2011 West Virginia Healthcare Associated Infection Plan

Executive Summary

- Advisory Group members advise on the statewide healthcare associated infections (HAI) prevention plan. Currently, there are 30 members in the Advisory Group. A full list of advisory group members can be found at: http://www.wvidep.org/HealthcareAssociatedInfections/tabid/1912/Default.aspx. The state HAI coordinator, Thein Shwe, was hired as of December 1, 2010.

- WV Bureau for Public Health (BPH) will meet with West Virginia Office of Health Facility Licensure and Certification (OHFLAC) and the medical, osteopathic, dental and nursing licensing boards on May 26, 2011 to develop written agreement for their roles and responsibilities and communication in healthcare associated infection outbreaks. A separate meeting will be held with the West Virginia Board of Pharmacy.

- Reporting of healthcare associated outbreaks is not explicitly required; however nursing home outbreaks are frequently reported to WV BPH's Division of Infectious Disease Epidemiology (DIDE). During 2011, ongoing efforts to train all staff in DIDE who conduct outbreak investigations will continue. In 2011, 3 staff will complete the Society of Healthcare Epidemiology of America (SHEA) training, and multiple staff will complete the Association of periOperative Registered Nurses (AORN) Ambulatory Surgery Center Infection Prevention course online. WV BPH is negotiating with Charleston Area Medical Center (CAMC) to "embed" epidemiologists at CAMC for a one-month rotation to learn more about infection control.

- During 2012, planning for revision of the reportable disease rule to include healthcare associated outbreaks in the list of reportable conditions will begin. The Advisory Group will be consulted about additional confidentiality provisions. By July 2013, West Virginia shall include guidance for reporting and investigation of healthcare associated outbreaks as part of the reportable disease protocol manual.

- West Virginia law requires that hospitals submit data on healthcare associated infections to the West Virginia Healthcare Authority (West Virginia HCA). The data to be submitted are determined by the West Virginia Infection Control Advisory Panel. In West Virginia, data on central line-associated blood stream infections (CLABSI) in medical intensive care units, surgical intensive units and medical-surgical intensive care units are reported through the National Healthcare Safety

Network (NHSN) effective July 1, 2009 and West Virginia HCA released baseline CLABSI data on January 27, 2011. Effective January 1, 2011, Centers for Medicaid and Medicare Services (CMS) also mandated reporting of CLABSI data through NHSN. Data collection has also been implemented for influenza immunization of healthcare workers in all hospitals in West Virginia during 2009. By December 31, 2011, a second priority prevention target shall be identified for mandatory reporting.

- West Virginia has requested a Council of State and Territorial Epidemiologists (CSTE) HAI fellow to conduct a pilot study to validate CLABSI data, if a fellow is assigned to West Virginia planning for data validation will begin in 2011.

- During 2009, West Virginia investigated two outbreaks in ambulatory care settings. Both outbreaks required notification of patients of possible exposure to blood-borne pathogens. As a result, West Virginia has accumulated examples of letters and websites used for patient notifications in a shared directory. In addition, West Virginia has adopted CDC guidelines for notification (see http://www.wvidep.org/AZIndexofInfectiousDiseases/InfectionControl/tabid/1783/Default.aspx). Moreover, the HAI coordinator will update notification criteria for serious infection control breaches documented at www.wvidep.org.

- During 2011, APIC training in infection prevention and control will be offered to staff of ambulatory surgical centers and physician practices where invasive procedures are offered. This is a priority because two outbreaks were identified in 2009 traced to inadequate infection prevention procedures in ambulatory care settings.

- Twenty one West Virginia hospitals have been participating in a successful American Hospital Association and Johns Hopkins-led collaborative to reduce central line associated blood stream infections (CLABSI). A letter was generated to hospital Chief Executive Officers (CEOs) in West Virginia, asking them to commit or renew their commitment to implementation of these SHEA / IDSA guidelines to prevent CLABSI in their facilities and to commit resources to implementation. One purpose of the signed commitment is to encourage communication between the administration, the medical staff and the infection preventionists about implementation of SHEA/IDSA recommendations.

- HAI coordinator will assemble background information on CLABSI prevention including tool kits, publications, information sheets, and other information for hospital infection preventionists. Information will be posted on the DIDE website and shared at APIC-WV meetings.

- West Virginia has several prevention collaboratives ongoing. Based on the results of needs assessment and direct outreach to collaboratives, a prevention working group may be assembled by the end of 2011. There is tremendous need for development of a long term care working group based on outbreaks investigations that have been conducted in the state. The HAI coordinator will develop a subcommittee jointly with West Virginia Healthcare Association and APIC-WV to address long-term care issues. The purpose of the group will be to identify needs and develop training and other interventions to reduce HAIs in long term care.

- Based on recommendations from the Advisory Group, a survey instrument has been drafted and will be distributed to hospital infection preventionists in West Virginia. Information will be collected on capacity, training needs, experience with surveillance using National Healthcare Safety Network (NHSN), and prevention activities. After data is collected, the result will be summarized and presented to the Advisory Group. Findings from healthcare associated outbreak investigations have already been presented to the Advisory Group as part of needs assessment. Because of findings from outbreak investigation, training will be provided to staff in ambulatory surgical centers, and a long term care working group will be established.

The full content of the 2011 HAI plan may be found at:

http://www.wvidep.org/HealthcareAssociatedInfections/tabid/1912/Default.aspx