HEALTH CARE ACQUIRED INFECTIONS ADVISOR COMMITTEE

January 13, 2009
1:00 pm TO 3:00 pm

Portland State Office- Building Rm. 1E
800 NE Oregon St.
Portland, OR

MEMBERS PRESENT: **Woody English, MD, Co-Chair**
Paul Cieslak, MD
Jim Dameron
Kathleen Elias (by phone)
Ron Jamtgaard
Laura Mason (by phone)
Jon Pelkey (by phone)
Mary Post
Kecia Rardin
Rodger Sleven, MD
John Townes, MD

MEMBERS EXCUSED: **Jim Barnhart**
Lynn-Marie Crider
Katrina Hedberg, MD, MPH
Barbara Prowe
Dee Dee Vallier

STAFF PRESENT: **Sean Kolmer, Data and Research Manager, OHPR**

ISSUES HEARD:

- **Call to Order**
- **Approval of 11/12/08 Minutes**
- **Update on Hospital Enrollment in NHSN**
- **Overview of HAI in Ambulatory Surgery Centers**
- **NICU Reporting**
- **Nursing Facility Reporting**
- **Additional Information for 2010 Reporting**
- **Staff Advisory Group Work Products, Work Plan, Membership**
- **Public Testimony**
- **Next Steps/Adjourn**

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

Co-Chairs **I. Call to Order**

The meeting was called to order at approximately 1:00 pm. There was a quorum.

Co-Chairs **II. Approval of 11/12/08 Minutes**

Motion to approve the minutes. Minutes approved unanimously.

Staff **III. Update on Hospital Enrollment in NHSN**

- All 57 hospitals are required to enroll in NHSN by the end of the year to begin reporting January 1.

- After enrolling the hospitals need to confer rights to OHPR. Only 12 have done so.
  - Woody English spoke with Providence hospitals and they have communicated they are waiting for an invitation to confer rights.
    - OHPR will send out a letter to the hospitals' infection prevention programs to remind them to confer rights and ask for feedback.
- The hospitals have 30 days after the end of each month to get their data in but they can go back and update it.
  - The technical group is in place to look at the data that comes in for validation and accountability.

Staff **IV. Overview of Ambulatory Surgery Centers in Oregon**

- Missouri is the best example of what ASC reporting looks like as they are using the same methodology.
- Breast surgery and hernia repair are the two surgeries they are reporting.
  - Almost every ASC is reporting zero infections.
  - Their annual report in 2007 shows their rates are less than 1 for the most part.

(Discussion)

- Their method of ascertaining cases is in part surveying physicians but is that the same as using cultures and readmission to hospital? The patient will go to the surgery center and the hospital to get admitted where the cultures are done so the information may not go back to the surgery center.
- The two procedures chosen wouldn't be expected to have a high infection rate so what would happen if they chose a higher-risk surgery?
  - These may be the most common procedures they do.
  - ASCs don't have the ability to keep people overnight so are limited on high-risk procedures.
- There could be a question as to the completeness of the surgeons' reporting since they are reporting on their own infections and could be a disincentive to report.
  - The group needs to consider whether there is enough data to make an informed decision to move forward with a reporting program for the ASCs.
- Is contacting a physician 30-60 days after a surgery to recall infections going to result in accurate reporting?
  - One way to validate that data would be to have a second surveillance method to check on the first one, but the sensitivity of that method in data collection needs to be determined.
- The group should consider working from process measures to outcome measures as there is a better understanding of process.
  - The alternative is to look New York's first year of reporting and develop a methodology with the ASCs
  - Start collecting data as a process measure to see what each ASCs process is to set up appropriate standards. Then have them send reports for spot-check verification to show what the ASCs do and create a consistent method between all ASCs.
  - Billing from one ASC to another is not even standardized.
  - As a process measure, look at industry standard among high-performing surgery centers. Collect information from ASCs about

- There needs to be a recommendation from the industry of what is considered "best practice" in this area, meet with industry leaders for a standardized approach to measure ASCs against in terms of process and agree to a package of criteria for the recommendation.

Staff **V. NICU Reporting**

- The committee needs to decide whether to include NICUs in the reporting.
- The technical group will be tasked with looking at Vermont Oxford vs. NHSN reporting if the committee wants to use NICUs and provide a recommendation to the committee.
  - All 7 NICUs are already subscribed to Vermont Oxford so there would not be additional cost there.
- The committee voted to include NICUs in the reporting.

Co-Chairs **VI. Nursing Facility Reporting**

- The committee needs to decide whether to include nursing homes in the reporting and look at their current reporting on urinary tract infections (UTI) to DHS.

(Discussion)

- Process measures will be important in nursing homes and UTIs may not be reliable.
- Line infections may have a higher morbidity in nursing homes than UTIs.
- The technical committee will be tasked with looking at nursing facility care and what information would be reported along with their current MDS reporting.

Co-Chairs **VII. Additional Information Committee Wants for Consideration into 2010 Reporting**

- Two issues to be discussed from the first set of rules are UTIs in hospitals and bloodstream infections and whether it is contained to the ICUs.

(Discussion)

- Another surgical site infection that could be added to NHSN is hips and the labor and cost would be simple.
- The committee will review data previously presented on central line infections and bring it up again in March.
- Another infection to consider is MRSA and whether to consider it in reporting.
  - If so, the NHSN MRDO Module needs to be looked at, which is scheduled to be released January 15th.
  - Can MRSA be defined as a public health issue rather than just a hospital issue?
  - Some strains of MRSA are endemic to hospitals, some to the community, and to what extent are they mixing? How well are the hospitals containing the spread of the community strains, which are more aggressive?
  - There is a mistaken opinion that all MRSA is acquired while receiving care in the hospital when the vast majority of patients brought it in with them.

- The committee will receive some formal information about MRSA.

Co-Chairs **VIII. Staff Advisory Group Work Products, Work Plan, and Membership**

- The technical group should come up with a March recommendation for NICUs, nursing facilities and what should be reported beyond current reporting, and MRSA, which will probably have recommendations later than March.
- The reporting workgroup will develop a document regarding the website with expectation for the public reporting and bring back a recommendation in March.

Co-Chairs **IX. Public Comment/Adjournment**

No public testimony provided.

Discussion

Through a John Hopkins grant for central line infection reduction, Oregon hospitals can report its data free using a checklist on central line insertion and have information sent back. This is a time and staff commitment for hospitals. Participation is voluntary and extends over a two-year time frame. Technical assistance will be provided.

The meeting was adjourned at approximately 3:00 pm.

Next meeting will be March 10, 1:00 pm to 3:00 pm, at the Portland State Office Building, Room 1E.

Submitted By:
Shawna Kennedy-Walters

Reviewed By:
Sean Kolmer

EXHIBIT SUMMARY
A – Agenda
B – November 12 th Meeting Minutes
C – Missouri Nosocomial Infection Reporting Data
D – HAIs in ASCs
E – HAIs in NICUs
F –NHSN Dialysis Outpatient Reporting
G – Oregon ASC Infection Control Practices Statistics

See Meeting Materials: http://www.oregon.gov/OHPPR/Healthcare_Acquired_infections.shtml