NJHA
NEW JERSEY HOSPITAL ASSOCIATION

Gary S. Carter, FACHE
President and
Chief Executive Officer

May 22, 2008

Hon. Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
Congress of the United States
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Mr. Waxman:

I am pleased to be able to respond to your letter of May 6 and to provide you with information on activities undertaken by the New Jersey Hospital Association (NJHA) and its Institute for Quality and Patient Safety (Institute) in the areas of healthcare associated infections.

Like the Michigan Hospital Association, we began a statewide initiative in 2004 to improve the quality and safety of care delivered in our hospitals' intensive care units. We were about six months behind Michigan with our initiative. Under the co-chairmanship of Dr. Peter Pronovost and Dr. Thomas Rainey, we worked for two years with our members, focusing on improving the culture of safety and reducing the incidence of ventilator associated pneumonia and central line bloodstream infections. Using materials from Johns Hopkins University and the Institute for Healthcare Improvement (IHI) teams implemented evidenced based best practices to work to eliminate these infections.

After two years, across all participating hospitals, there was a reduction of 73 percent in the incidence of central line bloodstream infections and a 55 percent reduction in the incidence of ventilator associated pneumonia. Many of our hospitals have gone one year or more with no infections of either type in their critically ill patients. While we do not have median and overall rates of these infections in our state, that information will be forthcoming because of recent legislation requiring reporting of certain infections to our Department of Health and Senior Services and public reporting of them.

760 Alexander Road • PO Box 1 • Princeton, New Jersey 08543-0001
Tel 609-275-4000 • Fax 609-275-4100

We are beginning a second round of our ICU collaborative on June 2-3 under the chairmanship of Dr. Mitchell Levy from Brown University and Rhode Island Hospital, and the president elect of the Society of Critical Care Medicine. We will be focusing our efforts again on preventing these infections, and will also be adding best practices in the identification and management of patients with sepsis and in the care and management of patients at the end of life in the critical care units.

Additionally, the Institute is coordinating another statewide initiative to reduce the incidence of antimicrobial resistance, in partnership with our Department of Health and Senior Services (NJDHSS) and funded by The Healthcare Foundation of New Jersey. We are in the second year of this initiative, focusing on reducing the incidence of catheter associated urinary tract infections, which account for approximately 40 percent of healthcare associated infections. Focusing on appropriate management of patients with urinary drainage catheters and getting them out as soon as possible, within three to four days unless appropriately indicated, we have over 125 hospitals, nursing homes, home health agencies and rehabilitation hospitals working to "get to zero" with these infections. We collect rates of infections on a monthly basis from all participating facilities as well as medical record reviews to determine appropriateness of use of the catheter, site where catheter inserted, and indications for continued use past three days. Many of our organizations have already adopted policies that call for discontinuing these catheters automatically in three to four days, unless the physician writes an order to the contrary with specific reasons why it should stay in the patient.

Additionally, in this second year of the collaborative, we have added a lot of content on reducing the incidence of methicillin-resistant S*taphlococcus Aureus* (MRSA). We have upcoming Webinars on best practices for hand-washing and for prevention and management of infections caused by *Clostridium difficile* for collaborative members. We have held five additional educational open to all New Jersey healthcare facilities on current concepts in the management of the critically ill patient, infection control, antibiotic resistance and healthcare associated infections.

The NJHA Institute just completed a two year initiative to reduce the incidence of pressure ulcers across the continuum of care. There was a reduction of 70 percent in the incidence of these ulcers across 150 hospitals, nursing homes, home health agencies, long term acute care and rehabilitation hospitals. Our collaborative has received national and international recognition and most of our materials were used by the Institute for Healthcare Improvement in their toolkit to reduce the incidence of pressure ulcers. Representatives from our regional office of the Centers for Medicare and Medicaid attended all of the learning sessions for that work as did representatives from our quality improvement organization and our Department of Health and Senior Services. While not directly related to infections, many of these pressure ulcers do become infected and are a

source of pain and complications for our patients. While this collaborative has formally ended, we continue to collect data from the organizations and have educational programs focused on new learning and evidence based practices in the prevention and management of pressure ulcers every six months.

Additionally, the vice presidents of medical affairs of our hospitals have moved to develop a workplan to help all healthcare facilities across the continuum of care to address issues with end-of-life care, hospice, palliative and futile care utilizing much of the data developed by the Dartmouth Atlas. A statewide forum is planned for the end of 2008 with a specific agenda to identify best practices and develop a toolkit and educational resources for all healthcare providers as well as patients and their families.

As I referenced above, New Jersey does have legislation on mandatory reporting of healthcare associated infections and on screening of patients for MRSA, and the reporting of those infections will be through the CDC's National Healthcare Safety Network. All of our hospitals are currently being trained on how to use this system to report, to monitor their progress on reducing rates of infections and to compare themselves against other organizations, both statewide and nationally. We actively supported this legislation. We also have a public reporting website (http://www.njhospitalcarecompare.com/) where hospital specific rates of surgical site infections are reported, among other clinical measures.

I hope this letter provides you with the information you need. If you need additional information, please do not hesitate to contact me or Aline Holmes, senior vice president, clinical affairs and the director of the NJHA Institute for Quality and Patient Safety.

Sincerely,

Gary S. Carter
President & CEO