Act 52 of 2007: the Authority’s Role, Progress to Date, and Future Goals

Healthcare-associated infections (HAIs) are a major threat to patient safety and are among the most common adverse events in healthcare. Approximately 2 million hospitalized patients develop HAIs annually in the United States, resulting in roughly 90,000 deaths. These infections result in increased morbidity, mortality, and significant healthcare expenditure. Patient safety may be compromised by the failure to follow best practices for minimizing the HAIs and by injudicious use of antibiotics, which results in the emergence of virulent and resistant organisms.

More patients are discharged from hospitals at an acuity level requiring skilled nursing care, which increases the burden on the long-term care system. Lack of resources in nursing homes compromises safe practices and puts patients at risk of infection. HAI incidence in nursing homes is not widely studied, but in a 3-year prospective study conducted in a San Diego nursing home with 300 hundred residents, the author reports results of approximately 7.1 infections per 1,000 resident days. Elsewhere in the United States, an average rate of approximately 4.1 infections per 1,000 resident days with a range of 0.8 to 9.5 has been reported. A recent study reported in April 2008 was undertaken in 133 U.S. Department of Veterans Affairs nursing homes. A point prevalence rate of 5.2 infections per 1,000 resident days is cited.

Although HAIs cannot be entirely eliminated, there are strategies that have been proven to be effective to significantly reduce numbers of cases and eliminate infections that are avoidable. An example includes implementation of evidence-based practices, including hand hygiene. The fact that some healthcare organizations have succeeded in managing infections and the risks to patients much better than others suggests a patient safety improvement gap between what is possible and what is currently widely implemented. Patient safety requires system- and discipline-wide action to identify and manage potential and actual HAI-related risks.

Pennsylvania became the first state in the nation to mandate reporting of HAIs, with public reporting of individual hospital data collected by the Pennsylvania Health Care Cost Containment Council (PHC4). Mandatory reporting by hospitals to PHC4 began in 2004, and the first public data report was released in July 2005.

Senate Bill 968 (Act 52) was signed into law by Governor Edward G. Rendell on July 20, 2007, as part of the Prescription for Pennsylvania healthcare reform plan. Act 52 focuses on the reduction and prevention of HAIs. It mandates that acute care facilities, nursing homes, and ambulatory surgery facilities develop and implement a comprehensive internal infection control plan for improving the health and safety of patients, residents, and healthcare workers. In addition, acute care facilities and nursing homes are required to report HAIs to the Pennsylvania Patient Safety Authority.

Under Act 52, an advisory panel of infection prevention and control experts was appointed by the Authority during fall 2007. The panel includes a subcommittee of long-term care experts. (For more information about the panel, see page 71 of the September 2007 issue of the Patient Safety Advisory at http://www.psa.state.pa.us/psa/lib/psa/advisories/sept_2007_advisory_v4_n3.pdf.)

To date, the panel has assisted in establishing requirements for the mandatory reporting of HAIs by hospitals and nursing homes. These requirements were published in the Pennsylvania Bulletin in a final notice for hospitals and a draft notice for nursing homes. (See “Notices in the Pennsylvania Bulletin.”) A final notice for nursing homes will be published when the public comment period relating to the draft has been completed. It is expected that nursing homes will begin mandatory reporting at the beginning of 2009.

The panel has also developed “best practice” questions for hospitals. This information was published in the Pennsylvania Bulletin in March 2008. These best practice questions are answered when hospitals enter HAI data into the Centers for Disease Control and Prevention’s Web-based surveillance system, the National Healthcare Safety Network (NHSN). On the advice of the panel, the Authority employed the “bundling” concept developed by the Institute for Healthcare Improvement to develop questions about central line and ventilator-associated pneumonia prevention. The Authority also developed questions to monitor the necessity of Foley catheters, as well as to monitor certain surgical procedures with the potential highest risk for infection. Using the Surgical Care Improvement Project (SCIP) measure of antibiotic prophylaxis, the Authority will be monitoring several surgical procedure categories.

Best practice questions are currently being developed for nursing homes utilizing resources such as F-tags (urinary incontinence F315), with assistance from the long-term care advisory subcommittee. These questions will be addressed in a final notice in the Pennsylvania Bulletin and in a future Pennsylvania Patient Safety Advisory article. The Authority will be conducting comprehensive educational programs for nursing homes relating to the reporting requirements and best practice questions.

* Bundling denotes developing a collection of processes needed to effectively care for patients undergoing particular treatments with inherent risks.
* SCIP is a national campaign and partnership of leading public and private healthcare organizations aimed at reducing surgical complications by 25% by the year 2010.
Act 52 requires the Authority to develop and implement educational programs for hospitals and nursing homes. The Authority has developed question-and-answer sheets and video tutorials for reporting requirements and answering best practice questions on NHSN. The video tutorials are hosted online by the Department of Health at [http://www.dsf.health.state.pa.us/health/cwp/view.asp?A=188&Q=250491](http://www.dsf.health.state.pa.us/health/cwp/view.asp?A=188&Q=250491). The PA-PSRS help desk and infection control analyst are available to provide assistance for individual hospitals on an as-needed basis. Educational programs have been presented during hospital council meetings in two regions to date. Development of the first set of nursing home programs to introduce reporting requirements and educate staff is underway and will be conducted in the near future.

Ongoing collection and analysis of HAI-related data from more than 250 hospitals and 800 nursing homes will assist the Authority in identifying trends, patterns, and potential process or system failures. Data analysis will allow the Authority to measure best practice outcomes and processes, and identify low and high performance, which will provide insight into barriers and strategies to overcome them.

Future HAI-related Advisory articles will convey information from event data analysis and the medical literature. These articles will provide strategies for process improvement and adoption of evidence-based best practices. The Advisory is new to nursing homes but the Authority intends it to be a useful information resource and tool for long-term care providers as well as acute care. The Authority will continue to provide up-to-date HAI-related information on its Web site ([http://www.psa.state.pa.us](http://www.psa.state.pa.us)).

## Notes

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THE PENNSYLVANIA PATIENT SAFETY AUTHORITY AND ITS CONTRACTORS

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