



2010 Healthcare-Associated Infections (HAI) Report: Q+A

October 2011

What is the HAI report and why is it needed?

Act 52 of 2007 requires hospitals in Pennsylvania to report HAIs to the Pennsylvania Department of Health (PADOH) through the Centers for Disease Control and Prevention's National Health Care Safety Network (NHSN), and to annually report progress in reducing the occurrence of HAIs in Pennsylvania hospitals. HAIs are proven to increase health care costs and are preventable. The Centers for Disease Control and Prevention (CDC) estimates that one in 20 hospitalized patients will contract a HAI. Last year's HAI report provided the baseline measures for HAI occurrence. The new report is the first that allows trends to be determined in order to identify where progress is being made and where additional efforts are needed.

What are the focuses of this year's report?

The report uses three benchmarks to determine hospital performance: catheter-associated urinary tract infections (CAUTIs), central-line blood stream infections (CLABSIs) and six types of surgical site infections (SSIs).

What are the six SSIs?

The six categories of SSIs, identified and agreed upon for benchmarking, include:

- Cardiac surgery
- Cardiac bypass graft surgery with one incision site
- Cardiac bypass graft surgery with two incision sites
- Prosthetic hip surgery
- Prosthetic knee surgery
- Abdominal hysterectomy

What is the difference between CAUTIs and CLABSIs?

CAUTIs are catheter-associated urinary tract infections, caused by use of a catheter to drain the bladder. CLABSIs are central line-associated bloodstream infections, caused by use of catheters that are inserted into the major blood vessels near the heart to infuse medications or monitor vital signs.

Why are these three conditions considered "benchmarks"?

These three infection types were selected by PADOH for benchmarking in consultation with the Statewide HAI Advisory Committee established under Act 52. CLABSIs are considered the "most severe" type of HAI since they occur in very sick patients and can have fatal outcomes. They are one of the major targets of HAI prevention efforts. CAUTIs are one of the most common type of HAIs because urinary catheters are commonly used in hospitals, allow us to develop rates for even the smallest hospitals. Surgical site infections cause significant illness and are

a common cause of readmission to the hospital. Several of the surgical site infections selected for benchmark monitoring are ones that have been selected nationally as “never events” (or events that should never occur).

What process do hospitals use to report these infections to the PADOH?

All hospitals are required to report all HAIs in all in-patient locations using the Patient Safety Module of CDC’s NHSN. PADOH accesses the information submitted to NHSN, which is a national system, and uses the data to develop our analyses and reports. These infection types are:

- Bone and joint infections
- Blood stream infections with or without a central line
- Central nervous system infections
- Cardiovascular system infections
- Eye, Ear Nose and Throat infections
- Gastrointestinal infections
- Lower respiratory tract infections
- Pneumonia whether ventilator or non-ventilator associated
- Reproductive tract infections
- Skin and soft tissue infections
- Surgical site infections
- Systemic infections
- Urinary tract infections with or without a catheter

Are hospitals required to report HAIs as they occur or simply as a cumulative total at the end of a given time period?

All hospitals are required to report HAIs as they occur, since any HAI is considered a serious event (as defined by Act 52) that must be reported within 24 hours of occurrence.

What do the “comprehensive efforts” that have been initiated to reduce HAIs consist of? Since Act 52 was enacted, all hospitals across the state have been working to implement science-based practices to control and prevent HAIs. The information collected also allows hospitals to examine their data, compare themselves to other hospitals, and determine where they need to focus their efforts to reduce and eventually eliminate HAIs. In addition, PADOH supports two prevention “collaboratives” where groups of hospitals are working together to reduce HAIs. One is in southeastern Pa. to reduce the occurrence of Clostridium difficile infections, a major cause of gastrointestinal problems and complications in hospitalized and nursing home patients. The other is in southwestern Pa. to reduce the incidence of surgical site infections.

How does the prevention collaborative work between the southwestern Pennsylvania hospitals?

The hospitals in the collaborative work together to design interventions that will reduce the occurrence of SSIs, implement those interventions, and collect data on both the use of these interventions (such as how a patient is prepped for surgery, hand hygiene compliance, post surgical wound care) and the occurrence of HAIs.

The collaborative is coordinated through the Three Rivers Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) chapter.

Does the Department of Health have any regulatory authority beyond reporting the numbers of HAIs found at hospitals in the state?

Yes. Act 52 stipulates that hospitals must reach benchmark reduction targets. Hospitals that fail to meet these targets are notified that they must develop strategies to address the problem. If these strategies fail to reduce HAIs, PADOH must provide technical assistance to address deficiencies. If that also does not work, then penalties can be imposed.

Are there any penalties for hospitals whose numbers of HAIs are considered disappointing or unsatisfactory?

See above.

What role does the PA Department of Health play when a hospital is performing unsuccessfully in regard to the number of HAIs it reports?

See above.