Washington Advocates for Patient Safety
Additional Comments on Draft Report
"Healthcare Associated Infections: 2013 Report to the Washington Legislature"
by the Washington Department of Health
July 12, 2013

In addition to the response that we submitted along with the Consumers Union, we would like to comment on addition issues that are raised in this report.

Executive Summary

Under RCW 42.70.056 as amended in 2013, we would recommend that the statement "Produce periodic (state-of-the-art) reports" be replaced with a measurable term as annually or quarterly.

We are concerned with the language on Page 4 "Recommendations that Require Change in Legislation" item 1 MRSA screening. Hospitals should not be making their own decisions based on their annual risk assessments; Hospitals should already have infection control policies, procedures and systems in place per 42 CFR 482.42. Hospitals should be reviewing actual infection rates, the root cause analysis of those, and corrective action plans (CAPS). Hospitals should also be screening these "in the most efficient manner" not the most cost effective.

I. Background

Page 5, third paragraph, last sentence it is stated that "The website has been available to the public since the end of 2009, and is updated at least once every year." Healthcare associated infection rates should be reported quarterly. This duty does not require much time (resources); the public needs more current data.

Page 6, under RCW 42.70.056 item 4 we recommend it be reworded as follows:

"*The list of surgical procedures for which surgical site infection reporting has been modified with House Bill 1471 and now includes more than is required by federal authorities; new rule making authority is also given to the department to expand the list of reportable conditions in the future*."

Also on Page 6 under this section, we have concerns with the language. A conservative approach that does not enforce compliance is not safe for patients. Availability of the infection rate data will assist the public in making informed choices of where they will "purchase" their healthcare. This data would include infection rates by a particular hospital, the number of deaths from those infections, how the bacteria were acquired, what types of bacteria the patient acquired, etc.

Also in this paragraph it is stated that *"Where we see an existing measure not serving its intended purpose well, we anticipate eliminating unsuccessful requirements."* It would be useful to see the DOH decision model on the criteria for eliminating unsuccessful requirements.

Page 9, first bullet: "Our annual validation program has been working well since 2009 with all applicable hospitals in Washington to ensure their reporting meets our defined standards for completeness and accuracy." If the annual DOH validation program has been working well since 2009 isn't it time for the DOH to consider a 3rd party audit to ensure the state validation system is working as documented? This criteria is used in National Quality Standards/ISO.

Page 9, Recommendation: It is stated that *"A growing number of other states have asked for our assistance in establishing a validation process with their hospitals."* We have questions about this validation process and why Washington State is deviating away from the CDC processes and tools. Why didn't the CDC ask for the Washington State process and change the federal process to match (if it works so well)?

III. Public Health Department Position on Adding, Deleting or Modify State Reporting Requirements by Rule"

It is stated that "*We do not feel that the CMS-mandated MRSA bacteremia rate is sufficiently meaningful to add to our state reports*." Then the "*secondary bloodstream infection*" was mentioned as more to do with "*deterioration in a patient's underlying condition than with infection prevention programs*."

We are concerned with this interpretation. If a patient is not MRSA positive on admission but becomes positive later while in the hospital, the likely cuprites is the ineffectiveness of MRSA surveillance and prevention procedures in that hospital. Most people in hospitals are sick and have various underlying conditions that would make them more susceptible to infections than healthy people. So, just like cases of primary infection, we believe that secondary infections should also be carefully evaluated and tracked for the causes and any deficiencies in the hospital's MRSA prevention policy.

Again, we greatly appreciate the opportunity to respond to the report. We hope to work closely with DoH and the HAI Advisory Committee to improve our state reporting on heath care-acquired infections and their elimination. If you have any questions, please contact Karie Fugate at katurnage@comcast.net or Yanling Yu at mydadmatters@gmail.com