

TABLE 168-1 SOURCES OF INFECTION CONTROL GUIDELINES AND OVERSIGHT

Organization	Role	Major Constituents	Website
Joint Commission	Regulatory	Hospitals, long-term-care facilities, laboratories	www.jointcommission.org
CAP	Regulatory	Laboratories	www.cap.org
OSHA	Regulatory	Workers	www.osha.gov
CMS	Regulatory	Medicare/Medicaid providers	www.cms.hhs.gov
PQRI	Regulatory and advisory	Eligible professionals	www.cms.hhs.gov/pqri/
HHS Action Plan	Regulatory and advisory	Health care and infection prevention personnel	www.hhs.gov/ash/initiatives/hai/actionplan/
CDC			
DHQP	Advisory	Health care facilities and personnel	www.cdc.gov/nceid/dhqp/
HICPAC	Advisory	Health care facilities and personnel	www.cdc.gov/hicpac/
NIOSH	Advisory	Workers	www.cdc.gov/niosh/
AHRQ	Advisory	Broad (e.g., health care personnel)	www.ahrq.gov
NQF	Advisory	Broad (e.g., health care personnel)	www.qualityforum.org
IOM	Advisory	Broad (e.g., health care personnel)	www.iom.edu
Federal Influenza Planning	Advisory	Health care and public health personnel	www.flu.gov/planning-preparedness/hospital#
Trust for America's Health	Advisory	Broad (e.g., the public)	healthyamericans.org
CSTE	Advisory and professional society	Public health personnel	www.cste.org
IDSA	Professional society	Infectious disease physicians/researchers	www.idsociety.org
SHEA	Professional society	Health care epidemiologists	www.shea-online.org
HIS	Professional society	Health care epidemiologists	www.his.org.uk
APIC	Professional society	Infection preventionists	www.apic.org
MedQIC	Quality improvement	Broad (e.g., health care personnel)	www.qualitynet.org
IHI	Quality improvement	Broad (e.g., health care personnel)	www.ihl.org
Leapfrog Group	Quality improvement	Broad (payers, consumers, employers, and health care personnel)	www.leapfroggroup.org
NSQIP	Quality improvement	Surgery services	www.acsnsqip.org

Abbreviations: AHRQ, Agency for Healthcare Research and Quality; APIC, Association for Professionals in Infection Control and Epidemiology; CAP, College of American Pathologists; CDC, Centers for Disease Control and Prevention; CMS, Centers for Medicare & Medicaid Services; CSTE, Council of State and Territorial Epidemiologists; DHQP, Division of Healthcare Quality Promotion; HHS, Health and Human Services; HICPAC, Healthcare Infection Control Practices Advisory Committee; HIS, Hospital Infection Society; IDSA, Infectious Diseases Society of America; IHI, Institute for Healthcare Improvement; IOM, Institute of Medicine; MedQIC, Medicare Quality Improvement Community; NIOSH, National Institute for Occupational Safety and Health; NQF, National Quality Forum; NSQIP, National Surgical Quality Improvement Program; OSHA, Occupational Safety & Health Administration; PQRI, Physician Quality Reporting Initiative; SHEA, Society for Healthcare Epidemiology of America.

report on processes of patient care (e.g., timely administration and appropriateness of perioperative antibiotic prophylaxis) and patient outcomes (e.g., surgical wound infection rates). Neither the carrot (pay-for-performance) nor the stick (nonpayment for preventable infections) appears to have impacted infection rates. The effect of public attention may be more positive; in 2009, the U.S. Department

of Health and Human Services released a major interagency Action Plan to Prevent Healthcare-Associated Infections, including a list of 5-year national prevention targets that are mostly on track (**Table 168-3**).

SURVEILLANCE

Traditionally, infection preventionists have surveyed inpatients for infections acquired in hospitals (defined as those neither present nor incubating at the time of admission). Surveillance most often requires review of microbiology laboratory results, “shoe-leather” epidemiology on nursing wards, and application of standardized definitions of infection. Progressively more infection-control programs use computerized hospital databases for algorithm-driven electronic surveillance (e.g., of vascular catheter and surgical wound infections) that removes observer bias and, by so doing, provides data that are more reliable for interfacility comparisons. Although infection surveillance in nursing homes and some long-term acute-care hospitals (LTACHs) is still in its formative stage, the role of these facilities in the transmission of antimicrobial-resistant pathogens will require their increased attention to infection surveillance and control.

Most hospitals aim surveillance at infections associated with high-level morbidity or expense. Quality-improvement activities in infection control have led to increased surveillance of personnel compliance with infection control policies (e.g., adherence to influenza vaccination recommendations). In the spirit of “what is measured improves,” the majority of states now require public reporting of processes for prevention of health care-associated infection and/or patient outcomes. As a result, in some locales, the surveillance pendulum is swinging

TABLE 168-2 HEALTH CARE–ACQUIRED CONDITIONS NOT ELIGIBLE FOR ADDITIONAL FEDERAL PAYMENT*

Foreign objects retained after surgery
Air embolism
Blood incompatibilities
Decubitus ulcers (stages III and IV)
Fractures/other injuries from falls or trauma
Catheter-associated urinary tract infections
Vascular catheter-associated infections
Manifestations of poor glycemic control
Surgical-site infection or mediastinitis following coronary artery bypass graft
Surgical-site infection following certain orthopedic procedures
Surgical-site infection following bariatric surgery for obesity
Surgical-site infection following cardiac electronic device implantation
Venous thromboembolism (after hip or knee replacement)
Iatrogenic pneumothorax with venous catheterization

*Based on the U.S. Federal Deficit Reduction Act of 2005. As of October 2012, Medicare stopped paying additional money to hospitals for these 14 health care–acquired conditions. See www.cms.gov/HospitalAcqCond/ (last accessed November 13, 2014).