Consumers Union and Washington Advocates for Patient Safety
Comments on Draft Report
"Healthcare Associated Infections: 2013 Report to the Washington Legislature"
by the Washington Department of Health
July 12, 2013

Thank you for the opportunity to comment on the Department of Health's draft report "Healthcare Associated Infections: 2013 Report to the Washington Legislature." Our comments below will follow the order as issues appear in the report. We support the work of the Hospital Associated Infections Advisory Committee to provide meaningful information to the public regarding health care-acquired infections.

I. Background

We are troubled that throughout the report, there appears to be sparse support for public reporting on health care-acquired infections – one primary purpose of this program. The skepticism with which the department approaches this responsibility comes through clearly and the department seems to be motivated to prove that public reporting has little or no impact. One recommendation in this report would redirect funds donated for the program to support a study to prove that public reporting has had "*no significant impact on preventing infections*." While it is accurate to say there has been no specific study isolating the impact of public reporting (but many that claim there is no evidence), it is important for people in Washington to be aware that many other state health departments and the Centers for Disease Control and Prevention (CDC) have attributed reductions of hospital-acquired infections to public reporting and view this activity as a critical, effective component of preventing and eliminating infections that kill almost 100,000 hospital patients each year:

- The CDC "*believes public reporting of healthcare-associated infections (HAIs) is an important component of national HAI elimination efforts. Research shows that when healthcare facilities are aware of their infection issues and implement concrete strategies to prevent them, rates of certain hospital infections can be decreased by more than 70 percent*."

- In New York's third year of reporting, many hospitals showed a decrease in certain surgical infections between 2006 and 2009, with 39% of hospitals reported zero infections for hip surgery; Rachel Stricof, director of the NY Department of Health's bureau of health–care–associated infections said, "*I do believe it is because of reporting*." In 2010, the state reported a 37% reduction in CLABSIs in ICUs since its first report in 2007.

- Colorado's 2012 report showed a 43% decrease in CLABSIs in adult ICUs from 2008-2010 and similar decreases in neonatal ICUs and long-term acute care hospitals; the report states: "*These data suggest that public reporting of infections may enhance individual facilities' accountability and focus on reducing infections*."

Additionally, one can look at the national data. Although rates of central line associated infections (CLABSI) in intensive care units (ICUs) had not changed significantly during the 30 years prior to public reporting, CDC documented a 58% reduction in CLABSIs over 9 years, during which reporting began and from 2008 to 2011 the agency documented a 41% reduction in these infections nationally. Similarly, a number of states (including those mentioned above) have documented significant reductions in the surgical site infections on their list of mandatory reporting.

It is important to recognize the role public reporting plays for accountability and simply to be able to actually measure infection rates from one point of time to another. Without reporting, that would be

impossible. While numerous other activities going on at the same time certainly contributed to reductions – such as the Institute for Healthcare Improvement's 100,000 Lives Campaign and Johns Hopkins' Dr. Peter Pronovost's checklist - it is our belief that public reporting paired with these collaborative activities is necessary to create an environment for eliminating infections. Of note, Dr. Pronovost had a difficult time recruiting volunteer hospitals to his program in states without mandatory reporting requirements. We hope that Washington officials will someday accept public reporting as a vital catalyst for change and tool for measuring progress.

II. HAI Reporting Currently Required of Hospitals

Recommendations on MDROs. We strongly oppose the legislative recommendation to remove the current requirement to screen certain high risk patients for MRSA colonization. Screening patients has been a successful strategy in reducing hospital-acquired MRSA infections throughout the country. The recommendation leaves it up to each hospital to decide what is best for them – which, history shows us, often fails the patients.

The report indicates that Washington hospitals are "maintaining low rates of MRSA infections…relative to the past decade" but provides no data. We believe each hospital should show their rates of MRSA infections have been reduced over a period of time before the committee starts discussions about eliminating this mandate. This requirement should not be changed until every hospital can demonstrate such a decline. Given the fact that the United States has worse statistics in comparison to many other northern European countries on containing MRSA and other dangerous MDROs, we must not drop mandatory reporting, which is needed to determine where MRSA and other MDROs are coming from and how effectively they are being controlled.

The report also mentions "promising new approaches," referencing a recent "REDUCE MRSA" study published in the New England Journal of Medicine. We are very concerned about this study, which evaluated whether daily bathing with chlorhexidine and decolonization with mupirocin in ICU settings would reduce MRSA infections. The study found "the effects of the strategies on ICU-attributable MRSA bloodstream infections were not significantly different across the study groups" (one group was screened for MRSA); it found that these practices reduced MRSA colonization (so did MRSA screening) and the rate of all bloodstream infections. But our greatest concern is the impact these practices might have if they are used on a broad basis. The authors in an editorial in the NEJM cautioned about widespread use of these "new approaches" exacerbating antibiotic resistance:

- "*Widespread use of chlorhexidine and mupirocin could possibly engender resistance*…"
- "*Weaknesses [of the study] include…a failure to assess for resistance to chlorhexidine or mupirocin…*" and "*mupirocin resistance is well documented, is associated with decolonization failure, and occurs commonly with mupirocin used in a widespread fashion. Thus we would urge caution in implementing the universal use of mupirocin in patients in the ICU*. "

In light of the potential for increasing resistance to widespread ineffectiveness of antibiotics, we would strongly oppose any recommendations for hospitals to use this practice on a broad basis.

Regarding the Recommendation to revise RCW 70.41.430, we support including review of each hospital's practices for preventing MDRO infections in all visits to facilities – including licensing inspections and quality or infection validation visits. However, we recommend that the revision require looking at the "*prevalence of infections*" as well as to "*whether each hospital maintains an adequate assessment process*." Focusing only on the latter will not benefit the public reporting on infection rates and fails to identify the many lives lost and harm done by these virulent infections.

III. Public Health Department Position on Adding, Deleting or Modify State Reporting Requirements by Rule

Generally, we do not object to Washington deviating from CMS reporting because consumers can readily find measures required by CMS on the Hospital Compare website. For example, Washington reports rates instead of Standardized Infection Ratios (SIRs). Consumers may wish to see hospital SIRs, which show a hospital's progress over time. However, we strongly recommend that the department publicly report both the numerator and denominator of each rate. Every other state does this or makes these data available. It is our understanding that this information – which reveals no personal health information or any information that could identify an individual patient or physician – is being withheld as an agency decision and not due to statutory restrictions. This is important information for consumers because it reveals the number of infections that occurred (numerator) and the population susceptible to getting HAIs (denominator). The latter number is an important clue to consumers regarding the size of the facility and scope of its services. Without these components, it is impossible for a consumer to discern rates between small and large providers other than a general designation indicated by an asterisk.

In general, we are fine with the principles the department is using when determining which "accountability measures" to add, but are puzzling as to why the first bullet[1] is included as a broad statement of "adverse events" rather than infections, the subject of this paper. It is possible that these principles have been adopted for a broader set of measures. If that is the case, we think it would be important for this report to indicate that the first bullet would not apply to selecting infection measures for reporting because there is a "realistic expectation" that all hospital-acquired infections can be prevented.

With regard to the decision not to report CAUTIs – again, we are not concerned about this because Washington consumers can simply go to Hospital Compare and find this information. However, we object to the report's message to policymakers that the CMS payment programs targeting CAUTIs are ineffective in helping to prevent them. Clearly, the CMS refusal to pay for these very preventable and common infections has accomplished the goal of increasing hospitals' attention to them. Hospitals generally ignored these infections before the federal payment programs were put into place. Further, they are easily prevented using simple steps (e.g., don't use a catheter or remove it as soon as possible).

With regard to the CMS reporting requirement on MRSA bacteremia: We agree that the national measure will only reveal a small subset of hospital-acquired MRSA infections and fails to reveal to the public the full extent of this huge problem. However, it is in line with all other national data collected by CDC-supported state-based laboratories and do reflect the most serious cases. Again, we have no objections to Washington choosing not to duplicate the reporting that is being done on the federal level. We would support a Washington law to require reporting all MRSA infections.

We support the addition of reporting *C.difficile* LabID infections and especially appreciate the description in this report regarding these types of infections. They will go a long way to inform the public and policymakers about the problem.

We support the department's efforts in the area of antibiotic stewardship – a very important component for eliminating health care-acquired infections. However, we would like to see a public

[1] "The measure should reflect an adverse event condition for which ability to prevent is a realistic expectation;"

component for this program as an educational tool to help consumers fully understand the impact of overuse of antibiotics.

Regarding the "merits of reporting compliance in each facility with other infection prevention strategies." While we certainly support the department working with hospitals internally on prevention practices and as a focus of collaboration aimed to educate and train health care workers on latest and most effective practices, we do not recommend these to be a focus for public reporting. We support expanding the scope of this work to other health care settings such as long-term care facilities and ambulatory surgical centers. And we support using immunization rates as a metric for hospital safety and safety of other facilities.

IV. Process Used to Evaluate the Quality and Accuracy of Reporting

While the department is proud of the validation methods it is using, we believe simply looking at the system a hospital has in place for infection control is insufficient to validate the data that is being publicly reported. We urge the Advisory Committee and the department to add to this method some validation of the actual data.

Further, the committee and policymakers should be aware that this method without validating the actual infection rates is not in line with best practices identified by the CDC through over a year of meetings with other state health department epidemiologists doing validation. For example, the CDC validation toolkit for CLABSI is available at http://www.cdc.gov/nhsn/toolkit/validation-clabsi/index.html.

Thank you again for allowing us to comment on this report. We look forward to working with the committee and the Department to ensure that the Washington program – for prevention and reporting – continues to work toward elimination of health care-acquired infections. If you have any questions, please contact Lisa McGiffert at lmcgiffert@consumer.org or Yanling Yu at mydadmatters@gmail.com.