

**National Action Plan to Prevent Healthcare-Associated Infections:
Roadmap to Elimination**

Stakeholder Call

**April 19, 2012
3:00 PM CT**

Coordinator: Thank you for standing by. At this time, participants are in listen-only mode. At the end of the presentation, there will be a question-and-answer session. You may press Star 1 on your touch-tone phone if you'd like to ask a question.

Today's conference is being recorded. If you have any objections, please disconnect at this time. Now, I'll be turning the call over to Dr. Don Wright, Deputy Assistant Secretary for Health in the U.S. Department of Health and Human Services. Sir, you may begin.

Dr. Don Wright: Thank you and good afternoon. As was said, I'm Dr. Don Wright, Deputy Assistant Secretary for Health and today's host.

Let me begin by welcoming to you to today's stakeholder phone call announcing the release for public comment of the National Action Plan to Prevent Healthcare-Associated Infections: Roadmap to Elimination.

Dr. Howard Koh, Assistant Secretary for Health, will lead off today's discussion. Dr. Koh serves as the 14th Assistant Secretary for Health for the U.S. Department of Health and Human Services. As the Assistant Secretary for Health, Dr. Koh oversees the Commissioned Corps of the U.S. Public Health Service as well the Office of the Surgeon General.

He also serves as a Senior Policy and Public Health Advisor to the Secretary. He leads an array of interdisciplinary programs relating to disease prevention and health promotion, including the reduction of health disparities, women's and minority health, HIV-AIDS, vaccine programs, physical fitness, sports and nutrition, bioethics, and population affairs.

Most relevant to today's call, Dr. Koh has provided strong leadership and commitment to the HHS effort to reduce, prevent, and hopefully someday eliminate healthcare-associated infections. Dr. Koh?

Dr. Howard Koh: Thank you very much, Dr. Wright, and welcome, everyone. It's great to have so many colleagues on this call.

I am absolutely delighted to have the privilege of reviewing for you some of the progress in the very exciting national initiative driven by the Department of Health and Human Services Action Plan to Prevent Healthcare-Associated Infections.

You all know that healthcare-associated infections, or HAIs as we call them, are defined as infections acquired while receiving care for other conditions.

Let me quickly review the history of this very exciting initiative. The first HHS HAI Action Plan was unveiled in 2009 and referenced in the Affordable Care Act of 2010. It subsequently catalyzed the development of 50 related state HAI action plans across the country. The goal of Phase 1 work was to prevent HAIs in hospital settings. We're very proud of this cascade of national commitment dedicated to promoting public health. It aligns with much of the recent work of the department with respect to building better systems of prevention.

This morning at 9 o'clock, the department announced the availability of a revised, updated, and expanded HAI Action Plan, which now extends to Phase 2 activities with the goal of also preventing HAIs in nonhospital settings and increasing flu vaccination of healthcare workers. To access the plan, simply visit hhs.gov/ash. A link on that home page will take you directly to the plan.

As the Assistant Secretary for Health, I am very proud to help the department and the country move toward transforming healthcare from a system focused almost solely on treatment, sometimes delivered late, to one focused on prevention delivered as early as possible. I am very committed to this mission, not simply as the Assistant Secretary but also as a former professor, state health commissioner, and clinician who has cared for patients for over 30 years.

I want to remind everyone on this call that prevention is the focus of Healthy People 2020, the nation's goals and objectives for a healthier nation that has served as a road map and a compass for the past 30 years. We unveiled Healthy People 2020 several years ago saying that we needed 2020 vision for a healthier America. And reducing healthcare-associated infections is a major Healthy People focus area and, therefore, represents a health target for the entire country. In fact, there are specific HAI objectives such as reducing central line-associated bloodstream infections (CLABSI) and Methicillin-Resistant *Staphylococcus aureus* (MRSA) by 75 percent by the beginning of the next decade.

Such goals are both aspirational and achievable. Reaching them can be extremely challenging when they involve changing behavior for busy professionals and large complex institutions such as hospitals.

But we owe it to our patients to reach these goals because people enter hospitals expecting to become healthier, not sicker.

And, furthermore, these crucial efforts build the trust that patients must have that the healthcare system helps them and does not harm them.

You all may know that, at any given moment, one in 20 hospital patients suffers from a healthcare-associated infection related to their ongoing care.

So, eliminating HAIs is a commitment that we need to make as a nation to promote prevention and uphold trust.

Today, just three years after the unveiling of the first HHS HAI Action Plan in 2009, we have witnessed striking reductions in key outcomes that we can attribute to rapidly changing professional behaviors.

These declines demonstrate that, as a nation, we are moving toward an improved culture of patient safety. Adherence to proven preventive practices is rapidly becoming the standard of care.

We have achieved these outcomes with the partnership of so many of you who are on this call today, so we are grateful to all of you.

Because of the work of so many, we have witnessed a triple win: a win for patients, a win for American healthcare, and a win for public-private partnerships.

For today's call, I'm honored to be joined by a number of outstanding leaders here at the department who have made valuable contributions to this progress.

First, Dr. Denise E. Cardo, Director of the CDC's Division of Healthcare Quality Promotion and the National Center for Emerging and Zoonotic Infectious Diseases, will quantify some of these recent successes. She will discuss the findings of the CDC's 2010 National and State SIRs report, which is also being released today.

Next we'll hear from Dr. Bill Munier, Director of the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality. He will review AHRQ's latest Comprehensive Unit-Based Safety Program (CUSP) for central line-associated bloodstream infections.

Both speakers will share their thoughts on recent progress and the important work that's still ahead of us.

Then, our moderator, Dr. Don Wright, Deputy Assistant Secretary for Disease Prevention and Health Promotion, who has spearheaded the HAI initiative since its inception, will describe the updated, revised HAI Action Plan that was released this morning, with an emphasis on work for the next phase which is reducing HAIs in nonhospital settings and increasing flu vaccination among healthcare workers.

I want to acknowledge Dr. Wright's superb leadership. Because of his oversight, the department's HAI initiative has become a model for us of how we can work together to build national infrastructure and operational excellence.

Then, last but certainly not least, we'll be hearing from Dr. Paul McGann and Mr. Dennis Wagner who are Co-leaders of the Partnership for Patients, the HHS initiative unveiled a year ago.

We are very excited about this new Partnership for Patients initiative that promises, first, to reduce preventable hospital-acquired conditions by 40 percent and, second, to reduce hospital readmissions by 20 percent by the end of 2013 compared to 2010. Dr. McGann and Mr. Wagner will describe how the Partnership for Patients can accelerate progress against HAIs in the more than 4,000 hospitals that are now full partners in this initiative.

There are so many on this call that we want to thank, so many partners who have made contributions both to this effort and to catalyze progress across the country. Just to mention two organizations, the Association of Professionals for Infection Control and the Society for Healthcare Epidemiology of America, among so many others, have been responsible for this progress.

We're thrilled to share this progress report with all of you today, as well as with some 8,000 partners who are part of the Partnerships for Patients. And that includes the 4,000 hospitals that we know will carry this information to employees and patients to send a message about why combating HAIs is everyone's business and how we need to go about it in the future.

We are very pleased that accelerating progress at this time will make a vital difference in people's lives at a time when it matters the most.

So, thank you so much for all your work up till now, and for redoubling your efforts for the future. We at HHS look forward to receiving your comments on this updated action plan unveiled this morning at ohq@hhs.gov. And I personally look forward to working with each and every one of you to improve patient safety in American healthcare for the future.

Now, I'll turn it over to Dr. Cardo of CDC.

Dr. Denise E. Cardo: Thank you, Dr. Koh. Today the CDC released a [new report](#) that demonstrates national progress on the metrics included in the National Action Plan to Prevent HAIs--for central line-associated bloodstream infections, catheter-associated urinary tract infections, and surgical site infections.

In addition to national progress, the report also includes state progress on central line-associated bloodstream infections for each of the 50 states.

The data in the report were submitted by hospitals to CDC's National Healthcare Safety Network, or NHSN, which is currently being used by almost all the hospitals in the United States to track and prevent healthcare-associated infections.

We're seeing major prevention progress for many healthcare-associated infections in U.S. hospitals. For central line-associated bloodstream infections, there is a 33 percent overall reduction compared to the baseline in 2008, with 35 percent reduction in adult intensive care units, 31 percent in neonatal intensive care units, and 28 percent reduction in all other hospital units. This is a major accomplishment.

We also are reporting 8 percent reduction in surgical site infections and 6 percent reduction in catheter-associated urinary tract infections when compared to the baseline.

For central line-associated bloodstream infections, I'm very happy to say that 21 states had significant reductions between 2009 and 2010.

This success has contributed to the progress we have seen on the national level. This is very good news.

It represents the work of state health departments, state hospital associations, quality improvement organizations, hospitals, experts in infection prevention, clinicians, patient advocates and many of you on the telephone today.

The report also highlights that more needs to be done. While we're seeing a lot of progress, for example, in surgical site infections, the progress is related to a few procedures in which we saw reductions. It's important to look at the data so we can also focus on future prevention strategies to address not just a few procedures but all procedures that can cause infections.

More good news is that coordinated efforts in HHS, such as the Partnership for Patients, can accelerate the successes we are seeing now. This report demonstrates the value of having clear national goals and a systematic way to track progress and to identify gaps in HAI prevention.

Together with colleagues in HHS, AHRQ, and CMS, we at CDC will continue to work towards the elimination of healthcare-associated infections and ensure that all patients receive the safest care possible.

Now I will turn to Dr. Bill Munier from the Agency for Healthcare Research and Quality. Bill?

Dr. Bill Munier: Thank you Dr. Cardo. Well, we're here today because preventing healthcare-associated infections is a very high national priority. Over the past several years, the Agency for Healthcare Research and Quality has demonstrated a sustained commitment to supporting this priority. We do, of course, work closely with our partners across the department and with the private sector. You just heard about statistics that show we are having a great deal of success preventing one of the most common complications of hospital care that patients face.

Since 2007, AHRQ has awarded over \$95 million for projects that are focused on the prevention of various HAIs, including central line-associated bloodstream infections, catheter-associated urinary tract infections, surgical site infections, ventilator assisted pneumonia, MRSA and *C. difficile* infections.

The national goals and benchmarks established by the Action Plan to monitor HAIs are being supported by CDC's surveillance system, NHSN, which Dr. Cardo just mentioned as well as through AHRQ's Healthcare Cost and Utilization Project, or HCUP.

HCUP data have shown recently that, while many healthcare-associated infections have declined in the 2000s, the number of hospital stays associated with *C. diff.* infections is at an historic high, although hospital stays do not seem to be continuing to climb but seem to have leveled off.

In addition to testing promising solutions in the field, AHRQ has developed a wealth of practical evidence-based information and tools that clinicians and healthcare organizations can use today to improve care and reduce or prevent instances of HAIs. A prime example is the Comprehensive Unit-Based Safety Program, or CUSP, that promotes a culture of safety and improves communication and teamwork among unit staff members. CUSP includes tools, such as a checklist, to support implementation of evidence-based infection prevention practices, for example, hand hygiene or removing unnecessary catheters, that are based on guidelines from the CDC. Since 2009, AHRQ has promoted the nationwide spread of CUSP to reduce central line-associated bloodstream infections, or CLABSI.

This effort has been highly successful. The success is part of an overall picture of reduction of CLABSI rates nationally over the past decade. And you just heard the latest gratifying figures from Dr. Cardo.

It is, nevertheless, useful to look at the results from AHRQ's CUSP for CLABSI project specifically because it shows what can be accomplished by a focused effort to reduce HAIs. In this project, CLABSI rates have been reduced more than 40 percent in participating ICUs across the country. This reduction is estimated to have prevented approximately 2,000 cases of CLABSI, saved nearly 500 lives, and averted over \$32 million in excess costs. Those figures are for the two years ending just last month in March. We just released them this month.

Building on AHRQ's success in the CUSP for CLABSI effort, other new CUSP projects will focus on catheter-associated urinary tract infections, surgical site infections, ventilator-associated pneumonia, and perinatal safety.

We also want to be sure that we acknowledge the primary role of Americans who work in hospitals. Doctors, nurses, and others such as infection control professionals, even people who clean hospital rooms, have had a hand in making these improvements real rather than just a goal. These people have adopted or developed successful new practices and implemented them consistently in thousands of hospitals across the nation. As a result, fewer patients have experienced infections and fewer patients have died unnecessarily. Without their work, none of the things we've done in Washington or Atlanta would have made any difference.

Finally, while it's important to promote the adoption of proven methods such as CUSP for reducing HAIs in clinical practice, it is also vitally important to advance our knowledge about HAIs so that tomorrow's prevention efforts will

be even more effective than today's. To this end, the National Action Plan has a research section that identifies the current gaps in knowledge and practice that need to be filled by further research studies to improve our efficacy and prevention.

I'd now like to turn the program back to Dr. Wright.

Dr. Don Wright: Thank you, Dr. Koh, Dr. Cardo and Dr. Munier. Let me begin by saying it's been my privilege to see this initiative gain what can only be described as amazing momentum over the past three years.

The National Action Plan to Prevent Healthcare Associated Infections: Roadmap to Elimination serves as a guide for HHS's effort to reduce healthcare-associated infections, infections that affect one out of every 20 hospital patients at any given time.

This document laid the groundwork for the prevention and, we hope, eventual elimination of healthcare-associated infections, starting in acute care hospitals. The first phase of the Action Plan, released in 2009, outlined not only best practices and methods for infection control in acute care hospitals but also metrics and goals by which we here at HHS could keep ourselves accountable in regard to the actual effects of our efforts. As you may have already heard, we have been successful. Progress has been made:

We've seen decreases in central line-associated bloodstream infections and an increase in adherence to proper central line insertion practices known as CLIP.

The rate of catheter-associated urinary tract infections has been reduced as has the rate of invasive MRSA infection.

The rate of surgical site infections is dropping. And I'm happy to report we've also seen an increase in adherence to the Surgical Care Improvement Project, or SCIP, measures.

While these measures show great improvement, there is always more work to be done. Specifically, we've not seen the type of decreases in the number of hospitalizations due to *Clostridium difficile* we had hoped to achieve. Instead, after a marked increase in the number of hospitalizations over the past few years, we have begun to see a leveling off in the rate of hospitalization.

While the data show promise, we continue to see the need to work diligently to prevent this class of infection while working to continue reducing those infections against which we've already made progress.

All the measures I've mentioned here, along with the associated five year goals and the interim data, can be found under the Healthcare-Associated Infections tab at www.hhs.gov/ash.

We recognize that these measures cover only those patients in acute care hospitals. And, while progress has been great, the intent and design of the Action Plan was to create a living document which would grow and change as needed.

It was with this in mind that the HHS Steering Committee for the Prevention of Healthcare-Associated Infections decided to expand the Action Plan beyond the acute care hospital setting and into other settings of care where patients are also at risk for potentially severe complications due to preventable infections.

Specifically, the Steering Committee identified ambulatory surgical centers and end-stage renal disease facilities as the next step, or phase, of the Action Plan. The Steering Committee also noted that some issues go beyond any one particular setting and sought to develop a national strategy to increase influenza vaccination rates of healthcare personnel regardless of healthcare setting.

The three draft chapters of Phase 2 of the Action Plan were released separately from the first phase in 2010. These chapters have been updated and are being re-released for public comment along with an updated version of the original Action Plan. This updated version of the Action Plan presents a vision for healthcare-associated infection reduction which doesn't stop at the hospital door and sets a tone in which the reduction of healthcare-associated infections is a necessary component of patient safety in any setting of care.

In ambulatory surgical centers, through increased coordination and collaboration within HHS and with our national stakeholders, we're shining a light into a setting that is often fragmented with a multitude of specialties each with their own different needs, a setting where often providers--while well-meaning--may lack the resources and time needed to train staff or keep up to date with the most current infection control practices. Even in the face of these great obstacles, we are confident that with time and hard work we can combat shelter-associated infections in ambulatory surgical centers through cooperation and collaboration in much the same way we've achieved success in acute care hospitals.

End-stage renal disease, or dialysis, facilities face their own set of challenges. By the nature of hemodialysis, patients are at an increased risk for infection, with infections the second leading cause of death after only cardiovascular disease. There's a great need to reduce the rates of healthcare-associated

infections in dialysis clinics and we hope, through work at HHS and with stakeholders, to advance the same type of bloodstream infection reductions that we've already documented in acute care settings.

Sometimes, an individualized or setting-specific intervention is not the prevention needed. At times, a broad-based approach which will affect every setting can help to prevent harm. It is estimated that influenza-associated deaths rates range between 3,000 and 50,000 each flu season. Healthcare personnel in all settings of care can become infected with influenza and transmit it to other healthcare personnel, to their families, and to the very same patients they are caring for.

The influenza vaccine is effective at preventing influenza and, therefore, effective at preventing the transmission of influenza. This one simple intervention has the potential to save lives across all settings of care, yet healthcare personnel influenza vaccination rates still lag behind the Healthy People 2020 goal of 90 percent. Preliminary data show that the vaccination rates are going up and we hope to assist this trend with the use of our chapter on healthcare personnel influenza vaccination.

In closing, let me say that the momentum we have seen in this area is impressive. But we know that this is due not only to the work here at HHS but also to the tireless work of those stakeholders and clinicians who seek to improve patient safety and care each and every day. It's those actions that really move the needle.

I want to congratulate everyone on the achievements we've made in acute care hospitals and look forward to continuing to combat healthcare-associated infections in those settings in the Phase 2 of Action Plan and all future iterations.

Together, we can reduce and eventually eliminate healthcare-associated infections.

At this time, I'll turn things over to Dennis Wagner, one of the Co-leads for the Partnership for Patients.

Dennis Wagner: Thank you Dr. Wright. I am delighted to be here on behalf of the Partnership for Patients initiative and, together with my co-director Dr. Paul McGann, to be in a position to contribute to the next phases of the exciting and successful work that's been done during these past several years.

We intend to do two things during the course of our brief remarks. One is to provide some brief background about the Partnership for Patients initiative and then, second, we will describe how our work, the work of other partners in the Department of Health and Human Services, our many external partners, and thousands of participating hospitals in this initiative will seek to leverage and implement the HAI Action Plan.

First, about the Partnership for Patients: The Partnership for Patients is a nationwide public-private collaboration that was launched by the U.S. Department of Health and Human Services and its partners in April of 2011.

The Partnership is really defined by its two names. The two goals of the Partnership for Patients are (1) to reduce preventable hospital-acquired conditions by 40 percent within three years, compared to 2010.

And (2) to improve care transitions so that 30-day readmissions to hospitals are reduced by 20 percent by 2013, also in comparison to 2010.

Since its launch, more than 8,400 partners representing clinicians and other healthcare providers, hospitals, consumers, community-based and patient advocacy organizations, employers, unions, health plans, state and local governments, area agencies on aging, and others have publicly pledged to support the goals of the Partnership for Patients.

We're grateful that many of these partners have made significant commitments and are acting to support the aims of the Partnership, working closely with each other and with federal agencies to make care better, safer, more reliable.

I'll give one example: The Blue Cross-Blue Shield Association is working with all of its Blue Cross-Blue Shield plans to carry out a reduced hospital readmissions program, a safe surgery program, a program to reduce hospital-acquired conditions through a hospital board trustee education program, with progress to be measured by the end of this year.

We're on a team with many other national partners, local partners, state partners, the National Business Group on Health, the AFL-CIO, the American Hospital Association, and many others.

Our investment in this work is substantial. HHS has committed up to \$1 billion in Affordable Care Act funding to help achieve the aims of the Partnership for Patients.

The Centers for Medicare and Medicaid Services Innovation Center is investing \$218 million in the work of 26 Hospital Engagement Networks to help more than 4,000 hospitals implement proven strategies to reduce preventable hospital-acquired conditions and to reduce the rate of readmissions for patients discharged from the hospital, all aimed at making

overall care safer. Nearly 4,000 hospitals from all 50 states, the District of Columbia and Puerto Rico are participating in one of these networks.

The CMS Innovation Center has also made more than \$500 million available through the community-based care transitions program, which was authorized by Section 3026 of the Affordable Care Act. This is to ensure that high-risk Medicare patients safely transition between settings of care to bring down readmissions. Thirty communities are participating in this work to date and they have participated with--partnered with--more than 126 acute care hospitals. And hundreds of healthcare and social services providers are going to be providing care transition services for more than 223,000 people with Medicare over the next two years.

The benefits of achieving the aims of the Partnership for Patients are extensive. Achieving these goals will save more than 60,000 lives, prevent millions of injuries and unnecessary complications of patient care, and have the potential to save up to \$35 billion. Expanded to ten years, the efforts of Partnership for Patients could potentially reduce Medicare expenditures by up to \$50 billion and result in billions more in Medicaid savings.

With that quick backdrop on the Partnership for Patients, I'm now going to turn to my co-director, Dr. Paul McGann, to talk about how we intend to use this extraordinary platform to continue to support the work of the HAI Action Plan.

Dr. Paul McGann: Thanks, Dennis. You know, one of the things we're most often asked is, "Could this new government program you just described, the big Partnership for Patients initiative, possibly interact with and help other government programs that might be in simultaneous action?" In the next couple of

minutes, I'm going to give five reasons why it's likely that this is going to happen.

The first reason is that this is new. The Partnership for Patients brings new momentum, new types of alignment, and new resources to prevent all-cause harm including healthcare-acquired infections. You can think of it as an engine. It's a new engine for change, a new engine for collaboration, and a new engine for partnerships. That's quite a resource for everybody to use.

The second reason is very simple and you've heard it already. We know this can be done. Dr. Cardo and Dr. Wright and Dr. Munier have a three-year history of interacting to reduce healthcare-acquired infections. And, you just heard the results of that interaction. So, it's not a question of discovering new knowledge. It's a question of spreading knowledge around the country. When we work together, these types of activities are always more powerful. Partnerships always work better.

The hospitals and hospital systems and the Hospital Engagement Networks have a long history of working on this already, even though they're new government contractors. Hospital systems such as Ascension Health, Intermountain Healthcare, and the Michigan Hospital Association have all demonstrated--even before the Partnership--tremendous accomplishment. So we know it can be done.

Third, there's a record of accomplishment. There are lots and lots of accomplishments here. Again, Dr. Cardo already went over some for the HAI Action Plan over the past three years.

But, even in the Hospital Engagement Networks, which were only launched in December 2011, we're already seeing a highly structured learning

collaborative launching. We just met with the American Hospital Association this morning, and they're launching this month some very big collaboratives in 33 states and hospital associations across the country. So there is already a record of accomplishment being laid down.

Fourth, we believe that, together, we're much stronger than we were separately. Together, we foster synergy. Partnerships aimed at specific goals such as the goals Dennis just described for the Partnership for Patients always accelerate progress. By working together, we can achieve much more than separately. And the key to spread is actually these partnerships. So, as we get into with the Partnership for Patients hospitals, the state and national associations, consumer groups, unions, employers, researchers, and community-based organizations and many other partners, the great work and the foundation built with the healthcare-associated infections Action Plan is going to spread rapidly throughout the country.

Finally, I'll return to where we began. The other main reason, the fifth reason that this is going to accelerate, is that significant resources are being brought to bear. We're looking at up to \$500 million of investment in the Hospital Engagement Networks, another \$500 million to reduce 30-day readmissions, which are often caused by healthcare-associated infections.

And I'm sitting at a table now looking around at some of the finest minds in the Department of Health--from AHRQ, CDC, the Office of the Assistant Secretary for Health, Dr. Koh, CMS, and other colleagues who couldn't join us today from the Health Resources and Services Administration, the Office of the National Coordinator, and the list could go on and on.

When you bring this many people and this many resources together at once it's amazing what can happen.

So, Dennis, as we look back toward our two goals—40 percent reduction in all-cause patient harm, 20 percent reduction in 30-day readmissions--we really do believe in the next couple of years we can save thousands of lives, prevent millions of injuries and readmissions, including those caused by infection, and save the healthcare system millions of dollars.

As the resources of the Partnership for Patients are added to the foundation built already by this program we believe that progress, indeed, will accelerate rapidly. Don?

Dr. Don Wright: Alright, operator, we're ready for the Q&A portion of the call.

Coordinator: Thank you. If you'd like to ask a question, please press Star 1 on your touch-tone phone. Please un-mute your phone and record your first and last name clearly when prompted.

To withdraw your question press Star 2. One moment for our first question.

Our first question comes from (David Birnbaum). Your line is open.

(David Birnbaum): Thank you. I have two questions and I appreciate this opportunity to comment on the draft Phase 2.

The first question for Dr. Wright is where do we send comments on the draft chapters? There's no easy link within the web site. Is it ohq@hhs.gov or will there be a link brought into this?

The second question is for the representatives from the Partnership for Patients. Some of the achievements that we have been promoting through

various publications are actually being questioned in other publications because the data underlined has not been adequately validated.

In order to solve that problem, and in order to solve the problem of the state health department HAI programs that are required to do validation in April of 2011, I did suggest that the Partnership for Patients should look at having the sole evaluation contractor subcontract to the state HAI programs so that we could be a small army in the field doing the validation work. It solves your problem of having validation. It solves our problem of stable funding. Nothing seems to have moved forward on that recommendation. Nothing in the original launch of the Partnership for Patients enabled the state HAI programs to participate. I am wondering if there is a specific plan to improve that for Phase 2?

Dr. Don Wright: David, thanks for calling in. I know you're one of the champions at the local level and have been for a number of years.

As relates to your first question, any comments about the Action Plan can be addressed to ohq@hhs.gov. And they'll come directly to our office here and we will be reviewing all those and taking them very, very seriously.

As relates to the Partnership for Patients, I'll reach out to Dr. McGann and Dennis Wagner to answer that question.

Dr. Paul McGann: Thanks very much, Don. We definitely heard the comments that were offered up to us. The Partnership is a big national program and it draws on fundamental data sources that come from two directions.

The first direction is big national data sources such as NHSN and MPSMS but the second and probably very important data sources are the local data

systems for each of the Hospital Engagement Networks. Validation of these data is critically important and has been incorporated into the evaluation structure of the Partnership for Patients and we're open to further improvements of that as we go along. Perhaps as the chief of our data and validation sector of the partnership I should ask Dr. Bill Munier to offer his comments as well.

Dr. Bill Munier: Sure. You bring up the issue about what are the quality [measures], the metrics upon which the Partnership is based. One of the things that we did when Don Berwick launched this program, really a couple of years ago now, was to spend time trying to assess just what the incidence of these various hospital-acquired conditions was, as well as to compute the baseline for readmissions. And one of the things I might point out is that, since the country is not on a uniform system for measuring these events, we had no way to determine automatically what the ongoing rate of adverse events in the United States was, or is, and no way to measure going forward with the system that everyone was using.

So we relied on research studies. And we actually spent a number of months with people all across the department researching the literature for the absolute best citations that we could find with respect to the incidence of adverse events, to the amount of harm they cause, to their expense, to their mortality, and to their preventability.

And those are the resources that you see that underlie the baselines--I shouldn't say the baselines, I should say the projections--for the Partnership over the three years. We also use existing systems to establish baselines and, then, as Dr. McGann has mentioned, have outlined a method by which the local Hospital Engagement Networks will measure their own progress.

What I would say is that it's a wakeup call in a sense to all of us that we need to begin to coalesce around common, scientifically supportable definitions for these adverse events so we can begin counting apples to apples and oranges to oranges.

The good news there is that the Agency for Healthcare Research and Quality, under the 2005 Patient Safety and Quality Improvement Act, has the authority to establish common definitions and reporting formats for all of quality and safety in all settings of care in the United States for licensed professionals. And we've been hard at work on that job for over five years now and we do have common formats, as we call them, for adverse events in hospitals. It's just that we weren't in a position at the time that the Partnership was launched to have operational electronic systems to employ those common formats. And it would not have been reasonable to ask hospitals to do so even if we had had a few available systems. But, five years from now, I hope we'll be in a different place, we'll be in a situation where we can all count things the same way. That is very important. Thank you.

Dr. Don Wright: Operator, next question.

Coordinator: Next question comes from Dr. (Kaminsky). Your line is open.

Dr. (Kaminsky): Yes, I'm Dr. (Kaminsky), a life member of the Association of Military Surgeons. I was just reading right here about a recent scientific study from the National Institutes of Health that mainly regards dead bacteria and how they've studied it and how they know how our immune system work.

What is your mindset there in regards to further research in the areas of infectious diseases in regard to this article of May 9, 2011?

I hear so much about prevention, but what about altering the immune system?
Is there any research been done on that in regard to what you do in your area?
I mean, it looks like a wonderful research project here.

Dr. Don Wright: I think we had a little bit of difficulty hearing your question. Dr. Cardo, do
have anything to add to the questioner?

Dr. Denise E. Cardo: We also had a difficulty here. I think the important piece that I wanted to
mention is, in order to prevent and control infections, we have to look, not for
a magic bullet, but at several strategies for how to do a safe procedure so that
we do not introduce or increase the chance of a patient's acquiring an
infection. There is some research that needs to be done at the patient level.
And that's what I think the question is about.

Dr. (Kaminsky): Yes it is, it is.

Dr. Denise E. Cardo: So I think we need to continue to implement what we know works, but we
know that in many situations we're not there yet.

I think that, with central line-associated bloodstream infections, like Dr. Bill
Munier mentioned with CUSP, we are seeing a major increase in clinicians
following evidence-based guidelines and that's why we're having the
decreases I mentioned. But, even for CLABSI, we need to do a little bit more
research for the ones that are not being presented and the same thing for
surgical site infections.

I think, for surgical site infections, we need to not only increase adherence to
what we know works but do research on additional measures that can make a
difference. And some may be on how to better improve the immune response
of some patients.

Dr. (Kaminsky): Yes, I agree with you. Yes, the research was funded by the National Institute of Allergy and Infectious Diseases.

And it's Caltech research by Dr. M-A-Z-M-A-N-I-N. And I was just very interested because I've been hearing about, you know, as a (unintelligible), we practice infection control. But, down the line, we're going to have to start looking, as these become more difficult and these bugs become more challenging, we're going to have to look at the other end. And I think Dr. Mazmanin is doing this at Caltech. Thank you.

Dr. Don Wright: Operator next question please.

Coordinator: Our next question comes from (Sue Chen). Your line is open.

(Sue Chen): Hi. Thank you for some of the answers. When (David Birnbaum) asked the question about potentially funding, using some of this \$500 million to potentially fund the state HAI program, I didn't really hear an answer to that question. Trying to get data into NHSN is a very complex process. It takes a lot of time. A lot of that work is done by the state health departments. And so I think it's a question that really deserves a more clear answer. Thank you.

Dr. Don Wright: Thank you. We'll have the Partnership for Patients Co-leads take that one on.

Dennis Wagner: Thank you. We have in place today, largely as a result of existing systems with NHSN with the MPMMS system and with AHRQs data systems, what we think is a very robust credible national strategy for collecting the necessary information to assess the impact of Partnership for Patients. That existing system was chosen as the principle mechanism for doing this work because it

does exist and it would not add a substantial burden to the work of the hospitals that are joining the Partnership for Patients.

The goal of reducing burden by the use of existing systems was I would say paramount to the work of the Partnership in developing its measurement strategy. As you heard earlier from Dr. McGann, that robust national system, based on existing reporting systems that we already have, is supplemented or complemented by the individual measurement systems of each of the Hospital Engagement Networks. And the resources that have been provided to those Hospital Engagement Networks are, in part, devoted to that work.

It is up to those networks to choose the systems that they think are the most viable, the most effective, particularly in ways that reduce the burden for the hospitals that are participating. Those are the places that the resources of the Partnership for Patients have been invested into this work.

We think that, in the case of the local measurement systems that the hospital engagement networks are using, the principal purpose of their work is to detect in real time and to collect in real time just enough information to allow the hospitals to determine whether or not they're making improvements. The national system is one that will enable the Partnership for Patients to assess its overall impact in what we think are very credible and very reliable ways although there are substantial lag times associated with that. I hope that more fully answers the question.

(Sue Chen): But, actually, what seems to be happening is that it really takes people to go and do some of these activities to make sure the data are good, et cetera. And while you're talking systems I'm not hearing about people.

Dennis Wagner: Well I think what I've heard in these two questions is a request for resources for the state agencies. And I'm not at this point in a place to say that we have those resources available.

Those resources have been allocated to the Hospital Engagement Networks for this purpose. Dr. Munier?

Dr. Bill Munier: Yes, I just wanted to add one thing and that was that, at a national level here, as we put the program together working with all the agencies including CDC and even the DOD, we had it high in our minds that we did not want to increase measurement burden at the local level.

And we were caught between wanting to be able to track performance and have some level of accountability to the organizations that were going to get all this money but, at the same time having to have some measurement systems in place, not wanting to have them add to what they were already doing. So the national measurement, which will be used to track performance as a nation in meeting our goals, will add zero burden because all those systems are ongoing and there is no added labor on the part of anyone.

The Hospital Engagement Networks are being held accountable just for being able to say that they're making progress. And they're working with their local providers to come up with a measurement system of their choice by which they are going to be able to say whether they've had success or not. But we left it that way on purpose to allow flexibility to those Hospital Engagement Networks to work with their participating providers to create the least possible additional burden while still measuring something that was credible.

We hear your distress. We know the burden associated with data collection. As a department we are trying to address it in the long term in terms of simplifying data collection burden for reporting purposes.

Dr. Denise E. Cardo: This is Dr. Denise Cardo from CDC. I just want to highlight that we know the importance of the state health departments in this whole process of not just data collection but validation. And, while we don't have--as Dr. Bill Munier has said--we don't have a lot of data for other adverse effects, I think the health departments with the hospitals play a very important role in collecting data that can allow us to even say where we are and what we need to do next. So we hear very clearly that we all need to sit together and determine a sustainable way in which we can support, not just your healthcare facilities, but also the health departments to continue in the mission. And especially when health departments and the states have a specific plan to achieve the goals that are included in the national HAI prevention plan.

Dr. Don Wright: Operator we have time for one more question.

Coordinator: Our next question comes from (Bridgette West). Your line is open.

(Bridgett West): Hi. This is Bridgette West with the Racial and Ethnic Health Disparities Coalition and African-American Health Alliance.

First of all thanks for the call. The question--more a request--is will you comment on how you're capitalizing on and including the direct involvement of community-based organizations, especially as relates to communities color and other vulnerable populations?

Dr. Paul McGann: Yes, thanks so much for the question. This is one of the very highest priorities of the Partnership for Patients.

So, maybe I'll start. We have two halves of our program. The first is the Affordable Care Act Section 3026, the Community-Based Care Transitions program. In the implementation of that program, which aims to reduce 30-day readmissions in Medicare beneficiaries, one of the requirements actually of being a successful applicant is that hospitals that are working on reducing their 30-day readmissions team up with a community-based organization. As we've reviewed these applications at CMS, we placed a high priority for community-based organizations and qualified applicants in communities of color and in disadvantaged communities to be admitted to that program and to get the resources which are directed not to the hospital but to the community-based organization.

So, we agree with you completely that that's a very high priority. And we've been trying as hard as we can to disseminate that information and act on it.

And the second . . .

(Bridgette West): How best do we follow-up and stay in touch with you on that?

Dr. Paul McGann: We'd be happy actually to meet and talk with you about this because it is a high priority and you may have ideas by which we can do that.

So is there a way for the questioner to leave her contact information?

Dr. Don Wright: (Bridgette) you can email OHQ @hhs.gov and I'll put you in contact.

(Bridgette West): OHQ?

Dr. Don Wright: Yes.

(Bridgette West): Is it just the general . . .

Dr. Don Wright: It . . .

Dr. Paul McGann: They'll get your--just give them your contact information and they'll get it to us.

(Bridgette West): Okay. Okay.

Dr. Paul McGann: Okay? We'd like to interact with you personally.

(BridgetteWest): Thank you.

Dr. Howard Koh: And this is Howard Koh. Maybe I can make the final comments here. Your question is very appropriate for this month.

We had exactly a year ago the unveiling of the most aggressive federal plan to reduce and eliminate racial and ethnic health disparities ever. That was unveiled by the Secretary personally...

(Bridgette West): Right.

Dr. Howard Koh: . . . a year ago.

(Bridgette West): Right.

Dr. Howard Koh: This is actually National Minority Health Month. And we have a whole series of events to highlight disparities in health outcomes of which this is one.

So, thank you for your commitment and we're going to incorporate this into our disparities work going forward.

(Bridgett West): And that language for that particular report was put in the appropriations report by Congressman Jesse Jackson of Illinois.

Dr. Don Wright: Thank you very much. I think we've come to the end of our time. I want to express my appreciation, first of all to the panelists that came from across the department to share some of their activities that were responsible for the reductions that we've seen.

But, I also want to express appreciation to all of you that are in the field that carry on this healthcare quality work at the local level. It's you, really, that we need to thank for the success that we've had. Thank you so much for tuning in.

Coordinator: Thanks for participating in today's conference. Please disconnect at this time.

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