

**HAI Collaborating Partners Committee**  
*Maine Quality Forum (MQF) • Maine Centers for Disease Control*

**Minutes of the Committee's meeting on April 24, 2015  
at Maine CDC, 2 Anthony Ave. Augusta**

**Members in attendance:** Ann Graves, Sandy Parker, Gwen Rogers, Kathy Day, Emily Brostek, Dr. Sandra Harris, Dr. August Valenti, Rick Danforth, Cathy Dragoni, Bob Abel, Karynlee Harrington, Rita Owsiak, Paul Livingston, Stuart Bratesman

Rita Owsiak called the meeting to order shortly after one o'clock and began with member introductions.

The minutes of the March 27<sup>th</sup> meeting were reviewed and amended.

The group adopted a suggestion to include a list of parking lot issues in the materials delivered in advance of each meeting.

Kathy Day presented an HAI-related patient story about her father. In 2008, two days after discharge from a hospital stay to treat a broken fibula, he developed pneumonia and became too weak to get out of bed. He spent the next 21 days in the hospital ICU. I took six days for the hospital to determine that his pneumonia had been caused by MRSA. In the meantime, he had been diagnosed with MRSA-related CAUTI by day four. During his inpatient stay, he also developed Vancomycin toxicity and a skin ulcer.

He was never able to walk again and died nine weeks after his discharge to a nursing facility. Within the same year, two other patients at the same hospital were reported to have died from MRSA infections acquired during joint replacement surgery. During her father's hospital stay, Ms. Day observed only sporadic staff compliance with hand hygiene, and never saw her father given an opportunity to wash his hands or use a hand sanitizer.

These incidents prompted her to become active in the cause to urge the Maine Legislature to require all hospitals to screen patients for MRSA and report data to the State. She and others testified and were successful in getting a mandatory screening bill passed, only to see it rescinded two years later. She closed by reminding her fellow committee members that every HAI data point represents a human being whose suffering may have been prevented.

The meeting then turned to the committee's work on advising on the development of a new State HAI Plan and reviewed the General Infection Control Worksheet that had been developed at the March 27<sup>th</sup> meeting. Ms. Graves suggested that the worksheet's activities be worded in an action format.

The Committee then turned to the State Plan's section on Device Associated Infections, beginning with goals and initiatives concerning catheter associated urinary tract infections (CAUTIs). CMS currently requires Inpatient Prospective Payment System (IPPS) hospitals to report ICU, medical unit, surgical unit and medical/surgical unit data on CAUTI infections to the CDC's National Healthcare Safety Network. Although Maine Critical Access Hospitals (CAHs) face no federal or state requirement to report on CAUTI infections, many Maine CAHs are already entering CAUTI data into NHSN.

However, many CAHs do not have the types of hospital units (listed above) that qualify for NHSN reporting. These CAHs have multi-purpose, mixed acuity units that not only serve

intensive care, medical and surgical patients, but other types as well. Mixed acuity units, and the types of patients they serve vary from hospital to hospital making comparisons difficult. It was suggested that MHDO could design a CAUTI data reporting form to allow CAHs to report data for mixed acuity unit ICU beds separately from other mixed acuity unit beds. However, another member noted that this suggestion would complicate data reporting tasks, especially a bed classified as intensive care on one day, could assigned a different classification on the next day, even with the same patient.

Other members recommended that if the State were to require CAUTI reporting for all hospitals, that it require all hospitals to submit CAUTI data via NHSN.

It was noted that while NHSN reports Standard Infection Ratios (SIRs) instead of simple infection rates, many Maine CAHs have fewer than the minimum number of CAUTIs needed to generate a reliable SIR. This problem even extends to some IPPS hospitals and will broaden if CAUTI rates decline.

One of the members asked about the definition of a CAUTI infection and raised concerns that different microbiology labs could arrive at different determinations of the same case. Ms. Owsiak answered that NHSN provides precise definitions for laboratory events, but that complications can arise when applying the clinical surveillance criteria for a suspected case of ventilator-associated pneumonia (VAP). For example, it may be difficult to determine whether the patient has had two worsening chest x-rays. Some have asked NHSN to make the VAP criteria more precise.

Another member pointed out the distinction between clinical definitions and surveillance definitions. A given case could meet the criteria for one, but not the other. However, physicians base their treatment decisions on clinical criteria, and not on surveillance definitions.

A concern was raised about the tendency of lay readers to incorrectly conflate "surveillance event" with "infection". Although a patient can be colonized with an infectious agent without developing an actual infection the general public often assume that surveillance event rates and infection rates are the same. However, it was also noted that while LabID events represent a proxy for infection rates, they do provide a standard measure of infection prevention program success.

Ms. Owsiak asked if the committee should recommend that mandatory CAUTI reporting for CAHs be added to the Chapter 270 State Rule.

Ms. Harrington reminded the group that while the HAI Collaborating Partners committee can offer recommendations for changes to Chapter 270's quality measure list, all changes require the endorsement from the Maine Quality Forum (MQF) advisory council and final approval from the Maine Health Data Organization's (MHDO) Board of Directors. Once the MHDO approves the proposed changes to Chapter 270 the Health and Human Services Committee of the Legislature has an opportunity to revise and ultimately must approve.

One member questioned whether CAHs would have a large enough number of CAUTI infections from which to drawn actionable conclusions.

Ms. Owsiak noted that CAHs can take lessons from CAUTI prevention initiatives at IPPS hospitals. The Medicare Quality Improvement Organization (QIO) will work with any hospital

that wants to participate in its CAUTI prevention program and that five or six CAHs have already signed up.

A discussion ensued about publishing NHSN's CAUTI data in the Maine HAI Annual Report. The members concurred that MQF already has the authority to include publicly available quality data in the Report. While CMS has considered adding IPPS hospital mixed acuity units to the existing CAUTI federal reporting requirements, several members thought it unlikely.

However, it was also reported that a growing number of CAHs have begun to submit data to NHSN due to the pressures and requirements of other third party payers and it was suggested that the majority of Maine CAHs are likely to do so by 2016.

Ms. Owsiak answered a question about measuring compliance with CAUTI prevention bundles, (a set of best practices aimed at reducing infection rates) by pointing out that neither the Institute for Healthcare Improvement (IHI) nor any other national organization have developed or endorsed any evidence-based CAUTI prevention bundle.

The committee then turned its discussion to central line catheter-associated blood stream infections (CLABSI). Several members expressed their wishes that Maine CLABSI reporting be limited to federally required hospital units at IPPS hospitals only. Ms. Harrington said that the Maine Quality Forum Advisory Committee would take these recommendation into consideration along with advice from other stakeholders.

Dr. Valenti recommended that all reported numbers be validated and accompanied by an explanation of their meaning. Ms. Owsiak explained that Maine CDC is placing each of the HAI outcomes measures on a rotating validation schedule, and its validation program would not be possible without MQF's financial support.

Ms. Rogers suggested that each of the HAI outcomes measures be validated, one per year, on a rotating basis.

Dr. Valenti replied that validating each measure once every five years is too long. The most important measures ought to be validated on a regular basis. Even spot validations would be very valuable. We need to have validation, he said, to give measures credibility

Ms. Harrington informed the group that MQF is funding a second validation contract with the John Snow Institute and said that it is her hope that MQF will continue to support validation projects in the future.

Ms. Owsiak asked for the committee's advice on criteria to determine when the State should retire quality indicators that measure compliance with HAI-related bundles, i.e., defined sets of best practices. She asked whether such criteria could be based on a threshold, for example, once every hospital has achieved 90% compliance.

Members expressed varying opinions. Some endorsed a 90% threshold and argued that:

- Perfect compliance is an unrealistic goal, given that lack of compliance above the 90% level is often due to problems with failure to properly document processes and procedures that were actually followed;
- Data collection for the HAI process compliance measures was time-consuming and diverted infection preventionists from staff education and other activities; and

- The State should retire all three HAI prevention compliance measures currently collected under Chapter 270.

Other members argued in favor of keeping the current measures, arguing that:

- Retiring a process compliance measure raises a risk of backsliding; and
- While many hospitals have demonstrated their ability to perform at 100% not all hospitals are doing so.

A couple of members responded that backsliding was unlikely given that the HAI prevention bundles have now become well-established standard procedures and that whole systems had been redesigned around CLABSI prevention.

Ms. Harrington informed the group that MQF's soon-to-be-released 2015 edition of the HAI Annual Report will show that compliance with the HAI-3 and HAI-4 CLABSI prevention measures has been improving over the past five years. She said there must be a balanced approach to the issue of measure retirement and transparency. She added that it would be helpful if the committee could recommend a standard for when a measure is retired, for example when the state average is at 98% or better. She also talked about a process for adding new measures.

Several members expressed general agreement with Ms. Harrington's suggestion, while others expressed concern that such standards not be based on single arbitrary numbers.

Ms. Owsiak turned the discussion to measures concerning Ventilator-Associated Pneumonia (VAP) prevention. She asked for the committee's advice as to whether Maine should continue to collect hospital data for the HAI-5 measure, compliance with the IHI's prevention bundle for ventilator-associated pneumonia (VAP) and if the State should begin to collect data on VAE events.

Several members recommended retiring data collection for HAI-5, commenting that:

- The IHI continues to revise and change the measure criteria;
- HAI-5 has poor inter-rater reliability;
- There is controversy whether some of the bundle elements are actually VAP-related or evidence-based; and
- HAI-5 data is not federally required.

One member also asked if there is a reason for MHDO to ask hospitals to report their numbers of ventilator days and central line catheter days.

The committee then proceeded to take up the question of extending HAI prevention quality measure reporting to long term care facilities.

Ms. Owsiak reported that it took a New Hampshire pilot project two years to bring 30-or-so long term care facilities to the point being able to submit HAI-related data to NHSN. The project faced challenges due to LTC staff turnover rates and that LTC staff members assigned to quality measure data reporting were also typically assigned with multiple other competing responsibilities. Within a year after the pilot project ended, only five facilities were still reporting. She added that Maine CDC does not have the resources to provide technical assistance on NHSN data reporting to all of Maine's more than 100 LTC facilities. She also

mentioned that NHSN as a separate set of measures for LTC, including symptomatic and asymptomatic urinary tract infections.

Some members suggested that it would be better to focus LTC facilities' attention on antibiotic use or skin ulcers and skin infections.

When asked what quality measures were currently collected from nursing facilities (NFs), Ms. Owsiak replied that it was only those measures recorded on the Minimum Data Set (MDS) resident assessment instrument and that residents were typically assessed only quarterly.

Several members offered suggestions:

- What about other types of facilities or home care?
- Should we begin requiring NF reporting of LabID events or conduct a pilot study? If it's difficult for NFs to submit LabID event data to NHSN, then could we require them to report data on positive cultures directly to MHDO using a spreadsheet reporting form? Could we combine a pilot study with a train-the-trainer program?
- Should we require NFs to report on positive urine cultures and the frequency of recurrent UTIs in the same patient?
- Could we begin a NF hand hygiene monitoring program?
- Should we require NFs to perform routine screening for MRSA and *C. difficile*?
- Should we focus on antibiotic treatment of non-symptomatic bacteria in the NF setting?
- Should we focus on the large number of line infections and MRSA issues at dialysis centers, especially stand-alone dialysis centers that aren't covered by hospital infection preventionists?

The committee agreed to give further discussion to the merits of expanding HAI quality measure reporting to other types of facilities.

Ms. Owsiak reminded the group that the next meeting will focus on mandated reporting for surgical site infections.

A suggestion was made to discuss whether the State's HAI Annual Report should include federally-collected data on infection rates associated with colon and abdominal hysterectomy surgery. Ms. Owsiak suggested that the next meeting also cover total hip replacement and cardiac surgery.

Ms. Day offered that she had a friend who could present a surgical site infection story at the start of the next meeting.

The committee agreed to change the next meeting date to May 29<sup>th</sup> to avoid conflicts with the Memorial Day weekend.

The meeting was adjourned at 4:00 PM