MARYLAND HEALTH CARE COMMISSION

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

March 26, 2014

Committee Members Present
Sara E. Cosgrove, MD, MS
Jacqueline Daley, HBSc, MLT, CIC, CSPDS
Elizabeth P. (Libby) Fuss, RN, MS, CIC
Emily Heil, PharmD (conference call)
Debra Illig, RN, MBA, CLNC
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
Renee Webster, RS
Lucy Wilson, MD, ScM

Committee Members Absent
Beverly Collins, MD, MBA, MS
Maria E. Eckart, RN, BSN, CIC
Anthony Harris, MD, MPH
Andrea Hyatt, CASC
Robert Imhoff
Peggy A. Pass, RN, BSN, MS, CIC
Patricia Swartz, MPH, MS

Public Attendance
Mary Clance (conference call)
Carolyn Jackson (conference call)
Erin Jones
Daryl Lazaro
Bev Miller
Rebecca Perlmutter
Katie Richards
Elizabeth Vaes (conference call)
Christina Ward (conference call)
Yuan Zhao
Commissioner Fran Phillips

Commission Staff
Ben Steffen
Theressa Lee
Kendall Kodey
Evanson Mukira
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.

2. Review of Previous Meeting Summary

The minutes of the previous meeting on January 22, 2014 were accepted by the committee with no corrections.

3. Review of new Maryland Quality Measures Data Center (QMDC) website

Ms. Lee stated the Hospital Guide is being redesigned. She reviewed the website framework with the group. She stated there will be a broader healthcare guide with different settings/providers guides available for consumers. She stated two focus groups have been held with a contractor. She said the HAI data is a priority for the first release of the guide. Consumers did not understand all the statistics with the HAI data. Additional focus groups will be held in April. Draft web pages will be presented to the consumers in the next focus groups. She noted that currently hospitals are compared to the national benchmark and there is no statewide metric. She mentioned comparing hospitals to a state metric and this may be presented to the focus group participants. She also noted that the website serves as a portal for hospitals to submit confidential information.

Ms. Lee stated that Maryland has been invited to participate on a workgroup of the Council of State and Territorial Epidemiologists on HAI data analysis and presentation. The group is working on standardization of HAI data elements for both consumers and healthcare professionals.

4. Update on SSI Audit

Ms. Witherspoon stated that the SSI audit was completed. For the audit, 419 cases were reviewed. Of these, 21 were under-reported SSIs. This is approximately 5% of the total cases reviewed. All but three final reports have been shared with hospitals. Updates to NHSN are due within two weeks of receiving the final report. A webinar will be held in the near future to review the results of the SSI audit with the hospitals. Ms. Lee stated that one meeting was held with a hospital to review the cases with the IP and other hospital staff including a surgeon. Ms. Lee stated that the SSI audit is meant to be a learning experience for both MHCC and the hospitals. She noted the challenge of whether or not to publicly report the data before the audit has been completed in the interest of timeliness. Ms. Lee said in the future there may be targeted auditing that does not include all hospitals.

5. The Maryland Antimicrobial Stewardship Project- A Statewide Initiative

Ms. Lee introduced Commissioner Fran Phillips and MHCC's Executive Director, Ben Steffen. She stated if the entire group was agreeable, Antimicrobial Stewardship could be a major focus of the group going forward for 2014 and 2015. The group could provide leadership to share best practices. Ms. Lee also spoke about providing education and guidance. Ms. Lee said hospitals may already have ASPs and the group needs to determine what role they would play. Dr. Wilson

stated that as a first step, the group could highlight what other organizations are already doing in regards to ASP in Maryland including, MHA, Delmarva, MHCC, DHMH, academic and non-academic hospitals. Mr. Lee mentioned that ASP questions were asked on the IPC survey. Ms. Witherspoon stated that 38 out of the 46 hospitals stated that an ASP is already in place. Of the 8 hospitals who stated they did not have an ASP in place, barriers included:

- Pharmacy not staffed to provide support (8 hospitals)
- No access to infectious disease physician and no access to pharmacist with infectious disease training/certification (7 hospitals)
- Limited or no support from hospital administration (2 hospitals)

Ms. Witherspoon stated that most hospitals are using antibiograms as a supplemental strategy. Over half of the facilities are educating staff, and promoting and implementing evidence based clinical practice guidelines with input from multiple disciplines. In regards to metrics/targets, many of the IPs were unsure, which may suggest that the ASP is not housed in Infection Control. Ms. Fuss stated that CEOs should be made aware of this initiative very soon as hospitals may need new positions to accomplish this. She believes this may be a major barrier. Dr. Wilson mentioned that CDC has "identifying leadership" as a core element of an ASP.

Dr. Cosgrove noted that many hospitals may have certain processes in place, but those alone do not constitute an ASP as defined in the CDC's Vital Signs documents. She noted that physician perception and related issues need to be addressed in a comprehensive way. Dr. Cosgrove mentioned that she and Dr. Thom are working with three community hospitals on a contract with CDC. She said there are people, mainly pharmacists, at each institution who are interested in ASPs and have started some of their own processes. She said the hospitals voiced concern over the need for support for an ASP from hospital leadership so they can communicate with physicians in a collegial environment. One of the main barriers is physician autonomy. Hospital leadership must make antimicrobial stewardship a priority and clearly articulate this to physicians. These programs also need financial resources. She and Dr. Thom are currently working on creating materials for this 2 year contract that she is willing to share with other facilities. Mr. Steffen asked if the hospitals already had an ASP in place or whether this program aimed to start an ASP. Dr. Cosgrove said the communication is determining what the hospital has in place and how they can help. There is a tool that encourages antibiotic timeout at 48-72 hours. A pharmacist would fill this paper out and deliver it to the treating physician. This would lead to a discussion about whether the antibiotics are still needed and what is the plan for the patient. Dr. Cosgrove said the contract involves holding conference calls, developing teaching materials, and having a presence at these institutions. Dr. Thom stated that they are tailoring the ASP to each facility. Dr. Cosgrove noted that the first meetings at the hospital included C-suite executives. She emphasized the importance of C-suite support for the initiative. Ms. Webster suggested converting the 7 core elements of the Vital Signs report into reportable, measurable data which may help hospitals put resources into ASPs.

Commissioner Phillips stated the Vital Signs lays out a way to move forward to an achievable goal. She discussed the need for a clearly defined goal. She discussed the need to include HSCRC and the Maryland Quality and Cost Council. Ms. Lee stated she had reached out to HSCRC to provide a representative for the group. Ms. Lee stated that California passed legislation that every hospital must have a system in place to evaluate the judicious use of

antibiotics. Ms. Lee envisions the statewide initiative would raise awareness of the need for ASP and perhaps implement certain guidelines that hospitals must have in place in terms of an ASP. The group discussed the need for collaboration among stakeholders who are also working on ASP in Maryland. Ms. Fuss said one goal of the group should be to define the components that need to be in place for a true ASP as some of the hospitals may be confused. Dr. Wilson noted that Georgia has a statewide program and they have an honor roll that highlights specific hospitals. She noted that it may not be possible to compare hospitals since each may be doing different ASP components. She said hospitals should show improvements or outcomes over time. Mr. Steffen noted the need for a framework going forward to detail the group's objectives. Dr. Thom stated that the plan should include roles and responsibilities, and list of potential tools. Dr. Cosgrove mentioned the need to tailor the ASP to the hospital and the need for all stakeholders to be on the same page.

Ms. Lee stated that staff can develop a proposal for the group to respond to, including the need for hospitals to meet the CDC requirements and the importance of CEO involvement. Ms. Miller from the Maryland Hospital Association (MHA) noted the American Hospital Association (AHA) is going to have a toolkit available in the summer with strategies to encourage appropriate use of antibiotics. Ms. Miller stated the Joint Commission (JC) may have ASP questions in the surveys, but it is not necessarily consistent. Ms. Webster said neither JC nor CMS has defined ASP. The National Patient Safety Goals are not specific, but state that an ASP should be in place. Ms. Fuss asked about literature showing efficacy of ASPs. Dr. Cosgrove stated there are articles that show infections decrease with ASPs and that the duration of antibiotic therapy is cut in half with prospective audit and feedback. Dr. Cosgrove stated hospitals should move quickly from proving they have a program in place to starting specific interventions. Dr. Cosgrove said hospitals should provide before and after data and given a list of 10 things to consider initiating. This will start quarterly meetings and the hospital will have to research how to obtain baseline data on antimicrobial use, as well as involve physicians and obtain data for follow up. Ms. Daley discussed efforts at her hospital and how it was tied into other efforts including reporting infection data to CMS, readmissions, and cost.

Dr. Wilson noted there are 15 interventions listed in CDC's framework and the group could create a list for hospitals from that section. Ms. Daley noted the need to involve community physicians. The group discussed the difficulty in targeting outpatient physicians. Patient request for antibiotics was also discussed as an issue. The group spoke of a need for a marketing campaign to target this problem. Ms. Webster noted that urgent care is not regulated, but suggested involving Patient First and MedStar Urgent Care in the workgroup. The group discussed CME requirements and the possibility of AS being made into a learning requirement. Commissioner Phillips noted that they could promote ASP through the boards. She discussed the need for professional and public outreach. Ms. Karanfil offered to reach out to MedStar Urgent Care. It was noted that community hospitals may not have the staff or resources to implement an ASP.

Ms. Illig noted at Adventist, post acute care facilities (specialty hospital, home health division, etc.) were included in their ASP. She noted the opportunities if the ASP was scalable and had key components that could be used in different settings. The group discussed the role of long term care facilities and the need for interventions specific to that setting as well. Dr. Cosgrove

stated that the federal level will likely make this a requirement in the coming years. CMS is interested in considering ASP as condition for participation and the NHSN AUR module will likely become a requirement. This initiative will help hospitals get ahead. Dr. Cosgrove noted that very few institutions in the US are using the AUR module. She discussed the issue with the vendors who appear to be waiting for the module to become a requirement before adding the capacity. Dr. Cosgrove does not think hospitals should be required to use that module at this point. Ms. Illig asked if there was a list of vendors who allow this data feed. Dr. Cosgrove said they all state they are working on it but that more money would be needed from the hospitals to implement. Mr. Steffen discussed asking vendors who sell systems in Maryland if they have this capability. Dr. Cosgrove stated most vendors are aware of the AUR module but cannot give a date as to when they can support the use of that module. Hospitals do not have additional funds to support this right now.

Ms. Jackson noted that CMS' next Scope of Work (SOW) will come out this summer and AS is a focus. Delmarva is working with 17 hospitals in Maryland. Most have an ASP but they don't have processes in place or leadership support. Delmarva provides webinars and data analysis.

Ms. Lee stated that staff will write up options for next steps and a plan for a statewide initiative including public awareness. Ms. Lee introduced Yuan Zhao, a Hopkins intern working on ASP. Mr. Steffen asked Dr. Cosgrove and Ms. Illig to share their specific program information. Dr. Cosgrove discussed involving third party payers in the discussion of ASP as they could impact hospitals. Ms. Lee noted that a third party payer representative used to be on the HAI Advisory Committee but a replacement is needed. Dr. Cosgrove noted that Kaiser CA has a large stewardship program. The group will look into ASP in Kaiser MidAtlantic.

Ms. Lee announced that Ms. Fuss is retiring and thanked her for her years of service.

6. Other Business

There was no other business.

7. Adjournment

Ms. Lee adjourned the meeting at 2:45pm.