HAH
Healthcare Association
of Hawaii

HOUSE COMMITTEE ON FINANCE
Rep. Marcus Oshiro, Chair

Conference Room 308
Feb. 23, 2010 at 4:30 p.m. (Agenda #5)

Opposing HB 2829 HD 1.

The Healthcare Association of Hawaii represents its member organizations that span the entire spectrum of health care, including all acute care hospitals, as well as long term care facilities, home care agencies, and hospices. Thank you for this opportunity to testify in support of the intent of HB 2829 HD 1, which requires hospital infection rates to be made available to the public. However, the Association opposes the bill because of other efforts to accomplish the same purpose as the bill.

The purpose of the bill is to healthcare-acquired infections, particularly in hospitals. On Jan. 6, 2010, the U.S. Department of Health and Human Services (HHS) issued an action plan to prevent healthcare-associated infections that includes five-year national prevention targets. In addition, the American Recovery and Reinvestment Act of 2009 (ARRA) provides funds to states through HHS to reduce healthcare-associated infections.

Hospitals in Hawaii have already begun to address this issue, individually and through the Association. To that end, the Association recently created the Patient Safety and Quality Committee, which will address the issue of healthcare-acquired infections, as well as other quality and patient safety issues faced by hospitals and other health care providers.

The committee is comprised of the quality officers of the organizations that span the Association's membership. These individuals have formal training in, and access to, the most recent information issued by HHS, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, and other national organizations regarding quality and patient safety. We believe that the expertise contained in and the recommendations that flow from this group should be a resource to the Legislature.

The stated purpose of the Patient Safety and Quality Committee is to formulate and implement strategies for organizations that belong to the Healthcare Association to collaborate in improving healthcare safety and quality for the citizens of Hawaii. As previously noted, all of Hawaii's hospitals are members of the Association, as well as long term care organizations, home care agencies, and hospices.

The Patient Safety and Quality Committee reports directly to the Association's Board of Directors. We would be glad to arrange for the committee to report regularly to the Legislature on its progress.

For the foregoing reasons, we ask the committee to hold HB 2829 HD 1.

SafePatientProject.org
ConsumersUnion

Testimony of Consumers Union
Hawaii House Finance Committee
Regarding House Bill 2829
Public Reporting of Hospital-acquired infection rates
February 23, 2010

Consumers Union, nonprofit publisher of *Consumer Reports*, strongly supports HB 2829, by Rep. Scott Nishimoto and others. HB2829 will require acute care hospitals to report the rate of certain hospital-acquired infections to the public.

Six years ago, Consumers Union launched a national campaign, www.StopHospitalInfections.org, advocating for public disclosure of hospital-acquired infection rates to inform people about the safety of their hospitals and to motivate hospitals to do more to prevent infections occurring in their facilities.

Twenty-seven states now have laws requiring reporting of hospital infection rates, an "outcome measure" that we believe is the best measure of the overall effectiveness of a hospital's infection control program. Twenty-one states use a system of reporting similar to that proposed in HB 2829.

HOSPITAL-ACQUIRED INFECTIONS ARE PREVENTABLE

Hospitals treat many very sick people who are more likely to contract an infection due to their already weakened state. Invasive procedures, like surgery, bypass the body's defenses against infection, creating natural pathways for disease. Intravascular (IV) lines used to deliver medication, fluids and nourishment also put patients at risk, especially those in intensive care units. Even so, most studies show that hospital infections can be significantly reduced by implementation of infection control practices, such as hand washing, and when hospitals commit to well organized infection control programs.

The problem is that not all hospitals use these proven strategies to prevent infections. For example, hand hygiene is the first line of defense against the spread of bacteria that cause infections in a hospital setting. Despite plenty of research establishing that improved hand washing reduces infection rates, hand washing compliance rates for nurses and doctors are generally less than 50%.

For the areas of the hospital most prone to the spread of infection, a number of other infection control practices have been proven effective, such as aggressive monitoring and education in neonatal ICU units and using catheters coated with antimicrobial or antiseptic agents. Surgical site infections, the second most common hospital-acquired infection, can be reduced through careful application of antibiotics before and after surgery. And a simple prevention checklist, paired with a culture of

safety that allows nurses to remind doctors to follow the checklist, has led to significant reductions in bloodstream infections.

Still, hospitals are not motivated to adopt these and other life-saving practices.

PUBLIC REPORTING WORKS

Epidemiologists, hospitals and the CDC identified the growing problem of preventable hospital-acquired infection more than three decades ago. Today many hospitals track their own infection rates, especially in units like the ICU or neonatal ward where infections are common or patients are particularly susceptible. But most do not currently report infection rates to any regulatory agency or accreditation body. They cannot compare their performance to other area hospitals, and their patients cannot know if they are getting the best available care.

Many states report hospital-specific quality of care information to the public, and in those states, hospitals are more motivated to improve their outcomes. Research shows the lowest performing hospitals are the most motivated to change.

New York was among the first states to compare hospital mortality for coronary artery bypass grafts (CABG). When the early reports were issued, hospitals with substantially higher mortality rates responded by examining their surgical systems and identifying areas of improvement. Winthrop University Hospital on Long Island fared poorly among heart programs, so it hired a renowned cardiologist to overhaul its program, hired additional staff, and created a new database system to monitor quality of care. Within two years, the cardiac program had one of the state's lowest mortality rates.

Since public reporting of infection rates is a relatively new activity, there is not yet much assessment of its impact on reducing infections. However, recent evidence from Pennsylvania shows the potential power of public reporting hospitals' infection rates. In the past two years of reporting all infections occurring in the states' hospitals, infections dropped by almost eight percent statewide. While not all hospitals reduced their infections, most did.

THE COST OF HOSPITAL-ACQUIRED INFECTIONS

The cost of hospital-acquired infections can be assessed at numerous levels. The **human cost** is by far the greatest: each year two million patients get an infection while being treated in our nation's hospitals, and almost 100,000 of them die[1] - more than die from car accidents and homicides combined.

Cost to the health care system: The Centers for Disease Control and Prevention (CDC) estimates the hospital costs for these infections to be as high as $45 billion each year.[2] Most estimates only look at hospital costs, but the cost for each patient goes far beyond hospital care to include medications, home health care, doctors' services, physical therapy, wound care, etc.

The best public estimates of the actual cost we have to date are from Pennsylvania, which reports rates on all four of the major types of infections (surgical site infections, blood-stream infections, ventilator associated pneumonia, and urinary

tract infections) and reports on infections occurring throughout the hospital. The state also collected information directly from private insurers to get a more accurate picture of the actual costs to the health care system.[3] The private insurance payments ranged from $27,000 for urinary tract infections to $80,000 for blood stream infections.[4] In 2005, Pennsylvania estimated the total charges for the state's infections at $1.4 billion.

The California governor's office estimated the cost of hospital-acquired infections in that state to be $3 billion each year.[5] And, a Massachusetts Panel estimated the total annual cost of hospital-acquired infections there to be $200 million to $473 million.[6]

Cost to State Government.

The cost of hospital-acquired infections to state funded health care programs is substantial and must be considered when looking at the investment needed for a public reporting system. The increased public and hospital awareness that comes with such a system will reduce infections and has the potential for saving significant state dollars.

While we do not know the actual cost to state health care programs in Hawaii, a 2007 study by the Association of Professionals in Infection Control and Epidemiology (APIC), found that Medicaid was the payer for 11.4% of hospital-acquired infection cases.[7] A 2005 Pennsylvania report analyzing who was paying for hospital-acquired infections in that state found that Medicaid paid for 9% of all hospital-acquired infections, accounting for 18% of the hospital charges for that state's infected patients. Pennsylvania estimated that the average charges for Medicaid patients with an infection were more than $391,000, while the average charges for Medicaid patients without an infection were just under $30,000.[8] Oregon estimated that the excess Medicaid costs for hospital-acquired infections in that state exceeded $2.4 million in 2005.[9]

HOSPITAL-ACQUIRED INFECTION REPORTING IN OTHER STATES

Twenty-seven state laws require reporting of the rate of various types of infections: AL, CA, CO, CT, DE, FL, IL, MA, MD, ME, MN, MO, NJ, NY, NH, OH, OK, OR, PA, RI, SC, TN, TX, VA, VT, WA, WVA. So far 17 states have issued reports - CO, DE, FL, IL, ME, MN, MO, NY, OH, OK, PA, RI, SC, TN, VA, VT, WA - which can be accessed at http://www.safepatientproject.org/content_type/state_disclosure_report/

Most of these states (21) have decided to use the CDC National Healthcare Safety Network (NHSN) as the data collector. While NHSN is a voluntary, confidential reporting system, the laws in these states establish the requirement to report infection rates. The hospitals send data to NHSN and then provide the information to the state agency responsible for the public reports. NHSN has been developed with these emerging state laws in mind and facilitates the sharing of data. The NHSN is an update of a system that was in place at CDC for more than 30 years. The prior system had limited capacity (315 hospitals) while NHSN states that it will be able to handle every hospital in the country.[10]

HB2892 would require Hawaii hospital to follow this method that other states have successfully used to require hospitals of all sizes to report their infections. There is no cost to the state to use the CDC NHSN system as the collector of hospital infection information.[11]

House Bill 2892 will significantly improve the safety of Hawaii's hospitals. We urge you to support its passage. Please contact me if you have any questions.

Lisa McGiffert
Campaign Manager
www.SafePatientProject.org
lmcgiffert@consumer.org
512-477-4431 ext 115
512-477-8934 fax

---

[1] "Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002," R. Monina Klevens, DDS, MPH, Jonathan R. Edwards, MS, Chesley L. Richards, Jr., MD, MPH, Teresa C. Horan, MPH, Robert P. Gaynes, MD, Daniel A. Pollock, MD, Denise M. Cardo, MD, Public Health Reports, March–April 2007, Volume 122, pp. 160-166.

2 Scott, R. Douglas, "The Direct Medical Costs of Health care-associated infections in U.S. Hospitals and the Benefits of Prevention," Centers for Disease Control and Prevention, March 2009.

3 "PHC4 • Hospital-acquired Infections in Pennsylvania, January 1, 2005 – December 31, 2005," November 2006, page 2.

[4] The average "costs" in Pennsylvania: SSI: $27,470; UTI: $43,932; VAP: $62,509; BSI: $80,233; Multiple infections: $91,898

[5] California Department of Public Health, Center for Health Care Quality, Healthcare Associated Infections Program, "Healthcare Associated Infections Plan," December 2009.

[6] JSI Research and Training Institute, Inc. in Collaboration with the Massachusetts Department of Public Health, "Prevention and Control of Healthcare-Associated Infections In Massachusetts Part 2: Findings from Complementary Research Activities," convened by the Betsy Lehman Center for Patient Safety and Medical Error Reduction, January 31, 2008

[7] Murphy, Denise, RN, BSN, MPH, CIC, Whiting, Joseph, MBA, FACHE, "Dispelling the Myths: The True Cost of Healthcare-Associated Infections," February 2007

[8] Pennsylvania Health Care Cost Containment Council, "Reducing Hospital-acquired Infections: The Business Case," Issue No. 8, November 2005

[9] Oregon Health Policy and Research, "Infections Due to Medical Care in Oregon Hospitals, 2003-2005," November 2006.

[10] http://www.cdc.gov/nhsn/

HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 23, 2010

The Honorable Marcus Oshiro, Chair
The Honorable Marilyn Lee, Vice Chair
House Committee on Finance

Re: HB 2829 HD1 – Relating to Health

Dear Chair Oshiro, Vice Chair Lee and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity provide testimony on HB 2829 HD1 which would require hospitals to report on infection rates. HMSA supports the intent of this measure.

This legislative session has already seen a plethora of measures wishing to gain more transparency from the health care system. Unfortunately at this time each bill only targets a single aspect of the system, such as the one before you today. We appreciate the intent of this measure as it attempts to work towards providing potentially useful information specifically related to hospital infection rates.

However, we do believe that in order for true transparency to be meaningful and useful, it needs to involve all stakeholders within the health care system, not just hospitals. The language in this measure would be useful to be included in a more comprehensive transparency effort and we hope that as the session moves forward, the dialogue on transparency will continue and be used to spur true change throughout the system.

Thank you for the opportunity to testify today.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

Hawaii State Legislature
House of Representatives
Committee on Finance
The Twenty-Fifth Legislature
Regular Session of 2010

February 23, 2010

Dear Committee on Finance:

My name is Elaine Shapiro and my husband got a staph infection in a Hawaii hospital. I support HB 2829 to require public reporting of hospital infection rates statewide. I want access to this information so that I can make better choices for me and my family. Hospitals should do a better job of following proven infection control practices, and making infection rates public spurs hospitals to improve. I have a personal story and I support this bill.

My husband had arthroscopic knee surgery mid-October of 2004 to repair a torn meniscus. He was put on antibiotics afterwards. He felt fairly well for a few days and then started developing pain and drainage. The antibiotic was changed to another stronger one but it did no good. The pain and drainage continued until about ten days after surgery, the doctor went in and surgically cleaned it out. When the lab work came back it was discovered that he had a staph infection. He continued to have a lot of pain and drainage. The doctor at this point put him on Zyvox at $60.00 per pill twice per day. The doctor had me clean it out several times a day to help with the drainage and healing process. Still no improvement, so on the first of December he went into surgery again for the third time to clean and hopefully cut the infection out. A week later he was feeling much better. Meanwhile he was in pain and could not get around for almost two months. My husband has since passed away.

I support HB 2829 so that all Hawaii residents can have access to hospital infection rates. Hospitals can do a better job of keeping our loved ones safe.

Sincerely,
Elaine Shapiro
Kihei, HI

Hawaii State Legislature
House of Representatives
Committee on Finance
The Twenty-Fifth Legislature
Regular Session of 2010

February 23, 2010

Dear Committee on Finance:

My name is Yvonne M. Hanato-Wells and my son, Schayle Kigen N. Hanato-Wells, acquired a MRSA infection in a Hawaii hospital. I am writing in support of HB 2829 to require public reporting of hospital infection rates. Please hear our stories and pain to help save and keep our loved ones healthy. Hospitals and doctors should do a better job controlling the spread of deadly infections like MRSA that patients never had before they were admitted to the hospital. If our loved ones survive they are never the same and have ongoing medical needs. I support this bill and I would like to share my family's personal experience with hospital infection.

On April 14, 2007 my son crashed into a tree after watching a basketball game. He was flown into North Hawaii Hospital to Queens Hospital. Doctor after doctor came in to examine him. He had a tube in his chest and a tracheotomy, his head was all cracked, his face was all smashed, jaw broken, bones broken in ear, and his neck was cracked several places 7th cervical on spinal cord. He couldn't talk, move, see, and could only hear on his right side. Doctors said that if he survived he might be quadriplegic. On April 26th Schayle was moved to the trauma ward and I complained to a nurse about something brown coming out of my son's mouth but nurses urged me not to worry and didn't see my son right away. After asking for help several times, nurses finally came and used two long cotton swabs to pull out the rotten gauze and didn't use gloves until after gauze was out. They did not wash out Schayle's mouth. His health kept declining. A few days later it was determined that he had a MRSA infection. During this time, my son was in a ton of pain all over his body. Doctors did not fix his neck as they said he was at risk for getting a MRSA infection again. Schayle has constant headache, pain, limited mobility and other health problems. My son will need ongoing care from the **Hospital Acquired MRSA** and his injuries. This has caused much financial and family hardship. My son is lucky he's alive.

I support HB 2829 so that Hawaii families can have more information about medical harm and so hospitals can reduce their infection rates.

Sincerely,
Yvonne M. Hanato-Wells
Kealakekua, Hawaii