

What's New with the SHARP Unit

Recent CRE Publication

Michigan was honored to publish their baseline surveillance data in *Infection Control and Hospital Epidemiology*, Special Topics Issue: MDROs and CRE. The Original Article titled, *Statewide Surveillance of Carbapenem-Resistant Enterobacteriaceae in Michigan*, was electronically published in March 2014 (*Infect Control Hosp Epidemiol* 2014;35(4):342-349).

Summer Intern

The SHARP Unit welcomes Xiaotong Liu this summer for a student internship. She is a current MPH student at the University of Michigan School of Public Health and will be assisting the SHARP Unit with data analysis.



In this issue

Drug Diversion P.1

What's New with SHARP

NHSN Surveillance Update P.2

National Progress Reports

CRE Update P.3

State Progress Reports

MRSA/CDI Update P.4

Save the Dates and Links

Drug Diversion in Health Care Professionals

According to the United States Drug Enforcement Administration (DEA), drug diversion is defined as the use of prescription drugs for recreational purposes. It involves diverting medically necessary prescription medication from those who need it to those who will use it illegally. While drug diversion is not a new phenomenon, States are reporting a significant increase in the problem, specifically for those in the medical community.

In December 2013, a Michigan nurse was found dead and a physician was found in cardiac arrest. They were separate incidents which happened on the same day in the same hospital system; both are linked to drug diversion. Healthcare workers that resort to drug diversion can endanger thousands of unknowing patients. While the impact of these two incidents is unknown at this time, nearly 8,000 people in eight states including Michigan were notified to seek hepatitis testing after David Kwiatkowski, a traveling hospital technician, was caught injecting himself with patients' pain medicine and refilling the syringes with saline. He infected at least 46 with hepatitis C, mostly in New Hampshire.

USA Today reviewed government data and independent studies on drug use among health care practitioners. They found that it is a pervasive problem, with an average of 103,000 healthcare professionals abusing or dependent on illicit drugs. It is an easily hidden problem, with safeguards to detect and prevent drug abuse rarely employed. Finally, it is poorly policed, with many states lacking rules to ensure that medical facilities alert law enforcement or regulatory agencies if they catch employees abusing or diverting drugs.

Abusing any drug is a violation of most health systems' policies. Yet many times there are no practices in place to monitor and enforce such policies. We should all be aware of this problem—it does happen. If you suspect drug diversion is occurring in your area, please report it to your administration. —Noreen Mollon, MollonN@michigan.gov

Sources: http://www.mlive.com/news/ann-arbor/index.ssf/2014/04/police_u-m_doctor_overdosed_on.html
<http://www.usatoday.com/story/news/nation/2014/04/15/doctors-addicted-drugs-health-care-diversion/7588401/>



CDC National HAI Progress Reports

The CDC recently released the National and State Healthcare-Associated Infections Progress Report, detailing national and state-by-state summaries of HAIs. Data were provided by CDC's National Healthcare Safety Network (NHSN) from over 12,500 hospitals nationally.

The National and State HAI Progress Report was created to be a reference for anyone looking for national and state HAI prevention progress. It was designed to be accessible to many audiences, and provides a technical appendix for detailed statistics and references.

On the national level, the report found a 44% decrease in CLABSIs between 2008 and 2012 as well as a 20% decrease in infections related to 10 surgical procedures in the same time frame. From 2009 to 2012, there was a 3% increase in CAUTIs nationally.

Baseline data were collected for MRSA bloodstream infections in 2011, and a 4% decrease was found between 2011 and 2012. Baseline data were also collected for hospital-onset *C.difficile* infections in 2011, and a 2% decrease was found in 2012 from 2011.

...state-specific reports
cont. on pg. 3



NHSN Surveillance Update

2014 again brings changes within NHSN. The March 2014 NHSN eNews lists the updates which should be reviewed by NHSN users as you are able. A few of these updates are listed below:

- Starting July 1, 2014, acute care facilities must begin reporting the Medicare Beneficiary Number (MBN) for Medicare patients. This MBN must be entered on all **event** records but it is not yet required to be entered on procedure records (SSI) at this time.
- Ambulatory surgical centers must begin reporting healthcare personnel influenza summary data via NHSN for the 2014-15 flu season beginning on October 1, 2014 and ending on March 31, 2015. Data must be entered by May 15, 2015.
- Migration to the Secure Access Management Systems (SAMS) began in late 2013, and is expected to be completed in 2 years. Current users of NHSN who are using a digital certificate will be **invited** through an email from CDC to become 'SAMified'. Follow CDC email instructions and provide requested identity documentation to complete the process. Each individual user must be SAMified (no sharing). New users of NHSN will be invited to use SAMS immediately upon registration without going through the digital certificate process.
- The new MDRO & CDI LabID Event Calculator is available and ready for use at <http://www.cdc.gov/nhsn/labid-calculator/index.html>. This is a web-based tool that is designed to help users learn how to accurately apply the MDRO & CDI LabID Event algorithms and assist in making the correct MDRO & CDI LabID Event determinations. This should be helpful to new users of this module.
- CDC cautions NHSN users about the criteria for determining whether an infection is considered to be Present on Admission (POA) or an HAI for NHSN reporting. Please check the March 2014 newsletter for tips, as well as an example for illustration purposes.
- Remember that your facility's CDI test type must be updated every quarter. This information has been added to the MDRO/CDI Module's summary data screen. Additional information regarding this is included in the March eNews from CDC.
- If you are having problems knowing whether to count observation patients in your FacWideln Patient Days and Admissions, please refer to the eNews from CDC at the top of page 9. This will help you determine whether to include these patients in your counts or not.

Lastly, remember that the MDCH SHARP Unit conducts a monthly conference call for NHSN users. This is on the 4th Wednesday of each month at 10:00 a.m. and generally lasts about one hour. Anyone is welcome to participate or listen in. An agenda and call-in instructions are posted on the SHARP HAI website at www.michigan.gov/hai. Click on "Next Call" under "Monthly Michigan NHSN Users Call and NHSN Updates" on the home page for this information.—Judy Weber, WeberJ4@michigan.gov

CRE Surveillance and Prevention Initiative

CRE Prevention in Michigan – We are making progress!!

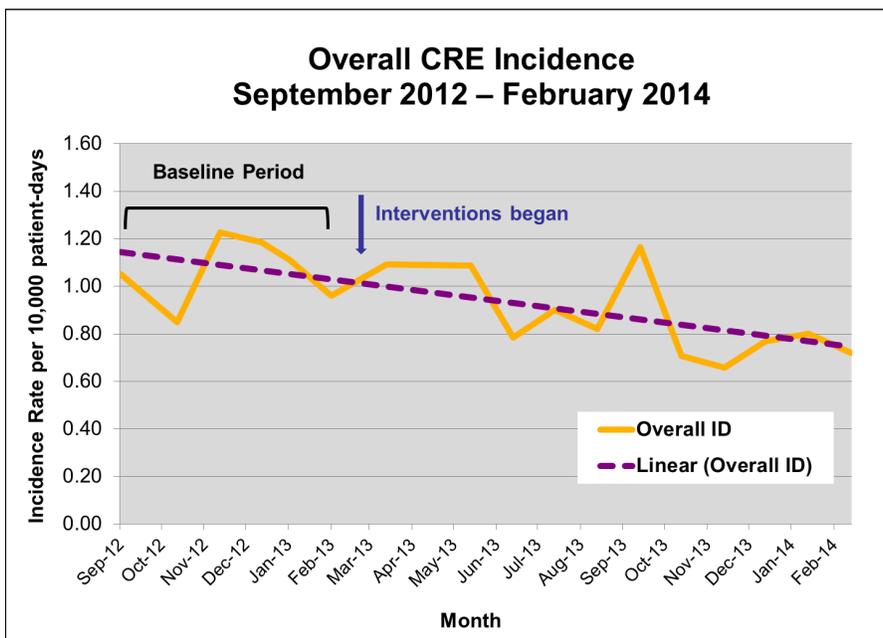
Since the CRE Surveillance and Prevention Initiative began, Michigan was able to determine a statewide baseline incidence rate for CRE which was previously unknown (1.07 cases per 10,000 patient-days). By implementing CRE Prevention measures and creating awareness around the state, Michigan decreased the CRE incidence rate to 0.88 cases per 10,000 patient-days (as of 4/29/14). Facilities participating implemented various CRE prevention plans focusing on everything from education and compliance with contact precautions, to implementing screening for populations at risk and the creation of physician-specific reports detailing carbapenem prescribing practices. Michigan's CRE Surveillance and Prevention Initiative, in which 21 acute care and LTAC facilities participate, was able to prevent 51 infections of CRE. In the 4 LTAC facilities alone, 19 infections of CRE were prevented.

CRE Partners in Prevention

The CRE Surveillance and Prevention Initiative held a quarterly *CRE Partners in Prevention* call on March 19th. During the call, one facility discussed the establishment of clinical alerts for physicians to order screening cultures for all patients admitted from LTACs. They also discussed their experience with launching an extensive CRE educational campaign within their facility. Another facility discussed how they monitor and promptly remove unnecessary devices from their patients as well as their facility-wide education efforts. The *CRE Partners in Prevention* call is an opportunity for facilities to collectively share and discuss experiences, lessons learned and best-practice approaches to CRE prevention.

CRE Surveillance and Prevention Initiative Expansion

The CRE Surveillance and Prevention Initiative was successful at maintaining enrollment of all 21 facilities. In addition, we have enrolled 7 new facilities to join us. Phase 1 of the initiative will be ending in August 2014. Phase 2 begins September 2014 and will continue through February 2016. The next phase will have a heavier focus on regional collaboration and partnerships. Meetings will be held to assist facilities across the healthcare continuum better communicate status and provide smoother transitions of patient between facilities. Partners will be sharing their prevention plans with each other to create a better sense of regional collaboration. We look forward to working with all of you! —Brenda Brennan, BrennanB@michigan.gov



CDC State HAI

Progress Reports

...cont. from pg. 2

The Michigan state-specific report showed 2012 HAI data for CLABSIs, CAUTIs, and SSIs (colon surgeries and abdominal hysterectomies). The Michigan CLABSI SIR was 0.43, or 57% lower than the national baseline, and only 2% of Michigan hospitals had a SIR higher than the national SIR of 0.56. Michigan's 2012 CLABSI SIR was significantly better than the 2012 National SIR. The Michigan CAUTI SIR was 1.00, which is about the same as the national CAUTI SIR of 1.03. However, only 14% of Michigan hospitals had an SIR higher than the national SIR.

The Michigan SIR for colon surgeries was 0.86, or 14% lower than the national baseline. This was similar to the national SIR of 0.80. Only 12% of Michigan hospitals had a colon surgery SIR higher than the national SIR. Finally, the Michigan SIR for abdominal hysterectomies was 1.07, or 7% higher than the national baseline. However, only 8% of Michigan hospitals had an abdominal hysterectomy SIR higher than the national SIR.

For more information, please visit: <http://www.cdc.gov/hai/progress-report/index.html>

—Allison Murad,
MuradA@michigan.gov





MRSA/CDI Prevention Initiative Update

Events/Calendar

Please visit our SHARP Unit Calendar, found on the SHARP Unit homepage. If you would like to add an event to this calendar, please email:

MDCH-SHARP@michigan.gov

Helpful Links

www.michigan.gov/hai

www.mhakeystonecenter.org

www.mpro.org

www.mi-marr.org

www.msipc.org

www.apic.org

www.hhs.gov/ash/initiatives/hai/

www.hospitalcompare.hhs.gov

www.cdc.gov/nhsn

www.cdc.gov/HAI/prevent/prevention.html

www.cdc.gov/HAI/organisms/cre

www.cdc.gov/HAI/organisms/cdiff/Cdiff_infect.html

Phase 1

Phase 1 of the prevention initiative ended on April 1, 2014. 12 acute care and 13 skilled nursing facilities submitted their MRSA and CDI LabID events on a monthly basis. Following their submission, MDCH provided the facilities with a monthly feedback report. This report also included cost analysis of MRSA and CDI. Four webinars were provided to the participating facilities. A survey was distributed to all participating facilities. A 25-question survey for MRSA/CDI champion feedback was developed and emailed to all facility champions, plus a local public health demonstration project. There was an 88.5% response rate to this survey which investigated involvement, training and education, operation, communication and monitoring.

Champions indicated that staff and departments included in their prevention and education efforts were nursing, environmental services, nursing assistants, physician groups, and administration. Policy and procedures which had been updated since joining the initiative included healthcare worker education, cleaning and disinfection of patient/resident equipment, and contact precautions.

When the facilities were asked to describe what they found to be the most beneficial aspect of participation in the MRSA/CDI Prevention Initiative they indicated information, collaboration, networking, sharing of information, resources, educational opportunities and data sharing. One of the strongest testimonial comments was: "This has driven home the fact that we are not competitors but colleagues, and our inter-connectivity can serve to better our practices".

Phase 2

Phase 2 of the prevention has begun and we have 12 acute facilities re-committing to the initiative, and 14 skilled nursing facilities. Eleven of the skilled nursing facilities have committed to using the NHSN Long Term Care Component in reporting their data to us.

We are eager to have any acute or skilled nursing facility join our prevention initiative! The benefits include education, networking, sharing of ideas and practices, and improving patient care.

If you would like to learn more about the MRSA/CDI Prevention Initiative, please contact: Gail Denkins, MRSA/CDI Prevention Initiative Coordinator
DenkinsG@michigan.gov or (517) 241-3638

ISSUE 7 Spring 2014 (Issued May 6, 2014)

4

Jennie Finks DVM, M MPH
SHARP Unit Manager and HAI Coordinator, Michigan Department of Community Health
201 Townsend St., Capitol View Building, Fifth Floor
Lansing, Michigan 48913
Phone: (517) 335-8165
Fax: (517) 335-8263
E-mail: FinksJ@michigan.gov

