VDH Healthcare-Associated Infections Reporting Advisory Work Group

Meeting Summary, June 20, 2008

Dr. Remley welcomed and thanked participants. She reviewed statistics emphasizing the magnitude of the healthcare-associated infections (HAI) problem. A Centers for Disease Control and Prevention (CDC) study in 2002 (Klevens, Edwards, Richards, et al. *Pub Health Rep* 2007;122:160-6) found that there were about 1.7 million HAIs occurred in U.S. hospitals. Of these, most (1.3 million) were outside of intensive care units. These numbers can also be presented as 9.3 infections per 1,000 patient-days, or 4.5 per 100 admissions. There were an estimated 99,000 deaths associated with these infections. The body sites associated with the greatest number of deaths were the estimated 36,000 deaths from pneumonia, and 31,000 from bloodstream infections. Of course, these figures do not count HAIs that occurred in the ambulatory care environment.

Dr, Remley also reviewed the context for our deliberations. In March, 2008 the U.S. General Accounting Office (GAO) issued a report recommending that the Secretary of HHS identify priorities among the recommended practices in CDC's guidelines and establish greater consistency and compatibility of the data collected across HHS on HAIs. HHS generally agreed with GAO's recommendations.

In April, 2008 Congressman Henry Waxman, Chairman of the House Committee on Oversight and Government Reform held a hearing on "Healthcare-associated Infections—A preventable Epidemic." In his introductory remarks he said that one objective was to better understand why the U.S. Department of Health and Human Services (HHS) is not doing more to lead in the dissemination and adoption of HAI prevention strategies.

The Joint Commission has made the reduction of HAIs a national patient safety goal, including compliance with CDC hand hygiene recommendations. Dr. Remley challenged the group to share what they are doing in their respective organizations to improve hand hygiene practices, which are so crucial to controlling HAIs. She mentioned that New York State has a law that categorizes failure to follow standard infection control practices as unprofessional conduct. She hopes that we can raise awareness and improve practices in Virginia without resorting to such punitive approaches.

The National Quality Forum (NQF) worked with a full range of stakeholders to identify performance measures that could be used across the spectrum of healthcare settings to provide meaningful information to consumers, purchasers, providers, healthcare professionals, quality improvement organizations, and researchers about healthcare-associated infections. Their report, entitled *National Voluntary Consensus Standards for the Reporting of Healthcare-Associated Infection Data*, was issued in early 2008.

Consumers Union annually summarizes state reporting requirements. According to their most recent report, 22 state laws require public reporting of hospital-acquired infection rates; 2 state laws require public reporting of infection information, but not specifically infection rates (CA,

RI); 2 state laws require confidential reporting of infection rates to state agencies (NE, NV); and 1 state law permits voluntary public reporting of infection information (AR).

Governor Kaine issued Executive Order 42, entitled *Strengthening Transparency and Accountability in Health Care* in 2006. Central to the Governor's policy is the finding that "The health care system in Virginia has many strengths, including world class health care institutions and remarkably dedicated health care providers. However, improvements can and must be made to promote increased quality, accountability, and transparency in health care. Better and more open information about the quality and price of health services can facilitate achieving these goals while avoiding duplication of effort and unnecessary administrative burdens."

Dr. Armstrong later reviewed existing infection control requirements. State licensure requirements (through VDH) for both hospitals and nursing homes require that an infection control infrastructure be in place in each institution. Also, under Medicare law, the Secretary of HHS establishes minimum health and safety quality standards, known as Conditions of Participation (CoP), which must be met by participants in the Medicare and Medicaid programs. The Centers for Medicare and Medicaid Services (CMS) deems certification of hospitals to the Joint Commission; the majority of Medicare participating hospitals are certified in this manner. JCAHO requires patient safety program & sentinel event reporting. Other hospitals are certified on behalf of Medicare by states (by VDH in Virginia).

Virginia's HAI reporting law was passed in 2005 (§ 32.1-35.1), became effective July 1, 2008 and states: "Acute care hospitals shall report information about nosocomial infections to the Centers for Disease Control and Prevention's National Healthcare Safety Network. Such hospitals shall release their infection data to the Board of Health. The specific infections to be reported, the hospitals required to report, and patient populations to be included shall be prescribed by Board regulation. Such hospital infection rate data may be released to the public by the Board, upon request." Related regulations, issued by VDH and recently finalized, require acute care hospitals with adult intensive care units to report central-line associated bloodstream infections (CLABSI) to the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Hospitals will have until January 31, 2009 to report July-December data; thereafter, hospitals will be required to report infection rate data on a quarterly basis. All participating hospitals must confer data access rights to VDH.

Dr. Armstrong articulated the charge to the Working Group: considering the potential advantages of greater transparency, technical feasibilities, and resource requirements, what, if anything, should the Commonwealth do additionally in the future with respect to public reporting of healthcare-associated infections, and what should be the timeframe for any such actions? These will be non-binding recommendations to the State Health Commissioner.

After some general discussion about the foregoing, Dr. Armstrong outlined some steps to be considered at future meetings:

- What do infection control activities in Virginia hospitals have in common?
- What is the history of National Nosocomial Infections Surveillance System (NNIS) and participating national 'leading edge' hospitals?

- National Healthcare Safety Network (NHSN) – what is it and how will it evolve over the next 5 years?
- What are the recommendations of expert groups like:
    - Healthcare Infection Control Practices Advisory Committee (HICPAC)?
    - Society for Healthcare Epidemiology of America (SHEA)?
    - Infectious Disease Society of America (IDSA)?
    - Council of State and Territorial Epidemiologists (CSTE)?
    - Centers for Disease Control and Prevention (CDC)?
- What sorts of implementation issues have been faced by other states that are further along on the HAI reporting journey?

The remainder of the meeting was held in conjunction with the VHHA Quality Advisory Committee and focused on ways to help Virginia hospitals reduce their rates of central-line associated blood stream infection (see separate summary).

The next meeting will be held in about 60 days (actual date to be announced), again in conjunction with the VHHA Advisory Committee.

Submitted by Carl Armstrong, MD
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