



June 19, 2008

Ruth Charbonneau, Director
Office of Legal and Regulatory Affairs
Office of the Commissioner
NJ Department of Health and Senior Services
PO Box 360
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RE: Comments PRN 2008-135 relating to Health care Facility Infection Reporting Act at N.J.S.A. 26:2H-1 et seq.

Consumers Union (CU) ¹ submits the following comments on the proposed regulations (NJAC8:56) to implement the Health Care Facility Infection Reporting Act.

Five years ago, CU launched a national campaign, www.StopHospitalInfections.org, advocating for public disclosure of hospital-acquired infection rates to inform people about the safety of their hospitals and to mobilize hospitals to do more to prevent infections occurring in their facilities. We helped to pass the public reporting law in New Jersey and are pleased to see the Act being implemented with these proposed rules. Our comments about specific provisions are below.

Getting to zero. We recommend that the final rule eliminate the phrase in the summary, "Scientific literature suggests that approximately one-third of these infections are preventable" because it contradicts the reality of remarkable prevention efforts taking place in NJ and around the country today. Further, it sets the wrong tone for this new law, which we expect to reduce infections by much more than one-third over time. The law itself states a desire to reach "a goal of zero health care facility-associated infections." And, there are numerous examples of experts rejecting this long-standing belief that most hospital-acquired infections are inevitable: CDC has set a prevention goal of zero; the Association of Professionals in Infection control and Epidemiology

¹ Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 4.5 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions that affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support

(APIC) has launched a "targeting zero" campaign,² the mission of which is "targeting zero healthcare-associated infections (HAIs); and the Institute for Healthcare Improvement's 100,000 Lives and 5 Million Lives Campaigns have demonstrated that many hospitals have reduced certain infections near zero.³

Economic Impact of hospital-acquired infections. The potential savings for the state if hospital-acquired infections are significantly reduced is great and we appreciate that these rules highlight the grave financial impact of this health care crisis.

The best public estimates we have to date of the overall impact to our health care system are from Pennsylvania which reports rates on all four of the major types of infections (surgical site infections, blood-stream infections, ventilator associated pneumonia, and urinary tract infections) and reports on infections occurring throughout the hospital. The state also collected information directly from private insurers to get a more accurate picture of the actual costs to the health care system.ⁱ The private insurance payments ranged from \$27,000 for urinary tract infections to \$80,000 for blood stream infections.ⁱⁱ In 2005, Pennsylvania estimated the total hospital charges for the state's infections at \$1.4 billion.

California Governor Schwarzenegger's office estimated the cost of hospital-acquired infections in that state to be \$3 billion. And, a Massachusetts Panel estimated the total cost of hospital-acquired infections in that state to be \$200 million to \$473 million.

Further, the impact on state government is substantial. A 2007 study by the APIC, found that Medicaid was the payer for 11.4% of hospital-acquired infection cases. A 2005 Pennsylvania report analyzing who was paying for hospital-acquired infections in that state found that Medicaid paid for 9% of all hospital-acquired infections, accounting for 18% of the hospital charges for that state's infected patients. Pennsylvania estimated that the average charges for Medicaid patients with an infection were more than \$391,000, while the average charges for Medicaid patients without an infection were just under \$30,000. Oregon estimated that the excess Medicaid costs for hospital-acquired infections in that state exceeded \$2.4 million in 2005.

Using CDC's National Healthcare Safety Network (NHSN) for state reporting.

We have been actively engaged in implementation of infection reporting laws in many states and support the route most are taking in using the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). While this system is still new, it represents the best process for standardizing reporting hospital infection rates to the public. We are pleased to see that the regulations specify New Jersey will use NHSN.

² http://www.apic.org/AM/Template.cfm?Section=Targeting_Zero

³

<http://www.ihl.org/IHI/Topics/CriticalCare/IntensiveCare/ImprovementStories/FSVAPGettingtoZeroandStayingThere.htm>

The MRSA module is not yet available at NHSN, however, we strongly recommend that the regulations require using the module to report MRSA infections as soon as it becomes available.

The NHSN provides standardized definitions and protocols, training modules, and regular support calls with states using the system which enables state public health staff to learn from each other. New York has used the system for more than a year and could provide valuable insight to NJ regarding use of the system. Many NJ hospitals are already using NHSN so the transition should be easier than if the state created its own collection system. The NHSN will enable New Jersey and other states to better understand the true depth of the hospital-acquired infection crisis and provide comparisons with similar hospitals around the country.

Confidentiality provisions. The regulations provide that the Department will only have access to CDC hospital infection data that does not contain “patient identifying information,” defined in these regulations as “patient name, social security number, identification number, gender, and date of birth.” We support strong protections of patient confidentiality, but are concerned that these provisions will hinder thorough analysis of hospital infection data, the ability to track readmissions, and validation efforts. Many health care data systems across the country maintain strict confidentiality of patient identifying elements while using these elements to create unique patient identifiers which would enable analysis and validation of the data without revealing the identity of any patient. We recommend that the department have access to this information, within a secure and confidential system.

Notification about readmissions. We support the provisions to establish a notification system among facilities for reporting surgical site infections. Since most of these infections’ symptoms occur after discharge, this kind of post discharge notification will enhance the accuracy of the public reports.

HAI data required to be reported. We appreciate the Department’s notification to hospitals of the reporting elements prior to the finalization of these rules. This will allow the collection of data to begin promptly.

However, we strongly recommend that future discussions on expanding reporting measures include a system of public input beyond the QIAC committee. Since QIAC meetings are not open to the public, most consumer organizations and other stakeholders that do not serve on the committee are unable to even monitor the discussions regarding hospital infection measures. Ideally, the QIAC meetings would be open to the public, but short of that, a public hearing should be held to allow others to suggest future expansions of the program.

We strongly recommend that the Department require hospitals to give the Department information on the pathogens causing the infections, which are reported to NHSN along with the infection case information. Also, public reports should include information regarding the prevalence of various pathogens that are resistant to antibiotics, like MRSA, and that are on the rise, like *c. difficile*. This is important

information for the public, the state and hospitals as they try to develop more effective infection control practices.

Data accuracy and retention. We recommend that 8:56-2.7(c) mandate rather than permit the conducting of audits. Auditing is an essential component of any public reporting system and without it, public trust in the data could be eroded.

Department use of reported data. We encourage public disclosure of the methods used to manipulate data so it presents understandable comparisons of hospital infection rates. This will be essential for consumers to understand the information being presented. Since the ultimate goal is zero, adjustments based on patient characteristics should be minimized. The NHSN system does make several adjustments, such as length of time for surgery.

Further, several states present the infection rates by grouping similar hospitals together. This method of stratifying the information helps consumers understand that they should not compare a small hospital to a large urban trauma center.

Consumers Union supports the adoption of these regulations with modifications as discussed in these comments. Public reporting is a powerful motivator to improve hospital care and we believe New Jersey patients will be safer as this comparative information becomes available. These infections must be stopped – they are preventable, they cost too much in lives and dollars, and it is time for the people of New Jersey to see the evidence of the effectiveness of their local hospitals' infection control. We appreciate the Department's lead role in putting this law into action.

Respectfully submitted,



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ⁱ "PHC4 • Hospital-acquired Infections in Pennsylvania, January 1, 2005 – December 31, 2005," November 2006, page 2.

ⁱⁱ The average "costs" in Pennsylvania: SSI: \$27,470; UTI: \$43,932; VAP: \$62,509; BSI: \$80,233; Multiple infections: \$91,898