August 24, 2011

Karen Adams, PhD, MT
Vice President, National Priorities
National Quality Forum
601 13th Street NW
Suite 500 North
Washington DC 20005

Dear Dr. Adams:

The Society for Healthcare Epidemiology of America (SHEA) and the Association for Professionals in Infection Control and Epidemiology (APIC) appreciate this opportunity to provide feedback surrounding the National Quality Forum’s National Priorities Partnership (NPP) draft report to the U.S. Department of Health and Human Services (HHS) on the 2012 National Quality Strategy.

SHEA is a professional society representing physicians and other healthcare professionals around the world with expertise in healthcare epidemiology and infection prevention and control. SHEA’s mission is to prevent and control healthcare-associated infections (HAIs) and advance the field of healthcare epidemiology. The Society leads this field by promoting science and research and providing high-quality education and training in epidemiologic methods and prevention strategies. SHEA upholds the value and critical contributions of healthcare epidemiology to improving patient care and healthcare worker safety in all healthcare settings.

APIC is a professional association of greater than 14,000 infection prevention professionals who direct and execute infection prevention programs that save lives and improve the bottom line for hospitals and other healthcare facilities around the globe. APIC’s mission is to improve health and patient safety by reducing risks of infection and other adverse outcomes. APIC advances this mission through education, research, collaboration, practice guidance, public policy and credentialing. SHEA and APIC support HHS’ development of a National Quality Strategy that fully addresses three overarching domains - better care, affordable care, and healthy people/healthy communities. We share this goal, and in particular, an unyielding focus on the prevention of healthcare-associated infections (HAIs) in our hospitals and health systems across all states, including outpatient settings.

SHEA and APIC actively contribute to performance measure development in this area. These activities include providing expert input to HHS on the measures and target goals included in its Action Plan to Prevent Health Care-Associated Infections and providing expert collaboration with the Centers for Disease Control and Prevention (CDC) on measure development. We understand that the Action Plan provided guidance for the HAI components of the National Quality Strategy. We strongly support this close alignment, given that development of the Action Plan included significant agency and stakeholder input on the issue of HAIs.

We applaud the NPP for this thoughtful document and agree that evidence-based approaches, coupled with investment in infrastructure ensuring adequate and customizable resources, and intense collaboration between all sectors and communities, are essential to ensure success. We believe that every healthcare institution should be working toward reduction of all healthcare-associated conditions including HAI. While
we are encouraged by recent reports of HAI reductions in central line-associated bloodstream infections (CLABSI) in intensive care units, continued progress is contingent upon sustained focus and resources.

Our organizations jointly authored a white paper last year entitled “Moving toward Elimination of Healthcare-Associated Infections: A Call to Action” with leading public health and infectious disease experts representing CDC, the Infectious Diseases Society of America (IDSA), the Association of State and Territorial Health Officials (ASTHO), the Council of State and Territorial Epidemiologists (CSTE) and the Pediatric Infectious Diseases Society (PIDS). The white paper was co-published in the journal *Infection Control and Hospital Epidemiology* and the *American Journal of Infection Control* and is attached for your reference.

The paper outlines a four-part framework for achieving elimination of HAIs including:

- Implementation of evidence-based practices that protect patients;
- Alignment of incentives to promote system-wide strategies for HAI prevention;
- Addressing gaps in knowledge to push beyond the current medical knowledge; and
- Collecting data to target prevention efforts and to measure progress.

The paper notes that these efforts must be supported by a substantial investment in research (we note that the NPP paper recognizes the need for research with no mention of the funding mechanism), novel prevention tools, improved levels of organizational and personal accountability, strong collaboration among all stakeholders and a national will to succeed. By illustration, we earlier highlighted challenges with some criteria for select sites of HAIs such as ventilator-associated pneumonia (VAP). CDC scientists, in collaboration with members of SHEA and APIC have established a workgroup to address concerns raised about the criteria for VAP and are engaging key stakeholders such as intensivists and critical care nurses in refining criteria. It will be important to test changes in criteria – even more so as the industry moves towards a pay for performance model as the goal remains to optimized safety and quality of care. This workgroup is also addressing some other NHSN surveillance criteria and we therefore encourage accommodation of a pilot study phase to assure changes achieve desired results. This is especially important as even modest changes in criteria need to be adopted across a very large pool of facilities that are participating in NHSN; currently this stands at approximately 4,500 hospitals.

SHEA and APIC believe that it is best to focus on outcomes over process measures, where possible. For example, consistent use of the CLIP bundle has led to steady decreases in CLABSI, but measuring CLABSI rates provides more significance for interested parties than measuring adherence to the CLIP bundle. However, in those cases where outcomes are not consistently defined or standardized, ventilator-associated pneumonia, for example, we believe that process measures have value until valid outcomes measures can be developed. Similarly, we’re already aware that CMS has adopted another outcome metric, catheter-associated urinary tract infection (CAUTI) rates among critically ill patients. This outcome is an important, but not complete picture of adherence with evidence-based guidelines involving this device. Processes such as proportion of urinary catheters that are ordered for appropriate indication, presence of reminder or stop order systems, and timely removal of these during postoperative period are valuable process metrics.

Though HAIs have been for nearly 40 years a focus of healthcare quality improvement efforts, there is a continuous need for improvement. While there has been an effort to standardize methodology and reporting organizations, there remains considerable duplication in the documentation required by State and Federal organizations. SHEA and APIC support public reporting as part of a comprehensive strategy to eliminate HAIs. As leaders in the field of infection prevention and control, SHEA and APIC members are deeply committed to the need for establishing a national standard of reporting for HAIs. In 2006, SHEA, APIC and IDSA jointly published model legislation and a toolkit outlining recommendations for design of public reporting programs at the state level ([http://www.shea-online.org/Policy/PositionsStatements.aspx](http://www.shea-online.org/Policy/PositionsStatements.aspx)). These recommendations focused on creating standardized definitions of HAIs, ensuring validated data and supporting the use of the
CDC’s National Healthcare Safety Network (NHSN) as a backbone for surveillance and public reporting. Of note, there is recent evidence that the growth of public mandates for release of data on a state-by-state basis has resulted in variation in methods, targeted metrics and thus questions of comparability have arisen. [Aswani MS, et al. Am J Med Qual. 2011 Sep-Oct;26(5):387-95] This highlights the need and value of harmonization of metrics on a nationwide basis.

We are pleased that nearly half of the states have adopted laws similar to this model. We believe it is time for a national standard that can ensure validated data and comparisons that accurately portray infection rates across geographic and health status-based risk categories. A national standard will provide all involved in the delivery of patient care — including the patient themselves — data for action that drives our progress toward elimination of HAIs. Our end goal is a public reporting system that is epidemiologically sound, scientifically valid, and fair to both healthcare providers and consumers.

We are pleased that the National Quality Strategy utilizes the NHSN to illustrate the types of measures useful in monitoring progress toward the goal of eliminating HAIs. The NHSN is based on epidemiologically sound, surveillance data and presents a national standard for reporting HAIs that accurately portrays infection rates across different geographic regions and categories of risk. CDC is developing electronic methodologies that will take advantage of the current capabilities of NHSN and reduce surveillance time and labor. NHSN provides the necessary risk adjusted standardized data of value to CMS and the public as well as to our efforts to measure true HAI rates as we strive to eliminate HAIs.

Lastly, we would like to bring to your attention the significant omission under the section of the report entitled “Healthy people/healthy communities” of the vaccination of healthcare providers (HCP) and of susceptible patient populations against vaccine preventable diseases, such as influenza, pertussis, and measles. Successful vaccination campaigns will result in increased protection of infants and children, and other susceptible populations, minimizing the spread of infections, outbreaks, and maximizing herd immunity which is particularly important in young infants and immune-compromised individuals. SHEA and APIC strongly support mandatory HCP vaccination, as well as public reporting of HCP vaccination rates, as evidenced by our position papers.

SHEA and APIC appreciate having the opportunity to review and comment on this important document.

Sincerely,

Steven M. Gordon, MD
2011 SHEA President

Russell Olmsted, MPH, CIC
2011 APIC President