HEALTH CARE ACQUIRED INFECTIONS ADVISOR COMMITTEE

March 10, 2010
1:00 pm to 3:00 pm

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

MEMBERS PRESENT:

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

MEMBERS EXCUSED: **Barbara Prowe**

STAFF PRESENT: **Jeanne Negley, Healthcare Acquired Infection Prevention Coordinator**
Elyssa Tran, Research & Data Manager
James Oliver, Research Analyst (by phone)

ISSUES HEARD:

- **Call to Order**
- **Approval of 1/13/10 Minutes**
- **Final Recommendations on Blueprint**
- **Update on Annual Surveys for Staff Flu Vaccinations and Ambulatory Surgery Center Best Practices**

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-Chair **II. Approval of the Minutes**

Dee Dee Vallier noted that she attended the last meeting by phone. With this correction, minutes were approved unanimously.

Ann Thomas
Jim Dameron
Staff

III. Final Recommendations on the Blueprint

Introduction

- It was noted that a decision was needed from the committee today to support the schedule to expand reporting. In order to have hospitals begin reporting on new measurements as of January 2011, we need a decision in March 2010 to allow for rule writing and public comment, following by the training needed to support the additional reporting.
- A list of five surgical site infections (SSIs) and the possible expansion of reporting locations for central line associated bloodstream infections (CLABSIs) were presented to the group.
- The proposed list was developed based on HAIs that had high incident rates, significant morbidity, and were performed by many Oregon hospitals.
- It was also noted that we have to balance the need for expansion with the need to minimizing reporting burden for providers.

Review of SSI and Expansion of CLABSI Reporting

- The following list was reviewed:
  - Laminectomy
  - Hip Prosthesis
  - Abdominal Hysterectomy
  - Colon Surgery
  - Open Reduction of Fracture
  - Expansion of CLABSI Reporting to all ICUs or hospital wide

- Discussion:
  - One member noted that selected measurements should focus primarily on the resulting severity of illness if an HAI is contracted. Procedures with the insertion of prosthesis should be included on the expanded list, because to address these HAIs, the surgery has to be repeated to remove the prosthesis and insert a new one. Fusion may be a better choice than laminectomy, given the insertion of prosthesis.
  - A concern was raised that this list of proposed surgical site infections was mainly limited to orthopedic procedures, rather than providing a picture of all surgical procedures at a hospital.
  - A question was raised if the list of SSI measures should be limited to elective surgeries.
  - Concern was raised regarding the open reduction of fracture measurement. It was relayed that the risk of contracting an HAI related to this procedure may be more strongly related to the severity of the trauma rather than the practices of a provider.
  - Providers voiced concern regarding the burden of time that would be required to collect and report the additional measurements. It was noted that the proposed list represented a significant increase in reporting workload for providers, and that the additional time spent reporting would reduce the amount of time infection control practitioners could spend on quality improvement. It was also noted that this would increase costs for hospitals.

- A member noted that having an HAI results in higher costs for consumers; the higher costs for treatment associated with HAIs are passed onto consumers, sometimes directly.
- A consumer urged that we agree now to expand central line associated bloodstream infection reporting, as this is an important source of infections with a high mortality rate.
- One member asked why C-Section was not included on this list, and it was relayed that this measurement was noted as being particularly time intensive to collect using NHSN methodology.
- Staff noted that we found that of the 51 hospitals in Oregon required to use NHSN for reporting of SSIs or CLABSIs, that 24 were using NHSN beyond reporting requirements, which suggests that hospitals find value in NHSN and there is some capacity to expand required reporting.

<u>Decision Made on Surgical Site Infection (SSI) and Expansion of Central Line Associated Bloodstream Infection (CLABSI) Reporting</u>

- Before deciding, the co-chair asked for any additions to the list, and vaginal hysterectomy and spinal fusion were discussed.

- Support was elicited for five surgical procedures

    - Support was recorded for four surgical procedures:
        - Hip prosthesis (strong support)
        - Laminectomy (strong support)
        - Colon (moderate support)
        - Abdominal hysterectomy (moderate support)

    - It was noted that spinal fusion should be added because providers will be reviewing the same records for laminectomy and it would not represent additional work.

- Open reduction of fracture and vaginal hysterectomy were discussed, but support was not recorded. These procedures may be revisited at a future meeting.

- Members noted there was insufficient discussion on the topic of CLABSI expansion to vote on this item and tabled it to the next meeting.

<u>Review and Evaluation of Structural/Process Measures</u>

- Members voiced strong support to add two Surgical Care Improvement Project (SCIP) Process of Care measures:
    - SCIP-Inf-4: Cardiac surgery patients with controlled 6 am postoperative serum glucose.
    - SCIP-Inf-10: Peri-operative temperature management

- Members requested more research on a third SCIP measurement
    - Mary Post will research SCIP-Inf-9 (Peri-operative urinary catheter removal on post operative day 1 or 2). This is a relatively new measurement, and Mary Post will research its effectiveness. Accumentra will check Federal policy regarding this measurement.

- Next step: Staff will draft process measure questions for review at next meeting.

- Members reviewed additional process measures that addressed the identification of best practices used to eliminate CLABSIs and SSIs; measured commitment to antimicrobial stewardship, and evaluated a hospital's dedication to reduce infections at the organizational level. Members noted these data could be collected in a survey.
- Regarding process measures related to MRSA and MDROs in general, members agreed to table this issue for the next meeting.

- Two additional AHRQ Patient Safety Indicators were presented for consideration. Members did not have time to discuss these items and tabled them for the next meeting.

Co-Chairs **IV. Update from Public Reporting Workgroup**

- Staff discussed that the creation of the "Peer" group was based on bed size. The range for the three groups was determined by using quartiles (i.e., the 25th and 75th percentile). A fourth group was identified as "teaching hospitals," as determined by the hospital's NHSN survey.
- Members requested that peer groups be reorganized into just three instead of four groups, and that the "teaching hospital" group be eliminated.
- Members requested that the "Peer" groups be labeled "Similar Size Hospital."

Co-Chairs **V. Update on Annual Surveys for Staff Flu Vaccination and Ambulatory Surgery Center Best Practices**

- The proposed staff flu vaccination form was briefly reviewed.
- It was noted that it is likely impracticable to ask hospitals to be responsible for the vaccination of subcontractor physicians. Therefore, it was suggested that the definition of healthcare worker would exclude subcontractor physicians.

Co-Chairs **VI. Additional Meeting Notes**

- Several agenda items were not discussed, including an update from Public Health regarding the Validation Study and the Ambulatory Surgery Center Best Practice Survey. These items will be tabled to the next meeting. In addition, a formal public comment period was not held at the end of the meeting. Public comment was provided and noted during the meeting.

The meeting was adjourned at approximately 3:00 pm.

Next meeting will be May 12, 1:00 pm to 3:00 pm, at the Portland State Office Building, 1C.

Submitted By:
Jeanne Negley

Reviewed By:
Elyssa Tran

EXHIBIT SUMMARY

A – Agenda
B – January 13, 2010 Minutes
C – Oregon Health Authority Update Presentation on HAI Reporting Program (February 22, 2010)
D – List of Blueprint Surgical Site Infections/Devices and Structure Process Measures
E – Outline of HAI Public Report
F – Handout from Public Health on Validation Study
G – Example of Staff Vaccination Survey

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