



Hospitals must come clean about a dirty secret: Up Close with RID's Betsy McCaughey, Ph.D.

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BY Rick Dana Barlow

Blame the estimate that one out of 20 patients in a hospital contracts an infection, adding a projected \$30 million collectively to hospital costs each year, on something so simple that would cause you to slap yourself upside the head.

Inadequate personal hygiene. Make that poor personal hygiene. Call it ignorance or negligence. Although we learned all about it as children (hopefully), somewhere along the highway of our personal and professional lives we set it aside. Perhaps it's the hustle and bustle of needing to get everything done at home or in the hospital. Quickly. Meeting deadlines, quotas, schedules, whatever.

As we've seen over the years – and been told consistently by infection control experts – antibiotic use isn't stemming the tide, and in fact may be contributing to the problem by mutating the bugs into something stronger.

Betsy McCaughey, Ph.D., former lieutenant governor of New York, simply finds this ghastly and unacceptable. As a result, she launched the Committee to Reduce Infection Deaths (RID) to raise the public's and industry's awareness and outrage about this issue to the point that healthcare facilities will be encouraged – first – or forced – ultimately – to clean up the mess that has festered for decades.

"We have the knowledge to prevent infection," she said. "What has been lacking is the will. Most hospitals have not made preventing infection a top priority."

The CDC shares some of the blame because the federal agency has "tracked the rapid rise in drug-resistant hospital infections for a quarter century, but has not advocated the rigorous precautions that can stop it," according to McCaughey, RID chairman.

Hospitals have resisted going on the offensive to prevent infection because they either don't think they can afford to pay for the necessary precautionary measures, or they simply don't want to do it. But McCaughey contended that they can't afford to avoid or ignore it any longer. "Infections erode hospital profits, because rarely are hospitals paid fully for the added weeks or months of care when patients get infections," she said.

Furthermore, if revenues and profits aren't enough to motivate facilities to get serious about preventing infections, then they'll likely face trial lawyers who view hospital infection as "the next asbestos" with "all the hot button essentials of a successful class action lawsuit." They'll also face mandated public disclosure in the form of state-legislated risk-adjusted hospital infection report cards, she added. Finally, McCaughey questioned how hospitals think they can prepare

themselves for a possible avian flu epidemic or bioterrorism pathogen when they "lack the discipline and staff training to stop ordinary bacterial infections from spreading patient to patient."

McCaughey makes her case rather vividly in RID's report "Unnecessary Deaths: The Human and Financial costs of Hospital Infections." She's using it as a weapon of truth to spur the healthcare industry, the public and politicians to action. Lest anyone dismiss the report as nothing more than an unfair condemnation of cash-strapped charitable organizations doing the best they can, it spotlights a handful of success stories from hospitals that are preventing infections by doing the right things. The report, and its parent organization, also attracted the support of several highly regarded infection control thought leaders, giving both the street credentials needed to turn heads and open eyes.

McCaughey's principles and passion drew Healthcare Purchasing News Senior Editor Rick Dana Barlow to ask her some pointed and poignant questions about how her organization's efforts realistically will change behavior among clinicians – behavioral modification that should make a difference in outcomes, quality and the bottom line.

HPN: RID's report 'Unnecessary Deaths' lists 'rigorous hand hygiene, meticulous cleaning of equipment and rooms in between patient use, testing incoming patients to identify those carrying drug-resistant staph or MRSA, and strictly isolating them to prevent transmission to other patients on hospital clothing, equipment, and hands' as the optimal solutions to preventing hospital infections. How can healthcare organizations effectively enforce any or all of these?

Enforcing hygiene requires leadership in the hospitals. A few hospitals in the U.S have reduced drug resistant infections by 85 percent or more in pilot programs, with leaders making hospital infection a top priority.

The major problem in all this is poor hygiene habits, something that all clinicians with a basic understanding of microbiology should be able to recognize and solve rather easily. The solution calls for behavior modification. So how do you effectively modify behavior in clinicians who should know better? Is education enough of a deterrent to negligent behavior? What about tying compliance to salary?

Several hospitals that have led the way in infection prevention are devising systems right now to deny admitting privileges to physicians who chronically fail to clean their hands and practice good hygiene.

The RID report mentions one hospital that is taking a hard line against staff and doctors who fail to 'chronically ignore hand cleaning rules' by firing staff and denying practice privileges to doctors. How does a hospital accomplish this with unions? How does a cash-strapped hospital kick out its top revenue producing doctors?

If you look at the evidence in the report, 'Unnecessary Deaths,' you will see that doctors who cause infections because of poor hygiene are wiping out the hospitals operating profits. They may appear to be top producers, producing top line revenues but not held responsible for enormous costs incurred when patients develop infections.

You criticize the CDC for not calling on hospitals to implement these precautions. Is that really the CDC's role? Doesn't the agency just develop guidelines and recommendations? Are you suggesting that standard precautions and recommendations by myriad medical and nursing associations are ineffective?

The CDC's guidelines are enormously influential. Hospitals use them as a convenient excuse for not doing more. Yet the research is copious that these precautions are ineffective. The Society for

Healthcare Epidemiologists of America issued a groundbreaking report in 2003 demonstrating the inadequacy of CDC standard precautions, and showing that surveillance culturing and contact precautions are necessary and sufficient to substantially reduce hospital infections.

If hospital infection is a 'far deadlier problem than the number of uninsured' then why isn't Congress (including Senate Majority Leader Bill Frist, who's a medical doctor, and New York presidential wannabees Sen. Hillary Clinton and Atty. Gen. Eliot Spitzer) up in arms about this? What are their reactions?

Sadly, politicians often harp on the same issues year after year, rather than listening to the public's concerns and responding with solutions.

Your organization works with health insurers to 'develop incentives for hospitals to improve infection control and to deliver life-saving information to patients,' but is that truly effective? Why not pursue stringent regulations and impose stiff penalties for non-compliance and incentives for compliance?

There are at least two reasons. Hospitals have tremendous political clout. They are often the largest employers in a community. Politicians are reluctant to press for regulations that displease the hospital industry. That is why the infection problem has been shielded by secrecy for so long. Secondly, imagine the level of government supervision and inspection required. Insurers look at the results and determine which hospitals are doing the best job of treating their subscribers without exposing them to infection.

How feasible is it to convince insurance companies to increase the rates they charge to facilities and practitioners who are flagrant and frequent violators of infection prevention precautions and to those patients who go to these organizations or see these clinicians? How about encouraging them to reduce reimbursement rates to these entities?

I disagree with that approach. Medicare, Medicaid, and private health plans should draw the line at doing business with hospitals with unusually high, risk adjusted infection rates. In the past, the indifference to quality shown by Medicare, particularly, has exposed patients to higher risk and raised health care costs. Why should a hospital providing good care and a hospital with high infection rates be paid the same rates?

You contend that Denmark, Holland and Finland brought their infection rates down below 1 percent after having similar rates as the U.S. But are their healthcare systems equivalent – or even comparable – to the U.S. system for a true apples-to-apples comparison to make the analogy reliable and valid?

Yes, there seems to be no relationship between mode of ownership of healthcare and infection rates. The U.K. is a socialized medical system but is plagued with high MRSA rates.

You calculate that hospital infections add an estimated \$30 billion to the nation's hospital costs each year. That amounts to nearly \$6 million per hospital (based on an AHA figure of 5,200 hospitals). What does that total encompass?

That total includes only the direct, additional cost of care delivered in the hospital as a result of infection, and generally the high cost is due to substantial increases in length of stay. The total does not include doctors' fees, lost time at work, or care outside the hospital.'

Hospital administrators may see this \$30 billion estimate as something they would have to deal with on the back end, provided they acknowledge they have an infection problem. Testing patients for MRSA and VRE, for example, represents front-end costs – something they have to pay out ahead of time, including keeping these tests in inventory, etc. Hospitals seem to be

willing to gamble that an outbreak won't happen so they don't have to incur the costs of rigorous precautions. How do you convince administrators that it's worth it to the bottom line?

The report includes substantial data showing that hospitals reap financial rewards immediately from infection control improvements, including surveillance culturing and contact precautions. Better infection control does not require huge capital outlays, such as with CPOE. See, for example, the Shadyside Hospital study. [Editor's Note: As excerpted from 'Unnecessary Deaths: Pittsburgh's Shadyside Hospital tamed a MRSA outbreak and saved 10 dollars for every dollar spent on improving hygiene, testing patients, and isolating those with MRSA.²⁶']

Most states don't even collect data on hospital infections, according to your report, and of the 21 that require hospitals to report infections serious enough to cause severe injury or death they seldom enforce it. How do you convince these 21 states to enforce what they have on the books already and then get the remainder to follow suit?

Getting hospitals to report honestly and fully is a problem. But that should not deter our efforts. The public has a right to this information.

The report states that 'publicly comparing hospital performance will motivate hospitals to improve.' In fact, six states – Florida, Missouri, Pennsylvania, Illinois, Virginia and New York – have passed laws requiring public access to hospital infection report cards. How are they enforced and how effective have they been to date? How effective do you anticipate they'll be?

Only one state has actually produced a report card so far – Pennsylvania. As the report shows, however, reporting quality improves quality. New York's experience with another type of hospital report card proves this. In 1989, New York became the first state to publish each hospital's risk-adjusted mortality rate for cardiac bypass surgery. The results? Deaths from bypass surgery dropped 40 percent, giving New York the lowest mortality rate in the nation for that procedure. Critics of hospital report cards speculate that deaths went down in New York because hospitals avoided treating the sickest patients, fearing that high risk operations would bring down the hospital's grade. However, the evidence proves that's untrue. Deaths declined for a different reason: Hospitals forced their worst performing surgeons — generally, those with low volume — to stop doing the procedure. Thank goodness! Patients of the 27 barred surgeons were more than three times as likely to die during surgery. In technical jargon, the 27 surgeons had an average risk-adjusted mortality rate of 11.9 percent, compared with a statewide average of 3.1%.ⁱ Wisconsin also found that report cards motivate poorly performing hospitals to improve, according to a 2001 study of 24 hospitals there.ⁱⁱ

Why should hospitals agree to infection report cards? If they accept public funds, why should it not be mandated?

It should be mandated. That is why RID has worked hard to win legislation in several states. Secrecy has allowed the infection problem to fester too long. If you need to be hospitalized, wouldn't you want to know which hospital in your area has the lowest infection rate? The irony is that it's easy to get information for the less important decisions you make in life, such as where to have lunch. Most states will help you find out which restaurants and delicatessens have been cited for health violations. But you can't find out which hospital has the worst infection rate. You can go home to make your own sandwich, but you can't perform surgery on yourself. HPN

For more information on the Committee to Reduce Infection Deaths (RID) and to download the 'Unnecessary Deaths' report, visit the organization's Web site at www.hospitalinfection.org. Also see page 20 and 22 for more RID tips

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