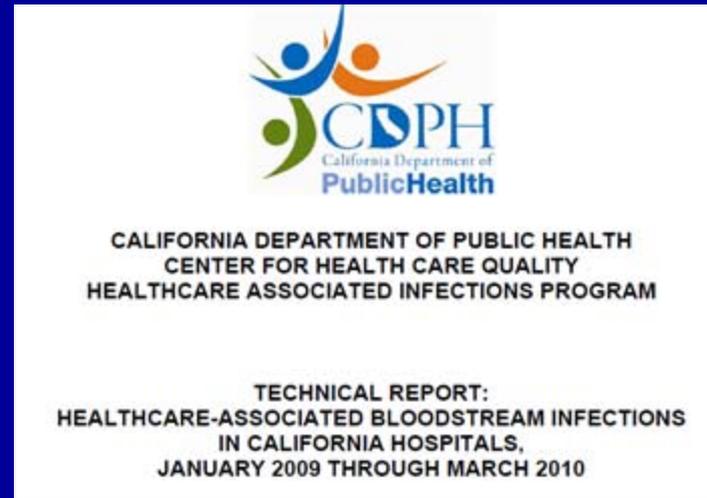


**CDPH Technical Report: Healthcare-associated
bloodstream infections in California hospitals,
January 2009 through March 2010**
Key findings, context, and action steps



Kate Cummings, MPH
Healthcare Associated Infections Program
California Department of Public Health

Some of the media outlets that covered the report:

- Fresno Bee
- Sacramento Bee
- San Francisco Chronicle
- Voice of Orange County

Said State Sen. Elaine Alquist, D-Santa Clara, who authored Nile's Law: "We have seen with other legislation that it takes time to refine the data collection process. It's a good first step. We're on the way, but it takes time." RedlandsDailyFacts.com

CDPH HAI Program strongly supports publicly reporting **quality data** on HAI rates

- These data offer:
 - Incentive for collaboration between hospitals and prevention experts based on benchmarking
 - Information to help hospitals improve care
 - Information to help consumers make more informed decisions on healthcare choices

Important caveats about publicly reported rates

- “Developers of reporting systems should avail themselves to **established and proven methods of collecting and reporting surveillance data**..... publicly reported HAI rates can mislead stakeholders if **inaccurate** information is disseminated....”¹

CDPH evaluated the quality of HAI BSI data reporting period 2009 – Q12010

- Non standard definitions and protocols
- Quality assurance and control occurred when data were no longer available
- Insufficient information for risk adjustment
- CDPH identified significant incorrect, inconsistent, and incomplete data and insufficient means by which to risk adjust

Key findings

- 383 reporting facilities
 - 336 (87.7%) reported complete MRSA and VRE BSI rates
 - 305 (79.6%) reported complete CLABSI rates
 - 19 (5.0%) reported no complete quarters of data

Context: interpreting rates

- A high rate may reflect
 - Non standard or inappropriate definitions
 - Weak infection control
 - Strong surveillance methods that favor more complete identification of infections
 - More medically complex patients
- A low rate may reflect
 - Non standard or inappropriate definitions
 - Strong infection control
 - Weak surveillance methods that favor non-detection of infections (missed cases)
 - Less medically complex patients

Lessons learned

- Hospitals made important strides on reporting but need to continue to build surveillance capacity to support quality data collection and reporting
- Using NHSN is an important step toward: standard definitions, protocols, and data entry and risk adjustment capability for CLABSI
- Timely QA/QC helps to identify systematic data issues early when corrections and revisions can still be made
- Data validation should begin as soon as possible
- ***Because of limitations, these rates are best thought of as a starting point for asking questions about the quality of care provided at the hospitals***

CDPH is committed to public
reporting HAI rates
based on quality data

What is needed to produce rates that are comparable across hospitals?

- Clear, uniform definitions for infections and populations at risk
- Consistent case finding strategies
- Data for risk adjustment
- Standard data collection and reporting instruments
- Quality assurance and control
- Data validation

Action steps for CDPH and hospitals

- Use NHSN
- Consistently apply NHSN definitions, protocols, and surveillance methods
 - Identify barriers
 - Best practices
- Implement timely QA/QC to help identify systematic data issues early
- Validate data

Next steps for 2012 report

- CDPH present to Advisory Committee planned activities for QA/QC, for the next reporting period
- Hospitals should report all data in compliance with NHSN protocols.
- CDPH will assist in identifying systematic errors but hospitals are solely responsible for their data
- For data submitted on or after April 1 2010, it is the expectation that hospitals are complying with NHSN reporting protocols and rates published in the next report will be considered comparable.