{Transcript has been edited for clarity.}

Hospital Infection Reporting: Science and Policy Considerations

A Teleconference

Presented by the
Public Health Law Association
and the
Public Health and Policy Interest Group, Health Law Section
American Bar Association

Coordinator Good afternoon, and welcome to today's conference call. All lines will be in a listen-only mode during the presentation. Today's conference call is being recorded for transcription purposes. Should you have any objections, you may disconnect at this time. I would now like to turn the conference over to your host for today, Ms. Lori Spencer. You may begin.

L. Spencer Good afternoon everyone and welcome to this teleconference on Hospital Infection Reporting, Science and Policy Considerations. This teleconference has been organized by the Public Health Law Association and is also sponsored by the Public Health and Policy Interest Group of the Health Law Section of the American Bar Association.

My name is Lori Spencer. As of Friday of this week I will be of Counsel in Atlantic Office of Smith Moore LLP, where I will continue my practice representing hospitals and health systems in business transactions and in complying with federal and state laws. So you know my perspective, if not my bias on the topic we are discussing today is the implications for hospitals and health systems. I am also President Elect of the Public Health Law Association.

Today we are fortunate to have on our panel some of the leaders of what we might call a movement toward requiring public disclosure of healthcare infection information. I want to thank our panelists, Dr. P.J. Brennan; Ms. Lisa McGiffert; Mr. David Carvalho; and Representative Bob McCluskey for agreeing to make themselves available for this teleconference. I also want to thank Susan Steeg, Executive Director of the Public Health Law Association, for her hard work in coordinating this program.

Our program today will go like this. I will start off with some background information and then I will introduce our first speaker. Each speaker will present for 15 minutes and the speakers have all agreed that I will give them a two minute warning and a cutoff notice. So please don’t be

surprised if I interrupt the speakers. I will also introduce each successive speaker, just before they begin their remarks.

We are allowing time at the end of the presentations for questions and answers. So if at any time during the presentations you would like to send in a question, please do that by e-mail to Susan Steeg, who will be triaging the questions for us. Susan's e-mail address is ssteeg@phla.info. Again, ssteeg@phla.info.

I also invite you, if you haven't done this already, to check the Public Health Law Association's web site for teleconference materials. Our web site address is www.phla.info. I wanted to note too that Representative McCluskey is not on the line with us yet; he'll be joining us toward the end of the teleconference to make his remarks and then to participate in the question and answer session.

My last housekeeping detail is to ask all of the participants to please complete the evaluation that was sent to you as part of the call-in information. It's my understanding that you have to complete the evaluation if you are applying for CLE credits.

Let me turn now to starting the substance of our teleconference. I want to point out first that at least some of our speakers today will address what I refer to as healthcare-associated infections or HAIs. In other words, the universe is larger than just hospital acquired infections and may include infections occurring in other healthcare settings, such as outpatient clinics. Whatever the setting though, there is no doubt that HAIs are a major public health problem in our country.

The current estimates are that there are two million infections annually, in hospitals alone, accounting for 90,000 deaths and $4.5 billion in excess healthcare costs, annually. As you will hear from our speakers, this data has resulted in legislative initiatives in a number of states to require public disclosure by healthcare providers, of the incidents of HAIs.

At the forefront of this movement is Consumer's Union, which is actively advocating for mandatory reporting measures. Our panelist, Lisa McGiffert directs this initiative and will provide details of it for us, during her remarks today.

Also, as you probably know, at the end of February of this year, the Healthcare Infection Control Practices Advisory Committee of the U.S. Department of Health and Human Services issued guidance on the public

reporting of healthcare-associated infections. We're very lucky to have Dr. Brennan with us today; he is the chair of that committee.

More locally at the state level, Representative McCluskey of Colorado is currently sponsoring a Public Disclosure Bill in the Colorado legislature and Mr. Carvalho is step ahead and charged with implementing one of these laws in his state, Illinois.

All of our speakers today will address the signs and policy considerations behind mandatory hospital infection reporting. I want you to be aware that the group on the teleconference today is the largest group assembled so far for a teleconference produced by the Public Health Law Association, and we all hope that you will find it very useful today.

Our first panelist is Mr. David Carvalho. David is a Deputy Director of the Illinois Department of Public Health, responsible for the Office of Policy, Planning and Statistics. His office includes the role of health policy, health statistics, health systems development and rural health. He served for eight years as the legal and policy advisor to the Cook County Bureau of Health Services and four years as legal counsel to the Cook County Board president. He also served as legal counsel to the Illinois Speaker of the House. He has law and bachelor degrees from Harvard

University. Mr. Carvalho, let me turn the program over to you for your remarks.

D. Carvalho

Thank you, Lori. I am going to be working off of a PowerPoint presentation, which is available at the Web site. If you haven't accessed that, it will make the presentation a little less intelligible, but I will try to calibrate my remarks to those who might not have access to the PowerPoint.

The Illinois Hospital Report Card Acts (and there are two) start from the premise that consumers have the right to access information about the quality of healthcare. These acts were adopted in 2003, during the spring legislative session, with effective dates thereafter. My office is now charged with the implementation of those two acts. As in most states, in Illinois the legislature enacts and then one of the agencies of the government promulgates and disseminates rules and educates the public on their use.

Something interesting about this legislation; it also created an advisory committee, which was and is charged with being meaningfully involved in the development of the entire process, and I'll get to that in a moment. Let me say something about the context in which this all occurred. You're all

familiar with the Institute of Medicine report of a few years back regarding medical errors. In addition, our local newspaper *The Chicago Tribune* ran a series on hospital infections, a key article on the subject appeared in *JAMA* about that time and then advocacy efforts such as those from Consumer's Union and also some union organizations in Illinois, all came to gather in 2003, to take advantage of a real sea change in the political landscape in Illinois.

For the first time there was a Democratic governor (the first in 26 years) and leadership of the General Assembly became Democratic in both chambers. So some legislation that had been stymied in the past suddenly sprang free. It also created a more union-friendly environment, and the proponents behind the Illinois Hospital Report Card Act in Illinois were labor unions.

There were two bills passed -- for ease of reference I'll refer to them as Senate Bill 59 and House Bill 2202 (I'm on slide six). They were bipartisan measures. Senate Bill 59 was sponsored by a then not well-known sponsor, Senator Barack Obama, who now has gone on to the U.S. Senate. House Bill 2202 was advocated for by the insurance industry. In each case the responsibility for oversight of the legislation and implementation was given to the Illinois Department of Public Health.

Senate Bill 59 took effect in 2004. It provides for quarterly reporting, but also provided that nothing was to take place until regulations were issued. House Bill 2202 (although the act took effect in the summer of 2003) had a statutory set of deadlines that stretch into 2005 and 2006.

Senate Bill 59, which had been advocated for by the Service Employees International Union, had three principal provisions: a requirement of reporting of nurse staffing ratios and infection rates, some data reporting requirements and some whistle blower protections. I'll skip over the nurse staffing ratio requirements, other than to say that I think the theory was that if you collected nurse staffing information and you collected nosocomial infection rate infection rate information, you would see a connection. When we collect the data, we will see.

Senate Bill 59 required nosocomial infection rates to be reported in three categories: class one surgical site infections, ventilator associated pneumonia and central line related bloodstream infections. The issues that were to be addressed in the rules were the methodology, which procedures would be covered, the format of reporting, and the like.

House Bill 2202 took a slightly different tack and called for the reporting of the 30 conditions and procedures that demonstrate the greatest degree of variation in patient charges and quality of care. The theory there being to be meaningful for consumers, it made the most sense to require the dissemination of information where there was a great degree of variation. If there was a procedure or a condition where all hospitals had very similar data, that wasn't particularly useful to consumers trying to make choices. So the Department is charged with identifying those conditions that had the greatest degree of variation and reporting the volume of cases, the average charges, the mortality rates adjusted for risk, and the nosocomial infection rates.

The process for these two bills is very elaborate, very protective of the integrity of the data and protective of the providers who are sharing data. This was all the result of a negotiated process – once these bills were introduced by the insurance industry and the labor organizations, the hospital association came into the mix and negotiated with the parties, which led to the final bill.

So the process called for the Department to organize an advisory committee that consisted of 12 different constituencies, ranging from public and private hospitals to organized labor and the health insurance

companies. The statute required that the advisory committee be meaningfully involved in all aspects of the development of the report card.

I have several slides that give you the specifics about how the committee was supposed to be involved and ensuring that the methodology is transparent, both to the providers and the public; the data are valid and reliable and that all limitations with this type of analysis are indicated in the reports that are disseminated. Also, each provider has an opportunity to review the information before it's disseminated and that appropriate risk adjustment takes place.

In addition to the statutory objectives, the Department established certain objectives of our own for this process. We want to try to rationalize our data collection and make sure that we aren't asking for the same type of information four different ways from providers and that we rely to the maximum extent possible upon data that is already being collected. We wanted, subject to meeting the needs of the Act, to minimize the administrative burden on providers, to try to achieve consensus, as we moved forward, to try not to reinvent wheels, and to try to be sensitive to different circumstances. Illinois, as with many states, is incredibly diverse, with 400 or 500 or 600 bed academic teaching hospitals, 12 or 14

bed critical access hospitals in rural areas, and everything in between. We wanted to make sure that we're sensitive to those differences.

We also wanted to make sure that this process derived from practice and did not dictate it, except to the extent necessary. By that I meant, if everybody was generally collecting information in a particular way in their computer systems and we could work with that, we didn't want to come out with something that was going to require everybody to change needlessly. We want to derive from practice, not dictate it.

We also wanted to be mindful of the efforts going on at the federal level and at JCAHO on the same subject, so that we don't have our providers going off in four different directions, when trying to respond to, basically, the same issue. And ultimately we wanted an education and outreach campaign at the end of the process.

The process has been ongoing for about a year now and one of the first things that we discovered in the area of nosocomial infection provisions of the statute is that, frankly, there was a problem with the way the statute was drafted. That's not surprising, as an early statute. In particular, and I've got the language in the slides, but for those who don't have them, let me get specific here.

The statute called for individual hospitals to prepare a quarterly report that in addition to the nurse staffing ratios would report nosocomial infection rates for certain specified clinical procedures that would be established by our department, by rule, under three categories: class one surgical site infection, ventilator associated pneumonia and central line related bloodstream infections. The act further provided that we would only disclose infection rates according to the current benchmarks of the Centers for Disease Control's National Nosocomial Infection Surveillance program.

What we came to realize was that there were no benchmarks for all of the categories laid out in the statute and that the NNIS program was going to be supplanted by some future program. Our statute wasn't written to include successor programs. We used the expertise of the advisory committee that we put together to propose an amendment to the statute to deal with these constraints. So if anybody is considering using the Illinois statute as a model, first off, wait until it's amended.

We have an amendment that is working its way through this year's General Assembly. Our General Assembly meets through May and what we're hoping to do is get the statute changed in a couple of key ways.

First, to change the requirement for nosocomial infection "rates" to be infection related "measures," taking into account that there may be measures that aren't strictly speaking, "rates." The changes would also take into account that we may want to do more than just two or three measures and that we want to be able to pick from both outcome and process measures.

Our statute currently is focused on outcome measures. A lot of what's going on at the national level involves process measures and we see value in both. We still want to include outcome measures, but we want the flexibility to pick and choose from among the best of both. There are also a language change proposed to refer to catheter-related, rather than line-related bloodstream infections.

If you do have the slides, there wasn't a good way or I couldn't figure out a good way to show strikeouts and underlines. So if you're looking at the last four slides that show the proposed changes, the new language is underlined and in faded type is the language that would be removed from the old statute. At the end of the day, if these amendments are adopted, we will be able to select from among surgical procedure outcome measures and infection control process measures for surgical procedures and for ventilator-associated pneumonia.

We further provide that going along with that idea of not wanting to reinvent the wheel (and this was a negotiated point), we would select measures from among those already developed by a number of enumerated national organizations: CDC, CMS, AHRQ, JCAHO and NQF. The idea being frankly and humbly that Illinois might not necessarily be in a position to come up with better measures than these national organizations have developed through consensus.

L. Spencer — David, this is your two minute warning.

D. Carvalho — Great, I'm just about there. The value-added that we hope to bring is to provide for uniform <u>mandatory</u> disclosure, selecting from the menu of measures that have been developed by some of these national organizations. While their measures may be voluntary or illustrative, we will, with the advice of our advisory committee, select from among them and make them mandatory in Illinois. Also to clear up the problem about being tied to a requirement that they be reported in accordance with the current benchmarks of NNIS, the amendment simply provides that we provide guidelines to facilitate the interpretation of the measures, using whatever benchmarks might be available from national organizations.

While we're moving forward on the requirements for disclosure relating to nurse staffing ratios, we are also working on developing rules and regulations to implement the statute in Illinois as we propose to amend it. We're hoping to have the bill to accomplish the amendments pop out of the legislature in late May.

As Lori will note, I actually have a facilities planning board (CON) meeting that I'm popping in and out of. So I hope to get back on the call to field any questions at the appropriate time. Thank you very much for your attention.

L. Spencer — David, thank you very much. Hopefully you'll be able to join us for the Q&A session at the end. Our next speaker is Dr. P.J. Brennan, who is the Chief of Healthcare Quality and Patient Safety at the University of Pennsylvania Health System and Professor of Medicine at the School of Medicine, in the Hospital of the University of Pennsylvania. Dr. Brennan has served as Director of Infection Control for 11 years at the hospital and at other periods of time held the same post at the Presbyterian Medical Center and the Philadelphia VA Medical Center.

In his current role, Dr. Brennan is focused on medication safety, improving communications, facilitating the reporting of errors and near

misses and linking cost containment efforts to measures of quality. Under his leadership, his University Health System has implemented an online incident reporting system to enable rapid reporting and response to occurrences throughout the healthcare system.

As I mentioned, he was appointed recently by Secretary Tommy Thompson to serve as Chair of the Healthcare Infection Control Practices Advisory Committee, for the Department of Health and Human Services. Dr. Brennan is a Fellow of the Infectious Diseases Society of America and the Society of Healthcare Epidemiologists of America. Dr. Brennan.

Dr. Brennan

Thank you, Lori. My presentation is on the Web page and I will follow through that, and I'll speak to this issue from my perspective on the Healthcare Infection Control Practices Advisory Committee (HICPAC) and add some additional color from my experiences in Pennsylvania, where I co-chair the advisory panel that is making input to the Healthcare Cost Containment Council here on this issue.

When HICPAC first took up this issue in March of 2004, there were two states that has passed legislation requiring public disclosure, Illinois being the first and Pennsylvania being the second and there were four other states, Vermont; Virginia; Missouri; and California that were considering

legislation at that point in time. HICPAC recognized this as a significant and important issue that infection control professionals would want us to weigh in on. So we convened the writing group in April of 2004 and developed a draft document, with the goal of having a document ready for publication by early 2005 and we have met that goal.

The initial phase of the writing process was a literature review, conducted systematically by two members of the Division of Healthcare Quality Promotion at CDC, Linda McKibben and Gabriel Fowler. They were looking into the background on the issue of public reporting in general and made important contributions that have not ended up in the document, but we have submitted for publication to another place.

The result of their review, basically, was that there really has not been experience with this, and so that review did not lend itself to HICPAC making a recommendation either for or against public disclosure of healthcare associated infections, in an attempt to reduce the incidence of those infections. There certainly is experience in other areas, particularly in coronary artery bypass surgery, where the literature would suggest that in New York and Pennsylvania that public disclosure led to a reduction in mortality in those states, in cabbage surgery.

By July of 2004, as the writing group was moving forward with it's work and holding regular conference calls we learned — and if you're following this on the PowerPoint presentation on the Web site, you can see that by July four states had approved legislation with Missouri and Florida joining the club and three were still under consideration. By October of 2004 there were still only four states with approval, but in the interval between July and October, two states had rejected their legislation, Virginia and California, with Governor Schwarzenegger citing issues of the burden on organizations and the validity of the process and recommended that the regulators and the healthcare community collaborate on this issue. Legislation has subsequently been reintroduced in California.

By October, several other states had become interested in the issue and I'm sure Lisa McGiffert will comment on this, but Consumer's Union had been seeking support in some of those states. By February of 2005, the map of the United States was pretty well swept with states that were considering legislation, but still only four had approved the legislation. I understand that recently Virginia passed a bill requiring public disclosure and I believe that was the fourth attempt in the Virginia assembly to pass such legislation. North Carolina has been added to the group that is considering legislation, as well.

So now there are nearly 40 states that have either approved or have legislation under consideration or have considered it at some time in the past. So this is clearly a movement that has gained a foothold, quickly, and at least in terms of consideration in the legislature and public awareness has passed the tipping point. In terms of adoption it hasn't moved quite as far, but I'm sure that other states will join the club.

In terms of the status of our guidance document, our recommendations are complete and the document was first released in recommendation form at a consensus conference held in Atlanta, in early February. The document will be published in the *American Journal of Infection Control*, in the April issue, in its full form, with all of the background and we turn this around in about a year, which is a record pace for HICPAC.

The main points of the document are the following, and we made four specific recommendations and I'll get into those in a moment, but there are some background points that I want to touch on. As I said earlier, based on the research that was done by Linda McKibben and Gabriel Fowler, we found that there was insufficient evidence to recommend for or against public reporting of healthcare-associated-infection, so we did not take a position on that, but recognize that states and regulatory agencies are moving forward with this and felt that despite the lack of evidence, it

was important that HICPAC weigh in and that over time that we recognize that that evidence will develop as these reporting systems take hold.

This document then, with the lack of evidence, is a consensus opinion of HICPAC and represents a guide to best practices. We believe that it's a starting point in the process of public disclosure of healthcare-associated infections, not an end point. HICPAC intends to keep this on as an active project, considering new process and outcome indicators as it goes forward and we're forming a subgroup to deal with this issue and we expect to make additional recommendations as we go forward.

The document is not model legislation. I'm sure that Lisa McGiffert will address that, but the document, I'll say again, is not model legislation. We intend this to be used by policy makers, program planners, consumer advocacy groups and we expect that since it will be published in the infection control literature, that infection control professionals will function as conduits for this information to the policy makers.

We advocate that in the development process, specific goals, objectives and priorities should be identified for the reporting system; that measurable outcomes should be chosen; and that currently established methods of public health surveillance should be used. Many report cards

that currently exist are very thin, in terms of identifying the limitations of the system and so we believe that the endorsers or the evidence that supports the choice of indicators should be represented as part of these reporting systems, as well as the sources of the data. It should be a useful tool that organizations and individual clinicians can use as part of performance improvement in their organizations.

So the four recommendations of the document are as follows. The first is to use established public health surveillance methods when designing and implementing mandatory HAI reporting systems, and I'll elaborate on each of these recommendations, in a moment. The second major recommendation is that in the development process, persons with expertise in the prevention and control of HAIs, should be included at an early point in time and that they should have oversight and operational activity, in terms of the products of the HAI public reporting systems.

The third major recommendation is that both process and outcome measures should be chosen, as appropriate, based on facility type and that these measures should be phased in over time, to maximize the acceptability to the providers and usefulness to consumers. Then the final recommendation is the regular and confidential feedback of performance data, should be provided to the providers, prior to public release. We

don't believe that this should be a gotcha process; it should be about performance improvement.

I'll give a little more detail on each of these recommendations. The first one is to use established public health surveillance methods. Appropriate events or risk adjusted event rates should be selected for monitoring. That means that appropriate patient populations should be chosen, that standard case finding methods and data validity checks should be used.

Organizations may have to change the way they do their work and the resources that they provide for this work. Also, that the processes should be adequately supported and resourced, useful and accessible reports should be available for all the stakeholders; that includes the providers, as well as the public and the regulators. Finally, we do not advocate for hospital discharge diagnostic codes, as the primary data source for HAI reporting systems, because of difficulties in aligning the results of hospital coding with infection, actual infection occurrences in hospitals.

Under the second major recommendation, to create a multi-disciplinary advisory panel, we acknowledge that there are many stakeholders and that we should be trying to create a win/win situation in which stakeholders outside of healthcare and stakeholders inside of healthcare are able to

participate and create a mutually beneficial system. Controversies have existed over the methods and so it's important to include the stakeholders and those with expertise, who can best advise us on the methods, so that we're not conducting large-scale experiments at considerable cost and considerable risk, both to the public and the organizations, as resources are diverted to undertake these significant projects. The development group should be multi-disciplinary.

In terms of process and outcome measures, based on facility type, as I said the measures should be phased in over time. This will maximize acceptability and usefulness to the consumers. We've recommended three process measures and two outcome measures.

The process measures are central venous catheter insertion practices — for those of you who are not healthcare professionals, central venous catheters are large bore lines that are put into the large veins, usually of the neck and the chest, and there is well-established science on the practices that can lead to infection reduction. A second process measure is surgical anti-microbial prophylaxis and a third is influenza vaccination coverage for healthcare workers and for patients.

In terms of outcome measures, the selection of the outcome measures should be based on the frequency, severity, preventability, likelihood of detection and accuracy of reporting. Whether to use process measures or outcome measures has been a controversial point. It was clear to us as we developed our guidance document that there's a strong desire for outcomes on the part of the public. However, outcomes require more in the way of risk adjustment process measures, which are really binary issues. For a process measure you've either done it or you haven't, and risk adjustment is not necessary.

So we do advocate for the use of well-established outcome measures, but we think they should be linked to process measures. So for example, for central line associated laboratory confirmed bloodstream infections, practices such as the use of maximal sterile barrier precautions, large drapes and gowning and gloving by the clinicians, as they would in an operating room, is an indicator of good practice and the use of certain types of topical antiseptics is an indicator of good practice. So we're choosing both process and outcome measures, but linking them, where if the process is carried out correctly, the outcome should be a good one.

So we describe central line insertion practices, in terms of the linkage. For surgical anti-microbial prophylaxis, we're advocating in process measures,

reviewing the number of surgical patients who receive anti-microbial's within one hour of the surgery, the number of patients who receive anti-microbial prophylaxis in general and the number who have antibiotics discontinued within 24 hours of the surgery. This should be focused on certain types of surgery, not in a broad swath across all surgical patients, but focused on certain specific types of surgical procedures.

For process measures under influenza vaccination, we would look at the number of vaccinations given to patients or healthcare workers, over all of those who would be eligible in each of those separate categories.

If you're following along in the handout, the next item is the recommended outcome measures. As I've said there are two there, central line associated bloodstream infections, where we advocate for looking at a targeted population in intensive care units. This is something that hospitals should be doing already, and we make some specific recommendations as to the frequency of the surveillance of this process, and then we have specific recommendations for surgical site infections, and I don't think I'll go into that in greater detail.

Finally, regular and confidential feedback is necessary. Organizations should have the opportunity to respond to data, before it goes public.

Because what we really want to have is the opportunity for organizations to improve their performance, as soon as possible.

The document does not address the specific resource issues and there's a great deal of discussion about this in infection control circles, at present. So we do not address staffing issues, but we acknowledge that a quality reporting system requires adequate resources and I think will require consideration, on the part of organizations, as to whether they need additional information system infrastructure or additional personnel to carry this out. But in any case, key infrastructure must be available.

In terms of risk adjustment, we acknowledge that the use of outcome indicators is labor intensive. That is the nature of risk adjustment, but it doesn't correct for variability among data collectors. Unless the systems are validated, the risk exists that the better surveyors, the better reporters, may appear worse in public disclosure.

L. Spencer Two minutes, Dr. Brennan.

Dr. Brennan Okay, almost there. Some states have been considering including ventilator associated pneumonias and urinary tract infections. We have not recommended that those outcome measures be included in this

document, because of the vagaries of the definitions and at the outset we wanted to avoid ambiguity. So we've stayed away from those two, although certainly some states are moving in that direction.

So in summary, HICPAC has produced a document that we believe is starting point that we hope will be useful to legislators and regulators in a broad sense, in terms of giving them direction on where to start with outcome and process measures. At the consensus conference that was sponsored by APIC, CDC and the Council of State and Territorial Epidemiologists in early February, a conference that was mostly attended by health professionals, we found that the consumer viewpoint was very enlightening. We heard about the on the ground experience in five states and we reviewed the recommendations.

We had an enthusiastic presentation from the National Quality Forum that promoted an interest in developing a national standard. Because we believe it would be much better for the nation and for the healthcare industry for there to be a national standard on this reporting process, rather than 50 different standards. There was very little opposition from the healthcare professionals expressed, and in general a positive view of public reporting was heard.

Lori, I think I'll stop there, and handle the questions later.

L. Spencer — Great. Thank you very much. I'd like to turn now to Lisa McGiffert. Lisa is a senior policy analyst on health issues, with the Southwest Office of Consumer's Union and she is the campaign director for StopHospitalInfections.org, which is one of Consumer's Union projects.

Before joining CU, Lisa was a policy analyst and legislative coordinator for the Texas Senate Committee on Health and Human Services, where for seven years she was actively involved in the development and implementation of state health and human services policy. Since 1991 she has directed advocacy efforts in Texas, on access to healthcare for low income Texans, health insurance issues, quality of healthcare, prescription drugs and conversion of charitable hospital and insurance plans. Lisa.

L. McGiffert — Hello, good afternoon, it's good to be here. I wanted to start by giving you just a little bit of background about Consumer's Union. We are the publisher of *Consumer Reports Magazine* and that's how most people know us. We're very committed to giving consumers information about quality and performance of products and services, as you well know, but that includes healthcare services. We are very concerned about the lack of information about our healthcare system and are trying to improve that.

Our organization has done quality of care work in the way of hospital and physician report cards, in the states of Texas and California, over the last ten years. We have some new services, including a Web site called Best Buy Drugs, where we're trying to give consumers more information about quality of care, quality of drugs, effectiveness of drugs is what that site is about.

So a lot of people ask us, "Why are we working on hospital acquired infections?" To simply put it, it's because it's a serious problem, and because we believe that more can be done to reduce hospital acquired infections and healthcare acquired infections, and that our goal should be to stop them. That should definitely be the ultimate goal of everyone.

This is a problem that affects two million people, every single year, and everyone who enters a hospital for care is at risk, as one in twenty of them are predicted to get infections. These people endure prolonged stays in the hospital and sometimes suffer debilitating and long-term health consequences from their experience, and an estimated 90,000 of them die every year. Our organization, through our web site, has heard from over 300 people who have shared their stories with us about their experiences with a hospital acquired infection.

We're working on this issue because it costs our healthcare system $5 billion a year, at least, and a lot of people say that that's a low estimate. We would like to see those dollars spent on other things, other healthcare needs.

We want to raise public awareness of the problem. Well we find that almost everyone knows someone who had a hospital acquired infection. They didn't have any idea that there were two million other people out there, every year, having the same experience.

We are in this to try to give system that is working, obviously doing a lot of discussing and meeting and training on how to prevent these infections. We're here to give them a little bit of a shove. We want to get them to take action and come to point where they're actually making some strong changes to improve the quality.

We've found that there is a pretty incredible code of secrecy and protectionism around this subject. There is a general feeling in the healthcare community that the public does not have a right to know about this issue. For 30 years, the CDC, through their NNIS system has operated a small scale, voluntary, confidential system. I like to call it the

longest pilot project in American healthcare history and we think it's time to try to do something else, something a little bit bigger and a little bit bolder.

Confidential reporting has also had pretty dismal results at JCAHO, in their sentinel event reporting. It's not public by hospital, but you can go on their web site and see aggregate numbers since 1996 and you'll see how low they are. That is completely confidential.

In non-scientific terms, this is a no-brainer. All the evidence indicates that hospital-acquired infections can be significantly reduced by adherence to policies, most hospitals, already have in place. If they add other new strategies, like protocols to prevent surgical site infections, we can prevent even more of these. So one has to wonder, why is this happening? Why aren't people doing more? Why is this problem escalating over recent years, as most of the research shows it is? We think a lot of it is because of secrecy and the resulting lack of public awareness, and we want to change that.

A recent interview in Health Affairs, with a well-respected voice in Quality of Care, Don Burwick, with the Institute of Healthcare Improvement, has shown a shift in his thinking. He said, "I have

completely lost faith in the concept of confidentiality as an important asset in improvement. On the contrary, I think that the more public we can be about performance, the more we're going to get serious about making changes. It's not just about incentives, it's about learning." We think that sums it up, quite a bit.

As far as Consumer's Unions work in the states, we do have a movement and we do have a web site that we've created, StopHospitalInfections.org, along with this campaign. It has provided, become kind of hub of information for the public and for the media. We have a model law on that site. We did look at the Illinois law and used that as a basis, but we did change it quite a bit, and in subsequent discussions with CDC, we made a number of changes that Illinois is now trying to now implement, get changed in their legislation.

This year, more than 30 states, and as Dr. Brennan said, almost 40, are or have considered legislation. This has been a very bipartisan issue across the country, which has helped its popularity. But much of the work in the legislative arena, has come because consumers have contacted their legislators, they've told them about the problem. They're doing some educating with legislators and they're providing them with a model act to use. That's basically how this movement has spread across the country.

As has been said, there are four states that already laws in place and the Virginia governor just signed a bill in Virginia. Of those four states, Pennsylvania is the only state that's currently, actively collecting information. No states have given the public reports yet. So we're still pretty early in the process.

Several states that are considering legislation this year have turned these bills into study bills. They started out as reporting, mandatory reporting bills and they've become bills to study the issue. We don't think that's really necessary, and as you can see, through the Illinois example, most of the states or the four states that are working on this, are taking their time. They're using advisory committees, they're working through all the concerns of the stakeholders and trying to figure out a system that works best for them.

So our effort is focused on public reporting of hospital-acquired infections and we believe that awareness is the first step towards this change and a lot of what we're doing is education. We do believe that comparisons among hospitals will provide an incentive to change and there is some evidence that public reporting on other hospital quality indicators, has improved care in the past.

This is a very new area of work, so there's not a lot of research. Since no public reports on hospital infections exist, obviously there's no evidence that it works and it changes behavior. However, there have been some public reports in Canada and England and people from those countries indicate that they are seeing some results, based on those public disclosures.

We believe public awareness of the problem has been hindered, not only by secrecy, but by the use of unfamiliar or confusing terminology and that semantics are important to getting the public to understand. Consumers don't really know what nosocomial infections are, and frankly, this new term that's being used, healthcare-associated infections, is confusing to consumers. That's why you'll hear me use the term, hospital-acquired infections or healthcare-acquired infections.

Our campaign is focusing on hospitals, because that's where most of the work has been done, and there are a lot of problems. All the statistics you've heard today are about hospital infections, not healthcare-associated infections.

The first users of the quality information, of course, are going to be the hospitals, themselves. So they will have some internal incentive to bring about some change. Now we've seen that firsthand in our work in Texas and we know that hospitals look at this information and that they've never seen how they compare with their direct competitors. They have had some benchmarks available to them, but that isn't the same as having some comparisons with the hospitals in your community.

We know that consumers aren't the first users of this information, but there are some people that are using it. Certainly large purchasers use it, employers and insurance companies. We believe that eventually consumers will begin to use this, once they become more familiar with quality of care information. Public pressure does work, especially in an area where the system is stuck or resisting change and there is still quite a bit of resistance. We still hear from a lot of healthcare professionals who say, "It's not really that big of a problem. More people don't get infections than do infections." But we still think it's a very serious problem.

With regard to how states go about this work, and the CDC recommendations that Dr. Brennan just laid out, we think it would be a bad idea if states change their laws to specifically reflect these current

CDC recommendations. They are planning to modify them over time, so we hope that most of the states will use general language and keep the law flexible and use the advisory committees to decide when to make changes in what they collect.

There are many arguments against public reporting and I'm going to probably just have time to touch on a few. Since this is a lawyers group, I guess I should start on the liability issue, which always comes up. Liability issues have not been a big problem in other hospital quality report cards, or when data has been made available to the public. What we're asking for here are rates and percentages, not information on specific incidences. If someone chooses to sue because of an infection incident, they're going to have to collect the information, just like they do today. This information is not going to help them in their lawsuit.

Our recommendation is that the laws should prohibit identifying patients and also not identify healthcare professionals, but to identify the hospitals. There are several states whose laws have added some language that these reports do not establish a standard of care and we're supportive of that.

Finally, we are not doing this work to enhance lawsuits, but we're doing it to prevent them, by preventing infections, and that's our goal.

One of the other major arguments is mandatory versus voluntary. That it would be better if hospitals could just voluntarily participate and we think it's pretty obvious that that leads to incomplete information. Maybe you have participation, but all the participants aren't giving all the information. A voluntary system does provide an incentive for good performers, but necessarily for poor performance. We think that that will leave a lot of information undisclosed, with a voluntary system.

Someone has already raised the issue of the national versus state reporting. We think it's highly unlikely that we'll have 50 states, with 50 different systems, before we have a national system in place, and we think eventually we do need a national system. But frankly, there is not consensus about what that national system should look like.

States were the first ones to establish quality report cards, and it makes sense, because their information is more close to the source of the information, and also where the public gets their care. We think states do a better job at ensuring that hospital quality information is valid and reliable and we think that the states have an important role to play, as experimental laboratories for new laws and policies that eventually become national.

Further, we see no commitment by any national agencies or even organizations, toward a mandatory reporting system. We think that if Congress were to debate this, it would probably take many, many years to pass it and we want to see some state work first, to see how to do this. We believe that the states will come up with different ideas and that some of the states will have good ideas and some of them will try something that won't work. It's better to try this out on a state level, then to impose some national standard that isn't going to work in the public reporting system.

The issue of process versus outcome measures has been touched on. We have been a strong voice for outcome measures. Consumers want to know, are the infections being reduced or are they increasing? Are the prevention measures working? We believe that there has to be a measurement of how many infections there are, what the rate of infection is in the mix, and certainly the process measures are appropriate for the hospitals to know what they should be doing to stop infections. And it helps for consumers to know what hospitals should be doing to stop infections. But without the outcome measure, the result, the information is inadequate. So we support both outcome and process measures.

L. Spencer — Lisa, I'll give you one more minute to wrap up, please.

L. McGiffert Okay. The whole issue of confidential versus public, I want to touch on that. There's seems to be quite a bit of talk about keeping this information confidential and that's the best way to work, and we don't think that that has shown to work very well. There's been some recent discussions in *JAMA* about this issue, and even indicated that a lot of hospital CEOs will not even voluntarily participate if it's a publicly disclosed issue.

I'll end there. There are many other arguments against this. But as I said, we believe that the public has a right to know about these and has a role to play in pushing the system to improve their prevention measures. Thank you.

L. Spencer Thank you, Lisa. At this time I'd like to introduce our final panelist, Representative Bob McCluskey, represents Fort Collins, Colorado in the Colorado House of Representatives. He is the author of House Bill 1128, which is pending in the Colorado legislature and covers this very issue. He received an MBA from Stanford University, where he also received his undergraduate degree. We're very grateful to have you with us, and I'd like to turn the program over to you now.

B. McCluskey Well thank you, I'm happy to be here and have the opportunity to speak. Obviously I haven't heard the previous testimony, so I'll try not to go back into that, and just start from what I've done.

This bill came from an earlier …, The National Conference of Insurance Legislators meeting that had model legislation. I'd like to take the opportunity to thank Lisa, who has been very helpful to me and a great resource in this process.

What I tried to do in the last couple of years, here in Colorado, I've been the Chairman of the Colorado Healthcare Mandates Commission and on the Business Affairs House Committee. We've been looking at the cost of healthcare insurance and a lot of that has been torte reform, but when I heard this issue and thought maybe it's obviously a large enough issue that maybe there's a different way to approach it. As I got into the process and talked to more people, I think in Colorado, could make a difference. Again, not the whole answer, but a piece of what we're trying to do for healthcare insurance for citizens in Colorado.

What we tried to do is start with the model legislation and I've tried to have a lot of meetings with different parts of industry, hospitals, providers,

infection practitioners, to try to move forward and see how we could adapt it what we think works in Colorado. How can we do a better job?

I understand in some other states there have been some issues on implementation in trying to do. So I wanted to sort of learn from other people. I think one of the key issues, obviously, as I've worked with people here, is the advisory committee that we have. I think the makeup of that reflects a lot of different parts of the state, people involved in the issue, consumers, business people, carriers, obviously the infection control people, trying to get the right mix and balance, so that we do want good information to come out of this. We don't want to just put something up and think we've got it done. But we're trying to do it right, and by having the people that can understand the information and put it out.

Again, one of our goals, which we do here at the legislature too, is we deal with the public. I don't want to put out information that only people in the industry understand, but the lay people can look at and it's meaningful to them. So I think we have a committee, it's still going through the process in the legislature, so it might be changed more, but we're trying to get that right mix, so that when we get the information, we can put out meaningful data to the citizens of Colorado.

One of the questions that people ask me is, "What do the numbers look like?" Obviously you've heard national numbers, probably already from Lisa, but in talking to the state health department here, what they've identified, we started, we tried to respond a little bit to the whitepaper we saw in November, about how to go through the process and identify — we've identified three infections and then we're going to move beyond that in the future, if the committee thinks it makes sense.

But the numbers I have, from a state standpoint, the potential for the infections that we're talking about, in one year, are about $3 million, is what the state paid through Medicaid, so that's the taxpayer piece that has been identified in Colorado, that could make a difference. We also think the business people, the consumers, the carriers all have a piece of this, that if we could work towards reducing the amount of time spent in hospitals, because of infections, there is a value to a lot of parts of the state in Colorado, to do that.

Now again, as I'm sure that everybody knows, we're not talking about going to zero, that's not what the bill says. We think by focusing on this and doing it the right way, it should bring some numbers down and if we need to put more resources, in the hospitals into that area, that makes sense on doing that.

The other piece, obviously that I'm sure you've heard a lot of comment on, is the risk adjustment. We think it's very important, as we go through the process, to bring the numbers in to do that. So that's part of the bill, obviously, we think that's an important part. The makeup advisory committee, the risk adjustment, we've slowed down how often, twice a year, the reports we need to do and we've reduced the number of infections we're looking at. So we're trying to start on a basis that we think is sustainable that we can get good information on, and then as we move on, if the advisory committee feels we need to add some more to that list, that makes sense.

So I think we've tried to listen to industry in Colorado, we've tried to follow some of the comments in the whitepaper on this and we want to try to have, probably, one of the best programs in the country.

I again, will respond to the comments I heard earlier about the national program versus the state program. Well I know from a state level, we see a lot of issues that we hear the federal government is going to be working on, but my question is, "When?" The dollars I've seen on that $3 million I mentioned a minute ago, I think that if that's 11% of the costs we have in the hospitals in Colorado, that the potential is much greater than that. It's

a very conservative estimate on the kind of dollars we're working on, and I think the potential is very good there that we can do something to reduce the cost of healthcare in Colorado.

So I'm trying to respond to what I think my constituents — and it's interesting, as I've gotten into this process and I've talked to different groups at meetings and get-togethers, even groups that are not in healthcare, and when the issue comes up on what I'm working on, how many people have come to me and said, "Gosh I have a sister, I have a brother, a mother, a grandmother or a friend that have been impacted by this." Some of the stories we've captured, grab your attention, and again, I think the healthcare providers we have in Colorado do a tremendous job, but this just says, if in some areas if we feel that there's more cost and more benefits out there in the greater part of the state, we should identify those and work on those, do that.

So again, I think we're trying to take what's been done across the country and I think because of the way that the bill is setup we will have time to work on an advisory committee. If other states are making some progress, either on a different weight risk adjustment or on how they approach the issues, certainly we'll try to capture that and include that in our program.

One of the comments made earlier that I'll comment on too is, I am purposely not trying to specify in statute each thing that we do along this process. I think as healthcare changes and there's new ways down the road to work on issues, a statutory change is more burdensome. So I'm looking towards the advisory committee to be able to respond to that. If it comes out that there's a new infection two years down the road that the committee thinks we should really focus on, rather than putting all that in statute, I'm putting a lot of the value of what we're doing in that committee.

One point that people ask me about, the information that I've seen says that the hospitals have been looking at these, for probably over 30 years. It's not a new issue. I think some hospitals that I've worked with here in Colorado are on top of it and they're doing a great job. It's just that we need to make sure from all the other people that are paying the bills, that we're doing all that we can across the state.

Some of the hospitals asked me, "Does this mean that we can use this in marketing?" I think in a market economy, if you have a consumer that goes out and thinks that I need to have something done in a hospital and someone is doing a better job than others, they have less stays, less days, I think that's something that they should be able to be aware of.

So I guess with that, let me stop. Again, I don't know what all you covered before, but we are looking in Colorado, I'm trying to look to have a fair and balanced approach to the issue. I think by the makeup of the committee, although not perfect, that we're moving in the direction to get that input and be able to deal with it properly, so that we can put out something to the lay people in Colorado and say, "This is what it means." They can look at it and understand it, and hopefully if that makes a difference on where they decide to go have work done in the healthcare areas, I think that's great.

So let me stop at this point. I guess … see if you have any questions.

L. Spencer — Thank you very much for joining us on the panel and for your remarks. Let me ask the participants, please, to continue sending in their questions to Susan Steeg at ssteeg@phla.info. At this time I'm going to go ahead and begin asking the panelists some of the questions that we have received during their remarks.

The first question is for you Dr. Brennan. You said during your presentation that the guidelines were just the starting point. The

questioner wanted to know what additional work your committee was planning in this area.

Dr. Brennan We plan to consider other possible indicators and put those forward. We plan to stay on top of the subject area and learn from the processes that are going forward, and make additional recommendations, as they seem appropriate. Since we've put the recommendations out, we've had comment and debate from a number of quarters on issues such as why we didn't include hand hygiene, for example and why we didn't include ventilator associated pneumonias and urinary tract infections. We're going to reexamine those issues and make recommendations down the road, as appropriate.

L. Spencer We have another question about the issue, and I think any one of the panelists, actually could respond to this. The question is, as opposed to having the focus on public disclosure, what about approaching the issue from the standpoint of offering some kind of incentives for performance. There is documented evidence that providers respond to incentives. So why is the public disclosure approach preferable, if it is, to tackling this issue in the way that other kinds of issues have been approached, using incentive programs?

L. McGiffert — I'll take a stab at that. I think that what this person may be talking about is incentives in the way of pay. That certainly has been a point of discussion around the country, to pay for performance. But you first have to measure it, and we think that it's important, as a part of measurement. I don't know who would measure; I guess some agency would get the information and keep it confidential. How would you base the payment, if you didn't make the information public, on the performance outcomes? If there's a performance measure, generally people need to know about it, in order to know to pay for that performance or to provide incentives.

We think that obviously the public has a need to know, but I don't know that we're at the point now were we can tie percentages, I mean performance to payment incentives. The area is too new, at this point, in my opinion.

Dr. Brennan — Lori, I'll just comment that on this subject and on the issue of a national standard for this, CMS has already gone way down the road on the issue of a national standard in certain areas. It's not a great leap for CMS to adopt some of these issues as pay for performance indicators. In fact they have a demonstration project that has been completed already on surgical infection prevention that may find its way into pay for performance in the not too distant future.

So I can certainly envision these indicators becoming part of a pay for performance system. But the fact of the matter is, if you put something out in public, on hospital or physician performance, hospitals and physicians will respond. The question is will they be responding in the right way and to the right information. So it makes it critical that the details of the reporting systems are worked out in advance, so that important resources are not diverted in the wrong direction.

L. Spencer Would you elaborate a little bit more on what you mean by diverted in the wrong direction?

Dr. Brennan Sure. If the information that is put out on outcomes, for example, is not adequately risk adjusted, then the information that goes public, may cause an organization that might actually be performing well, but in a high-risk population, to expend resources on improving an outcome, and while we can always afford to improve our outcomes, it may not be the best place to put its resources, because it may actually be performing well, but it's misrepresented in the public report. So the details of the reporting system certainly do matter.

L. McGiffert I would just add that if you had a confidential, not public, pay for performance system, you'd have the same kind of issues that Dr. Brennan just raised. Note that the CMS system does include public disclosure and it is voluntary.

D. Carvalho This is Dave, I'm back on the call. Two other points would be that you could also cause, if you don't have adequate risk adjustment of course, cause people to shun dealing with high-risk populations. But also the question suggests that it's an either/or and I'm not sure that it's an either/or. First off, because if you had pay for performance and the payer was a public payer, at least in Illinois, the reimbursement rates would be public information anyway. So if you were making deferent payments, based on how people ranked on some of these measures, the fact that they were getting different payments, would also become public.

B. McCluskey Let me add that we have to realize who are paying these costs now. If you have the public, either through Medicaid or individual businesses or consumers are paying these costs, it's not clear to me that you should have to pay an incentive to bring the numbers down. I would hope the marketplace, if there is competition in a particular market, can look at these and they would be rewarded by doing that. But realize who's paying the cost now. But I do agree, risk ….

Dr. Brennan What is being proposed by CMS is not an additional cost, as it's going forward in Medicare, it's really level funding that's being put forward, a small portion of which, is being proposed to be redistributed to better performers, away from lesser performers.

L. Spencer Anything else on that point? Lisa we have a question directed to you. The questioner said, "You mentioned that you found strong public support for outcome information." The questioner wonders, where you found this strong support and if you could describe that in greater detail.

L. McGiffert Well the support is in wanting to find out where the infections are occurring. Our campaign is basically based on public disclosure, and we have gotten quite a strong response from the public on the issue of disclosing this information. People want to know whether their hospital has a higher incident rate. They want to know if their hospital is safe, safer than maybe another hospital.

As far as scientific numbers, surveys of the public, we've not done that, but we do know that this issue has resonated strongly with the public and that that is why legislation has been filed across the country, because people are feeling like they should know what the infection situation is in

their different hospitals. How well are the hospitals doing at controlling infections. That's the strong response that we've seen, in our work.

L. Spencer This question is also directed to you, but I think any of you could respond. The question says, "State budgets are strapped all over the country, are the state agencies charged with setting up reporting systems receiving new funding for the programs?"

D. Carvalho In Illinois I can speak to that.

L. Spencer Did you write that question?

D. Carvalho No, as a matter of fact, no I was unfunded and so we are actually quite strapped for doing this. One of the things that is part of our bill that would fix the legislation, is one that would also allow us to charge for our discharge data, charge commercial entities that want to purchase discharge data from us, with the idea that those resources would then be devoted to funding the report card.

B. McCluskey In my bill, the way our state legislature runs, is you have to put in costs, if there are additional FTEs or people that were needed to do the program. That is part of the bill. I think there's always discussion on how much the

cost will be on it, but we will provide more funding to do it. The initial look at it though is, if it costs us $250,000 a year, to save at least $3 million in Medicaid costs, most business people would say that that's a pretty good return.

L. Spencer Representative McCluskey, there's a question for you, which is, "Discuss what you did to build consensus around your bill."

B. McCluskey Okay, I'm happy to do that. How did we build consensus? Well the approach I have to legislation, which I do on all my legislation, is to reach out to people that are affected by it, and in industry that are doing it already. That way, rather than just taking an idea and trying to make it law, I talk to people that are actually doing and saying, "If we could improve upon the bill, how would you do it?"

We have had a lot of changes to the bill, a lot of amendments to the bill, and again it's not completely through the process yet. I feel though that most of the people in the industry understand the bill now, they understand the direction we're going, we're getting more support for it all the time. It's been sitting in appropriations for some time now, so it will come out in the next couple of weeks. But I think the going consensus, I have reached out, originally when we drafted the bill, we were sending so many

copies out, I mentioned to our drafter that we might as well put it on the Internet.

My approach has always been to put it out to anybody concerned or interested or I think might be interested, take their input in and see if it moves the bill in a positive direction. We've had a lot of good input, I'd say, and that's how we build consensus around it. There are still some issues, I'm sure a lot of the groups would still like to change the makeup of the advisory committee. I try to take the broad view of the constituents in Colorado and say what we'll give is the best product and that's how I've built consensus on it.

L. Spencer Thank you. Another questioner has asked, "What methods are available to assure complete, consistent and accurate reporting, so that organizations can be compared, fairly?"

B. McCluskey Is that for me?

L. Spencer Not to anyone in particular, but you'd be a good candidate for it.

B. McCluskey Well certainly as I've read the literature, there's a concern about under-reporting. I've seen that in some of the national data from the past, the

concern about, will you just report good information. Since we make it mandatory and we have penalties in the bill, for not reporting timely or accurately, there's an incentive to do that. I think that's necessary in a mandatory program that you have to have penalties. That's not the focus of the bill. We're not doing this to raise money from penalties, but we need to make sure that there is accurate and complete information provided by all the hospitals, so we can compare them on an apples-to-apples basis.

L. McGiffert I think definitely you need to build in some kind of a validation system and a feedback loop and get the information checked and have some checks and balances on the accuracy. See if it's going to work. I mean most of the literature out there about resistance is speculative, although there has been a recent survey of hospital CEOs in the *JAMA* magazine that says they won't report everything. So we may eventually have to find other ways to collect the information that doesn't require their cooperation.

Dr. Brennan I think the issue of validity is an important one. The NNIS system underwent a validation study and it was done on a relatively small number of hospitals and it was expensive and lengthy and time consuming. To

conduct validation on a state the size of Pennsylvania will be an enormous undertaking. So I think that that does remain a risk.

States have looked to CDCs NNIS system and the successor system, the National Healthcare Safety Network as possible solutions. But the application of those systems is more than just branding. I mean hospitals that participate in those systems undergo training and understand the definitions and participate in CDC sponsored conferences to ensure that they're doing things as they should be done. So validation, I think, is a definite hazard in these systems.

D. Carvalho Illinois as well included, we have very strong whistleblower protection for employees. So there's also bottom/up incentives for full disclosure.

L. Spencer Anything else on that point? Let me combine two questions. The first is, "What tools will a healthcare facility have outside of its individual public relations department, to share with the public, what policies and improvement practices they are implementing, to reduce the risk of healthcare-acquired-infections?" Related to that, there's a question about whether the Consumer's Union has tried to form alliances or work collaboratively with trade associations, like the American Hospital

Association, on these issues. So perhaps, Lisa, you could start first to address these questions.

L. McGiffert Well we've certainly had discussions with hospital associations in various states. We've been working with APIC and we're an active participant in their consensus conference. We'll work with any trade associations that ask to sit down with them. In the states, like I said, in a number of the states where we've been actively involved, we have actually participated in meetings where they've been present and met with them. So we're certainly open to that.

Our goal is to represent consumer's interests and the hospital association's goal is to represent hospital interests. Sometimes we can come together and have to sort of haggle over the details and come to some kind of consensus; we're certainly used to doing that, and are willing to do that.

We are also going to participate in the upcoming SHEA conference, which is an organization for epidemiologists and we are very open to working with other groups.

L. Spencer Is anyone aware of a particular means of communicating to the public?

L. McGiffert Well I think I will address that, because I think hospitals generally have no problem addressing the issues about their hospital, what's going on in their hospital, they do quite a bit of marketing. We think it would be a great idea if they included information about how they are preventing infections and what kinds of things they're doing. If they advertise those things, it allows the public to know what's going on. It might instill some confidence in the public. If the public is in the hospital and sees it not happening, they can call it to their attention. So I'm not sure whether the questioner is asking if there's going to be some kind of public funding for this. I don't know of any bills that are including that.

Some of the bills do include, as do many hospital quality report cards, they include an opportunity for the hospitals to insert comments and feedback into the report. I suspect that we'll see some of that.

D. Carvalho Yes, Illinois' legislation allows hospitals to insert that into their report.

L. Spencer Do you envision that some of these state laws will actually require the preparation of an action plan of some kind?

L. McGiffert Well most of these laws are not enforcement laws, and actually, I think there are laws in place now that require an action plan when a significant

problem is identified. Certainly the hospital policies require action plans, as a rule, if there's a problem. So I don't know if that's going to get any more attention.

M — I could envision that the report card information could come to the attention of the regulators. But as the previous speaker just mentioned, I worked at hospital eight years ago, where part of our action plan was putting armed guards at the surgery door and turning away surgeons who didn't wash their hands. So it's been around for some time.

L. McGiffert — I thought about getting an army of volunteers that could just be kind of nags. You know people that nag the workers to wash their hands and just kind of wonder around the halls and say, "Have you washed your hands?" Maybe that would work.

L. Spencer — We're getting near the end of our time, so I'm going to present this as our last question. That is, "Is the vision and expectation of the group that over time, the reporting will really be required of primarily or exclusively hospitals or that we will see reporting from other kinds of healthcare entities, nursing homes and the like?"

Dr. Brennan HICPAC believes that the methods are likely to be applicable to healthcare settings, outside of hospitals. We believe that the indicators that are chosen ought to be appropriate for the facility and as more and more care is provided in situations outside of an inpatient setting, that reporting ought to move into those settings. Some of what we've already recommended would be applicable in those settings, such as surgical site infections and a process measure such as influenza vaccination.

Now having said that, it's important to recognize that this would require some change in practice, in order to do that and we're not stepping away from that. We acknowledge, and in fact we think we should embrace the need for those changes, as our system changes.

D. Carvalho In Illinois we're moving in the direction — there's a bill in to require discharge data to be collected from ambulatory surgical treatment centers. There's a provision in the bill to include nosocomial infection rating reporting there too, but that provision is proving problematic, because I think on the outcome side, some of these measures are hard to translate from one setting to another, perhaps the process ones are easier, but in a surgical center, outpatient surgical center, you may not even know which surgical center is responsible for the — they may not even know that

there's an infection that occurs after the surgery, because the person may report it to another hospital.

L. Spencer — Anything further from the panelists?

L. McGiffert — Well the issue collecting this information on ambulatory surgical centers has certainly come up in quite a few states and so there is a recognition that ideally you would want to have an idea of how well they are doing it, at preventing infections. We think that would be a good idea, but it does create some problems. I believe that long-term care facilities, like nursing homes, already do have some sort of reporting mechanism for infections, in their facilities.

L. Spencer — Well I'm very mindful of our time and I'm very appreciative of the time the panel members have already given. I want to thank you, once again, very much for participating in this teleconference today. Thanks to all of the participants, and I greatly appreciate the time and effort all of you have made. So we will signoff at this time. Thank you very much.

Coordinator — Thank you all for joining today's conference call. Have a good afternoon. You may disconnect your lines at this time.