New York State Department of Health (NYSDOH) Hospital-Acquired Infection (HAI) Reporting Program: Policy for Facilities with Consecutive Years of High HAI Rates

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A. Purpose: The purpose of this document is to describe the procedure that the NYSDOH Hospital-Acquired Infection (HAI) Reporting Program, NYSDOH Office of Public Health (OPH), NYSDOH Office of Primary Care and Health Systems Management (OPCHSM), and reporting facilities will follow when facilities are identified as having significantly high HAI rates.

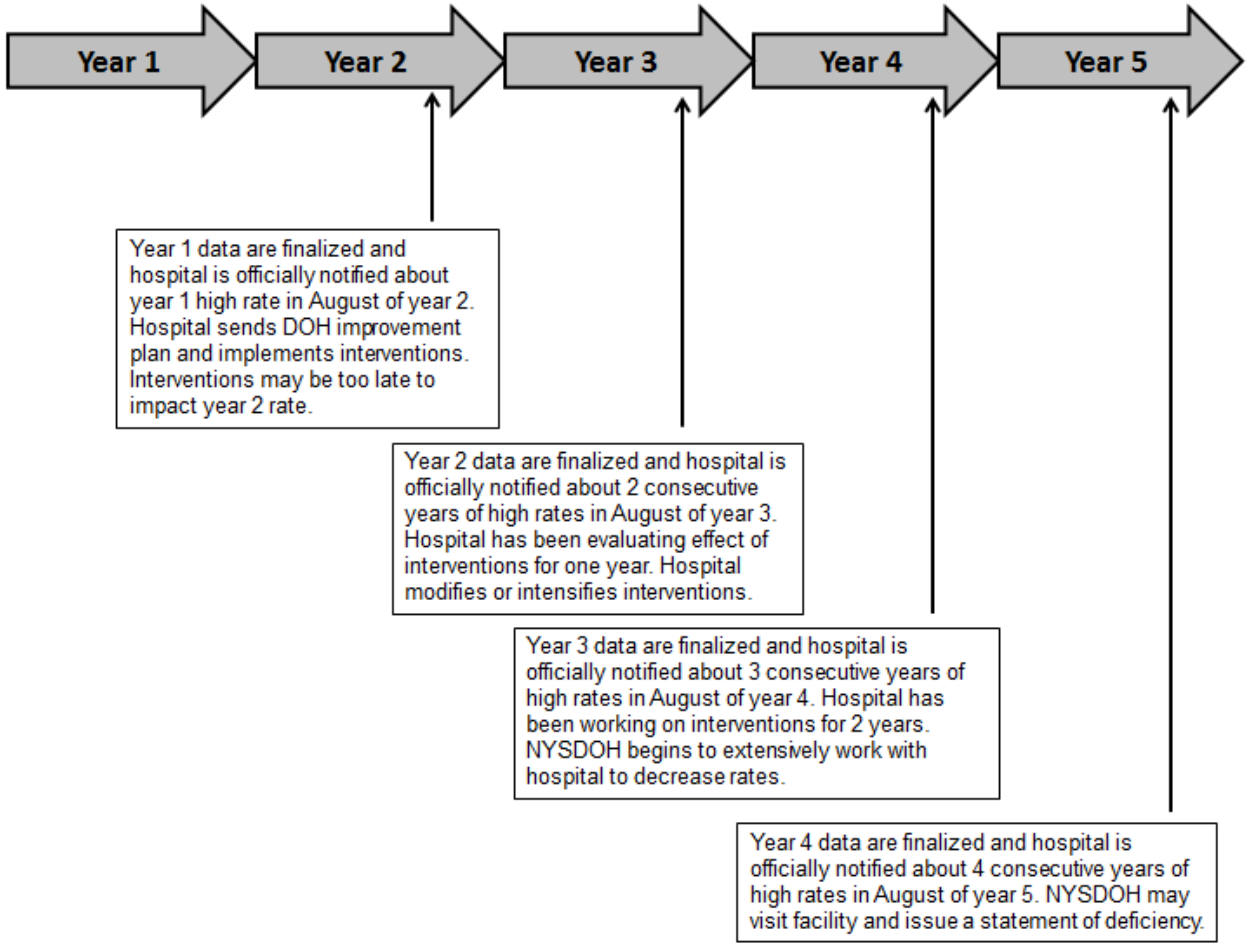
B. Background: In accordance with NYS Public Health Law § 2819, the NYSDOH HAI reporting program publishes annual reports summarizing facility-specific HAI rates for selected indicators for mandatory reporting.

- For central line-associated bloodstream infections, surgical site infections, *Clostridium difficile* infections, and other newly reportable infections where risk adjustment data are available, each facility's HAI rates are compared to the state average by type of infection. Facilities with rates that are significantly higher or lower than the state average are flagged in the public report.
- For some reportable infections where risk adjustment cannot be done, each facility's infection rate may be compared to the facility's rate during the previous year. Facilities with rates that are significantly higher or lower than their rate in the previous year are flagged in the public report.

C. Policy: Hospitals with an HAI rate that is flagged high for a specific reporting indicator are contacted in an effort to assist them in their quality improvement and infection prevention activities to reduce infection rates. The amount of contact increases with the number of years of consecutive high rates.

The policy and procedures pertain to the final rates that are published each year. HAI staff periodically inform facility Infection Preventionists (IPs) of their preliminary rates. In April after the close of the year, all facilities are asked to review the year's preliminary data for accuracy. Final data cleaning occurs between April and June. Final rates are typically sent to facilities in early August. The following diagram shows the key events on the timeline.

Figure 1: Timeline showing delay between data, notification, intervention, and effects of intervention



D. Procedure

1) Hospital is flagged high for only **one year** for one or more indicators.
   HAI staff will:
   - Notify (phone and/or email) the facility IP that data for a specific indicator is flagged high. Included in the notification:
     - The rate will be flagged in the annual HAI report to the public, and the facility should be prepared to respond to the report.
     - HAI staff will offer references to guidance documents that may assist in the improvement process.
     - An investigation (i.e. root cause analysis (RCA)) should be initiated to determine any similarities in the reported events or breaches in infection prevention practices.
   - Prioritize this facility's audit to verify the accuracy of the reported data and review the surveillance and infection prevention methods in place at the hospital.

Facility IP will:

- Notify the CEO and departments involved in patient care related to the high indicator.
- Provide a written response within three weeks documenting any practice changes that will be implemented or the need and plans to reinforce existing infection prevention practices to improve the infection rate. It should also identify the facility staff, committees and departments involved in the improvement process.

2) Hospital is flagged high for **second consecutive year** for the same indicator(s).
HAI staff will:
    - Provide written notification to the facility IP that data for a specific indicator is flagged high for a second consecutive year. Included in the written notification:
        - The same information as above for the first year, and
        - Availability of HAI representative to meet with facility staff to review data and improvement plans.
    - If the facility response is inadequate, HAI staff will cc the CEO in a follow-up email to the IP.
    - Inform OPCHSM of the facility's HAI infection rate and improvement plans.
    - Schedule a follow-up audit based on the time line of the improvement plan to verify the accuracy of the reported data and the prevention methods implemented.

    Facility IP will:
    - Notify the CEO and departments involved in patient care related to the high indicator.
    - Provide a written response within three weeks documenting any practice changes that will be implemented or the need and plans to reinforce existing infection prevention practices to improve the infection rate. It should also identify the facility staff, committees and departments involved in the improvement process.

3) Hospital is flagged high for the **third consecutive year** for the same indicator(s).
HAI staff will:
    - Provide written notification to the facility CEO and IP that data for a specific indicator is flagged high for a third consecutive year. This notification will be signed by the Director of the Bureau of Healthcare Associated Infections and cc'd to the following staff:
        - Director, HAI Reporting Program
        - Director, Division of Epidemiology
        - Director, Center for Community Health
        - Director, OPH
        - Director, OPCHSM
        - Director, OPCHSM Division of Hospitals and Diagnostic Treatment Centers
        - Regional Office Director, Disease Control or Epidemiology
        - Regional Office Director, OPCHSM

    The above staff will receive a draft version of the notification at least two weeks before hospital notification to give them the opportunity to consider whether the notification will impact any of their activities or ongoing investigations.

Included in the written notification:
    - Facility will be flagged in the annual HAI report to the public and the facility should be prepared to respond to the report.
    - Facility must provide a written account that assesses why previous improvements did not successfully reduce HAI rates and provide an adjusted plan for improvement.
    - HAI representatives are available to meet with facility staff to review data and improvement plans.
- Send a written response to the facility's plan within three weeks, recommending additional corrective actions if applicable, which are prioritized in order of patient safety.
- Discuss the issues with OPCHSM and provide OPCHSM with a list of indicator-specific prevention measures that OPCHSM may use if they choose to visit the facility.
- Schedule a follow-up audit based on the time line of the improvement plan to verify the accuracy of the reported data and the prevention methods implemented.

Facility will:

- Provide a written account that assesses why previous improvements did not successfully reduce HAI rates and provide an adjusted plan for improvement within three weeks.

4) Hospital is flagged high the **fourth consecutive year** for the same indicator(s).
NYSDOH staff will:
    - Provide written notification to the facility as described above for the third year, with additional information about planned OPCHSM actions.
    - Review quarterly data with the facility over the next year.
    - Schedule a follow-up audit to verify the accuracy of reported data and implementation of improvements in prevention practices.
    - OPCHSM and/or HAI staff may jointly visit the facility and meet with the stakeholders (e.g. Chief Medical Officer, CEO, IP, epidemiologist, surgical chiefs, nursing, quality directors, risk management, corporate compliance officers) to assess the adequacy of the plan of correction.
    - As applicable, OPCHSM may issue a Statement of Deficiency (SOD).

Facility will:

- Provide a written account that assesses why previous improvements did not successfully reduce HAI rates and provide an adjusted plan for improvement within three weeks.

Note: Hospital-specific HAI rate were first published using 2008 data, and NYS HAI staff informally discussed HAI prevention plans with hospitals flagged with significantly high rates. When this document was first issued in January 2013 (and applied to 2012 data), "third consecutive year" and "fourth consecutive year" protocols could not be followed exactly because the documentation surrounding the first two years of high rates was not always available. Because *Clostridium difficile* infection rates were not risk adjusted until 2013, 2013 is considered to be year 1 for this indicator.

E. Resources & Guidelines

a. **Society for Healthcare Epidemiology of America (SHEA)**: Compendium of Strategies to Prevent HAIs.
http://www.shea-online.org/GuidelinesResources/CompendiumofStrategiestoPreventHAIs.aspx

b. Association for Professionals in Infection Control and Epidemiology (APIC): Implementation Guides

i. Guide for the Prevention of Mediastinitis Surgical Site Infections Following Cardiac Surgery (2008).
ii. Guide to the Elimination of Orthopedic Surgical Site Infections (2010).
iii. Guide to the Elimination of *Clostridium difficile* in Healthcare Settings (2008).

c. Centers for Disease Control and Prevention (CDC): Scientific guidelines

i. Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011.
ii. Guidance on Public Reporting of Healthcare-Associated Infections: Recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC), 2005.
iii. Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2008.
iv. Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007.
v. Guidelines for Environmental Infection Control in Health-Care Facilities, 2003.
vi. Guideline for Hand Hygiene in Health-Care Settings: Recommendations of HICPAC, SHEA, APIC & IDSA Hand Hygiene Task Force, 2002.
vii. Guideline for the Prevention of Surgical Site Infections, 1999.

d. **National Healthcare Safety Network (NHSN):** Patient Safety Component
http://www.cdc.gov/nhsn/TOC_PSCManual.html