Multi-Drug Resistant Organisms & Hospital Acquired Conditions

Size of the Problem and Mechanisms of Control

Kentucky House Health and Welfare Committee
Nov. 19th, 2014

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Health Watch USA

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..

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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.

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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

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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.

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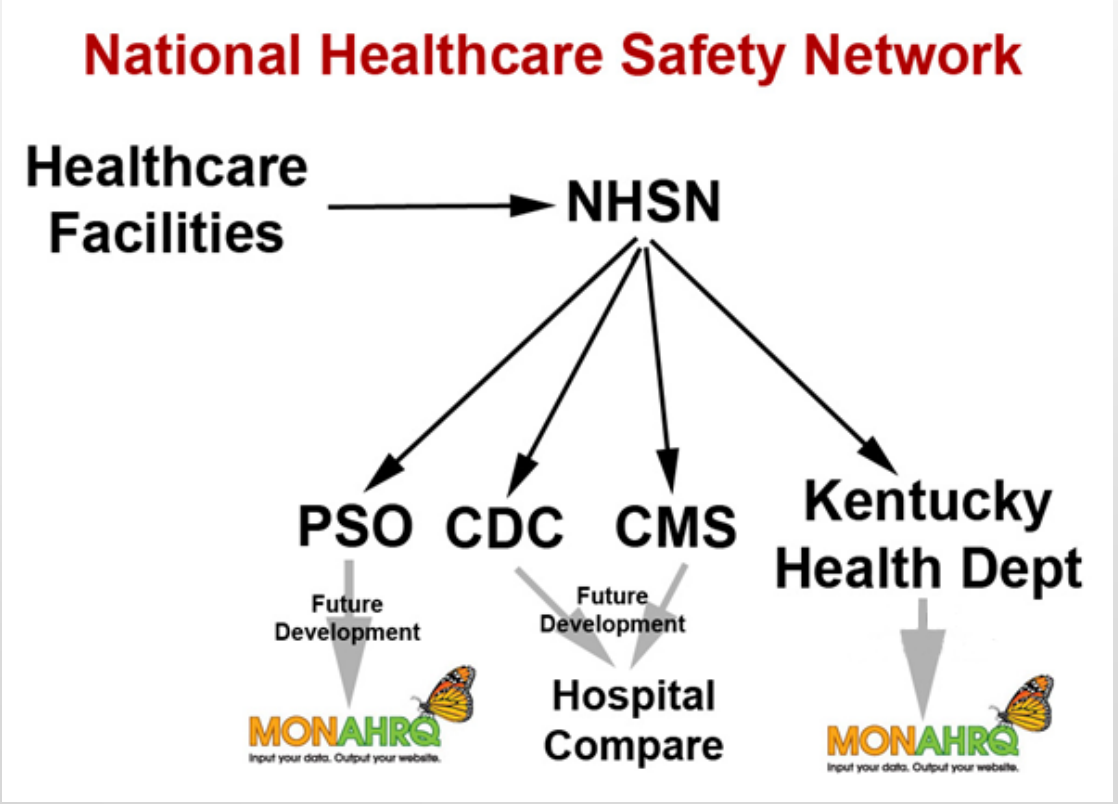
Timely Access to Data Reported to National Healthcare Safety Network

- NOT Duplicative.
- Health Department did not have access to actionable data.



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Timely Access to Data Reported to National Healthcare Safety Network

- NOT Duplicative.
- Health Department did not have access to actionable data.

  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."

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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".

Levinson DR. Adverse Events in Hospital: Overview of key issues. Dept. of Health and Human Services, Office of Inspector General. Dec 2008, Page 25, 32 http://oig.hhs.gov/oei/reports/oei-06-07-00470.pdf

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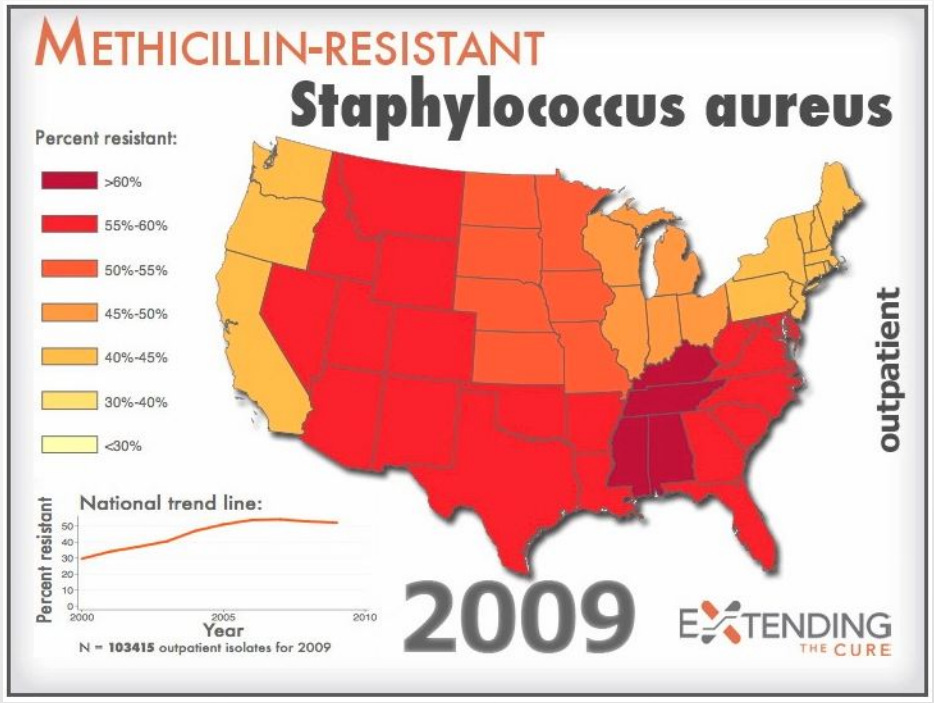
Methicillin-Resistant Staphylococcus Aureus - MRSA

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.



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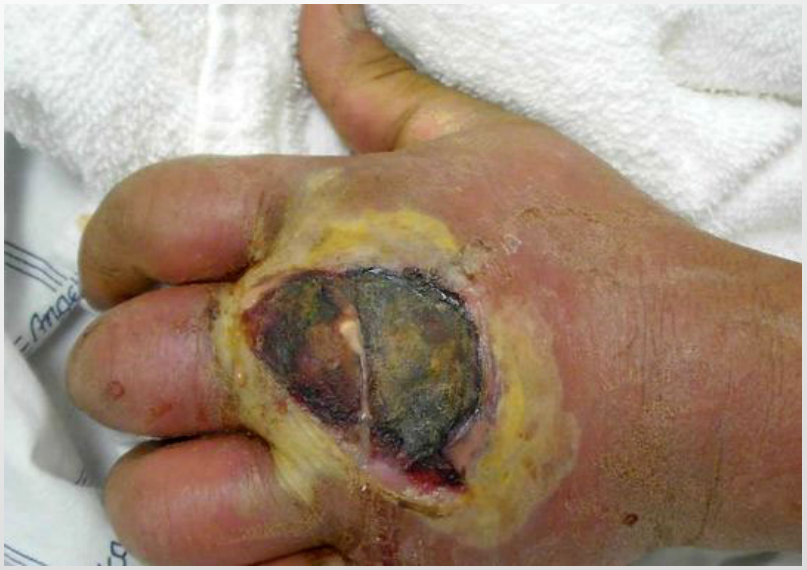
Methicillin-Resistant Staphylococcus Aureus - MRSA

- 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.



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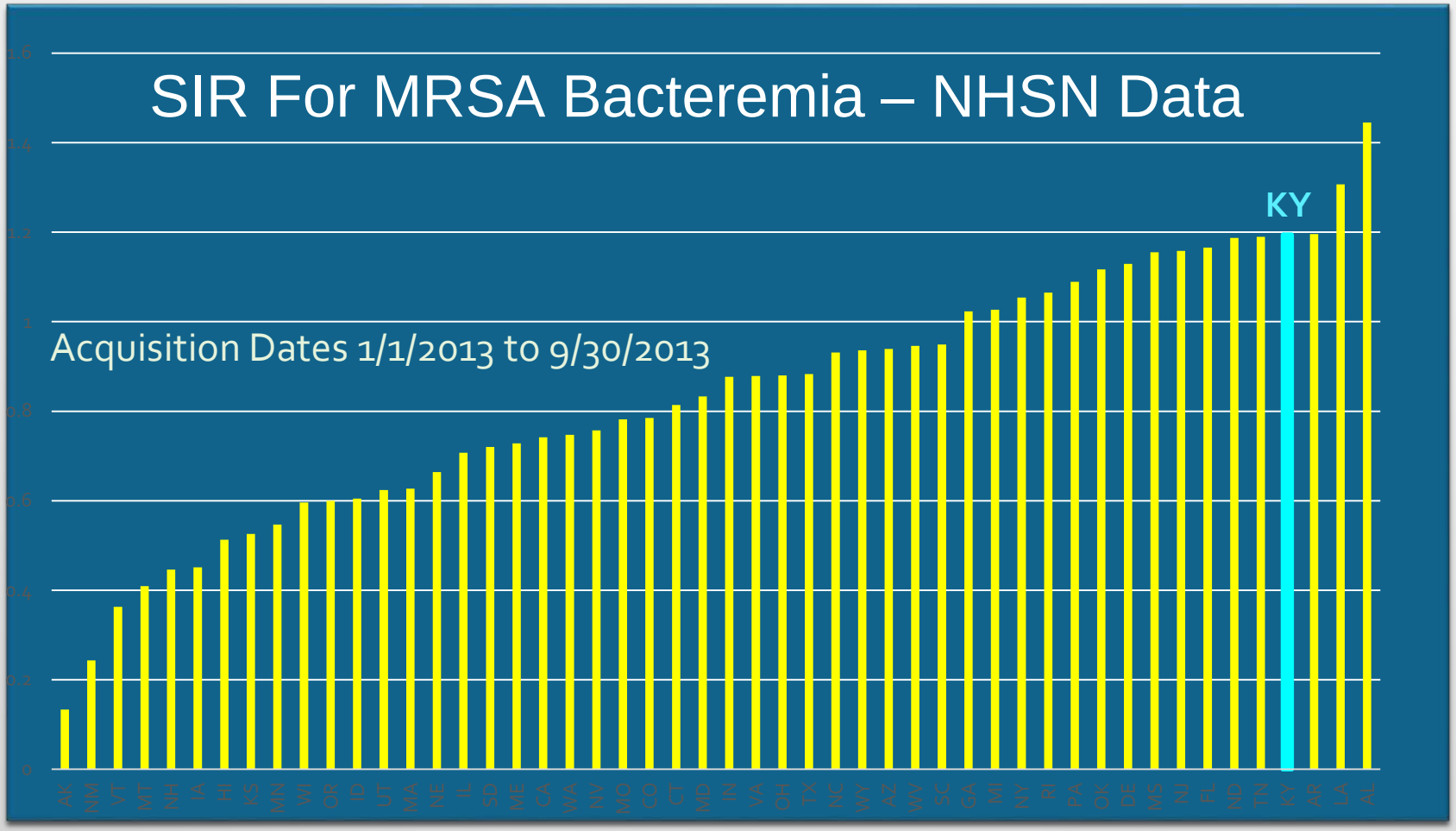
MRSA Bacteremia in Kentucky



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.

A Perspective on How the United States Fell Behind Northern Europe in the Battle Against Methicillin Resistant Staphylococcus Aureus. Antimicrobial Agents and Chemotherapy. (Ahead of Print. Oct. 7, 2013.) Dec. 2013 57(12):5789-5791. PMID: 24100502
http://aac.asm.org/content/57/12/5789.full.pdf

- **-- A conflict of interest may bias recommendations.**

Wu AW, Kavanagh KT, Pronovost PJ, Bates DW. Editorial: Conflict of Interest, Dr. Charles Denham and the Journal of Patient Safety. Journal of Patient Safety. June 16, 2014. (In Review).

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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.

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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"

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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.

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Hospital Acquired Conditions

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Feds stop public disclosure of many serious hospital errors

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

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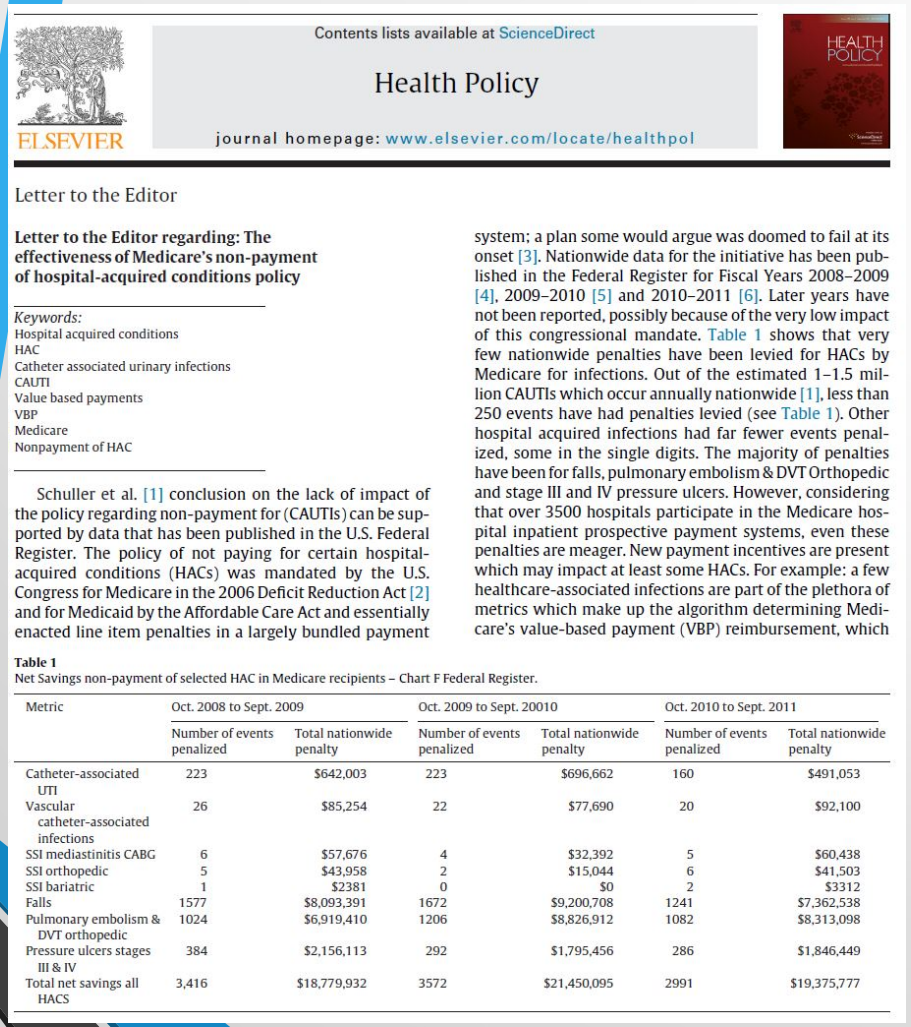
The federal government this month quietly stopped publicly reporting when hospitals leave foreign objects in patients' bodies or make a host of other life-threatening mistakes.

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



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Letter to the Editor

Letter to the Editor regarding: The effectiveness of Medicare's non-payment of hospital-acquired conditions policy

Keywords:
Hospital acquired conditions
HAC
Catheter associated urinary infections
CAUTI
Value based payments
VBP
Medicare
Nonpayment of HAC

Schuller et al. [1] conclusion on the lack of impact of the policy regarding non-payment for (CAUTIs) can be supported by data that has been published in the U.S. Federal Register. The policy of not paying for certain hospital-acquired conditions (HACs) was mandated by the U.S. Congress for Medicare in the 2006 Deficit Reduction Act [2] and for Medicaid by the Affordable Care Act and essentially enacted line item penalties in a largely bundled payment system; a plan some would argue was doomed to fail at its onset [3]. Nationwide data for the initiative has been published in the Federal Register for Fiscal Years 2008–2009 [4], 2009–2010 [5] and 2010–2011 [6]. Later years have not been reported, possibly because of the very low impact of this congressional mandate. Table 1 shows that very few nationwide penalties have been levied for HACs by Medicare for infections. Out of the estimated 1–1.5 million CAUTIs which occur annually nationwide [1], less than 250 events have had penalties levied (see Table 1). Other hospital acquired infections had far fewer events penalized, some in the single digits. The majority of penalties have been for falls, pulmonary embolism & DVT Orthopedic and stage III and IV pressure ulcers. However, considering that over 3500 hospitals participate in the Medicare hospital inpatient prospective payment systems, even these penalties are meager. New payment incentives are present which may impact at least some HACs. For example: a few healthcare-associated infections are part of the plethora of metrics which make up the algorithm determining Medicare's value-based payment (VBP) reimbursement, which

Table 1
Net Savings non-payment of selected HAC in Medicare recipients – Chart F Federal Register.

Metric	Oct. 2008 to Sept. 2009		Oct. 2009 to Sept. 20010		Oct. 2010 to Sept. 2011	
	Number of events penalized	Total nationwide penalty	Number of events penalized	Total nationwide penalty	Number of events penalized	Total nationwide penalty
Catheter-associated UTI	223	$642,003	223	$696,662	160	$491,053
Vascular catheter-associated infections	26	$85,254	22	$77,690	20	$92,100
SSI mediastinitis CABG	6	$57,676	4	$32,392	5	$60,438
SSI orthopedic	5	$43,958	2	$15,044	6	$41,503
SSI bariatric	1	$2381	0	$0	2	$3312
Falls	1577	$8,093,391	1672	$9,200,708	1241	$7,362,538
Pulmonary embolism & DVT orthopedic	1024	$6,919,410	1206	$8,826,912	1082	$8,313,098
Pressure ulcers stages III & IV	384	$2,156,113	292	$1,795,456	286	$1,846,449
Total net savings all HACS	3,416	$18,779,932	3572	$21,450,095	2991	$19,375,777

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


Thank You!