

## CMS Wants More HAI Data in 2011

Joseph Goedert  
May 4, 2010  
[HealthDataManagement.com](http://HealthDataManagement.com)

The Centers for Medicare and Medicaid Services (CMS) is proposing to collect from hospitals two measures of healthcare-acquired infections, beginning with Jan. 1, 2011 discharges, which would influence Medicare payment determinations starting in fiscal year 2013.

The measures would cover central line associated blood stream infections and surgical site infections, according to a proposed rule for inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system for fiscal year 2011. CMS published the proposed rule on May 4 in the *Federal Register*. The agency, in the rule, expressed concern about the lack of progress in reducing the rates of health care-associated infections that was recently reported in the 2009 National Healthcare Quality Report.

In the proposed rule, CMS reiterates its intention to collect data for the Reporting Hospital Quality Data for Annual Payment Update program, known as RHQDAPU, from registries to enable expansion of the program without increasing data collection burdens on hospitals. "We continue to evaluate the feasibility of leveraging registry-based data collection mechanisms for the RHQDAPU

program and we are proposing to collect such data for the FY 2013 payment determination."

CMS further continues to be interested in the reporting of quality measures through electronic health records (HER). "The electronic specifications and interoperability standards for EHR-based collection and transmission of the data elements for the ED Throughput, Stroke and Venous Thromboembolism measures have been finalized by the Health Information Technology Standards Panel and are available for review and testing at <http://www.hitsp.org>," according to the proposed rule.

"We anticipate testing the components required for the submission of clinical quality data extracted from EHRs for these measures, and are exploring different mechanisms and formats that will aid the submission process, as well as ensure that the summary measure results extracted from the EHRs are reliable. We anticipate moving forward with testing CMS' technical ability to accept data from EHRs for the ED, Stroke and VTE measures as early as summer of 2011."

The proposed rule is available at [federalregister.gov](http://federalregister.gov).

## GNO Central Line-Associated Bloodstream Infections (CLABSI) Prevention Collaborative

The Healthcare-Associated Infections (HAI) Initiative addresses two necessities when considering HAI: surveillance and prevention. While National Healthcare Safety Network (NHSN) addresses surveillance needs, prevention will be fostered through prevention collaboratives that allow the exchange of best-practices among participating facilities.

The first Central Line-Associated Bloodstream Infections (CLABSI) collaborative for Louisiana will be launched through the Greater New Orleans area APIC chapter in June 2010, and will continue until May 2011.

Through participation in the collaborative, infection preventionists (IP) will be allowed to follow NHSN definitions for the tracking of CLABSI in ICU and NICU locations.

Participation requires the submission of monthly CLABSI data that is de-identified for the protection of facility anonymity. A template is provided for the submission of data.

In addition to the submission of data, participating facilities will participate in monthly meetings (teleconferences, face-to-face, and webinars) for the exchange of best practices for the reduction of CLABSI.

The benefits of participating in the prevention collaboratives are that IPs will be able to exchange best practices with their colleagues in infection control and become familiar with NHSN reporting requirements.

Learning objectives of the CLABSI Collaborative will to receive tools for measuring CLABSI and safety culture in ICUs, and receive ongoing support through monthly calls.

Prevention collaboratives put IPs "in the driver's seat" to identify tools that work for their facilities. Facilitation of meetings and documentation of best practices implemented will be conducted by Infectious Disease Epidemiology Section (IDES).

After the pilot program is extended to facilities in the Greater New Orleans area, mirroring collaboratives will be established throughout the state.



Learn more about this free service, training, and enrollment at [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)

### Statewide NHSN Trainings Coming Soon!

Registration for the statewide NHSN trainings will be made available in June:

- July 26 – New Orleans
- July 30 – Lafayette
- August 5 – Alexandria
- August 6 – Shreveport
- Baton Rouge date to be determined

# Hospital Monitors Infectious Diseases Using Real-Time Surveillance

Cynthia Johnson  
March 17, 2010  
[HealthLeadersMedia.com](http://HealthLeadersMedia.com)

*The following is an excerpt from "Hospital Monitors Infectious Diseases Using Real-Time Surveillance" by Cynthia Johnson of Health Leaders Media. The article features an interview with Susan Waguespack of St. Elizabeth's Hospital in Gonzales, LA. Full text may be accessed at the following URL:*  
<http://www.healthleadersmedia.com/page-1/TEC-248111/Hospital-Monitors-Infectious-Diseases-Using-RealTime-Surveillance>

The responsibilities of an infection preventionist have never been more daunting. In addition to targeting interventions that protect patients from hospital-acquired infections, an increasing number of states have made reporting them mandatory.

Susan Waguespack, RN, is the lone infection preventionist at St. Elizabeth Hospital in Gonzales, LA. She even doubles as the employee health coordinator for the 78-bed facility, which is the smallest of four hospitals in the Franciscan Missionaries of Our Lady of Health System (FMOLHS).

In May 2009, FMOLHS implemented a system manufactured by Milpitis, CA-based Quantros, Inc., to help improve quality, safety, and accreditation standards compliance. Waguespack, who had been requesting a surveillance system for more than a year, welcomed the opportunity to leverage the system's real-time infection surveillance and case management capabilities and abandon her time-consuming and cumbersome paper-based processes.

Prior to the system, Waguespack's processes were primarily paper-based. She used computerized charting, printouts, and her own custom-made Microsoft Excel spreadsheets. When incidents were found, they were documented on paper.

"Here I am at the end of the month with 50 or 60 individual sheets of paper that I have to compile into a line list to make it easier for me to see if there are any trends or if there's anything that I'm noticing that is out of the ordinary," Waguespack says.

Her processes are now computerized since she started managing them using the IC Insight tool within Quantros. At the end of the month, she now clicks on a spreadsheet to generate a custom report that takes approximately five to 10 minutes. The report contains data that would have taken her days to compile.

Beginning in January 2010, hospitals were required to comply with The Joint Commission's NPSGs. Waguespack points out that one of the goals is to prevent MDROs from spreading.

In the future, Waguespack may need to comply with state reporting regulations. Although the state of Louisiana does not require mandatory reporting, Waguespack says the system has capabilities that ensure that the facility will be in line with mandatory reporting if it becomes a requirement in the future.

"When we do have to start reporting up to the state, we want to make sure we're reporting the same thing—that we're comparing apples to apples," says Waguespack. "That's going to be critical."

In January, St. Elizabeth Hospital was re-accredited by The Joint Commission. During the process, surveyors told Waguespack that her infection control and prevention (ICP) program was "best practice." Surveyors found no issues at all in regards to the hospital's compliance with NPSGs.

## CDC director: HAIs unacceptable, but true change may require health reform

Gary Evans  
March 19, 2010  
[AHCMedia.com](http://AHCMedia.com)

*The following is an excerpt. Full text may be accessed at the following URL:*  
<http://www.thefreelibrary.com/CDC+director:+Toll+of+HAIs+unacceptable.-a0225387146>.

The staggering burden of health care associated infections (HAIs) in lives and dollars is "unacceptable," but changing the status quo is difficult because the health care system is woefully skewed toward treatment rather than prevention, Thomas Frieden, MD, MPH, director of the Centers for Disease Control and Prevention, said Thursday in Atlanta at the opening of the Fifth Decennial International Conference on HAIs.

"The toll of HAIs is unacceptable," he said. "One in 20 patients in U.S. hospitals each year becomes infected. There are an estimated 100,000 deaths annually, \$33 billion dollars in medical costs, longer hospitalizations and we don't [even] know what the burden is outside of hospitals."

## NHSN Trainings to Be Held Statewide This Summer

The Infectious Disease Epidemiology Section (IDES) is planning five National Healthcare Safety Network (NHSN) trainings statewide this summer at the end of July and the beginning of August. Trainings will start a couple of weeks after the APIC convention in New Orleans.

Trainings will be one-day events that IPs may choose training dates based on geographic and scheduling convenience.

NHSN topics that will be covered at each training will be as follows: 1) overview of NHSN, device-associated modules (CLABSI, VAP, CAUTI); 2) data entry, import and customization; and 3) protocols and definitions. At the conclusion of each training, CDC will dial in for a question and answer period with training participants.

Training details are being finalized, and the registration form will be distributed via email.

Visit [www.cdc.gov/nhsn/training.html](http://www.cdc.gov/nhsn/training.html) to preview the lessons that will be covered at each of the trainings.



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# Sternal Wound Infection Rates Performance Improvement

## Process: APIC Abstract Published 2008

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**Issue:** During 4<sup>th</sup> quarter 2008 infection prevention surveillance, a significant increase in sternal wound infections post coronary artery bypass graft (CABG) surgery was observed at Louisiana Medical Center and Heart Hospital (LMCHH). In 2007, sternal wound infections occurred in .55% of the total number of sternotomies, and in 2008, that number rose to 1.12%. Sternal wound infections can be harmful to the patient's recovery and overall health, and are costly for hospitals. The cost of sternal wound infections in 2007 and 2008 has been estimated to be \$132,960 in 2007 and 199,440 in 2008.\*

**Project:** Since January 2009, in efforts to improve these rates, the following has been implemented: the infection control (IC) committee met at least monthly to develop and evaluate processes focusing on Key Elements: 1) 4<sup>th</sup> Quarter increase in sternal wound infection rates; 2) Multi drug resistant organism (MDRO) screening and Infection Prevention Protocol is reviewed with surgeons, cardiologists, and nursing staff; 3) Infection Protocol for SSI direct observation/data collected; 4) implementation of all components of protocol; 5) personnel competencies & training; 6) continue surveillance. Changes to the standard care of the CABG patient: implemented pre-/post-operative (night before/morning of) wiping of patient with 2% CHG cloths; pre-/post-operative (night

before/morning of) oral cavity cleansing with CHG oral rinse, as well as post-operative suctioning; pre-operative nares screening for MRSA: swab each nares, and any skin lesions; pre-operative initiation of mupirocin ointment treatment 1gm intranasal BID, 48 hrs prior to cardiac surgery. If surgery scheduled less than 48 hrs mupirocin is started as soon as possible; adjusting Ancef antibiotic prophylaxis IVPB dosing from 1g to 2g in patients more than 60 kg in pre-op holding within 60 minutes prior to incision; Ancef 1gm IVP administration intraoperatively every 3-4 hours while surgical incision is open; antibiotic prophylaxis use discontinued within 24 hours post anesthesia stop time.

**Results:** Since implementing these pre- and post-operative care change at LMCHH, and following the infection control methodology defined above, of a total of 178 sternotomies, sternal wound infections rates have been at zero for the year 2009. The costs associated with sternal wound infections during 2009 has been \$0.

**Lessons:** Pre-/post-operative preventative measures, including bathing and oral cavity cleansing of the patient with CHG, pre-operative screening for MRSA and provision of pre-operative treatment, as well as the addition of <24 hours of antibiotics both pre- and intra- operatively, can be beneficial to both patients and hospitals by decreasing the rates of sternal wound infections following CABG.

*Kohut, K, APIC (2008). Guide for the prevention of mediastinitis surgical site infections following cardiac surgery: APIC Elimination Guide, Washington, DC.*

## Comprehensive Unit-Based Safety Program to Combat Bloodstream Infections “On the CUSP: Stop BSI”

The following is an excerpt from Wisconsin Hospital Association's brochure on their approach to the Comprehensive Unit-Based Safety Program. Full text of the publication may be accessed at the following URL: [http://www.wha.org/pubArchive/friday\\_packet/CUSP2009Brochure.pdf](http://www.wha.org/pubArchive/friday_packet/CUSP2009Brochure.pdf)

The CUSP: STOP BSI project is a national collaborative designed to improve the culture of safety and specific clinical outcomes in the intensive care unit.

The collaboration will leverage the experience of the Johns Hopkins Quality and Safety Research Group (JHU QSRG), Michigan Health and Hospital Association Keystone Center, Health Research and Educational Trust (HRET) and hospitals from 28 states over three years.

The specific program components include implementation of the comprehensive unit-based safety program (CUSP), and activities to measure and eliminate central line associated blood stream infections

(CLABSI). Additional hospital-acquired infections may be addressed based on participating hospitals interest and time.

Each year, 250,000 cases of CLABSI occur in U.S. hospitals with 18 percent of those cases resulting in death. In addition to the hardship this causes to our patients, physicians and hospital staff, CLABSIs account for \$3 billion in excess health care costs per year.

The good news is that CLABSIs are often preventable and we have the science and methods to prevent them. How do we know this? Working with the JHU QSRG and the Michigan Hospital Association Keystone Center, Michigan hospitals have nearly

eliminated CLABSIs in 103 intensive care units and have sustained these gains for four years.

By participating in this project, your hospital will have access to education, strategies, benchmarks, and lessons learned from hospitals throughout the U.S. so that your hospital can join the ranks of those dedicated to eliminating CLABSIs.

There are no program costs to hospitals that choose to participate in the project. Hospital staff time and resources used for data collection and improvement, as well as travel expenses to attend the workshops will be the responsibility of the participating hospital.