OHIO HOSPITAL ASSOCIATION

May 28, 2008

The Honorable Henry Waxman
Chairman, Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515-6143
VIA FACSIMILE: 202-225-4784

Dear Congressman Waxman:

On behalf of the Ohio Hospital Association (OHA) and more than 170 member hospitals and health systems, we thank you for the opportunity to share some of the exciting initiatives Ohio is undertaking to improve patient safety and quality of care.

Your questions regarding central-line-associated bloodstream infections (CLABSIs) and the Michigan Hospital Association initiative are timely. The Ohio Hospital Association (OHA) currently is working with Sen. Sherrod Brown (D-OH) on a federal appropriations request that would, if approved, allow OHA to undertake a similar project in Ohio hospitals. Through this project, OHA hopes to not only measure the current median and overall rates of CLABSIs in Ohio, but also to achieve reductions in those rates similar to the results demonstrated recently in Michigan. Sen. Brown is a strong advocate of our planned project and is optimistic OHA will be successful in its appropriations request. OHA will continue to lay the preparatory groundwork for the project while the appropriation process continues, with a plan to formally launch the program in early to mid 2009.

Beyond the planned initiative detailed above, OHA currently manages five regional quality improvement collaboratives across the state -- Dayton, Cincinnati, Columbus, Northeast Ohio, and all children's hospitals in Ohio. These collaboratives involve more than 80 hospitals with the goal of improving the quality of hospital care delivered in the participating communities. Two of these collaboratives currently are collecting ICU central-line data. Other collaborative projects are producing validated results (the latest of which has just been published by the American Heart Association in *Circulation*) and are illustrating sustainable and replicable best practices to improve outcomes.

The first collaborative project was established in Dayton in 1999 in conjunction with the Greater Dayton Area Hospital Association (GDAHA) to improve the outcomes of care in cardiac patients in Montgomery County, Ohio. The success of this project cannot be overstated. By reducing heart attack mortality rates by 36 percent, the Dayton initiative won the prestigious 2001 Ernest A. Codman Award from the Joint Commission (TJC). Additional quality improvement work has been added to GDAHA's Performance Improvement Project in the areas of pneumonia and deep-vein thrombosis (DVT).

The Central Ohio Quality Collaborative and the Northeast Ohio Quality Collaborative, both founded in 2007, represent the collective commitment of area hospitals to share practices and improve patient safety. They currently focus on stroke-related care and congestive heart failure care, respectively. The Greater Cincinnati Hospital Quality Improvement Project, launched in 2005, similarly has focused on congestive heart failure outcomes, as well as providing performance measures for hospitals, physicians, and quality management professionals to cooperatively improve care.

The Ohio Children's Hospital Association Quality Improvement Collaborative, formed in 2007, draws on the collective experience and expertise of six participating children's hospitals as they work to improve team-based approaches to pediatric code recognition, response, and communication. Their efforts reduced cardiopulmonary arrest codes outside the intensive care unit (ICU) by more than 20 percent.

In addition to these five collaboratives, OHA is a founding organization and a principal source of funding for the Ohio Patient Safety Institute (OPSI). OPSI is a partnership of the Ohio Hospital Association, the Ohio State Medical Association, and the Ohio Osteopathic Association and represents more than 170 hospitals and more than 9,000 physicians. Among other pioneering patient safety initiatives, OPSI developed the first statewide Surgical/Procedural Verification Protocol (wrong site / patient surgery), which has been recognized by TJC. In collaboration with VHA, Inc. and more than 50 hospitals statewide, OPSI recently undertook a statewide initiative to reduce life-threatening complications associated with anticoagulants (blood thinners). In addition, OPSI has undertaken work surrounding medication safety, including developing medication literature for patients with limited literacy or who speak English as a second language. OPSI has shared this work with the international health care community.

In closing, it is important to note the Hospital Measures Advisory Committee, established under state law, recommended public reporting in Ohio of both MRSA and C-Dif infections beginning in 2009.

Through these and other projects, Ohio hospitals are demonstrating a commitment to reducing infection rates, promoting safety protocols, and continually improving the quality of care. And while measuring such rates as CLABSIs and other infections representing an important step toward these goals, Ohio hospitals are proving that collaboration and shared experience is the fastest way to improve quality.

Once again, we appreciate the opportunity to share with you some of the projects we are undertaking on behalf of our patients. We look forward to working with you and your colleagues in Congress on these issues.

Sincerely,

James R. Castle
President and CEO

c: U.S. House Committee on Oversight and Government Reform Minority Office, Ohio congressional delegation, Ohio Patient Safety Institute, Ohio allied regional hospital associations, American Hospital Association.