



LATE TESTIMONY

HOUSE COMMITTEE ON HEALTH
Rep. Ryan I. Yamane, Chair

Conference Room 329
Feb. 4, 2011 at 9:00 a.m.

Supporting HB 889 with an amendment.

The Healthcare Association of Hawaii (HAH) advocates for its member organizations that span the entire spectrum of health care, including all acute care hospitals, as well as long term care facilities, home care agencies, and hospices. The Healthcare Association supports HB 889 with an amendment. HB 889 requires hospitals to report to the Department of Health (DOH) certain hospital-acquired infections (HAIs).

HAIs are of great concern to all hospitals, which are making many efforts to reduce and prevent them. The federal government is driving the effort to reduce HAIs. For example the Agency for Healthcare Research and Quality (AHRQ) has funded numerous HAI projects. In addition, the Centers for Medicare and Medicaid Services (CMS) plans to have hospitals report certain types of HAIs, including central line-associated bloodstream infections (CLABSI) and surgical site infections (SSI).

The reporting and analysis of HAI data involves issues such as confidentiality, infrastructure, and funding. DOH, HAH, and Mountain-Pacific Quality Health are working to coordinate government agencies and providers to maximize the effectiveness of all efforts to control HAIs.

In addition, the Healthcare Association has created a Quality Committee composed of representatives of hospitals, nursing homes, and home care agencies. The committee has adopted various initiatives to reduce and prevent HAIs and is collaborating with DOH, AHRQ, the American Hospital Association (AHA), and Johns Hopkins University Quality and Safety Research Group. The committee is addressing a range of different types of infections and is targeting catheter-associated urinary tract infections (CAUTI) at this time.

DOH, HAH, Mountain-Pacific Quality Health, and HHIC have worked together to develop HB 406, which requires certain types of HAIs to be reported. The substance of HB 406 should replace the substance of HB 889 so that it can align with federal efforts to reduce HAIs.

Attached to this testimony is a table showing the types of HAIs that will be reported from 2011 to 2013. It is our understanding that the Department of Health would report CLABSI by June 2012 and SSI by June 2013.

With the proposed amendment, the Healthcare Association supports HB 889.

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Healthcare Associated Infections Reporting

Healthcare associated infection Reporting	CMS reporting dates	Department of Health Reporting
Central Line associated bloodstream infections	January 2011-December 2011	June 2012
Surgical Site Infections	January 2012-December 2012	June 2013
Ventilator associated pneumonia	Has not been determined by CMS	
Catheter-associated urinary tract infections	Has not been determined by CMS	
Methicillin resistant staphylococcus aureus	Has not been determined by CMS	



**Testimony of Consumers Union
Hawaii House Health and Welfare Committee
Regarding House Bill 889
Public Reporting of Hospital-acquired infection rates
January 4, 2011**

Consumers Union, nonprofit publisher of *Consumer Reports*, strongly supports HB 889, by Rep. Scott Nishimoto and others. HB889 will require acute care hospitals in Hawaii to report the rate of certain hospital-acquired infections to the public.

In 2003, Consumers Union launched a national campaign 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. The Safe Patient Project (www.SafePatientProject.org) now covers several medical harm issues in addition to health care-acquired infections: drug safety, medical errors and physician accountability.

Twenty-seven states and the District of Columbia 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-two states use a system of reporting similar to that proposed in HB 889.

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 often not motivated to adopt these and other life-saving practices even though most infections are preventable. Full commitment of the entire organization is

necessary to make hospitals safer – from the CEO to the housekeeping staff to the physician leaders to the bedside nurses. Everyone must be involved to prevent infections.

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, evidence from Pennsylvania shows the potential power of public reporting hospitals' infection rates. In a two year period in which the same measures were reported, the number of infections dropped by almost eight percent statewide. While not all hospitals reduced their infections, most did. Also, in New York's third year of reporting, many hospitals showed a decrease in certain surgical infections between 2006 and 2009, with 39% of hospitals reporting zero infections for hip surgery. Also, significant reductions were documented in the state for central line associated bloodstream infections.ⁱ

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 almost two million patients get an infection while being treated in our nation's hospitals, and almost 100,000 of them dieⁱⁱ - 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.ⁱⁱⁱ 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, and wound care.

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, bloodstream infections, ventilator associated pneumonia, and urinary tract infections) and reports on infections occurring throughout the hospital. In its first several years of reporting, the state also collected information directly from private insurers to get a more accurate picture of the actual costs to the health care system.^{iv} The private insurance payments ranged from \$27,000 for urinary tract infections to \$80,000 for blood stream infections.^v In 2005, Pennsylvania estimated the total charges for that 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.^{vi} 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.^{vii} Oregon estimated that the excess Medicaid costs for hospital-acquired infections in that state exceeded \$2.4 million in 2005.^{viii}

HOSPITAL-ACQUIRED INFECTION REPORTING IN OTHER STATES

Twenty-seven state laws and the District of Columbia 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 22 states have issued reports - which can be accessed at http://www.safepatientproject.org/content_type/state_disclosure_report/

Most of these states (22 and the District of Columbia) 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 is now collecting data from more than X hospitals and has the capacity to collect information from every hospital in the country. With this new system, states, hospitals and CDC has improved awareness of the problem.

HB889 would require Hawaii hospitals to report infections using the CDC NHSN system. There is no cost to the state to use this system as the collector of hospital infection information.

FEDERAL REPORTING OF HOSPITAL-ACQUIRED INFECTION AND WHY STATE LAWS ARE STILL NEEDED.

Beginning January 1, 2011, the federal government implemented a reporting policy for hospital-acquired infections – hospitals that do not report their central line associated bloodstream infections in the ICU for 2010 will incur a two percent cut in their Medicare payments. This has proved to be a strong incentive as almost all hospitals covered by this policy have chosen to report other quality measures (published on Hospital Compare website).

So, with this federal policy, why should a state pass a reporting law? There are several reasons:

- All hospitals are not required to report under the federal policy, for example, children's hospitals and critical access hospitals are not covered. Most state laws cover all hospitals.
- Most states require more information to be reported to the public than the federal policy, such as would be required under HB889.
- States can use the information collected to assist hospitals in improving their safety by identifying those that need the most help and creating collaborative projects among hospitals.
- States regulate hospitals and are in a position to use this information could to put in place corrective actions where needed.
- Consumers are more likely to seek information from their local agencies than the federal government and states can help to make the information more understandable to the public.
- Finally, states can validate the information to ensure that reporting is accurate and reliable.

House Bill 889 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 New York State Health Department, "Hospital-acquired infections New York State 2009," September 1, 2010.

ⁱⁱ "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.

ⁱⁱⁱ 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.

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

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

^{vi} Murphy, Denise and Whiting, Joseph, "Dispelling the Myths: The True Costs of Health care Associated Infections," Feb 2007, page 3.

^{vii} PHC4 Research Brief, "Reducing Hospital-acquired Infections: The Business Case," Issue No. 8 • November 2005, page 2.

^{viii} Oregon Health Policy and Research, Research Brief, "Infections Due to Medical Care In Oregon Hospitals, 2003-2005."