

**Pediatric SSI Reporting  
Friday, March 18, 2011  
10 AM – Phone Conference**

**Attendance:**

Name	Institution
Alice Pong, MD	UCSD
Alexis Elward, MD	Washington University in St. Louis
Kristina A. Bryant, MD	University of Louisville, Shea Pediatric Leadership
Mary C Virgallito, RN	CHLA
Kathleen L. Mathews, RN	Lucile Packard
Kathleen M. Gutierrez, MD	Lucile Packard
Jean Wiedeman, MD	UCD
Amy Nichols, RN	UCSF
Renata Briones, RN	Madeira Children's Hospital
Jon Rosenberg, MD	Chief of HAI Program
Brian Lee, MD	Children's Hospital, Oakland
Lilly LaBar, RN	Children's Hospital, Oakland
Mae Huo	Children's Hospital, Oakland

TOPIC	DISCUSSION	ACTION/OUTCOME	NEXT REVIEW
Call to Order	The Pediatric Surgical Site Infection (SSI) Reporting meeting was held on Friday, March 18, 2011.	Dr. Lee and L. LaBar called the meeting to order at 10 AM.	
Attendance	Roll call and brief introductions were made.	Noted.	
Brief Review of Bagley Keene Provisions	<p>A representative from CDPH needs to be present and invite the public to join in on the conference call. Members are reminded to please articulate names during roll call, since this is also an opportunity for the public to address subcommittee members.</p> <p><u>Recording Meetings</u> There will be full disclosure of meeting contents. Members have the right to record the meeting if it is not disruptive. If CDPH records the meeting in any way, these materials are subject to the public records act and can be erased within 30 days.</p> <p>Mae Huo will be taking meeting minutes.</p>	Noted.	As needed.
Welcome	<p>Dr. Lee and L. LaBar welcome all participants as members of the Healthcare Associated Infections (HAI) Advisory Committee of California.</p> <p>New mandates for the prevention of HAIs and public reporting has been passed by the HAI Advisory Committee, but this committee is composed mainly of people from adult hospitals with very little pediatric representation. The recommendations are therefore very adult focused and this is the reason why this subcommittee was formed.</p>	Noted.	
Agenda	<p>The agenda was posted 10 days prior to the meeting. A, Nichols, Dr. Elward, and R. Briones did not receive agenda.</p> <p>Vote taken.</p>	<p>L. LaBar sent agenda to members who did not receive it.</p> <p>Approved by all members.</p>	
Review of SB 1058	<p><u>What California currently/will require for SSI reporting:</u></p> <ul style="list-style-type: none"> <li>• Starting 01/2009 - Each healthcare facility reports quarterly.</li> <li>• Starting 01/2012 – CDPH will post incidence rates on their website, including number of inpatient days.</li> </ul> <p><u>All Facilities Letter (AFL)</u> In preparation for the 2012 requirement of public reporting, the HAI Advisory Committee made recommendations that were</p>	Noted.	As needed.

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	<p>released 3/11/2011 in the form of an AFL that focused on the reporting of adult procedures.</p> <ul style="list-style-type: none"> <li>• 2 mandatory reported procedures: Coronary bypass graft (CBGB/CBGC) and hip prosthesis.</li> <li>• List of 14 other procedures to choose from (via risk assessment) if the facility does not do the 2 mandatory reported procedures above.</li> <li>• At least 2 procedures need to be reported.</li> </ul> <p>Reporting will be done through NHSN.</p>		
<p>Applying Law in Pediatrics</p>	<p>Currently, pediatric facilities would follow the AFL and choose two procedures from the list (via risk assessment) if they do not do one or both of the mandatory reported procedures.</p> <p>HAI Advisory Committee to move forward in pediatric reporting.</p> <ul style="list-style-type: none"> <li>• Choose 2 mandatory procedures to report.</li> <li>• List of other procedures to choose from (via risk assessment) if facility does not do one or both of the mandatory procedures.</li> <li>• At least 2 procedures will be reported.</li> </ul> <p><u>Legal</u> Dr. Rosenberg points out that once the proposal is approved by the Advisory Committee, there shouldn't be any legal issues. For the time being, no legal mechanism distinguishes pediatrics from adults or excludes pediatrics facilities from reporting CBGB/CBGC if these procedures are done. Because of this, if the subcommittee was to propose substituting 2 alternate procedures for pediatric facilities, it needs to be done ASAP.</p>		
<p>Applying the Law in Pediatrics</p>	<p>Dr. Lee states that the purpose of this meeting is to discuss pediatric surgical procedures that are appropriate to report publicly because many pediatric settings do fewer/no CBGB/CBGC and hip prosthesis procedures. The goal is to choose two for mandatory reporting (perhaps one cardiac, one ortho).</p> <p>Dr. Wiedeman, MD had conversations with UC Davis surgeons about the pediatric surgeries in the community and hospital, clean and clean contaminated. Appendectomies, hernias, lymph nodes, and congenital clefts are some procedures that were named.</p> <p>K. Mathews suggests picking a cardiac surgery and an ortho surgery that most Children's Hospitals would perform.</p> <p>Dr. Wiedeman reminds members that the purpose of SB 1058 is to monitor all hospitals in California. Dr. Rosenberg adds that there are no exclusionary criteria for pediatric facilities.</p> <p>Many facilities serve mixed adult and pediatric populations. If pediatric procedures are few in number, reported values would probably come from only the adult procedures. Dr. Wiedeman asks if reports can be segregated by adult and pediatric populations in the event that data from one population is poor and does not accurately represent the healthcare facility as a whole.</p> <p>L. LaBar adds that there should be consideration by the HAI Advisory Committee that children are more at risk in certain surgeries. Dr. Rosenberg uses the example of CLABSI reporting. Adult, pediatric, and neonatal populations are reported separately because the rate and procedures are different.</p> <p>R. Briones suggests that CSF shunts are done at Madeira Children's Hospital, but Dr. Lee states that neurosurgeries are not required by law to be reported.</p>		

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	<p>Dr. Gutierrez suggests GI/appendix surgery because it is more applicable to various populations in many different types of hospitals. Dr. Pong agrees.</p> <p>L. LaBar urges the team to consider not only volume, but also risk. Dr. Gutierrez questions the definition of “high risk”. Patients do well in spinal fusion procedures, but the risk is significantly higher. L. LaBar states that spinal fusion procedures are reported at Children’s Hospital, Oakland. There were 59 reported procedures in 2010. NHSN requires a denominator of at least 25. High risk stems from the fact that those who acquire infections have high morbidity.</p> <p>Dr. Bryant agrees that stakes are high for spinal fusion infections. The NHSN criteria have been a challenge however. When patients come back with drains, they are disqualified from NHSN reporting. This makes it difficult to follow spinal fusion patients.</p> <p>Dr. Elward adds that spinal fusion falls into 2 categories and so more risk stratifications are needed to ensure public understanding. M. Virgallito also agrees that the risks for the 2 classifications are very different.</p>		
<p>Applying the Law in Pediatrics</p>	<p><u>Risk Assessment/Stratification</u> Dr. Lee asks Dr. Rosenberg whether there will be risk stratification done when data is entered into NHSN, who responds that there are 3 planned educational webinars regarding the AFL. There is indeed a new risk assessment process, which is one of the key reasons for the ability to use NHSN to report SSIs.</p> <p>In contrast to the old risk stratification system, there is now a multivariate risk formula. It is only executed within NHSN but the code will be released sometime in the future. It uses patient demographic information such as ASA score, teaching status, wound status, length of surgery, gender, BMI, etc. This is used on a patient specific basis to adjust their risk of infection. NHSN then calculates the standardized infection ratio for that hospital.</p> <p>Dr. Elward asks if every surgery has been validated.</p> <p>Dr. Elward will send paper on risk index validation of a cardiac patient to L. LaBar.</p> <p>A. Nichols noticed that the new NHSN SIR, spinal fusion does not include pediatric focused variables. A. Nichols has looked and have not found pediatric surgeries pulled out separately, at least in the most recent report for 2009. There seems to be no way of using NHSN for standardized reporting at this time.</p> <p>Dr. Lee asks whether CDPH would accept reporting from non NHSN sources. Dr. Rosenberg responds that at some point, data needs to be entered electronically and it is preferably done through NHSN.</p> <p>Dr. Lee is concerned that there will be risk adjustment applied to any procedure that we choose. Therefore, we should focus the meeting on selecting 2 procedures to report and address risk assessment issues at a future meeting. It has been decided thus far that spinal fusion has high morbidity and appendix procedures have high volume and is more widely done.</p>	<p>Dr. Rosenberg will pass this question on.</p>	
<p>Applying the Law in Pediatrics</p>	<p>Dr. Pong asks how specific would we have to be in naming a procedure to report, since cardiac procedures have wide variation in level of risk. Dr. Lee brings the question to Dr. Rosenberg and asks if CDPH would pull out data from 1 type of surgery or use all</p>		

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	<p>data from the general category. Dr. Rosenberg responds that there is no legal reason why the ICD 9 Code cannot be used as long as it is possible and if that is what the committee recommends. The only glitch may be that risk assessment will need to be done by NHSN methodology.</p> <p>A. Nichols asks if the data can be pulled out by age only. If the subcommittee was to recommend to the HAI committee to assign a certain ICD 9 Code for patients of a certain age group, then is there a way for CDPH to pull out procedure data for that age group (in facilities with mixed pediatric and adult populations)?</p>	<p>Dr. Rosenberg answers that age is an entry item and we can do any analysis on a data item that is uniformly entered into NHSN. The only limitation is generating the SIR, because this can only be done in NHSN. Eventually, this may be able to be done externally. This often generates 2 or 3 rates for each hospital when the goal of the SIR is to generate 1 rate of infection based on the stratification of surgeries.</p>	
<p>Applying the Law in Pediatrics</p>	<p>01/2012 – CMS may introduce mandatory reporting of SSI through NHSN for hospitals that participate in Medicare reimbursement.</p> <p>The IPPS system does not apply to pediatric facilities yet and SSI reporting may not either.</p>		
<p>Applying the Law in Pediatrics</p>	<p>Dr. Lee asks for a vote on the general agreement of picking 2 procedures to be reported in any hospital with pediatric populations. What these procedures are will be discussed at a future meeting.</p> <p>Dr. Rosenberg restates that there is no legal mechanism in place that exempts pediatric hospitals from not reporting in the meantime. If the subcommittee decides to leave the reporting policy as it, pediatric hospitals that don't perform either CBGB/CBGC or hip prosthesis procedures (or both) will need to choose two procedures from the AFL's list based on risk assessment. He is able to provide a spreadsheet of the number of surgeries in 2009 for all NHSN categories that were included in the AFL by hospital, if this will help.</p> <p>Dr. Lee states that pediatric facilities should be accountable for 2 surgeries specific to pediatrics.</p> <p>Dr. Rosenberg adds that this is a piece of flawed legislation. The obvious surgical categories may be more inclusive. He suggests that the subcommittee selects procedures that have some purpose.</p> <p>Dr. Rosenberg adds that if there is a valid risk adjustment process in NHSN, then pediatric hospitals that currently do surveillance for all SSIs will receive some added value to the data they enter. One option is surgeon identity, so rates can be generated by surgeon.</p> <p>K. Mathews asks if there is any leeway in the law for the subcommittee to put together a risk assessment plan for pediatric facilities since this is a new requirement.</p> <p>Dr. Rosenberg responds that the NHSN risk adjustment methodology will be different for pediatric facilities and the subcommittee will need legal rationale to change reporting parameters for pediatric hospitals to comply with the law as it is written. Some states do not track procedures by age.</p> <p>Dr. Rosenberg reminds the group that if no recommendations on</p>	<p>Dr. Rosenberg to look into other state's reporting systems.</p>	<p>As needed.</p>

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	<p>pediatric procedures are made, pediatric facilities need to follow AFL guidelines, unless the group decides that those guidelines are misapplied.</p> <p>Dr. Lee asks Dr. Rosenberg to forward NHSN response to committee members.</p>	<p>Dr. Lee withdraws his motion for a vote due to need for further discussion.</p>	
<p>Summary/ Homework</p>	<p>Members to go back and speak with surgical services of individual facilities to determine the types of cardiac surgeries that are performed for each ICD 9 Code, in case the subcommittee wishes to proceed this way.</p>		<p>As needed.</p>
<p>Next Meeting</p>	<p>Follow up meetings will be scheduled.</p>	<p>Noted.</p>	
<p>Adjournment</p>		<p>Dr. Lee and Lilly LaBar adjourned the meeting at 11:14 AM.</p>	