



**American Hospital
Association**

**Statement of the
American Hospital Association
before the
U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Oversight and Investigations Hearing**

**Public Reporting of “Hospital-Acquired Infections”
Empowering Consumers, Saving Lives**

March 29, 2006

Controlling and preventing infections is a patient safety priority for America’s hospitals and permeates every aspect of hospital care. Hospitals understand that better, safer care, faster recovery, improved comfort for patients, and lower health care costs all come from reducing and preventing infections. A number of exciting initiatives are achieving remarkable results in reducing and preventing healthcare-associated infections (HAIs). We will provide important information on what HAIs are and what is being done every day in America’s hospitals to address them. In addition, we will describe our support for sharing meaningful information on HAIs with the public and how the American Hospital Association (AHA) is partnering with public and private organizations to make this happen.

BACKGROUND

The risk of infection from numerous sources threatens people every day. We are exposed to bacteria and viruses that cause colds, strep throat, ear infections or more serious infections such as sexually transmitted diseases or pneumonia. But in the health care setting, such as a doctor’s office, nursing home or hospital, the risk of infection is more acute for two key reasons: Patients’ immune systems may already be weakened by disease, injury or the medications and procedures being used to treat whatever has prompted them to seek care; and people may come into contact with others infected by more powerful viruses and bacteria.

Hospitals and clinicians understand that they must take action to ensure that the risk of infection is minimized, and they are taking precautionary steps that range from the routine sterilization of instruments to the use of specialized ventilation systems to reduce the chance of the airborne spread of germs. For effective strategies to prevent infections, hospitals look to the guidelines developed by the Centers for Disease Control and Prevention (CDC) and professional

associations, such as the Association for Professionals in Infection Control and Epidemiology, the Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America.

Many hospitals also have become involved in a variety of national and local efforts targeting infections, including the Surgical Care Improvement Project, the 100,000 Lives Campaign organized by the Institute for Healthcare Improvement, the Maryland Patient Safety Center, the Keystone Project of the Michigan Health & Hospital Association and other collaborative efforts. Each of these efforts emphasizes changing practices and procedures to adopt strategies shown to be effective in reducing infections. Such strategies include common sense precautions like hand washing, and changing care practices, such as appropriately timing the administration of an antibiotic so that it is received an hour before the start of a major surgery; keeping patients' body temperature at a consistent level during certain surgeries, and several specific protocols for patients on ventilators. Many hospitals also are adopting highly sophisticated services, such as in-house genetics labs that allow staff to test specimens of bacteria and identify an organism's genetic "fingerprint" within hours so they can move more quickly to contain and eradicate infections.

In spite of these actions, the risk of infection can never totally be eliminated.

What is a healthcare-associated infection? Healthcare-associated infections – terminology adopted by the CDC – are generally defined as any infection that develops in a patient 48 hours or more after being seen in a health care setting. More specifically, it refers to an infection acquired in the setting in which health care was provided, which was not present or incubating at the time the patient was treated. “Hospital-acquired infection,” the term used by the Subcommittee in the title of today’s hearing, is a subset of this broader issue.

Occurrence rate. HAIs can occur within any health care setting. In hospitals, the greatest risk for infections is found among post-surgical patients, intensive care unit (ICU) patients and patients with serious diseases, such as HIV and cancer. It is estimated that between 5 percent and 10 percent of hospitalized patients in the U.S. will experience an HAI. Similar rates are seen in Australia and most European countries. Infection rates for long-term care facilities are estimated to range from 1 percent to 14 percent. While HAIs occur in all health care settings, we are unaware of reliable data for infection rates for ambulatory surgery centers, physician offices or other health care settings.

It also is important to note that not all infections are the same. Some, such as blood stream infections, are particularly dangerous, while urinary tract infections are less likely to lead to long-lasting harm for the patient.

Making matters more complex, several new strains of bacteria have emerged that are resistant to the usual antibiotics available to clinicians and are therefore particularly difficult to combat. Hospitals and other health care organizations are taking steps to reduce the development of antibiotic resistance, particularly with surgical wound infections, by monitoring when antibiotics are instituted, whether they are the right antibiotics to be used in either preventing or treating an

infection, and by having those antibiotics discontinued at the appropriate time so that overuse does not lead to resistance.

Existing regulation of HAIs. Health care organizations are regulated by many agencies at the state and federal levels, such as Medicare and Medicaid. In addition, approximately 80 percent of hospitals, which represent about 95 percent of hospital beds in the United States, are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Each government agency and the JCAHO have infection regulations that an organization must comply with in order to be licensed and/or accredited.

- Every hospital treating Medicare patients must have an active program for the prevention, control and investigation of infections and communicable diseases.
- Every hospital that is accredited by the JCAHO must have a program for reporting infection surveillance, prevention and control. They also must have an infection control officer in place.
- Three types of surveillance can be used by a health care organization:
 1. Hospital-wide or “active” – provides data on all infection sites/units.
 2. Targeted surveillance – provides data on specific infections/units.
 3. Objective/priority-based – focuses on specific institutional problems.
- Staffing – The general recommendation is one infection control practitioner (often a nurse) to 250 beds, but many hospitals have one practitioner to 125 beds.

REPORTING

It has been difficult to find measures that will lead to meaningful, accurate information for the public about HAIs. In fact, the CDC’s Healthcare Infection Control Practices Advisory Committee has concluded that there is insufficient evidence to recommend for or against public reporting of HAIs. Some professional organizations have issued guidance concerning how infection rates should be reported. According to infection control experts such as the Association for Professionals in Infection Control and Epidemiology and the Society for Healthcare Epidemiology of America, an infection rate must be calculated based on a standardized process. It must specify which type of patient is to be sampled; how patients will be identified; against what measures patients will be evaluated; and how infections will be defined and reported. A lack of a clear methodology and standardized definitions and procedures could result in inaccurate reporting of infection rates.

Just last year, Congress enacted federal legislation that created a framework and process for reporting medical errors, of which HAIs are one. The Patient Safety and Quality Improvement Act of 2005 (P.L. 109-41) is a milestone. It will allow hospitals, physicians and other health care providers to voluntarily report medical errors as well as other events that did not – but could have – resulted in a medical error in a manner that is legally privileged and confidential. As a result, this law is much more likely to encourage such reporting and to help establish within health care a “culture of safety.” Reports made under the law to Patient Safety Organizations allow experts to analyze problems, share recommended solutions and advance patient safety. The legislation will facilitate the sharing of infection-related data and best preventative practices.

AHA VIEW

The AHA supports sharing information about healthcare-associated infections with the public. That information must be meaningful for consumers and must:

- be based on solid data and good measures (see Attachment A for AHA's Principles of Quality Measures);
- target infections that have the highest potential for greatest harm; and
- focus on areas where clinically proven prevention efforts exist.

The AHA supports voluntary reporting of HAI-related information through the Hospital Quality Alliance (HQA). The HQA is a public-private partnership of hospitals, consumer groups, clinicians and the government formed to collect and report agreed-upon hospital quality measures to the public. The HQA is made up of government agencies, including the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ); professional organizations, such as the AHA, American Medical Association, American Nurses Association, Association of American Medical Colleges, Federation of American Hospitals, JCAHO, National Association of Children's Hospitals and Related Institutions, National Quality Forum (NQF) and U.S. Chamber; and consumer organizations such as, AARP, AFL-CIO and the Consumer-Purchaser Disclosure Project.

Specifically, the AHA supports voluntary reporting through the HQA of surgical infection prevention measures, surgical wound infection rates and central line blood stream infection rates. Further, the HQA is working to make data on these measures public.

- **Surgical infection prevention measures.** More than 1,300 hospitals are already sharing comparable information on infection prevention measures on the HQA's Web site, www.HospitalCompare.hhs.gov. Others are in the process of beginning to collect and share this data, so the number of hospitals reporting these measures will increase over time.
- **Surgical wound infection rates.** The HQA, as a part of its agreement to adopt the Surgical Care Improvement Project (SCIP) measures, will consider adding surgical wound infection rates as soon as the technical specifications are finalized by SCIP. A national quality partnership, SCIP's goal is to reduce the most common surgical complications, including surgical wound infections and pneumonia, by 25 percent by 2010. The SCIP Steering Committee is comprised of 10 national organizations including the AHRQ, American College of Surgeons, CDC, CMS, Institute for Healthcare Improvement (IHI), and AHA among others.
- **Central line blood stream infection rates.** Hospitals have not yet been asked to submit these data because the measures are undergoing review as part of the NQF's consensus process. Once adopted as an NQF-endorsed standard measure, the HQA will move forward to collect and report data on these measures.

Hospitals are working hard to improve the quality and safety of patient care. In fact, hospitals and health systems across America are involved in several exciting initiatives in which they are achieving remarkable results in reducing and preventing HAIs. Here are a few examples:

- The Michigan Health & Hospital Association's Keystone Project, working with the Johns Hopkins University, has achieved significant, measurable improvements in reducing HAIs. Of the 127 ICUs participating, 68 have reported zero blood stream infections or ventilator-associated pneumonia for six months or more.
- In 2004, the Maryland Patient Safety Center, a partnership of the Maryland Hospital Association and Delmarva Foundation, set out to improve care in the ICU. Using evidence-based protocols, the collaborative saw the rate of preventable catheter-related blood stream infections reduced by 36 percent and ventilator-associated pneumonia drop by nearly 20 percent within nine months.
- Through the IHI's 100,000 Lives Campaign more than 3,000 hospitals are implementing one or more evidence-based interventions and establishing new standards of care. For example, a consortium of 23 well-respected teaching hospitals in New Jersey have reduced their blood stream infection rates by 50 percent, and in their ICUs, the rate of ventilator-associated pneumonia has been reduced by 75 percent over a nine-month period. In addition, 14 other hospitals have had no cases of ventilator-associated pneumonia for one year or more. Further, participants in IHI's collaboratives to prevent surgical site infections and central line infections have seen their infection rates plummet, often to zero.

Finally, the CDC is an essential partner in hospitals' efforts to fight HAIs. As such, we are concerned over the proposed cuts to the CDC that are included in the Administration's budget proposal for fiscal year 2007. Some reports estimate the cuts to be as deep as 8 percent over two years.

CONCLUSION

Hospitals work every day, in conjunction with physicians, nurses and other hospital staff, to provide the best possible care for their patients. This includes battling all infections, regardless of their origination, as well as stepping up efforts to ensure that the delivery of care itself does not spread infection. It also includes efforts to tackle infections that continue to grow resistant to available antibiotics. Equally important, hospitals are committed to providing consumers with meaningful information that will allow them to make informed health care decisions.

Voluntary efforts, such as those found in the Patient Safety and Quality Improvement Act of 2005 and the HQA and its Hospital Compare Web site, will produce the most meaningful information, lead to a focus on infection prevention and ultimately lead to increased improvements in quality of care. The AHA will continue collaborating with the CMS, AHRQ, CDC and others to help hospitals provide the safest, most effective care possible. We also welcome the opportunity to work with members of the Subcommittee on this important issue.

AHA Principles of Quality Measures

Assessing and improving the quality of health care services is one of the most important functions of our health care system. Health care providers must rely on sound data as they strive to continuously improve patient care. In addition, quality information is needed to assure and inform consumers who are choosing health care providers and making treatment decisions. In order to meet these goals, certain principles need to guide the development of quality measures:

- Quality measures must be data based, scientifically driven, and should produce consistent and credible results.
- Quality measures should be valid, reliable, precise and meaningful.
- Quality measurement should include structure, process and outcome measures.
- Quality measurement activities should stimulate improvement and learning, support effective staff practices, and be conducted in a non-punitive, blame-free manner.
- Health care organizations, physicians and other caregivers should work collaboratively to implement a set of quality measures that are prioritized and trended over time, with formal processes in place to improve performance and reduce variation.
- Methodologies used to create quality measures must be shared publicly to ensure the integrity and enhanced understanding of reported data.
- Quality measurement should seek to reduce burden, increase uniformity and increase comparability.
- Quality measures should demonstrate value and cost-effectiveness.