May 30, 2008

The Honorable Henry A. Waxman
U.S. House of Representatives
Chairman, Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, D.C. 20515-6143

Dear Congressman Waxman:

On behalf of our 73 member hospitals and health systems, the West Virginia Hospital Association (WVHA) appreciates the opportunity to share with you a number of member quality and patient safety initiatives currently underway. More specifically, your inquiry dated May 6, 2008, relating to healthcare associated infections (HAIs) provides a timely opportunity to share with you recent legislative activity in West Virginia facilitated by the WVHA.

First and foremost, preventing HAIs is a top concern of West Virginia hospitals; so is identifying, controlling and eliminating hospital infections. Through their many infection control programs, hospitals continuously strive to improve care and create a safe environment by using the most current science, techniques and products to reduce the risk of getting an infection while in the hospital. We see that dedication to doing the right thing in every health care professional, in every hospital, every day.

There is always opportunity to improve in this important endeavor, and that is why during this past legislative session, the WVHA proposed legislation, and the Legislature and Governor ultimately approved, House Bill 4418, establishing a statewide reporting system for hospitals to report their infection rates.

This bill was the product of a collaborative effort among our member hospitals and policymakers, under the guiding principal that hospital accountability and transparency is key to improving patient outcomes and to providing savings in the health care delivery system.

House Bill 4418 completed legislative action on March 4, 2008, and was approved by the Governor on March 14, 2008. The bill officially goes into effect 90 days from passage, with various built-in timelines for implementation over the next year. I'm pleased to report that work is already underway in establishing the infrastructure and successful collaborations necessary to obtain the state hospital clinical data identified in your inquiry.

The provisions of the legislation require hospitals to report information on HAIs in the manner prescribed by the Centers for Disease Control and Prevention (CDC) infection collection and reporting tool – National Health Care Safety Network (NHSN). The legislation makes the reporting of infections as defined by the NHSN mandatory for all hospitals beginning July 1, 2009.

The need to raise awareness and to communicate the provisions of the bill to our member hospitals is of primary importance, and so we've already taken the necessary steps to meet the first deadline established under the bill.

We've communicated the need to first begin the multi-step process for project enrollment with the CDC and for identifying the appropriate member of the hospital team to oversee the project.

Pursuant to the provisions of HB 4418, the regulatory body of West Virginia hospitals, the West Virginia Health Care Authority (WVHCA), is responsible for coordinating this statewide collection and reporting initiative with the guidance of an expert advisory panel established in the legislation. With WVHA input, the statewide panel is in the process of being formed and will include a variety of physicians, infection control practitioners and state officials, credentialed in various aspects of infection control.

Hospitals will submit all required data to the NHSN and that data will be reported to the Authority to be made available to the public on their West Virginia Hospital Charges and Quality Reports website – Compare Care - http://www.comparecarewv.gov/. Additionally, there are several legislative reporting requirements established in the bill to ensure policymakers are made aware of the status of key findings and outcomes.

The passage of this legislation illustrates that WVHA continues to serve as an important source to the State in leveraging the various strategies that may have a significant impact on healthcare-associated infections and other quality measures.

Also, like the Michigan Hospital Association, (MHA), the WVHA has created the infrastructure and collaborative environment to address a variety of quality of care issues in West Virginia hospitals. In fact, we have been working with West Virginia hospitals since the WVHA Board of Trustees approved the development of the West Virginia Center for Patient Safety in 2007. The Center's goal is to improve patient safety and the quality of health care through the application of science and implementation of best-practice, evidence-based medicine to save lives and reduce costs. Partner organizations include the West Virginia Medical Institute (WVMI), our State's Quality Improvement Organization and the West Virginia State Medical Association (WVSMA).

A key project of the Council was the establishment of a Uniform Medication Form designed to keep track of all the prescription medications, over-the-counter medications, and herbal supplements that a person takes when they are home. With this project, it is our goal that medication safety will be improved by providing a universally consistent

process for communicating vital patient information regarding all medications and allergies across the continuum of care.

An arm of the WVCPS is the West Virginia Patient Safety Council (WVPSC) to provide an ongoing stream of methodology to improve internal hospital quality of care and patient safety systems. Several hospital projects have been completed or are underway including universal color-coding for hospital emergencies to address the lack of uniformity that exists among organizations on the emergency code systems. The outcome of these discussions led to a project focused on hospitals using color-coded armbands to signify a message to employees about special needs for their patients. Other projects include incorporating and expanding the "Universal Protocol" for preventing wrong site surgery created by the Joint Commission.

We would be happy to share more information on these and other quality and patient safety projects facilitated and sponsored by the WVHA. It is important to point out however that although hospitals would like to participate in all initiatives, each hospital must prioritize efforts according to available resources, constraints and organizational and individual capacity for engaging in such efforts. External funding ultimately becomes a source of concern.

However, it is through these and other projects that we believe the WVPSC and the WVCPS has transformed the culture of competition related to quality care to one of collaboration where organizations freely and voluntarily share data and experiences in order to learn from one another how to achieve excellence for all patients in West Virginia hospitals.

Finally, I am pleased to inform you that WVHA and its member hospital are scheduled to implement the *ICU Collaborative* in coordination with Johns Hopkins to address infections in hospital intensive care units. We anticipate the kick-off for this project will be in late summer-early fall of 2008 and we are excited about the changes and improvements to patient care that this collaborative will bring to West Virginia's hospitals.

The WVHA and its member hospitals are proud to be among the state associations leading the efforts to institute statewide quality and patient safety programs including the prevention of infection. We are particularly proud of having worked collaboratively to ensure passage of statewide infection collection and reporting legislation that we believe will serve as a launching pad for other quality and patient safety initiatives leading to comprehensive data collection. We stand ready to work with key stakeholders and policymakers in seeing these efforts through.

We concur with your assessment that hospital associations have a key role to play in any national effort to address HAIs. As the direct line contact for most hospitals in the nation, state associations and the American Hospital Association (AHA) can play a key role to facilitate setting priorities which streamline and enhance the implementation of the most appropriate of the large number of recommended practices cited in the recent report by

the Government Accounting Office (GAO) report you reference. It is important to point out however, that data collection, analysis and dissemination as well as education and collaborative learning opportunities necessitate resources that stretch already strained hospital association and member hospital finances.

I welcome the opportunity to share with the oversight committee the work that WVHA and its members are doing in the area of HAIs and other quality and patient safety initiatives. Promoting quality and safety in health care delivery is a core value for WVHA and all of its member hospitals. Please do not hesitate to contact me at (304) 353-9716 or at joelet@wvha.org.

Sincerely,

Joseph M. Letnaunchyn
President

cc: The Honorable Shelley Moore Capito
The Honorable Alan B. Mollohan
The Honorable Nick Rahall