



# Hospital Value-Based Purchasing (VBP) Quality Reporting Program

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## Support Contractor

### Hospital Value-Based Purchasing (VBP) Program Patient Safety Series: SSI Colon Surgery and SSI Hysterectomy

#### Questions and Answers

##### Moderator:

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Hospital Inpatient Value, Incentives, and Quality Reporting (VIQR)  
Outreach and Education Support Contractor (SC)

##### Speakers:

**Carolina HealthCare System Pineville**

**Ellen Crabtree, BSN, RN, CSPAN-CAPA**  
Pre-op Clinical Supervisor

**Laura Schuetz, BSN, RN, CPAN**  
Nurse Manager, Pre-Anesthesia Testing

**Tammie Stahl, MHS, CRNA**  
Anesthesia Clinical Coordinator

**Heather Gore, BSN, RN**  
Clinical Supervisor

**Allison Paysour, BSN, RN**  
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Clinical Supervisor, Surgical Unit

**Robert Packer Hospital**

**Andrew Klee, MS, MPH, CIC**  
Infection Preventionist

**December 14, 2015**  
**2 p.m. ET**

### Carolina HealthCare System Pineville

**Question 1:** Has the improvement in standardized infection rate (SIR) for colon surgery and abdominal hysterectomy Surgical Site Infections (SSIs) been maintained during the past calendar year?



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- Answer 1:** This data will not be available until first quarter 2016.
- Question 2:** Are you not using an Electronic Health Record (EHR)? If so, what are you using instead of the "orange sheet?"
- Answer 2:** We use Cerner for our Electronic Health Record (EHR). The orange form is a tool and is not a part of the permanent record.
- Question 3:** Do you have guidance to providers for re-dosing antibiotics intra-operatively for longer duration procedures?
- Answer 3:** Yes, we have a protocol for cases over 120 minutes. The CRNAs follow written guidelines intraoperatively and are responsible for the re-dosing after communicating with the surgeon
- Question 4:** Did the clock start at the beginning of prep or at the end of prep?
- Answer 4:** The three minute timer begins at the end of the prep.
- Question 5:** Did you say that every patient is admitted the night before surgery?
- Answer 5:** No, most patients come in the day of surgery and stay at least one night post-op.
- Question 6:** Do you do mostly open colectomies or laparoscopic colectomy? What type of dressing did you mention you are using?
- Answer 6:** Most of our procedures are laparoscopic. For our laparoscopic procedures, the incisions are closed with Dermabond. Open procedures have the incision covered with an AQUACEL<sup>®</sup> Ag Surgical<sup>™</sup> dressing.
- Question 7:** Were the patients also instructed to complete a chlorhexidine gluconate (CHG) bath the night before surgery? Also, were your patients screened for Methicillin-Resistant *Staphylococcus Aureus* (MRSA)?
- Answer 7:** Our hysterectomy and colon patients do not complete CHG baths at home. Our patients are risk-stratified for MRSA screening.
- Question 8:** Did the patients have hair removal outside the Operating Room (OR), if needed?
- Answer 8:** No, all hair removal or clipping takes place in the OR for hysterectomy and colon patients.



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- Question 9:** Have you initiated a determination of using different sterile instruments to close the incision than were used during the colon surgery itself?
- Answer 9:** Once the instruments have been contaminated, they are removed from the field and are not used again. Clean instruments are used for closure.
- Question 10:** How do you monitor that the patient is correctly using the CHG wipes before surgery? For example, if the patient cannot physically reach all parts of their body.
- Answer 10:** The patient is given verbal and written instructions. If they ask questions, seem unsure, or are physically incapacitated, we do the bath for them. The nurse assesses the patient's understanding after the bathing instructions.
- Question 11:** Is Vancomycin your antibiotic of choice for allergies?
- Answer 11:** No, not for hysterectomy or colon surgeries. We use a standard pre-op antibiotic protocol that allows for physician preference and allergies.
- Question 12:** Are your documents/checklists embedded in your electronic medical record? Please describe in more detail how you use the checklist and keep it moving through phases of care.
- Answer 12:** Some checklists are part of the permanent record, some are not. The Surgical Safety Checklist is not part of the permanent record. It is placed with the patient's paper documents in Pre-op and follows the patient through the OR.
- Question 13:** What is the surgical skin prep that was used for hysterectomy and colon cases?
- Answer 13:** We use ChloroPrep®.
- Question 14:** Would it be possible to get a copy of the sheet that is given to the patient to decrease SSI?
- Answer 14:** We are happy to share our patient education sheet. It can be found on <http://www.qualityreportingcenter.com/inpatient/vbp-archived-events/>.
- Question 15:** What is the brand of the wipes that are color coded for parts of the body?
- Answer 15:** Sage Wipes. The wipes themselves are not color-coded, the visual aid is color-coded.



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**Question 16:** You stated you use orange Surgical Care Improvement Project (SCIP) forms. What are those forms, what is their content and who completes them, are they documented in Electronic Medical Record (EMR)?

**Answer 16:** The orange SCIP forms are a tool used by nursing. The forms start in Pre-op, follow the patient through the OR to PACU, and are completed on the inpatient surgical unit. The tool helps track the time-sensitive actions surrounding SCIP measures. The form is not a part of the permanent medical record and is completed by nursing. The Surgical Safety Checklist is a tool used in Pre-op through the end of the operative procedure. In addition, the checklist is used by the Operating Room staff to evaluate the case and follow-up with any issues that may have occurred. The orange SCIP form follows the patient from Pre-op through admission to the inpatient unit post-operatively. The RN is able to see the status of the measures at a glance. It was implemented as a tool to assist teammates in following best practices.

**Question 17:** How did you get buy-in from the staff and physicians for the team?

**Answer 17:** For the timeout portion that was physician led, we had multiple meetings with the OR team and our physician, Dr. Thies. He would discuss our team at all of the physician meetings and encouraged the other physicians to participate. We also sent and encouraged all of our teammates through the team steps programs, and if they had issues or concerns, we took them very seriously and addressed them right away.

**Question 18:** Have you seen evidence that one CHG chin-to-toe bath has been effective? What evidence did you use to implement this? The info I've seen is only for total hip arthroplasty (THA) and/or total knee arthroplasty (TKA), not Colonoscopy and Hysterectomy.

**Answer 18:** <http://sageproducts.com/clinical-information-reducing-surgical-complications-ssi/>. The Carolinas HealthCare System Surgical Quality and Safety Operations Committee, which is surgeon led, considered the information in the attached documents and link in determining the SSI components adopted for use within system facilities.

**Question 19:** For the Quality Assurance (QA) Nurse that assisted with compliance, what was the nurse's function out on the unit? Was it to answer questions?

**Answer 19:** The QA Nurse rounded as needed, generally at least once a day, and she served as a resource to the front line nurses, providing on-the-spot education as needed. In addition to answering questions, she looked at SCIP patients and reminded



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nurses proactively to dose antibiotics and make sure that Lovenox or beta-blockers were given in the appropriate timeframes.

**Question 20:** How do you monitor that the patient is correctly using the chlorhexidine gluconate (CHG) wipes the morning of surgery, i.e., if the patient is elderly or just cannot physically "reach" all the nooks and crannies of their body?

**Answer 20:** The patient is given verbal and written instructions. If they ask questions, seem unsure, or are physically incapacitated, we do the bath for them. The nurse assesses the patient's understanding after the bathing instructions.

**Question 21:** Do you use Purple Top PDI wipes – Super Sani-Cloth<sup>®</sup> Germicidal Disposable Wipe? Is it effective against *C. Diff* spores? Do you use a different wipe for *C. Diff*?

**Answer 21:** Yes, we use Super Sani-Cloth<sup>®</sup> Germicidal Disposable Wipes for general cleaning. Sani-Cloth Beach Germicidal Disposable Wipes are used for *C. Diff*; they are bactericidal, fungicidal, tuberculocidal and virucidal.

**Question 22:** If a betadine paint/scrub was used, what would be the drying time?

**Answer 22:** We used a standard three minute dry time.

**Question 23:** Did I understand you to say you left the AQUACEL<sup>®</sup> Ag Surgical<sup>™</sup> dressing on for 10 days?

**Answer 23:** The AQUACEL<sup>®</sup> Ag Surgical<sup>™</sup> dressings are designed to remain in place for 7–10 days. We follow the guidelines unless the dressing integrity has been compromised. When a dressing has been compromised we replace it with a new AQUACEL<sup>®</sup> Ag Surgical<sup>™</sup> dressing on the inpatient unit.

**Question 24:** Do you use the seven-day sterile dressing for colon and abdominal hysterectomy only, or for all of your surgeries?

**Answer 24:** Dermabond is generally used for laparoscopic procedures. AQUACEL<sup>®</sup> Ag Surgical<sup>™</sup> dressings are used for most open surgical procedures and are also frequently used in our orthopedic patient population.

**Question 25:** Would it be possible to get a copy of the orange sheet?

**Answer 25:** Yes, we would be happy to share. This can be found on <http://www.qualityreportingcenter.com/inpatient/vbp-archived-events/>.



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**Question 26:** Has the improvement in SIRs for colon surgery and abdominal hysterectomy been maintained during the past calendar year?

**Answer 26:** This data will not be available until first quarter 2016.

**Question 27:** How did you decide on AQUACEL<sup>®</sup> Ag Extra<sup>™</sup>, and what other particulars were there for post-op wound management?

**Answer 27:** The use of AQUACEL<sup>®</sup> Ag Surgical<sup>™</sup> dressing was a surgeon led decision, first trialed with the orthopedic population and eventually spread to abdominal surgeries, as well. If the dressing is compromised or saturated, a replacement AQUACEL<sup>®</sup> Ag Surgical<sup>™</sup> dressing is applied.

**Question 28:** Did the patients have hair removal outside the OR if needed?

**Answer 28:** Hair removal for colon and hysterectomy cases takes place in the OR.

**Question 29:** Are inpatients and outpatients bathed with CHG wipes prior to surgery?

**Answer 29:** Inpatients are not bathed with CHG wipes prior to surgery on the inpatient unit. The CHG baths are performed in the pre-operative area.

**Question 30:** Why are patients not told to bathe the evening prior to surgery?

**Answer 30:** Patients are instructed by their surgeon on bathing the evening prior to surgery.

**Question 31:** Please define what a separate closing table is. What do you mean by separate closing table?

**Answer 31:** We do not have a designated closing table; however, we separate the contaminated instruments.

**Question 32:** What is AQUACEL<sup>®</sup> Ag Extra<sup>™</sup> comprised of that separates it from another type of dressing?

**Answer 32:** AQUACEL<sup>®</sup> Ag Surgical<sup>™</sup> dressings use Hydrofiber Technology that contour to wound beds minimizing “dead space” where bacteria can grow and maintain moisture balance in the wound bed, it responds to wound conditions providing rapid and sustained antimicrobial activity and locks in exudate, trapping bacteria which helps minimize wound and cross-infection during removal.



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**Question 33:** What different sizes of AQUACEL<sup>®</sup> Ag Extra<sup>™</sup> dressing for laparoscopic colon surgeries are available? Is one dressing applied to each laparoscopic puncture site?

**Answer 33:** Laparoscopic surgeries generally do not have AQUACEL<sup>®</sup> Ag Surgical<sup>™</sup> dressings used; these procedures are closed with Dermabond. The AQUACEL<sup>®</sup> Ag Surgical<sup>™</sup> dressings we use range from 4-inches to 14-inches in length.

### Robert Packer Hospital

**Question 34:** Have you noticed a change in OR turnover time? Did the time between cases increase?

**Answer 34:** We are just beginning to take a look at the effects on turnover time. With the addition of UV disinfection, we anticipate an increase in the time required. Based on our experience with the inpatient sites, we know that it takes about five minutes per position when you're using UV disinfection. Additionally, for most rooms, beds will need to be moved two or three times. We estimate that the process has added about 15 minutes to our in-patient sites. Depending on the size of the operating room, one would expect to move beds and equipment around a few times, as well. So, anticipate adding at least 15 minutes to your turn around time.

**Question 35:** Who in your facility does the DAZO<sup>®</sup> Fluorescent Marking Gel auditing in the OR?

**Answer 35:** In the inpatient units, it has been our housekeeping manager to go and do it after one of our technicians was done cleaning a room. In the OR, it's one of our managers in that environment there. So, after a case was done, the manager would duck in quickly and dust some of the multiple high-touch areas off the room, about 17 of them actually. After the room was cleaned, the manager would go back in with the black light to determine exactly where they missed.

**Question 36:** Is it correct that they request to re-dose the antibiotic, Ancef, intra-operatively, if the procedure is longer than two hours?

**Answer 36:** Yes, if the procedure exceeds four hours, yes.

**Question 37:** With the nGage System, do staff have to wear two badges, one for ID and one for data collection?



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- Answer 37:** That's correct. They wear their normal employee ID badge and the nGage badge. Most of them can wear it on the same clip, so it doesn't take up any additional space on their uniform.
- Question 38:** I'd like to hear more information about the hand hygiene check, in regards to the nGage System.
- Answer 38:** Yes, absolutely. We're one of the few facilities across the country that is utilizing an automated surveillance system, so I would imagine there'd be quite a bit of interest in learning more about it. We are definitely willing to share what we have so far. Our resources can be found at:  
<http://www.qualityreportingcenter.com/inpatient/vbp-archived-events/>.
- Question 39:** How many concurrent quality abstractors do you have?
- Answer 39:** We have a total of six concurrent quality abstractors
- Question 40:** Do you use UV for disinfection or for monitoring the effectiveness of cleaning?
- Answer 40:** We use UV disinfection as an adjunct to the manual cleaning process. So, following the discharge of our *C. difficile* inpatients, we have someone come in with the UV light (following the usual manual cleaning with bleach) and use that device in multiple positions throughout the room. This adds about an additional 10 to 15 minutes to a turn-around time for a room.
- Question 41:** When re-gloving at the time of fascia closure, are the MDs using instant surgical scrub after removing gloves before re-gloving?
- Answer 41:** Yes.
- Question 42:** With your nGage System, did you have trouble with the system registering staff scanning, and was the scanning based on badge identity or sensing hand at hand cleaning product station?
- Answer 42:** The way the system runs here is, we have what's called communication in that we are wired into the soap and sanitizer dispensers both inside inpatient rooms and in hallways on our inpatient units, and staff that work on those units each carry a RFID badge that's unique to their own person. So, when they enter and exit a particular patient room, their activation of any of the dispensers in that immediate area gets an indication of overall compliance.
- Question 43:** Are you continuing to monitor SCIP measures even though they are no longer required?





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- Answer 43:** Yes, it still serves as a helpful internal benchmark, despite it not being required for any external recording.
- Question 44:** What is the oral combination of drugs that are used for colon surgeries? Our general surgeons report a large percentage of patients who can't tolerate those drugs and have severe vomiting, thus coming to the OR quite dehydrated. Do you have any advice?
- Answer 44:** We follow the recommendations of the ASHP (American Society of Health System Pharmacists) for both our oral prep and re-dosing of antibiotics. These recommendations include alternative regimens for patients known to experience adverse effects.
- Question 45:** How do you obtain a list of denominator procedures from Epic? Do you use Optime or patient billing?
- Answer 45:** We utilize patient billing to obtain a list of denominator procedures. This system also interfaces with our infection surveillance system, Theradoc, to generate a streamlined list of these procedures.
- Question 46:** How often do you use UV light in OR?
- Answer 46:** We will be using UV disinfection in between certain cases (i.e. patients with active *C. difficile*), as well as during terminal cleaning of the rooms at the end of the day.
- Question 47:** Do you utilize CHG wipes on day of surgery? If so, does the patient or the staff perform the CHG wipe?
- Answer 47:** Yes, we utilize CHG wipes on the day of surgery. This is performed by the staff.
- Question 48:** Can Robert Packer share the tools they utilize to debrief an SSI?
- Answer 48:** We utilize the Theradoc infection surveillance system to detect, document, and report our SSIs.
- Question 49:** How are SSI colon events tracked in your facility's internal reports? NHSN data or NSQIP data? SSI rate or SIR? Risk indexed?
- Answer 49:** We utilize both NHSN and NSQIP data. For the committees and other groups I mentioned during the presentation, the physicians who attend prefer the NSQIP data. For reporting to other internal groups (Infection Control, Patient Safety), we utilize the NHSN (and thus the SIR) data.



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- Question 50:** Could Robert Packer elaborate more on the preoperative Glycemic Management? What happens if the surgeon is notified? What are the expectations?
- Answer 50:** We empower the surgeon to make the call whether to continue with the procedure that day or cancel/postpone the case. That provider knows the patient best, including any co-morbidities or other relevant factors that would factor into that decision.
- Question 51:** What were the areas that the OR staff identified as potential contributors for SSI's?
- Answer 51:** The most significant observation of the OR staff had to do with the physical environment of the OR rooms themselves. This included everything from equipment, shelving, and other objects in the room that really did not need to be there, to improperly wiping down equipment.
- Question 52:** What is the price tag of the Proventix NGage system you use?
- Answer 52:** The price of the Proventix NGage system is dependent on a number of factors, including number of beds and rooms that would be monitored, the number of staff who would wear the RFID badges, and the relevant infrastructure costs (for example, the cost of electrical wiring). If you check out [www.proventix.com](http://www.proventix.com), you can find contact information for a representative that can help guide a facility through determining those costs.
- Question 53:** How did you get the surgeons to forego or postpone a surgery based on an elevated HbA1c?
- Answer 53:** Again, we empower the surgeon to make that decision, based on their knowledge of the patient. Our peer review process ensures that should complication occur, the physician has a forum for providing the justification for their decision, and our other surgeons can learn from that experience (either positive or negative).
- Question 54:** Did any of the presenters also use SPY equipment before re-anastomosing the bowel to assure healthy tissue?
- Answer 54:** No.
- Question 55:** Are there additional measures taken when a colon presents as a class three or four, contaminated or dirty?



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**Answer 55:** No additional measures.

**Question 56:** What action is taken, in addition to surgeon notification, when HbA1c is >8.0?

**Answer 56:** It is the surgeon's call whether to continue the case or cancel/postpone.

### Both Hospitals

**Question 57:** Can either of you share any measures that you took in cases of unplanned/emergent colon or hysterectomy cases that assisted in the decrease of your SSIs?

**Answer 57:** *Carolinas:* Unplanned or emergent patients do not get a CHG bath; however, the OR procedures, prepping, dry time, surgeon led timeout, and use of the surgical safety checklist are all standardized and used for all patients. The same applies to the SCIP measures.

*Robert Packer:* We would do the same.

**Question 58:** We are paying great attention to the SCIP measure and starting antibiotics on time. We are wondering about the importance of validating the antibiotic completion time. Are there any correlations in your study? We would like to get completion time validated, documented, and incorporated into our checklist to determine any SSI correlation for surgeries in patients with higher BMI that have a higher tissue perfusion.

**Answer 58:** *Robert Packer:* At this point, we have not noticed a correlation between BMI and ABX time, although a correlation has been validated in several other literature sources. We do drill down to that level on EPIC and Uptime and do feel it is something worth keeping an eye on, especially with our significant morbidly obese portion of the population.

*Carolinas:* We followed this data for approximately a year. We found that at least  $\frac{1}{2}$  to  $\frac{3}{4}$  of Vancomycin was infused prior to incision. We did not study this data for correlation to SSI.

**Question 59:** Do you use oral antibiotics for all patients undergoing colon surgery?

**Answer 59:** *Robert Packer:* Not every single patient every time, but oral administration of antibiotics is the preferred method to utilize whenever possible.

*Carolinas:* No



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**Question 60:** How were pre-op antibiotics selected? Did you use the American Society of Health-System Pharmacists (ASHP) guidelines?

**Answer 60:** *Robert Packer:* Yes, we use the ASHP guidelines.

*Carolinas:* We have a protocol that is in place throughout the hospital system that was approved by pharmacy and therapeutics.

**Question 61:** Please elaborate more for "wound protectors." Are they the same as wound retractors? Please provide an example of a wound protector.

**Answer 61:** *Robert Packer:* Yes, this is likely the same product. It is a plastic device that fits around the circumference of the wound site and allows for better exposure, visualization, and specimen retrieval. It is an elastic product that fits around the circumference of the working area and allows for an essentially better exposure of the sites and the visualization of the site.

*Carolinas:* We do not use wound protectors. The wound protector, from what I understand, is an elastic product that fits around the circumference of the working area and allows for an essentially better exposure of the sites and the visualization of the site.

**Question 62:** Can you share the sheet you give patients about decreasing SSIs with all of us?

**Answer 62:** *Robert Packer:* Yes, we would be happy to share that information. Please find the resources at <http://www.qualityreportingcenter.com/inpatient/vbp-archived-events/>.

*Carolinas:* Yes, we certainly will. Please find the resources at <http://www.qualityreportingcenter.com/inpatient/vbp-archived-events/>.

**Question 63:** Is AQUACEL<sup>®</sup> Ag Extra<sup>™</sup> dressing originally placed in the OR or the post-op unit?

**Answer 63:** *Robert Packer:* N/A (We do not use the Aquacel.)

*Carolinas:* AQUACEL<sup>®</sup> Ag Surgical<sup>™</sup> dressings are placed in the OR.

**Question 64:** What cleaning product do you use for cleaning between cases?

**Answer 64:** *Robert Packer:* I know we recently started looking at a new product that I believe is from EcoLab called Oxivir and supposedly it is less harsh than using a bleach lotion but a little bit more effective than using something that would be like a quaternary-based component. We're just starting to take a look at that, so



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I can't really speak to how effective it is compared to what we've been using in the past.

**Carolinas:** We use Sani Master for our floors. We also use Purple Top Super-Sani Cloth Wipes manufactured by PVI. They are germicidal and are used to clean all of our surfaces and our beds. In addition, our operating rooms are terminally cleaned every 24 hours.

**Question 65:** What are your thoughts about the use of Bair Huggers and the research stating that they may increase the risk of SSIs?

**Answer 65:** **Robert Packer:** That's an interesting question; I saw it pop up a couple of times during the course of the presentation. We have not seen any subsequent infections in those patient populations here at our facility. However, I would like to take a look at that literature, if the questioner could you forward the link for that literature.

**Carolinas:** We are currently researching options for warming, such as conductive fabric warming. Our infection rate is very low with our current method of warming.

**Question 66:** What is your ideal time for antibiotic administration: anytime within one hour prior or is it a set number of minutes prior to the incision?

**Answer 66:** **Robert Packer:** Within 1 hour, as close to the incision time as possible.

**Carolinas:** Anytime within the hour of incision is acceptable; 2 hours for Vancomycin.

**Question 67:** Do you use weight-based dosing for Ancef antibiotics?

**Answer 67:** **Robert Packer:** No.

**Carolinas:** Yes.

**Question 68:** Do you have literature on hemoglobin (HGB) A1C of 6.5%?

**Answer 68:** **Robert Packer:** No.

**Carolinas:** No.

**Question 69:** What are your SSI and SIR [rates] for colon surgeries and abdominal hysterectomies?



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**Answer 69:** *Robert Packer:* The table on Slide 7 of Robert Packer's presentation has the SIR data.

*Carolinas:* Please refer to our presentation slides.

**Question 70:** MRSA Infections or Bacteremia only?

**Answer 70:** *Robert Packer:* No, SSIs or skin/soft tissue infections would be included, as well.

*Carolinas:* Our SSI tracking includes all organisms.

**Question 71:** You mentioned that you "clip" in the OR. Are you using clippers that collect the hair? If not, do you re-prep the skin after the clipping is completed? If prior, how are you assuring that the hair clippings aren't re-contaminating the area?

**Answer 71:** *Robert Packer:* N/A (hair removed prior to OR.)

*Carolinas:* All hair clipping is done prior to skin prep.

**Question 72:** Do you use chlorhexidine gluconate (CHG) for vaginal prep?

**Answer 72:** *Robert Packer:* No.

*Carolinas:* No, we use betadine solution.

**Question 73:** Is chlorhexidine gluconate (CHG) used as the skin prep for emergency cases?

**Answer 73:** *Robert Packer:* No, it is used for the majority of our elective cases.

*Carolinas:* Yes.

**Question 74:** What is the surgical skin prep that was used for hysterectomy and colon cases, CHG?

**Answer 74:** *Robert Packer:* Yes.

*Carolinas:* Chloro-Prep.

**Question 75:** Have you initiated a determination on using different sterile instruments to close the incision than those used during the colon surgery itself?

**Answer 75:** *Robert Packer:* Yes, different instruments as part of a separate closing table.



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*Carolinas:* No, once the instruments have been contaminated, they are removed from the field and they are not used again. Clean instruments are used for closure.

**Question 76:** Do you do mostly open colectomies or laparoscopic colectomy? What type of dressing did you mention you are using?

**Answer 76:** *Robert Packer:* We do a mix of open and lap colectomies.

*Carolinas:* Most of our procedures are laparoscopic. For our laparoscopic procedures the incisions are closed with Dermabond. Open procedures have the incision covered with an AQUACEL<sup>®</sup> Ag Surgical<sup>™</sup> dressing.

**Question 77:** Our patients may receive an antibiotic in the ER. Do you re-dose the patient in the preoperative area?

**Answer 77:** *Robert Packer:* We do not provide the antibiotic in the ER. Our anesthesiologists have taken on this responsibility, and their process is to administer as close to incision as possible (within the 1-hour timeframe).

*Carolinas:* We prefer all antibiotic dosing to be completed in the Pre-op area. If antibiotics are given in the ED, a discussion is held with the surgeon and re-dosing occurs on an individual basis.

**Question 78:** What would be the average annual volume of colon surgeries or abdominal hysterectomies for each facility?

**Answer 78:** *Robert Packer:* About 160–170 COLO, and about 170 HYST.

*Carolinas:* Colons: 125. Hysterectomies: 300.

**Question 79:** What types of organisms were most identified in those found to be SSI? If enteric, were the infections mostly identified as abscesses?

**Answer 79:** *Robert Packer:* The majority of organisms have been enteric, and a significant number were indeed manifested as abscesses.

*Carolinas:* The majority of organisms identified were enteric pathogens (including Enterococcus and Klebsiella) that met IAB criteria, i.e., abscesses. We did identify one SSI to be MRSA.

**Question 80:** Is Vancomycin your antibiotic of choice for allergies?



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**Answer 80:** *Robert Packer:* For some patients, although we try to identify alternatives whenever possible.

*Carolinas:* No, not for hysterectomy or colon surgeries. We use a standard pre-op antibiotic protocol that allows for physician preference and patient allergies.

**Question 81:** Can you elaborate on the method used to observe hand hygiene?

**Answer 81:** *Robert Packer:* We utilize the nGage monitoring system from Proventix.

*Carolinas:* We monitor hand hygiene through random surveys by an Infection Prevention Assistant.

**Question 82:** Are the laparoscopic colon procedures that you perform entirely laparoscopic or are they hand assisted?

**Answer 82:** *Robert Packer:* We have a mix of both types, including robotic-assisted.

*Carolinas:* A combination of both; some are entirely laparoscopic, some are hand assisted.

### Hospital Inpatient VIQR Outreach and Education SC

**Question 83:** Considering Healthcare-Associated Infections (HAIs) are part of the Hospital-Acquired Condition (HAC) penalty program and now also part of the VBP metric, could facilities be penalized twice?

**Answer 83:** You are correct that many of the measures in the Safety Domain, including the HAI measures and AHRQ PSI-90 Composite, overlap with the measures included in the HAC Reduction Program. CMS has previously stated that these measures are of great importance in healthcare quality and there should be emphasis on the reductions of infections and HACs. Although it is possible to receive a payment reduction due to both programs, it is also possible that hospitals may not receive a reduction or even receive an increase in payments due to the Hospital VBP Program.

**Question 84:** Is there a performance threshold for SSI-colon just like there is one for the colon and hysterectomy SSI composite?

**Answer 84:** There are separate performance standards (benchmark and achievement threshold) values for SSI-Colon and SSI-Abdominal Hysterectomy. However, they are still combined to one measure score by weighting the individual





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measure scores by the performance period predicted number of infections for each measure strata.

**Question 85:** We have a low SSI rate so we do not have enough information for a SIR. The problem is that we are doing well with this, but it goes out to other organizations that we do not report it given that the CDC cannot give us a SIR. Is there a way to make a note of this, so people do not think we are not reporting due to a high rate that may make us look bad?

**Answer 85:** You are correct. The CDC does not calculate a SIR when the predicted number of infections calculated by CDC is less than 1,000. When this occurs, a hospital is not eligible to receive a measure score for the Hospital VBP Program; however, the lack of a measure score does not adversely impact a hospital because the domain scores are normalized to account for only the measures for which the hospital met the minimum case counts. In terms of public reporting, when a hospital does not meet the minimum of 1,000 predicted infections but did submit data to NHSN, the hospital will receive a footnote 13. Footnote 13 indicates that *a SIR could not be calculated for the reporting period*, but not that the hospital didn't submit data. Hospitals that did not submit data for the measure would receive a footnote 5, *no data is available for the measure*, on *Hospital Compare*.

**Question 86:** The Hospital VBP Program FY 2017 Domains and Measures NHSN MRSA being followed is for Required IQR MRSA Bacteremia infections only, is that correct?

**Answer 86:** I don't know if I fully understand your question, but I believe you are correct. The MRSA measure that is used in the Hospital VBP Program uses the data reported into NHSN for the purposes of the Hospital IQR Program.

**Question 87:** When calculating the performance score, I understand that if you only have one SSI with an expected number of infections, that procedure counts 100%. Is the breakdown 50% for each if you have an expected number in both SSIs?

**Answer 87:** When both strata meet the minimum of 1,000 predicted infections, the individual measure scores are weighted by the performance period predicted number of infections to calculate the final SSI measure score.

**Question 88:** If you know, could you share anticipated or new infection control measures for next the fiscal year?



## Hospital Value-Based Purchasing (VBP) Quality Reporting Program

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**Answer 88:** It is anticipated that CMS will propose the FY 2019 Hospital VBP Program methodology in the FY 2017 IPPS/LTCH Proposed Rule slated to be released in the spring of 2016.

**Question 89:** Is there a handout or flyer that explains how the number of predicted infections are determined and which dates are included for the calculation of the SIR? Additionally, are there examples of the calculation steps of VBP points for the SSI measures within Safety?

**Answer 89:** In order to receive Achievement Points or Improvement Points, a minimum of one predicted infection needs to be calculated by the Centers for Disease Control and Prevention (CDC). The predicted infections are not actual infections. The predicted infections are used in calculating the Standardized Infection Ratio (SIR), which is used in the Hospital VBP Program. The SIR is calculated by dividing a hospital's actual reported infections by CDC's calculated predicted infections for that CCN. This is explained on the CDC website:  
[http://www.cdc.gov/nhsn/PDFs/Newsletters/NHSN\\_NL\\_OCT\\_2010SE\\_final.pdf](http://www.cdc.gov/nhsn/PDFs/Newsletters/NHSN_NL_OCT_2010SE_final.pdf).

Baseline and performance periods, as well as thresholds and benchmarks, are outlined in the Domain Weighting Infographics located at  
<http://www.qualityreportingcenter.com/inpatient/iqr/tools/>.

For assistance in calculating scores for your HAI measures, refer to the many tools available on the Hospital Value-Based Purchasing *QualityNet* page:  
<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPPage%2FQnetTier3&cid=1228772237202>.

**Question 90:** There is a document that shows in what percentile of the national averages a facility falls under, depending on the composite SSI and SIR. This percentile is also used to determine the number of HAC points. I am looking for the equivalent data just for SSI Colon in order to be able to answer the following question: in which percentile of the nation is our hospital performing?

**Answer 90:** For questions regarding the HAC Reduction Program, please contact [HACRP@lantanagroup.com](mailto:HACRP@lantanagroup.com).

**Question 91:** Where can I get the slides for this presentation?

**Answer 91:** The slides are available on the *Quality Reporting Center* here:  
<http://www.qualityreportingcenter.com/inpatient/vbp-archived-events/>.

**Question 92:** Can you obtain a certificate of completion even if you don't need Continuing Education credits? I'm not a registered nurse; I work as a Quality Professional.



## Hospital Value-Based Purchasing (VBP) Quality Reporting Program

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- Answer 92:** Yes, you complete the survey and then register as a new user, using your personal email account. When asked for a license number, just put in whatever acronyms are used for your licensure.
- Question 93:** Please define the time periods for fiscal years.
- Answer 93:** The baseline and performance periods for Hospital VBP fiscal years are displayed on *QualityNet* at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772237410>.
- Question 94:** I'd like to use the individual SSI strata to calculate my hospital's SSI Measure Score. Where can I find that formula?
- Answer 94:** You can find that formula in the FY 2014 IPPS Final Rule in the Hospital Value-Based Purchasing (HVBP) Program section. We have also listed out step-by-step instructions on how to calculate all the HVBP scores in the FY 2016 presentation that is listed on *QualityNet* from July of 2015. To understand scoring and calculate your hospital's measure scores, please refer to the resources on *QualityNet* at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772237202>.
- Question 95:** My hospital does not perform abdominal hysterectomies, but we do perform colon surgeries. How is the SSI measure score calculated when only one of the SSI strata has data?
- Answer 95:** So, when only one of the SSI strata has data, you weigh the total measure score for the SSI to 100 percent of the strata that does have the data. So, for example, if the abdominal hysterectomy met the one predicted infection threshold to have the SIR calculated and your hospital did not in the colon stratum, you would receive the measure score for the abdominal hysterectomy. Vice versa would be true if you receive the measure score in colon, but not the abdominal hysterectomy stratum. You would only receive the score for the colon surgery.
- Question 96:** Are there a minimum number of surgical cases needed to obtain a score for the SSI measure and Hospital VBP? When will the Hospital Value-Based Purchasing Program start using the Sepsis measure?
- Answer 96:** There is not a minimum case or surgical case count that is the minimum case amount for the measure. It is actually the predicted number of infections. All HAI measures have a minimum predicted number of infections of 1.000. If you meet that threshold in any given measure, a SIR would then be calculated.



## Hospital Value-Based Purchasing (VBP) Quality Reporting Program

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CMS has not proposed Sepsis be included in the HVBP Program or any measure that could be included in future fiscal years. I would recommend referencing the newest upcoming proposed rule that should be released this spring. Also, you have an opportunity to comment on any proposed rule, so feel free to submit any comments or opinions to CMS.

**Question 97:** How can we confirm if the correct data has been uploaded, given, or sent to CMS from NHSN?

**Answer 97:** When a hospital submits data for an NHSN submission deadline, on that date, CDC freezes that data and provides it to CMS. CMS then uses that information for the IQR preview reports that you receive, as well as *Hospital Compare*, and the HVBP Program. You can use NHSN to cross-check and ensure that the reports for CMS are correct. However, as a word of caution, if you modify any of the data that you previously submitted after the submission deadline, that data will not be reflected in the CMS report. As mentioned before, CDC freezes that data and then provides it to CMS. So, it is a best practice to print off or use screen shots of the data at the submission deadline so you can then go back later and then cross-check with the same information.

**END**