Health Care Quality Performance (HCQP) Program

HOSPITAL-ACQUIRED INFECTIONS AND PREVENTION ADVISORY SUBCOMMITTEE

8:00-9:00am, June 15, 2009
HEALTH, Room 401

Goals/Objectives

- To discuss upcoming HAI reports, future planning and MRSA process and outcome 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 at 8:05 and discussed today's meeting objectives (above).

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

- Len reported on progress to date:

Report	Status
1. SCIP	– Posted on the Web site
2. CLABSI	– Data received 6/13; to be posted this week after 24-hour advance notice for hospitals
3. Employee flu vaccination	– Awaiting data
4. Hand hygiene processes	– Defining measures (handout)

- Work to date is also summarized in an Addendum to the public reporting program's Annual Report (attached; not handed out)
- Pat shared her concerns about ensuring that consumers know that outcome measures (MRSA, c-diff, etc.) are under consideration, and how 'community-acquired' vs. 'hospital-acquired' infections differ. Sam indicated that HEALTH can include contextual information in the press release that accompanies the SCIP measures (already posted) and CLABSI rates (due for release).

Time	Topic/Notes

- **Recommendation**: Participants suggested that the Steering Committee consider a HAI-specific FAQ that includes questions re: 'community-acquired,' etc. Also, it was recommended to link to HEALTH's educational information about MRSA, C. difficile, and other microbial pathogens of public health significance.
- **Action items:**
  - Work with Annemarie Beardsworth, Public Informations Officer, to include HAI reporting context in the accompanying press release (Sam)
  - Share links for educational resources w/ Program staff (Rob)
  - Recommend a HAI-specific FAQ to the Steering Committee (Rosa & Sam)

8:10 am **Future Planning/HAI Grant Application**
Samara Viner-Brown, MS

- Sam described a CDC grant opportunity that is offering stimulus funding for states to develop and implement a plan to monitor, report, and improve healthcare-associated infections (attached; not handed out). The grant affords an opportunity for RI to greatly expand our HAI work, in part by:
  - Sustaining the Subcommittee's work, outside the Program's funding;
  - Ensuring that all hospitals are enrolled in NHSN;
  - Providing technical support and education to hospitals re: NHSN and HAIs;
  - Reporting at least two outcomes measures (e.g., MRSA, c-diff); and
  - Potentially leveraging existing stakeholder support and relationships (e.g., from the ICU Collaborative and Surviving Sepsis Campaign) to form a new Collaborative focused on preventing HAIs.

  The overall goal would be to build the infrastructure (data collection help, education, etc.) necessary to report HAI process and outcome measures using a sustainable reporting mechanism (NHSN), and lay the groundwork to report similar measures in other healthcare settings.
- HEALTH is still determining whether to go for all three parts (A, B, & C) or how to navigate the politics to ensure the best chance of receiving funding (possibly A & B).
- Because the grant application has a very short time-frame, HEALTH is asking for hospitals' ideas and support (via letters of support) this week. If awarded the grant, there is a six-month planning period (starting in August) that would enable Rhode Island to determine a strategic plan for implementing the project.
- **Action items:**
  - Distribute the request for proposal to meeting participants (Sam)
  - Let Sam know if your organization is willing to provide a letter of support (all)
  - Share any grant ideas with Sam (all)

8:40 am **2nd Round Measure Development**
Leonard Mermel, DO, ScM

- The Subcommittee reviewed the three proposed hand hygiene measures, updated since the last meeting (handout):
  1. Hand hygiene and glove use educational program in place
  2. Hand hygiene compliance measured
  3. Hand hygiene compliance data shared with hospital staff and administration
- Currently, only observation data 'counts' (= a 'Yes') for Measure 2. Meeting

Time	Topic/Notes
	participants suggested collecting (but not reporting) information about hospital size and/or the number of units, shifts, etc. where observation data are collected. The Subcommittee can use this for future version of Measure 2. – **Action items:** • Incorporate participants' edits, e.g., adding info about how hand hygiene relates to infection control (Rosa) • Review the hand hygiene Technical Page, share comments with Rosa, and come to the next meeting prepared to discuss (all)
8:55 am	**Action Items & Next Meeting** *Leonard Mermel, DO, ScM* *Samara Viner-Brown, MS* – See above action items. – Next meeting: TBD via email

Health Care Quality Performance (HCQP) Program

FAQ ABOUT DATA REPORTING

Frequently Asked Questions (FAQ)

This page provides additional details about Rhode Island's public reporting program, including how it chooses what information to release and what to think about when looking at the information.

1. **How does Rhode Island's public reporting program decide what to report?**

   The public reporting program requires all Rhode Island healthcare providers to release information about how they care for patients. Healthcare providers are licensed facilities, like home health agencies, hospitals, and nursing homes, and also doctors. We began reporting information for hospitals in 2001, and have since added home health agencies, nursing homes, and physicians. We select the topics for public reporting based on local interest in the topic and how useful the information will be.

2. **How should I use this information?**

   You should view the publicly reported data as one source of information that can help you get a complete picture of a particular healthcare provider. We encourage you to use other sources, too, such as talking to your doctor, visiting healthcare facilities to look around, and asking questions of the doctors, nurses, and other staff you meet. You can visit a healthcare provider's Web site to learn more about how each provider makes sure that it provides high-quality care for its patients.

3. **Can you determine a health care provider's overall quality based on its scores?**

   These scores reflect specific components of health care. Healthcare providers give care for other medical conditions and illnesses that are not yet included in the information released publicly. You should view the publicly reported data as one source of information that can help you get a complete picture of a particular healthcare provider (see #2).

4. **More specifically, how do you decide which measures to release?**

   We work closely with committees of healthcare providers and others interested in healthcare quality. Together, we identify existing sources of information (or data) and measures. Whenever possible, we look for measures that have been tested and proven to reliably and accurately (see #8 and #9) measure a particular healthcare outcome or process (see #11 and #12). If no data or measures exist for a particular topic, we create a measure using available measurement and reporting standards, and then collect information from healthcare providers.

5. **Why do you look for existing sources of information?**

   Because the Department of Health continues to publicly report new information each year, we try to find information sources that require little, if any, additional data collection by the healthcare providers. We want their resources and focus to remain on providing the highest level of care for their patients.

6. **Why do you look for measures that have been tested?**

   There are two main reasons:

   - First, we want information that is reliable and accurate (see #7 and #8). This is important because you can use this information to make decisions about your health care, and also because healthcare providers use it to improve the quality of the care they provide. It can be expensive and time-consuming to test a measure, so it's helpful to look for measures that have already been tested. If no data or measures exist for a particular topic, we collect information from healthcare providers.

- Second, we want the ability to compare Rhode Island healthcare to healthcare provided elsewhere. If we use a measure that has been tested and is in use elsewhere, we can sometimes compare local performance to the national average (for example) or another "benchmark."

7. How do you know that the information is meaningful?

While there is no "perfect" source of information, whenever possible, we look for measures that have been tested and proven to reliably and accurately measure a particular healthcare outcome or process. Our goal is to identify and release useful information that helps people make decisions about healthcare. When you look at the information, we encourage you to contact the healthcare provider directly to ask questions.

8. What does it mean that a measure is "reliable"?

If you collect information several times, and the information is the same (or nearly the same) every time, then it is considered reliable. It's important that the information also be accurate (see #8).

9. What does it mean that a measure is "accurate"?

If the information you collect is as close as possible to the real truth, then it is accurate. For example, if a patient is seen by a doctor and the information you have says they were seen by a doctor, then it is accurate. If your information says they were not seen by a doctor, it is inaccurate.

10. What affects the reliability and accuracy of information?

It's important that we collect information from enough patients, or have a large enough "sample," to draw conclusions. To help ensure that the publicly reported information adequately reflects providers' care, we only release information if there are enough patients included. For example, only if there are more than 20 patients. (For statistical reasons, the minimum number can be different in different reports.)

11. What if the data you release are *not* reliable or accurate?

We make every attempt to ensure that the information we release is meaningful. However, we encourage you to view the public reports as one source of information (among many) that can help you get a complete picture of a particular healthcare provider (see #6).

12. What is an "outcome measure"?

An outcome measure reflects *the results of the care providers give* to patients, or what the patients' health status is after receiving care. For example, the percent of patients at a healthcare facility who have pain is an outcome measure.

13. What is a "process measure"?

A process measure reflects *how providers care for their patients*. For example, the percent of patients at a healthcare facility who are asked if they have pain is a process measure.

14. What is a "structural measure"?

A structural measure reflects the physical environment in which providers care for patients. For example, whether or not a physician uses an electronic health record is a structural measure.

15. Can I participate in the public reporting program?

Yes. The program is open to all who are interested in participating. To learn about HCQP meetings, please visit the Open Meetings Web site, where meeting notices are posted, or call Rosa Baier at 401-528-3205.

Health Care Quality Performance (HCQP) Program

CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS (CLABSI) RATES

Data Report
January-March 2009

The CLABSI rates 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.

Please note: Because there are differences between types of patients each intensive care unit (ICU) in the state cares for, each hospital's ICU is compared to other ICUs in Rhode Island (if there are any) and nationally that provide similar care. With questions about a hospital's score or how to compare one hospital to another in Rhode Island, please contact the hospital(s) directly.

Figure 1: CLABSI infection rate among [type of ICU]

GRAPH TO BE HERE

Hospital Infection Rate
(Per 1,000 Central Line Days)

For this measure, lower scores are better

Health Care Quality Performance (HCQP) Program

CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS (CLABSI) RATES

Technical Page

The CLABSI rates 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 measure, including its data source, how it is calculated, and why it is important.

Data Source

Rhode Island hospitals collect information about their CLABSI rates for each intensive care unit (ICU) and share it with the Department of Health for reporting. Many Rhode Island hospitals have been collecting this information for several years as part of Rhode Island's ICU Collaborative. The rates are based on bloodstream infections that occur in the intensive care unit (ICU). The closer the rate is to zero, the better.

Measure Calculation

For each hospital, the CLABSI infection rate is calculated as follows:

$$\textit{Infection rate} = \frac{\textit{(patients who develop a central line associated bloodstream infection)}}{\textit{(number of central line days)}} \times 1{,}000$$

The number of patients who develop a central line associated bloodstream infection is the **numerator**. The number of central line days (the number of days when patients could have developed an infection) is the **denominator**. The score, or **infection rate**, is the numerator divided by the denominator multiplied by 1,000. Hospitals' ICU rates are compared to other ICUs in Rhode Island (if there are any) and nationally that provide similar care. If there are too few central line days in the denominator, no rate is reported for that ICU.

Measure Information (adapted from the National Healthcare Safety Network)

Measure	Why is this information important?
Central Line Associated Bloodstream Infection (CLABSI) Rate	This measures primary bloodstream infections in patients that had a central line placed within (less than) 48 hours before the development of the infection. Central line infections are important because they are the most common bloodstream infections. These infections can harm patients and also because CLABSIs are considered reasonably preventable with proper care of patients' central lines.

Definitions

Term	What does this mean?
Bloodstream infection	A bloodstream infection occurs when bacteria enter patients' blood, for example through their central line.
Central line	A "central line" is a special kind of IV or flexible tube that connects directly to a patient's heart or a major blood vessel. It can be used to draw blood or give patients medication or nutrition.
Intensive Care Unit (ICU)	A hospital unit that cares for critically ill patients.
Rate	A score that reflects new (hospital-acquired) infections over a period of time; for the CLABSI infection rates, three months.

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. Hand hygiene and glove use educational program in place	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	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	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:

1. **Does your hospital have an educational program regarding the following?** *(Select all that apply.)*
   - ☐ Principles of hand hygiene
   - ☐ Proper glove use

2. **Does your hospital measure hand hygiene compliance on a regular basis?**
   - ☐ 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. *Please specify average number of observations/month:* _____
      - ☐ 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.)*
   - ☐ Credentialed staff
   - ☐ Chief Executive Officer (CEO)
   - ☐ Executive Leadership
   - ☐ None of the above

Measure Definitions

The measures are calculated based on the following definitions:

1. **Hand hygiene and glove use educational program in place**
   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: "Credentialed 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
Credentialed staff	▪ Healthcare workers engaged in direct patient contact, including: – Certified nursing assistants (CNAs) – Licensed practical nurses (LPNs) – Registered nurses (RNs) – Physician assistants (PAs) – Nurse practitioners (NPs) – Physicians (MDs and DOs) ▪ Includes clinicians who are hospital employees and also those who are not hospital employees.
Direct patient contact	▪ Any face-to-face interaction with patients.
Executive leadership	▪ 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	▪ A general term that applies to cleaning hands with soap and water or using an antiseptic (e.g., alcohol) hand rub, gel, or foam (i.e., hand sanitizer).
Measuring compliance	▪ The act of collecting data on hand hygiene compliance by collecting data.
Monitoring compliance	▪ 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.
Physicians	▪ Includes both Medical Doctors (MDs) and Doctors of Osteopathy (DOs). ▪ Includes physicians who are hospital employees (e.g., hospitalists) and also those who are not hospital employees, but have direct patient contact with patients at the hospital.
Program to improve rates	▪ A team of staff, usually with different types of experience, who meet regularly to review data, identify improvement opportunities, and implement projects to improve the hospital's performance.