



Health Care Quality Performance (HCQP) Program

HOSPITAL-ACQUIRED INFECTIONS AND PREVENTION ADVISORY SUBCOMMITTEE

8:00-9:00am, July 27, 2009

HEALTH, Room 401

Goals/Objectives

- To discuss HAI work to date and make policy recommendations for pending and upcoming reports

Voting Members

- | | | |
|--|---|--|
| <input type="checkbox"/> Utpala Bandy, MD | <input checked="" type="checkbox"/> Andrew Komensky, RN | <input type="checkbox"/> Lee Ann Quinn, RN, BS, CIC |
| <input checked="" type="checkbox"/> Margaret Cornell, MS, RN | <input type="checkbox"/> Pat Mastors | <input checked="" type="checkbox"/> Janet Robinson, RN, Med, CIC |
| <input checked="" type="checkbox"/> Robert Crausman, MD | <input checked="" type="checkbox"/> Leonard Mermel, DO, ScM | <input checked="" type="checkbox"/> Nancy Vallande, MSM, MT, CIC |
| <input type="checkbox"/> Marlene Fishman, MPH, CIC | <input checked="" type="checkbox"/> Kathleen O'Connell, RN | <input checked="" type="checkbox"/> Sam Viner-Brown, MS |
| <input checked="" type="checkbox"/> Julie Jefferson, RN, MPH, CIC | <input type="checkbox"/> Harold Picken, MD | <input type="checkbox"/> Gloria Williams, MS |
| <input checked="" type="checkbox"/> Diane Kitson-Clark, RN, MSN, CIC
(representative) | <input type="checkbox"/> Aurora Pop-Vicas, MD | |

Time

Topic/Notes

- | | |
|---------|---|
| 8:00 am | <p>Welcome & Meeting Objective
 <i>Leonard Mermel, DO, ScM (Co-Chair)</i>
 <i>Samara Viner-Brown, MS (Co-Chair)</i></p> <ul style="list-style-type: none"> – Len opened the meeting at 8:05 and discussed today's meeting objectives (above). – Sam gave updates on the following: <ul style="list-style-type: none"> • <u>Milbank Memorial Fund HAI meeting</u>: Sam attended a one-day meeting in New York City on 7/20, which included 14 states, the CDC, etc., and provided a forum to discuss HAI reporting, including work to date and best practices. • Action item: Sam to share the electronic meeting presentations (once received). • <u>CDC HAI Prevention Grant</u>: Sam thanked everyone for their help compiling the grant and shared a brief abstract of HEALTH's submission. She expects to receive a response from the CDC by the end of August. |
| 8:10 am | <p>SCIP Graphs
 <i>Samara Viner-Brown, MS</i></p> <ul style="list-style-type: none"> – The graphs and FAQ were posted to the Web site in June (as previously discussed). The accompanying press release is pending, and will likely include the other hospital reporting work (i.e., pressure ulcer process measures). |

- **Action item:** Sam to continue to work with HEALTH’s Public Informations Officer to generate and release the press release

8:15 am

CLABSI Graphs

Rosa Baier, MPH

Rachel Voss

- Rosa shared a draft of the CLABSI graphs, which reflect Quarter 1, 2009 (Jan-Mar). This draft is not for distribution beyond the Subcommittee.
- Rachel and Len shared research on the minimum # of catheter-days required to report data that is statistically valid:
 - Based on the CDC’s annual report, one potential threshold is 50 catheter days per month, which we could extrapolate to 150 catheter days per quarter. This would mean suppressing several local units.
 - In conversations with the CDC, Len was advised to consider use of a Standardized Infection Ratio (SIR) for reporting CLABSI rates per 1,000 catheter days:
 - SIRs >1.0 signify a higher than expected infection rate; <1.0 is lower than expected; and 1.0 is the same as the expected rate based on NHSN data.
 - The CDC statistician did not recommend a minimum number of catheter days for reporting.
 - There are several upcoming CDC Webinars in which use of SIR will be discussed :
 - July 31st at 1pm
 - August 14th at 11am
- Enroll at <http://www.doodle.com/z8e3ncmqvz3udd7p> to receive call-in information, etc.
- Regardless of the methodology, we need to decide how best to present the info to a public audience. For example, if using an SIR to determine meaningful differences in a rate from a given ICU compared with NHSN rate for the same type of ICU, should we present the SIR? Or use bar graph (as in the draft) and the SIR results to signify (in words or symbols) what’s above/below average?
- **Action items:**
 - Rachel and Len to continue to research reporting methods
 - Rosa to verify the expected date for the new quarter of data
 - Rachel will review how other states have used an SIR in reporting CLABSIs

8:35am

Influenza Vaccination Reporting

Samara Viner-Brown, MS

- The 2008-2009 vaccination data were due to HEALTH on 6/30. John Fulton is in the process of reviewing the data and will share it with us as soon as it’s final.
- John is also reviewing the proposed revisions for 2009-2010, and determining whether or not to apply these revisions to other healthcare settings.

- **Action items:**
 - Once the data are received, Rosa and Rachel to populate the draft report
 - Rosa to resend:
 1. The results/summary of the hospital feasibility survey, and
 2. The revised data collection forms.

8:45 am **MRSA Measure Development**

Leonard Mermel, DO, ScM

- Rosa reviewed the draft process measures, and reminded the group about the outstanding questions about determining what constitutes “passing” Measure 2:
 - What are the sampling requirements for observation (eg, were observations done on different patient care units, during different shifts, and did observations involve multiple healthcare worker types—eg physicians, nurses, etc.)?
 - What is the minimum number of observations per month?
- The group suggested aligning the measure with the Joint Commission monograph.
- **Action items:**
 - Len, Rosa, and Sam to review the monograph and revise the draft measures

8:55 am **Action Items & Next Steps**

Leonard Mermel, DO, ScM

Samara Viner-Brown, MS

- See above action items.
- **Next meeting:** 8-9am, 9/14



Health Care Quality Performance (HCQP) Program

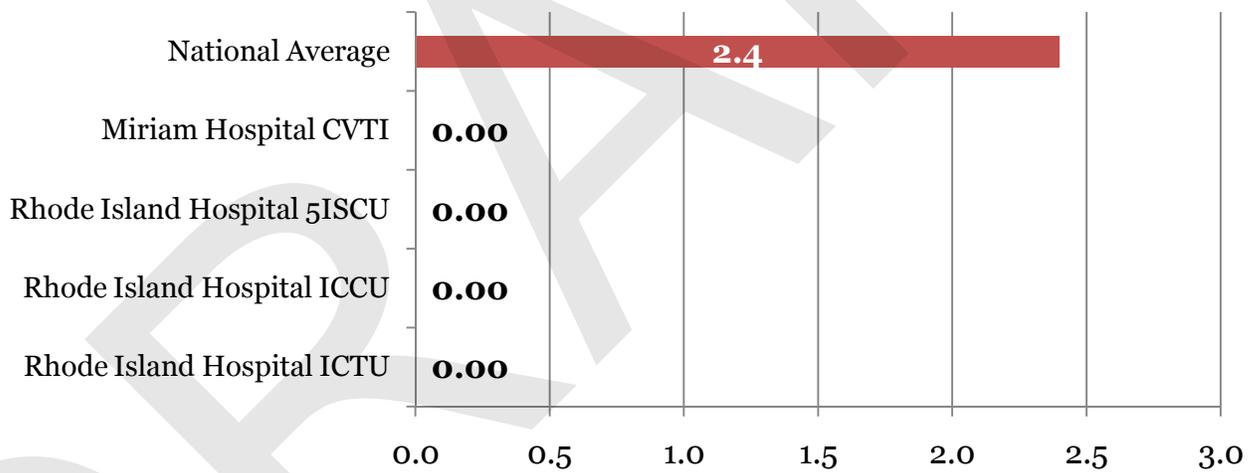
CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS (CLABSI) RATES

Data Report
January-March 2009

The CLABSI rates are [reported on the Department of Health's \(HEALTH's\) Web site](#) as part of the HCQP Program's Hospital-Acquired Infections work. You can learn more about the measures—including their data source, how they are calculated, and why each is important—by reading the Technical Page.

Please note: Because each intensive care unit (ICU) in the state cares for people with very specific medical problems, each ICU is compared to other ICUs in Rhode Island (if there are any) and nationally that provide similar care. With questions about a hospital's ICU score or how to compare one ICU to another in Rhode Island, please contact the hospitals directly.

Figure 1: CLABSI Infection Rate among Adult Step-Down Units (Post-Critical Care)



Hospital Infection Rate
(Per 1,000 Central Line Days)

← For this measure, **lower** scores are better

CVTI: Cardiovascular thoracic intermediate care unit
ICCU: Intermediate coronary care unit
5ISCU: Intermediate surgical care unit
ICTU: Intermediate cardiothoracic unit

Figure 2: CLABSI Infection Rate among Coronary Critical Care Units (CCU)

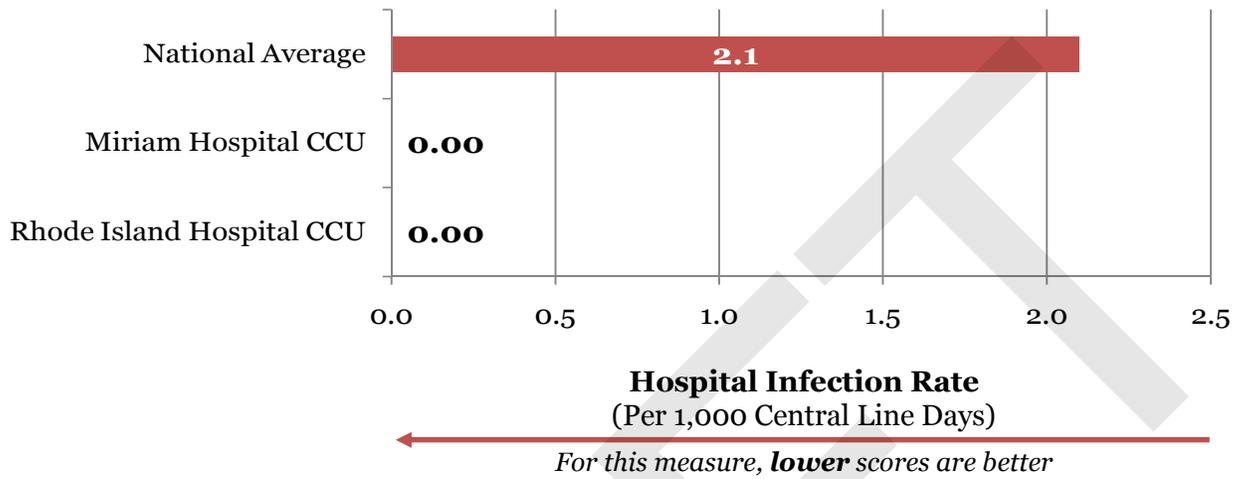


Figure 3: CLABSI Infection Rate among Medical Intensive Care Units (MICU)

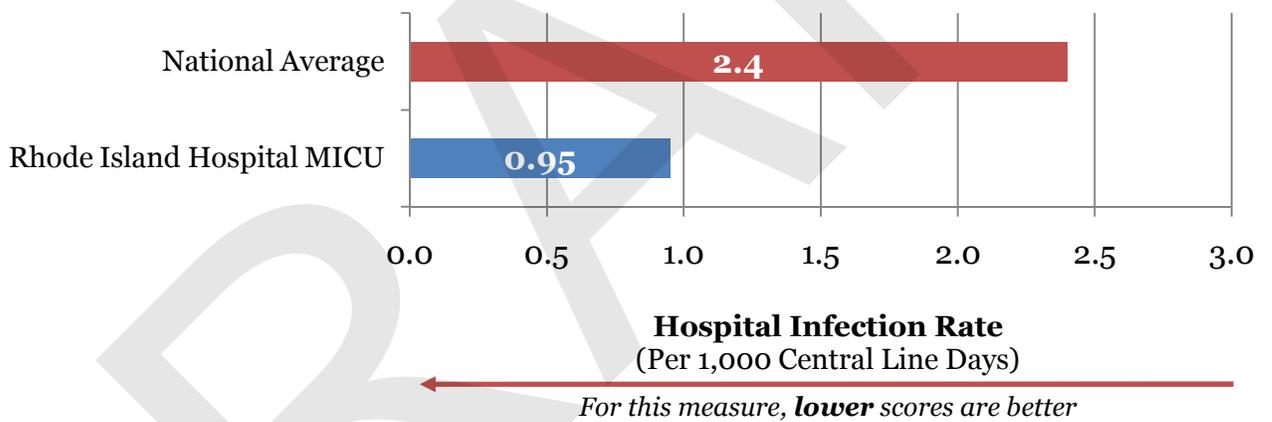
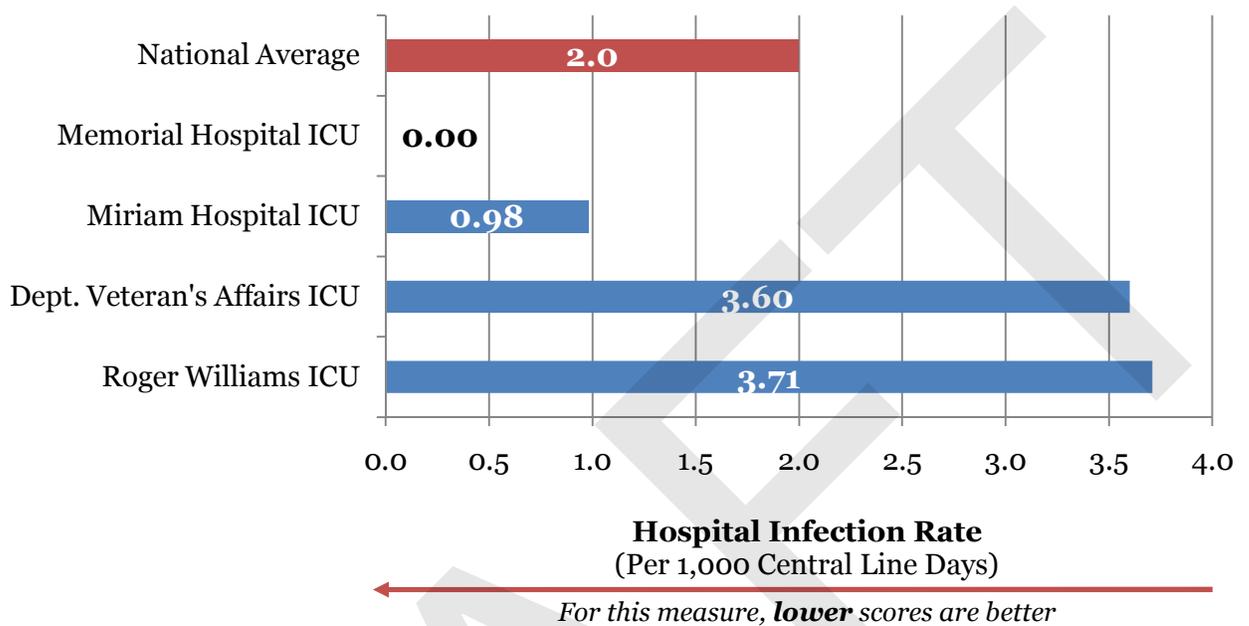


Figure 4: CLABSI Infection Rate among Medical/Surgical Critical Care Units (ICU) at Major Teaching Hospitals



ICU: Intensive care unit

Figure 5: CLABSI Infection Rate among Medical/Surgical Critical Care Units (ICU) at All Other Hospitals

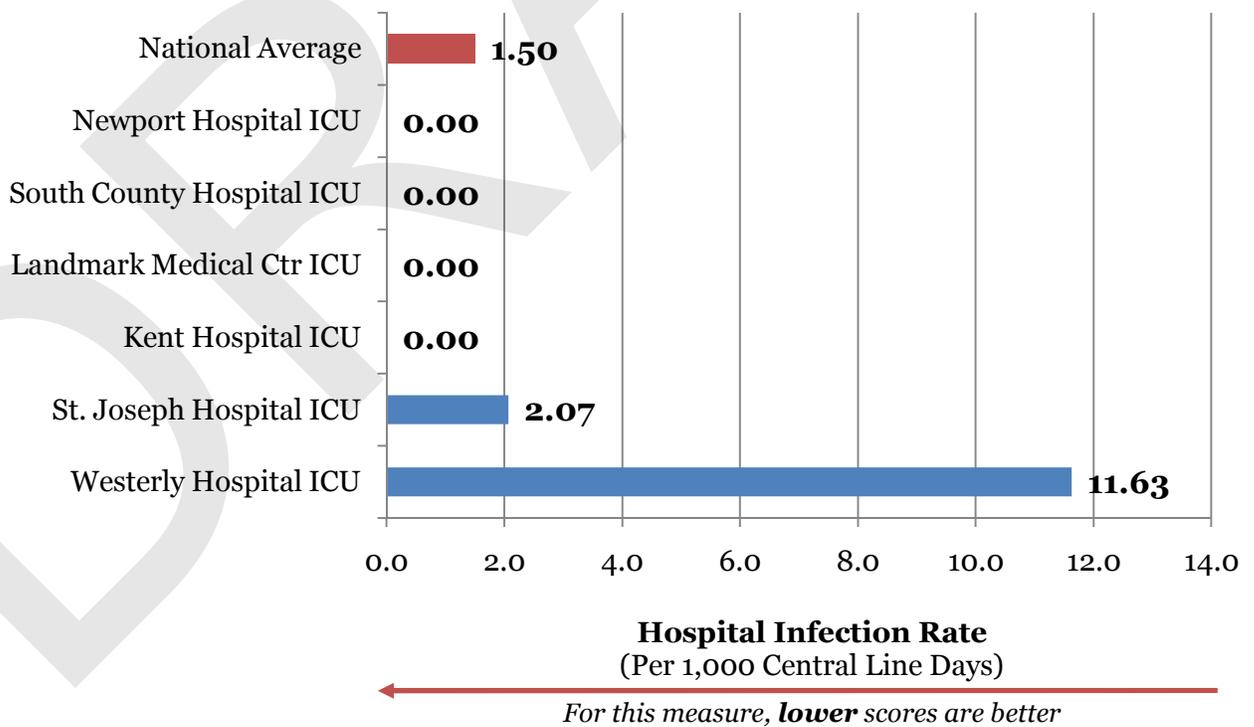


Figure 6: CLABSI Infection Rate among Level III Neonatal Intensive Care Units (NICU), by Birthweight

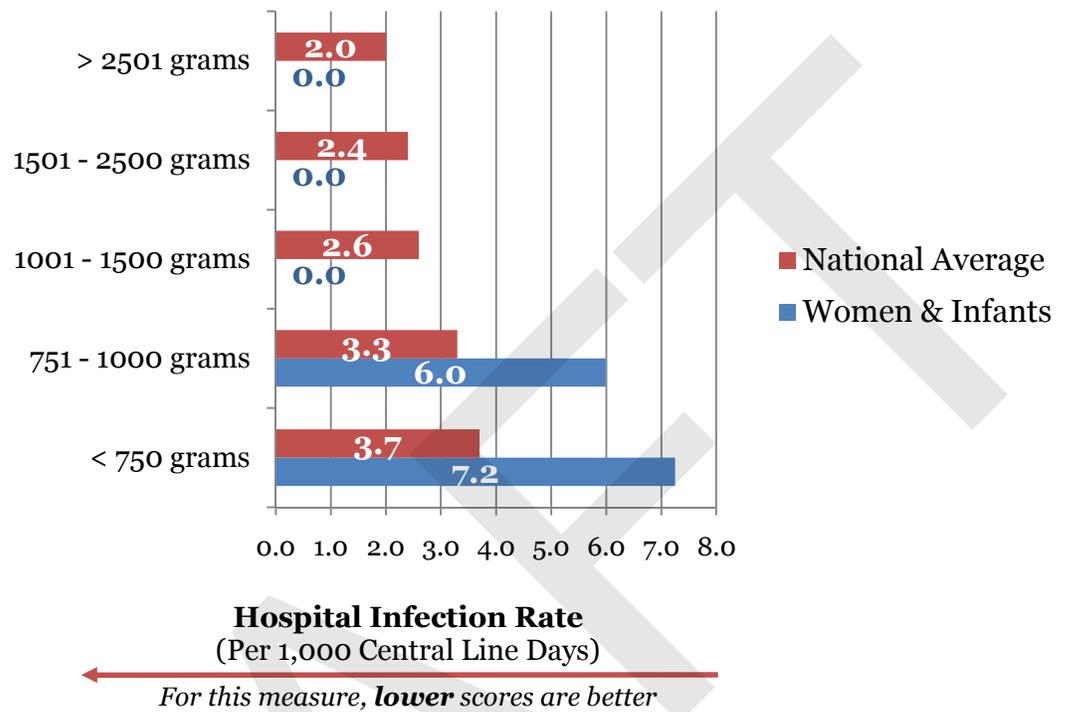


Figure 7: Umbilical Catheter-Associated Infection Rate among Level III NICUs, by Birthweight

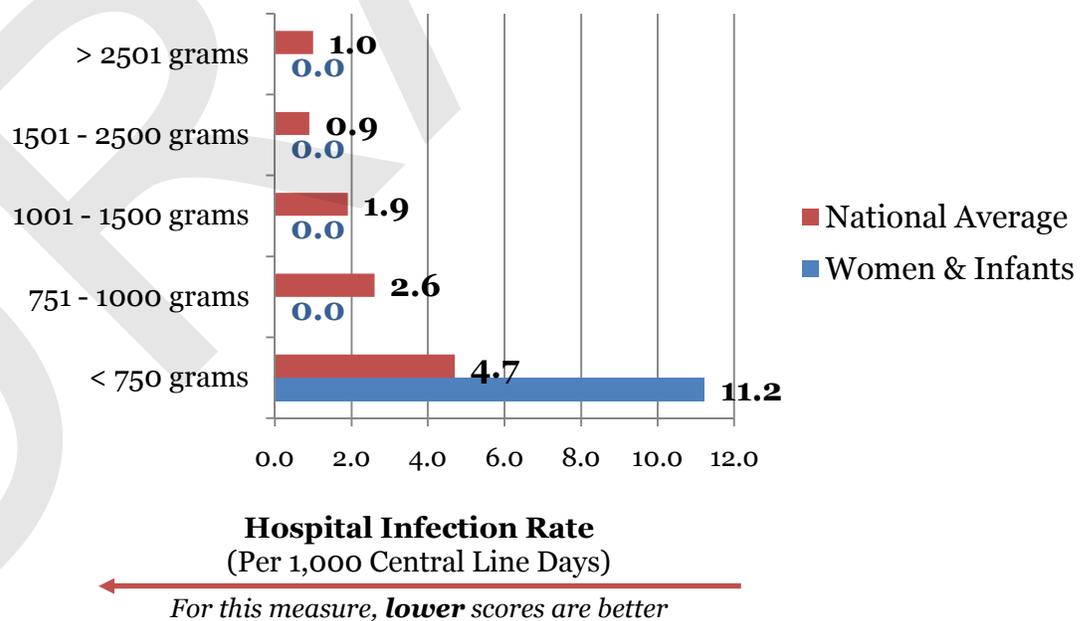


Figure 8: CLABSI Infection Rate among Neurosurgical Intensive Care Units (INC)

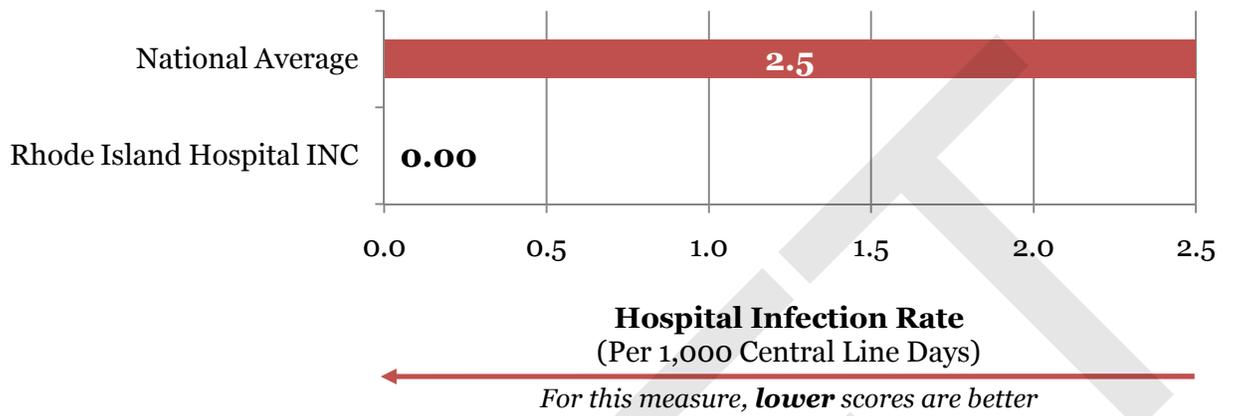


Figure 9: CLABSI Infection Rate among Pediatric Medical/Surgical Intensive Care Units (PICU)

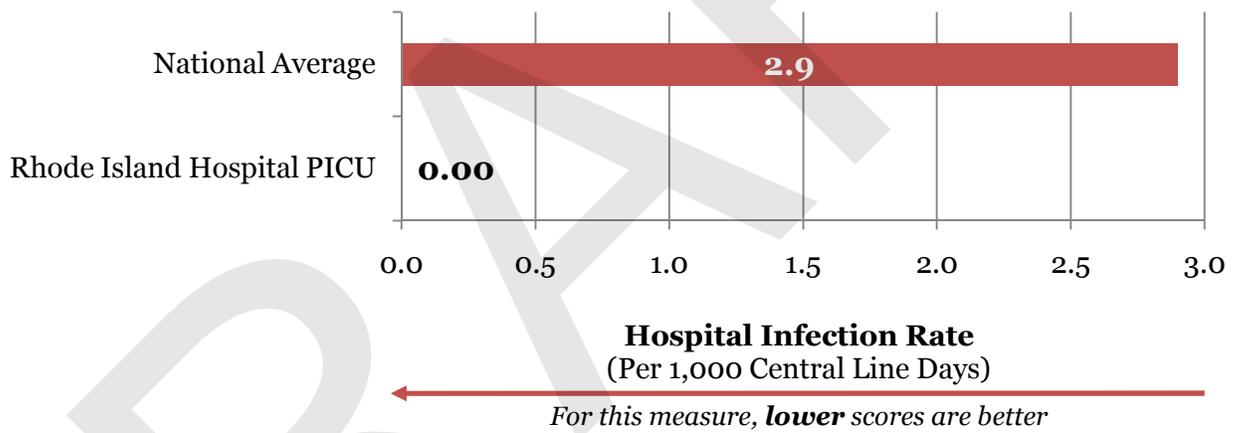


Figure 10: CLABSI Infection Rate among Respiratory Intensive Care Units (RICU)

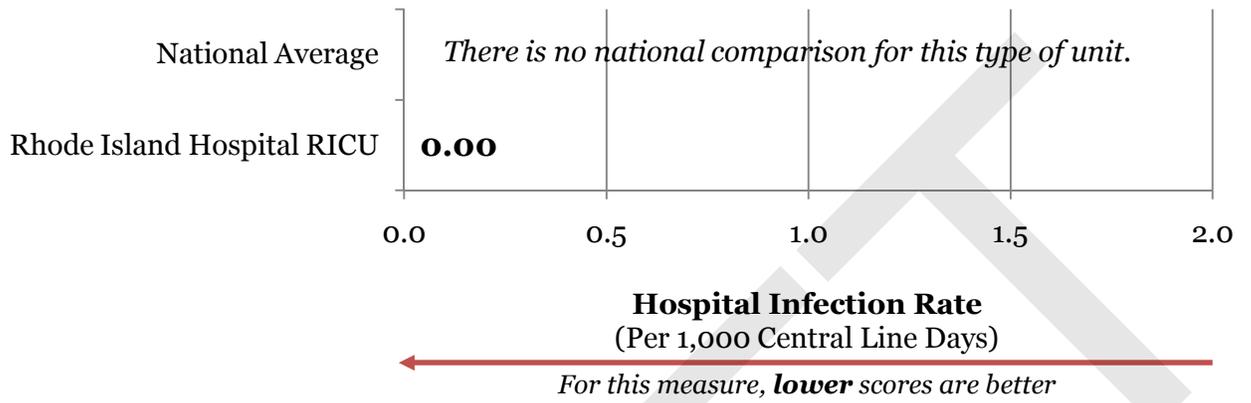


Figure 11: CLABSI Infection Rate among Surgical Intensive Care Units (SICU)

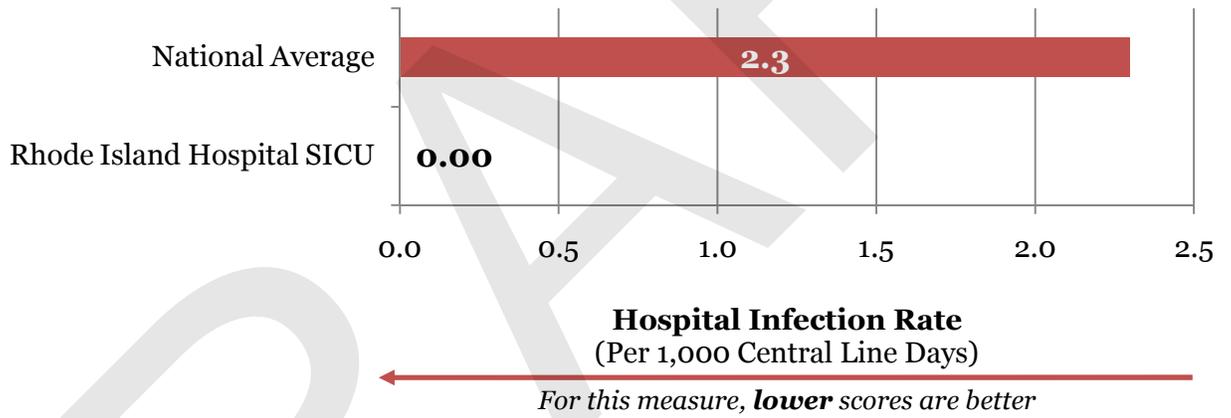
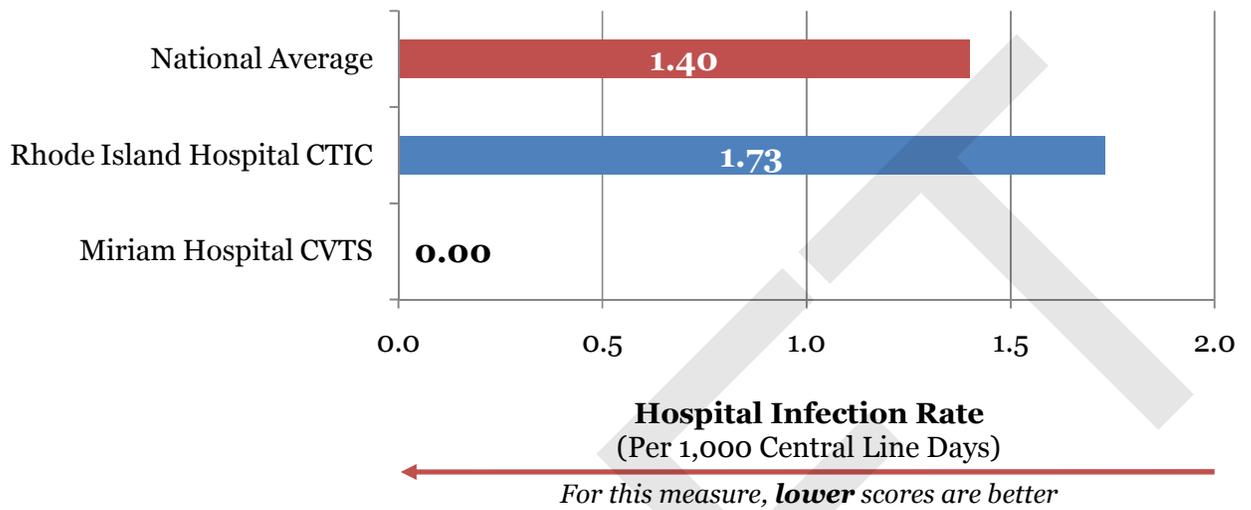
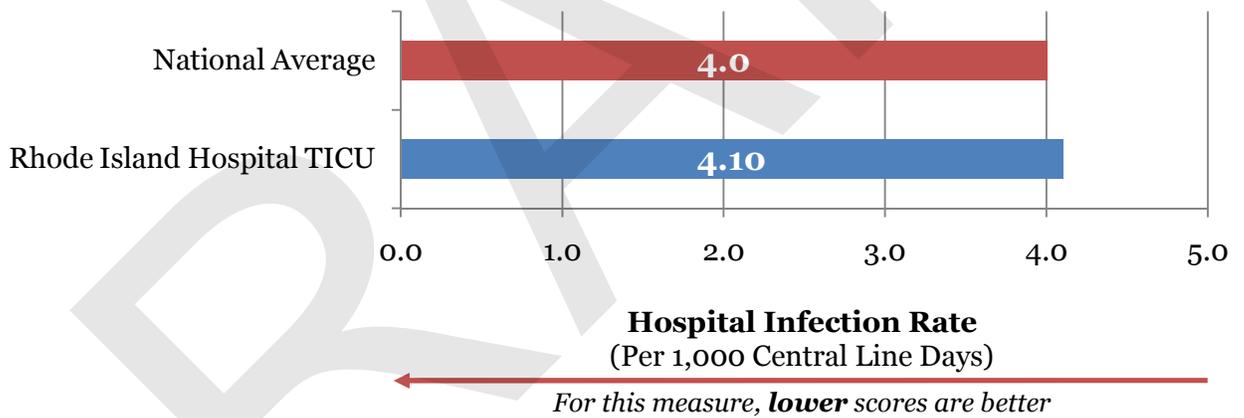


Figure 12: CLABSI Infection Rate among Surgical Cardiothoracic Critical Care Units



CTIC: Cardiothoracic intensive care unit
CVTS: Surgical cardiovascular-thoracic unit

Figure 13: CLABSI Infection Rate among Trauma Intensive Care Units (TICU)



Template for State Healthcare Associated Infections Plans

In response to the increasing concerns about the public health impact of healthcare-associated infections (HAIs), the US Department of Health and Human Services (HHS) has developed an Action Plan to Prevent Healthcare-Associated Infections (HHS Action Plan). The HHS Action Plan includes recommendations for surveillance, research, communication and metrics for measuring progress towards national goals. Three overarching priorities have been identified:

- Progress towards 5-year national prevention targets (e.g.,50-70% reduction in bloodstream infections);
- Improve use and quality of the metrics and supporting systems needed to assess progress towards meeting the targets; and
- Prioritization and broad implementation of current evidence-based prevention recommendations.

In a concurrent development, the 2009 Omnibus bill requires states receiving Preventive Health and Health Services (PHHS) Block Grant funds to certify that they will submit a plan to reduce HAIs to the Secretary of Health and Human Services not later than January 1, 2010. In order to assist states in responding within the short timeline required by that language and to facilitate coordination with national HAI prevention efforts, the Centers for Disease Control and Prevention (CDC) has drafted a template to assist state planning efforts in the prevention of HAIs.

This template will help to ensure progress towards national prevention targets as described in the HHS Action Plan, wherein CDC is leading the implementation of recommendations on National Prevention Targets and Metrics and the implementation of priority prevention recommendations, while allowing flexibility to tailor the plan to each state's specific needs.

Initial emphasis for HAI prevention may focus on acute care, inpatient settings, yet the need for prevention activities for outpatient settings is recognized. State health departments are increasingly challenged by the needs to identify, respond to, and prevent HAI across the continuum of settings where healthcare is currently delivered. The public health model's population based perspective places health departments in a unique and important role in this area, particularly given shifts in healthcare delivery from acute care settings to ambulatory and long term care settings. In the non-hospital setting, infection control and oversight have been lacking and outbreaks –which can have a wide-ranging and substantial impact on affected communities-, are increasingly reported. At the same time, trends toward mandatory reporting of HAIs from hospitals reflect increased demand for accountability from the public.

The current template targets the following areas:

1. Develop or Enhance HAI Program Infrastructure
2. Surveillance, Detection, Reporting, and Response
3. Prevention
4. Evaluation, Oversight and Communication

Framework and Funding for Prevention of HAIs

CDC's framework for the prevention of HAIs builds on a coordinated effort of federal, state and partner organizations. The framework is based on a collaborative public health approach that includes surveillance, outbreak response, research, training and education, and systematic implementation of prevention practices. Recent legislation in support of HAI prevention provides a unique opportunity to strengthen existing and expand state capacity for prevention efforts.

Support for HAI prevention has been enhanced through the American Recovery and Reinvestment Act (ARRA). Congress allocated \$40 million through CDC to support state health department efforts to prevent HAIs by enhancing state capacity for HAI prevention, leverage CDC's National Health Care Safety Network to assess progress and support the dissemination of HHS evidence-based practices within healthcare facilities, and pursue state-based collaborative implementation strategies. In addition, the Center for Medicaid Services (CMS) will support expansion of State Survey Agency inspection capability of Ambulatory Surgery Centers nationwide through \$10 million of ARRA funds. This template is intended to support the high level of reporting and accountability required of ARRA recipients.

Template for developing HAI plan

The following template provides choices for developing or enhancing state HAI prevention activities in the four areas identified above. States can choose to target different levels of HAI prevention efforts indicated by checking appropriate boxes. (Level I indicates basic elements to begin HAI prevention efforts, Level II for intermediate and Level III more mature efforts). This can serve as the state's HAI plan for submission. If your state has an existing plan, you may choose to incorporate that plan into the template below or submit the existing plan in place of the template provided.

For each section, please choose elements which best support current activities or planned activities. Current activities are those in which the state is presently engaged and includes activities that are scheduled to begin using currently available resources. Planned

activities represent future directions the state would like to move in to meet currently unmet needs, contingent on available resources and competing priorities. A section for additional activities is included to accommodate plans beyond the principal categories.

1. Develop or Enhance HAI program infrastructure

Successful HAI prevention requires close integration and collaboration with state and local infection prevention activities and systems. Consistency and compatibility of HAI data collected across facilities will allow for greater success in reaching state and national goals. Please select areas for development or enhancement of state HAI surveillance, prevention and control efforts.

Table 1: State infrastructure planning for HAI surveillance, prevention and control.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
Level I	<input type="checkbox"/>	<input type="checkbox"/>	1. Establish statewide HAI prevention leadership through the formation of multidisciplinary group or state HAI advisory council <ul style="list-style-type: none"> i. Collaborate with local and regional partners (e.g., state hospital associations, professional societies for infection control and healthcare epidemiology, academic organizations, laboratorians and networks of acute care hospitals and long term care facilities (LTCFs)) ii. Identify specific HAI prevention targets consistent with HHS priorities 	
	<input type="checkbox"/>	<input type="checkbox"/>		
			<i>Other activities or descriptions (not required):</i>	
	<input type="checkbox"/>	<input type="checkbox"/>	2. Establish an HAI surveillance prevention and control program <ul style="list-style-type: none"> i. Designate a State HAI Prevention Coordinator 	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> ii. Develop dedicated, trained HAI staff with at least one FTE (or contracted equivalent) to oversee the four major HAI activity areas (Integration, Collaboration, and Capacity Building; Reporting, Detection, Response and Surveillance; Prevention; Evaluation, Oversight and Communication) 	
			<i>Other activities or descriptions (not required):</i>	
	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> 3. Integrate laboratory activities with HAI surveillance, prevention and control efforts. <ul style="list-style-type: none"> i. Improve laboratory capacity to confirm emerging resistance in HAI pathogens and perform typing where appropriate (e.g., outbreak investigation support, HL7 messaging of laboratory results) 	
			<i>Other activities or descriptions (not required):</i>	
Level II	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> 4. Improve coordination among government agencies or organizations that share responsibility for assuring or overseeing HAI surveillance, prevention and control (e.g., State Survey agencies, Communicable Disease Control, state licensing boards) 	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
			<i>Other activities or descriptions (not required):</i>	
	<input type="checkbox"/>	<input type="checkbox"/>	5. Facilitate use of standards-based formats (e.g., Clinical Document Architecture, electronic messages) by healthcare facilities for purposes of electronic reporting of HAI data. Providing technical assistance or other incentives for implementations of standards-based reporting can help develop capacity for HAI surveillance and other types of public health surveillance, such as for conditions deemed reportable to state and local health agencies using electronic laboratory reporting (ELR). Facilitating use of standards-based solutions for external reporting also can strengthen relationships between healthcare facilities and regional nodes of healthcare information, such as Regional Health Information Organizations (RHIOs) and Health Information Exchanges (HIEs). These relationships, in turn, can yield broader benefits for public health by consolidating electronic reporting through regional nodes.	
			<i>Other activities or descriptions (not required):</i>	
Please also describe any additional activities, not listed above, that your state plans to undertake. Please include target dates for any new activities.				

2. Surveillance, Detection, Reporting, and Response

Timely and accurate monitoring remains necessary to gauge progress towards HAI elimination. Public health surveillance has been defined as the ongoing, systematic collection, analysis, and interpretation of data essential to the planning, implementation, and evaluation of public health practice, and timely dissemination to those responsible for prevention and control.¹ Increased participation in systems such as the National Healthcare Safety Network (NHSN) has been demonstrated to promote HAI reduction. This, combined with improvements to simplify and enhance data collection, and improve dissemination of results to healthcare providers and the public are essential steps toward increasing HAI prevention capacity.

The HHS Action Plan identifies targets and metrics for five categories of HAIs and identified Ventilator-associated Pneumonia as an HAI under development for metrics and targets (Appendix 1):

- Central Line-associated Blood Stream Infections (CLABSI)
- *Clostridium difficile* Infections (CDI)
- Catheter-associated Urinary Tract Infections (CAUTI)
- Methicillin-resistant *Staphylococcus aureus* (MRSA) Infections
- Surgical Site Infections (SSI)
- Ventilator-associated Pneumonia (VAP)

Work is ongoing to identify optimal metrics and targets for VAP infection. However, detection and measurement with existing tools and methods can be combined with recognized prevention practices in states where an opportunity exists to pursue prevention activities on that topic.

State capacity for investigating and responding to outbreaks and emerging infections among patients and healthcare providers is central to HAI prevention. Investigation of outbreaks helps identify preventable causes of infections including issues with the improper use or handling of medical devices; contamination of medical products; and unsafe clinical practices. Please choose items to include in your plan at the planning levels desired.

¹ Thacker SB, Berkelman RL. Public health surveillance in the United States. *Epidemiol Rev* 1988;10:164-90.

Table 2: State planning for surveillance, detection, reporting, and response for HAIs

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
Level I	<input type="checkbox"/>	<input type="checkbox"/>	1. Improve HAI outbreak detection and investigation <ul style="list-style-type: none"> i. Work with partners including CSTE, CDC, state legislatures, and providers across the healthcare continuum to improve outbreak reporting to state health departments ii. Establish protocols and provide training for health department staff to investigate outbreaks, clusters or unusual cases of HAIs. iii. Develop mechanisms to protect facility/provider/patient identity when investigating incidents and potential outbreaks during the initial evaluation phase where possible to promote reporting of outbreaks iv. Improve overall use of surveillance data to identify and prevent HAI outbreaks or transmission in HC settings (e.g., hepatitis B, hepatitis C, multi-drug resistant organisms (MDRO), and other reportable HAIs) 	
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
		<i>Other activities or descriptions (not required):</i>		

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
	<input type="checkbox"/>	<input type="checkbox"/>	2. Enhance laboratory capacity for state and local detection and response to new and emerging HAI issues.	
			<i>Other activities or descriptions (not required):</i>	
Level II	<input type="checkbox"/>	<input type="checkbox"/>	3. Improve communication of HAI outbreaks and infection control breaches <ul style="list-style-type: none"> i. Develop standard reporting criteria including, number, size and type of HAI outbreak for health departments and CDC ii. Establish mechanisms or protocols for exchanging information about outbreaks or breaches among state and local governmental partners (e.g., State Survey agencies, Communicable Disease Control, state licensing boards) 	
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>	4. Identify at least 2 priority prevention targets for surveillance in support of the HHS HAI Action Plan <ul style="list-style-type: none"> i. Central Line-associated Bloodstream Infections (CLABSI) ii. <i>Clostridium difficile</i> Infections (CDI) 	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
	<input type="checkbox"/>	<input type="checkbox"/>	iii. Catheter-associated Urinary Tract Infections (CAUTI)	
	<input type="checkbox"/>	<input type="checkbox"/>	iv. Methicillin-resistant Staphylococcus aureus (MRSA) Infections	
	<input type="checkbox"/>	<input type="checkbox"/>	v. Surgical Site Infections (SSI)	
	<input type="checkbox"/>	<input type="checkbox"/>	vi. Ventilator-associated Pneumonia (VAP)	
	<i>Other activities or descriptions (not required):</i>			
	<input type="checkbox"/>	<input type="checkbox"/>	5. Adopt national standards for data and technology to track HAIs (e.g., NHSN).	
	<input type="checkbox"/>	<input type="checkbox"/>	i. Develop metrics to measure progress towards national goals (align with targeted state goals). (See Appendix 1).	
			ii. Establish baseline measurements for prevention targets	
	<i>Other activities or descriptions (not required):</i>			
	<input type="checkbox"/>	<input type="checkbox"/>	6. Develop state surveillance training competencies	
			i. Conduct local training for appropriate use of surveillance systems (e.g., NHSN) including facility and group enrollment, data collection, management, and analysis	
	<i>Other activities or descriptions (not required):</i>			

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
	<input type="checkbox"/>	<input type="checkbox"/>	7. Develop tailored reports of data analyses for state or region prepared by state personnel	
			<i>Other activities or descriptions (not required):</i>	
Level III	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	8. Validate data entered into HAI surveillance (e.g., through healthcare records review, parallel database comparison) to measure accuracy and reliability of HAI data collection <ul style="list-style-type: none"> i. Develop a validation plan ii. Pilot test validation methods in a sample of healthcare facilities iii. Modify validation plan and methods in accordance with findings from pilot project iv. Implement validation plan and methods in all healthcare facilities participating in HAI surveillance v. Analyze and report validation findings vi. Use validation findings to provide operational guidance for healthcare facilities that targets any data shortcomings detected 	
			<i>Other activities or descriptions (not required):</i>	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
	<input type="checkbox"/>	<input type="checkbox"/>	9. Develop preparedness plans for improved response to HAI <ul style="list-style-type: none"> i. Define processes and tiered response criteria to handle increased reports of serious infection control breaches (e.g., syringe reuse), suspect cases/clusters, and outbreaks 	
			<i>Other activities or descriptions (not required):</i>	
	<input type="checkbox"/>	<input type="checkbox"/>	10. Collaborate with professional licensing organizations to identify and investigate complaints related to provider infection control practice in non-hospital settings, and to set standards for continuing education and training	
			<i>Other activities or descriptions (not required):</i>	
	<input type="checkbox"/>	<input type="checkbox"/>	11. Adopt integration and interoperability standards for HAI information systems and data sources <ul style="list-style-type: none"> i. Improve overall use of surveillance data to identify and prevent HAI outbreaks or transmission in HC settings (e.g., hepatitis B, hepatitis C, multi-drug resistant organisms (MDRO), and other reportable 	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
	<input type="checkbox"/>	<input type="checkbox"/>	<p>HAI) across the spectrum of inpatient and outpatient healthcare settings</p> <p>ii. Promote definitional alignment and data element standardization needed to link HAI data across the nation.</p>	
			<i>Other activities or descriptions (not required):</i>	
	<input type="checkbox"/>	<input type="checkbox"/>	<p>12. Enhance electronic reporting and information technology for healthcare facilities to reduce reporting burden and increase timeliness, efficiency, comprehensiveness, and reliability of the data</p> <p>i. Report HAI data to the public</p>	
			<i>Other activities or descriptions (not required):</i>	
	<input type="checkbox"/>	<input type="checkbox"/>	<p>13. Make available risk-adjusted HAI data that enables state agencies to make comparisons between hospitals.</p>	
			<i>Other activities or descriptions (not required):</i>	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
	<input type="checkbox"/>	<input type="checkbox"/>	14. Enhance surveillance and detection of HAIs in nonhospital settings	
			<i>Other activities or descriptions (not required):</i>	
Please also describe any additional activities, not listed above, that your state plans to undertake. Please include target dates for any new activities.				

3. Prevention

State implementation of HHS Healthcare Infection Control Practices Advisory Committee (HICPAC) recommendations is a critical step towards the elimination of HAIs. CDC with HICPAC has developed evidence-based HAI prevention guidelines cited in the HHS Action Plan for implementation. These guidelines are translated into practice and implemented by multiple groups in hospital settings for the prevention of HAIs. CDC guidelines have also served as the basis the Centers for Medicare and Medicaid Services (CMS) Surgical Care Improvement Project. These evidence-based recommendations have also been incorporated into Joint Commission standards for accreditation of U.S. hospitals and have been endorsed by the National Quality Forum. Please select areas for development or enhancement of state HAI prevention efforts.

Table 3: State planning for HAI prevention activities

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
Level I	<input type="checkbox"/>	<input type="checkbox"/>	1. Implement HICPAC recommendations. i. Develop strategies for implementation of HICPAC recommendations for at least 2 prevention targets specified by the state multidisciplinary group.	
			<i>Other activities or descriptions (not required):</i>	
	<input type="checkbox"/>	<input type="checkbox"/>	2. Establish prevention working group under the state HAI advisory council to coordinate state HAI collaboratives i. Assemble expertise to consult, advise, and coach inpatient healthcare facilities involved in HAI prevention collaboratives	
			<i>Other activities or descriptions (not required):</i>	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>3. Establish HAI collaboratives with at least 10 hospitals (i.e. this may require a multi-state or regional collaborative in low population density regions)</p> <ul style="list-style-type: none"> i. Identify staff trained in project coordination, infection control, and collaborative coordination ii. Develop a communication strategy to facilitate peer-to-peer learning and sharing of best practices iii. Establish and adhere to feedback of a clear and standardized outcome data to track progress 	
			<i>Other activities or descriptions (not required):</i>	
	<input type="checkbox"/>	<input type="checkbox"/>	<p>4. Develop state HAI prevention training competencies</p> <ul style="list-style-type: none"> i. Consider establishing requirements for education and training of healthcare professionals in HAI prevention (e.g., certification requirements, public education campaigns and targeted provider education) or work with healthcare partners to establish best practices for training and certification 	
			<i>Other activities or descriptions (not required):</i>	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
Level II	<input type="checkbox"/>	<input type="checkbox"/>	5. Implement strategies for compliance to promote adherence to HICPAC recommendations <ul style="list-style-type: none"> i. Consider developing statutory or regulatory standards for healthcare infection control and prevention or work with healthcare partners to establish best practices to ensure adherence ii. Coordinate/liaise with regulation and oversight activities such as inpatient or outpatient facility licensing/accrediting bodies and professional licensing organizations to prevent HAIs iii. Improve regulatory oversight of hospitals, enhancing surveyor training and tools, and adding sources and uses of infection control data iv. Consider expanding regulation and oversight activities to currently unregulated settings where healthcare is delivered or work with healthcare partners to establish best practices to ensure adherence 	
			<i>Other activities or descriptions (not required):</i>	
	<input type="checkbox"/>	<input type="checkbox"/>	6. Enhance prevention infrastructure by increasing joint collaboratives with at least 20 hospitals (i.e. this may require a multi-state or regional collaborative in low population density regions)	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
			<i>Other activities or descriptions (not required):</i>	
	<input type="checkbox"/>	<input type="checkbox"/>	7. Establish collaborative to prevent HAIs in nonhospital settings (e.g., long term care, dialysis)	
			<i>Other activities or descriptions (not required):</i>	
Please also describe any additional activities, not listed above, that your state plans to undertake. Please include target dates for any new activities.				

4. Evaluation and Communications

Program evaluation is an essential organizational practice in public health. Continuous evaluation and communication of practice findings integrates science as a basis for decision-making and action for the prevention of HAIs. Evaluation and communication allows for learning and ongoing improvement to occur. Routine, practical evaluations can inform strategies for the prevention and control of HAIs. Please select areas for development or enhancement of state HAI prevention efforts.

Table 4: State HAI communication and evaluation planning

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway)	Target Dates for Implementation
Level I	<input type="checkbox"/>	<input type="checkbox"/>	1. Conduct needs assessment and/or evaluation of the state HAI program to learn how to increase impact <ul style="list-style-type: none"> i. Establish evaluation activity to measure progress towards targets and ii. Establish systems for refining approaches based on data gathered 	
	<input type="checkbox"/>	<input type="checkbox"/>		
				<i>Other activities or descriptions (not required):</i>
	<input type="checkbox"/>	<input type="checkbox"/>	2. Develop and implement a communication plan about the state's HAI program and progress to meet public and private stakeholders needs <ul style="list-style-type: none"> i. Disseminate state priorities for HAI prevention to healthcare organizations, professional provider organizations, governmental agencies, non-profit public health organizations, and the public 	

			<i>Other activities or descriptions (not required):</i>	
Level II	<input type="checkbox"/>	<input type="checkbox"/>	3. Provide consumers access to useful healthcare quality measures	
			<i>Other activities or descriptions (not required):</i>	
Level III	<input type="checkbox"/>	<input type="checkbox"/>	4. Identify priorities and provide input to partners to help guide patient safety initiatives and research aimed at reducing HAIs	
			<i>Other activities or descriptions (not required):</i>	
Please also describe any additional activities, not listed above, that your state plans to undertake. Please include target dates for any new activities.				

Appendix 1.

The HHS Action plan identifies metrics and 5-year national prevention targets. These metrics and prevention targets were developed by representatives from various federal agencies, the Healthcare Infection Control Practices Advisory Committee (HICPAC), professional and scientific organizations, researchers, and other stakeholders. The group of experts was charged with identifying potential targets and metrics for six categories of healthcare-associated infections:

- Central Line-associated Bloodstream Infections (CLABSI)
- Clostridium difficile Infections (CDI)
- Catheter-associated Urinary Tract Infections (CAUTI)
- Methicillin-resistant Staphylococcus aureus (MRSA) Infections
- Surgical Site Infections (SSI)
- Ventilator-associated Pneumonia (VAP)

Following the development of draft metrics as part of the HHS Action Plan in January 2009, HHS solicited comments from stakeholders for review.

Stakeholder feedback and revisions to the original draft Metrics

Comments on the initial draft metrics published as part of the HHS Action Plan in January 2009 were reviewed and incorporated into revised metrics. While comments ranged from high level strategic observations to technical measurement details, commenters encouraged established baselines, both at the national and local level, use of standardized definitions and methods, engagement with the National Quality Forum, raised concerns regarding the use of a national targets for payment or accreditation purposes and of the validity of proposed measures, and would like to have both a target rate and a percent reduction for all metrics. Furthermore, commenters emphasized the need for flexibility in the metrics, to accommodate advances in electronic reporting and information technology and for advances in prevention of HAIs, in particular ventilator-associated pneumonia.

To address comments received on the Action Plan Metrics and Targets, proposed metrics have been updated to include source of metric data, baselines, and which agency would coordinate the measure. To respond to the requests for percentage reduction in HAIs in addition to HAI rates, a new type of metric, the standardized infection ratio (SIR), is being proposed. Below is a detailed technical description of the SIR.

To address concerns regarding validity, HHS is providing funding, utilizing Recovery Act of 2009 funds, to CDC to support states in validating NHSN-related measures and to support reporting on HHS metrics through NHSN. Also, most of the reporting metrics outlined here have already

been endorsed by NQF and for population-based national measures on MRSA and *C. difficile*, work to develop hospital level measures will be conducted in the next year utilizing HHS support to CDC through funds available in the Recovery Act.

Finally, to address concerns regarding flexibility in accommodating new measures, reviewing progress on current measures, and incorporating new sources of measure data (e.g., electronic data, administrative data) or new measures, HHS and its constituent agencies will commit to an annual review and update of the HHS Action Plan Targets and Metrics.

Below is a table of the revised metrics described in the HHS Action plan. Please select items or add additional items for state planning efforts.

Metric Number and Label	Original HAI Elimination Metric	HAI Comparison Metric	Measurement System	National Baseline Established (State Baselines Established)	National 5-Year Prevention Target	Coordinator of Measurement System	Is the metric NQF endorsed?
1. CLABSI 1	CLABSIs per 1000 device days by ICU and other locations	CLABSI SIR	CDC NHSN Device-Associated Module	2006-2008 (proposed 2009, in consultation with states)	Reduce the CLABSI SIR by at least 50% from baseline or to zero in ICU and other locations	CDC	Yes [†]
2. CLIP 1 (formerly CLABSI 4)	Central line bundle compliance	CLIP Adherence percentage	CDC NHSN CLIP in Device-Associated Module	2009 (proposed 2009, in consultation with states)	100% adherence with central line bundle	CDC	Yes [†]
3a. C diff 1	Case rate per patient days; administrative/discharge data for ICD-9 CM coded <i>Clostridium difficile</i> Infections	Hospitalizations with <i>C. difficile</i> per 1000 patient discharges	Hospital discharge data	2008 (proposed 2008, in consultation with states)	At least 30% reduction in hospitalizations with <i>C. difficile</i> per 1000 patient discharges	AHRQ	No
3b. C diff 2 (new)		<i>C. difficile</i> SIR	CDC NHSN MDRO/CDAD Module LabID [†]	2009-2010	Reduce the facility-wide healthcare facility-onset <i>C. difficile</i> LabID event SIR by at least 30% from baseline or to zero	CDC	No

Metric Number and Label	Original HAI Elimination Metric	HAI Comparison Metric	Measurement System	National Baseline Established (State Baselines Established)	National 5-Year Prevention Target	Coordinator of Measurement System	Is the metric NQF endorsed?
4. CAUTI 2	# of symptomatic UTI per 1,000 urinary catheter days	CAUTI SIR	CDC NHSN Device-Associated Module	2009 for ICUs and other locations 2009 for other hospital units (proposed 2009, in consultation with states)	Reduce the CAUTI SIR by at least 25% from baseline or to zero in ICU and other locations	CDC	Yes
5a. MRSA 1	Incidence rate (number per 100,000 persons) of invasive MRSA infections	MRSA Incidence rate	CDC EIP/ABCs	2007-2008 (for non-EIP states, MRSA metric to be developed in collaboration with EIP states)	At least a 50% reduction in incidence of healthcare-associated invasive MRSA infections	CDC	No
5b. MRSA 2 (new)		MRSA bacteremia SIR	CDC NHSN MDRO/CDAD Module LabID [‡]	2009-2010	Reduce the facility-wide healthcare facility-onset MRSA bacteremia LabID event SIR by at least 25% from baseline or to zero	CDC	No
6. SSI 1	Deep incision and organ space infection rates using NHSN definitions (SCIP procedures)	SSI SIR	CDC NHSN Procedure-Associated Module	2006-2008 (proposed 2009, in consultation with states)	Reduce the admission and readmission SSI [§] SIR by at least 25% from baseline or to zero	CDC	Yes [¶]
7. SCIP 1 (formerly SSI 2)	Adherence to SCIP/NQF infection process measures	SCIP Adherence percentage	CMS SCIP	To be determined by CMS	At least 95% adherence to process measures to prevent surgical site infections	CMS	Yes

* NHSN SIR metric is derived from NQF-endorsed metric data

† NHSN does not collect information on daily review of line necessity, which is part of the NQF

‡ LabID, events reported through laboratory detection methods that produce proxy measures for infection surveillance

§ Inclusion of SSI events detected on admission and readmission reduces potential bias introduced by variability in post-discharge surveillance efforts

¶ The NQF-endorsed metric includes deep wound and organ space SSIs only which are included the target.

Understanding the Relationship between HAI Rate and SIR Comparison Metrics

The Original HAI Elimination Metrics listed above are very useful for performing evaluations. Several of these metrics are based on the science employed in the NHSN. For example, metric #1 (CLABSI 1) for CLABSI events measures the number of CLABSI events per 1000 device (central line) days by ICU and other locations. While national aggregate CLABSI data are published in the annual NHSN Reports these rates must be stratified by types of locations to be risk-adjusted. This scientifically sound risk-adjustment strategy creates a practical challenge to summarizing this information nationally, regionally or even for an individual healthcare facility. For instance, when comparing CLABSI rates, there may be quite a number of different types of locations for which a CLABSI rate could be reported. Given CLABSI rates among 15 different types of locations, one may observe many different combinations of patterns of temporal changes. This raises the need for a way to combine CLABSI rate data across location types.

A standardized infection ratio (SIR) is identical in concept to a standardized mortality ratio and can be used as an indirect standardization method for summarizing HAI experience across any number of stratified groups of data. To illustrate the method for calculating an SIR and understand how it could be used as an HAI comparison metric, the following example data are displayed below:

Risk Group Stratifier	Observed CLABSI Rates			NHSN CLABSI Rates for 2008 (Standard Population)		
Location Type	#CLABSI	#Central line-days	CLABSI rate*	#CLABSI	#Central line-days	CLABSI rate*
ICU	170	100,000	1.7	1200	600,000	2.0
WARD	58	58,000	1.0	600	400,000	1.5
$\text{SIR} = \frac{\text{observed}}{\text{expected}} = \frac{170 + 58}{100000 \times \left(\frac{2}{1000}\right) + 58,000 \times \left(\frac{1.5}{1000}\right)} = \frac{228}{200 + 87} = \frac{228}{287} = 0.79 \quad 95\% \text{CI} = (0.628, 0.989)$						

* defined as the number of CLABSIs per 1000 central line-days

In the table above, there are two strata to illustrate risk-adjustment by location type for which national data exist from NHSN. The SIR calculation is based on dividing the total number of observed CLABSI events by an “expected” number using the CLABSI rates from the standard population. This “expected” number is calculated by multiplying the national CLABSI rate from the standard population by the observed number of central line-days for each stratum which can also be understood as a prediction or projection. If the observed data represented a follow-up period such as 2009 one would state that an SIR of 0.79 implies that there was a 21% reduction in CLABSIs overall for the nation, region or facility.

The SIR concept and calculation is completely based on the underlying CLABSI rate data that exist across a potentially large group of strata. Thus, the SIR provides a single metric for performing comparisons rather than attempting to perform multiple comparisons across many strata which makes the task

cumbersome. Given the underlying CLABSI rate data, one retains the option to perform comparisons within a particular set of strata where observed rates may differ significantly from the standard populations. These types of more detailed comparisons could be very useful and necessary for identifying areas for more focused prevention efforts.

The National 5-year prevention target for metric #1 could be implemented using the concept of an SIR equal to 0.25 as the goal. That is, an SIR value based on the observed CLABSI rate data at the 5-year mark could be calculated using NHSN CLABSI rate data stratified by location type as the baseline to assess whether the 75% reduction goal was met. There are statistical methods that allow for calculation of confidence intervals, hypothesis testing and graphical presentation using this HAI summary comparison metric called the SIR.

The SIR concept and calculation can be applied equitably to other HAI metrics list above. This is especially true for HAI metrics for which national data are available and reasonably precise using a measurement system such as the NHSN. The SIR calculation methods differ in the risk group stratification only. To better understand metric #6 (SSI 1) see the following example data and SIR calculation:

Risk Group Stratifiers		Observed SSI Rates			NHSN SSI Rates for 2008 (Standard Population)		
Procedure Code	Risk Index Category	#SSI [†]	#procedures	SSI rate [*]	#SSI [†]	#procedures	SSI rate [*]
CBGB	1	315	12,600	2.5	2100	70,000	3.0
CBGB	2,3	210	7000	3.0	1000	20,000	5.0
HPRO	1	111	7400	1.5	1020	60,000	1.7
$\text{SIR} = \frac{\text{observed}}{\text{expected}} = \frac{315 + 210 + 111}{12600 \times \left(\frac{3.0}{100}\right) + 7000 \times \left(\frac{5.0}{100}\right) + 7400 \left(\frac{1.7}{100}\right)} = \frac{636}{378 + 350 + 125.8} = \frac{636}{853.8} = 0.74 \quad 95\% \text{CI} = (0.649, 0.851)$							

[†] SSI, surgical site infection

^{*} defined as the number of deep incision or organ space SSIs per 100 procedures

This example uses SSI rate data stratified by procedure and risk index category. Nevertheless, an SIR can be calculated using the same calculation process as for CLABSI data except using different risk group stratifiers for these example data. The SIR for this set of observed data is 0.74 which indicates there's a 26% reduction in the number of SSI events based on the baseline NHSN SSI rates as representing the standard population. Once again, these data can reflect the national picture at the 5-year mark and the SIR can serve as metric that summarizes the SSI experience into a single comparison.

There are clear advantages to reporting and comparing a single number for prevention assessment. However, since the SIR calculations are based on standard HAI rates among individual risk groups there is the ability to perform more detailed comparisons within any individual risk group should the need arise. Furthermore, the process for determining the best risk-adjustment for any HAI rate data is flexible and always based on more detailed risk factor analyses that provide ample scientific rigor supporting any SIR calculations. The extent to which any HAI rate data can be risk-adjusted is obviously related to the detail and volume of data that exist in a given measurement system.

In addition to the simplicity of the SIR concept and the advantages listed above, it's important to note another benefit of using an SIR comparison metric for HAI data. If there was need at any level of aggregation (national, regional, facility-wide, etc.) to combine the SIR values across mutually-exclusive data one could do so. The below table demonstrates how the example data from the previous two metric settings could be summarized.

HAI Metric	Observed HAIs			Expected HAIs		
	#CLABSI	#SSI [†]	#Combined HAI	#CLABSI	#SSI [†]	#Combined HAI
CLABSI 1	228			287		
SSI 1		636			853.8	
Combined HAI			228 + 636 = 864			287+853.8 = 1140.8
$\text{SIR} = \frac{\text{observed}}{\text{expected}} = \frac{228 + 636}{287 + 853.8} = \frac{864}{1140.8} = 0.76 \quad 95\% \text{CI} = (0.673, 0.849)$						

[†] SSI, surgical site infection



Health Care Quality Performance (HCQP) Program

HAND HYGIENE COMPLIANCE

Technical Page

The hand hygiene compliance measures are [reported on the Department of Health's \(HEALTH's\) Web site](#) as part of the HCQP Program's Hospital-Acquired Infections work. This information provides additional details about the measures, including their data source, how they are calculated, and why each is important.

Measures

The Program has defined three hand hygiene compliance measures:

Measure	Why is this information important?
1. Hand hygiene and glove use educational program in place	Clean hands are the single most important strategy to prevent germs from spreading in hospitals. Making sure that staff know hand hygiene—how to clean their hands with an alcohol-based product or soap and water—and how to use gloves is important.
2. Hand hygiene compliance measured	Going to different parts of the hospital (wards, clinics, etc.) to see if staff are actually cleaning their hands properly before and after caring for patients is important. This information helps hospitals know how often staff are cleaning their hands properly. They can then use this information to improve hand hygiene compliance, and help to prevent the spread of germs.
3. Hand hygiene compliance data shared with hospital staff and executives	It is important for hospitals to use the information they collect about how staff are cleaning their hands to provide feedback. This feedback should include the staff who were observed and also as s the hospital administration. This tells them if they are doing a good job or need to improve.

These measures are process measures. Process measures look at *how* hospitals work. The goal is for every hospital to have a 'Yes' for all three measures.

Data Source

The hand hygiene compliance measures are calculated based on information collected each year from hospitals in Rhode Island. Hospitals answer the following questions:

1. **Does your hospital have an educational program regarding the following?** (*Select all that apply.*)
 - Principles of hand hygiene
 - Proper glove use

2. **Does your hospital measure hand hygiene compliance on a regular basis?**
 - No (Stop)
 - Yes
 - a. **How does your hospital measure hand hygiene compliance?**
 - By measuring the volume of hand cleansing agent used (e.g., hand sanitizer)
 - Through direct observation. *Please specify average number of observations/month:* _____
 - Other (please specify): _____
 - b. **How often does your hospital measure hand hygiene compliance?**
 - Every quarter (3 months)
 - Monthly
 - Weekly
 - Daily
 - Other (please specify): _____
3. **Does your hospital have an ongoing program to improve hand hygiene compliance rates?**
 - No
 - Yes
4. **Does your hospital provide feedback regarding hand hygiene compliance to the following?**
(Select all that apply.)
 - Credentialed staff
 - Chief Executive Officer (CEO)
 - Executive Leadership
 - None of the above

Measure Definitions

The measures are calculated based on the following definitions:

1. **Hand hygiene and glove use educational program in place**
Yes: Q1: Both “Principles of hand hygiene” AND “Proper glove use” checked
2. **Hand hygiene compliance measured**
Yes: Q2: Yes, AND
Q2a: “By measuring compliance through direct observation,” AND
Q2b: At least quarterly
3. **Hand hygiene compliance reported**
Yes: Measure 2: Yes, AND
Q3: Yes, AND
Q4: “Credentialed staff,” and “Chief Executive Officer” and/or “Executive Leadership” checked

Definitions

To make sure that hospitals answer the above questions the same way, the program has defined some key terms included in the questions. These definitions are:

Key Term/Phrase	Definition
Credentialed staff	<ul style="list-style-type: none"> ▪ Healthcare workers engaged in direct patient contact, including: <ul style="list-style-type: none"> – Certified nursing assistants (CNAs) – Licensed practical nurses (LPNs) – Registered nurses (RNs) – Physician assistants (PAs) – Nurse practitioners (NPs) – Physicians (MDs and DOs) ▪ Includes clinicians who are hospital employees and also those who are not hospital employees.
Direct patient contact	<ul style="list-style-type: none"> ▪ Any face-to-face interaction with patients.
Executive leadership	<ul style="list-style-type: none"> ▪ High-level hospital administrative staff who run the hospital, including people such as the president and vice president, chief executive officer (CEO), chief financial officer (CFO), chief medical officer (CMO), chief nursing officer (CNO), chief operating officer (COO), and others.
Hand hygiene	<ul style="list-style-type: none"> ▪ A general term that applies to cleaning hands with soap and water or using an antiseptic (e.g., alcohol) hand rub, gel, or foam (i.e., hand sanitizer).
Measuring compliance	<ul style="list-style-type: none"> ▪ The act of collecting data on hand hygiene compliance by collecting data.
Monitoring compliance	<ul style="list-style-type: none"> ▪ The act of using collected data to look at how hospitals' compliance rates change over time (e.g., looking at trends). ▪ May be part of a program or quality improvement initiative to improve the hospital's hand hygiene compliance.
Physicians	<ul style="list-style-type: none"> ▪ Includes both Medical Doctors (MDs) and Doctors of Osteopathy (DOs). ▪ Includes physicians who are hospital employees (e.g., hospitalists) and also those who are not hospital employees, but have direct patient contact with patients at the hospital.
Program to improve rates	<ul style="list-style-type: none"> ▪ A team of staff, usually with different types of experience, who meet regularly to review data, identify improvement opportunities, and implement projects to improve the hospital's performance.

Department of Health (HEALTH) Influenza Vaccination Form Feedback

1. Please indicate the level of difficulty or ease of collecting information for the following types of healthcare workers (HCWs):					
	Very difficult	Somewhat difficult	Somewhat easy	Very easy	Response Count
CNAs	0.0% (0)	37.5% (3)	50.0% (4)	12.5% (1)	8
Nurses (RNs, LPNs)	0.0% (0)	37.5% (3)	50.0% (4)	12.5% (1)	8
Physicians (MDs, DOs, NPs, PAs)	62.5% (5)	37.5% (3)	0.0% (0)	0.0% (0)	8
Others (e.g., students)	14.3% (1)	57.1% (4)	28.6% (2)	0.0% (0)	7
Please provide any comments on collecting data by HCW type:					5
<i>answered question</i>					8
<i>skipped question</i>					0

2. Please indicate the level of difficulty or ease of collecting information by employee status:					
	Very difficult	Somewhat difficult	Somewhat easy	Very easy	Response Count
Employees	0.0% (0)	37.5% (3)	50.0% (4)	12.5% (1)	8
Non-employees	50.0% (4)	37.5% (3)	0.0% (0)	12.5% (1)	8
Please provide any comments on collecting data by employee status:					2
<i>answered question</i>					8
<i>skipped question</i>					0

3. Can your hospital collect these data for the 2009-2010 influenza season? (beginning Oct 2009)			
		Response Percent	Response Count
Yes		87.5%	7
No. Please explain why not:		12.5%	1
<i>answered question</i>			8
<i>skipped question</i>			0

4. Please provide any additional feedback about the suggested revisions or your hospital's ability to collect these data.

		Response Count
		7
	<i>answered question</i>	7
	<i>skipped question</i>	1

5. Please provide the following information, so that we can follow-up with you for clarification or more information:

		Response Percent	Response Count
Hospital:	<input type="text"/>	100.0%	7
Your Name:	<input type="text"/>	100.0%	7
Your Title:	<input type="text"/>	100.0%	7
Email Address:	<input type="text"/>	100.0%	7
Phone Number:	<input type="text"/>	100.0%	7
	<i>answered question</i>		7
	<i>skipped question</i>		1