

Public Reporting of Hospital Acquired Infections

Supported by:

- **28 States Have Implemented Public Reporting Laws**
- **Centers for Disease Control and Prevention (CDC)**
- **Association of Professionals in Infection Control and Epidemiology (APIC)**
- **Society of Healthcare Epidemiology of America (SHEA)**
- **Infectious Diseases Society of America (IDSA)**
- **Council of State and Territorial Epidemiologists (CSTE)**

Enclosures

- **CDC Statement: Public Reporting of Healthcare-Associated Infections.**
- **Statement by SHEA and APIC in Response to Consumer Reports Infections Rates Report and Database.**
- **Experts Support National Public Reporting of Healthcare-Associated Infections (SHEA, APIC, IDSA, CSTE)**
- **Public Reporting Model Law For Kentucky**

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Media Statement

CDC Statement: Public Reporting of Healthcare-Associated Infections

For Immediate Release: February 2, 2010

Contact: CDC Division of Media Relations, Phone: (404) 639-3286

<http://www.cdc.gov/media/pressrel/2010/s100202.htm>

Recently, several state health departments and Consumer Reports magazine released summaries of infection rates in healthcare facilities.

The Centers for Disease Control and Prevention (CDC) believes public reporting of healthcare-associated infections (HAIs) is an important component of national HAI elimination efforts. Research shows that when healthcare facilities are aware of their infection issues and implement concrete strategies to prevent them, rates of certain hospital infections can be decreased by more than 70 percent.

"Eliminating healthcare-associated infections is a top priority for CDC," said Dr. Denise Cardo, director of CDC's Division of Healthcare Quality Promotion. "The tracking and reporting of healthcare-associated infections is an important step toward healthcare transparency. Infection data can give healthcare facilities, patients and public health agencies the knowledge needed to design and implement prevention strategies that protect patients and save lives."

HAIs are not only a problem for individual healthcare facilities – they represent a public health issue that requires many people and organizations to work together in a comprehensive effort to attack these largely preventable infections. CDC is working with partners and states to implement infection prevention tools and increase their use of the agency's National Healthcare Safety Network (NHSN). This network is a surveillance system that allows HAI data to be tracked, analyzed and shared to maximize prevention efforts.

In 2003, CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) published guidance to states for implementation of HAI public reporting. Currently, 28 states have implemented public reporting laws, 21 of which utilize NHSN for their reporting requirements. CDC works to assist facilities and states working under a legislative mandate. CDC's collaborations with several states have demonstrated that implementing CDC's HAI prevention guidelines and using NHSN to monitor progress can achieve major decreases in HAIs. Recent investments through the American Reinvestment and Recovery Act are furthering this mission toward HAI elimination.

For HICPAC's guidance on public reporting of HAIs:
<http://www.cdc.gov/hicpac/pubReportGuide/publicReportingHAI.html>

Statement by the Society for Healthcare Epidemiology of America in response to Consumer Reports Hospital Infection Rates Report and Database

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The report released by Consumer Reports on infection rates in healthcare facilities highlights the importance of transparent public reporting to engaging patients in the healthcare process and aiding their healthcare decisions. The Society for Healthcare Epidemiology of America (SHEA) supports public reporting as part of a comprehensive strategy to eliminate healthcare-associated infections (HAIs). Such data should stimulate immediate and sustained action by healthcare facilities to improve adherence to evidence-based prevention practices – the basis for checklists, innovative prevention programs, and other strategies – that can yield measurable improvements and indeed, elimination of HAIs.

As leaders in the field of infection prevention and control, SHEA members are deeply committed to the need for establishing a national standard of reporting for HAIs. In 2006, SHEA, the Infectious Diseases Society of America (IDSA), and the Association for Professionals in Infection Control and Epidemiology (APIC) jointly published model legislation and a toolkit outlining recommendations for design of public reporting programs at the state level (<http://www.shea-online.org/policy>). These recommendations focused on creating standardized definitions of healthcare associated infections, ensuring validated data and supporting the use of the Centers for Disease Control and Prevention's (CDC) National Health Safety Network as a backbone for surveillance and public reporting.

We are pleased that nearly half of the states have adopted laws similar to this model. However, SHEA believes it is time for a national standard that can ensure validated data and comparisons that accurately portray infection rates across geographic and health status-based risk categories. Such attention must be paid to ensure that patients and healthcare facilities have comparable information and that the focus remains on continuous improvement at each facility. A national standard will give all of us involved in the delivery of patient care – including the patient themselves – data for action that drives our progress toward elimination of HAIs.

Ultimately, a crucial byproduct of public reporting is patient and family engagement. SHEA is dedicated to translating evidence into useful information and tools that help patients and their families make decisions before, during, and after care in a healthcare facility. Since 2008, SHEA has made available **free** information resources for patients and families derived from evidence-based guidelines for preventing HAIs. These patient guides provide information on six types of HAIs and identify important practices that they should expect from their providers, important questions that patients and families should ask during their care, and steps that patients and their families can take to prevent infections during care in the healthcare facility and at home. These guides are endorsed by the major organizations dedicated to patient safety, and to the elimination of HAIs including SHEA, IDSA, APIC, the CDC, the American Hospital Association, and the Joint Commission. They are widely used by nurses, patient educators and others in healthcare facilities across the nation to empower patients and families. These resources can be found at: <http://www.preventinghais.com> OR <http://www.shea-online.org/about/patientguides.cfm>

The focus on public transparency can lead to a culture of accountability, continuous healthcare quality improvement, and patient engagement. Combined with the dedicated efforts of thousands of healthcare workers to implement evidence-based practice, and with the power of science to guide all of those efforts true progress toward elimination of HAIs can be realized.

APIC Statement in Response to *Consumer Reports* “Deadly infections: Hospitals can lower the risk, but many fail to act”

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Washington, DC, February 3, 2010 -- The following statement is attributable to Kathy Warye, CEO of the Association for Professionals in Infection Control and Epidemiology (APIC):

“The March 2010 issue of *Consumer Reports* (available online February 1), “Deadly infections: Hospitals can lower the risk, but many fail to act,” addresses one of the most pressing healthcare issues facing our nation today: healthcare-associated infections (HAIs). As a patient safety advocate, the Association for Professionals in Infection Control and Epidemiology (APIC) appreciates the fact that *Consumer Reports* has chosen to focus on the checklist that many hospitals are using to prevent deadly bloodstream infections and has included summaries of central-line associated bloodstream infection (CLABSI) rates in healthcare facilities.

Since 1972, APIC has provided thought leadership on infection prevention to drive attention to the critical need to protect patients from HAIs. APIC has established itself as an authority in the application of evidence-based infection control measures and hospital epidemiology.

“In 2004, APIC announced its support of public reporting of healthcare-associated infections as a path to improved quality and patient safety. Further, APIC supported http://www.apic.org/Content/NavigationMenu/GovernmentAdvocacy/PublicPolicyLibrary/Health_Care_Reform_HAIs_Joint_Letter_July_16_Final.pdf the HAI reporting language in the House of Representatives Healthcare Reform legislation, which would require nationwide HAI reporting through the Center for Disease Control and Prevention’s National Healthcare Surveillance Network. We believe this network is the best method for ensuring the establishment of a scientifically meaningful reporting and monitoring system for HAIs.

“While not all HAIs are preventable, APIC believes that every healthcare institution should be working toward a goal of zero healthcare-associated infections <http://www.apic.org/AM/CM/ContentDisplay.cfm?ContentFileID=11707> . Many of our member facilities have seen that central-line associated bloodstream infections can be reduced to zero, and that in many instances zero can be maintained. We’ve also seen that reducing infections can significantly improve a healthcare institution’s financial bottom line. All institutions should be adopting evidence-based interventions to reduce CLABSIs and ensuring that these measures are consistently applied.

“But prevention can only occur when top leaders target zero as their goal, invest in their infection prevention programs to assure the resources needed for optimal programs -- including resources necessary to track, monitor and publicly report these infections, and make infection prevention and control everyone’s job across the institution. Healthcare leaders must understand the cost of infections erodes the bottom line, and they need to allocate the resources to infection prevention making it an institution-wide priority.

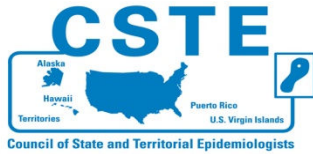
“At a time when HAIs threaten the public health, infection prevention departments at healthcare facilities need to be growing, not shrinking. Unfortunately, a 2009 APIC survey http://www.apic.org/AM/Template.cfm?Section=Economic_Survey_2009&Template=/CM/ContentDisplay.cfm&ContentID=13565 showed that 41 percent of hospitals in the U.S. are cutting staff, resources and education for infection prevention in response to the economic downturn.

“APIC’s *Targeting Zero* http://www.apic.org/AM/Template.cfm?Section=Targeting_Zero2&Template=/CM/ContentDispla

[y.cfm&ContentID=13484](#) initiative provides education to help prevent the most common and deadly HAIs. APIC's evidence-based elimination guides translate CDC recommendations into straightforward infection prevention strategies for healthcare workers.

“Protecting patients from harm is the motivation to eliminate preventable infections and is the right thing to do for our patients and for our healthcare institutions.”

APIC's mission is to improve health and patient safety by reducing risks of infection and other adverse outcomes. The association's more than 13,000 members direct infection prevention programs that save lives and improve the bottom line for hospitals and other healthcare facilities around the globe. APIC advances its mission through education, research, collaboration, practice guidance, public policy and credentialing. Visit APIC online at www.apic.org. For consumer-related information, visit <http://www.preventinfection.org>.



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EXPERTS SUPPORT NATIONAL PUBLIC REPORTING OF HEALTHCARE-ASSOCIATED INFECTIONS

Stronger Efforts Needed on Drug-Resistant Organisms

Washington, July 20, 2009 – Five organizations representing the nation’s experts in infectious diseases medicine, infection prevention in healthcare settings, and public health and disease prevention announced their support for a provision requiring national reporting of healthcare-associated infection (HAI) rates, which is contained within the healthcare reform bill introduced by leaders of the U.S. House of Representatives.

The Association for Professionals in Infection Control and Epidemiology (APIC), the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), the Council of State and Territorial Epidemiologists (CSTE) and the Trust for America’s Health (TFAH) sent a joint letter to members of Congress who will be voting on the legislation (HR 3200, the America’s Affordable Health Choices Act) in the coming days.

The bill would require hospitals and ambulatory surgical centers to report HAI data through an existing national reporting network managed by the Centers for Disease Control and Prevention (CDC) as a condition of participation in Medicare and Medicaid.

“Overall -- this is a win for patients,” said APIC 2009 President Christine J. Nutty, RN, MSN, CIC. “Public reporting of HAIs may drive further improvement in healthcare processes which will reduce infections, save lives, and preserve healthcare dollars. We are pleased that the House bill would also address the need for highly trained staff to effectively implement the system.”

In the U.S., HAIs claim 99,000 lives annually and incur more than \$20 billion in excess healthcare costs.

“This legislation will assure accountability and transparency as the nation moves to address this growing public health problem,” said Jeffrey Levi, PhD, Executive Director of Trust for America’s Health. “Patients have a right to know how well they are protected from healthcare-associated infections and this level of openness will encourage healthcare facilities to improve their outcomes.”

The groups agreed that the public reporting provision found in HR 3200 is superior to approaches that have been put forth in other legislation. HR 3200 will establish a single national standard for HAI reporting, and it will ensure that public health scientists at CDC determine which infections are reported and how. By mandating reporting via CDC's National Healthcare Safety Network, the bill will build on existing mechanisms and create the robust system we need to monitor, study, and ultimately prevent HAIs.

"Using CDC's network means that everyone will be looking for the same information in the same way," said Mark E. Rupp, MD, president of SHEA. "This approach for HAI reporting will be a more accurate way to compare local and national infection rates and trends. This will give us the science base we need to better prevent HAIs."

One element missing from the bill, the organizations noted, was the lack of a much-needed, strengthened federal approach to deal with antimicrobial resistant organisms.

"Overall, we applaud the approach taken on public reporting," said Anne Gershon, MD, FIDSA, president of IDSA. "However, we hope congressional leaders also will adopt new strategies to address drug-resistant pathogens, which are the cause of so many debilitating infections and patient deaths in healthcare facilities each year."

To address antimicrobial resistant organisms, the groups have urged Congress to amend HR 3200 to include the Strategies to Address Antimicrobial Resistance (STAAR) Act, H.R. 2400, introduced earlier this year by Rep. Jim Matheson (R-UT), which will build up federal efforts on surveillance, research, and prevention and control of drug-resistant infections.

APIC's mission is to improve health and patient safety by reducing risks of infection and other adverse outcomes. The association's more than 12,000 members direct infection prevention programs in healthcare facilities around the globe. See www.apic.org.

The Infectious Diseases Society of America (IDSA) represents more than 8,600 infectious diseases physicians and scientists devoted to patient care, education, research, and public health. See www.idsociety.org.

The Society for Healthcare Epidemiology of America (SHEA) represents 1,500 physicians, infection control practitioners, and other healthcare professionals dedicated to maintaining the utmost quality of patient care and healthcare worker safety in all healthcare settings. See www.shea-online.org.

Council of State and Territorial Epidemiologists (CSTE), a professional association of over 1,150 members, represents the interests of public health epidemiologists for the 50 States, 6 Territories, Puerto Rico and the Virgin Islands. See www.cste.org.

Trust for America's Health (TFAH) is a non-profit, non-partisan organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. See healthyamericans.org.

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AN ACT relating to health facility-acquired infections.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

SECTION 1. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

For the purposes of Sections 1 to 4 of this Act:

- (1) "Health facility" means an acute or critical care hospital, rehabilitation or surgical center, nursing facility, or ambulatory care center;
- (2) "Health facility-acquired infection" or "HAI" means a localized or systemic condition that:
 - (a) Results from an adverse reaction to the presence of an infectious agent(s) or its toxin(s).
 - (b) There must be no evidence that the infection was present or incubating at the time of admission to the acute care setting, unless the infection was related to a previous admission to the same facility.
- (3) "Multi-drug resistant organism" or "MDRO," means any bacterium resistant to three (3) or more classes of antibiotics AND including methicillin-resistant staphylococcus aureus (MRSA), vancomycin-resistant enterococci (VRE), Clostridium Difficile, Enterobacteriaceae, Acinetobacter, ceftazidime-resistant Klebsiella, and gram negative bacilli (GNB) or other organisms identified by the federal Centers for Disease Control and Prevention or Kentucky Cabinet of Health and Family Services as a multidrug resistant organism.
- (4) "Secretary" means the Kentucky Secretary of Health and Family Services or the Secretary who oversees the Kentucky Department for Public Health.

SECTION 2. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

The General Assembly finds and declares that:

- (1) Over 1.7 million patients in the nation become infected after entering health facilities each year and about one hundred thousand (100,000) die as a result of those infections;
- (2) Methicillin-resistant staphylococcus aureus (MRSA) is a common staphylococcal infection that is resistant to powerful antimicrobial agents and is increasingly prevalent in health care settings;
- (3) Because it can survive on cloth and plastic for up to ninety (90) days, MRSA is frequently transmitted by contaminated hands, clothes, and noninvasive instruments and the number of patients who can become infected from one (1) carrier multiplies dramatically;
- (4) The federal Centers for Disease Control and Prevention estimates that one (1) in twenty (20) patients entering a health facility carries MRSA and reports that MRSA accounts for sixty percent (60%) of infections in American hospitals in 2004, an increase from two percent (2%) in 1974, and currently increasing, in 2007 the Association for Professionals in Infection Control and Epidemiology reported that the prevalence of MRSA was increasing eight times more than expected;
- (5) The Association for Professionals in Infection Control and Epidemiology report that the incidence of Clostridium Difficile is increasing more than 10 times as

- expected, and the American Journal of Infection Control reports that Kentucky has the sixth highest rate of infection in the United States;
- (6) The nationwide cost to treat hospitalized patients infected with HAI is estimated to be between 28 to 45 billion dollars, the CDC estimates the increase in cost for Ventilator Associated Pneumonia, Surgical Site Infections and Catheter Associated Bloodstream Infections ranging from \$28,404 to \$34,670 per patient;
 - (7) Multidrug resistant infections are preventable, and recent data support a multifaceted approach to successfully combat infections, including routine screening, isolation of colonized and infected patients, strict compliance with hygiene guidelines, and a change in the institutional culture to ensure that infection prevention and control is everyone's job and is a natural component of care at each patient encounter each day;
 - (8) Virtually all published analyses that compare the cost of screening patients upon admission and the adoption of effective infection control practices with the cost of caring for infected patients conclude that caring for infected patients is much more expensive;
 - (9) Routine screening and isolation of all patients with MRSA in hospitals in Denmark and Holland have reduced their MRSA infection rate to ten percent (10%) of their bacterial infections and, following a pilot program by the United States Department of Veterans Affairs' Pittsburgh Healthcare System that reduced MRSA infections in its surgical care unit by seventy percent (70%), all Department of Veterans Affairs health facilities have been directed to develop and implement similar procedures, Northwest University reported that the aggregate hospital-associated MRSA disease prevalence density decreased by 69.6% after universal surveillance was instituted;
 - (10) The federal Centers for Disease Control and Prevention reports that the number of cases of health facility-acquired infections exceeds the number of cases of any other reportable disease, and more deaths are associated with health facility-acquired infection than several of the top ten (10) leading causes of death reported in the United States;
 - (11) The APIC (Association for Professionals in Infection Control and Epidemiology), SHEA (Society for Healthcare Epidemiology of America), IDSA (Infectious Diseases Society of America), CSTE (Council of State and Territorial Epidemiologists) and TFHA (Trust for America's Health) agree with the public reporting option in proposed congressional legislation;
 - (12) In support of public reporting, the Centers for Disease Control and Prevention have stated that tracking and reporting of healthcare associated infection data can provide healthcare facilities, patients and public health agencies the knowledge needed to design and implement prevention strategies that protect patients and save lives.
 - (13) It is a matter of public health and fiscal policy that patients in Kentucky's health facilities receive health care that incorporates best practices in infection control, not only to protect their health and their lives, but also to ensure the economic viability of Kentucky's health facilities.

SECTION 3. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

- (1) Within ninety (90) days of the effective date of this Act, all health facilities shall implement an infection prevention program at least includes intensive care units, surgical units, or other units or areas where there is a significant risk of health facility-acquired infection. By January 1, 2011, each health facility's infection prevention program shall be implemented throughout the facility.
- (2) As a condition of licensure, a health facility shall implement best practices and effective strategies for an infection prevention program in accordance with subsection (1) of this section and implement best practices for preventing MDROs and other pathogens as the Secretary determines appropriate that include but are not limited to:
 - (a) Contact precautions as specified by the federal Centers for Disease Control and Prevention for patients found to be positive for MDROs;
 - (b) Strict adherence to hygiene guidelines that include but are not limited to health facility staff hand washing prior to and after patient contact;
 - (c) The development of a written infection prevention and control policy with input from front-line caregivers, and the posting of public notices regarding the infection prevention and control policy; and
 - (d) A worker and staff education requirement regarding modes of transmission of MDROs, use of protective equipment, disinfection policies and procedures, and other preventive measures.
- (3) Surveillance Cultures:
 - (a) Not later than 180 days after the date of enactment of this Act, each acute care hospital shall screen for MRSA infections, and such other MDRO pathogens as the Secretary deems necessary, for each patient entering an intensive care unit or other high risk hospital department (as defined by the Secretary).
 - (b) The Secretary, consulting guidelines established by the Centers for Disease Control and Prevention, shall establish a process and a timetable for extending the screening requirements of Section 3 (3)(a) of this Act to all patients admitted to a health facility or discharged from an acute or critical care hospital, or nursing facility not later than January 1, 2014.
 - (c) The Secretary may waive the requirements of Section 3 (3), if the Secretary determines, consulting guidelines established by the Centers for Disease Control and Prevention and after public hearing, that the rate of MRSA infections or other infections has declined to a level at which further screening is no longer needed.
 - (4) The Cabinet for Health and Family Services shall make data available on its Web site at least annually in understandable language with sufficient explanations to allow consumers to draw meaningful comparisons between health facilities as relevant data becomes available. Data shall include but not be limited to:

- (a) The facility's rate of health facility-acquired infections;
 - (b) The rate of health facility-acquired MDRO infections; and
 - (c) The total number of MDRO infections found on surveillance cultures on admission.
- (d) The rate of positive conversions of discharge cultures at acute and critical care hospitals, and nursing facilities.
- (5) Health facilities shall use the Centers for Disease Control and Prevention's NHSN (National Healthcare Safety Network) reporting system or other data collection method as determined by the Secretary for implementation of this Act.
- (6) The Secretary shall by July 1, 2011 implement a method for patients to report HAI to verify the data reported by health facilities.
- (7) The Secretary of the Cabinet for Health and Family Services shall serve as chief administrative officer for the health data collection functions of this Act. Neither the Secretary nor any employee of the cabinet shall be subject to any personal liability for any loss sustained or damage suffered on account of any action or inaction related to this Act.
- (8) The Secretary of the Cabinet for Health and Family Services shall report by each January 30 to the Legislative Research Commission and the Governor on the rate and trend of health facility-acquired infections, the effectiveness of the requirements of Sections 1 to 4 of this Act on reducing the rate of health facility-acquired infections and recommendations for improvement.

SECTION 4. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

A health facility that violates any provision of Section 3 of this Act shall for the first violation within a six-month period, be cited and shall submit a corrective action plan within ten (10) business days of the citation. For a second violation within a six-month period, a health facility shall be fined up to one thousand dollars (\$1,000) per day until the violation is corrected. For three or more violations within a six-month period, a health facility shall be fined up to \$20,000 for each violation and shall be fined up to two thousand dollars (\$2,000) per day until all violations are corrected.