities, according to CDC</li> <li>b. EIP and DCH have been providing training thumb</li> </ol> </li> </ol>	Update NHSN and G-SNUG enrollment; continue to encourage participation and resource development	Teresa Fox Nancy White	Ongoing

		<p>drives for new and existing NHSN users to enhance sign-up, use and standardization of NHSN definitions.</p> <ol style="list-style-type: none"> <li>2. To achieve GA-State NHSN Users' Group (G-SNUG) participation among 50% of NHSN hospitals (from zero to 14 or more) by January, 2011. <ol style="list-style-type: none"> <li>a. No hospitals were reporting to G-SNUG, primarily because protections were not in place to protect raw data from Open Records Act Requests.</li> <li>b. CDC/NHSN are developing a means by which facilities in non-mandate states like GA can report anonymously to the State Users' Group</li> <li>c. GA DCH leadership are considering establishing a reporting law to provide state HAI epidemiologists access to HAI data.</li> </ol> </li> <li>3. Presently, only Acute care facilities are being asked to report, but in the future other types of facilities may be included (i.e. Ambulatory Care Centers, LTCF and Dialysis).</li> </ol>			
Collaborative I CLABSI – CUSP	Denise Flook	CUSP-Stop BSI collaborative has achieved much success in participating units during 2010 and is recruiting a new cohort for 2011. The goals for the collaborative are to eliminate CLABSI (state mean < 1/1000 device days with a median of zero), to improve safety culture by 50% and to learn from one defect per month. The focus of the project is unit based. The project focus for 2010 was the insertion of the line, but in 2011 the focus of the project will include maintenance and accessing the line after insertion.	To continue to recruit and apply national guidelines and checklists to the CLABSI process	Denise Flook	Ongoing
Collaborative II LTCF educational Activities	Cindy Prosnak	Joint venture between GMCF, DCH, CDC and state regulators for the education of LTCF ICPs, state surveyors, and local public health on infection control in LTCFs. The educational program is under development and the first presentation is scheduled for September, 2010 GMCF also heads an MRSA prevention collaborative: Team STEPPS.	Update on collaborative	Cindy Prosnak	Ongoing
Collaborative III CDI	Kate Arnold & Marcia Delk	Discussed a possible C.diff collaborative involving WellStar Hospitals and associated LTCFs in Atlanta. Discussions have involved CDC investigators, state facilitators, WellStar leadership, LTCF specialists, and GMCF QIO coordinators	Update on collaborative	Kate Arnold	Ongoing
EIP Project	Susan Ray	EIP not discussed due to time restrains	To be presented at next		

			meeting		
CMS Proposed Rules	Denise Flook	Discussed anticipated impact on GA hospitals of the proposed CMS regulations regarding the reporting of HAIs for annual payment (Reporting Hospital Quality Data for Annual Payment Update- RHQDAPU). There is uncertainty over specific details of the rule. Committee wants to review GA selected SSIs reportable after CMS publishes its selected surgical procedures. This information is expected in August, 2010.	To continue to monitor and update committee on the new CMS proposed payment guidelines	Denise Flook	September, 2010
Georgia Draft HAI Reporting Law	Kate Arnold	DCH Leadership has requested that DCH with the advice of the GHAIAC actively investigate and formulate draft legislation concerning HAIs for the next general session of the GA legislature. A draft law was distributed and reviewed section by section. Advisor comments and suggestions included: 1) make law concise 2) include protections from use for civil suits, 3) include resources for validation of data, 4) include resources for ongoing NHSN training due to workforce turnover 5) recommended a needs assessment (TBD at GIPN). The committee recommended that DCH create a work group to review and make recommendation in drafting the new law. Work group to provide update at next meeting.	Design and administer ICP Needs Assessment  Meet with DCH and GHA lawyers.  Create legal work group of committee for drafting the HAI Reporting Law	Teresa Fox  Kate Arnold, Teresa Fox  Group	October, 2010  August, 2010  September, 2010
Work groups	Teresa Fox	Presented a list of possible work groups that may be needed: there were 4 initially work groups identified: Reporting format, legislative, collaborative activities, and risk-adjustment of data. Volunteers for each work group were requested.	Work group membership will be addressed and available for next meeting	Teresa Fox	September, 2010
Next meeting	Teresa Fox	Consensus decision to hold full-day quarterly meetings on Wednesdays. Members asked to send a representative, if unable to attend. GHA and Children's Hospital of Atlanta volunteered to provide meeting space.	Set up next meeting and prepare a proposed meeting calendar for the rest of 2010 and for 2011	Teresa Fox	2 <sup>nd</sup> Meeting scheduled for September 22, 2010 at CHOA Tullie Circle
Adjournment	Kate Arnold	Meeting was adjourned at 3:15 PM.			