

# Perspectives from the Field

“Progress Toward Eliminating  
Healthcare-Associated Infections”

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Arlington, VA

# Presentation Overview

- Linda Greene
  - Association for Professionals in Infection Control and Epidemiology
- Neil Fishman
  - Society for Healthcare Epidemiology of America
- Steve Ostroff
  - Pennsylvania State Department of Health
- Lisa McGiffert
  - Consumers Union
- Maulik Joshi
  - American Hospital Association



# Stakeholder Perspective: Association of Professionals in Infection Control and Epidemiology (APIC)

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# Perspectives

**With regard to HAI prevention and control, how has your role and that of your peers and colleagues changed or evolved in the past two years?**

- **Increased Responsibilities** – State based legislation has focused more attention on HAIs
- **Intensification of efforts to provide measurable results of infection control efforts** – Improvements in CLABSI rates, decrease in invasive MRSA; Challenges – C. Difficile
- **Increased focus on activities that can contribute to the bottom line** – Value based purchasing as highlighting the cost of infection, efficiency data, LOS, readmission data
- **Increased emphasis on engaging stakeholders, collaboration, and team work** – Growing body of evidence on the value of team work - Pittsburgh Regional, NYS Quality Improvement Projects



# Perspectives

**What major opportunities exist for accelerating progress?**

- **Address infrastructure and resources for infection prevention programs**
- **Use of NHSN data** – Support use of SIR, expand use of NHSN data
- **Translational research** – Bringing evidence to the bedside – what works, how to implement it, ease of implementation, can it be applied in different settings and size organizations (ICU vs. general care, community vs. academic), and is it sustainable?
- **Expansion of antimicrobial stewardship programs**
- **Use of Surveillance Technologies**
- **More research on effectiveness of administrative data for select purposes**



# Perspectives

**What are some priorities for action over the next 12 - 24 months that could accelerate progress toward preventing HAIs?**

- **Assure valid measures and metrics for HAI reporting that have support from key stakeholders** – Consider some evidence based process measures  
(Example UTI – meta-analysis Meddings *CID* 2010)
- **Accelerate implementation of evidence based interventions to prevent infections** (those that score high on quality and strength of evidence)
- **Assure that Infection Prevention Course work is part of every medical school, nursing school, and other direct care provider curriculum**
- **Assure that educational offerings are available to increase understanding of prevention practices in a wide range of healthcare settings**
- **Tap into further potential for automated surveillance and link it to the EMR**



# Stakeholder Perspective: Society for Healthcare Epidemiology of America (SHEA)

Neil Fishman



# Stakeholder Perspective: Pennsylvania State Department of Health

Stephen M. Ostroff MD  
Pennsylvania Department of Health



# Pennsylvania HAI Milestones

- 2001: Pittsburgh Regional Health Initiative
- 2005: Mandated HAI reporting to PA Healthcare Cost Containment Council
- 2007: “Rx for Pennsylvania”
- 2007: Mandated HAI reporting to PA Dept of Health using NHSN (Act 52)
- 2008: HAI reporting starts under Act 52
- 2009: ARRA Stimulus Funding



# Act 52 Highlights

- Expansive HAI reporting:
  - All 250 ACFs; all locations; all HAIs; NHSN
  - All 722 LTCFs; all HAIs; unspecified system
- Mandatory MDRO screening
  - LTCFs & other hi-risk populations
- Analysis
  - Facility-specific rates
  - Compare like facilities
  - Temporal trends
  - Compare PA to rest of country
- Annual reduction targets & penalties



# Evolving HAI Infrastructure

- Statewide HAI Advisory Committee
- Media campaign on HAIs – [cleanhandssavelives.org](http://cleanhandssavelives.org)
- Two DOH units for HAIs (Compliance & Analysis)
  - Combined >20 FTEs
- “Home brew” system for LTCF reporting
  - Modified McGeer definitions
- Two published reports on HAIs
  - Released by Governor in major stakeholder events
- Two ARRA funded prevention collaboratives
- Validation studies underway

# Strengths

- HAIs on the radar screen in PA
- Large HAI database
  - >26,000 reports annually (approx 10% of all NHSN data)
- HAI capacity in health department
- Enhanced relations between hospitals & public health
- Linkage to reduction targets

# Challenges

- Major burden on data suppliers
- Data management, quality, and validation
- NHSN not a “state” system
- Measuring:
  - non-acute care general hospitals
  - small hospitals
- Nursing home settings
  - How to analyze data?
- Analysis and report generation
  - Data utilization for research purposes

# Perspectives

- **Need to standardize national surveillance of HAIs**
  - Currently 27 states have “mandated” reporting
  - Not all use NHSN
  - Different states monitor different HAIs
- **CLABSI surveillance does not equal HAI surveillance**
  - Minimizes importance of other HAIs
- **Hospital surveillance does not equal HAI surveillance**



# Perspectives

- **Restrain proliferation of federal data demands and federal reports of HAIs**
  - CDC
    - State-by-state reports not especially useful
  - AHRQ
  - CMS
- **Simplify reporting burden at the facility level**
  - Automation effort by CDC very welcome
- **Need for a national HAI reporting summit**
- **Increase focus on other health care settings**



# Stakeholder Perspective: Consumers Union

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# Public Reporting

## A consumer movement

- 2003: launch of Consumers Union's Stop Hospital Infections Project
- 2004: PA, IL, MO, FL
- 2009: 27 states require reporting hospital infection rates
- Sept 2010: 22 states require use of NHSN
- Sept 2010: 20 reports issued so far



# Why publicly report? Benefit to consumers

- Patients' right to know
- Patient informed choices – evidence-based medicine
- Stimulate conversations between doctors and patients about quality and safety
- Inform policymakers about the financial and human costs of these preventable injuries
- Dynamic process: public awareness of performance can stimulate pressure from community (media, conversations among providers; doctors might pressure hospital improvement)



# Why publicly report?

## Benefit to health care system

- Inform hospitals and providers how they compare
- Stimulate change within the hospital
  - Cultural attitudes
  - Active identification when infections occur creates a change in behavior more than assessing performance after the fact through analyzing billing data
- Stimulate conversations among professionals
- Improve awareness of prevention strategies – they don't necessarily know how to improve care (IHI and Pronovost campaigns are examples of “helpers”)
- Creates early innovators speaking out about their results



# Over 3000 stories have put a human face on medical harm



Safe Patient Project: Share Your Story - Windows Internet Explorer

http://www.safepatientproject.org/share\_your\_story.html

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Safe Patient Project: Share Your Story

# Safe Patient Project

End secrecy, save lives.

Consumers Union

ACT NOW TOPICS BLOG SHARE YOUR STORY VIDEO ESPAÑOL ABOUT US

## Tell Us Your Story!

We want to hear from you. Your willingness to share your stories helps us pass laws to protect you and your family.

### Hospital Acquired Infections



Have you or a loved one contracted a hospital infection when you went in for surgery or other illness? We would like to hear your story, or any other comment you may have about your hospital experience. [SHARE »](#)

[Read Hospital Acquired Infections stories »](#)

### Doctor Accountability



Have you or a loved one had tests, surgeries, procedures or medications that you thought were unnecessary? If so, we would like to hear your story. [SHARE »](#)

Have you or a loved one been harmed by a doctor or medical staff person when seeking medical treatment? We would like to hear your story, or any other comment you may have about the experience.

### Drug Safety



Share your Drug Safety story!

Have you or a loved one had trouble with or had a problem with prescription drugs? Have you experienced harmful side effects from medications or been misled by a drug company advertisement? We would like to hear your story, or any other comment you may have about your experience with prescription medicines. [SHARE »](#)

[Read Drug Safety stories »](#)

### Medical Errors



Have you or a loved one been harmed by a medical error at a hospital or doctor's office? We would like to hear your story. [SHARE »](#)

Were you ever given the wrong drug or wrong dosage? Did your doctor fail to inform you about side effects? Share your story. [SHARE »](#)

[Read Medical Errors stories »](#)

### RECENTLY ADDED STORIES

Browse the most recently published stories from consumers like you.

**MICHAEL SKOLNIK OF COLORADO**



After Michael Skolnik passed out in September 2001, his neurosurgeon told his parents that Michael needed to have brain surgery within two days. The three hour operation lasted six hours with no cyst ever being found. This marked the beginning of a 32-month nightmare of brain surgeries, infections, and more than \$4,000,000 in medical bills. [Read more Doctor Accountability stories »](#)

**MY HOSPITAL INFECTION NIGHTMARE**



In November 2006, following a medical procedure, I came down with a 104 fever with an extreme headache. Informing the doctor of my symptoms, I was told I had probably caught a "flu bug"™ and to wait it out until my post-op appointment two weeks later. [Read more Hospital Acquired Infections stories »](#)

**BROTHER BLEED TO DEATH FROM CENTRAL LINE MEDICAL ERROR**

http://www.safepatientproject.org/sys-drug\_safety.html

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https://secure.consumersunion.org/site/Advocacy?cmd=display&page=L Consumers Union of United States, Inc. [US] Google

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# Safe Patient Project

End secrecy, save lives.

Consumers Union

ACT NOW TOPICS BLOG SHARE YOUR STORY VIDEO ESPAÑOL ABOUT US

## Is your hospital on the checklist?



An innovative "checklist" to reduce central line bloodstream infections in intensive care units has had incredible success in hospitals where it's been adopted. **Make sure your area hospitals use it too – it doesn't take a law, just some public pressure!**

Ask your state lawmakers to get local hospitals on board with this lifesaving campaign. More than 30,000 Americans die each year from central line associated blood stream infections (CLABSI)—and federal researchers just reported an 8 percent increase in these infections over the year before.

We can prevent these unnecessary deaths by getting hospital workers to follow a simple checklist that has been proven to reduce infections by two-thirds. **Send an email now to your state legislators so they know residents are asking for this common-sense prevention program.**

Find out if your hospital is on the checklist: <http://www.safercare.net/OTCSBSI/Participation.html>

Recipients

What's up in your state?

Choose a state...

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# Role of consumers over past 2 years

- Consumer engagement/consumer voices
- Public awareness
- Implementation issues
- Reports issued
- Culture change... can the system truly accept the goal of zero?

# Opportunities for progress

- Public accountability using national/state action plans; benchmark against zero
- Validation of NHSN reports using other data sources
- Keep momentum rising - resources should reflect scope of problem; a national campaign like that for polio eradication
- Meaningful use of NHSN and CDC ABC lab data - more “real time” data
- Ensure all plans for EMR, HIT, HIE puts patient safety at the forefront



# Priorities to accelerate prevention next 12-24 months

- Expansion of hospital reporting outside of the ICU; VAP; all surgeries; outpatient settings
- MDRO reporting and screening – MRSA, C. difficile, VRE, and other HAIs caused by resistant superbugs
- Disclosures to patients
- Environmental disinfection
- Antibiotic stewardship – with teeth
- Support to community-wide projects; not solitary hospital departments
- Consider use of Sentinel database (PDUFA)



# Stakeholder Perspective: American Hospital Association (AHA)

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# Perspectives

**With regard to HAI prevention and control, how has your role and that of your peers and colleagues changed or evolved in the past two years?**

- Hospitals have shown “laser like” focus on infections (during times of resource constraints)
- Hospitals have made significant resource investments
- Governance and leadership have made infection prevention part of their organizational dashboards and accountability (e.g., financial linkage)
- Increasing number of local and national models of success for replication

# Perspectives

## What major opportunities exist for accelerating progress?

- Accomplishments: Keystone Project; National CUSP/CLABSI Project (AHRQ, HRET, JHU, MHA); AHRQ's Investments in Infection Prevention
- Continue to build evidence base (e.g., “how to” in ED and ambulatory settings)
- Better understand translation from evidence to practice
- Continuous learning of spread/dissemination science
- Continuous learning of sustainability



# Perspectives

**What are some priorities for action over the next 12 - 24 months that could accelerate progress toward preventing HAIs?**

- Develop the evidence base for other infections and in other settings
- Additional testing in other settings
- Invest in more implementation science focus – spread/ dissemination
  - Getting beyond “campaign creep”