FALL 2009 IDN SUMMIT
PEER-TO-PEER LEARNING EXCHANGE
RESEARCH REPORTS

Hospital Acquired Infections (HAIs)

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SUPPLY CHAIN AND HOSPITAL ACQUIRED INFECTIONS (HAI'S)

The changing role of supply chain professionals:

"Their world has expanded well beyond the narrow limits of just buying at the best price. In the 21st century, they must also be well informed on a large number of subjects outside what used to be their normal purview. These include not only information technology, lean management, and others, but very importantly the area of infection prevention and disease management."

Michael Bohon, CPSM, CMRP, Managing Director, HealthCare Solutions Bureau, LLC, Show Low, Arizona

"Supply-chain managers are in a position to balance the SC function with their hospital's goals regarding safety, infection prevention, and patient outcomes. While cost is important, it is crucial that SC managers are involved in the preventive process."

Cindi Crosby, Vice President, Clinical Operations Management, Cardinal Health, Dublin, Ohio

"It will require education on how to evaluate antibacterial claims on products to distinguish them from data on reducing infections. Understanding the risk of infection for each type of product and its use or application requires teamwork and partnership between SC managers and IPs."

Gina Pugliese, Vice-President, Premier Safety Institute, Charlotte, North Carolina

"A key element and critical success factor of bundles is the empowerment of each member of the team to have permission to call out to colleagues when a step in the process is not being carried out according to protocol."

Judene Bartley, MS, MPH, CIC, Clinical Consultant, Premier Safety Institute, Charlotte, North Carolina

"We have to step outside our logistics comfort zone and objectively examine outcome statistics to determine if a given product improves infection rates. If you find that such a product delivers, we have a responsibility to contract the product at a price that balances cost and value. And if a product does not live up to its marketing, we have a similar responsibility to say no."

Jay Kirkpatrick, CEO, Nashville Supply Chain Services, Nashville, Tennessee

The Problem

Mandatory national reporting of medical errors should be a top priority in Congress, according to many legislators. Dead by Mistake (http://www.chron.com/deadbymistake/), a Hearst Newspapers investigation of medical errors published in July 2009, revealed that with nearly 200,000 people dying from medical errors and infections in hospitals throughout the U.S. — and hundreds of thousands suffering from debilitating injuries — there's no national system for tracking deaths from medical care.

Many are now recommending a federal commission of physicians, researchers and patient-safety experts to review common errors and recommend proven solutions that would become federal regulations. Such an effort might involve regulations for marking a surgical site or a checklist for inserting a catheter. Both are known practices for avoiding medical errors, but their use is not widespread.

Others organizations, such as Consumers Union (https://secure.consumersunion.org/site/SPageServer?pagename=SHI_spp_petition) have renewed its call for public disclosure of medical mistakes and allowing patients to review the practices of local hospitals. Consumers Union supports (http://cu.convio.net/site/PageServer?pagename=spp_To_Delay_Is_Deadly_Executive_Summary) nationwide MVP reporting: mandatory, validated and public disclosure at a facility-specific level. Most state reporting systems now divulge only statewide information.

Still others believe that any efforts to address medical errors must wait until after a cooling down of the healthcare reform debate. But according to Basic to Basics, an August 2009 report from Public Citizen (http://www.citizen.org/documents/BackToBasics.pdf), implementation of 10 core cost-cutting patient safety measures would save an estimated 85,000 lives and $35 billion per year.

The financial toll of failing to follow safety procedures is astounding. Severe pressure ulcers cost an average of $70,000 apiece to treat or some $5.5 billion annually. A catheter infection costs $45,000, while each instance of ventilator-associated pneumonia costs $5,800. Avoidable surgical errors cost an estimated $20 billion a year, bed sores $11 billion and preventable adverse drug reactions $3.5 billion.

Broad-based Solutions

Public Citizen has proposed that in order to prevent medical mistakes, including hospital-acquired and healthcare-associated infections, healthcare providers use the following measures:

- A checklist to reduce avoidable deaths and injuries resulting from surgical procedures
- Best practices to prevent ventilator-associated pneumonia
- Best practices to prevent pressure ulcers
- Safeguards and quality control measures to reduce medication errors
- Best practices to prevent patient falls
- A checklist to prevent catheter infections
- Improve nurse staffing ratios

- Permit standing orders to increase flu and pneumococcal vaccinations in the elderly
- Beta-blockers after heart attacks
- Advanced care planning

Public Citizen also proposes five steps involving the government:
- Compel providers to use proven patient safety practices through regulations (HHS) and legislation (Congress).
- Invest in the supply of nurses; set federal minimums for nurse-to-patient ratios.
- Require mandatory reporting of adverse events with internal reporting and whistle-blower protections.
- Require hospitals to report physician discipline and sustain peer review.

Consumers Union has joined the call for action by citing the abiding lack of progress 10 years after the Institute of Medicine (http://www.nap.edu/openbook.php?isbn=0309068371) discovered that up to 98,000 people die annually from preventable medical errors. Consumers Union reviewed and reiterated four key IOM recommendations to make healthcare safer:

Implement safe medication practices: Following the IOM's recommendation, use the FDA to provide more oversight on drugs; use computerized physician order entry (CPOE) in hospitals; and disclose errors by facility through a national system.

Create accountability through transparency: Develop a system of facility-specific reporting of medical harm that is mandatory, validated and public.

Measure the problem: Use the Center for Patient Safety within the federal Agency for Healthcare Research and Quality (AHRQ) to measure the magnitude of medical errors.

Raise standards for competency in patient safety: Develop standards for patient safety competency and ensure that physicians, nurses and other providers are competent in patient safety practices.

(Other broad recommendations appear in HHS's Action Plan to Prevent Healthcare Associated Infections (http://www.hhs.gov/ophs/initiatives/hai/draft-hai-plan-01062009.pdf), which appears in the appendix of this document.)

One of the strongest proposals related to healthcare-associated infections comes from a coalition of organizations devoted to infectious disease, infection prevention, and public health and disease prevention. The Association for Professionals in Infection Control and Epidemiology (APIC) (http://www.apic.org), the Society for Healthcare Epidemiology of America (SHEA) (http://www.shea-online.org), the Infectious Diseases Society of America (IDSA) (http://www.idsociety.org), the Council of State and Territorial Epidemiologists (CSTE) (http://www.cste.org) and the Trust for America's Health (TFAH) (http://www.trustforamericashealth.org) joined forces to support a bill requiring hospitals and ambulatory surgical centers to report HAI data through an existing national reporting network managed by the Centers for Disease Control and Prevention (CDC) as a condition of participation in Medicare and Medicaid.

Others have gone so far as to recommend a new government agency to monitor patient safety efforts. Writing in the New York Times, Jim Hall, former chairman of the National Transportation Safety Board, argued for a National Medical Safety Board that would collect regional data on patient safety, determine preventive measures and make recommendations to state and federal regulators, hospitals and healthcare officials. "When such a board discovered new solutions to old problems, its advice would have the credibility that comes with independent investigation," writes Hall. "In some cases, the board might recommend practices that doctors are already aware of, but for some reason, do not employ; the public awareness that would follow would pressure hospitals to do better."

Fortunately, progress is being on a variety of fronts:

ARRA and ambulatory care: Twelve states will receive funds to improve care and prevent healthcare-associated infections under the Recovery Act. The 12 states – Maine, New Jersey, Maryland, Florida, North Carolina, Indiana, Michigan, Arkansas, Oregon, Utah, Wyoming and Kansas – will survey more than 125 ambulatory surgical centers (ASCs) before September 30, 2009, using a new CMS survey process and a tool developed with the CDC.

HHS funding: More than $9 million will be available in October 2009 for all states to make additional inspections of ASCs with the new and improved survey tool. The CDC will also make $40 million available to state public health departments to create or expand state-based HAI prevention and surveillance efforts. These programs are outlined in HHS' 2009 Action Plan to Prevent Health care-Associated Infections (http://www.hhs.gov/ophs/initiatives/hai/prevention.html).

State leadership: The New York Department of Health (http://www.health.state.ny.us/press/releases/2009/2009-06- 30_hospital_acquire_infection_report.htm) provides a hospital-by-hospital accounting of how many patients are getting sick from certain infections acquired during treatment throughout the state. The report is based on 2008 data submitted by 186 hospitals to the Centers for Disease Control and Prevention's National Healthcare Safety Network.

Legislation: HR 2937, introduced by Representative Jackie Speier (CA), would require hospitals to screen patients to identify those who are carriers of Methicillin-resistant Staphylococcus aureus (MRSA) bacteria as part of a strategy aimed at preventing the spread of MRSA infections to other patients. The bill requires hospitals to disclose MRSA infection rates to the public and encourages hospitals to follow other measures to improve patient safety.

Role of supply chain in reducing HAI's

Following are several recommendations made by supply chain professionals in relation to HAI's

Be prepared to respond to government pressures over "never events."

In discussing new and emerging roles for financial, infection control and supply chain professionals in preventing healthcare-associated infections, Kathy Wayne, CEO of APIC, offered this advice (http://www.hfma.org/publications/business_caring_newsletter/exclusives/The+Supply+Chain+Role+in+Reducing+Infections.htm):

- Look for hospitals to seek strategies to prevent never events.
- Consider products with infection control or antimicrobial properties, including an antimicrobial-impregnated dressing or suture or a silver-tipped, urinary tract catheter or an antibiotic-impregnated catheter. (See also Crosby, C., "Products that help reduce HAIs," Materials Management in Health Care, September 2008) (http://matmanmag.com/matmanmag_app/jsp/articledisplay.jsp?dcrpath=MATMANMAG/Article/data/02FEB2009/0902MMH_DEPT_AHRMM&domain=MATMANMAG).
- Be prepared to demonstrate savings, just as hospitals must demonstrate costs of HAIs. "Most of these infection-fighting types of devices and supplies cost pennies on the dollar in comparison to the cost of the infection," says Wayne.
- Use infection control professional support to overcome purchasing department resistance to more costly products.
- Consider antimicrobial dressings that have been proven to reduce bioburden (or the number of microorganisms) on the skin, as well as dressings designed to reduce bio-film, a sticky substance created naturally by the body after a surgical or other type of procedure.
- Work with ICPs to make the case that even though a catheter with antimicrobial properties may cost more, it prevents infections and therefore saves money.
- Use epidemiological data and studies—ideally backed up with economic analysis–to identify products with ICPs with infection-reducing properties that generate better outcomes and reduce costs.

Other ideas relative to supply chain include the following:

- **Deliver value:** "Balance the cost of supplies to care for our patients against the potential of improved are," advises Jay Kirkpatrick, CEO of Nashville Supply Chain Services (http://matmanmag.com/matmanmag_app/jsp/articledisplay.jsp?dcrpath=MATMANMAG/Article/data/02FEB2009/0902MMH_DEPT_AHRMM&domain=MATMANMAG). He advises supply chain executives to examine outcome statistics to determine if a given product improves infection rates and contract the product at a price that balances cost and value. Also ensure that a well-thought out value analysis process is in place within the organization. Involve key executives, develop reports on cost reductions and total supply costs along with justifications, and keep executives informed on supply chain successes

- **Grasp the discipline of infection control:** Work with infection control, counsels Kirkpatrick. This requires that supply chain professionals "become educated in the area of hospital-borne infections, understand the clinical efficacy of various administration techniques and procedures and ultimately develop a strong relationship with the infection control nurse." (For more information see CDS materials at http://www.cdc.gov/ncidod/dhqp/, as well as http://www.infectioncontroltoday.com/).

- **Collaborate with ICPs to prevent infections.** Cindi Crosby, Vice President, Clinical Operations Management, Cardinal Health, Dublin, Ohio (http://www.hpnonline.com/inside/2008-12/0812-IC-Organisms.html), recommends that supply chain professionals do the following: make ordering products that reduce infections a priority; talk to clinicians to learn about products and their use; study the facility's infection control data and national guidelines; contact manufacturers about opportunities to ensure correct product use, involving the facility's education team and infection control staff; review use or purchase histories of products; and use electronic surveillance systems instead of manual surveillance.

- **Stay up-to-date on infection prevention and control as practiced in healthcare facilities.** Materials Management in Health Care (http://www.matmanmag.com/matmanmag/images/pdf/2008PDFs/1208BG_MMHC.pdf) reported that in 2008 more virulent strains of MRSA caused 76 percent of professionals to implement additional MRSA intervention and transmission prevention strategies. Many continue to struggle with monitoring and reinforcing hand hygiene protocols. Such data is likely to change over time, so it's important to stay current by reading the latest reports and studies.

- **Be aware of the concept of "bundling" or "bundles," clusters of validates procedures for patients at risk.** (see http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/ImprovementStories/BundleUpforSafety.htm for a more extensive explanation). Bundling involves care team collaboration and a careful analysis of patient demographics, historical infection trends, antimicrobial-resistance patterns, resources, data on cost-effectiveness of products, and previous initiatives (http://www.hpnonline.com/inside/2008-12/0812-IC-Organisms.html). It also involves performance of four or five steps. If only three of four steps in a bundle are performed or if the steps are performed for one patient and not another, the healthcare provider gets a failing grade (http://www.hpnonline.com/inside/2009-01/0901-IC-Bundling.html).

- **Provide and take advantage of sound educational programming.** Mark Semmelmayer, communications manager, Kimberly-Clark Health Care, documents the impact of his company's Not on My Watch tour, including the role of in-facility events and communication to focus staff awareness and build empowerment. "An organizational commitment that facilitates empowerment and confidence in the ability to improve patient care is contagious and becomes a rallying point for everyone," writes Semmelmayer (http://www.hpnonline.com/inside/2009-01/0901-InfectProtect.html). (For an example of how one organization used the Kimberly-Clark program, see http://www.novationco.com/pressroom/releases/news_080228.asp).

- **Make a concerted effort to adhere to standards.** Chuck Hughes, general manager and lead educator for SPSmedical Supply Corp., Rush, New York, advises manufacturers to be aware of and follow best practices with regard to proper attire, hand washing and authorized entry into restricted areas (http://www.matmanmag.com/matmanmag_app/jsp/articledisplay.jsp?dcrpath=MATMANMAG/Article/data/03MAR2008/0803MMH_FEA_InfectionControl&domain=MATMANMAG). Also important is sponsorship of certification scholarships for staff working in sterile processing and low-cost or no-cost CE programs at facilities that reinforce best practices as defined by standards of the Association for the Advancement of Medical Instrumentation (AAMI).

- **Engage in infectious disease disaster planning.** Address infection control issues such as surveillance, isolation, protective equipment, hygiene, quarantine, cleaning and disinfection, treatment, prophylaxis, vaccination, and post-mortem care, advises Terri Rebmann, Ph.D., R.N., C.I.C., associate director for curricular affairs, Institute of Biosecurity, Assistant Professor, Division of Environmental and Occupational Health at Saint Louis University, School of Public Health. Be sure to expand policies and procedures while making them more flexible (http://www.matmanmag.com/matmanmag_app/jsp/articledisplay.jsp?dcrpath=MATMANMAG/Article/data/08AUG2008/0808MMH_FEA_Hotline&domain=MATMANMAG).

RESOURCES

Geisinger Steels Itself for Supply Chain Success
http://www.hpnonline.com/inside/2008-07/0807-MMDOY.html

Compendium of Strategies to Reduce Healthcare-Associated Infections in Acute Care Hospitals
http://www.shea-online.org/about/compendium.cfm

The Direct Cost of Healthcare Associated Infections and the Benefits of Prevention
http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf

Health-Care-Associated Infections in Hospitals: An Overview of State Reporting Programs and Individual Hospital Initiatives to Reduce Certain Infections (GAO)
http://www.gao.gov/products/GAO-08-808

Introduction to Evidence-Based Practices and Bundling (Premier Safety Institute)
http://www.premierinc.com/quality-safety/tools-services/safety/topics/bundling/

X-ray Machines Spread Bugs in ICUs
http://www.medpagetoday.com/CriticalCare/GeneralCriticalCare/15411

Perforated gloves tied to risk for surgical site infection
http://www.clinicaladvisor.com/Perforated-gloves-tied-to-risk-for-surgical-site-infection/article/140628/

Fresh approaches to stemming the MRSA tide
http://www.matmanmag.com/matmanmag_app/jsp/articledisplay.jsp?dcrpath=MATMANMAG/Article/data/08AUG2009/0908MMH_FEA_InfectionControl&domain=MATMANMAG

Health-Care-Associated Infections in Hospitals: Number Associated with Medical Devices Unknown, but Experts Report Provider Practices as a Significant Factor
http://www.gao.gov/new.items/d081091r.pdf

Dispelling the Myths: The True Costs of Healthcare-Associated Infections
http://www.sealshield.com/apic.pdf

State Laws Relating to Hospital Acquired Infections
http://www.ncsl.org/IssuesResearch/Health/HospitalacquiredInfectionsHomepage/tabid/14084/Default.aspx

Re-hospitalizations among Patients in the Medicare Fee-for-Service Program
http://content.nejm.org/cgi/content/full/360/14/1418?ijkey=3CQjS3yxXjOtY&keytype=ref&siteid=nejm

Testimony in Support of the MRSA Bill
http://www.safepatientproject.org/pdf/Written%20Testimony%20of%20Michael%20Bennett%202009%20Senate%20Finance.pdf

Adverse Events in Hospitals: Overview of Key Issues
http://www.oig.hhs.gov/oei/reports/oei-06-07-00470.pdf

Medicare Nonpayment of Hospital Acquired Infections
http://www.ncsl.org/IssuesResearch/Health/MedicareNonpaymentforHospitalAcquiredConditio/tabid/14747/Default.aspx

HHS Action Plan to Prevent Healthcare-Associated Infections
http://www.hhs.gov/ophs/initiatives/hai/index.html

Potentially Deadly Infection Doubles among Hospital Patients over the Last Five Years
http://www.ahrq.gov/news/nn/nn042308.htm

Healthcare-Associated Infections: A Preventable Epidemic
http://oversight.house.gov/story.asp?ID=1881

Congressional Legislation Concerning Hospital Infections
http://www.safepatientproject.org/2009/06/congressional_legislation_111t.html

MRSA Screening Bill Pushed in Congress
http://www.safepatientproject.org/2009/06/mrsa_screening_bill_pushed_in.html

State hospital-acquired infection public reporting and MRSA prevention bills under consideration in 2008
http://www.consumersunion.org/campaigns/2008%20state%20legislative%20web%20chart.pdf

Prevent Infection
http://apic.informz.net/apic/archives/archive_495488.html

MRSA Fact Sheet
http://www.safepatientproject.org/pdf/CDC%20MRSA%20Fact%20Sheet%20-%20English.pdf

Hospital-acquired infection public reporting and MRSA related bills under consideration by states in 2009

http://www.safepatientproject.org/2009%20state%20legislative%20web%20chart.htm

APPENDIX

HHS Action Plan to Prevent Healthcare-Associated Infections: Executive Summary

Background on Healthcare-Associated Infections

The Department of Health and Human Services (HHS) "Action Plan to Prevent Healthcare-Associated Infections" (Plan) represents a culmination of several months of research, deliberation, and public comment to identify the key actions needed to achieve and sustain progress in protecting patients from the transmission of serious, and in some cases, deadly infections.

Healthcare-associated infections (HAIs) are infections that patients acquire while receiving treatment for medical or surgical conditions. HAIs occur in all settings of care, including acute care within hospitals and same day surgical centers, ambulatory outpatient care in healthcare clinics, and in long-term care facilities, such as nursing homes and rehabilitation facilities. HAIs are associated with a variety of causes, including (but not limited to) the use of medical devices, such as catheters and ventilators, complications following a surgical procedure, transmission between patients and healthcare workers, or the result of antibiotic overuse.

Healthcare-associated infections exact a significant toll on human life. They are among the leading causes of death in the United States, accounting for an estimated 1.7 million infections and 99,000 associated deaths in 2002. In hospitals, they are a significant cause of morbidity and mortality.[1] Hospital stays for Methicillin-resistant Staphylococcus aureus (MRSA) infection have more than tripled since 2000 and have increased nearly ten-fold since 1995.[2]

Four categories of infections account for approximately three quarters of HAIs in the acute care hospital setting. These four categories are: 1) Surgical site infections; 2) Central line-associated bloodstream infections; 3) Ventilator-associated pneumonia, and; 4) Catheter-associated urinary tract infections. In addition, infections associated with Clostridium difficile and MRSA also contribute significantly to the overall problem. The frequency of HAIs varies by location. Currently, urinary tract infections comprise the highest percentage (34%) of HAIs followed by surgical site infections (17%), bloodstream infections (14%), and pneumonia (13%).[3]

In addition to the substantial human suffering exacted by HAIs, the financial burden attributable to these infections is staggering. It is estimated that HAIs incur an estimated $28 to $33 billion in excess healthcare costs each year.[4] Whereas not all Staphylococcus aureus infections are healthcare-associated, healthcare charges for Staphylococcus aureus bloodstream infections for Medicare patients exceeded $2.5 billion in 2005.[5]

HHS Action Plan to Prevent Healthcare-Associated Infections

In response to the increasing threat of HAIs and national and international concern, the Department has composed a Steering Committee of senior-level representatives from the Offices and Operating Divisions of HHS and conducted a number of in-person meetings and conferences with Federal experts. The Department's Action Plan toward the prevention and elimination of HAIs includes goals toward which the healthcare and public health communities have been moving over the past several years. Despite uncertainty about whether there ultimately will be a limit on meeting this goal, the decision to move forward has been embraced by the Steering Committee.

A five-point draft strategy was developed by HHS for the Action Plan and included:

- Establish an HHS Steering Committee for the Prevention of Healthcare-Associated Infections to develop an Action Plan.
- Begin to prioritize, in partnership with the HHS Secretary's Healthcare Infection Control Practices Advisory Committee (HICPAC), the significant scientific questions that need to be addressed to move the field forward rapidly and the current 1,200 recommended clinical practices to facilitate rapid implementation amongst healthcare organizations.
- Identify and explore policy options for regulatory oversight of recommended practices and provide critical compliance assistance to select hospitals.
- Work to establish greater consistency and compatibility of HAI data through developing standardized definitions and measures for HAIs.
- Strive to build on the principles of transparency and consumer choice to create incentives and motivate healthcare organizations and providers to provide better, more efficient care.

Some of the most prominent clinicians, scientists, and other public health professionals within HHS in concert with key individuals from other federal Departments worked to develop a road-map for addressing this important public health and patient safety issue in the short- and long-term. Five working groups of the HHS Steering Committee met this past year, deliberated on known facts, research needs, and how to prevent HAIs. The primary topics of the five working groups with their respective agency leads were:

- The Prevention and Implementation working group led by the Centers for Disease Control and Prevention (CDC),
- The Research working group led by the Agency for Healthcare Research and Quality (AHRQ),
- The Information Systems and Technology working group co-chaired by the Office of the National Coordinator for Health Information Technology (ONC) and CDC,
- The Incentives and Oversight working group led by the Centers for Medicare and Medicaid Services (CMS), and,
- The Outreach and Messaging working group led by the Office of Public Health and Science (OPHS).

The HHS Steering Committee and its sub-groups, which composed the Action Plan to Prevent Healthcare-Associated Infections, accomplished the following:

- Identified metrics with corresponding national five-year prevention targets
- Identified gaps in the current knowledge of HAIs and created an agenda for current and future research on HAIs
- Recommended standardization of data elements and adoption and use of data and technology standards to track HAIs
- Documented the current regulatory and administrative authority and initiatives/strategies of CMS (working with other HHS Operating Divisions and federal partners) used to prevent and combat HAIs
- Developed a progressive campaign to release and publicize the Action Plan in concert with a number of national partners in the federal, academic, non-profit, and private sectors. This messaging and communications strategy will target a number of audiences using the principles of social marketing and risk communication to also reach the public at large.

Top Ten Messages on HAIs and the Action Plan[6]

- Many healthcare-associated infections are preventable.
- A systemic approach to reducing the transmission of disease can be more effective than disease-specific approaches.
- Developing and supporting basic and translational studies to address the gaps in the science in this field will allow generation of additional strategies to reduce the risks of HAI transmission.
- It will take a strong partnership between federal and local/state governments and communities to truly help prevent HAIs. HHS is committed to this partnership and many of its Operating Divisions are and will be involved.
- The education of best practices for providers and other healthcare personnel is critical to prevent HAIs.
- Specific metrics and national targets have been developed by HHS in concert with national experts on controlling infections.
- Educating patients on HAIs and how to prevent them is a critical part of the national effort.
- An informed media can help promote the education of the American public about the need to prevent HAIs and what HHS and its partners are doing.
- Preventive steps to control and prevent HAIs are cost-effective, save lives, and reduce disability for Americans.
- The time to act on HAIs is now, and HHS and its partners are working closely with providers, health systems, community leaders, and governments to help prevent HAIs.

Priority Recommendations of the Prevention and Implementation Group

- Progress towards five-year national prevention targets
- Use and improve the metrics and supporting systems needed to assess progress towards meeting the targets
- Consider recommendations, grouped by priority module, outlined for each of the guidelines addressed

Priority Recommendations of the Research Group

- Perform Research Projects to Address Specific Knowledge Gaps (Basic Science, Epidemiology, and Practices)
    - o Basic Science
        - Develop strategies for preventing and/or eliminating biofilms associated with medical devices
    - o Epidemiology
        - Study the epidemiology of bloodstream infections that occur outside of the hospital
        - Establish the preventability of Clostridium difficile infection (CDI) through a regional hospital collaborative intervention
        - Establish the preventability of unnecessary antimicrobial use through a multi-center collaborative intervention
        - Establish the preventability of surgical site infection (SSI) through a multi-center collaborative intervention

- Practices
- Assess the effectiveness of the ICU-wide application of a MRSA decolonization strategy
- Perform Research Projects to Enhance the Implementation and Impact of Existing, Evidence-Based Infection Control Practices
  - Investigate the human cultural and organizational barriers to successful implementation of practices at the unit and institutional levels
  - Develop and evaluate novel and automatable strategies for measuring HAIs
  - Evaluate and validate standardized post-discharge surveillance methodology
  - Develop proxy measures for ventilator-associated pneumonia (VAP) (i.e., acute lung injury) for inter-facility comparisons
  - Develop standardized methods for measuring and reporting compliance with broad-based prevention practices (e.g., hand hygiene)

Priority Recommendations of the Information Systems and Technology Group

- Form an Interagency Working Group to enhance the federal capacity to lead a national prevention strategy
- Conduct a comprehensive HAI database inventory to guide future plans for near-, mid-, and long-term integration and interoperability projects and to establish the extent of definitional alignment and data element standardization needed to link HAI data across the nation
- Enhance individual agency systems to extend their coverage or establish new interfaces with other systems
- Accelerate transition to electronic reporting by healthcare facilities to reduce their reporting burden and increase timeliness, efficiency, comprehensiveness, and reliability of the data

Priority Recommendations of the Incentives and Oversight Group

- Improve regulatory oversight of hospitals and CMS oversight of the hospital accreditation program by refining the current method of measuring Accreditation Organization performance, enhancing surveyor training and tools, and adding sources and uses of infection control data
- Continue to incorporate measures of infection prevention and outcomes into Hospital Value-Based Purchasing (VBP) Plan methodology through implementing performance-based payment for hospitals, including measures of infection prevention and outcomes as a basis for payment
- Expand measures in CMS Hospital Compare which improves the quality and transparency of hospital care by increasing public accountability and provides consumers access to important hospital quality of care measures

Priority Objectives of the Outreach and Messaging Group

- Increase support for the HHS Action Plan to Prevent HAI's
- Increase knowledge and awareness of key messages and prevention practices among providers, consumers, the media, and general public

CONCLUSION AND CONTACTS

Healthcare-associated infections are one of the most preventable causes of leading mortality in the U.S. The infections also add a significant economic burden to the healthcare system. The Department, in conjunction with experts, has developed an action plan to help reduce, prevent, and eventually eliminate much of the significant burden to our nation, health systems, communities, and individuals of HAIs.

We strongly encourage you to read the HHS Action Plan to Prevent Healthcare-Associated Infections. For additional details on what is in the Action Plan or on what HHS is doing to address this critical public health issue, please contact the HHS Office of Public Health and Science.

[1] Klevens RM, Edwards J, Richards C, Horan T, Gaynes R, Pollock D, Cardo D. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. *Public Health Reports* 2007; 122:160-166.

[2] Elixhauser A and Steiner C. Infections with Methicillin-Resistant Staphylococcus Aureus (MRSA) in U.S. Hospitals, 1993–2005. *AHRQ Healthcare Cost and Utilization Project Statistical Brief* 2007; 35:1-10.

[3] Klevens RM, Edwards J, Richards C, Horan T, Gaynes R, Pollock D, Cardo D. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. *Public Health Reports* 2007; 122:160-166.

[4] Scott Rd. The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention, 2009. Division of Healthcare Quality Promotion, National Center for Preparedness, Detection, and Control of Infectious Diseases, Coordinating Center for Infectious Diseases, Centers for Disease Control and Prevention, February 2009.

[5] http://hcupnet.ahrq.gov/

[6] That HHS and Collaborators will communicate these to many stakeholders and the public – including healthcare organizations, professional provider organizations, governmental agencies, non-profit public health organizations, and the public.

CONCLUSION

The Fall IDN Summit Hospital Acquired Infections Peer-to-Peer Learning Exchange Lunch took place at the Gaylord Texan on Wednesday, September 23rd from 11:30 am - 12:30 pm. The session was attended by supply chain executives from various stakeholders: health systems, GPOs and suppliers. Below, please find the edited transcripts of the discussions that took place during the exchange.

TRANSCRIPT

SHARON: All right. Let's go ahead and get started. I'm Sharon, and I want to thank you all for coming here. I am not the speaker. I will be the facilitator for Healthcare Acquired Infections.. In case somebody just came in, we're talking about what number this is, and he said he thought he read somewhere it was three. I don't know that exact number, but it's one of the leading causes of death, and that is very scary to say.
Participant: The CDC's numbers are 97,000 people a year.
SHARON: That's just astounding. So probably – what I think will be helpful, and you guys tell me if it's not helpful, I'd just like to hear what some people are doing for certain healthcare acquired infections. I thought maybe we could do some dialogue, conversation like that. So whoever wants to jump out there, go ahead. Nobody wants to go? So are most of you guys are from hospitals? Are you providers? Those of you that are in hospitals, are you all using the IDN manuals for the infections?
Participant: Yes.
SHARON: Having good success with that?
Participant: Can I ask a question on that? Do people talk about the bundle they use? In talking to people, the content of the bundle varies. I'm just curious what people – how people respond to the bundle.
SHARON: On the back bundle is – has that elevated 30 to 45 degrees, PUD and PDT proto labs. That is core. I tell a lot of people about it. I don't know if anybody else has done that. That's the thing I've seen.
Particpant: That pretty common?
Participant: Yes.
Participant: As well as the additional learning implementing oral care standard, but that's newer.
Participant: I have a question. Just a general question. A lot of the – a lot of hospital acquired infections, physicians are the cause because if you don't watch how you walk, and you bump into the patients with jackets that are carrying that, and I – it's a known fact. What are we doing?
SHARON: I'll direct that. I don't know. Hospitals are learning now. It's a health issue for hospitals, and I don't know if anybody is addressing that. And if they did address that, I don't know. There are physicians before. I don't know how receptive they would be to it. I mean, I'm sure some of them would.
Participant: Well, people with the issue of taking – a lot of old time pediatricians, they always wore bow ties because kids would grab on to the ties, and that used to spread the disease. Now that the reports are out, there's a good chance that the ties and jackets are spreading it. It's very interesting that very few people know anything about it other than we all know about the hand washing, which, you know, we have all these machines all over the place with the gel, but still that's a conveyor of a potential infection.
Participant: Our surgical chief, he doesn't wear the tie. He goes without the tie. They want to show their residents what to do.
Participant: Look at what we know. And I'm not sure if you mentioned stethoscopes earlier, but what do we know about stethoscopes and the germs, and we're still putting them around our necks.
Participant: I'm an infectious disease specialist. I think when you really define the context to the healthcare associated infections, what really worries the clinicians more so than anything else is the emergence of commensal organ symptoms that have fallen in the context of a normal floor as opposed to a pathogenically (inaudible) organism.
There was a study that was published a couple weeks ago in the New York Journal of Medicine with respect to four beaches in South Carolina that were – they were sampled, and the samples from these four beaches were heavily contaminated with methicillin, amoxicillin resistant staph, so when you really look at the ideology of the emergence of these community acquired organisms that have developed some sort of a genetic phenotype in becoming more and more resistant to multidrugs, and you bring that in the context of a heavily controlled environment such as hospitals, and now you are really disseminating it to the attires of the physicians and the healthcare providers.
You really have to be very cognizant about the dangers that may be associated with some of these commensal organisms, so the idea is not whether or not the physician or the healthcare provider is actually carrying a multidrug resistant. The challenge is really controlling an environment that is highly susceptible to these organisms, obviously, and it really doesn't have to be across the board.
I mean, if you really go back – I just came back yesterday from nearly about a four to five day crash course on the Joint Commission requirements, Joint Commission has ruled out a number of key requirements around the elements of performance that fall into efficient safety as part of the national issue safety goals as well as into hospital acquired healthcare associated infections, so really, the challenge is, how you really control the influx of these commensal organisms from a community oriented environment, i.e. skilled nursing homes where the majority of these organisms may be residing, and when they are transferred to the hospitals, how do you really balance this out?
The nonacute care for alternate sites were not heavily required to adhere against the Joint Commission's requirements because they were not traditionally regulated by Joint Commission or any other agency. Typically, they were functioning under the auspices of the state requirements, and now, really, we are just beginning to scratch the tip of the iceberg to say, we've got to go back and control that. Because as much as you want to reach your hospitals, at the end of the day, you know, it really is hitting your cost, and when you are really exposing the hospitals against the very, very tough set of regulatory requirements, then it 7 becomes a challenge for them to really abide by all of them.
Participant: I think just to build on what you're saying, a hundred percent agree. I just flew in from Arkansas where we kicked

off the first ever research that's going to be done, and it's community based, where we're sponsored by the healthcare system in Jonesboro, supported by the governor's office, and goes across all regions of the business community, schools, churches, transit authority, everywhere. All we're doing is reaching out to the community to educate, provide access to and monitor the use of hand hygiene, and literally every classroom, every building, every business in the Jonesboro area, and it's because they have a five time higher incidence of MRSA in their healthcare systems than anywhere else in the United States, and what they're finding is 70 percent of the people that walk through the front door have some form of multidrug resistant organism, heavy, heavy, MRSA's and I never say it right. Acinetobacter. And what's really interesting about this is they have 10-year baseline on MRSA through their ERG, Blue Cross, Blue Shield, and we're going to ask them to measure after going heavily – getting heavily 8 entrenched in the community to measure now what happens in terms of the DRG applications for multidrug resistant organisms, because if you have an MRSA problem, you're going to have a DRG problem. But what's really interesting and you brought up patient safety guidelines, and everybody says, how am I going to do this? But Rule 13 says we need to get patients and families involved in hand hygiene, and what are you doing as a hospital to get patients and families involved in hand hygiene, which is a very difficult thing to do when you have bedbound patients. It goes back to nursing homes. You know, how many people have brought in where they have no infection prevention in nursing homes, people having to operate, what do they do? They bring them to the hospital. So I think one of the biggest challenges, just to the point that you're saying, that we have in healthcare is controlling the multidrug resistant organism walking in the front door of the hospitals, and that means that – and it's as simple as hand hygiene and critical surface disinfection and doing the simple things that we know every day are important to prevent the spread and infection points for cross contamination, and it all starts with hand hygiene.
Participant: I think also, part of it really ties up to physician's education, not – I mean, the other thing to understand are the ideology of transition for MRSA or DRG's. But really, new studies are coming out these days with respect to cedeficil as the primary ideological agent of the PMT, colitis, and right now, you know, there are some phenotypes of cedeficil that could not be really treated if you are able to typically identify, you know, the culprit of which one happens to bear pathogenic gene and which one does not. So not all the cedeficils are created equal, so, along that line, you really having access to these type of knowledge of the clinicians can really reach out to the infection control specialist or to the clinical microbiology department and because I want to phenotypically identify whether I'm dealing with a multidrug resistant as opposed to an innocent c-def. And that really will prohibit the use of extended antibiotic treatment in the hospitals. So that really ties up, again, with how much education do you need across the board? Oftentimes, what I see when I go into the hospitals, and I see that there is a value system that is focusing on the various stages of the surgical or the pharmacy side of it. You really don't see infection control to be very heavily integrated into 10 the value of the hospital, and that to me is a bad omen.
Participant: It's funny because we went to a round table where health team services was kicking off their HAI recommendations for the coming year, and the board had all federal sitting on it, and there wasn't one infection preventionist sitting in that community to talk about infection prevention. They tell us these are the new guidelines, but how do we implement them? There's not – whether it's a healthcare system or state or a federal body giving that, you know, this is what we're going to do. We have to bring infection preventionists into that circle because they're the ones that have to make it happen.
Participant: Are there similar situations here that on the H1N1 prescriptions, there are some strict mandates from the hospitals that require all employees to be vaccinated because there are some institutions –
Participant: One state, I believe. I believe only one state requires – unless it's changed recently. I think it's New York or Massachusetts or something.
Participant: Some hospitals, actually, you know, I always –
Participant: Where it was mandated, New York State Department of Health.
Participant: Yes. New York. Right. But some 11 hospitals have really taken upon themselves – you know, the one that I happen to be part-time in the medical school was Virginia University Medical School has required all of its systems, hospital systems, employees to be vaccinated, and it's mandatory. They have given them, actually, a due date by middle of October that all the employees have to be vaccinated. So there are some institutions that are doing that. Do you see that becoming more common in your hospitals? You do?
Participant: At our system, they have the option to decline at this time, but we – in the Minneapolis area, we have about seven hospitals and – because that's how we treat our flu vaccine too, but we're hoping we can eventually move towards mandates. The last study I read, 200,000 patients a year get the flu from their clinician or their bedside provider.
Participant: Things are so serious in the New York City hospitals, it's required for every city employee, which is 39,000, and if they're not vaccinated by November 30th, they will be off payroll. Plain and simple.
Participant: Really?
Participant: Are they sure they're going to have the vaccine by then? This must be mid October.
Participant: There are two stages. One was the 12 seasonal flu that they have to take, and two, they did make that statement that if it's available, you will be expected to take it. We all know that the state departments are going to spread the H1N1, it's theirs. If it's not available, of course you can't get it, but if it's available, you will be expected to receive it.
Participant: That's how New York is getting, too.
Participant: So what do you do, then, if you're allergic to duck embryo?
Participant: Then you have to get a letter from your primary care physician. There are exceptions. You have to get a letter, though. You cannot get a letter from the physician in the hospital saying you're allergic. You have to get a letter from your primary care physician saying that your allergic.
Participant: How do you know if you're allergic?

Participant: When you get your second vaccination.
Participant: But there are some bylaws that are coming out for certain population of patients where a monovalent vaccine is really indicated as opposed to the polyvalent, so the CDC is defining that for H1N1.
Participant: That would be nice. Is anyone doing anything with regard to long patient waits and waiting rooms? And we talk about them walking in through the door, and then we put them in a room with a bunch of sick people and then wonder why things spread. So we're looking at that in our system. Has anyone – at least right now, if we identify somebody's coughing and has flu-like symptoms, we do get them out of that area, but you don't always have the physical space to do that.
Participant: At our hospital, they are set up for – separate for flu patients area. If we are expecting or they're suspecting that the person has the flu, they are separated. They don't want to clog the ER with the flu.
Participant: They have to put on masks. If they're coughing and sick, they will be given masks.
Participant: But of course, who's really dangerous are the ones that don't have the symptoms yet, who are coming in there, especially children that are touching everything.
Participant: We're seeing flu stations get put up in some facilities where you walk in to be checked because you think you have a flu, and there's hand hygiene, a face mask, different things like that that can be made available with signage. I mean, the big thing is communicating what you want them to do, and you know, most hospitals don't have the luxury of having a 4 sick room and a clean room, so you're going to have to 2 provide some help.
Participant: Not only that, if you remember what 2 happened in May to June, the volume of people coming into the emergency room just
Participant: On the news this morning, Austin is already getting hit pretty hard with the flu patients, and they set up triage tents in the parking lot to funnel people through that process, and if they are truly, really sick, then they need to proceed in to get more treatment. If they're not exhibiting extreme symptoms at that point, they're getting a to the flu tent and sent back home to recuperate, but they're not going to have them go into the emergency department, and it's a series of tents set up. That was just on the news this morning.
Participant: I guess my worry is that – I mean, one of the rooms that my hospital has set up is that if you have the – if you strike a fever, then for 24 hours you're not allowed to come back to the hospital. And how many people really go and get a clinical evaluation within the first 24 hours to determine whether it's a viral ideology of some sort and past, you know, the rule in or rule out. They don't. So I mean, at some point, this is going to really lead to labor shortage, because if the healthcare workers are not allowed to come in because she's got a fever, so the first 24 hours I have a fever, all right, second 24 hours comes in and then you continue to have a fever, you go to your clinician, and he has to run the tests, you know, to determine – so by the time, really, this thing is worked out clinically, you know, you may be 72 hours into it, and yet, you know, in this day and age with the shortages of, you know, healthcare providers in the care areas, it's going to be a major challenge, you know.
Participant: Well in Minnesota, at least Twin Cities, we're encouraging people to stay home, too, not even go, and they're not even running tests to make sure because it doesn't, you know, what are you going to do anyway?
Participant: We're already seeing a shortage in our hospital because school started in the middle of August, and it broke out in the all the schools, so, of course, a lot of nurses, female, young, have school-age children, so they're out with the kids, out themselves. We're not running the tests either, and we're starting to experience that, and our emergency rooms keeps breaking records, and every time we think it's as high as we can go, it's breaking another record, so we're seeing it on both sides, and I'm really starting to get worried as to where it's all going to end.
Participant: Yeah.
Participant: I have a question about New York. I work with Sodexho. What do you do with your management people from other companies that are working within the hospitals in New York?
Participant: We've been told that they will have to get – they will have to provide documents that they have the flu shot, especially if they're in any patient care area.
Participant: Well, yeah, food service and environmental –
Participant: Yeah. They have to. Just like all our volunteers have to be vaccinated.
Participant: Where we are, there is medical policy that everyone must have the vaccination, number one, which includes the vendors, the visitors, anyone who's entering the hospital. They must have it. Either they have to get the vaccine, or they must have some kind of certificate. For us, they may get the certificate.
Participant: So patient visitors, you say?
Participant: I'm not sure about patient visitors – to the nursery would have to. I think you, you know, considering our volume, it would be almost impossible to check every single visitor coming in, and we can't control that, but certain things we can control, but I think to the nursery is one of them.
Participant: That goes back to what we were talking about earlier. It's so crazy. We cause the care givers to wash their hands, to go in with gloves and masks and let this giant mass of, you know, 30,000 admissions a year at the hospital, which means there's 30,000, at least, guests coming in the front door. What are you doing to try and mitigate that a little bit? In your facility, have you done anything to try and, you know, stop and say, hey, wash your hands?
Participant: When they come in, we have one of those dispensers with big signs, please encourage the patient you're visiting to please use this. But like many urban hospitals, the amount of people coming in just miss it. Some will do it. Some won't. Now, there was one hospital I saw – I thought it was a good idea. As people came in, they funneled them like a bank line, so it got smaller and smaller, and there was a machine right in front, so it almost forced them to do it, as opposed to just opening up and letting the people come through. That's probably -

Participant: Small suggestion is a pilot program we've done is – when people are signing in, do you make them wear the name tags, or do you not? Do they have to sign in?
Participant: No, they have to give their name at the desk.
Participant: Okay, some of the hospitals now are – nobody gets past that desk until somebody monitors them washing their hands.
Participant: That's funny because the patients – they have the hand sanitizer next to the basket. They have to wash.
Participant: You know, the hospitals traditionally – under the Joint Commission's requirements, the hospitals have to follow the credentialing with their suppliers and their vendors and you know, as part of that, it's going to be really tough from an enforcement perspective because, you know, you're not dealing with large national suppliers that understand the pathway of going after credential. So you could technically say, as part of your credentialing, you are also required for all your reps and everyone coming into the hospital have to be vaccinated, but when you're dealing with a local supplier, whether it's a laundromat or catering services or cleaning services, that's going to be tough to enforce this type of requirements at the local level. So you know, if – if you really look at the history of polio, how we have been able to eradicate it from the face of the planet. I mean, it took over 19 decades to do that. Now we're trying to stop a pandemic within the matter of one season. That's just not going to happen. So there will be some, you know, fallout, I guess. The concern that we have, all of us is in the care area right now, you start applying these types of restrictions with respect to the work flow, ultimately that's going to affect your throughput. Hospitals are not ready for a major obstacle of this magnitude to go into various areas because right now if you really look at it, the infection control is, like, I'm responsible. If you look at this and tell you what the challenges are in terms of the transmission of the infectious ideologies, and if the clinicians are held against those restrictions, you're going to get through the all work flow, you know, PACU, all the other areas that will be impacted in some way or fashion.
Participant: I would think the best we can hope for, because we're not going to be able to completely control this, is just to get the community and the public to think about making it a practice to wash their hands. It's that simple. And we all know – it amazes me. I watch people come out of bathroom, even at an APIC conference, who don't wash their hands. You want to arrest them. 20
Participant: Right. You're right.
Participant: I think the figure is still about 30 percent. When they put the hidden cameras in the bathrooms –
Participant: And then they come out and shake your hand.
Participant: Yeah. You know, and of course I think a recent study just came out that hand washing doesn't necessarily help as much with some of the disease transmission. It's covering the cough, but it's not – and then what's in the air, so it doesn't matter how much you wash if somebody's coughing in your face.
Participant: The good thing is that maybe as much awareness and education you're doing at the public level, you know, hand is probably the safest area – your worry is that if you're going in, you know, you want – you come across somebody in the care area, just make sure you don't grab their arms, because they sneeze into their arm, so that ultimately becomes the most infected area. So just make sure you don't come in contact with that area.
SHARON: You're talking about the sneezing and the coughing. Yesterday, there was somebody right behind me, and they were coughing the whole time and sneezing, and that's all I could think about was, I'm going to be sick.
Participant: Yeah.
Participant: And he wasn't coughing in his arm either. I started to educate him. Particpant : I have a question. This is going to be very centered around the flu because that's what's on everyone's mind right now, but ongoing things in the hospital that involve infections have to do with administration of drugs, of food and procedures. And we know that damage relates to bacterial group, and I manufacture temperature instruments, so I'm curious whether there is a focus on managing temperatures more to reduce hospital acquired infections.
Participant: I have an answer to that. What we do is we have this device called isomax, and all the medication, food, are connected with that.
Participant: Do you see a trend in the industry – or others, do you see a trend in going more toward electronic monitoring? **Participant:** I think – we have off hours all weekend, so we started with that.
Participant: I think people would be stretched to try to equate 1– if the temperature went out of whack, and somebody got an infection, I think that would be very hard to prove. Most people do it because it's a 22 Joint Commission requirement. How do you know the temperature didn't – the refrigerator didn't conk out for four hours and just before you came in, it went back on, and – but I think it would be kind of a stretch to prove a relationship –
Participant: – with a specific incident. But as a general practice –
Participant: Yes.
Participant: The reason it's a Joint Commission requirement –
Participant: Absolutely. That's why most of us do it, because it's a Joint Commission requirement. I want to go back to your statement before about c-def. In many cases, you could almost plot c-def occurrences with antibiotic use. It's always one for one, especially elderly patients over 65 or 70, certainly antibiotics are always 100 percent sure of giving them c-def. If you could control the use of antibiotics in certain groups of patients, you'd probably have a better chance of controlling this WC, which is – by the way, certifications were proven very difficult to do that.
Participant: I think part of that also gets back to the education of the clinicians. I have seen in the residency program in which I participate individuals that are rotating through the infectious disease 23 department. They're knowledge, you know, at the early onset of their clinical training is very limited in understanding some of the dynamics of working out, you know, these bugs. So let's say for the sake of the argument, if you've got an indwelling catheter that has been inline for, let's say, 15 or 20 years. You send it out for clinical evaluation, and you articulate two or three different organisms from the catheter, and then you work this up, it

could very well be a contaminant. Right? So if the physician is not very well educated with respect to the ideology of some of the bugs that have been isolated from that site and question the sterility of that isolation, then it could be led into a massive treatment of the clinician. So what I am saying is that the clinical work-up could be only one angle to the overall clinical decision, but not the entire solution, and that's really the piece that bugs me, in a sense, because a lot of, physicians are not very familiar to read these antibiograms very effectively and understanding the CDC recommendations with some of these or the American Association of Microbiology for some of these nuances, and that's really the scariest piece for us, because we see, oftentimes, the physicians are putting the patients on extended antibiotic treatment, particularly with the beta-lactam drugs, which are notorious in terms of the capability of some of the organisms to develop an enzyme which is called a beta – lactamase enzyme, and they become an ESBL, or extended beta-lactam resistant, so those are the ones that really worries you, so you're right. And guess what? Every time that you have a one for one for cedeficil, this happens to be – the majority of those happen to be in the beta-lactam family. So you have to be careful, you know, how – and that goes really back to the education of the clinicians. Do they really understand some of the new sciences that have evolved in the last decade in that area? And try to apply it.

SHARON: I think one other thing we haven't talked much about is the surgical side of infections, which is also one of the top four. One of our hospitals had Joint Commission visit last week, and in our community in Birmingham, they were looking at whether people could wear their own shirts in, and they won't go one way or the other. I think there's a paper out there saying it's okay. These surveyors that were here said that, well, they finally did say it was okay, but you had to wash them at home and put them in a plastic bag and put them on here. Does everybody wear scrubs in, or do you make them change? Anybody know anything about that?

Participant: It's facility by facility. I would say 80 percent of the facilities I walk into say you can't walk in with your own scrubs. We have to issue the scrubs.

Participant: So then they wear a nursing uniform and not scrubs? That's the same thing.

Participant: But is the concern not only what's coming in but it's going out, which is really the more greater concern.

Participant: It is when you walk into the hospital, and also, in our cafeteria, it is policy if someone walks in with the scrubs, do not serve them, and give the name to us. They don't serve anybody who's coming walking in with scrubs into the cafeteria.

Participant: Unfortunately, my hospital has a mixture of both. There are people walking out with the scrubs and coming in. Partici-pants : Uh, surgical site infections. I've spent a lot of time in the O.R., and at least you put a sterile gown over those. The things that scare me are, you know, 40-pound orthopedic sets that come in and out before a procedure, and they throw it into a flash 26 sterilizer that is 30 years old and doubtful at best, and they put the magical sterile towel – I mean, I've seen draped gown surgical – or scrubs that walk out, gown, gloves, with the sterile towel that they lay over the top, and they grab that and walk into the room. It's dripping wet, and you know, they spent 25 minutes setting up a back table with 30 different cannisters, impeccable aseptic presentation, and then they come in and drop a wet, just flashed, 300-component, 40-pound tray on top of that table.

SHARON: Joint Commission is looking at flash trays now. They're looking at what is acceptable and what is not, and they're also going to compare your flash – for example, if they look at your orthopedic infection rates, and they see that they're up, and they see that's what you're flashing your orthopedic implements –

Participant: I think that's – it's so hard. Surgical site infections, it's so hard to narrow it down. Is it a break in technique? Did they use something that wasn't sterile? Was it happenstance? How do we ever prove what is a surgical site infection? So it really just goes to process, and if we don't get our processes under control, we'll never be able to narrow that – I mean, so many people make so many claims about things, and you know, I just – what goes on in terms of cleaning and disinfecting instrumentation in the basement, and so what is sterile and what isn't sterile. I mean, in the O.R., process validation is key. You have to prove that what you're claiming in terms is what is sterile is sterile here. We throw a biological indicator into a container, and we say, sterile, because we killed the biological indicator, which is definitely not your worst case scenario, but they're very easy to kill these days. Most of them don't even have an aught-six dose in them anymore. They're aught-four. So surgical site infections is a very compli-cated thing, but it has to start with enforcement. We all talked about no more flashing. It's got to go away, or somebody has to invent a way to flash that really works.

Participant: Sharon, was your initial scrub question related to the O.R.?

SHARON: It was in general.

Participant: Because in our O.R., you have to use our scrubs. Recovery room, pre-op.

Participant: It started in Birmingham, and it just started at one hospital and was a cost issue, and once 28 it was accepted there, it spread like wildfire. They don't provide scrubs.

Participant: You know, the CMS guidelines followed by – we're actively involved with pre-warmed patients. We're becoming a little more aggressive about it, and they're even – I just read an article that the short stay patient is even at greater risk for not staying warm. The short procedure. And I can't remember the reason why. It was some physiological reason why. Maybe the anesthetic agent. So we're also warming our O.R.'s, but I don't know how many degrees that is, and we're trying to improve our temperature monitoring frequency.

SHARON: All right, you guys. Thanks for coming.

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