CDPH HAI Program Overview

San Diego APIC Chapter
San Diego
January 11, 2017

Lynn Janssen, Chief
Healthcare-Associated Infections Program
Center for Health Care Quality
California Department of Public Health

Objectives

1. Describe the CDPH HAI Program and activities
2. Discuss future HAI prevention plans
3. Seek input of APIC / infection preventionists on how public health can assist in HAI prevention

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HAI Program, Center for Health Care Quality

Created by mandate to oversee the prevention, surveillance, and reporting of healthcare-associated infections, and to:

1. Produce annual HAI public reports to support informed choices for healthcare consumers and prompt providers to take actions to prevent infections.
2. Actively engage in HAI prevention by performing site visits to hospitals, SNF, and other healthcare facilities, convening regional collaboratives, and providing education
3. Provide consultation and assistance to local public health for infection prevention and outbreaks that occur in healthcare facilities.

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Additional CDC-Supported HAI Prevention Activities

Activities	Timeframe
• HAI Program infrastructure • Antimicrobial resistance program • Dialysis BSI prevention program • Injection safety program	2014-2019
• Assessment for CA Ebola hospitals • Strengthening outbreak response	2015-2017
• Expanding healthcare assessments to build infection prevention capacity broadly	2016-2018

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HAI Program Leaders

HAI Program Leaders		Primary Responsibility
Lynn Janssen, MS, CIC, CHCQ	Chief, HAI Program	Strategy, operations, performance management, and communications
Erin Epson, MD	Assistant Chief / Public Health Medical Officer	Antimicrobial resistance prevention program and HAI outbreaks team lead
Vicki Keller, RN,MSN,PHN,CIC	Coordinator, HAI Liaison IP Program	Prevention outreach portfolio, onsite infection prevention assessments, onsite data validation (through Dec 2015 only), and annual education plan
Neely Kazerouni, DrPH, MPH	Chief, Epidemiology Unit	Epidemiology, data quality, data analysis, data management, and production of the annual HAI report
Janice Kim, MD / Jon Rosenberg, MD	Public Health Medical Officers	Outbreak investigations and response
Lori Schaumleffel	HAI Performance Coordinator	Ebola assessments and reporting, monitoring progress of grant-related performance metrics
Teresa Nelson	LTAC Liaison IP Coordinator	Outreach and prevention plans for California's 24 LTAC hospitals

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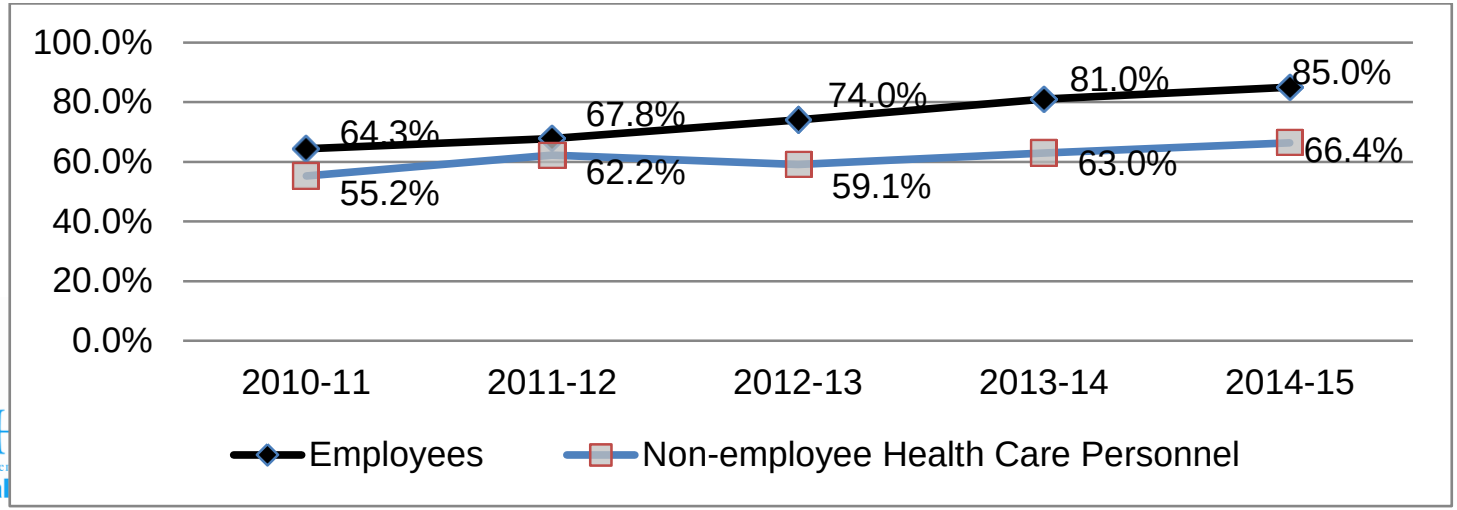
HCP Influenza Vaccination - Annual Report

- Data reported by 400 acute care hospitals to NHSN
- Published via a web page that includes report of key findings and public health actions, 5 data tables, technical report
- 2014-2015 flu season data continued to show incremental improvement in HCP vaccination rates

Figure. Influenza Vaccination Percentage by Healthcare Personnel Category in California Hospitals, 2010-2015



HAI in California Hospitals - Annual Report

- Data reported by 400 acute care hospitals (no exclusions for size) to the National Healthcare Safety Network (NHSN)
- Published via a web page that includes
  - Summary report of key findings and public health action
  - >95 data tables
  - Interactive map
  - Technical reports for each infection type

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Annual Report of HAI in CA Hospitals, 2014

Table. Numbers of Healthcare-Associated Infections (HAI) Reported by California Hospitals and Comparisons of Statewide HAI Incidence to National Baselines, 2014

	No. of HAI Reported by California Hospitals in 2014	2014 California HAI Data Compared with National Baselines*
CDI	10,588	↑ **9% since 2011**
CLABSI	2809	↓ **49% since 2008**
MRSA BSI	705	↓ **24% since 2011**
VRE BSI	782	*No national baseline*
SSI – All Surgeries	4,316	↓ **40% since 2008**
SSI – Colon Surgery	911	**No difference from 2008**
SSI – Abdom. Hysterectomy	168	↓ **20% since 2008**

**National baselines are based on surveillance data reported by U.S. hospitals to the Centers for Disease Control and Prevention's National Healthcare Safety Network.*

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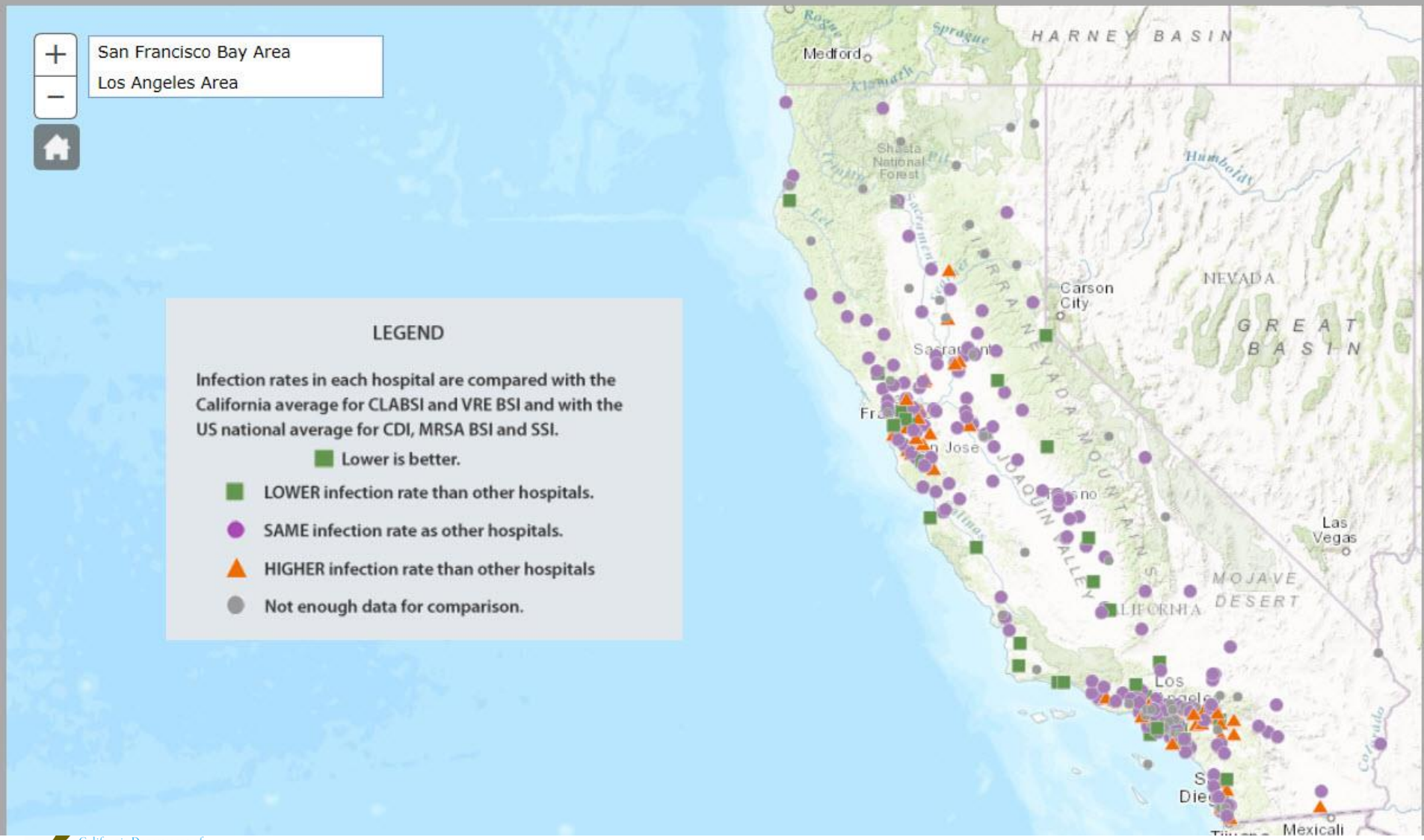
My Hospital's Infections

Search Hospital Name or City

Hospital Profile | CDI | CLABSI | MRSA | VRE | SSI

San Francisco Bay Area
Los Angeles Area



LEGEND

Infection rates in each hospital are compared with the California average for CLABSI and VRE BSI and with the US national average for CDI, MRSA BSI and SSI.

Lower is better.

- LOWER infection rate than other hospitals.
- SAME infection rate as other hospitals.
- HIGHER infection rate than other hospitals
- Not enough data for comparison.

HAI Liaison IP Program

Supervisor – Vicki Keller

Liaison IPs Northern CA –

- Terry Nelson
- Lori Schaumleffel
- Aileen de los Angeles

Liaison IPs Southern CA –

- Idamae Kennedy
- Tracy Lanier
- Zenith Khwaja

Statewide –

- Teresa Nelson – LTAC Hospitals/Injection Safety
- Sheila Segura – Outpatient Dialysis Clinics
- Hosniyeh Bagheri – Smaller Volume Hospitals

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Liaison Infection Preventionist (IP) Program

- Regionally-based Liaison IPs, highly experienced, certified in infection control and epidemiology (CIC)
- Assigned approximately 45 larger volume hospitals each
  - One Liaison IP assigned 140 smaller volume hospitals
- Conduct monthly regional calls to connect with their area hospitals and relay updates from CDPH HAI Program
- Expanding to non-hospital settings beginning in 2016
  - Skilled nursing facilities, ambulatory surgery clinics, outpatient clinics

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HAI Data for Action Strategy

- 4th year of performing outreach to hospitals with high HAI incidence as indicated in the annual public report
- 128 hospitals* with statistically high infection incidence in 2014 identified and prioritized
  - *Clostridium difficile* infection - 67 hospitals
  - CLABSI - 24 hospitals
  - Surgical site infections – 54 hospitals
  - MRSA/VRE bloodstream infections – 26 hospitals

*34 hospitals had more than one infection type with high incidence

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Liaison IP Onsite Prevention Assessments

Targeted Number of CDC-funded Infection Control Assessments (Number of infection control assessments planned for each setting type) **Jan 2015-May 2018**						
	Hospital*	**Nursing Home**	**LTAC Hospital**	**Outpatient Clinic (non-ASC)**	**ASC**	**Dialysis Center**
2015 (Jan-Dec)	90	0			0	34
2016 (Jan-June)	75	80			0	34
2016 (July-Dec)	45	60			30	34
2017 (Jan-June)	30	60			30	34
2017 (July-Dec)	45	60			30	34
2018 (Jan-May)	30	60			30	34
Total Planned	**315**	**320**	**23**	**90**	**120**	**204**
Total Completed (by 2.1.16)	**84**		**8**		**0**	**46**
Progress toward goal	27%	0%	35%	0%	0%	23%

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* Will continue data for action strategy, targeting hospitals that have high HAI incidence as indicated in public report

CDPH Lead for Coordination of Ebola Hospital Preparedness

HAI Program Coordinator - Lori Schaumleffel

- Deploy a CDPH Ebola Assessment Team to continue readiness monitoring and visit new Ebola Assessment Hospitals
  - HAI Liaison IP assigned to the facility
  - Laboratory safety specialist
  - Occupational health specialist
  - Waste management specialist
- Coordinate with Local Public Health Officer and local EMS

California Ebola Treatment and Assessment Centers

Region 9 Special Pathogens Center

- Cedars Sinai Medical Center

Ebola Treatment Hospitals

- UC Davis Health System
- UC San Francisco Medical Center
- UCLA Medical Center
- UC Irvine Medical Center
- Kaiser Permanente Medical Center – South Sacramento
- Kaiser Foundation Hospitals – Oakland & So. Sacramento

Ebola Assessment Hospitals

- UC San Diego Medical Center
- Mercy Medical Center – Redding
- Children's Hospital of Los Angeles
- Rady Children's Hospital of San Diego

California Campaign to Prevent Bloodstream Infections in Hemodialysis Patients

- 514 outpatient hemodialysis centers in California
- HAI Program staff includes a full-time Dialysis Liaison IP
- Five-year plan to provide onsite assessments and strategies to prevent bloodstream infections
  - One-day assessments of adherence to CDC prevention strategies with same day feedback
  - Webinars, website, and a one-day infection prevention class

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Core Actions to Address Antimicrobial Resistance

- **Improve antimicrobial prescribing** through antimicrobial stewardship
- **Preventing infections and transmission** of antimicrobial resistant pathogens
- **Tracking antimicrobial resistance** patterns

Our HAI Program has activities in each of these core areas

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Supporting California ASP Adoption

ASP Collaborative for **Hospitals**

- Jan-Dec 2015
- 150 hospitals participated
- Facilitate compliance with Senate Bill 1311 - required ASP by July 1, 2015
- Provided a forum to support hospitals to develop or enhance ASPs

ASP Webinar Series for **Skilled Nursing Facilities**

- Mar-Sep 2016
- All 1100 SNF invited
- Facilitate compliance with Senate Bill 361 - requires ASP by Jan 1, 2017
- Provide a forum to support SNF to develop or enhance ASPs

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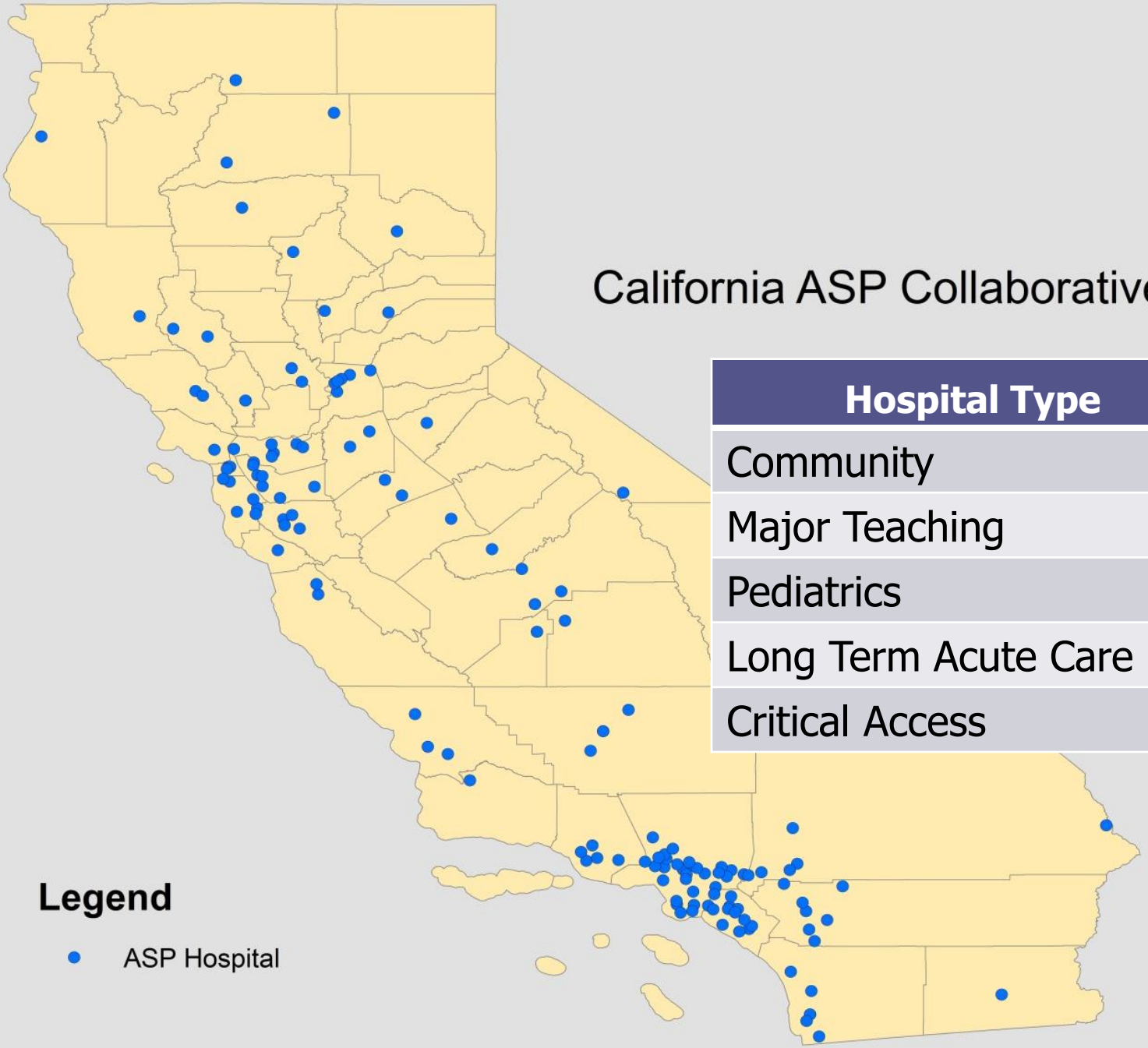
ASPs promote patient safety, and decrease CDI and antimicrobial resistance

California ASP Collaborative Hospitals



Hospital Type	No. (%)
Community	122 (81)
Major Teaching	5 (3)
Pediatrics	8 (5)
Long Term Acute Care	9 (6)
Critical Access	7 (5)

Developing a Model Regional Approach to Antimicrobial Resistance and CDI Prevention

Objectives:

1. **Monitor adherence** to infection prevention practices in hospitals and long-term care facilities
   - Contact precautions
   - Hand hygiene
   - Communication when transferring patients with CDI/AR
2. Start or enhance an **antimicrobial stewardship program** with particular attention to CDI
3. Evaluate and enhance **environmental cleaning**

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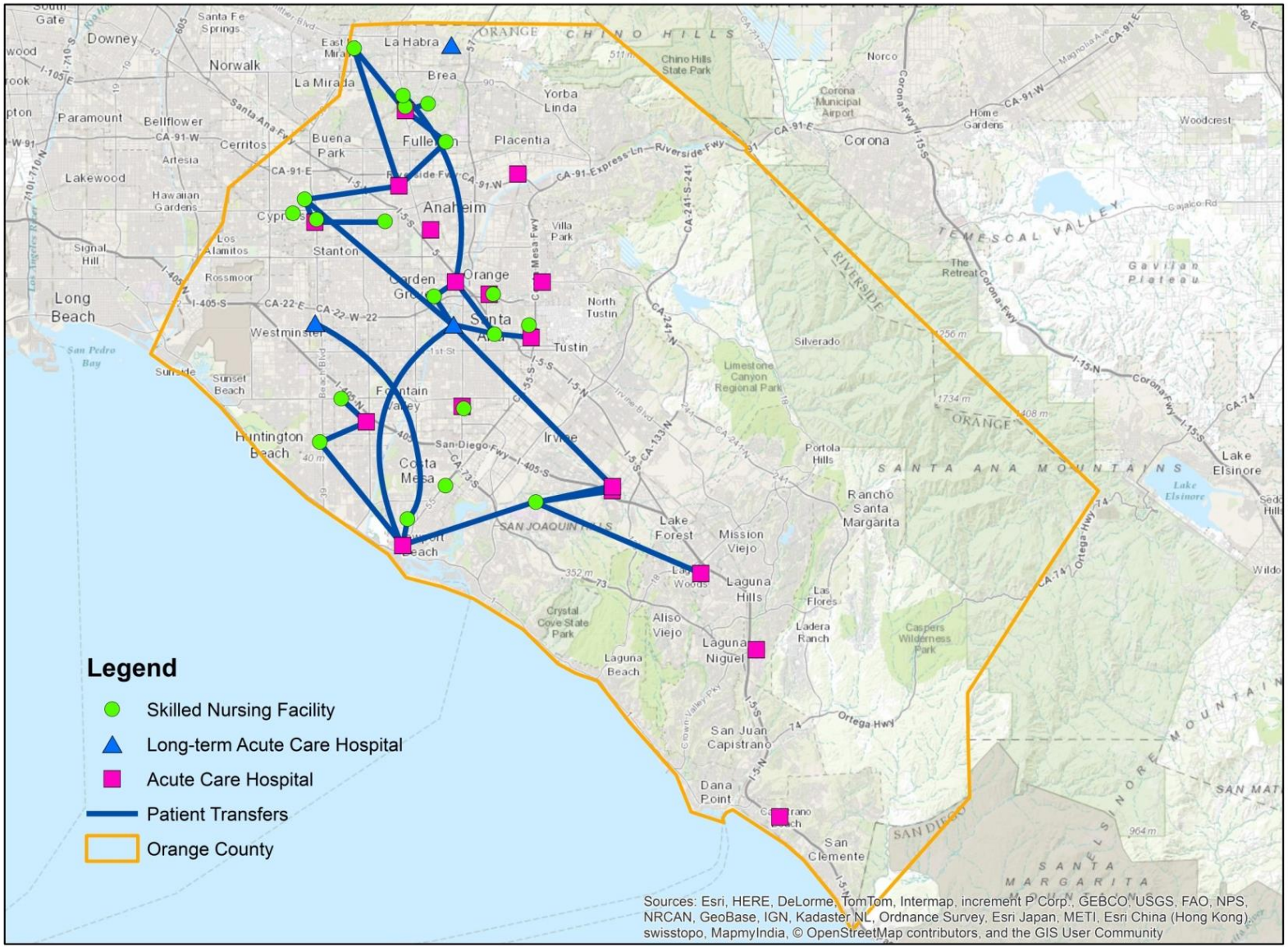
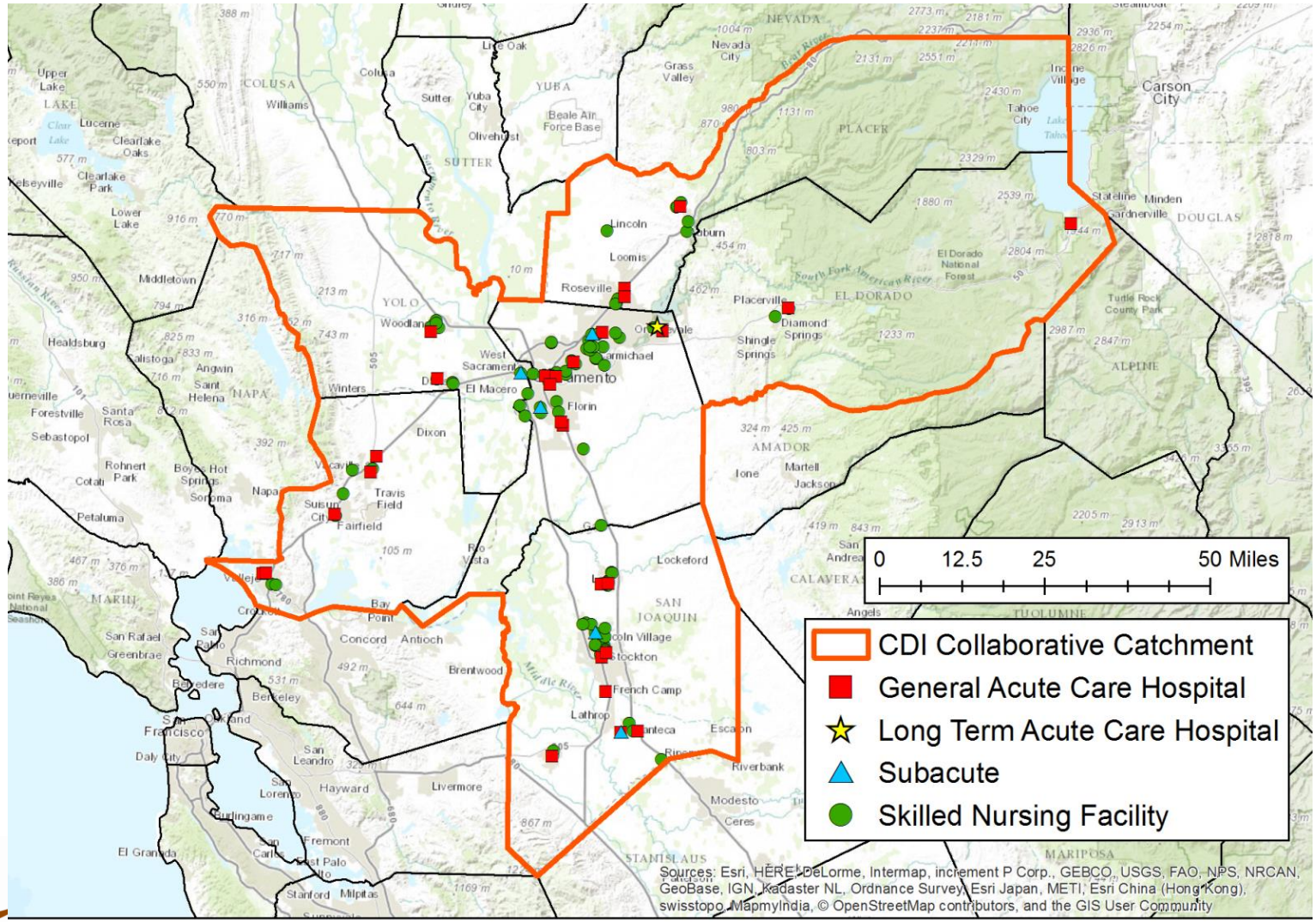
Orange County CDI Collaborative Participants



Sacramento Metro CDI Prevention Collaborative



Participating Counties: El Dorado, Placer, Sacramento, San Joaquin, Solano, Yolo

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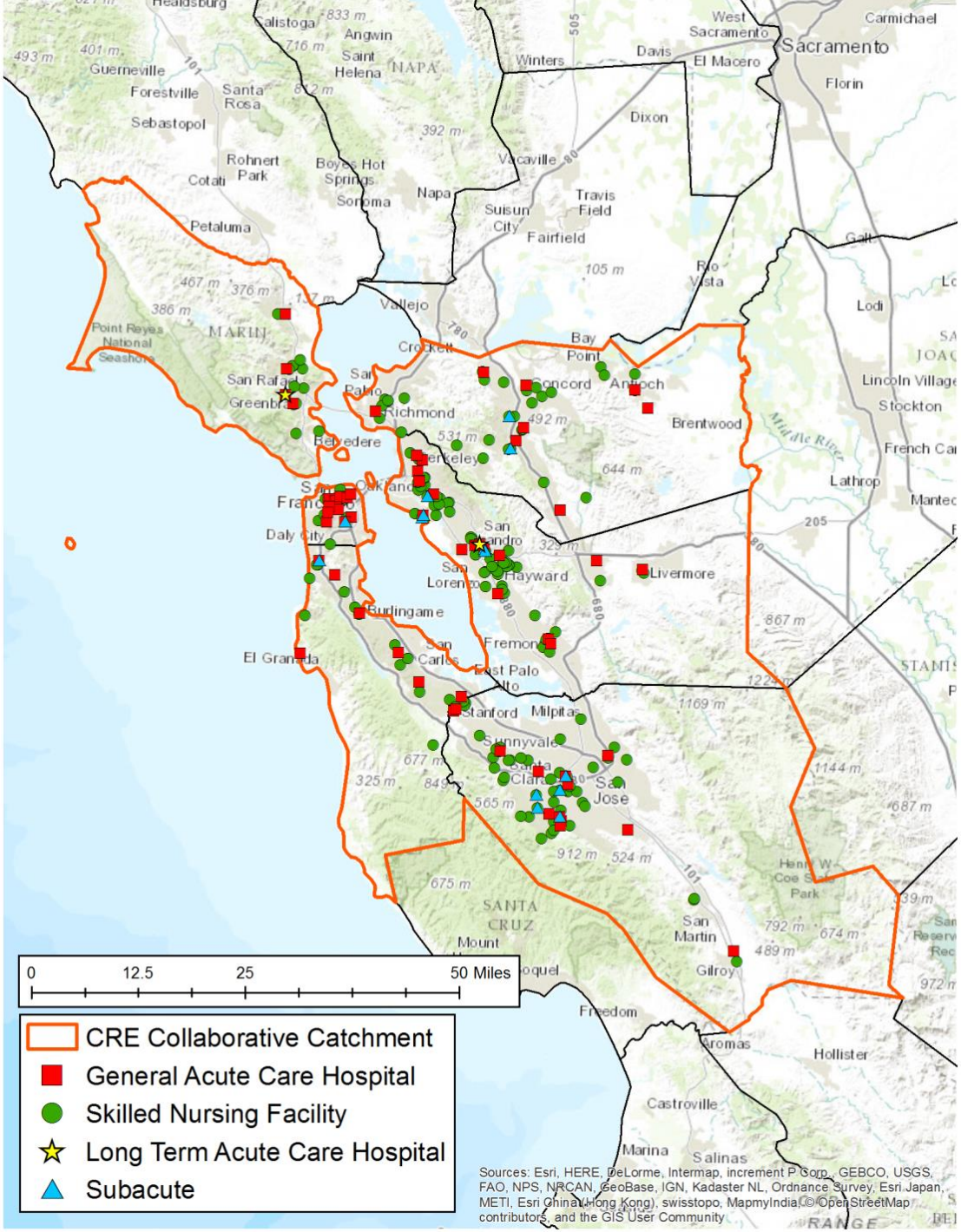
San Francisco Bay Area CRE Prevention Collaborative



Participating Counties

- Alameda
- Contra Costa
- Marin
- San Francisco
- San Mateo
- Santa Clara

CDPH HAI Program Role in Outbreak Investigations

- Subject matter experts in infection prevention and control
- Provide consultation and support to local public health agencies
- Coordinate with CDC content experts for up-to-date guidance and recommendations
- Coordinate outbreak investigations that cross local health jurisdiction boundaries
- Provide guidance and recommendations to CDPH L&C and other regulatory agencies

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HAI Program Outbreak Investigations / Consultations, 2015

By Pathogen:	No. (%)
Legionella species	14 (24%)
Klebsiella species (CRE)	7 (12%)
Hepatitis B or C Virus	6 (10%)
C. difficile infection	5 (9%)
S. aureus[1]	4 (7%)
MDRO (other than CRE)	3 (5%)
Other	19 (33%)
Total	**58 (100%)**

By Facility Type:	No. (%)
Acute Care Hospital[2]	24 (41%)
Skilled Nursing Facility	13 (22%)
Multiple Facility Types[3]	5 (9%)
Outpatient Clinic/Setting	5 (9%)
Other Residential Care	5 (9%)
Ambulatory Surgery/ASC	4 (7%)
Dialysis Clinic	2 (3%)
Total	**58 (100%)**

[1] Includes 2 MRSA and 2 MSSA
[2] Includes 1 LTAC Hospital
[3] Includes Acute Care Hospitals plus Skilled Nursing Facilities or Dialysis Clinics

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en Español
- Su salud en su idioma

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- Licensing and Certification
- WIC

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- Decisions Pending & Opportunities for Public Participation
- Diseases & Conditions
- Job Opportunities
- Language Access Complaint Process
- Local Health Services
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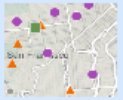
Related Links
- California Health and Human Services Agency
- Department of Health Care Services (includes Medi-Cal)
- State Agencies Directory

Home > Programs > Healthcare Associated Infections Program

Healthcare-Associated Infections (HAI) Program

The Healthcare-Associated Infections (HAI) Program is one of two programs in the Center for Health Care Quality of the California Department of Public Health. The Program was created by mandate to oversee the prevention, surveillance and reporting of healthcare-associated infections in California's general acute care hospitals. HAIs are the most common complication of hospital care. It is estimated that each year there are 722,000 infections, 75,000 deaths, and 1 in 25 hospital patients at any given time has an infection contracted during the course of their hospital care. HAIs result in an estimated $30 billion in excess healthcare costs nationally each year. Since 2010, the HAI Program has: produced annual public reports of hospital HAI data to inform choices of healthcare consumers and prompt providers to take actions to prevent infections; actively engaged in HAI prevention by performing site visits to hospitals with high infection rates, convening prevention collaboratives, and providing infection prevention education; and provided consultation and assistance to local public health for infection outbreaks that occur in healthcare facilities. The vision of the HAI Program is to eliminate HAIs for all Californians.

What You Can Do To Prevent HAI

Me And My Family	Healthcare Providers	Public Health Partners	HAI Committee & Laws	My Hospital's Infections Map	Annual HAI Report
					

Healthcare Associated Infections - Advisory Committee
- HAI Advisory Committee

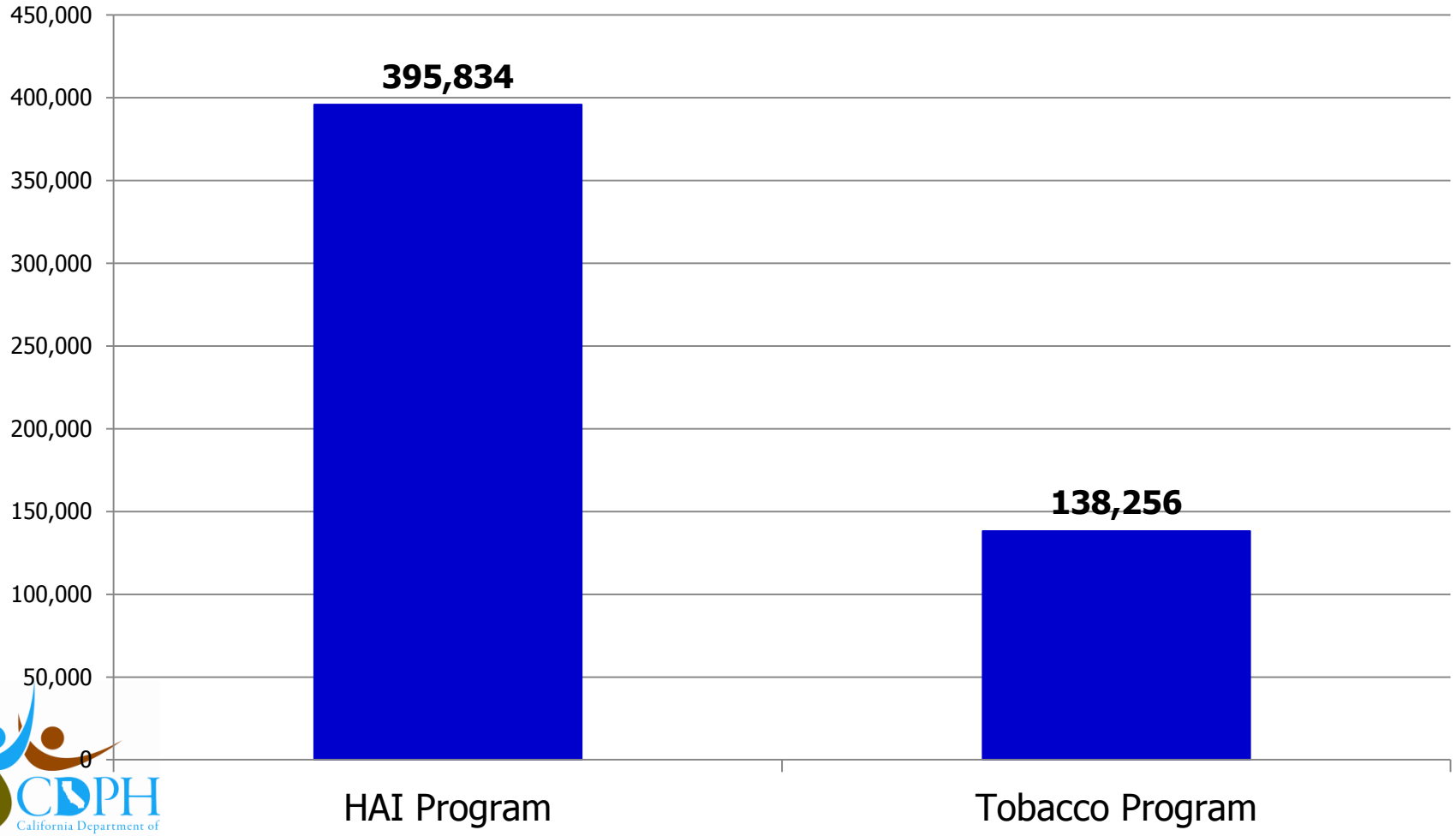
Antimicrobial Resistance
- New CDPH Antimicrobial Stewardship Program (ASP) Toolkit 2015
- Antimicrobial Resistance
- California Antimicrobial Stewardship Program Initiative
- Spotlight on Antimicrobial Stewardship Program Project Invitation 2014

Public Reporting - Preventing Hospital Infections
- New HAI Information and Reports
  2013 HAI Annual Report Now Published
- New My Hospital's Infections Map
  Interactive Map 2013 Data -- This map can be used with some mobile devices and tablets.
- New Healthcare Personnel Influenza Vaccination Reports
  Annual Report Now Published for 2013-2014 Respiratory Season

HAI Education for Healthcare Professionals
- New California One and Only Campaign - Injection Safety
- Updated Basics of Infection Prevention Guidelines
  Two-Day Mini Course
- Sustaining Infection Prevention Progress
- Educational Offerings by HAI Program Staff -- 2015 Educational Calendar

Resources
- Association of Professionals in Infection Control and Hospital Epidemiology (APIC) -- selected links
- Centers for Disease Control and Prevention (CDC) -- selected links
- Society for Healthcare Epidemiology of America (SHEA) -- selected links
- Infectious Diseases Society of America (IDSA) (New Window) -- selected links
- UCSD Infection Prevention Course -- Designed to Meet CA SB 158 Requirements (PDF, New Window)

Webpage Views - CDPH Programs January to July 2015



2015 Top Ten HAI Page Views

	Pages	Average Time Viewed (Seconds)
1	Healthcare-Associated Infections Main Page	73
2	California Antimicrobial Stewardship Program Initiative	180
3	HAI Information and Current Reports	124
4	Cleaning, Disinfection and Sterilization ("Basics of IP" course)	190
5	Who is at Risk of Getting a MRSA Infection?	84
6	What is a CLABSI?	97
7	Vancomycin-resistant Enterococci (VRE)	89
8	Carbapenem-Resistant Enterobacteriaceae (CRE)	137
9	MRSA: Methicillin-Resistant Staphylococcus aureus	97
10	Clostridium Difficile Infection (CDI)	79

California Injection Safety Program

ONE NEEDLE, ONE SYRINGE, ONLY ONE TIME.
Safe Injection Practices Coalition
www.ONEandONLYcampaign.org

About the Campaign | Safe Injection Practices | Healthcare Provider Information | Patient Information | Campaign Resources | News | Contact Us

California

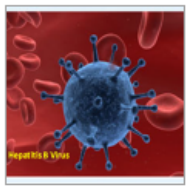
News & Events

» **Injection Safety is Everyone's Responsibility**

The Centers for Disease Control and Prevention (CDC) estimate that in recent years, unsafe injection practices have affected more than 150,000 patients in the United States, including 11,500 in California. CDC recommends that healthcare providers NEVER administer medications from the same syringe to more than one patient, even if the needle is changed. It is your right to know that your provider will use a new syringe and new needle every time.

The California One & Only Campaign encourages healthcare organizations and individuals to promote public awareness of safe injection practices. **To become a member of the California One & Only campaign,** click here

» **Hepatitis B and C Outbreaks in California**



CDC summarized 44 healthcare-associated outbreaks of hepatitis B and C in non-hospital settings from 2008-2014. Six of the outbreaks occurred in California; 2700 people were notified of possible exposure and 27 patients were found to be infected. The outbreaks occurred in two skilled nursing facilities, two assisted living facilities, a pain management clinic, and an outpatient dialysis clinic.

Unsafe injection practices that resulted in these infections included reusing syringes, contaminated multi-dose medication vials, and single-dose vials used for more than one patient.

USE AN INJECTION SAFETY CHECKLIST

It is every patient's right to receive a safe injection. Are healthcare workers always following safe injection practices at YOUR facility? Safe injection practices are a set of measures that define how to give injections in a safe manner for patients and healthcare providers. The California One &Only Campaign encourages healthcare workers to review and use the Injection Safety Checklist to assess their practices. The checklist, developed by CDC and the Safe Injection Practices Coalition, includes nine observations to help healthcare workers ensure they are adhering to safe injection practices during the care of patients. To download and share the Injection Safety Checklist, click here

WHEN IN DOUBT, THROW IT OUT!

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Summary

- The CDPH HAI Program is committed to reducing HAI in California
  - Using Data for Action to prioritize and focus on hospitals with continued high HAI incidence
  - A regional approach is being modeled for AR prevention; CDI prevention is a high priority
  - Ensuring preparedness for Ebola and other emerging infectious diseases has expanded our outreach
  - External input is sought from the HAI Advisory Committee and others to enhance our efforts

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CDPH HAI Program and APIC Discussions

- How do you think the HAI Program can be most helpful to your prevention efforts?
- Would you be willing to recommend SNF, ASCs, or outpatient clinics that could benefit from an infection prevention assessment?
  - How would you suggest we proceed?
- Other questions?

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