ALLEGHENY GENERAL HOSPITAL

WEST PENN ALLEGHENY HEALTH SYSTEM

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CONNIE M. CIBRONE
President and Chief Executive Officer

February 15, 2008

Marc P. Volavka, Executive Director
Pennsylvania Health Care Cost Containment Council
225 Market Street, Suite 400
Harrisburg, PA 17101

Dear Mr. Volavka:

Allegheny General Hospital (AGH) remains committed to providing superior medical care within the safest environment possible for our patients. To that end, our hospital medical staff and senior administrative staff continues to work together towards educational modeling by adhering to nationally accepted best practices and embracing newer models and technologies to improve the quality of healthcare our patients receive. AGH has earned a reputation for infection prevention leadership as evidenced by recognition by The Association for Professionals in Infection Control and Epidemiology (APIC). We were at the forefront of collaborative efforts involving the Pittsburgh Regional Healthcare Initiative. Our goal as a hospital is consistent with the principles set forth by the Pennsylvania Health Care Cost Containment Council. It is our hope that this evolving effort at statewide reporting facilitates the elimination of infections in the hospital setting.

We would like to specifically address our successful efforts and comment on some of our ongoing challenges.

Urinary Tract Infections:
Our number of UTI's is down by 5% from 2005 to 2006. We are aggressively working on changes to policies, have a dedicated UTI elimination group, and have instituted initiatives to implement best practices, and change unnecessary laboratory testing for urine cultures.. We would like to specifically draw attention to the 25% drop in cases when comparing fourth quarter data from 2005 to that of 2006. It is our hope that the multimodal efforts to change the culture in the hospital and work towards further eliminating UTI's will continue this positive trend.

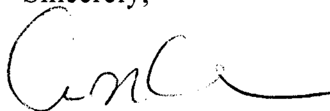
Bloodstream/Device Associated Infections:
We remain strongly committed to the elimination of bloodstream infections and have placed a great deal of focus on standardization of devices, techniques, and educational protocols. This has lead to reduced errors and increased compliance with strategies to reduce the incidence of these regrettable occurrences. Our rates of device-associated infection reflect this aggressive hospital wide effort and with rates of 0.9 per 1000 cases compared with rates of 1.7 per 1000 cases for our peer group and 1.2 per 1000 statewide we believe that we have identified a reproducible model which consistently proves effective. Our non-device associated bloodstream infection rate has been more difficult to qualify and represents a broad range of primary infectious processes making it challenging to attribute specific causes or identify universal interventions which could harness this problem. At the same time we feel that it is noteworthy that comparisons between fourth quarter data from 2005 to 2006 showed increases in rates for our peer group (134 in 2005; 173 in 2006) and statewide (224 in 2005; 300 in 2006) but our hospital specific numbers remained essentially unchanged (12 cases in 2005; 13 cases in 2006).

Pneumonia (Device Associated; Non-Device Associated):
Our rates of hospital acquired pneumonia which are device associated have been variable. Comparisons between our rates from the 4th quarter of 2005 and the 4th quarter of 2006 show that our rates were up 0.6 per 1000 cases to 1.2 per 1000 cases and yet generally consistent with our peers when comparing these two time intervals (1.1 per 1000 cases to 0.7 per 1000 cases). We feel that it is important to mention that our rates of mortality for device associated pneumonia are below our peer group as well as statewide. Our non-device associated pneumonia rate was consistent with our peers 1 per 1000 vs. 0.9 per 1000 and below those statewide trends 1.4 per 1000. Comparisons between 2005 and 2006 data for non-device associated pneumonia are incomplete given that these infections began to be reported to PHC4 in the fourth quarter of 2005.

Surgical Site Infections:
Our surgical site infections are significantly lower for 2006 (20 per 1000 cases) in comparison with (2005 data 41 per 1000 cases). We feel that this improvement is particularly significant in that the rates are down (nearly 50%) in the face of a broader data set for 2006 which captured additional sites of potential surgical infectious complications. Additionally, our rates of surgical site infection were far below our peer group 1.9 per 1000 versus 4.1 per 1000. Additionally, AGH continued to outperform in this category across the state (4.2 per 1000 cases).

Gastrointestinal Infections:
This category largely represents complications related to Clostridium difficile. Our aggressive prevention practices for this and other multi-drug resistant pathogens has resulted in heightened awareness and monitoring especially given the emergence of the recognized highly virulent strain of this bacterial infection. Our rates were at 2.3 per 1000 cases which were just under our peer group and statewide rates which were both reported at 2.5 per 1000 cases.

Sincerely,



Connie M. Cibrone