Multi-Drug Resistant Organisms & Hospital Acquired Conditions

Size of the Problem and Mechanisms of Control

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The information in this presentation is the express opinion of Kevin T Kavanagh
MDROs Places Facilities at Risk

- Dangerous Infections such as Ebola, CRE are real and place the entire facility at risk.
- But so do MRSA, C. Difficile and Other Dangerous Bacteria..
Transparency is Important

- Health Watch USA feels public reporting promotes quality of the health care system and certainly as evidenced by the Ebola outbreak, transparency promoted the rapid adoption of stronger protocols to confront Ebola throughout the nation.
Revised Kentucky Regulations

The following parts will be discussed:

- Definition of an Outbreak.
- Timely Access of the KY Dept. of Health to NHSN Data.
- Laboratory Reporting of Bacteria, Including MRSA
Definition of An Outbreak

• Before – CDC: “Above a baseline” was used and what a baseline was in the eye of the beholder.

• The problem of a loose definition of an outbreak was exemplified by the apparent discrepancy between the CRE events found by reporter Laura Ungar and those reported to the State of Kentucky (April 2013).

• Proposed Regulation – Outbreak is quantified.

“HAI outbreak” means:

(a) The occurrence of two (2) or more HAIs that are epidemiologically linked or connected by person, place, or time; or

(b) A single case of an HAI not commonly diagnosed such as a postsurgical group A Streptococcus infection or healthcare-associated Legionella infection.
Timely Access to Data Reported to National Healthcare Safety Network

- NOT Duplicative.
- Health Department did not have access to actionable data.
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New KY Regulation “Section 12: Healthcare-Associated Infection Surveillance. A healthcare facility in Kentucky that participates in CMS reporting programs shall authorize the CDC to allow the Kentucky Department for Public Health to access health care-associated infection data reported to NHSN.”
Voluntary Reporting

• The U.S. House Committee members appeared to be reluctant to trust self reporting in travelers with exposure to Ebola.

• The same is true for other industries, including the healthcare industry.

• This is just human nature.

“An observation included in this report was from officials at the Joint Commission who estimated that only 0.1% of sentinel (severe) events are reported”.

Methicillin-Resistant Staphylococcus Aureus - MRSA

In Northern Europe – Less than 5% of Staph Cultures are MRSA Positive.

In the United States – 50% of Staph Cultures are MRSA Positive.

In the Region Kentucky Resides – Almost 70% of Staph Cultures are MRSA Positive.
Methicillin-Resistant Staphylococcus Aureus - MRSA

- Since 2008 we have been trying to have these infections reported.
- Assured all is well.

MRSA is reported to the NHSN for only bloodstream infections (lab event).
-- The picture to the right would not be reportable.
Kentucky has the 4th highest incidence in the 50 States.
Why is this epidemic not under control?

• Not Adopting Effective Prevention Protocols

-- A desire to not have mandates legislated may have led to the not setting of standards.

http://aac.asm.org/content/57/12/5789.full.pdf

• -- A conflict of interest may bias recommendations.

Ebola Has Demonstrated The Need For Stricter Guidelines

- A “one size does not fit all” mentality has created confusion and a “do what you want approach” in many institutions who do not know what their size is.
- National Nurses United (NNU) statement: “Multiple choice is not a standard”

You know there is trouble when the largest Nursing Union is testifying before a Republican Committee and is running these issue advertisements prior to an election.
Standards Regarding Surveillance

• For Ebola: Surveillance and isolation is advocated and felt as being mandatory.

• The desire not to have mandates has led to not having standards.

• Union of Concerned Scientists: “Downplaying evidence and playing up false uncertainty”
Stronger Recommended Standards

• Definition of Outbreak – New Regulation Addresses. Quantitate what an outbreak is not “above baseline”.

• NNU calling for better recommendations for Personnel Protective Equipment.

• Better definition of Contact Precautions. “A single patient room is preferred for patients who require Contact Precautions.”
Precautions for Suspected Patients

Ebola has demonstrated the need to take precautions for suspected patients as if they were confirmed patients.

• Patients suspected of having diarrhea from C. Difficile should be isolated until tests are back.
Feds stop public disclosure of many serious hospital errors

Jayne O'Donnell, USA TODAY 9:50 a.m. EDT August 6, 2014

The federal government this month quietly stopped publicly reporting when hospitals leave foreign objects in patients’ bodies or make a host of other life-threatening mistakes.

The change, which the Centers for Medicare and Medicaid Services (CMS) denied last year that it was making, means people are out of luck if they want to search which hospitals cause high rates of problems.
Hospital Acquired Conditions

Non-Payment of Hospital Acquired Conditions.
--- Because of billing complexities this policy was ineffective.

1% Penalty for Hospital Acquired Conditions in lower Tier (25%) of Hospitals.
--- This policy was enacted for FY 2015

Kavanagh KT, Letter to the Editor regarding: The effectiveness of Medicare's policy of non-payment of hospital acquired conditions. Health Policy. 2014