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# The Star-Ledger

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### The hidden danger at hospitals

#### State conceals which had potentially lethal infectious outbreaks

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Eleven outbreaks of dangerous infections took place in New Jersey hospitals last year, some of them life-threatening.

State health officials will tell you the names of the pathogens, even the counties where outbreaks occurred. But they won't disclose what consumers most want to know: the names of the hospitals.

While the 11 outbreaks represent a small number of overall hospital infections, the secrecy is typical of how state government and New Jersey hospitals approach the problem.

More than a dozen states, including New York, Pennsylvania and Connecticut, have responded to mounting alarm over such infections -- especially those resistant to antibiotics -- by requiring hospitals to make infection rates public.

New Jersey, however, lags far behind with a system that leaves consumers in the dark. The stakes are high. Hospital infections kill more than 100,000 Americans each year and add at least \$7 billion to the nation's health care costs.

"Why is New Jersey not demanding public reporting of hospital infections?" asked David B. Nash, director of health policy at Jefferson Medical College in Philadelphia and a proponent of Pennsylvania's new reporting law. "Sunshine is the best disinfectant."

Most of the limited data New Jersey does collect is not made public. A state surveillance system rates hospitals based on lab reports of antibiotic resistant organisms -- those worrisome "super bugs" -- but uses facility codes to shield the names in public documents.

State health officials said the surveillance system is not designed for consumers and would not help them select the best hospitals. But the effort to shield names shows just how sensitive the topic of hospital infections remains.

Consumer groups are calling for more openness.

"Secrecy has allowed this problem to fester for far too long. You can call your local health department and get more information on a restaurant," said Betsy McCaughey, a former New York lieutenant governor and now chairwoman of the Committee to Reduce Infection Deaths, an advocacy group.

Intensive efforts by hospitals can dramatically lower infection rates. About three years ago, 18 of New Jersey's 80 acute-care hospitals created stringent infection control programs in their intensive care units through an effort organized by the New Jersey Hospital Association.

Collectively, the 18 hospitals reported that over two years they cut ventilator-related pneumonia by more than half -- from 5.14 cases per 1,000 ventilator days to 2.3 -- and central blood line infections by an even a greater percentage. Both infections can be deadly.

The effort showed that low-tech interventions, such as strict hand washing policies and measures to get patients off ventilators and intravenous lines more quickly, can make a difference. Yet even hospitals boasting about lowered rates of infection declined to make their rates public.

"There was a presumption that these (infections) were an inevitable risk of surgery and hospitalization," McCaughey said. "But there's compelling evidence now that nearly all are preventable."

### **FEELING LUCK TO BE ALIVE**

Gerald Isaacson underwent a cardiac catheterization at Robert Wood Johnson University Hospital in New Brunswick because of chest pains he attributed to acid reflux. But his doctor wanted to be sure.

In October 2005, doctors inserted a thin plastic tube through a leg artery and into his heart. It turned out his heart was fine. A few days later, however, his leg began hurting during a ballroom dancing lesson. During a checkup, he showed the nurse a lump where the tube entered his leg.

"They sent me right to the ER," the 63-year-old Isaacson recalled. The Somerset resident was admitted to the hospital for five days of intravenous treatment and discharged with a regimen of antibiotics, including one that cost \$800 a day. He said he was lucky the infection was localized and did not enter his bloodstream, which could have been lethal.

"I'm not vindictive, and I consider myself lucky," Isaacson said. "But nobody offered to take care of anything for me. Nobody ever said, 'I'm sorry,' or took responsibility. If they did an investigation they did not tell me about it."

A spokesman for the hospital, Mark Broadhurst, said he could not comment. However, he said the type of infection described is extremely rare and would trigger an investigation. He said the hospital works aggressively to combat infections, and that employees follow a comprehensive checklist and stringent protocols.

### **HOSPITALS DEFEND SELVES**

Many hospital officials insisted their organizations were working harder than ever to reduce infections. They said no clear guidelines existed to create a fair and useful reporting system, and that even the definition of a hospital-acquired infection was not clear-cut. Some patients may already have an infection when they enter a hospital, for instance.

"The more transparent we are, the better," said John Brennan, senior vice president for clinical services for the Saint Barnabas Health Care System. "But there is no good report card."

He said the hospitals in the Saint Barnabas system voluntarily submit infection data to the Institute for Health Care Improvement, a private, nonprofit health care improvement organization based in Massachusetts. To encourage reporting, the institute does not make that data public, a spokesperson said.

Hospitals also said they collect infection data for their internal use, and many work with national health quality programs to compare their rates with other hospitals.

"We don't generally disclose the rates, but we participate in a national health safety network," said Joan Lebow, a spokeswoman for Atlantic Health, which operates Morristown Memorial Hospital and Overlook Hospital in Summit. "We make sure we meet or exceed standards."

Others questioned whether a reporting system could be fair.

"There are nuances. How do you compare a hospital like ours that takes care of transplant patients and patients with multiple illnesses and unusual diseases?" said Melvin P. Weinstein, chief of infectious disease at Robert Wood Johnson University Hospital. "Can you compare us to a community hospital seeing run-of-the-mill patients?"

Eddy Bresnitz, the state's epidemiologist, said the state health department supports transparency, as long as a fair system can be devised.

"You have to understand what you are comparing," he said.

Consumer advocates acknowledge that infections are not as easily rated as, say, mortality. But they said definable data can be collected, such as post-surgical infections, central blood line infections or ventilator-associated pneumonia.

Nash, of Jefferson Medical College, said he frequently hears the same objections to reporting.

"The typical myth is, 'Look, we take care of really sick people. You can expect someone to get an infection,'" Nash said. "But you cannot predict the chance of a hospital-acquired infection based on the patient's severity of illness upon admission. A high infection rate is a result of failed hospital processes."

Lisa McGiffert, manager of Stop Hospital Infections, a campaign by Consumers Union, said states have created fair systems by adjusting for risk, a common practice. Several states follow definitions and guidelines developed by the federal Centers for Disease Control and Prevention. She said public reporting is crucial to reducing infections and saving lives.

"If hospitals know this information will be made public, things will be different," she said.

Pennsylvania officials have created a Web site ([www.phc4.org](http://www.phc4.org)) where consumers can find infection rates for individual hospitals, learn the percentage of infected patients who died and the average cost to treat each infection. In 2004, the state found that 11,688 people were treated for hospital infections.

The cost for a densely populated state to create an infection reporting system can be as high as \$1 million, McGiffert said. The CDC estimates the cost of treating 2 million or so patients who acquire infections in hospitals is at least \$7 billion a year.

### **'SHE SUFFERED'**

Mary LaStacione, who lived alone in Bernardsville, was 93 and in remarkably good health when a doctor incorrectly diagnosed pneumonia and admitted her to Overlook Hospital, her family said. After being confined to bed for several days, she developed diarrhea, which worsened. Her family said she contracted C-difficile -- an antibiotic-resistant bacteria that attacks the digestive system -- while in the hospital. She became weak and died three months later in a nursing home.

"I know she was older and might have gone one day in her sleep," said daughter-in-law Theresa Symonds of Basking Ridge. "But to see her go this way was horrendous. She was skin and bones. She suffered. ... And the day before she went into the hospital she was outside her house with a cane in one hand and a leaf blower in the other."

The hospital could not comment on specific cases, a spokesperson said.

### **CREATING A NEW SYSTEM**

The state's Epidemiology Surveillance System uses hospital laboratory results to track several antibiotic-resistant organisms. That system, however, is severely backlogged. The most recent report -- issued in 2003 -- uses data from 2001.

Bresnitz said staffing limitations have led to the backlog. In addition, he said the hospital laboratory reports are now on paper and the state is working toward creating an electronic system to get information back to hospitals more quickly.

"Then we can get back to hospitals in real time," Bresnitz said. "Right now, they (the reports) are basically sitting there."

A Star-Ledger request filed under the state Open Public Records Act for data collected by the surveillance system for 2005 and 2006 -- but not yet compiled in a report -- was denied by the state Department of Health and Senior Services. The department's denial letter said the information, by law, is available only to health agencies, and that additionally "records concerning morbidity, mortality and reportable diseases of named persons" are exempt under an executive order.

Bresnitz said the system was not designed for consumer use.

"This is basically a resource for practitioners in hospital settings to know the prevalence of various infections in hospitals and to get guidance on what antibiotics might be appropriate," he said.

But health care advocates said better surveillance of antibiotic-resistant infections is critical at a time of heightened concerns over bioterrorism.

"The lack of information is shocking," said David Knowlton, president of the New Jersey Health Care Quality Institute, a nonprofit organization. "There are security issues here."

Some state legislators are getting involved. State Sen. Barbara Buono (D-Middlesex) has sponsored a bill that would require hospitals to check all intensive care unit patients for MRSA, an especially lethal and antibiotic-resistant type of staph infection. The most recent surveillance report identified 3,903 examples of MRSA in New Jersey hospitals in 2001.

"In Europe, every patient is tested for MRSA upon entering the hospital," she said. Europe is eradicating MRSA, she said.

The bill does not require the state to make hospital MRSA rates public. Buono wants public reporting, she said, but she said state health officials told her there was no funding to turn the data into a report suitable for consumers.

A spokesman for the AARP of New Jersey called the bill "a good step," but said it didn't go far enough.

"We still think information about infection rates should be available to the public," said spokesman Douglas Johnston. "Our members absolutely care about this issue."

There are some signs of openness. Just three weeks ago, the New Jersey Hospital Association began posting limited data on post-surgical infections on its Web site. It names specific hospitals and compares rates with "expected" rates.

Aline Holmes, the association's senior vice president for clinical affairs, said the association expects to provide additional data in the future.

"Our board thinks transparency is the right way to go," Holmes said.

### **A DAUGHTER'S ANGUISH**

Minodora Tibrea did not expect to take up the cause of hospital infections. Not until her mother, Ruxanda Tibrea, had her gallbladder removed at Meadowlands Hospital in Secaucus. The 67-year-old woman was not in good health, suffering from osteoporosis and multiple myeloma, as well as a bedsore that her daughter said was healed when she entered the hospital for surgery.

The daughter believes the hospital should have known her mother was susceptible to an infection and worked harder to prevent one -- or should have intervened sooner when she said clear signs appeared.

Her mother died on April 6, 2005 -- two weeks after her surgery. The death certificate lists the primary cause as "septic shock," which is physiologic shock caused by overwhelming infection. Three other causes are listed, too, including pneumonia.

The hospital said laws prevent it from commenting on specific cases, but said it has worked with the hospital association to reduce infection rates. The hospital said it went 14 months without one case of ventilator-associated pneumonia, for instance, and 10 months without any central blood line infections in the ICU.

"We're proud of that," said Ken Garay, the hospital's director of medical affairs.

But Tibrea's anguished daughter believes the hospital did not protect her mother from infection. The 31-year-old photographer and administrative assistant who lives in Brooklyn remains angry and unconvinced.

"This should never have happened," she said.

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