Health Care Quality Performance (HCQP) Program

HOSPITAL-ACQUIRED INFECTIONS AND PREVENTION ADVISORY SUBCOMMITTEE

8:00-9:00am, April 27, 2009
HEALTH, Room 401

Goals/Objectives
▪ To discuss the details related to data collection for 1st and 2nd round HAI measures

Voting Members		
☐ Utpala Bandy, MD	☐ Andrew Komensky, RN	☐ Lee Ann Quinn, RN, BS, CIC
✓ Margaret Cornell, MS, RN	✓ Pat Mastors	✓ Janet Robinson, RN, Med, CIC
✓ Robert Crausman, MD	✓ Leonard Mermel, DO, ScM	☐ Nancy Vallande, MSM, MT, CIC
✓ Marlene Fishman, MPH, CIC	☐ Kathleen O'Connell, RN	✓ Sam Viner-Brown, MS
✓ Julie Jefferson, RN, MPH, CIC	☐ Harold Picken, MD	✓ Gloria Williams, MS
✓ Diane Kitson-Clark, RN, MSN, CIC	☐ Aurora Pop-Vicas, MD	

Time	Topic/Notes
8:00 am	**Welcome & Meeting Objective** Leonard Mermel, DO, ScM (*Co-Chair*) Samara Viner-Brown, MS (*Co-Chair*)

– Len opened the meeting and reviewed progress to date:

- <u>Employee influenza vaccination</u>:
  - The letter and survey were sent to the Health Directors; survey responses are due Wednesday, 4/29. Preliminary results indicate that collecting the data may be difficult, but 7 of 8 respondents (to date) say it's feasible for the 2009-2010 flu season.
  - Julie suggested that it may be helpful if HEALTH ultimately mandated this reporting, rather than requesting it.
- <u>MRSA process measures</u>:
  - Sam, Len, and Rosa are operationalizing the process measures, e.g., to determine what constitutes a "Yes" response to measuring hand washing, and will share thoughts at the next meeting.
  - Simultaneously, the Subcommittee will continue discussion of the outcome measure (below).

8:05 am **1st Round Data Reports**
Leonard Mermel, DO, ScM

- ICU data: Rachel Voss, MPH Assistant at Quality Partners, described the Program's work since the last meeting:
  - Although Q1 2009 data are not yet available, Rachel and Margaret met to review the data and discuss how to obtain them.
  - The hospitals/ICUs not participating in the ICU Collaborative will need to submit data through the database. To do so, they will need additional information (including definitions) and directions about how to submit the data. Some of this work will be done off-line (outside the Subcommittee).
  - **Note**: Margaret shared news that the database is now funded through August 31, 2011, but cautioned the Subcommittee to implement contingency plans in case funding does not continue past 2011. The data are not owned by the Collaborative, but the database itself is proprietary.
  - Each ICU measure will have multiple graphs, one per ICU type. The graphs will include the NHSN risk-stratified national benchmark in lieu of a state average. Len suggested that the graphs or technical pages include footnotes indicating why hospitals are not listed (if ineligible or excluded due to low denominators).
  - Rachel also created a draft technical page (see handout).
  - **Action items:**
    - Continue to determine how to communicate with and collect data from non-ICU Collaborative hospitals (Rachel and Margaret)
    - Create draft graphs and technical pages for each measure (Rachel)
    - Send suggested edits for Technical page to rvoss@riqio.sdps.org by Tuesday, May 5th (Subcommittee members)
- SCIP I, II, and III:
  - Rachel created populated graphs, using live data from the most recent quarter (Q2 2008). As with above, Len suggested that the graphs or technical pages include footnotes indicating why hospitals are not listed (if ineligible or excluded due to low denominators).
  - Rachel also created a draft technical page (see handout).
  - **Action item**: Send suggested edits for Technical page to rvoss@riqio.sdps.org by Tuesday, May 5th (Subcommittee members)
- Should we present longitudinal data? **Recommendation**: The Subcommittee will continue to explore if/how to report data longitudinally, but—in the meantime—move forward with the existing reporting formats to ensure that information is published in a timely manner. The technical reports will be amended to include a table with four quarters of data, where available.
- For the 1st tier measures, the estimated reporting timeline (sequentially) is:

Measure(s)	Estimated Publication
1. SCIP I, II, and III	May 2009
2. ICU measures	June 2009
3. Influenza vaccination	July 2009

8:45 am **2nd Round Measure Development**
Leonard Mermel, DO, ScM

- MRSA Process Measures:
  - At the last meeting, the Subcommittee reviewed the survey results and recommended several dichotomous questions for reporting.
  - **Action item**: Sam, Len, and Rosa are operationalizing the process measures (e.g., to determine what constitutes a "Yes" response to measuring hand washing) and will share thoughts at the next meeting.
- MRSA Outcome Measure:
  - Len reviewed the discussion to date about reporting hospital-wide (not ICU-specific) primary blood stream infections (BSIs).
  - The consensus was that most hospitals have numerator data readily available, but that the Subcommittee needs to define the denominator. The NHSN definitions (1,000 patient days) would allow consistency with other reporting efforts.

8:55 am **Action Items & Next Steps**
Leonard Mermel, DO, ScM
Samara Viner-Brown, MS

- See above action items. In addition, the Program staff will look at other states' reporting efforts to see what report formats they are using for the 1st tier measures.
- Next meeting: 8-9am, May 18, 2009 (now confirmed)

Technical Page – Hospital Acquired Infection Quality Measures

Intensive Care Unit (ICU) Central-line Associated Bloodstream Infections (CLABSI)

Performance Measures

The bloodstream infection data for intensive care units is based on the number of hospital-acquired infections that occur in an ICU. The closer the rate is to zero, the better.

Methodology

A hospital may have more than one ICU—each ICU reports separately. The numerator is the number of infections within a 30-day period. The denominator is central line days within the same period, obtained by counting the number of patients with one or more central lines. The CLABSI rate is obtained by dividing the number of infections by the number of central line days and multiplying by 1,000. The rate is reported as number of infections per 1,000 central line days.

Special Considerations

- If there are too few patients in the denominator, no rate is reported for that ICU.
- Because there are different kinds of ICUs, comparisons are made between the most similar ICUs and compared to the national average rate for that type of ICU.

Detail for Providers

More detail available on NHSN website: www.cdc.gov/ncidod/dhqp/nhsn.html

- Central line associated bloodstream infection (CLABSI): primary bloodstream infection (BSI) in a patient that had a central line *within 48 hours* before the development of the infection.
- Central line: vascular infusion device that terminates at or close to the heart or one of the great vessels. The following are considered great vessels:

- Aorta
- Pulmonary artery
- Superior vena cava
- Inferior vena cava
- Common femoral veins
- Brachiocephalicveins
- Internal jugular veins
- Subclavian veins
- External iliac veins
- Umbilical artery in neonates

- If the BSI develops in a patient within 48 hours of transfer from one inpatient location to another, indicate the location of *origin* on the infection report.
- Indicate the specific type of BSI
    - Laboratory-confirmed Bloodstream Infection (LCBI)
    - Clinical Sepsis (CSEP)-is only used for neonates (<30 days old) and infants (<12 months old)
- Refer to the website for how to count central line-days if a patient has an umbilical catheter and a central line, or a temporary central line and a permanent central line.

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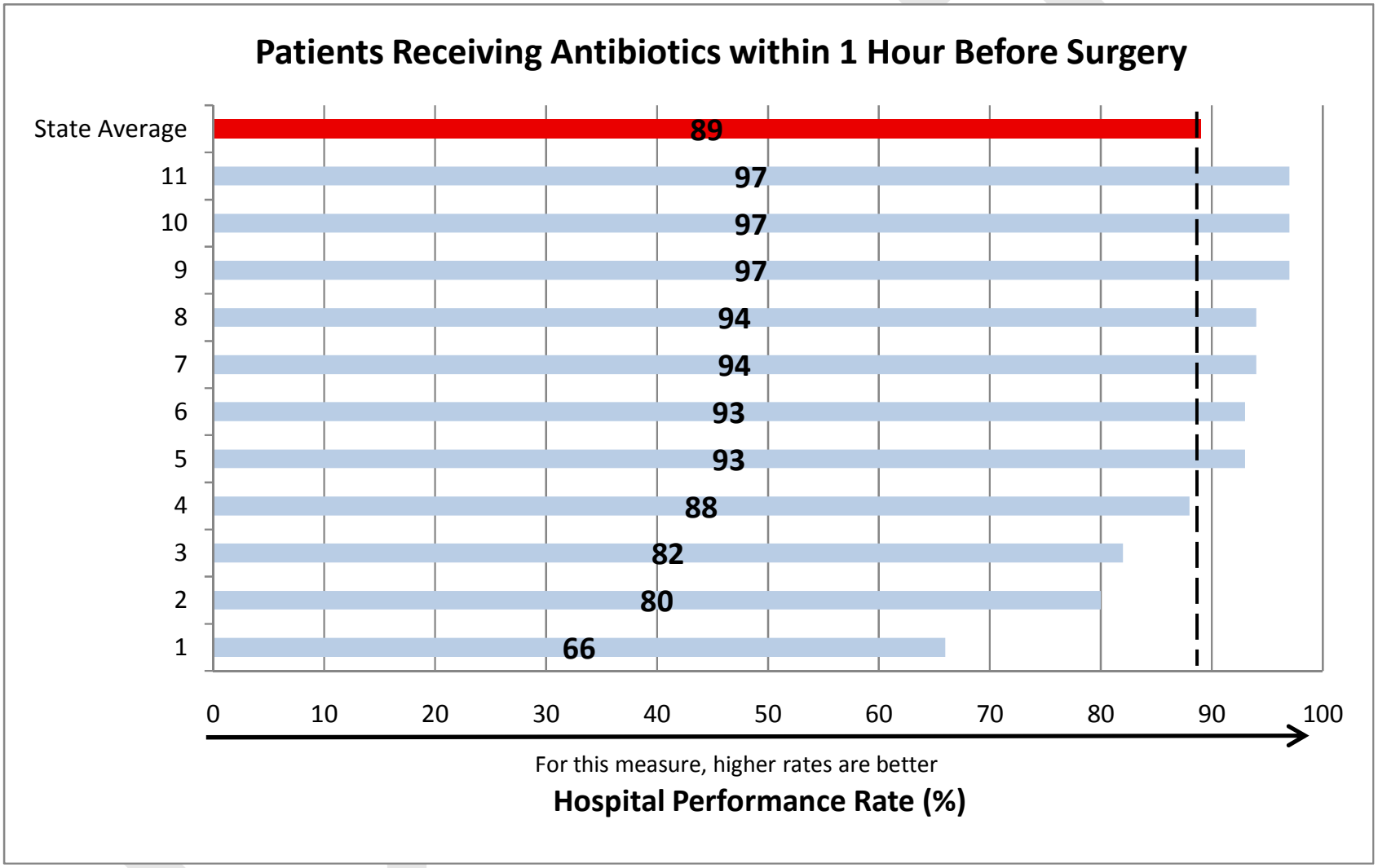
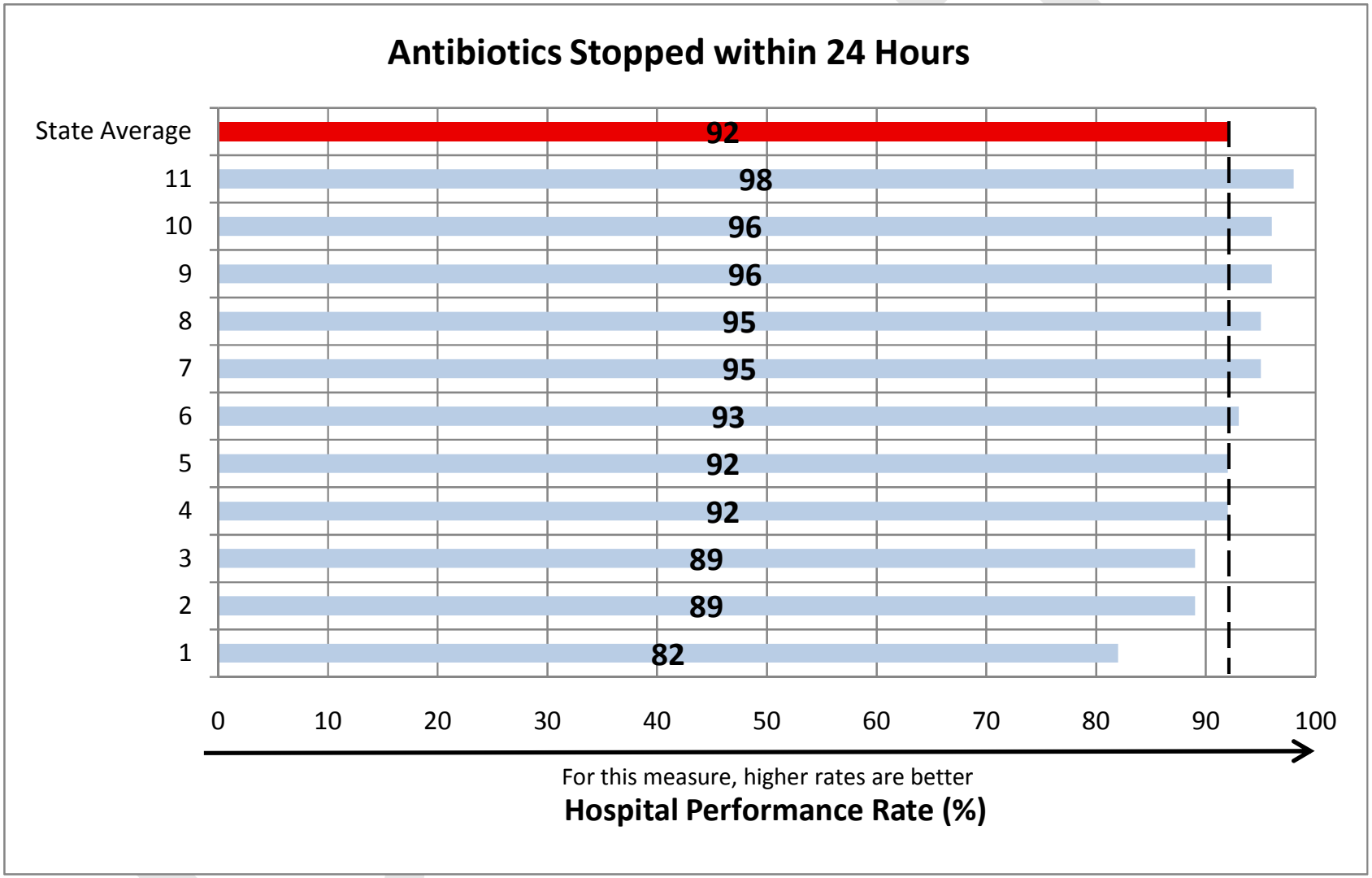
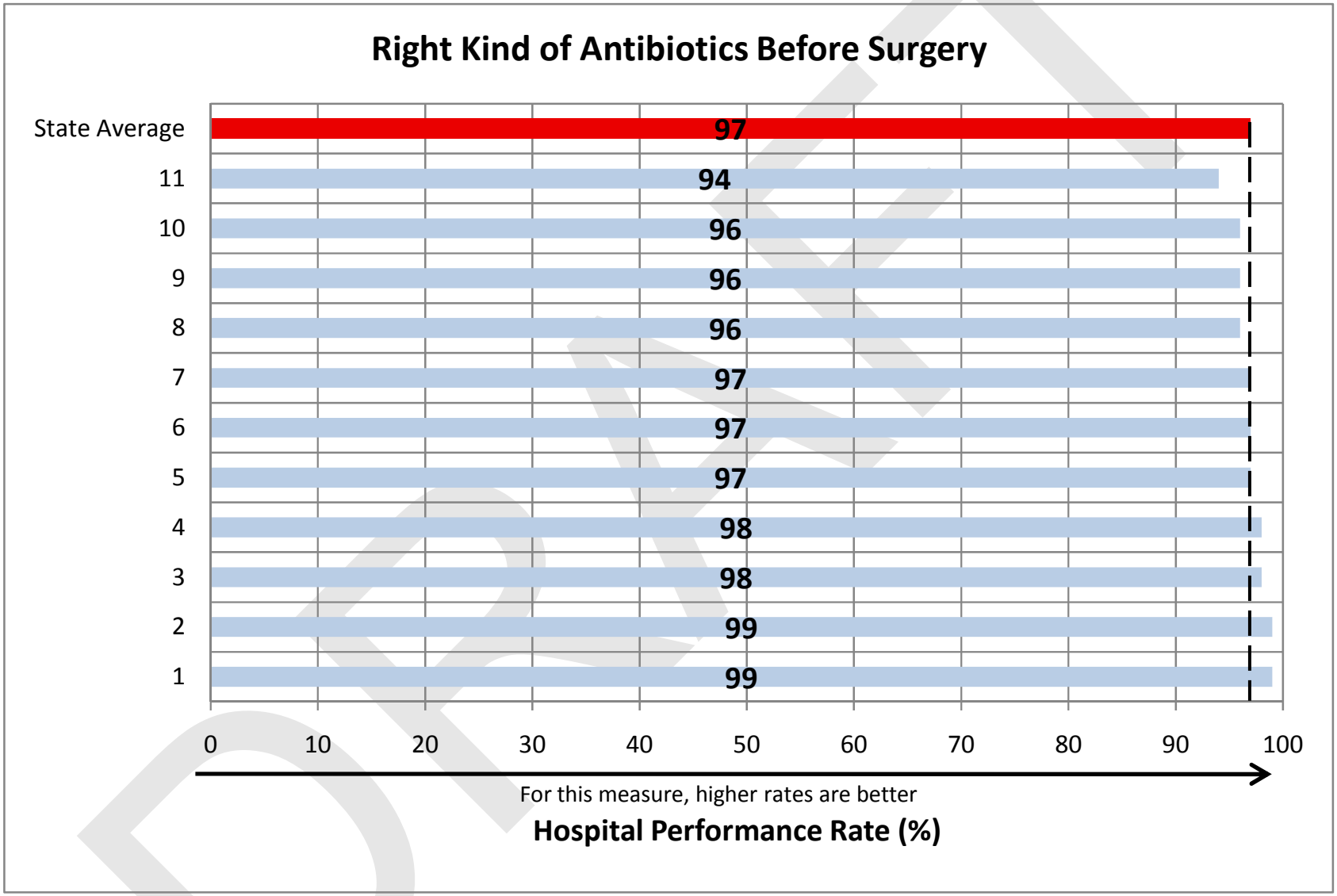

Patients Receiving Antibiotics within 1 Hour Before Surgery
State Average
11
10
9
8
7
6
5
4
3
2
1
89
97
97
97
94
94
93
93
88
82
80
66
0
10
20
30
40
50
60
70
80
90
100
For this measure, higher rates are better
Hospital Performance Rate (%)


Antibiotics Stopped within 24 Hours
State Average
11
10
9
8
7
6
5
4
3
2
1
92
98
96
96
95
95
93
92
92
89
89
82
0
10
20
30
40
50
60
70
80
90
100
For this measure, higher rates are better
Hospital Performance Rate (%)


Right Kind of Antibiotics Before Surgery
State Average
11
10
9
8
7
6
5
4
3
2
1
97
94
96
96
96
97
97
97
98
98
99
99
0
10
20
30
40
50
60
70
80
90
100
For this measure, higher rates are better
Hospital Performance Rate (%)

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Technical Page – Hospital Acquired Infection Quality Measures

Surgical Care Improvement Project (SCIP)

Performance Measures

The surgical infection data includes several individual indicators as reported on the CMS hospital compare website http://www.hospitalcompare.hhs.gov. The state's first report will report only the first three measures (listed below):

Surgical Infection Quality Indicators

- Percent of patients given antibiotics within one hour prior to surgery
- Percent of patients given the right kind of antibiotics before surgery
- Percent of patients who stop receiving antibiotics within 24 hours of surgery

Methodology

For each measure, the numerator is the number of patients who receive antibiotics of the appropriate kind/timing. The denominator is the total number of eligible surgical patients. The numerator is divided by the denominator and is expressed as a percentage. Percentages for individual hospitals are compared to the state average percentage.

Quality Measure	Why is This Information Important?
Percent of surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection	Surgical wound infections can be prevented. Medical research shows that surgery patients who get antibiotics within the hour before their surgery are less likely to get wound infections. Getting an antibiotic earlier, or after surgery begins, is not as effective. Hospital staff should make sure surgery patients get antibiotics at the right time. Higher percentages are better.
Percent of surgery patients who were given the right kind of antibiotic to help prevent infection	Surgical wound infections can be prevented. Medical research has shown that certain antibiotics work better to prevent wound infections for certain types of surgery. Hospital staff should make sure patients get the antibiotic that works best for their type of surgery. Higher percentages are better.
Percent of surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery)	Antibiotics are often given to patients before surgery to prevent infection. Taking these antibiotics for more than 24 hours after routine surgery is usually not necessary. Continuing the medication longer than necessary can increase the risk of side effects such as stomach aches and serious types of diarrhea. Also, when antibiotics are used for too long, patients can develop resistance to them and the antibiotics won't work as well. Higher percentages are better.

From the U.S. Department of Health and Human Services. www.hospitalcompare.hhs.gov

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