HEALTH CARE ACQUIRED INFECTIONS ADVISOR COMMITTEE

July 14, 2010
1:00 pm to 3:00 pm

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

MEMBERS PRESENT:

Woody English, MD, Co-Chair
Paul Cieslak, MD
Ron Jamtgaard
Jon Pelkey (phone)
Kecia Rardin, RN
Rodger Sleven, MD (phone)
John Townes, MD
Dee Dee Vallier

MEMBERS EXCUSED: **Jim Dameron, Co-Chair**
Kathleen Elias, RN
Laura Mason, RN, BSN
Mary Post, RN, CIC

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 5/12/10 Minutes**
- **Thoughts on Future Direction of HAI Advisory Committee**
- **Recommendations from Nursing Home Subcommittee**
- **Update on Ambulatory Surgical Centers**
- **Next Steps**
- **Public Comment / 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-Chair **II. Approval of the Minutes**

The minutes were unanimously approved.

Staff **III. Update on Revised Rules**

- The revised rules have been finalized, and our surgical site infections have been added: colon surgery, hip prosthesis, laminectomy, and

abdominal hysterectomy. Spinal fusion was removed from the proposed list of procedures during the review of the draft rule. Coronary artery bypass grafts with chest-only incision has been removed from the required reporting procedures effective January 2011, as only one hospital in the state performed over 20 of these procedures during 2009.

Staff **IV. Thoughts on Future Direction of HAI Advisory Committee**

- During the first week of June 2010, OHPR met with CDC and discussed how the CDC is aligning its efforts with the CMS and federal reform. The Patient Protection and Affordable Care Act of 2010 includes:
    - Pay-for-performance/Value Based Purchasing Program for HAIs.
    - Providing for public posting of HAI outcomes in the future on Hospital Compare
- To implement this healthcare reform, there is a CMS-proposed inpatient prospective payment system rule that identifies using NHSN to report CLABSIs and SSIs as part of the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) for CMS reimbursement.
    - The SSIs include cardiac surgery, hip and knee prosthesis, hysterectomies and vascular surgeries.
- All comments have been received regarding this draft rule, and at the end of the summer the final rule will be determined.
- Site visits were conducted with the CDC at Columbia Memorial, Kaiser Sunnyside, and Portland Providence hospitals.
    - They all support public reporting and two already report all surgical procedures to NHSN.
    - There is strong support for infection control programs.
    - The CDC strongly recommends NHSN and is looking for solutions to reduce the reporting burden for hospitals.
    - There will be two trainings with the CDC on NHSN: SSI Infection Identification, September 15th, and Reporting and Data Analysis, on October 27th, both from 11:00-12:30.
- Dee Dee Vallier's consumer communication on HAIs:
    - The CDC is moving forward aggressively on public reporting and are using "elimination" rather than "reducing" with infections.
    - The key to reducing infections is transparency.
    - Public reporting of healthcare acquired infections is significant in infection prevention.
    - 70% of invasive MRSA are post-discharge and just requiring ICUs to report invasive MRSA excludes a large proportion of HAIs.
    - Validation should be conducted by the Department of Health, which is trained to do this.
    - Validation recommendations will be changing in CDC guidelines
    - Invasive MRSA rates have gone down due to public reporting and practices.
        - Approximately 85% of MRSA onsets are healthcare associated infections, and 15% are community acquired infections.
    - Reported potential revisions to SSI denominators include reporting of diabetes and BMI.
- A review of the 2007 HAI Advisory Charter shows that many of the objectives have been met.
    - The committee has prescribed HAI measures that hospitals must report, but are working on long-term care facilities and ASCs.

They are waiting for the tier 2 US HHS plan in the fall of 2010 to review the Federal government's guidelines in ASCs and dialysis centers.
    - The use of NHSN fulfills several of the objectives of the committee charter.
- The charter should be updated to reflect what has been done and the direction the committee will be taking in the future.
- Due in part to the state's budget crisis, the HAI meetings will start meeting quarterly, with the next meeting held October 13th.
- Those committee members with expiring terms were acknowledged, and an active recruitment will take place for new members, to fall within constraints listed in the statute.

Nursing Home Committee

V. Recommendations from Nursing Home

- This subcommittee considered several potential methods to gather data on Clostridium difficile and urinary tract infections:
    1. Add to MDS reporting: make the reporting an addition to the MDS reporting on the form under "Optional Reporting." That requires several DHS and CMS approvals, and CMS thought it could be arduous but could work.
    2. Add to public health lab reporting: the data would be collected through county public health offices. The problem is that lab results are sometimes sent to the ordering physician and county, not always to the nursing home.
    3. A manual system: 142 nursing homes would have to report on two infections, which could potentially take a lot of staff time.
    4. NHSN: The unanimous conclusion was that a new module coming out in 2011 for long-term care facilities would be the best option.
- The recommendations are:
    1. Continue to push for standardized definitions used for CMS and CDC.
    2. Plan to use the forthcoming CDC version of NHSN adapted for long-term care facilities to collect data on the two infections.
    3. Develop a training program to provide four hours per trainee as soon as the software is available.
    4. Test the reporting program on a pilot basis with eight to ten facilities.
    5. Amend the process and training is needed.
    6. Continue to review the CDC system and other options that arise.
    7. Wait for implementation of the new NHSN system.
    8. Implement new NHSN system as soon as is possible.
- Summer 2011 was recently announced as the timeframe for CDC's implementation.
- The group unanimously voted **to endorse** the Nursing Home Subcommittee's recommendations.

Staff

VI. Update on Ambulatory Surgical Centers

- The administrative rules state the group is to prepare an annual survey of "Evidence-Based Elements of Patient Safety Performance for ASCs.
- There is a committee of eleven members representing the different specialties.
- A draft has been written up of what should be included in it.

- The plan is to send it out, get feedback on it, process the feedback, and report back to the committee on the timeline for getting it implemented.

Co-Chairs **VII. Public Comment / Adjourn**

- Jody Joyce from Legacy Health made the following comments:
  1. CMS HAI reporting currently is based on administrative coding, not NHSN. There will be a "learning curve" for hospitals AND for CMS as we move to NHSN for CMS's Healthcare-Acquired Conditions. I suspect we will also be subject to CMS audits of our work. This will be adding strain to our Infection Prevention & Control teams.
  2. Half of our CLABSIs occur in our ICUs and about half on our floors.
  3. Adding diabetes status as an NHSN field would be difficult, because this condition is under-diagnosed. There would be many false negatives if you added this field. Adding BMI makes sense and is easy as long as you have a patient's height and weight.
  4. We have numerous Legacy leaders who I am sure would be willing to be a member of the Advisory Committee.
  5. Quarterly reporting of CLABSIs could be feasible if you use rolling-12-month averages, otherwise rates will fluctuate so dramatically that it may be difficult to interpret. Quarterly report of SSIs would be more problematic because it would increase the frequency of determining denominators.
  6. Is there a role for this group in improvement instead of just reporting? E.g. encouraging the patient's role, pre-op skin prep, post-op dressing changes, laundering linens and clothing, promoting effective practices (e.g. the "process measure" discussions), risk adjustment; either refining what is reported (e.g. excluding "dirty" cases) or helping distinguish or interpret major risk considerations across or within facilities.
  7. Facilitating IT standardization, e.g. requesting reason timelines for CDC NHSN changes, working with Cerner and Epic on solutions (e.g. nondiscrete data issue from Cerner Micro).

Next meeting will be October 13th, 1:00 pm to 3:00 pm, at the Portland State Office Building, 1D.

Submitted By:
Shawna Kennedy-Walters

Reviewed By:
Jeanne Negley

EXHIBIT SUMMARY
A – Agenda
B – March 10, 2010 Minutes
C – Revised OARs
D – Thoughts on Future Direction of Advisory Committee
E – Draft of Ambulatory Surgical Center Survey on Evidence-Based Elements of Patient Safety Performance
F – Nursing Home Subcommittee Notes July 1, 2010

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