HAI Collaborating Partners Committee

Maine Quality Forum (MQF) • Maine Centers for Disease Control

Minutes of the committee's first meeting on March 6, 2015 at Maine CDC, Augusta

Members in attendance: Robert Abel, Rick Danforth, Kathy Day, Cathy Dragoni, Ann Graves, Danielle Hersey, William Jenkins, Sandy Parker, Dale Payne, Gwen Rogers, Linda Ruterbories, Tyson Thornton, Rita Owsiak (Maine CDC), Karynlee Harrington (MQF), Paul Livingston (staff), Stuart Bratesman (staff)

1. Rita Owsiak opened the meeting at 1:00 PM by asking each member to provide a brief introduction. She then reviewed the Charge for the Committee and noted that each member had been invited to join the Committee because of the special knowledge that he or she possessed about different aspects of infection prevention and control

2. Karynlee Harrington presented a draft of the Committee's Operating Guidelines, noting that they are intended to formalize process issues for a large group that has a lot to accomplish in a short period of time. She highlighted the following areas:

> *Decision Making:* Recommendations require a quorum. The Committee will aim to reach consensus on clearly defined issues, while allowing every viewpoint to be heard. If the Committee cannot achieve consensus, then then the majority will decide.
>
> Members agreed that the decision making rules are clear and to accept them.
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> *Meeting Format:* Meetings will always start on-time, open with a welcome, the agenda, review of ground rules and introductions. Meetings will close with a preview of the issues to be decided in the next meeting.
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> The MHDO website can be set up to be a repository of information for meeting materials. Members have a responsibility to arrive at each meeting informed and prepared to actively participate.
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> Later in the agenda, the Committee will need to discuss whether to form sub-committees to deal with particular issues and the frequency of meetings between now and September.

In answer to Kathy Day's question, Ms. Harrington replied that the meetings will be open to the public, in person or by phone, and that the staff will need to determine if the meetings must be posted in advance.

3. Ms. Owsiak presented a review of the 2015 State HAI Plan Development document. In 2010, each state was asked by the federal CDC to develop an HAI plan along prescribed lines. Maine has achieved all of the objectives of the 2010 plan. However, in the wake of the recent Ebola outbreak, the U.S. CDC recognized the need to develop more comprehensive infection prevention and control capabilities across the broad spectrum of healthcare facilities and physician offices. Therefore, each state is now required to produce a new 5-year HAI plan by this fall. The new plan will need to identify, address and resolve Maine's gaps in infection control.

Therefore, the Committee's first task is to advise Maine CDC on ten specific components of the new plan.

Ms. Owsiak made the following comments and observations about the 2015 Plan Development document:

a) General Infection Prevention and Control

i) Acute care outbreak recent statistics – Each table displays data, by year, on the number of outbreaks, the annual attack rate for patients and staff, the average number of days it took to end each outbreak, and the number of persons who died while infected (even if death was due to an unrelated cause).

ii) Long-term care outbreaks – These tables display the same information. In rows reporting that the minimum percent of residents infected and staff infected were both zero, this means that one-or-more outbreaks occurred where no residents, but some staff were infected, and one-or-more other outbreaks occurred where some residents, but no staff were infected.

Although not reported in the table, Ms. Owsiak noted that facilities have responded to C.diff outbreaks faster this year, and ending outbreaks sooner.

Action items related to general infection and control:

- Sixteen states have varying requirements to train, license or credential facility staff in infection control. Should Maine do likewise? Committee members asked:

  Is there evidence that these requirements have made a difference in the incidence of infections? How do different states define the training requirements? Would it be fair to require training for some professions, but not others?

  Ms. Owsiak noted that the federal CDC is suggesting a focus on hands-on care providers, but that New Hampshire's 2012 Hepatitis C outbreak was caused by a lab technician.

- Should the Legislature grant Maine CDC the authority to compel healthcare facilities to allow Maine CDC to perform infection control surveys? At present, Maine CDC cannot obtain authority without proof of infection transmission from a source case to another patient. Some facilities fear liability based on potential findings.

  Gwen Rogers noted the expense and time required to host a survey and that many hospitals are already required to host somewhat redundant surveys by the Joint Commission, CMS, OSHA and others and that she'd be reluctant to have to host yet another survey that covers the same ground as the existing ones.

  Kathy Day observed that not all hospitals receive Joint commission surveys and recommended that Maine CDC should perform a mandatory survey in the event of future HAI outbreaks.

  Sandy Parker recommended that we compile a list of HAI-related survey requirements by type of facility.

  Emily Brostek suggested that the Committee review the laws and rules of other states that grant their public health departments the authority to conduct HAI-related facility surveys and assessments.

  Ms. Owsiak asked the Committee to review and consider the variety of circumstances that should trigger a mandatory facility survey.

b) Device Associated Infections

i) When comparing Maine's device-associated infection rates to existing national benchmarks, our worst category is catheter-associated urinary tract infection (CAUTI) and the national goal is to reduce the 2015 national baseline rate of CAUTI infections by 25% by 2020. CMS requires Prospective Payment Hospitals (PPS) to report CAUTI data, and those reports are currently limited to ICUs only. However, they are now expanding the reporting requirement to medical/surgical units.

Danielle Hersey announced that HealthCentric Advisors, CMS's New England Quality Innovation Network-Quality Improvement Organization (QIN-QIO), is conducting a CAUTI reduction education initiative this year.

When asked how HealthCentric Advisors' role differs from Maine CDC's, she replied that they are developing a collaboration to avoid duplication, per orders from CMS.

Ms. Owsiak pointed out that if the State Plan were to recommend that all hospitals be required to report CAUTI data, then the recommendation would have to address the issue of mixed acuity units in small-to-medium size hospitals.

Ms. Rogers noted that some hospitals could avoid data reporting requirements by taking advantage of the numerous options allowed in designating hospital units. She also questioned the ability to compare one hospital's mixed acuity unit to another given the wide variety of components that can be included in any given mixed acuity unit.

Ms. Owsiak mentioned that there has been some discussion about creating a national HAI database for critical access hospitals. However, the Standardized Infection Ratio (SIR) method that the federal CDC uses to report HAI rates for larger hospitals, is inappropriate and unusable for reporting on hospitals that have a small number of cases.

Ann Graves pointed to the great dissimilarities between many Critical Access hospitals, noting that some of the ones out West have as few as only four beds. Ms. Rogers added that for small hospitals with few reportable patient days, the change of just one infection can make a very large difference in the size of a hospital's reported infection rate.

ii) Central-line associated blood stream infection (CLABSI): The new national goal is to reduce the CLABSI SIR by 50% from the 2015 baseline by 2020. Instead of using the SIR, Maine reports the CLABSI infection rate per 1,000 central line catheter days. While Maine has seen improvement in its ICU CLABSI rates, the rate in the NICU setting appears to have risen, but that could due to random chance given the small number of cases.

iii) Maine's hospital compliance rates for the HAI prevention bundles have been flat at around 90% for a number of years. Ms. Owsiak said the Committee may want to think about recommending that the State retire those measures and replace them with new measures that have more room (and more need) for improvement. Ms. Rogers suggested that the bundle compliance rates would appear higher were it not for lapses in documentation. Ms. Owsiak agreed that if the documentation had been complete for every case, the compliance rate would probably be closed to 100% than to 90%.

The federal government may soon require reporting on rates of ventilator-associated infections. However, it would be challenging to define the measure, given that the same types of infection that can be acquired due to the use of a mechanical ventilator can also be cause by other, unrelated means. Ms. Graves pointed out that the older ventilator infection measure was so poorly defined, that it was plagued by low inter-rater reliability.

c) Procedure Associated Infections

Ms. Owsiak reported that the Maine hospital SIR for abdominal hysterectomies had increased between 2012 and 2013 to the point that it was no longer better than the national baseline SIR. Several members noted that while the trend was disconcerting, the volume of abdominal hysterectomies is decreasing in light of newer, less invasive procedures.

On the other hand, while the Maine hospital SIR for colon-surgery had improved between 2012 and 2013, it still remained above the national baseline SIR.

Ms. Harrington noted that based on the CMS decision to suspend mandatory hospital reporting of the Surgical Care Improvement Project (SCIP) quality measures as of January 1, 2015, the Maine Health Data Organization (MHDO) announced that they would do likewise.

d) Multi-drug Resistant Organisms

Maine measures the incidence of multi-drug resistant organism infections via a proxy measure, Lab ID events. It's much easier and less of a burden on hospitals than to require them to base their reporting on surveillance.

Maine's SIR for MRSA is better than the current national baseline. The Committee will need to decide whether to recommend that we continue annual MRSA Lab ID validation, or reallocate those resources to validate other HAI measures.

Ms. Harrington noted that the validation requirements of the Maine Chapter 270 rules need clarification. The current rule is somewhat ambiguous on this issue.

C.diff Lab ID events come in three varieties:

- Hospital onset (HO);
- Community onset (CO); and
- Community onset - Health Care Facility Associated (CO-HCFA), defined as appearing in a patient who had C.diff upon hospital readmission within 30 days of discharge from the same hospital.

Maine's C.diff SIR is better than the national baseline. But Maine's C.diff infection rates have been trending upward, just as C.diff rates have been doing across the rest of the country.

Ms. Harrington announced that the 2015 edition of the Maine Quality Forum's *HAI Annual Report* will report each hospital's HO Lab ID event rate instead of each hospital's CO-HCFA Lab ID event rate. However, the Annual Report will still present CO-HCFA C.diff Lab ID event rates at the regional or statewide level.

Ms. Owsiak mentioned that Long term care facilities are not required to report C.diff infections or Lab IDs. However, Maine CDC does look at C.diff outbreaks in long term care settings.

e) Antimicrobial Stewardship

The incidence of Extended Spectrum beta-lactamase (ESBL - bacterial enzymes that breakdown the effectiveness of antibiotics) is on the rise on the West Coast. Cathy Dragoni noted that NordX labs have seen a small increase in Maine.

Tyson Thornton explained that antimicrobial stewardship issues are not limited to overuse. The bigger issues are choosing the right antibiotic, the right dose and making sure they are taken for the right length of time.

Ms. Owsiak told the members that Maine has no mandated reporting for antimicrobial use. NHSN has just come out with their new Antimicrobial Use and Resistance (AUR) reporting module, but, at present, it is optional, not federally mandated. The Council of State and Territorial Epidemiologists (CSTE) has approved a position statement on antimicrobial stewardship and they want to convene a meeting of the states. She said that Maine convened its own two-or-three-day antimicrobial stewardship workshop attended by representatives from every hospital, but it was five years ago.

Mr. Tyson said that what worries him most is not antimicrobial misuse at acute care facilities. Rather, his greatest concern is the poor selection of antibiotics in primary care offices and long term care facilities. He said that facilities often ask their physicians to prescribe an antibiotic without testing a culture.

Next Steps

Ms. Owsiak reminded the Committee that Maine CDC's deadline for submitting the new state HAI plan comes due on October 1st. In order to meet this deadline, she recommended that the Committee meet monthly and that all members prepare in advance to participate in discussions and recommendations for each of the following monthly topic assignments:

- March General infection prevention and control
- April Device-associated infections
- May Procedure-associated infections
- June Multi-drug resistant disease organisms
- July Antimicrobial stewardship
- August Any remaining pending items and an overall review of the proposed State Plan.

The Committee then discussed the length and format of future meetings. After a discussion, they agreed to conduct each meeting from 1:00-to-4:00 pm on the 4th Friday of each month, beginning with the 4th Friday in March.

The Committee staff will distribute a worksheet in advance of each meeting. Members should review the worksheet and come prepared with goals and strategies for discussion. Ms. Owsiak noted that the federal CDC has listed a greater number of required elements for the general infection prevention and control topic than for other topics. While the monthly distribution will include information materials and recommended readings, every member is also encouraged to conduct his or her own independent research on each upcoming meeting topic, and to solicit opinions and advice from their own constituencies and/or other members of their profession.

Ms. Rogers recommended that the Committee should chose or develop measurable goals or smart goals. Ms. Graves added that the Committee should concentrate on designing recommendations that deliver the biggest bang for the buck.

Ms. Harrington reiterated that the Committee's future meetings will be real working sessions with the expectation that the group will approve a set of written recommendations before each meeting's end.

In answer to a question from Kathy Day, Ms. Owsiak and Ms. Harrington replied that the recommendations could include suggestions for new Chapter 270 reporting measures.

Upcoming Meeting Schedule

Friday, March 27th	Friday, June 26th
Friday, April 24th	Friday, July 24th
Friday, May 22nd	Friday, August 28th

All meetings are to begin at 1:00 pm sharp, and are expected to last for three hours. Meetings will be held in Augusta, with the specific location for future meetings to be announced.

The meeting was adjourned at 3:15 pm.