VERMONT ASSOCIATION OF
HOSPITALS AND HEALTH SYSTEMS

May 28, 2008

The Honorable Henry A. Waxman
2157 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Chairman:

I am writing to respond to your request of May 6 regarding central line-associated blood stream infections. Below I have outlined our answers to the specific questions asked of us in that letter. I have also taken this opportunity to provide you with some thoughts about how our hospitals might best be assisted in their efforts to improve the care they provide.

Question 1
The Vermont Association of Hospitals and Health Systems (VAHHS) has been a close partner with state officials and policy makers regarding public reporting of hospital performance data. Reporting on central line-associated blood stream infections is one of our most recent endeavors so we do have data available from the National Healthcare Safety Network (NHSN).

As a small rural state where a majority of our hospitals are Critical Access Hospitals, only 8 of our 14 acute care hospitals meet the Centers for Disease Control (CDC) standards for producing rates. Some do not have ICUs as defined by the CDC and others have too few central line days. For those hospitals that do meet CDC definitions, new data will be publicly reported on June 1, 2008. It will show that **our median rates for central line associated blood stream infections are zero**. More specifically, our 7 hospitals that have combined medical/surgical ICUs are all reporting 0 infections per 1,000 central line days. Our one hospital that has separate medical and surgical ICUs (Fletcher Allen Health Care) has a medical ICU rate of 2.4 infections per 1,000 central line days and a surgical ICU rate of 2.0 infections per 1,000 central line days. But these rates do not tell the whole improvement story. Comparing the hospital's rates from the three months prior to the hospital's implementation of the Institute for Healthcare Improvement bundle in June 2006 to the most recent three months shows that Fletcher Allen Health Care has reduced their rates in the Medical ICU to zero (a 100 percent reduction) and their rates in the Surgical ICU to 1.09 (a 68 percent reduction). These improvements demonstrate their commitment to achieving and maintaining the goal of zero central line-associated blood stream infections.

Question 2
The Vermont Association of Hospitals and Health Systems is one of the country's smallest associations. Given that, rather than implementing quality improvement projects ourselves (as associations like Michigan's are able to do), we leverage regional and national partners. In the case of central line-associated blood stream infections, we worked to ensure that all of our hospitals enrolled in the Institute for Healthcare Improvement's (IHI) 100 Thousand Lives and now 5 Million Lives Campaigns. Central line-associated blood stream infections are a core component of the Campaign and IHI makes many tools, materials and telephone/web-based learning opportunities available to hospitals. As I am sure you know their materials are based on the Michigan program.

Question 3
Our hospitals are all working hard to reduce infections in their individual hospitals. We are also working on these issues as an association. Several years ago we supported the Vermont Program for Quality in Health Care's efforts to help hospitals improve hand hygiene compliance, a critical component of all infection reduction efforts. In addition, our hospitals have successfully worked closely with the Northeast Health Care Quality Foundation, our Quality Improvement Organization (QIO), to improve surgical infection prevention. We are currently considering partnering with our QIO on a new project related to reducing methicillin-resistant staphylococcus aureus (MRSA) infections. In terms of more general quality improvement support, for the last three years we were able to leverage dollars that allowed our hospitals to enroll in the IHI IMPACT program. Through that program which serves only a few hundred hospitals, our members worked closely with IHI faculty and learned from hospitals around the country on a variety of projects ranging from physician office practice redesign to "transforming care at the bedside," a comprehensive program to improve care on hospital medical/surgical units.

General Comments
In considering how we work with hospitals to improve quality and patient safety in general, there are several critical issues we would like to respectfully offer for your consideration.

One of the greatest barriers to our efforts to help hospitals improve quality and patient safety is the lack of a focused and manageable national agenda for measurement and improvement. We are dismayed by the proposed Inpatient Prospective Payment System rule recently released by the Centers for Medicare and Medicaid Services (CMS). That rule calls for the reporting of 43 new measures, for a total of 72 individual inpatient measures. This is in addition to the new outpatient measures our prospective payment system hospitals are implementing. While some of the new measures can be gathered from administrative data rather than the more time-consuming chart review, all of these measures will require our hospitals' attention. We are also somewhat mystified that the new measures do not include the infection measures recommended by the Hospital Quality Alliance that we are implementing as part of our state hospital report cards.

While we understand and support the public interest in reviewing hospital performance, this scattershot approach dilutes the efforts of hospitals. We welcome the work of the National Quality Forum's National Priorities Partners Project to try to develop national priorities and hope it can help bring some focus to what is right now an overwhelming set of expectations.

VAHHS • 148 Main Street, Montpelier, VT 05602 • Tel: 802-223-3461 • Fax: 802-223-0364 • www.VAHHS.org

Probably the single most helpful action from the Federal government to improve quality and patient safety in Vermont has been to fund our regional QIO. Our QIO has provided on-site support within the walls of our hospitals. They have brought effective tools and ideas to our members. They have alerted our hospitals to the pitfalls others have experienced in their improvement efforts. As a small and rural state with limited local resources, their assistance has been invaluable.

We hope that the increasing public interest in patient safety will not result in overly prescriptive state and federal mandates to implement specific improvement programs. Hospitals need flexibility to work on projects that will have the greatest impact to their patients. In addition, the "state of the art" of patient safety and quality improvement changes more quickly than legislative or regulatory bodies may be able to respond. We believe the most effective approach for our hospitals would be to combine (1) a focused and limited set of national priorities for measurement and improvement with (2) a clearinghouse for improvement tools and inexpensive web-based learning opportunities such as is currently provided by IHI and (3) support for organizations like QIOs to provide hands-on assistance to hospitals.

Thank you very much for the opportunity to share with you our work and our thoughts on these important issues. Please do not hesitate to contact Jill Olson, Vice President of Policy and Operations if you have any questions we can help to answer.

Sincerely,

Marie Beatrice Grause, R.N., J.D.
President and CEO

cc: The Honorable Thomas M. Davis, III
The Honorable Peter Welch

VAHHS • 148 Main Street, Montpelier, VT 05602 • Tel: 802-223-3461 • Fax: 802-223-0364 • www.VAHHS.org