Consumer Comments
U.S. Department of Health and Human Services
Action Plan to Prevent Healthcare-Associated Infections
February 6, 2009

These comments are submitted by Consumers Union, The Coalition For Patients' Rights, Mothers Against Medical Error, nile's project MRSA, New Hampshire Patient Voices, Connecticut Center for Patient Safety, Colorado Citizens for Accountability Patients Right To Know, Alliance for Safety Awareness for Patients, and individuals from throughout the country who are working together to eliminate hospital-acquired infections.

We strongly support the Plan's goal of eliminating health care-acquired infections. We acknowledge the important progress of the various federal agencies working together to establish a coordinated effort to develop this Plan. But we challenge the need for more committees. We need a strong leader who can command action. Attempting to get consensus among all the stakeholders has not led to reducing infections in the past and delays action. We agree that hospital-acquired infections are "largely preventable and can be drastically reduced" – the problem is that the healthcare industry does not believe it.

While this Plan is an impressive compendium of the hospital-acquired infection landscape, it lacks bold recommendations and specific actions backed by government oversight and mandates. It includes no mention of "mandates" or "requirements" that are certainly warranted by the dramatic national hospital-acquired infection statistics. Further, there is little emphasis on public transparency or the need to ensure accuracy of reports through validation of infection data submitted by hospitals. Most of the "actions" in the Plan involve more planning and the five-point strategy is couched in permissive and voluntary terms. This perpetuates the historical problem in infection prevention – leaving decisions to act in the hands of health care providers who have not and will not choose to take aggressive action.

We recommend that the Plan include a call for a national mandatory reporting of hospital infection rates – informing the public is an essential component of creating safe hospitals. Most of the 25 state infection-reporting programs have decided to use the CDC National Healthcare Safety Network (NHSN) for data submission and analysis. The states then use the NHSN information to create public reports that are understandable and allow for comparisons of hospitals. On a

national basis, this information could be presented through the CMS Hospital Compare site.

Eliminating infections acquired in hospital settings is a daunting task, however, the Plan's failure to address infections occurring in long-term care facilities and ambulatory surgical centers is a serious omission. These facilities most likely account for a significant portion of health care-acquired infections, although there is less information about their incidences than hospitals. The Plan should include actions to address infections in these facilities.

Another major omission in the Plan is the lack of policy discussions regarding appropriate behavior of health care workers, doctors, and hospitals when a patient is infected. Patients and their families should be immediately and fully informed about preventable infections. They should be advised as to methods of transmission and provided with clear information about avoiding transmission when discharged from the hospital; especially in cases involving MRSA, *C. difficile* and other drug resistant infections.

Section 4: Targets and Metrics.

General comments.

We strongly support the focus on outcomes and the two long-established prevention practices relating to surgical and bloodstream infections that every hospital should be using 100% of the time.

However, the five-year targets set out in the Plan continue the problem of benchmarking against an average of results from a subset of hospitals. If hospitals consider their infection control performance acceptable by comparing it to these averages, it misses the fact that millions of patients are still being infected. If the average is bad –– then there is no progress. The benchmark for hospital infections should be zero.

There are no targets for Ventilator Associated Pneumonia (VAP), not even for process measures. This is not in line with the National Quality Forum, which endorsed a VAP prevention bundle. Nor does it recognize the significant results hospitals have achieved in the Institute for Healthcare Improvement campaigns by using the VAP bundle. VAPs are the most common hospital-acquired infection in ICU, where it is connected with high mortality rates. We recommend including targets for VAP.

We are concerned that the assessment of meeting targets will be misleading when based on data from the NHSN modules that are used by a small subset of hospitals (e.g., modules relating to urinary tract infections, multi-drug resistant organisms, and central line insertion practices). These metrics will be meaningless in national assessments of progress if they do not reflect progress of hospitals throughout the country. To ensure that the metrics actually demonstrate improvement throughout the country, we recommend that HHS require all hospitals to report to NHSN on these targeted measures. Short of that, the metrics should include information identifying the number and type of hospitals participating in the metric.

<u>Specific comments on targets:</u>
IV. Central Line-associated Bloodstream Infections (CLABSI). Building on targets and metrics already adopted by National Quality Forum (NQF) and the Society of Healthcare Epidemiologists in America (SHEA), does not move us forward. For example, the target for reducing CLABSI perpetuates the current limitation in most hospitals of only tracking and focusing prevention in the ICU. The Plan should move beyond the status quo and begin setting goals for preventing infections that occur throughout the facility. The metric appears to give hospitals a choice of which locations to be measured, allowing them to focus only on selected locations. Most state laws are collecting data on ICU CLABSIs and most are reporting this information to NHSN. Thus, we recommend expanding the targeted activity into other areas of the hospital.

V: Clostridium difficile infections. Setting the *C.difficile* target so low (30% reduction) sends the message that most of these infections cannot be eliminated. This is not acceptable as we face an epidemic of *C. difficile* infections. AHRQ indicates that *C.difficile* rates more than doubled between 2001 and 2005, and in the prior eight years the number of cases increased by 74%. Serious and aggressive action is needed in light of new strains that are harming new populations. Because the increased rate and virulence of these infections have reached a critical state, we recommend that hospitals be required to use the NHSN MDRO module for reporting *C. difficile* infections.. We call to your attention a 2005 nationwide VA study and report[i] that found less than half of *C. difficile* infections were detected through ICD-9 codes compared with reports from infection preventionists collecting the data and reporting it on a monthly basis, making a

more compelling reason to require hospitals to use the MDRO module for reporting *C. difficile* cases.

"Patient care environment," i.e., thoroughly cleaning and disinfecting rooms, is a well-established component of infection control, especially with regard to *C. difficile*. It is also common sense - we do not need a study to understand that jumping out of an airplane without a parachute could kill you.

Surveying whether hospitals have antibiotic stewardship programs in place is not an effective strategy for the increasing problem of antibiotic resistance. HHS should mandate that every hospital have such a program and accreditation surveys should evaluate their effectiveness. Antibiotic resistance is a crisis and we cannot make progress with voluntary programs.

VI: Catheter-Associated Urinary Tract Infections (CAUTI). Most striking is the low target for reduction of CAUTIs. Since the CMS has targeted CAUTIs in its no-payment policy, these infections should significantly decrease. The target should be at least below the current NHSN 25% percentile – similar to the other outcome measures in the Plan for common types of infections. Simple best practices already exist for preventing CAUTIs. We do not need to develop new ones. The first strategy is to avoid using catheters in the first place and the second strategy is to ensure there are systems in place to prompt timely removal of the catheters. Do these basic steps first, then assess if more research is needed.

VII: Methicillin-resistant Staphylococcus aureus (MRSA). We recommend including a process metric of the number of hospitals using the evidence-based strategy of active detection and isolation (ADI) for the reduction of MRSA. The Veterans Administration hospital system is screening every patient and many hospitals throughout the U.S. are screening targeted populations, resulting in significant reductions of MRSA infections. A recent survey by APIC of its infection preventionist members found that 55% said their hospital was not doing enough to combat MRSA, 49% said they are doing MRSA screening, most had stepped up hand hygiene efforts and use of contact precautions, and 46% said they hoped their employers would implement targeted or universal screening. Further, four states now require hospitals to screen targeted high-risk populations. ADI is a well documented successful prevention technique that should be included in the plan. Its omission is unacceptable.

Further, with this significant activity taking place, the target for reducing MRSA should be much higher than 50%.

X: Other Considerations. Infrastructure and cost issues are raised, but are discussed without factoring in the extraordinary costs of hospital-acquired infections. Certainly, the federal government and individual hospitals will need to invest more resources in order to eliminate hospital-acquired infections. While using the NHSN system – a surveillance system – as the reporting system and source for metrics can help hospitals improve their infection prevention efforts, the Plan should include further exploration of incorporating electronic methods for identifying when these infections occur within a hospital. These methods are being used in various ways throughout the country and will be needed if we are ever to get beyond the limited monitoring currently being done in US hospitals (i.e., ICUs and selected surgeries). We support the recommendation in Section 6, Research, II, A, (2), to evaluate these strategies.

We strongly support increasing resources for infection prevention using existing evidence-based methods, validating data, examining the impact of other factors such as nurse-patient ratios (add infection preventionist-bed ratios also), and improved analyses by "cross-walking" the multitude of data resources available through NHSN, CMS, AHRQ, electronic laboratory information, and state data sources.

Validation of data used to assess progress, including instituting validation processes at NHSN, is essential. HHS should tap into the experiences of the states, where most of the hospital infection disclosure laws require validation. This is often done through chart reviews, but more innovative methods should be explored. Without validation, public reporting might as well be voluntary.

Section 5 – Prevention:

The problem with the extensive pool of prevention guidelines and research is not so much one of prioritization but one of implementation. We urge HHS to require action by hospitals and to make them accountable to the public for their infection prevention programs, or lack thereof. For example, that there still is no accountability for such a basic infection control priority as hand hygiene compliance is unacceptable. And, when will we stop this endless discussion about health care worker vaccinations? The debating should stop and HHS should require all health care workers to be vaccinated.

The Plan should clearly state an expectation of hospitals to implement these prioritized prevention recommendations, which will be measured based on the metrics set out by the Plan. We appreciate the acknowledgement of this in Section 6-Research, II, A, (1), and recommend that it also be included in a more prominent place in the executive summary.

A significant omission in this section is active detection and isolation of MRSA and other MDRO patients. The Veterans Administration has a year of universal screening behind them and the Plan should acknowledge and review the positive outcomes from this national program.

Section 6 – Research.

We agree that overall compliance with current recommended best practices is pathetic at best. The Plan's focus should be on implementing well-researched basic prevention strategies to a high degree of confidence before spending a lot of time and money on more research. Efforts should include designing and requiring infection control curriculums for all medical schools.

We strongly support increased efforts in developing the use of electronic data for measuring processes and outcomes [II,A,(3)]. We also support improving methods for capturing CLABSI and other adverse events relating to catheters outside of intensive care units [II, B, (1)] where most of these infections occur.

Regarding VAP, we find it curious that the Plan does not include a call for modifications to the CDC definition. This seems to be the single most frequently identified barrier to tracking these infections. The NQF hospital infection work several years ago urged for this definition change as soon as possible to enable better tracking of these deadly infections. But it is unclear whether any progress has been made.

We agree that developing a standardized measurement system for Hand Hygiene is a high priority but it does not need more research – plenty of hand washing studies are available and most find that observation is the best way to measure this. Systems of random hidden video surveillance cameras monitored by hospital staff could quickly assess the areas of non-compliance. However, measurement without disclosure means nothing. Results of hand hygiene compliance should be posted in the hospital lobby for patients to view.

We recommend creation of a national database to capture the many small-scale research projects done throughout the country. These are done at individual hospitals every year, often shared at

conferences, but poorly shared beyond those settings and never compiled. The database should be searchable so similar projects could be identified and possibly connect teams working on them.

Section 7 – Information Systems and Technology

There is no mention about informing the public in this section, rather it is solely focused on information sharing among agencies and hospitals/professionals. Public disclosure of hospital infection information plays an integral part in eliminating infections and it should be a primary focus of the Plan. We support efforts to ensure that more timely information is delivered to the public. We also support collaboration among the agencies in an effort to present a more accurate estimate of hospital-acquired infections occurring across the nation. Using the multiple sources of information from hospitals available to the federal government (NHSN, Medicare, AHRQ) can lead to a more complete picture of the hospital-acquired infections. We caution against too much "common reporting" and too much emphasis on "reporting burdens on health care facilities" that could result in less information available about hospital-acquired infections. We have seen this happen with the common reporting currently used by CMS in Hospital Compare, the Joint Commission, and any number of state reports to the public. All provide the same information when each could provide different measures to bring together a more comprehensive assessment of quality and safety.

The HHS Plan should include efforts to analyze the state based data as well as the Medicare data – so populations of all ages are included in the metrics.

Section 8 – Incentives and Oversight.

Currently oversight is nonexistent. Restaurant kitchens are inspected but not operating rooms. HHS should mandate unannounced infection control inspections of every hospital on a regular basis. Hospital-wide inspections should be done yearly by the Joint Commission and other accrediting bodies.

Three times this report mentions that compliance with existing best practices could dramatically reduce infection rates yet it fails to describe how HHS intends to increase levels of compliance. Voluntary compliance has failed. HHS recommendations largely address clinical issues when physicians are a major part of the problem. Significant investments should be made to enable better oversight of hospitals' infection prevention programs.

We strongly support analysis of complaint data in assessing performance of accrediting organizations. Further, we recommend that complaint information by facility be disclosed to the public (while protecting the identity of the patient).

We recommend going beyond simply training hospital surveyors in infection control issues; the law should require an infection preventionist to be part of every survey team.

Value Based Purchasing. Hospital-acquired conditions and Present on Admission. We support continued expansion of the list of hospital-acquired conditions and adoption of ICD-10. On page 67, this section references problems with including MRSA and *C. difficile* on the list, stating that the current coding does not differentiate between colonization and infection. It is our understanding that the newly adopted MRSA codes do allow this differentiation, one of the reasons for developing the new codes. We also recommend public reporting of the incidences of hospital-acquired conditions, by facility. CMS should closely monitor complaints from Medicare recipients regarding inappropriate billing for services related to hospital-acquired conditions. The policy does not allow such billing, but patients will probably get bills. But more needs to be done for these patients, as many of the conditions, especially infections, require years of extensive health care services for which they must pay significant out-of-pocket costs. This burden should not fall on the patients who are harmed by their hospital care.

Hospital Pay-for-Reporting. We recommend the inclusion of hospital infection related outcome measures, such as hospitals infection rates, in this program. Quick outcome measures that could be easily included with the FY2010 additions are the infection related measures on the AHRQ Patient Safety Indicators.

Value-based Purchasing. We support paying for results rather than simply paying for reporting; this should be linked to outcomes and not processes.

Transparency. Hospital Compare should provide the public with more outcome measures.

In conclusion, we appreciate the opportunity to comment on the Plan and look forward to working with HHS in strengthening and implementing it.

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[i] "Under Secretary for Health's Information Letter, Clostridium Difficile (C. Difficile)," Department of Veterans Affairs, Veterans Health Administration, IL 10-2005-018, September 8, 2005.