



Testimony
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Subcommittee on Labor, Health, and Human Services, Education, and
Related Agencies
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Pathway to Health Reform:
HHS Action Plan to Prevent Healthcare-Associated Infections

Statement of
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Introduction

Good morning Chairman Obey, Ranking Member Tiahrt and other distinguished Members of the Committee. I am Dr. Don Wright, Principal Deputy Assistant Secretary for Health in the Office of Public Health and Science (OPHS) at the U.S. Department of Health and Human Services (HHS).

I am pleased to be here to describe HHS' efforts to reduce the rates of healthcare-associated infections (HAI) and the development of the HHS Action Plan to Prevent Healthcare-Associated Infections. There are several agencies within the Department that have played significant roles in addressing this important public health challenge, including the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Medicare and Medicaid Services (CMS). My colleagues from CDC and AHRQ are here today to talk about the considerable work occurring in their agencies with respect to the prevention of healthcare-associated infections. My CMS colleagues are also here to address any questions you may have about the healthcare-acquired infection prevention initiatives that CMS is implementing.

Today, I will focus my remarks in four specific areas: (1) the development of the HHS Action Plan to Prevent Healthcare-Associated Infections; (2) the future direction of the coordinated HHS effort; (3) how the American Recovery and Reinvestment Act of 2009 (ARRA) and the Fiscal Year (FY) 2009 Omnibus Bill funds will support prevention

activities outlined in the Action Plan; and (4) how prevention activities improve healthcare quality in a reformed health system.

Background

Healthcare-associated infections (HAI) are infections that patients acquire while receiving treatment for medical or surgical conditions. Healthcare-associated infections occur in all settings of care including hospitals, same-day surgical centers, ambulatory outpatient care clinics, and long-term care facilities, such as nursing homes and rehabilitation centers. The infections are associated with a variety of causes including the use of medical devices, such as catheters and ventilators, complications following surgical procedures, and transmission between patients and healthcare workers.

Healthcare-associated infections exact a significant toll on human life. They are among the top ten leading causes of death in the United States, accounting for an estimated 1.7 million infections and 99,000 associated deaths in 2002.¹ In hospitals, they are a significant cause of morbidity and mortality.

In addition to the substantial human suffering exacted by healthcare-associated infections, the financial burden attributable to these infections is staggering. It is estimated that healthcare-associated infections incur an estimated \$28 to \$33 billion in excess healthcare costs each year.² Despite the sobering facts, healthcare-associated

¹ Klevens RM, Edwards J, Richards C, Horan T, Gaynes R, Pollock D, Cardo D. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. *Public Health Reports* 2007; 122:160-166.

² Scott Rd. The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention, 2009. Division of Healthcare Quality Promotion, National Center for Preparedness, Detection, and Control of Infectious Diseases, Coordinating Center for Infectious Diseases, Centers for Disease Control and Prevention, February 2009.

infections are largely preventable and can be drastically reduced in order to save lives and avoid excess costs. Recent research efforts in Pennsylvania supported by AHRQ and CDC have shown that implementation of HAI prevention recommendations can reduce healthcare-associated bloodstream infections by as much as 70 percent for bloodstream infections through targeted approaches.^{3,4} Broad implementation of prevention guidelines can result in reductions in healthcare-associated infections, which will save lives and reduce suffering. The growing demands on the healthcare system, coupled with concerns of antimicrobial-resistant pathogens and rising healthcare costs, reinforce the imperative to address this issue.

Development of the HHS Action Plan to Prevent Healthcare-Associated Infections

In recognition of this important public health and patient safety problem, HHS has developed a comprehensive plan to prevent healthcare-associated infections over the next several years. Successful infection prevention and elimination efforts have been underway for years across the various agencies within HHS. However, in 2008, HHS began a concerted, Departmental-wide effort to approach this issue. The goal of the effort was to marshal the extensive and diverse resources of HHS and cooperate effectively with public and private sector partners to accomplish the large-scale prevention of healthcare-associated infections.

³ MMWR. Reduction in Central Line--Associated Bloodstream Infections Among Patients in Intensive Care Units --- Pennsylvania, April 2001--March 2005. October 14, 2005 / 54(40); 1013-1016.

⁴ Pronovost P, Needham D, Berenholtz S, et al. An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU. N Engl J Med 2006; 355:2725-2732.

In March 2008, the Government Accountability Office (GAO) completed a review of healthcare-associated infections in hospitals.⁵ The GAO acknowledged HHS-supported efforts, but noted a lack of centralized coordination of activities in order to appropriately leverage resources across the Department. The report encouraged HHS to further its leadership of preventing healthcare-associated infections through enhanced coordination of all intervention activities. In particular, the report directed the Department to (1) prioritize existing recommended infection control practices to facilitate their implementation in healthcare facilities and (2) reduce “silos” across its Operating Divisions with regards to the various information technology systems used to measure healthcare-associated infections. While there are numerous systems and databases collecting HAI-related data across HHS, the GAO noted a need for greater consistency and compatibility of the data to enhance the information provided, including data used to obtain reliable national estimates of the major types of healthcare-associated infections.

In order to improve and expand HAI prevention efforts, the Department established the Steering Committee for the Prevention of Healthcare-Associated Infections in the summer of 2008. The Steering Committee included senior-level representatives from the Offices and Operating Divisions of HHS, including AHRQ, the Office of the Assistant Secretary for Public Affairs, the Office of the Assistant Secretary for Planning and Evaluation, CDC, CMS, the Food and Drug Administration (FDA), the National Institutes of Health (NIH), and the Office of the National Coordinator for Health Information Technology (ONC). The Steering Committee was chaired by me as the

⁵ United States Government Accountability Office. Health-Care-Associated Infections in Hospitals. GAO-08-283, Washington, DC, April 2008.

Principal Deputy Assistant Secretary for Health within OPHS which is within the Office of the Secretary (OS). The HHS Deputy Secretary charged the Steering Committee with developing the Action Plan to Prevent Healthcare-Associated Infections. This plan established national goals and outlined key actions for enhancing and coordinating HHS-supported efforts. In addition, the plan outlined opportunities for collaboration with external partners.

The Steering Committee utilized a working group structure to accomplish its charge. The working groups were each led by one or two agencies and comprised of subject matter experts across the Department. Each of the five working groups enumerated strategies for accomplishing a portion of the Action Plan:

- The *Prevention and Implementation* group, in partnership with HHS' Healthcare Infection Control Practices Advisory Committee (HICPAC), prioritized existing recommended clinical practices to facilitate implementation in healthcare organizations;
- The *Research* group identified gaps in the existing knowledge base of current infection control practices and developed a coordinated research agenda to strengthen the science for infection control and prevention in hospitals;
- The *Information Systems and Technology* group established a plan to progress towards the standardized measures and definitional data alignment needed to measure healthcare-associated infections across agencies and provided opportunities to make the varied HHS data systems interoperable to enhance understanding of healthcare-associated infections;

- The *Incentive and Oversight* group explored opportunities for evaluating compliance with infection control practices in hospitals through certification processes required for Medicare participation and identified additional options for the use of payment policies and financial incentives to motivate organizations to provide better, more efficient care; and
- The *Outreach and Messaging* group developed a plan for national messaging regarding HAI prevention to raise awareness among various stakeholder groups across the United States with particular emphasis on empowering healthcare consumers to be active participants in preventing healthcare-associated infections.

Given the substantial breadth and depth of healthcare-associated infections, the Steering Committee decided to concentrate its activities on a first tier of six high priority HAI-related areas within the acute care hospital setting. Surgical site infections, central line-associated bloodstream infections, ventilator-associated pneumonia, and catheter-associated urinary tract infections account for approximately three quarters of healthcare-associated infections in the acute care hospital setting.⁶ Thus, these four infection categories were included in the initiative's first tier.

In addition, the Steering Committee believed it was important to address emerging HAI issues, and therefore decided to include two organism specific priorities: *Clostridium difficile*, as well as methicillin-resistant *Staphylococcus aureus* (MRSA) in its first tier efforts. A recent publication demonstrated that *Clostridium difficile* is occurring almost as

⁶ Klevens RM, Edwards J, Richards C, Horan T, Gaynes R, Pollock D, Cardo D. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. *Public Health Reports* 2007; 122:160-166.

frequently in the hospital setting as MRSA, impacting resource use and inpatient mortality.⁷ Methicillin-resistant *Staphylococcus aureus* was addressed as a causative organism, given its contribution to the four HAI priority procedures. While remaining aware of the larger issues regarding HAI prevention, including settings outside of the hospital, the initial development phase of the Action Plan focused on the hospital setting, four site-specific infections, and two emerging organisms defined in the first tier.

A critical step in the Action Plan development process was the identification of priority measures and five-year national prevention targets for assessing progress in HAI prevention. The targets serve to enable the Department to evaluate progress and focus prevention efforts, including priority setting and task assignment, in order to efficiently achieve the goals outlined in the Action Plan. Recognizing the importance of working synergistically with partners, the primary measures selected by the Steering Committee complement and support existing national measures and targets identified and/or adopted by key national stakeholder organizations. Shared measures promote the efficiency of all organizations working to prevent healthcare-associated infections and discourage unnecessary duplication of efforts. In addition, the Steering Committee sought to coordinate measure identification and target setting with existing Departmental initiatives, including Healthy People 2020, a science-based, 10-year list of national objectives for promoting health and preventing disease.

⁷ Elixhauser A and Jung M. Clostridium Difficile-Associated Disease in U.S. Hospitals, 1993–2005. *AHRQ Healthcare Cost and Utilization Project Statistical Brief* 2008; 50:1-11.

The Action Plan was issued in January 2009. Concurrently, comments were invited from the public in order to further engage stakeholders and solicit input on how to enhance the Action Plan and establish priorities for HAI prevention. Notices were placed on the Department's website, posted in the Federal Register, and sent to key partners in order to obtain valuable input. The initial comment period closed in early February 2009 with receipt of comments from professional organizations, businesses, and individual healthcare consumers. Substantial comments were received from all major stakeholder organizations. The feedback received was positive with many organizations applauding the government for its work in coordinating activities and establishing prevention priorities across the Department, as well as for developing the Action Plan in such a short period of time. Also, several organizations and individuals noted they were pleased that the issue had risen to the level of national importance it had.

Future Direction of the HHS Healthcare-Associated Infections Prevention Effort

While there has been considerable activity across HHS related to the prevention of healthcare-associated infections, more work needs to be done. The Department is in the process of synthesizing the comments received from the public and revising the Action Plan in the spring of 2009. In addition, we are planning three public engagement meetings for the spring and summer of 2009 to connect with healthcare consumers and receive additional input on the Action Plan. The first meeting will be held in Washington, DC in the spring with the others to follow in locations across the country.

The Steering Committee resumed meetings in March 2009 with the purpose of implementing the steps outlined in the Action Plan and commencing discussions on the next tier of the effort. Recognizing the dramatic expansion of healthcare provision in outpatient settings, the Steering Committee will focus its second tier efforts on the ambulatory care setting. Ambulatory Surgical Centers (ASCs) have been the fastest growing provider type participating in Medicare, increasing in number by more than 61 percent between 2000 and the start of 2009.⁸ It is estimated that Ambulatory Surgical Centers performed 14.9 million procedures in 2006 or 43 percent of all same-day surgeries.

FY 2009 Funded Activities Outlined in the Action Plan

OPHS, consistent with its leadership role in developing the HHS Action Plan to Prevent Healthcare-Associated Infections, will continue to provide coordination and oversight of the overall Departmental healthcare-associated infections prevention effort. With the \$5 million in funding provided to the OS in the FY 2009 Omnibus Bill, OPHS plans to continue the valuable work of the HHS Steering Committee for the Prevention of Healthcare-Associated Infections and provide the necessary leadership, coordination, and infrastructure for supporting the Steering Committee's activities. The Steering Committee will have the continued responsibility for coordinating implementation of the Action Plan across the Department and monitoring and tracking progress in achieving the national goals outlined in the Action Plan, as well as for commencing second tier efforts. In addition, the Steering Committee will continue to coordinate the use of HAI-related ARRA funds.

⁸ CMS Survey & Certification (S&C) Providing Data Quickly (PDQ) Database.

As outlined in the Action Plan, OPHS also plans to use the FY 2009 funds provided in the Omnibus to develop and implement a national campaign to raise awareness of the importance of addressing healthcare-associated infections. Outreach efforts will include gathering healthcare providers from various healthcare institutions for regional stakeholder meetings to get their input on how to best address HAI prevention. The campaign will also focus on empowering consumers to be active participants in preventing healthcare-associated infections and encouraging them to be more involved in their own healthcare. The campaign could include creative uses of new media, television, radio, and print announcements, as well as the development and dissemination of an HAI prevention toolkit.

Funds will also be provided to inter-agency projects designed to support the development and deployment of a standards-based solution for integrating data collection across specific HHS data systems. The intent of these projects is to use interoperability standards to reduce “siloes” Departmental data systems, reduce data collection and reporting burdens for healthcare facilities, and progress towards the achievement of broader goals, including the wide-scale adoption of electronic health records. In addition to positioning the Department to be better able to leverage information technology resources to prevent healthcare-associated infections, these projects directly address the concerns raised in the GAO report.

In addition, funds will be provided to CDC to collaborate with AHRQ and CMS as described in the Action Plan and develop systematic processes, based on health services research findings and cost benefit analyses for ongoing prioritization of CDC prevention recommendations, identifying those recommendations in which investments will yield the greatest potential benefits to patient safety. Additional FY 2009 funds provided in the Omnibus will be provided to CMS to perform an inter-agency (AHRQ/CDC/CMS) evaluation of the Medicare Hospital-Acquired Conditions (HAC) payment policy, which was also discussed in the Action Plan.

The ARRA included \$50 million for HAI prevention. The Steering Committee deliberated over the best use of these monies, which were strictly defined to be distributed to the states, and jointly decided on the most appropriate projects to fund. In a moment, you will hear from Dr. Besser who will describe how \$40 million of these ARRA funds will be spent to support activities outlined in the Action Plan to benefit the states. The remaining \$10 million will be used by CMS to rollout a new infection control survey instrument for inspections of Ambulatory Surgical Centers. Inspections have proven to be potent deterrents to relaxed infection control practices and thus have much potential for preventing healthcare-associated infections.

To help prevent serious infections resulting from services performed in Ambulatory Surgical Centers, CMS will use the funds provided in the ARRA to implement the nationwide application of a new infection control survey tool developed in consultation with CDC and a case tracer methodology that tracks a patient's care from admission to

discharge. In addition, CMS will use the ARRA funds to survey Ambulatory Surgical Centers using this survey application at the rate of approximately once every three years during this national pilot.

A CMS/CDC pilot program tested the enhanced survey process in Maryland, Oklahoma, and North Carolina in 2008 and demonstrated superior results in the ability to detect deficient infection control practices. The particular focus on Ambulatory Surgical Centers for this funding was chosen because the available infection control tool was developed for Ambulatory Surgical Centers and because of the likely continuing infection control deficiencies in this setting.

The primary use of these dollars will be to pay for the expansion of Ambulatory Surgical Center surveys (both in quality, time, and number) using the new infection control tool and case tracer methodology. The funds will allow states to hire additional surveyors (one to four per state dependent upon Ambulatory Surgical Center growth), which will increase a state's capacity to maintain expected levels of Ambulatory Surgical Center inspections while building greater capacity to use the improved survey tool nationwide. In recent years, funding for survey and certification activities supported recertification of Ambulatory Surgical Centers once every ten to fourteen years;⁹ this new funding will enable CMS to perform targeted survey and certification activities much more frequently.

Healthcare-Associated Infection Prevention in a Reformed Health System

⁹ CMS FY 2009 Congressional Justification, page 65.

The administration has made the expansion of affordable healthcare a priority. Access to healthcare is essential for improving the health of the population and the competitiveness of American businesses. The President has articulated that in order to reform healthcare, prevention, healthcare quality, and patient safety must also be priorities.

Monitoring and preventing healthcare-associated infections is fundamental to protecting patients and improving healthcare quality. The investment of the ARRA and the FY 2009 appropriations represent critical investments that can yield quantifiable health impact. Moreover, improving the oversight of inspections in outpatient settings provides a baseline of protection where healthcare delivery has expanded dramatically over the previous decade. As care has exploded in outpatient settings, oversight of these facilities has not kept pace. If ambulatory surgical centers or any healthcare provider compromises on the fundamentals of safe practice -- such as the safe delivery of injections and medications -- patients will suffer the consequences.

If we are to succeed in expanding access to healthcare, we must ensure that the healthcare delivered is safe and effective. Just as healthcare delivery and care are dynamic processes that evolve with the emergence of new treatments and technologies, so too must HAI prevention and patient safety evolve. The sources and routes of tomorrow's infections are unknown. Thus, we must remain vigilant in our monitoring of healthcare-associated infections and consistent in our application of evidence-based HAI prevention recommendations. The President has articulated that we must improve both access and quality in healthcare; HHS is dedicated to seeing that these goals are achieved.

Thank you for the opportunity to testify today; I am happy to take any questions you may have.

Principal Deputy Assistant Secretary for Health

Biography of Don Wright, M.D., M.P.H. Principal Deputy Assistant Secretary for Health U.S. Department of Health and Human Services

Dr. Don Wright became the Principal Deputy Assistant Secretary for Health on December 10, 2007. Dr. Wright acts as an advisor to the Assistant Secretary for Health on matters involving the nation's public health and science. His responsibilities include planning and execution of public health policy as it relates to disease prevention, health promotion, women's and minority health, the reduction of health disparities, the fight against HIV/AIDS, blood safety, and pandemic influenza planning. Dr. Wright also has broad management and policy responsibility for the HHS Office of Public Health and Science.

Prior to becoming the Principal Deputy Assistant Secretary for Health, Dr. Wright served as the Director of the Office of Occupational Medicine for the Occupational Safety and Health Administration (OSHA). As a result of his leadership, OSHA now recognizes impairment with drug and alcohol as an avoidable workplace hazard and recommends the adoption of Drug Free Workplace Programs as part of a comprehensive occupational health and safety program.

In response to the 9/11 terrorist attack and Hurricane Katrina, Dr. Wright organized and moderated nationwide conferences focused on enhancing hospital emergency preparedness for natural disasters, acts of terrorism and pandemic influenza. While at OSHA, Dr. Wright developed strong collaborative working relationships with the Centers for Disease Control and Prevention, the American Red Cross, the Joint Commission on Accreditation of Healthcare Organizations, and the American Heart Association on issues related to health and safety.

As a clinician, Dr. Wright dedicated himself to the prevention of injuries and illnesses. During his 15 years in the private sector, Dr. Wright maintained an extensive clinical and consulting practice in Central Texas.

Dr. Wright received his undergraduate degree from Texas Tech University and his medical degree from the University of Texas. Dr. Wright completed his family medicine residency training at Baylor College of Medicine. In addition to his medical degree, Dr. Wright holds a Master of Public Health degree from the Medical College of Wisconsin. He is board certified in both Family Medicine and Preventive Medicine and is a fellow of the American College of Occupational and Environmental Medicine and the American Academy of Family Physicians.