HEALTHCARE-ASSOCIATED INFECTIONS:

A PREVENTABLE EPIDEMIC

Wednesday, April 16, 2008

House of Representatives,

Committee on Oversight and

Government Reform,

Washington, D.C.

Committee Hearings

of the

U.S. HOUSE OF REPRESENTATIVES

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The committee met, pursuant to call, at 11:09 a.m. In Room 2154, Rayburn House Office Building, Hon. Henry A. Waxman [chairman of the committee] presiding.

Present: Representatives Waxman, Kucinich, Davis of Illinois, Watson, Yarmuth, McCollum, Hodes, Sarbanes, Davis of Virginia, Burton, Shays, and Platts

Also Present: Representative Murphy of Pennsylvania.

Staff Present: Andy Schneider, Chief Health Counsel; Sarah Despres, Senior Health Counsel; Steve Cha, Professional Staff Member, Earley Green, Chief Clerk, Teresa Coufal, Deputy Clerk; Jesseca Boyers, Special Assistant; Ella

Hoffman, Press Assistant; Leneal Scott, Information Systems Manager; Kerry Gutknecht, Staff Assistant; Miriam Edel, Staff Assistant; Larry Halloran, Minority Staff Director; Jennifer Safavian, Minority Chief Counsel for Oversight and Investigation; Ashley Callen, Minority Counsel; Jill Schmaltz, Minority Professional Staff Member; Patrick Lyden, Minority Parliamentarian and Member Services Coordinator; Benjamin Chance, Minority Professional Staff Member; and John Ohly, Minority Staff Assistant.

Chairman WAXMAN. The meeting of the committee will come to order. Today we will examine an epidemic that causes about 2 million infections and 100,000 deaths each year and costs the Nation billions of dollars. This epidemic ranks sixth among the leading causes of death. It is largely preventable, and the sad fact is we are not doing nearly enough to prevent it.

The epidemic I am referring to is healthcare-associated infections. These are the infections that patients get when they are in the hospital, clinic, or even their doctor's office, receiving treatment for other illnesses.

Today's discussion will be limited to the infections patients get in the hospital. There are several types of healthcare-associated infections. Patients often need large catheters placed into their bloodstream. Improper procedures by physicians and nurses can contaminate these lines and cause bloodstream infections. When patients need surgery, improper procedures can lead to unnecessary infections of the surgical site.

Today's hearing will focus on what the Department of Health and Human Services is doing to address this epidemic. According to new findings by the Government Accountability Office, the Department is not providing the necessary leadership. It has not identified for hospitals the most important infection-control practices, and it is not

coordinating the collection of data from hospitals in order to avoid duplication and unnecessary burden.

The failure of HHS leadership is particularly regrettable because these illnesses, deaths, and costs are preventable. Moreover, the preventive measures don't require new technologies or large investments.

Thanks to the work of one of our witnesses, Dr. Peter Pronovost, and the efforts of Michigan hospitals, we know that by taking simple steps hospitals can significantly reduce the number of patients who become infected when they are receiving treatment for another condition. These steps are not expensive. Healthcare workers should wash their hands before inserting the catheter into a blood vessel. If a patient is going to undergo a surgical procedure, the hair around the surgical site should be removed with clippers, not a razor, so as to avoid nicks and cuts that can be roots of infection. Catheters should be withdrawn as soon as they are no longer necessary.

We are going to hear this morning from a hospital administrator whose hospital has taken these simple infection-control measures. He will explain that his hospital's infection rate dropped precipitously.

How many deaths could be prevented if all the hospitals took these simple steps? I asked the Society of Healthcare Epidemiologists to prepare an estimate of the number of

deaths from healthcare-associated infections that could be prevented by using proven interventions. They noted that data was limited, and analyzed just four kinds of healthcare-associated infections. According to their analysis, we could prevent tens of thousands of deaths each year just by doing what we already know how to do.

Earlier this week the Institute of Medicine reported that there would be a large cost savings if we simply put our knowledge into action. The IOM conservatively estimated that healthcare-associated infections result in extra costs of about 5 billion with a "B," billion per year to society as a whole.

Other infection-control measures may be promising, but are less well understood. For instance, two articles recently appeared in the top medical journals about screening for the drug-resistant bacteria known as MRSA. One concluded that MRSA screening did work. One concluded it did not.

HHS needs to help hospitals understand which strategies do work. But hospitals should not wait while HHS sorts out all the evidence. They should adopt the simple measures that are already proven and give their patients the benefit of the lowest achievable risk of infection.

It is not too often that a prevention strategy comes along that is simple, inexpensive to implement, and proven to be effective in reducing the number of patients' deaths. The

experience of the Michigan hospitals demonstrates clearly that this prevention strategy works.

Today we will try to understand why the Department of Health and Human Services is not doing more to lead in the dissemination and adoption of this strategy nationwide.

[Prepared statement of Chairman Waxman follows:]

******** INSERT 1-1 ********

Chairman WAXMAN. Before we call on the witnesses, I want to recognize Mr. Tom Davis for an opening statement.

Mr. DAVIS OF VIRGINIA. Thank you, Mr. Chairman.

A century and a half ago, Hungarian physician Ignaz Semmelweis noted that one of three women died from fever--one in three women died from fever after giving birth in hospitals. He was the first to make the connection between basic hygiene practices by doctors and the deadly trend. When he instructed his students to wash their hands before examining patients, the maternal death rate fell to less than 1 percent.

Today we think of our healthcare system as highly advanced and technologically sophisticated. But hospital infection rates remain stubbornly and unacceptably high. The very complexity of modern healthcare delivery can give persistent microbes many more places to hide. Distracted by all the costly gadgets, effective and cheap low-tech solutions like basic hand hygiene can be overlooked and undervalued.

This year, in this country, 1.7 million patients will contract an infection in a healthcare facility; 98,000 of those patients will not survive. Those who do may face degraded health, unnecessary time away from work and family, and the additional costs of treating a preventable complication of their original care.

Ed Lawton is one of those survivors. Facing surgery in 1998, Mr. Lawton could not have foreseen the most dangerous threat to his health would be antibiotic-resistant infections acquired in the hospital. That contamination put his life in danger, and needlessly added years to the course of his recovery. Mr. Lawton is a constituent of mine and a victim of the painful, costly, and too often deadly epidemic of hospital-acquired infections. His sad saga brings meaning to the often lifeless statistics about our healthcare system's dirty secrets. We are grateful he could be here to testify today on the impact and implications of this intractable public health threat.

On top of the human suffering, treatment of hospital-acquired infections adds $5 billion to healthcare spending annually. In a system already strained to meet urgent needs, the $5 billion is wasted fixing preventable mistakes. Those resources could be used to treat vulnerable children, or research or a cure for debilitating disease. Reducing the instance of infection would improve the quality of care, prevent needless suffering and death, and reduce waste.

It is a problem with known solutions, but the healthcare system has been largely ineffective at making progress. Why? One answer seems to be pervasive financial incentives that simply pay the bill for care-induced infections rather than

reward prevention or punish carelessness.

In an effort to reverse that flow, the Department of Health and Human Services recently engaged the powerful fiscal tool available to the Federal Government in the healthcare marketplace: Medicare repayments. By withholding reimbursements for certain hospital infections, the Federal Government sends a powerful signal that healthcare spending should align more closely with quality outcomes, and the signal is being heard.

That change in Medicare policy helped pave the way for similar changes in private insurance reimbursement. At the request of the Minority, the Leapfrog Group will testify this morning. They represent large private purchasers of healthcare, and will discuss the importance of incentives to focus spending on the quality, not just the quantity of care. We appreciate the Chairman's willingness to include their testimony in today's hearing. It is still too early to know the impact of these reforms, and the opportunities for change have not been exhausted.

HHS has yet to maximize the use of various health surveillance databases, expand the type of infections Medicare will no longer pay for, and partner with hospitals and payers to make infectious-control activities a priority. Health facility boards and CEOs need to be clear that infection prevention is an indispensable element in the

standard of care. Cultural behavioral norms will have to change and money may have to be invested to implement infection-control guidelines. And hospital accreditation standards should reflect stronger anti-infection requirements, demanding more than just a plan, but an actual program that produces measurable outcomes to reduce contamination.

We do know that there are significant opportunities to effect change in hospital infection rates. The Centers for Disease Control and Prevention has developed detailed guidelines for infection control. We will also hear about private research into healthcareinterventions that have dramatically lowered infection rates. The answer may seem simple--a little soap, a drop of bleach--but the broad-scale changes needed to clean up healthcare institutions won't be easy. Hearings like this shine the disinfecting light of public discourse on a critical public health problem, and we look forward to today's testimony. Thank you.

[The information follows:]

******** COMMITTEE INSERT ********

Chairman WAXMAN. Thank you very much, Mr. Davis.

I want to call forward our Panel 1: Edward Lawton a survivor of hospital-acquired infections; Cynthia Bascetta, Director for Healthcare Issues, Government Accountability Office; Peter Pronovost, Medical Director, Center for Innovation in Quality Patient Care and assistant professor, Department of Anesthesiology and Critical Care Medicine at Johns Hopkins University School of Medicine; John Labriola, Senior Vice President and Hospital Director, William Beaumont Hospital, Royal Oak; Leah Binder, Chief Executive Officer of the Leapfrog Group; Don Wright, M.D., Principal Deputy Assistant Secretary for Health, U.S. Department of Health and Human Services.

As you come forward to take your seat, why don't you remain standing, because it is the practice of this committee that all witnesses that testify do so under oath. So I would like you to please raise your right hand.

Mr. DAVIS OF VIRGINIA. Mr. Chairman, could I ask unanimous consent to let Mr. Murphy of Pennsylvania, Mr. Tim Murphy, participate in the hearing?

Chairman WAXMAN. Without objection, we would welcome his participation. We are pleased to welcome you today.

[Witnesses sworn.]

Chairman WAXMAN. The Chair wants to note for the record all the witnesses answered in the affirmative. So you are

properly under oath. And we want to welcome you to give your testimony. Your written statements that have been submitted in advance will be part of the record in full.

We would like to ask each of you to limit your oral presentation to around 5 minutes. We will have a clock, a buzzer over there that doesn't ring, but it does have a light. And when the green light is on it means your time is still going. For the last minute it will turn yellow. And then when the time is up, it will turn red. And when you see it red, I would hope you would conclude your remarks or summarize them very quickly.

Mr. Lawton, thank you so much for being here. I want to welcome you, and particularly note you are a constituent of Mr. Davis', and for being willing to share the unfortunate circumstances that befell you, which are going to be helpful to us to learn.

There is a button on the base of the mike, and be sure to pull it close enough so that it will all be picked up.

STATEMENTS OF EDWARD LAWTON, A SURVIVOR OF HOSPITAL-ACQUIRED INFECT IONS; CYNTHIA BASCETTA, DIRECTOR FOR HEALTHCARE ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE; PET ER PRONOVOST, M.D., PhD, MEDICAL DIRECTOR, CENTER FOR INNOVATION IN QUALITY PATIENT CARE AND ASSISTANT PROFESSOR, DEPARTMENT OF ANESTHESIOLOGY AND CRITICAL CARE MEDICINE, JOHNS HOPKINS UNIVERSITY, SCHOOL OF MEDICINE; JOHN LABRIOLA, SENIOR VICE PRESIDENT AND HOSPITAL DIRECTOR, WILLIAM BEAUMONT HOSPITAL-ROYAL OAK; LEAH BINDER, CHIEF EXECUTIVE OFFICER, THE LEAPFROG GROUP; AND DON WRIGHT, M.D., MPH, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF EDWARD LAWTON

Mr. LAWTON. Chairman Waxman, Ranking Member Davis, members of the House Committee on Oversight and Government Reform, distinguished and honored guests, my name is Edward Lawton, and today I sit before you, a survivor of healthcare-acquired MRSA, VRE, osteomyelitis, and klebsiella.

Today is very special not only because of the privilege of speaking before you, but because it is the tenth anniversary of my survival of the two most serious aforementioned healthcare-acquired infections. Ten years ago

today, following two scheduled back surgeries, I lay in a hospital bed diagnosed with MRSA. Later, VRE and osteomyelitis would also be identified.

Ultimately, in 1998 I spent 9 months surviving what I characterize as the fog of survival. I had five back surgeries, many smaller procedures, injections too numerous to count, and more prescribed drugs than I can recall. Three of those surgeries necessitated debridement. My doctor was required to open me up three times over a period of 90 days and surgically remove contaminated tissue and foreign matter. Consequences of the infections had broader implications relating to nerve and skeletal damage and other health consequences, most of which you cannot see.

Returning home in late 1998, I spent the next 5-1/2 years reconstituting my life, despite the fact that I could no longer independently stand or walk. Five open back wounds also diminished my homecoming. They never healed. A wound specialist advised me the wounds couldn't heal due to osteomyelitis. He said I could only be treated by more surgery, without assurances of resolution. I felt trapped, facing an inevitable consequence.

I survived, but according to CDC estimates approximately 99,000 others among the population of nearly 2 million patients nationwide, all diagnosed with healthcare-acquired infections, died that same year in America. In the past

decade of my survival, approximately 20 million people were diagnosed with avoidable healthcare-acquired infections, with more than 1 million patients dying. Those are staggering statistics.

In 2004, I was rehospitalized. I had the surgery, and afterwards my doctor told me I would require additional surgeries to remove substantial infectious fluids in my body, along with the remaining rods and screws, all contaminated by klebsiella. I had two additional surgeries among other specialized care. My 6-1/2-year infection saga finally seemed over, along with the open back wounds.

In 2004, unlike my earlier hospitalizations, I insisted upon certain protective measures during my hospital stay. I had educated myself since 1998, and I refused to die because of someone's dirty hands or complacent attitude. This time I didn't contract a hospital infection. I have detailed my initiatives in my accompanying written statement.

In 1998, I witnessed and experienced unconscionable acts of hospital staff. If these well-trained, well-educated medical professionals had complied with their own standards and protocols, I probably would have walked into this hearing as a spectator rather than entering in a wheelchair as a witness.

Past years' testimony to Congress by former secretaries and assistant secretaries of the Department of Health and

Human Services all consistently acknowledged the crisis of healthcare-acquired infections, yet well-educated and well-trained medical practitioners continued perpetuating the culture of complacency, ignoring the same rules we teach our children to follow before they sit at a dinner table.

Medical practitioners routinely claim that due to the inherent dangers of their work environment, healthcare infection-related deaths are unavoidable. Is that the interpretation of friendly fire? Consider that for 42 years, police officers in America have carried what is called the "rights card" so any interview with a suspect is preceded by the reading of the person's constitutional rights. Eight years ago Chief Justice William Rehnquist stated the advisement of rights was part of the national culture.

Why shouldn't medical practitioners carry anti-infection cards to protect the survival rights of patients by explaining fundamental hygienic protocols? I have created a sample for your review and consideration. Sadly, during my presentation today, someone died in America due to an infection they contracted in the hospital they trusted.

Finally, Americans ought to know what is occurring in their hospitals. We can research nearly anything on the Internet. Why don't we have the same right to check out a hospital before we risk our lives entering it?

Thank you for your courtesy. I hope my comments

contribute to converting HHS sound bites into meaningful, proactive workplace attitudes, ending the scourge of healthcare-acquired infections.

Chairman WAXMAN. Thank you very much, Mr. Lawton.

Mr. LAWTON. Thank you, sir.

[Prepared statement of Mr. Lawson follows:]

******** INSERT 1-2 ********

Chairman WAXMAN. Ms. Bascetta.

STATEMENT OF CYNTHIA BASCETTA

Ms. BASCETTA. Mr. Chairman, Mr. Davis, and other members of the committee, thank you for the opportunity to discuss our report, completed at your request--

Chairman WAXMAN. There is a button on the base of the mike.

Ms. BASCETTA. It is on. It is probably not close enough.

Chairman WAXMAN. Pull it a little closer.

Ms. BASCETTA.--to discuss our report, completed at your request, on healthcare-associated infections in hospitals.

Common HAIs, such as bloodstream, surgical site, and urinary tract infections can be deadly. And evidence is mounting that they also take an economic toll on our healthcare system and on the hospitals in which they occur.

But patients should not have to accept HAIs as a necessary risk of medical treatment. In fact, some hospitals have dramatically lowered their HAI rates by using new infection-control techniques and by enforcing others, like hand washing, which was proven to save patients' lives more than 100 years ago.

Our report identified ongoing HHS activities that could help reduce HAIs. CDC has issued 13 guidelines for hospitals that contain almost 1,200 recommended practices. And 500 of them are strongly recommended. However, only a few of them are incorporated by CMS and accrediting organizations in the required standards for hospitals.

Second, HHS has multiple HAI databases, but none provide a complete picture about the magnitude of the problem. Some of the databases are limited by nonrepresentative sampling, and reporting differences impede combining the data to better understand the extent of HAIs and to measure progress in reducing rates.

A good example is the lack of linkage between one database on surgical infection rates and another on surgical processes of care, even though these databases cover some of the same patients.

Third, both AHRQ and CDC fund research aimed at reducing HAIs. However, there is little evidence of their collaboration to maximize the return on research dollars and avoid duplication.

And finally, CMS has included some HAI-related measures in its pay-for-performance program for hospitals and has targeted three preventable HAIs for which it will eliminate Medicare patients beginning this October. But it is too early to tell how effective this will be and how many

conditions can be tackled through the payment system.

Despite these actions, we believe that HHS is not exploiting its leverage to reduce or eliminate HAIs. We concluded that leadership from the Secretary is required for HHS to bring to bear the multiple ways for influencing hospitals to tackle the HAI problem. However, an official from HHS told us that no one within the Office of the Secretary is responsible for coordinating infection-control activities across the Department.

In light of the prevalence and the serious consequences of HAIs, this lack of leadership has already resulted in lost opportunities to take concerted action to reduce the suffering and death caused by these infections. We made two recommendations that, if implemented, could help HHS gain sufficient traction to be more effective.

First, we recommended that the Secretary identify priorities among CDC's recommended practices and determine how to promote their implementation. This would include whether to incorporate selected practices into CMS's conditions of participation for hospitals. In its comments on our draft report, CMS said that it welcomed the opportunity to work with CDC on this matter. CDC has categorized the practices on the basis of the strength of scientific evidence, but work by AHRQ suggests that cost, complexity, organizational obstacles, and other factors are

necessary in considering how to set priorities.

Making headway is important because the large number of practices and the lack of departmental-level prioritization has hindered efforts to promote their implementation. Clear priorities could assist CMS and the hospital accrediting organizations in determining whether additional recommended practices ought to become part of the required infection-control standards for hospitals. And it could also help hospitals themselves monitor their own efforts to reduce HAIs.

Our second recommendation was for the Secretary to establish greater consistency and compatibility of HAI data collected across HHS to increase information available, including reliable national estimates. HHS's comments acknowledged the need for greater consistency and compatibility and identified actions that CMS would take, as well as noted that CDC has recently begun working toward greater alignment with CMS. We encourage HHS to act quickly so it can draw a more complete picture of the HAI problem.

Although we found CDC, CMS, and AHRQ officials discussed HAI data collection with each other, they were not taking steps to integrate any of the existing databases by, for example, creating linkages or standardizing patient identifiers. We believe this would enable HHS to do a better job connecting the dots regarding how hospitals can reduce

these often preventable infections. That concludes my comments.

Chairman WAXMAN. Thank you very much for the report and for your testimony today.

[Prepared statement of Ms. Bascetta follows:]

******** INSERT 1-3 ********

Chairman WAXMAN. Dr. Pronovost?

STATEMENT OF PETER PRONOVOST

Dr. PRONOVOST. Mr. Chairman, Mr. Davis, and members of the committee, thank you for having me here today.

The suffering that Mr. Lawton incurred ought never happen, nor should the excess costs that he incurred because of that.

I would like to share my reflections on why I think it happened and what we might do about it. There was a promising violinist who was a mother of two who woke up one night with tingling in her hand and slurred speech. She had a CAT scan that showed a large brain tumor. The surgeons did a very technical test to measure her blood flow, that showed that where they planned on cutting was the part of her brain that actually allowed her to play the violin. And based on that technical test, they changed how they were going to cut, and she woke up with no deficit and is playing the violin now.

That case is one example of the dramatic benefits we have had, as the U.S. public, from investments in biomedical research. And that is one of many. Our life expectancy since 1955 is up from 69 to 78 years. AIDS is now virtually

a chronic disease. Many cancers, including childhood cancers, are curable. And, indeed, a recent report said the U.S. is more productive in research than the entire European Union. And yet that same healthcare system infects Mr. Lawton, leaves surgical equipment in patients, overdoses children with heparin, and kills 98,000 people a year. And when we hear this, how could we possibly explain this discrepancy?

And perhaps most concerning is the recent Commonwealth report that showed that the U.S. ranks dead last in measures of quality and access and efficiency among the 29 other countries in the Organization for Economic Cooperation and Development. And when I think about this, how could it happen, without trivializing it, the basic issue is that we have failed to view the delivery of healthcare as a science. That science or traditional biomedical science has funded looking at genes and finding new therapies, but once we find them or at least have a hunch, knowing whether they really work in the real world or whether patients get them hasn't been a priority.

Indeed, we spend a dollar for biomedical research for every penny that we spend on research into safety and healthcare delivery. And so it is entirely predictable and understandable that we are ranked as the world's preeminent biomedical sciences and yet are dead last in outcomes and

quality.

Now, the public has seen the benefits when we do make some small investments. I was fortunate enough to lead a project funded by the Agency for Healthcare Research and Quality, which, by the way, the direct costs were about 350,000 a year for 2 years. We summarized the CDC guidelines and made a checklist to reduce those infections and pilot-tested it at my hospital, Johns Hopkins.

We then partnered with the Michigan Hospital Association Safety Center at 127 ICUs in Michigan to put it in. We didn't know that we could move all these infections from the "inevitable" bucket to the "preventable," but we thought we needed to try. The results were, frankly, breathtaking and were published in the New England Journal of Medicine and subsequently in the New Yorker. We virtually eliminated those infections.

The median rate of infections was zero in those hospitals; the overall rate was reduced by 66 percent. And those rates now have stayed that low for 4 years after this infection. The estimates are that annually it was saving somewhere around 1,800 lives and nearly $200 million in costs, all for an investment of 350,000.

Unfortunately, though, there is far too few of those programs that exist. We don't have a funding mechanism to develop those programs, nor do we have funding to train

people who can lead them. But what it showed for us is when they are done well, there is a hunger for it.

The hospitals in Michigan are saying, What is the next program we can put in? They want one for surgical-site infections or surgical safety, to tackle MRSA and VRE in a meaningful way. And other States, including Oregon and California, Arizona, and Ohio are asking, Could we come and do this? So we really need HHS leadership.

Importantly, though, there seems to be barriers for this, that indeed OHRP charged that this study violated the protection of human subjects and that the study ought not continue. They subsequently allowed us to continue in Michigan, but there is not at all clarity about what is going to be required to prevent these infections in Ohio and California or for the myriad of other quality improvement programs that the country so desperately needs.

And so I would ask the committee to consider four concrete things that I think can make the difference.

The first is, I think, supplying some support for AHRQ to make this program national, and to develop a pipeline of other programs that the country is hungry for, to do in a scientifically sound way. I think you could urge HHS to clarify from OHRP what are the requirements to do these so that we don't risk running afoul of regulations.

I think we need to increase funding for biomedical

research, and especially alter that ratio of a dollar to a penny. It is appalling. Imagine what would happen if it was a dollar to a dime or a dollar to a quarter.

And finally, we need to have programs to treat more people; so there are many more people, like myself or my colleagues, who can do these in a more robust way.

Your committee through this has the opportunity to save more lives this year than we have in the last decade. And it is going to take courageous leaders who are going to do this. And I hope your committee can move us beyond the far too common rhetoric of high-quality, low-cost care to make that a reality.

We have a program that works, that the return on investment is almost ridiculous, and we need leadership to make that happen--so that Mr. Lawton becomes a rare, rare exception. Thank you.

Chairman WAXMAN. Thank you very much.

[Prepared statement of Dr. Pronovost follows:]

******** INSERT 1-4 ********

Chairman WAXMAN. Mr. Labriola?

Mr. LABRIOLA. Good morning, Chairman Waxman and committee members. My name is John Labriola. I am the hospital director of William Beaumont Hospital in Royal Oak, Michigan. And thank you for the opportunity to offer comments on this most important subject.

You had asked us to prepare and respond to some questions about healthcare-associated infections dealing with implications, barriers, costs and benefits. And, hopefully, our written testimony has done that.

I just show you we had prepared a book last year. This book really represents a compendium of all of the different initiatives that we do at the hospital. The purpose of the book was to show to our staff and our board and leadership what is being done. But I think, more importantly, it was prepared to demonstrate our commitment to this culture of safety that exists in our hospital.

It is interesting that the mention of culture was brought up earlier by Mr. Lawton. So in our case, it is the combination of all of these activities, and more to develop, that will improve care.

We are a very large hospital. We have a very high patient census, both in terms of inpatient admissions and surgeries. We are one of the largest hospitals in the country. The culture of safety that I mentioned is a result

of decisions that were made by our hospital and medical leadership and supported by our board many, many years ago. They established as an expectation, as a core belief, the importance of safety for each and every patient in our hospital. To create this culture has required will and courage. It represents a commitment to challenge and change, when necessary, the traditional beliefs and approaches to care that are found in our hospital, and really throughout the healthcare system.

We feel that at its core, patient safety is about the dignity and respect of our patients. There are no alternatives. It is difficult for me to isolate a cost for patient safety. To us it is not a program or an approach, it is embedded in the way we deliver care. It is how we hire our staff. It is how we train our staff. It is part of our expectation of our staff. We take words like "teamwork" and "collaboration" very seriously. We ensure that all of our staff, from our very skilled intensivists and nurses, our house staff, our support staff, work together in a prescriptive manner that defines and ensures that all treatments and care for our patients is appropriate.

We have conducted over 40,000 briefings, done before every surgery, to go over checklists so that everyone on the surgical team confirms the patient, the site, what is to be done by all the team members.

Behaviors of engagement and empowerment are emphasized and supported by all members of our leadership team so that anyone can stop a procedure if they feel something is not being done correctly.

The Institute of Medicine's compelling reports have been a call to action for all of us in healthcare. There is so much more to do and improve in all of our systems and processes. So for us, the adoption of the principles that surround Keystone, which is what Dr. Pronovost was referring to, were very easy for us to support and embrace; we, along with all the other hospitals in Michigan.

The Keystone Michigan project has been a tremendous benefit to us. Our patients are someone's family member, their loved ones. When they are in our care they are to be protected. That is why we have taken this so seriously, and why we need to do what we have done.

Thank you for giving me the opportunity to talk about Beaumont and its wonderful staff.

Chairman WAXMAN. Thank you very much, Mr. Labriola.

[Prepared statement of Mr. Labriola follows:]

******** INSERT 1-5 ********

Chairman WAXMAN. Is it Binder or Binder?

Ms. BINDER. Binder.

Chairman WAXMAN. Binder. Ms. Binder, we are pleased to have you with us. And there is a button on the base. Yes.

STATEMENT OF LEAH BINDER

Ms. BINDER. Thank you. Thank you, Chairman Waxman, Representative Davis, and members of the committee for the opportunity to testify today on the problem of hospital-acquired infections.

I am the CEO of The Leapfrog Group, which is a member-supported nonprofit organization representing a consortium of major companies and other private and public purchasers of healthcare benefits for more than 37 million Americans in all 50 States. As our founders envisioned it, Leapfrog triggers giant leaps forward in safety, quality, and affordability of healthcare; hence, our name.

And we have two key business principles underlying our work and underlying what I will talk about today in terms of our perspective on hospital-acquired infections.

One is transparency. Healthcare quality data should be made public, understandable, and accessible, supporting informed decision-making by those who use and pay for

healthcare.

And two, common sense alignment of payment with patient outcomes. Financial incentives and rewards should be used to promote high-quality, high-value healthcare that produces the best possible outcomes for patients. We call this value-based purchasing.

Leapfrog conducts an annual survey of hospitals, called the Leapfrog Hospital Survey. It is completed by about 1,300 hospitals, which represent more than 60 percent of the inpatient beds in the country. Several items on the Leapfrog survey address whether hospitals have deployed proven methods to reduce hospital-acquired infections. Unfortunately, last year we found that 87 percent of the hospitals completing the Leapfrog survey do not take the recommended steps to prevent avoidable infections.

Leapfrog also applies our principles of transparency to call for changes in the way hospitals handle medical errors and infections. We call for hospitals to apologize to victims, something Mr. Lawton did not receive and deserved.

We also call for hospitals to conduct root-cause analyses, publicly report these events, and waive all charges related to them. Many health plans now ask hospitals to adhere to these principles, and we are confident they will soon be standard practice.

The statistics, as we have discussed today, are

breathtaking. Infections kill almost twice as many people as breast cancer and HIV/AIDS put together. Despite the overwhelming impact of these preventable infections on U.S. citizens, eradication has not been prioritized to the same extent as other very important issues.

We believe that hospital-acquired infections are emblematic of a larger problem in our healthcare system. We as governmental and private sector payers have not traditionally aligned financial incentives with patient well-being, and unfortunately in some ways we get what we pay for. We pay for this surgery, that medication, this x-ray, without tying the payment to quality outcomes for the patient. We pay the same even when errors occur that jeopardize the patient's health or life. Indeed, we pay more for poor performance.

On average, hospital-acquired infections add over $15,000 to the patient's hospital bill, amounting to over $30 billion a year wasted on avoidable costs. We must assume that money is concentrated on hospitals with the worst record of hospital-acquired infections.

As a former executive in a hospital network, I can say I know firsthand the pressure to direct resources within the hospital system toward the high-profit, new surgical suite, and not toward the unreimbursed infection-control program. We as purchasers have an obligation to take some of that

pressure off.

Leapfrog has been pleased to support HHS Secretary Leavitt's efforts to foster increased healthcare transparency and promote a healthcare market that recognizes and rewards quality. We have worked with some very dedicated and visionary colleagues throughout HHS, from AHRQ to CMS and CDC. Unfortunately, many of their efforts and many of the components of Secretary Leavitt's vision are not being prioritized and coordinated effectively enough at this point. We offer the following recommendations.

Federal agencies must view this problem as a priority. We must measure the right things. We must be measuring patient outcome. We do not have enough measures to actually tell us if a particular procedure or a particular protocol we are measuring leads to the outcomes we seek.

We must tie payments with outcomes. And that is something that we have been working with CMS jointly on in many ways.

We would like to see much more aggressive actions, as outlined in my written testimony. We must work together to improve transparency. Hospital Compare is an excellent Web site, but we believe it needs more outcomes-oriented measures, and would like to work more closely with the Department to see that happen.

We also need to acknowledge and support voluntary

efforts by hospitals across the country, such as Mr. Labriola's. They are very impressive efforts. They are very powerful. And they are not supported in terms of payment or in terms of the kind of recognition that good hospitals deserve. The recognition is money in the bank, too, because hospitals are often in competitive marketplaces, and people deserve to know if one hospital is really putting the effort out to achieve the right outcomes for patients.

And finally, we would like to grant HHS more authority around value-based purchasing. We, among private sector employers, would like to commend Congress for your bold step in the Deficit Reduction Act of 2005 towards redressing the current perverse payment system.

In November 2007, HHS submitted a plan for the implementation of value-based healthcare purchasing as requested in section 5001(b). Our employer members unequivocally support CMS's plan to replace the current payment structure with this new program that includes both public reporting and financial incentives for better performance as tools to drive improvements in clinical quality, patient-centeredness, and efficiency.

The proposed rule change would implement payment reforms, strongly recommended by both the IOM and MedPac. We would like to see if there is anything that could come out of today's work; and your work as the committee would be more

support for this proposed rule change. Thank you.

Chairman WAXMAN. Thank you, very much, Ms. Binder.

[Prepared statement of Ms. Binder follows:]

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Chairman WAXMAN. Dr. Wright.

STATEMENT OF DON WRIGHT, M.D., MPH, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. WRIGHT. Good morning, Chairman Waxman, Ranking Member Davis, and other distinguished members of the committee. I am Don Wright the Principal Deputy Assistant Secretary for Health in the U.S. Department of Health and Human Services, Office of Public Health and Science. Thank you for this opportunity to appear before you on behalf of HHS to discuss our efforts to reduce the rates of healthcare-associated infections.

There are several operating divisions within the Department that have taken lead roles in addressing this important public health challenge. These include the Center for Disease Control and Prevention, the Agency for Healthcare Research and Quality, and the Centers for Medicare and Medicaid Services. There are also a number of examples of how these agencies have worked collaboratively on this important issue.

We do recognize that there has been significant progress made in several areas. However, HHS also recognizes more

work and leadership are necessary to enhance patient safety.

I want to take this opportunity to highlight some of our activities within the Department that relate to or address healthcare-associated infections. The CDC leads and supports a range of infection-prevention activities on behalf of HHS. For example, the Agency produces evidence-based guidelines that serve as the standard of care in U.S. hospitals, and guides to clinical practices of healthcare providers.

The Healthcare Infection Control Practices Advisory Board, an advisory committee to HHS and CDC, has provided recommendations for the development of evidence-based guidelines for the prevention of healthcare-associated infections. And most recently, the CDC published guidelines to prevent the emergence of antimicrobial resistance and stop transmission of methicillin-resistant staphylococcus aureus, or MRSA, and other antimicrobial-resistant pathogens in healthcare settings.

A second way the Department works to prevent healthcare-associated infections is through the Agency for Healthcare Research and Quality, the lead agency for patient safety. In 2007, AHRQ invested nearly 2 million in reducing HAIs through its program, Accelerating Change and Transformation in Organizations and Networks, a field-based research mechanism designed to promote innovation in

healthcare delivery.

AHRQ awarded five task orders to ACTION partners to support infection mitigation activities at 72 hospitals. For 12 months, teams at each participating hospital will implement clinical training using AHRQ-supported evidence-based tools for improving infection safety. The findings from the HAI initiative will provide information on the barriers and challenges to improving and sustaining infection safety.

In addition to these activities, there are interagency initiatives that have recently been launched to reduce the rates of healthcare-associated infections. For instance, in fiscal year 2008, AHRQ was awarded 5 million to implement a new initiative, in collaboration with both the CDC and CMS. To identify gaps in prevention, diagnosis, and treatment of MRSA-related infections across the healthcare system.

CDC plans to use this new knowledge and findings to update multidrug resistant organism prevention, Healthcare Infection Control Practices Advisory Committee recommendations, to modify MRSA clinical management recommendations as appropriate, and to advise prevention implementation campaigns on how best to prevent MRSA infections. CMSexpects that the MRSA Initiative project results will enhance the quality of care for Medicare beneficiaries and, in general, public health.

Although we have a number of interagency activities in place, we also know that there is a need to establish greater consistency and compatibility of healthcare-associated infection data. That is why the CDC and other HHS agencies have made a concerted effort to establish compatibility of healthcare-associated infection data across the Department. CDC and CMS are working collaboratively toward a common set of data requirements for monitoring both healthcare-associated infections and adherence to their prevention guidelines. Presently, they are working together on data requirements for measurement of MRSA and toward an agreement on the surgical procedures that should be monitored as part of public reporting of surgical-site infection rates.

Before I close, I wanted to also mention the novel approach to reducing healthcare-associated infection through payment policy incentives. This is commonly referred to as value-based purchasing, and is currently being undertaken by CMS. The Deficit Reduction Act required CMS to select certain conditions for which Medicare will no longer pay an additional amount when that condition is acquired during a hospitalization.

CMS has collaborated closely with CDC on the selection of these conditions, with particular attention to identifying evidence-based guidelines that are consistent with CDC's recommended practice. Thus, the Medicare payment provision

is closely tied to CDC's prioritized practices.

On Monday of this week, CMS announced additional steps to strengthen the tie between the quality of care provided to Medicare beneficiaries and payment for those services provided when they are in the hospital by proposing to expand the list of conditions. The proposed regulation builds on efforts across Medicare to transform the program to a prudent purchaser of healthcare services, paying based on quality of care, not just quantity of service.

You have just heard me discuss activities related to the prevention of HAIs, payment policy incentives, and also surveillance and monitoring of healthcare-associated infections. However, I think it is also important to note that we recognize that the implementation of healthcare institutions of quality improvement protocols can significantly reduce the number of healthcare-associated infections. I know you join me in saying that quality improvement research needs to continue to improve patient safety for all Americans. What I hope to convey during today's testimony is that the reduction of healthcare-associated infections to enhance patient safety and reduce unnecessary cost is a top priority for HHS. HHS looks forward to working with all stakeholders, public and private, in meeting its shared responsibility to reduce healthcare-associated infections. I will be pleased to

answer any questions that you might have.

Chairman WAXMAN. Thank you very much for your testimony.

[Prepared statement of Dr. Wright follows:]

******** INSERT 1-7 ********

Chairman WAXMAN. And I want to thank all of you for your presentation to us. You seem to be of one mind that there is something we can do about a problem that is an extraordinary one in costing lives and money, that could be prevented.

Maybe I will start off the questions. You might have heard bells. We are being called to the House floor for some votes. We will break in a minute. But let's see how far we can get.

Let me try to understand the scope of this problem. According to the Centers for Disease Control's best estimates, there are 1.7 million hospital-associated infections which lead to 100,000 deaths each year. And these are largely preventable infections. And they come at a price. They come at a price not only to the person infected, who may lose his or her life, they come at a price to the government, to employers, to members of the family. The Institute of Medicine said we could save $5 billion. Now, most people who die of these infections don't have it on their death certificate that they died of a hospital infection. They usually have something else reported typically as the cause of death.

But if we were able to look at this chart that I am going to put up on the screen, or one that is already standing on the pedestal there, what we have seen is that if

you look at hospital-associated infections, it would be the sixth leading cause of death, higher than even diabetes. But unlike other causes of death, this is one we know how to reduce.

Dr. Pronovost, you now have several years of experience working with the hospitals in Michigan. You have a checklist for these hospitals to follow. If all hospital ICUs in every State were to use the same checklist, how many lives do you estimate we could be saving?

Dr. PRONOVOST. Mr. Chairman, the number of deaths from this particular type of infection is 28,000 a year. And the costs are somewhere between 2- and $3 billion a year for these catheter-related infections. I would add, though, that our knowledge of both how to measure and the extent to which we could actually prevent these infections for other infections is less mature. For these, though, there is no doubt that we used to think they were all inevitable. Now we know they are virtually all preventable. The others, though, I think the science still has to mature to say how much of them--certainly some, but I don't know that we are comfortable in saying what percentage are.

Chairman WAXMAN. Now, the GAO did an evaluation of our efforts in that regard. And Ms. Bascetta, you found that we just seem to have a very haphazard way of approaching the problem from the government's perspective. What would allow

us to make sure that all the hospitals are doing the same thing that Dr. Pronovost and the hospitals say they want to be able to do?

Ms. BASCETTA. Well, I think there are some basic infection-control measures that are known that should be taken by all hospitals. And then another important point to remember is that a hospital--it is important for hospitals to assess their own particular risks. Some of them may need to prioritize things differently than others. So we don't necessarily want them to all be tackling exactly the same problem, although there are certainly common approaches that they should take.

And our belief is that HHS could be doing a much better job bringing to bear its collective expertise from CDC and AHRQ and CMS to use these various leverage points to influence hospitals to take the measures that they need to take.

Chairman WAXMAN. What is the problem? Three separate agencies at HHS are not talking to each other, or are they taking too long at each of these agencies to figure out what recommendations to make, and make sure that the hospitals are following them?

Ms. BASCETTA. Well, although they all seem to have a sense of urgency about the problem, collectively they haven't achieved what we call "traction" in our report. And we think

it is because, although they talk to one another, most of their discussions are so far in the nature of updating one another about their independent actions or their independent databases. There isn't the synergy that is needed to ratchet up the attention to how they can strategically attack the problem and how they can get the word out to hospitals about their expectations and about what hospitals can do.

Chairman WAXMAN. We want this hearing to be a constructive hearing, because after this hearing is over we want to see action, using low-cost technology in proven ways to reduce these infections to save lives.

Dr. Pronovost, you developed a checklist. It looks like the government is giving a very long list of things for hospitals to do, but you had a simple checklist. Why aren't hospitals just following your checklist?

Dr. PRONOVOST. Well, in part, because as you alluded to, the typical way of summarizing guidelines is to make these often elegant but 200- to 300-page documents that clinicians don't read. They are too busy. And so we summarized the very detailed CDC guidelines into five key points and packaged them in a way. But what we were lucky enough to do, with some funding from AHRQ, was to find the science. And it is really almost social science of how do you get behavior change. How do we make something in a way that clinicians buy into? And part of it is having rigorous

measurements so they believe the results.

In this case we measured infections quite robustly, having good evidence on which to act on, and then using some internal levers--payment system is one of them--that they are encouraged to say, I have to do the right thing. And we have made it easy for them.

Chairman WAXMAN. Thank you. My time has expired. Mr. Davis.

Mr. DAVIS OF VIRGINIA. We have a quick vote coming up. Let me ask Mr. Lawton--thank you for being here. The Leapfrog Group recommends that when a patient is a victim of a medical error or an infection, hospitals should apologize to the victims, conduct root-cause analysis, publicly report events, and waive all charges related to them. Did the hospital that treated you take any of those steps after your infection in 1998?

Mr. LAWTON. Not that I can recall.

Mr. DAVIS OF VIRGINIA. Would those steps have impacted your experience at the hospital?

Mr. LAWTON. Well, it would have helped me. The experiences I went through, from what I remember--and I try not to remember--were fairly traumatic. And I kind of suffered through all of them. But I mean, the folks were nice. I know everybody was busy trying to help people in the hospital. But I really didn't feel that a lot of attention

was given to that. It was just part of the process. They were going through their day-to-day activities and my situation--

Mr. DAVIS OF VIRGINIA. Just mailing it in. Thank you.

Ms. Binder, one of the outcomes that must be avoided is that in good-faith attempts to reduce infections, the Federal Government and the payers overburden hospitals with bureaucracy to the point that energy is spent fulfilling requirements versus improving care. That is also the balance.

Are there opportunities for the private sector and the Federal Government to collaborate to avoid overburdening hospitals?

Ms. BINDER. Yes. And we have been working on collaborating on exactly that issue for some time now, and continue to do so. The key issue, as I stated in my testimony for The Leapfrog Group, is that we are measuring--whatever measures we ask hospitals to report--are measuring outcomes of care. Our focus is on whether or not the patient improves or how the patient does. The patient outcomes should be preeminent.

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[12:07 p.m.]

Ms. BASCETTA. The patient outcome should be preeminent.

Now, it is very difficult sometimes to find a measure that will address patient outcomes. But if a measure will look at, for example, a procedure in a hospital setting, then we ought to have evidence that that procedure leads to positive patient outcome. So one of the issues that we have been working with our colleagues on, the Federal Government with and our employer members, is to identify measures that are outcomes-oriented and to apply those in the public setting in a transparent way so people are aware of how patients do when they go to one hospital versus another. And I think we do have more work to be done. Hospital Compare, as stated, the employers are not comfortable that it has enough outcome-oriented measures. We would like to see more of that.

Mr. DAVIS OF VIRGINIA. Dr. Pronovost, part of the frustration with infection controls, that in some areas there is evidence of effective interventions that reduce infection rates, but those interventions just aren't widely implemented. How do you explain this gap, where we have the knowledge but it is just not happening on the ground?

Dr. PRONOVOST. That is absolutely the case. And if you

listen to this testimony, it is remarkable; that must be one of the few things that everyone on the panel agrees with. We all are acknowledging there is a problem. We want to help it. I think, as an industry, we have been talking past each other, and we really need some strategic leadership.

What I would say is, because we viewed getting doctors and nurses to change these things as seen as an AHRQ. Yet, medicine can go around the way it wants to. And what we have learned is that there is as rigorous a science of measuring these things and of implementing change as there is in finding the human genome. It takes different skills, but we have invested in learning how to do that. And I think, with some investments, we can dramatically ratchet up how effective and efficient we are in implementing these programs.

Mr. DAVIS OF VIRGINIA. Behavioral change is one of the most difficult obstacles in a case like this. What are some of the challenges in achieving behavioral change, even when someone isn't watching?

Dr. PRONOVOST. And payment policies have to be part of it, but payment policies that run ahead of science aren't going to get us where we need to be. So even if you prefer, one of the things we are not going to pay for is ventilator-associated pneumonia. With our current ability to diagnose that, ensuring we will have 30 false positives, that

is patients who don't really have it, for every one that we diagnose correctly. And certainly we need to allow for policy, but we also need to invest in how to diagnose the darned thing right so that--and how much we can really prevent it, so that we are paving a way to create a wise and just payment system.

The behavioral change has to be multi-factorial. Aligning the payment system is a component. Measurement and giving feedback is another component in making sure that the evidence is sound and is packaged in a way that is practical for busy clinicians, such things as a checklist and not a 200-page guideline, are all things that seem to work.

Chairman WAXMAN. Thank you very much, Mr. Davis.

We are going to have to respond to the vote on the House floor, and it will probably take 20 minutes because there are four separate votes that will be reduced to 5 minutes after the first.

But I do want to recognize Ms. Norton, because while we tried to make it otherwise, she still does not have a vote as a full Member of the House of Representatives. So I want to recognize her for 5 minutes. And when she has completed her 5 minutes, maybe witnesses can take a break themselves and grab a quick bite in a very, very short period of time.

And we will get back hereby 12:30. Thank you.

Ms. NORTON. Thank you very much, Mr. Chairman.

Occasionally you gain something from not having a vote on the House floor. I do get to vote on the Committee of the Whole. This is not a Committee of the Whole vote. And I am pleased that I vote in this committee. It is a very important committee to our country.

I am going to ask you about the rather, for me, frightening notion of infections that appear possible to be spread in hospitals and may be brought into hospitals. It has been brought to my attention, and I am going to try to pronounce this without knowing if it is correct, that a highly resistant bacteria that apparently has ravaged soldiers in Iraq and Afghanistan called Acinetobacter. And, for some, the bacteria can mean the loss of limbs that are otherwise saved, and lives.

The reason I bring this question to you is that, for example, at Bethesda, they said they found hundreds of positive cultures. And I was particularly concerned that, of those who have died, the seven who have died, or that the Defense Department acknowledges have died, from this particular bacteria, five were non-active-duty patients being treated in the same hospitals as infected service patients.

This is an apparently highly resistant bacteria. And according to the experts, the only drugs they found--they don't know--and they believe that this particular bacteria quickly colonizes in such a way to make it resistant to even

other pharmaceuticals which are found, but one was found at Walter Reed here in our District. Some of these have been at Walter Reed here in our District. And one of the doctors said that one of the antibiotics that he has not used in recent years that could be used here is called Colistin. But he hasn't used it because it causes or could cause nerve damage and kidney damage, which is also what this particular bacteria sometimes causes.

Now, they don't know where this came from. I do not believe this originated in hospitals, and they are trying to find out. They don't think it originated in the soil in Iraq. They think, however, that it lies dormant in open wounds. As quick as the paramedics, and they have been miracle workers, have been, that this may be the cause for it.

Well, these soldiers are coming back in large numbers. They are going all over the country. Some of them go to military hospitals, most of them probably would not unless--well, sometimes I suppose if they have a wound. And here we are concerned about kind of low-cost, easy ways to deal with infections that we are well aware of, we know how to combat.

My question really goes to whether hospitals are prepared to deal with the introduction of new infections. People come in the hospital sick. They can be infected with

things. And if we can't deal with infections that arise in the hospital, what chance do we have of dealing with what amounts to a global health system as well, where people come with whatever they bring from other countries, including our own American soldiers?

One, do you know anything about this particular bacterium? And, two, what should hospitals do now that soldiers are coming back, and some of them may be treated in ordinary hospitals and by ordinary physicians, about the introduction of bacteria such as this? And is this a rare case? It certainly isn't rare in the Armed Services. Perhaps it hasn't killed large numbers of people. But the possibility of it spreading, and particularly in hospitals, and then being carried heaven knows where exists when people come back.

Quite apart from the important work you have done and commented upon here, are hospitals prepared to deal with the introduction of new kinds of bacteria that they in turn spread to others in the hospital and elsewhere? Don't all of you speak at once.

What would you do if, in fact, maybe as a law school hypothetical, if you knew that there was a patient who had tested positive for this bacteria but was ill of something else? What would you, or what would your hospital do in that case?

Dr. PRONOVOST. These micro-organisms are in some sense the most brilliant scientists, because no matter how clever we think we are with getting drugs, biology or evolution seems to make them resistant to many things. So this Acinetobacter is like a number of other infections, others including pseudomonas that you may have heard. And, by the way, your medical knowledge is impressive. We will give you a degree from Johns Hopkins.

And we struggle with this all the time of having these organisms that are resistant. And, indeed, on many patients, I use Colistin because it is the only drug that works and the risk-benefit ratio is, without a drug, they will most likely die, so we accept some risk of harm.

The strategies that we do are, one would be a surveillance. First, we have to make sure we identify when patients have them. And, if they do, we put that--

Ms. NORTON. Can we test for this? Apparently, we know how to test for it. Will we test for it? Should we be alerting--I guess military hospitals may test for it. But if this bacteria is spread, perhaps it spreads through hospitals. Should we try to get us more tests?

Dr. PRONOVOST. Right now it is probably tested for if someone has some other infections.

Ms. NORTON. If they are tested for some other infections.

Dr. PRONOVOST. It would come up. Right. And typically hospitals, and almost all hospitals, have the ability to say what antibiotics might be effective in treating that infection, and that patient would be isolated. In other words, they would be put in a separate room, and clinicians would have to have what is called contact precautions. So, they would not be allowed to go in the room without having a special gown on to prevent them from spreading it to other patients. There typically would be some environmental surveillance and cleaning, so that we don't have our stethoscopes or the computers or the beds harbor this infection. And maybe we try to treat it with other antibiotics that we could, fully acknowledging that we may induce some harm in trying to save a life or limb.

Ms. NORTON. Ms. Bascetta, do you have a comment?

Ms. BASCETTA. Yes. Your comment brings to light that we are focused on HHS, but as you point out DOD and VA as well have their own Federal hospital system. And I know that the military has a way of tracking global emerging infectious disease, as does CDC. So perhaps Dr. Wright would like to comment on whether HHS, or--I am sure they are--to what extent HHS and DOD and VA are working together on these kinds of issues.

Ms. NORTON. For example, do you think at least the ordinary civilian hospitals ought to be alerted to this

infection as something they ought to look for?

Dr. WRIGHT. Yes, Congresswoman.

Acinetobacter really is a problem that has been in intensive care units and has been a problem among soldiers returning from Iraq, as you said. But I think it is important to note that it is not a rare case, and it has actually been a problem in the United States, here locally as well.

As far as the problem with our soldiers, let me assure you that the CDC is working very collaboratively with Walter Reed, looking at that issue, trying to better understand this particular problem and how we can prevent it in the future.

Along that same line, I would like to say that the CDC has done an excellent job in recently releasing guidelines that deal with multi-drug-resistant organisms in hospitals. Certainly MRSA has been an issue that received a great deal of media attention, but it clearly is not the only bacteria that has achieved resistant status. And their approach is to look from a holistic standpoint: What is it that we can do to eliminate these infections from bacteria that have developed resistance?

Ms. NORTON. Thank you.

You are dealing often with infections which do not resist, and yet we still have them. So I am just moving the trajectory up somewhat to say that there is likely to be more

and more of these resistant infections that you encounter.

Thank you very much for your testimony. The hearing is recessed. They will return.

[Recess.]

Chairman WAXMAN. Yarmuth.

Mr. YARMUTH. Thank you, Mr. Chairman.

Dr. Wright, in your testimony, you considered that the hospital-associated infections are an important public health challenge. I think that is the way you phrased it. And you also said that more work and leadership is necessary to enhance patient safety. You also detailed various activities that different agencies within the Department are undertaking. That is helpful as far as it goes. But given the stakes involved, it doesn't seem to me that it goes nearly far enough.

We apparently have an epidemic of hospital-associated infections in this country if we are talking about virtually 100,000 people dying a year, resulting in all those deaths and avoidable costs of billions of dollars. And I think every hospital patient and family member has a right to expect more from our government and from the Department. At a minimum, they have a right to expect leadership in this area. And today's GAO report states that no one within the Office of the Secretary is responsible for coordinating infection control activities across HHS. Your testimony does

not really address this point, so I would like to have a response to that specific issue.

So, why hasn't there been a coordinated response to this epidemic within the Department?

Dr. WRIGHT. Thank you, Congressman.

The Office of Public Health and Science is in the Office of the Secretary at HHS. I serve as the principal Deputy Assistant Secretary. That particular office is headed by the Assistant Secretary for Health. And the Assistant Secretary for Health is very frequently asked to serve in a coordinating role on issues that involve many of our agencies or operating divisions, and coordinate activities across those.

In the area of healthcare-associated infections, there is a good example of where this office has had a key role in coordination, and it relates to immunizations for seasonal flu for healthcare workers. You are probably well aware that the Center for Disease Control has long stated that healthcare workers are a top priority for receiving this vaccine, and yet the numbers of healthcare workers that actually receive the vaccine is somewhat disappointing. It is only about 40 percent.

Now, this is an issue that has both occupational health concerns as well as patient safety concerns. Certainly a healthcare worker who is exposed on the job by taking care of

an influenza patient has a risk of workplace transmission. But, also, there is the concern that a healthcare worker could inadvertently infect patients that they come in contact on a ward. As a result of that, the Assistant Secretary for Health coordinated--led and coordinated an interagency working group that involved all the major operating divisions of the HHS to address this particular healthcare concern.

The first goal of this particular task force was to see what we could do within the HHS family. There are numerous healthcare workers within HHS and the Indian Health Service and the National Institutes of Health and CDC and Federal Occupational Health. What is it that we can do to set the example? And then, more importantly, what is it that we can do with our other Federal partners and the Veterans Administration and Department of Defense, as well as private sector hospitals, to increase the immunization rate for seasonal influenza. So there is a coordination role. There is a leadership role within the Office of Public Health to work across operating divisions as it relates to issues of healthcare-associated infections.

Mr. YARMUTH. But that doesn't deal specifically with these situations in the hospital. That is a different example. So my question would be, do you think this approach is working? Because apparently, from the data that we have, this type of approach is not working, and there does seem to

be a lack of a coordinated effort within the Department.

Dr. WRIGHT. Congressman, there is some good news with healthcare-associated infections. We are seeing improvement in bloodstream infections, partly done by Dr. Pronovost's work and work that was done in Pittsburgh. We are also seeing improvement as it relates to surgical site infections.

That said, clearly there is a great deal of work to be done. And we at the Department do have opportunities to collaborate, and there are examples where we collaborate across operating divisions or agencies in a very effective way. Another great example--

Mr. YARMUTH. I just want to ask Ms. Bascetta whose report this was if this is the type of cooperation that GAO envisioned when it issued its report and the recommendations that that agency made.

Ms. BASCETTA. No, it isn't. And I would like to point out that, and HHS had an opportunity to comment on our report, and they did not bring up that they were in fact coordinating or collaborating at the level that we would have expected. I think they certainly have the potential to do that. And an example of what we would expect to see is some sort of strategy that takes the offense in dealing with HAIs at a much higher level than having their components do their very good but relatively independent activities so far.

Mr. YARMUTH. Thank you for that. I think that is an

approach that we all would prefer to see.

Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you, Mr. Yarmuth.

Mr. Burton.

Mr. BURTON. Thank you, Mr. Chairman.

First of all, I want to apologize. I had several other meetings going on, so I haven't been here to hear all of your testimony, but I will read it, and my staff and I will go over it.

I have a couple of questions, and Ms. McCaughey is here, and I appreciate you being here on such short notice. She is the head of the Committee to Reduce Infection Deaths, and she is a former Lieutenant Governor of New York.

And in her article, I would like to read this to you, she says: Restaurants and cruise ships are inspected for cleanliness. Food processing plants are tested for bacterial content on cutting boards and equipment. But hospitals, even operating rooms, are exempt. The Joint Commission which inspects and accredits U.S. hospitals doesn't measure cleanliness, neither do most State Health Departments nor the Federal Centers for Disease Control and Prevention.

Now, I am going to ask her when she gets before the committee if that is true. But if that is true, that is criminal. That is absolutely criminal.

I also found in this little brochure, it says, "things

that you should ask a doctor and say to hospitals to reduce your risk of getting an infection." And there are 15 things on here. And it says: Ask the hospital staff to clean their hands before treating you. Before your doctor uses a stethoscope to listen to your chest, ask him to put some alcohol on it to clean it. If you need a central line catheter, ask your doctor about the benefits of one that is antibiotic impregnated or antiseptic coated to reduce infections. If you need surgery, choose a surgeon with a low infection rate. Beginning 3 to 5 days before surgery, shower or bathe daily with chlorhexidine soap.

And it goes on and on and on. And all this ought to be academic to a hospital. The patient should not have to ask these questions.

I mean, when I went into a hospital, I had a shoulder injury, and my doctor was supposed to be the best. I won't go into his name now, but he was pretty negligent. And after about 3 or 4 weeks after the surgery, 2 weeks, I had trouble in my shoulder and he said, "well, see how you are working with it." And I raised my arm. He says, "well, you don't have any problem." He says, "you are doing well." And I said, "but I am telling you, something is wrong."

I came back to Washington, and I kept telling myself. I flew back. When I flew back, I said, "I am telling you something is wrong." And he said, "well, you can get an MRI,

and it will cost about $1,000, but you don't need it." I went to get the MRI at 8:30 at night. He called me and said, can you be at the hospital tomorrow at 7:00? I was at the hospital at 7:00 the next morning. He had to operate on me four more times. They had to cut into the bone and the muscle, and he said I might have arthritis and never be able to use the arm again. But we worked real hard, so it is okay.

But the point is, it was an infection that I got either through the surgery or the hospital, and he wouldn't even acknowledge it without testing it. And it was just lucky that I found out about it. And I talked to the surgeon here at the Capitol, our doctor, when he came in, and he said he had a person with a similar problem who had an infection and dropped dead right after he met with him because the infection had spread so much.

I guess the question I would like to ask you generally, and I don't know which one of you to address this to, is, why aren't we, across the country and the States and the HHS and FDA, why aren't we insisting that these 15 steps be implemented in every single hospital across this country? And if what Ms. McCaughey says, that restaurants and cruise ships and food processing plants are tested for bacteria, if they are doing it there, why aren't we doing it in the hospitals? I mean, I just don't understand it. And if they

are handing out this brochure for me to ask my doctor of things to do, and most people aren't going to see this thing. They are never going to see this thing. And so they are going to go in, and they are going to rely on the nurses to wash their hands and do all the things that this thing says. Why isn't that standard operating procedure? And, why isn't there a requirement to make sure these things are done in every hospital in this country? Now, with that, any one of you can answer.

Ms. BINDER. I couldn't agree with you more. As I talked about earlier, the Leapfrog survey last year of covering about 60 percent of the in-patient beds in this country found that--we found that 87 percent of those responding to our voluntary survey did not undertake the required practices for safe practices for a hospital, which was astounding to us, even though we came into this realizing this was a problem.

Fundamentally, I worked in a hospital. I know it is extremely difficult to make the kinds of changes that are needed to have safe practices. You have to educate every staff person, not just the physician and not just the nurses; but the person who admits the patient, the janitor, everybody has to understand and comply completely with safe practices to prevent infection. To get to that point--

Mr. BURTON. I am running out of time, if the Chairman

will give me one more second here. This is probably the most important thing that people deal with regarding their health, and you just said that it is very difficult. Even if it is difficult, it should be done.

Ms. BINDER. Absolutely.

Mr. BURTON. And there ought to be penalties imposed by FDA, HHS, or State health agencies to make sure that this stuff is done. And if a nurse or a doctor doesn't comply with the requirements, they ought to be penalized severely. Severely. Because people are dying because of that.

With that, Mr. Chairman, I am sorry I took so much time.

Chairman WAXMAN. Thank you, Mr. Burton.

Mr. Hodes.

Mr. HODES. Thank you, Mr. Chairman.

The testimony from Dr. Pronovost and Mr. Labriola is very convincing about the results in Michigan, and I think you have made a convincing case for replicating the Michigan project in every State in the country. Every ICU patient should have the benefit of reductions of risk of infection that come from the application of a checklist regardless of what State they are in. And, frankly, not just in ICUs, but in all other areas of care in the hospitals where there is a risk of infection.

Now, the Michigan project was made possible by $1 million from Merck, and estimates apparently vary as to the

benefits. Dr. Pronovost pointed out in his testimony that, for every dollar we spend on biomedical research, we spend only a penny on research. So there we have, I don't know, a 100 to 1 ratio. But it looks like we saved about $200 million for the $1 million investment in Michigan.

Now, the Department's budget for fiscal year 2009 heads in the opposite direction. AHRQ's fiscal year 2008 budget for general patient safety research is $34 million. For the next year, the Department proposes to cut this amount by $2 million. I find it incomprehensible. In a New Yorker article, which with the permission of the chair, I will submit for the record.

[The information follows:]

******** INSERT 2-1 ********

Chairman WAXMAN. Without objection, we will make it part of the record.

Mr. HODES. Thank you, Mr. Chairman.

The interviewer asked Mr. Pronovost how much it would cost him to do for the whole country what he did for Michigan. About $2 million, he said, maybe $3 million, mostly for the technical work of signing up hospitals to participate State By State and coordinating a database to track the results. He has already devised a plan to do it in all of Spain for less. Quote, "We could get ICU checklists in use throughout the United States within 2 years, if the country wanted it," he said. Well, I think the country wants it. I think the country needs it.

So, Dr. Pronovost, how are we able to fund the replication of what you did in Michigan if it cuts its budget by the $2 million that you say we need to spend to move this nationwide?

Dr. PRONOVOST. Congressman, I completely agree with the sentiment that I don't understand the logic of saying these are national problems while we need to make wise investments, because the return on them in lives saved and in dollars to the health care system are real. For example, yesterday I was in Pennsylvania. Tonight I am flying to California to try to get them to sign up for that, for this program. But what that screams to me is, where is the leadership? Because

I am happy to do it, but it certainly should be a much more integrated program with AHRQ, with CDC, perhaps with NIH of saying, what don't we know that we need to also learn for CMS with payment policy, with consumer groups and this public-private partnership to work together to do this.

Infections needs the equivalent of what we did in Polio. Polio used to kill 350,000 people a year in the 1980s. We collaborated and worked together, and now it is less than a thousand--none in the U.S.--and in one small part of Africa. And we need that collaborative effort.

Mr. HODES. It strikes me that dealing with infections with the simple use of a checklist is really pretty low-hanging fruit in terms of expenditures of health care dollars in terms of the savings of lives and money. Is that correct?

Dr. PRONOVOST. Absolutely.

Mr. HODES. Let me ask the panel. Would any of you fly in an airplane today if you knew that the pilot was not completing a pre-flight checklist? Would any of you fly? The answer is, no, of course not. So why should anybody go into a hospital in the United States, given what we now know about what checklists do, and go into an ICU or other area of the hospital where infections are possible and be subject to care without having a checklist there? I can't understand why we are not making that investment.

And Dr. Wright, I just ask you this. You have heard Ms. Bascetta's testimony. Have you not?

Dr. WRIGHT. Yes.

Mr. HODES. Did you read the GAO report?

Dr. WRIGHT. I did.

Mr. HODES. Are you willing to go back to HHS and produce the synergy, which frankly seems pretty simple given all the good work you are doing, the synergy among the different silos in HHS to create the momentum that we need to follow the GAO recommendations and get on this in a very coordinated way? Because you are doing lots of work, but it sounds like there are some simple things the GAO has pointed out your agency needs to do to get it better. Are you willing to do it?

Dr. WRIGHT. As I said in my initial testimony, we think that there are great opportunities for enhanced collaboration and cooperation at HHS and will make efforts to carry that out, and in the area of healthcare-associated infections and in other areas as well.

Mr. HODES. I appreciate the opportunities, and I don't want to belabor the point. My question is, will you follow the recommendations that the GAO has set out as a path for you to collaborate in the area of reducing infections?

Dr. WRIGHT. This is a top priority for HHS, to lower healthcare-associated infections. And certainly we need to

collaborate. We must collaborate. We must do better working across the very important operating divisions, from NIH to CDC to AHRQ, et cetera.

Mr. HODES. Thank you for that answer. I understand it is a priority. My question was, will you follow the GAO recommendations, yes or no?

Dr. WRIGHT. We will make every effort to move forward with the recommendations as made by the GAO.

Mr. HODES. I will take that as a yes. Thank you.

Chairman WAXMAN. Thank you, Mr. Hodes.

Ms. McCollum.

Ms. MCCOLLUM. Thank you, Mr. Chairman. I am going to read from something, and then, Mr. Chairman, I have two articles I would like to submit for the record.

[The information follows:]

******** INSERT 2-2 ********

Ms. MCCOLLUM. Patient Safety: In 2003, Minnesota passed groundbreaking legislation, the Adverse Health Events Reporting Law. Minnesota hospitals report adverse health events, 28 types of events defined by the National Quality Forum. The Minnesota Department of Health publishes an annual report of these events which includes the number and types of events of each hospital in the State. And you can go on a Web site to see the report. And our hospitals are complying with this. Minnesota in fact has been consistently recognized for overall health quality performance. In 2006, it was ranked number two by the Agency for Health Care Research and Quality for Overall Health Care, Quality Performance, and was recognized by the Center for Medicaid and Medicare as a high-quality, low-cost State. Also, 10 hospitals were recognized by Health Grades to an elite list of 2007 distinguished hospitals for patient safety, a designation which goes to hospitals scoring in the top 15 percent of national patient safety indicators.

Minnesota hospitals credit their success to their ability to share information across facilities through the Minnesota Hospital Association's web-based information Patient Registry. Under this initiative, hospitals not only report events, but they also openly--openly--exchange lessons learned.

GAO has reported the need for improvement and

coordination for sharing. The three agencies, CDC, CMS, and the Agency for Health Care Quality Research, need to be sharing.

Are there any plans underway at HHS to improve the sharing about best practices? That is one question I have.

And, how will this information get to hospitals and providers?

So, for three of you, I have three specific questions.

Ms. Bascetta, what level of cooperation did GAO really find using these different databases? And, is there any meaningful effort at the Department level to coordinate the data collection among different agencies?

Dr. Pronovost, is there research physicians working on quality improvement? And, does it make sense to you that the Department databases are not linked?

And then, finally, Mr. Wright, President Bush has talked about the four cornerstones of the better health care system. The first is information and technology interoperability. How is it even possible then that your own internal databases aren't linked? And, can you show us the plan, show this committee the plan that you just alluded to, to Mr. Hodes, that you have to make this a reality? Where is the plan? And is that plan 2011? And if it is 2011, how do we make that plan 2009, 2010? Thank you.

Ms. BASCETTA. You asked about the level of cooperation

that we have seen, and whether there is evidence of a meaningful effort to coordinate. And we would have to say that, so far, we have not seen a meaningful effort to coordinate or collaborate at the level that is necessary to really make headway on this problem.

HHS has 60 days from the release of the report to respond in writing to our recommendations as to how they plan to implement them, and we will be looking very closely at what they tell us.

Ms. MCCOLLUM. And what is 60 days?

Ms. BASCETTA. Sixty days from today.

Dr. PRONOVOST. Congresswoman McCollum, the need to improve quality and safety is going to require skilled workers who know how to measure, how to do improvement and how to lead these efforts. And there are virtually no programs in this country to train doctors or nurses in public health to get these degrees. We have quite robust training if you want as to basic research. Now we have programs if you want to do clinical trials and find drug therapies. And I think this is a glaring oversight. We need to do improve those programs so that people can do scholarly work like that has been going on in Minnesota or our Michigan project.

From a research perspective or just from a public perspective, I think it is completely unacceptable that we can't link these databases, because at the end of the day,

the public, like Mr. Lawton, want to know, am I safer? And I think we deserve to give them a credible answer, and it is only going to happen with data.

Dr. WRIGHT. First of all, let me say that we at HHS fully realize that health information technology is a crucial link moving forward in all areas of patient safety, not only in the area of reducing healthcare-acquired infections. And we are making efforts to move along that, in that direction.

Secretary Leavitt has asked AHRQ to provide common formats for new patient safety organizations. CMS and CDC are working very closely towards a common set of data requirements. As far as our surveillance system, we certainly believe that what gets measured gets improved. In the National Health Care Safety Network, which is the CDC surveillance tool, I think was reported in the GAO report only had 500 participants. That has grown exponentially. We are now up to 1,400 less than a year later, and we expect that to be 2,000 by the end of next year.

Ms. MCCOLLUM. Mr. Wright, I asked you the plan. And your time is up, and I would like to hear where the plan is.

Dr. WRIGHT. Our efforts to work with software vendors to make sure that, for hospitals, that they will be able to--that the systems are interoperable and can be released into the National Health Care Safety Network, which will provide us additional information in a more timely fashion.

Ms. MCCOLLUM. Mr. Chair, I asked where the plan was. I heard goals. I heard dreams. I didn't hear clear sets of objectives. Is the committee planning on being able to resubmit a question to ask for a definite plan in a timeline?

Chairman WAXMAN. We will certainly have the record open if a member wishes to ask a question and get a written response. But I think the purpose of this hearing is to make sure that something gets done. And it doesn't have to be this second, but we want to impress on HHS that we want them to act. And I think Mr. Hodes' question was very, very targeted. I don't think Dr. Wright is in a position to tell us his plan at this moment. But we will check with him next week.

Ms. MCCOLLUM. Thank you, Mr. Chairman.

Chairman WAXMAN. Thank you very much.

We are pleased to have Congressman Murphy with us today, and I want to recognize him for 5 minutes to ask questions.

Mr. MURPHY. Thank you, Mr. Chairman. It is good to be back. I used to be a member of this committee. And also I have a bill sitting out there for a couple of years, called The Healthy Hospitals Act, which would require hospitals to report infection rates; and ask HHS to devise a system to do that; and also, recognizing a lot of savings comes from that, establish a grant program for those hospital that dramatically lower their rate or maintain a very low level of

infections.

A couple things first, and then I am going to ask you all one question, if you can answer that.

It amazes me that I can go online and find out if any airline I want to take is going to depart on time. I cannot go online and find out if I am going to depart from a hospital. Many States have laws on this. Pennsylvania has a law of things that require reporting; you are able to go and compare and find out different infection rates for different hospitals. And I also know that when hospitals, such as the VA system in Pittsburgh, worked towards identification and eradication as much as possible of nosocomial infections, they were able to drop the rate by some 60 percent of one type. And actually paying attention to one type helped them reduce all others.

I also note the number of people per day that die from healthcare-acquired infections, 270 or so, give or take, roughly the population you would see on an airplane. And if an airplane went down today and 270 people were killed, it would be a huge national tragedy. If tomorrow a plane crashed where 270 people were killed, you would have lots of questions being asked, lots of Federal agencies would begin to investigate. If, on the third day, a plane went down, crashed, killed 270 people, my guess is every airline in America would stop flying. But we have been putting up with

this for years.

A few years ago, when I first introduced my bill, it still has been part of this every day; even while this committee has been holding hearings, people have died.

Given that scenario, I would like to ask each one of you, just answer yes or no, do you believe the Federal Government should mandate a uniform reporting system for healthcare-acquired infections with the results available to the public online?

Mr. Lawton.

Mr. LAWTON. Yes, sir.

Mr. MURPHY. Ms. Bascetta.

Ms. BASCETTA. Yes.

Mr. MURPHY. Dr. Pronovost.

Dr. PRONOVOST. Yes. And I would like to see it coupled with efforts to reduce those infections.

Mr. MURPHY. Mr. Labriola.

Mr. LABRIOLA. Yes, sir.

Mr. MURPHY. Ms. Binder.

Ms. BINDER. Yes.

Mr. MURPHY. Dr. Wright.

Dr. WRIGHT. Certainly we support transparency in health care. It is one of the Secretary's top priorities, and States are really taking the lead in this area. There are 25 States now that mandate reporting back to State agencies of

healthcare-associated infections on a hospital basis. Two States in particular, Vermont and North or South Carolina, are now making that information available. Certainly we in the Federal system will be looking to those States as a laboratory to see what next steps the Federal Government should do.

Mr. MURPHY. I appreciate that. And many States have made some changes. One of my points was, if you got sick today in Washington, D.C., and you needed to choose a hospital, would you know which one to choose? I think the answer is no. And if you weren't in Vermont or Pennsylvania, where the information is available online, the answer is no. And given 100,000 deaths a year, I agree--and I certainly commend Secretary Leavitt. He has been a champ in pushing for transparency, and he and I have had many conversations. I appreciate that.

But this is my final question to the panel: Should we move quickly in terms of a Federal standard to move forward in reporting that is available to the public? Go down the line again. Mr. Lawton.

Mr. LAWTON. Absolutely. Yes.

Mr. MURPHY. Ms. Bascetta.

Ms. BASCETTA. Yes, urgency is very important.

Mr. MURPHY. Dr. Pronovost.

Dr. PRONOVOST. My mother is having an operation in a

week from now. I sure hope she would have some of these tools available.

Mr. MURPHY. Mr. Labriola.

Mr. LABRIOLA. Clearly the magnitude of the problem requires urgency. I would just ask, from the other side of it, that it be very, very thoughtful in terms of what and how and the method in which it is done. More requirements may not necessarily just make it better for the patients. It has to be thoughtfully done.

Mr. MURPHY. I appreciate that.

Ms. Binder.

Ms. BINDER. We 100 percent agree there needs to be much more urgency. And I will point out that the Leapfrog Group does publish some of the results on infections for various hospitals that respond to our survey. And we stand ready to help in any way in working Federal agencies to do similar work.

Mr. MURPHY. Dr. Wright.

Dr. WRIGHT. Yes, we need to move.

Mr. MURPHY. I appreciate that. Because I also think that if we move quickly and called upon HHS to at least have some standards--and I recognize we don't want to burden hospitals with paperwork. But I also know, when I have spoken to hospitals, they do pay attention. They do reduce infection rates, and they find they save a lot of money for

each patient.

Mr. Chairman, I thank you for indulging me and allowing me to sit on this committee hearing. I appreciate that.

Chairman WAXMAN. Thank you very much, Mr. Murphy, for being here. I wish you were back on our committee. I appreciate the leadership you have given to this and other health issues. I know, at this time, the Energy and Commerce Committee is considering a bill that you have co-sponsored that I have joined you on to make sure that we have the adequate funds for the most vulnerable in our population for healthcare services. So I very much appreciate your being here. Thank you.

Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman.

I apologize for not being here for the whole hearing, and welcome the witnesses.

I am intrigued by the sort of payment dimension of this, how you used payment as a carrot and stick. And there was a comment that we are all familiar with this adage, that what gets measured gets done. But in health care, what gets paid for often is what gets done.

So, Dr. Pronovost, I would be interested in, I was reading your testimony, maybe you speaking a little bit more directly with respect to the reimbursement regime. What particular things do you see us using increased reimbursement

for, new reimbursement for to enhance; and then I know you also talked about in effect penalties where people don't take steps to address complications that could be avoided. Although you did point out that there is not sufficient research yet, maybe to put that kind of approach into play. So if you could just kind of talk about the carrot and stick from the funding and reimbursement side.

Dr. PRONOVOST. Sure. Congressman Sarbanes, for far too long, the healthcare community has labeled all these complications in the inevitable bucket. And we know that was a mistake, and patients like Mr. Lawton suffered for that. What we have done now is labeled them at the other extreme, all in the preventable bucket, and are trying to align payment policies with that. And we certainly need to align payment with high quality. The problem is they are not all preventable. And truth is, probably somewhere in the middle, and so we have to do things wisely.

What I believe we should do is those where CMS's complications that they are not going to pay for, I quite frankly think the only two that the science is robust enough--and what I mean by that is that we know how to measure them and we have good evidence that most, not all, but the majority are preventable are catheter-related bloodstream infections and retained foreign bodies after surgery; we leave things in that we shouldn't.

The others, we are not even clear how to measure accurately let alone to have any idea how many are preventable. We need to. And so I think the leadership ought to be, let's learn how to tackle, let's make a national goal to eliminated these catheter-related bloodstream infections, and find out what does it take to get all the different agencies CMF with policy, CDC with measurement, AHRQ implementing these programs, to really lick a problem well and, in the meantime, support efforts so we do learn how to measure more outcomes and estimate that they are preventable, we can have more Michigan projects so the public has a group of outcome measures that they could believe that hospitals aren't paying for things but that we are not holding them liable for things that really aren't preventable, because that is going to be gamesmanship, and we are going to be in the same place 10 years from now where we have data but harm continues unabated.

Mr. SARBANES. What about on the sort of front-end side of it? Should there be more funding in the form of reimbursement targeted to training and other things that are going on in hospital settings or other provider settings?

Dr. PRONOVOST. Absolutely. Right now, there are two medical schools, maybe three, one including Johns Hopkins, that has a required course for patient safety for medical students. And you say, well, why aren't there teachers?

Because most don't have people who know this stuff well enough to teach it. They have geneticists and physiologists, but they don't have safety experts. And we need absolutely to invest in training that we are producing doctors and nurses who, at a minimum, are skilled in the basics of this, and that we have populated it with people who have formal training like myself who know how to measure it in a scholarly way, who know how to lead health systems and do the quality improvement efforts that can really realize the benefits that the public so dramatically wants.

Mr. SARBANES. One last question, which is a completely different question. To what degree have we seen, or do you predict we will see going forward, actual implications for the design of--physical design and layout and so forth of hospitals and different provider venues in response to this healthcare-acquired infection issue?

Dr. PRONOVOST. I think the science of how do you design a safe hospital is immature, but we are doing that. And I have worked with five different hospitals, including my own, who, for the first time, built mock shelves of what they are doing to simulate how easy it is to do hand hygiene? How easy it is to prevent these infections? What the physical layout should be? And I think those requirements ought to be built into the design as they are planning new hospitals. I think a big limitation of that is most hospitals don't have

people with those skills, and so what we need to continue to do-- we set up a program for the World Health Organization to train leaders in patient safety, and several countries around the world are supporting those people to get public health degrees at the Johns Hopkins School of Public Health. And they work with us to be trained and go back to their country. There is no support for a U.S. person on there, and I think there needs to be.

Mr. SARBANES. Thank you.

Chairman WAXMAN. Thank you, Mr. Sarbanes.

You have been a terrific panel. We raised this question with the GAO, and we asked them to give us a report, because we are aware of the work that Dr. Pronovost and many others have been doing. We have heard about the successes in Michigan and elsewhere. We asked the Secretary to come in, and the Secretary wasn't able to make it. The first suggestion of the Department was have the Centers for Disease Control come in. Well, Centers for Disease Controls are one of three agencies that have been mentioned that deal in this area. What the GAO report has told us is that we need stronger leadership and coordination at the Departmental level, and that is why I am glad Dr. Wright is here representing the full Department.

This is a classic example of a national problem, and we ought to find an easy way to use techniques that are

available and have been successful. I know that no hospital, and I am sure that Mr. Labriola will tell me this, wants to be inundated with all sorts of checklists of this and that and the other. Let's coordinate what is essential, what is successful, and what is doable, and make sure the job gets done. We can criticize each other. We can say things haven't been successful, and there is a lot of justification for it. But what we wanted from this hearing is not just to criticize but to urge that the Department take the leadership. And we are willing to work with the Department to give them any assistance that they need, but we are going to have a period of time, a short period of time in which we want to make sure something gets done.

So we will be checking in with the Secretary and Dr. Wright. And in the meantime, if we don't see aggressive action from HHS, this committee is going to ask each of the State hospitals associations what their plans are to adopt these proven measures we discussed today. I would prefer that we use all the tools that we have at the Federal level, because all hospitals take patients for which the taxpayers in this country pay them compensation for, at least the Medicare and the Medicaid population, and through that, we want to make sure that the hospitals are doing what they need.

But this is not to be punitive. This is to be

constructive. And we all need to work together to use our best guidance as to how we can accomplish those goals.

I want to thank GAO for the report that you have done and all of the witnesses for your presentations.

Mr. Lawton, I am sorry you had to go through what you did, but at least you are here to tell us that we don't want others, to happen to them what happened to you. And it is preventable.

Mr. BURTON. Mr. Chairman, if I may make one comment.

Chairman WAXMAN. Yes, Mr. Burton.

Mr. BURTON. I agree with you that we shouldn't be overly critical of many of the people who are trying to do the right thing, but I do think that punitive action sometimes is necessary. If we have a food processing plant that is letting salmonella come out of their plants on a regular basis, we would close it down or we would penalize them severely. And I think if hospitals across this country are letting 100,000 people a year die a because of bacterial infections, then there ought to be penalties involved. And those who are responsible should have punitive action taken against them. We are talking about American lives here, and I think there ought to be penalties for people who don't do the job properly.

With that, thank you very much, Mr. Chairman.

Chairman WAXMAN. I appreciate that. And we want to use

all the tools that we have available to us. Penalties is obviously one tool, but guidance and coordination and successfully setting out what needs to be done along with recommendations of the GAO I think will get us there. We want to prevent the infections, and we want to prevent the penalties, because we want to make sure that not each individual has to check just the hospital but that the hospital systems are working so that each individual who goes to a hospital is going to get the best possible care.

I want to thank you very much for your presentation. We have one other witness, and I want to ask her to come forward as this panel leaves. Thank you.

STATEMENT OF BETSEY MCCAUGHEY, PH.D., FOUNDER AND CHAIRMAN, COMMITTEE TO REDUCE INFECTION DEATHS.

Chairman WAXMAN. Our last witness is Dr. Betsy McCaughey, who is the former Lieutenant Governor of New York. She is testifying today as the founder and chair of the Committee to Reduce Infection Deaths, a nonprofit group dedicated to reducing deaths from hospital infections. We are pleased to welcome you to our hearing today.

It is the committee's policy to swear in all witnesses before they testify, so I would like to ask you, if you would, to rise and raise your hand.

[Witness sworn.]

Ms. MCCAUGHEY. The question is, is the Federal Government--

Chairman WAXMAN. Just a minute. If you have a prepared statement, we are going to put it in the record. So I am going to--

Ms. MCCAUGHEY. I am just going to tell you what I think.

Chairman WAXMAN. We are going to give you 5 minutes to say what you are going to say. Since you were here for the first panel, you can give us your comments on what they had to say and your thoughts on how to get this job done.

RPTS JOHNSON

DCMN NORMAN

[1:28 p.m.]

Chairman WAXMAN. There is a button on the base of the mike. Is it on?

Ms. MCCAUGHEY. Is the Federal Government doing everything it should to prevent hospital infections? The answer is "no." And actually, the Centers for Disease Control and Prevention is largely to blame. The CDC has consistently understated the size of this problem and the cost of the problem. And their lax guidelines give hospitals an excuse to do too little.

So I am going to provide you with four kinds of information in these 5 minutes: the size of the problem, the cost of the problem, and the CDC's two most serious or deadly mistakes.

First, the size of the problem. The CDC claims that 1.7 million people contract infections in the hospital each year, but the truth is several times that number. And the data prove it.

I am going to hold up this chart to show you. Methicillin-resistant staphylococcus aureus, or MRSA, is one of the fast-growing hospital infection problems in the United States. In 1993, there were 2,000 hospital-acquired MRSA infections, according to the AHRQ. Last year 880,000--the

largest-ever survey of hospital infections in U.S. Hospitals, published in December in the American Journal of Infection Control, showed that 2.4 percent of all hospital patients acquired healthcare-related MRSA infections--880,000 during the course of a year. That is from one bacterium. Imagine how many infections there are from Acinetobacter, Pseudomonas, klebsiellas, vancomycin-resistant enterococcus, Clostridium difficile, and the other bacteria contained within the hospital.

Dr. Julie Gerberding testified to this committee in November that MRSA hospital-acquired infections are only 8 percent of the total. All right. So clearly these facts discredit the CDC estimate of 1.7 million infections. That guesstimate, that irresponsible guesstimate is based on a sliver of evidence that is 6 years old, from 2002.

The Centers for Disease Control and Prevention also understates the cost of this problem. The average hospital infection adds $15,275 to the medical costs of caring for a patient in the hospital. That means that 2 million hospital infections a year would add 30.5 billion a year to the Nation's health tab. So you do the arithmetic. What that really means is that the United States is spending as much treating hospital infections as the entire Medicare Part D drug benefit. We could be paying for drugs for all seniors for what we are spending on treating these hospital

infections.

But the problem doesn't end there. What causes these infections? Unclean hands, inadequately cleaned equipment and rooms, and lax procedures in the hospital. The Centers for Disease Control and Prevention has for many years now advocated rigorous hand hygiene. That is a start, but it is not enough, because as long as hospitals are heavily contaminated with these bacteria on all the surfaces, doctors' and nurses' hands are going to be recontaminated seconds after they wash and glove, when they touch a computer keyboard, a bed rail, a privacy curtain, any surface or tool within the hospital.

How dirty are hospitals? Research shows that three-quarters of surfaces in hospitals are contaminated with vancomycin-resistant enterococcus and methicillin-resistant staphylococcus and other bacteria. A recent study done by Boston University of 49 operating rooms in four New England hospitals found that over half the surfaces in the operating room that are supposed to be disinfected were left untouched by the cleaners. And a follow-up study of over 1,100 patient rooms, all the way from Washington, D.C. To Boston, found that over half the surfaces in patient rooms were also overlooked by the cleaners. Numerous studies link contaminated blood pressure cuffs, unclean EKG wires, and other equipment with hospital infections.

A recent study done right down the street at the University of Maryland showed that 65 percent of doctors and other medical professionals admit they change their white lab coat less than once a week, even though they know it is contaminated; 15 percent admitted they changed it less than once a month.

The Centers for Disease Control and Prevention's standards of hospital hygiene are so vague as to be meaningless. They are mind-numbing. And as you pointed out, Congressman Burton, restaurants are inspected for cleanliness in this country but not hospitals.

An accreditation by the Joint Commission is no guarantee that a hospital is clean. In fact, last year a study done showed that 25 percent of hospitals deemed unsanitary in the State of California by State health department inspectors responding to complaints had been accredited within the previous 12 months.

Hospitals in the United States used to inspect surfaces, test surfaces for bacteria levels. In 1970, the CDC and the American Hospital Association jointly announced that hospitals should stop doing that testing because they considered it a waste of money. And since that time, as late as this year right now, the Centers for Disease Control and Prevention adheres to that position against bacterial testing of surfaces in hospitals.

Bacterial testing of surfaces is so simple and so inexpensive that it is routine in the food processing industry. And I would like to ask you, Congressman Burton, whether you think that it is more necessary to test for bacteria at a hot dog factory than in an operating room.

Finally, the Centers for Disease Control and Prevention has also failed to call for screening for MRSA. You cannot control the spread of this deadly bacteria in hospitals if you don't know the source. People are carrying this bacteria on their skin and enter the hospital shed it everywhere, on wheelchairs, on bed rails, on stethoscopes, on the floor, on literally every surface. It doesn't make them sick until it gets inside their body via a ventilator, an IV, a urinary tract catheter, or a surgical incision.

But testing, which is a simple noninvasive nasal swab or skin swab, enables the hospital to take the precautions to prevent that bacteria from spreading to all the other patients in the hospital.

A new study just out from Case Western Reserve 2 weeks ago, shows that people who are unknowing carriers of MRSA are just as contagious as those who are infected and currently isolated in hospitals. Denmark, Holland, and Finland virtually eradicated these bugs in their hospitals through screening and cleaning, and the British National Health Service is now making screening universal. Some 50 studies

in the United States prove that it is effective and that it has reduced MRSA infections, where it has been tried here, by 60 to 90 percent. And yet--and the entire Veterans Administration is now launching universal screening.

The CDC continues to delay recommending universal screening. And every year of delay is costing millions--billions of dollars and thousands of lives. And that is my statement. Thank you.

Chairman WAXMAN. Thank you very much.

[The information follows:]

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Chairman WAXMAN. I am going to recognize Mr. Burton to ask questions.

Mr. BURTON. First of all, I want to thank you for coming on such short notice. And I want to thank you for your dedication to investigating all these things. What do you think ought to be done? I mean you have expressed very clearly the problem.

Ms. MCCAUGHEY. First of all, let me say what ought to be done.

Mr. BURTON. And the Chairman has indicated you have had a GAO study that is being conducted right now on the hospitals. What do you think should be done by the FDA and CDC and HHS to correct these problems? And is there a time frame within which you think it can be done?

Ms. MCCAUGHEY. Number one, American people deserve clean hospitals. Clean them or close them. That is what they are doing in Britain now. Now, they don't have a better healthcare system than we do, but there the political leaders are very, very engaged in affording the public clean hospitals. And that is the least we can do.

We cannot cure every major illness in the United States, but we can guarantee that patients have a clean hospital. And it is not rocket science to inspect a hospital for cleanliness. Yet when I called the Joint Commission and asked them if they inspect for cleanliness when they go to

accredit a hospital, they say no.

The CDC has reams of paper, hundreds of pages devoted to the issue of hospital hygiene. It is mumbo-jumbo. You can say in two or three pages how to inspect a hospital for cleanliness, how to test the surfaces for bacteria, as was done routinely before 1970. You can say that doctors should change their lab coat every day to avoid their own clothing becoming vectors for disease. So the least we can expect is rigorous hygiene in our hospitals. And it is highly cost-effective.

Mr. BURTON. You think that within a relatively short period of time, with the proper instructions, that they could clean up most of the hospitals?

Ms. MCCAUGHEY. Yes. Let me give you an example. In Los Angeles, restaurants are inspected three times a year for cleanliness and the results are posted in the restaurant window. But not hospitals. You don't have to go to a restaurant. You can go home and make your own lunch.

Mr. BURTON. Yeah. What kind of penalties do you think should be imposed if hospitals would not adhere to the requirements of keeping the place clean?

Ms. MCCAUGHEY. You are the lawmakers, but it seems to me there should be substantial penalties. The greatest, of course, is adverse publicity. Hospitals are advertising for our business. You hear their ads on the radio, Come to our

hospital. We have the best doctors, the latest technology. They are not telling you how many patients get an infection under their care.

But now in Britain and Ireland and Scotland, hospitals are routinely inspected every year for cleanliness. And the red, yellow or green ratings are posted and publicized. And you can bet that the newspapers in the United States would carry those results as well.

Mr. BURTON. I can't understand why--I mean, Health and Human Services and the FDA are charged with the responsibility of making sure that we have the best healthcare in the world. And I can't understand why they would not take the kind of advice you are giving to heart and actually do this. Can you give me a reason why you think this isn't happening? Because, I mean--

Ms. MCCAUGHEY. I can.

Mr. BURTON. We have had these people before the committee many times, the Chairman--and when I was Chairman--and they seem like they are dedicated. And I can't figure out why they wouldn't do this.

Ms. MCCAUGHEY. Yes. I must say I am amazed. When I spoke with the Joint Commission about it, the Vice President for Quality said, We can only ask hospitals to do so much. But is asking for a clean room too much? So much of this is about hygiene.

Mr. BURTON. Well, I appreciate your being here. I think this is something, Mr. Chairman, we ought to pursue as diligently as possible. I know you feel the same way. And if there is any way we can urge or force the health agencies to be more diligent in this regard, I would really appreciate it.

And as a person who suffered infections that darn near cost me mobility in my left arm, and possibly my life, and I had to spend 6 or 7 weeks with a bag full of antibiotics hanging from a stand to keep me from having an infection that would kill me, I can attest to the fact that I know this stuff goes on.

And there ought to be some way that the hospitals and FDA and CDC and HHS can implement a program that will make sure--that will minimize the possibility of these infections. And I would like to have your statistical data.

Ms. MCCAUGHEY. Of course. With all the footnotes, I am submitting the entire thing in evidence. Let me just add this. I am not asking the hospitals to do something they cannot afford to do. Numerous studies illustrate that the more rigorous cleaning that I have discussed actually yields a very handsome financial return without a capital outlay. It can be done in the first year.

In Rush Medical College in Chicago, the researchers who identified the frequently overlooked areas of the operating

rooms and patients' rooms that were not cleaned worked with the cleaning staff, showed them how to clean properly, drench and wait, not just a quick spray and wipe, and how important it was to get certain surfaces that were always overlooked. They reduced the spread of another nasty bug, VRE, vancomycin-resistant enterococcus by two-thirds simply working with the cleaning staff.

Another hospital experienced a 350 percent return the first year by adding cleaning staff and working with them to identify the often overlooked areas. So cleaning is a highly effective strategy to reduce the spread of most bacteria.

Chairman WAXMAN. Thank you very much. Did you read the GAO report?

Ms. MCCAUGHEY. I haven't gotten it yet. I requested it, but I am looking forward to reading it very soon.

Chairman WAXMAN. I would be interested in your response to it. What GAO had to say was that they are not as harsh on CDC as you seem to be. They point out that the CDC and the other agencies within Department of Health and Human Services--and there is no one giving guidance when you have three different agencies promoting different database, different rules, and so on and so forth. But we need rules and we need to approach this as a Federal responsibility.

Ms. MCCAUGHEY. I would like to add one other thing.

Chairman WAXMAN. Let me finish.

What was recommended to us in that first panel were some things that I think are doable. And when they are done, they have been very successful. What you are advocating goes beyond that. And I think you are--from what I understand your analysis of the possibility of infection from a lot of the cleaning problems is accurate, but there seems to be some controversy as to whether all of that is necessary.

I don't know the accuracy of it, but that is what we have been told by some of the scientists. What we want to have done is, first of all, what can be done now to reduce infections get done; get the best science on what else needs to be done; and then make sure that the best science is implemented.

And you have come before us and given us a broader perspective. And you are right in pointing out that it is not just a hospital infection. MRSA is a problem beyond the hospitals themselves. And we want to recognize that fact and make sure we get strategies in place to approach that.

So I appreciate your passion on this issue and the work you have done. And I want you to give us your comments on that GAO report. Because what we want to do is make sure that we do what can be done, do what must be done, and prevent these diseases. And I thank you very much for being here.

I am going to have to end the hearing because there is

another group that is going to be coming into the meeting room. But thank you so much. And this committee hearing stands adjourned.

[The information follows:]

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[The information follows:]

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[Whereupon, at 1:44 p.m., the committee was adjourned.]