

**Pediatric SSI Reporting
Monday, April 11, 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	Children's Hospital, LA
Kathleen L. Mathews, RN	Lucile Packard
Kathleen M. Gutierrez, MD	Lucile Packard
Jean Wiedeman, MD	UCD
Amy Nichols, RN	UCSF
Jorge Palacios	Healthcare Associate Infections (HAI) Program, California Department of Public Health (CDPH)
Gregg Pullen	Children's Hospital, Central California
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 Monday, April 11, 2011.	Dr. Lee and L. LaBar called the meeting to order at 10 AM.	
Attendance	<p>Roll call.</p> <p>Brief self-introduction by Jorge Palacios, Associate Health Program Adviser, HAI Program, CDPH. His primary duties include communication with the community and clinicians.</p> <p>L. LaBar asks whether a representative from NHSN will be joining in on the conference call. J. Palacios responds, not today, but definitely at a future meeting.</p>	Noted.	
Minutes Review	The minutes once approved will be posted to the HAI Advisory Committee website. The minutes will serve as a summary of the meeting. Members of the subcommittee are asked to read and approve the minutes.	K. Mathews moves to approve the minutes. Dr. Gutierrez seconds the motion. Minutes approved.	
Agenda	All members present confirmed receiving the agenda.	Dr. Elward moves to approve the agenda. Dr. Wiederman seconds the motion. Agenda approved.	
Review of SB1058	<p>Dr. Lee reminds the subcommittee that SB 1058 is the law and we must uphold the letter of the law. The legal department of CDPH will monitor compliance, and so will the consumer.</p> <p>Past experience with the HAI Advisory Committee, has shown that exceptions to the law are not generally been allowed.</p> <p>Starting 1/1/2012, information on SSIs will be posted on the CDPH website.</p> <p>Dr. Lee read aloud a section of SB1058: <i>"The department shall follow a risk adjustment process that is consistent with the federal Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN), or its successor, risk adjustment, and use its definitions, unless the department adopts, by regulation, a fair and equitable risk adjustment process that is consistent with the recommendations of the Healthcare Associated Infection Advisory Committee (HAI-AC), established pursuant to Section 1288.5, or its successor."</i></p> <p>In summary, the above passage reminds facilities that they are</p>	The purpose of SB1058 is to improve the quality of care in California and to increase transparency so that consumers can make informed decisions.	

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	<p>required by California law to use NHSN definitions and risk adjustment processes.</p> <p>The only way to make changes would be by regulation, but this is a several year process according to J. Rosenberg, MD.</p> <p>In the short term, we must abide by the law and use NHSN risk adjustment methodology. In the long term, we may be able to use a different risk adjustment methodology tailored for pediatrics.</p> <p>Dr. Wiederman asks if NHSN risk adjustment methods are specific to pediatrics. If not, how can these methods be employed? Dr. Lee responds that NHSN requires the use of their methodologies and it is not known whether they are valid for pediatrics, but probably not.</p>		
Attendance	A. Nichols and M. Virgallito join the conference.	Noted.	
Applying the Law in Pediatrics	<p><u>Risk Adjustment</u></p> <p>Dr. Gutierrez asks if J. Rosenberg, MD is going to check on how risk adjustment should be applied to pediatrics. J. Palacios suggests waiting for an answer from the NHSN representative who is anticipated to participate on future conference calls. If at all possible, the answer should be documented in writing. NHSN has not provided Dr. Rosenhberg with a clear answer.</p> <p>To carve out an exception is not likely, especially for the short term. If the subcommittee chooses to make long term recommendations, whether they are heeded or accepted is a different issue.</p> <p>K. Mathews mentions an article that was recommended by Dr. Elward titled “Risk Adjustment for Surgical Site Infection After Median Sternotomy in Children”. This article relates to the problem in the lack of risk stratification for pediatric populations. Because the law has gone into effect on 4/1/11 per the AFL, the main goal of this subcommittee is to first decide on the best way for pediatric facilities to be compliant with the law.</p> <p>Dr. Elward suggests choosing procedures that are high volume but low risk to minimize the amount of risk adjustment needed.</p> <p>K. Mathews and L. LaBar agree. The risk adjustment process for pediatrics has not been established and this subcommittee will definitely discuss this topic in the future. For now, the first priority is to proceed as the law states, which means identifying procedures to report.</p>	<p>K. Mathews motions to make recommendations to HAI Advisory Committee and NHSN to develop and adopt, with the subcommittee’s assistance, a risk adjustment system for pediatrics. A. Nichols seconds the motion. Roll call was made and the motion is approved unanimously.</p>	
Applying the Law in Pediatrics	<p><u>Procedures</u></p> <p>L. LaBar had mapped procedures to procedure codes in the manual. Some of the procedures did not have a matching code; lowering the denominator. At Children’s Oakland the code is not assigned in the OR but is instead left up to the coders in Medical Records (MR) / Health Information Management (HIM). L. LaBar states the concern that NHSN codes present is that they may not be all inclusive within the category and asked if anyone else had a similar problem. K. Mathews stated that they have had similar issues. M. Virgallito also states that they have had similar problems sometimes but will double check. The rest of the subcommittee did not respond with having major problems of a similar nature.</p>		

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	<p>Dr. Gutierrez states that a HIM representative match procedures with ICD9 codes at Lucile Packard.</p> <p>G. Pullen states that as a subcommittee, recommendations may be made to the state of California to extract a few ICD 9 codes for public reporting purposes. When a few procedures are extracted, a question arose as to whether risk adjustment will happen/be applied or will it only apply to the larger category. J. Palacios did not have an answer at this time.</p> <p>L. LaBar states that it makes sense to risk stratify by ICD 9 codes.</p> <p>K. Mathews states that for some hospitals, ICD 9 codes will not risk stratify appropriately, leading to reluctance to use the data.</p> <p>Dr. Lee suggests adding a disclaimer, in the same format as public reporting for CLABSIs, that states “be aware that this data may be limited because of the following reasons” or “not validated in pediatrics”. This way, the information will be made available to the consumer/reviewer. K. Mathews agrees but adds that people look at comparisons. Stating a disclaimer does not prevent reviewers to make the same comparisons, especially if they do not know the differences. Dr. Lee agrees with K. Mathews and adds that this issue has been discussed in the HAI Advisory Committee. This, however, will not be a reason that will exclude pediatric facilities from reporting.</p> <p>M. Virgallito asks if the subcommittee is considering VP shunt reporting. Dr. Lee responds that even though they are straightforward in tracking, it is a neurosurgical procedure and not mandated by state law to be reported. It cannot take the place of the mandated surgical categories but can be voluntarily submitted to NHSN.</p>	<p>Dr. Lee will research the ability to stratify based on ICD 9 codes.</p>	<p>Next meeting.</p>
<p>Applying the Law in Pediatrics</p>	<p><u>Procedures: SF</u></p> <p>Dr. Gutierrez considered procedures from Lucile Packard that may be reasonably reported. Spinal fusion (SF) is one category.</p> <p>L. LaBar states that SF had easy ICD 9 code denominator correlation and the denominator was within the category of reporting. K. Mathews, A. Nichols, Dr. Gutierrez, M. Virgallito, and G. Pullen agree.</p> <p>Dr. Lee restates the fact that SF is relatively easy to track and have working numerator and denominators. He asks if other institutions have enough SF procedures to report.</p> <p>Dr. Pong states that UCSD has enough procedures and asks whether SF can be stratified by high and low risk. Drs. Pong and Elward raises the concern of whether or not there are different ICD 9 codes for high versus low risk SF procedures to obtain comparable data between institutions.</p> <p>A question was raised regarding NHSN criteria for SSI. Dr Lee clarifies that NHSN definitions excludes surgery with a drain going through the incision site. Dr. Bryant adds that the incision has to be closed initially.</p> <p>M. Virgallito states that there will be less need for risk stratification if there is a way to distinguish SF procedures for idiopathic scoliosis versus nonidiopathic scoliosis.</p> <p>G. Pullen and A. Nichols both stated that their respective facilities had some concerns on reporting SF due to the risk differences between idiopathic scoliosis and other high risk types. Lucile</p>	<p>Question to ask NHSN.</p> <p>Members of the subcommittee are asked to go back to their institutions and speak to the surgeons to get a sense of how many SF procedures would meet this NHSN criteria.</p>	<p>Next meeting.</p>

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	Packard had no issues.		
Applying the Law in Pediatrics	<p><u>Procedures: CV</u></p> <p>Dr. Gutierrez considered procedures from Lucile Packard that may be reasonably reported. In the cardiovascular (CV) category, pacemaker insertion was identified. A risk adjustment strategy is needed even for this type of relatively simple procedure because CV anomalies are varied and important to take note.</p> <p>Dr. Pong from UCSD states that they considered CV surgery but there is a wide variety of types (open versus closed heart pace maker insertions) that have different associated risk.</p> <p>A. Nichols from UCSF looked at cardiothoracic procedures and found approximately 18 ICD9 codes. Pace maker insertion seems to be a reasonable procedure to report. Another set of ICD 9 codes was regarding valve and septum repair. All other procedure types had a denominator of close to or less than 25 for the year. Dr. Elward asks whether the valve/septum repair procedures were independent or associated with other surgeries. A. Nichols cannot answer this because her data is solely based on the ICD 9 codes.</p> <p>Dr. Lee then asks about denominator requirements for cardiac surgeries.</p> <p>Dr. Gutierrez answers that Lucile Packard meets the criteria for 25 per year but doesn't have the exact numbers.</p> <p>Dr Pong states that there were 14 closed heart pace maker insertions and 3 open heart insertions in 2010 at UCSD. There may be more and it is unclear whether some procedures were rolled up into other types of surgeries.</p> <p>M. Virgallito reports that Children's Hospital, LA had 7 straight pace maker implants and 5 repairs in June-December 2010.</p> <p>L. LaBar reports that Children's Hospital, Oakland had 3 in the month of March.</p>	Members should obtain numbers of pace maker surgeries and valve/septum surgeries to discuss at the next meeting.	Next meeting.
Applying the Law in Pediatrics	<p><u>Procedures: GI</u></p> <p>M. Virgallito states that Children's Hospital LA looked at high volume low risk surgeries, appendectomies in particular.</p> <p>Dr. Pong from UCSD states that they considered appendectomies also, but the large denominator will prove to be an unreasonable work load. There is also the difficulty of distinguishing a SSI and initial complications of an appendicitis (contaminated vs clean-contaminated).</p> <p>G. Pullen adds that the state requires class 1 or 2 procedures and appendectomies are mostly wound class 3 and 4.</p> <p>Dr. Lee asks if there are other GI relevant surgeries that are reasonable to report.</p> <p>Dr. Elward suggests hernia repairs. M. Virgallito responds that Children's Hospital, LA does not have high volume for this procedure.</p>	Appendectomies will not be considered due to discussed problems.	
Applying the Law in Pediatrics	<p><u>Procedures: Other</u></p> <p>Dr. Lee suggests open reduction of fracture as another Ortho procedure option for reporting.</p> <p>G. Pullen added that Children's Hospital, Central CA surgeons</p>		

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	<p>also suggested this procedure, but the Infectious Diseases (ID) physicians were against using this procedure due to some of the procedures having very high risk. Some include external fixation device(s) that introduce infection risk.</p>		
<p>Summary/ Homework</p>	<p>Members should look into SF and CV procedures done at their individual institutions. They should also compare ICD 9 codes and interview surgeons about the drain issue as it relates to SF surgeries.</p> <p>L. LaBar and Dr. Lee will be attending the HAI Advisory Committee meeting this Thursday, 4/14/11, and will report on the progress of this subcommittee.</p>		<p>As needed.</p>
<p>Current Progress</p>	<p>K. Mathews asks the subcommittee members what strategies have they put into place at their facilities to stay compliant with the law.</p> <p>G. Pullen states that Children’s Hospital, Central CA has chosen SF and heart surgery. Information Technology staff are pulling denominator data. Surveillance has been initiated.</p> <p>M. Virgallito states that Children’s Hospital, LA has chosen SF and cardiac procedures. They have been doing surveillance for internal purposes. HIM uses a 3M application that mines the Cerner medical records for surgeries, which then downloads denominator data to NHSN. They have previously met with the state regarding this system and also for the possibility of aiding other facilities.</p> <p>A. Nichols states that UCSF have applied adult indicators and changing over to pediatrics will not be difficult once decisions have been made.</p> <p>L. LaBar raises the issue of data mining and reconciliation, which have been reported to the HAI Advisory Committee. She also adds that at Children’s Hospital, Oakland, CV and SF procedures are being reported.</p> <p>G. Pullen asks whether a facility must contact CDPH to inform them of our choice of procedure. J. Palacios will share this question with J. Rosenberg, who will send a response to L. LaBar and Dr. Lee to share with the entire subcommittee. As a preliminary answer, L. LaBar states that the NHSN reporting plan should be sufficient.</p>		
<p>Next Meeting</p>	<p>Follow up meeting will be scheduled in a few weeks. Formal recommendations are the goal for the next meeting so that pediatric facilities can have guidance as soon as possible. Also, NHSN should be participating in the conference call so that the topic of risk adjustment can be better explored.</p>	<p>Noted.</p>	
<p>Adjournment</p>	<p>Reminder: as of 4/1/11, facilities should be reporting based on AFL guidelines.</p>	<p>Dr. Lee and L. LaBar, RN adjourned the meeting at 11:00 AM.</p>	