HAP

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

May 30, 2008

The Honorable Henry A. Waxman
Chair, Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, D.C. 20515-6143

Dear Chairman Waxman:
The Hospital & Healthsystem Association of Pennsylvania (HAP) is a membership organization representing more than 250 acute and specialty care hospitals in Pennsylvania. We are pleased to respond to your May 6, 2008, letter requesting information pertaining to HAP's statewide quality and patient safety initiatives. Techniques and protocols continue to evolve, like medicine itself. There is a need for diverse action to discover innovative and successful strategies for ever-improving quality and patient safety. Your committee is likely to receive information from around the country indicating that.

On an annual basis, HAP, through our Board of Directors, establishes its quality and patient safety agenda to assist Pennsylvania hospitals and health systems in their inherent leadership role regarding patient safety and quality, of which preventing health care-associated infections is a component. In order to best address your questions, our response addresses the broader context of our association's agenda regarding quality and patient safety.

HAP has long partnered with regional, statewide, and national organizations on efforts to improve quality and safety. We serve in a key role as a convener of collaborative (both regional and statewide) efforts that seek to improve care. These efforts include educational programs, including an annual patient safety symposium, at which hospital leaders, physicians, nurses, and other stakeholders come together around best practices and approaches to improving care, and toolkits or guidance on various initiatives (the most recent being guidance on implementing color-coded, patient wristbands as a safety measure). These efforts, when coupled with Pennsylvania government initiatives on which hospitals have worked, have advanced the quality and safety of hospital care in our state.

In 1999, following the first release of the Institute of Medicine's report, *To Err Is Human: Building A Safer Health System*, HAP brought together diverse organizations from across the state, representing nurses, physicians, payers, government, pharmacists, business, labor, and others to begin the Pennsylvania Patient Safety Collaborative. In 2001, the collaborative released a HAP monograph, *Elements of a Culture of Safety*, that provided the case for making patient safety a hospital corporate and governance priority, and how to approach incorporating patient safety in organizations' daily activities. This

4750 Lindle Road
P.O. Box 8600
Harrisburg, PA 17105-8600
717.564.9200 Phone
717.561.5334 Fax
haponline.org

collaborative was instrumental in bringing together facilities and practitioners, and led to a number of important Pennsylvania initiatives, including improving clinician-patient communication when medical errors occur.

Around that same time, HAP published a Pennsylvania statewide edition of the *Dartmouth Atlas* that examined clinical variations in health care by regions of the state, building on the work of Dartmouth College researchers (John Wennberg, M.D., Elliot Fisher, M.D., et al). The Pennsylvania-specific publication fostered discussions across the state about working within hospital administrative and clinical (medical and nursing) leadership to advance efforts to reduce clinical variation as part of quality improvement efforts at the hospital level.

I provide these examples to demonstrate that our association, through the involvement of our member hospitals and health systems, has long focused on improving the quality and safety of patient care in our communities. Some of our more recent major initiatives are highlighted in the following paragraphs.

In 2004, hospitals and health systems from across the commonwealth joined with the **Institute for Healthcare Improvement (IHI)** and other organizations in the 100,000 Lives Campaign, a national effort to reduce preventable deaths in U.S. hospitals. Last year, IHI stated that nationally the 3,100 hospitals that participated in the initiative saved an estimated 122,000 lives in 18 months. In Pennsylvania, HAP worked with public and private sector organizations to support hospitals as they implemented new standards of care to prevent infections, reduce medication errors, and improve care. One of the campaign's major goal areas was to prevent central line infections, and during the two-year campaign period (2005-2007), hospital participation in this effort increased from 41 percent of hospitals implementing best practices hospital-wide to nearly 70 percent.

In addition, through the IHI Campaign, HAP has worked with the Pennsylvania Patient Safety Authority *(a state agency whose mission is to reduce and eliminate medical errors by identifying problems and recommending solutions)*, Quality Insights of Pennsylvania *(the federal quality improvement organization)*, VHA East, VHA Pennsylvania, the Hospital Council of Western Pennsylvania, and the Health Care Improvement Foundation affiliated with the Delaware Valley Healthcare Council *(the southeastern Pennsylvania office of HAP)*.

More recently, IHI announced a new campaign, the 5 Million Lives Campaign, a voluntary initiative to protect patients from five million incidents of medical harm for the period December 2006—December 2008. HAP and the other Pennsylvania partners are working with member hospitals and health systems on this new campaign. Through these efforts, more than 150 Pennsylvania hospitals have taken the initiative to implement best

practices. Our 2008 campaign priorities are developing successful strategies and initiatives related to preventing bed sores in hospitalized patients, engaging boards of trustees in patient safety and quality, and preventing *Methicillin-resistant Staphylococcus aureus* (MRSA) infection. The IHI campaign is just one of the many collaborative initiatives underway in the commonwealth, which bring together innovative clinical leaders and knowledge to advance health care quality and safety.

In southeastern Pennsylvania, the **Health Care Improvement Foundation** (affiliated with the Delaware Valley Healthcare Council of HAP), was successful in working with the Institute of Safe Medical Practices and the ECRI Institute to develop and implement a regional medication safety program in southeastern Pennsylvania hospitals. The medication safety program received national recognition in a Joint Commission publication and the *Journal of the American Medical Association.* More recently, the foundation has built upon this success, in partnership with Independence Blue Cross, by embarking in 2006 on the Partnership for Patient Care. This collaborative effort focused on hospital-acquired infections, including advancing best practices associated with preventing surgical-site and bloodstream infections. In 2007, the Partnership made preventing and reducing MRSA a major priority.

The **Pittsburgh Regional Healthcare Initiative**, since 1997 has fostered collaborative approaches between providers (including more than 40 hospitals), employers, government, and others to improve health care for patients in southwest Pennsylvania. It is through this initiative that hospitals, including general acute care hospitals and the VA Medical Center in southwestern Pennsylvania, have reduced bloodstream infections associated with the use of intravenous catheters and developed best practice approaches to reduce MRSA; addressed *Clostridium Difficile* (C-diff), and reduced regional mortality and readmissions following coronary artery bypass graft surgery. These efforts have been reported in various national journals and the Centers for Disease Control & Prevention (CDC) publications. Members of the teams that have initiated these successful efforts have served as faculty at educational programs offered around the state.

The national **Surgical Care Improvement Project**, initiated in 2003 by the Centers for Medicare & Medicaid Services and the CDC, sets out best practices related to preventing surgical complications, including surgical site infections. This project brought together national experts and clinical organizations, including Pennsylvania's quality improvement organization (Quality Insights of Pennsylvania) to identify best practices around prophylactic use of antibiotics, selection of antibiotics, and the timing of discontinuing antibiotic use.

In 2005, HAP published ***Pennsylvania Hospitals: Quality Indicator Report,*** using the inpatient quality indicators, patient safety indicators, and prevention quality indicators

developed by the Agency for Healthcare Research and Quality (AHRQ). The report included all payer patient data from 2002 and 2003, and provided hospital-specific, peer group, statewide, multi-state, and national comparisons. The purpose of this report was to provide comparative data to hospitals that would help their internal quality and safety improvement efforts identify areas needing discussion and possible improvement.

Other HAP initiatives that support the quality and patient safety leadership agenda have included:

- **Improving Patient Flow**—HAP initiated a statewide initiative with other state health care organizations to improve capacity management at Pennsylvania's hospitals by identifying the best practices and techniques to better manage facility use and reduce emergency department crowding.
- **Better Work/Better Care**—As part of a grant from the federal Health Research Services Administration, HAP worked with six community hospitals that were partnered with six nursing Magnet hospitals to improve staff communication, direct nursing involvement in decision-making, and cultural awareness, both to improve the environment of care and the quality of care.
- **Just Culture**—HAP convened state officials and other key stakeholder groups to develop a common framework for accountability in promoting a culture of safety.
- **Continuous Survey Readiness**—HAP manages a program offered by the Joint Commission in which more than 60 Pennsylvania hospitals, including Veteran's Administration hospitals, participate to continually improve the quality of care.

The success of HAP's and our member hospitals' and health systems' efforts in the above-mentioned programs has been because they both initiate and support innovative efforts, as the IHI states "to discover, cultivate, and demonstrate the feasibility of new, more capable, designs." HAP's commitment to its member hospitals and health systems is to assist in taking information and making it knowledge by bringing together experts, both within the state and from across the nation, and to enable the sharing of best practices and techniques so that all hospitals, and ultimately the patients they serve, can benefit from this knowledge and expertise. Each year, HAP holds an achievement award program to recognize innovative efforts. The knowledge gained through participation in collaborative programs is clearly reflected in recent achievement award winners that addressed, for example, reduction of ventilator-associated pneumonia in small and community hospitals, or reduction of the incidence of MRSA in an urban hospital.

In addition, Pennsylvania has led other states in state agency involvement in improving the quality of care and patient safety. In 2002, as part of Pennsylvania's Act 13, the Medical Care Availability and Reduction of Error Act, our state established the Pennsylvania Patient Safety Authority that allows for confidential reporting of serious

events (defined as clinical care that result in death, compromises patient safety, and/or results in unanticipated injury to a patient) and incidents (defined as clinical care that could have injured a patient but did not cause injury or require additional care) by hospitals, ambulatory surgery centers, and birthing centers.

The authority's purpose is to analyze the reports it receives and to provide guidance to the health care field as a result of this important information system. The authority does so through advisories which are issued periodically. Health care-associated infections have been part of this system, and the authority has issued advisories addressing infections. Most recently, the authority adopted a strategic plan that calls for advancing leadership regarding patient safety and is collaborating with HAP and the national Center for Health Care Governance to pilot trustee education regarding quality and safety later this year. HAP supported Act 13 and was integral in its creation and passage.

Pennsylvania also has a central health care data repository—the Pennsylvania Health Care Cost Containment Council—to which hospitals have been reporting patient quality and financial data since 1986. More recently, the council enacted reporting of hospital-acquired infections beginning in 2006, using a two digit code on the uniform bill to indicate the presence of an infection. As the first state in the nation to collect data on hospital-acquired infections, Pennsylvania has had a greater opportunity for public accountability in our state than has ever existed before. The reporting requirements, however, did not include sufficient detail to enable the council to provide the type of data that your letter asks for, which is the type of information that clinicians seek in evaluating the performance within their facilities consistent with best practices of care.

Therefore, in 2007, Pennsylvania enacted Act 52, the Health Care-Associated Infection Act, which addresses infection control and reporting. Beginning in 2008, all hospitals are required to use the entire reporting protocol of the CDC's National Healthcare Safety Network (NHSN) for purposes of reporting infections acquired while hospitalized. Act 52 also requires that nursing homes begin reporting infections acquired by nursing home patients, and the state is currently working on the method and mechanisms to accomplish this objective. The act also required hospitals, ambulatory surgery centers, and nursing homes to update infection control and prevention plans, including taking steps to address drug-resistant infections, such as MRSA. Act 52 also integrated the reporting efforts to enable three Pennsylvania state agencies—the Pennsylvania Patient Safety Authority, the Pennsylvania Department of Health (which is the state licensing and public health agency), and the Pennsylvania Health Care Cost Containment Council—to utilize the information that hospitals are submitting to the National Healthcare Safety Network to fulfill their agency obligations to the public. Finally, the act identified a series of public health requirements to be fulfilled by the Pennsylvania Department of Health around prevention of community-acquired infections and education of the public regarding

health care-associated infection prevention. HAP supported Act 52 and was integral in its creation and passage.

HAP believes that providing the above context of collaboration and regulatory efforts was imperative to our responding to the specific questions your May 6, 2008, letter raised:

1. *If known, what are the median and overall rates of central line-associated bloodstream infections in the intensive care units in hospitals in your state, using standard definitions of CLABSIs as provided by the Centers for Disease Control (CDC) and Prevention for the purpose of the National Healthcare Safety Network?*

   Response: Pennsylvania's Act 52 of 2007, the Health Care-Associated Infection Act, required all hospitals to use the CDC's National Healthcare Safety Network for purposes of reporting infections acquired while hospitalized. This requirement took effect in February 2008. Act 52 also enables three Pennsylvania state agencies to utilize the information that hospitals are submitting to the National Healthcare Safety Network to fulfill their agency obligations to the public. These include the Pennsylvania Patient Safety Authority, the Pennsylvania Department of Health, and the Pennsylvania Health Care Cost Containment Council—the latter of which will be preparing public reports on infections acquired during hospitalization consistent with CDC definitions. Given the act's recent implementation, the data that you requested is not yet available in Pennsylvania. Data previously collected and reported by the Pennsylvania Health Care Cost Containment Council does not include sufficient information to provide the data your letter requested. However, infection rates for every Pennsylvania general acute care hospital were published for 2005 and 2006. This data can be found at http://www.phc4.org/reports/hai/.

2. *If the rates are unknown or if the median rate is above zero, do you have plans to replicate the Michigan Hospital Association program in your state? If so, when do you anticipate initiating the program?*

   Response: In 2004, as previously stated, HAP, along with other statewide and regional organizations, embraced the Institute for Healthcare Improvement's (IHI) 100,000 Lives Campaign. The Pennsylvania Partnership adopted the initial campaign priority goals and strategies, which included a recommended bundle of care for eliminating central-line associated blood stream infections that is consistent with the checklist developed through the Michigan Hospital Association's work with Johns Hopkins. In 2004, 120 Pennsylvania acute care

hospitals signed onto this campaign that year. Currently, there are more than 150 Pennsylvania acute care hospitals participating in our state's IHI 5 Million Lives Campaign, of which the continued elimination and prevention of these infections remains a priority. In addition, Pennsylvania hospitals and health systems will be able to track improvements through the use of the NHSN data. This will indicate where initiatives have had an impact and help us and our member hospitals to focus future actions and collaborations.

3. *What other activities are your member hospitals taking to address health care-associated infections? Which infections are you targeting? What is your evidence of success?*

   Response: Through the IHI Pennsylvania Partnership and regional collaborative, there also has been a focus on preventing ventilator-associated pneumonia, surgical site infections, and MRSA. Best practices on implementing the ventilator-associated pneumonia bundle (or checklist) have been part of educational sessions, and most recently, information on successful implementation at community hospitals and a pediatric hospital were shared at HAP's annual Patient Safety Symposium in April 2008. HAP has partnered with Quality Insights of Pennsylvania to conduct regional education on *Transforming Surgical Care—Going from Good to Great,* and recognized best practices on preventing surgical care through cardiothoracic glycemic control at the Patient Safety Symposium. HAP's efforts regarding MRSA have been focused on both reducing this infection in hospital settings, as well as providing a greater awareness of community-associated MRSA infection. HAP conducted a series of regional education forums at which hospitals that have demonstrated best practices in reducing MRSA presented. Faculty in many of the sessions included staff from the state's Veteran's Affairs Medical Centers that had been part of the VA System's *Getting to Zero* program. In addition, over the past several years, HAP has shared information with school districts across the commonwealth to create a greater awareness of the potential threat of MRSA particularly for student athletes.

   In subsequent years, The Pennsylvania Partnership will be using information reported through the National Healthcare Safety Network to assist it in analyzing trends and developing priorities for future initiatives, collaboration, and education regarding health care-associated infections.

HAP and its member hospitals and health systems stand by our commitment to quality and patient safety and believe that the health care professionals who work in hospitals and the trustees who guide the mission of hospitals are demonstrating this commitment

every day in communities across the commonwealth. We stand by our commitment to report information on health care-associated infections so that patients and their families can use this information as part of their decision-making regarding health care. We stand by our commitment to bring experts together to enable the sharing of best practices so that all hospitals, and ultimately the patients they serve, can benefit from this knowledge and expertise. HAP and its member hospitals and health systems welcome the opportunity to work with this committee and other stakeholders on health care-associated infections.

Please feel free to contact me, Paula Bussard, HAP's senior vice president, policy & regulatory services, at pbussard@haponline.org or at (717) 561-5344, or Michael Strazzella, HAP's vice president, federal relations, at mstrazzella@haponline.org or at (202) 863-9287, if you require any additional information on the items included in this letter.

Sincerely,

Carolyn F. Scanlan

CAROLYN A. SCANLAN
President and Chief Executive Officer

c: Tom Davis, Ranking Minority Member