

# **Recommendations for Conducting Healthcare-Associated Infections Surveillance in New Mexico**

Report Prepared by the Healthcare-Associated Infections Advisory Committee

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## Executive Summary

Significant activity has taken place with respect to healthcare-associated infections (HAIs) at the national, state and local levels. In 2008, the Committee of Oversight and Government Reform in the House of Representatives noted that at the federal level, while much data on HAIs were available, it has not been integrated and, while many evidence-based practices to prevent HAIs are available, the agencies that have developed them have failed to prioritize and promote the implementation of these practices in a cohesive fashion. They also found that 29 states with mandated public reporting have designed surveillance programs focused on only a few outcome and process measures developed or endorsed by the Centers for Disease Control and Prevention (CDC). These mandated programs used the National Healthcare Safety Network (NHSN) and reported that substantial resources, including human resources, are required to collect these HAI data through chart review and application of stringent criteria.

State-specific experience implementing legally mandated public reporting of HAIs underscores the findings of the above-mentioned committee. For example, Colorado law requires health facilities to collect data on infection rates for: a) cardiac surgical site infections; b) orthopedic surgical site infections; c) central line related bloodstream infections. Many of the difficulties the Colorado health facilities experienced with the NHSN reporting system were “. . . due to limited time and resources.” The Colorado Department of Public Health and Environment (CODPHE) is the lead state agency administering the initiative and they stated that “the department has expended all available staff enrolling 25 percent of the targeted facilities” and also expressed concern “that there are no resources designated to develop a state system that would ensure the accuracy and completeness of the data going into and being extracted from the reporting database.”

Keeping this context in mind, the New Mexico HAI Advisory Committee (HAI AC) has proceeded to guide a one-year pilot with six hospitals that started reporting HAIs July 1, 2008 for central line associated bloodstream infections (CLABSIs) using NHSN and health care worker (HCW) influenza vaccination rates using tools developed by the HAI AC. The HAI AC is facilitated by the New Mexico Department of Health (NMDOH) and has been meeting monthly since February 2008. Four work groups consisting of representatives from the HAI AC and also from individuals outside of the committee have been meeting regularly and reporting their progress to the HAI AC on: a) technical issues; b) public reporting/risk communication; c) NHSN users; d) quality assurance. Significant resources--including time, human and material--have been expended by the HAI AC, the work groups and the participating hospitals.

HAI AC currently recommends:

- Expand reporting of CLABSIs and HCW influenza vaccination rates to include additional hospitals and plan for public reporting to begin after one additional year of data collection in order to:
  - More completely validate and analyze the data
  - Utilize the first year of pilot data to develop and test (e.g., with focus groups, experts in the field) public reporting mechanisms
  - Educate/recruit additional New Mexico hospitals to join the HAI reporting initiative
- Recommend to the New Mexico Legislature that mandated reporting be considered to start July 1, 2010 with adequate resources for implementation
- If HAI reporting is mandated, program development would include:
  - Hospital training; data collection/management/analysis/dissemination; public reporting

## **Perspectives: National Trends in Healthcare-Associated Infections Surveillance and Public Reporting**

In the year since House Joint Memorial 67 Task Force submitted the ‘Report on the Feasibility of Conducting Surveillance for Healthcare-Associated Infections in New Mexico’ (November 1, 2007), nationwide activities related to surveillance and quality improvement for healthcare-associated infections (HAIs) have advanced markedly.

### Federal Agencies

In 2008, the Committee of Oversight and Government Reform, U.S. House of Representatives, led by Representative Henry Waxman, called three agencies within the Department for Health and Human Services (HHS) to task for failing to generate integrated data on healthcare quality and for inadequate attention to prevention practices. The committee noted that the Centers for Medicare and Medicaid (CMS), Centers for Disease Control and Prevention (CDC), and Agency for Healthcare Research and Quality (AHRQ) all generate data on HAIs in different databases that do not communicate with one another, and that while over 1,200 evidence-based practices to prevent HAI have been listed by CDC and AHRQ, these agencies have failed to prioritize and promote the implementation of these practices in a cohesive fashion.<sup>1</sup>

In September 2008, the above-mentioned committee examined all aspects of reporting and improvement and found that 23 states with mandated public reporting have designed surveillance programs focused on a few outcome and process measures developed or endorsed by CDC and collected using the National Healthcare Safety Network (NHSN). The emphasis has been on accurate data collection which can be validated by independent observers. The committee found that substantial resources, including human resources, were required to collect these data through chart review and application of stringent criteria. The General Accounting Office (GAO) also surveyed 14 hospitals with initiatives to reduce the prevalence of methicillin-resistant *Staphylococcus aureus* (MRSA) through active surveillance, testing and decolonization.<sup>2</sup> The NHSN system now offers a module for reporting infections with multi-drug resistant organisms.

One stimulus for hospitals to improve the safety of care through reduction of HAIs came into effect in October 2008, when CMS started withholding payments for selected complications of care, including selected HAIs, if they had not been present on admission. Although many facilities had already realized that prevention of HAI could be cost-saving, this change in reimbursement tipped the financial analysis further in favor of prevention.<sup>3</sup>

### National Professional Organizations

The Society for Hospital Epidemiology of America (SHEA) and Infectious Diseases Society of America (IDSA), in partnership with the Association for Professionals in Infection Control and Epidemiology (APIC), the Joint Commission, Institute for Healthcare Improvement (IHI), and the American Hospital Association (AHA), recently published a compendium of preventive strategies for HAIs. This publication, freely available on the World Wide Web at <http://www.journals.uchicago.edu/toc/iche/2008/29/s1>, stratifies the interventions based on the strength of the supporting evidence, suggests performance measures based on outcomes and process, and acknowledges that many issues remain unresolved. The compendium also

incorporates HAI prevention initiatives, required measures, and guidelines from organizations, including the Institute of Medicine (IOM), the Joint Commission, the National Quality Forum and IHI in addition to the Federal agencies.<sup>4</sup> The compendium is more up to date and accessible than prior CDC guidelines for prevention of HAI. This collaboration is characteristic of the patient safety movement, which involves many interconnected groups using the best available evidence to achieve reduction of HAIs in areas not yet addressed by government regulation or even accrediting agencies.

### State/Regional Collaborations

Infection control professionals (ICPs) working on the front lines have provided information in the last year demonstrating that multidrug-resistant organisms such as MRSA and the emerging threat of *Clostridium difficile* associated disease (CDAD) are much more prevalent than previously thought.<sup>5,6</sup> Since these organisms are carried by patients between facilities and are difficult to contain, regional collaborative groups are emerging across the country to share information and implementation strategies (Note: an internet search identifies MRSA collaboratives in Arizona, the Delaware-Maryland-Virginia area, Tennessee, Kentucky, the Pittsburgh area, the Philadelphia area, the Chicago area, Indiana, North Carolina, Washington, New Mexico, the Veterans Health Administration [VHA] and Hospital Corporation of America [HCA] networks and VHA hospitals and nursing homes.) Some collaboratives share critical infection control data on patients through advanced information technology and health information exchanges.<sup>7</sup>

While these grassroots groups forge ahead, the national research agenda has been revised to emphasize translational research, of which phase 3 translation (“T3”) attempts to move evidence-based guidelines into health practice. Progress in the science of quality improvement is essential to optimize the spread of innovation in healthcare settings.<sup>8</sup>

### **Update on State-Specific Efforts Directed toward Public Reporting of HAI Surveillance**

Other states’ legislation and experiences have provided valuable information for development of HAI surveillance systems in New Mexico. To date, 29 states have healthcare-associated reporting laws and regulations (See Appendix C: APIC Overview of State HAI Reporting Laws). Three states with mandated public reporting were selected to highlight some lessons learned.

#### Colorado

In Colorado, HB 06-1045 was signed into law on June 2, 2006. This law requires health facilities to collect data on infection rates for: a) cardiac surgical site infections; b) orthopedic surgical site infections; c) central line related bloodstream infections. It also requires individuals collecting HAI data to be certified in infection control if in a facility with 51 or more beds; CDC recommends one certified ICP per 100 hospital beds. Facilities report the infection data to NHSN. Data was legislated to be collected annually beginning July 31, 2007.

The Colorado Department of Public Health and Environment (CODPHE) is the lead state agency administering the initiative. CODPHE relies primarily on one project manager to oversee the disclosure initiative with support from their volunteer advisory committee, department and

division staff, and CDC staff responsible for the NHSN reporting database. Many of the difficulties the Colorado health facilities experienced with the NHSN reporting system were “due to limited time and resources” according to the CODPHE’s status report dated 1/15/2008 (Available at: <http://www.cdphe.state.co.us/hf/PatientSafety/HFAI/HFAIfirstannualreport01-15-08.pdf> ). This same report states that “the department has expended all available staff enrolling 25 percent of the targeted facilities” and goes on to express concern “that there are no resources designated to develop a state system that would ensure the accuracy and completeness of the data going into and being extracted from the reporting database.”

The semi-annual bulletin dated July 1, 2008 (Available at: <http://www.cdphe.state.co.us/hf/PatientSafety/HFAI/springbulletin1.pdf> ) states “the CODPHE depends on accurate information from reporting facilities and NHSN to produce the [infection] reports. The department does not perform data validation or audit facilities to ensure the data is complete.”

### New York

Chapter 284 of the Public Health Law was signed into law on July 19, 2005. This law requires hospitals to report to the department of health information on hospital acquired infections. Pilot phase reporting (no public reporting by hospital name) was slated to begin January 1, 2007. Annual reports issued after that time (HAI rates for 2008) will provide data by hospital. Reports will include: a) central-line related bloodstream infections; b) select surgical site wound infections associated with critical care units. Reporting will not be required more than every six months.

New York State Department of Health (NYSDOH) oversees the program and has a program director, program manager, data manager, data analyst, program operations director, an administrative assistant and five regionally based ICPs. New York also receives additional support from its division directors and CDC staff responsible for the NHSN reporting database. New York’s HAI program staff conducts on-site audits to evaluate surveillance methods, interpretation of surveillance definitions and completeness of reporting. The program’s ongoing education has been maintained via telephone, regional training sessions to discuss modifications to the reporting system and new selection of indicators, on-site hospital visits, additions to the HAI web site and through distributing an electronic newsletter.

NYSDOH also established a goal to prevent the HAIs they selected for reporting purposes and have charged their hospitals to use the HAI reporting system to evaluate risk factors and potential interventions, and to use the data to evaluate the impact of initiatives to improve quality of care. The full report, "New York State Hospital-Acquired Infection Reporting System Pilot Year – 2007" is available at:

[http://www.nyhealth.gov/nysdoh/hospital/reports/hospital\\_acquired\\_infections/](http://www.nyhealth.gov/nysdoh/hospital/reports/hospital_acquired_infections/)

### Tennessee

Public Chapter 904, formerly SB 278, was signed into law on June 20, 2006. This law requires facilities with an average daily census of at least 25 inpatients, or outpatient facilities that perform an annual average of 25 procedures per day, to join NHSN within 120 days of when it becomes open to the facility’s type of license. With the exception of burn units and level 1 trauma units, facilities must grant the Tennessee Department of Health access to the NHSN

database for CLABSIs, and surgical site infections (SSIs) for coronary artery bypass grafts (CABGs).

The Department of Health will disseminate public reports, with facility specific rates for facilities with more than 30 central line insertions per year; however, only aggregate statewide performance on CABG surgical infection rates will be circulated. Tennessee's first comprehensive report on CLABSIs will be released in 2009. At this time, no formal plan exists for data validation. However, Tennessee is considering utilizing a system that may compare CLABSIs reported via NHSN to blood stream infections (BSIs) generated via hospital laboratories to possibly identify discrepancies.

### **Update on the New Mexico HAI Pilot Year**

The New Mexico HAI Advisory Committee (HAI AC) formed at the direction of NMDOH Secretary Vigil (See Appendix D: Letter from the Secretary of Health: Appointment of HAI Advisory Committee). The pilot year (July 1, 2008 – June 31, 2009) includes surveillance for two HAI indicators: 1) CLABSIs in adult intensive-care units (ICUs); 2) influenza vaccination rates of healthcare workers (HCWs).

#### HAI Advisory Committee's Scope of Work Statement

The HAI Advisory Committee created a scope of work statement to define the group's objectives and goals.

- Provide guidance/recommendations for the pilot year. The pilot's success will be measured by the participation of a minimum of 3 hospitals which will utilize both a surveillance system, such as the National Healthcare Safety Network (NHSN), and Advisory Committee-defined methodology to report on:
  - Central-line-associated bloodstream infections in adult intensive care units
  - Influenza vaccination rates of healthcare workers
- Evaluation of the feasibility of conducting HAI surveillance, process, and quality of data collected
- End-of-pilot recommendations (in the form of a written report) to include reporter liability; patient confidentiality; public reporting methods, formats, and venues for consumers; potential legislation; required resources; and suggestions for how to proceed with expansion of indicators to all acute care hospitals, not including federal or IHS facilities, as directed by the Secretary of Health.

The HAI AC is facilitated by NMDOH Epidemiology and Response Division (ERD) representatives and has been meeting monthly starting in February 2008. The HAI AC includes representatives from:

- a) Consumers
- b) New Mexico Association for Professionals in Infection Control and Epidemiology (APIC)
- c) NM Hospital Association (NMHA)
- d) NM hospitals (including large and smaller rural settings)
- e) Health Policy Commission (HPC)
- f) New Mexico Medical Review Association (NMMRA)
- g) Local representatives of the Society for Healthcare Epidemiology of America (SHEA)
- h) NMDOH

(See Appendix E: Members of the New Mexico HAI Advisory Committee.)

### Rationale for Selection of the National Healthcare Safety Network (NHSN) as the HAI Surveillance System

The HAI AC recommended the use of NHSN, a CDC-developed and supported electronic system. Utilization of the NHSN presents several significant benefits. First, the system is already being used by many states, thus making possible the collection of both standardized data for New Mexico hospitals and benchmark New Mexico data to compare with other states participating in NHSN. Second, this recommendation eliminates the need to fund and design a data system unique to New Mexico. Additionally, NHSN has confidentiality protections through the Public Health Service Act. And finally, since CDC is the host for the NHSN system, it is responsible for the updates and upgrades to the data system.

The NHSN reporting tool is a secure, digital certificate, web-enabled system. Participating facilities use NHSN to enter, analyze and share data. In order to participate in NHSN, facilities must submit data for at least one module for at least six months of a calendar year, use CDC definitions and codes for data collection, report events within 30 days of the end of the month, and pass quality control checks for completeness and accuracy. CDC also recommends that a trained ICP or hospital epidemiologist administer the HAI surveillance program in each healthcare setting. The recommendations do allow for other personnel to be trained to screen for events and collect, enter and analyze data. A facility may share all or some of its data by conferring rights to access. This feature permits data sharing with the Department of Health, thereby supplying a mechanism to provide for public reporting.

CDC has enrolled approximately 2000 facilities in the NHSN reporting system.<sup>9</sup> The most recent data release incorporates data from 621 hospitals reporting data from 2006 through 2007.<sup>10</sup> The infection rates reported are remarkable for their improvement over the last publication of rates from the CDC National Nosocomial Infection Surveillance (NNIS) system, which covered the period up to 2005.<sup>11</sup>

### Update on the Selection of Central line Associated Bloodstream Infections (CLABSIs) as a HAI Indicator for the Pilot Year

The HJM 67 Task Force recommended CLABSI surveillance because it scored well on a guiding principle that measures used should be based on objective, accurate and consistent definitions that may be applied by all New Mexico hospitals that are subject to reporting requirements and across continuing healthcare systems. There is scientific evidence that many of these infections can be prevented with the implementation and consistent use of evidence-based processes of care.<sup>12</sup> Participating hospitals started collecting data for CLABSIs on July 1, 2008. The mechanism for reporting CLABSIs is a module within the NHSN system.

Pilot hospitals have submitted data based on information gathered since July 1, 2008. Analysis of the first three months of data does not indicate that any of the participating hospitals have rates notably higher than NHSN rates. Data submitted by the pilot hospitals will be reviewed in an ongoing fashion and rates will be calculated and reported in de-identified fashion at the end of the pilot year. Assurances have been given to pilot hospitals that, during the pilot year, data submitted to NHSN to which NMDOH has been granted viewing privileges will be treated confidentially with respect to hospital and patient identifiers (See Appendix D: Letter from the Secretary of Health: Appointment of HAI Advisory Committee). The HAI AC will be

working with the pilot hospitals in order to present early preliminary data to the Legislature during the upcoming 2009 Legislative Session without identifying patients or hospitals, following the NMDOH small numbers guidelines (See Appendix F: New Mexico Rule for Small Numbers and Public Data Release and Appendix G: New Mexico Healthcare-Associated Infections Pilot Status Report and Preliminary Data: January 15, 2009).

### Update on the Selection of Healthcare worker (HCW) influenza immunization as a HAI Indicator for the Pilot Year

Influenza vaccination coverage of HCWs was selected as an indicator because HCW vaccination for influenza is a critical patient safety measure endorsed by CDC, Joint Commission, and many professional organizations. Studies have shown that increasing vaccination rates of HCWs who provide care to elderly patients can lead to marked decreases in mortality (e.g., in patients in long-term care settings). Despite this knowledge, even best performing organizations rarely exceed 70% immunization rates (data from the University Health Consortium). According to CDC, in the 2005-2006 influenza season, only 42% of surveyed HCWs received influenza vaccination. In past years, nosocomial influenza infections have been documented in healthcare settings and HCWs have been implicated as the potential source of these infections.

Measuring HCW influenza immunization rates is a requirement of the Joint Commission, which also requires year-to-year improvements and expansion of facility programs. All facilities accredited by the Joint Commission are encouraged to participate in the Joint Commission's Influenza Vaccination Challenge for the influenza 2008-9 influenza season. The Joint Commission will recognize all facilities achieving vaccination rates of HCWs higher than the historical norm of 43%.

Initially, a module to report HCW influenza vaccinations was to be available through NHSN; however, this mechanism of reporting is not yet available for the 2008-2009 influenza season. Instead, a Microsoft Excel® spreadsheet is being used to collect and submit data related to this measure during the New Mexico HAI pilot. Along with the spreadsheet, an instruction sheet providing data requirements and specific definition information was given to the facilities in order to assure that all facilities understood the requirements (See Appendix F: Healthcare Worker Influenza Immunization Guidelines for the New Mexico Pilot Year).

### Pilot Participants

The request for hospitals to volunteer for the pilot year was facilitated by the New Mexico Hospital Association (NMHA). Hospitals were assured that their participation would yield data that would be kept confidential during this pilot year and that they would be used to inform future recommendations regarding HAI surveillance in New Mexico. While the Secretary of Health requested the participation of a minimum of three hospitals, six agreed to join the pilot year:

- Gerald Champion Regional Medical Center, Alamogordo, NM
- Heart Hospital of New Mexico, Albuquerque, NM
- Memorial Medical Center, Las Cruces, NM
- Presbyterian Hospital, Albuquerque, NM
- San Juan Regional Medical Center, Farmington, NM
- University of New Mexico Hospital, Albuquerque, NM

These six healthcare facilities represent both large and smaller hospitals, as well as urban and more rural facilities, thereby offering diversity among facilities participating in the pilot year. ICPs at the facilities are the primary person(s) responsible for maintaining accurate reporting of data during this HAI pilot year.

### HAI Advisory Committee Work Groups

In order to fully utilize HAI Advisory Committee members' time and expertise, work groups were formed to address specific issues surrounding HAI surveillance and public reporting in New Mexico. Work group membership may also include individuals who do not serve on the HAI AC but who bring additional skills and knowledge to the work group. Work groups report to the HAI AC to inform its recommendations.

#### *Technical Issues Work Group*

The work group leaders are Susan Kellie (UNM) and Carlene Brown (NMMRA). The group's activities include:

- Ensure that the data collection requirements of the public reporting system (with regard to measures selected, definitions, populations surveyed and surveillance criteria) are standardized and consistent with the recommendations and requirements of national organizations and agencies.
- Use established risk adjustment methodologies for reporting HAI measures.
- Consider electronic health records and information technology systems that may be utilized to replace manual data collection methods.

Most of the group's work has centered on how to define and collect HCW influenza vaccination data: the group established the definitions and guidelines to collect these data.

#### *Public Reporting/Risk Communication Work Group*

Christina Ewers and Chad Smelser (NMDOH) serve as co-leaders for this group. Group members include representatives from NMHA, a consumer, APIC, Public Information Officers from hospitals, and other NMDOH members, including its Communications Director. Overall, the role of the group is to make recommendations about how to most effectively communicate HAI data from the initiative to the public. In order to achieve this goal, the group identified its responsibilities:

- Make recommendations regarding the format and venue(s) for public reporting.
- Assess the effects of public reporting of HAIs.
- Work with Public Information Officers within participating agencies and facilities to generate press releases about the pilot project.
- Develop messages regarding risk adjustment.

Once the group determines that information pertinent for the public is available, a manner(s) of distribution will be recommended. Mechanisms for distribution to the public may include press releases, web site postings, and/or published reports. Regardless of the mechanism of dissemination, talking points regarding the information will be made available for Public Information Officers/agencies to respond accurately and consistently to media inquiries.

Two press releases were generated about the HAI pilot year: the first one announced the Secretary's directive for the pilot year and the second release contained updates about participants and the two HAI indicators chosen for the pilot year. Dissemination of data should be approved by the HAI AC as it relates to content: they should assure that comparisons are statistically sound and that the narrative explanations are accurate. The work group plans to develop methods to assess the comprehensibility and impact of reports as they relate to the public.

### *NHSN Users' Work Group*

Leaders, Cynthia Connell and Christina Ewers (NMDOH), conduct monthly conference calls with the ICPS from the six participating hospitals. The focus activities include:

- Provide advice to the HAI AC in relation to surveillance activities and NHSN methodology and applications.
- Provide advice and support to infection control staff from participating facilities to apply NHSN methodology to report cases of HAIs identified during the project.
- Facilitate training of infection control staff from participating facilities and support staff in epidemiology, facility-specific surveillance programs, NHSN surveillance software and other applications.
- Assist hospitals to use the reporting data in order to: a) provide feedback to their healthcare providers about the facility's performance; b) provide additional information to guide the hospital's ongoing efforts to prevent HAI; c) compare the facility's data with others in the health care system.
- Develop a system for recruiting new hospitals to participate in the program.

Initially efforts of this group centered on NHSN enrollment and education regarding NHSN protocols and methodology for CLABSIs. Hospitals began submitting these data as of July 1, 2008. Monthly timelines are created and discussed during monthly telephone meetings so that the pilot hospitals understand and follow the expected goals of the program.

### *Quality Assurance*

Joan Baumbach and Chad Smelser (NMDOH) lead this group with participation from ICPS and NMHA. The activities include:

- Assessment of the quality and completeness of training of pilot hospitals.
- Assessment of the quality/standardization of implementation of NHSN by pilot hospitals.
- Development of tools for monitoring quality of data (including surveillance systems to obtain the data and data submitted through NHSN).
- Development of validation methods and tools to evaluate quality, including accuracy and completeness, of HAIs being reported by pilot hospitals.

The group's efforts are directed at creating tools and processes to assure that quality data is being submitted by the hospitals. The following tools/processes have been developed:

1. Worksheet for hospitals to determine whether a positive blood culture meets CLABSI definitions.
2. Review of all entered CLABSI events by an experienced ICP to assure that they meet definitions.
3. Review of entered denominator data to check for gross errors, including:
  - a) Check that the number of line days does not exceed the number of patient days (not possible)
  - b) Check for excessively large increases or declines in line or patient days month to month (these tend to be somewhat stable)
  - c) Check that the line days and patient days are not exactly the same in a given month (unlikely event)
  - d) Check that the line days and/or patient days are not exactly the same month to month (unlikely event)
4. Monthly phone calls by an experienced ICP to pilot hospitals provides support, reviews positive blood cultures, and answer questions about NHSN.
5. Recommendation for each facility to develop an 'internal review' checklist so that a single ICP is not solely responsible for making decision about HAIs.
6. Case studies of positive blood cultures.

Questionnaires were administered to each of the pilot hospitals to assess how they conduct their CLABSI and HCW vaccination rate surveillance. The results of this survey will be reported to provide information about how each hospital is performing surveillance: the information should help inform future recommendations.

## Recommendations for Actions

The HAI AC recognizes the potential value of surveillance for HAIs to a) inform the public and b) implement evidence-based prevention methods in the institutions from which the data is collected. Based on experience, the HAI AC offers several general recommendations regarding HAI surveillance and public reporting in New Mexico:

- Expand reporting of CLABSIs and HCW influenza vaccination rates to include additional hospitals and plan for hospital-specific (i.e., named) public reporting to begin after one additional year of data collection in order to:
  - Gain more experience validating and analyzing the data
  - Utilize the first year of pilot data to develop and test (e.g., with focus groups, experts in the field) public reporting mechanisms
  - Educate/recruit additional New Mexico hospitals to join the HAI reporting initiative
- Recommend to the New Mexico Legislature that mandated reporting be considered to start July 1, 2010 with adequate resources for implementation for:
  - CLABSIs in hospitals with ICUs that fit NHSN definitions
  - Influenza vaccination rates of HCWs
- If HAI reporting is mandated, program development would include:
  - Hospital training; data collection/management/analysis/dissemination; public reporting

### Topic-specific Preliminary Recommendations

#### *Surveillance*

HAI AC believes that CLABSI surveillance in acute care hospitals utilizing NHSN for reporting is feasible and worthwhile. Therefore, it recommends the expansion of CLABSI surveillance to all hospitals with either an adult and/or pediatric intensive care unit that have at least 50 line-days per year or an average census of 50 patients per year (per NHSN definitions) to start July 1, 2010. In the intervening time, additional hospitals beyond the six pilot hospitals will be recruited to join voluntary reporting. All reported data, including patient identifiers, would be made available to NMDOH. CLABSI rates would be calculated for each type of ICU for patients with a central line, with the ICU type as the sole risk adjustment. NHSN definitions list several types of adult ICUs including medical, medical/surgical, neurosurgical, surgical cardiothoracic, and others, and one pediatric ICU that is a pediatric medical/surgical ICU. The HAI AC also recommends that HCW influenza vaccination rates continue to be reported by the current pilot hospitals as well as additional healthcare settings as determined by the HAI AC.

NMDOH recognizes the federal Healthcare Infection Control Practices Advisory Committee (HICPAC) recommendation to gradually implement any new public reporting system by incrementally introducing new reporting requirements. HICPAC is the nation's expert in infection control and serves as the advisory committee to CDC and the Secretary of HHS. The HICPAC recommendation indicated that implementing a reporting system too quickly could contribute to poor data quality and data misinterpretation (available at: <http://www.cdc.gov/ncidod/dhqp/pdf/hicpac/PublicReportingGuide.pdf>).

## *Education and Reporting*

HAI-related education for all stakeholders (i.e., members of the HAI AC, participating hospitals and the public) is a critical element to the success of a statewide HAI reporting and prevention system. Education initiatives should commence well in advance of public reporting of HAIs, whether mandated by the Legislature or conducted on a voluntary basis.

Given that such education requirements will be significant and on-going, NMDOH proposes to request the advice and assistance of CDC, NMMRA, APICNM and the NMHA. Although the NHSN enrollment process is not complex, it is time consuming and can take two months or longer to complete; therefore, education on the enrollment process would have to begin well in advance of new reporting requirements for additional facilities. Some aspects of education would include:

- Training of employees overseeing system development and implementation, including at NMDOH and within participating hospitals.
- Development of guidelines and tools on how to conduct HAI surveillance.
- Training of hospitals on how to develop and/or modifying hospital-based HAI surveillance systems.
- NHSN enrollment procedures for hospitals.
- NHSN standard definitions and patient safety manual.
- Use of NHSN, including data entry and analysis.
- Reporting indicators, including updates and changes.

The HAI AC recommends that prior to expanded voluntary and mandated reporting, knowledgeable persons introduce HAI surveillance to personnel of each hospital to include their chief executive officer (CEO), chief nursing officers (CNO), ICP/s and others involved in infection control as appropriate, quality managers, and other administrators as needed, to assist in the implementation of HAI reporting. Providing education is critical to the success of HAI surveillance and reporting: facilities must gain an understanding of some of the complexities of setting up such systems and subsequently support their staff that will conduct the work and also adjust resource allocation as necessary. Participating healthcare facilities should provide adequate numbers of trained personnel to collect HAI data. Turn-over of ICPs can be high, necessitating cross-training and back-up personnel to ensure compliance with reporting requirements and patient safety.

The HAI AC also recommends that it continue to provide guidance to the initiative, including establishing feedback mechanism for hospitals to receive performance data so that quality improvement interventions may be adopted or adjusted accordingly.

Assuring the dissemination of useful and meaningful reports to consumers is essential (See Appendix G: New Mexico Healthcare-Associated Infections Pilot Status Report and Preliminary Data: January 15, 2009). Important constituencies to educate within the public include recipients of healthcare, the media, and elected officials. Education should include the following subject matter a) what are HAIs and the rationale for choosing CLABSIs and HCW influenza vaccination rates as the first focus areas for reporting; b) the types and definitions of data that will be publicly reported; c) development of new reporting measures in the future; d) evidence-based best practices for reducing the transmission of organisms/infections in general and of various HAIs in particular.

## *Legal*

The information received from hospitals through their voluntary enrollment and participation in NHSN and the New Mexico HAI pilot is subject to the U.S. Public Health Service Act. This Act gives a basic level of assurance of confidentiality protecting against the disclosure of any information that would permit the identification of any individual or institution. Such information is guaranteed to be held in strict confidence and used only for the purposes stated. Under this Act, identifying information shall not be disclosed or released without the consent of the individual or the institution involved.

Due to an increased public awareness of HAIs and the uses of data collection, several movements for public disclosure of HAI rates in the United States have emerged. Thus, several states have enacted legislation for the mandatory reporting of HAIs, and most include provisions for public disclosure. These statutes also, however, include confidentiality provisions.

If New Mexico legislation is introduced to enact a mandatory reporting system, the legislation should incorporate provisions that will provide further confidentiality protection – beyond that afforded through the Public Health Service Act – to any information reported. The legislation should include explicit provisions regarding the contents of any publicly available reports and otherwise set limits on public disclosure of any reported data. In particular, the legislation should include: a) provisions that patient confidentiality and facility information will be strongly protected; b) clarification that published infection rates do not establish a standard of care; and c) provisions that any data, materials, or underlying documents are exempt from public disclosure, are not subject to discovery, and are not admissible as evidence in any legal proceeding. (See Appendix H: Confidentiality under the Current “Voluntary” Program).

## *Resources*

Adequate resources are essential to implement the above-mentioned surveillance, reporting and education recommendations. In order for NMDOH to assure that implementation is conducted in a quality fashion so that the public and hospitals can benefit from the effort made, resources are required to:

- 1) Train and certify NMDOH staff involved in infection control, HAI surveillance and the use of the NHSN database.
- 2) Work with each hospital to assure that they conduct HAI surveillance correctly and know how to correctly use the NHSN database.
- 3) Work with each hospital to assure consistency and accuracy of surveillance within and between hospitals.
- 4) Conduct quality assurance audits of participating hospitals.
- 5) Conduct regular analyses of data and prepare public and other reports.
- 6) Work with hospitals to assure implementation of evidence-based processes of care, if not already in place, in order to prevent or minimize the incidence of infection.
- 7) Work with consumers to identify the best mechanisms for public reporting.
- 8) Promote infrastructure to train and certify HCWs in infection control to supply the increasing demand in this work force.

During the pilot, NMDOH will have provided approximately \$230,000 of in-kind services, each pilot hospital a minimum of approximately \$170,000 and the HAI AC and workgroups approximately \$100,000 for a total estimate of \$1,350,000 that will be expended in-

kind by those supporting the initiative during the pilot year. At a minimum, the HAI AC recommends that three dedicated full-time positions be dedicated to ongoing activities: a) program manager; b) epidemiologist; c) infection control professional at an expense of approximately \$350,000 for their salaries and fringe benefits and related support (e.g., information technology, travel, and communications).

In conclusion, if the goal of performing surveillance is to reduce the numbers of HAIs, consideration should be given to establishing a Patient Safety Organization (PSO) in New Mexico. These organizations, established by the 2005 Patient Safety and Quality Improvement Act, allow for aggregation and analysis of adverse events with additional guaranteed confidentiality protections for participating facilities. These organizations develop educational, collaborative interventions to address all aspects of patient safety.<sup>15</sup>

Expansion and support of the infection control workforce is urgently needed in our state. Fewer than 20 certified infection control professionals are now active in New Mexico, serving the needs of over 4,000 acute care patients (C. Moore, RN, President, APIC-NM, personal communication). Certification requires experience in all the elements of an infection control program and a written examination. While larger facilities are able to support internal training programs, this option is not available for small hospitals and other healthcare employers. The National Healthcare Safety Network reporting structure requires “trained infection preventionists” (a new term for infection control professionals) to generate accurate data.

Publishing outcomes is not sufficient to reduce the risk of HAIs. Most New Mexicans do not have a choice about where they receive healthcare, especially for acute illnesses or emergency procedures. State support for a PSO would be an important step to making health care safer for everyone.

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## APPENDIX A

### ACRONYMS

AHA	American Hospital Association
AHRQ	Agency for Healthcare Research and Quality
APIC	Association for Professionals in Infection Control and Epidemiology
BSI	Blood stream infection
CABG	Coronary Artery Bypass Graft
CDAD	<i>Clostridium difficile</i> Associated Disease
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CLABI	Central line associated bloodstream infection
CMS	Centers for Medicare and Medicaid
CNO	Chief Nursing Officer
CODPHE	Colorado Department of Public Health and Environment
GAO	General Accounting Office
HAI	Healthcare-associated Infection
HAI AC	New Mexico HAI Advisory Committee
HCA	Hospital Corporation of America
HCW	Health care worker
HHS	Department for Health and Human Services
HICPAC	Healthcare Infection Control Practices Advisory Committee
ICP	Infection Control Professional
ICU	Intensive Care Unit
IDSA	Infectious Diseases Society of America
IHI	Institute for Healthcare Improvement
IOM	Institute of Medicine
NMDOH	New Mexico Department of Health
NHSN	National Healthcare Safety Network
NMHA	New Mexico Hospital Association
NYSDOH	New York State Department of Health
SHEA	Society for Hospital Epidemiology of America
SSI	Surgical Site Infection
VHA	Veterans Health Administration

## APPENDIX B

### GLOSSARY

Central line-associated bloodstream infection (CLABSI): A primary bloodstream infection (BSI) in a patient that had a central line within the 48-hour period before the development of the BSI. If the BSI develops within the 48-hours of discharge from a location, it is associated with the discharging location. (CDC, The National Healthcare Safety Network Manual: Patient Safety Component Protocol, January, 2008)

Healthcare-associated infection (HAI): A localized or systemic condition that: a) results from an adverse reaction to the presence of an infectious agent or its toxin; and b) was not present or incubating at the time of admission to the healthcare facility. (CDC, The National Healthcare Safety Network Manual: Patient Safety Component Protocol, January, 2008)

Healthcare Worker: Worker with direct patient contact and a proportion of persons working in essential healthcare support services needed to maintain healthcare services (e.g., dietary, housekeeping, admissions, blood collection staff, respiratory therapy staff, imaging services).

Intensive care unit (ICU): A nursing care area that provides intensive observation, diagnosis, and therapeutic procedures for adults and/or children who are critically ill. An ICU excludes nursing areas that provide step-down, intermediate care or telemetry only. Specialty care areas are also excluded. The type of ICU is determined by the kind of patients cared for in that unit. That is, if 80% of patients are of a certain type (e.g., patients with trauma), then that ICU is designated as that type of unit (in this case, trauma ICU). When a unit houses roughly equal populations of medical and surgical patients, it is called a medical/surgical unit. (CDC, The National Healthcare Safety Network Manual: Patient Safety Component Protocol, January, 2008)

Nosocomial: Originating or taking place in a hospital, acquired in a hospital, especially in reference to an infection: in regards to infections, those that were not present or incubating prior to the patient being admitted to the hospital, but that occurred within 72 hours after admittance to the hospital.

Risk adjusted: A standardized method used to ensure that intrinsic and extrinsic risk factors for a healthcare-associated infection are considered in the calculation of healthcare-associated infection rates.

Surveillance: Ongoing, systematic collection, analysis, and interpretation of health-related data essential to the planning, implementation and evaluation of public health practice, closely integrated with the timely dissemination of these data to those responsible for prevention and control.

## **APPENDIX C**

### **APIC OVERVIEW OF STATE HAI REPORTING LAWS**

## APIC OVERVIEW OF STATE HAI REPORTING LAWS

STATE	LAW	YEAR ENACTED	REPORT TO WHOM?	WHEN REPORTING TO COMMENCE	REPORT THROUGH NHSN?	WHAT GETS REPORTED	ADVISORY COMMITTEE?	
AR	Public Act 845 (HB 2735)	2007	Facilities may <i>voluntarily</i> submit quarterly reports to Division of Health of the State Department of Health and Human Services; Health Dept. submits summary of reports annually to legislature and makes them publicly available on website.	Facility reporting to Division of Health may begin January 31, 2009 or any time thereafter, according to quarterly schedule (April 30, July 31, October 31, January 31). First annual report to be published on or before January 1, 2010.	Data collection and analysis methodology to be determined by Advisory Committee, who may consider existing systems.	Facilities report surgical site infections from: 1) Coronary artery bypass 2) total hip or knee arthroplasty 3) knee arthroscopy 4) hernia repair; Central line-associated bloodstream infection in ICU. Annual report includes aggregate, not facility specific, information.	"Health Facility", including hospitals, outpatient surgery centers, public health centers, and recuperation centers.	Yes. Includes Infection Control Professionals
AR	Chapter 296 (SB 1058)	2008	Hospitals report to State Department of Public Health. Department will make information available on its website according to prescribed schedule. Healthcare provider must notify patient when patient tests positive for MRSA.	1/1/2009 - hospital quarterly reporting begins; 1/1/2011 - department post CLASBI and MRSA rates on website; 1/1/2012 - department post incidence rate of deep or organ space surgical site infections, orthopedic, cardiac, and gastrointestinal surgical procedures.	Yes	HA-MRSA bloodstream infection; HA-clostridium difficile infection; HA-VRE bloodstream infection; central line-associated bloodstream infections and total central line days; surgical site infections of deep or organ space surgical sites, orthopedic surgical sites, cardiac surgical sites, and gastrointestinal surgical sites designated as clean and clean-contaminated, and the number of surgeries for each site.	MRSA - testing of patients scheduled for inpatient surgery; discharged from acute care hospital within 30 days prior to current admission; to be admitted to ICU or burn unit; receiving inpatient dialysis treatment; transferred from skilled nursing facility.	Already in existence per previous law. HAI-AC assist health department in drafting regulations for implementation of this law.
CA	Chapter 526 (SB 739)	2006	General acute care hospitals report to State Department of Public Health.	Phased-in. New reporting requirements begin 1/1/2007, 1/1/2008; other surveillance and prevention measures implemented 1/1/2009.	Yes.	Beginning 1/1/2007-implementation of infection surveillance and prevention process measures, including risk and cost of the number of invasive patient procedures performed at the hospital; number of ICU beds; number of emergency department visits; number of outpatient visits by department; number of licensed beds; changing demographics of the community; estimated need and recommendations for additional resources for infectino prevention and control programs. Beginning 1/1/2008-implementation of process measures, initially including central line insertion practices, surgical antimicrobial prophylaxis, and influenza vaccination of patients and healthcare personnel.	Facility wide	Yes.
CA								

## APIC OVERVIEW OF STATE HAI REPORTING LAWS

STATE	LAW	YEAR ENACTED	REPORT TO WHOM?	WHEN REPORTING TO COMMENCE	REPORT THROUGH NHSN?	WHAT GETS REPORTED	ADVISORY COMMITTEE?	
CO	Chapter 316 (HB 06-1045)	2006	Physicians who diagnose HAIs must report them to facilities in which procedure was performed; health facilities must report HAIs to NHSN and grant access to state health department. Health department will make summarized data available to the public on its website.	Reporting to NHSN to begin July 31, 2007. Beginning January 15, 2008, the health department will provide annual report to legislature summarizing risk-adjusted health facility data. Annual report will be made available to the public on health department website.	Facilities report to NHSN and must grant access to state health department.	Cardiac surgical site infections, orthopedic surgical site infections, central line-related bloodstream infections. By November 1, 2008, Advisory Committee to recommend inclusion of abdominal surgical site infection and at least one other HAI, or explain why no addition is necessary.	"Health Facility" includes hospitals, hospital units, ambulatory surgical centers, and dialysis treatment clinics. Also physicians diagnosing HAIs must report to the facility. By Nov. 1, 2008, Advisory Committee to recommend to health department whether long-term acute care hospitals should be added to data collection and reporting requirement.	Includes 4 Infection Preventionists, including 1 from ASC and 3 CBIC-certified RNs. Advisory Committee assists health department with oversight, evaluation, and developing methodologies for information collection and dissemination.
CT	Public Act 06-142 (SB 160)	2006	State Department of Public Health to report to the General Assembly on plan to implement mandatory reporting system for HAIs recommended by Advisory Committee, and then report annually to General Assembly on information collected through mandatory reporting system. Annual report will be made available to the public.	By 10/1/07, state health department will "within available appropriations" implement recommendations of Advisory Committee with respect to establishing an HAI mandatory reporting system and submit a report on the plan to the General Assembly. On 10/1/08 and annually thereafter, the health department will report to the General Assembly on data collected under the mandatory reporting system.	Not specified	To be determined by Advisory Committee.	To be determined by Advisory Committee.	Yes, to convene no later than 9/1/06. To advise the health department with respect to development, implementation, operation and monitoring of a mandatory reporting system for HAIs; identify, evaluation and recommend standardized measures, processes for reporting; and recommend methods for increasing public awareness about effective measures to reduce the spread of infections in communities and healthcare settings.
CT	Public Act 08-12 (SB 579)	2008	Hospitals report to State Department of Public Health, which will make the information public.	By January 1, 2009	Not specified	Hospital plan to reduce the incidence of MRSA infection at the hospital.	Not specified	N/A



## APIC OVERVIEW OF STATE HAI REPORTING LAWS

STATE	LAW	YEAR ENACTED	REPORT TO WHOM?	WHEN REPORTING TO COMMENCE	REPORT THROUGH NHSN?	WHAT GETS REPORTED	ADVISORY COMMITTEE?
DE	House Substitute #1 (for HB 47)	2007	Hospitals report quarterly to State Department of Health and Social Services. Department reports annually to legislature. Both quarterly and annual reports available to public after inspection by hospitals.	First annual report due by 6/30/2009.	Hospitals must enroll in NHSN by 12/31/2007 and use NHSN definitions in reporting HAI rates, but not specified if reporting through NHSN.	To be determined by Advisory Committee, and may include HAI rates related to clinical procedures such as surgical site infections for total hip and knee arthroplasty; central line-related bloodstream infections in ICU; and direct healthcare provider influenza vaccination rates. After 6/30/2010 Department may revise categories for reporting.	To be determined by Advisory Committee.  Yes. Includes one infection preventionist. Purpose of Advisory Committee to assist Department in developing all aspects of the methodology for collection, analyzing and reporting data.
FL	Chapter No. 2004-297 (HB 1629)	2004	Healthcare facilities report to state Agency for Health Care Administration	Not specified	No	To be determined by rulemaking	To be determined.
IL	Public Act 093-0563 (SB 59)	2003	Hospitals report to State Department of Public Health quarterly, then submit annual summary report, which will be made available to the public.	Not specified	Not specified, but reporting according to NNIS benchmarks.	Specific details to be determined by Department of Public Health, but categories in which rate reporting is required includes Class I surgical site infection, ventilator-associated pneumonia, and central line-related bloodstream infection.	Not specified  Yes, to be organized by Department of Public Health. Advisory Committee will advise on all reporting required under this Act, not just HAI reporting. Does not specify inclusion of infection preventionist.
IL	Public Act 095-0282 (HB 192)	2007	State Department of Public Health provide periodic reports and updates to public officials and the general public on new developments in prevention and management of MDROs. Department also required to publish annual report on MRSA and C.Diff. infections (based on Hospital Discharge Datasheets).	Not specified	No	New developments in prevention and management of MDROs; information on MRSA and C.Diff. infections (type of information not specified).	Not specified  N/A



## APIC OVERVIEW OF STATE HAI REPORTING LAWS

STATE	LAW	YEAR ENACTED	REPORT TO WHOM?	WHEN REPORTING TO COMMENCE	REPORT THROUGH NHSN?	WHAT GETS REPORTED	ADVISORY COMMITTEE?	
IL	Public Act 095-0312 (SB 233)	2007	(This is primarily an MDRO prevention and control law, not reporting). Hospitals report to State Department of Public Health on number of MRSA infections that are present on admission and that occurred during the hospital stay. Department will make information available to the public in an annual report and include the information in the Hospital Report Card.	Commencement date not specified, but bill is repealed January 1, 2011.	No	MRSA	ICUs and other high-risk patients.	No
ME	Public Law Chapter 594 (LD 2297)	2008	Providers report healthcare quality data, including HAI infection quality data, to the Maine Health Data Organization. Maine Center for Disease Control and Prevention reports annually to Legislature on statewide collaborative efforts with infection preventionists to control and prevent HAIs. Annual report made available to the public.	January 30, 2009	Not specified	Provider-specific performance report based on healthcare quality data.	Not specified	Not specified
ME	Chapter 42 Maryland Public Law (SB 135)	2006	Hospitals report to the Maryland Health Care Commission; Commission reports annually to the Legislature. Comparable evaluation system shall adhere to recommendations of CDC and HICPAC for public reporting of HAIs.	July 1, 2006	Not specified	Not specified.	Not specified	Not specified
MD								



## APIC OVERVIEW OF STATE HAI REPORTING LAWS

STATE	LAW	YEAR ENACTED	REPORT TO WHOM?	WHEN REPORTING TO COMMENCE	REPORT THROUGH NHSN?	WHAT GETS REPORTED	ADVISORY COMMITTEE?
MA	Chapter 305 (S 2863)	2008	Health Care Quality and Cost Council, which will include information on its website.	Unclear	Not specified	Not specified.	Not specified
MN	Chapter 147 (HF 1078) (see Article 14 Sec. 1)	2007	Minnesota Hospital Association will develop a web-based system by which to report to the public.	January 1, 2009	No	Hospital-specific performance on HAI public reporting measures as published by NQF. No specifics listed in the law, but website must provide information that compares hospital-specific data to hospital statewide data, and must be updated annually.	No
MO	SB 1279	2004	Laboratories, healthcare providers and healthcare facilities (including hospitals, ambulatory surgical centers, and other facilities) will report to the State Department of Health and Senior Services. Physicians' offices are exempt. Reports published on the health department website.	7/1/05 department promulgate rules; 12/31/06 first report issued by department.	To be determined based on recommendation of Advisory Committee	Incidence rates for Class I surgical site infections; ventilator-associated pneumonia; central line-related bloodstream infections; other categories to be established by rule. Data submitted by laboratories to be determined by regulation, but will include number of MRSA and VRE patients, by facility.	Yes.
NE	Nebraska Revised Statutes Ch. 71, Secs. 71-8717 and 8718 (LB 361)	2005	Providers required to report to the Patient Safety Organization. Providers may elect to control with Patient Safety Organization.	Not specified	N/A	Unanticipated death or major permanent loss of function associated with HAIs. (MRSA, VRE, VISA/VRSA incidence reportable as communicable diseases - by regulation).	No



## APIC OVERVIEW OF STATE HAI REPORTING LAWS

STATE	LAW	YEAR ENACTED	REPORT TO WHOM?	WHEN REPORTING TO COMMENCE	REPORT THROUGH NHSN?	WHAT GETS REPORTED	ADVISORY COMMITTEE?	
NV	Chapter 191 (AB 59)	2005	Patient Safety Officer of the medical facility reports to the Nevada State Health Division.	No specified. However, effective date of law was October 1, 2005, and this law amended a mandatory reporting law already in existence to add HAIs to the sentinel events required to be reported.	No	Surgical site infections, ventilator-associated pneumonia, central line-related bloodstream infections, and urinary tract infections.	Not specified	N/A
NH	Chapter 292 (HB 1741)	2006	Hospitals report to State Department of Health and Human Services. Department develop statewide database of reported infection information to make available to the public.	1/1/08 - hospitals begin reporting for a 6-month pilot phase; 9/1/09 - Health Department issue a report to hospitals to assess overall accuracy of data; 2/1/09 - First public report to be issued.	No, but guidelines, definitions, etc. should be consistent with NHSN, HICPAC, CDC, CMS, TJC, NQF, and the Hospital Quality Alliance.	Central line-related bloodstream infection; ventilator-associated pneumonia; surgical wound infections; plus process measures including adherence rates of central line insertion practices; surgical antimicrobial prophylaxis; and coverage rates of influenza vaccination for healthcare personnel and patients/residents.	All	No
NH	2007 Chapter 120 (S 2580)	2007	General hospitals report to State Department of Health and Senior Services the number of cases of hospital-acquired MRSA in the facility.	Infection prevention program to begin implementation by Sept. 1, 2007. Reporting commencement date to be determined by regulation.	No	Hospital-acquired MRSA	All	No
NJ	P.L. 2007 Chapter 196 (S 147)	2007	General hospitals report quarterly to the State Department of Health and Senior Services. Information to be made available to the public on department website in a format the department deems appropriate to enable comparison among hospitals.	Thirty days after adoption of regulations.	To be determined by regulation.	To be determined by regulation.	Not specified	No
NJ	P.L. 2007 Chapter 196 (S 147)	2007	General hospitals report quarterly to the State Department of Health and Senior Services. Information to be made available to the public on department website in a format the department deems appropriate to enable comparison among hospitals.	Thirty days after adoption of regulations.	To be determined by regulation.	To be determined by regulation.	Not specified	No



## APIC OVERVIEW OF STATE HAI REPORTING LAWS

STATE	LAW	YEAR ENACTED	REPORT TO WHOM?	WHEN REPORTING TO COMMENCE	REPORT THROUGH NHSN?	WHAT GETS REPORTED		ADVISORY COMMITTEE?
NY	Chapter 284 of 2005 (A 3698)	2005	Hospitals report to the NY State Department of Health every six months. Health Department will establish state-wide database to publicly report HAI data, and submit an annual report to the governor and legislature which will be published on the department's website.	1/1/2006-dept. establish HAI reporting system; 1/1/2007-hosp. rptng begins in 1-year pilot phase (hospital identifiers encrypted in pilot phase); 3/1/2008-dept. report to hospitals assessing the accuracy of data submitted in pilot; subsequent reports will include hospital identifiers.	Yes	Hospitals report surgical wound infections, central line-related bloodstream infections, and ventilator associated pneumonia. Annual dept. report to governor and legislature includes risk-adjusted HAI rates for each hospital; analysis of trends in HAI infection and control state-wide, regionally, and nationally; and narrative description of lessons for safety and quality improvement.	Initially, reporting only in critical care units	Bill includes consultation with technical advisors, but no formal advisory committee.
OK	Chapter 315 (HB 2842)	2006	Annual report of hospital performance, including facility-specific quality indicators, to be published.	No specified.	No	Quality indicators to include AHRQ Patient Safety Indicators, ventilator-associated pneumonia, device-related bloodstream infections.	Acute care ICU.	Oklahoma Hospital Advisory Council established as part of broad Medicaid Reform law to advise State Board of Health and State Department of Health regarding hospital operations, including patient safety measures.
OR	Chapter 838 Laws of 2007 (HB 2524)	2007	Healthcare facilities report to the Office for Oregon Health Policy and Research, which will be made available to the public. In order to avoid duplication, information will be reported in a manner similar to that reported to the state Department of Human Services and to CMS.	1/1/2008 - Office adopt rules for HAI reporting program; 1/1/2009 - facilities begin reporting; 1/1/2010 - reports disclosed to the public every 6 months; 1/1/2011 - public reports updated quarterly.	Not specified but reporting mechanism to be determined by HAI Advisory Committee.	To be determined by regulation, taking into account advice from HAI Advisory Committee. Infection measures to be reported may include surgical site infections; central line-related bloodstream infections; urinary tract infections, and process measures designed to ensure quality and reduce HAIs.	To be determined. Healthcare facility includes hospitals, long term care facilities, ambulatory surgery centers, outpatient renal dialysis facilities, and freestanding birthing centers.	Yes.
OR	Act 52 (SB 968)	2007	Hospitals report to CDC/NHSN. Nursing homes report to State Department of Health and the Pennsylvania Patient Safety Authority.	2/1/2007 - hospitals begin monthly reporting through NHSN, and authorizing health department and patient safety authority to have access to data.	Yes.	To be determined by health department and patient safety authority.	Facility wide	Yes.
PA								

## APIC OVERVIEW OF STATE HAI REPORTING LAWS

STATE	LAW	YEAR ENACTED	REPORT TO WHOM?	WHEN REPORTING TO COMMENCE	REPORT THROUGH NHSN?	WHAT GETS REPORTED	ADVISORY COMMITTEE?
RI	Chapter 097 (S 2382)	2008	Hospitals report quarterly to State Health Department. Department submit annual report to the Legislature summarizing hospital quarterly reports; report published on Department website. Annual report to include plain-language executive summary; discussion of findings, conclusions, and trends; comparison to prior years; and policy recommendations as appropriate.	4/1/2009 - hospital quarterly reporting; 10/2010 - annual reports due; 12/2010 - annual reports published on website.	To be determined by Healthcare Quality Steering Committee and HAI Advisory Committee.	To be determined by regulation upon advice of Steering Committee and Advisory Committee. Specific procedures may include surgical site infection; ventilator-associated pneumonia; central line-related bloodstream infections; urinary tract infections. May also include process of care measures such as compliance with SIP/SCIP parameters, prevention bundles for CLABSI, prevention bundles for CA-UTI, hand hygiene compliance, compliance with isolation precautions.	To be determined.  Healthcare Quality Steering Committee (chaired by state health director) and Hospital-Acquired Infections and Prevention Advisory Committee, appointed as permanent subcommittee to Steering Committee, with majority of members representing infection control community.
RI	Act 293 (S1318)	2006	Hospitals report every 6 months to the State Department of Health and Environmental Control. Reports made available to public at hospitals and from Department. Department submit annual report to General Assembly summarizing hospital reports; report published on Department website. Annual report to include plain-language executive summary; discussion of findings, conclusions, and trends; comparison to prior years; and policy recommendations as appropriate.	2/1/2008 - hospitals begin reporting; 2/1/2009 - first Department annual report published.	To be determined by Advisory Committee and Department, which will consider, but not limited to existing systems such as NHSN.	Specific clinical procedures to be recommended by Advisory Committee, including surgical site infection; ventilator-associated pneumonia; central line-related bloodstream infection. Also report on completeness of certain selected infection control processes, as recommended by Advisory Committee.	To be determined.  Yes.
SC	Chapter 904 (SB 2578)	2006	Hospitals to register and report through NHSN and grant State Department of Health access to database on selected procedures. Department to disseminate public reports based on data. update reports every 6 months.	Within 4 months of NHSN becoming available to facility.	Yes.	Central line-associated bloodstream infections (facility-specific rates only displayed for facilities with more than 30 central line insertions per year); surgical site infections for coronary artery bypass grafts (Department will report only aggregate statewide performance on CABG surgical infection rates).	CLABSI - ICUs, excluding burn units and Level 1 Trauma units; SSI for CABG - not specified.  Task Force to clarify Interpretive Guidelines for Reporting Unusual Events with regard to Class I and Class II surgical site infections. Task Force to report to health Commissioner.
TN							



## APIC OVERVIEW OF STATE HAI REPORTING LAWS

STATE	LAW	YEAR ENACTED	REPORT TO WHOM?	WHEN REPORTING TO COMMENCE	REPORT THROUGH NHSN?	WHAT GETS REPORTED	ADVISORY COMMITTEE?	
TX	SB 288	2007	Healthcare facilities report to the Department of State Health Services. The Department will make a summary of facility reports available to the public. Timeframes for facility and department reporting to be determined by regulation.	To be determined by regulation. Texas HAI Reporting System to be developed by 6/1/2008.	No	Incidence of surgical site infections for colon surgery, hip and knee arthroplasty; abdominal and vaginal hysterectomy; coronary artery bypass graft; and vascular procedures. Pediatric and adolescent hospitals report incidence of SSIs for cardiac procedures (excluding thoracic cardiac procedures); ventriculoperitoneal shunt procedures; and spinal surgery with instrumentation. General hospitals report incidence of central line-associated primary bloodstream infections occurring in special care setting; incidence of respiratory syncytial virus occurring in pediatric inpatient unit. Law establishes alternative reporting requirements for facilities that perform fewer than an average of 50 procedures per month for reportable procedures.	See previous column. Healthcare facilities include general hospitals and ambulatory surgical centers.	Yes.
TX	HB 1062	2007	PILOT PROGRAM: All clinical laboratories within the area of the pilot program report to the program administrator. Program to compile a summary of data by location to make available to the public.	Pilot program commenced upon enactment of legislation 6/16/2007. Department of State Health Services to submit report to Legislature on effectiveness of pilot program in tracking and reducing number of MRSA infections within the area of the pilot program by 9/1/2009. Submission of this report concludes and abolishes the program.	No	All cases of MRSA	Laboratories	N/A



## APIC OVERVIEW OF STATE HAI REPORTING LAWS

STATE	LAW	YEAR ENACTED	REPORT TO WHOM?	WHEN REPORTING TO COMMENCE	REPORT THROUGH NHSN?	WHAT GETS REPORTED	ADVISORY COMMITTEE?	
UT	Utah Administrative Code, Rule R386-705	2008	Hospitals report to State Department of Health, Bureau of Epidemiology. Information will be made available upon request.	Effective date of Rule 11/1/2008.	Not specified. To be determined by health department.	Number of central-line patient days; each case of central line-associated bloodstream infection; influenza vaccination rates for healthcare workers.	CLABSI - general or specialty care ICU beds, except bone marrow transplant units, newborn or neonatal ICUs or nursing areas that provide step-down, intermediate care, or telemetry monitoring.	No
VT	Act 215 (H 881) - only Section 327-Hospital Infection Rate Reporting	2006	Hospitals report to State Department of Health.	Not specified	Not specified	To be determined by regulation. Measures of hospital-acquired infection included in broader hospital community report.	Not specified	Public Oversight Commission to work with the health commissioner and representatives of hospital, healthcare professional, and patient advocacy groups to establish format and content for community reports.
VA	Chapter 444 (H 1570)	2005	Acute care hospitals report to CDC's NHSN and release data to State Board of Health. Data may be released to the public by the Board upon request.	July 1, 2008	Yes	To be determined by Board of Health Regulation	To be determined by Board of Health Regulation	No



## APIC OVERVIEW OF STATE HAI REPORTING LAWS

STATE	LAW	YEAR ENACTED	REPORT TO WHOM?	WHEN REPORTING TO COMMENCE	REPORT THROUGH NHSN?	WHAT GETS REPORTED	ADVISORY COMMITTEE?	
	Chapter 261 (HB 1106)	2007	Hospitals report HAIs to CDC, process measures reported to CMS. Hospitals must release or grant access to information to state health department. Health department report to legislature (beginning 2011). Beginning 12/1/09, health department prepare and public annual report comparing HAI rates at individual hospitals, publish on its website.	7/1/08 -- CLABSI in ICU; 1/1/09 - VAP; 1/1/2010 - SSI for deep sternal wound for cardiac surgery, including CABG, total hip and knee replacement surgery, and abdominal and vaginal hysterectomy.	Facilities report to NHSN until health department determines otherwise. Health Department may require reporting to CMS if/when it determines that data can be reporting according to "definitions, methods, requirements and procedures of the Hospital Compare Program while providing substantially the same information to the public.	Central line-associated bloodstream infection in ICU; Ventilator-associated pneumonia; surgical site infection for the following procedures: Deep sternal wound for cardiac surgery, including coronary artery bypass graft; total hip and knee replacement surgery; and abdominal and vaginal hysterectomy.	Yes. Includes Infection Preventionists. Advisory Committee assists health department by making recommendations on allowing hospitals to review and verify data being released in the public report, and considering methodologies and practices recommended by CMS, CDC, The Joint Commission, National Quality Forum, Institute for Healthcare Improvement and other relevant organizations.	
WA	Chapter 114, Acts of 2008 (HB 4418)	2008	Hospitals report to the WV Health Care Authority (a division of the State Department of Health and Human Resources). Information to be made available to the public in a manner to be determined by Advisory Panel.	July 1, 2009	Yes	To be determined by Infection Control Advisory Panel.	To be determined by Infection Control Advisory Panel.	Yes. Other functions include providing guidance to hospitals in their collection of HAIs data; providing evidence-based practices in control and prevention of HAIs; establish reasonable goals to reduce the number of HAIs; develop plans for analyzing hospital data; and developing HAI advisories for hospital distribution.
WV								

**ACRONYMS:**  
 CABG -- coronary artery bypass graft  
 CA-UTI -- catheter-associated urinary tract infections  
 CLABSI -- central line-associate bloodstream infections  
 HAI -- healthcare-associated infection  
 ICU -- intensive care unit  
 MDRO -- multidrug-resistant organism  
 MRSA -- methicillin-resistant staphylococcus aureus  
 NHSN -- CDC's National Healthcare Safety Network  
 SSI -- surgical site Infection  
 VAP -- ventilator-associated pneumonia  
 VRE -- vancomycin-resistant enterococci  
 VRSA -- vancomycin-resistant staphylococcus aureus  
 VISA -- vancomycin-intermediate/resistant staphylococcus aureus

## APPENDIX D

### LETTER FROM THE SECRETARY OF HEALTH: APPOINTMENT OF THE HAI ADVISORY COMMITTEE



February 7, 2008

Dear Members of the HJM 67 Task Force,

I would first like to offer my sincere gratitude for your report entitled “Feasibility of Conducting Surveillance for Healthcare-Associated Infections (HAIs) in New Mexico” in response to House Joint Memorial 67. I have carefully read your report studying this important issue and have the following points to make:

- I direct the Epidemiology and Response Division (ERD) of the New Mexico Department of Health to appoint a multi-disciplinary advisory committee to guide the development of HAI surveillance methods, reporting methods to the public, and inform any future legislation on HAI surveillance in New Mexico. It is my hope that you will all be able to continue working on this issue in some fashion.
- The first year of HAI surveillance will be a pilot year that is voluntary for healthcare facilities and provides a confidential report of findings. The New Mexico Hospital Association shall be a key partner in identifying a minimum of three hospitals to participate in this pilot year. These facilities should be identified prior to April 30, 2008.
- Your research and work has identified two logical, evidence-based measures to monitor in this first pilot year: a) central-line-associated bloodstream infections and b) influenza vaccination rates of healthcare workers. These measures should be systematically monitored by the pilot facilities beginning no later than June 30, 2008.
- An analysis of the first month of data collection should occur no later than July 30, 2008. Following the first six months of data collection, a thorough evaluation of the process and quality of data will occur. After the pilot, the measures will be expanded to all acute care hospitals as directed by the Advisory Committee. Other evidence-based measures, as determined by the Advisory Committee may be added in the future depending on resource availability.
- Implementing a system such as the National Healthcare Safety Network (NHSN) will align New Mexico’s efforts with national movements and is a logical step forward. Training in this system or a similar system for the pilot facilities should be initiated as soon as these facilities are identified and should be completed no later than May 15, 2008.

- Your other recommendations regarding reporter liability, patient confidentiality, public reporting method, and identification of healthcare facilities are important elements for the Advisory Committee to consider as this work proceeds.

I recommend that your task force resume meeting as quickly as possible. NMDOH will appoint the Advisory Committee from appropriate stakeholders and ask that as it manages the implementation of HAI surveillance consistent with your recommendations. At this point, no new funds have been identified or procured to perform this work although this may change at some point in the future as this effort develops. I compliment and thank you for your contributions thus far and believe that your expertise will continue to benefit all New Mexicans as we work toward decreasing the burden of healthcare-associated infections.

Sincerely,

Alfredo Vigil, MD  
Secretary, New Mexico Department of Health

Cc: Karen Armitage, MD MPH, Chief Medical Officer, New Mexico Department of Health

## APPENDIX E

### MEMBERS OF THE NEW MEXICO HAI ADVISORY COMMITTEE

Facilitator:

Joan Baumbach, MD, MPH, MS  
Infectious Disease Epidemiology Bureau Chief, NMDOH

Scribe:

Anne Timmins, MPH, BChD  
Quality Improvement Coordinator, New Mexico Medical Review Association (NMMRA)

Karen Armitage, MD  
Chief Medical Officer, NMDOH

Carlene Brown, MPH, CPHQ (Voting member)  
Quality Improvement Manager, New Mexico Medical Review Association (NMMRA)

Sandra Cole, RN, BA  
Bureau Chief, Health Facilities Licensing and Certification, NMDOH

Cynthia Connell, BS, MT (ASCP), CIC

Infection Control Consultant, NMDOH

Jeff Dye, MBA, FACHE (Voting member)  
President and CEO, New Mexico Hospital Association

Christina Ewers, RN (Voting member)  
Nurse Epidemiologist, NMDOH

Trish Garduño, BS  
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Ellen Interlandi, RN, MHM, NE-BC  
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Mary T. Jaco, RN, MSN, CIC (Voting member)  
Infection Control Practitioner, Presbyterian Healthcare Services  
Central New Mexico

Kristine “Kooch” Jacobus, MA (Voting member)  
Deputy Director, NM Health Policy Commission

Susan M. Kellie, MD, MPH (Voting member)  
Associate Professor of Medicine  
Division of Infectious Diseases, University of New Mexico School of Medicine  
Hospital Epidemiologist, University of New Mexico Health Sciences Center, and  
New Mexico Veterans' Administration Healthcare System

Nancy Mikkelsen, BSN, MA, CIC (Voting member)  
President of APIC New Mexico and Infection Control Practitioner  
Kindred Hospital, Albuquerque

Sandra O'Kelly, BSN (Voting member)  
Infection Control/Safety Coordinator, Holy Cross Hospital

Julie Reagan, JD, MPH  
Assistant General Counsel, NMDOH

Ophelia Rinaldi, LISW (Voting member)  
Consumer Representative

David Rodriguez, LPN, LNHA, SMAT  
Deputy Director, Division of Health Improvement, NMDOH

C. Mack Sewell, DrPH, MS  
State Epidemiologist, NMDOH

Chad Smelser, MD  
Medical Epidemiologist, NMDOH

Liz Stefanics, PhD  
Director, NM Health Policy Commission

David W. Stryker, MD (Voting member)  
Infectious Disease Practitioner/Epidemiologist  
Presbyterian Healthcare Services

## APPENDIX F

### NEW MEXICO RULE FOR SMALL NUMBERS AND PUBLIC DATA RELEASE

<u>Specified population</u>	<u>Numerator</u>	<u>Action</u>
<b>Event set*</b>		
<b>&lt;20</b>	<b>1-3</b>	<b>Suppress (and suppress other cells allowing calculation of 1-3)</b>
<b>&gt;=20</b>	<b>all</b>	<b>Release</b>

\*Event set – the set of which the numerator is an immediate subset

Percentages or rates that can be used to determine the value of suppressed cells must also be suppressed.

These guidelines do not relieve the data user of the responsibility to be aware of the confidentiality issues regarding the data and to appropriately present data.

Do not suppress the number of births or deaths at the state, district, or county levels presented by standard racial/ethnic groups, standard age groups, sex, prenatal care, birth weight categories, birth order, plurality, total anomalies, marital status, or NCHS standard 113 cause of death categories.

## **APPENDIX G**

### **NEW MEXICO HEALTHCARE-ASSOCIATED INFECTIONS PILOT STATUS REPORT AND PRELIMINARY DATA JANUARY 15, 2009**

## **New Mexico Healthcare-Associated Infections Pilot Status Report and Preliminary Data: January 15, 2009**

### **Which are the 6 hospitals that agreed to participate in the New Mexico healthcare-associated infections pilot year?**

- Gerald Champion Regional Medical Center, Alamogordo, NM
- Heart Hospital of New Mexico, Albuquerque, NM
- Memorial Medical Center, Las Cruces, NM
- Presbyterian Hospital, Albuquerque, NM
- San Juan Regional Medical Center, Farmington, NM
- University of New Mexico Hospital, Albuquerque, NM

### **What measures are being reported in the healthcare-associated infection (HAI) pilot year?**

As of July 1, 2008, the New Mexico pilot hospitals started reporting 2 measures: 1) central line associated bloodstream infections (CLABSIs) in a total of 9 adult ICU settings on a monthly basis; and 2) health care worker (HCW) influenza vaccination rates.

### **Why are the preliminary pilot year data aggregated with no hospitals identified?**

Six New Mexico hospitals volunteered to participate in a pilot year: they were assured that the first year of HAI surveillance would be treated confidentially. The pilot year data will enable the HAI Advisory Committee to determine how to most accurately and effectively present the data to the public.

### **Are there any considerations about which I should be aware when reviewing the data?**

The New Mexico pilot hospitals are entering data into the National Healthcare Safety Network (NHSN), an electronic surveillance system maintained by the Centers for Disease Control and Prevention (CDC). One should be careful when drawing conclusions from this information. For example, age, underlying diseases, or severity of illness are factors that can influence a patient's risk for infection. Hospitals that treat patients at greater risk of infection may be expected to have higher rates. Keep in mind that a hospital's infection rate is only one thing to consider when choosing where to get care. The advice of physicians, the hospital's and specialists' experience with the type of care needed, and other factors unique to each given situation should be considered as well. Few patients and small numbers of infections may distort a given hospital's reported performance.

## **Central Line Associated Bloodstream Infection (CLABSI) Rates**

### **What is a "central line"?**

A "central line" is a flexible tube that is inserted near the patient's heart or into one of the large veins or arteries. A central line can be used to give fluids, measure the amount of fluid in the body, or to give medications. Because of where it is located, it can cause potentially dangerous bloodstream infections.

### **What is a "central line day"?**

For purposes of this pilot "central line days" are the total number of days a central line is in place for patients in Intensive Care Units (ICUs). The count is performed each day; each patient with one or more central lines at the time the count is performed is counted as one central line day.

### **What is an "intensive care unit"?**

ICUs are hospital units that provide intensive observation and treatment for patients either dealing with, or at risk of developing, life threatening problems. ICUs are described by the types of patients in them; smaller hospitals typically care for both medical and surgical patients in a combined medical/surgical ICU, while larger hospitals typically have separate ICUs for medical patients and surgical patients. Different types of ICUs may treat patients with different levels of patient illness and therefore must be compared by the NHSN protocol only to ICU locations meeting the same definition. Therefore, different ICU types have different associated infection rates when compared within the NHSN system.

### **What is a Central Line Associated Bloodstream Infection (CLABSI) Rate?**

The CLABSI rate is the number of infections per 1,000 central line days. Lower rates are better: the goal is to have zero infections. Infection rates can appear to be lower or higher than the national average, but after statistical testing, they may be found to be "similar to the national average." One reason may be that hospitals with a small number of central line days compared to all hospitals enrolled in NHSN (i.e., national comparison group) have more unstable rates. A single infection can result in a rate that is higher than the national average. It is also difficult to draw conclusions from a report of zero infections when there are low numbers of central line days.

### **How do hospitals collect and report data?**

Hospitals utilize the NHSN surveillance system to report the data. They are using NHSN definitions and methodology to define CLABSIs.

**Central Line Associated Bloodstream Infection (CLABSI) Rates  
NM Pilot Hospitals surveillance: July 1, 2008 through December 31, 2008**

	<b>NM Pilot Hospitals 9 ICUs Total Number of Infections</b>	<b>NM Pilot Hospitals 9 ICUs Total Number of Central Line Days</b>	<b>NM Pilot Hospitals 9 ICUs Combined CLABSI Rate (per 1,000 central line days)</b>	<b>NHSN Hospitals Pooled Mean CLABSI Rates (Ranges reflect the different types of Adult ICUs in Pilot) NHSN Summary data, November 2008</b>
Aggregated data	12	12664	0.9	1.4 – 2.5

**Healthcare Worker (HCW) Influenza Vaccination Rates**

**Who is considered a HCW?**

All staff with potential contact with patients and their families and visitors, even those not classified as performing “direct patient care”, are considered HCWs; therefore, all paid staff and all medical staff with privileges, plus residents, will be included in this surveillance. “Medical staff” includes all licensed independent providers with hospital privileges, including physicians and midlevel medical providers. Hospitals will not include volunteers and students in their data submission.

**How do hospitals collect and report data?**

All facilities completed a survey about their hospital’s current policies and procedures for HCW influenza vaccination. All had the capability of assessing total employee numbers and total medical staff numbers, recording influenza vaccines given, and providing an overall rate of vaccination of hospital employees plus medical staff. Almost all facilities could provide a rate deemed accurate, despite—in most cases—using paper records which were simply counted or transferred to electronic databases for analysis. For this pilot, hospitals report data electronically on a spreadsheet.

**PRELIMINARY INTERIM DATA ONLY**

**Healthcare Worker (HCW) Influenza Immunization Rates  
Early Influenza Season NM Pilot Hospitals Surveillance through December 15, 2008**

<b>Hospital</b>	<b>Total Number of HCWs Who Received an Influenza Immunization</b>	<b>Total Number of HCWs</b>	<b>Combined HCW Influenza Immunization Rate</b>	<b>Compared with the Joint Commission’s Influenza Vaccination Challenge for the 2008-9 season (43%)</b>
Aggregated data (All 6 NM Pilot Hospitals reporting)	6510	17795	36.6%	Preliminary data- final will be completed 3/30/2009 and reported by 5/15/2009

The data for HCW influenza vaccinations reflect only those HCWs vaccinated for influenza as of December 15<sup>th</sup>, 2008. Hospital personnel responsible for collecting influenza vaccination data are currently still vaccinating hospital staff. Vaccination for influenza will be ongoing during the winter months; therefore, it is likely that final rates will be higher when hospitals resubmit the number of HCWs vaccinated by March 30, 2009 in their final reports. NMDOH reported the start of the influenza season on January 15, 2009.

## APPENDIX H

### CONFIDENTIALITY UNDER THE CURRENT “VOLUNTARY” PROGRAM

Hospitals volunteering in the Healthcare-Associated Infection Pilot Project participate by enrollment in the National Healthcare Safety Network (NHSN). The NHSN is an internet-based surveillance system established through the CDC. The CDC is authorized under Title III, Sections 301, 304 and 306 of the Public Health Service Act to collect data on HAIs. Thus, the information received from hospitals through their enrollment and participation in the NHSN is subject to the U.S. Public Health Service Act.

Upon enrollment into NHSN, each facility is given the following assurance of confidentiality:

The information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not be disclosed or released without the consent of the individual, or the institution in accordance with Section 304, 306, and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).<sup>1</sup>

The CDC interprets this confidentiality protection to apply to all information provided to the NHSN by hospitals and other healthcare providers. The specific provision of the Public Health Service Act applicable to public disclosure, section 242m(d), provides as follows:

No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under [applicable sections of the Public Health Service Act] may be used for any purposes other than the purpose for which it was supplied unless such establishment or person has consented ... to its use for such other purposes[.]

Thus, the information collected under the department’s pilot program is confidential pursuant to 42 U.S.C. 242m(d). It may not be released or disclosed for any purposes other than the purposes for which it was supplied unless the person and institution has consented to its release. The CDC applies a very strict stance with regards to disclosure of the information. For example, if a patient requests his or her own records contained in any submitted information, the CDC takes the position that the records cannot be released unless the institution involved also consents to the release.

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<sup>1</sup> See, CDC, *National Healthcare Safety Network (NHSN). Purposes, Eligibility, Requirements, and Confidentiality*. Available online at:

<http://www.cdc.gov/ncidod/dhqp/pdf/nhsn/NHSNPurposesEligibilityRequirementsConfidentiality.pdf>. Accessed on March 3, 2008.

## Confidentiality of Mandatory Reporting Programs

The NHSN is a voluntary system, as is the department's pilot program. Due to an increased public awareness of HAIs and the uses of data collection, there has been a movement for public disclosure of healthcare infection rates in the United States.<sup>2</sup> Several states have enacted legislation for the mandatory reporting of HAIs, and most include provisions for public disclosure.<sup>3</sup> These statutes also, however, include confidentiality provisions.

Colorado's statute provides an excellent example. Colorado law requires the production and public disclosure of an annual report which compares the risk-adjusted, hospital-acquired infection rates for each individual health facility in the state. The report includes a discussion of findings, conclusions, and trends concerning the overall state of hospital-acquired infections in the state, including a comparison to prior years when available. C.R.S. 25-3-603. However, the Colorado law also provides for the confidentiality of patient and facility information. The statute protects any information that could be used to identify a patient, including the patient's social security number. C.R.S. 25-3-604 (2007). It also protects information gained from a health facility from public disclosure, discovery, subpoena, or other means of legal compulsion. C.R.S. 25-3-605. The information may not be admitted as evidence or otherwise disclosed in a civil, criminal or administrative proceeding. *Id.*

If New Mexico legislation is introduced in the future to enact a mandatory HAI reporting system, the following provisions should be incorporated to provide further confidentiality protection to any information reported:

- Patient confidentiality shall be strongly protected.
- Legislation should clarify that published infection rates do not establish a standard of care.
- Social security numbers and other patient identifying numbers should be protected.
- Any data, materials, or underlying documents are exempt from public disclosure, are not subject to discovery, and are not admissible as evidence in any legal proceeding.

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<sup>2</sup> United States Department of Health & Human Services. *Statement by Denise Cardo, Director, Division of Healthcare Quality Promotion, CDC, on the CDC's Role in Monitoring and Preventing Healthcare-Associated Infections*. Before the Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, U.S. House of Representatives. March 29, 2006.

<sup>3</sup> *Id.*

## **Conclusion**

In conclusion, the information gathered under the department's voluntary HAI pilot program is confidential under the provisions of the Public Health Service Act. If the department decides to introduce legislation requiring mandatory reporting of HAI from all health-care facilities in New Mexico, that legislation should include explicit provisions for the contents of any publicly available reports. In addition, such legislation should include confidentiality provisions to provide for stronger protections than that provided in the Public Health Service Act. In particular, the language of the legislation should provide for patient privacy and protect facility information. It should state that facility information is not subject to discovery, subpoenas, or other means of legal compulsion and may not be admitted as evidence or otherwise disclosed in any civil, criminal, or administrative proceeding.

## APPENDIX I

### HEALTHCARE WORKERS INFLUENZA IMMUNIZATION GUIDELINES FOR THE NEW MEXICO PILOT YEAR

#### **Pilot project on reporting Healthcare-associated infections: Healthcare worker influenza immunization rate**

##### **Background discussion:**

The following requirements for reporting rates of employee influenza immunization are based on a pilot survey of 7 hospitals in New Mexico. All facilities surveyed had the capability of assessing total employee numbers, total medical staff numbers, recording influenza vaccines given, and providing an overall rate of immunization of hospital employees plus medical staff. Almost all facilities could provide a rate deemed accurate, despite using, in most cases, paper records which were simply counted or transferred to electronic databases for analysis.

Measurement of unit-specific influenza vaccination rates may be performed for internal quality assurance purposes and to guide vaccination efforts, but unit-specific rates are not required for the pilot project. The pilot project acknowledges the fluidity of staffing in hospitals and staff turnover. All staff have potential contact with patients and their families and visitors, even those not classified as performing “direct patient care”, hence all paid staff and all medical staff with privileges, plus residents, will be included in this surveillance. Many medical staff maintains privileges at multiple facilities, and many healthcare workers work at more than one facility, so these individuals may be counted more than once. “Medical staff” includes all licensed independent providers with hospital privileges, including physicians and midlevels. In this setting, an employee’s or physician/midlevel’s report that they were immunized elsewhere is sufficient to document vaccination for that healthcare worker.

Hospitals should not include volunteers and students in their data submission. Many hospitals include volunteers in their vaccination programs, but volunteers are not usually included in employee health records and may also be immunized elsewhere. Students may intern at multiple facilities. Hosting facilities have vaccination requirements for students, and are encouraged to add a requirement for influenza vaccination.

Other opportunities for facilities include participation in the New Mexico Influenza Vaccine Consortium to facilitate the supply of vaccine and materials to support employee immunization programs. University Hospital has enrolled in the University Health Consortium Influenza Vaccination Benchmarking Project to improve healthcare worker immunization rates. All facilities accredited by the Joint Commission are encouraged to participate in the Joint Commission’s Influenza Vaccination Challenge for the 2008-9 influenza season. The Joint Commission will recognize all facilities achieving immunization rates of healthcare workers higher than the historical norm of 43%. From the results of our pilot survey, we would expect all participants to be able to achieve this recognition. This program is being run by Joint Commission Resources and participants may enroll at [www.fluvaccinationchallenge.com](http://www.fluvaccinationchallenge.com).

**Reporting requirements:**

**Core measures for the pilot project include the following:**

**Denominator:**

# of all hospital employees (non-physician) on payroll as of September 30, 2008 (current immunization season) (Note: the number should be the number of individuals employed, not FTE).

PLUS

# of medical staff (including employed physicians and residents) as of September 30, 2008.  
Denominator data must be submitted to the project by November 1, 2008

**Numerator:**

# of all hospital employees immunized as of March 31, 2009 (current immunization season)

PLUS

# of medical staff immunized as of March 31, 2009 (includes resident physicians)  
Numerator data must be submitted to the project by May 15, 2009

**Information on data gathering and analysis:**

Participants are also required to submit a brief description of their HCW vaccination processes, to include the following:

1. How information is obtained to ascertain number of employees on payroll and all medical staff (plus residents).
2. How the information on each individual immunized is collected (consent form, roster, direct entry into computer system etc).
3. How the immunization data are linked to the employee database and medical staff database (data entry on each individual, automated system, tally of paper records such as consent forms or roster etc).

As applicable, how information is collected on employees declining influenza vaccination (declination form, roster etc).