**HAI/AR Collaborating Partners Committee**

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

**Minutes of the Committee's meeting of June 1, 2018   
at Pine Tree Room at 2 Anthony Avenue, Augusta, Maine**

In attendance:

*Members:* Kathy Day, Donna Dunton, Ann Graves, Karynlee Harrington, Danielle Hersey, William Jenkins, Lynn Johnston, Jennifer Liao, Rita Owsiak, Sandy Parker, Dale Payne, and Dr. Gwen Rogers

*Staff:* Stuart Bratesman

*Guests:* Troy Cutler, Amanda Gagnon (Healthcentric Advisors) and Judy Tupper (Muskie School of Public Service at USM)

**Summary of recommendations approved by vote**

None

**Summary of follow-up items**

1. The committee will have a future discussion on:

• whether to recommend a State rule to require mandatory notification when one hospital diagnoses an infection in a patient recently treated at another hospital;

• proposing a Chapter 270 amendment to authorize Maine CDC to access any hospital data voluntarily submitted for the NHSN’s *Antibiotic Use and Resistance (AUR)* module; and

• creating a definition of “outbreak”.

Ms. Owsiak called the meeting to order at 12:12 PM.

The minutes were read and approved.

**Old Business**

*Validation Update*

Ms. Owsiak reviewed the list of measures on the external validation schedule through 2022:

* 2018 CLABSI
* 2019 CAUTI
* 2020 MRSA-BSI and *C. difficle*
* 2021 Surgical Site Infections for colon surgery and hysterectomies
* 2022 CAUTI, MRSA, and *C. difficle* for all rehabilitation units, including NERH

John Snow, Inc. (JSI) will be conducting the validation studies and their final report will be due to MQF by the end of each year.

Dr. Rogers expressed concern about the burden large hospitals face in providing all the necessary documentation for an on-site study and took exception to the unfairness of allowing smaller hospitals to participate in a simpler remote study. She contended that every hospital should be required to produce the same number of medical charts.

Ms. Owsiak responded that the validation studies for small hospitals were often briefer because many had zero infections to review, but that the remote studies were more extensive and thorough than some may have been given to believe. She also explained that in the future, as more hospitals allow JSI to access their electronic medical record systems (EMRs), nearly all studies will be conducted remotely, and that remote studies reduce the cost to the State. She also reminded members that if CMS selects a hospital for a federal validation, they can be excluded from the State sample.

Ms. Graves noted that the CMS Clinical Data Abstraction Center (CDAC) still requires paper records instead of remotely performing electronic validations. She also explained that even if a hospital has reported zero infections, an on-site validation offers a greater learning opportunity and reduces the risk of an infection having been missed due to a misinterpretation of the definitions.

Dr. Rogers noted that Maine Medical Center would be greatly reluctant to allow third-party remote access to its EMR.

Mr. Cutler added that while more hospitals were allowing remote validation, many hospitals are concerned about risk of a data breach.

A discussion ensued about the fairness of identifying an error for a hospital for failing to count an infection only discovered when one of their discharged surgical patients visited another hospital’s ER.

Ms. Day recommended adoption of a State rule to require mandatory notification when one hospital diagnoses an infection in a patient recently treated at another hospital. The topic will be included in the agenda for a future Collaborating Partners meeting.

*HAI Annual Report Update*

Ms. Harrington thanked those members who reviewed a draft of this year’s *HAI Annual Report* and noted that nearly all of their suggestions were incorporated in the final version.

She added that MQF plans to design a new, less technical format for future reports and requested members to email her their suggestions. She will report back to the committee’s next meeting after MQF and Maine CDC hold a preliminary planning meeting later in June.

Dr. Rogers noted that she shares the report’s graphs with her hospital’s staff to show them they could be doing better and to encourage improvement.

*Chapter 270 Update*

Ms. Harrington reviewed proposed amendments to State Rule Chapter 270, “Uniform Reporting System for Health Care Quality Data Sets.” She explained that the MHDO Board will be asking at their June 7th meeting to authorize MHDO to open the rulemaking process and that the Board’s public hearing on proposed changes is likely to be scheduled for this fall. The proposed changes include:

* Removing all three bundle compliance measures, (effective 6/30/2019), because Maine hospitals have been performing so well:
  + HAI-3 Percent compliance with all five evidence-based interventions for patients with intravascular central catheters (central line bundle compliance) in intensive care units;
  + HAI-4 Percent compliance with the four insertion-related evidence-based interventions for patients with intravascular central catheters (central line bundle compliance) placed preoperatively, in pre-operative areas, operating rooms, and recovery areas; and,
  + HAI-5 Percent compliance with all five evidence-based interventions for patients with mechanical ventilation (ventilator bundle compliance) in intensive care units.
* Adding two new Surgical Site Infection rate measures for:
  + Patients undergoing inpatient knee prosthesis (arthroplasty of knee) surgical procedures (KPRO) (Measure steward – NHSN); and
  + Patients undergoing inpatient hip prosthesis (arthroplasty of hip) surgical procedures (HPRO) (Measure steward – NHSN);
* Adding “device insertion date” as a required data element for the existing HAI-1 and HAI-2 central-line (or umbilical) catheter associated bloodstream infection measures; and
* Adding a new *C. difficile* LabID Event measure for nursing facilities.

Ms. Owsiak explained that the device insertion date will help Maine CDC determine whether a catheter-related infection was more likely to have been caused by an insertion issue or by problems with longer-term care and maintenance.

In response to a question, Ms. Harrington assured the group that device insertion dates will play no role in public reporting. She also informed the committee that MQF will commission a *C. difficile* LabID event reporting online training module for nursing facility IPs and other staff.

When asked about the consequences for a nursing home if it misses a *C. difficile* reporting deadline due to IP turnover problems, Ms. Harrington replied that MHDO is far more interested helping data submitters solve problems rather than impose fines. She added, though, that if a facility repeatedly missed deadlines despite continued technical assistance from MHDO, then MHDO would reluctantly ask the Board to impose a fine.

Ms. Owsiak added that the 4½-month reporting deadline should help facilities work through problems due to IP transitions. She recommended that facilities contact Maine CDC well before the deadline so they could assist them.

Ms. Hersey noted that the Healthcentric Advisor’s nursing facility pilot project had found very low numbers of *C. difficile* LabID events.

Mr. Bratesman described another proposed change to Chapter 270. The current version of Chapter 270 authorizes Maine CDC and MHDO to access data for any additional HAI measures if CMS had required a PPS hospital to submit it to NHSN under the CMS Inpatient Quality Reporting Program. The proposed change would apply to HAI data reported by any healthcare facility to NHSN under a state or federal mandate. The proposed change would obviate the need to add a set of specific Chapter 270 measures for the outpatient dialysis facility HAI quality indicators federally mandated by CMS.

Ms. Owsiak described another proposed Chapter 270 change that would add mixed acuity wards to the list of hospital units required to submit CLABSI data for HAI-1. The HAI-1 measure currently covers adult and pediatric ICUs, medical, surgical and medical/surgical units. However, if a hospital has none of those, then they are currently instructed to substitute their mixed acuity unit, instead. As a consequence, if a hospital that is submitting CLABSI data for their medical unit has no ICU, then they might not be reporting data on the ICU patients treated in mixed acuity.

Ms. Harrington said she would work with Sandy Parker at MHA to coordinate Chapter 270 discussions before the proposed amendments are published in advance of MHDO’s public hearing.

*Granting access to data*

Ms. Owsiak opened a discussion on defining limits to Maine CDC’s authority to share a hospital’s NHSN data with other organizations, such as a HIN or QIN-QIO, when jointly engaged in a performance improvement project. The group arrived at a consensus that while Maine CDC could use the data internally to determine recommendations for which facilities to invite to participate in a collaborative, or share statewide aggregate data with other parties, no disclosure of hospital-specific data should be made without the hospital’s prior written authorization.

**New Business**

*Should we have a Chapter 270 measure for NHSN Antibiotic Use and Resistance (AUR) Data?*

Ms. Owsiak proposed a new Chapter 270 measure to authorize Maine CDC to access the AUR module data that hospitals voluntarily submit to NHSN. She explained that Maine CDC would prefer to have access under Chapter 270 rather than rely on a data use agreement with each hospital, because if a facility withdraws from the agreement, then Maine CDC has 30 days to destroy every document that references that data. She reiterated that Maine CDC had no interest in proposing mandatory reporting, but rather, to have Chapter 270 authorization to access AUR data that has been voluntarily submitted. She pointed out that other states have been using the data to map regional changes in antibiotic resistance over time.

Ms. Harrington added that MHDO had no interest having AUR the data for public reporting.

After quite a bit of discussion, the group decided to put the issue in the parking lot and add it to the agenda for a future date.

*A review of the NHSN’s Maine hospital data for 2017*

Ms. Owsiak gave a presentation to show how the Maine hospital Standardized Infection Ratios (SIRs) for different HAI infection measures compare to the national goals for 2020. While Maine has already met the 2020 goal for *C. difficile*, the statewide hospital CLABSI SIR is a little higher than it should be to meet the goal by 2020. Maine CDC is encouraging facilities with higher CLABSI SIRs to adopt the federal CDC’s Targeted Assessment for Prevention (TAP) strategy.

While Maine’s MRSA blood stream infection (BSI) SIR is close to target, it did see a small setback in 2017. The Maine Surgical Site Infection (SSI) SIR has been improving at a rate to meet the target goal by 2020. However, while the PPS (larger and medium-size) hospital SIR for CAUTI appeared to be in line back in 2015 to meet the 2020 goal, it has risen in both years since then.

The presentation was followed by a discussion of some prevention methods for MRSA-BSI, CLABSI, and CAUTI. Mr. Cutler reported his facility’s decision to reduce the risk of MRSA infection by giving a daily chlorhexidine bath to every inpatient throughout the hospital. Ms. Day advocated expanding MRSA data submission and reporting to all types of MRSA infections instead of limiting them to MRSA-BSI. She pointed out that the VA hospital strategy of active detection and isolation has reduced their MRSA infection rates by 60%. She also recommended that every hospital follow Maine Medical Center’s example by screening every inpatient for MRSA upon admission.

Dr. Rogers added that it’s much easier to prevent the spread of MRSA when patients are in single rooms. She also said Maine Medical Center is focusing its energy on preventing *Candida auris* and CRE, because of their higher danger.

Ms. Owsiak observed that although her former hospital in Oregon had private rooms and employed universal patient screening, its MRSA rate remained higher than surrounding hospitals until it initiated a more aggressive hand hygiene program.

*Outbreak Public Reporting*

Ms. Owsiak explained Maine CDC’s current approach to outbreaks. When Maine CDC or a facility identify an outbreak, they work together to bring it under control. The Maine CDC publishes the number of outbreaks by county in its annual report. No individual-level or protected health information can be released. However, Maine CDC can reveal some details about an outbreak to seek additional cases or aid an investigation.

Facilities can notify patients and family during an infection control breach or voluntarily inform the public by posting and publishing outbreak-related information and restrictions.

Ms. Day argued for the public’s right to be informed whenever an outbreak occurs. She said that if the hospital her father had chosen for rehab had been required to inform him and his family of the MRSA outbreak that had already killed two patients, he would have gone to a different facility and avoided contracting his own fatal infection.

Dr. Rogers maintained a public reporting policy could not be implemented in the absence of an agreed definition of “outbreak”.

Mr. Cutler spoke to the difficulty of specifying which rules should apply to each of many different kinds of complex situations. He and others expressed concerns about the risk of unintended harm to patients who delay a medical procedure upon hearing news of an outbreak that would not have effected them. Dr. Rogers expressed apprehension at the prospect of an inflexible rule requiring notification to patients in hospital rooms too far from the outbreak to be affected. Ms. Dunton questioned how a hospital could notify parents of an outbreak in the NICU when it was medically necessary for their baby to stay there.

Ms. Day said the committee needed to prioritize the goal of defining an outbreak. She upheld the consumer’s absolute right to be able to make informed choices and decisions. She said that even if a patient still decides to enter the hospital in spite of an outbreak, they could still use the information to take precautions or warn family and friends not to visit.

There was general agreement that any notification or public reporting should be based on actionable information that patients, family members and visitors can use to prevent the spread of infection.

The discussion then turned to developing a protocol for communication between facilities in the event of an outbreak and the role for public health during an outbreak when a patient with an emerging pathogen (e.g., *Candida auris*, CRE or others) is transferred across state lines.

*Antimicrobial Resistance*

Dr. Liao presented an overview on antimicrobial stewardship. She announced that 15 of Maine’s 17 PPS hospitals have met all 7 of the U.S. CDC’s Core Elements of antibiotic stewardship, as have 12 of 16 CAH hospitals and 56% of Maine nursing facilities.

The committee then discussed recommendations for how Maine CDC could best support antimicrobial stewardship in healthcare facilities. Suggestions included expanding public education programs through public service announcements on TV; following Connecticut’s example of placing public education ads on the sides of state vehicles; and broadening the distribution of the antimicrobial patient education packages.

Ms. Hersey reported that when the patient education package pilot program was introduced the number of patient complaints about having been refused antibiotics went way down.

A suggestion was made to include dentists and veterinarians in antimicrobial stewardship efforts.

Dr. Liao then asked for recommendations for forming an antimicrobial resistance subcommittee.

Dr. Rogers suggested hospitals should be represented by pharmacists, not infection preventionists. She also recommended that the subcommittee should include community pharmacies, ambulatory physicians, and nurses recruited through their respective state organizations.

The meeting adjourned at 4:04 PM.