MARYLAND HEALTH CARE COMMISSION

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

July 27, 2016

Committee Members Present	**Committee Members Absent**
Veronica Black, MBA	Maria E. Eckart, RN, BSN, CIC
Sara E. Cosgrove, MD, MS (conference call)	Anthony Harris, MD, MPH
Lynne V. Karanfil, RN, MA, CIC (conference call)	Emily Heil, PharmD
Stephanie Mayoryk, RN, BSN, CIC	Andrea Hyatt, CASC
Bryan T. Meehan, Sr. (conference call)	Robert Imhoff
Jack Schwartz, JD (conference call)	Michael Anne Preas, RN, BSN, CIC
Darlene Smith, RN, CIC	Rajesh Shah (conference call)
Geeta Sood, MD (conference call)	Kerri Thom, MD
Renee Webster, RS (conference call)	Lucy Wilson, MD, ScM

Public Attendance	**Commission Staff**
Richard Brooks, MDH	Theressa Lee
Peggy Pass, RN	Courtney Carta
Elisabeth Vaeth, MDH	Julie Deppe
Eileen Witherspoon, HQI	
Justin Ziombra, MHA	
Andrea Zumbrum, HSCRC	

1. Call to Order

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

2. Update on CY2016 HAI Public Reporting

Overview of the website

Ms. Carta gave a brief update of the website, the Maryland Health Care Quality Reports. She reviewed where and how to find the most current HAI data for CY2016. Ms. Carta also reviewed how to get more detailed information from individual hospitals, as well as how to compare multiple hospitals.

Updated CY2016 HAI Results

Ms. Carta gave a brief overview of the state reporting requirements for HAIs. She said there were no requirement changes in 2016 and performance results were similar to 2015 for most infection types.

- CLABSI:

Ms. Carta noted that hospitals are required to report on CLABSIs in ICUs, NICUs, and select non-ICU wards. The 2016 statewide performance of total CLABSIs was better than the national benchmark with 0.65 SIR which is the same as the 2015 performance. There were 378 infections statewide and 2 hospitals performed better than the national benchmark. The 2016 statewide performance for ICUs was better than the national benchmark with 0.64 SIR which was similar to 2015 performance. There were 183 infections statewide; 7 hospitals performed better than the national benchmark and 2 hospitals performed worse. The 2016 statewide performance for NICUs was better than the national benchmark with 0.38 SIR, similar to the 2015 performance. There were 19 infections statewide and 2 hospitals performed better than the national benchmark. The 2016 statewide performance for select non-ICU wards was better than the national benchmark with 0.72 SIR which was similar to 2015 performance. There were 176 infections statewide; 3 hospitals performed better than the national benchmark and 1 hospital performed worse. Ms. Carta reviewed trending and noted that CLABSIs in Maryland have been reduced by 43% since CY2010. There has been a slight uptick in number of CLABSI infections, but central line days continue to decrease. CLABSIs in NICUs have been are the lowest since public reporting began, and have been reduced by over 53%. CLABSIs in select non-ICU wards has remained steady since public reporting began in 2015.

- CAUTI:

Ms. Carta noted that hospitals are required to report CAUTIs for ICUs and select non-ICU wards. The 2016 statewide performance for total CAUTIs was better than the national benchmark, with a 0.64 SIR, which is similar to 2015 performance. There were 381 infections statewide. Fourteen hospitals performed better than the national benchmark; this represents twice as many as 2015. The 2016 statewide performance for ICUs was better than the national benchmark with 0.68 SIR which was similar to 2015 performance. There were 234 infections statewide. Six hospitals performed better than the national benchmark and 1 hospital performed worse. The 2016 statewide performance for select non-ICU wards was better than the national benchmark with 0.57 SIR which was similar to 2015 performance. There were 147 infections statewide and 8 hospitals performed better than the national benchmark. Ms. Carta reviewed trending and noted that although Maryland continues to perform better than the national benchmark, CAUTI trends have remained unchanged.

- MRSA and CDI:

Ms. Carta noted that the 2016 statewide performance for MRSA was similar to the national benchmark with 1.14 SIR. This represents an improvement from 2015, where performance was worse than the national benchmark. There were 200 infections statewide. One hospital performed better than the national benchmark and 4 hospitals performed worse. The 2016 statewide performance for CDI was better than the national benchmark with 0.95 SIR. This represents an improvement since 2015, when performance was worse than the national benchmark. There were 2,070 infections statewide. Eight hospitals performed better than the

national benchmark and 3 performed worse. Ms. Carta reviewed trending and noted that MRSA has shown improvement but there is still work that needs to be done. Hospitals have also made good progress for CDI and should continue to strive for further improvement.

- SSI:

Ms. Carta noted that hospitals are required to report on 5 SSI categories- hip replacement, knee replacement, coronary artery bypass graft, abdominal hysterectomy and colon surgery. Hip replacement, knee replacement, and CABG are Maryland specific measures. The 2015 statewide performance for hip replacement was better than the national benchmark with 0.71 SIR which is similar to 2015 performance. There were 59 infections statewide and 2 hospitals performed better than the national benchmark. The 2016 statewide performance for knee replacement was better than the national benchmark with 0.46 SIR which was similar to 2015 performance. There were 47 infections statewide; 4 hospitals performed better than the national benchmark and 2 hospitals performed worse. The 2016 statewide performance for CABG was better than the national benchmark with 0.53 SIR; however, this was higher than the 2015 SIR of 0.35. There were 17 infections statewide and no hospitals performed better than the national benchmark. Abdominal hysterectomy showed improved performance from 2015. Statewide performance was better than the national benchmark with 0.68 SIR. This is a 28% improvement compared to the 2015 SIR, which was similar to the national benchmark. However, no individual hospitals performed better than the national benchmark. 2016 Statewide performance for colon surgery was similar to 2015 performance with an SIR of 0.95, which is not statistically different than the national benchmark. Three hospitals performed better than the national benchmark and 2 hospitals performed worse than the national benchmark. Ms. Carta reviewed SSI trending over the years 2011 to 2016 showed improvement in most categories since reporting began but variation was seen across the years. Ms. Mayoryk noted that there was a slight definition change in 2016 and SSIs exclude infections present at the time of surgery (PATOS).

- Healthcare Personnel (HCP) Flu Vaccination:

Ms. Carta stated Maryland has ranked in the top 3 nationally on HCP flu vaccination rates for the past few years. State rankings for this year have not been released yet but the state is holding steady at approximately 97% HCP vaccinated in hospitals. 46 of the 47 hospitals have a mandatory policy in place. Garrett Regional Medical Center is the one hospital without a mandatory policy but has a strong vaccination rate.

Ms. Carta highlighted the staff priorities for the remainder of the year which are focused on monitoring CDC's NHSN Rebaselining efforts and promoting consumer awareness and use of the website. Ms. Carta noted that the new baselines will take effect for CY2017 public reporting so the ability to trend will be lost. Ms. Carta mentioned the ability to use TAP reports to help facilities hone in on specific units that may need special attention. Ms. Mayoryk cautioned that most infection preventionists are aware of problem units so that TAP reports might not be particularly useful. Ms. Carta reiterated the focus on antimicrobial stewardship with staff monitoring CMS proposed ASP requirements as a condition of participation, becoming familiar with AUR module in case that becomes a requirement, and creating a consumer focused issue brief on correct antibiotic use.

Discussion

Ms. Pass noted that the group should focus on hospitals that have higher infection rates. Ms. Lee noted that we reach out to individual hospitals but MHCC is open to suggestions on how to be more helpful to hospitals. Ms. Pass suggested a survey aimed at IPs to determine what activities would be helpful to help improve infections rates. Ms. Mayoryk suggested reaching out to IPs versus utilizing resources for TAP reports because TAP reports aren't especially useful. The group also discussed inviting hospitals in for a semi-annual meeting to talk about successes or effective programs. The group agreed that the idea of sharing interventions could be helpful to IPs. Ms. Lee stated that it might be useful to highlight particular successes, with a focus on potential solutions. Dr. Cosgrove suggested that poor performing hospitals could present what they are doing to improve their performance and get feedback from a larger audience. Ms. Lee stated that could be an option to present in front of the Advisory Committee or in front of the Commissioners. MHCC will discuss a standardized approach to determine which hospitals would be required to participate. Mr. Ziombra mentioned that most infection types are tied in to payment policy.

3. Redefine the Role of the Committee

Ms. Lee mentioned that historically, the group helped to determine which measures should be required. Now that MHCC aligns with CMS, the role of the committee has changed. The HAI Advisory Committee is still very important, but the focus has shifted. As outpatient measures are becoming more of a priority, MHCC may request help from the Committee to determine which facilities and HAI measures should be included. MHCC will most likely postpone the next committee meeting, but will send an update to the group via email. Ms. Lee reiterated the importance of the group, even though meetings have been less frequent.

4. Other Business

The group discussed potential projects or areas of focus for the future. Ms. Pass asked about long term care infection measures and noted that there is a major gap for infection data in long term care. Ms. Lee noted that NHSN collects some of that data, but MHCC does not report on it because it is not required by CMS. Ms. Mayoryk said some HAI information could be available in MDS. Ms. Witherspoon mentioned that some long term care facilities are reporting CDI data in NHSN but it's not required. Dr. Cosgove mentioned that long term care facilities have limited resources and surveillance is a challenge. Dr. Cosgove mentioned a CMS pilot program with ambulatory surgical centers looking at antibiotics infection prevention and suggested that it might be worth a discussion with CMS. She also noted that it's important to align with MIPS/APM programs from a stewardship standpoint. Ms. Lee also noted that MHCC can also use existing data to look at infections across facility transfers.

The group discussed other measures that could be required. Ms. Lee also mentioned the potential use of sepsis as a measure. Mr. Brooks mentioned that the Department of Health Emerging Infections Program is participating in a pilot with patients who have been coded as having sepsis. The program is looking at risk factors and understand the problem. He mentioned that data quality issues are a common problem with sepsis. The group discussed the Maryland-specific requirements (e.g, hip, knee, CABG) and whether we should continue collecting those measures

or if others might be more appropriate. One suggestion was to look at cesarean section data but Ms. Sood noted that it could create some potential problems due to large variability with follow-up, where many infections are reported after follow-up. Ms. Mayoryk suggested looking at orthopedic procedures. Ms. Pass suggested replacing hip or knee procedures with spinal procedures. Ms. Sood noted that changing procedures might place an added burden on hospitals. Mr. Ziombra suggested obtaining input from a variety of IPs before making any requirement changes.

MHCC will plan a webinar to share the results of the CY2016 HAI results with hospital IPs.

5. Adjournment: Next Meeting Date- Tentative October 25, 2016

Ms. Lee ended the meeting at approximately 2:15 pm.