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SHEA Election Results

The results of the SHEA elections for 1991 are: Vice-President, Donald E. Craven, MD; and Councilors, John M. Boyce, MD, and August J. Valenti, MD

Joint Commission Infection Control Indicators, Part II

In October's Newsletter, Robert Haley, MD, Chair of the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) Infection Control Indicators Task Force, presented Part I of a report on the Task Force. This issue, he brings us Part II.

FORM OF INDICATORS

While it is premature to speculate on the inclusion of any particular indicator, it is important to convey the general form that the task force has chosen for the indicators. Though not all indicators will be similarly amenable, most will be formulated as rates of specific nosocomial infections. To minimize the amount of surveillance effort, the rates will be measured in high-risk patient groups defined by easily ascertainable clinical parameters (e.g., service, special care units, certain operations). When possible, a high-risk population used for measuring one indicator will be used for measuring others as well. In general, Centers for Disease Control (CDC) definitions will be used to define the outcome events, although minor modifications may be suggested to the CDC. When possible, intrinsic risk indexes will be specified either for selecting high-risk groups for surveillance or for stratifying the rates in the analysis to control for differences in the distribution of intrinsic risk factors among hospitals.

Unavoidably, the task force will have to step out in front of existing practice in a few areas where current surveillance techniques are not sufficient to ensure valid measurements. For example, where intrinsic risk indexes are not yet accepted, the JCAHO will have to develop or select one or more on a tentative basis pending research to validate better ones. Where inhospital surveillance has been proven to be inadequate for measuring infections that often occur after the patient's discharge, limited postdischarge follow-up may be required. Where there is likelihood of some hospitals falling short in the completeness or accuracy of their surveillance, some mechanism must be established at least to detect the shortcomings so that they can be corrected.

PROJECTED SCHEDULE

The task force expects to produce a final draft of the indicators for testing at or shortly after its October 31 meeting. These will be tested for clarity, face validity, clinical importance, efficacy in raising valid questions, feasibility and cost of data collection, and evaluation of JCAHO data systems.

From now through early November, the JCAHO will be soliciting volunteer hospitals to serve as alpha test sites for the initial draft indicators. Approximately 15 U.S. hospitals will be selected to represent about equally the broad strata formed by hospital size (large and small), medical school affiliation and general medical/surgical versus children's or other specialty hospitals. Those interested in volunteering should contact the Field Activities Staff, Department of Outcomes Research and Development, JCAHO, 1 Renaissance Blvd., Oakbrook Terrace, IL 60181.

The alpha test sites will collect data for one month in the spring of 1991, preceded by a period of orientation and training. After anal-

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ysis by the JCAHO staff, the task force will reconvene in the summer of 1991 to evaluate the results of the alpha test and compile a list of indicators that should advance to the next phase of testing.

Over that summer, the JCAHO will recruit approximately 400 hospitals to participate in the more extensive beta testing, which will focus more on the validity of data collection, utility for identifying opportunities for improvement, methods for feeding back normative comparisons to hospitals, and testing of the actual computing and data transmission techniques. The beta test sites will be oriented and trained in the fall of 1991, and the collection of a year's worth of data should be finished by December 1992. Thereafter, following a final review by the task force, the indicators will be ready for wider application.

The above milestones should convey the general approaches to be taken, whereas the time frames are likely to change.

COMMENT

There can be little doubt that outcome measurement with feedback to staff is instrumental in bringing about behavior and environmental changes that improve the outcome of patients. Three decades of the epidemiologic tradition in hospital infection control have evolved an effective approach based on the measurement of rates of adverse events, as distinct from the listing of single events. Hospital decision-makers have shown a willingness to devote substantial resources to measurement, but these have been disproportionately directed to the tracking of single adverse events through quality assurance departments, largely prompted by past JCAHO inclinations as well as the intuitive approach of clinicians. While the epidemiologic approach has enjoyed widespread use by infection control professionals, the support for it among hospital administrators and clinical heads has remained relatively small.

The JCAHO's development of indicators for infection control promises to afford an opportunity for the epidemiologic approach to clinical measurement and feedback to go head-to-head with the single event approach. If past patterns continue, hospital administrators are likely to support the measurement requirements of the new JCAHO indicators, particularly in view of the increasing pressure on the hospital community to ensure quality of care and show that they are doing it. If so, this indicator-development process may provide the vehicle for launching the epidemiologic method into the mainstream of hospital quality improvement, first for reducing infectious complications and perhaps soon thereafter for addressing noninfectious complications, as many clinical epidemiologists have been urging.

To date, the JCAHO staff has enthusiastically welcomed the epidemiologic approach. Some have conjectured that ideas introduced through the development of the infection control indicators will have an important impact on the development and revision of all the other JCAHO indicators. At any rate, as the indicator experiment unfolds, hospital epidemiologists and infection control practitioners must take advantage of the opportunity by studying the draft indicators when they are released, providing constructive critique as appropriate, volunteering their hospitals and their time to participate in the alpha and beta tests of the indicators, and working to make the process successful.

MEMBERS OF THE JCAHO'S INFECTION CONTROL INDICATORS TASK FORCE

Robert W. Haley, MD (Chair)
University of Texas Southwestern Medical Center at Dallas
Darnell Abbott, RN, MPH, CIC
Johnson and Johnson Medical Products, Inc.
Carol Applegeet, MSN
Humana Hospital Suburban
Dennis Brimhall, MM
University of Colorado Health Science Center
Robert E. Condon, MD
The Medical College of Wisconsin
Theodore C. Eickhoff, MD
Presbyterian/Saint Luke's Center for Health Sciences Education
Walter Hierholzer, MD
Yale-New Haven Hospital
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Hillcrest Medical Center
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Ronald Lee Nichols, MD
Tulane University School of Medicine
Terri Rearick, RN, CIC
The Children's Memorial Hospital
Eva N. Skinner, RN
American Association of Retired Persons
Steven Weinstein, MPH, CIC
University of Massachusetts Medical Center

Job Market

The Hospital Infections Program (HIP), Centers for Disease Control (CDC), is seeking a medical epidemiologist to work in the Nosocomial Infections Surveillance Activity. The applicant should have an MD degree and have experience in epidemiology. Board certification or board eligibility in infectious diseases and experience in microcomputer and mainframe computer use are desirable.

The Nosocomial Infections Surveillance Activity is responsible for the National Nosocomial Infec-

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tions Surveillance System (NNIS). NNIS is the only national surveillance system for nosocomial infections. Data are collected and provided to the CDC by 100 NNIS member hospitals using microcomputer software (NNIS IDEAS) developed by HIP. In addition, the Surveillance Activity is responsible for a recently initiated study examining nosocomial infections in a cohort of hospitalized acquired immunodeficiency syndrome (AIDS) patients. Data from this study will be collected and provided to the CDC by participating hospitals using microcomputer software to be developed by HIP.

The candidate selected for this position will become part of a team of professionals that will establish priorities for analyzing existing NNIS data, develop new surveillance components that address specific areas of inquiry and develop methodologies to evaluate the effectiveness of NNIS as a tool to prevent nosocomial infections. The candidate also will initiate and coordinate multicenter, hospital-based studies in specific areas, including examining risk factors for nosocomial infections among immunosuppressed patients, antibiotic resistance among nosocomial pathogens and ways to apply newly developed or acquired laboratory research techniques on antimicrobial resistance to epidemiologic studies.

This assignment is available immediately. Interested persons are encouraged to send a curriculum vitae with names of three references to William V. Nelson, Personnel Management Office, Centers for Disease Control (DO1), Atlanta, GA 30333; (404) 639-3271. Candidates who wish further information about the Activity should call Robert Gaynes, MD, at (404) 639-3504.

Membership Application Inquiry:

Mail to: Secretary
Society of Hospital
Epidemiologists of America
c/o Slack, Incorporated
6900 Grove Road
Thorofare, NJ 08086

NAME: _____
CURRENT POSITION: _____
ADDRESS: _____
_____
_____ ZIP _____

Doctoral Degree __ MD __ PhD
Date and University:
_____

Specify work in hospital epidemiology and related fields:
_____
_____

Dates in this position:
_____

Related work in the field:
_____

(✓) Check type of membership application:

__ Active Membership
(Calendar year dues $75)

__ Associate Membership
(Calendar year dues ($35)

Brief items of interest for the SHEA Newsletter may be sent to Robert A. Weinstein, MD, SHEA Newsletter Editor, Division of Infectious Diseases, Michael Reese Hospital, Lake Shore Drive at 31st St., Chicago, IL 60616. ***Copy must be typed, doublespaced and may not exceed five pages,***

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