# "Is the Answer Blowin' in the Wind?"

*Keynote Address by Senator Richard T. Moore*
*Senate Chairman, Committee on Health Care Financing*
**Massachusetts Hospital Association/Coalition for Prevention of Medical Errors**
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As early as 1843, Dr. Oliver Wendell Holmes, a leader of the Massachusetts Medical Society in his day, advocated hand-washing to prevent childbed fever. Holmes was horrified by the prevalence in American hospitals of the fever, which he believed to be an infectious disease passed to pregnant women by the unwashed hands of doctors. He recommended that a physician finding two cases of the disease in his practice within a short time should remove himself from obstetrical duty for a month. Holmes's ideas were greeted with disdain by many physicians of his time.

In the intervening 175 years until today, many scientists and medical professionals, including the Institute of Medicine, have agreed with Dr. Holmes findings about health system acquired infections. Since the IOM report, a number of states have taken steps to reduce the scourge of nosocomial infections with their attendant higher costs of care and preventable deaths.

In the last decade, Massachusetts health care leaders organized the first-in-the-nation Coalition for the Prevention of Medical Errors. Massachusetts state government established the Betsy Lehman Center for Patient Safety in the Department of Public Health and made infection prevention a state priority. These efforts are helping to improve quality and contain costs in the effort to make health reform sustainable. The Massachusetts-based Institute for Healthcare Improvement [IHI] also launched two life saving campaigns to prevent infections and reduce medical errors. The Massachusetts Hospital Association took a leadership position among the nation's hospital associations initiating "Patients First," which includes an attention to quality improvement initiatives among which is infection prevention.

With statutory direction and over two million dollars in funding provided by the Legislature through both our landmark Health Care Reform law [Chapter 58 of the Acts of 2006] and the Quality Improvement and Cost Containment law [Chapter 305 of the Acts of 2008], the Coalition and MHA have been offering programming to support the prevention of healthcare acquired infections throughout the Commonwealth. Executive and clinical leadership in every one of the state's acute care hospitals have pledged their support for infection prevention and success stories are emerging that offer real hope for the future. The report released today – ***"Infection Prevention Highlights from Massachusetts Hospitals"*** – can guide, and should inspire, both consumers and provider toward even greater success!

However, not every health professional – including even some here in Massachusetts despite these concerted efforts– have embraced the IOM recommendations on preventing infections and

other medical errors in their practice. Today, the Centers for Disease Control and Prevention reports that, nationally, an estimated 2 million patients get infections in hospitals and as many as 90,000 die from such infections each year. Sadly, Massachusetts has a share in those statistics!

Chances are only 50-50 that the doctor treating any of us in the hospital today, even when performing surgery, has washed his hands, according to some reports. That means the odds of getting an infection while in the care of a health provider are the same as flipping a coin! Actually, it's worse than that. According to the National Quality Forum, hand-washing compliance at hospitals is generally less than 50 percent!

No hospital leader should assume that because the term "HAI" now stands for "healthcare associated infection" rather than "hospital acquired infection," that there can be any relaxation on efforts to prevent infections in hospitals. Just because hospitals aren't the only health care providers who fail to prevent infections among their patients, there is no justification for lowering the priority of HAI prevention! On the contrary, hospitals should be leading the way for other providers in their regions!

In testimony presented in March 2006 to the U. S. House of Representatives Committee on Energy and Commerce Subcommittee on Oversight and Investigations, Denise Cardo, MD, state:

> *"Healthcare associated infections are a threat to patient safety. While many organizations are working hard to prevent infections and fight antimicrobial resistance in U.S. healthcare settings, this issue continues to be a challenge. These problems are larger than any one institution or agency can solve alone. Individuals at the federal, state, and local levels, in the public and private sector, need to work together to improve strategies to meet this healthcare challenge. The information derived from public reporting of healthcare associated infections can be a catalyst for increased adherence to recommendations, while steering public and private efforts to develop new strategies to prevent healthcare-associated infections."*

Dr. Cardo's central point is worth repeating – that "information derived from public reporting of healthcare associated infections can be a catalyst for increased adherence to recommendations, while steering public and private efforts to develop new strategies to prevent healthcare-associated infections." If health care leaders are seeking to demonstrate the "power of audacious goals," as the upcoming panel will hopefully discuss, then institution-specific public reporting of infections must surely be high on that list. Why? Because executive and clinical leaders just saying that infection prevention is job one, doesn't prevent infections! Audacious goals must be supported by audacious actions!

Let me cite two reports that demonstrate the need for action, not just at the top, but at every level of the organization, and for every level of the organization to understand that those at the top –

executives and their boards of trustees as well as clinical leadership – take infection prevention very seriously.

In a 2007 poll of infection prevention professionals by ***Medical News Today*** conducted six months after the Association for Professionals in Infection Control and Epidemiology's (APIC's) national MRSA Prevalence Study revealed troubling comments. While 59% of the 2,100 who responded were adopting, or have already adopted, interventions to address Methicillin-resistant Staphylococcus Aureus (MRSA), 50 percent said their health care facility is not doing as much as it could or should to stop transmission of MRSA. What an incredible finding as we worry about the next pandemic!

Only last month, in May 2009, Consumer Union issued a searing report entitled: "To Err is Human – To Delay is Deadly," noting that ten years after the IOM's report on medical errors as many as a million people may have died and billions of dollars have been wasted. That estimate is based on the IOM estimate of 98,000 deaths and medical error costs of $17-29 billion a year times ten since the report could find little at the national level to demonstrate that any of the Institute's recommendations had been adopted that would have allow tracking and collection of any efforts by hospitals or others to reduce medication errors and health-system acquired infections or improve physician competency.

These largely preventable infections and deaths are completely unacceptable! In the prophetic words of songwriter Bob Dylan, "how many deaths will it take 'til we know that too many people have died?"

A March 2009 report by R. Douglas Scott II, sponsored by the CDC's Division of Healthcare Quality Promotion; the National Center for Preparedness, Detection and Control of Infectious Diseases; and the Coordinating Center for Infectious Diseases entitled, ***"The Direct Medical Costs of Healthcare-Associated Infections in U. S. Hospitals and the Benefits of Prevention***," reviewed public medical and economic literature to provide a range of estimates for the annual direct hospital cost of treating HAI's. Using the Consumer Price Index for inpatient hospital services, the study estimated that the annual cost of HAI's to U. S. Hospitals ranging from $35.7 to $45 billion!

Furthermore, after adjusting for the range of effectiveness of possible infection control interventions, the benefits of prevention range from a low of $5.7 to $6.8 billion if only 20% of infections are preventable to a high of $25.0 to $31.5 billion if as many as 70% of infections are preventable.

Recently passed state hospital infection disclosure laws should begin to increase public accountability on Healthcare Acquired Infections (HAI's). Some 26 states, including Massachusetts, now have mandatory reporting systems for HAI's. All of these states require

public disclosure of hospital specific rates of select HAI's, and 12 states (CO, FL, IL, NY, NH, OH, OR, PA, RI, SC, TX, and VT) require systems to validate the data for accuracy.

Preliminary evidence collected in Pennsylvania – the only state currently reporting all types of HAI's – shows public reporting is an effective tool in reducing infections. Pennsylvania's overall infection rate decreased by 8 percent after two consecutive years of reporting comparable infection data.

Massachusetts recognized in both Chapter 58 of the Acts of 2006, our landmark Health Reform Law, and Chapter 305 of the Acts of 2008, our Quality Improvement and Cost Containment initiative, that preventing infections was a major key to the sustainability of our first-in-the-nation comprehensive expansion of access to health care. The Legislature has appropriated over $2 million toward establishing a statewide infection prevention program.

As of July 2008, the 74 Massachusetts acute care hospitals were required to report data on HAI to the Massachusetts Department of Public Health and to the Betsy Lehman Center through the CDC's National Healthcare Safety Network (NHSN) surveillance system. DPH compiled the data for the first four months, and presented a preliminary report of the aggregated data to the Health Care Quality and Cost Council in April 2009. However, since the data only covered 4 months of reporting, the numbers were small and therefore no conclusions could be drawn. Specific hospitals were not identified in the report. The next report is due out in February 2010, which will include hospital-specific data, at which point some trends should be identified.

As the Obama Administration and lawmakers in Congress are working on legislation to address the rising cost of health care and expand access to coverage, reducing medical harm -- including hospital-acquired infections and medication errors -- would not only improve patient care but also provide significant cost savings to help make expanded access to health coverage possible.

One way for the national health reform law to improve quality and contain costs, I believe, would be to require that all health care providers – acute and non-acute hospitals, ambulatory surgical centers and, perhaps even, physician group practices – to utilize CDC's National Healthcare Safety Network surveillance system for all types of HAI's. Furthermore, the federal government should establish national requirements for the validation of the data submitted.

While the public waits for full implementation of the Massachusetts Infection Prevention public reporting, or for any new federal requirements that are being discussed in national health reform, there is no valid reason to delay taking proven – largely low tech – steps to improve the safety of all patients.

- First, let's finally implement Dr. Holmes' plan for hand-washing! "National Clean Hands Week" is celebrated this year during the week of September 20-26, 2009 – three

months from now. Some of our hospitals, as today's Infection Prevention report highlights, have already reported success in this area, and they can serve as role models or coaches for others in their regions. Couldn't the MHA, the Coalition for the Prevention of Medical Errors, the Betsy Lehman Center and the DPH set a goal to advocate hand-washing by every staff member, patient and visitor to launch a renewed organizational effort to raise compliance with hand-washing protocols? Are doctors, nurses, and other hospital staffers really too busy, too distracted – or worse, too arrogant – to wash up?

- Second, why can't every surgical unit in hospitals and ambulatory surgical centers pledge not later than October 1, 2009 to follow guidelines to prevent surgical site infections such as providing antibiotics within an hour of surgery and continuing antibiotics for the recommended time after surgery? And is there any valid reason why the pledge cannot be followed by active enforcement of the policy?
- Third, why can't all of our acute care hospitals expand their infection prevention activities to move beyond reporting one or two types of infections to all types of infections by the time of the release of the next state infection report early next year? Now that would be an audacious goal!
- Fourth, why can't other Massachusetts health care providers such as skilled nursing facilities, ambulatory surgical centers, and physician practices, led by the Department of Public Health, the Coalition and the Massachusetts Hospital Association embrace the infection prevention priorities?
- Finally, why can't we begin planning now for even more audacious goals and launch a major initiative for all health care institutions and providers for a concerted effort to prevent infections to accompany the next state infection prevention report when it is released early next year?

These questions are not intended to be rhetorical! If we are truly committed to "audacious goals," quality and safety – especially infection prevention – must be the top priority for Massachusetts' leaders in hospitals and other health care settings.

How many patients must die needlessly before everyone gets serious about preventing Healthcare Associated Infections? How many scarce healthcare dollars will be spent – and wasted – before we finally put an end to extended hospitalizations resulting from preventable infections? In Bob Dylan's words, are the answers to these questions going to continue "blowin' in the wind" for another decade or more? In the presentations that follow this morning, and in our collective response to those presentations when we return to our respective institutions, the question we must answer is whether Massachusetts health care providers can finally get serious about preventing of infections. Our answer must be a resounding, "Yes, We Can!"