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**Testimony of Consumers Union
Hawaii House Committee on Judiciary
Regarding House Bill 2829
Public Reporting of Hospital-acquired infection rates
February 9, 2010**

Consumers Union, nonprofit publisher of *Consumer Reports*, strongly supports HB 2829, by Rep. Scott Nishimoto and others. HB2829 will require acute care hospitals in Hawaii to report the rate of certain hospital-acquired infections to the public.

Six years ago, Consumers Union launched a national campaign, www.StopHospitalInfections.org, advocating for public disclosure of hospital-acquired infection rates to inform people about the safety of their hospitals and to motivate hospitals to do more to prevent infections occurring in their facilities.

Twenty-seven states now have laws requiring reporting of hospital infection rates, an "outcome measure" that we believe is the best measure of the overall effectiveness of a hospital's infection control program. Twenty-one states use a system of reporting similar to that proposed in HB 2829.

HOSPITAL-ACQUIRED INFECTIONS ARE PREVENTABLE

Hospitals treat many very sick people who are more likely to contract an infection due to their already weakened state. Invasive procedures, like surgery, bypass the body's defenses against infection, creating natural pathways for disease. Intravascular (IV) lines used to deliver medication, fluids and nourishment also put patients at risk, especially those in intensive care units. Even so, most studies show that hospital infections can be significantly reduced by implementation of infection control practices, such as hand washing, and when hospitals commit to well organized infection control programs.

The problem is that not all hospitals use these proven strategies to prevent infections. For example, hand hygiene is the first line of defense against the spread of bacteria that cause infections in a hospital setting. Despite plenty of research establishing that improved hand washing reduces infection rates, hand washing compliance rates for nurses and doctors are generally less than 50%.

For the areas of the hospital most prone to the spread of infection, a number of other infection control practices have been proven effective, such as aggressive monitoring and education in neonatal ICU units and using catheters coated with antimicrobial or antiseptic agents. Surgical site infections, the second most common hospital-acquired infection, can be reduced through careful application of antibiotics before and after surgery. And a simple prevention checklist, paired with a culture of

safety that allows nurses to remind doctors to follow the checklist, has led to significant reductions in bloodstream infections.

Still, hospitals are not motivated to adopt these and other life-saving practices.

PUBLIC REPORTING WORKS

Epidemiologists, hospitals and the CDC identified the growing problem of preventable hospital-acquired infection more than three decades ago. Today many hospitals track their own infection rates, especially in units like the ICU or neonatal ward where infections are common or patients are particularly susceptible. But most do not currently report infection rates to any regulatory agency or accreditation body. They cannot compare their performance to other area hospitals, and their patients cannot know if they are getting the best available care.

Many states report hospital-specific quality of care information to the public, and in those states, hospitals are more motivated to improve their outcomes. Research shows the lowest performing hospitals are the most motivated to change.

New York was among the first states to compare hospital mortality for coronary artery bypass grafts (CABG). When the early reports were issued, hospitals with substantially higher mortality rates responded by examining their surgical systems and identifying areas of improvement. Winthrop University Hospital on Long Island fared poorly among heart programs, so it hired a renowned cardiologist to overhaul its program, hired additional staff, and created a new database system to monitor quality of care. Within two years, the cardiac program had one of the state's lowest mortality rates.

Since public reporting of infection rates is a relatively new activity, there is not yet much assessment of its impact on reducing infections. However, recent evidence from Pennsylvania shows the potential power of public reporting hospitals' infection rates. In the past two years of reporting all infections occurring in the states' hospitals, infections dropped by almost eight percent statewide. While not all hospitals reduced their infections, most did.

THE COST OF HOSPITAL-ACQUIRED INFECTIONS

The cost of hospital-acquired infections can be assessed at numerous levels. The **human cost** is by far the greatest: each year two million patients get an infection while being treated in our nation's hospitals, and almost 100,000 of them dieⁱ - more than die from car accidents and homicides combined.

Cost to the health care system: The Centers for Disease Control and Prevention (CDC) estimates the hospital costs for these infections to be as high as \$45 billion each year.ⁱⁱ Most estimates only look at hospital costs, but the cost for each patient goes far beyond hospital care to include medications, home health care, doctors' services, physical therapy, wound care, etc.

The best public estimates of the actual cost we have to date are from Pennsylvania, which reports rates on all four of the major types of infections (surgical site infections, blood-stream infections, ventilator associated pneumonia, and urinary

tract infections) and reports on infections occurring throughout the hospital. The state also collected information directly from private insurers to get a more accurate picture of the actual costs to the health care system.ⁱⁱⁱ The private insurance payments ranged from \$27,000 for urinary tract infections to \$80,000 for blood stream infections.^{iv} In 2005, Pennsylvania estimated the total charges for the state's infections at \$1.4 billion.

The California governor's office estimated the cost of hospital-acquired infections in that state to be \$3 billion each year. And, a Massachusetts Panel estimated the total annual cost of hospital-acquired infections there to be \$200 million to \$473 million.

Cost to State Government.

The cost of hospital-acquired infections to state funded health care programs is substantial and must be considered when looking at the investment needed for a public reporting system. The increased public and hospital awareness that comes with such a system will reduce infections and has the potential for saving significant state dollars.

While we do not know the actual cost to state health care programs in Hawaii, a 2007 study by the Association of Professionals in Infection Control and Epidemiology (APIC), found that Medicaid was the payer for 11.4% of hospital-acquired infection cases. A 2005 Pennsylvania report analyzing who was paying for hospital-acquired infections in that state found that Medicaid paid for 9% of all hospital-acquired infections, accounting for 18% of the hospital charges for that state's infected patients. Pennsylvania estimated that the average charges for Medicaid patients with an infection were more than \$391,000, while the average charges for Medicaid patients without an infection were just under \$30,000. Oregon estimated that the excess Medicaid costs for hospital-acquired infections in that state exceeded \$2.4 million in 2005.

HOSPITAL-ACQUIRED INFECTION REPORTING IN OTHER STATES

Twenty-seven state laws require reporting of the rate of various types of infections: AL, CA, CO, CT, DE, FL, IL, MA, MD, ME, MN, MO, NJ, NY, NH, OH, OK, OR, PA, RI, SC, TN, TX, VA, VT, WA, WVA. So far 17 states have issued reports - CO, DE, FL, IL, ME, MN, MO, NY, OH, OK, PA, RI, SC, TN, VA, VT, WA - which can be accessed at http://www.safepatientproject.org/content_type/state_disclosure_report/

Most of these states (21) have decided to use the CDC National Healthcare Safety Network (NHSN) as the data collector. While NHSN is a voluntary, confidential reporting system, the laws in these states establish the requirement to report infection rates. The hospitals send data to NHSN and then provide the information to the state agency responsible for the public reports. NHSN has been developed with these emerging state laws in mind and facilitates the sharing of data. The NHSN is an update of a system that was in place at CDC for more than 30 years. The prior system had limited capacity (315 hospitals) while NHSN states that it will be able to handle every hospital in the country.

HB2892 would require Hawaii hospital to follow this method that other states have successfully used to require hospitals of all sizes to report their infections. There is no cost to the state to use the CDC NHSN system as the collector of hospital infection information.

House Bill 2892 will significantly improve the safety of Hawaii's hospitals. We urge you to support its passage. Please contact me if you have any questions.

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ⁱ "Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002," R. Monina Klevens, DDS, MPH, Jonathan R. Edwards, MS, Chesley L. Richards, Jr., MD, MPH, Teresa C. Horan, MPH, Robert P. Gaynes, MD, Daniel A. Pollock, MD, Denise M. Cardo, MD, Public Health Reports, March-April 2007, Volume 122, pp. 160-166.

ⁱⁱ Scott, R. Douglas, "The Direct Medical Costs of Health care-associated infections in U.S. Hospitals and the Benefits of Prevention," Centers for Disease Control and Prevention, March 2009.

ⁱⁱⁱ "PHC4 • Hospital-acquired Infections in Pennsylvania, January 1, 2005 – December 31, 2005," November 2006, page 2.

^{iv} The average "costs" in Pennsylvania: SSI: \$27,470; UTI: \$43,932; VAP: \$62,509; BSI: \$80,233; Multiple infections: \$91,898