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David Blumenthal, MD, MPP
National Coordinator for Health Information Technology
US Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Dear Dr. Blumenthal:

The Association for Professionals in Infection Control and Epidemiology (APIC) appreciates the opportunity to provide input on the Meaningful Use Stage 2 proposal. APIC is a nonprofit, multi-disciplinary, international organization representing over 14,000 infection preventionists (IPs), whose mission is to improve health and promote safety by reducing the risks of infection and adverse outcomes in patients and healthcare personnel. Our members are critical to efforts to provide data for internal facility quality improvement efforts, as well as public health efforts.

Statement of the Problem

Since 2003, a rapidly growing number of states have been enacting laws that require hospitals, and in some states other healthcare facilities, to report data regarding healthcare-associated infections (HAIs) to a state agency. The majority require reporting through the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). While NHSN has steadily improved its user interface, manual data entry especially for the NHSN Surgical Site Infection (SSI) module strains infection prevention and control program resources in hospitals that lack sufficient staff, computer support or both.[1] Last year in at least one state, this resulted in new legislation that delayed mandatory public reporting of SSI to the state health department through NHSN by up to 3 years.[2] At the federal level, new Centers for Medicare and Medicaid Services (CMS) rules of participation passed in 2010 requires hospitals to report central line-associated bloodstream infections (CLABSIs) through NHSN starting January 2011 and will require hospitals to report SSI through NHSN starting with January 2012 admissions.[3] There are currently discussions among the CDC, CMS and the American College of Surgeons to harmonize the SSI measure.

HAI has been recognized as one of six "winnable battles" by the CDC.[4] However, unless hospitals are able to provide data reliably, and the accuracy of their surveillance programs can be validated to the same degree that other industries validate quality, there is a real risk that public reporting programs will fail to maintain any credibility. Credible proof that the battle is

being won requires accurate and meaningful surveillance results. This will require investment in computer technology and resources capable of supporting the needs of hospital infection surveillance programs.

The federal HITECH Act offers a large financial incentive for hospitals and other healthcare providers to purchase computer systems that meet "meaningful use" criteria. NHSN has already done much of what meaningful use requires for public health informatics, so infection surveillance networks through NHSN should serve as a model for other public health specialties that have not already:

- identified essential data elements and created data dictionaries,
- mapped those data elements to clinical record structures,
- developed implementation guides for clinical document architecture,
- established secure communication through defined clinical document architecture messaging between hospital and NHSN computer systems, and from NHSN to state health department computer systems,
- created heuristics to turn data into information, and
- established capacity in public health programs to receive and process this information.

NHSN already has done all this, with modules capable of accepting CLABSI, SSI and other infection site data pertinent to several federal incentive programs' reporting needs (i.e. U.S. Dept. of Health and Human Services Action Plan to Prevent Healthcare-Associated Infections;[5] CMS Inpatient Prospective Payment System (IPPS) program;[6] and future CMS value-based purchasing pay-for-performance criteria based on what quartile a facility is in with respect to healthcare-associated infection rates under the Patient Protection and Affordable Care Act). However, HAI surveillance has been considered a low priority in the staged meaningful use criteria. It currently sits as an optional consideration in Stage 3 (automated real-time surveillance and comprehensive patient data access) rather than as a core requirement in Stage 1 (public health reporting and quality reporting) or Stage 2. This delays financial incentives for hospitals to include HAI in their system selection criteria until 2015-2016. Hospitals need to have those informatics systems in place in 2011-2012 to meet current state and federal mandates for HAI reporting.

Statement of the desired action to be taken

Office of the National Coordinator for Health Information Technology (ONC) should move healthcare-associated infection surveillance (reporting through NHSN) from a Stage 3 optional consideration to a Stage 2 Quality Reporting core requirement in its criteria for meaningful use. This would move the financial incentive from 2015-2016 to 2013-2014. Specifically the following healthcare-associated infection measures should be included as criteria for Meaningful Use:

A) Core requirement under Stage 2:

1) NHSN: Central line associated blood stream infections (CLABSI)

2) NHSN: Catheter associated urinary tract infections (CAUTI)
3) NHSN: Laboratory identified events: multi-drug resistant organism/*Clostridium difficile* (MDRO/CDAD) module

B) Optional under Stage 2:
NHSN: Central Line Insertion Practices (CLIP)

C) Core requirement under Stage 3:
1) NHSN: Central Line Insertion Practices (CLIP)
2) NHSN: Surgical Site Infections (SSI)

Public Health Impact

The network already made operational by CDC spans infection surveillance software vendors, clinical information system vendors, NHSN, and state HAI programs. This could serve as a model for other public health areas of meaningful use. A majority of hospitals today lack surveillance or clinical information system software, so must therefore rely on manual HAI data retrieval and input to meet requirements of federal and state mandatory public reporting requirements. The desired action would provide them with significant financial incentives in time to meet data input requirements that tax current capacity. Beyond improving efficiency for hospitals, an additional benefit would be more reliable accuracy in reporting. In 2009, APIC issued a position paper highlighting the importance of electronic surveillance software systems.[7] Electronic data collection and data mining systems now provide innovative and sophisticated means to integrate information from electronic health care records into meaningful information which can be used for HAI prevention by infection preventionists at the front lines. NHSN has developed capabilities through clinical document architecture (CDA) to allow for messaging and data transfer directly to NHSN. Validation of data is critical to the success of electronic surveillance. As these technologies are further tested and enhanced, automated detection holds promise in providing greater efficiency and more accurate and reliable data and will provide a standardized, interoperable and validated approach to information exchange. State health department HAI public reporting programs would also benefit from this increase in accuracy and reliability.

There should be no new cost implications for public health agencies since NHSN already has undertaken the necessary developmental work, CMS and state laws already have established the required reporting network groups. Costs for hospitals to acquire these computer systems is due to existing CMS rules, not of moving infection surveillance reporting through NHSN to Stage 2 Quality Reporting core requirement for meaningful use. Timely and accurate data on HAI occurrence are necessary to define the scope of the problem (and its variability across locations) and to assess progress toward elimination. Incidence data allow healthcare epidemiologists and infection preventionists to detect HAIs, to inform clinicians about how best to implement prevention interventions, and to assess the impact of those interventions.[8]

Again, APIC appreciates the opportunity to provide input and look forward to continuing to work with ONC to encourage the meaningful us of health information technology.

Sincerely,

Russell N. Olmsted, MPH, CIC
2011 APIC President

IV. References:

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2. http://apps.leg.wa.gov/billinfo/summary.aspx?bill=2828&year=2009

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4. http://www.cdc.gov/about/winnablebattles.htm

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