American Hospital Association

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February 5, 2009

Donald Wright, M.D., M.P.H.
Principal Deputy Assistant Secretary for Health
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., 716-G
Washington, DC 20201

Dear Dr. Wright:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 38,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Department of Health and Human Services' (HHS) *Action Plan to Prevent Healthcare-Associated Infections.* Our specific comments on each section of the plan are discussed below.

TARGETS AND METRICS

The AHA appreciates that HHS recognizes the importance of working synergistically with other national stakeholder organizations, such as the National Quality Forum (NQF) National Priorities Partners, to identify common targets and metrics. The National Priorities Partners consists of health care providers and purchasers, government agencies, organizations dedicated to quality improvement and measurement, and consumer representatives. The group's broad representation provides a consensus among stakeholders that holds tremendous promise as a collective effort around an agreed upon set of priority infection-related issues. Many of the targets and metrics identified by HHS are NQF-endorsed measures or goals of the National Priorities Partners. However, the department's plan also includes several new goals that are not part of the National Priorities Partners set. We urge HHS to strictly adopt only the goals and objectives previously adopted by the National Priorities Partners.

PRIORITIZED RECOMMENDATIONS

The AHA is pleased that HHS included updated guidelines from the Society for Healthcare Epidemiology (SHEA)/Infectious Diseases Society of America (IDSA) *Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals* to capture practices not included in previous Centers for Disease Control and Prevention (CDC) guidelines. The SHEA/IDSA guidelines reflect the most recent recommended practices and represent a consensus of among stakeholder organizations. However, we are concerned that HHS included

only priority recommendations that are specific to individual infection types and ignored more global recommendations, such as hand-washing, to prevent and reduce all infections. Global recommendations can reduce infections of all types and from all organisms and are an important component of a hospital's infection control strategy. We urge HHS to include some broader recommendations for infection control and recommend that the department refer to the SHEA/IDSA compendium, as it offers the most salient and timely set of recommendations.

INCENTIVES AND OVERSIGHT

This section of HHS' report outlines the various regulatory and oversight policies of the Medicare and Medicaid programs that could support the department's initiative to reduce infections. It was primarily written by the Centers for Medicare & Medicaid Services (CMS) and reviews the Medicare Conditions of Participation (CoPs), the quality performance measurement pay-for-reporting program, and other policies and programs run by CMS.

We appreciate that CMS acknowledges that flexibility must be built into the Medicare CoPs to allow for advances in medical practice that improve the quality of care. The development of best practices and nationally recognized guidelines often is updated more quickly in practice than CMS can update its regulatory policies. We believe allowing hospitals and practitioners this flexibility to adopt new innovations is critically important. A vital part of this flexibility is allowing hospitals to conduct their own needs assessment and determine the infection control issues that are most pertinent to their patients and communities. Hospitals should be allowed to focus on those issues most relevant to their own facilities; attention to specific organisms or types of infections should never be dictated into the CoPs.

CMS notes that the CoPs are written in a general fashion, and that the Interpretive Guidelines for the CoPs provide a more specific discussion of what steps hospitals should take to reduce and prevent infections. However, we find that the Interpretive Guidelines are a poor vehicle for the promulgation of these types of regulatory requirements. The Interpretive Guidelines are written exclusively by CMS with no opportunity for public comment. In developing this action plan to reduce infections, HHS has reached out to external stakeholders and made a point to include opportunities for public comment in the development and finalization of the action plan. We hope that the same spirit of inclusiveness will be offered if CMS chooses to update the infection control requirements of the CoPs and their Interpretive Guidelines.

For the purposes of the hospital-acquired conditions policy, the *Deficit Reduction Act of 2005* required CMS to identify preventable complications of care that are either high cost or high volume or both; result in the assignment of a patient to a Medicare diagnosis-related group (DRG) that has a higher payment when present as a secondary diagnosis; and be reasonably preventable through the application of evidence-based guidelines. CMS expanded its list of hospital-acquired conditions before the policy was fully implemented and has expressed through the HHS action plan and other venues that it intends to consider further expanding the list of conditions. Before adding new conditions to its list, the AHA encourages CMS to consider the unintended consequences that could arise from the hospital-acquired conditions policy. Trying to accurately code for some of these conditions that are present on admission may lead to

excessive testing for patients entering the hospital. The necessity to complete diagnostic tests before a patient is admitted to confirm whether an infection is present on admission could lead to delayed admissions for some patients and disrupt efficient patient flow. Before expanding the current list of conditions, CMS should conduct an evaluation of the implementation of the current list of conditions to examine for any unintended consequences.

CMS discusses the collection of data on hospital quality through the Hospital Quality Alliance (HQA) initiative and the Medicare pay-for-reporting program and suggests that additional infection-related measures could be added to the pay-for-reporting program in the future. The AHA recommends that two measures of infection rates for surgical site infections and central line catheter-associated blood stream infections should be a priority for inclusion in the pay-for-reporting program. These measures were adopted by the HQA in 2008, yet CMS chose not to include them for reporting for fiscal year 2010. These measures are ready for implementation for public reporting. They have been thoroughly specified, are currently used in other reporting initiatives, are salient to consumers and hold important information that hospitals can use for their quality improvement programs.

In general, we believe that all measures added for public reporting must first go through the rigorous, consensus-based assessment processes of both the NQF and the HQA. Through the NQF, interested health care stakeholders come together to choose measures that are useful for these quality improvement purposes. Through the HQA, public and private partners come together to identify and focus on areas for quality improvement that are critical to hospitalized patients and choose from among the NQF-endorsed measures those that best assess quality in the selected priority areas.

RESEARCH

The AHA is pleased that the department's agenda includes research to examine the barriers to adherence to recommended practices and the development of strategies to overcome those barriers. More translational research is needed to help us understand how to take the scientific evidence that shows how infections can be prevented and determine how to implement those practices in real-world care delivery settings. We agree with the department that more information is needed to understand the human and organizational factors affecting the adoption of effective infection control and prevention interventions.

INFORMATION SYSTEMS AND TECHNOLOGY

The AHA agrees with HHS that the separate data systems and databases currently used by different agencies have resulted in data "silos" that prevent the synthesis and integration of information and stifles our ability to learn from these efforts. Providers should be able to report healthcare-associated infection data and other quality data to the department using one common data source. A common data source will eliminate reporting redundancy and ensure that data element definitions and formats are standardized.

The *Hospital Compare* system, administered by CMS, should be the common data platform that is used and more resources should be devoted to improving and upgrading its infrastructure. A

main advantage of the *Hospital Compare* system is that the data collected through it are comparable, reliable and validated, and shared with the public. Because the *Hospital Compare* system uses detailed data specifications and processes, all information collected through it is comparable across providers and audited to ensure its accuracy. The data collection systems used by other HHS agencies do not have this same reliability. Therefore, we recommend that *Hospital Compare* be used as the centralized data system. However, to ensure that the *Hospital Compare* system can manage the inclusion of an increased amount of data, HHS should make significant upgrades to the system's capacity.

Thank you for this opportunity to comment. If you have any questions about these remarks, please contact me or Nancy Foster, vice president for quality and patient safety, at (202) 626-2337 or nfoster@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

Cc: Julie Moreno, HHS
Rani Jeeva, HHS