**State HAI Plan 2015: Development**

Evaluation Summary of HAI Plan 2010

Current Initiatives & Data Analysis

Action Items for Consideration

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# State of Maine HAI Plan 2010 – Evaluation Summary

|  |  |  |  |
| --- | --- | --- | --- |
| **#** | **2010 Plan** | **2014 Status** | **Dashboard** |
| 1 | Establish leadership trough HAI Advisory Committee. | * MIPC: 2008-2013
* MQF HAI Subcommittee: 2013-2014
* HAI Collaborating Partners Committee: 2015 -
 | ☺ |
| 2 | Establish an HAI surveillance prevention and control program | * HAI Coordinator designated.
* Total staff = 1 FTE.
 | ☺ |
| 3 | Integrate laboratory activities with HAI surveillance, prevention and control efforts. | * HAI collaboration with state lab (HETL), regional labs (Nordx, ALI) and local labs.
 | ☺ |
| 4 | Facilitate use of standards-based formats for electronic reporting of HAI data. | * Electronic reporting of HAI related Notifiable Conditions
 | ☺ |
| 5 | Improve HAI outbreak detection and investigation | * Protocols for ILI, GI/Norovirus, CDI in LTC – have data
* Pending: HAI Outbreak (drug diversion, dirty equip)
 | ☺ |
| 6 | Enhance laboratory capacity for state and local detection and response to new and emerging HAI issues. | * Added: PFGE for CD and PCR for CRE
 | ☺ |
| 7 | Identify at least 2 priority prevention targets for surveillance. | * Central Line Insertion bundle.
* Ventilator Associated Pneumonia bundle.
* SCIP measures
 | ☺ |
| 8 | Adopt national standards for data and technology to track HAIs | * NHSN
 | ☺ |
| 9 | Develop state surveillance training competencies for NHSN | * All acute care hospitals utilizing NHSN.
* HAI Coordinator continues to assist with training.
 | ☺ |
| 10 | Develop tailored reports of data analyses for state or region. | * MQF HAI Annual Report, by state, by facility.
* CEO Dashboard Reports, facility specific.
 | ☺ |
| 11 | Validate data entered into HAI surveillance systems. | * Validated data = CDI, MRSA, CLABSI
* Pending = CAUTI, SSI (plan for both in 2015)
 | ☺ |
| 12 | Establish prevention work group under the HAI Advisory Committee to coordinate HAI collaborative(s), implement HICPAC recommendations | * SSI: Crosswalk of all agencies SSI recommendations
* MRSA: 2 yr pilot for active surveillance cultures
* CLABSI: Outlier identification and focused improvement
* CDI: Nursing home reduction program, MHA focus project
 | ☺ |
| 13 | Establish HAI collaborative(s) with at least 10 hospitals. | * Hand Hygiene (36 hospitals) – ended in 2013.
* Maine CDC partnered with QIO on collaborate(s).
 | ☺ |
| 14 | Develop state HAI prevention training competencies. | * Training resources were developed by APIC for acute Infection Preventionist, Muskie is working on a project for on-line training for LTC Infection Preventionist.
 | ☺ |
| 15 | Conduct needs assessment of state HAI program. | * Assess progress toward HAI reduction goals.
 | ☺ |
| 16 | Develop and implement a communication plan about state’s HAI program and progress. | * Maine CDC HAI website.
* MQF HAI Annual Report
 | ☺ |

# Current Initiatives & Data Analysis

## General Infections

### General Infection Prevention and Control

**Current Initiatives:**

1. HAI Outbreak Investigation Protocol and State Response Plan – under construction.
2. Track outbreak data, as a measure of general infection control practices, include all healthcare settings.
3. Monitor facility (Acute and LTC) compliance with HCW influenza vaccinations.

**HCW Influenza Monitoring:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Healthcare setting** | **Reporting mandated by** | **2012-2013** | **2013-2014** | **2014-2015** |
| Acute | CMS & Maine | 84% | 88% | Pending |
| Long Term Care | Maine | n/a | 56% | Pending |
| Ambulatory Surgery | CMS | n/a | n/a | Pending |

\*Inpatient Psychiatric Facilities (CMS) mandated to report starting with 2015-2016 influenza season.

**Acute Care Outbreaks**

**GI Outbreak-Acute** (Outbreak definition: 2 or more unrelated persons with compatible illness and epi-linked)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **MMWR Year** | **Number of Outbreaks** | **TREND** | **Average Attack Rate % (min, max)** | **Average Number of Days from****First Case to Last Case Ill**  | **Total Deaths** |
| **for Patients** | **for Staff** |
| 2013 | 4 | 🡻 | 42.8 (24, 50) | 51.3 (20, 100) | 15 | 0 |
| 2014 | 4 | 30.5 (7, 54) | 11.3 (0, 33) | 9 | 0 |
| 2015-YTD\* | 0 | - | - | - | - |

**\*As of 2/26/2015**

**ILI Outbreak-Acute** (Outbreak definition: One or more patients with lab-confirmed influenza with s/s onset ≥ 48 hrs. post-admission)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MMWR Year** | **Number of Outbreaks** | **TREND** | **Average Attack Rate % (min, max)** | **Avg. # of Days from Investigation Start Date to Close of Outbreak** | **Average Vaccination Rate** | **Total Deaths** |
| **for Patients** | **for Staff** | **Patients** | **Staff** |
| 2013 | 3 | 🡹 | 24.4 (5, 50) | 9.9 (2, 19) | 10 | 44.0 | 82.3 | 0 |
| 2014 | 3 | 11.8 (4, 19) | 6  | 16 | 63.0 | 69.0 | 0 |
| 2015-YTD\* | 9 | 11.2 (3, 29.4) | 3.9 (0, 9) | 8 | 41.3 | 91.9 | 0 |

**\*As of 2/26/2015**

**HAI Outbreak – Acute** (Outbreak definition: Breach in safe injection or infection control practice that may put others at risk for transmission of bloodborne pathogens; or bacterial or viral pathogens not categorized above)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year** | **Type** | **Event** | **Transmission** | **Pathogen** |
| 2013 | Equipment Cleaning  | Patient pattern identified – post eye surgery | 2 | Toxic anterior segment syndrome (TASS) |
| Equipment Cleaning | Facility identified breach in cleaning practices for cystoscopies | 0 | N/A |
| 2014 | Equipment CleaningEnvironmental Cleaning | Patient pattern identified on 2 units. | 7 | *Serretia marcesans*(Respiratory, Blood) |
| Drug Diversion | HCW diverting drugs, extra drugs stored in dispensing system. Theft vs. Diversion.  | 0 | N/A |

**Long-Term Care Outbreaks**

**GI Outbreak-LTC** (Outbreak definition: 2 or more unrelated persons with compatible illness and epi-linked)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MMWR Year** | **Number of Outbreaks** | **TREND** | **Average Attack Rate % (min, max)**  | **Average Number of Days from****First Case to Last Case Ill** | **Total Deaths** | **Average # Hospitalized (min, Max)** |
| **Residents** | **Staff** |
| 2013 | 63 | 🡹 | 34.4 (0, 81) | 16.9 (0, 58) | 12 | 5  | 0.8 (0, 5) |
| 2014 | 53 | 24.3 (0, 67) | 12.1 (0, 68) | 11 | 4 | 0.3 (0, 2) |
| 2015-YTD\* | 10 | 39.8 (17, 53) | 25.4 (0, 67) | 15 | 2 | 0.1 (0, 1) |

 **\*As of 2/26/2015**

**ILI Outbreak-LTC** (Outbreak definition: One case of confirmed influenza by any testing method in a LTC facility resident)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **MMWR Year** | **Number of Outbreaks** | **TREND** | **Average Attack Rate % (min, max)** | **Avg. # of Days from Investigation Start Date to Close of Outbreak** | **Average Vaccination Rate** | **Total Deaths** | **Average # Hospitalized (min, Max)** |
| **Residents** | **Staff** | **Residents** | **Staff** |
| 2013 | 110 | 🡹 | 14.8 (0, 83) | 8.1 (0, 68) | 14 | 91.5 | 67.9 | 25 (24 r, 1s) | 1.1 (0, 7) |
| 2014 | 71 | 14.7 (0.6, 64) | 7.0 (0, 33) | 13 | 87.2 | 68.9 | 6 | 1.4 (0, 7) |
| 2015-YTD\* | 105 | 16.7 (1, 83) | 10.3 (0, 75) | 13 | 91.7 | 64.7 | 24 (23 r, 1s) | 1.1 (0, 7) |

 **\*As of 2/26/2015**

**HAI Outbreak – LTC** (Outbreak definition: Breach in safe injection or infection control practice that may put others at risk for transmission of bloodborne pathogens; or bacterial or viral pathogens not categorized above)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year** | **Type** | **Event** | **Transmission** | **Pathogen** |
| 2013 | None | N/A | N/A | N/A |
| 2014 | None | N/A | N/A | N/A |

**CDI Outbreaks-LTC** (Outbreak definition: One confirmed case or two suspect cases with epidemiological link)

|  |  |  |  |
| --- | --- | --- | --- |
| **MMWR Year** | **# Outbreaks** | **TREND** | **Total # Died** |
| 2013 | 4 | 🡻 | 3 |
| 2014 | 3 | 0 |

**Ambulatory Care Outbreaks**

**HAI Outbreak – Ambulatory Care** (Outbreak definition: Breach in safe injection or infection control practice that may put others at risk for transmission of bloodborne pathogens; or bacterial or viral pathogens not categorized above)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Year** | **Setting** | **Type** | **Event** | **Transmission** | **Pathogen** |
| 2013 | None | n/a | n/a | n/a | n/a |
| 2014 | Clinic | Safe Injection Practice | Reuse of needle to access multi-dose vial (TST testing). | 0 | n/a |

**Action Items:**

* All healthcare facilities can provide safe healthcare. States are asked to explore more effective and proactive oversight of healthcare settings including acute, long-term care and outpatient facilities, by implementing programs to improve general infection control practices (e.g. disinfection/sterilization, environmental cleaning, safe device use, standard and transmission-based precautions, use of personal protective equipment) through assessment of competency and training needs. Design a sustainable process to ensure ongoing adherence and promotion of best infection control practice (federal CDC, ELC funding grant).
	+ Assess gaps in Infection Control practices and outbreak reporting – prioritize Ebola treatment and assessment facilities, expand to other acute care and non-acute care settings. Develop mitigation strategies for addressing identified gaps.
	+ **STATEMENT IN STATE HAI PLAN REQUIRED !**
* Authority by which to conduct infection control infections – either as assessment surveys or post breach in IC practices. Currently, only have authority if others are known to be at risk – e.g. exposure event, source patient is positive for a blood-borne pathogen.
* EMS Infection Control Education and Training – Regional EMS leaders are looking for standardize guidelines and web-based training, especially around emerging pathogens (Jay Bradshaw).

## Device Associated Infections

### ACUTE CARE: Catheter Associated Urinary Tract Infection

|  |  |  |
| --- | --- | --- |
| **Maine Trend** |  | **Maine Compared to U.S.** |
| CAUTI | Number ofHospitals Reporting | **2011** | **2012** | **2013** | Trend |  | **Maine****2013** | **Compare (SIR)** |
| **Federal Data SIR** | 21 |  | **1.91** | **1.72** | 🡻 |  | **1.72** | 1.06 | Nat’l SIR2013 |
|  |  |  |  |  |  |  | 0.75 | HP 20202013 |
|  |  |  |  |  |  |  | 🡻 25%\* | HP 20202020 |

 \*from 2015 Baseline

**Current Initiatives:**

1. Assess for facility outliers.

[Outlier: Facility that has a CAUTI SIR above national benchmark and needs to reduce 10 or more CAUTIs to reach national benchmark.]

|  |  |
| --- | --- |
|  | 2013 data |
| # Hospitals | 2 |

**Action Items:**

* Healthcentric Advisors CAUTI collaborative under development.
* External validation of CAUTI data – planned for 2015.
* Mixed Acuity Units – how to capture data.

### ACUTE CARE: Central Line Associated Blood Stream Infection

|  |  |  |
| --- | --- | --- |
| **Maine Trend** |  | Maine compared to U.S. |
| CLABSI | # of Hospitals Reporting | 2011 | 2012 | 2013 | Trend |  | Maine2013 | Compare (SIR) |
| Federal Data **SIR** | 21 |  | **0.93** | **0.66** | 🡻 |  | **0.66** | 0.54 | Nat’l SIR2013 |
|  |  |  |  |  |  |  | 0.50 | HP 20202013 |
|  |  |  |  |  |  |  | 🡻 50%\* | HP 20202020 |

 \*from 2015 Baseline

**Current Initiatives:**

1. Endorse the surveillance of CLABSI at all acute care hospitals (ACH) in Maine with a state reporting mandate. [not all ACHs have ICUs]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | # Hospitals Reporting | 07/2010-06/2011 | 07/2011-06/2012 | 07/2012-06/2013 | Trend |
| ICU Rate | 20 | 1.4 | 1.7 | 1.1 | **🡻** |
| NICU Rate | 3 | 0.6 | 2.5 | 2.9 | 🡹 |

1. Endorse the use of the IHI Central Line Insertion bundle prevention measures at all ACHs with a state reporting mandate.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | # Hospitals Reporting | 07/2010-06/2011 | 07/2011-06/2012 | 07/2012-06/2013 | Trend |
| ICU | 36 | 92% | 94% | 90% | **=** |
| Surgical Services | 36 | 96% | 97% | 96% | **=** |

1. Assess for facility outliers.

[Outlier: Facility that has a CLABSI SIR above national benchmark and needs to reduce 5 or more CLABSIs to reach national benchmark.]

|  |  |
| --- | --- |
|  | **2013 data** |
| # Hospitals | 1 |

1. External Validation of CLABSI data (provided by alternate funding source) for all acute IPPS hospitals with ICUs.

|  |  |
| --- | --- |
| **Metric** | **2012** |
| Error Rate | 7% |
| Device Day Error Rate – (calculation??) | 25% |

**Action Items:**

* QIN-QIO Healthcentric Advisors collaborative under development.
* Discuss reporting mandate for IHI Central Line Insertion bundle.
* Mixed Acuity Units – how to capture data.

### ACUTE CARE: Ventilator Associated Pneumonia / Ventilator Associated Event

|  |  |  |
| --- | --- | --- |
| **Maine Trend** |  | Maine compared to U.S. |
| VAP/VAE | # of Hospitals Reporting | 2011 | 2012 | 2013 | Trend |  | Maine2013 | Compare (SIR) |
| Federal Data**SIR** | 0 |  |  |  |  |  |  |  | Nat’l SIR2013 |
|  |  |  |  |  |  |  |  | HP20202013 |
|  |  |  |  |  |  |  |  | HP20202020 |

**Current Initiatives:**

1. Endorse the use of the IHI Ventilator Associated Pneumonia bundle prevention measure with a state reporting mandate.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | # of Hospitals Reporting | 07/2010-06/2011 | 07/2011-06/2012 | 07/2012-06/2013 | Trend |
| ICU | 36 | 91% | 90% | 89% | **=** |

**Action Items:**

* Discontinue reporting mandate for IHI Ventilator Associated Pneumonia bundle.

## Procedure Associated Infections

### ACUTE CARE: Surgical Site Infections

COLO = Colon Procedures HYST = Abdominal Hysterectomies

|  |  |  |
| --- | --- | --- |
| Maine Trend |  | Maine compared to U.S. |
| Federal Data**SIR** | # ofHospitals Reporting | 2011 | 2012 | 2013 | Trend |  | Maine2013 | Compare (SIR) |
| COLO | 21 |  | **1.22** | **1.20** | 🡻 |  | **1.20** | 0.92 | Nat’l SIR2013 |  |  | 0.75 | HP 20202013 |
| HYST | 19 |  | **0.77** | **0.87** | 🡹 |  | **0.87** | 0.86 |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  | 🡻 30%\* | HP 20202020 |

 \*from 2015 Baseline

**Current Initiatives:**

1. Endorse use of SCIP prevention measures with a state reporting mandate.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | # of Hospitals Reporting | 07/2010-06/2011 | 07/2011-06/2012 | 07/2012-06/2013 | Trend |
| SCIP 1A – Abx 1 hr prior | 36 | 99% | 99% | 99% | **=** |
| SCIP 2A – Right Abx | 36 | 99% | 99% | 99% | = |
| SCIP 3 – Abx dc’d , 24 hr | 36 | 98% | 99% | 99% | = |
| SCIP 4 – Cardiac Gluc. | 3 | 95% | 98% | 98% | = |
| SCIP 9 – Foley cath out  | 36 |  |  | 99% | ? |
| SCIP 10 – Periop Temp | 36 | 100% | 100% | 100% | = |

**SCIP REQUIREMENTS RETIRED AS OF 2015 – ON THE FEDERAL LEVEL**

1. Assess for facility outliers.

[Outlier: Facility that has a SSI SIR above national benchmark and needs to reduce 5 or more SSIs to reach national benchmark.]

|  |  |
| --- | --- |
|  | 2013 data |
| # Hospitals | COLO = 3HYST = 1 |

**Action Items:**

* External validation of SSI data – planned for 2015
* Discuss reporting mandate for SCIP measures.

## Multi-drug Resistant Organism (MDRO) Infections

**Surveillance for MRSA and CDI are by Lab ID Event surveillance definitions. It is important to note that Lab ID Events do not necessarily equate to HAIs.**

Lab ID Event surveillance methodology is based solely on dates (admission date to specimen collection date) to determine event reporting as community onset (CO) vs healthcare facility onset (HO). When comparing Lab ID - HO events to the more detailed HAI surveillance events, the Lab ID - HO Events will be higher due to lack of further filtering based on infection-related criteria.

### ACUTE CARE: MRSA - Lab ID Data

|  |  |  |
| --- | --- | --- |
| Maine Trend |  | Maine compared to U.S. |
| MRSA-BSI | # ofHospitals Reporting | 2011 | 2012 | 2013 | Trend |  | Maine2013 | Compare (SIR) |
| Federal Data**Lab ID SIR** | 25 |  |  | **0.72** | ? |  | **0.72** | 0.92 | Nat’l SIR2013 |
|  |  |  |  |  |  |  | 0.75 | HP 20202013 |
|  |  |  |  |  |  |  | 🡻 50%\* | HP 20202020 |

 \*from 2015 Baseline

**Current Initiatives:**

1. Endorse the surveillance of MRSA (all specimen sources) at all acute care hospitals (ACH) in Maine with a state reporting mandate.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | # of Hospitals Reporting | 07/2010-06/2011 | 07/2011-06/2012 | 07/2012-06/2013 | Trend |
| MRSA Lab ID Rate (ALL specimen sources) | 36 |  | 0.19 | 0.16 | **🡻** |

1. Endorse assessing accuracy of MRSA data with a state mandate for data validation.

|  |  |  |
| --- | --- | --- |
| Metric | 2012-2013 | 2014 |
| Surveillance Method | HAI | Lab ID |
| Facilities | 10 of 36 | 17 of 35 |
| Error Rate | 1% | Pending |
| Sensitivity – captured event without missing | --- | Pending |
| PPV – capture event without over-reporting | --- | Pending |
| Admission Date Accuracy | --- | Pending |
| Specimen Date Accuracy | --- | Pending |

1. Assess for facility outliers.

[Outlier: Facility that has a MRSA-BSI SIR above national benchmark and needs to reduce 5 or more MRSA-BSIs to reach national benchmark.]

|  |  |
| --- | --- |
|  | 2013 data |
| # Hospitals | 0 |

**Action Items:**

* Discuss reporting mandate to conduct MRSA external validation annually.

### ACUTE CARE: *Clostridium difficile* – Lab ID Data

|  |  |  |
| --- | --- | --- |
| Maine Trend |  | Maine compared to U.S. |
| CDI | # ofHospitals Reporting | 2011 | 2012 | 2013 | Trend |  | Maine2013 | Compare (SIR) |
| Federal Data**Lab ID SIR** | 36 |  |  | **0.53** | ? |  | **0.53** | 0.90 | Nat’l SIR2013 |
|  |  |  |  |  |  |  | 0.70 | HP 20202013 |
|  |  |  |  |  |  |  | 🡻 30%\* | HP 20202020 |

 \*from 2015 Baseline

**Current Initiatives:**

1. Endorse the surveillance of CDI at all acute care hospitals (ACH) in Maine with a state reporting mandate.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | # Hospitals Reporting | 10/2010-09/2011 | 10/2011-09/2012 | 10/2012-09/2013 | Trend |
| CDI Rate – Lab ID Event | 36 |  | 6.6 | 6.9 | **🡹** |

1. Endorse assessing accuracy of CDI data with a state mandate for data validation.

|  |  |  |
| --- | --- | --- |
| Metric | 2012-2013 | 2013-2014 |
| Surveillance Method | Lab ID | Lab ID |
| Facilities | 14 of 36 | 22 of 35 |
| Error Rate | 7% | 3% |
| Sensitivity – captured event without missing | --- | 98% |
| PPV – capture event without over-reporting | --- | 99% |
| Admission Date Accuracy | --- | 99% |
| Specimen Date Accuracy | --- | 98% |

1. Assess for facility outliers.

[Outlier: Facility that has a CDI SIR above national benchmark and needs to reduce 5 or more CDIs to reach national benchmark.]

|  |  |
| --- | --- |
|  | 2013 data |
| # Hospitals | 0 |

**Action Items:**

* Discuss reporting mandate to conduct C. diff external validation annually.

### Antimicrobial Stewardship

**Current Initiatives:**

1. Track healthcare setting investigations related to MDROs.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Year** | **Facility** | **MDRO** | **Response – Brief Summary** | **County** |
| 2013 | Extended Care | CDI | 10 positive cases of C. difficile, 1 died (HAI related?) | Kennebec |
| Extended Care | CDI | 3 positive cases of C. difficile | Kennebec |
| Extended Care | CDI | 2 positive cases of C. difficile | Franklin |
| Extended Care | CDI | 7 positive cases of C. difficile, 2 died (HAI related?). 5 first cases had been at same acute care facility | Franklin |
| 2014 | Extended Care | CDI | 3 positive cases of C. difficile | York |
| Extended Care | CDI | 2 positive cases of C. difficile | Kennebec |
| Extended Care | CDI | 3 positive cases of C. difficile | Aroostook |
| 2015 | Extended Care | ESBL | 7 positive cases of ESBL in last year, low incidence in county-PENDING | Penobscot |
| Extended Care | ESBL | 2 positive cases of ESBL recently, low incidence in county-PENDING | Somerset |

**Action Items:**

* CSTE recommends that all state health departments evaluate and incorporate stewardship activities across healthcare settings into their HAI programs. [CSTE Position Statement 2014]. Examples:
	+ Convene a state workshop on Antimicrobial Stewardship. **[Maine hosted AMS course for Pharm + Physician, each ACH, 2010]**
	+ Assess Antimicrobial Stewardship Activities and Needs (e.g. survey facilities, focus groups).
	+ Collect and Evaluate Antimicrobial Use Data (e.g. NHSN AUR Module, point prevalence surveys, days of therapy monitor, behavioral risk factor surveillance).