D R A F T

HAI/AR Collaborating Partners Committee

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

Minutes of the Committee's meeting of October 26, 2018
at Pine Tree Room at 2 Anthony Avenue, Augusta, Maine

In attendance:

Members: Dr. Siiri Bennett, Kathy Day, Cathy Dragoni, Donna Dunton, Ann Graves, Karynlee Harrington, Danielle Hersey, Lynn Johnston, Jennifer Liao, Nick Matluk, Rita Owsiak, Dr. Gwen Rogers, Sandy Parker, and Ann Woloson

Staff: Stuart Bratesman

Guests: Shaun Alfreds, Kim Church, and Amanda Gagnon

Rita Owsiak called the meeting to order, shortly after noon. The minutes of the August 24th meeting were read and approved.

Ms. Owsiak welcomed the committee's newest member, Ann Woloson, Executive Director of Consumers for Affordable Health Care.

Ms. Owsiak also told the group that efforts were ongoing to recruit new member to represent pharmacy, healthcare administration, and nursing executives. Sandra Parker noted she had recommendations for the latter two positions.

Ms. Owsiak announced that Allied Laboratories, Inc. (ALI) is now known as Northern Light Laboratory.

She then introduced Shaun Alfreds, CEO of HealthInfoNet, who provided an overview of his organization's role as Maine's State-designated health information exchange. HealthInfoNet was established as an independent, non-profit organization, governed by a community board. It combines information from separate health care sites to create a single electronic patient health record in real time as physicians, laboratories and other providers enter their information. The system, which also stores patient healthcare claims data from MaineCare and pharmacy benefits managers, automates reporting for hospitals and serves public health needs such as disease surveillance.

In all, it currently serves as a data repository for 1.6 million lives; with secure data connections with all of Maine's acute care hospitals, all but two of Maine's Federally Qualified Health Centers, the national VA system and 780 different organizations in all. He added that 85% of primary care practices are participating (with InterMed being a big exception), as well as 48 of Maine's 94 nursing homes, and multiple home health agencies.

The patient-specific information stored in HealthInfoNet supports the coordination of care and treatment decisions, and provides physicians with real-time notifications whenever one of their patients arrives in an emergency room, is admitted to, or discharged from a hospital, or when new lab results arrive. Other features include predictive analytics to spot patient healthcare risks and improve care management, a real-time quality measure dashboard that allows Maine CDC to track diabetes, hypertension and obesity, a MaineCare care management and ED utilization reporting tool and a hospital utilization dashboard.

When asked if the Maine Department of Corrections had joined the network, Mr. Alfreds explained that they have had discussions, but nothing has developed. He also pointed out that neither the Dorothea Dix, nor Riverview psychiatric centers have joined, in part due to issues with federal privacy regulations.

Next, Karynlee Harrington, Executive Director of the Maine Health Data Organization (MHDO) provided an overview of her organizations role as the State's health care data center. The Legislature created MHDO in 1995 as an independent State Agency, governed by a multi-stakeholder board representing payers, providers, employers, hospitals, consumers and government. The Governor appoints MHDO board members. Karynlee described MHDO's purpose as defined in statute as the following: to create and maintain a useful, objective, reliable and comprehensive health information data warehouse that is used to improve the health of Maine citizens **and** to promote transparency of the cost and quality of healthcare in the State of Maine by procedure, payer, facility and provider in collaboration with the Maine Quality Forum (MQF).

MHDO is responsible for the collection, storage, management and distribution of healthcare data and information, including medical and pharmacy claims data from both the private and public payers, hospital inpatient and outpatient encounter which includes visits to hospital-owned primary care and specialty practices, hospital quality data and hospital financial and organizational data. . Ms. Harrington said that MHDO's data is the only data set in the state that she is aware of that can connect prescription drug data with an associated diagnosis on a provider claim. Karynlee provided an example the group has previously discussed, specific to their work around antibiotic resistance. MHDO is working with Ms. Owsiak and Dr. Liao to look at a dx of the common cold and a corresponding prescription for an antibiotic. There will be more to report as this work unfolds. In all, MHDO maintains over 1 billion healthcare records and that number grows each month with the submission of new data.

Ms. Harrington noted that the Maine Hospital Association (MHA) uses MHDO data to generate reports for CFOs and provided examples of how a variety of other organizations has used MHDO's healthcare data. She also reminded the group of the MHDO and MQF's collaborative effort of promoting the transparency of healthcare costs and quality via the website CompareMaine.

MHDO recently released an RFP to redesign MHDO's core website to make it more accessible. They also plan to add new, procedure-specific quality measures to CompareMaine.

MHDO also produces ad hoc reports, either as required by their governing statute, or for external users, on topics such as how many babies have been born addicted to a particular drug; the annual number of falls resulting in an emergency room visit; or the number of opioid prescriptions filled for a specific diagnosis. Ms. Day asked if MHDO could collaborate with HealthInfoNet to coordinate information on vaccinations given by pharmacies. Ms. Harrington responded that there could be an opportunity, and Mr. Alfreds added that HealthInfoNet sees big gaps in immunization data, in part due to Walmart and Target's resistance to participate in data submission.

Ms. Johnston noted it is a big challenge for nursing homes to find out if residents have received immunizations prior to admission.

When Ms. Owsiak asked if HealthInfoNet could create a registry for multi-drug resistant organisms (MDROs), Mr. Alfreds responded that this could be possible.

Ms. Owsiak asked if the Maine CDCs field epidemiologists could access HealthInfoNet for public health surveillance. Mr. Alfreds explained that Maine CDC does not have the authority to access identified patient data from HealthInfoNet and that any data released to Maine CDC is de-identified. HealthInfoNet has a complex data governance process and data releases must be approved the by the data submitter.

Ms. Parker asked if patients can access their data in HealthInfoNet and wondered if patients would be comfortable knowing all the places where their data is going. She said she might have reservations about having her personal healthcare information disclosed to the Maine CDC.

Mr. Alfreds replied that the patient opt-out rate has remained stable at 1.8%. He said HealthInfoNet has about 1 or 2 patients a month coming in to ask for the audit of who has accessed their information.

New State HAI/AR Plan for 2020-24

Ms. Owsiak introduced the next topic on the agenda, the need to develop a new 2020-2024 five-year HAI/AR State Plan, and began with a discussion of the State Plan's *Respond* section with emphasis on emerging pathogens. She reviewed State surveillance of emerging pathogens.

She also described the U.S. CDC's *Interim Guidance for a Public Health Response to Contain Novel or Targeted Multidrug-resistant Organisms (MDROs),* and said the CDC is performing Colistin-resistant pathogen prevalence studies in every state. Ms. Owsiak reported that Maine CDC is monitoring pan-resistant organisms. If a hospital detects one, they will submit it to the state public health laboratory so it can be forwarded to a national lab for verification.

She then reviewed the World Health Organization's (WHO) list of special pathogens likely to cause a severe outbreak in the near future, and for which few or no medical countermeasures exist.

The new State Plan needs to address:

- Ebola readiness checks of Maine's three assessment hospitals;
- The need to determine whether the Ebola strategy is appropriate to other special pathogens;
- Converting the existing State Plan's approach to Ebola to a broader approach encompassing different responses to different categories of special pathogens; and
- The need for a greater focus on front line hospital readiness.

Ms. Owsiak then turned to the *Prevent* section of the State Plan and Maine's HAI reduction strategy.

Each June, Maine CDC produces a CEO dashboard report delivered annually to hospital CEOs and Infection Preventionists (IPs). The dashboard displays the hospital's Standardized Infection Ratio (SIR)* for each of six types of HAIs. Facilities use it for their infection control plans and other purposes. Hospitals with any SIR above the 2020 national HHS goal also receive a high-

* The SIR is the ratio of a hospital's actual number of infections (or LabID events) to the risk-adjusted expected number. A SIR below 1.0 means the hospital's performance is better than the national baseline, while a SIR above 1.0 is worse than the national baseline.

rate report, and Maine CDC tries to encourage them to use the federal CDC's Targeted Assessment for Prevention (TAP) Strategy.

This year, although Maine CDC sent high rate reports to ten hospitals, only two of them signed up for TAP. Seven or eight of the hospitals had a formal reduction program in place. However, having a formal program does not guarantee reduction. Of the ten hospitals, four were CLABSI or CAUTI free for 8-to-16 months.

Ms. Owsiak asked the group if, as our HAI numbers get lower, is there a preferred approach for reduction.

Dr. Rogers questioned how realistic is to get our infection numbers down to zero, and stay at zero over the long term. She contended there is an irreducible minimum, especially with complex patients, and noted that Maine Medical Center receives the sickest and most complex patients in the state.

Ms. Owsiak replied that Maine will have to see where the federal government sets the new HAI goals and noted that the national goals for 2030 will be lower than the current goals for 2020. The U.S. DHHS set the 2020 HAI goals at anywhere from 25% to 50% below each 2015 national baseline SIR. The new goals, which are not likely to be announced until the spring of 2021, will probably be based similar reductions below the new national baseline using CY 2020 data.

Ms. Owsiak then presented a table of the impacts of five types of HAIs, listing for each:

- Maine's 2017 number of infections (or LabID events);
- The estimated healthcare cost per infection or event;
- The total annual healthcare cost for Maine (number of infections times average cost);
- Maine's number deaths based on estimated mortality rates found in the medical literature;
- Maine's 2017 SIR (in reference to the 2015 baseline); and
- The U.S. DHHS target SIR for 2020.

She then asked the group if it wanted to focus the State Plans attention on the HAIs furthest from the DHHS 2020 goals or on those HAIs having the largest impact in cost and mortality.

While some members proposed setting the focus on HAIs causing the greatest numbers of deaths and disability, others pointed out that approach would give first priority to *C.difficile*, the one HAI for which Maine had already met and exceeded the 2020 national reduction goal.

Ms. Owsiak proposed a mixed approach centered on CLABSI and MRSA, since they have both high mortality rates (per infection), and Maine SIRs still above the 2020 goal.

Some members argued against using LabID-based measures and questioned their validity has a reliable proxy for actual infections. Another argued against using the colon surgery surgical site infection (SSI) measure, given that the colon is an unclean surgical site.

The group found general agreement on prioritizing reduction strategies for CLABSI and CAUTI since they were furthest from achieving the 2020 national goals.

Ms. Day recommended the State require death certificates to specify the type of infection involved in the cause of death, to allow us to determine the actual mortality rates for different types of HAIs.

Ms. Owsiak asked that if new State Plan were to designate CLABSI and CAUTI as first tier priorities, then which HAIs would the group want to choose for phase two.

Ms. Parker suggested postponing that determination until the new State Plan's second year to allow a reassessment based on new data.

Dr. Rogers asked if the new plan would set HAI goals for long-term care.

Others noted that Maine's HAIs are concentrated in a small number of facilities and questioned whether it was worthwhile to target resources on hospitals that are already close to goal.

The discussion turned to how many HAIs to target at one time. Members noted that targeting a larger variety of HAIs would burden hospitals and Maine CDC, and that working on reducing one type of HAI has an overlapping beneficial effect on others.

Ms. Parker proposed prioritizing CLABSI, MRSA and CAUTI at facilities that are at double-digits above their target number of infections (or LabIDs).

Ms. Owsiak recommended revisiting the issue at the next meeting when the group will have the benefit of newer data.

She then asked the group to consider issues around methodology:

- Target high-rate facilities for reduction
    - Using formal strategy or TAP Strategy?
- If a hospital had a significantly high rate, would we want Maine CDC's Healthcare Epidemiology Program to conduct a non-regulatory Targeted Infection Control Assessment?
- What other reduction strategies would we want to offer facilities with low numbers of infections per year?

Dr. Rogers recommended that Maine CDC conduct Targeted Infection Control Assessment only at the invitation of a facility.

Ms. Graves suggested there is more value in performing a root-cause analysis (RCA) prior to a Targeted Infection Control Assessment, given that a root-cause analysis might reveal patient issues, rather than facility issues, had caused an HAI.

Dr. Rogers replied that Maine Medical Center already performs an RCA on every CLABSI and CAUTI. However, she noted it does not really get to cause, but rather to proximate issues. Her hospital used to find commonalities between infections, but no longer. They recently had one where the RCA could not identify a cause.

Others noted that most facilities are using RCAs and that they are more useful in early stages of approaching a problem.

Ms. Day asked if family and patients are included in root cause analyses, and Ms. Owsiak replied it would be unusual.

Ms. Day contended that family and patient involvement would be useful, since a family member may notice a nurse not using gloves during a central line placement, and that such information might not otherwise emerge.

Ms. Parker asked if there was any data on the results following a TAP, and asked if TAP and the Infection Control Assessment and Response (ICAR) Program had been validated.

Dr. Liao replied that ICAR had evolved from an Ebola-focused strategy to broader applications and Ms. Owsiak added that neither had been validated yet.

Ms. Harrington proposed that Maine CDC offer each hospital a range of approaches from which they could voluntarily choose.

The meeting turned to the issue of seeking stronger commitments of CEO support for HAI reduction strategies.

When the group was asked if there were any objections to including facility names in facility comparison maps, Dr. Rogers said she'd prefer identifying hospitals only by their Maine Hospital Association (MHA) Peer Group designation.

Ms. Parker observed that the MHA's Quality Council had made HAIs a priority a few years ago, but it made little difference with CEOs. She concluded that the general shotgun approach was ineffective, but offered to speak with an individual CEO, if requested by an IP.

Ms. Owsiak then presented a question, "What's next for Maine?" She noted that while we have hospital data for five types of HAIs, hospitals accounted for only 1% of all 3,468 healthcare facilities in the state. The more than 900 long-term care facilities made up another 27%, while the remaining 72% were in outpatient care.

Ms. Harrington offered that MHDO could provide data on the share of healthcare spending by facility type.

Ms. Owsiak proposed that the State Plan address outpatient clinics by doing more work on reducing the overprescribing of antibiotics. Family practice physicians, physician assistants and nurse practitioners prescribe the most oral antibiotics. The U.S. CDC estimated that across different age groups, unnecessary antibiotics account for 18% to 35% of all antibiotic prescriptions. For acute respiratory conditions this range increases to 34% to 70%.

She said that tackling the problem will require more Maine-specific data on outpatient antibiotic prescribing patterns, and that Maine CDC plans to work with MHDO next year to obtain antibiotic utilization data from the All-Payer Claims Database. She proposed using the data to set goals, and to target antibiotic reduction activities, and to measure success.

Several members spoke to the need for more consumer education. Dr. Rogers suggested that physicians who more frequently prescribe at a patient's request get higher marks on Internet rating websites and in CG-CAHPS. She said parents often pressure doctors to prescribe an antibiotic for a sick child to get them back into school or daycare sooner.

Ms. Parker recommended inviting an outpatient physician or nurse practitioner to discuss this issue with the committee.

When the group began to discuss the feasibility of working with employers to exclude coverage for inappropriate antibiotics, Ms. Parker noted there are some grey areas among conditions where it might or might not be appropriate. She recommended instead encouraging employers to help educate their employees.

Ms. Owsiak asked for suggestions on how to engage non-IP healthcare professions groups, such as pharmacists, physicians, nurse practitioners and physician assistants on antibiotic-related topics, for example, understanding carbapenem-resistant Enterobacteriaceae (CRE) and differences between carbapenemase-producing CRE (CP-CRE) and, non CP-CRE.

She also asked for advice on the best places, aside from healthcare facilities, for public or patient education. Suggestions included:

- working with partners, such as AARP and the Area Agencies on Aging (AAAs);
- asking hospitals and professional societies to help promote Antibiotic Awareness Week in November;
- asking Maine Public Radio to devote a full broadcast of their *Maine Calling* show to antibiotics and do likewise for locally produced TV shows such as *207*; and
- distributing the Maine CDC's antibiotic awareness brochure through the Maine AMA, hospitals and employers.

Ms. Owsiak thanked the group for their suggestions and announced the meeting dates for 2019 would be February 22, April 26, August 23, and October 25th. She also told the group that the next meeting was likely to be held at the Maine Healthcare Association and the meeting would discuss drafting the new State Plan, and response to outbreaks, including program authority to enter a facility.