Managing SSI surveillance in an ASC

Tracking surgical site infections (SSI) is not easy for ambulatory surgical centers (ASC). Most patients are gone soon after waking up, but infections may not occur for days, weeks, or, in the case of implants, up to a year or more.

Yet tighter infection reporting rules (along with other quality measures) are on the way, and ASCs are making an effort to find the most reliable surveillance methods.

Looking for numbers

A growing number of states are requiring ASCs to report postoperative infections, and the Department of Health and Human Services (HHS) plans to do the same at the federal level. In the September 2010 draft of Tier 2 of its Action Plan to Prevent Healthcare-Associated Infections (HAI), which addresses ASCs, HHS explains: “National estimates regarding the number of HAIs originating in ASCs are not available and little is known about infection control practices in these settings. Current data related to SSIs and other HAIs come primarily from hospitals, which have an established infrastructure with staff dedicated to infection control and HAI surveillance. This infrastructure is largely absent in ASCs.”

HHS estimates that the 5,100 Medicare-certified ASCs collectively performed 6 million surgical procedures in 2007, costing Medicare $3 billion.

Currently, the Joint Commission’s National Patient Safety Goals for ASCs (NPSG.07.05.01) require ASCs to measure infection rates for 30 days following most procedures and a full year following implants, which can range from total joints to intraocular lenses.

As the draft Action Plan notes, ASC accreditation surveys, as well as the Conditions for Coverage from the Centers for Medicare and Medicaid Services (CMS), focus on infection prevention measures, such as hand hygiene and reprocessing methods, as opposed to outcomes. Later this year, HHS expects to complete development of a national database of ASC infection control practices and to issue an updated version of the Action Plan.

The next step will be to determine infection rates and their causes, the goal of the surveillance systems.

Ask the surgeon

The most obvious way of learning about infections is from the surgeons, experts agree, but only as long as the surgeons follow through. At one group of 4 surgery centers in Florida, a monthly infection/complication letter to surgeons asks about 30-day postop results as well as any infections from implants performed within the past year.

ASC staff also telephone a random sample of at least 30 patients each month to ask about infections and other concerns.

The survey is “fairly typical for an ASC,” according to the director, who adds, “Neither is foolproof, but they are the best we can come up with.” A recent Joint Commission
At the 2 surgery centers owned by Excela Health in Greensburg, Pennsylvania, surgeons also receive letters asking for postop information. According to Marcia Cook, MPM, RN, Excela’s vice president of perioperative services, average response rates are 90% at Norwin Medical Commons and 84% at the Surgery Center of Westmoreland.

“We report that also to the OR committee, as well as the department of surgery,” she says, “to send the message to the surgeons about the importance of a return on those letters.”

The HHS Action Plan lists other methods of tracking outpatient infections, such as mail surveys sent to patients, outpatient chart reviews, and review of insurance claims that could reveal treatment for infections. All of these methods, HHS warns, are either labor intensive or not completely reliable.

Use technology

“In a perfect world, we’d all have electronic medical records (EMRs), and an ASC could go to the postdischarge record,” says Peggy SaBell, MS, RN, CIC. “But we’re not there yet.”

SaBell is a spokeswoman for the Association for Professionals in Infection Control and Epidemiology (APIC) and regional director of infection prevention for Kaiser Permanente in Denver. Kaiser does have EMRs, and its outpatient facilities routinely coordinate with their inpatient counterparts.

“We get calls right away if a Kaiser member who has had surgery at our ASC is admitted with a surgical site infection,” she says. “We sit on our partner hospitals’ infection control committees.”

Like many large hospital systems, Kaiser has data-mining capabilities.

It is a relatively simple matter to search records for antibiotic orders, laboratory reports, and physician visits, any of which can help identify an infection following an outpatient procedure.

Relationships are important

But what if an ASC is independently owned and still using paper records?

While some ASCs may feel alone in their efforts to track infections or are reliant on responses from surgeons and patients over whom they have limited influence, they may have more resources than they realize.

“I think ASCs have to have a multi-pronged approach,” SaBell says.

There is no reason they cannot develop follow-up reporting systems with the hos-
pitals in the community, SaBell says. In smaller communities, there may be 1 or 2 hospitals, and the ASCs would have good relationships with them, as well as with local primary care physicians. Contact would be frequent, if not highly structured.

In any case, ASCs can work to establish regular contact. “They could ask their local hospital infection prevention departments to let them know if a patient is readmitted.”

The infection prevention specialist at an ASC may be a part-timer in that capacity with another primary responsibility, but she or he could attend professional meetings (such as local chapters of APIC) and ask for advice.

“You have to get some networking established and create some relationships,” SaBell says.

The track record so far

One reason HHS is determined to establish surveillance standards is that until now, the outpatient surgery industry, which includes ASCs, has come to the public’s attention only in cases of a serious outbreak.

Such was the case after patients were infected with hepatitis C at the Las Vegas Endoscopy Center in 2007 and 2008.

The event continues to influence policies, including the Action Plan, designed to monitor more closely the safety records of outpatient facilities. As the Action Plan notes, “In response to a 2008 outbreak of hepatitis C virus infections at a Nevada ASC, national attention quickly focused on ASCs and triggered questions related to their performance and safety and oversight.”

Currently, ASCs claim an excellent track record: in 2010, for example, at Westmoreland, only 1 infection was reported out of 420 physician responses. The Florida centers had “3 or 4 in the last 4 years,” according to the director, who noted that the majority of infections occur after the patient goes home and result from failure to comply with wound care instructions. (APIC’S SaBell disputes this: “The majority of surgical site infections originate during surgery.”)

The need for consistency

Such anecdotal reports, however, will not satisfy the demand for an accurate picture of the industry’s safety record.

The Action Plan outlines 3 problems in accomplishing this goal:
• Currently, no national database exists of HAIs that originate in ASCs.
• ASCs have no way to tie compliance with safety measures to improved outcomes or reductions in HAIs.
• ASCs need “additional guidance” in performing postdischarge surveillance.

To obtain a valid picture of postop infection rates (or any other performance measure), a consistent, nationwide system must evolve. Currently, each state has a different reporting system or else none at all. SaBell’s state, Colorado, issues a list of 15 surveillance methods and, since 2008, ASCs have been required to report on which methods they use.

In her APIC role, SaBell is concerned that no similar nationwide assessment exists.

“I believe ASCs have a low infection rate,” she says. “The problem is the processes that we have to identify infections are not the best. There could be issues that we really don’t know about.”

For a reporting system to be credible, she says, first, all parties must use the same terms and definitions. Second, they must use comparable data collection methods: Patient self-reports and EMR entries could yield widely different results, for example.
Policies and perceptions

The Nevada outbreak illustrated the difficulty ASCs have making their case to consumers and policy makers. As the Florida ASC director notes, there are many types of outpatient facilities, including physician offices and nonaccredited or nonlicensed centers.

In March 2011, Ambulatory Surgery Center Association chair David Shapiro, MD, met with HHS officials to review the Action Plan. Shapiro also is cochair of the ASC Quality Collaboration.

In an August 27, 2010, letter to CMS, the group endorsed the concept of adding a surgical site infection count to other quality measures under consideration but noted that it is difficult for ASCs to reliably check outcomes after 30 days or a year.

Shapiro defends the industry’s efforts to prevent and track infections. “ASCs have always gone the extra mile to identify any infections that might be linked to a procedure that a patient has undergone in the ASC,” he told OR Manager. Based on voluntary reports from ASC Association members, the SSI rate is less than 1.5 per 1,000 patient encounters.

The question that really needs to be addressed, Shapiro suggests, is “How do we get others to take seriously the infection reports that ASCs make?” He plans to host a second meeting with CMS, the ASC Association, and other interested organizations “to get an answer to that question and others like it.”

Reference