PUBLIC HEALTH DIVISION
Acute and Communicable Disease Prevention
Kate Brown, Governor

Oregon Health Authority

800 NE Oregon St, Suite 772
Portland, OR 97232
Voice: 971-673-1111
Fax: 971-673-1100
TTY: 971-673-0372

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Dear Partner,

Oregon healthcare facilities named *Clostridium difficile* infection (CDI) as one of their top three challenges in a recent needs assessment. This letter invites you and your facility to join a state-led, CDC collaborative to decrease the incidence and transmission of CDI, and improve interfacility communication. CDI is one of the most common healthcare-associated infections (HAIs). CDI is reportable by hospitals to the National Health Safety Network (NHSN). The public health impact of CDI is significant, because it can complicate other illnesses and spread when infected patients transfer from one facility to another.

Regardless of its origin, there are steps a facility can take to prevent the emergence, transmission, and complications of CDI. In addition, the same precautions used to prevent CDI prevent most other healthcare-associated infections, compounding the medical and financial benefits of CDI prevention.

The goals of this project are to:

- Understand the prevalence and transmission of healthcare associated *Clostridium difficile*.
- Implement and improve guidelines to prevent healthcare transmission of *C. difficile*.
- Develop communication strategies between healthcare facilities.

The facility-level goals for this project are to:

- Establish or improve **surveillance, identification, testing, and response to *C. difficile* infection (CDI) by enrollment in the National Health Safety Network** and **calculate CDI prevalence** at our facility, thus providing a baseline to see effects of interventions, like antibiotic stewardship.
- Identify **opportunities to prevent transmission of *C. difficile*** by improving best practices based on our facility's needs.
- Implement or improve existing **environmental cleaning and disinfection practices** using observations and audits.
- **Establish or expand antibiotic stewardship practices**; for example, audits for antibiotic indication, physician orders for cultures, and standard criteria for infection.
- Implement or improve **intra- and inter-facility communication of *C. difficile* and other multidrug-resistant organism (MDRO) infections** within our facility and to other facilities.

Because CDI prevention requires teamwork across the continuum of care, the Oregon Healthcare Associated Infections program invites your facility to participate in our CDI prevention initiative.

This collaborative is a voluntary partnership between state and federal public health agencies and healthcare facilities to share and learn about CDI transmission and prevention. Sharing CDI prevention strategies with others demonstrates your facility's commitment to learning and providing the best possible care for your patients and residents.

In order to participate in this effort, the following requirements are recommended:

- Facility Contact – this is generally an Infection Preventionist in hospitals and the Director of Nursing in long term care facilities (LTCFs).
- Identification of 1 or 2 main referral facilities for each hospital; identification of 1 referral hospital for each LTCF.
- National Health Safety Network (NHSN) enrollment and monthly data submission for CDI: we will assist your facility with this process.
- Administrative support for participation in project.
- About 10–12 hours a month for surveillance, data entry, projects, education
    - Includes 1-hour phone calls with state project manager every month.
- Completion of facility assessment
    - Baseline at first visit and follow-up at last visit.
    - Chart review of CDI or MDRO patients by state project manager.

The Oregon Health Authority is pleased to launch this CDI collaborative and have the support of the leadership and staff at facilities like yours.

We look forward to working with you and your facility.
Sincerely,

Zintars Beldavs, MS
HAI Program Manager

Genevieve Buser
Public Health Physician

800 NE Oregon St., Suite 772
Portland, OR 97232
Genevieve.l.buser@state.or.us
Tel. 971-673-1111, Fax: 971-673-1100

Top 10 Reasons to participate in the Oregon CDI Initiative:

10. **Prevention Saves Money**: Healthcare-associated infection (HAI) prevention efforts save money.
9. **"Sharing Shows Caring":** Sharing *Clostridium difficile* infection (CDI) prevention strategies with others demonstrates that your facility is committed to providing the best quality of care for your patients, residents, and the community.[3]
8. **Stay on the Cutting Edge of Infection Prevention:** Participation provides your facility with the opportunity to have regular contact with subject matter experts from your state health department and the Centers for Disease Control and Prevention (CDC).[4]
7. Collect and Use Data for Action in Prevention Efforts:[3]
    - Identify scope of problem – both in your facility and in your region.
    - Track progress of interventions – data can help identify the most effective strategies.
    - Compare your data to regional and national trends to help you guide efforts –the data you collect can help define HAI prevention policies at multiple levels.
6. **Build your "Tool Box":** The CDI Collaborative can provide tools to assess infection prevention protocols in your facility, identify areas of strength, and areas of improvement that can sometimes be difficult to do "on your own".[6]
5. **Share the Knowledge:** The CDI Collaborative provides opportunities to learn from others – what has worked, what didn't work.[5]
4. **Promotes Creative Problem Solving:** Collaborative participation can foster creative solutions, by encouraging participants to think "outside the box" to address infection control concerns, while still relying on evidence-based practices.[7]
3. **Support and Promote a "Culture of Safety" at your Facility**: Support from facility leaders is crucial to the success of any HAI prevention program, and empowers other staff members to act on behalf of patient safety.[3]
2. **HAI Prevention is Key:** Infections like CDI are (1) harmful to patients, (2) costly, and (3) preventable.[1]
1. **WE CAN'T DO IT WITHOUT YOU!**

References:

1. Vital signs: preventing *Clostridium difficile* infections. *MMWR Morb Mortal Wkly Rep.* 2012;61(9):157-162.

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3. Cardo D, Dennehy PH, Halverson P, et al. Moving toward elimination of healthcare-associated infections: a call to action. *Infect Control Hosp Epidemiol.* 2010;31(11):1101-1105.

4. Fischer L, Ellingson K, McCormick K, Sinkowitz-Cochran R. The role of the public health analyst in the delivery of technical assistance to state health departments for healthcare-associated infection prevention. *Med Care.* 2014;52(2 Suppl 1):S54-59.

5. Plsek PE. Collaborating across organizational boundaries to improve the quality of care. *Am J Infect Control.* 1997;25(2):85-95.

6. Srinivasan A, Craig M, Cardo D. The power of policy change, federal collaboration, and state coordination in healthcare-associated infection prevention. *Clin Infect Dis.* 2012;55(3):426-431.

7. Sawyer M, Weeks K, Goeschel CA, et al. Using evidence, rigorous measurement, and collaboration to eliminate central catheter-associated bloodstream infections. *Crit Care Med.* 2010;38(8 Suppl):S292-298.

Summary Oregon *Clostridium difficile* Initiative 2015

Objectives of Project:
1. To understand the prevalence and transmission of *Clostridium difficile* at Oregon healthcare facilities.
2. To implement and improve guidelines to prevent transmission of *C. difficile* infection (CDI) among healthcare settings.
3. To develop communication strategies between healthcare facilities.

Facility level objectives:

1. Establish or improve **surveillance, identification, testing, and response to *C. difficile* infection (CDI) by enrollment in the National Health Safety Network** and **calculate CDI prevalence** at our facility, thus providing a baseline to see effects of interventions, like antibiotic stewardship.
2. Identify **opportunities to prevent transmission of *C. difficile*** by improving best practices based on our facility's needs.
3. Implement or improve existing **environmental cleaning and disinfection practices** using observations and audits.
4. **Establish or expand antibiotic stewardship practices**; for example, audits for antibiotic indication, physician orders for cultures, and standard criteria for infection.
5. Implement or improve **intra- and inter-facility communication of *C. difficile* and other multidrug-resistant organism (MDRO) infections** within our facility and to other facilities.

Timeline: 6 -12 months

Requirements:
1. Facility Contact: usually the Director of Nursing (for LTCF) or an Infection Preventionist (for hospital)
2. National Health Safety Network (NHSN) enrollment. If a LTCF, the project will help your facility enroll.
3. Administrative support for participation in project.
4. About 10–12 hours a month, including 1-hour phone call with state project manager monthly.
5. Completion of facility assessment: Baseline at first visit and follow-up at last visit.
6. Charts review of residents with CDI or other MDRO, available on day of assessment.

Take-away:
1. Participation in an implementation and quality improvement project for accreditation or other QI requirements.
2. Assessment of current CDI practices and suggestions for improvement from CDC-based CDI improvement project.
3. Opportunity to be a leader in improved hospital-long term care facility communication.
4. For LTCFs, assistance with NHSN enrollment, surveillance, and CDI prevention efforts.

Contact info:
Genevieve Buser
Work cell: 971-409-8616
Genevieve.l.buser@state.or.us