



Health Care Quality Performance (HCQP) Program

HOSPITAL-ACQUIRED INFECTIONS AND PREVENTION ADVISORY SUBCOMMITTEE

8:00-9:30am, February 22, 2010

Department of Administration, Conference Room B

Goals/Objectives

- To discuss HAI work to date and make policy recommendations for pending and upcoming reports

Voting Members

T Rosa Baier, MPH	T Maureen Marsella, RN, BS	G Janet Robinson, RN, Med, CIC
G Utpala Bandy, MD	G Pat Mastors	T Nancy Vallande, MSM, MT, CIC
T Margaret Cornell, MS, RN	T Leonard Mermel, DO, ScM	G Cindy Vanner
T Marlene Fishman, MPH, CIC	T Kathleen O'Connell, RN	T Sam Viner-Brown, MS
T Julie Jefferson, RN, MPH, CIC	G Harold Picken, MD	G Gloria Williams, MS
T Diane Kitson-Clark, RN, MSN, CIC	G Aurora Pop-Vicas, MD	
T Andrew Komensky, RN	T Lee Ann Quinn, RN, BS, CIC	

Time

Topic/Notes

8:05am **Welcome & Administrative Updates**

Leonard Mermel, DO, ScM
Samara Viner-Brown, MS

- Len welcomed the group and reviewed the meeting objectives. Rosa then provided updates on the previous meeting's action items:
 - ✓ Make group's edits to the hand hygiene survey & letter by 1/29 (Rosa) – **done**
 - ✓ Send survey & letter to Infection Preventionists and CEOs by 2/3 (Sam) – **done**
 - ✓ Distribute Subcommittee survey to prioritize HHS topics by 2/5 (Rosa) – **done**
- As discussed previously, the CDC grant's conference calls on the State HAI Plan, NHSN, and MDRO Collaborative (which was not funded in Rhode Island) have continued. Maureen is monitoring discussions about NHSN, in particular, to keep abreast of NHSN activities and expectations. The CDC has shared some tools and resources and, depending on the topics the Subcommittee chooses, Maureen will identify and share appropriate materials.

8:10am **Data Updates**

Rosa Baier, MPH

- Rosa provided a brief update on completed and proposed data reports:

Report	Data Period	Last Updated
SCIP I, II, and III measures	Apr 08-Mar 09	Jan 10
CLABSI rates	Q4 09	Feb 10

Proposed Report	Status
Employee flu vaccination	Awaiting data
Hand hygiene	Pending report format

- The CLABSI reports were distributed for the 5-day preview period last Friday and will be posted on the HCQP Program website this Friday, 2/26/10:
<http://www.health.ri.gov/chic/performance/hospitals.php>
- The hand hygiene report format is pending today’s Subcommittee discussion (below), but ready to be populated and posted once the format is approved.

8:15am **Hand Hygiene Report**

Leonard Mermel, DO, ScM

Samara Viner-Brown, MS

- The group reviewed the draft report and technical information pages, providing suggested edits and additions to both, including:
 - Updating the technical information questions to mirror those on the survey
 - Changing the footnotes on the report to include the same language
- **Recommendations:**
 - Send the report for a 5-day preview period prior to posting the results
 - Notify the hospital CEOs, CNOs, and CMOs of the new report
- **Action items:**
 - Send the report to each hospital’s point of contact for the preview (Rosa)
 - Notify hospital CEOs, CNOs, and CMOs of new report (Sam)

8:25am **Prioritize HHS Topics**

Leonard Mermel, DO, ScM

Samara Viner-Brown, MS

- The group reviewed the HHS topics (included in the appendix for the State HAI Plan, beginning on p. 19) and the Subcommittee’s prioritization survey results (handout). The goal is to identify two additional HHS topics for reporting.
- The Subcommittee’s highest-priority topics (SCIP 1 and CLABSI 1) are those that the HCQP Program is already reporting, so the group’s discussion began with priority #3 (C diff 1) and continued down the list.
- **Recommendations:**
 - Although the Subcommittee expressed continued concern about the data definitions and data collection strategy, including data validation and staff level of effort, the Voting Members opted to prioritize the topics as follows:

1. MRSA (yes – 9, no – 2, abstain – 2)
2. C diff (yes – 8, no – 3, abstain – 2)
3. CLIP (yes – 6, no – 5, abstain – 2)

(Sam and Rosa abstained from voting.) Specific measurement strategies will be the focus of the March meeting.

- Discussion centered on the likelihood of NHSN becoming a Federal mandate; if it does, it will require significant changes in current workflow and additional resource allocation, including potential reallocation of entire Infection Control Departments. As a result, the Subcommittee recommended that NHSN issues are raised to hospital leadership in a timely manner.

– **Action items:**

- Share detailed measure definitions for MRSA, C diff, & CLIP (Sam, Len, & Rosa)
- Choose two topics AND measurement strategy at next meeting (Subcommittee)
- Initiate initial communication about NHSN with HARI Board (Gina)
- Obtain additional info about NHSN requirements (ICPSNE group)
- Jointly share info about NHSN requirements with hospital leadership (Sam & Gina)

8:55am

Action Items & Next Steps

Leonard Mermel, DO, ScM

Samara Viner-Brown, MS

- The group revisited the upcoming meeting length, option to revert back to 60 minutes unless a need arises for longer discussions.
- **Next meeting:** 3/29 [note 4th Monday, rather than 3rd]



Health Care Quality Performance (HCQP) Program

HOSPITAL HAND HYGIENE

Data Report, February 2010

Clean hands are the single most important strategy to prevent germs from spreading in hospital. As a result, how hospital healthcare workers clean their hands—their “hand hygiene”—is an important part of how the hospital controls infections. Hospitals’ hand hygiene processes are [reported on the Department of Health’s \(HEALTH’s\) Web site](#) as part of the HCQP Program’s hospital reporting work. You can learn more about these measures—including what each measure means, how it is calculated, and why this information is important—by reading the Technical Page. With questions about a hospital’s performance, please contact the hospital directly by clicking on each hospital’s name.

Hospital (Alphabetical)	Hand Hygiene & Glove Use Education Provided*	Hand Hygiene Measured ^H (Yes/No)	Hand Hygiene Reported ^I
Kent County Memorial Hospital			
Landmark Medical Center			
Memorial Hospital			
Miriam Hospital			
Newport Hospital			
Our Lady of Fatima Hospital			
Rhode Island Hospital			
Roger Williams Medical Center			
South County Hospital			
Westerly Hospital			
Women & Infants’ Hospital			

* Hand hygiene and glove use educational program in place

^H Hand hygiene compliance measured through direct observation, at least once every three months (quarterly)

^I Hand hygiene compliance measured through direct observation, at least once every three months (quarterly), with feedback provided to credentialed staff, the Chief Executive Officer, and Executive Leadership



Health Care Quality Performance (HCQP) Program

HOSPITAL HAND HYGIENE

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.

Measure Information

Topic	Why is this information important?
1. Hand hygiene & glove use education provided	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 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 reported	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 the hospital administration. This tells the hospital if their staff 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.

Definitions

Key Term/Phrase	Definition
Credentialed staff and licensed independent practitioners (LIPs)	<ul style="list-style-type: none"> ▪ Healthcare workers engaged in direct patient contact, including: <ul style="list-style-type: none"> – 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	<ul style="list-style-type: none"> ▪ Any face-to-face interaction with patients.
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 (i.e., hand sanitizer).

Key Term/Phrase	Definition
Measuring hand hygiene	<ul style="list-style-type: none"> ▪ The act of collecting data on hand hygiene compliance by collecting data, for example by observing staff.
Monitoring hand hygiene	<ul style="list-style-type: none"> ▪ The act of using collected data to look at how a hospital’s compliance rate changes 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	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ 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.

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 \rightarrow
 - a. **How does your hospital measure hand hygiene compliance?**
 - By measuring the volume of hand cleansing agent (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.)*
 - Credentialed staff and licensed independent practitioners (LIPs)
 - Chief Executive Officer (CEO)
 - Executive Leadership
 - None of the above

Measure Calculation

The measure scores (Y/N) 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/LIPs” and “CEO” AND “Executive Leadership” checked



Health Care Quality Performance (HCQP) Program

PRIORITIZATION OF HHS TOPICS

Survey Results, 2/22

Goal: To choose at least two additional HHS topics for upcoming HCQP Program reporting, using HAI Subcommittee input

Topic, by Rank	Description	Ave. Rank (1-8)	Measurement System	National Baseline (5-Year Target)	Notes
1. SCIP 1	Adherence to SCIP/NQF infection process measures	-	CMS SCIP	TBD (95% adherence)	Already reported
2. CLABSI 1	CLABSIs per 1,000 device days by ICU	-	NHSN Device-Associated Module	2006-2008 (Reduce SIR 50% or to 0%)	Already reported using NHSN standards, but not NHSN system
3. C diff 1	Case rate per patient days	3.3	Hospital Discharge Data Set	2008 (30% reduction)	
4. MRSA 2	SIR for bacteremia rate	3.6	NHSN MDRO/CDAD Module LabID	2009-2010 (Reduce SIR 25% or to 0%)	
5. CLIP 1	Central line bundle compliance	3.9	NHSN CLIP in Device-Associated Module	2009 (100% adherence)	
6. MRSA 1	Invasive MRSA infections incidence per 100,000 persons	4.1	CDC EIP/ABCs	2007-2008 (50% reduction)	
7. SSI 1	Deep incision and organ space infection rates	4.8	NHSN Procedure-Associated Module	2006-2008 (Reduce by 25% or to 0%)	SCIP procedures
8. C diff 2	SIR for rate	5.2	NHSN MDRO/CDAD Module LabID	2009-2010 (Reduce by 30% or to 0%)	
9. CAUTI 2	# of symptomatic UTI per 1,000 urinary catheter days	5.8	NHSN CLIP in Device-Associated Module	2009 (Reduce SIR 25% or to 0%)	

SIR: Standardized Incidence Ratio

Free-text responses:

1. I strongly support efforts to assess and limit the incidence of Clostridium Difficile, as it has widest implications for morbidity and mortality, is relatively difficult to eradicate in the environment, is perhaps least understood by the medical community, and as treatment options are limited.
2. For C.diff, do not use ICD 9 codes. Re MRSA 1: how do you define 'persons'? NHSN definitions for CA-UTI are difficult; most often, we cannot meet the criteria to classify as CA-UTI.
3. Do not have enough information to rank the proposed measures other than CLABSI and bundle. Suggest more information on what is currently being collected, how the measures are collected and review if standardization is a common theme across hospitals.
4. We can report:
 1. HAI Cdiff (NHSN def.) by 1000 patient days
 2. HAI MRSA bacteria by 1000 device days
 3. HAI MRSA invasive by 1000 patient days
 4. as reported by ICU collaborative
 5. HA CLABSI by 1000 line days
 6. HA CAUTI critical care only by 1000 device days
 7. SSI is targeted to Ortho and CardiacNote: Cdiff 1: we will not report discharge data.