Sutter Health Summary of Regulatory Requirements - Infection Prevention Elements

Effective Date	Ca State SB 739			Ca State SB 158			Ca State SB 1058 (Niles Law)			The Joint Commission- NPSG		
	Section	**Requirement**	**Met**	**Section**	**Requirement**	**Met**	**Section**	**Requirement**	**Met**	**Section**	**Requirement**	**Met**
1/1/2007	**Strategic Plan: Infection Surveill. And Prevention Report [1288.6]** Sec 2.a.1	Each general acute care hospital, in collaboration with ICPs, and with the participation of senior leadership shall, as a component of its strategic plan, at least once every three years, prepare a written report that examines the hospital's existing resources and evaluates the quality and effectiveness of the hospital's infection surveillance and prevention program.										
	Strategic Plan: Infection Surveill. & Prevention Report [1288.6] Sec 2.a.2	The report shall evaluate and include information on all of the following: (A) The risk and cost of the # of invasive pt procedures performed. (B) # of ICU beds. (C) # of ED visits (D) # of outpt visits by dept. (E) # of licensed beds. (F) Employee health and occ. health measures implemented (G) Changing demographics of the community served by the hospital. (H) An estimate of the need and recommendations for additional resources for infection prevention and control programs necessary to address the findings of the plan.										
	Strategic Plan: Infection Surveill. & Prevention Report [1288.6] Sec 2.a.3	Update report annually, and revise at regular intervals, if necessary, to accommodate tech advances and new information & findings contained in the triennial strategic plan with respect to improving disease surveillance and the prevention of HAI.										

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	CLABSI Prevention [1288.6] Sec 2.b	Each general acute care hospital that uses central venous catheters (CVCs) shall implement policies and procedures to prevent occurrences of HAI, as recommended by the Centers for Disease Control and Prevention intravascular BSI guidelines or other evidence-based national guidelines, as recommended by the HAI-AC.										
	CLABSI Internal Reporting Sec 2 [1288.6] b	A general acute care hospital that uses CVCs shall internally report CLABSI rates in ICUs, utilizing device days to calculate the rate for each type of ICU, to the appropriate medical staff committee of the hospital on a regular basis.										
7/1/2007	Sec 2 [1288.7]	CDPH shall require that each general acute care hospital, in accordance with the Centers for Disease Control guidelines, take all of the following actions:										
	Influenza Vaccine Sec 2 [1288.7] a	Annually offer onsite influenza vaccinations, if available, to all hospital employees at no cost to the employee. Require employees to be vaccinated, or if the employee elects not to be vaccinated, sign declination.										
	Seasonal Flu Plan Sec 2 [1288.7] b	Institute respiratory hygiene and cough etiquette protocols, develop and implement procedures for the isolation of patients with influenza, and adopt a seasonal influenza plan.										
	Pandemic Flu Sec 2 [1288.7] c	Revise an existing or develop a new disaster plan that includes a pandemic influenza component. The plan shall also document any actual or recommended collaboration with local, regional, and state public health agencies or officials in the event of an influenza pandemic.										

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1/1/2008	**Judicious Use of Abx** Sec 2 [1288.8] a.4	CDPH to require that general acute care hospitals develop a process for evaluating the judicious use of antibiotics, the results of which shall be monitored jointly by appropriate representatives and committees involved in quality improvement activities.		**Judicious Use of Abx** Sec 6.a.3	(SB 739 language repeated)							
	Reporting of Data to NHSN Sec 2 [1288.8] d	(d) Each general acute care hospital shall also submit data on implemented process measures to the National Healthcare Safety Network of the CDC, or to any other scientifically valid national HAI reporting system based upon the recommendation of the CDC Healthcare Infection Control Practices Advisory Committee.		**Reporting of data to NHSN** Sec 6.d	(SB 739 language repeated)							
	HAI Surveillance Definitions Sec2 [1288.8] d	Utilize the CDC definitions and methodologies for surveillance of HAI		**HAI Surveillance Definitions/ Reporting to CHART** Sec 6.d	(SB 739 language repeated)							
	Reporting to CHART Sec 2 [1288.8] d	For hospitals participating in the California Hospital Assessment and Reporting Task Force (CHART), publicly report HAI measures										
	Annual Report to CDPH on HAI Sec 2 [1288.8] b	Report annually to the California Department of Health Services (CDHS), to become the Department of Public Health, on its implementation of specified infection surveillance and infection prevention process measures										
	Register with NHSN AFL 07-37	CDPH Licensing and Certification Program now requires that all general acute care hospitals use NHSN for reporting to CDPH the SB 739 mandated measures that are available through NHSN. Hospitals should enroll now.										
7/1/2008	**Join CDPH Group AFL 08-10**	Confer NHSN rights to CDPH for access of mandated data.										

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	AFL 08-10 CLIP Reporting	Central Line Insertion Practices (CLIP) - Collect CLIP data for all CVC insertions in adult ICUs. Submit data electronically once NHSN online module is released.										
	AFL 08-10 Daily Assessment for necessity of CL	All hospitals are required to develop and implement a process to ensure the licensed caregiver (with the authority to order insertion or discontinuance of the CL) completes a daily assessment for continued line necessity.										
	AFL 08-10 Surgical Antimicrobial Prophylaxis	Required reporting of CMS SCIP measures #1-3										
9/1/2008	**Prioritized list of healthcare personnel AFL 08-17**	Develop prioritized list of healthcare personnel not included in the facility's roster of employees AND who have frequent patient contact. *Note: Facilities may choose to report vaccination rates and informed declination rates for all healthcare personnel not included in 'employees' and bypass creating this list.										
9/30/2008	**2007-2008 Flu Vaccination Declination Rates AFL 08-17**	Report 2007-2008 season flu vaccination / declination rates for employees to CDPH. In addition, report vaccination rate (number of employees who received a vaccination/total number of employees)										
	Develop and implement outreach plan for all healthcare personnel AFL 08-17	Take actions to ensure that all healthcare personnel are offered education on influenza and the opportunity to receive the vaccine during the influenza season. (Sept 1, 2008-March 31, 2009)										

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	Incorporate verbiage into Delineation Forms AFL 08-17	Incorporate following phrase into all informed declination and attestation forms: "I have declined the influenza vaccination for the xxx influenza season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention (CDC) for all healthcare personnel to prevent infection from and transmission of influenza and its complications, including death, to my patients, my coworkers, my family, and my community."										
10/30/2008	**2008-2009 Flu Pre-Season Survey AFL 08-17**	Submit Pre-season Survey on Influenza programs for Healthcare personnel to CDPH. (AFL Attachment E)										
										Pt Info re: Inf Control Measures NPSG 13.01.01 EP 2	The hospital provides pt with info re: infection control measures for hand hygiene, respiratory etiquette, and contact precautions according to pt condition. Discuss with pt and family on day pt enters hospital or ASAP. Pt understanding is evaluated and documented.	
1/1/2009				**Hand Hygiene** Sec 3.a	A health facility shall implement a facility-wide hand hygiene program					**Prevention of adverse events in surgery** NPSG 13.01.01 EP3	For surgical pts, hospital describes measures to be taken to prevent adverse events in surgery, including but not limited to: pt identification, infection prevention, site marking. Pt understanding is evaluated and documented.	
										Apr-09		
	VAP Prevention Sec 2 [1288.9] b	CDPH to require each general acute care hospital to develop policies and procedures to implement the current Centers for Disease Control and Prevention guidelines and Institute for Healthcare Improvement (IHI) process measures designed to prevent ventilator associated pneumonia.					IC Policy [Title 22 70739] Sec 3.e	**The infection control policy , at a minimum, shall include all of the following:**		Prevention of HAI due to MDRO 07.03.01 EP 1	Hospital leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of 07.03.01	

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				EVS Staff Training Sec 7.d	Environmental services staff shall be trained by the hospital and shall be observed for compliance with hospital sanitation measures. The training shall be given at the start of employment, when new prevention measures have been adopted, and annually thereafter. Cultures of the environment may be randomly obtained by the hospital to determine compliance with hospital sanitation procedures.		**Disinfect Environ.** Sec 3.e.2	Regular disinfection of all restrooms, countertops, furniture, televisions, telephones, bedding, office equipment, and surfaces in patient rooms, nursing stations, and storage units.		**Prevention of CLABSI** 07.04.01 EP 1	Hospital leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of 07.04.01	
				Patient Safety Plan Sec 2.a	Health facility shall develop, implement, and comply with a patient safety plan. The plan shall be developed by the facility, in consultation with the facility's various health care professionals.		**Clean & disinfect med equip..** Sec 3.e.3	Regular removal of accumulations of bodily fluids and intravenous substances, and cleaning and disinfection of all movable medical equipment, including point-of-care testing devices such as glucometers, and transportable medical devices.		**Prevention of SSI** 07.05.01 EP 1	Hospital leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of 07.05.01	
				Sec 2.b	**The patient safety plan shall include at a minimum:**		**Clean & disinfect common areas** Sec 3.e.4	Regular cleaning and disinfection of all surfaces in common areas in the facility such as elevators, meeting rooms, and lounges		**Jul-09**		
										Prevention of HAI due to MDRO 07.03.01 EP 2	An implementation work plan is in place that identifies adequate resources, assigned accountabilities, and time line for full implementation by Jan 1, 2010.	
				Patient Safety Comm. Sec 2.b.1	Patient Safety Committee (or equivalent committee) composed of the facility's various health care professionals (docs, nurses, pharm, etc) **The committee shall, at a minimum, provide for the establishment of all of the following:**					**Prevention of CLABSI** 07.04.01 EP 2	An implementation work plan is in place that identifies adequate resources, assigned accountabilities, and time line for full implementation by Jan 1, 2010.	
				Sec 2.b.1.A	Review and approve the patient safety plan					**Prevention of SSI** 07.05.01 EP 2	An implementation work plan is in place that identifies adequate resources, assigned accountabilities, and time line for full implementation by Jan 1, 2010.	
				Sec 2.b.1.B	Receive and review reports of patient safety events as defined in subdivision 2.c		**Infection Control Officer** Sec 3.f	Facility shall designate an infection control officer who, in conjunction with the hospital infection control committee, shall ensure implementation of the testing and reporting provisions of Section 3 and the other hospital infection control efforts.		**Oct-09**		
										Prevention of HAI due to MDRO 07.03.01 EP 3	Pilot testing in at least one clinical area is under way.	

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				Sec 2.b.1.C	Monitor implementation of corrective actions for patient safety events			The reports shall be presented to the appropriate committee for review.		**Prevention of CLABSI** 07.04.01 EP 3	Pilot testing in at least one clinical area is under way.	
				Sec 2.b.1.D	Make recommendations to eliminate future patient safety events		**MRSA Testing** [1255.8] Sec 3.b.1	**Each patient who is admitted to a health facility shall be tested for MRSA in the following cases, within 24 hours of admission:**		**Prevention of SSI** 07.05.01 EP 3	Pilot testing in at least one clinical area is under way.	
										Full Implementation by 1/1/2010		
				Sec 2.b.1.E	Review and revise the patient safety plan, at least once a year, but more often if necessary, to evaluate and update the plan, and to incorporate advancements in patient safety practices		**MRSA Testing - Pre-op** Sec 3.b.1.A	Patient is scheduled for inpatient surgery and has a documented medical condition making the patient susceptible to infection, based either upon CDC findings or the recommendations of the HAI-AC or its successor.		**Prevention of HAI due to MDRO** NPSG 07.03.01	Implement evidence based practice to prevent HAI due to MDRO. Applies to, but is not limited to, epidemiologically important organisms such as MRSA, C diff, VRE, and multidrug resistant gram negative bacteria. This requirement has a one year phase in period that includes defined milestones at 3, 6, and 9 months in 2009. **EP 4:** Elements of performance are fully implemented across the hospital	
				Patient Safety Event Reporting Sec 2.b.2	A reporting system for patient safety events that allows anyone involved, including, but not limited to, health care practitioners, facility employees, patients, and visitors, to report a patient safety event.		**MRSA Testing - Hosp admit 30 days prior** Sec 3.b.1.B	Documented that the patient has been previously d/c'ed from a general acute care hospital within 30 days prior to the current hospital admission.		07.03.01 EP 5	Conduct periodic risk assessments of MDRO acquisition and transmission. (see also IC 01.03.01 EPs 1-5)	
				Sec 2.b.4	A reporting process that supports and encourages a culture of safety and reporting patient safety events		**MRSA Testing - ICU/Burn** Sec 3.b.1.C	Admitted to an ICU or burn unit		07.03.01 EP 6	Based on the results of the risk assessment, the hospital educates staff and LIPs about HAI, MDROs, and prevention strategies at hire, and annually thereafter. Note: The education provided recognizes the diverse roles of staff and LIPs and is consistent with their roles within the hospital. (See also HR.01.05.03, EP4)	
				Safety Event Analyses (RCA) Sec 2.b.3	A process for an interdisciplinary team of facility staff to conduct analyses, including but not limited to, root cause analyses of patient safety events.		**MRSA Testing - Inpt Dialysis** Sec 3.b.1.D	Receives inpatient dialysis treatment		07.03.01 EP 7	Hospital educates patients, and their families as needed, who are infected or colonized with a MDRO about HAI prevention strategies.	
				Sec 2.b.5	A process for providing ongoing patient safety training for facility personnel and health care practitioners		**MRSA Testing - SNF** Sec 3.b.1.E	Transferred from a SNF		07.03.01 EP 8	Hospital implements a surveillance program for MDROs based on the risk assessment.	

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							MRSA + Notification Sec 3.b.3	If a patient tests positive for MRSA, the attending physician shall inform the patient or the patient's representative immediately or as soon as practically possible.		07.03.01 EP 9	Hospital measures and monitors MDRO prevention processes and outcomes including the following: MDRO infection rates using evidence based metrics, compliance with evidence-based guidelines or best practices, evaluation of the education program provided to staff and LIPs.	
							MRSA + DC Instruction Sec 3.b.4	Patient who tests positive for MRSA infection shall receive, prior to discharge, oral and written instruction regarding aftercare and precautions to prevent the spread of the infection to others.		07.03.01 EP10	Hospital provides MDRO surveillance data to key stakeholders, including leaders, LIPs, nursing staff, and other clinicians.	
							HAI Reporting [1288.55] Sec 4.a	**Health facility shall report the following HAI quarterly:**		07.03.01 EP11	Hospital implements policies and practices aimed at reducing the risk of transmitting MDROs that meet regulatory requirements and are aligned with evidence-based standards (for example, the CDC and/or professional organization guidelines.)	
							HA-MRSA HA-C diff HA-VRE Reporting Sec 4.a.1	All cases of HA-MRSA BSI, HA-C diff infections, and HA-VRE BSI, and the number of inpatient days		07.03.01 EP 12 & 13	When indicated by the risk assessment, the hospital implements a lab-based alert system that identifies new patients, readmits, and transfers with MDROs. The alert system may be manual, electronic, or both.	
							CLABSI Reporting Sec 4.a.2	All CLABSI and the total CL days		**Prevention of CLABSI** NPSG 07.04.01	Implement best practices or evidence based guidelines to prevent CLABSI. Note: this covers short and long term CVCs and PICCs. This requirement has a one year phase in period that includes defined milestones at 3, 6, and 9 months in 2009. **EP 4:** Elements of performance are fully implemented across the hospital	

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	SSI Prevention Sec 2 [1288.9] a	Require each general acute care hospital to develop, implement, and periodically evaluate compliance with policies and procedures to prevent secondary surgical site infections (SSI).					**SSI Reporting** Sec 4.a.3	All HA-SSI of deep organ space surgical sites, HA-SSI of ortho, cardiac, and GI surgical sites designated as clean and clean-contaminated, and the number of surgeries involving these surgery types.		07.04.01 EP 5	Educate health care workers who are involved in these procedures about HAI, CLABSI, and the importance of preventions. Ed occurs upon hire, annually, and when involvement in these procedures is added to an individual's job responsibilities. *note: "Health care worker" includes all who are involved in these procedures including physicians.	
		The results of this evaluation shall be monitored by the infection prevention committee and reported to the surgical committee of the hospital.					**Report to NHSN** Sec 4.d	Health facilities that report data pursuant to the system shall report this data to the NHSN and CDPH as appropriate.		07.04.01 EP 6	Prior to insertion of a CVC, the hospital educates patients, and their families as needed, about CLABSI prevention.	
Future Hospital Requirements												
										Continued: Full Implementation by 1/1/2010		
1/1/2010				**ID Physician CME** Sec 7.a	A physician designated as a hospital epidemiologist or infection surveillance, prevention, and control committee chairperson shall participate in a continuing medical education (CME) training program offered by the CDC and the Society for Healthcare Epidemiologists of America, or other recognized professional organization. The CME program shall be specific to infection surveillance, prevention, and control. Documentation of attendance shall be placed in the physician's credentialing file.					07.04.01 EP 7	Implements policies and practices aimed at reducing the risk of CLABSIs that meet regulatory requirements and are aligned with evidence-based standards (e.g. CDC or prof. org.)	
				Physician/LIP training - Prevention of transmission of HAI Sec 7.b	All staff and contract physicians and all other licensed independent contractors, including, but not limited to, NPs and PAs, shall be trained in methods to prevent transmission of HAI, including, but not limited to, MRSA and Clostridium difficile infection.					07.04.01 EP 8	Conducts periodic risk assessments for CLABSIs, measures CLABSI rates, monitors compliance with best practices or evidence based guidelines, and evals the effectiveness of prevention efforts.	

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				Hospital Employee Training Sec 7.c	All permanent and temporary hospital employees and contractual staff, including students, shall be trained in hospital-specific infection prevention and control policies, including, patient hygiene, and environmental sanitation procedures. The training shall be given annually and when new policies have been adopted by the infection surveillance, prevention, and control committee.					07.04.01 EP 9	Provides CLABSI rate data and prevention outcome measures to key stakeholders including leaders, LIPs, nursing staff, and other clinicians.	
										07.04.01 EP10	Use a catheter checklist and a standardized protocol for CVC insertion.	
										07.04.01 EP11	Perform hand hygiene prior to insertion or manipulation.	
										07.04.01 EP12	For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable.	
										07.04.01 EP13	Use a standardized supply cart or kit that is all inclusive for the insertion of CVCs.	
										07.04.01 EP14	Standardized protocol for maximum sterile barrier precautions during CVC insertion	
										07.04.01 EP15	Chlorhexidine-based antiseptic for skin prep during CVC insertion in pts > 2 months of age, unless contraindicated	
										07.04.01 EP16	Standardized protocol to disinfect catheter hubs and injection ports before accessing the ports	
										07.04.01 EP17	Evaluate all CVCs routinely and remove nonessential catheters	
										Prevention of SSI 07.05.01	Implement best practices for preventing surgical site infections. Note: This requirement has a one year phase in period that includes defined milestones at 3, 6, and 9 months in 2009. **EP 4:** Elements of performance are fully implemented across the hospital	

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										07.05.01 EP 5	Educate health care workers involved in surgical procedures about HAI, SSI, and the importance of preventions. Ed occurs upon hire, annually, and when involvement in surgical procedures is added to an individual's job responsibilities. *note: "Health care worker" includes all who are involved in these procedures including physicians.	
										07.05.01 EP 6	Prior to all surgical procedures of a CVC, educate patients, and their families as needed, about SSI prevention.	
										07.05.01 EP 7	Implement policies and practices aimed at reducing the risk of SSI that meet regulatory requirements and are aligned with evidence based guidelines (e.g. CDC or Prof. Org.)	
										07.05.01 EP 8	Conduct periodic risk assessments for SSI, selects SSI measures using best practices or evidence based guidelines, monitors compliance with best practices or evidence based guidelines, and evaluates the effectiveness of prevention efforts.	
										07.05.01 EP 9	Measurement strategies follow evidence based guidelines and SSI rates are measured for the first 30 days following procedures that do not involve inserting implantable devices and for the first year for procedures involving implantable devices.	
										07.05.01 EP10	Provides SSI rate data and prevention outcome measures to key stakeholders including leaders, LIPs, nursing staff, and other clinicians.	

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										07.05.01 EP11	Antimicrobial agents for prophylaxis used for a particular procedure or disease are administered according to evidence based standards and guidelines for best practices. Administer IV antimicrobial prophy within one hour before incision (2 hrs for Vanco and flouroquinolones). DC agent within 24 hrs post surgery (48 hrs for cardiothoracic)	
										07.05.01 EP12	When hair removal is necessary, the hospital uses clippers or depilatories.	
1/1/2011				**IV, Epidural, Enteral Feeding Connections** Sec 3.b	A health facility is prohibited from using an intravenous connection, epidural connection, or enteral feeding connection that would fit into a connection port other than the type it was intended for, unless an emergency or urgent situation exists and the prohibition impairs the ability to provide health care.		**MRSA Testing prior to DC** Sec 3.c	A patient tested in accordance with subdivision 3.b and who shows evidence of increased risk of invasive MRSA shall again be tested for MRSA immediately prior to discharge from the facility. This subdivision shall not apply to a patient who has tested positive for MRSA infection of colonization upon entering the facility.				
							MRSA + DC Instructions Sec 3.d	A patient who is tested pursuant to subdivision 3.c and who tests positive for MRSA infection shall receive oral and written instructions regarding aftercare and precautions to prevent the spread of the infection to others.				
CDPH and HAI-AC Responsibilities (Partial List)												
1/1/2008	**Additional Process and Outcome Measures** Sec 2 [1288.8] c	The HAI-AC shall make recommendations for phasing in the implementation and public reporting of additional process measures and outcome measures and, in doing so, shall consider the measures recommended by the CDC.		**Additional Process and Outcome Measures** Sec 6.c	(SB 739 language repeated)							
1/1/2009				HAI-AC Duties	The HAI-AC will:							
				# of Infection Prevention Professionals Sec 5.d.2	Recommend a method by which the number of infection prevention professionals would be assessed in each hospital							

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				NHSN Data Audit Sec 5.d.4	Recommend a method by which hospitals are audited to determine the validity and reliability of data submitted to the NHSN and the CDPH.							
				HAI post Discharge Sec 5.d.5	Recommend a standardized method by which an HAI occurring after hospital discharge would be identified							
				Public Reporting Sec 5.d.6	Recommend a method by which risk-adjusted HAI data would be reported to the public, the Legislature, and the Governor							
	CDPH Surveys Sec 2 [1288.9] c	During surveys, evaluate the facility's compliance with existing policies and procedures to prevent HAI, including any externally or internally reported HAI process and outcome measures.		**Evaluation by CDPH** Sec 5.d.7	Recommend a standardized method by which CDPH health facility evaluator nurses and consultants would evaluate health care workers for compliance with infection prevention procedures including, but not limited to, hand hygiene and environmental sanitation procedures							
				Infection Prevention Professional Training Sec 5.d.8	Recommend a method by which all hospital infection prevention professionals would be trained to use the NHSN HAI surveillance reporting system							
1/1/2011				**Annual report - Publicly reported HAI** Sec 6.e.5	CDPH will provide to the Governor, the Legislature, and the Chairs of the Senate Committee on Health and Assembly Committee on Health, and post on the department's Web site, an annual report of publicly reported HAI infection information received and reported.							

Definitions (Partial List)

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	Healthcare personnel (HCP) - CDC Definition	“all paid and unpaid persons working in healthcare settings who have the potential for exposure to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons (e.g., clerical, dietary, housekeeping, maintenance, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP.”		**Definitions: HAI** Sec 4.b	"Health-care associated infection", "health facility acquired infection", or "HAI" means an infection defined by the National Health and Safety Network of the federal CDC, unless CDPH adopts a definition consistent with the recommendation of the advisory committee or its successor.						"Health-Care Worker"-includes all who are involved in certain procedures including physicians. (i.e. SSI prevention, insertion of Central Lines).	
				Definitions: Infection Prevention Professional	"Infection Prevention Professional" means a registered nurse, medical technologist, or other salaried employee or consultant who, within two years of appointment, will meet the education and experience requirements for certification established by the national Certification board for Infection Control and Epidemiology (CBIC), but does not include a physician who is appointed or receives a stipend as the infection prevention and control committee chairperson or hospital epidemiologist.							
				Definitions: NHSN	"National Healthcare Safety Network" or "NHSN" means a secure, Internet-based system developed and managed by the federal CDC to collect, analyze, and report risk-adjusted HAI data related to the incidence of HAI and the process measures implemented to prevent these infections							