According to the Centers for Disease Control and Prevention (CDC), there were approximately 1.7 million hospital-acquired infections in 2002 alone. This epidemic, which according to CDC and other experts is largely preventable, kills an estimated 100,000 people and costs federal health programs, private health insurers, and individual patients and their families billions of dollars every year.

On Wednesday, April 16, 2008, the Committee held a hearing titled "Healthcare-Associated Infections: A Preventable Epidemic." The purpose of this hearing was to evaluate the steps the Department of Health and Human Services (HHS) and its agencies are taking to combat this epidemic. Through Medicare, Medicaid, and other health programs it administers, HHS is the nation's single largest purchaser of inpatient hospital care and will spend over $160 billion on such services this year.

At the hearing, the Government Accountability Office (GAO) released a report prepared at the request of Chairman Waxman, Healthcare-Associated Infections in Hospitals: Leadership Needed from HHS to Prioritize Prevention Practices and Improve Data on these Infections. The report recommends that HHS (1) identify priorities among prevention practices recommended by the CDC and determine how to promote their implementation and (2) establish greater consistency of data on hospital-associated infections collected by different agencies within the Department.

Mr. Edward Lawton, a retired Air Force officer and survivor of multiple hospital-acquired infections, described his experiences during hospitalization for such infections. He testified that patients should have greater access to information about hospital infection rates, and he urged health care professionals working in hospitals to carry cards with them that explain simple hygiene protocols.

Cynthia Bascetta, Director for Health Care Issues at the Government Accountability Office (GAO), described GAO's findings about efforts at HHS to reduce hospital-acquired infections. She testified that agencies such as CDC, the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Medicare & Medicaid Services (CMS) had undertaken important efforts to reduce infection rates, such as developing recommended practices and collecting data to understand the nature and scope of the problem. She also testified that the Department had failed to coordinate these efforts, undercutting their effectiveness: "Unfortunately, leadership from the Secretary of HHS is currently lacking ¦ Without such leadership, the department is unlikely to be able to effectively leverage its various methods to

have a significant effect on the suffering and death caused by HAIs."

Peter Pronovost, MD, PhD, the Medical Director of the Center for Innovation in Quality Patient Care at Johns Hopkins University, described his research into the use of a checklist to eliminate catheter-related blood stream infections among patients in intensive care units in Michigan. He testified that the overall rate of these infections in participating ICUs was reduced by two-thirds. He estimated that if implemented nationally, this program "could substantially reduce" the 28,000 deaths and $3 billion in excess costs attributable to these infections.

John Labriola, Senior Vice President of the William Beaumont Hospital in Royal Oak Michigan, described his hospital's participation in the program to reduce catheter-related blood stream infections among ICU patients in Michigan. He testified that his hospital experienced a 53% reduction in blood stream infections between 2006 and 2007.

Dr. Don Wright, Principal Deputy Assistant Secretary for Health at the Department of Health and Human Services (HHS), described the efforts that agencies within HHS are taking to address the problem of healthcare-associated infections. He testified that the reduction of healthcare-associated infections to enhance patient safety and reduce unnecessary costs is "a top priority of HHS," but he also acknowledged that "more work and leadership is needed to enhance patient safety in this regard."

Leah Binder, CEO of the Leapfrog Group, a consortium of major employers, testified that hospital-acquired infections add over $15,000 to a patient's hospital bill, or $30 billion per year in "wasted avoidable costs." She testified that the Leapfrog Group agrees with the GAO's conclusions that "meaningful, nation-wide reductions in hospital-acquired infections are only achievable if HHS makes this an agency-wide priority."

Betsy McCaughey, founder and Chairman of the Committee to Reduce Infection Deaths, raised concerns about whether CDC is accurately counting the number of hospital-acquired infections and whether CDC's guidance to hospitals for preventing infections is sufficient.