Maryland
Hospital Association

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May 29, 2008

The Honorable Henry A. Waxman,
Chairman, Committee on Oversight and Government Reform
U. S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Chairman Waxman:

I am writing in response to your May 6, 2008 letter requesting information on efforts undertaken in Maryland and by the Maryland Hospital Association (MHA) focused on reducing health care-associated infections. At the outset, I want to express our sincere appreciation for your interest in obtaining a real understanding of what hospitals are doing in this area. The effective prevention, detection, and treatment of community- and health care-associated infections are a clear focus of hospitals throughout Maryland and across the country. Health care providers understand the seriousness of the problem and are working every day to address it.

Maryland hospitals have a long established track record of supporting public reporting of all types of information at the hospital level; e.g., detailed financial and cost data through the Health Services Cost Review Commission (HSCRC)—the hospital rate-setting commission in Maryland; quality data to allow comparisons at the state and national levels; and, annual community benefit reporting. Building upon that base, Maryland policymakers have developed a comprehensive and coordinated strategy for addressing patient safety issues, including infections.

MARYLAND STRATEGY

In 2001, with MHA's support, the Maryland General Assembly passed a law charging the Maryland Health Care Commission (MHCC) with studying the feasibility of developing a system for reducing incidences of preventable adverse events in Maryland, including, but not limited to, a system of reporting such incidences. MHA strongly advocated for a statewide approach to improving the overall quality and safety of our state's health care system. The approach developed by the MHCC combines public and private sector efforts in a three-pronged patient safety strategy:

- Mandatory hospital reporting to the Department of Health's Office of Health Care Quality of Level I adverse events—events that result in death or serious disability;

- Creation of a Maryland Patient Safety Center to provide education and training on safer practices and to develop a voluntary reporting system for all adverse events and near misses; and,
- Expanding the MHCC's hospital report cards to include additional quality information, such as information on health care-acquired infections and the rate-setting commission's initiative to link quality improvement to hospital reimbursement rates.

Maryland Focus on Infection Prevention

Subsequent to the development of this overall patient safety strategy, a number of initiatives and regulatory components have been put in place to implement it. While these components have matured as the science and technology have matured and different regulatory agencies have become involved, they have been coordinated. Great effort has been taken to assure that Maryland's regulatory and other quality improvement initiatives are not duplicative of one another, but rather build upon what has been learned from previous initiatives. Today Maryland's structure includes:

Maryland Patient Safety Center (MPSC)

In 2004, the MHCC designated MHA and the Delmarva Foundation to operate the Maryland Patient Safety Center jointly. The purpose of the center is to make Maryland the safest state in the country for hospital patients by focusing on improvement of systems of care, reduction of occurrences of adverse events, and improvement in the culture of patient safety at Maryland health care facilities. The center is designed to accomplish the following goals:

- Develop a grassroots model for building consensus to improve patient safety in Maryland;
- Promote a "culture of safety" modeled after safety in commercial aviation and nuclear power that encourages system improvements rather than faulting individuals;
- Collect, analyze, and share appropriate information about adverse events and near misses;
- Develop and provide education for health care professionals, hospitals, nursing home staff, and health care providers, including sharing "best practices" from Maryland and worldwide;
- Sponsor patient safety collaboratives that will bring together providers and national experts to focus on specific process improvements; and,
- Lead applied research to find and implement safer processes and practices in Maryland.

Below is a general description of the various initiatives put in place by the MPSC to accomplish the aforementioned goals, as well as estimated outcomes and expected savings of each initiative.

Since 2004, the MPSC has:

- Trained more than 8,540 health care professionals in initiatives to improve patient safety;
- Engaged more than 150 teams from hospitals throughout the state in Safety Culture Collaboratives which, to date, have focused on hospitals reducing health care-associated infections in intensive care units, improving safety in emergency departments, reducing harm

and death among newborns, and reducing the spread of health care-associated infections known as MRSA; and,

- Earned the John M. Eisenberg Award from the Joint Commission and National Quality Forum for Patient Safety and Quality in 2005, for national/regional innovation in patient safety.

MPSC-specific initiatives have included:

ICU Safety Culture Collaborative

A collaborative is a focused, intensive, year-long program that brings together multidisciplinary hospital teams and national improvement experts to achieve rapid and dramatic improvements in specific patient care areas. The MPSC's first safety culture collaborative focused on Intensive Care Units (ICUs). Hospital teams of physicians, nurses, and other clinical staff, with the oversight of their CEO, medical director, or other senior leader, developed strategies to reduce infections, better coordinate care, and improve the teamwork of frontline ICU workers.

The collaborative included 52 teams from 37 hospitals across Maryland and focused specifically on the prevention of ventilator-associated pneumonia and bloodstream infections of ICU patients. Highlights of the collaborative include:

- ICUs from five hospitals met the challenge of zero ventilator-associated pneumonia episodes;
- Overall, ventilator-associated pneumonia has been reduced 20 percent in participating ICUs;
- Based on statistical modeling, an estimated 755 ventilator-associated pneumonia infections are being prevented annually, 75 lives were saved, and hospital costs were reduced by approximately $35 million;
- Ten hospitals achieved zero catheter-associated bloodstream infection episodes;
- Overall, catheter-associated bloodstream infections have been reduced by 36 percent;
- Based on statistical modeling, an estimated 358 bloodstream infections are being avoided annually, 62 lives were saved, and hospital costs were reduced by approximately $5 million; and,
- In total, an estimated 1,113 ventilator-associated pneumonia or catheter-related blood stream infections are prevented annually, 140 lives are saved, and $40 million in annual cost savings are achieved.

MRSA Prevention Initiative

More than two years ago, the MPSC became actively engaged in working with hospitals to help eliminate the transmission of MRSA. In January 2006, the MPSC held a full-day symposium for hospital leaders on eliminating MRSA. This was followed by a number of other programs dedicated to this topic at both the Center's annual patient safety conference in March and again at the annual Medical Staff Governance and Leadership Conference for hospital executives, medical staff leaders, and trustees.

Building upon these educational efforts, the MPSC partnered with the Plexus Institute, Centers for Disease Control and Prevention, and the Positive Deviance Initiative at Tufts University, with grant support from the Robert Wood Johnson Foundation and CareFirst BlueCross BlueShield, to pilot test an innovative approach for eliminating MRSA. The Positive Deviance strategy provides a design that enables the very people whose behavior needs to change, to solve the problem with solutions already present within their organization.

The rollout of the Center's behavior-based MRSA Prevention Initiative was carefully staged to ensure maximum impact. The project was launched with two Maryland hospitals selected to participate as beta sites with four other beta hospitals, and 41 partner facilities around the country in the first large-scale application of Positive Deviance to health care in the United States. In the next phase, these two hospitals shared their experiences with eight additional Maryland hospitals interested in adopting this approach. These initial hospitals experienced a 30 percent decrease in new MRSA infections. In November 2007, the Initiative was expanded again so that currently 38 Maryland hospitals, long term care facilities, and dialysis centers are committed to using this new approach for making lasting improvements to stamp out this deadly infection.

Education and Training

The Patient Safety Center also offers training sessions and educational conferences designed to create awareness of the need for improved patient safety; fosters a shift in culture to make significant changes in health care processes; and, disseminates "best practices." These educational sessions—offered at no charge to participants—include:

- In-depth training on Root Cause Analysis (RCA), Failure Mode and Effect Analysis (FMEA), and other process skills essential to effective patient safety improvement;
- Two-day workshops for all department leaders in health care institutions in Maryland, focusing on skills to enhance patient safety at the unit level;
- Lean/Six Sigma Green Belt and Black Belt;
- Teamwork strengthening;
- Using the TeamSTEPPS curriculum developed by the Department of Defense's Patient Safety Program in collaboration with the AHRQ; and,
- An annual conference on patient safety, attended by over 1,200 hospital and nursing home staff.

MEDSAFE Medication Safety Program

This statewide initiative, started by MHA in 2000, and now part of the MPSC, uses a nationally-validated survey (the Institute for Safe Medication Practices Medication Safety Self-Assessment Tool) to enable hospital-based teams to establish a baseline for their hospital's medication use practices and then measure progress over successive administrations of this survey. To help share better safety practices, MHA has sponsored day-long educational conferences for MEDSAFE teams. Forty-nine Maryland hospitals have participated in the MEDSAFE project since its inception.

Adverse Event and "Near Miss" Reporting

The MPSC has developed a voluntary adverse event and "near miss" reporting system to complement the Department of Health and Mental Hygiene's (DHMH) mandatory reporting of deaths and events that cause serious disability. Using a secure, Web-based medical error reporting system that is customized for Maryland hospitals, the MPSC collects anonymous reports of errors and "near misses," analyzes the data for trends and patterns, and uses the resulting information to develop safety alerts as well as identify best practices to share with Maryland providers. Thirty-two hospitals are now reporting adverse event and near miss data to the MPSC and the data base includes more than 10,000 records.

ADDITIONAL MHA INITIATIVES

In addition to working with public policymakers on improvements to the formal regulatory structure, Maryland hospitals have developed and endorsed a specific policy related to preventing MRSA infection and transmission. The policy recommends that every Maryland hospital:

- Develop strategies to improve hand hygiene and monitor compliance;
- Implement enhanced environmental cleaning practices and monitor for adherence to facility procedures for cleaning and disinfection;
- Provide education to facilitate behavior change through improved understanding of MRSA to personnel in all capacities, from physicians, nurses, and other caregivers, to support associates, housekeepers, patients, and visitors;
- Perform a risk assessment to determine what interventions are necessary, including assessment of the benefit of active surveillance testing;
- Implement and monitor adherence to contact precautions for all patients identified with MRSA;
- Evaluate existing prevention strategies for effectiveness and modify them as necessary; and,
- Review and update their infection prevention and control plan in light of new evidence-based research and scientific findings.

Reaching Out to the Community

Over the last two months, 25 Maryland hospitals participated in a statewide community outreach effort on MRSA awareness. These forums provided an opportunity to educate community members about MRSA, the differences between health care-associated MRSA and community-associated MRSA, what hospitals are doing to reduce infection transmission, and what community members can do to reduce their risk. In addition, legislation was enacted in the recently concluded General Assembly session to require DHMH to embark on a hand hygiene public awareness campaign.

OTHER MARYLAND EFFORTS

Office of Health Care Quality (OHCQ)

In March 2004, new regulations from the Office of Health Care Quality mandated that hospitals report all Level 1 adverse events—death or permanent disability due to errors—to the Department of Health and Mental Hygiene and perform a root cause analysis on such events. In addition, in early 2008, the OHCQ issued new and undated hospital infection prevention and control regulations.

Maryland Health Care Commission (MHCC)

In 1999, supported by MHA, legislation was enacted requiring the Maryland Health Care Commission (MHCC) to establish a system to evaluate comparatively quality of care outcomes and performance measurements of hospitals. This resulted in the development of a Web-based Maryland Hospital Performance Evaluation Guide, which served as a model for the development of the national Hospital Compare Web site, launched in 2005 by the Centers for Medicare and Medicaid Services (CMS) and the Hospital Quality Alliance (a collaborative effort of organizations representing hospitals, doctors, employers, accrediting organizations, other federal agencies, and the public). In addition to reporting to the MHCC, all Maryland acute care hospitals voluntarily submit data on their quality efforts for publication on the Hospital Compare Web site.

Both the Maryland and national public reporting initiatives continue to evolve and expand the numbers and types of measures reported. In 2005 and 2006, MHA supported the Maryland Health Care Commission's plan and subsequent legislation for publicly reporting health care-associated infections data on the Maryland Hospital Performance Evaluation Guide. The guide provides a solid foundation for further transparency on quality, which MHA and Maryland hospitals fully support.

In November 2007, the MHCC released the report of its Technical Advisory Committee on Healthcare-Associated Infections for *Developing a System for Collecting and Publicly Reporting Data on Healthcare-Associated Infections in Maryland* (attached). This extensive study provides an excellent framework for reporting health care-associated infection information—including prevention of MRSA—and lays out a phased implementation plan. (A copy of the report is enclosed for your information.)

Health Services Cost Review Commission (HSCRC)

Under the Maryland hospital rate-setting system, Maryland hospitals must publicly report detailed cost and financial information. In recent years, the system has been utilized to further a number of public policy quality initiatives, including mechanisms to educate, recruit, and retain nurses; the development of a pay-for-performance program; the uniform reporting of hospital community benefits; and, funding of the Maryland Patient Safety Center. The system also allows for the hospital report card to include information on hospital charges to enable consumers to compare prices as well as quality across hospitals.

Governor's Health Quality and Cost Council

Late last year, Governor O'Malley issued an Executive Order establishing a Health Quality and Cost Council consisting of the Lt. Governor as chair; DHMH Secretary as vice chair; and, seven members representing health insurance carriers, employers, health care providers, consumers and health care quality experts. The charge of the council is to coordinate and facilitate collaboration on health care quality improvement and cost containment initiatives and make recommendations on initiatives and priorities to policymakers, et al.

CONCLUSION

As you can see from the above, Maryland has taken a comprehensive strategic approach to improve patient safety, including the reduction of health care-associated infections. The approach focuses on identifying best practices, educating providers on those best practices, integrating the best practices with strategies for stronger team coordination, measuring progress with data collection, and public accountability and reporting through the MHCC hospital report card mechanism.

Critical to the success of this approach, however, is having the science associated with infection prevention and control practices dictate what hospitals and other health care providers should do in this area. There must be flexibility in the regulatory environment to accommodate the evolution of best practices as they emerge. And, the regulatory entities at the state and federal levels need to be coordinated to avoid duplication, confusion, and differing focuses.

Thank you for the opportunity to share information on the initiatives underway in Maryland to improve patient safety, especially with regard to health care-associated infections. If you would like additional information, please do not hesitate to contact me.

Sincerely,

Cal Pierson

Calvin M. Pierson
President

Enclosure

cc: Members, Maryland Congressional Delegation