



Health Care Quality Performance (HCQP) Program

HOSPITAL-ACQUIRED INFECTIONS AND PREVENTION ADVISORY SUBCOMMITTEE

8:00-9:00am, May 18, 2009
HEALTH, Room 401

Goals/Objectives

- To discuss upcoming HAI reports and operationalize the MRSA process and outcome measures.

Voting Members

- | | | |
|--|---|--|
| <input type="checkbox"/> Utpala Bandy, MD | <input checked="" type="checkbox"/> Andrew Komensky, RN | <input checked="" type="checkbox"/> Lee Ann Quinn, RN, BS, CIC |
| <input type="checkbox"/> Margaret Cornell, MS, RN | <input checked="" type="checkbox"/> Pat Mastors | <input checked="" type="checkbox"/> Janet Robinson, RN, Med, CIC |
| <input type="checkbox"/> Robert Crausman, MD | <input checked="" type="checkbox"/> Leonard Mermel, DO, ScM | <input type="checkbox"/> Nancy Vallande, MSM, MT, CIC |
| <input checked="" type="checkbox"/> Marlene Fishman, MPH, CIC | <input checked="" type="checkbox"/> Kathleen O'Connell, RN | <input checked="" type="checkbox"/> Sam Viner-Brown, MS |
| <input checked="" type="checkbox"/> Julie Jefferson, RN, MPH, CIC | <input type="checkbox"/> Harold Picken, MD | <input type="checkbox"/> Gloria Williams, MS |
| <input checked="" type="checkbox"/> Diane Kitson-Clark, RN, MSN, CIC | <input type="checkbox"/> 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 reported on progress to date:
 - o Surgical Care Infection Program (SCIP) I, II, and III
 - o Central line-related bloodstream infections (CLABSI)
 - o Employee flu vaccination
 - o MRSA process measures measures/data
 - o MRSA outcome measure(s)
- Ready (with edits)
 } Awaiting data
 } Finalizing
 } collection strategy

- 8:05 am **1st Round Data Reports**
Leonard Mermel, DO, ScM
- Again, several measures are ready and/or awaiting data:
 - o SCIP graphs (handout):
 - The populated graphs are up for approval by the Steering Committee at the meeting later today. Subcommittee members requested several changes (see action items) before the graphs are published, and recommended that hospitals be allowed the opportunity to comment on their rates. This policy decision will go before the Steering Committee at today's (5/18) meeting.

- **Action items:**
 - Rosa will add the national average, remove the state average dotted line on the graphs, and remove 'all' from the Technical Page description of the sample of patients included in denominator.
 - Len, Sam, and Rosa will develop an FAQ about the limitations of the data, such as issues regarding sample size, etc., which are generic to all of the measures (hospital and other settings) being reported by the Program.
 - HEALTH will develop and publish a press release, mostly likely to be released after the graphs are posted.
 - Rosa will notify Gina (and Gina will notify the hospitals) (1) when the graphs, Technical Page, and FAQ are posted on HEALTH's site (www.health.ri.gov/chic/performance) and (2) prior to the press release.
 - Based on the previous meeting's recommendations, subsequent public reports will explore ways to incorporate longitudinal data (e.g., several quarters of data on the same graph). Note, however, that the SCIP data do reflect a four-quarter average (now reflected on the graphs).
- CLABSI graph:
 - We can populate the graphs as soon as the Q1 2009 data (reflecting the NHSN definitions) are available; these are due to the ICU Collaborative on 5/22, but there will be a short lag time before they are complete. We anticipate a first report ~June 2009.
 - At the same time, we will be exploring how to collect NICU and PICU data. Those data may be added subsequent to the first report.
- Influenza vaccination:
 - Sam reported that the Director requested these reports be prioritized (given the recent H1N1 flu).
 - We can populate the graphs as soon as the 2008-2009 flu season data are submitted to HEALTH. Data are due to HEALTH by 5/31 and the report was anticipated for July; we may be able to move this forward slightly.

8:45 am **2nd Round Measure Development**

Leonard Mermel, DO, ScM

- The Subcommittee reviewed three proposed MRSA process measures dealing with hand hygiene (handout):
 1. Clinical staff trained in proper hand hygiene and glove use upon hire
 2. Hand hygiene compliance measured at least quarterly
 3. Hand hygiene compliance data shared with hospital staff and executives at least quarterly
- Rosa shared the text of several embedded comments (which didn't print):
 - Remember that the primary audience is consumers (6th grade reading level).
 - Should Measure 1 be restricted to employees, or everyone with patient contact?
 - Should Question 2a collect information on the number of patients observed? The # of units? There could be a minimum for passing the measure (getting a "Yes").
- The group began discussion. Suggestions included separating Measure 1 into two measures, one for credentialed staff (e.g., physicians, PAs, dentists, podiatrists, etc.)

and one for all other staff, and restricting “Yes” to those who receive training (1) prior to their first patient contact (i.e., for new clinicians) and (2) at least annually thereafter.

- **Action items:** Subcommittee members will:
 - o Share additional edits/thoughts (e.g., changes to the definitions, new definitions) with Rosa via email (rbaier@riqio.sdps.org), and
 - o Come prepared to continue the discussion at the next meeting.
- The discussion will be continued at the next meeting.

8:55 am

Action Items & Next Steps

Leonard Mermel, DO, ScM

Samara Viner-Brown, MS

- See above action items.
- Meeting scheduled: TBD – the room is *not* available on 6/1, the tentative date.



Health Care Quality Performance (HCQP) Program

SURGICAL CARE IMPROVEMENT PROJECT (SCIP) MEASURES

Data Report
July-September (Quarter 3), 2008

The SCIP measures are [reported on the Department of Health’s \(HEALTH’s\) Web site](#) as part of the HCQP Program’s Hospital-Acquired Infections work. You can learn more about the measures—including their data source, how they are calculated, and why each is important—by reading the Technical Page.

Figure 1: Percent of surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection

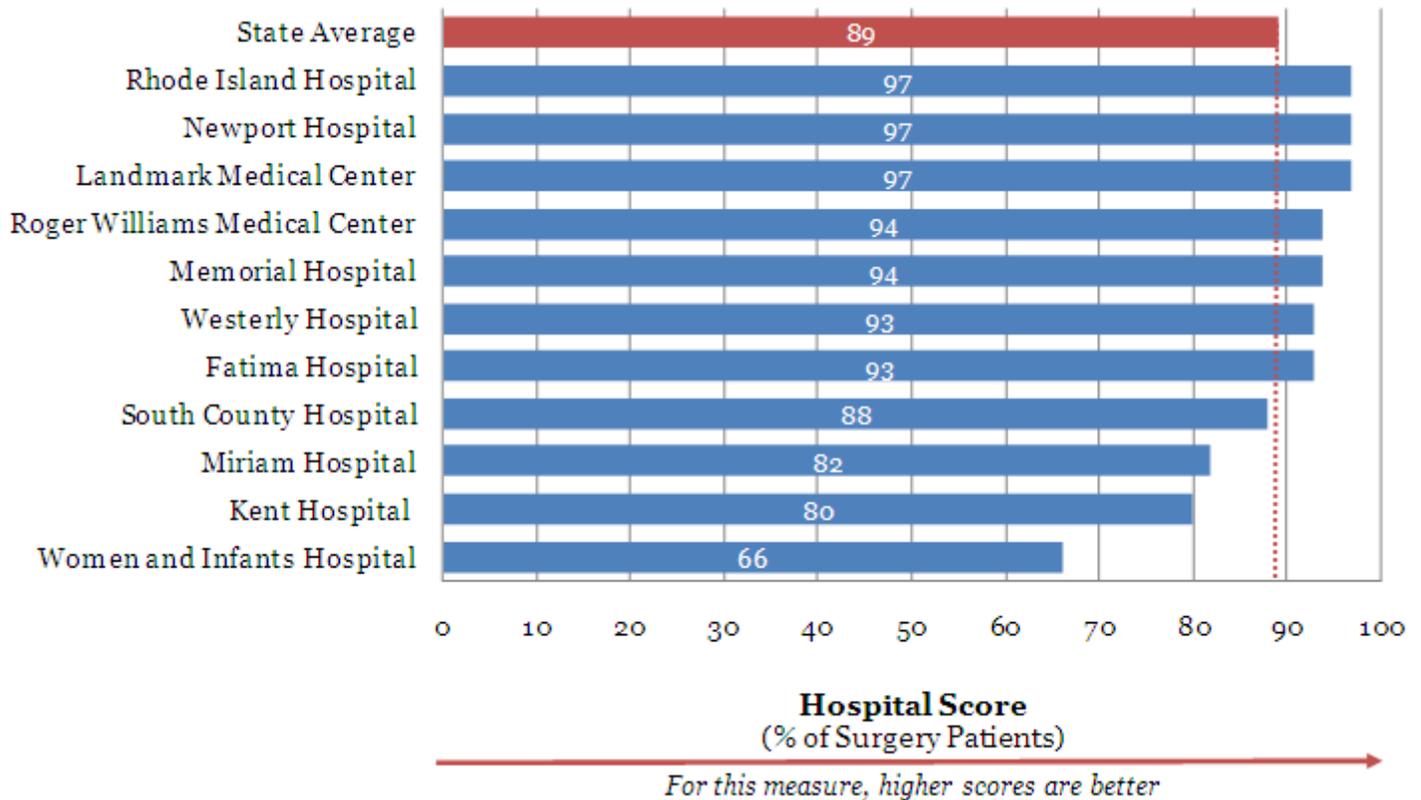


Figure 2: Percent of surgery patients who were given the right kind of antibiotic to help prevent infection

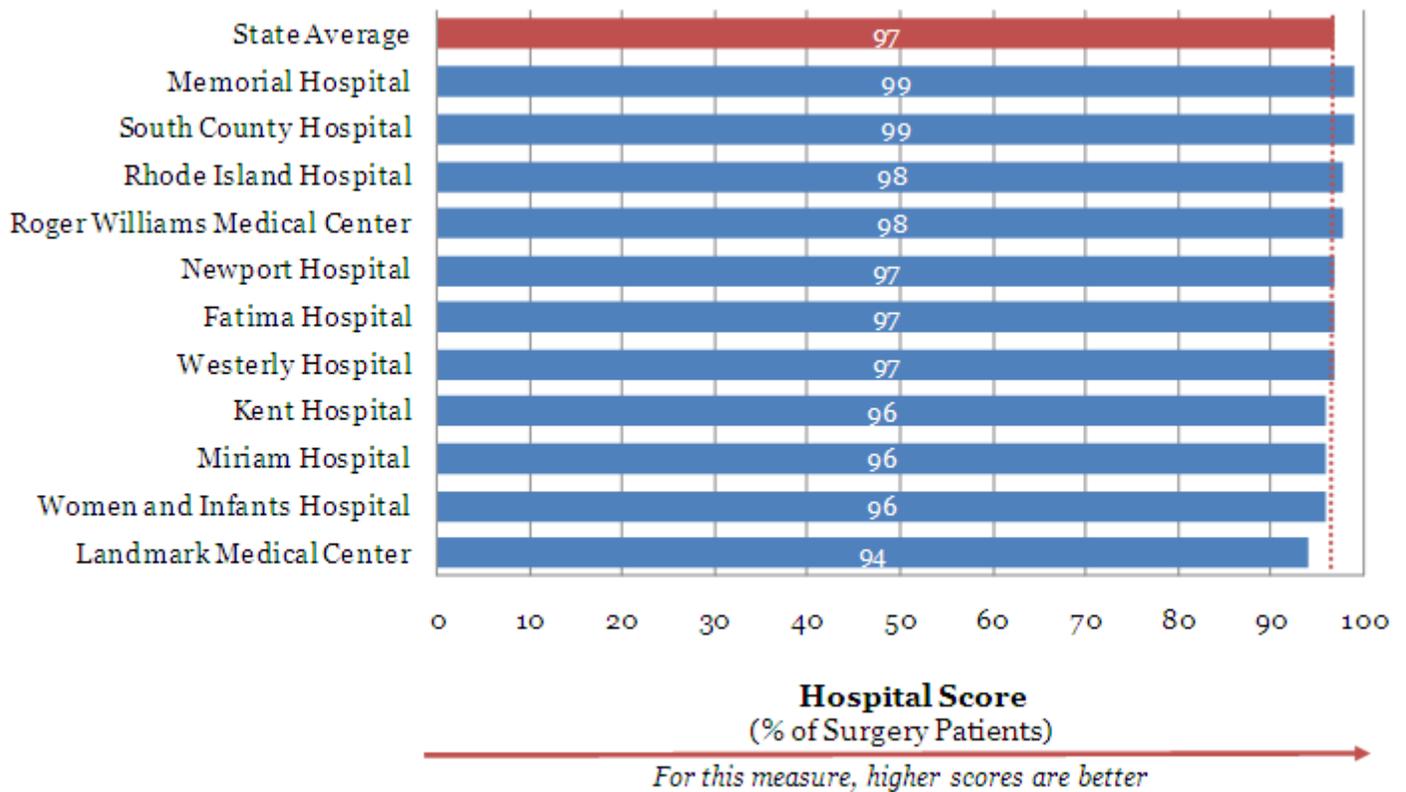
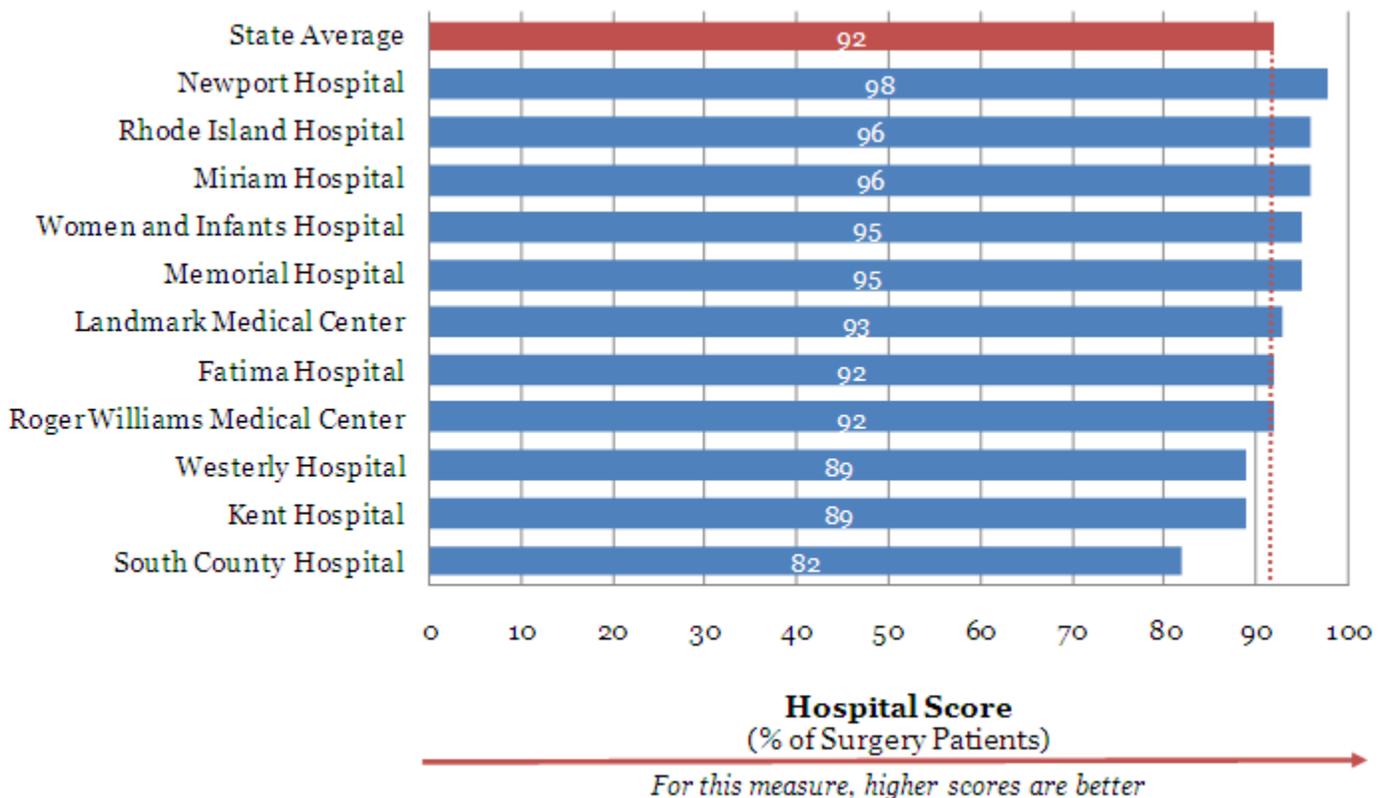


Figure 3: Percent of surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery)





Health Care Quality Performance (HCQP) Program

SURGICAL CARE IMPROVEMENT PROJECT (SCIP) MEASURES

Technical Page

The SCIP measures are [reported on the Department of Health’s \(HEALTH’s\) Web site](#) as part of the HCQP Program’s Hospital-Acquired Infections work. The information on this page provides additional details about the measures, including their data source, how they are calculated, and why each is important.

Data Source

HEALTH’s public reports include three of these surgical infection measures from Medicare’s [Hospital Compare](#):

- 1. Percent of surgery patients given antibiotics within one hour prior to surgery
 - 2. Percent of surgery patients given the right kind of antibiotics before surgery
 - 3. Percent of surgery patients who stop receiving antibiotics within 24 hours of surgery
- } Higher is better

Measure Calculation

For each measure, the score is calculated as follows:

$$\text{Percent of patients} = \frac{\text{(patients receiving indicated care)}}{\text{(all surgical patients who should receive the care)}}$$

The number of patients who receive the indicated care (e.g., appropriate antibiotics) is the **numerator**. The number of surgical patients who should receive the care (are eligible for it) is the **denominator**. The percent of patients, or **measure score**, is the numerator divided by the denominator. Hospitals’ measure scores are compared to one another and to the state average.

Measure Information (adapted from Medicare)

Measure	Why is this information important?
1. 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. Getting an antibiotic within one hour before surgery reduces the risk of wound infections. Hospital staff should make sure surgery patients get antibiotics at the right time. This measure shows how often hospital staff make sure surgery patients get antibiotics at the right time.
2. Percent of surgery patients who were given the right kind of antibiotic to help prevent infection.	Surgical wound infections can be prevented. Some antibiotics work better than others 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. This measure shows how often hospital staff make sure patients get the right kind of antibiotic medication for their surgery.
3. Percent of surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery).	Taking preventive antibiotics for more than 24 hours after routine surgery is usually not necessary. This measure shows how often hospitals stopped giving antibiotics to surgery patients when they were no longer needed to prevent surgical infection.



Health Care Quality Performance (HCQP) Program

HAND HYGIENE COMPLIANCE

Technical Page

The hand hygiene compliance measures are [reported on the Department of Health’s \(HEALTH’s\) Web site](#) as part of the HCQP Program’s Hospital-Acquired Infections work. This information provides additional details about the measures, including their data source, how they are calculated, and why each is important.

Measures

The Program has defined three hand hygiene compliance measures:

Measure	Why is this information important?
1. Clinical staff trained in proper hand hygiene and glove use upon hire	Clean hands are the single most important strategy to prevent germs from spreading in hospitals. Making sure that staff know hand hygiene—how to clean their hands with an alcohol-based product or soap and water—and how to use gloves is important.
2. Hand hygiene compliance measured at least quarterly	Going to different parts of the hospital (wards, clinics, etc.) to see if staff are actually cleaning their hands properly before and after caring for patients is important. This information helps hospitals know how often staff are cleaning their hands properly. They can then use this information to improve hand hygiene compliance, and help to prevent the spread of germs.
3. Hand hygiene compliance data shared with hospital staff and executives at least quarterly	It is important for hospitals to use the information they collect about how staff are cleaning their hands to provide feedback. This feedback should include the staff who were observed and also as s the hospital administration. This tells them if they are doing a good job or need to improve.

These measures are process measures. Process measures look at *how* hospitals work. The goal is for every hospital to have a ‘Yes’ for all three measures.

Data Source

The hand hygiene compliance measures are calculated based on information collected each year from hospitals in Rhode Island. Hospitals answer the following questions:

- Does your hospital teach the following to clinical staff upon hire?** *(Select all that apply.)*

 - Principles of hand hygiene
 - Proper glove use
 - Neither
- Does your hospital measure hand hygiene compliance?**

 - No *(Stop)*
 - Yes ↘

- a. **How does your hospital measure hand hygiene compliance?**
 - By measuring the volume of hand cleansing agent used (e.g., hand sanitizer)
 - Through direct observation
 - Other (*please specify*): _____
- b. **How often does your hospital measure hand hygiene compliance?**
 - Every quarter (3 months)
 - Monthly
 - Weekly
 - Daily
 - Other (*please specify*): _____
- 3. **Does your hospital have an ongoing program to improve hand hygiene compliance rates?**
 - No
 - Yes
- 4. **Does your hospital provide feedback regarding hand hygiene compliance to the following?**
(*Select all that apply.*)
 - Clinical staff
 - Chief Executive Officer (CEO)
 - Executive Leadership
 - None of the above

Measure Definitions

The measures are calculated based on the following definitions:

- 1. **Clinical staff trained in hand hygiene and glove use upon hire**
Yes: Q1: Both “Principles of hand hygiene” AND “Proper glove use” checked
- 2. **Hand hygiene compliance measured**
Yes: Q2: Yes, AND
Q2a: “By measuring compliance through direct observation,” AND
Q2b: At least quarterly
- 3. **Hand hygiene compliance reported**
Yes: Measure 2: Yes, AND
Q3: Yes, AND
Q4: “Clinical staff,” and “Chief Executive Officer” and/or “Executive Leadership” checked

Definitions

To make sure that hospitals answer the above questions the same way, the program has defined some key terms included in the questions. These definitions are:

Key Term/Phrase	Definition
Clinical staff	<ul style="list-style-type: none"> ▪ Healthcare workers engaged in direct patient contact, including: <ul style="list-style-type: none"> – Certified nursing assistants – Licensed nurse practitioners – Registered nurses – Physician assistants – Nurse practitioners – Physicians (MDs and DOs) ▪ Includes healthcare workers who are hospital employees and healthcare workers who are non-employees

Key Term/Phrase	Definition
Executive leadership	<ul style="list-style-type: none"> ▪ High-level hospital administrative staff who run the hospital, including people such as the president and vice president, chief executive officer (CEO), chief financial officer (CFO), chief medical officer (CMO), chief nursing officer (CNO), chief operating officer (COO), and others.
Hand hygiene	<ul style="list-style-type: none"> ▪ A general term that applies to cleaning hands with soap and water or using an antiseptic (e.g., alcohol) hand rub, gel, or foam (e.g., hand sanitizer).
Measuring compliance	<ul style="list-style-type: none"> ▪ The act of collecting data on hand hygiene compliance by collecting data.
Monitoring compliance	<ul style="list-style-type: none"> ▪ The act of using collected data to look at how hospitals’ compliance rates change over time (e.g., looking at trends). ▪ May be part of a program or quality improvement initiative to improve the hospital’s hand hygiene compliance.
Program to improve rates	<ul style="list-style-type: none"> ▪ A team of staff members, usually with different types of experience, who meet regularly to review data, identify improvement opportunities, and implement projects to improve the hospital’s performance.