

Hospitals will report patient infections or face losing funds

Treasure Valley medical centers are among those nationwide that have been preparing to meet this requirement.

BY TONY PUGH

MCCLATCHY NEWSPAPERS

Hoping to erase a troubling legacy of preventable infections and deaths, most U.S. hospitals on Jan. 1 will begin reporting the number of patients who contract bloodstream infections following their treatment in intensive-care units.

In the Treasure Valley, Saint Alphonsus and St. Luke's medical centers will both partici-

pate, spokespeople said.

"We've been working on this for more than five years," said Saint Al's spokeswoman Elizabeth Duncan. "We've changed policies, procedures, practices, equipment and communications surrounding this critically important issue. For example, inserting a catheter is now a surgical procedure, and the physician dons a gown, gloves and mask. We also use something

called a BIOPATCH, which is impregnated with CHG, a disinfectant that prevents germs from getting into the catheter. It has been a comprehensive approach to improving patient safety."

St. Luke's spokesman Ken Dey said the hospital system has made the same efforts and its catheter-related infections are well below the national average.

"Patient safety is a huge priority for us and preventing infections is a big part of that," he said.

St. Luke's already reports catheter infections to Medicare,

though the information isn't made public, he said.

The information about infections involving catheters will be made public on a government website later in 2011, giving consumers a fast, easy way to see which hospitals best protect patients from one of the most lethal, yet avoidable medical conditions.

Catheters are tubes used to draw blood or provide fluid or medication to patients. They're commonly inserted into a patient's large vein, usually in the

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INFECTIONS

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chest, neck, arm or groin, and can remain in the body for several weeks.

Infections result if bacteria or germs travel through the line and into the bloodstream.

Nearly 250,000 bloodstream infections occur each year in U.S. hospitals due to catheters, and they contribute to roughly 31,000 patient deaths annually.

But research shows that nearly all the infections are preventable when safety measures are used consistently by hospital staff.

FINANCIAL CONSEQUENCES

The new reporting requirement for the infections is technically voluntary.

But if any of the nation's 4,300 acute-care hospitals don't comply, they would lose 2 percent of their Medicare funding beginning in fiscal year 2013.

The financial incentive plus public scrutiny of hospital infection rates will ensure strong compliance, experts say. More importantly, they say, the new measure will focus more attention on hospital hygiene, which should improve patient safety and shorten the average length of hospitalization.

It's the latest move by the federal government to force hospitals to step up the fight against health care-related infections and a host of virulent superbugs that are growing more resistant to antibiotics. Beginning in 2012, hospitals will have to report the number and rate of surgical site infections, which occur more than 290,000 times a year and claim more than 8,200 lives.

The new mandates are good news for Ed Lawton of Fairfax, Va., who has to use a wheelchair after being stricken with three infections while he was hospitalized for back surgery in 1998.

"I used to lie in bed and think 'I can die just because someone forgot to wash their hands,'" Lawton recalled last week. "At least now, some information will be available to give the public a sense of whether they're going into a hospital that has a chronic problem. We all should have an expectation that we're not going to go to the doctor and get worse."

But sadly, that's exactly what happens to 5 to 10 percent of patients who contract a health care-associated infection while hospitalized.

A BIG PROBLEM

The Centers for Disease Control and Prevention estimates that Americans contract 2 million infections a year while receiving medical care and pay about \$6.5 billion for the extra treatment. About 1.7 million health care-associated infections occur in U.S. hospitals. They lead to about 90,000 preventable deaths annually, the CDC estimates.

That would make infections from medical care the sixth most frequent cause of death in the U.S. in 2007, the last year for which those annual mortality data are available.

Only heart disease, cancer, strokes, lower respiratory diseases and accidents killed more Americans that year, according to government figures.

"If any other industry was accidentally causing over 90,000 deaths a year, it would be out of business," said Betsy McCaughey, the chairman

and founder of the Committee to Reduce Infection Deaths. McCaughey, a former Republican lieutenant governor of New York, was a controversial figure last year for her suggestion that seniors would suffer under Democrats' efforts to overhaul the health care system.

ACTION, NOT INFORMATION NEEDED

McCaughey said the infection reporting rule will encourage hospitals to better police their facilities, but added that 27 states already require reporting on health care-related infections, and the problem is still raging.

"We don't need more information," McCaughey said. "We need clean hospitals and we need them now. We need clean hands, clean bedrails, clean curtains and clean lab coats."

Lawton, a retired Air Force captain, required five additional surgeries because of his infections, two of which were resistant to antibiotics. His experience has made him a stickler for cleanliness.

"I can assure you, when I go into a hospital (or medical setting), nobody touches me without washing their hands," Lawton said. "There's still young doctors or interns who haven't been exposed to the infection problem and don't realize that they're endangering me by touching me without washing their hands."

WHAT AND WHEN HOSPITALS REPORT

The new rule calls for acute-care hospitals — those that provide 24-hour care and have emergency rooms — to report four times a year on the number and rate of patients who get catheter-relat-

ed bloodstream infections in intensive care units and in neo-natal intensive care units.

The data for each hospital will be publicly reported later next year on the Hospital Compare website of the U.S. Department of Health and Human Services.

In October 2008, Medicare stopped paying for the treatment of certain infections that patients contracted while in a hospital. In addition, HHS is also planning to publicly report individual hospital data on eight other health care-acquired conditions, including infections specifically caused by vascular catheters and catheter-related urinary tract infections, which are the most common infection that occurs during treatment.

CONTRIBUTING FACTORS AND CURES

Simple pressures and stresses of hospital life — long hours, staff shortages and spending less time with more patients — cause medical caregivers not to wash their hands or change their gloves as often as they should, said Dr. Brian Koll, the chief of infection control at Beth Israel Medical Center in New York City.

"I don't want people to think that people are doing this in a malicious or malignant manner. It's just a part of human nature," Koll said.

In 2005, Koll led an effort to eliminate catheter-related bloodstream infections in the intensive care units at 36 hospitals in the New York area. Administrators, nurses and the health care unions all bought in.

By 2008, the rate of infection had dropped 70 percent collectively and more than half of participating hospitals cut their infection rate by at least 50 percent.

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The key was using a checklist of preventative measures for each patient and making it easier for staff to follow proper hygiene practices. Koll made sure alcohol-based hand sanitizers were everywhere and urged staff to remind each other about hand washing.

A similar effort in Michigan, known as the Keystone Project, saw the rate of catheter-related bloodstream infections fall to zero for 18 months in 103 intensive care units that participated in the project.

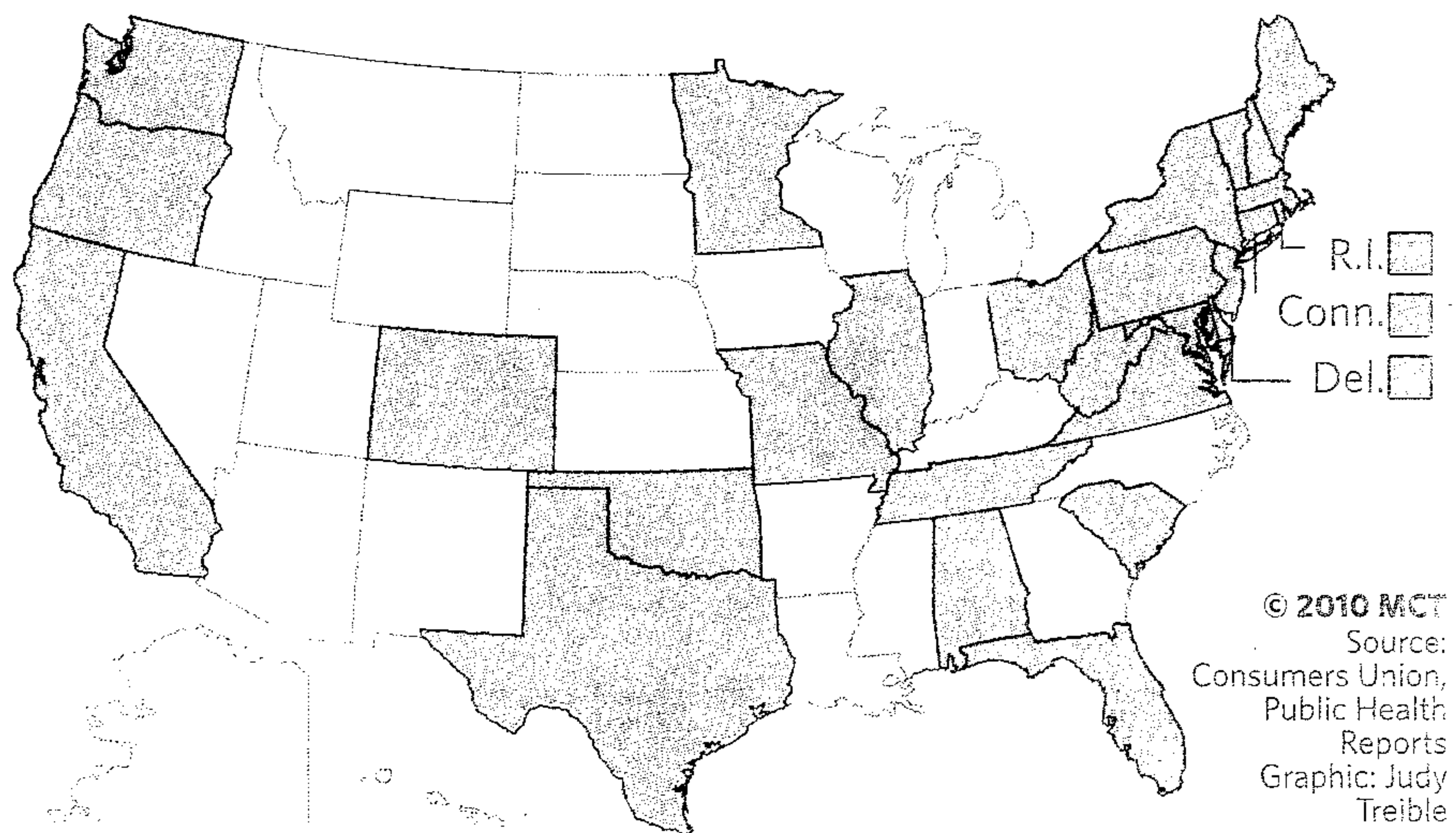
Nancy Foster, vice president of quality and patient safety policy at the American Hospital Association, said the results changed the thinking of many who believed that a certain level of infections were inevitable in hospitals, considering the dangerous nature of the work and the large numbers of sick people.

“Keystone has taught us that that’s not true. If you figure out what the right steps are and how we can deliver them each and every time, we can get to zero or near zero,” Foster said.

Statesman staff contributed.

REPORTING INFECTIONS

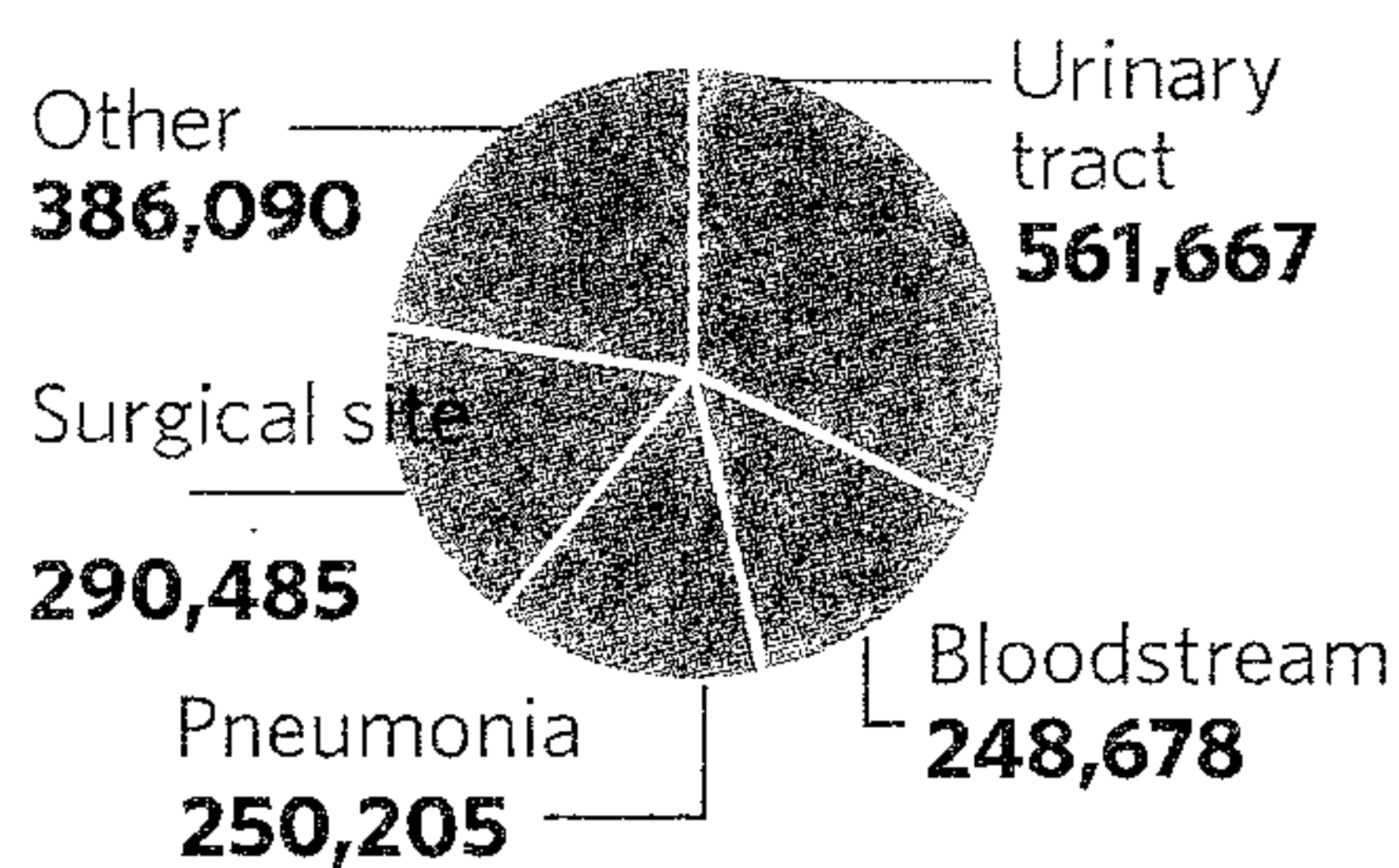
Between 5 and 10 percent of all patients contract at least one healthcare-associated infection (HAI) during their stay at U.S. hospitals. States that require public reporting of HAI cases:



Where HAI strikes Major sites of infection at hospitals

2002 data

Annual cases Total: 1.7 million



Annual deaths Total: 98,987

