May 28, 2008

The Hon. Henry A Waxman, Chairman
Committee on Oversight and Government Reform
Congress of the United States
House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515-6143

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Dover, DE 19904
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Dear Chairman Waxman:

Thank you for your inquiry regarding efforts underway in Delaware to combat healthcare-associated infections (your letter of May 6th, 2008).

On behalf of Delaware's hospitals, I am happy to discuss our focus on patient quality and well being by our association members. Our Board of Directors has made patient quality a priority and seeks to ensure that every patient enjoys a quality experience in whichever Delaware facility they may access.

In order to fulfill that priority, the Delaware Healthcare Association has in the last year:

- Adopted a policy for every member of non-payment for nine serious adverse events (becoming the third state to do so behind Massachusetts and Minnesota);
- Put together a working group to adopt a state-wide color coding regime for patient wrist bands to avoid mistakes that may be made by medical personnel who work in multiple facilities;
- Are creating (for June, 2008 release) a website that will list quality indicators from MEDPAR files for all Delaware hospitals as well as certain operating data;
- Are in the process of undertaking a joint public relations campaign with the Medical Society of Delaware to distribute information to the public regarding Methicillin-resistant Staphylococcus aureus (MRSA).

In addition, we actively worked with legislative and state administration officials to craft Delaware's Infection Control Reporting Act (HS 1 for HB 47 *Hospitals Infections*

Disclosure Act of the 144th General Assembly). The bill requires hospitals and correctional facilities to report quarterly data on hospital acquired infection rates. Infections required to be reported include surgical site infections, ventilator-associated pneumonia, central line-related bloodstream infections, urinary tract infections as well as others to be identified by a panel established under the bill. The bill was signed into law by Governor Ruth Ann Minner in July of 2007. Infection control specialists from Delaware hospitals are actively participating as members of the panel created by the law that will issue regulations governing the breadth and scope of reports;

Our hospitals are very involved with various quality initiatives and groups. We actively partner and participate with our state's quality assurance organization *Quality Insights of Delaware*, the states Medicare Quality Improvement Organization. Our hospitals work with the Institute for Healthcare Improvement, university and foundation sponsored quality organizations and initiatives and participate in patient quality and safety forums.

In response to the Committee's specific questions, the experience of Delaware hospitals with regard to quality measurements has been good generally (see specific responses excerpted at the end of this letter).

Our members generally know their rates of central line-associated bloodstream infections in intensive care units using Centers for Disease Control CLABSIs definitions. Their rates tend to be below national averages. Members are also aware of Dr. Peter Pronovost's work (he developed the program the Michigan Hospital Association adopted) and have integrated or are planning to integrate lessons from same into their practices. Members have also tackled other quality issues and achieved success. One hospital focused on Ventilator Association Pneumonias and achieved results significantly better than national standards. Another member pursued a Hand Hygiene Awareness Campaign which dramatically increased compliance rates vis a vis standards. A hospital implemented the Institute for Healthcare Improvement's (IHI) Ventilator Associated Pneumonia (VAP) "bundle" back in 2005 and have had ZERO VAP since April 2005

Detailed response excerpts from association members to committee questions are below:

Committee Question 1*: If known, what are the median and overall rates of central line-associated bloodstream infections in the intensive care units in hospitals in your state, using standard definitions of CLABSIs as provided by the Centers for Disease Control (CDC) and prevention for the purpose of the National Healthcare Safety Network?* Generally
A member reported: We have followed our ICU central line associated bloodstream infections for many years and in late 2006 began focusing our attention to this even further as a result of the work of Dr. Peter Pronovost. We use the following national standard formula to calculate Hospital Acquired Central Venous Catheter Blood Stream Infection Rate (HAI CVC BSI Rate) Observed # of CVC BSI infection/# of CVC days on Unit x 1000 Our *overall* intensive care rate for 2006 was 4.4 and in 2007 dropped to 0.8 well below the national average of 5.3. This National Average reference comes from the National Healthcare Safety Network Report summary data 2006, issued in June 2007 representing

36 pediatric hospitals.
A member reported: Yes, we have collected data on CLBSI's for several years.
A member reported: Historically we have benchmarked against ourselves because the national benchmark is higher. As of Jan 1, 2008 will are doing both.
A member reported: Organization monitors central line associated blood stream infections in all Intensive Care Units. Because we have been a member of the CDC National Nosocomial Infection Surveillance System (NNIS) since 1995, now the National Healthcare Safety Network (NHSN), we are able to benchmark nationally.
Committee Question 2: *If the rates are unknown or if the median rate is above zero, do you have plans to replicate the Michigan Hospital Association program for your state? If so, when do you anticipate initiating the program?* Generally
A member reported: We are aware and have had Dr. Pronovost on our campus to present his work in this field. The learning's from Dr. Pronovost's work have been incorporated into the NACHRI prevention of Central Line Infection bundle. By collaborating with other NACHRI Hospitals on this project we have significantly reduced our CVC BSI Rate. In our PICU we reduced this rate from 5.8 to 0.8 and in the CICU from 5.2 to 1.1.
A member reported: Yes, are aware of the project
A member reported: We are aware of Dr. Peter Pronovost to combat healthcare-associated infections and are in process of reviewing this.
A member reported: We were aware of Dr. Pronovost's project and implemented several of the evidenced based interventions in our ICUs, some of which were also in published in the CDC "Guidelines for the Prevention of Intravascular Catheter-Related Infections (2002). Hand washing observations and education, use of full barrier precautions during line insertions, and the use of chlorhexidine for site preparation before central line placement were implemented between 2002 and 2004**.**
Committee Question 3: *What other activities are your member hospitals taking to address healthcare-associated infections? Which infections are you targeting? What is your evidence of success?* Generally
A member reported: Our Infection Control program has worked diligently to reduce Ventilator Association Pneumonias in the ICU. For the ICU Ventilator Associated Pneumonia we have improved our rates as noted below due to utilizing an oral hygiene toothette product from Sage two times a day for all ventilated patients. This oral hygiene process is scheduled to occur at change of shift each day to help nurses include it into the routine patient care for the shift. Our rates are as follows and is calculated based on the # of patient ventilator days. The pooled mean for rates of the 32 pediatric hospitals participating in the National Healthcare Safety Network is 2.5. PICU 2006 = 0.2 CICU 2006 = 1.3 PICU 2007 =0 CICU 2007 = 0.8

A member reported: Hand Hygiene Awareness Campaign which includes implementation of the 2002 CDC Hand Hygiene Recommendations and three teams to monitor compliance of team members throughout the organization has resulted in an increase from 50%-90% compliance with hand washing practices; Bundling to make the most of best practices: four years ago began interventions related to ventilator care (elevated head of bed, daily assessment of readiness to extubate, peptic ulcer disease prophylasis and DVT prophylaxis) which resulted in a decrease to > 0.5% Ventilator Associated Pneumonia rate; three years ago began using chlorohexadine skin antisepsis and educating nurses and physicians about use of maximal barrier precautions when inserting lines, optimal catheter site selection, and daily review of the line necessity has resulted in a decrease in healthcare associated CLBSI's from 7.5 to 1.8% .
We are still focusing in on Surgical Site Prevention with monitoring use of prophylactic antibiotics, appropriate hair removal and perioperative glucose control.

A member reported: 1. Selected "Eliminate the Spread of Infection" as our Hospital Corporate Performance Improvement Goal for 2008
2. Implemented the Institute for Healthcare Improvement's (IHI) Ventilator Associated Pneumonia (VAP) "bundle" back in 2005 and have had ZERO VAP since April 2005.
3. Strengthened our Pneumococcal and Influenza Program: At the end of the 1st quarter of 2005, our rate for Pneumococcal Vaccination was 59% and the rate for Influenza Vaccination was 49%. At the end of the 4th quarter of 2007, both the Pneumoccal and Influenza Vaccination rates were 100%.
4. Implemented the IHI's Central Line "bundle" house wide in 2007 and are currently monitoring the outcomes of this initiative.
5. Implemented active surveillance of high-risk patients for MRSA in the ICU in 2007.
6. Enhanced our hand hygiene monitoring methods for 2008.
7. We are currently working in collaboration with Quality Insights of DE on improving our Surgical Care Improvement Project measures.
8. Invited speakers in to educate physicians and other healthcare providers on reducing the prevalence of c-difficile.

In addition to the above, Brenda Johnson, ICP mentioned the following infection prevention initiatives:
* using alcohol-based hand rubs since 2001
* initiated alcohol-based surgical hand scrub Nov 2007
* initiated standardized process for contact precautions Feb 2006
* look at antimicrobial patterns of organisms annually (antibiogram)
* developed plan for pandemic influenza and other infectious disease outbreaks
* daily urinary catheter assessment to prevent UTI
* updating housekeeping procedures & cleaning/disinfection products
* annual TB risk assessment with annual N95 respirator fit testing and appropriate HCW TB skin testing
* HCW influenza vaccination program & other HCW vaccination routinely offered by Emp Health

* Sharps injury reduction program
* Plan interventions prior to renovation/construction projects
* Developed policy for animals in the hospital in 2005

A member reported: Since 2004 chlorhexidine became the skin antiseptic of choice for Organization. In at least one ICU, special procedure carts were developed to improve the availability of central line equipment and improve compliance with use of full barriers. In 2003 we implemented the use of a checklist in our medical ICU to monitor compliance with all aspect of the CDC guidelines related to central line insertion. We also monitor the insertion sites and make recommendations to physicians to avoid use of the femoral site, also recommended in Dr. Pronovost's study. Team feedback and sharing of infection data with management and staff improved awareness and compliance with the recommendations. This is an ongoing process.

Results: Quarterly rates were calculated the same as in Dr. Pronovost's project and NHSN using infections per 1000 catheter days.
Example: The infection rate for central line associated blood stream infections for a medical ICU in the first year (2004-2005) after implementing the evidenced based interventions showed an 88% improvement. In 2004 the CA-BSI rate for this unit was 12.6/1000 device days compared to the NNIS pooled mean of 5.7/1000 device days. In 2005 the rate fell to 1.5 /1000 device days. We continue these interventions and add additional measures such as those from the Institute of Health Improvement (IHI).

Other evidenced based initiatives such as the VAP "bundle" from the Institute of Health Improvement (IHI) have been implemented at Christiana Care (2005- present) to reduce the incidence of ventilator associated pneumonia (VAP). Similar success has been noted as a result of these interventions. For example, in 2004 the ICU VAP combined baseline rate was 11.1 infections /1000 ventilator days compared to NNIS. At the end of the first year after initiating the bundle the infection rate dropped to 3.5/1000 device days for a 68% improvement. In 2008 the rates continue to improve or remain stable.

Identifying that BSIs can cause high mortality and morbidity, the Hospital Infection Advisory Committee has selected CA-BSIs as the hospital's first measure for public infection reporting. Infection rates from one ICU from each hospital will be included in the first report.

Delaware Healthcare Association members are serious about undertaking continuous improvement in order to ensure hospitals are safe and that every patient in a Delaware hospital enjoys a quality care experience. It has been my pleasure to respond to your request on behalf of our association.

Sincerely,

Wayne A. Smith
President and CEO

Delaware Healthcare Association