



*Quality Care*

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Marc P. Volavka  
Executive Director  
Pennsylvania Health Care Cost Containment Council  
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Dear Mr. Volavka,

We are writing on behalf of the University of Pittsburgh Medical Center (UPMC). Thank you for affording us this opportunity to comment on the health-care associated infections (HAIs) report that is scheduled for release on November 14, 2006. UPMC supports public reporting of HAIs. We believe that identification of certain infection types with feed-back to the clinicians and administrators is essential for process improvement. To that end, we further believe that the data needs to be meaningful and actionable. This will ultimately benefit the providers and purchasers but most importantly, it will benefit the patient as it is our primary goal to support patient safety and as you are well aware, safer patients result in cost containment.

UPMC places a priority on patient safety and has implemented evidenced based best practice guided initiatives to prevent and control HAIs:

1. One of our system-wide quality initiatives includes implementation of best-practice recommendation "bundles" to prevent central line associated bacteremias (CLABs), the most common type of healthcare associated blood stream infections reported to PHC4. Our system has reduced CLABs by greater than 78 % since the implementation of this bundle in 2003 and our current rate is 0.7 CLABs/1,000 central line days. This rate can be compared to every hospital in the world as all hospitals use the same methods for calculating and is the lowest rate reported across this number of hospitals and has been sustained for 3 years.
2. We have implemented other "bundles" to eliminate ventilator associated pneumonias and Clostridium difficile gastroenteritis healthcare associated infections: two very troublesome, high risk infections.
3. In 2005, UPMC implemented an active surveillance culturing program for methicillin-resistant Staph aureus (MRSA) to identify patients who are infected or colonized with MRSA when they are admitted to high-risk areas of our hospitals. In the pilot project, there was a 90% reduction in MRSA HAI. Now this approach is used system-wide and is being rolled out across our region by the Southwestern PA Professionals in Infection Control (SWPPIC).

While we support public reporting, and as Pennsylvania is the first state in the nation to begin reporting HAI information, there are no clinically validated benchmarks by which one can evaluate hospital-specific data. We believe that it is critical for PHC4 to continue to work with researchers and others such as the Centers for Disease Control and Prevention (CDC) in being able to 1) refine the data to enable comparison of the risk of infection for

comparable groups of patients, 2) evaluate the additional costs and patient days that are truly attributable to the infection, rather than the underlying disease conditions that led to the hospitalization, 3) enable understanding of occurrences of diagnoses and procedures, and 4) provide trend analysis over time to enable evaluation of interventions and best practices to prevent and control infection.

With this first release of data for the year 2005, it is important to keep in mind that hospitals were not required to fully report all HAIs until January of 2006. This limits the use of data to fully assess hospital-wide surveillance and reporting for the state of PA. Many facilities across the state of PA use standard CDC reporting methods for determining whether an infection is healthcare associated. As such, the definition of a surgical site infection (SSI) requires the review of patients post-operatively for 30 days (and in some cases when an implantable device has been used, a full year) for assessment of a SSI. During 2005, the PHC4 requirement for reporting SSIs evolved. By the Q3 2005, it was ultimately decided that only SSIs that occurred during the hospitalization in which the surgery took place should be reported. The majority of hospitals in our Health System (exclusions included UPMC Bedford, UPMC Northwest, and UPMC St. Margaret) were using the more accurate SSI capture, as per CDC recommendations. This resulted in over reporting of SSIs. For example, at UPMC Presbyterian Shadyside where the more accurate SSI capture was used until Q3, 67% more SSIs were reported than would have been required.

Other methodological problems with the report include the use of a general denominator (number of admissions to the hospital) rather than a specific one (device days) that accurately represents the population at risk, not merely the entire population. Hospitals having a very large ICU population (an overwhelming proportion of which will require central line access and mechanical ventilation) have a much higher population at risk for developing an infection from a life-saving device such as a central line catheter or a ventilator than hospitals with less acute patient populations. Hospitals do not have equal proportions of patients requiring devices associated with infections. Their general rates (all patients admitted to the hospital) are thus differentially affected. This prohibits fair comparisons between populations. This denominator issue is especially troubling because PHC4 mandates the reporting of specific device usage across all hospitals.

We at UPMC are proud of the strides we have made in reducing HAIs and will continue to focus on reducing infections to better serve our patients. Once again, thank you for this opportunity to comment.

Sincerely,



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