MARYLAND HEALTH CARE COMMISSION

Summary of the Healthcare-Associated Infections (HAI)
Advisory Committee Meeting

May 20, 2015

Committee Members Present
Anthony Harris, MD, MPH (conference call)
Emily Heil, PharmD (conference call)
Lynne V. Karanfil, RN, MA, CIC
Peggy A. Pass, RN, BSN, MS, CIC (conference call)
Brenda Roup, Ph.D, RN, CIC
Jack Schwartz, JD (conference call)

Committee Members Absent
Sara E. Cosgrove, MD, MS
Maria E. Eckart, RN, BSN, CIC
Andrea Hyatt, CASC
Debra Illig, RN, MBA, CLNC
Robert Imhoff
Michael Anne Preas, RN, BSN, CIC
Patricia Swartz, MPH, MS
Kerri Thom, MD
Renee Webster, RS
Lucy Wilson, MD, ScM

Public Attendance
Mary Clance (conference call)
Dianne Feeney, HSCRC
Julia Gardner (conference call)
Kerri Huber (conference call)
Rachel Pierre-Mathieu, OHCQ (conference call)
Katie Richards (conference call)
Beth Rowse (conference call)
Deb Smith, VHQC
Geeta Sood (conference call)
Carol Whalen, VHQC
Justin Ziombra, MHA (conference call)

Commission Staff
Theressa Lee
Evanson Mukira
Eileen Witherspoon

1. Call to Order

Theressa Lee, Director, Center for Quality Measurement and Reporting, called the meeting to order at 1:00 p.m.

2. Review of Previous Meeting Summary

The minutes of the previous meeting on April 22, 2015 were accepted by the committee with no corrections.

3. Discussion on Inclusion/Exclusion of Inpatient Rehabilitation and Psychiatric Facility Locations Based on Separate CCN for MDRO Module

Ms. Lee stated that under the CMS waiver, Maryland hospitals do not report their inpatient rehab and psychiatric units under a separate CCN identifier. Unlike hospitals in other states, these units are reported using the hospital CCN. As of January 1, 2015, CDC requires that these units be reported separately through NHSN, using the unit CCN identifier. The concern was that Maryland data would be reported differently than the national data with the inclusion of these units.

Ms. Lee said staff were trying to work through how to report in Maryland. Ms. Witherspoon noted that a proposed strategy would be to map those locations but not report the units as part of FacWideIN similar to the way the ED and observation units are currently set up. Ms. Huber noted that CDC responded that units that are physically located in another building, a separate facility should be set-up in NHSN. Ms. Lee noted that units that are in separate buildings are still under the same CCN. She is not sure NHSN can have two facilities set-up with the same CCN. Ms. Lee wants the units in the system but not included in hospital wide reporting. There was discussion on how the locations would be set-up and separated from the current reporting requirement. Dr. Sood noted that everyone was in agreement that these units' rates should not be included in FacWideIN reporting, but that the data should be captured. She offered that her hospital would test setting up the locations in NHSN and report back.

Ms. Feeney noted that there are a number of facilities in the all payer model that are currently not required to report such as LTAC hospitals. She said HSCRC will be looking at quality measures for these facilities to determine if systematic reporting is occurring. She said requirements may have to be added in the near future for these facilities and this will be discussed with MHCC staff. She said both chronic care facilities and chronic care beds within a larger facility will likely be affected. Dr. Roup asked about DHMH behavioral health facilities. She said the data is not reported into NHSN because it is not currently required. She said these facilities are licensed as special hospitals and receive JC accreditation. Ms. Feeney said the main focus has always been on acute care facilities in the past but this is likely expanding to chronic, specialty, rehab, and others. Dr. Sood noted that these facilities should be compared separately from acute care facilities due to different patient populations, risk factors, etc. Ms. Lee and Ms. Feeney agreed. Ms. Lee noted another group could be set-up to focus on the other settings.

4. Update on HAI Data Audit

Ms. Lee noted that the last year of the audit is upcoming. Ms. Lee noted that alternatives are being explored to on-site audits for all hospitals. She noted the burden to hospitals and MHCC staff in trying to accomplish on-site auditing with the expanded data reporting requirements. She noted that HSCRC data was used to screen the data for possible data quality concerns. She noted that certain types of cases or hospitals may be targeted in the last year with an emphasis on education for lessons learned from the audits and provide screening tools for hospitals. Ms. Lee said the data is to be reviewed before it is publicly reported. Ms. Lee said even after the last year of the audit, data validation will still need to happen but not at a comprehensive level for all data every time. Dr. Roup suggested rotating the HAIs so not all the data is audited at the same time.

Ms. Karanfil asked if a data request would be forthcoming for CLABSI and CAUTI. Ms. Lee said yes, the data would be requested. She said the lab should be involved with these requests so the IP is not pulling data by hand. Ms. Karanfil asked for a longer lead time with at least 4 weeks with the next request.

Ms. Karanfil noted that the CDI SIR is based on lab methodology. Since Maryland did not do as well on CDI, it would be worth validating the lab methodology for the hospitals. Dr. Harris agrees. Ms. Witherspoon noted that one hospital had checked "other" and wrote in PCR, but she has not checked all facilities. She can follow up with the hospitals that checked "other" in that field on the quarterly Summary Data form. Ms. Smith noted that some information from the NHSN annual survey also impacts the CDI SIR calculation. Dr. Harris noted that if Maryland hospitals are using PCR more often than other states that the rate will be higher and the risk adjustment methodology may not be enough. He said the group should review the NHSN SIR adjustment. Ms. Karanfil agreed that maybe the risk adjustment needs to be updated by CDC now that there is more data. Dr. Harris stated he was under the impression that most Maryland hospitals were using PCR. Ms. Witherspoon noted that based on the last MHCC annual survey, 70-80% of Maryland hospitals were using PCR. Dr. Clance noted this is higher than the national average. Dr. Harris noted more clinicians are aware of *C. diff* and more tests are being ordered. With the use of PCR, this results in a higher number of positive test results some of which are false positives. Dr. Clance noted that she is aware of tests being ordered inappropriately as well. Dr. Sood suggested asking hospitals about the number of tests ordered on the annual survey. Dr. Harris noted that utilization measurements are gaining popularity. He noted that there has not been a decrease in CAUTI nationally but there has been a large decrease in the use of Foleys. There is a push to collect data on Foley utilization. Dr. Harris said this information would be valuable in *C. diff* in assessing over-testing and/or higher acuity units.

Ms. Smith asked if that would be a rate of testing. Dr. Sood said it would be measured as a utilization ratio of number of *C. diff* tests per 1,000 patient days. Dr. Harris noted that in Foleys, if you decrease the number of Foley days per 1,000 patient days (outcomes measure), this shows the unit is doing better by reducing the use of Foleys. He noted that *C. diff* is more complicated. For example, if there were two same units and one had a higher *C. diff* testing rate, it's likely that unit is over-testing. He noted that certain units are going to have a higher *C. diff* testing rate for good reasons such as one that houses bone marrow transplant patients.

5. Update on Upcoming Focus Groups

Ms. Lee noted that focus groups were used throughout the process of developing the new website and will be used as the website continues to evolve. She said tentative dates for mid-June have been set for the next round of focus groups. The focus groups will review the homepage topics to determine if consumers are interested in this information or if they would like to see anything else. She noted that if any committee members have a chance to review the website and have any recommendations to please pass that along to MHCC staff. She also said if there was any information the committee would want the focus groups to review, to let her know.

6. Other Business

Ms. Smith noted that VHQC is in their recruitment phase for upcoming projects. She noted there are webinars that are open to all, however there are also monthly calls that are available only to network providers who are signed up for VHQC projects. She noted that for the last CMS Statement of Work, VHQC ran a collaborative with the Virginia Department of Health for *C. diff* for nursing homes and hospitals. She said test type and *C. diff* focus definitely made a difference. The collaborative showed an increase in *C. diff* but it began the year that reporting became mandatory. A 45% decrease in *C. diff* was seen in nursing homes. A main focus was reducing erroneous testing. Many facilities were over-testing with PCR. Antimicrobial use was also decreased for asymptomatic bacteriuria. She noted that nursing homes were self-reporting as they were not set-up to use NHSN.

Ms. Smith noted that VHQC is enrolled in a pilot program with CMS and CDC to develop the Targeted Assessment for Prevention (TAP) Report for *C. diff*. They have a draft and will share with the group for feedback. Ms. Smith noted that another way to have better risk adjustment is by reviewing the TAP Report. She said it contains information on the CAD (cumulative attributable difference) and this metric is going to replace SIR at some point. The CAD is a more accurate number; it provides information on the number of infections the facility or unit has above or below the national average. Facilities will know how many infections they need to reduce to reach the national average. Ms. Lee confirmed several committee members would be interested in reviewing the draft TAP Report for CDI. Ms. Smith noted that VHQC has also partnered with Johns Hopkins for the CUSP for Mechanically Ventilated Patients or MVP as the coordinating entity for VHQC provider hospitals. They are recruiting 10 hospitals in Virginia and Maryland for this year-long program to prevent VAEs. There was discussion about the VAE measure and the possibility that it may be removed in the near future.

Ms. Witherspoon noted that one hospital had contacted her concerning a SIR calculation in NHSN involving a patient in two units. A MRSA event was being counted as hospital-onset even though it was a duplicate case with an earlier event in the ED. NHSN was contacted and they responded there was a glitch in the system that they were working on. Ms. Witherspoon requested that hospitals check their data and if there are any similar issues to notify her. Ms. Smith asked if NHSN was going to correct the report. Ms. Witherspoon said that NHSN was aware of the issue and were going to note another occurrence.

Ms. Witherspoon noted that an email will be sent to the IPs later this day clarifying some changes to the MDRO module. The ED and observation unit denominator data has to be submitted separately from FacWideIN. Also a few hospitals had MDRO events in only their ED and not in any inpatient units. The facilities need to check "Report No Events" for the FacWideIN location.

7. Adjournment: Next Meeting Date- July 22, 2015

Ms. Lee adjourned the meeting at 2:00 pm. She reminded the committee will not be meeting in June.