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**Testimony**
**of the**
**American Hospital Association**
**before the**
**Subcommittee on Labor, HHS and Education**
**of the**
**House Committee on Appropriations**

**"Healthcare-Associated Infections"**
**April 1, 2009**

Good morning, Mr. Chairman. I am Bob Hyzy, M.D., a board certified pulmonologist and critical care medicine doctor – what some call an intensivist – at the University of Michigan Hospitals and Health System in Ann Arbor. My title at the University is Associate Professor of Medicine, Division of Pulmonary and Critical Care. I also am Director of the Critical Care Medicine Unit at the University of Michigan Hospital and Chair of the hospital's Critical Care Committee. And I chair the steering committee of the Michigan Health and Hospital Association's (MHA) Keystone Intensive Care Unit (ICU) project.

I am pleased to be here today to represent the American Hospital Association (AHA) and its nearly 5,000 member hospitals, health systems and other health care organizations, its 38,000 individual members, and the dedicated hospital leaders, doctors, nurses, pharmacists and other health care workers who care for patients every day in our hospitals. I will share with you our thoughts on how prevention strategies and best practices are reducing healthcare-associated infection (HAI) rates, and how the hospital field is working collaboratively to implement these strategies more broadly.

I have not only had the responsibility of implementing the Keystone project at my own hospital and health system, I also have worked with the staff of the MHA to provide local clinical expertise to complement the national expertise of Dr. Peter Pronovost, the project's director, whom I am proud to share this table with. It was his work at the Johns Hopkins University Quality and Safety Research Group that created the underlying system from which the Keystone ICU project has grown.

**THE KEYSTONE ICU PROJECT**

The MHA Keystone Center for Patient Safety & Quality was created by Michigan hospitals in March 2003. It brings together hospitals, state and national patient safety experts and evidence-based best practices to improve patient safety and reduce costs by improving the quality of care delivered at the bedside. Through the MHA Keystone Center, Michigan hospitals have voluntarily improved the safety and quality of health care through the application of the scientific method and the implementation of evidence-based best practices that are saving lives and reducing health care costs. The Center has been funded to date by the Agency for Health Care Research and Quality (AHRQ), MHA-member hospitals, federal and state grants, and Blue Cross Blue Shield of Michigan. The Center, and its collaborative work, reflects the commitment of hospital leaders and others to voluntarily improve the safety of the care they provide, including reducing infections.

The Centers for Disease Control and Prevention has estimated that 2 million Americans contract an infection while receiving medical treatment. Hospital infections are believed to cost Americans between $4.5 billion and $6.5 billion in extra health care costs annually.

In the past, some levels of infection were seen as inevitable, and we were doing well to keep the level low as more "superbugs" emerged. Then, Keystone and similar projects came along. Its key focus has been on central-line associated blood stream infections … that is, infections related to catheters that are inserted directly into a blood vessel with a direct line to the heart because these patients are very sick and unable to have a catheter stuck into a peripheral vein. Using the Keystone protocols, what was once an infection rate of approximately 2.7 per 1,000 catheter days has been driven down to near zero, a remarkable achievement, especially considering these are among our sickest patients.

However, to achieve those results required the dedication and commitment of leaders and caregivers at individual institutions, as well as the leadership of an effective coordinating body.

We estimate that, last year, Michigan hospitals saved nearly 1,500 lives and $175 million by participating in the Keystone ICU project. Senior officials at AHRQ describe the project as among their most successful initiatives, and would like it to be a model for the dissemination and implementation of other evidence-based safety and quality initiatives.

At the institution level, specifically my hospital, our success has been gratifying. My Critical Care Medicine Unit has decreased our catheter-associated bloodstream infection rate 74 percent over the course of five years; the rate is now nearly zero. More importantly, we have created a culture of change that is self-sustaining and that recognizes that good is simply not good enough and that our practice of critical care is not static; we can always improve. We now have monthly interdisciplinary patient safety rounds where a recent case is examined by staff and resident physicians, nurses and respiratory therapists.

Other members of my institution are taking leadership roles in statewide quality initiatives: Dr. Sanjay Saint, a nationally recognized expert in HAIs, is leading our state's effort to decrease urinary tract infection in Michigan hospitals. Finally, we are working to enhance our medical school curriculum in order to ensure that all students graduating from the University of Michigan Medical School understand, as the quality guru W. Edwards Deming said, "If you can't describe what you are doing as a process, you don't know what you are doing."

Our success depended on our ability to do a number of things:

- Provide the internal organizational and clinical leadership to create the right culture for success, and to allocate the necessary resources;

- Engage everyone in the work; infections were everyone's responsibility, not just that of the infection control committee;

- Test the changes we made in our care processes, capture the data that lets us know if those changes yield better results, and cement those changes into place when they work or discard them if they don't; and

- Share information with our patients and with the broader community that we serve.

The Keystone Center was invaluable to us because it provided:

- Access to clinical expertise and system change expertise;
- Ideas, strategies, and tools to be used at all levels of the organization;
- And infrastructure that enabled information to be shared among all involved; and
- Data aggregation, feedback and benchmarking.

**WHERE ARE WE HEADED?**

Mr. Chairman, hospitals are hungry for the kind of change that initiatives like the Keystone project can bring, and the AHA is taking the lead in helping to meet that demand. Through its Health Research and Educational Trust (HRET), and with $3 million in funding from AHRQ, "On the CUSP: Stop Bloodstream Infections" is being implemented in 10 states ("CUSP" stands for Comprehensive Unit-Based Safety Program"). By putting the program in place in at least 100 hospitals across the country, the goal is to reduce the average rate of central-line infections in those hospitals by 80 percent, from the national average of five infections per 1,000 catheter days to one infection for every 1,000 catheter days, and to improve the patient safety culture by 50 percent.

Another key aim of the initiative is to build a multi-disciplinary infrastructure for sustaining this and future patient safety improvement innovations.

The following 10 state hospital associations and patient safety groups were selected to participate in the infection reduction program:

- California Hospital Association, in collaboration with the California Hospital Patient Safety Organization
- Colorado Hospital Association
- Florida Hospital Association
- Massachusetts Hospital Association
- Nebraska Hospital Association
- The North Carolina Center for Hospital Quality and Patient Safety
- Ohio Patient Safety Institute, in collaboration with the Ohio Hospital Association
- Hospital & Healthsystem Association of Pennsylvania
- Texas Hospital Association
- Washington State Hospital Association

HRET and its partners at Johns Hopkins and MHA will work with these organizations to choose at least 10 hospitals from each participating state, and will develop an educational toolkit and other resources to encourage adoption of the specific, evidence-based steps hospitals can take to reduce these infections in ICUs.

In addition, a second project is spearheaded by the Johns Hopkins Quality and Safety Research Group in partnership with the MHA Keystone Center and is funded by donations and the Sandler Foundation of the Jewish Community Endowment Fund. The following organizations have been selected to participate in this project:

- Arkansas Hospital Association
- Connecticut Hospital Association
- Georgia Hospital Association
- Coordinating Agencies of Hawaii
- Illinois Hospital Association
- Indiana Hospital Association
- Minnesota Hospital Association
- Missouri Hospital Association
- New Hampshire Foundation for Healthy Communities
- New Jersey Hospital Association
- New Mexico Hospital Association
- Healthcare Association of New York State
- Oklahoma Hospital Association
- Oregon Hospital Association
- South Carolina Hospital Association
- Tennessee Hospital Association
- West Virginia Hospital Association
- Wisconsin Hospital Association

Together, Mr. Chairman, these two efforts greatly expand the unprecedented opportunity to reduce these infections across the country, and will allow us to triple the reach of the original project.

A key goal in all of this is to ultimately replicate with other types of infections the success we have had reducing central-line infections. Surgical site infections are likely our next opportunity because of work that has already been done by the Surgical Care Improvement Project (which I address below), the National Surgical Quality Improvement Project, and the Surgical Checklist developed by Atul Gawande and adopted by the World Health Organization. Then we would likely tackle catheter-associated urinary tract infections, and as we meet with success, move on to other areas of care that currently seem intractably problematic.

**OTHER FIELD RESOURCES**

Mr. Chairman, please do not let me give the impression that the Keystone Project, and the initiatives underway to implement it more broadly, is the extent of the field's work on infection control. Much more is being done, by individual hospitals as well as by the associations that represent them.

The Surgical Care Improvement Project (SCIP), a national quality partnership of the AHA, American College of Surgeons, Centers for Disease Control and Prevention, The Joint Commission, Centers for Medicare & Medicaid Services (CMS) and many others, aims to reduce the most common surgical complications, including surgical wound infections and pneumonia, by 25 percent by 2010. The project promotes clinically proven prevention steps that every hospital can adopt to improve the care of surgical patients, such as maintaining normal body temperature and glucose levels, and clipping, not shaving, the incision skin area. SCIP is one of many initiatives that hospitals are undertaking to reduce and prevent HAIs as well as other adverse complications from surgery.

In addition, late last year, for the first time, five leading health care organizations came together to publish practical, science-based strategies to help prevent the six most important healthcare-associated infections. The AHA joined with the Society for Healthcare Epidemiology of America, the Infectious Diseases Society of America, the Association for Professionals in Infection Control and Epidemiology, and The Joint Commission, to release the *Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals.*

The compendium brings together practices and sciences that we know are effective in preventing infections, and provides recommendations that are understandable, easy-to-use and that stress accountability. Six of the most important preventable HAIs with the greatest impact on morbidity and mortality were identified, including central-line infections, with recommendations prioritized into two categories:

- Minimum basic practices that should be adopted by all acute-care hospitals; and

- Special approaches for use in locations and/or populations within the hospitals when infections are not controlled using basic practices.

Two sections focus on preventing the spread of specific organisms, including staph; and four sections focus on device-and procedure-associated infections, including central-line infections, ventilator-associated pneumonia, catheter-associated urinary tract infection, and surgical site infection.

The AHA Quality Center helps hospitals accelerate their quality improvement processes. The Center is a one-stop shop that consolidates information that is continually refreshed and updated with essential knowledge from across the hospital field. It includes the AHA Quality Call Center, which with a toll-free number connects hospital leaders to the quality and patient safety resources that can help them meet their quality leadership challenges. The Quality Center also collaborates with leading quality and patient safety organizations to sponsor educational sessions to disseminate demonstrated practices and emerging concepts, and offers an online Opportunity Assessment to accelerate quality and patient safety improvement.

**WHAT CAN CONGRESS DO?**

Mr. Chairman, let me begin with what we urge Congress *not* to do.

The AHA supports sharing information about HAIs with the public. That information must be meaningful for consumers and must be based on solid data and good measures, target infections that have the highest potential for the greatest harm, and focus on areas where clinically proven prevention efforts exist.

Specifically, the AHA supports voluntary reporting through the Hospital Quality Alliance (HQA) of surgical infection prevention measures, surgical wound infection rates and Central-line blood stream infection rates.

Since 2002, the HQA has worked with hospitals to share with the public reliable, credible and useful information on hospital quality. The AHA, the Association of American Medical Colleges and the Federation of American Hospitals invited government agencies, professional organizations, purchaser alliances, consumer organizations and others to forge a shared national strategy for accurate quality measurement and public accountability. Initially, the effort began as a voluntary one to share data with the public. Congress, recognizing the importance of this initiative, began linking submission of data requested by the HQA to receipt of the full Medicare market basket update for hospital inpatient payment. The effort has expanded to include new measures each year.

The HQA's Web site, www.hospitalcompare.hhs.gov, helps the public better understand how care is provided by their hospitals. More than 4,200 acute-care hospitals now display data, and hospital leaders and clinicians also use the data to identify organizations with stellar performance so they can learn from these outstanding practices.

The work of the HQA depends on having scientifically sound and meaningful measures that have been endorsed through the National Quality Forum's (NQF) consensus development process. To ensure that the NQF can continue to assess and endorse measures that will lead to important information being available to the public, the AHA and our partners in the HQA support legislation that would ensure the federal government gives core support for this public-private entity that provides a vital public service.

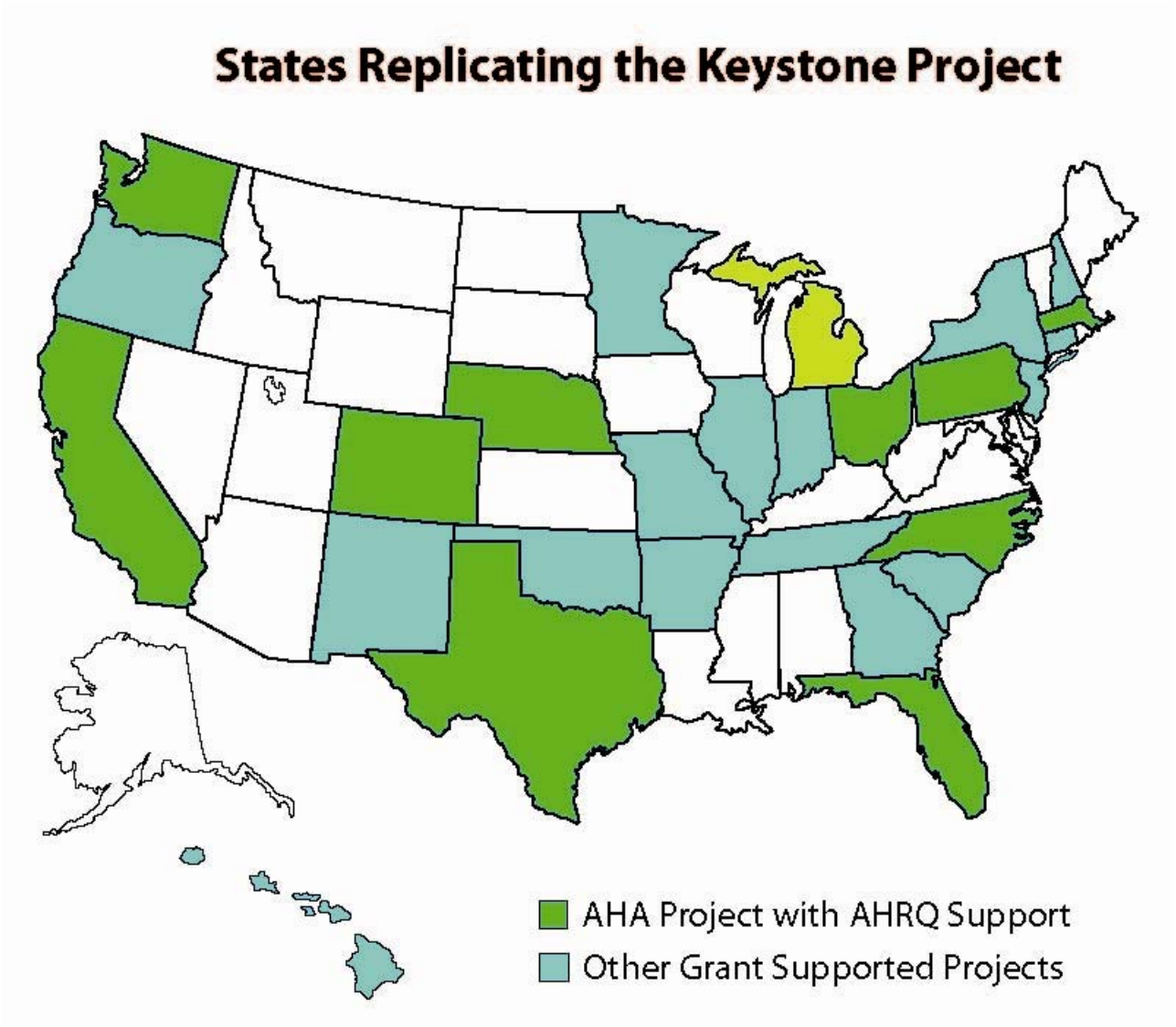
The HQA provides a firm foundation for further transparency. However, hospitals face multiple requests for quality data from insurers, employer groups, accreditors and government agencies. These myriad demands create confusion and frustration for hospitals and the public, rather than illuminating key aspects of quality. We strongly urge that quality data should be reported in just one way to just one place: the Hospital Quality Alliance. It is a proven system; it works.

Now, Mr. Chairman, what *can* Congress do? Invest in quality! Funding from AHRQ has been, and continues to be, a vital lifeline to hospitals' ability to improve infection rates through these programs.

In the fiscal year 2009 omnibus appropriations bill and the *American Recovery and Reinvestment Act*, Congress devoted resources for states and hospitals to create HAI reduction plans and implement prevention strategies. We agree with the subcommittee that eliminating HAIs should be a national health priority, and we deeply appreciate your willingness to invest in these life-saving and resource-saving programs.

**CONCLUSION**

Mr. Chairman, we stand at the CUSP – pun intended – of great change in health care. Health care reform is being demanded by policymakers as well as the public. At the same time, behind the scenes in hospitals across the country, people are hard at work making other kids of changes … some little, some more sweeping, but all with the goal of making care better and safer for patients. Our efforts to improve infection rates have brought about what some originally thought was impossible improvement. But through the hard work and dedication of hospital leaders and those on the front lines of care, we have been greatly successful, and we are very proud of the way the field has embraced these initiatives. Now, there is much more work to do to build on this success. We appreciate your interest in this important topic, your support for our efforts, and we look forward to working with you as we make health care as safe as possible for the patients we serve.


States Replicating the Keystone Project
AHA Project with AHRQ Support
Other Grant Supported Projects