Hospital Infections are Underreported

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You may not like the mining industry, but if it was run like our health care system, you would never hear of an accident and the miners would be charged for their own rescue. This metaphor was made more relevant by the recent Office of Inspector General (OIG) report which revealed that only one in seven hospital errors are reported to the facility's administration.

A functioning public reporting system is desperately needed, as Kentucky's current reporting system is broken. Preliminary data from the State Department of Public Health revealed only two reports of infection outbreaks by all Kentucky hospitals during 2011. Reporting of outbreaks is mandatory and this data validates how grossly under reported this epidemic really is.

Similar to the current testimony in Frankfort on the need for transparency of deaths occurring with children in foster care, the public has the right to know the rates of infections at their health care and long-term care facilities. The federal government has formed a standardized framework for reporting that requires only a few infections to be reported. However, a comprehensive statewide system that involves all types of infections is needed to create change in the health care industry.

Also, public reporting is one of the main strategies that drive improved health care quality. Similar to standardized school testing, the public's knowledge of how a community hospital is doing forces internal improvement. And in health care this improvement is desperately needed, as health care-acquired infections account for nearly 100,000 annual deaths in the United States, which equates to almost 1,400 deaths in Kentucky. It's not all bad news, as marked reductions in infection rates have been observed in Tennessee and Pennsylvania after enacting their public reporting initiatives.

The health care industry has fought the term "Never Events" by advocating that these events can't be prevented. But more and more we are realizing they can be. MRSA, the hard-to-treat deadly staph infection, should not occur in clean

surgical cases and neither should the deadly infections that can arise from treatment catheters inserted into large veins (CLABSI).

Kentucky still has a significant problem with MRSA. Twenty-five to 30 percent of all individuals carry a form of the staph bacteria. In the region that includes Kentucky, The Center for Disease Dynamics, Economics and Policy reports that almost 70 percent of the staph cultures are positive for MRSA. This is one of the highest in the world, where in Northern Europe this rate is less than 5 percent.

There is no question that high-risk or very sick patients are more likely to develop an infection. What is not said, however, is this occurs only if the patient is exposed to the bacteria. For example, for a hospital to receive the highest rating by Consumer Union for the prevention of CLABSIs, the hospital has to achieve a CLABSI rate of zero. These infections should be in the single digits regardless of the type of patient being treated.

Not all infections can have this remarkable reduction, but a significant number can. In addition, researchers at the University of Pennsylvania have recently reported that reductions of 55 to 70 percent can be achieved in a wide range of infections at high-functioning institutions.

Also, public reporting motivates facilities to adopt best practices. The Centers for Disease Control and Prevention operates the national health care Safety Network, a secure, non-duplicative and standardized reporting system. By using this system Kentucky can gather data, apply for grants and effectively confront this epidemic. One of the top priorities of the Kentucky Legislature should be passage of legislation mandating public reporting of health care-acquired infections.

When largely preventable infections do occur, the public should not be charged for care related to them, including future hospitalizations. Currently, Medicare has this policy along with a few private insurance companies. However, because of the complexities of hospital billing practices during the first year of its nonpayment policy, Medicare only recouped $18.8 million . Not charging the patient for hospital-acquired conditions and infections has not been widely adopted by the health care industry, but needs to be.

It is of utmost importance to prevent future health care-acquired conditions and infections and to implement effective prevention protocols. The rates of infections acquired at health care facilities should be made public, and patients who acquire these infections should not be charged for their rescue.

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