# DRAFT

## Connecticut Healthcare Associated Infections Advisory Committee
## Strategic Planning Workgroup
## Minutes
## June 17, 2009

**Attendees:** Ray Andrews, Lauren Backman, Karen Buckley-Bates, Lillian Burns, Louise Dembry, Brian Fillipo, Richard Garibaldi, Alison Hong, Jenny Kitsen, Cynthia Lambert, Peggy Lynch, Jennifer Martin, Tom Meehan, Richard Melchreit, Mary Pakulski, Jean Rexford, Richard Rodriguez, Diane Steverman, Douglas Waite

**Call to order:** Richard Melchreit called the meeting to order at 11:30 a.m.

**Review and approval of prior Strategic Planning Workgroup conference call minutes (January 23, 2009):** The draft minutes were reviewed, and accepted as written.

**Strategic program planning:**
The federal DHHS plan and Omnibus 2009 legislation requires that each state write and submit a state plan to DHHS by January 1, 2009. One of the key elements of the national plan is seven national targets (a.k.a. metrics), some of which are outcomes (reduction in CLABSIs below the current 25$^{th}$ percentile) and some of which are process measures (SCIP compliance over 95%). These must be achieved in each state in five years. In the current year each state is expected to begin tracking and reporting at least two of the seven metrics. Connecticut already tracks one of these: CLABSIs in one ICU in each hospital; therefore, we must add at least one metric in the next year, though out plan could add more, or include other metrics in addition to the two we must address.

The Workgroup reviewed the chart of national metrics vs. Connecticut activities to determine which of the metrics might be added:

- The group advised against adding additional locations (e.g., additional ICUs) to the CLABSI metric in the next year. This metric should continue and the data be revalidated without significant change in the metric. Longer term, this can be revisited.

- Adding the central line insertion practices metric to the program in the next year should be considered. It is a logical addition to the outcome measure we already track. However, though members cautioned against mandating all hospitals use the NHSN CLIP module. They suggested the hospitals be surveyed and given latitude in determining how this would be tracked. A chart that compared the IHI "bundle" to the Johns Hopkins, IHI, and CLIP "checklists" was reviewed. The checklists focus on insertion and do not include the bundle element of daily checks to determine whether the line can be removed. Connecticut is participating in the Johns Hopkins CUSP: Stop BSI project - CHA is leading the Connecticut site activities. Thirteen of the 30 acute care hospitals are participating.

- Another metric worth considering is the MRSA metric, as Connecticut has an active prevention collaborative lead by the state QIO, Qualigdim. Making MRSA one of our

metrics might promote the collaborative and help it expand beyond its current five participating hospitals. It was suggested that we consider c. difficle as a metric, rather than MRSA, because c. diff. is a high and emerging prevention priority in health care facilities. These metrics will likely be a lower priority for inclusion in the state plan at this time than CL insertion metric, but should stay on the list for consideration.

- Urinary catheter metrics – the group did not feel these two metrics were a high priority for tracking at this time in comparison to the others.

- Surgical site infections – the group discussed the SCIP practices metric. The advantage of this metric is that it is already being collected and reported to CSMS, so it would involve no extra work for hospitals. Including it in the state plan and DPH public reporting would increase its availability to the public and require almost no additional cost and little additional staff time. Members raised concerns in the past about the quality of the Hospital Compare SCIP data. The metric could stay in consideration as an option, but the issue of data validity needs to be explored. It would be a lower priority than the CL insertion metric.

The workgroup recommended that the draft plan clearly articulate 5year and 1 year objectives, and outline a process for progress from 1 year achievement, to the expected achievements at the end of the 5 year planning period. We should build our 5-year plan off of the federal requirements, as least as a starting point, and we should ensure they are always included. Currently, the planning and HAI reporting in Connecticut has focused almost exclusively on the 30 acute care hospitals. The Strategic Planning Group discussed the expansion of the plan to non-hospital settings, such as LTC facilities, surgical centers, and dialysis facilities. The Network of New England (dialysis centers) and DPH HAI program personnel have become engaged in a series of conference calls, part of the national prevention collaborative that CDC has developed, lead by the Delmarva Foundation and the Maryland state health department. It was decided that the engagement of other non-hospitals partners and planning for dialysis center involvement should be part of the state HAI planning, but that initiation of process or outcome tacking or full-bore state-based prevention collaboratives this year would be premature.

The dialysis centers already report HAI data to CMS, this date could possibly be included in the state plan for surveillance, much as the SCIP data reported to CMS is being considered. LIC facilities are very diverse and have significant resource issues that will take a lot of planning and participation from LTC representatives to adequately address in planning.

## Next steps for the Committee, future meetings:

DPH staff will incorporate the ideas from the meeting in to a draft state HAI Plan, using the draft template supplied by CDC. This will be emailed to the Strategic Planning Workgroup by July 10. The workgroup will likely have a conference call 1 week later to discuss the draft. The revised draft will be shared with the full HAI committee for further discussion at its August 5th meeting, leading to one or more revision cycles before it is submitted to the DPH Commissioner for review in the autumn.

## Adjournment:

The meeting was adjourned at 12:52 p.m.