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February 25, 2011

Department of Health and Human Services
Office of the National Coordinator for Health Information
Technology
Mary Switzer Building
330 C Street, SW
Suite 1200
Washington, DC 20201

Attention: Joshua Seidman

To Whom It May Concern:

The Society for Healthcare Epidemiology of America (SHEA) appreciates the opportunity to provide comments regarding Electronic Reporting of Healthcare-Associated Infection Data.

SHEA was founded in 1980 and represents a growing and active membership of physicians and other healthcare professionals responsible for patient safety and quality improvement. The Society works to maintain the utmost quality of patient care and healthcare worker safety in all healthcare settings, applying epidemiologic principles and prevention strategies to a wide range of quality-of-care issues.

Healthcare Associated Infection (HAI) surveillance has been considered a low priority in the staged “meaningful use” criteria. HAI currently are an optional consideration in Stage 3 (automated real-time surveillance & comprehensive patient data access) rather than as a core requirement in Stage 1 (public health reporting & quality reporting) or Stage 2. We believe the relegation of HAI surveillance to Stage 3 is a significant missed opportunity to capture low hanging fruit in the implementation of “meaningful use” information technology. As a result the Federal HITECH Act financial incentive for hospitals and other healthcare providers to

purchase systems that meet “meaningful use” criteria for HAI will be delayed until 2015-2016.

More than 4,000 of our nation’s 5,000 plus hospitals now report HAI surveillance data to the National Healthcare Safety Network (NHSN) of the Centers for Disease Control and Prevention. More than 20 states have statutory HAI reporting requirements and most require participation in NHSN. This existing federally funded network can serve as a model for the use of public health informatics and infection surveillance and enable hospitals to adopt electronic methods rather than continue to engage in the costly, cumbersome and time consuming manual activities that currently characterize much of HAI reporting in the United States. NHSN has developed modules capable of accepting Central Line Associated Bloodstream Infection, Surgical Site Infection and other infection site data pertinent to several federal incentive program reporting needs (e.g., Department of Health and Human Services Action Plan to Prevent Healthcare-Associated Infections; CMS Inpatient Prospective Payment System (IPPS) program; and CMS value-based purchasing).

We propose the following actions:

The 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 Improving Quality, Safety and Efficiency Reporting core requirement in its criteria for meaningful use. This would move the financial incentive for hospital forward from 2015-2016 to 2013-2014. Such a move would accelerate the stated goals of the CDC, SHEA and other professional societies to eliminate HAIs and build upon the progress and investment already made by HHS and the CDC.

Specifically the following healthcare associated 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) NSHN: Laboratory identified events: multi-drug resistant organism/ *Clostridium difficile* (MDRO/CDAD) module

B) Optional under Stage 2:

- 1) 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)

These actions would have very important ramifications and could serve as a model for other public health areas of meaningful use:

1. The network already made operational by CDC spans infection surveillance software vendors, clinical information system vendors, NHSN, and state HAI programs.
2. A majority of hospitals that lack surveillance or clinical information system software and that rely on manual HAI data input to meet requirements of federal and state mandatory public reporting requirement, would now have significant financial incentives in time to meet data input requirements.
3. An additional significant benefit of electronic data reporting would be more reliable accuracy in reporting. Significant deviation in applying NHSN case definitions, as well as lower detection sensitivity overall, was found among hospitals with well-established manual review of clinical records when compared to review of those same records by a computer algorithm.

There should be no new cost implications for public health agencies since NHSN already has undertaken the necessary developmental work and 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.

We encourage the serious consideration of this proposal to accelerate the investment in network infrastructure that has been made by the federal government and already adopted by most hospitals in the United States. We appreciate the opportunity to comment and would be pleased to provide further supporting evidence at your discretion.

Sincerely yours,



Steven M. Gordon, MD
SHEA President