May 30, 2008

Representative Henry A. Waxman
Chair, Committee on Oversight and Government Reform
Congress of the United States
2157 Rayburn House Office Building
Washington, D. C. 20515-6143

Re: Healthcare-Associated Infections

Dear Representative Waxman,

On behalf of our 200 Illinois member hospitals, the Illinois Hospital Association thanks you for the opportunity to share with the Committee on Oversight and Government Reform efforts undertaken by IHA and Illinois hospitals to address healthcare-associated infections (HAI). This letter responds to your May 6, 2008, request for information on the above-referenced topic.

Illinois hospitals are actively engaged in improving the quality of care offered in their facilities, particularly with respect to HAI. These activities take many shapes and forms including the participation in statewide learning collaboratives to share successful strategies, the implementation of evidence-based best practices as well as the monitoring and reporting of results. While there is always room to improve, significant work is already underway to provide high quality care in the safest manner possible.

IHA agrees that the state hospital associations, in collaboration with their national counterparts, are well positioned to lead efforts to improve health care quality and patient safety. There are already numerous efforts underway across the country that illustrate this point. Through partnership with the public sector, these voluntary, private efforts can quickly and efficiently respond to local concerns and priorities and lead to the implementation of effective quality improvement strategies.

Given these efforts, we do have concern that increasing the number of reporting mandates on hospitals may choke off resources currently being devoted to these important, voluntary improvement efforts. State hospital associations and the American Hospital Association can play an important role in setting priorities in this arena. In addition, we believe that federal funding should be provided to help support statewide collaborative efforts. Many hospitals, especially those that are financially fragile, face particular challenges in devoting the resources needed to collect and analyze data, participate in learning collaboratives and participate in the staff education and training that is critical to these efforts. State hospital associations, that rely on member dues for these activities, face similar constraints.

Question 1. If known, what are the median and overall rates of central line-associated bloodstream infections in the intensive care units in hospitals in your state, using standard

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definitions of CLABSIs as provided by the CDC for the purpose of the National Healthcare Safety Network?

While individual hospitals track and use this data in their quality improvement efforts, at this time, neither the State of Illinois nor the Illinois Hospital Association collect rates of central line-associated bloodstream infections in intensive care units in Illinois. Under the Illinois Hospital Report Card Act and its implementing regulations, Illinois hospitals are scheduled to begin reporting to the State CLABSI rates in designated critical care units as of July 1, 2008. Additionally, it was anticipated that this data would be incorporated into the data collected as part of the Hospital Quality Alliance, the public-private collaboration consisting of the Centers for Medicare and Medicaid Services (CMS), the American Hospital Association and other stakeholders to measure and report on the quality of care provided by the nation's hospitals. While CLABSI was recommended to be included in the data to be reported beginning in federal fiscal year 2009, it was not included in CMS's proposed inpatient payment regulation.

While Illinois is not currently collecting CLABSI data, it should be noted that Illinois hospitals do collect and report to the State numerous quality measures, including data related to healthcare-acquired infections. In fact, in 2003 Illinois adopted one of the first hospital quality reporting and disclosure laws in the country, the Illinois Hospital Report Card Act (Public Act 93-563). This law requires the reporting and disclosure of nurse staffing information as well as infection process and outcome measurements.

Challenges with NHSN. While Illinois hospitals adhere to the Medicare Conditions of Participation and, therefore, follow the CDC definition of CLABSI, few participate in the National Health Safety Network (NHSN). While about 20 Illinois hospitals participated in the former CDC DOS based NISS system, very few have transitioned to the NHSN. Concerns with the NHSN include: difficult to enter information; does not take input from existing EHRs or other data sources; stand-alone, "silo" approach to infection reporting; 90 pages of documentation to simply enter some information for CLABSI; poor service and educational support; CDC staff realize support shortcomings and have warned states that they cannot accommodate an entire state participating unless the state or others do training and education; and no feedback at state level – an early adopter state is still waiting for over a year to get results from the system. To be a useful tool in efforts to improve quality, any data reporting systems need to be efficient and effective and providing meaningful feedback to the reporting entities.

Question 2. If the rates are unknown or if the median rate is above zero, do you have plans to replicate the Michigan Hospital Association program in your state? If so, when do you anticipate initiating the program?

IHI Participation. Over 180 of the approximately 200 Illinois community hospitals participate in the Institute for Healthcare Improvement's (IHI) 5 Million Lives Campaign. This campaign has reducing CLABSIs as one of its initiatives – using the same approach that was employed in the Michigan Hospital Association program. As discussed more fully below, IHA and Illinois hospitals have actively embraced the quality improvement efforts of the Institute for Healthcare Improvement.

Comprehensive Approach to Infections Throughout Hospital. As patients move in and out of ICUs, it is imperative that hospitals not only look at and study ICU infections but tailor their infection reduction and eradication program to all areas of the hospital. If we are truly interested in reducing infections to as close as possible to zero, we should be developing and implementing screening processes and sharing intervention strategies through IHI and the Hospital Quality Alliance. IHI and HQA are two well established performance improvement organizations that provide highly regarded services to provider organizations and encourage and embrace participation at local and national levels. State hospital associations and other specialty and national organizations facilitate these exchanges and improvement initiatives.

Question 3. What other activities are your member hospitals taking to address healthcare-associated infections? What infections are you targeting? What is your evidence of success?

Illinois hospitals are engaged in a broad range of strategies to improve quality and patient safety, including efforts to address healthcare-associated infections (HAI), as described below. In considering policy options to address HAI, we respectfully urge the Committee to recognize the full constellation of quality improvement activities underway, to avoid policy strategies that will unintentionally detract from other important improvement efforts.

In particular, it should be noted that data collection and reporting, while important, is only one part of the overall effort that is needed to improve quality. The development of best practices, the sharing of experiences, the education and training of staff are, in many respects, the most challenging aspects of bringing about change within an organization. Consequently, efforts to bring about lasting change and improvement in quality and patient safety require much more than simply another mandate to collect and report data.

Efforts to improve quality and patient safety in Illinois include:

Institute for Healthcare Improvement (IHI) – *More than 180 Illinois hospitals are active participants in the IHI 5 Million Lives Campaign* which includes the following targeted areas for infection reduction and eradication:

- Prevent central line infections - This initiative includes the exact same steps as used by the Michigan Hospital Association project.

- Prevent surgical site infections.

- Prevent ventilator-associated pneumonia.

- Reduce surgical complications by reliably implementing all of the changes in care recommended by the Surgical Care Improvement Program.

- Prevent pressure ulcers by reliably using science-based guidelines for their prevention.

- Reduce *Methicillin-resistant Staphylococcus aureus* (MRSA) infections by reliably implementing scientifically proven infection control practices.

Illinois Mentors. IHA serves as the facilitator between Illinois member hospitals and IHI. As part of our ongoing effort to ensure active participation and improvement, IHA developed a mentor conference call series led by IHA, IHI, and mentor hospitals in Illinois. Illinois is the state with the largest volume of mentor hospitals that have successfully implemented the IHI Campaign Initiatives and now share their experiences and educate other hospitals. Northwestern Memorial Hospital serves as the Illinois faculty and mentor on Central Line-Associated Bloodstream Infections.

Educational Programs. IHA has numerous ongoing educational programs in conjunction with IHI for the 5 Million Lives Campaign. Most recently, we held the Illinois Quality Leadership Conference on May 15 and 16, 2008, with faculty and mentor hospitals from IHI and Illinois. Continuous educational opportunities are offered throughout the year.

IHI MRSA Challenge. IHI has also tackled central line bloodstream infections by tackling the bacteria that are the cause of 50—75% of all CLABSIs – MRSA. IHI and its member hospitals challenged hospitals nation-wide to reduce MRSA within all hospital care settings by the end of December 2008.

IHA Patient Safety Collaborative – The IHA Patient Safety Collaborative (IHA PSC) is a nationally recognized program, acknowledged by past participants for accelerating change within their organizations by providing a framework for change and establishing

accountability to improve the safety and quality of care[1]. Now in its 4th year, the IHA PSC is a voluntary, intensive, eight-month improvement program designed to support hospital implementation of safety practices. It is funded with fees paid by the participating hospitals. At the end of each Collaborative, a statewide conference is held where hospitals that participated in the Collaborative share with their colleagues from throughout the state the lessons they learned from their participation in the Collaborative.

Participation in the Collaborative is recognized as a visible commitment to improving the quality and safety of care - since 2005, more than 85 Illinois hospitals have participated in one or more of IHA's Patient Safety Collaboratives. BlueCross/BlueShield of Illinois has recognized participation in the IHA Collaborative in the 2006 and 2007 Hospital Quality Surveys. The IHA model for collaborative learning is taught as part of the graduate program in patient safety at Northwestern University in the Chicago area. Lessons learned during the Collaborative have been shared through 17 regional and national presentations, including at the 2006 Quality Colloquium at Harvard University in Cambridge, MA; the 2007 National Health Information Management and System Society (HIMSS) Meeting in New Orleans, LA; and a nationwide Webinar sponsored by HIMSS.

Issues addressed by each of the four IHA PSC's are:

2008 —Hospital Acquired Conditions: Catheter-associated urinary tract infections (CAUTIs), Pressure Ulcers and Injuries Due to Falls. CAUTIs account for 40 % of all hospital-acquired infections and 1 million additional hospital days each year. In Illinois, CAUTIs are an area of intense focus for hospital participants in the 2008 IHA Patient Safety Collaborative (PSC). In addition to working independently, hospitals involved in the Collaborative work collectively to align definitions and measures with those recommended by national organizations, e.g., the National Quality Forum and the Centers for Disease Control. Collaborative participants explore patterns of utilization, implement evidence-based best practices for care of indwelling catheters, use critical thinking to promote appropriate use and timely removal of indwelling catheters, improve communication among caregivers and between sites of care, and educate both clinicians and non-clinicians to provide safe, timely, effective, efficient patient-centered care. Surveys, chart audits, and process measures are used to assess practice; data collection is executed as per definitions and measures outlined by CMS or NDNQI. Through measurement approaches, we are positioned to be able to demonstrate a reduction in CAUTIs.

2007 – Working as One: Patients, Families, and Caregivers. Patient and family involvement in quality and safety was brought to life by participants in the 2007 Collaborative. Measures and tools were designed specifically for the participants to

[1] You may access additional information on the IHA Patient Safety Collaborative at http://www.ihatoday.org/issues/safety/collaborative/collaborative.html

develop an understanding of what must be done to prepare patients, families, staff, and organizations to work together to improve the quality and safety of care. Organizations were challenged to involve executives in rounds to speak with staff and patients, to involve patients and families in the redesign of processes as well as root cause analysis, and to establish defined roles and responsibilities on committees key to the quality and safety infrastructure of the organization.

2006 – From Hand to Hand: Strengthening the Connection. Participants in the Collaborative sought to improve communication among caregivers and between areas to prevent adverse events. Together, they developed the measures and tools to understand current practice, facilitated the redesign of processes, identified critical elements to be addressed in a handoff communication, and measured the effectiveness of handoff communication. This effort built on the lessons learned from the 2005 IHA PSC which addressed medication reconciliation.

2005 – Medication Reconciliation. Participants engaged national and regional experts in face-to-face discussions to develop strategies specific to their organization, designed tools to understand and measure current practice, explored barriers to desired performance, and planned for strategic implementation to achieve sustainable improvements in patient outcomes through the prevention of adverse medication events.

MRSA Reduction and Eradication. Like the rest of the nation, Illinois has seen the rapid increase in healthcare-acquired and community-acquired MRSA patients in hospital, nursing home, and other healthcare settings. As MRSA makes up the largest volume of CLABSIs in ICUs, Illinois hospitals and IHA have focused efforts on working to eradicate MRSA in addition to efforts with IHI on CLABSIs.

Illinois MRSA Legislation. While CDC and others observed the increase in MRSA, IHA took a national leadership role by supporting groundbreaking state legislation in 2007 to require hospitals to screen for MRSA in patients in all ICUs and other "at risk patients" as identified by the hospital (Public Acts 95-282 and 95-312). The result has been an increase in identification of patients coming in with MRSA throughout the hospital setting and an opportunity to prevent transmission through proper screening, hand hygiene, use of personal protection equipment, and thorough cleaning of room, supplies, and equipment utilized during the patient's stay.

Ongoing Support. IHA has held a number of educational programs – in-person training, webinars, conference calls, and televideo conferences on proper screening and successful approaches for identifying patients with MRSA and successful initiatives for reducing MRSA transmission within the hospital setting. IHA has engaged community activists on MRSA and have involved them in our initiatives as well as participated with our hospitals in community forums.

Data Collection and Reporting. The State of Illinois has been a leader in enacting several laws requiring the reporting and disclosure by hospitals of quality related information[2]. These laws include:

Hospital Report Card Act – (Public Act 93-563, enacted in 2003). This Act requires the reporting and disclosure of nurse staffing information and infection process and outcome measures.

Consumer Guide – (Public Acts 94-27 and 94-501, enacted in 2005). The Consumer Guide, a report to be posted on the Illinois Department of Public Health's web site, will include at least 60 conditions and procedures, including volume of cases, average charges, risk-adjusted mortality rates, complications, hospital infections and surgical infections.

Multi-Drug Resistant Organisms (MRSA, C-Diff) – (Public Acts 95-282 and 95-312, enacted in 2007). Among other provisions, these Acts require the Illinois Department of Public Health to publish a yearly report on MRSA and clostridium difficile infections based upon hospital inpatient discharge data.

As discussed earlier, in addition to complying with these state reporting and disclosure mandates, Illinois hospitals are also complying with federal reporting requirements as well as voluntary reporting and disclosure efforts. At some point, the time, energy and resources needed to comply with the ever-growing reporting mandates will limit hospitals' ability to devote resources to other critical quality improvement efforts, such as participation in Patient Safety Collaboratives.

In sum, when considering the federal government's role in addressing this issue, we suggest that it is important for policymakers to consider the broad array of quality improvement activities that are currently underway. In developing federal policy in this area, we respectfully suggest it be crafted with the following principles in mind:

- Avoid duplicating existing efforts or mandates.
- Provide guidance in prioritizing areas for improvement while recognizing the need for flexibility to respond to local concerns and priorities.
- As states vary in their health needs, provide funding to support initiatives to address concerns identified within each state, such as the IHA Patient Safety Collaborative.

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[2] You may access additional information on the State of Illinois's hospital public reporting requirements at http://www.ihatoday.org/issues/quality/statereq.html

- Partner with state hospital associations and the American Hospital Association to build on the infrastructure and leadership that they have demonstrated in quality improvement and patient safety through efforts such as the Hospital Quality Alliance.

Improving the quality of care and patient safety has been and will continue to be a strategic imperative for IHA and Illinois hospitals. In short, it is not just what we do, it is who we are. Thank you for the opportunity to share with you our experience in working to reduce healthcare-associated infections as part of our overall efforts to improve quality and patient safety. We welcome the opportunity to work with you to achieve this important objective.

If you require additional information or clarification, please contact me by e-mail at krobbins@ihastaff.org or by telephone at 630-276-5710.

Sincerely,

Kenneth C. Robbins
President

cc: Sarah Despres, Committee Staff
Committee Minority Office
American Hospital Association

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