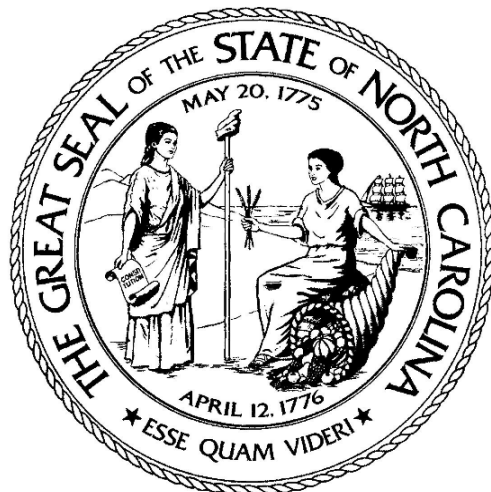


NORTH CAROLINA GENERAL ASSEMBLY



JOINT STUDY COMMITTEE ON HOSPITAL INFECTION CONTROL AND DISCLOSURE REPORT

JANUARY 2009

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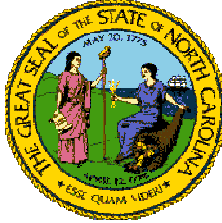
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TRANSMITTAL LETTER



Joint Study Committee on Hospital Infection Control and Disclosure

January 27, 2009

TO THE MEMBERS OF THE 2009 GENERAL ASSEMBLY:

Attached for your consideration is the report of the Joint Study Committee on Hospital Infection Control and Disclosure, established pursuant to G.S. 120-19.6(a1) and Rule 26(a) of the Rules of the House of Representatives of the 2007 General Assembly.

The Joint Study Committee on Hospital Infection Control and Disclosure respectfully submits the following report.

Senator William Purcell
Co-Chair

Representative Martha Alexander
Co-Chair

**Marc Basnight
President Pro
Tempore,
North Carolina Senate**



**Joe Hackney
Speaker,
North Carolina
House of
Representatives**

Raleigh, North Carolina 27601-1096

Joint Study Committee on Hospital Infection Control and Disclosure

WHEREAS, the Centers for Disease Control and Prevention (CDC) reports that approximately 2,000,000 people annually become ill from hospital-acquired infections, called nosocomial infections, and about 90,000 people die each year from hospital-acquired infections; and

WHEREAS, the CDC reports that hospital-acquired infections add at least \$5,000,000,000 annually to the nation's health care bill; and

WHEREAS, a Pennsylvania report on hospital-acquired infections found that 76% of the cost for treating infections in that state was billed to public health insurance; and

WHEREAS, the CDC reports that despite the risks associated with nosocomial infections, information on nosocomial infection rates is hard to obtain, even though basic data is compiled as hospitals monitor infections, particularly in intensive care units and following surgery; and

WHEREAS, the CDC estimates, based on voluntary reporting, that hospital-acquired infections have become America's leading cause of death from infectious disease; and

WHEREAS, it is the intent of the General Assembly to enact a law requiring public disclosure of hospital-acquired infection incidence rates to become effective in 2010;

NOW THEREFORE,

Section 1. The **Joint Study Committee on Hospital Infection Control and Disclosure** (hereinafter "Committee") is established by the President Pro Tempore of the Senate and the Speaker of the House of Representatives pursuant to G.S. 120-19.6(a1), Rule 31 of the Rules of the Senate of the 2007 General Assembly, and Rule 26(a) of the Rules of the House of Representatives of the 2007 General Assembly.

Section 2. The Committee consists of 12 members, including 4 legislators and 8 public members. The President Pro Tempore of the Senate shall appoint 2 Senators to the Committee, and the Speaker of the House of Representatives shall appoint 2 Representatives to the Committee. The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each appoint a co-chair from among their respective appointees. The Committee and the terms of the members shall expire when the Committee submits a final report to the General Assembly. Members serve at the pleasure of the appointing officer.

Legislative Members

President Pro Tempore Appointments

Senator William Purcell, Co-Chair
Senator Doug Berger
Dr. Keith Ramsey, Pitt County
Ms. Robin Carver, Johnston County

Dr. Dan Sexton, Durham County
Mr. Jay Currin, Cumberland County

Speaker of the House Appointments

Representative Martha Alexander, Co-Chair
Representative Lucy T. Allen
Ms. Jayne P. Lee, Moore County
Dr. Christopher T. Aul, Cumberland County

Dr. William A. Rutala, PhD, Orange County
Ms. Marina B. Barber, Orange County

Public Members

The President Pro Tempore of the Senate appoints the following 4 public members to the Committee:

- A hospital infection control professional, upon the recommendation of the North Carolina Hospital Association.
- A physician who is a member of the Society for Health Care Epidemiology, upon the recommendation of the Society for Health Care Epidemiology.
- The Director of the Duke Infection Control Network, or the Director's designee.
- A member of the general public who is neither a health care professional nor affiliated with a health care facility.

The Speaker of the House of Representatives appoints the following 4 public members to the Committee:

- A hospital infection control professional, upon the recommendation of the North Carolina Hospital Association.
- A physician who is a member of the Society for Health Care Epidemiology, upon the recommendation of the Society for Health Care Epidemiology.
- The Director of the Statewide Program for Infection Control and Epidemiology at the School of Medicine of the University of North Carolina at Chapel Hill.
- A member of the general public who is neither a health care professional nor affiliated with a health care facility.

Section 3. The Committee shall consider the methodology to be used for collecting, analyzing, and disclosing publicly the information on hospital-acquired infection incidence rates. This shall include collection methods, formatting, and methods and means for release and dissemination. The Committee shall propose standardized criteria and methods for data submitted to the statewide data processor under G.S. 131E-214.2. The Committee shall also propose a process to ensure that information and data on hospital-acquired infection incidence rates shall not be made available to the public in any form unless the information and data have been reviewed, adjusted, and validated according to the following principles:

- (1) Before disclosing information or data to the public, the entire methodology for collection and analysis shall be disclosed to all relevant organizations and to all hospitals and ambulatory surgical facilities that are the subject of the information or data.

- (2) Data collection and analytical methodologies shall be used that meet accepted standards of validity and reliability before any information is made available to the public.
- (3) Comparisons among hospitals and freestanding ambulatory surgical facilities shall adjust for patient case mix and other relevant risk factors and control for provider peer groups, when appropriate.
- (4) The limitations of the data sources and analytical methodologies used to develop comparative hospital and freestanding ambulatory surgical facility information shall be clearly identified and acknowledged, including the appropriate and inappropriate uses of the data.
- (5) To the greatest extent possible, comparative hospital and freestanding ambulatory surgical facility information initiatives shall use standard-based norms derived from widely accepted provider-developed practice guidelines.
- (6) Comparative hospital and freestanding ambulatory surgical facility information and other information that the statewide data processor or the Department of Health and Human Services has compiled regarding the hospital or freestanding ambulatory surgical facility shall be shared with the hospital or freestanding ambulatory surgical facility under review prior to public dissemination of the information, and the hospital or freestanding ambulatory surgical facility shall have 30 days to make corrections and to add helpful explanatory comments about the information before the publication.
- (7) Safeguards shall be implemented to protect against (a) the unauthorized use or disclosure of hospital and freestanding ambulatory surgical facility information and (b) the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective hospital or freestanding ambulatory surgical facility data.
- (8) A process shall be created to ensure that data collection, analysis, and dissemination methodologies are evaluated regularly.
- (9) A process shall be created to ensure that only the most basic identifying information from submitted reports is used, and except as otherwise authorized by Article 11A of Chapter 131E of the General Statutes, information identifying a patient, employee, or licensed professional shall not be released.

Section 4. The Committee shall meet upon the call of the chair. A quorum of the Committee is a majority of its members. No action may be taken except by a majority vote at a meeting at which a quorum is present.

Section 5. The Committee, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and Article 5A of Chapter 120 of the General Statutes. The Committee may contract for professional, clerical, or consultant services, as provided by G.S. 120-32.02.

Section 6. Members of the Committee shall receive per diem, subsistence, and travel allowance as provided in G.S. 120-3.1, 138-5 and 138-6, as appropriate.

Section 7. The expenses of the Committee shall be considered expenses incurred for the joint operation of the General Assembly. An initial allocation of \$50,000 shall be provided to the Committee from funds appropriated to the General Assembly.

Section 8. The Legislative Services Officer shall assign professional and clerical staff to assist the Committee in its work. The Director of Legislative Assistants of the House of Representatives and the Director of Legislative Assistants of the Senate shall assign clerical support staff to the Committee.

Section 9. The Committee may meet at various locations around the State in order to promote greater public participation in its deliberations.

Section 10. The Committee may submit an interim report on the results of its study, including any proposed legislation, to the members of the Senate and the House of Representatives, on or before May 1, 2008, by filing a copy of the report with the Office of the President Pro Tempore of the Senate, the Office of the Speaker of the House of Representatives, and the Legislative Library. The Committee shall submit a final report on the results of its study, including any proposed legislation, to the members of the Senate and the House of Representatives, on or before December 31, 2008, by filing a copy of the report with the Office of the President Pro Tempore of the Senate, the Office of the Speaker of the House of Representatives, and the Legislative Library. The Committee shall terminate on December 31, 2008, or upon the filing of its final report, whichever occurs first.

Effective this 2nd day of April, 2008.



Marc Basnight
President Pro Tempore of the Senate



Joe Hackney
Speaker of the House of Representatives

**JOINT STUDY COMMITTEE ON HOSPITAL
INFECTION CONTROL AND DISCLOSURE
MEMBERSHIP LIST**

**President Pro Tempore
Appointments:**

Sen. William Purcell, M.D.-Co-Chair

Senator Doug Berger

Ms. Robin Carver

Mr. Jay Currin

Dr. Keith Ramsey

Dr. Dan Sexton

**Speaker of the House of Representatives
Appointments:**

Representative Martha Alexander, Co-Chair

Representative Lucy Allen

Dr. Christopher T. Aul

Ms. Marina Barber

Ms. Jayne P. Lee

Dr. William A. Rutala

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TABLE OF CONTENTS

Letter of Transmittal	i
Authorization Letter.....	ii
Commission Membership	vi
Commission Proceedings	2
Recommendations.....	3
Draft Legislation.....	5
Appendix A.....	7
Appendix B.....	11

COMMISSION PROCEEDINGS

The Joint Study Committee on Infection Control and Disclosure met 4 times during the 2008-2009 interim. The Joint Study Committee on Infection Control and Disclosure heard from the individuals listed below during the meeting. Detailed minutes and information from each Committee meeting are available in the Legislative Library.

September 16, 2008

- Shawn Parker, Legislative Analyst, Research Division, provided the committee with an overview of healthcare associated infection collection and reporting initiatives by states.
- Ben Popkin, Staff Attorney, Research Division, presented observations and recommendations of the Healthcare Infection Control Practices Advisory Committee.

October 13, 2008

- Carol Koeble, Director, North Carolina Center for Hospital Quality and Patient Safety and Joanne Campione, Clinical Measurement Services, North Carolina Center for Hospital Quality and Patient Safety, gave a presentation on current initiatives focused on preventing infections in North Carolina hospitals.
- Ben Popkin, Staff Attorney, Research Division, summarized the findings from the 2005 North Carolina hospital survey on public reporting of healthcare associated infections and discussed components necessary for legislation on the public reporting of healthcare associated infections.

November 18, 2008

- William Cramer, Director of Healthcare Associated Infection Prevention, Pennsylvania Department of Health, gave a presentation on Pennsylvania's experience with reporting on healthcare associated infections.

January 22, 2009

- Ben Popkin, Staff Attorney, Research Division, presented a draft final committee report to the committee for their review and approval. The committee discussed the report, including the proposed surveillance and reporting methodology, recommendations, and legislation, voting to approve the report as amended in committee. The adopted proposal calls for an incremental approach to be taken by dedicated staff in the DHHS, Division of Public Health, beginning with reporting of Central Line-Associated Bloodstream Infections (CLABSI) and expanding to include additional process and outcome measures as appropriate.

RECOMMENDATIONS

Co-Chairs:

Senator William Purcell, MD
Representative Martha Alexander

FINDINGS:

The Joint Study Committee on Hospital Infection Control and Disclosure reviewed information about actions that other states have taken regarding surveillance and reporting of healthcare acquired infections in their states. The landscape of this issue is currently in flux, with much attention and some action being taken at the federal level, and a range of state-level initiatives being implemented across the nation, with varying amounts of success.

Lessons learned from other states' experiences implementing broad, comprehensive surveillance efforts indicated that such efforts were often costly, cumbersome, and frequently failed to produce the desired results (validated information made available to the public in a useful format on a timely basis). In contrast, states that pursued incremental approaches reported having achieved positive results regarding rates of infections in their facilities. Given this, the committee recommends that the General Assembly support an incremental approach to the collection and reporting of data on hospital-acquired infections in this State. Building on expertise of existing staff in the Communicable Disease Branch of the Division of Public Health, dedicated staff would be hired to create a system to collect and report on a readily available outcome measure, central-line associated blood stream infections (CLABSI) in hospital intensive care units. The system would then expand to include additional healthcare facilities and additional outcome and process measures as data collection, validation and other system capabilities develop.

The committee stresses the importance that the methodology ultimately implemented provide healthcare facilities with the opportunity to review data and analyses prior to public disclosure of the data (allowing for corrections or explanations to be provided where appropriate), require that comparisons among facilities be adjusted for different patient case mixes and other relevant risk factors, and that other data or analytical limitations be clearly noted when the data is reported. Patient confidentiality shall be preserved at all stages and safeguards against unauthorized use or disclosure of any facility or patient information collected shall be paramount.

In light of these findings, the Joint Study Committee on Hospital Infection Control and Disclosure makes the following recommendations to the 2009 Regular Session of the 2009 General Assembly:

RECOMMENDATION 1:

The Joint Study Committee on Hospital Infection Control and Disclosure recommends implementation of a mandatory, State-operated, Statewide hospital acquired infection

surveillance and reporting system. To this end, the Committee recommends that the General Assembly appropriate \$650,410 for the 2009-2010 fiscal year and \$517,410 for the 2010-2011 fiscal year to establish and operate the system within the Department of Health and Human Services, Division of Public Health.

RECOMMENDATION 2:

The Joint Study Committee on Hospital Infection Control and Disclosure recommends that the President Pro Tempore of the Senate and the Speaker of the House of Representatives reestablish, by letter, the Joint Study Committee on Hospital Infection Control and Disclosure, as initially authorized, to meet during the interim periods of the 2009-2010 biennium.

DRAFT LEGISLATION

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009**

H

D

BILL DRAFT 2009-MGz-15 [v.3] (1/21)

**(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
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Short Title: Funds For Nosocomial Infections Surveillance.

(Public)

Sponsors: Representative.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR SURVEILLANCE OF
HOSPITAL-ACQUIRED INFECTIONS IN NORTH CAROLINA, AS
RECOMMENDED BY THE JOINT STUDY COMMITTEE ON HOSPITAL
INFECTION CONTROL AND DISCLOSURE.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, the sum of six hundred fifty thousand four hundred ten dollars (\$650,410) for the 2009-2010 fiscal year, and the sum of five hundred seventeen thousand four hundred ten dollars (\$517,410) for the 2010-2011 fiscal year in recurring funds to develop and implement a mandatory statewide hospital-acquired infections surveillance and reporting system, as recommended by the Joint Study Committee on Hospital Infection Control and Disclosure. These funds shall be used to accomplish all of the following:

- (1) Establish new positions within the Communicable Disease Branch to implement a statewide hospital-acquired infections surveillance and reporting system.
- (2) Purchase equipment and provide operational support for the new positions established within the Communicable Disease Branch.
- (3) Establish and support an information technology position within the Department to customize the North Carolina Electronic Disease Surveillance System for data collection under the statewide hospital-acquired infections surveillance and reporting system.
- (4) Develop and implement a training program for hospital staff.
- (5) Develop a methodology for public disclosure of validated hospital-acquired infections data.

SECTION 2. This act becomes effective July 1, 2009.

APPENDIX A

SURVEILLANCE OF HOSPITAL ACQUIRED INFECTIONS IN NORTH CAROLINA

Proposal for incremental surveillance coordinated by NC DHHS Division of Public Health

-- Central Line-Associated Bloodstream Infection as a pilot reportable condition --

Proposed methodology and estimation of resource needs

I. Key principles for determining surveillance methodology

1. Adopt national standards (e.g., case definitions, minimum data elements) ensuring comparability with other states and with national data.
2. Implement surveillance in a “pilot phase” or incrementally with single outcome measure, Central Line-Associated Bloodstream Infection (CLABSI).
3. Conduct surveillance on a target population at risk: inpatients in Intensive Care Units (ICU).
4. Event data: Collect numerator and denominator data to allow measure of incidence rates and incidence rate ratios of CLABSIs; infections (numerator), and additional data (denominator) allowing stratification by risk, e.g., patient-days (for rate calculation), central line-days (for utilization ratio), ICU type, age group, comorbidity, etc.
5. Validation through systematic auditing (e.g., annually, bi-annually) to ensure compliance and data quality built-in as part of surveillance method.

II. Surveillance data sources: Intensive Care Units (ICUs)

Adult ICUs: 1941 beds in 100 hospitals. Bed breakdown: 518 Cardiac ICU; 1057 General ICU; 116 Neurosurgery ICU; 250 Surgery ICU.

Peds/Neonatal ICUs: 803 beds in 29 hospitals. Bed breakdown: 700 beds Neonatal ICU; 103 beds Pediatric ICU.

Trauma Centers (beds included above):

- 6 Trauma Centers Level 1
- 3 Trauma Centers Level 2
- 3 Trauma Centers Level 3

Total of 100 hospitals. (Trauma centers and neonatal and pediatric ICUs are located among the 100 hospitals with adult ICUs.)

**(Adapted from NC DPH - DRAFT 12/16/2008)*

III. Budget for Year 1

Personnel:

- Additional funding is needed for the Communicable Disease Branch to implement HAI surveillance in North Carolina hospitals.
- This program would require 5 new positions:
 - 1 program director (\$85,000);
 - 1 Nurse Consultant or Senior Infection Control Practitioner for training, analysis and reporting (\$75,000);
 - 2 ICPs, Public Health Epidemiologists able to abstract medical files, or Nurse Supervisors, for auditing and assistance activities (2x\$65,000=\$130,000);
 - 1 Administrative Support position (~\$40,000).
- Estimated salary cost: \$330,000; fringe benefits (7.65% Soc Sec; 8.14% Ret.; plus \$4,167/FTE Med Ins.) \$52,107 + \$20,835 = \$72,942.

Total Personnel costs with NC DPH Communicable Disease Branch (5 FTEs): \$402,942

Operating budget:

- Office furniture for 5 new positions: \$3,000 each, 1 time. Subtotal: \$15,000
- Computers: \$2,000 each, 1 time = \$10,000; phones (land line and cell phone): \$2,500 recurring. Subtotal: \$12,500
- Travel (for training, implementation and first audits, year 1): Average of three positions taking three trips per month, ~200 miles round trip, @\$0.55/mile, for 12 months. Subtotal: \$11,880

Total Operating budget for positions above: \$38,880

Surveillance system IT Support:

- A programmer position would be needed for customization of NCEDSS, designed currently for event data collection, but not for data collection on population at risk, which is needed for this surveillance program (denominator data): Salary \$85,000 plus fringe benefit \$17,588 = \$102,588.
- Operating budget (furniture \$3,000 1 time; computer \$2,000 1 time; phones: \$500): \$5,500.

Total NCEDSS IT budget: \$108,088

Training and implementation:

Development in Year 1 of curriculum, material and Web site for the training program preceding implementation for ICPs in 100 NC hospitals; one ICP per hospital in smaller institutions, and 2-3 ICPs in larger ones. It is anticipated that this training program would

*(Adapted from NC DPH - DRAFT 12/16/2008)

require significant contracted services from professional trainers, comparable to training organized for NC EDSS deployment for use by Local Health Department staff.

Estimated Training Contract Costs: \$100,000

Total Estimated Budget Year 1

- **\$649,910**

**(Adapted from NC DPH - DRAFT 12/16/2008)*

APPENDIX B

EXAMPLES OF EXPERIENCES IN OTHER STATES

Assessment by New York State DOH after one year of pilot program. *Reasons why NY chose to use NHSN versus their nedss based system, NYS Hospital Acquired Infections Reporting System (Rachel Stricof, Program Director):*

- 10% NYS hospitals were already participating in NHSN.
- Hospitals in same network would have been unable to share data through their NEDSS based system.
- NHSN is usable by both hospital and health department (in real-time and therefore the data is actionable by hospital).
- Quick calculation of rates and comparison with national data.
- HAI uses complex case definition and NHSN provides good support for interpreting what and how to report.
- NHSN easily creates automated reports.
- Hospitals have to grant access to state – however NHSN establishes “group functionality” so states can view all reporting hospital’s data (every year hospitals grant access to mandated data variables).
- NYS hired regional auditor staff (35 – 40 hospitals per epidemiologist).

New York State PROGRAM PERSONNEL (NY State Population Estimate=19M; ~NCx2)

Central Office:

- Program Director – Rachel L. Stricof, MT, MPH., CIC
- Program Manager – Carole Van Antwerpen, RN, BSN, CIC – 9/7/06 - present
- Program Operations Manager – Cindi (Coluccio) Dubner, BS – 7/13/06 - present
- Data Manager – Karolina Schabzes, MPH – 8/1/06 - 8/24/07
- Data Analyst – Boldtsetseg Tserenpuntsag, DrPh – 11/2/06 - present
- Administrative Assistant – Patricia Lewis, AAS - 9/16/06 – present

Regional Staff:

- Western Region – Peggy Hazamy, RN, BSN, CIC – 2/8/07 - present
- Central Region - Diana Doughty, RN, MBA, CIC, CPHQ – 2/8/07 - present
- Capital Region – covered by Program Manager, Carole Van Antwerpen, RN, BSN, CIC
- New Rochelle Region – Betsy Todd, RN, MPH, CIC – 3/8/07 – 5/16/08
- Long Island Region – Marie Tsivitis, MPH, CIC – 3/8/07 - present
- New York City Region – Kathleen Gase, MPH, CIC – 10/1/07 – present

Students from the School of Public Health:

- Kamal Siag, MD - 5/17/07 - 8/24/07
- Edgar Manukyan, MD - 8/20/07 to 5/07
- Andrea Fischer, MPH - 1/3/08 to Present

TOTAL: ~10 FTEs (5 central, 5 regional)+ students

Central Line Associated Blood Stream Infection Rates observed in NYS: ICU-specific rates varied from 2.0 infections per 1,000 central line days in cardiothoracic patients to 4.0 infections per 1,000 central line days in pediatric ICU patients.

**(Adapted from NC DPH - DRAFT 12/16/2008)*

South Carolina -- Hospital Infection Disclosure Act (HIDA)

Law passed in 2006. South Carolina uses NHSN, and posts reports on its Web site every 6 months. Initially, SC tracked three types of infection: CLABSI, Surgical Site Infections, blood culture positive for MRSA. Began audits in March, 2008, with validation visits planned to all reporting hospitals. Web site urges the public to be cautious about rushing to interpretation and conclusions by comparing hospital data. Among lessons learned, Jerry Gibson, MD, MPH, State Epidemiologist of SC cites the following: ask for a pilot year and funding for it; emphasize reporting process over infections; work with stakeholders on politics and funding; conduct intensive training with hospitals; validation is not optional; don't underestimate the complexity of reporting the data.

Colorado Hospital-Acquired Infection Disclosure Act

Act was approved in June, 2006. Requires hospitals, hospital units, ambulatory surgical centers and dialysis treatment centers to report HAI, as a condition of their state licensure. Gradual implementation, starting with surveillance of CLABSI and SSIs associated with Coronary Artery Bypass Grafts and two types of orthopedic surgery: hip and knee replacement. The reporting system in Colorado is the CDC's NHSN. Training and enrolment process can take up to two months, and any mistake made during the enrollment process can result in having to re-enroll. Many of the difficulties health facilities have experienced with the NHSN reporting system were due to limited time and resources. This program in Colorado struggles with insufficient funding and staffing, hampering validation activities. Their report cites the staffing of the NY State program as part of a better designed program. Among limitations, they note that the legislation was written assuming the CDC staff responsible for NHSN would handle most of the training but in fact even devoting all available state staff to this task was not sufficient, and at the time of writing their report in January, 2008, six months after data collection started, only 25% of targeted facilities were reporting and only one month of data from 42 of 57 reporting facilities was available for analysis. For some procedures like hip or knee replacement, monitoring is required up to a full year to verify if a procedure related infection has occurred.

Missouri HAI Surveillance.

Missouri passed a law in 2004 requiring hospitals and ambulatory care centers to report CLABSI, SSI, and Ventilator-Associated Pneumonias. Surveillance began in July, 2005, with monthly reports of CLABSI in selected ICUs. Data collection on SSIs, from hospitals and ambulatory surgical centers began in January, 2006. Missouri is one of only 3 states among 23 where the GAO conducted a review (see below), who decided to use a state developed system.

From GAO Report, September, 2008: *“Since CDC opened enrollment in NHSN to all hospitals [in June, 2007], no state has chosen not to use NHSN to collect at least some of its HAI data. In addition to New York, Colorado, South Carolina, and Vermont began collecting data through NHSN in 2007, and 13 other states have decided to use NHSN for their HAI public reporting programs. Included in the latter group is Pennsylvania, which discontinued its original system in favor of NHSN starting in January 2008. Meanwhile Minnesota, New Jersey, and Texas are considering whether to use NHSN to collect HAI data for public reporting. Currently, only 3 states—Florida, Maine, and Missouri—use systems that do not rely on the NHSN to collect HAI data, though Maine and Missouri draw on CDC's definitions.”*

**(Adapted from NC DPH - DRAFT 12/16/2008)*