WISCONSIN HOSPITAL ASSOCIATION, INC.

May 27, 2008

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

Dear Mr. Waxman:

On behalf of the Wisconsin Hospital Association (WHA), I want to thank you for the opportunity to discuss the work that Wisconsin has undertaken to *reduce hospital acquired infections (HAI).* We are aware of the morbidity, mortality and costs associated with HAI and strongly believe that more can, and will be done to minimize the impact of HAI on the patients that we serve.

Our Association continues to advance Wisconsin hospitals' quality and safety transparency agenda through our public reporting system called *CheckPoint* (www.wicheckpoint.org). Nearly all of Wisconsin's 125 hospitals voluntarily report data to *CheckPoint* based on their patient population, this includes our 60 Critical Access Hospital members. The *CheckPoint* measures reflect evidence-based practices known to improve patient outcomes. When available, CheckPoint utilizes measures and benchmarks developed by credible national organizations like The Joint Commission or the Center for Medicare and Medicaid Services. If measures are not available from national organizations in a specific area of interest, we look to professional associations or other reputable sources for measure definitions.

Currently, the measures reported in *CheckPoint* are predominately process measures that drive improvement by providing baseline information hospitals can use to set improvement goals and ongoing data to track progress compared to similar hospitals in our state. *CheckPoint* is also a consumer education tool as the information reported reflects clinical interventions that consumers should be know for their specific diagnosis.

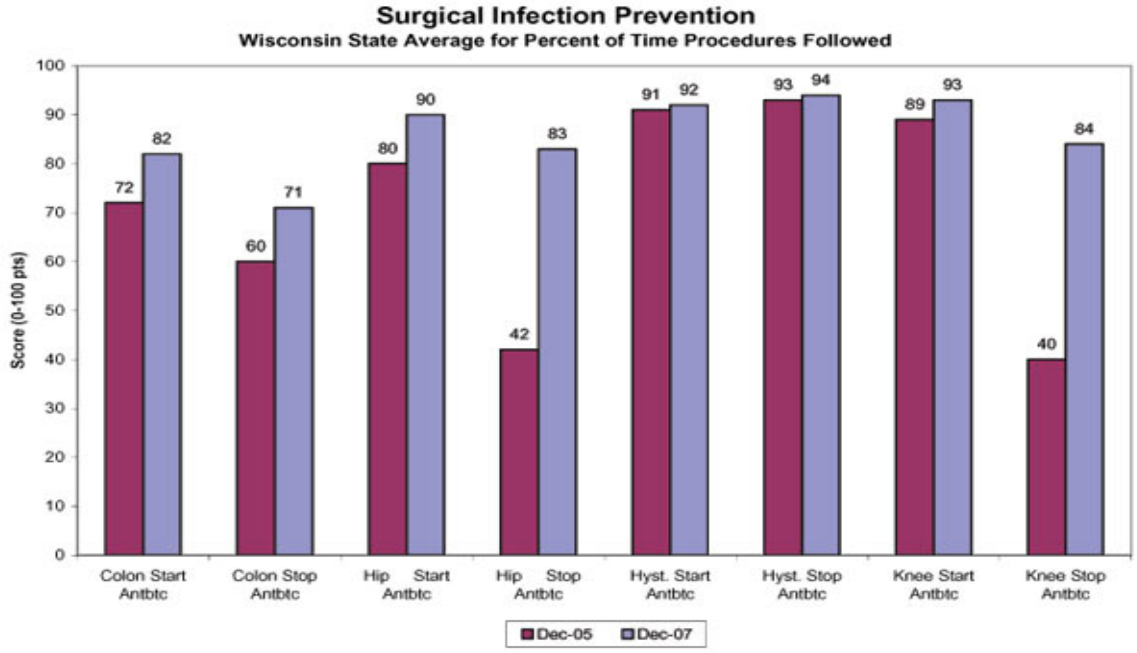
Per your specific questions:

1. **If known, what are the median and overall rates of central line-associated bloodstream infection in the intensive care units (ICU) in hospitals in your state, using the standard definitions of CLABSIs as provided by the Center for Disease Control (CDC) and prevention for the purpose of the National Healthcare Safety Network (NHSN)?**

WHA does not collect median and overall rates of CLABSI in the ICU for Wisconsin hospitals. However, in partnership with the Wisconsin chapters of the Association of Professionals in Infection Control and Epidemiology, we continuously monitor the work of the Healthcare Infection Control Practices Advisory Committee for the CDC and the National Quality Forum (NQF) related to hospital-acquired infection rate reporting. The critical barrier to HAI rate reporting is the *lack of common definitions for most HAI*. Without nationally agreed-upon standard definitions of what constitutes an infection, we believe that data collected by individual hospitals will vary, making the information misleading, if not useless, to consumers.

Although the CDC data collection system does contain definitions for select HAI's, these definitions are not broadly used outside of the CDC system. Beyond the need for standard definitions, a data submission system must be available at a reasonable cost for hospitals to transmit data to a centralized system for state level reporting. Few Wisconsin hospitals report data to the NHSN or any other national or state data reporting system.

To address concerns about HAI's Wisconsin hospitals begin reporting surgical infection prevention (SIP) measures in 2005. Currently, twenty-one SIP measures are reported on *CheckPoint* for seven common procedures; CABG, other cardiac, colon, hip, knee and vascular surgery, and hysterectomy. These measures indicate how well a hospital is adhering to evidence-based guidelines on the appropriate use of antibiotics before and after surgery, as well as the use of the best antibiotic for a specific procedure. There are currently 90 hospitals publicly reporting SIP measures through CheckPoint. As you can see from the graph below, our state average for these measures has *improved substantially in just two years.*



In 2009, WHA will expand public reporting of infection prevention measures by adding the Surgical Care Improvement Project measures to CheckPoint. These measures are endorsed for public reporting by the National Quality Forum and will be used by the Hospital Quality Alliance.

WHA is also stepping up our investigation into evidence-based, national measures of HAI rates that will standardize the measure definitions that Wisconsin hospitals use to collect data and to identify a state-wide data collection system prepare our hospitals for voluntary, public reporting of HAI rates through CheckPoint.

2. If the 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?

At the state level, Wisconsin has embarked on several initiatives to address HAIs. An overview of each initiative is provided below.

Surgical Infection Prevention Collaborative

In 2003, MetaStar, Wisconsin's Quality Improvement Organization (QIO), led the Surgical Infection Prevention Collaborative (SIP). Seventeen Wisconsin health systems and hospitals participated in this collaborative, two of which had participated in the national Institute for Healthcare Improvement (IHI) Break Though Series on Surgical Infection Prevention. Since Wisconsin has multiple integrated health systems that include many hospitals in each system, the results of this initiative expanded well beyond the formal participants.

This project, supported by CMS's QIO Program, was structured using the IHI collaborative model for quality improvement to spread existing knowledge to multiple settings to accomplish a common aim. The project expanded over two years and included standardized data collection and reporting, three separate two day learning sessions, conference calls and telephone support.

Participating hospitals learned about the personal, organizational and financial burden of surgical site infections (SSI), as well as timely and appropriate antibiotic prophylaxis, the impact of optimal oxygenation and temperature on reducing SSI and many other proactive interventions that have been proven to reduce SSIs. After ten months, participating hospitals reported a 50% overall improvement in applying these interventions.

Surgical Care Improvement Project

In 2005, MetaStar led the Wisconsin activities of the national Surgical Care Improvement Project. This project built on the work of SIP and added interventions known to reduce another complication of surgery, venous thromboembolism. Fifteen hospitals participated in this project supported by CMS's QIO Program. By re-measurement in 2007, these hospitals achieved an aggregate 65% improvement in reliably implementing the interventions.

Central Line Infection Initiative: What Can You Do In 90 Days?

In 2005, MetaStar sponsored and led the Central Line Infection Initiative with the goal of dramatically decreasing the rate or eliminating central venous catheter associated bloodstream infections (CLABSI). The objectives of this initiative were to:

- Understand the significance of CLABSI
- Understand the gap in current practice associated with central line infection
- Understand the pathogenesis of CLABSI
- Discuss recommended practices for reduction of CLABSI
- Describe a new program in Wisconsin for safe subclavian catheter insertion

Twenty-six Wisconsin health system and community based hospitals participated in this initiative. This project used the Institute for Healthcare Improvement collaborative learning model and consisted of monthly data reports, a full day learning session to educate participants on the current evidence and practices to prevent CLABSI, conference calls and telephone support. At the conclusion of the initiative, each hospital was required to create a story board to communicate their project to staff within their hospital.

This project was funded by MetaStar independent of its CMS contract, and therefore, was not continued beyond the conclusion of the initial project.

WHA Rural Hospital Surgical Care Improvement Project

In 2006-2007, the WHA lead the Rural Hospital Surgical Care Improvement Project in which twenty-one rural hospitals actively participated. This project was funded by the Wisconsin Office of Rural Health Flex grant and therefore, provided a unique opportunity to work exclusively on the barriers to improvement of rural/critical access hospitals. The project goals where to:

- Engage rural hospitals in a structured shared learning project that required a team approach
- Teach rural hospitals how to use objective data in their decision making
- Support and implement process changes to improve their surgical outcomes
- Educate rural hospitals regarding the connection between nationally recognized quality indicators and process improvement within the hospital setting

The project focused on prevention of three key surgical complications; surgical site infections, cardiovascular complication and blood clots. The project included monthly data collection, three full day learning sessions, conference call on special topics and a push strategy to assure all participating hospitals had access to current research and best practices. A project evaluation revealed that 100% of participating hospitals indicated that all project goals were met for their hospital.

Institute of Health Care Improvement 100,000 Lives Campaign

In December 2004, the Institute of Health Care Improvement (IHI) initiated a campaign to save 100,000 lives using proven process changes to eliminate unnecessary deaths in hospitals. Three of the six improvement topics in this campaign are targeted at HAI. Seven statewide organizations, including MetaStar, Wisconsin Hospital Association (WHA), Wisconsin Medical Society, Wisconsin Nurses Association, Wisconsin Organization of Nurse Executives, Wisconsin Rural Health Cooperative and the Pharmacy Society of Wisconsin worked together to support this effort through a work group called the Wisconsin Node. Over 70% of Wisconsin hospitals are active members of the IHI campaign with many more enacting these process changes. The result of an annual survey to track progress with these improvement topics indicates that Wisconsin hospitals have made significant advancements over the past year.

	June 2005 (N=59)	**July 2006 (N=53)**
HAI Intervention	% of Eligible Hospitals Fully Implemented	% of Eligible Hospitals Fully Implemented
Surgical Site Infection	35%	70%
Central Line Infection	20%	71%
Ventilator-Associated Pneumonia	25%	70%

3. **What other activities are your member hospitals taking to address healthcare-associated infections? What infections are you targeting? What is your evidence of success?**

All Wisconsin hospitals support a comprehensive infection control program that systematically monitors and evaluates all actual and potential infections so that they can quickly identify preventable infections and correct care processes that might contribute to them. Hospitals continuously strive to

improve their care by using the most current science, techniques and products to reduce the risk of spreading infections from patient to patient.

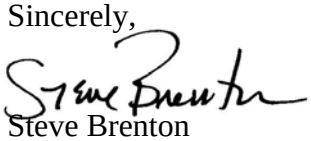
The WHA will continue to monitor the work of national organizations for additional opportunities to measure and reduce HAI that meet the high standards that Wisconsin residents deserve. To this end, we will:

- Expand the information available through CheckPoint by adding nationally recognized, evidence based infection related process measures in 2009
- Continue to evaluate the opportunity to report HAI rates on the CheckPoint Web site
- Evaluate the opportunity to become a state wide patient safety organization under the Patient Safety and Quality Improvement Act
- Continue to work with other state and regional organizations to evaluate Wisconsin hospital's need for improvement support through collaborative learning or other improvement models

Hospitals and the communities they serve share the same goal: to eliminate every HAI possible using reliable, accurate data and evidence-based interventions. As in many areas of performance improvement, Wisconsin hospitals are already deeply engaged in this effort and are sharing information with the public to enhance knowledge and decision- making.

Feel free to contact me with any comments or questions at 608-274-1820 or sbrenton@wha.org

Sincerely,



Steve Brenton
WHA President