Wyoming HAI Prevention Advisory Group (WHAIPAG)
Conference Call Minutes
May 3, 2012, 7:00am

*Note this meeting was held in person at the 2nd Annual Wyoming Infection Prevention Conference, Casper, WY May 2nd and 3rd.

- Ellen introduced two documents containing the CAUTI and CLABSI rate data from hospitals across the state and collected in the NHSN system. Data shown in the tables and graphs: 1. represent all hospitals combined for a statewide rate, and 2. are gathered from October 2011 through March 2012.
  - CAUTI related data take home messages:
    1. Catheter Utilization is the number of catheters per days used.
    2. The primary recommended practice to prevent CAUTI is to decrease the use of catheters thus reducing the rate of catheter utilization.
    3. The number of facilities reporting catheter utilization has varied from 3 to 24 of the 27 total facilities participating in the MPQH HAI prevention project.
    4. Intensive Care Unit (ICU) specific catheter utilization rate ranged from 0.69 (at the highest) in December 2011 to 0.27 (the lowest) in November 2011.
    5. Medical-surgical and/or other (med-surg/other) unit specific catheter utilization rate ranged from 0.24 (the highest) in both November 2011 and February 2012 to 0.14 (the lowest) in March 2012.
    6. CAUTI rate is the number of CAUTIs per 1000 catheter days.
    7. ICU specific CAUTI rate ranged from 4.94 (the highest) in December 2011 to 0.0 (the lowest) for three consecutive months of January through March 2012.
    8. Med-surg/other unit specific CAUTI rate ranged from 2.92 (the highest) in January 2012 to 0.0 (the lowest) in October 2011 and March 2012.
    9. There has been a substantial decrease in hospitals reporting CAUTI rate and catheter utilization in the most recent couple months thus we need to get hospitals back on track.
    10. The catheter utilization and CAUTI rates don't seem to correlate. This may be an issue of non-reporting as well as delays in reporting. The hospitals are not required to report the data until 1 month after the month they were monitoring. Hence there is substantial lag time and the rates shown here may continually change as more data is entered.
  - CLABSI related data take home messages:
    1. CLABSI rate is the number of CLABSIs per 1000 central line days.
    2. The number of facilities reporting CLABSI rate varied from 11 to 25 of the 27 facilities participating in the MPQH HAI prevention project.
    3. Both ICU and med-surg/other unit specific CLABSI rates have been 0.0 for the previous 6 months.
    4. Again, there was a drop in the number of facilities reporting CLABSI in the most recent couple months, thus we need to get hospital back up and running on NHSN.
  - Tom, statistician with MPQH, will continue to run these reports and share with WHAIPAG on a monthly basis for the duration of the project.
- Ellen introduced the HAI prevention project Crosswalk document. This document describes the various HAI prevention initiatives/projects currently ongoing in the state, the measures hospitals are required to report for each initiative/project, the type of data used to track the measures, the

date the initiative began collecting (i.e. required reporting) data, and whether or not the data is published on the Hospital Compare website (for public disclosure). Highlights include:

- Definitions for abbreviations include:
  1. OQR = Outpatient Quality Reporting = Requirement from U.S. Center for Medicare/Medicaid Services (CMS) in order for hospitals that have outpatient services to get the best reimbursement/payment and to avoid financial penalties.

*Ellen will look into whether or not Ambulatory Surgical Centers (ASCs) are also required by CMS to report these measures.

  2. MBQIP = Medicare Beneficiary Quality Improvement Project = Kansas Hospital Association project = Flex Project
  3. IQR = Inpatient Quality Reporting = Requirement from U.S. Center for Medicare/Medicaid Services (CMS) in order for hospitals to get the best reimbursement/payment and to avoid financial penalties.
  4. VBP = Value Based Purchasing = Partnership for Patients Project = hospitals get extra or bonus payments based on the data entered into the IQR system for this project.
  5. Abstraction = infection preventionists must pull the data manually from medical records
  6. Claims = data is pulled electronically from insurance (primarily CMS) claims forms of the medicare and medicaid beneficiaries.
  7. Structural =

*Ellen will look into what is structural data.

  8. 10SOW = 10^{th} Scope of Work = Under current contract terms with CMS, MPQH is collecting this data either through NHSN or another data management and analysis software program.

- This is a draft document! It does not include the measures reported for hospitals participating in the On The CUSP: Stop HAI project through the Wyoming Hospital Association. Additionally, considering HAI prevention and quality improvement are hot topics right now, this table will likely be continually updated as new projects begin.
- OQR, IQR and VBP initiatives are generally restricted to acute care hospitals, and those hospitals that are included in the "prospective payment system" (PPS) through CMS. However, critical access hospitals (CAHs) in Wyoming are now also voluntarily reporting some of these measures into NHSN in order to participate in MPQH HAI Prevention Project and 10SOW.
- Dialysis centers are considered completely separate, and have an entirely different set of measures to report. Currently there are three measures they must report into NHSN any 2 or 3 months during 2012. These measures are: I.V. antimicrobial starts, positive blood cultures, and signs of vascular access infection.
- ASCs will have some measures required by CMS to report in the future. A likely requirement will be for this data to be entered into NHSN. However, the proposed reporting requirements have not been finalized.
- All of the measures listed on this table, regardless of initiative, have come from rules set by CMS, and thus are not under our control.
- Russ brought up a concern about the typical situation in Wyoming where many patients are moved quickly to other hospitals outside of the state. Additionally, healthcare for rural states like Wyoming extends beyond state borders and the range of federal programs. This is a concern primarily for underreporting of HAIs.
- The current recommendation from HHS, CDC, CMS, etc. is for the hospital that inherits a patient with an HAI to notify the previous facility of the HAI. But it is then up to the original facility to report that HAI as their own.

  - Sheila raised a concern as to whether or not this practice of notifying the previous facility is a violation of HIPPA. This is not a HIPPA violation, as it is considered continuity of care.
- Emily introduced the final version of the CAUTI prevention practices assessment survey results. Highlights include:
  - RNs were the most often reported healthcare provider type employed to insert catheters. This would be a good target audience for CAUTI prevention education efforts.
  - A couple areas that need more clarification included:
    1. the number of hospitals that monitor insertion techniques and whether or not those techniques are always performed according aseptic techniques and using sterile equipment.
    2. the number of hospitals that provide education to caregivers on readily available supplies, and if that correlates to the number of hospitals actually provide supplies readily available.
  - A substantial number of hospitals don't monitor insertion practices
  - A very small number of hospitals reported never disconnecting catheters from collection systems for purposes such as irrigation. It's a recommended best practice to never disconnect the catheters unless an obstruction is anticipated.
  - A small number of hospitals reported never screening for asymptomatic bacteriuria (ASB). Screening for ASB is not recommended.
  - The group discussed the need for piloting these surveys in the future to ask the questions in a better more understandable manner.
  - Because we want to compare responses at a later date, we cannont change the questions, however we can provide definitions for the categories of always, often, sometimes, rarely and never for future surveys.
- Ellen introduced to the group the idea of hiring an intern to work on the resource manual suggested at our last meeting (April). Due to time constraints on this meeting, the group decided to continue this discussion at the next WHAIPAG meeting.
- The next meeting will be on and at our regularly scheduled day and time: ***Thursday, June 7, 2012 at 1pm***.