Council of State and Territorial Epidemiologists

April 22, 2008

The Honorable Richard J. Durbin
309 Hart Senate Office Building
Washington, D.C. 20510

RE: Re: Senate Bill 2278, Community and Healthcare-Associated Infections Reduction Act of 2007

Dear Senator Durbin:

The Council of State and Territorial Epidemiologists (CSTE) has read S. 2278, the *Community and Healthcare-Associated Infections Reduction Act of 2007,* with interest and fully agrees that healthcare associated infections (HAI) and antibiotic resistant organisms pose a significant threat to patients and to public health.

CSTE is an organization of Member States and also a professional association with over 1,150 public health epidemiologists working in all 50 states as well as local, tribal, and territorial health agencies to detect, prevent and control conditions that impact the public's health. CSTE's members possess expertise in surveillance and epidemiology in a broad range of areas, including communicable diseases, immunization, environmental health, chronic diseases, occupational health, injury control, maternal and child health and oral health.

CSTE believes there is much that can and needs to be done to reduce HAI and antibiotic resistant infections. We applaud you for sharing our commitment to prevent these infections. To increase the impact of this bill and to ensure that resources are used most wisely we provide the following comments:

Section 4:

The Healthcare Infection Control Practices Advisory Committee (HICPAC), an established federal advisory board, should be tasked to develop best-practices guidelines for internal infection control plans. This will reduce duplication of effort, and will reduce the potential for conflicting guidelines. A major barrier to effective implementation of infection control measures is the publication of conflicting guidelines. HICPAC already has established credibility in this arena; AHRQ is already represented at HICPAC. The HICPAC working group should consult with CMS.

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Section 5: (a)

Tremendous benefit can be gained by the collection of data in a standardized manner. The National Healthcare Safety Network (NHSN) could provide very useful platform to implement this. NHSN has developed standardized protocols and definitions which will be very helpful in this regard. However, the proposed timeline of 120 days is unrealistic and counterproductive. We urge that this be extended to at least 365 days following appropriation of sufficient funds to allow for enhancements to NSHN. This will also provide sufficient time to enroll hospitals into NHSN and for hospital staff to be trained in the definitions and protocols.

In addition, we propose:

CSTE and States should work with CDC in a manner analogous to the National Notifiable Disease Surveillance System process to decide which specific HAI (for example central line associated blood stream infections) and multi-drug-resistant organisms (MDROs) should be reported nationally and develop case definitions and protocols. Several States have already implemented mandatory reporting of HAI. It is important to take into account the lessons learned from these States in making such determinations. CSTE proposes that a subset of HAI and MDROs be reported nationally from every hospital. Individual States and hospitals should decide which additional HAI should be reported and/or monitored to meet their local needs. NHSN can provide a useful platform to collect these data. The MDRO module that could be used to collect data on community-onset and healthcare onset MRSA is still under development. It is essential to pilot proposed definitions and protocols before requiring data collection on a national level.

There are tremendous opportunities to take advantage of electronic data exchange to support current and future modules within NHSN. This requires the development of standards if they do not already exist and to implement them when they are available. There is a need to develop clinical document architecture specifications and implementation guidance for events and process measures such as central line insertion practices. This will avoid duplicate data entry and collisions with vendor developed systems. There are numerous other opportunities for electronic data exchange that will allow us to collect data in a much smarter, effective manner. It will take time (at least one year) and sufficient resources to develop and/or implement these. This would obviate duplicate data entry and allow infection control professionals to spend time preventing infections and evaluating the impact of prevention measures instead of just counting infections and entering data. CDC should work with CSTE and CMS on methods to provide incentives to vendors and hospitals to reduce data entry burden by infection control professionals.

To ensure good data quality, users have to be well trained in data definitions and protocols. This takes time and resources. Online training and competency modules would need to be developed, as well as “train the trainer” sessions for key staff within States. It is vital to ensure that data collected are valid, i.e., cases are counted and the definitions applied correctly. Validation protocols, including competency requirements for infection control professionals conducting validation need to be developed. Resources need to be provided to States to perform validation.

It also is important to clarify the following:

- that community infections in this bill refers only to community-onset MRSA, not all other communicable diseases in general.
- distinguish between community-onset and hospital-onset MRSA infections (5.a.2.A) rather than using the phrase “present on admission”
- CDC is not a regulatory agency; CDC should partner with CMS and CSTE to ensure that hospitals accurately and timely track and report data (5.a.-3)
- CDC should also consult with CSTE (5.b)

- State health departments need to have access to real-time data' there should be no delay. This is possible within NHSN; several States that have implemented mandatory reporting are taking advantage of this already. (5.d)

Section 8:

CSTE suggests that the existing Active Bacterial Core (ABC) Surveillance component of the Emerging Infections Program, a grant provided by CDC, be expanded to evaluate the impact of prevention activities. This would take advantage of existing infrastructure and outcome measurement.

In addition, CSTE suggests that grant funding be provided to States to allow them to replicate the Michigan Keystone ICU project. There is a lot of technical knowledge on infection prevention activities. What is desperately needed is how to implement these (adaptive processes). The Michigan Keystone Initiative provides a good model on how this could be achieved. Funds would need to be appropriated.

Section 9:

CSTE would welcome the opportunity to be a member of the proposed working group and suggests that the working group work in collaboration with HICPAC for the reasons outlined in our comments on Section 4.

CSTE is fully committed to reducing HAI and community-onset MRSA. We would welcome the opportunity to discuss this further. If you have questions or comments, please contact the lead CSTE consultant on HAI, Dr. Marion Kainer MD, MPH, FRACP, Director of the Hospital Infections and Antimicrobial Resistance Program, Tennessee Department of Health. [Phone: office: 615-741-7247, cell: 615-330-6162; fax: 615-741-3857; email: marion.kainer@state.tn.us; mailing address: 425 5th Avenue, Cordell Hull Bldg, Floor 1, CEDS, Nashville, TN 37243]

Sincerely,

Patrick J. McConnon, MPH
Executive Director

cc: Sen. Edward M. Kennedy