ALLEGHENY
GENERAL HOSPITAL

WEST PENN ALLEGHENY HEALTH SYSTEM

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David H. Wilderman, Acting Executive Director
The Pennsylvania Health Care Cost Containment Council
225 Market Street, Suite 400
Harrisburg, PA 17101

October 16, 2008

Dear Mr. Wilderman:

Allegheny General Hospital (AGH) is committed to creating a model for healthcare which accomplishes our primary objective of providing optimal medical care within an environment which is safe and adheres to a no tolerance policy for any hospital associated complications. Hospital acquired infections reflect shortcomings in the current model of medical care and we aim to overcome these deficiencies. Our medical and administrative staff embraces accepted best practices. Additionally, we also challenge failed strategies with an attempt to creatively provide more effective solutions which can help with the implementation of such policies. AGH has earned a reputation for infection prevention leadership and each new year we aim to reinvigorate our own message and challenge ourselves with the goal of superceding our own progress and achievements. We espouse the policies of the Pennsylvania Health Care Cost Containment Council and it is our hope that this statewide effort will facilitate and help actualize the elimination of healthcare associated infections.

We would like to specifically address our successful efforts and reflect upon some of our shortcomings.

Urinary Tract Infections:
Our number of UTI's is down by 6% from 2006 to 2007. We are aggressively working on this initiative with a dedicated multidisciplinary UTI prevention group which meets regularly. Our primary objectives have been the implementation of best practices through aggressive educational forums for nursing and physician staff, change attitudes to avoid indiscriminant placement of urinary catheters, and raising awareness so that we can more effectively avoid unnecessary testing and treatment. These policy changes are difficult to implement but necessary and require aggressive intervention. Our underlying ambition is to develop a generalized cultural awareness of this problem so that alternatives to catheter placement are explored. We aim to overcome complacency towards device placement by scrutinizing this problem allowing for more judicious habits which will ultimately reduce urinary tract infections.

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 0.8 per 1000 cases compared with rates of 1.3 per 1000 cases amongst our peer group. We believe that we have identified a reproducible model which embraces the concept of "bundling" of ideas and processes which are predictable, reduce complications, and have served as a model for other safety initiatives. Our non-device associated bloodstream infection rate has been more difficult to qualify and represents a broad range of primary infectious processes. These realities make it challenging to attribute specific causes or identify universal interventions which could harness this problem but our goal is to analyze this trend so that these findings are not blanketly attributed to a single cause.

Pneumonia (Device Associated; Non-Device Associated):
Our rates of hospital acquired pneumonia have gone down modestly in both device and non-device categories. Our non-device associated pneumonia rate decreased to 0.9 per 1000 cases whereas our peers increased their rate from 0.9 to 1.1 per 1000 cases. Our strategy for the reduction of hospital acquired pneumonia is characterized by routinely repeating our goal for adherence to best practices, identifying lapses in policy, and aggressive intervention in situations of deficiency. Cases of hospital acquired pneumonia are reviewed by both pulmonary and infectious disease physicians on a monthly basis where trends can be identified allowing for more insight into subsequent interventions. Our intensive care physician and nursing staff have worked on audits to enforce angle of bed policy and patient oropharyngeal care. Our antimicrobial management team maintains efforts to ensure appropriate and judicious use of antibiotics. All of these efforts we believe will allow for continued reduction in rates of infection despite our ever increasing complex patient base.

Surgical Site Infections:
Our surgical site infections were minimally changed for 2007 from our 2006 rate (2.2 from 1.9 per 1000 cases). Of note, our performance distinctly exceeds our peer rate (down to 3.6 from 4.1 per 1000 cases) and AGH continued to outperform in this category across the state (4.0 per 1000 cases). Many of our surgical disciplines have embraced more aggressive preoperative screening policies and attempts at decolonization. We believe there is a need to continually explore new avenues which have the potential to bolster our baseline policies of ensuring proper timing of antibiotic prophylaxis and optimization of skin antisepsis.

Gastrointestinal Infections:
This category largely represents complications related to Clostridium difficile. We have seen traditional seasonal increases in cases of C. difficile but are also faced with the rise in highly pathogenic strains of this organism and the challenges of disease recurrence. We have policies in place to rapidly deploy signage for contact isolation of confirmed or suspected cases of C. difficile and utilize reminders for optimal hand hygiene and have standardized our terminal room cleaning process in these instances to eliminate an environmental hazard. Ultimately, this problem has emerged as a more aggressive threat and warrants careful attention to established infection prevention practices, sound utilization of antibiotics, and adherence to changes in industry policy for treatment of severe cases of C. difficile so that our numbers of cases respond favorably and our patient outcomes are superior.

Sincerely,

Connie M. Cibrone
President and Chief Executive Officer