MARYLAND HEALTH CARE COMMISSION

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

February 24, 2016

Committee Members Present
Sara E. Cosgrove, MD, MS
Maria E. Eckart, RN, BSN, CIC
Anthony Harris, MD, MPH
Emily Heil, PharmD
Debra Illig, RN, MBA, CLNC (conference call)
Lynne V. Karanfil, RN, MA, CIC
Stephanie Mayoryk, RN, BSN, CIC
Bryan T. Meehan, Sr.
Brenda Roup, Ph.D, RN, CIC
Rajesh Shah (conference call)
Geeta Sood, MD (conference call)
Kerri Thom, MD
Lucy Wilson, MD, ScM

Committee Members Absent
Andrea Hyatt, CASC
Robert Imhoff
Peggy A. Pass, RN, BSN, MS, CIC
Michael Anne Preas, RN, BSN, CIC
Jack Schwartz, JD
Renee Webster, RS

Public Attendance
Mary Clance (conference call)
Katie Richards, DHMH
Carol Whalen, VHQC
Justin Ziombra, MHA (conference call)

Commission Staff
Theressa Lee
Julie Deppe
Mariam Rahman
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. She introduced four new committee members: Stephanie Mayoryk, Bryan T. Meehan, Sr., Geeta Sood, and Rajesh Shah.

2. Review of Previous Meeting Summary

The minutes of the previous meeting on October 28, 2015 were accepted by the committee with no corrections.

3. Discussion on Evolving Role of HAI Advisory Committee

Ms. Lee reminded the group that the HAI Advisory Committee was established 10 years ago. She reviewed the milestones of HAI quality initiatives in Maryland and noted that Maryland was an early adopter of NHSN. She said that Maryland was one of the worst states in the country with CLABSI and the hospitals were able to bring the infections down by 50% within a few years of public reporting. Active surveillance testing for MRSA began in 2009 and ended in 2012 with high hospital performance. The state also began healthcare worker influenza vaccination in 2009 and Maryland had the highest vaccination rate in the country last year. SSI reporting began in 2010 for hip, knee, and CABG procedures. She noted consumer focus groups were held in 2010 for public reporting of CLABSI data. Data validation began in 2011 and NHSN CDI Lab ID reporting began in 2013. In 2013, the MHCC and HSCRC issued a joint policy statement that expanded Maryland HAI reporting to align with CMS requirements in support of the new All Payer Waiver. This expanded reporting policy added MRSA, CAUTI, and SSI for colon and abdominal hysterectomy procedure data to the list of NHSN HAI data collection requirements effective January 1, 2014.

In 2013, the committee also agreed to direct resources toward a focus on antimicrobial stewardship (AS) and a series of questions were developed and added to the 2013-14 HAI Annual Survey to obtain a better understanding of hospital awareness of and participation in AS activities. In June of 2014, the MHCC staff performed an environmental scan of ASP related activities nationally and within other states. DHMH agreed to take the lead on establishing a statewide AS collaborative going forward. Effective January 2016, the HAI Committee will meet on a quarterly basis. During the interim months, the MHCC meeting room will be used to host the AS Workgroup, led by Lucy Wilson. The workgroup meetings will be open to the HAI Advisory Committee as well as to the public.

Ms. Lee also noted that the development of a new comprehensive consumer-oriented website for reporting quality and performance data has been a major focus in 2014-2015. She noted the expanded responsibilities of MHCC hospital quality staff under the agency reorganization that consolidated all quality, performance monitoring, and public reporting into one center. The new Center for Quality Measurement and Reporting encompasses hospitals, long term care facilities, ambulatory surgery centers and commercial health benefit plans within its scope of operations. The staff is also looking for opportunities to streamline the HAI data quality review and validation process, in light of the expanded data collection requirements. Ms. Lee stated that hospitals have been notified that MHCC staff are no longer able to monitor NHSN submissions on a monthly basis to provide ongoing feedback on data completeness.

Dr. Roup asked about the expansion to outpatient settings. Ms. Lee noted that ambulatory surgery centers are required to report to NHSN on HCP influenza vaccination rates. She noted that the use of NHSN may be required at facilities outside of the acute care setting in the near future such as long term care facilities. Ms. Lee noted that emergency department measures were an area of concern for Maryland hospitals. Mr. Meehan asked if the mission and vision statement had been updated. Ms. Lee said the vision statement is still appropriate but noted the mission statement could be modified.

Dr. Clance asked about the issue of nursing homes as reservoirs of resistant infections and how to improve that. Ms. Eckart said that issue is in the forefront. Dr. Roup mentioned that CMS has a proposed rule that will rewrite the regulations of nursing homes and it included infection control throughout. Each facility would be required to have a designated IP. The draft document is available online. She noted that DHMH trains long term care IPs but these staff members are not currently dedicated to infection control and there is a high rate of turnover. For antimicrobial stewardship, Dr. Roup noted that medical directors need to get involved.

Dr. Harris asked that the committee's vision and mission statement be circulated to the group. The group discussed the changing role of the committee as Maryland aligned with CMS reporting requirements in 2014 as part of the state's CMS waiver. Ms. Lee noted that this changed the role of the committee. The committee's role does not include identifying the HAI types that hospitals will report. She sees the committee's role as a convener of stakeholders, sharing information and collaborating as well as identifying prevention activities and prevention targets, and monitoring progress. Ms. Karanfil noted that the committee never completed a research project on infection control staffing. She noted that Infection Preventionists are tasked with these expanded reporting requirements and no measures have been removed as others have been added, for example the SSIs for Hip, Knee, and CABG. She noted that Pennsylvania addressed staffing needs to support the reporting requirements. Dr. Harris noted that SHEA and APIC are relaying a joint editorial that as reporting requirements have gone up, infection rates are going down, and this is a successful trend. He said more staffing support would be expected but that is not happening. APIC will be releasing a study on manpower issues across the country to set better performing institutions' staffing as the goal for all institutions. He noted there is an *Infection Control & Hospital Epidemiology* white paper on infrastructure requirements for hospital epidemiology that could provide support for hospital infection control programs in negotiations and to provide leverage. The group discussed reviewing the documents and sharing practical information with the hospitals. Ms. Karanfil asked about resources for smaller hospitals in support of antimicrobial stewardship programs (ASP). She said some hospitals do not have infectious disease doctors. Dr. Cosgrove noted that IDSA has written about the role of ID doctors in ASP and discusses their reimbursement. She said hospital administration needs to support ASPs financially. She said academic and private practices will differ in their ASPs. Ms. Heil said ASPs are well represented in academic medical centers but lacking in community settings. She noted there are far fewer ID-trained pharmacists than ID doctors. Ms. Lee noted that MHCC cannot advocate for a certain number of staff members but can share supporting documents and present information to the HSCRC for consideration. Dr. Harris said there are two relevant documents, on addresses the skill set needed for a hospital epidemiologist (ICHE). Dr. Harris said the documents are very long and a quick summary is needed, including a reasonable number of FTEs for the size of the hospital. Mr. Ziombra stated the infrastructure document would be helpful for engaging discussions with HSCRC.

4. Maryland Health Care Quality Reports

Review Updates to the Website

Ms. Rahman reviewed the layout of the comprehensive website including the new Health Plan Guide and the feature topics related to preventing infections. She noted that these will be updated

on an on-going basis. She also mentioned that users can sign up for updates. Ms. Rahman discussed the private side of the website that is used for data submission by the hospitals. This area will be expanded to share documents with hospitals and as a communication tool for posting notices, schedules, and policy documents.

Ms. Rahman reviewed the updated hospital emergency department wait time measures and noted that Maryland hospitals are performing below the national average for both inpatient and outpatient measures. She also noted the updated hospital pricing data and the enhancements to the Health Plan Guide

Mr. Meehan asked if analytics were used on the website. Ms. Rahman said Google Analytics are available on the website. Dr. Harris stated the more data available, the more confused consumers may be about how to interpret the data. He would be interested to see how many times people view the more detailed data on the website. Mr. Meehan noted the website had a lot of good information but people may not be aware it's available. Ms. Lee agreed and noted that the staff is charged with increasing public awareness and use of the website, but the center is extremely short staffed currently. Mr. Meehan noted it would be interesting to see how many people are accessing the website through mobile devices and how the website views on those devices. Ms. Lee noted that making the website mobile friendly was an option but at the time it was not a high priority. It will be on a list for future enhancements. Mr. Meehan noted that more people use mobile devices over home computers.

Discuss Dissemination Strategies

Ms. Lee noted that a Request for Information (RFI) notice has been posted to get additional information from marketing and public relation firms on increasing public awareness and use of the site. The staff created a dissemination plan that is very broad, but a more focused approach is needed to engage targeted audiences.

5. Discussion of Upcoming Public Reporting of CLABSI and CAUTI

Expansion to Adult/Pediatric Medical/Surgical Wards

Ms. Witherspoon noted that CLABSI and CAUTI reporting was expanded to adult and pediatric medical, surgical, and medical/surgical wards as of January 1, 2015. This data will be reported for first time in April. Ms. Rahman showed how the table is currently displaying and Ms. Witherspoon noted that staff recommend updating the sub topics to broader categories of ICUs only, Non-ICUs only, and Total Units to be more consumer friendly. Ms. Witherspoon noted that NICU is not required for CAUTI reporting. She said CMS currently rolls all ICUs into one data display for consumers. NICUs are no longer broken out by birth weight categories for reporting. The committee recommended that NICU be reported separately from the other ICU categories for CLABSI. The committee agreed to the following categories - ICU, non-ICU, and total for CAUTI; and ICU, non-ICU, NICU, and total for CLABSI.

ICU Specific Data Display

The ICU-specific data would still be available in a PDF format in either the private side or as a link at the bottom of the table for those who are interested. Dr. Wilson asked if the more detailed

ICU-specific data would be available to people outside of the hospitals. Ms. Lee said yes the data would be available to everyone with no password required.

SIR for Smaller Hospitals

Ms. Witherspoon noted that for CLABSI, CAUTI, and SSI data, SIRs were being calculated by MHCC staff if NHSN did not provide the calculation. This impacted low denominator hospitals as NHSN will not calculate a SIR if the number of expected infections is less than 1. NHSN recommends against calculating SIRs in these instances as the statistic is not precise. Staff are recommending that manual calculations no longer be done for these HAI categories. Ms. Witherspoon noted that the hospital performance will state "not enough data to calculate." She noted that CY2015 CLABSI preliminary data showed 14 hospitals would be impacted in one of the new sub topics; four hospitals would have all their totals affected. The data will still be available to view on the table. Dr. Harris noted that the SIR is not meant to compare two hospitals. Ms. Lee stated that HSCRC is also using this data now and consistency is important. The committee agrees with this change.

6. Discussion of SSI SIR for COLO and HYST (CMS Complex 30 Day vs Complex A/R)

Ms. Witherspoon noted that CMS is using the Complex 30 Day SIR while MHCC is reporting with the Complex A/R (Admission/Readmission) SIR. Ms. Witherspoon reviewed the differences between the two SIRs and noted that HSCRC is requesting the CMS Complex 30 Day SIR for their calculations. She noted that only infections found during admission and readmission are counted in the Complex A/R SIR and this model also risk adjusts on more factors than the CMS Complex 30 Day SIR. She noted that the CMS SIR is only available for colon and abdominal hysterectomy. Dr. Sood noted that procedures that last too long are also excluded from the CMS SIRs. Ms. Witherspoon noted that the next update of SSI data will be in July.

Ms. Witherspoon reviewed comparison data between the two SIR models. The procedure counts are not the same for every facility between the two SIR models. She noted the state's performance based on the SIR for abdominal hysterectomy went from "same" under the current model to "worse" under the CMS model. The current Complex A/R model has more procedures and less infections than the CMS model for the state. Dr. Harris asked if most of the other states are using the CMS model. Ms. Witherspoon noted she was on a VHQC call and Virginia was using the Complex A/R model that Maryland is currently using. Dr. Thom noted that it would be helpful to have the data match between the organizations. Mr. Ziombra noted the Complex 30 Day SIR is on Hospital Compare for CMS. Ms. Lee reiterated that this model is not available for the other SSIs of hip, knee, and CABG. Dr. Sood stated that the Complex A/R model is more clinically relevant and should be used by CMS. Dr. Harris noted that the CMS model requires good communication between facilities. He said NQF may be the best organization to discuss the measure before it is endorsed and put into effect. Ms. Mayoryk stated that the data is retrospectively risk adjusted. Dr. Thom stated that NHSN is re-running analysis with 2015 data that will impact the SIRs. Dr. Harris asked if the website had facilities' overall patient case-mix information, for example a facility that sees high acuity patients would be identified. Ms. Lee stated that data is not currently on the website. Dr. Harris said that would be valid to provide to highlight disparities in patients seen in each hospital. Ms. Lee said this would be at the hospital-level. Dr. Harris noted that the risk-adjustment on the SIRs is not perfect. If a hospital has a high

risk population, this will impact the performance as well. Ms. Karanfil noted that infections are being reported that are not considered clinical infections to follow surveillance definitions. Dr. Sood noted that Pennsylvania and Israel create peer groups to compare hospitals including academic hospitals and community hospitals to compare similar hospitals. She was interested in the case-mix index as a parameter. Dr. Harris said the consumers should be aware the measures are risk-adjusted but that the methodology is evolving. Ms. Mayoryk stated that only age and ASA score are used for risk adjusting the CMS Complex 30 Day SIR model and the data would lose the more robust risk adjustment of the A/R model. Ms. Lee asked how important it was to align with HSCRC and CMS. Ms. Karanfil stated that the issue is to improve and the A/R model is needed with the more robust risk adjustment. Ms. Lee noted that regardless of how the data is publicly reported, HSCRC will receive the data in the CMS 30 Day Complex SIR model. Dr. Cosgrove mentioned that the rationale for using the other model could be provided on the website to explain the differences. The committee decided to stay with the current A/R model for SSI public reporting.

7. <u>Update on CDC Release of 2014 HAI Progress Report</u>

Ms. Witherspoon discussed the 2014 HAI Progress Report and noted the data is CY2014. This was the first year CAUTI and MRSA were required to be reported and the first full year of CDI reporting. Maryland continues to do well with CLABSI compared to the baseline; however, compared to the nation's performance last year, Maryland is beginning to level off while the nation continues to improve. CAUTI is 35% higher compared to the baseline and 36% higher than the 2014 national SIR. Ms. Witherspoon pulled preliminary 2015 data and CAUTI is showing improvement. MRSA bacteremia is 22% higher compared to the baseline and 41% higher than the 2014 national SIR. Preliminary CY 2015 data shows no improvement. CDI LabID is 20% higher than the baseline and 31% higher than the 2014 national SIR. CY2015 CDI LabID data is showing improvement. Dr. Thom asked if the improvement in CAUTI was due to the definition changes in NHSN as of 2015. Ms. Witherspoon will look into that as there was a huge decrease. Dr. Harris asked if CDI is adjusted for testing method, Ms. Witherspoon stated the data is adjusted for CDI testing. Ms. Witherspoon noted VHQC noted Maryland hospitals had higher rates of CDI than Virginia hospitals and the group was going to look into testing methods in Maryland vs Virginia hospitals to see if that was impacting the data. Dr. Cosgrove stated there is a lot of MRSA present in Baltimore and hospitals are going to have more people coming in to facilities with risks for this infection. Ms. Mayoryk stated persistence infections are being reported repeatedly for the same patient. Mr. Ziombra asked if the data in the report was only for required units or everything in plan for the hospitals. Ms. Witherspoon stated CDC has followed CMS requirements in the past reporting on ICUs and wards, but she will confirm. Ms. Richards noted that not just acute care hospitals are included in the report. Ms. Witherspoon said 48 hospitals are included in the report and MHCC reporting covers 47 hospitals. Ms. Karanfil asked if MHA would come up with talking points. Mr. Ziombra said they are. Ms. Witherspoon noted abdominal hysterectomy SSI was 18% higher than baseline but not significantly higher and 44% higher than the 2014 national SIR (statistically significant). Ms. Witherspoon stated colon surgery SSI was 4% lower than the national baseline and 1% lower than the 2014 national SIR but neither were statistically significant. Ms. Witherspoon noted that VHQC has a collaborative with 20+ Maryland hospitals focusing on CLABSI, CAUTI, and CDI. The question was asked where Maryland ranks in the nation. Ms. Witherspoon will confirm and update the

committee. The committee discussed the high Maryland MRSA prevalence and how that impacts hospital data. They noted MSSA is also a dangerous infection but it is not measured.

8. Other Business

Dr. Wilson noted the Antimicrobial Stewardship group will be meeting after the HAI advisory meeting for an initial discussion and planning meeting. Ms. Lee noted this meeting will be held on a monthly basis while HAI advisory meetings will be held quarterly. For March, the ASP meeting will be held during the normal HAI advisory meeting time. Committee members are welcome to attend.

9. Adjournment: Next Meeting Date- April 27, 2016

Ms. Lee adjourned the meeting at 3:00 pm. She reminded the committee the next meeting is scheduled for April 27, 2016.