Oregon Association
of Hospitals and Health Systems

Chu
Despres
Health

Responds to a May 5, 2008 letter

May 29, 2008

The Honorable Henry A. Waxman
Chairman
The Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Chairman Waxman:

Thank you for the opportunity to respond to your request for information regarding healthcare associated infections and activity in Oregon. Your inquiry is very timely and welcome in light of this important issue and the extensive efforts underway in Oregon in both the public and private sectors.

Oregon hospitals and the Oregon Association of Hospitals and Health Systems (OAHHS) realize that we must do all we can to eliminate patient infections that occur in the course of hospital care. The impact of infections on our already vulnerable patients is devastating and unacceptable. This correspondence will update you on our extensive efforts to ensure no patient receives an infection while in an Oregon hospital. We know, however, that we still must do more. We realize that to eliminate health care acquired infections in our hospitals, we must continue to work diligently within and between hospital settings and with our partners across the nation to address this critical issue.

Rates of central line-associated bloodstream infections. You have inquired about the median and overall rates of central line-associated bloodstream infections of intensive care unit (ICU) patients. To date, we do not have this specific information for all Oregon hospitals but we will have rates beginning no later than January, 2010 pursuant to a new state law. Currently, all Oregon hospitals track this information internally. In addition, OAHHS displays other valuable quality measures for Oregon hospitals on our quality website (www.orhospitalquality.org) and the OAHHS board of trustees has directed additional measures be added to provide even greater accountability and transparency.

Michigan program and other activities: You have asked if we plan to replicate the Michigan Hospital Association program in our state. First, we congratulate our colleagues in Michigan for the fine work they have done; the Michigan project is indeed a tremendous success story. While we remain open and interested in what Michigan has done, Oregon hospitals have addressed healthcare acquired infections in a variety of ways, including:

New state law: As mentioned, Oregon passed legislation during the 2007 legislative session mandating hospitals, ambulatory surgery centers and long term care facilities report infection

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rates to the state. OAHHS participated in the drafting of this legislation and testified in support of it. The administrative rules implementing this legislation are almost finalized and currently call for reporting of ICU central line-associated bloodstream infections (CLABSIs) using standard National Healthcare Safety Network (NHSN) definitions and processes. We do not expect this requirement to change in the final version of the rules.

In addition to CLABSIs, the current version of the administrative rules also will require hospitals to report surgical site infection rates for coronary bypass graft (CABG) surgery with both chest and graft incisions, CABG surgery with chest incisions only, and knee prosthesis procedures. We also will report process measures, including the CMS Surgical Care Improvement Project (SCIP) measures for prophylactic antibiotics received within one hour prior to surgical incision, prophylactic antibiotic selection for surgical patients, and prophylactic antibiotics discontinued within 24 hours after surgery end time.

Hospitals will begin reporting these rates in January, 2009. The state will publicly disclose facility level and state level healthcare acquired infection information beginning no later than January, 2010.

Other quality data collection efforts

- Oregon hospitals participate in the Oregon Patient Safety Reporting Program. This voluntary program calls for reporting of adverse events, including infections that are preventable and cause serious physical injury or death, to the Oregon Patient Safety Commission. This information is available to the public in an aggregate format.
- Oregon hospitals also report quality data to a multitude of other entities, including The Joint Commission, Centers for Medicare and Medicaid Services, Leapfrog, Institute for Healthcare Improvement 5 Million Lives Campaign, Magnet Program, Vermont Oxford Network, National Quality Forum, and the National Surgical Quality Improvement Program to name a few

Other infection control projects

- OAHHS, in partnership with the Oregon Medical Association, has sponsored a Hand Hygiene Project to increase hand hygiene compliance for hospital personnel as an important element in overall infection prevention. We are in the process of rolling out our successful pilot to the entire state of Oregon. In addition to encouraging consistent hand hygiene, we track rates of compliance and provide feedback reports to hospitals to monitor progress.
- Later this year we hope to target hospital management of MRSA and include community outreach strategies as well.
- The OAHHS board of trustees adopted a resolution in February, 2008 that Oregon hospitals would not seek payment for adverse events, including infections that are under our control and cause serious physical injury or death.

Evidence of Success: With infections, we ultimately must measure our success by tracking and analyzing the data: Do the infection outcomes and processes we report to the state improve? Do individual hospital measurements of infection rates show improvement? Is the SCIP data

improving? How are the rates of hand hygiene compliance progressing? These numbers will improve not just through participation in one particular program but through all the efforts described above.

But it is not just infections... Reducing infections is a critical part of hospital patient safety and quality but it is not the only thing:

- OAHHS, in partnership with the Oregon Patient Safety Commission, implemented a standardized color-coded wristband project. In this highly successful program, over 90% of all Oregon hospitals are now using the same color of patient wristbands to designate certain alert conditions and have eliminated the confusion and potential for mistake that comes with color variability.
- OAHHS is actively working on better prevention and care for pressure ulcers in partnership with the long term care community and other partners.
- OAHHS, through its partnership with the Oregon Medical Association, is working to help hospitals and physicians implement a more effective medication reconciliation process.
- Many hospitals also participate in the Patient Safety Alliance, a collaborative effort between Acumentra Health, Oregon's Quality Improvement Organization (QIO), and an Oregon medical malpractice insurer. This alliance is working to promote excellence and safety in the inpatient setting through obstetric and surgical collaboratives.

We hope this letter has provided insight regarding our efforts to address and eliminate healthcare associated infections in Oregon. Please be assured our commitment to this issue is paramount. Oregon hospitals are focused on providing high quality and safe patient care. Please contact me if I can provide any additional information to assist you in this important inquiry.

Very Truly Yours,

Gwen M. Dayton

Gwen M. Dayton
Executive Vice President and General Counsel

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