VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

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May 30, 2008

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

Dear Chairman Waxman:

On behalf of the Virginia Hospital & Healthcare Association (VHHA) and its 49 health system and hospital members, representing 112 community, psychiatric, rehabilitation and specialty hospitals throughout Virginia, I thank you for your letter of May 6, 2008, regarding healthcare-associated infections (HAI). This issue is an important priority for us. We are proud of and welcome the opportunity to share our continuous and collaborative efforts to improve the quality and safety of patient care and to reduce the number and effects of HAIs within our hospitals. Consistent with the Institute of Medicine (IOM) six dimensions of health care, we believe that optimal health and health care should be safe, effective, efficient, patient- and family-centered, timely and equitable. Our efforts to achieve advancements in these areas are highlighted below in response to the three questions posed in your letter.

We also recognize that there are always lessons to be learned from others in the field that may bolster our ongoing efforts. We applaud the HAI reduction efforts and success of the Michigan Health & Hospital Association (MHA). In fact, several months ago we reached out to them and already have engaged MHA to help replicate their success in Virginia. We agree that measures (whether process or outcomes) are important for setting a baseline, for monitoring process/progress and for setting goals. We also think measures in and of themselves will not create improvements in the quality of care, safety and service in health care. True improvements for patient care will result from the communication, cooperation and collaboration of a multidisciplinary team approach and the creation of a culture of quality and safety across the continuum of care.

In short, we realize measures are important, but we believe collaboration and culture are imperative. Voluntary, public reporting of measures and collaborative efforts to improve health and health care will be more effective in Virginia than legislative or regulatory mandates. Indeed, the MHA experience in HAI reduction efforts as well as Virginia's own initiatives to date are prime examples of how a voluntary, collaborative approach can, as the Institute for Health Improvement (IHI) refers to improvement, "move your dot" for health care quality and safety without adding new layers of governmental rules to an already highly-regulated field.

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 of Disease Control and Prevention (CDC) and prevention for the purpose of the National Healthcare Safety Network?*

VHHA currently is in the process of surveying its member hospitals to determine a statewide baseline for CLABSI in the 81 adult ICUs within Virginia. Many VHHA member hospitals and health systems have had success reducing infection rates, including CLABSI, within their hospitals and specifically within their ICUs (Please see representative success stories below). To date, we have data from 35 of the 81 adult ICUs across Virginia, representing 59% of the total adult ICU beds within Virginia, with the following median and overall rates of CLABSIs per 1,000 central line days:

Median: 1.3
Overall: 2.3

Question 2

*If rates are unknown or if the median rate is above zero, do you have plans to replicate the Michigan Hospital Association program in your state? If so, when do you anticipate initiating the program?*

Early in 2007, VHHA embarked on a "Healthy Virginia" reform framework to improve health and health care within the Commonwealth. Stimulus for this work included Governor Timothy M. Kaine's Health Reform Commission; the Commonwealth Fund of 2007 report of state-by-state rankings on access, quality, avoidable hospital use and costs, equity and healthy lives; and the American Hospital Association (AHA) "Health for Life" health reform initiative.

One of the major pillars of the VHHA framework is "higher quality care," and HAI reduction is a core requirement within this framework. VHHA has engaged its members in an initiative to reduce central line associated bloodstream infections (CLABSI) in all VHHA hospitals with adult ICUs. This will involve tracking and public reporting of CLABSI infection rates to the Virginia Department of Health and a collaborative effort by the hospitals to implement the five-step process bundle recommended by Dr. Peter Pronovost in the MHA experience to lower infection rates.

Following the CLASBI initiative, the next priority area to reduce HAIs in Virginia hospitals will be ventilator-associated pneumonias (VAP) in the ICU, and VHHA will work to conform to and implement the MHA model.

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?*

VHHA and its members have been and currently are highly invested in the IHI's "100,000 Lives" and "5 Million Lives" campaigns, which recommend 12 proven interventions for improving quality of care and patient safety. Virginia has received national recognition for its outstanding efforts in the number of participating hospitals, number of interventions implemented, number of lives saved and level of "mentor" hospitals. Mentor hospitals are facilities that have IHI certification for success in these 12 interventions and that are available to assist/mentor other hospitals around the country with effective implementation of the interventions.

Highlighted below are some of the Virginia success stories on the five infection-related interventions of these campaigns.

Prevent central line infections (CLI)

- Reduced CLI rate per 1,000 line days from 10.5 to 0 over a five-month period.
- Reduced the bacteremia rate per 1,000 line days from 14.5 to 0 after implementation of chlorhexidine skin antisepsis and dressing kits.
- Reduced CLI by 35.9% over a 12-month period in 13 adult ICUs, representing 161 adult ICU beds across six hospitals. This reduction represents 37 fewer CLIs.

Prevent surgical site infections (SSI)

- Increased surgical cases with on-time prophylactic antibiotic administration from 80% to 100% over a one-month period.
- Increased number of surgical patients who received prophylactic antibiotics and whose antibiotics were discontinued within 24 hours after surgery from 70% to 100% over a five-month period.
- Increased number of patients with appropriate surgical site hair removal with clippers rather than razors from 60% to 100% over a two-month period.

Prevent ventilator-associated pneumonia (VAP)

- Reduced ICU VAP rate per 1,000 ventilator days from five to zero over a six-month period. [Note: With both CLI and VAP, reduced average ICU length of stay from 5.4 days to 3.4 days over an eight-month period].
- Reduced VAP rates 64.5% over a 24-month period, across 13 ICUs in six hospitals. This reduction represents 80 fewer total VAPs.

Reduce methicillin-resistant *Staphylococcus aureus* (MRSA) infection by implementing infection control practices

- Reduced critical care MRSA infections 28% over a 12-month period.
- Reduced MRSA infection rate to zero in medical intensive care unit for five consecutive months.

Reduce surgical complications by reliably implementing all of the changes recommended in the surgical care improvement project (SCIP)

- Reduced surgical complication rates from 10.2% to 6.60% in two hospitals over a 12-month period.

In addition to their work in the two IHI Campaigns, VHHA members actively are engaged in other hospital-focused efforts at the national and state level to improve quality of care and safety in hospital settings, reduce the rate of infections in hospitals and collect and provide to the public useful and meaningful information on these data:

- Virginia hospitals, as most hospitals do nationally, adhere to the Joint Commission requirements (including those that address HAIs) and participate in the Centers for Medicare & Medicaid Services quality and patient satisfaction public reporting efforts.
- In the Commonwealth, Virginians Improving Patient Care & Safety (VIPCS) was created in 1999 to bring stakeholders together from across the state to address health quality and safety issues. VHHA is a founding member of VIPC&S, and has played a leadership role so to align the mission, vision and goals of VIPC&S with the IOM six dimensions of quality health care.
- VHHA and its member hospitals have an exemplary working relationship with the Virginia Department of Health (VDH) and often work together on issues of quality and patient safety:
  - In 2005, the Virginia General Assembly passed a law, supported by Virginia's hospitals, that requires hospitals to report certain nosocomial infections information, starting with CLABSI in adult ICUs in acute care hospitals, to the CDC National Healthcare Safety Network (NHSN) and authorize access to the data by VDH for public disclosure. This approach was identified as the best way to produce meaningful data based on uniform measures. Virginia hospitals will begin reporting their data to NHSN in July 2008 and VDH will compile the first report in January 2009. Thereafter, reporting will occur quarterly.
  - VHHA and VDH offer timely statewide conferences on quality and patient safety. The most recent was on current issues and trends surrounding methicillin-resistant *Staphylococcus Aureus*.
- VHHA has begun an initiative to standardize inpatient color-coded wristbands across the Commonwealth to reduce potential medical errors and patient harm.

Virginians deserve the best care our hospitals can provide. VHHA member hospitals constantly examine and improve procedures and the hospital environment to continually improve the quality of care and to lower the risk of infection in our hospitals. By voluntarily reporting infection control and quality data, our members can learn from one another and establish standards that will improve the health care system. Public reporting allows our patients to become better health care consumers and assists hospitals in identifying needed quality improvements. Through this culture of openness and accountability, hospitals, their employees and physician partners will establish stronger relationships with their patients built on trust. Hospitals will be better able to analyze the quality of care in their facilities and apply that learning to improved patient care.

With all these initiatives, interventions, activities, measures, and, most importantly, collaboration between our hospitals, Virginia is well on its way to addressing the issue of HAIs within our hospitals and health systems. That stated, we still continue to do more in this area and other areas of quality and patient safety. Our reform framework will definitely place our hospitals and health systems in good stead to meet these issues and any new challenges that lie ahead.

Once again, thank you for your letter. If I may be of any further assistance, please do not hesitate to contact me.

Sincerely,

Laurens Sartoris

Laurens Sartoris
President