PERSPECTIVE

Promoting Health Care Transparency and Competition

The Case for Surveillance for MRSA

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By Kevin T Kavanagh, MD

Should patients admitted to hospitals be routinely tested for MRSA (methicillin-resistant Staphococcus aureus) was one of the topics of the March 6, 2008 Senate Health and Welfare Committee in Frankfort. A bill submitted by Senator McGaha, SB 183, requires this, along with mandatory public reporting of health facility infection rates. In the past, screening for common illnesses in all patients admitted to a facility was common place, now it is seldom done.

One of the presenters who spoke against SB 183 stated that their Kentucky Hospital considers patients who have been hospitalized at another institution at risk of having MRSA. A testament that if you go to a health care facility in Kentucky you are likely to pick up MRSA whether you want it or not. This is confirmed by a research study by Klevens et.al. published in JAMA (2007) which reports 62% of patients with a MRSA infection that developed in the community or within 48 hours of hospitalization, had been previously hospitalized within the last 12 months. Other risk factors were a history of surgery in 30%, and admission from a long term care facility in 31%.

Multi-resistant drug organisms and healthcare acquired infections (HAIs) are a huge problem. One which according to the CDC is more common than any other reportable disease and "deaths associated with HAIs in hospitals exceeded the number attributable to several of the top ten leading causes of death reported in the U.S. vital statistics.".

As outlined in the proposed SB 183: "Routine screening and isolation of all patients with MRSA in hospitals in Denmark and Holland have reduced their MRSA infection rate to ten percent (10%) of their bacterial infections and, following a pilot program by the United States Department of Veterans Affairs' Pittsburgh Healthcare System that reduced MRSA infections in its surgical care unit by seventy percent (70%), all Department of Veterans Affairs health care facilities have been directed to develop and implement similar procedures."

The Lexington Veterans Administration Hospital's findings are staggering: 10% of all patient admissions are MRSA culture positive and of these 17% develop infection, compared to less than 1% of culture negative patients.

I hate to make a Pinto style cost benefit analysis. But it seems I more and more have been asked to do so. So for those of you who value economics as the primary mechanism to make healthcare decisions, here it is. The cost of taking care of healthcare acquired infections has drastically changed. No longer is just the cost of testing an issue. The accounting issue is that Medicare and likely soon to follow, Medicaid and Private Insurance, will not pay if an infection is acquired at a healthcare facility. The health care facility will no longer profit from their patients developing an infection. Instead, they will have to foot the bill.

For example, a small hospital with 25,000 admissions can no longer be just concerned with the cost of $250,000 to $750,000 for identification of asymptomatic patients. In 2005, the State of Pennsylvania found an incidence of hospital acquired Infections of over 1% of all admissions. The real increase in cost is estimated by the State of Oregon to be $32,000 and Pennsylvania to be $52,600 per patient of care that the hospital may not be reimbursed

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Summary
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"Deaths associated with HAIs in hospitals exceeded the number attributable to several of the top ten leading causes of death reported in the U.S. vital statistics."— CDC

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for. Thus, one could argue that Medicare patient admissions in the State of Kentucky would develop 2,500 hospital acquired infections and at risk of losing between $80,000,000 to $131,000,000 in revenue.

It makes no difference if you want to spend preventive money elsewhere, the fact is you need to spend it everywhere or the losses to the institution will be staggering.

Because of the increase risk of developing an infection in a patient colonized with MRSA, one might be able to make the argument that if colonized and an infection occurs, payment should still take place.

One could argue that Medicare patient admissions in the State of Kentucky would develop 2,500 hospital acquired infections and at risk of losing between $80,000,000 to $131,000,000 in revenue.

Facilities that are against patient identification are not only placing the general public at risk but also may be securing their financial demise.

SB 183 is one of the most important public safety legislation which is currently being considered in Frankfort. However, the bill goes even farther and mandates public disclosure and reporting of facility infection rates. This increases transparence and empowers patients allowing free market pressure to promote and maintain healthcare quality.

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