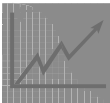




RAISING THE BAR ON INFECTION CONTROL WITHOUT BEING CRUSHED BENEATH IT

Sharon Burnett, RN, BSN, MBA
Vice President of Licensure, Regulation and Accreditation
Missouri Hospital Association
573/893-3700
sburnett@mail.mhanet.com





RAISING THE BAR

A story of how legislators, regulators, consumer advocates, infection control professionals and provider groups have worked together to raise the bar on infection prevention and control in Missouri and avoid being crushed by the burden of data collection and reporting.





The Climate Was Right

1999 IOM Report –

- hospital-acquired infections affect about 1 in 20 hospital patients
- add almost \$5 billion a year to our nation's health-care bill
- more people die from such infections than from auto accidents and homicides combined.

Chicago Tribune 2002 Story – Dirty Hospitals

Newsweek, Time, Readers Digest and even The Wall Street Journal





What The States Are Doing

22 states have public reporting laws of hospital-acquired infection rates

To date, only four states have actually released to the public reports – Missouri, Pennsylvania, Florida and Vermont

Three types of public reporting laws

- Report Process Measures (CMS measures, LeapFrog or IHI bundles)
- Report Hospital-Acquired Infection rates (CLABs, SSIs, VAPs, UTIs)
- Report AHRQ Patient Safety Indicator measures related to infections (infections due to medical care and postoperative sepsis)





What North Carolina Is Doing Legislation

HB 1738

Created an advisory commission to make recommendations in 2009 regarding the creation of a public reporting system for the reporting SSIs, VAPs and CLABs.

It will require additional legislation before public reporting becomes mandatory.






Early Reporters

Missouri	Report CLABs, SSIs, VAPs, CMS process measures (2006)
Florida	Report AHRQ Patient Safety Indicator measures related to infections (2005)
Vermont	CMS process measures and CLABs (2007)
Pennsylvania	Report HAIs to Pennsylvania Health Care Cost Containment Council (PHC4) HAIs at discharge using Uniform Bill Designated Field -21d and Designated Codes for Infections (2005)



Field 21d - Hospital-Acquired Infection

<p>01 = Indwelling Urinary Catheter Associated Urinary Tract Infection</p> <p>02 = Surgical Site Infection</p> <p>03 = Ventilator Associated Pneumonia</p> <p>04 = Central Line Associated Bloodstream Infection</p> <p>05 = Bone and Joint Infection</p> <p>06 = Central Nervous System Infection</p> <p>07 = Cardiovascular System Infection</p> <p>08 = Eye, Ear, Nose, Throat, or Mouth Infection, Including Upper Respiratory Infections (not required)</p> <p>09 = Gastrointestinal System Infection</p> <p>10 = Lower Respiratory Tract Infection, Other Than Pneumonia</p>	<p>11 = Reproductive Tract Infection</p> <p>12 = Skin and Soft Tissue Infection</p> <p>13 = Systemic Infection (not required)</p> <p>21 = Urinary Tract Infection (not device related)</p> <p>23 = Pneumonia (not device related)</p> <p>24 = Bloodstream Infection (not device related)</p> <p>29 = <i>Clostridium difficile</i></p> <p>99 = No Hospital Acquired Infection Present</p>
--	--



The Pennsylvania Story - 2008


Act 52 of 2007

Reporting to NHSN replaces reporting to PHC4


Under NHSN hospitals must confer reporting rights to PHC4, DOH, and PSA

Any infection reported to NHSN is considered a serious event and requires written disclosure

Require adoption of MRSA active surveillance in hospitals and nursing homes for all patients at admission along with periodic random screening and screening of staff




Consumers Union
Publisher of Consumers Reports
 End hospital secrecy and save lives.





The Missouri Story "Get on the Train or Get Out of the Way!"

Ray Wagner – *"Missouri Father on a Crusade"*

Consumer's Union
 St. Louis Business Health Coalition



Raymond Wagner Jr.



“The best way to predict the future is to create it.”

Peter Drucker

Lead the train or get run over by it

Involve IC experts early and often

Take the high road to patient safety

Don't oppose the concept just the particulars

Facts or data never trump patient stories





MHA's Principles for Infection Control Reporting

Standards for collecting and analyzing infection data need to be based on sound scientific principles endorsed by federal and state infection control experts.

CDC's National Healthcare Safety Network (NHSN) should be adopted as the model for tracking, collecting, risk adjusting and reporting nosocomial infections in Missouri.

The collection of infection data should not be so administratively burdensome as to take away from hospital efforts to prevent infections through education and prevention.





The Legislation - SB 1279

Authorized DHSS to develop regulations to collect, analyze and report nosocomial infection data from hospitals and ASCs

NHSN was to be the reporting vehicle

Required incidence reporting and facility-specific publication on "subsets" of three major categories

- Central Line Associated Bactermias (CLABs)
- Surgical Site Infections (SSIs)
- Ventilator-Associated Pneumonia (VAPs)





The Legislation - SB 1279

Appoints a state Infection Control Advisory Panel to provide guidance and oversight

Requires hospitals to do hand hygiene surveillance

Requires laboratories to submit yearly antibiogram data

Requires reporting of MRSA and VRE nosocomial "rates"





The Drafting of the Regulations... the Devil Is in the detail!

- Involve IC experts early and often
- NHSN - the bible
- Take time to do it right....Do it right the first time
- Give the public (not health plans and the consumer union) what it needs
- Advisory Panel -- Be inclusive rather than exclusive but exclude dominators





The Reporting Regulations


Reporting of Healthcare Associated Infections (HAIs)

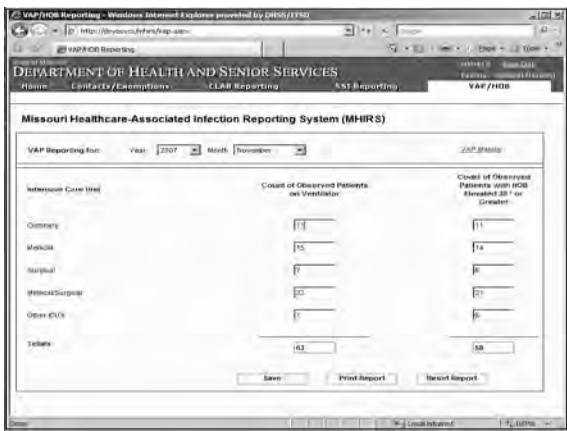
- Central Line Associated Bacterimias (CLABs) in ICUs. Started July 1, 2005 – first report 12/31/06
- Surgical Site Infections (SSIs) Started January 1, 2005 – first report 3/31/07
 - Hospitals - Abdominal hysterectomy, CABG, Hip prosthesis
 - ASCs – Herniorrhaphy and breast procedures
- Ventilator-Associated Pneumonia (VAPs) – By law was to start by 7/1/06.



HOB Process Measurement

- Collection follows The Joint Commission's *Specifications Manual for National Hospital Quality Forum - ICU measures*
- Began Fall, 2007
- Minimum of 100 ICU ventilator days/year
- 48 out of 50 applicable hospitals are voluntarily submitting data






Missouri 2008

HB 1546

- Replaces VAP rate with HOB process measurement
- Originally required whole house active surveillance for MRSA and isolation of patients infected or colonized with MRSA
- Now requires hospitals to have a MRSA control program that
 - isolates identified MRSA-colonized or infected patients OR uses alternative methods to reduce the risk of MRSA transmission when private rooms are not available
 - establishes procedures, protocols, and education for staff known to be MRSA-colonized or infected
 - establishes an infection-control MRSA intervention protocol
 - requires mandatory MRSA educational programs for personnel



Is this what the public wanted?

Who looks at this data anyway?

Why does everyone look so good?

Are our infection rates improving?

Or...

Are our numbers just getting better?

Are we wasting valuable resources by collecting, analyzing and reporting this stuff?



It Raised the Bar from the ICP to the Administration and Now to the Board

"Patient outcomes didn't do it. It took a law and the risk of our hospital being compared to other hospitals to get the administration's attention."

"Now we have board members saying 'why are our rates still so high and what do you need from us to increase compliance?'"





PRESENT ON ADMISSION






Present On Admission Enables...

- All payers to determine if condition occurred prior to or was hospital-acquired;
- CMS, payers and employers to restructure payment for healthcare based on quality of care delivered; and
- advocacy groups to get the public reporting data they want.




 **Is It About the Data or the Money?**


"No other industry generates revenue from mistakes."
THE BOSTON GLOBE


Insurer Anthem To No Longer Pay For 11 Medical Errors
ST. LOUIS POST-DISPATCH 04/03/2008

"Anthem Blue Cross Blue Shield in Missouri announced the plan Wednesday as part of a national initiative by Wellpoint Inc., its parent company and the nation's largest insurer."



**It's not about the money,
it's about patients' lives!**

 **N H S N**

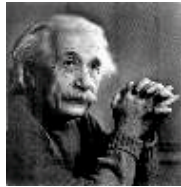


So what are we suppose to do now?



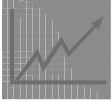
Insanity

“Insanity is doing the same thing over and over again and expecting different results.” Albert Einstein



MHA

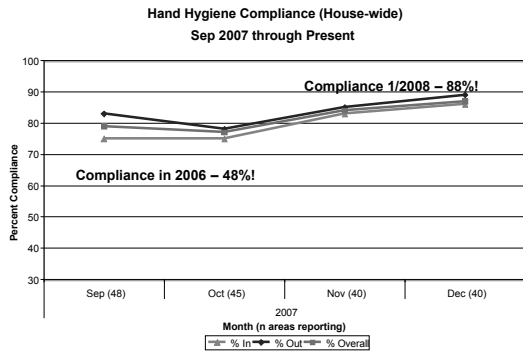
“It is not about which hospital has better numbers, it’s all about which hospitals deliver the best and safest care.”

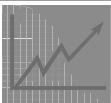


Raising The Bar

It's all about the processes and systems employed by the hospital.

Remember Hand Hygiene Surveillance?





Raising The Bar

- Set the bar very high
- Put a human face on the data
- Engage the hospital administrators and the board
- Give them the good, the bad and the ugly
- Create a sense of urgency
- Understand the total organizational impact
- Make the business case
- Change the culture

*"If not us, who.
If not now, when?"*

- Robert Kennedy

For More Information

MHIRS <http://www.dhss.mo.gov/MHIRS/>
Center for Health Information Management and Evaluation (CHIME)
Missouri Department of Health and Senior Services
PO Box 570
Jefferson City, MO 65102-0570
Telephone: 573-751-6272 or (toll-free) 800-392-0272
Fax: 573-526-4102
Email: mhirs@dhss.mo.gov

Sharon Burnett, RN, BSN, MBA
Vice President of Licensure, Regulation and Accreditation
Missouri Hospital Association
4712 Country Club Drive
Jefferson City, MO 65109-4541
Phone: 573/893-3700, ext. 1304
Fax 573/893-7665
sburnett@mail.mhanet.com