

SB


208

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Senator Gary Stevens
Alaska State Legislature

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Memo

To: Senator Fred Dyson, Senate HESS Committee
From: Senator Gary Stevens 
Date: 1/23/2006
Re: Committee hearing request

I would like to request a HESS Committee hearing on Senate Bill 208, "An Act requiring hospitals to collect data and disclose reports of hospital-acquired infections" at your earliest convenience.

Thank you for your consideration of this request.

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Sponsor Statement for SB 208

SB 208 "An Act requiring hospitals to collect data and disclose reports of hospital-acquired infections" is a consumer protection measure for health care patients.

Shockingly, some 2 million infections a year are acquired in hospitals and an estimated 90,000 people die as a result of these infections, making it the sixth-leading cause of death in the country. The cost to the consumers is also enormous between \$4.5 and \$11 billion a year. Given these alarming statistics, it is vital for consumers to have full knowledge of how medical facilities fare with infection rates. SB 208 helps accomplish this goal by requiring hospitals to collect data about hospital-acquired infection rates for surgical site infections, ventilator-associated pneumonia, central line-related bloodstream infections, urinary tract infections and other categories of infections as adopted by the Department of Health and Social Services by regulation. This information would be prepared for quarterly disclosure reports for the public in a way that does not disclose confidential patient information nor identify persons involved in an incident of infection.

This bill is not meant to threaten or cast doubt on Alaska's health care facilities. It will, however, help consumers make informed choices and compel facilities to try harder to prevent healthcare associated infections.

I ask for your support of SB 208.

LEGAL SERVICES

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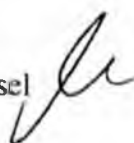
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

January 10, 2006

SUBJECT: Hospital Acquired Infection Reporting (SB 208)
(Work Order No. 24-LS1213\A)

TO: Senator Gary Stevens
Attn: Doug Letch

FROM: Jean M. Mischel
Legislative Counsel 

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Requires hospitals to collect data and prepare and disclose reports on hospital acquired infection rates.

Section 2. Authorizes the Department of Health and Social Services to adopt regulations consistent with section 1 of the bill.

Section 3. Provides an effective date for section 1 of July 1, 2007.

JMM:ljw
06-008.ljw



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Web posted Monday, January 16, 2006

Bill would require hospitals to release infection statistics to public

By **HAL SPENCE**
Peninsula Clarion

Alaska hospitals would be required to release information about cases of infection acquired by patients during hospital stays under a bill proposed by Senate Majority Leader Gary Stevens.

"A good friend of mine was in the hospital last year for a simple operation and wound up with an infection that put him close to death," the Republican from Kodiak said in an interview Tuesday. "I started looking into the facts."

Stevens said he learned that some 2 million infections a year are acquired in hospitals and that an estimated 90,000 people die annually as a result.

"It's the sixth-leading cause of death in the country," he said. "That's shocking to realize, but it is something that is correctable."

Nationally, it is estimated that hospital-acquired infections, called nosocomial infections, cost consumers \$4.5 billion to \$11 billion a year. At least a third are considered preventable, according to the Center for Disease Control and Prevention.

Reducing the rates of in-hospital infections would take greater vigilance by hospitals and by their often-overworked doctors and staff, Stevens said.



Majority Leader Gary Stevens



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Today's front page



"It may often be as simple as washing hands between patients" or "making sure patients are getting the right antibiotics before incisions," he said.

David Gilbreath, CEO Central Peninsula General Hospital

Senate Bill 208 would require hospitals to collect data about hospital-acquired infection rates for surgical site infections, ventilator-associated pneumonia, central line-related bloodstream infections, urinary tract infections and other categories of infections as adopted by the Department of Health and Social Services by regulation. (See sidebar, this page) If passed, SB 208's provisions would go into effect July 1, 2007.

His motivation, Stevens said, was a belief that the medical services-buying public has a right to know a facility's in-hospital infection rate.

"Consumers should have full knowledge about what places to try to avoid," he said.

He also said introduction of the bill was not meant to cast aspersions or threaten Alaska hospitals.

"It is nothing about hospitals in the areas I represent," he said, adding that he'd spoken with representatives of one facility who agreed public disclosure of infection rates was a good idea.

The bill would require hospitals to collect infection data and prepare quarterly disclosure reports for the public. Those reports would be written in a way that would not disclose confidential patient information nor identify persons involved in an incident of infection. Quarterly reports would have to be posted at the hospital and available on request.

David Gilbreath, director of Central Peninsula General Hospital, said he has always been supportive of releasing such information to the public.

"The data is available and not at all a headache to report," he said.

CPGH has joined the 100,000 Lives Campaign sponsored by the Institute for Healthcare Improvement that is promoting specific measures to cut hospital deaths nationwide, including those caused by nosocomial infections. Some 3,000 hospitals have joined the effort. Dr. Todd Boling, a general surgeon and chief of the medical staff, who assumed his position in July 2005, is heading the campaign at CPGH, Gilbreath said.

"We don't know what the impact is going to be, but we have

team members, including physicians, looking at the campaign components (the types of infections). We have made adjustments and our infection rate is extremely low," Gilbreath said.

Ken Simmons, CPGH's infection control officer, said that in 2002, the hospital recorded roughly 3.6 hospital-acquired infections per 1,000 patient days. That figure has fallen each year since, and while all the data is not yet in for 2005, it appears the hospital will achieve a rate of better than the 2.9 per 1,000 patient days registered in 2004, Simmons said.

He noted that it would be important if the law passes that every hospital report the data the same way so consumers could accurately compare facilities.

South Peninsula Hospital Administrator Charlie Franz said he, too, would have no problem making such information available, saying he is trying to make the hospital's activities "as transparent as possible."

SPH has not, so far, joined the IHI campaign, Franz said, but the staff has begun to implement portions of the program and phasing into the campaign is under consideration.

		
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December 8, 2005

The Honorable Norman Rokeberg
Alaska State House of Representatives
716 West 4th Avenue
Anchorage, AK 99501

Re: Mandatory reporting of healthcare associated infections (HAIs)

Dear Representative Rokeberg:

In February of this year, there was a conference titled "Healthcare-Associated Infections: Realizing the Benefits of Mandatory Public Reporting" that was sponsored by the Association for Professionals in Infection Control and Epidemiology (APIC), in partnership with the Centers for Disease Control and Prevention (CDC), Consumers Union (CU), National Quality Forum (NQF), and the Society for Healthcare Epidemiology of America (SHEA).

The premise of the conference was that consumers have a right to know certain statistics about healthcare facilities and that public reporting of infection rates, along with other quality indicators, will allow the public to make informed choices and will also compel facilities to strive harder to prevent healthcare-associated infections (HAI). Mandatory public reporting has been adopted as a campaign by the Consumer's Union (<http://www.consumersunion.org>). Citizens are encouraged to contact their legislators to express concern and demand action. With the common goal of ensuring patient safety, healthcare organizations, such as APIC and SHEA, have become involved with guiding the process of mandatory reporting so as to achieve the intended outcomes, but guarantee that the systems generated are practical and meaningful. It is important to point out that all organizations, including the Consumers Union want to see hospital specific data, not physician specific data being reported. If a physician has a high infection rate that would be reflected in the hospital's rates and is the responsibility of that hospital to address.

Since the conference, the NQF has agreed to move forward in developing a comprehensive set of national consensus standards for the collection and public reporting of HAIs. Both SHEA and Infectious Disease Society of America (IDSA) Board of Directors have endorsed the recommendations of the CDC Healthcare Infection Control Practices Advisory Committee (HICPAC) entitled "Guidance on Public Reporting of Healthcare-Associated Infections." The guidelines offer four main overarching recommendations regarding mandatory reporting of HAIs:

- 1) Use established public health surveillance methods when designing and implementing mandatory HAI reporting systems.
- 2) Create a multidisciplinary advisory panel to monitor the planning and oversight of the operations and products of HAI public reporting systems.
- 3) Choose appropriate process and outcome measures based on facility type and phase in measures gradually to allow time for facilities to adapt and to permit ongoing evaluation of data validity.
- 4) Provide regular and confidential feedback of performance data to health care providers.

Seven states have enacted legislation to require health care organizations to publicly report HAIs, with one state (Nevada) reporting only to state government. Four others are considering such legislation in 2005. Six states have study bills, while 21 states have failed legislation in 2005. The importance of HAIs and the need to prevent them cannot be questioned, however, the potential pitfalls of public reporting are numerous. For example, the selection of appropriate, risk adjusted outcomes, inclusion of process measures, development of standardized methods of data collection, and sensitivity towards the resources available to infection control departments to collect such data are critically important. If these potential pitfalls are not addressed in legislation, then the public reporting systems will mislead the public with inaccurate data.

Four states where reporting has been mandated presented their programs, but did not dwell on the legal authority for reporting or details of the particular reporting body. These states are Pennsylvania, Missouri, Illinois, and Florida. California passed a bill in 2004 but the California Hospital Association was very aggressive in opposing the bill as it was written and the Governor vetoed the bill. Several other states have legislation pending this session, with most states having deadlines to file their first reports by 2006. With the exception of Missouri, the requirement for reporting has been an unfunded mandate. For states without established legislation, the Consumers Union has drafted language that could be adopted (see <http://www.consumersunion.org/pub/campaignstophospitalinfections/000879>).

Among those who have passed legislation, there is wide variation in what is being reported and where reports are received. For example, Pennsylvania has a stand alone state agency that receives reports about HAIs in addition to other information, e.g., costs, etc. (see <http://www.phc4.org/Default.htm>). Pennsylvania was the first state to enact mandatory reporting that started in 2004 and is the example of "how not to do it."

Missouri appears to be the only state that received funding attached to the bill to manage the reports coming into their Department of Health, Section of Information Management. Florida's bill mandated reporting to their hospital licensing agency. Reports in Illinois must be made to the Department of Public Health, although the exact location was not specified. The IL Hospital Association is also very active in compiling and risk-adjusting data.

For Alaska, there seems to be several issues to address that might require a legal opinion. For example, which state agency has the statutory authority to compel hospitals to report rates or other indicators? If they go to Public Health, how would the current Epidemiology regulations need to be amended? Is staff from the Office of Health Facilities Licensing and Certification (HFLC) aware of the potential for a mandatory reporting bill? Is the Alaska State Hospital and Nursing Home Association (ASHNHA) aware of the potential for a mandatory reporting bill? Will there be consequences associated with reporting, e.g., the draft Consumers Union bill has associated penalties with noncompliance? Before drafting legislation, these questions should be addressed.

What do Alaskans want? Is it different from what is wanted in other states? The Consumers Union claims that consumers nationwide desire statewide reporting from hospitals. Before creating legislation to address this issue, it would be beneficial to understand what Alaskans want to know. If Alaskan consumers want to compare hospitals within the state to each other, then statewide hospital report cards will meet their need. However, if they are more interested in knowing how in-state facilities compare to out-of-state ones, then creating state-specific legislation might not meet their need. For that case, advocating for a system of nationally mandated reporting would better allow for state to state comparisons.

The issue of *nationally* mandating reporting was not addressed at the conference and it is unlikely a nationally mandated reporting system available to the public would be implemented in a timely fashion. The National Healthcare Safety Network (NHSN) is implementing a voluntary national reporting system that is scheduled to be up and running by this summer. Hospitals can choose to allow other agencies e.g., State Health Departments, viewing privileges of the data but a public viewing component on the level of individual hospitals is not planned for NHSN.

Who are the stakeholders in Alaska? Because the mandating of reporting has the potential to overwhelm healthcare and reporting agency resources, attention must be paid to issues such as the timeline and content of reports.

Based on the experiences of the states who have passed legislation, the formation of an Advisory Group to provide guidance and oversight to the process seems critical. Among the states with passed or pending legislation, the composition of these groups varies, but usually includes hospital epidemiologists, consumers, infection control professionals, state hospital association representatives, among others. The Group can steer the legislation to reflect consensus on reporting schedules, data formatting, consistency with national standards, etc. As for many legal processes, the wording of the actual bill may be broad, with the Advisory Group responsible for developing specific parameters to address the purpose of the bill.

As mentioned above, it is unclear if the Alaska HFLC or ASHNHA are aware of this issue. Especially relevant to Alaska is the position of small hospitals and stand alone surgery centers. Some reporting systems have exempted smaller hospitals with low patient censuses or who do a low number of specific surgical cases; would this address the Alaskan consumers' concerns? If smaller hospitals are exempted and since ANMC serves a very specific population there is the potential for it to become an issue of Alaska Regional's HAI rates compared to Providence Alaska's HAI rates. If that is the case, and what consumers want, should both facilities agree on what should be reported and report voluntarily without enacting legislation at this time?

Because there is great diversity in Alaska hospitals and healthcare facilities, it will be important to ensure that all stakeholders are engaged. For more information on infection surveillance, prevention, and control programs, please visit the APIC website at www.apic.org.

We hope this information is helpful as decisions are being made about mandatory reporting here in Alaska. If we can assist in any way, please do not hesitate to ask.

Sincerely,

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**GUIDANCE ON PUBLIC REPORTING OF HEALTHCARE-ASSOCIATED
INFECTIONS**

**Recommendations of the Healthcare Infection Control Practices Advisory
Committee**

Executive Summary

Healthcare-associated infections (HAIs) are a major public health problem in the United States. In hospitals alone, HAIs account for an estimated 2 million infections, 90,000 deaths, and \$4.5 billion dollars in excess healthcare costs annually. Since 1970, a group of U.S. hospitals (now numbering nearly 300) has voluntarily reported to the Centers for Disease Control and Prevention (CDC), on a confidential basis, data on selected HAIs that occur in their hospitals.

Since 2002, four states have enacted legislation that requires healthcare organizations to publicly disclose HAI rates. Similar legislative efforts are underway in several other states. Advocates of mandatory public reporting of HAIs believe that making such information publicly available will enable consumers to make more informed choices about their healthcare and improve overall healthcare quality by reducing HAIs. Further, they believe that patients have a right to know this information. However, others have expressed concern that the reliability of public reporting systems may be compromised by institutional variability in the definitions used for HAIs, or in the methods and resources used to identify HAIs.

Presently, there is insufficient evidence on the merits and limitations of an HAI public reporting system. Therefore, the Healthcare Infection Control Practices Advisory Committee (HICPAC) has not recommended for or against mandatory public reporting of HAI rates. However, HICPAC has developed this guidance document based on established principles for public health and HAI reporting systems. This document is intended to assist policymakers, program planners, consumer advocacy organizations

and others tasked with designing and implementing public reporting systems for HAIs.

The document provides a framework for legislators, but does not provide model legislation.

HICPAC recommends that persons who design and implement such systems 1) use established public health surveillance methods when designing and implementing mandatory HAI reporting systems; 2) create multidisciplinary advisory panels, including persons with expertise in the prevention and control of HAIs, to monitor the planning and oversight of HAI public reporting systems; 3) choose appropriate process and outcome measures based on facility type and phase in measures to allow time for facilities to adapt and to permit ongoing evaluation of data validity; and 4) provide regular and confidential feedback of performance data to healthcare providers.

Specifically, HICPAC recommends that states establishing public reporting systems for HAIs select one or more of the following process or outcome measures as appropriate for hospitals or long-term care facilities in their jurisdictions: 1) central-line insertion practices, 2) surgical antimicrobial prophylaxis; 3) influenza vaccination coverage among patients and healthcare personnel; 4) central line-associated bloodstream infections; and 5) surgical site infections following selected operations. HICPAC will update these recommendations as more research and experience become available.

Introduction

Consumer demand for healthcare information, including data about the performance of healthcare providers, has increased steadily over the past decade. Many state and national initiatives are underway to mandate or induce healthcare organizations to publicly disclose information regarding institutional and physician performance. Mandatory public reporting of healthcare performance is intended to enable stakeholders, including consumers, to make more informed choices on healthcare issues.

Public reporting of healthcare performance information has taken several forms. Healthcare performance reports (report cards and honor rolls) typically describe the outcomes of medical care in terms of mortality, selected complications, or medical errors and, to a lesser extent, economic outcomes. Increasingly, process measures (i.e., measurement of adherence to recommended healthcare practices, such as handwashing) are being used as an indicator of how well an organization adheres to established standards of practice with the implicit assumption that good processes lead to good healthcare outcomes. National healthcare quality improvement initiatives, notably those of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the Centers for Medicare & Medicaid Services (CMS), and the Hospital Quality Alliance, use process measures in their public reporting initiatives.

Healthcare-associated infections (HAIs) are infections that patients acquire during the course of receiving treatment for other conditions (see Glossary for full definition of this and other terms used in this document). In hospitals alone, HAIs account for an estimated 2 million infections, 90,000 deaths, and \$4.5 billion dollars in excess healthcare costs annually (1); however, few of the existing report cards on hospital performance use

HAIs as a quality indicator. Since 2002, four states (Illinois, Pennsylvania, Missouri, and Florida) have enacted legislation mandating hospitals and healthcare organizations to publicly disclose HAI rates. Similar legislative efforts are underway in several other states.

Because of the increasing legislative and regulatory interest in this area, the Healthcare Infection Control Practices Advisory Committee (HICPAC) conducted a scientific literature review to evaluate the merits and limitations of HAI reporting systems. We found no published information on the effectiveness of public reporting systems in reducing HAIs. Therefore, HICPAC has concluded that there is insufficient evidence at this time to recommend for or against public reporting of HAIs.

However, to assist those who will be tasked with designing and implementing such reporting systems, HICPAC presents the following framework for an HAI reporting system and recommendations for process and outcome measures to be included in the system. The framework and recommendations are based on established principles for public health and HAI surveillance. This document is intended primarily for policymakers, program planners, consumer advocacy organizations, and others who will be developing and maintaining public reporting systems for HAI. The document does not provide model legislation.

This document represents the consensus opinion of HICPAC. HICPAC is a federal advisory committee that was established in 1991 to provide advice and guidance to the Department of Health and Human Services and CDC regarding surveillance, prevention, and control of HAIs and related events in healthcare settings. These recommendations also have been endorsed by the Association for Professionals in

Infection Control and Epidemiology, the Council of State and Territorial Epidemiologists, and the Society for Healthcare Epidemiology of America. These recommendations will be updated as new information becomes available.

Essential Elements of a Public Reporting System for HAIs

As a first step, the goals, objectives, and priorities of a public reporting system should be clearly specified and the information to be monitored should be measurable to ensure that the system can be held accountable by stakeholders. The reporting system should collect and report healthcare data that are useful not only to the public, but also to the facility for its quality improvement efforts. This can be achieved by selection of appropriate measures and patient populations to monitor; use of standardized case-finding methods and data validity checks; adequate support for infrastructure, resources, and infection control professionals; adjustment for underlying infection risk; and production of useful and accessible reports for stakeholders, with feedback to healthcare providers. The planning and oversight of the system should be monitored by a multidisciplinary group composed of public health officials, consumers, healthcare providers, and healthcare infection control professionals.

Identifying Appropriate Measures of Healthcare Performance

Monitoring both process and outcome measures and assessing their correlation is a comprehensive approach to quality improvement. Standardized process and outcome measures for national healthcare performance for hospitals, nursing homes, and other settings have been endorsed through the National Quality Forum (NQF) voluntary consensus process (2-4). NQF also has developed a model policy on the endorsement of

proprietary performance measures (5). Several other agencies and organizations, including CDC, CMS, the Agency for Healthcare Quality and Research, JCAHO, the Leapfrog organization, and the National Committee for Quality Assurance, also have developed healthcare quality measures. Healthcare performance reports should identify the sources and endorsers of the measures and the sources of the data used (e.g., administrative or clinical).

Process measures are desirable for inclusion in a public reporting system because the target adherence rate of 100% to these practices is unambiguous. Furthermore, process measures do not require adjustment for the patient's underlying risk of infection. Process measures that are selected for inclusion in a public reporting system should be those that measure common practices, are valid for a variety of healthcare settings (e.g., small, rural vs. large, urban hospitals); and can be clearly specified (e.g., appropriate exclusion and inclusion criteria). Process measures meeting these criteria include adherence rates of central-line insertion practices and surgical antimicrobial prophylaxis and coverage rates of influenza vaccination for healthcare personnel and patients/residents (Table 1). Collection of data on one or more of these process measures already is recommended by the NQF and required by CMS and JCAHO for their purposes.

Outcome measures should be chosen for reporting based on the frequency, severity, and preventability of the outcomes and the likelihood that they can be detected and reported accurately (6). Outcome measures meeting these criteria include central line-associated, laboratory-confirmed primary bloodstream infections (CLA-LCBI) in intensive care units (ICU) and surgical site infections (SSIs) following selected

operations (Table 2). Although CLA-LCBIs and SSIs occur at relatively low rates, they are associated with substantial morbidity and mortality and excess healthcare costs. Also, there are well-established prevention strategies for CLA-LCBIs and SSIs (7,8).

Therefore, highest priority should be given to monitoring these two HAIs and providers' adherence to the related processes of care (i.e., central-line insertion practices for CLA-LCBI and surgical antimicrobial prophylaxis for SSIs).

Use of other HAIs in public reporting systems may be more difficult. For example, catheter-associated urinary tract infections, though they may occur more frequently than CLA-LCBIs or SSIs, are associated with a lower morbidity and mortality; therefore, monitoring these infections likely has less prevention effectiveness relative to the burden of data collection and reporting. On the other hand, HAIs such as ventilator-associated pneumonia, which occur relatively infrequently but have substantial morbidity and mortality, are difficult to detect accurately. Including such HAIs in a reporting system may result in invalid comparisons of infection rates and be misleading to consumers.

Monitoring of process and outcome measures should be phased in gradually to allow time for facilities to adapt and to permit ongoing evaluation of data validity.

Identifying Patient Populations for Monitoring

CDC (9) and other authorities (10) no longer recommend collection or reporting of hospital-wide overall HAI rates because 1) HAI rates are low in many hospital locations (which makes routine inclusion of these units unhelpful), 2) collecting hospital-wide data is labor intensive and may divert resources from prevention activities, and 3) methods for hospital-wide risk adjustment have not been developed. Rather than

hospital-wide rates, reporting rates of specific HAI for specific hospital units or operation-specific rates of SSIs is recommended (9). This practice can help ensure that data collection is concentrated in populations where HAIs are more frequent and that rates are calculated that are more useful for targeting prevention and making comparisons among facilities or within facilities over time.

Case-Finding

Once the population at risk for HAIs has been identified, standardized methods for case-finding should be adopted. Such methods help to reduce surveillance bias (i.e., the finding of higher rates at institutions that do a more complete job of case-finding). Incentives to find cases of HAI may be helpful. Conversely, punitive measures for hospitals that report high rates may encourage underreporting.

Traditional case-finding methods for HAIs include review of medical records, laboratory reports, and antibiotic administration records. However, these standard case-finding methods can be enhanced. For example, substantially more SSIs are found when administrative data sources (e.g., *International Classification of Diseases, 9th Revision* [ICD-9], discharge codes) are used in combination with antimicrobial receipt to flag charts for careful review (11,12). However, the accuracy of case-finding using ICD-9 codes alone likely varies by HAI type and by hospital. Therefore, ICD-9 discharge codes should not be relied upon as the sole source for HAI monitoring systems.

Traditional HAI case-finding methods were developed in an era when patients' lengths of hospitalization were much longer than they are today, allowing most HAIs to be detected during the hospital stay. However, for SSIs in particular, the current climate of short stays and rapid transfers to other facilities makes accurate detection difficult

because as many as 50% of SSIs do not become evident until after hospital discharge or transfer (13). Since there is no consensus on which postdischarge surveillance methods are the most accurate and practical for detection of SSIs (7), the limitations of current case-finding methods should be recognized if SSIs are selected for inclusion in mandatory reporting systems.

Validation of Data

A method to validate data should be considered in any mandatory reporting system to ensure that HAIs are being accurately and completely reported and that rates are comparable from hospital to hospital or among all hospitals in the reporting system. The importance of validation was emphasized by a CDC study of the accuracy of reporting to the NNIS system, which found that although hospitals identified and reported most of the HAIs that occurred, the accuracy varied by infection site (14).

Resources and Infrastructure Needed for a Reporting System

A reporting system can not produce quality data without adequate resources. At the institution level, trained personnel with dedicated time are required, e.g., infection control professionals to conduct HAI surveillance. At the system level, key infrastructure includes instruction manuals, training materials, data collection forms, methods for data entry and submission, databases to receive and aggregate the data, appropriate quality checks, computer programs for data analysis, and standardized reports for dissemination of results. Computer resources within reporting systems must include both hardware and software and a standard user interface. In order to collect detailed data on factors such as use of invasive devices (e.g., central lines), patient care location within the facility, and

type of operation, extensive data dictionaries and coding schema must be developed and maintained.

HAI Rates and Risk Adjustment

For optimal comparison purposes, HAI rates should be adjusted for the potential differences in risk factors. For example, in the NNIS system, device-associated infections are risk adjusted by calculating rates per 1,000 device-days (e.g., CLA-LCBI per 1,000 central line-days) and stratifying by unit type (15,16,17). For that system, risk adjustment of SSIs is done by calculating of operation-specific rates stratified by a standardized risk index (17,18,19). Although these methods do not incorporate all potential confounding variables, they provide an acceptable level of risk adjustment that avoids the data collection burden that would be required to adjust for all variables.

Risk adjustment is labor intensive because data must be collected on the entire population at risk (the denominator) rather than only the fraction with HAIs (the numerator). Risk adjustment can not correct for variability among data collectors in the accuracy of finding and reporting events. Further, current risk-adjustment methods improve but do not guarantee the validity of inter-hospital comparisons, especially comparisons involving facilities with diverse patient populations (e.g., community versus tertiary-care hospitals).

Valid event rates are facilitated by selecting events that occur frequently enough and at-risk populations that are large enough to produce adequate sample sizes. Unfortunately, use of stratification (e.g., calculation of rates separately in multiple categories) for risk adjustment may lead to small numbers of HAIs in any one category

and thereby yield unstable rates, as is the case of a small hospital with low surgical volume.

Producing Useful Reports and Feedback

Publicly released reports must convey scientific meaning in a manner that is useful and interpretable to a diverse audience. Collaboration between subject matter experts, statisticians, and communicators is necessary in developing these reports. The reports should provide useful information to the various users and highlight potential limitations of both the data and the methods used for risk adjustment. In a new reporting system, data should be examined and validated before initial release; in addition, sufficient sample size should be accumulated so that rates are stable at the time of public release. Lastly, feedback of performance data should be given to healthcare providers regularly so that interventions to improve performance can be implemented as quickly as possible. For example, feedback of SSI rates to surgeons has been shown to be an important component of strategies to reduce SSI risk (20).

Adapting Established Methods for Use in Mandatory Reporting Systems

Where appropriate, developers of reporting systems should avail themselves of established and proven methods of collecting and reporting surveillance data. For example, many of the methods, attributes, and protocols of CDC's NNIS system may be applicable for public reporting systems. A detailed description of the NNIS methodologies has been described elsewhere (17), and additional information on NNIS is available at www.cdc.gov/ncidod/hip/surveill/nnis.htm.

Most reporting systems, such as NNIS, use manual data collection methods. In most instances, information in computer databases, when available, can be substituted for

manually collected data (21,22). However, when manual data collection is necessary, alternate approaches include limiting reporting to well-defined and readily identifiable events, using simpler and more objective event definitions (23), and sampling to obtain denominators (24). These approaches could decrease the burden of data collection and improve the consistency of reporting among facilities. If data collection were simplified, expanding the number of infection types and locations in which they are monitored may become more feasible.

Potential Consequences of Mandatory Public Reporting Systems

Mandatory reporting of HAIs will provide consumers and stakeholders with additional information for making informed healthcare choices. Further, reports from private systems suggest that participation in an organized, ongoing system for monitoring and reporting of HAIs may reduce HAI rates (25,26). This same beneficial consequence may apply to mandatory public reporting systems. Conversely, as with voluntary private reporting, mandatory public reporting that doesn't incorporate sound surveillance principles and reasonable goals may divert resources to reporting infections and collecting data for risk adjustment and away from patient care and prevention; such reporting also could result in unintended disincentives to treat patients at high risk for HAI. In addition, current standard methods for HAI surveillance were developed for voluntary use and may need to be modified for mandatory reporting. Lastly, publicly reported HAI rates can mislead stakeholders if inaccurate information is disseminated. Therefore, in a mandatory public report of HAI information, the limitations of current methods should be clearly communicated within the publicly released report.

Research and Evaluation Needs

Research and evaluation of existing and future HAI reporting systems will be needed to answer questions about 1) the comparative effectiveness and efficiency of public and private reporting systems and 2) the incidence and prevention of unintended consequences. Ongoing evaluation of each system will be needed to confirm the appropriateness of the methods used and the validity of the results.

Recommendations

The Healthcare Infection Control Practices Advisory Committee (HICPAC) proposes four overarching recommendations regarding the mandatory public reporting of healthcare-associated infections (HAIs). These recommendations are intended to guide policymakers in the creation of statewide reporting systems for healthcare facilities in their jurisdictions.

1. **Use established public health surveillance methods when designing and implementing mandatory HAI reporting systems. This process involves:**
 - a. selection of appropriate process and outcome measures to monitor;
 - b. selection of appropriate patient populations to monitor;
 - c. use of standardized case-finding methods and data validity checks;
 - d. provision of adequate support and resources;
 - e. adjustment for underlying infection risk; and
 - f. production of useful and accessible reports to stakeholders.

Do not use hospital discharge diagnostic codes as the sole data source for HAI public reporting systems.

2. **Create a multidisciplinary advisory panel to monitor the planning and oversight of the operations and products of HAI public reporting systems.**

This team should include persons with expertise in the prevention and control of HAIs.
3. **Choose appropriate process and outcome measures based on facility type and phase in measures gradually to allow time for facilities to adapt and to permit ongoing evaluation of data validity. States can select from the**

following measures as appropriate for hospitals or long-term care facilities in their jurisdictions.

- a. Three process measures are appropriate for hospitals and one (iii below) is appropriate for long-term care facilities participating in a mandatory HAI reporting system (Table 1).
 - i. Central-line insertion practices (with the goal of targeting intensive care unit [ICU]-specific central line-associated, laboratory-confirmed bloodstream infections [CLA-LCBIs] can be measured by all hospitals that have the type of ICUs selected for monitoring (e.g., medical or surgical).
 - ii. Surgical antimicrobial prophylaxis (with the goal of targeting surgical site infection [SSI] rates) can be measured by all hospitals that conduct the operations selected for monitoring.
 - iii. Influenza vaccination coverage rates for healthcare personnel and patients can be measured by all hospitals and long-term care facilities. For example:
 1. Coverage rates for healthcare personnel can be measured in all hospitals and long-term care facilities.
 2. Coverage rates for high-risk patients can be measured in all hospitals.
 3. Coverage rates for all residents can be measured in all long-term care facilities.

b. Two outcome measures are appropriate for some hospitals participating in a mandatory HAI reporting system (Table 2).

i. CLA-LCBIs.

ii. SSIs following selected operations.

Hospitals for which these measures are appropriate are those in which the frequency of the HAI is sufficient to achieve statistically stable rates. To foster performance improvement, the HAI rate to be reported should be coupled with a process measure of adherence to the prevention practice known to lower the rate (see 3ai and 3aii). For example, hospitals in states where reporting of SSIs is mandated should monitor and report adherence to recommended standards for surgical prophylaxis (see 3aii).

4. **Provide regular and confidential feedback of performance data to healthcare providers.** This practice may encourage low performers to implement targeted prevention activities and increase the acceptability of the public reporting systems within the healthcare sector.

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Table 1. Recommended Process Measures for a Mandatory Public Reporting System on Healthcare-associated Infections

Events	Measures	Rationale for Inclusion	Potential Limitations
<p>Central line insertion (CLI) practices</p>	<p>Two measures (expressed as a percentage) (8):</p> <p><u>Numerators:</u> Number of CLI in which:</p> <ol style="list-style-type: none"> 1) Maximal sterile barrier precautions were used 2) Chlorhexidine gluconate (preferred), tincture of iodine, an iodophor, or 70% alcohol used as skin antiseptic <p><u>Denominator:</u> Number of CLIs</p>	<p>Unambiguous target goal (100%).</p> <p>Risk-adjustment is unnecessary.</p> <p>Proven prevention effectiveness (8):</p> <p>Use of maximal barrier precautions during insertion and chlorhexidine skin antiseptics have been shown to be associated with an 84% and 49% reduction in central line-associated bloodstream infection rates, respectively (27,28).</p>	<p>Methods for data collection not yet standardized.</p> <p>Manual data collection likely to be tedious and labor intensive, and data are not included in medical records.</p>
<p>Surgical antimicrobial prophylaxis (AMP)</p>	<p>Three measures (expressed as a percentage) (29):</p> <p><u>Numerators:</u> Number of surgical patients:</p> <ol style="list-style-type: none"> 1) Who received AMP within 1 hour prior to surgical incision (or 2 hours if receiving vancomycin or a fluoroquinolone) 2) Who received AMP recommended for their surgical procedure 3) Whose prophylactic antibiotics were discontinued within 24 hours after surgery end time <p><u>Denominator:</u> All selected surgical patients</p>	<p>Unambiguous target goal (100%).</p> <p>Risk-adjustment is unnecessary.</p> <p>Proven prevention effectiveness (7):</p> <p>Administering the appropriate antimicrobial agent within 1 hour before the incision has been shown to reduce surgical site infections (SSIs).</p> <p>Prolonged duration of surgical prophylaxis (>24 hrs) has been associated with increased risk of antimicrobial-resistant SSI.</p>	<p>Manual data collection may be tedious and labor intensive, but data can be abstracted from medical records.</p>

<p>Influenza vaccination of patients and healthcare personnel</p>	<p>Two measures (each expressed as a percentage of coverage) (30):</p> <p><u>Numerators</u>: Number of influenza vaccinations given to eligible patients or healthcare personnel</p> <p><u>Denominators</u>: Number of patients or healthcare personnel eligible for influenza vaccine</p>	<p>Proven prevention effectiveness (30-32):</p> <p>Vaccination of high-risk patients and healthcare personnel has been shown to be effective in preventing influenza</p>	<p>Manual data collection may be tedious and labor intensive.</p>
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Table 2. Recommended Outcome Measures for a Mandatory Public Reporting System on Healthcare-associated Infections

Events	Measures	Rationale for Inclusion	Potential Limitations
<p>1. Central line-associated laboratory-confirmed primary bloodstream infection (CLA-LCBI)*</p>	<p><u>Numerator:</u> Number of CLA-LCBI</p> <p><u>Denominator:</u> Number of central-line days in each population at risk, expressed per 1,000</p> <p><u>Populations at risk:</u> Patients with central lines cared for in different types of intensive care units (ICUs)*</p> <p><u>Risk stratification:</u> By type of ICU</p> <p><u>Frequency of monitoring:</u> 12 months per year for ICU with ≤ 5 beds; 6 months per year for ICU with > 5 beds</p> <p><u>Frequency of rate calculation:</u> Monthly (or quarterly for small ICUs) for internal hospital quality improvement purposes</p> <p><u>Frequency of rate reporting:</u> Annually using all the data to calculate the rate</p>	<p>Overall, an infrequent event but one that is associated with substantial cost, morbidity, and mortality.</p> <p>Reliable laboratory test available for identification (i.e., positive blood culture).</p> <p>Prevention guidelines exist (8) and insertion processes can be monitored concurrently.</p> <p>Sensitivity*: 85%; predictive value positive (PVP)*: 75% (14)</p>	<p>LCBI* can be challenging to diagnose since the definition includes criteria that are difficult to interpret (e.g., single-positive blood cultures from skin commensal organisms may not represent true infections.) To offset this limitation, a system could include only those CLA-LCBI identified by criterion 1, which will result in smaller numerators and therefore will require longer periods of time for sufficient data accumulation for rates to become stable/meaningful.</p> <p>Standard definition of central line* requires knowing where the tip of the line terminates, which is not always documented and can therefore lead to misclassification of lines.</p>

Events	Measures	Rationale for Inclusion	Potential Limitations
<p>2. Surgical site infection (SSI)*</p>	<p><u>Numerator:</u> Number of SSI for each specific type of operation*</p> <p><u>Denominator:</u> Total number of each specific type of operation, expressed per 100</p> <p><u>Risk stratification:</u> Focus on high-volume operations and stratify by type of operation and National Nosocomial Infections Surveillance (NNIS) SSI risk index*</p> <p><u>Alternate risk adjustment:</u> For low-volume operations, by standardized infection ratio*</p>	<p>Low frequency event but one that is associated with substantial cost, morbidity, and mortality.</p> <p>Prevention guidelines exist (7) and certain important processes can be monitored concurrently.</p> <p>Sensitivity*: 67%; PVP*: 73% (14)</p>	<p>Rates dependent on surveillance intensity, especially completeness of post-discharge surveillance (50% become evident after discharge and may not be detected).</p> <p>SSI definitions include a "physician diagnosis" criterion, which reduces objectivity.</p>

*See Glossary.

GLOSSARY

- **Central line:** A vascular infusion device that terminates at or close to the heart or in one of the great vessels. In the National Healthcare Safety Network (NHSN), the system replacing NNIS, the following are considered great vessels for the purpose of reporting central-line infections and counting central-line days: aorta, pulmonary artery, superior vena cava, inferior vena cava, brachiocephalic veins, internal jugular veins, subclavian veins, external iliac veins, and common femoral veins.

NOTE: In neonates, the umbilical artery/vein is considered a great vessel.

NOTE: Neither the location of the insertion site nor the type of device may be used to determine if a line qualifies as a central line. The device must terminate in one of these vessels or in or near the heart to qualify as a central line. NOTE: Pacemaker wires and other noninfusion devices inserted into central blood vessels or the heart are not considered central lines.

- **CLA-LCBI:** please see **Laboratory-confirmed primary bloodstream infection.**
- **Confounding:** The distortion of the apparent effect of an exposure on risk brought about by the association with other factors that can influence the outcome (33). Risk adjustment is performed to minimize the effects of patient co-morbidities and use of invasive devices (the confounding factors) on the estimate of risk for a unit or facility (the exposure).
- **Device-associated infection:** An infection in a patient with a device (e.g., ventilator or central line) that was used within the 48-hour period before the infection's onset.

If the time interval was longer than 48 hours, compelling evidence must be present to indicate that the infection was associated with use of the device. For catheter-associated urinary tract infection (UTI), the indwelling urinary catheter must have been in place within the 7-day period before positive laboratory results or signs and symptoms meeting the criteria for UTI were evident (17).

- **Healthcare-associated infection:** A localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that a) occurs in a patient in a healthcare setting (e.g., a hospital or outpatient clinic), b) was not found to be present or incubating at the time of admission unless the infection was related to a previous admission to the same setting, and c) if the setting is a hospital, meets the criteria for a specific infection site as defined by CDC (17). (See also **Nosocomial**.)
- **Intensive-care unit (ICU):** A hospital unit that provides intensive observation, diagnostic, and therapeutic procedures for adults and/or children who are critically ill. An ICU *excludes* bone marrow transplant units and nursing areas that provide step-down, intermediate care or telemetry only. The type of ICU is determined by the service designation of the majority of patients cared for by the unit (i.e., if 80% of the patients are on a certain service [e.g., general surgery], then the ICU is designated as that type of unit [e.g., surgical ICU]). An ICU with approximately equal numbers of medical and surgical patients is designated as a combined medical/surgical ICU (17).
- **Laboratory-confirmed primary bloodstream infection (LCBI):** A primary bloodstream infection identified by laboratory tests with or without clinical signs or

symptoms; most often associated with the use of catheters or other invasive medical devices. For the CDC surveillance definition of I.CBIs, please see reference 14 or www.cdc.gov/ncidod/hip/surveill/nnis.htm.

- **NNIS SSI Risk index:** A score used to predict a surgical patient's risk of acquiring a surgical-site infection. The risk index score, ranging from 0 to 3, is the number of risk factors present among the following: a) a patient with an American Society of Anesthesiologists' physical status classification score of 3, 4, or 5 (34), b) an operation classified as contaminated or dirty infected (35,36), and c) an operation lasting over T hours, where T depends upon the operation being performed (19). Current T values can be found in the NNIS Report at www.cdc.gov/ncidod/hip/surveill/nnis.htm.
- **Nosocomial:** Originating or taking place in a hospital.
- **Outcomes:** All the possible results that may stem from exposure to a causal factor or from preventive or therapeutic interventions (33) (e.g., mortality, cost, and development of a healthcare-associated infection).
- **Predictive value positive:** The proportion of infections reported by a surveillance or reporting system that are true infections (6,14).
- **Private reporting system:** A system that provides information about the quality of health services or systems for the purposes of improving the quality of the services or systems. By definition, the general public is not given access to the data; instead, the data are typically provided to the organization or healthcare workers whose performance is being assessed. The provision of these data is intended as an intervention to improve the performance of that entity or person.

- **Process measure:** A measure of recommended infection control or other practices (e.g., compliance with hand hygiene recommendations).
- **Public reporting system:** A system that provides the public with information about the performance or quality of health services or systems for the purpose of improving the performance or quality of the services or systems.
- **Risk adjustment:** A summarizing procedure for a statistical measure in which the effects of differences in composition (e.g., confounding factors) of the populations being compared have been minimized by statistical methods (e.g., standardization and logistic regression) (33).
- **Sensitivity:** The proportion of true infections that are reported by a surveillance or reporting system. May also refer to the ability of the reporting system to detect outbreaks or unusual clusters of the adverse event (in time or place) (6,14).
- **SSI Risk Index:** please see **NNIS SSI Risk Index**.
- **Standardized infection ratio:** The standardized infection ratio as used in this document is an example of indirect standardization in which the observed number of surgical site infections (SSIs) is divided by the expected number of SSIs. The expected number of SSIs is calculated by using NNIS SSI risk index category-specific data from a standard population (e.g., the NNIS system data published in the NNIS Report) and the number of operations in each risk index category performed by a surgeon, a surgical subspecialty service, or a hospital. [Detailed explanation and examples can be found in Horan TC, Culver DH. Comparing surgical site infection rates. In: Pfeiffer JA, Ed. APIC text of infection control

and epidemiology. Washington, DC: Association for Professionals in Infection Control, 2000. Chapter 14, p. 1-7.]

- **Surgical site infection (SSI):** An infection of the incision or organ/space operated on during a surgical procedure. For the CDC surveillance definition of an SSI, please see reference 14 or www.cdc.gov/ncidod/hip/surveill/nnis.htm.
- **Surveillance:** The ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health (6).

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