ConsumersUnion
POLICY & ACTION FROM CONSUMER REPORTS

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Don Wright
Deputy Assistant Secretary for Health
Director, Office of Disease Prevention and Health Promotion
Office of the Assistant Secretary for Health
Delivered via email to ohq@hhs.gov

Dear Deputy Assistant Secretary Wright:

The Safe Patient Project of Consumers Union, the policy and action division of Consumer Reports, and the patient safety advocates signing these comments submit the following comments about the proposed 2020 targets for the National Action Plan to Prevent HealthCare Associated Infections. We strongly support continuation of the Action Plan for the next five years. This week's CDC report indicating that one in 25 patients are infected while hospitalized indicates that slight progress has been made, but there is much more that needs to be done.

In general, we believe aggregating these targets hides areas of significant problems and that the HHS targets should be set for each individual hospital, as well as for the country in the aggregate. While the progress of individual hospital scores can be seen on the CMS Hospital Compare website, HHS could enhance public and provider understanding regarding how close hospitals are to meeting the targets by providing analyses beyond simple national aggregated percentages. For example, an analysis that compares how the states are progressing or how teaching hospitals are doing or how close midsized community hospitals are to reaching the targets.

When they were set five years ago, the Safe Patient Project network commented that the Action Plan targets were too low. It is a profound disappointment that none of the targets from the prior Action Plan have been met. We believe it is time to step up the pressure for significantly reducing these preventable infections that cause significant death and injury to patients in our nation's hospitals. Clearly tying the "action" to those hospitals not making progress could help to bring about needed changes.

We recommend adding some critical measures to these targets. Several are related to the significant problem of antibiotic resistance, including the looming danger of infections for which there are no treatments and a rapidly diminishing supply of antibiotics that are effective against infections caused by an increasing population of superbugs. These threaten modern health care as we know it. It is imperative for the HHS Action Plan to reflect this reality. We make the following recommendations:

- Add antibiotic stewardship measures with 5-year targets to include appropriate use of antibiotics, which can be measured using CDC's new NHSN antibiotic use and resistance module.[1] The recent CDC report on the inappropriate use of antibiotics in hospitals highlights the problem.
- Add infections caused by CRE (Carbapenem Resistant Enterobacteriaceae) to the action plan. A baseline should be established in January 2015 with the 5-year target being less

than one percent increase in the occurrence of these infections. We also recommend developing several related process measures based on recommendations by CDC.[2]

- Add a measure for pneumonia. As indicated in the recently released CDC prevalence numbers published in the NEJM, pneumonia tied with surgical site infections as the top type of infection – accounting for approximately 22% of all HAIs. This is not new. Pneumonia was the leading type of infection in the last prevalence estimate in 2007. Yet, it has not been a major focus of prevention efforts. Such a focus should start with this new Action Plan.

Below are our comments on the specific targets proposed:

1. Reduce central line-associated bloodstream infections (CLABSI) in intensive care units and ward-located patients: Certainly CLABSIs in the ICU are where we have seen the most progress, but too many hospitals are not making annual progress. We recommend that this target be assessed and reported separately in the ICU and in the wards, as is planned for CAUTIs. It is unclear whether the intent is to do so.

2. Reduce catheter-associated urinary tracts infections (CAUTI) in intensive care units and ward-located patients: We support establishing targets separately for ICU-related CAUTIs and CAUTIs occurring in wards and for the progress to be assessed and reported each year separately. Because there was such little progress in this area over the past five years, setting the same target for the next five years doesn't seem to move us toward elimination of CAUTIs. We recommend increasing the target for CAUTI reduction to 50% from the 2015 baseline (which will likely be within a few percentage points of the prior baseline).

3. Reduce the incidence of invasive health care-associated methicillin-resistant Staphylococcus aureus (MRSA) infections: Although this measure is limited to only a few locations, rather than nationwide, we believe there is some merit to establishing targets for reductions. However, we would like to see clarification that the measure calculation will combine both facility-onset AND community-onset health care acquired infections to give an accurate assessment of MRSA HAIs. Previous studies have found that 82% of these invasive MRSA infections reported by the EIP Network Surveillance are health care associated.[3]

4. Reduce facility-onset methicillin- resistant Staphylococcus aureus (MRSA) in facility-wide health care: We continue to be concerned about this measure as it only identifies a small number of MRSA infections occurring in hospitals. It is quite meaningless and random as to whether the symptoms of the infections show up before a patient leaves the hospital. It is influenced by a hospital's discharge policies or at which point in a person's hospitalization they become infected. Since this is a CMS measure, we agree it should be included. However, we recommend that HHS, in collaboration with CMS, develop a requirement for Medicare certified hospitals to track infections for at least 30 days post discharge so that this measure can be expanded to include community onset HAIs.

5. Reduce facility-onset Clostridium difficile infections in facility-wide health care: We recommend changing this target to 50% reduction from the 2015 baseline: The progress in reducing c.diff infections has been poor, with less than 5% reduction since 2010. Setting the target at 30% - the same as the prior target – seems to support inertia. We recognize that this is a tough infection to prevent, but hospitals must step up with better strategies for doing so. We reiterate our recommendation that HHS, in collaboration with CMS, develop a requirement for

Medicare certified hospitals to track infections for at least 30 days post discharge, so this measure can eventually include those HAIs that are identified after patients leave the hospital.

6. Reduce the rate of Clostridium difficile hospitalizations: This measure is clearly moving in the wrong direction and more serious actions need to be taken to curtail the spread of c.diff infections. The target set for this measure is too low – considering the rate has increased since 2008. We recommend setting the new target at 50% reduction from the 2015 baseline. We must step up our efforts in this ever-increasing threat to patient safety.

7. Reduce Surgical Site Infection (SSI) admission and readmission: Our primary recommendation on this measure is to provide more clarity about the details. Although this is the identical wording as the prior action plan, it is unclear whether all SSIs reported to NHSN are included in this measure or only those included in the CMS public reporting program. Further, it is unclear whether hospital-onset SSIs are combined with those identified upon readmission in determining overall progress.

8. Surgical Care Improvement Project (SCIP) Measures: Adherence to process measures to prevent Surgical Site Infection (SSI): We support eliminating these process measures from the action plan since hospitals are nearing 100% compliance with these evidence-based prevention strategies. Although we have serious concerns that hospitals too often use antibiotics that are not appropriate for specific patients undergoing specific procedures, we believe using the new CDC antibiotic use and resistance module will provide a more accurate assessment than the SCIP Infection measure 2. Please add this to the new targets.

We appreciate the opportunity to provide comments to this proposal and look forward to continuing working with you and your staff toward eliminating health care-acquired infections.

Sincerely,

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[1] http://www.cdc.gov/nhsn/acute-care-hospital/aur/
[2] http://www.cdc.gov/hai/organisms/cre/cre-toolkit/f-level-prevention.html#facility-measures
[3] Kallen AJ1, Mu Y, Bulens S, Reingold A, Petit S, Gershman K, Ray SM, Harrison LH, Lynfield R, Dumyati G, Townes JM, Schaffner W, Patel PR, Fridkin SK; Active Bacterial Core surveillance (ABCs) MRSA Investigators of the Emerging Infections Program. Health care-associated invasive MRSA infections, 2005-2008. JAMA. 2010 Aug 11;304(6):641-8. doi: 10.1001/jama.2010.1115.