

## Several HAI initiatives begin to show results

The prevention of hospital-acquired infection (HAI) continues to gain national attention from the media and, of late, numerous state legislatures. However, many independent initiatives have been engaged in the battle against HAI for some time. And several are showing signs of progress.

### **Committee to Reduce Infection Deaths**

The Committee to Reduce Infection Deaths (RID) was formed to push hospitals to be responsible for infection prevention, educate patients about the risk of HAIs and alert the public about hospitals that have high nosocomial infection rates. RID hosts forums for lawmakers, health care professionals and patient advocates to educate them about how to prevent infection and how much money it will save them. RID also partners with lawmakers on passing hospital reporting legislation and with health insurers to provide incentives for hospitals to lower their infection rates. In addition, RID encourages medical and nursing schools to teach their students about the importance of preventing the spread of bacteria when working with patients.

### **Institute for Healthcare Improvement**

Based in Cambridge, Mass., the Institute for Healthcare Improvement (IHI) launched a landmark campaign in December 2004 to save 100,000 lives in U.S. hospitals by June 14, 2006.

More than 3,000 acute care hospitals in all 50 states and the District of Columbia joined the campaign, which is demonstrating remarkable achievement in patient care. Twenty hospitals enrolled in the campaign, for instance, have had no cases of ventilator-associated pneumonia (VAP) in a year or more. VAP is a leading killer among HAIs.

The campaign asks participating hospitals to focus on six quality improvement changes. And while not all of the six are specifically related to infection control, three of them – prevention of central line, surgical site and VAP infections – are.

The results of the initiative proved to be more effective than expected. An estimated 122,300 lives were saved by the end of the campaign. This number was calculated by subtracting actual deaths from expected deaths after adjusting for changes in patient volume and risk. This campaign proved how many lives can be saved through preventive measures.

### **Pennsylvania Health Care Cost Containment Council**

The Pennsylvania Health Care Cost Containment Council (PHC4) began a groundbreaking study of HAI rates among 173 Pennsylvania hospitals in 2004. The results of the study show that the cost of HAIs in Pennsylvania alone exceeds \$2 billion in additional costs each year. The study has been instrumental in bringing HAI to the forefront of the national health care dialogue. In fact, the PHC4 study is largely responsible for legislation making HAI reporting mandatory in at least a dozen states.

## **StopHospitalInfections.org**

While the lion's share of HAI prevention initiatives has risen from within the health care community, one consumer-driven program of note is StopHospitalInfections.org, a Web site sponsored by Consumers Union, the nonprofit publisher of Consumer Reports. The site is designed to inform consumers about the prevalence of HAI and encourage voluntary and legislated reporting of HAIs by hospitals nationwide.

The Web site takes a consumer-oriented approach including an online petition for hospitals to make HAI data available to consumers, an opportunity for people to share HAI stories and a clearinghouse for HAI-related news.

## **National Quality Forum**

The National Quality Forum (NQF) is a nonprofit membership organization that includes health care providers, consumers, employers, insurers and other stakeholders working to develop and implement a national strategy for health care quality measurement and reporting. In a 2003 report titled "Safe Practices for Better Healthcare: A Consensus Report," NQF endorsed 30 patient safety practices to reduce the incidence of HAIs and inform patients of the hospitals that have the best records.

## **National Patient Safety Foundation**

The National Patient Safety Foundation (NPSF) has teamed up with the American Hospital Association (AHA) and the American Medical Association (AMA) to create a brochure, "Preventing Infection in the Hospital – What you as a patient can do," as part of the NPSF's Stand Up for Patient Safety project. The brochure is meant to be a resource for patients to take an active part in safeguarding their health while in the hospital. It encourages patients to have an open dialogue with the health care staff and stresses sanitary practices patients can employ to reduce infection. The Stand Up for Safety project provides other educational tools and programs and sponsors conferences on safety topics. NPSF, along with several other partners, also sponsors the Patient Safety Leadership Fellowship to bring together senior health care leaders for an intensive year-long program to advance patient safety science.

## **Joint Commission on Accreditation of Healthcare Organizations**

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) evaluates and accredits more than 15,000 health care organizations and programs in the United States. Since 1951, JCAHO has maintained standards that focus on improving the quality and safety of care provided by health care organizations. JCAHO's comprehensive accreditation process evaluates an organization's compliance with these standards and other accreditation requirements. JCAHO is actively involved with preventing HAI through two major initiatives: National Patient Safety Goals and Three Things You Can Do to Prevent Infection: A Speak Up Initiative. The National Patient Safety Goals consist of 14 objectives that address health care-associated infection, patient involvement and the reduction of influenza and pneumococcal disease. Recently, JCAHO announced the approval of an infection control standard that requires accredited organizations to offer influenza vaccinations to staff with close patient contact. Beginning on Jan. 1, 2007, this measure will be required of all critical access hospitals and hospital and long term care accreditation programs in order to receive accreditation from JCAHO.

## **American Society for Healthcare Risk Management**

Formed to advance safe and trusted patient-centered health care delivery, the American Society for Healthcare Risk Management (ASHRM) promotes proactive and innovative management of organization-wide risk. In May 2006, ASHRM began hosting a Patient Safety Curriculum consisting of three sessions intended to educate health care risk professionals on patient safety. The sessions address varying topics including patient safety awareness, effective communications, reduction in human error and planning patient safety programs.

## **Agency for Healthcare Research and Quality**

The Agency for Healthcare Research and Quality (AHRQ) has given grants to organizations such as the Pittsburgh Regional Healthcare Initiative, the University of Pittsburgh and other research organizations to study the implementation and use of patient safety reporting systems to refine how to translate the information listed in patient safety reports into knowledge for health care workers. The grants allow researchers to identify and implement the most effective strategies for preventing HAIs. In a recent report titled "Making Health Care Safer: A Critical Analysis of Patient Safety Practices," the AHRQ sought to investigate the prevalence of safety problems in varying practices, as well as investigate what they were doing to eliminate these problems. It also looked at data on the financial impact the problem was having on institutions. The results of the study are to be used by the National Quality Foundation to compile a list of proven patient safety practices that should be used by hospitals.

## **Centers for Medicare and Medicaid Services**

The Centers for Medicare and Medicaid Services (CMS) and Premier Inc. (a nationwide organization of nonprofit hospitals) have teamed up to form the Premier Hospital Quality Incentive Demonstration, a program that rewards top-performing hospitals by increasing their payment for Medicare patients. The hospitals will be rated by data that evaluates 34 quality measures relating to five clinical conditions. The data then is collected by the CMS and publicly reported on its Web site. The hospitals that score in the top 10 percent for a given set of measures will receive a 2-percent bonus payment on top of the standard Diagnosis-Related Group payment for relevant discharges. The next highest 10 percent will receive a 1-percent bonus. After three years, the hospitals that do not meet a predetermined threshold score on quality measures will be subject to reductions in payment.

## **Centers for Disease Control and Prevention**

The Centers for Disease Control and Prevention's National Nosocomial Infections Surveillance (NNIS) system collects HAI information voluntarily submitted by hospitals using a standardized set of 13 types of HAIs. The CDC also has an established national risk-adjusted benchmark for HAI rates and sends back aggregate data to hospital infection control practitioners to help guide prevention efforts.

## **Voluntary Hospital Association**

The Voluntary Hospital Association (VHA) is a nonprofit network of community hospitals that establishes best-practice standards and encourages health care providers within their network to embrace them. One of its initiatives, "Transformation of the ICU Program," was designed to apply a uniform set of performance standards to ICUs in order to reduce VAP and central blood line infection. Almost 1,700 members participated. Many were able to lower their incidences of infections, while a few even reported no infections after participating in the program.

## **The Leapfrog Group**

The Leapfrog Group is an initiative driven by organizations that buy health care who are working to initiate breakthrough improvements in the safety, quality and affordability of health care for Americans. The voluntary program is aimed to improve the health industry through improving health care safety, quality and customer value and rewarding good results. The Leapfrog Group is well-known for its Hospital Quality and Safety Survey, which measures hospitals in 31 regions, covering almost half of the U.S. population. Leapfrog rates hospitals by using four hospital quality and safety measurements that determine health care provider performance comparisons and hospital rewards. The group measures quality by examining: computer physician order entry; evidence-based hospital referral; intensive care unit (ICU) staffing by physicians experienced in critical care medicine; and The Leapfrog Safe Practices Score, based on the NQF-endorsed Safe Practices. Leapfrog also has launched the Leapfrog Hospital Rewards Program – a new pay-for-performance program that drives improvements in hospital quality and efficiency in five clinical areas while demonstrating dollar savings as hospital performance improves.