MARYLAND HEALTH CARE COMMISSION

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

January 22, 2014

Committee Members Present
Beverly Collins, MD, MBA, MS (conference call)
Sara E. Cosgrove, MD, MS (conference call)
Jacqueline Daley, HBSc, MLT, CIC, CSPDS
Maria E. Eckart, RN, BSN, CIC (conference call)
Elizabeth P. (Libby) Fuss, RN, MS, CIC (conference call)
Anthony Harris, MD, MPH (conference call)
Emily Heil, PharmD (conference call)
Debra Illig, RN, MBA, CLNC (conference call)
Lynne V. Karanfil, RN, MA, CIC (conference call)
Michael Anne Preas, RN, BSN, CIC (conference call)
Brenda Roup, Ph.D, RN, CIC
Jack Schwartz, JD (conference call)
Kerri Thom, MD (conference call)
Renee Webster, RS (conference call)
Lucy Wilson, MD, ScM

Committee Members Absent
Andrea Hyatt, CASC
Robert Imhoff
Peggy A. Pass, RN, BSN, MS, CIC
Patricia Swartz, MPH, MS

Public Attendance
Mary Clance (conference call)
Julia Gardner (conference call)
Kerri Huber (conference call)
Carolyn Jackson (conference call)
Donna Lemmert (conference call)
Christina Ward (conference call)
Trish Perl (conference call)
Katie Richards (conference call)
Janet Robinson (conference call)
Geeta Sood (conference call)
Commissioner Fran Phillips (conference call)

Commission Staff
Theressa Lee
Evanson Mukira
Mariam Rahman
Eileen Witherspoon (conference call)

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

Ms. Lee asked the committee members to inform staff if they had any edits to the October 23, 2013 meeting. The summary will be approved at the next meeting.

3. Update on FY2013 CLABSI Data & CY2012 SSI Reporting

Mr. Mukira stated that Maryland hospitals reported 187 CLABSIs in ICUs for FY2013. He noted that when reporting began for FY2010, 472 cases were reported. The reduction from FY2010 to FY2013 is approximately 60%. Adult ICUs saw an approximate 61% reduction from FY2010 to FY2013; NICUs had a 27% reduction from FY2010 to FY2013. Maryland has improved and is now better than the national average. Mr. Mukira noted that in FY2010, six hospitals had zero infections; that number has increased to 17 hospitals for FY2013.

Ms. Lee noted that Maryland has improved substantially since reporting began in FY2010. She noted that Maryland was one of the first states to report and audit this data which may have impacted the higher rates of infection first seen in FY2010. She noted that the reduction from FY2012 to FY2013 was around 9% so the reduction rate is slowing. She said HHS set a target of a 50% reduction in CLABSIs in 5 years and Maryland met that in 3 years. She assumes the reduction rate will continue to level off.

Ms. Fuss noted that the last column on the document should state that this is the difference from FY2010 to FY2013. Several hospitals did not show an improvement as they had zero infections for both FY2012 and FY2013. Ms. Lee stated that with the new guide, the data will not be presented this way. Ms. Daley asked if there was any insight as to why the NICUs were not improving like the other ICUs. Mr. Mukira noted that there are 16 NICUs compared to about 90 ICUs. Ms. Daley asked if all the birth weights were rolled into one group. Mr. Mukira stated that was the case. Ms. Daley said in the redesign that should be made clearer. Ms. Lee noted that NHSN does not publicly report the NICU data. Dr. Clance noted that chlorehexidine is not used in NICUs for line placement and maybe that played a part.

Ms. Lee stated the data would be posted to the Hospital Guide within in the next two weeks.

Ms. Lee stated that SSI data is collected on hip, knee, and CABG procedures. Reporting began in CY2011 and CDC required a 12 month period of monitoring for any procedure with an implant. There was a 13% decrease in CY2012 from CY2011. Three hospitals performed better than the national experience, three hospitals performed worse. Ms. Daley asked if the audit on CY2011 data would impact these results. Ms. Lee stated that this document does not reflect the audited data. She said MHCC must balance releasing current data with releasing audited data. Ms. Lee noted that the audit did find several under-reported SSIs which would need to be added. Ms. Lee noted that hospitals were able to preview and correct any inaccuracies in the document. Ms. Daley asked if data was going to be posted to the Hospital Guide prior to audits in the future. Ms. Lee said the committee should spend some time on that issue in the future. Ms. Lee noted that waiting for the audit to be completed will result in less timely data on the Guide. She stated that with CLABSI, the audits have resulted in fairly minimal data changes over time. She expects this to happen with SSIs as well.

Ms. Phillips, a new MHCC Commissioner, wanted to thank the group and commission staff on their work with HAIs. She stated commissioners have asked whether Maryland should raise the bar to look at the top 10% of states and make that the target for HAIs going forward. Ms. Fuss noted that very few states audit the data and that auditing is essential to being able to trust the data. Ms. Lee said the group can talk about the metrics and this will impact the redesign of the Guide. She mentioned one possibility is that hospitals could be compared to the national experience and also to other hospitals in the state.

4. <u>Discussion on SSI Audit</u>

Ms. Witherspoon stated that the current SSI audit focused on numerator cases for CY2011. Originally both CY2011 and CY2012 were to be included in the audit, but the data analysis for CY2012 would have delayed the audit. For the audit, 442 cases were identified as possible under-reported cases based on analysis of NHSN data compared to HSCRC administrative data. Forty-two Maryland acute care hospitals have been audited to date. Based on the chart reviews completed at those hospitals, there have been 17 confirmed under-reported cases. Dr. Harris asked if there was any document with this information. Ms. Witherspoon stated that final reports for the hospitals as well as an educational webinar will be available once the results of the audits have been finalized. Ms. Fuss noted there were 46 hospitals total. Ms. Witherspoon stated that 3 hospitals did not have any cases in the targeted group and one hospital did not perform any of those surgeries.

Ms. Fuss stated she was concerned that the cases were picked based on the coding data. She felt that the audit did not target SSI surveillance cases. She said that differences between surveillance data and coding data were highlighted, and the audit did not check if surveillance definitions were followed. She would like to have more information on the selection of charts. She stated she did discover coding issues on 2 cases at her hospital and that was useful. Dr. Harris asked if Ms. Fuss wanted additional information on how the cases were randomly selected. Ms. Fuss stated it appeared that the cases were not randomly selected, but targeted as possible under-reported cases. She stated no reported SSIs were checked to validate that part of the surveillance was correct. She was not sure if other hospitals had their SSI data checked. She said over-reporting would not be detected if only under-reported cases were targeted. She stated that this needs to be balanced in future audits. Ms. Lee stated that the administrative data was used as a screening tool only. With limited funds, MHCC wanted to focus the audit. Ms. Lee noted that 17 cases were identified using the administrative data and several hospitals have recognized coding issues. Some hospitals have asked for the auditors' tool so they can check their own data. Ms. Fuss said infections in the coding may have nothing to do with the surgical site. Ms. Lee stated that the committee will need to determine how the cases will be chosen with the next audit as this is an evolving process. Ms. Daley agreed with Ms. Fuss that the audit focused on the coding of the cases. She felt that the audit pointed out coding issues and process issues. She hopes the next audit would focus on SSIs and whether she called the case correctly. Ms. Witherspoon stated that no over-reports were found at this point in the audit in regards to Ms. Daley's question.

Dr. Sood noted that NHSN's criteria changed for POA (present on admission) criteria for SSIs. Previously a patient with an infected joint who underwent a second stage revision, would not be

considered a SSI if the joint became infected with the same organism. It would be considered POA and excluded as an HAI. The new definition however does not allow for this exclusion. Dr. Sood expressed concern that this will discourage surgeons from performing revision surgeries as well as discourage best practices to cure these infections. She has contacted CDC with her concerns. CDC replied that beginning in calendar year 2015, they will allow hospitals to qualify those infections with a field to note that this infection was present in the previously infected joint. She does not think these cases should be part of public reporting. Ms. Daley agreed and has also contacted CDC about the issue. She stated that a patient can still have an infection in the joint even when pathology shows otherwise. She thinks the data should not be included in NHSN data as well. Dr. Sood will forward the email communication with CDC. Dr. Sood noted that this is a new issue. Ms. Fuss stated that MHCC should be able to decide whether or not to report these cases as they have made similar decisions in the past, for example to exclude superficial SSIs from public reporting. Ms. Daley mentioned that MHCC benchmarks against NHSN's national rate so that would be impacted if the cases were removed from analysis. She suggested an asterisk be added to explain. Dr. Harris agreed these cases should not be publicly reported and to add an asterisk. She mentioned that she has concerns if these cases are left in, that it could lead to underreporting and changing practices that do not follow standards of care. She said decisions are made based on public reporting numbers. Ms. Lee said the committee will revisit this issue. She stated that MHCC may be restricted by the need to be consistent with CMS in regards to public reporting.

5. <u>Discussion on Antimicrobial Stewardship Programs</u>

Ms. Lee stated that Commissioner Fran Phillips has mentioned the need to implement a statewide strategy for Antimicrobial Stewardship Programs (ASP). Commissioner Phillips stated other states have worked with hospitals to implement ASPs. She stated that ASPs are important in preventing MDRO infections upstream, instead of reacting to MDROs. She emphasized the need to collaborate across institutional boundaries and with the community to prevent antibiotic resistance. She also noted that this issue is an opportunity to be creative in addressing the challenges associated with the new Medicare Waiver. She stated that Maryland should look for model best practices to adopt.

Dr. Cosgrove noted that Johns Hopkins Hospital and University of Maryland Medical Center received a contract from CDC. They will work collaboratively to study implementation of stewardship programs in community and academic hospital settings. The group will be creating resources and Dr. Cosgrove said the resources can be made available for other institutions. Hospitals participating under the Hopkins system are Sibley, Suburban, Johns Hopkins Hospital, and Bayview. University of Maryland hospitals include University of Maryland Medical Center and St. Joseph Medical Center. The collaborative will include extensive data collection. One feature will be the implementation of an antibiotic timeout in which pharmacy will identify any patients on antibiotics for 48-72 hours and trigger a review by the ASP team. They will also develop forms and educational materials which will be used as part of the implementation. These may be helpful for the statewide collaborative. While the Hopkins-UMMC collaborative cannot expand the official CDC project, they would be happy to share the educational materials. Dr. Cosgrove believes the statewide ASP initiative has good timing as CDC is providing a Vital Signs on ASP in March. There will be a press conference along with web-based and written

materials available. She said that the statewide initiative should decide what ASP to implement and what tools are already available. Dr. Thom reiterated the willingness to help other hospitals if they want to institute an ASP.

Dr. Wilson suggested the formation of a subcommittee in the HAI advisory committee to focus on ASP. She noted that the MDRO collaborative may be another possible place to house the ASP initiative. She noted that perhaps the group could use the next point prevalence survey to determine antibiotic use. She mentioned other work DHMH has done that is relevant including CRE and Acinetobacter surveillance from labs, and the *Get Smart* program in outpatient settings which looked at clinical documentation support systems and electronic order entry. She had worked with a pilot program at a VA hospital on the Eastern Shore looking at electronic records and ASP in upper respiratory infection cases. There is also a an ASP option in a pilot program at a long-term care facility that is working with DHMH on a *C. diff* initiative. She mentioned Dr. Roup teaches at the Infection Control Institute and perhaps she could push for more ASP education.

Ms. Jackson reviewed pertinent initiatives underway with Delmarva including *C. diff* prevention. Ms. Jackson mentioned that other states have been successful in lowering the infection rates and antibiotic usage. In the California model, acute care hospitals are given a menu of options of how to participate in stewardship. The hospitals can use what they already have and add on regional support measures. Ms. Jackson noted that it will be important to engage hospitals, especially hospitals in the *C. diff* collaborative to determine where they are in regards to implementing ASP. Ms Illig mentioned that ASP has been an integral part of the Adventist plan for 2.5 years. She recommended that this ASP initiative add to what hospitals have already established. She would be willing to share what Adventist has done.

Dr. Heil mentioned that the Maryland Society for Health System Pharmacists has an ASP Committee that she chairs, which includes 26 hospital representatives. She noted that these pharmacists perform ASPs as part of their job requirement. She stated they would be a good resource for intervention ideas and data. The committee has monthly conference calls. Dr. Wilson asked if the calls were open to non-pharmacists. Dr. Heil will check, but she believes the calls are open to the public.

Commissioner Phillips noted that the current ASP efforts in the state were not as coordinated as they could be. She stated that a good question for further consideration is where to best house the locus of coordination. She noted that other groups to include could be primary care physicians and ambulatory settings, as well as patients to provide education. She stated the group needs to determine best practices and core elements for ASP in various settings. She also reiterated the need to use resources that are already underway. Ms. Jackson said CDC published a change package that she will forward to the group. Dr. Wilson mentioned she could send out the 2007 IDSA guidelines. Dr. Cosgrove noted that a revision to those guidelines is due out by the end of year.

Dr. Cosgrove asked if there were ASP questions on the IPC Annual Survey. Ms. Lee confirmed that there was one question currently on the survey. Dr. Cosgrove stated it would be helpful to get an understanding of what hospitals and long-term care facilities are currently doing or what

they would need from the group. Ms. Lee stated that staff will add additional questions to the survey. Ms. Illig recommended adding a question about ASP metrics currently in place. Dr. Wilson asked if the CMS survey has similar questions that MHCC could use. Dr. Cosgrove mentioned that the CMS survey was a draft document, and she was not sure if the ASP questions were permanent. Dr. Sood mentioned that she was asked by Joint Commission if the hospital had an ASP in place, but the question was vague. They asked how the ASP worked. Ms. Illig mentioned that she was also asked about ASP on several Joint Commission surveys but the questions varied each time. Ms. Fuss suggested adding a question asking how data mining software has helped with ASP implementation. Dr. Cosgrove suggested adding a question for the hospitals to identify a contact for future ASP materials, trainings, etc. Commissioner Phillips mentioned some other possible groups to contact including the Patient Safety Center, DHMH, and the Quality and Cost Council.

6. Update *Clostridium difficile* Reporting through NHSN

Ms. Witherspoon stated that the CDI data has been entered by all hospitals from July through November 2013. Once December data has been entered which is due at the end of January, MHCC will have 6 months of data available and will provide preliminary results at that point.

7. Review of Upcoming 2013-2014 HCP Influenza Vaccination Reporting Requirement

Ms. Lee noted that the NHSN module will be used for the first time this year. She stated there is movement to have an outpatient HCP influenza vaccination reporting requirement. MHCC was concerned about how to separate inpatient from outpatient HCP. Additional work is needed by CDC to create these mutually exclusive surveys. Ms. Lee noted that MHCC is now collecting information to support the modernized waiver, including outpatient data. Issues may come up as to which facilities are included and how it impacts inpatient reporting. Ms. Daley noted that CMS is publishing data on outpatient criteria and focusing on population health. Ms. Lee stated that questions about outpatient NHSN measures will need to be addressed with HSCRC. The issue of infection prevention program staffing was discussed as the increase in reporting requirements is an issue.

8. Finalize 2014 Infection Prevention and Control Annual Survey

Ms. Witherspoon will update the survey based on the ASP discussion. She will send out the questions to the group for a final review. Ms. Jackson suggested adding a question about average daily census. Ms. Fuss agrees with that addition. Ms. Witherspoon suggested removing "mixed" as an option for surveillance. The MRSA test question will remain as the MRSA bacteremia reporting requirement began January 1st. There was a suggestion to remove the mandatory influenza vaccination question. Ms. Witherspoon stated that while most hospitals do have that policy in place, not all hospitals do. This question will allow staff to trend the mandatory policies over time. Ms. Jackson asked when the survey will be sent to the hospitals. Ms. Witherspoon said the survey should go out by the end of January or early February.

9. Update on MHA Activities

No updates reported.

10. Other Business

Ms. Lee reported that the new modernized Medicare Waiver has been approved. MHCC has agreed to align hospital reporting requirements to CMS requirements in support of the new waiver. As a result, there are new HAI data reporting requirements that apply to Maryland hospitals (e.g,, CAUTI in ICUs, SSI for colon and abdominal hysterectomy).

11. Adjournment

The meeting adjourned at approximately 2:47 p.m. The next meeting is scheduled for February 26, 2014.