HEALTH CARE ACQUIRED INFECTIONS ADVISORY COMMITTEE

March 11, 2008
2:00 p.m. to 4:00 p.m.

Portland State Office Building, Room 1C
800 NE Oregon
Portland, Oregon

MEMBERS PRESENT:
Woody English, MD, Co-Chair
Mel Kohn, MD, Co-Chair
Paul Cieslack, MD
Jim Dameron
Kathleen Elias
Ron Jamtgaard
Jon Pelkey (by phone)
Mary Post
John Townes, MD (by phone)
Dee Dee Vallier
Rodger Sleven, MD
Jim Barnhart (by phone)
Laura Mason (by phone)
Kecia Reardon

MEMBERS EXCUSED:
Patricia Martinez, MD
Lynn-Marie Crider
Barbara Prowe

STAFF PRESENT:
Sean Kolmer, Research Manager
James Oliver, Data Analyst

ISSUES HEARD:

- **Call to Order**
- **Approval of 02/12/08 Minutes**
- **Proposed Facility Changes for 2009 reporting**
- **Finalization of SSI Procedures for 2009**
- **Finalization of CLABSI Procedures for 2009**
- **Discussion of SCIP process measures**
- **Discussion of work plan for next 3 meetings**
- **Public Testimony/Adjourn**

(Digitally Recorded)

Chair English **I. Call to order – There is a quorum.**

The meeting to order at 2:10 p.m. There was a quorum.

Chair English **II. Approval of 02/12/08 Minutes (See Exhibit B)**

Minutes are approved by acclaim.

Sean Kolmer **III. Proposed Facility Changes for 2009 reporting (See Exhibit Materials C)**

- Staff reviewed what facilities would be required to report in the first year: Hospital, Ambulatory Surgery Centers (ASC) and outpatient dialysis centers initially had been identified.
  - It was related that there had been thoughtful discussion on hospitals but ASCs and dialysis centers have not been addressed. Staff recommended focusing on hospitals for 2009 and implement reporting for dialysis centers and ASCs in 2010.

- Notice was received from National Healthcare Safety Network (NHSN) announcing outpatient and free-standing ASC modules will be available in May. This would enable the Committee to:
  - adapt without having to create "homegrown" modules;
  - provides standardization across facilities;
  - three facility types within one system; and
- Skilled nursing facilities (SNFs) may be problematic
    - MDS process and data is being collected and sent at least a portion of the infection rate on quarterly basis for each individual resident.
    - MDS explained as a mandated federal system required for Medicare and Medicaid that requires reporting of infection data.
    - Staff has MDS forms.
    - All SNFs are participating. State can obtain data.
    - Data is aggregated now
    - Can data be obtained from other states?
      - Data goes to CMS then CMS shows facts with agreements around it and provides to DHS.
    - Patient-based and denominator discussed. .
    - Could start getting information.
  - Timeline discussed and clarified.
    - Rules due in May for public comment.
    - Suggestion to do hospitals and for 2010 look at the three additional groups with caveat that nursing facilities may take a different path.
    - Possible barriers for including the SNFs discussed.
  - Staff will get information on how quickly that data can be obtained.
  - Rules shall be adopted no later than July 1, 2008, and reporting shall begin no later than January 1, 2009.
  - It was suggested to have rules for SNFs in September to start in April of next year. Must give facilities six months before beginning reporting.
  - Suggestion to form sub-committee to address issue and bring back to Committee
- Consensus:
  - Hospitals 2009, rules done in May and final by July 1
  - Next 4 weeks a working group will develop rules for nursing facilities.
  - Dialysis and outpatient surgical centers will be designated as next item of business.

Sean Kolmer

IV. Finalization of SSI procedures for 2009

Staff reviewed last meeting's four surgeries brought forward for selecting a second surgery. They were: knee replacement, hip replacement, colon surgery, and abdominal hysterectomy.

- Knee replacement is the surgery of choice, but was open for discussion.
- Reasons for choice discussed including younger population involved, and ease of comparability of statistics with other hospitals.
- Inclusion/exclusion of revisions discussed, including timeline for reporting.

- NHSN definition relates that any surgery involving placement of prosthetic material is at risk for surgical site infection for 12 months. Changing that timeline may cause confusion. NHSN methodology for capturing data discussed.
- Debate on superficial knee infections that may be unreported and how to capture that data including:
  - Three-month rate versus twelve month rate.
  - To what extent does NHSN dictate the follow-up of cases, the manner in which cases will be followed and ascertained?
    - Set the timeframe then process is determined by those reporting.
    - Concern expressed on discrepancies of reporting by hospitals.
    - Hospital reporting responsibility when a second hospital discovers the infection is related. The original hospital is contacted.
  - Discussion on surgeon's signing off.
  - Do we need another sub-committee?
  - Legislative testimony on mechanism to ensure original hospital is notified that they have an infection to report.
  - Another issue, Oregon Board of Nursing, in the past, has related that nurses cannot follow-up with a patient in Washington.
  - For obtaining additional data, it was suggested that the Cancer Registry model working for prosthetic material implantation for tracking infections could be applied to other infection reporting. Timeline would need to be set.
  - Auditing is part of the legislation.
  - Concern expressed it would put a burden and no system in place to do. Address later possibility of capturing this additional data later.
  - Are we not going to do superficial infections? Discussion that it can be subjective at the superficial level. Argument for including superficial infections is made. Do the ASCs have data that can be used? Can home infusion centers help with reporting?
  - Technical meeting is requested to meet on this subject and communicate concerns to Committee for consideration.
  - Process needs to be standardized. Technical Committee will come back with a recommendation.
    - Find out if there are other states addressing this issue.
    - How active the surveillance is affects how important the auditing is.

Sean Kolmer

V. Finalization of CLABSI procedures for 2009 (See Exhibit Materials E)

- Issue is to identify what unit will be used to collect data, likely a critical care unit so denominator (central line days) can be determined.
- NHSN allows for hospital identification of critical care units or medical/surgical units.
- Chair English recommended staying with NHSN methodology.
- Definition of a critical care unit discussed and it was stated that hospitals reconfigure populations including definition of medical/surgical.
- Process is standardized and will allow to benchmark across country with like hospitals recommended to stay with NHSN.

- Consensus to have adult medical, medical/surgical and surgical ICUs reported.
- Clarification of 48 hour tracking requirement provided.
- Question asked if pediatric ICUs are off of the table.
  - Only two presently exist.
  - NICUs and complexity of capturing data discussed.
  - Option of reporting and decision to publish determined later.
- NICUs will be included. It is a part of the NHSN process.

Sean Kolmer **VI. Discussion of SCIP process measures (See Exhibit Materials F)**

Staff opened discussion on process measures relating that 53 Oregon hospitals are reporting to CMS and it was recommended to use national standards to compare to other hospitals in the country.

- Process measures addressed. Measures are in relation to infections. It was noted that some SCIP measures have nothing to do with infections.
  - 1-4, 6 and 7
  - Report by Texas Board was related that they would not include process measures for the following reasons:
    - process measures are already being reported to other organizations; and
    - Infection risk is the result of many processes and may limit focus of hospitals
  - Bill 2524 was quoted: ". . . health care facility process measures designed to insure quality and to reduce health care acquired infections." This was noted to be the distinguishing legislation of the Oregon bill that it included process measures.
  - Discussion that it may lend to confusion for consumers. Committee should contemplate how it is packaged.
  - It was suggested that any hospitals already reporting to CMS would continue and hospitals not reporting could send data to this Committee.
  - Consensus to pull infection-related infection module of SCIP measures and write the rules in such a way that requirement is expanded.
- Discussion of vaccinations and health care workers low rate of those workers being vaccinated.
  - Suggestion to ask institution what percentage of workforce has received influenza vaccine every year. Implication that staff may pass flu to patients.
  - Need to define what is an appropriate workforce. Staff will develop and bring back to committee.
- Draft of rules will be brought to next meeting.
- Ron Jamtgaard will work with Woody and Sean on rules of reporting.

Sean Kolmer **VII. Public Testimony**

- No public testimony offered.

Co-Chairs **VIII. Other Topics/Adjournment**

- CMS data is a year old, process is slow.
- Time standard for reporting data.
- Include time structures in the rules. CMS updates quarterly but 3 quarters behind.

The meeting was adjourned at approximately 4:00 pm.

Next meeting is April 8, 2008.

Submitted By: Paula Hird Reviewed By: Sean Kolmer, Research Manager

EXHIBIT MATERIALS:

A. March 11 Agenda
B. Minutes from 02/11/08
C. Procedure Draft Matrix
D. Central Line Blood Stream Infection Rationale and Recommendation draft
E. Matrix from 2006 AHA Survey
F. HHS Process of Care Measure Graphs

http://www.oregon.gov/OHPPR/docs/MeetingMaterials_031108.pdf