Healthcare Quality Reporting Program

HOSPITAL-ACQUIRED INFECTIONS AND PREVENTION ADVISORY SUBCOMMITTEE

8:00-9:00am, 10/21/13 at Healthcentric Advisors

Goals/Objectives
▪ To discuss HAI work to date and make policy recommendations for pending and upcoming reports

Members		
✓ Nicole Alexander, MD	✓ Maureen Marsella, RN, BS	☐ Lee Ann Quinn, RN, BS, CIC
✓ Rosa Baier, MPH	✓ Linda McDonald, RN	✓ Janet Robinson, RN, Med, CIC
☐ Utpala Bandy, MD	✓ Leonard Mermel, DO, ScM	✓ Nancy Vallande, MSM, MT, CIC
✓ Emily Cooper, MPH	☐ Pat Mastors	✓ Cindy Vanner
✓ Marlene Fishman, MPH, CIC	✓ Robin Neale, MT (ASCP), SM,CIC	✓ Samara Viner-Brown, MS
✓ Yongwen Jiang	✓ Kathleen O'Connell, RN,BSN,CIC	
☐ Julie Jefferson, RN, MPH, CIC	☐ Sheila Turner, RN, MA	

Time	Topic/Notes

8:00am **Welcome & Administrative Updates**
Leonard Mermel, DO, ScM
Samara Viner-Brown, MS

- Len welcomed participants and reviewed today's meeting objectives before discussing the previous meeting's action items:
  - **Align four- and two-week submission reminders with CMS calendar** (Ann) – Complete

    The four- and two-week submission reminders have been aligned and are being sent to the committee. The next submission deadline is November 15.
  - **Follow up with Dr. Bandy re: SNF CRE reporting** (Sam) – Complete

    Sam spoke with Dr. Bandy and learned that carbapenem-resistant Enterobacteriaceae (CRE) is not reportable for skilled nursing facilities (SNFs), meaning that HEALTH does not require facilities to report cases.

    Janet commented that even though CRE are not mandatory reportable events, HEALTH asked East Side Labs to report them as communicable diseases. HEALTH sometimes – but not always – calls a SNF after being notified of a case.

    Nicole commented that HEALTH is trying to develop a policy regarding CREs in SNFs. Rosa said that, if it's helpful, the Nursing Home Subcommittee is a venue where Nicole could present the draft policy and solicit input regarding any outstanding questions.
  - **Revise MRSA CLABSI letter and send to Hospital** (Emily/Rosa) – Complete

    Rosa reported that the letter was finalized and emailed to hospital CEOs, with

Time	Topic/Notes

copies sent to the committee and to all infection preventionists.

- **Send out preview of hospital flu reports (Ann)** – Complete

  The preview process is complete and the final reports (Care Outcomes and Methods) have been published: www.health.ri.gov/data/hospitalquality/

- **Create consumer-friendly report format (Emily/Rosa)** – In progress

  The group discussed the draft report during today's meeting (see below).

- **Outreach to Bradley Hospital for flu data (Maureen)** – Complete

  Maureen asked Bradley to submit data using the HEALTH link, which they did; HEALTH then sent the data to program staff for inclusion in the report. We will add the new data to the Care Outcomes report and reissue it.

8:05am **'Consumer-Friendly' Report Format**
Rosa Baier, MPH
Emily Cooper, MPH

- Review previous discussion:

  Rosa briefly described the history of the 'consumer-friendly' report, which the committee discussed in August. The goal is to create a one-page summary report that consolidates some of the information that the program publishes (or links to) for hospitals, so that consumers can have access more comprehensive information in a single location.

  Due to space limitations, the report will not be all-inclusive, but a summary of important data in a printer-friendly format. The thought is that if this report is a one page document, it is more likely that it will be distributed to, and used by, consumers.

- Discussion:

  Emily and Rosa created a draft (see handout) for the group to discuss. The language at the top of the report is from previous HAI white papers and a similar report being created for nursing homes. We spelled out links (vs. inserting hyperlinks) to ensure that people viewing hard copies will be able to access the information. However, Emily suggested hyperlinking the facility names to hospitals' websites, too.

  Rosa asked the group to consider the questions sent with the agenda:

  - Is the language clear?
  - Is the "right" information included?
  - Is there anything we should add or remove?

  The group then discussed the reports, making suggested edits. Suggestions included:

  - Eliminating 'city' and 'hand hygiene reported,'
  - Aligning the *C. difficile* and MRSA measures with CMS,
  - Adding CAUTI and CLABSI from Hospital Compare,
  - Rephrasing the hand hygiene measures as questions,
  - Adding a sentence about different populations measured (ICU or hospital-wide),
  - Replacing the 'serious surgical complications' measure with surgical mortality, and
  - Adding patient satisfaction with cleanliness.

  Discussion themes also included the following:

  - *How to reflect different hospital specialties (casemix)*

Time	Topic/Notes
	Marlene suggested replacing city with hospital specialty, such as psychiatric or geriatrics; this might help consumers better understand variation among the measures, and asking hospitals to list their top two specialties. Maureen responded that some hospitals have different CMS Certification Numbers (CCNs) for specialty units and others do not, so this could be confusing to consumers.
	• *How to accurately describe the measures*
	Marlene raised some questions about how to indicate the different populations included in each measure, or the fact that hospitals specialize in different populations (discussed above). Len suggested adding language, and Rosa indicated that additional detail would be included in the Methods report.
	• *Which quality measures to include*
	Rosa noted that readmission was included at the request of Dr. Fine and the Steering Committee, and the group agreed with using the overall readmission rate vs. one of the three condition-specific rates available (acute myocardial infarction, congestive heart failure and pneumonia).
	Maureen advocated for the 'falls and trauma' measure, noting that a recent Joint Commission report noted that falls are the number one problem in certain hospitals.
	After discussion of the 'serious surgical complications' measure (what's included? is it meaningful?) the group recommended replacing it with a surgical mortality measure. Marlene also suggested vetting the report as a whole (and this section, in particular) with the Hospital Subcommittee and the Steering Committee.
	• *Which HAI measures to include*
	Robin suggested aligning the measures with CMS, including switching CDI for LabID and reporting MRSA instead of MRSA CLABSI. These data are available in NHSN, even though CMS has not begun publicly reporting them yet. Rosa asked the group for permission for Healthcentric Advisors to access NHSN data for C. difficile and MRSA, and the group agreed. Marlene asked that the five-day preview period process continue for data obtained from NHSN.
	Nicole suggested adding CAUTI, because consumers are aware of this issue. Len commented that the current measure is limited to ICUs where interventions aimed at reducing bladder catheter use is least likely to be realized, but agreed that it would be worthwhile to include it until hospital-wide CAUTI data are available in January 2015.
	• *Which satisfaction measures to include*
	There was some disagreement among the group about the value of the 'willingness to recommend' category, with some saying it may not be helpful and others saying it is valued by their leadership. Nicole suggested adding additional satisfaction measures, such as satisfaction with cleanliness.
	- <u>Next steps</u>
	Emily and Rosa will share the report template with the Hospital Subcommittee (TBD) and Steering Committee (11/25/13). Linda suggested inviting Len or Maureen to that meeting to answer questions. Once the report template is finalized, it will be

Time	Topic/Notes
	populated and updated every time new information is available.
8:40am	**Healthcare Worker Influenza Vaccination** *Rosa Baier, MPH* *Emily Cooper, MPH* - Review additions to Methods report: After publishing the Care Outcomes reports, the team realized that the terminology in the reports was not defined in the Methods report. Emily drafted definitions to add to the hospital, home health and nursing home reports (see hospital handout) and want the group's input on the language included. **Because the meeting adjourned without addressing this discussion topic, Rosa asked the group to review the definitions and email feedback to Emily at ecooper@healthcentricadvisors.org.** In commenting, Rosa asked the group to consider the questions sent with the agenda: • Are the definitions clear? • Is there anything we should add or remove? She noted that the definitions were derived from several sources: NHSN (hospitals), HEALTH's January data collection links (all facilities), HEALTH's SurveyMonkey link (all facilities except hospitals) and the Rules and Regulations (all facilities). Our goals are to: 1) ensure that the definitions are accurate, and 2) identify any recommended edits for HEALTH, based on alignment with NHSN. Marlene suggested specifying that if a person works for a healthcare system (such as Care New England) rather than the facility itself, than they are not considered an employee. - Next steps Emily will incorporate the group's recommendations, and then she and Rosa will work with the immunizations program to finalize the Methods report and to convey any suggested requests for edits to HEALTH's data collection forms.
8:55am	**Open Forum & Action Items** *Rosa Baier, MPH* - **Action items:** • Update the draft summary report (Emily/Rosa) • Share draft summary report with Hospital Subcommittee (Rosa/Emily) • Share draft summary report with Steering Committee (Rosa/Emily) • Provide any flu vaccination Methods definition edits to Emily (All) • Finalize the flu definitions with the immunizations program (Rosa/Emily) - **Next meeting:** 12/16/13

Healthcare Quality Reporting Program

HOSPITAL EMPLOYEE INFLUENZA VACCINATION STATUS

Methods

Hospital employee influenza vaccination rates are reported annually on the Department of Health's (HEALTH's) Website as part of the public reporting program. The information on this page provides additional details about the influenza vaccination rates, including their data source, how they are calculated, and why influenza vaccination is important for hospital employees.

Measure Information

Measure	Why is this information important?
1. Influenza Vaccination Status for Hospital Healthcare Workers	Influenza, or the flu, can be very serious for hospital patients. Vaccinating healthcare workers is important because influenza spreads from person to person. Vaccination can prevent its spread from healthcare workers to patients. This measure looks at how often healthcare workers receive influenza vaccination during the influenza season (October-March). There are three percentages that total 100% altogether: 1. % vaccinated, 2. % who declined vaccination, and 3. % with unknown vaccination status. These categories are reported for all healthcare workers who are hospital employees, and then broken down for the three types of healthcare workers listed below. This information is updated annually in the Spring.

Data Source

In hospitals, some of the doctors who care for patients are hospital employees and some are not hospital employees, but have "privileges" to see their patients when they are hospitalized. Hospitals collect influenza vaccination data for the healthcare workers who are their employees during each influenza season (October-March) and submit that data to the National Healthcare Safety Network (NHSN) reporting system. HEALTH then collects the following information:

1. Type of healthcare worker (e.g., doctor, nurse)
2. Who received influenza vaccination, either at the hospital where they are employed or somewhere else
3. Who did not receive influenza vaccination, either at the hospital where they are employed or anywhere else (and why they declined)
4. Whose vaccination status is unknown, either because the employee did not know or did not tell the hospital

HEALTH's public reports include overall influenza vaccination rates for all healthcare workers who are hospital employees, and then break down the information for three different types of hospital employees:

1. Employees
2. Licensed Independent Practitioners
3. Non-Employees, such as students or volunteers

Definitions

Word or Phrase	What does this mean?
Direct Patient Contact	Direct patient contact means any routinely-anticipated face-to-face interaction with patients in a healthcare facility. This is usually defined as any healthcare worker who comes within six feet of patients.
Healthcare Workers (HCWs)	Healthcare workers, sometimes abbreviated HCWs, are defined as workers with direct patient contact who are physically present in the facility for at least one working day during the reporting period (October 1 -March 31). This category includes both employees and non-employees.
Employee	Employees are healthcare workers who are paid by the facility (i.e., on the facility's payroll). They can be temporary or permanent employees.
Non-Employee	Non-employees are healthcare workers who are not paid by the facility. Non-employees include some licensed independent practitioners (physicians, advance practice registered nurses and physician assistants), if they are not paid by the facility, adult students/trainees and volunteers.
Licensed Independent Practitioners (LIPs)	Licensed independent practitioners are clinicians who are permitted by law to provide patient care without direction or supervision, within the scope of the clinician's license. This includes physicians, advance practice registered nurses and physician assistants who are either employees or non-employees who are allowed to practice at the facility (i.e., have privileges).
Vaccine Status: Declined	Healthcare workers who are not vaccinated because they have declined vaccination. Reasons for declining may be religious or philosophical, or because they have a health condition that is different from the conditions listed as medical contraindications (below).
Vaccine Status: Contraindication or Medical Exemption	Healthcare workers who are not vaccinated because they have a health condition that means they should not be vaccinated. A contraindication or medical exemption is a health condition or factor that is a reason to withhold a certain medical treatment, like a vaccine. Accepted contraindications or medical exemptions are: severe allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or to a vaccine component, including egg protein, or a history of Guillain-Barré Syndrome within six weeks of a previous influenza vaccination. Guillain-Barré Syndrome a serious disorder that occurs when the body's defense (immune) system mistakenly attacks part of the nervous system.
Vaccine Status: Unknown	Healthcare workers whose vaccination status is unknown, because the facility does not have paperwork showing if they were vaccinated or not. This category also includes healthcare workers whose vaccination status does not fit into one of the other vaccine status categories.

Measure Calculation

For each measure, the score includes all three of the following percentages:

Measure/ Healthcare Worker Type	Numerator	Denominator*
Employees		
% vaccinated	# who received influenza vaccination	Total # of Employees
% who declined vaccination	# who declined influenza vaccination	Total # of Employees
% with unknown vaccination status	# with unknown vaccination status	Total # of Employees
Licensed Independent Practitioners (LIPs)		
% vaccinated	# who received influenza vaccination	Total # of LIPs
% who declined vaccination	# who declined influenza vaccination	Total # of LIPs
% with unknown vaccination status	# with unknown vaccination status	Total # of LIPs
Non-Employees		
% vaccinated	# who received influenza vaccination	Total # of Non-employees
% who declined vaccination	# who declined influenza vaccination	Total # of Non-employees
% with unknown vaccination status	# with unknown vaccination status	Total # of Non-employees
All Healthcare Workers		
% vaccinated	# who received influenza vaccination	Total # of Healthcare workers
% who declined vaccination	# who declined influenza vaccination	Total # of Healthcare workers
% with unknown vaccination status	# with unknown vaccination status	Total # of Healthcare workers

For each healthcare worker type (e.g., Employees), the three percentages add up to 100%:

100% = (% vaccinated) + (% who declined vaccination) + (% whose vaccination status is unknown)

Hospitals' measure scores are compared to each other and to the state average. State averages are calculated using the total numbers (all hospitals) for each category. The example below gives the average vaccination rate among Employees:

Average Employee vaccination rate (%) = *# Employees vaccinated (all hospitals) / Total # of Employees (all hospitals)* x *100*

Data Table, 2012-2013

The data table below provides additional details which are not presented in the Care Outcomes report, including counts for the number of healthcare workers who received influenza vaccination, declined it, or whose vaccination status is unknown. These are the numbers used to calculate the percentages included in the Care Outcomes report graphs.

Hospital (Alphabetical)	Healthcare Worker Type*															
	All Healthcare Workers				Employees				Licensed Independent Practitioners				Non-Employees			
	Y	N	UK	T	Y	N	UK	T	Y	N	UK	T	Y	N	UK	T
	Count															
Butler Hospital	1,014	53	30	1,104	842	53	2	904	86	0	7	93	86	0	21	107
Eleanor Slater Hospital	969	93	28	1,113	855	83	23	979	21	1	1	41	93	9	4	90
Kent Hospital	3,149	224	12	3,396	2,526	218	8	2,760	328	1	2	332	295	5	2	304
Landmark Medical Center	985	135	31	1,151	754	126	31	911	118	5	0	123	113	4	0	117
Memorial Hospital	1,836	154	0	2,002	1,439	140	0	1,588	197	8	0	206	200	6	0	208
The Miriam Hospital	3,380	360	888	4,649	2,341	312	0	2,674	908	48	231	1,187	131	0	657	788
Newport Hospital	1,120	62	393	1,582	830	61	1	897	162	0	78	241	128	1	314	444
Our Lady of Fatima Hospital	1,468	167	22	1,665	981	116	3	1,106	275	20	13	310	212	31	6	249
Rhode Island Hospital	8,948	1,436	1,503	11,901	6,944	1,224	19	8,201	1,442	95	381	1,918	562	117	1,103	1,782
Roger Williams Medical Center	1,391	122	0	1,518	852	85	0	942	439	33	0	472	100	4	0	104
South County Hospital	1,204	0	0	1,209	955	0	0	959	148	0	0	148	101	0	0	102
The Westerly Hospital	980	129	13	1,122	648	98	0	746	83	3	13	99	249	28	0	277
Women and Infants' Hospital	3,762	126	106	4,026	2,640	126	33	2,829	610	0	0	612	512	0	73	585
Total	31,167	3,206	3,085	37,609	23,454	2,781	120	26,475	4,923	220	755	5,923	2,790	205	2,210	5,211

Y = Received influenza vaccination; N = Declined influenza vaccination; UK = Unknown vaccination status; T = Total

*Y, N and UK columns will not add up to the total columns because the total columns include employees that had a contraindication or medical exemption to the influenza vaccine

Healthcare Quality Reporting Program

Hospital Summary Report

The Rhode Island Department of Health publishes information about hospitals. If you know that you or a family member will need hospital care, this information can help you compare hospitals and choose among them. You may also want to ask your doctor, friends and family members for their thoughts and experiences.

This report summarizes information from the Department of Health (www.health.ri.gov/hospitals/about/quality) and Medicare (www.medicare.gov/hospitalcompare). Reports with more information are available at those websites.

This report is updated every time there is new information for one of the columns below. You can learn more about what is in this report, including definitions and time periods for each column of information, by reading the Methods Report. Please contact hospitals directly with questions.

Contact Information:			Hand Hygiene:			Quality:				Infections:			Satisfaction:	
Facility, Alphabetical	City	Phone	Education Provided	Measured	Reported	Falls and Injuries	Severe Pressure Sores (Bed Sores)	Rate of Readmission after Discharge	Serious Surgical Complications	Employees Who Received Flu Vaccination	C. Difficile Infections	MRSA Bloodstream Infections	Overall Rating of Hospital	Willingness to Recommend Hospital
Kent Hospital														
Landmark Medical Center														
Memorial Hospital														
Newport Hospital														
Our Lady of Fatima Hospital														
Rhode Island Hospital														
Roger Williams Medical Center														
South County Hospital														
The Miriam Hospital														
The Westerly Hospital														
Women & Infants' Hospital														

♦ *Worse than expected,* ♦♦ *about the same as expected,* ♦♦♦ *better than expected*
Reports with more information are available at www.health.ri.gov/hospitals/about/quality.

Comment [RB1]: This language is adapted from the language on the public reporting website and included in previous reports or white papers.

Comment [RB2]: Because these reports may be printed in hard copy, spelling out links may be preferable to hyperlinks.

Comment [RB3]: Is this the right contact information to include?

Comment [RB4]: These measures are selected from among those on Hospital Compare. Are there others we should include instead or in addition to these?

Comment [RB5]: These are the two overall satisfaction measures from Hospital Compare.

Comment [RB8]: This is one of the measures the Hospital Subcommittee worked on for several years.

Comment [RB9]: Dr. Fine and the Steering Committee have asked us to report readmissions. This is one of several readmissions measures available from Hospital Compare; is it the right one to include for consumers?

Comment [RB6]: These are the acute-care hospitals. We do not have data for all measures for other hospitals.

Comment [RB7]: Do we need to include phone number?

Impact of Non-FDA-Approved CLSI Breakpoint Criteria on Laboratory Carbapenem-Resistant Enterobacteriaceae Detection Practices: A State-Wide Assessment (ID#1831)

Nicole E. Alexander-Scott[1,2], Cindy Vanner[2], Rosa Baier[3], Kimberle C. Chapin[1], and Leonard Mermel[1]

1. Warren Alpert Medical School of Brown University-affiliated Hospitals; 2. RI Department. of Health; 3. Healthcentric Advisors, Providence, RI

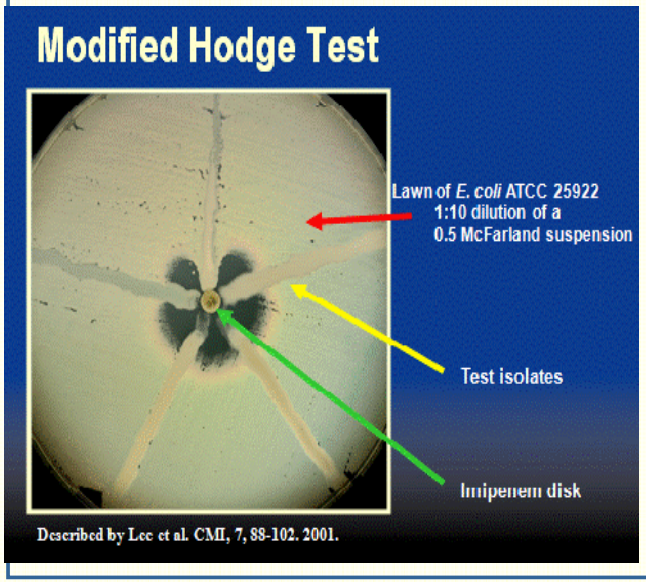
Background

- Infections due to carbapenem-resistant Enterobacteriaceae (CRE) are associated with high mortality.
- Rhode Island Department of Health and its Healthcare-Acquired Infection Advisory Subcommittee surveyed the state's facility clinical microbiology laboratories to assess current CRE detection practices and surveillance.

Methods

- 20-item questionnaire
- 11 clinical microbiology laboratory supervisors that represented - throughout the state:
  - all 12 acute-care facilities
  - one acute and long-term facility with psychiatric services
  - one commercial laboratory that serves RI's long-term care facilities

The questionnaire assessed:



- Carbapenem breakpoints
- use of a Modified Hodge Test and other secondary testing methods
- susceptibility testing verification studies and barriers to conducting them as well as methods of reporting CRE

Results

- The response rate was **100%**.
- All respondents reported that their laboratories detected at most **one CRE each month**, despite varying numbers of Modified Hodge Tests performed monthly (range 1-68).
- Only two respondents (18%) reported documenting intermediate resistance as "**non-susceptible**."
- When CRE was detected, 91 of respondents reported flagging the patient's chart and informing the **facility infection control** department.
- Among the laboratories that tested meropenem, imipenem, or ertapenem susceptibilities, none of the laboratory supervisors reported using the **new CLSI breakpoint** recommendations in their initial susceptibility testing.
- Although 27% of respondents reported interest in conducting the **necessary verification studies** to modify their automated antibiotic susceptibility testing (AST) system to accommodate the newest breakpoints, none have conducted the verification studies or modified their existing systems.
- All respondents reported **preferring to wait** until manufacturers update their AST system breakpoints after the FDA accepts the newest CLSI breakpoints for carbapenems.

Conclusion

Our findings reveal high testing practice variability and raise concern for undetected CRE, as none of the laboratory supervisors in Rhode Island reported using the current CLSI breakpoints.