**Michigan's Healthcare-Associated Infection (HAI)
Surveillance and Prevention Plan Q&A Conference Call Transcript
March 17, 2010 at 2:00 PM**

Speakers:
Jennie Finks – Leader, Surveillance for Healthcare-Associated & Resistant Pathogens
(SHARP) Unit, Michigan Department of Community Health (MDCH)
Teri Lee Dyke – Infection Control Nurse Consultant, SHARP Unit, MDCH
Judy Weber – Hospital Liaison, SHARP Unit, MDCH
Lisa Sturm –Past-President of APIC-GD, and member of the MI HAI Prevention
Advisory Group

Finks – This is Jennie Finks for the Michigan Department of Community Health
(MDCH), Surveillance for Healthcare-Associated and Resistant Pathogens (SHARP)
Unit. Thanks to everyone for calling in today for our informational conference call on the
state HAI Surveillance and Prevention Plan. If there are any advisory group members on
the call and you would like to add to anything being said, please feel free to speak up.

Finks – We will start with a basic overview on what the SHARP Unit is, why we were
founded, and how we are funded. The Surveillance for Healthcare-Associated and
Resistant Pathogens (SHARP) Unit was formed at MDCH in early 2009, in response to
state money to focus on antimicrobial resistant organisms. In the summer of 2009 we
became aware of grant monies available though the American Recovery and
Reinvestment Act (ARRA). The specific goal of ARRA is to increase the state
infrastructure to conduct healthcare-associated infection (HAI) surveillance and
prevention statewide. The MDCH SHARP Unit did apply for and receive ARRA grant
monies. The money will fund SHARP from September 2009 till the end of December
2011.

Under the ARRA grant we have three primary objectives or activity areas. The first is
state HAI prevention coordination. This involves the formation of an advisory group,
which we had done prior to becoming aware of the ARRA grant money. Our Advisory
Group is multi-disciplinary and comprised of Infection Preventionists and HAI
prevention representatives from many agencies:
- MDCH — both the Bureau of Epidemiology and the Bureau of Laboratories
- The Michigan Society for Infection Prevention & Control (MSIPC)
- The Association for Professionals in Infection Control and Epidemiology —
  Greater Detroit Chapter (APIC-GD)
- The South Central Association for Clinical Microbiology (SCACM)
- The Michigan Antibiotic Resistance Reduction Coalition (MARR)
- The Michigan Health and Hospital Association, Keystone Center for Patient
  Safety and Quality (MHA Keystone)
- MPRO — Michigan's quality improvement organization
- The Michigan Association for Local Public Health (MALPH)
- The Michigan Infectious Disease Society (MIDS)
- A consumer representative.

We have quite a broad spectrum of folks who are well versed in infection control and HAIs in our Advisory Group. Our Advisory Group initially helped us write our Michigan HAI Surveillance and Prevention Plan. All states that received ARRA funding were required to write up a plan and submit it to the Department of Health and Human Services (HHS) by January 1, 2010. The Centers for Disease Control and Prevention (CDC) did provide a template to states; which we used. We modified it throughout to make it Michigan-specific and to say what we wanted it to say. SHARP submitted our plan to HHS in December of 2009. A copy of our plan is available on our new website (http://www.michigan.gov/hai). The plan goes over all of our goals and objectives that we hope to accomplish with this ARRA funding.

You will notice by looking quickly at that plan that nowhere does it say that we are pushing for mandated reporting of HAIs. Our surveillance and prevention objectives are strictly <u>voluntary</u>. We really want to work with hospitals and think that we can build upon the good works of the MHA Keystone project, and expand the results that they have seen in reducing HAI rates in specific units and specific types of infections. We could accomplish those same things on a voluntary basis across the state, but it does require a little more work.

Moving on, our second main activity of the ARRA grant money is to conduct surveillance. Our advisory group targeted two organisms, rather than focusing on device-associated infections. We are looking at methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* (C.difficle). We chose to conduct surveillance using the new multidrug-resistant organism/*Clostridium difficile*-associated disease (MDRO/CDAD) module of CDC's National Healthcare Safety Network (NHSN). The MDRO/CDAD module went live in spring 2009. We will be using the Lab ID Event option of the module, which means that there is no clinical interpretation required on your part. You rely on laboratory-identified cases. NHSN does an interpretation based upon date-of-admission to date-of-infection to determine if cases are healthcare- or community-onset and where the case should be attributed. We chose the Lab ID Event option because we thought it would be the least amount of work for those contributing data and would require less of your time. We do realize that IPs are already spread pretty thin.

We ask that if folks are going to contribute to our surveillance initiative that they collect a minimum of three consecutive months of data from any location (unit) of your choosing. You can pick the unit in which you would like to conduct surveillance. If you are doing surveillance with MPRO for their MRSA initiative, we would like to request that you choose a different location than the one that you're using for MPRO data. However, that is up to you.

We have a data use agreement (DUA) that we developed with our legal team here at MDCH. It thoroughly assures hospital confidentiality and that we aren't releasing any hospital names or specific locations that are contributing data to our surveillance initiative. Further, it assures that hospital data is exempt from Freedom of Information Act (FOIA) requests. It's our goal to have enough hospitals participating statewide that

we would be able to look at infection trends across the state, then hopefully be able to break that down regionally, but this will require having enough hospitals participating that we aren't inadvertently releasing any hospital's identity. For the time being we will just have a statewide trend because we are still a little low on our numbers. When we do our data analysis, our data will be hospital de-identified, aggregated, and summarized to show trends of antimicrobial resistant organisms, healthcare-associated infections, and emerging pathogen occurrence. We plan on having summary reports quarterly and those will also be posted online. Our first quarterly report has already been posted online. There isn't much data contained in it because we are still in the early stages of enrolling hospitals.

Our targets under the surveillance initiative are to have thirty (30) hospitals contributing data to us by the end of 2010. To get three (3) months of consecutive data we need hospitals enrolled and conferring rights to us within NHSN by October 1, 2010. We hope to have fifty (50) hospitals by October 1, 2011. To date, we have seven (7) hospitals that have signed the DUA, which is the first step in getting involved in our surveillance initiative. Of those seven (7) hospitals, five (5) of them have conferred rights to have us view their MRSA data, and four (4) have conferred rights to view their *C.difficile* data. The remaining hospitals have conferred rights for various other modules that they are using in NHSN. We have five (5) who have conferred rights for Central Line-Associated Bloodstream Infection (CLABSI), four (4) for Ventilator-Associated Pneumonia (VAP), four (4) for Catheter-Associated Urinary Tract Infection (CAUTI), three (3) for Surgical Site Infection (SSI), and one (1) for Post Procedure Pneumonia (PPP). This just emphasizes that, although our surveillance initiative is for MRSA and *C.difficile*, we are more than happy to look at any data that you're already collecting in NHSN that you would like to share with us. Any additional data outside our surveillance initiative goals really helps us broaden the picture and broaden our understanding on what is happening across the state. We would like MRSA data and *C.difficile* data, but are more than willing to take anything that your hospital is willing to give us.

Dyke – Because NHSN will not share any data (about how many Michigan hospitals are participating, which hospitals are NSHN participants, or which modules are being used) with us.

Finks – According to the agreement that CDC makes with each individual hospital when they sign up to use NHSN, CDC cannot tell SHARP which hospitals in Michigan are using NHSN, and they won't let SHARP see any of the data. This arrangement for data sharing has to be made between each individual hospital and the state. To participate in our surveillance initiative you do need to be a NHSN user. If you are not already enrolled in NHSN, that is the first step and we are happy to help you through and assist as much as we can.

You might ask, "Why would you want to do this? It sounds like more work than I'm already doing". The first reason is because you get to feel good that you are helping us learn what our Michigan trends are. Or you can always use this contribution to the Michigan surveillance effort as evidence that you are complying with the joint

commission standards (National Patient Safety Goal 7) that requires you to conduct surveillance for HAIs. Also, participating in this effort will give you the ability to monitor the impact of prevention initiatives that you may have going on in your individual facilities. It also allows you to compare your HAI rates to other Michigan hospitals and national level data because we use the NHSN system which has standardized definitions. The CDC and MDCH will do our very best to provide technical support that you might need for NHSN problems. We are here to offer data analysis and interpretation support. Last, but definitely not least, we are planning on providing ongoing training throughout this effort to hospitals which participate in the surveillance initiative. We hope to offer this training beyond the end of the ARRA monies as well.

The first "training" is what you're listening to right now. This is a way for us to touch base and address any issues and concerns that you might have. We are planning to have a two-part NHSN webinar training sometime in May. The webinars will focus specifically on the conferring rights procedure, the MDRO/CDAD module and analysis of MDRO/CDAD data. The webinar is going to be offered by SHARP with assistance from CDC. In fact our very own Kathy Allen-Bridson, who used to work with us at MDCH and many of you may know, will be conducting that webinar remotely from Atlanta. We are hoping in the fall of 2010 we can offer an annual conference with some hands-on NHSN training. We would like to be able to do that in the fall, and are looking at the best available dates and the best venue for the training.

The last initiative under ARRA funding is the prevention initiative. Our advisory group has directed us to focus on two existing prevention initiatives: the Michigan Health and Hospital Association (MHA) Keystone: HAI — CAUTI initiative, and the MPRO MDRO/MRSA initiative. We are looking for ways to act in support of these existing prevention initiatives and help extend the benefits of their work, without asking IPs to do more.

If you have any questions that you're not comfortable asking online feel free to contact us. Our contact information is on the website http://www.michigan.gov/hai. We will now open the floor up to people who have any specific or general questions.

Sturm – I reviewed the summary report that just came out and I want to emphasize what an added value this could be for facilities. If an institution is seeing a spike in MRSA or *C.difficil*e, that type of summary report can either validate that something is happening in the community or confirm that it is something that may just be occurring in one's institution. It is nice to have in the event your institution has a spike or increase, you can see if others in the region are experiencing one too.

Finks – We are really hoping to get enough hospitals to participate statewide that we would be able to break down rates and trends by region. In a particular region we would be able to say "southeast Michigan is having a problem with MRSA but the rest of the state is not right now" or that "central Michigan is having a little peak in *C.difficile*." You would know pretty specifically how you fit into the state picture. This will require a lot

more hospitals than are currently involved in the data collection and surveillance to participate. We are really hoping to drum up more participants.

Weber – I just wanted to mention that we put a survey on HealthWatch back in September 2009. This is one of the initial ways we were trying to get information. Through that questionnaire we are trying to get a better feel for which hospitals in Michigan are using NHSN, and which modules they are using. We really have no idea who is using NHSN because CDC cannot share that information. Also, from that survey we were trying to get some feedback on which hospitals would be interested in participating with us. Fifty-two (52) hospitals in Michigan have responded to the survey, and seven (7) of these hospitals have currently signed on with us. There are another thirty-five (35) hospitals that are interested in participating with us. After you fill out that survey, whether you are interested or are not sure if you're interested (because most hospitals have to run this through their administration), I will contact you via email or phone. I will get more information from you. If you are an interested hospital, but not currently using NHSN, I would urge you to contact CDC to get enrolled in NHSN.

SHARP's HealthWatch survey is a starting point for us to see who is interested or not interested in Michigan. Certainly those of you on the phone, if you are interested and want more information but don't want to do the survey, you can contact any of us directly and talk to us about what is to be involved. As Jennie mentioned, we are interested in the MDRO/CDAD module primarily right now. We are looking at MRSA and *C.difficile* infections. However, if you're not doing that right now and don't feel like you have the time to participate in that module, we are interested in any of the other data you are collecting. Again, we can't see any of that data, it goes directly to CDC. Until we get a signed DUA from you that says you are going to share the data with us, we cannot see any of the CDC data.

Finks – Even after you sign the DUA, you have to go into the NHSN system and do a procedure called "conferring rights." Then you would have to join our state level group and tell NHSN that it is ok to show us your data. You get to pick what we can and can't see month to month. You can choose to not share with us at any point that you feel like you have shared enough. If you have expressed interest and are on this call, but feel like there is some limitation or barrier to signing up, we would sure like to hear what those barriers are so we can work through them. Or if there are similar barriers that other hospitals/infection preventionists are facing, perhaps we can work on those together. If there is something particular holding you back, please let us know what that is.

Dyke – It seemed like getting the DUA signed was a fairly lengthy process. It didn't happen as quickly as folks thought it would. So even if you start now, expect that it will probably take a little time to run that up through the channels of administration.

Weber – We do recommend that you share the DUA with your administration and also that your legal council reviews the DUA to make sure they know what's involved in the agreement. Generally, it's been the administration signing the agreement. We need two

original copies sent back to us. I get the internal signatures here and will return one of the originals copies to you for your files.

Finks – Once you receive that copy back is when you would get on NHSN and join the group to confer rights. The procedure to get your legal team and administration signatures may take quite a while.

Dyke – If it's a health system that has multiple acute care sites, because we are starting with acute care sites, is it one DUA? Or do you need one for each of the sites?

Weber – It depends upon the hospitals. Most hospitals have chosen to do their own DUA. If a hospital is part of a system and the entire system wants to go on, that can be written into the agreement that it covers the entire system.

Finks – To date, hospitals in larger systems have been signing on as individual entities. That is something that is flexible.

Dyke – How many licensed hospitals are in Michigan?

Finks – Approximately 144

Anonymous caller – Maybe offer a webinar in regard to helping confer rights.

Finks – We are talking with Kathy from CDC. They are quite busy in Atlanta getting ready for the Decennial Conference which starts tomorrow. We're discussing what we would like to cover in that May conference. From our perspective, since we are focused on the MDRO/CDAD module, we would really like this webinar to be largely focused on the state's initiative, that is: getting hospitals to sign onto NHSN, conferring rights to SHARP within NHSN, and using this particular module. We thought we would do a quick overview on what the conferring rights procedure looks like for those of you who haven't conferred rights to MPRO, your larger hospital system, or any other group. It seems to be a confusing process for people. We will likely spend the majority of time on data entry and analysis in the MDRO/CDAD module and what that looks like from month to month. If folks have ideas on other things that would be very helpful for us to cover in the May webinar, please email one of us at the SHARP Unit to let us know. We haven't finalized anything for the webinar yet. We are still open for suggestions. Again, selfishly, we are really looking for focus on MDRO/CDAD module, but if there are things that a lot of people need help with, let us know and we can work to get that included.

Weber – In the SHARP Unit we are not experts with NHSN. We are learning the system here, too. A lot of you are probably better at it because you're entering the data. As we go along we are learning a lot from all of you from your questions. If we can't answer it, we can go to CDC to see if we can get your answers. Please keep us informed as to what your issues are.

Dyke – The two day conference in May is going to be pretty much open?

Finks – That is something that we are going to have to discuss with the Advisory Group on whether the conference is going to be open enrollment or if we need some sort of DUA. It may be only open to folks that are in the planning stages of becoming involved with our initiatives. Also, we don't know how many seats we will have available. It's our goal to have it open to everyone. We will know more and get that out to our partner organizations on the Advisory Group and our website as we decide on those details. (NOTE: It has been decided that the webinar will be open to all. It will, however, be most beneficial to those people who have some familiarity with NHSN.)

Weber - I've had conversations with several hospitals that are interested. I know some of you are new with NHSN and there is some confusion about sharing information with SHARP and with MPRO. Those are issues we are trying to work through and get answers for. I don't know if any of you on the call are considering participating. We would like to know what some of your issues are, and some questions you would like us to answer.

We kind of teased you today with the one question about mandatory reporting: What MDCH thinks about mandatory reporting and the apparent national push for it? We know that currently twenty-eight (28) states have mandatory reporting. State mandated reporting has been going on for several years; there are many states every year that pass active legislation for mandatory reporting. Twenty-one (21) of twenty-eight (28) states with mandated reporting actually have public reporting. In those states, they post individual hospital's infection rates to the public. There have been several attempts in Michigan to pass mandatory reporting, but this legislation has not gone anywhere. At the state health department, we are not promoting mandatory reporting. We feel that hospitals in Michigan are already doing a good job working with MHA Keystone and MPRO. This is not something we are pushing for. It does appear that there is a federal push to get mandatory reporting. I think this is something that you all should be aware of. It is certainly something that we are watching closely and a lot of hospitals are watching also. I just wanted to mention that because we kind of teased you with that question to get you to participate on the call. Are there any questions about that?

Anonymous caller – The first step that I would have to do is sign up with NHSN to join. I'm a "lone ranger" in a 300 bed hospital. Is there any way to estimate the time commitment with doing this?

Finks – It really depends on how much you want to use NHSN and what modules you sign up for. The initial joining of NHSN, setting up your monthly surveillance plan, and conferring rights, takes some time. There is definitely a learning curve there. I'm hoping that someone is on the call that is using NHSN on a regular basis and can answer this question. (No response). It is my understanding that how much time you spend day to day, week to week, month to month, is very much dependent on which parts of NHSN you're using, how large your hospital is, and how many of those particular types of infections you see. We appreciate that many of you are "lone rangers" and totally overwhelmed by the many tasks that you have to accomplish on a day to day basis. We

would really like for folks to be signed on with us indefinitely but if at any time it becomes something that you can't manage and need to step back from, you do have an out. If you decide to go ahead and sign on with NHSN, and confer rights to us with this particular module, and you find a month into it that it's something you can't do, we understand. We would love it if you could participate forever.

Dyke – I think IPs should try to align it with your infection prevention plan, your hospital surveillance plan that already exists. Hospitals aren't really doing anything new, just using the information that is already being collected and sharing it with a national database. The benefit is not only monitoring your own progress and rate, or impact on your rates, but the ability to compare nationally. If you participate with the SHARP, you will be able to compare on a statewide basis.

Finks – I should mention the NHSN team down at CDC is doing a lot of work on doing some electronic messaging with individual hospital's data mining tools and infection control software that hospitals are using. This will allow messaging directly into NSHN. You would be able to do downloads and uploads between your software and NHSN. This will most likely cut data entry time. Unfortunately, that technology is not available for all the parts of NHSN just yet. Nor is it available for all of the different software programs that different hospitals use. CDC is working on it and we hope things get easier in the near future for data sharing with NHSN, and therefore with us. Does anyone out there currently use the MDRO/CDAD module? No responses.

Weber – The other thing is that, I believe Jennie mentioned earlier, if you do participate in NHSN, it also helps you be in compliance with some of the new Joint Commission National Patient Safety Goals as far as doing surveillance for multi-drug resistant organisms or CLASBI and SSI. In one respect it does become a lot of work but it also helps you on the side of being in compliance with Joint Commission so you might want to think about that also.

Finks – I do want to mention that we are taking minutes during this call and do plan on typing up the Q & A and posting it on our website. If there are questions you have and are not comfortable asking on the phone, you can email one of us and we will include that question and answer without your name. We will work on figuring out a rough estimate of how much time the MDRO/CDAD reporting takes per month. Again my thought is that it's going to depend on how big of a unit you're reporting for and how many infections you have. I would say how much time you spend at it is largely up to you and dependent on your hospital data. We will work on getting a more concrete answer for that and will post it online, hopefully within the next couple of weeks. Again if you would like to ask a question either anonymously or with your name attached, please just email one of the SHARP members and we will post that question and hopefully an answer online.

Dyke – We talked a little bit about once we get a fair number of people participating with us to have the ability to have "super users" (people with a lot of experience) to share some of their tips or maybe some short cuts for data entry, creating reports, and line

listing, things like that. That is just something we are looking at down the road and to get additional assistance for training for NHSN usage.

Finks – Are there any other thoughts, questions, comments, ideas?

Sturm - I think your website is great, especially all the links and resources. You did a very nice job.

Finks – If folks on the call haven't had an opportunity to look, please go spend a little time on that website. It's not just our Surveillance & Prevention Plan and our monthly reports. We did try to make a website to hold a lot of information that you would need on a day-to-day basis all in one place. If you have any suggestions for documents or additional links that we could add to the website that would make it more useable for you, please forward that to us as well.

Andrea – I work at an LTAC (long-term acute-care) that is located inside of a hospital (NOTE: LTAC and hospital names have been removed for confidentiality). Are you looking at using our data also for infection control?

Finks – I think because you're a long-term acute care that you would technically fall under the NHSN umbrella of an acute care hospital. Yes, we would take that at this time. We are aware that HAIs are not unique to acute care and long-term acute care hospitals, and know that they are a problem in ambulatory care and in long-term care as well. However, we had to start somewhere, so we are starting with acute care facilities. We do hope that we can roll out the surveillance to ambulatory surgical centers and long-term care facilities in the future as well.

Dyke – There are also online training modules for NHSN. If you don't have any experience with NHSN and are just here listening, wondering if this is a possibility, NSHN has online training programs and modules. If you haven't looked at them, take a peek at them. It might help you to understand some of the benefits of participating.

Weber – Are there any other thoughts or questions? Is everything clear? It does get a little confusing. I must say if you haven't been using NHSN, it is a little bit confusing when you get started but it does get better. I think if someone is interested, go to that survey site. The survey is still active. We did send information out on how to link to the survey. The website is http://www.michigan.gov/healthwatch, select the survey called 'NHSN participation, 2009' and then put in the password. (NOTE: Contact Judy Weber, at weberj4@michigan.gov or at 517-335-8331, to obtain the password.)

Finks - If you would like that information emailed to you, please contact us. Thanks very much for taking the time to call in and listen today. Again, please feel free to contact us with any questions, thoughts, and ideas. We are always receptive to that. Thanks so much for calling in today.
(NOTE: The website for more information and to reach the SHARP Unit is www.michigan.gov/hai)