TESTIMONY TO THE HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
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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 will offer a brief analysis of the problem and some recommendations for effective response.

About Leapfrog
I am Leah Binder, CEO of The Leapfrog Group, a member-supported nonprofit organization representing a consortium of major companies and other private and public purchasers of health care benefits for more than 37 million Americans in all 50 states. These employers formed Leapfrog to encourage significant change in the quality and safety of health care in America. As our founders envisioned it, Leapfrog triggers giant "leaps" forward in safety, quality, and affordability of health care—hence our name. We have two key business principles underlying our work:

1) *Transparency*: Healthcare quality data should be made public, understandable, and accessible, supporting informed decisionmaking by those who use and pay for healthcare, and
2) *Common sense alignment of payment with patient outcomes*: Financial incentives and rewards should be used to promote the high-quality, high value health care that produces the best possible outcomes for patients. We call this value-based purchasing.

Leapfrog conducts an annual voluntary survey of hospitals, called the Leapfrog Hospital Survey, which is completed by over 1300 hospitals representing more than 60% of inpatient beds in the country. Survey results addressing quality and patient safety are published, and regional employer coalitions as well as health plans and others use those results to structure rewards and incentive programs. Several items in the survey address hospital acquired infections, including prevention of aspiration and ventilator associated pneumonia, central venous catheter related bloodstream infection prevention, surgical site infection prevention, and hand hygiene.

Unfortunately, last year we found that 87% of hospitals completing the survey do NOT take all of the recommended steps to prevent avoidable infections. You may view survey results on our website, www.Leapfroggroup.org.

Leapfrog also applies our principles of transparency and payment incentives to call for changes in the way hospitals handle medical errors, hospital-acquired infections, and what we call "never events." We call for hospitals to apologize to victims, conduct root-cause analyses, publicly report never events, and waive all charges related to them. Many health plans now ask hospitals to adhere to these principles, and we are confident this will soon be the standard of practice for all hospitals.

Leapfrog's use of public reporting to drive market competition and our application of payment incentives to reward and improve quality and value have caused a stir in the health care world. These basic market concepts of competition and value have been the bedrock business principles for centuries, and health care should not be exempt from such accountability. Nonetheless, until Leapfrog was formed in 2000 by a coalition of business groups on health and employers, the two concepts of public reporting and payment incentives had not been systematically applied together to motivate change in the healthcare system.

The roots of the problem

As you have undoubtedly heard from other speakers, each year two million people - one out of every 20 people who obtain care at an American hospital - contract an infection during their care; 90,000 of them die. To put that into context, infections kill almost twice as many people as breast cancer and HIV/AIDS put together. Despite the overwhelming impact of these preventable infections on US citizens, eradication has not been prioritized to the same extent as these other issues. It is long past time for bold action and real, focused leadership to address hospital acquired infections-it is a public health emergency, and scores of lives are lost while we delay implementing well-understood preventions.

Hospital-acquired infections are emblematic of a larger problem in our health care system: we do not align financial incentives with patient well-being. We as governmental and private sector payers have traditionally structured payment to hospitals to compensate individual protocols and procedures no matter how those procedures turn out. We pay for this surgery, that medication, this X-Ray without tying payment to quality outcomes. Even with DRGs we pay for bundles of procedures regardless of quality, and until recently, we pay even if they are performed mistakenly and jeopardize the patient's life and health. Indeed, medical errors result in *increased* payments to hospitals to cover the additional treatment needed to remedy the error. 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 at hospitals with the *worst* record for hospital acquired infections. This perverse payment system impedes the implementation of critical quality processes.

We as purchasers in both the public and private sectors must continue working together to rapidly realign incentives to encourage systemic change in the delivery of care and to reward good outcomes. As a former executive in a hospital network, I can say this is not a mere theoretical point. When resources grow scarce and the future seems uncertain amid ongoing state and federal reforms, hospitals face understandable temptation to direct resources to the high-profit new surgical suite and not their unreimbursed infection control program.

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The 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 health care purchasing as requested in Section 5001(b). Our employer members unequivocally support CMS' 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. Unfortunately, Congress did not grant HHS this authority in the Medicare legislation passed in December, 2007. One of the most valuable steps this committee could take would be to grant the HHS Secretary the authority to implement this proposed rule. This action would not only help stop the occurrence of hospital-acquired infections, but also bring us a major step closer to attaining the larger goals of improving overall health care quality and efficiency.

We are on the right track in integrating public and private sector strategies to influence transparency and value-based payment reform, but progress is unacceptably slow. Leapfrog was pleased to support HHS Secretary Leavitt's efforts to foster increased health care transparency and promote a health care market that recognizes and rewards quality through its value-based purchasing plans. Unfortunately, many of the components of Secretary Leavitt's vision are not being prioritized within HHS to effectively generate change. The private purchasers understand the complexities of coordinating the efforts with this mammoth agency, but we agree with the GAO's contention that meaningful, nationwide reductions in hospital-acquired infections are only achievable if HHS makes this an agency-wide priority. One example where a lack of coordination has slowed implementation of changes that would help reduce hospital acquired infections is apparent in the recently released plan for establishing Patient Safety Organizations. These entities are meant to serve as a vehicle to collect and act upon information about incidences of hospital-acquired infections, but the proposed regulations are so onerous and misaligned that this good idea is likely to fail before it begins.

Recommendations

The good news about addressing hospital acquired infections is that unlike breast cancer or HIV/AIDS, we know quite a bit about the cure. The problem is that we have not aligned incentives and rewards to make hospitals more effective at getting to that cure.

We offer the following recommendations.

1) *Federal agencies must view the problem as a priority*. Given the health risk to Americans, hospital-acquired infections deserve top-priority attention. Agencies addressing the issue should be tasked to coordinate efforts, and invest in improved data interoperability to identify the problem and measure progress. Such coordination is difficult in federal agencies without leadership to assure its high level of priority on a day-to-day basis. We recommend that the agency be asked to establishing a rigorous inter-agency plan including milestones and an aggressive timeline for implementation.
2) *Measure the right things*. Our propensity for focusing exclusively on a hospital's procedures exacerbates problems like hospital acquired infections, which are not

about any one procedure but about the overall function of the hospital. We must have more measures that demonstrate whether and how well a hospital and/or provider is making systemic change to improve outcomes for patients.

3) *Tie payment to outcomes*. Once we measure patient outcomes, we are positioned to offer incentives and rewards to hospitals that achieve them. We congratulate CMS for working toward this goal in its Medicare performance standards, but again would like to see progress expanded, accelerated, and integrated with federal health agencies. Leapfrog produced an evidence-based payment framework we can use in the private sector, and our work would undoubtedly help CMS to achieve similar results on the public side, but we have not been able to access data from Medicare to apply it ourselves to the public side. However, we stand ready to help in this area.
4) *We must work together to improve transparency*. The results of good measures need to be made public in a usable format to enhance healthy market competition. Hospitals that achieve excellence and/or show dramatic improvement ought to be rewarded not only with financial gain, but also with public recognition, which is money in the bank for hospitals in competitive markets. The CMS Hospital Compare website is a good start, but does not include enough outcomes-based measures and indicators we believe are essential.
5) *Acknowledge and support voluntary efforts by hospitals across the country.* If it were easy to prevent infections, there would not be any. In fact, it is extraordinarily difficult to systematically prevent infections in a hospital. People who provide care in hospitals do not want to see patients suffer and sometimes die of preventable afflictions, but they can be overwhelmed by competing priorities. By rewarding and acknowledging hospitals that demonstrate results, we clear the way for providers to bring the full force of their ingenuity and caring toward solving the problem. We should support providers with the best possible research on reduction of HAIs, financial incentives that help support the level of effort, and support for information technology and other systems improvements to help hospitals be most effective in improving patient outcomes.

Thank you for the opportunity to testify, and for your leadership and fast action in addressing this critical issue.

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