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## [State MRSA Laws](#)

Laws relating to methicillin-resistant Staphylococcus aureus (MRSA) testing, reporting and prevention.

## [Map of state hospital infection reporting activity](#)

Map of the U.S. detailing reporting of hospital infection rates by state.

## [State Hospital Infection Disclosure Laws](#)

Summary of state laws as of October 2008.

## [State Hospital-acquired Infection public reporting and MRSA prevention bills under consideration in 2008](#)

This chart details hospital infection reporting bills being considered by state legislatures in 2008. Twenty one states have laws that require public reporting of infection rates.

## [Congressional Legislation](#)

Hospital-acquired infection public reporting bills and antibiotic resistant protection and prevention bills under consideration in Congress.

## [Hospital-acquired infection public reporting bills under consideration in 2007](#)

This chart details hospital infection reporting bills being considered by state legislatures in 2007. Twenty one states have laws that require public reporting of infection rates.

## State hospital infection reports now available:

Select from list below



## More About The Issue

### [A Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals](#)

A Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals puts existing guidelines and clinical experience into a more practical format that is more useful to health care workers and hospital staff and can help hospitals design comprehensive infection control programs. The compendium covers surgical site infections, central-line-associated bloodstream



## REAL PEOPLE, REAL STORIES

### **Kelsie Knepp, Lapel, Indiana**

Kelsie Knepp was an active 17-year-old high school volleyball player when a bad landing on a spike injured her ACL. She went in for knee surgery on September 17, 2007 expecting to be back at school after just one week. Kelsie went back to class, but developed soreness in her leg and felt so sick she wasn't able to go back the next



day. Instead, she went back to the hospital where doctors determined she had developed an infection, opened her surgical incision and cleaned out the wound. A nurse handed Kelsie's mother a pamphlet on MRSA, with the doctor dismissing the infection as "bad luck." Kelsie had a MRSA infection in her blood and was sent home with a PICC line that she used until the end of October. [Read more »](#)

### [Share your hospital infection story.](#)

Have you or a loved one contracted a hospital infection when you went in for surgery or other illness? Over a 1000 people have shared their hospital infection experiences. We would like to hear your story. [Read their stories.](#)



# Safe Patient Project

## Expanded Patient Safety Campaign

- Hospital-acquired infections, including prevention of superbug infections
- Drug safety: FDA reforms and direct-to-consumer advertising (drugs and devices)
- Medical errors/medication errors: disclosure and payment structure; impact of over-treatment
- Physician Profile Disclosure Act: information people should have about their doctors

# Impact of Hospital-Acquired Infections

- Nearly 2 million patients are infected in hospitals each year (CDC)
- 1 in 20 hospital patients get an infection while there (CDC)
- Almost 100,000 patients die from hospital infections each year (CDC)
- average cost of a serious infection following surgery: \$57,000 (AHRQ)
- \$27.5 billion a year in hospital costs alone (CDC, John Jernigan)
- 76% of hospital infections were billed to Medicare (67%) and Medicaid (PHC4)



## **Consumers are driving change because the health care system failed to do so**

Culture of inevitability and acceptance  
Debating “preventable”

Semantics of obfuscation  
Nosocomial to health care associated

Getting to zero v. average

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Originally published Tuesday, November 18, 2008 at 12:00 AM

Comments (15) E-mail article Print view

## MRSA: Patients revolt against hospital secrecy

MRSA: Consumers have launched a battle against hospital secrecy and demanded aggressive steps to control infections like MRSA. But in Washington state, MRSA rates remain hidden and state initiatives to combat the drug-resistant germ have come up short.

By Michael J. Berens and Ken Armstrong  
Seattle Times staff reporters

A night-shift nurse slipped into Jeanine Thomas' hospital room and whispered, "I don't know how you're taking this so well. If I were you, I'd be curled up in a ball crying."

The remark mystified Thomas. She'd had ankle surgery, and yes, there had been complications. But she thought she was recovering. Was there something she didn't know?

In November 2000, Thomas, then a 45-year-old antiques dealer, had slipped on ice and shattered her left ankle outside her suburban Chicago home. But days after surgery at her local hospital, the skin surrounding the incisions turned black, and her body swelled. Doctors wanted to amputate, but Thomas, an avid tennis player,



MIKE SEGEL / THE SEATTLE TIMES  
MRSA survivor Jeanine Thomas has become one of the nation's most influential patient advocates for hospital transparency.

### More Local News

- MRSA: Patients revolt against hospital sec
- UPDATE - 02:15 PM
- Threat reported on Washington ferry
- Average family "pretty solid"
- Lynnwood tries for more turf in South Snoh
- County
- Marysville man held in shooting of daughte

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## State work

- Disclose hospital infection rates
- Require hospitals to use Active Detection and Isolation (ADI) to prevent MRSA infections
- Implementation of state laws – advisory committees, promoting reports when issued, public education
- Accountability of hospitals – working directly to change hospitals in your community



# Why publicly report?

- Improve quality
- Right to know
- Inform hospitals and providers how they compare
- Patient informed choices – evidence-based medicine
- Stimulate change within the hospital – does active identification create a change in behavior?
- Stimulate conversations about quality and safety (for those without choice)
- Public awareness of performance can stimulate pressure from community (media, conversations with other providers – docs re hospital, e.g.)

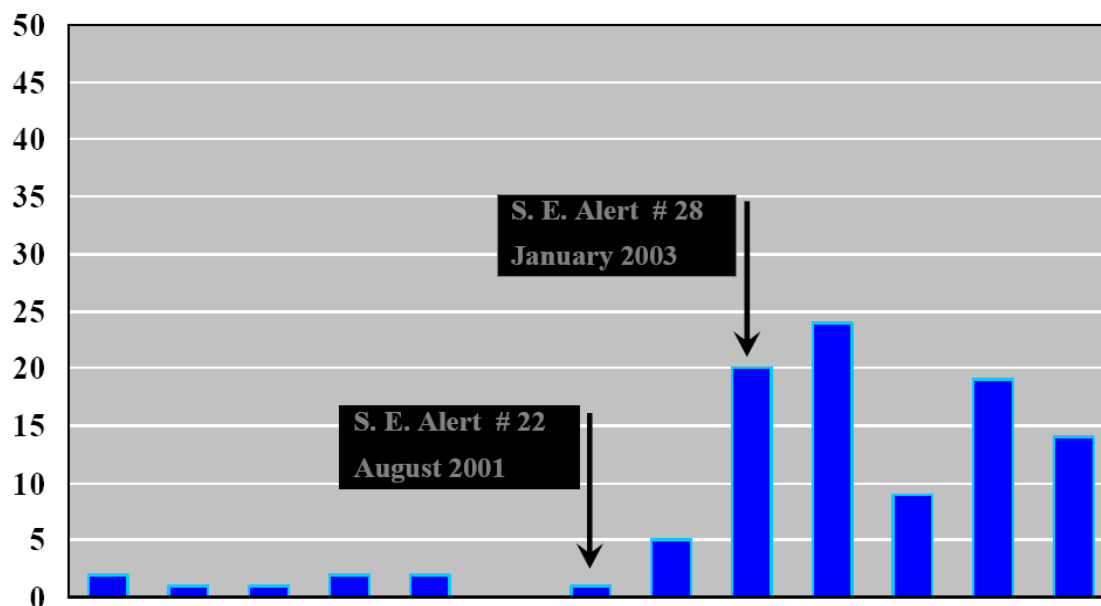


# Voluntary reporting doesn't work

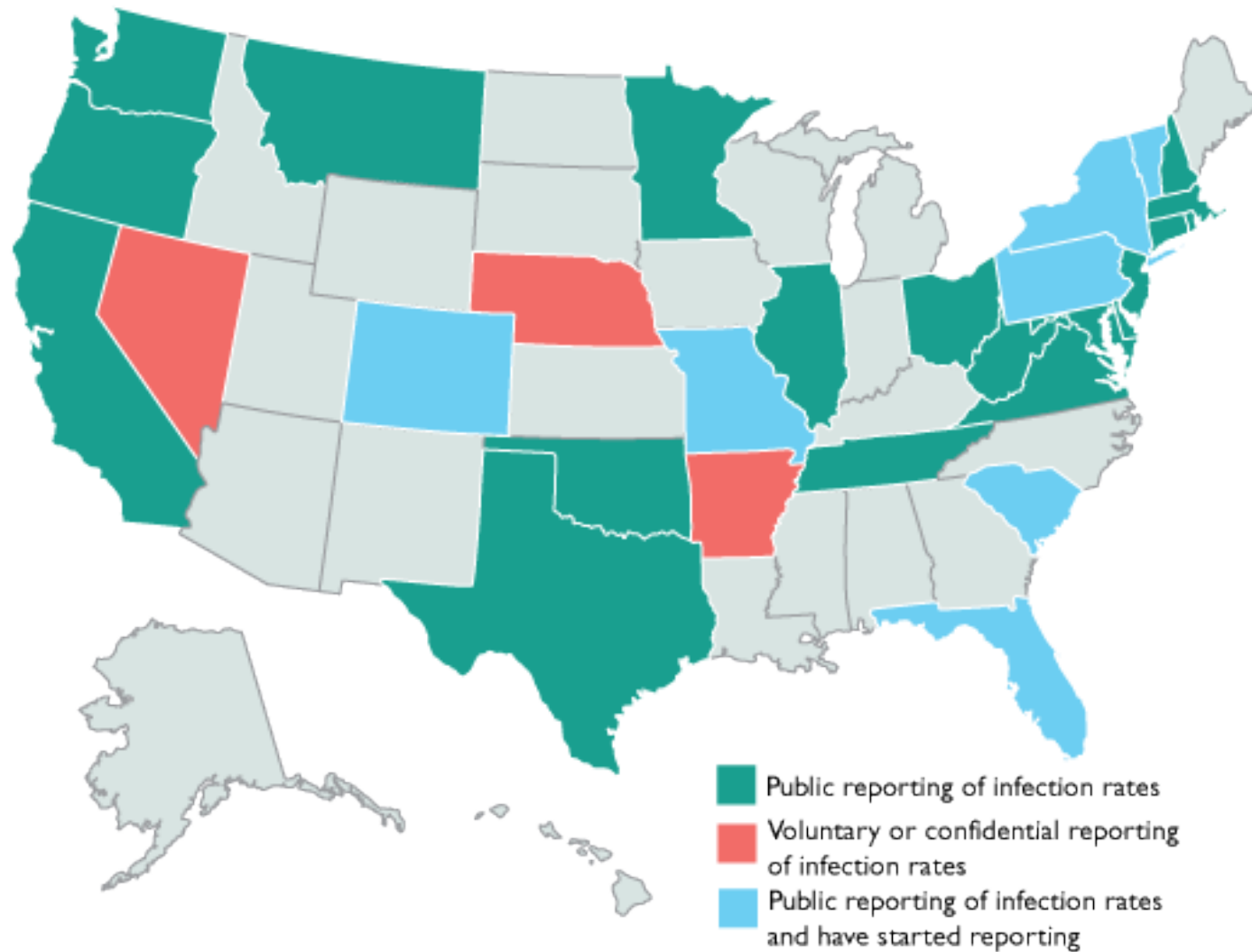
## Joint Commission

### Sentinel Event Statistics: 1995-2007

#### Infection-related Events Reviewed by Year



# Reporting of hospital infection rates



# Tips for the Public Reports

- Consistent and sustainable; regular reports
- Timely -- 12 month accumulated rates, updated quarterly – a “rolling” 12-month period
- Comparisons from year to year to mark improvement and should distinguish among hospitals
- Reports designed with consumer in mind; the top and bottom performers are obvious
- Ability to access hospital-specific information - maps are useful
- Quick at-a-glance graphics that allow for comparisons in numerous ways – regionally and among like hospitals in the state
- Data should include various levels of information: rates, numbers of infections, mortality, length of stay, mortality
- Analysis of the data – translations and conclusions; semantics are important (goal of zero; “as expected” in Florida)
- Drill down information that can be accessed with a click through – these should be interactive reports that allow for adding information
- Widely disseminated in the community

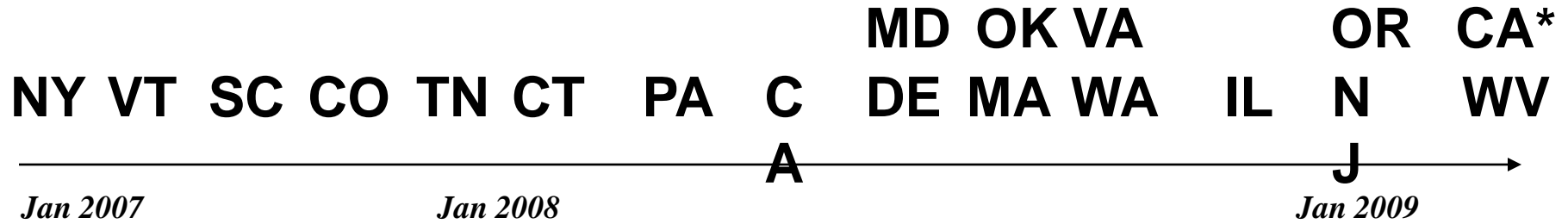
# CDC National Healthcare Safety Network

- NNIS: Voluntary system for monitoring nosocomial infections - 315 hospitals (1970 - 2004)
- NHSN: Voluntary system for monitoring healthcare-associated events and processes (2005 - )
- Used to comply with State legislation that mandates reporting of HAI data - 1930 hospitals (2007+)



# 18 States Using NHSN for Public Reporting

(Combined information from CDC and Consumers Union as of 11-08)

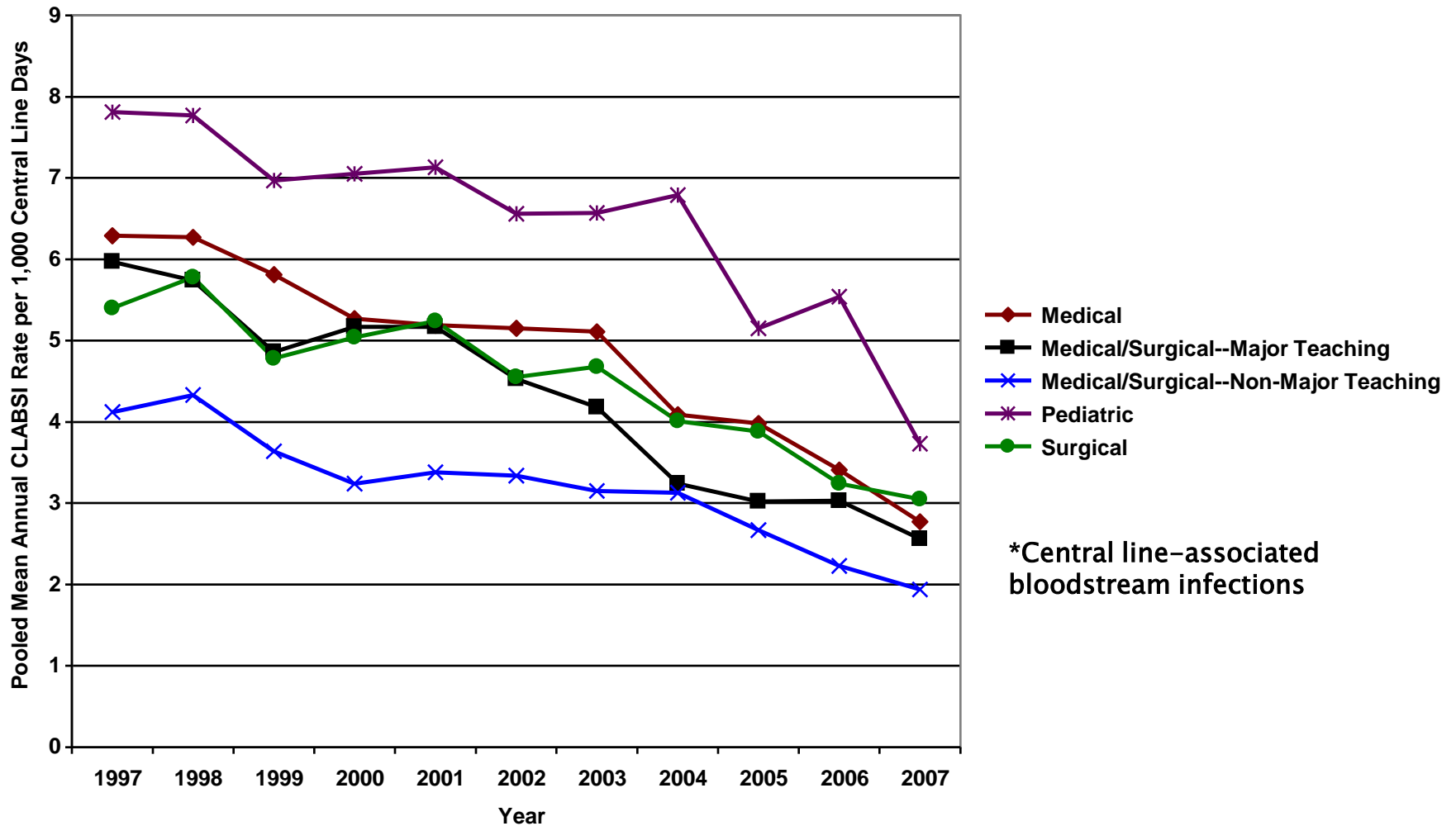


CLABSI (central line associated blood stream infections)	CA*, CO, CT, DE, IL, MA, MD, NJ, NY, OK, OR, PA, SC, TN, VA, VT, WA
CAUTI (catheter-associated urinary tract infections)	PA
SSI (surgical site infections)	CA*, CO, DE, MA, NJ, NY, OR, PA, SC, TN, VT
VAP (ventilator-associated pneumonia)	OK, PA, SC, WA
Dialysis events	PA
MDRO (mult drug resist orgnsm)	CA*, MD, NJ, PA
Process measures	CA, DE, MD, NH, NJ, PA, VT

# Hospitals Participating in NHSN are Preventing Bloodstream Infections

Trends in Bloodstream Infections\* by ICU Type, United States, 1997–2007

(Centers for Disease Control and Prevention Presentation 11–08)



# MRSA by the numbers

- 95,000 serious MRSA infections in 2005, up from prior estimate of 31,000 in 2000 (CDC)
- Almost 19,000 hospital patients died in 2005 from serious MRSA infections (CDC)
- 85% of serious MRSA infections were acquired while getting health care – hospitals, nursing homes, dialysis (CDC)
- 58% of health care acquired infection symptoms surface while in the community, not while in the hospital (CDC)
- One of every 20 (5%) of the 368,600 patients treated in U.S. hospitals in 2005 for MRSA died (AHRQ)
- standardized incidence rate of serious MRSA infections was 32 per 100,000 people (CDC)

# MRSA screening studies

*Harbath, Stephen et al, "Universal screening for MRSA at hospital admission and nosocomial infection in surgical patients," Journal of the American Medical Assn, March 12, 2008, pp. 1149-1157.*

## Swiss hospital

- Conclusion: “universal screening” does not reduce infections, but was not “universal”
- Screened surgical patients only, but 31% had no culture result prior to operation
  - Prophylactic antibiotics and decolonization cannot occur – defeats purpose of screening
  - Group of patients with results prior to operation and appropriate prevention used = zero infections
- Extremely low infection rate at the start
- Did not measure the effect on the whole hospital



# MRSA screening studies

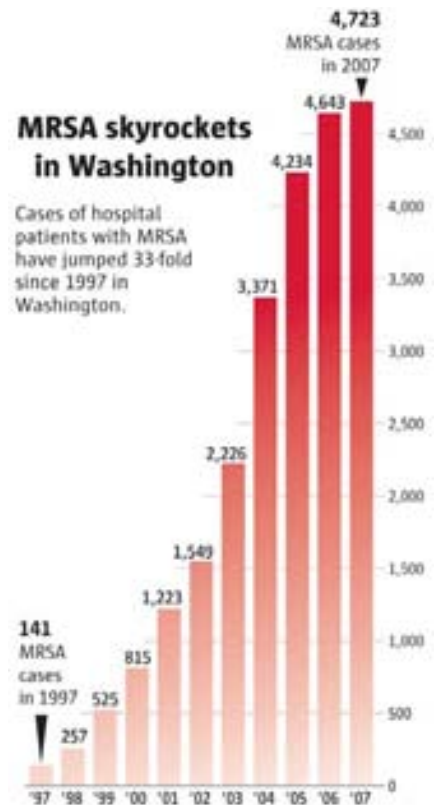
*Robicsek, Ari et al, "Universal Surveillance for Methicillin-Resistant Staphylococcus aureus in 3 Affiliated Hospitals," Annals of Internal Medicine, March 18, 2008, p. 416.*

Evanston, IL – 3 hospital system

- Conclusion: “universal screening” significantly reduced infections
- Hospital-wide effect measured
- Over 50% reduction in MRSA infections using universal screening in the hospital system
  - 70% reduction during course of their study
- Previous targeted screening did not significantly reduce infections

# Seattle Times series on MRSA - 11/08

## Investigative reporting works



Source: Seattle Times analysis; state Department of Health data  
AMANDA RAYMOND / THE SEATTLE TIMES

- Used billing data and hidden information in state death certificates
- Found repeated violations of infection prevention policies: e.g., a surgeon refusing to use a mask, blood technicians touching materials with contaminated hands, and rooming MRSA patients with those who don't have the germ.
- Tracked back to an outbreak at one hospital in the 1980s and looked at the hospital today
- Surveyed hospitals' infection control policies and reviewed health department inspection records

# C. Difficile - the newest old bug

## **New strain in new populations -**

- BI/NAP1 resistant to certain antibiotics and more toxic (fluoroquinolones);
- In 2005 CDC researchers called an epidemic

## **APIC Prevalence study - 11/08 - on any given day...**

- 13 out of every 1,000 -- over 7100 inpatients infected or colonized with *C. diff* (94.4 percent infected)
- 73% infected in health care facilities
- Cost approximately \$35 million (daily)
- Kills 380 patients (daily)
- Rate is 6.5 to 20 times higher than previous incidence estimates

## **Agency for Healthcare Research & Improvement (AHRQ)**

- Hospital patients with *C.-diff.* infections more than doubled between 2001 and 2005 - to 301,200 patients in 2005 (AHRQ HCUP)
- Death rates rose from 1.2% in 2000 to 2.2% in 2004 (data from death records and the National Inpatient Sample)

## C. Difficile - Cont'd

### What needs to be done?

- Improved cleanliness in hospitals - bleach cleaning solution is most effective.
  - Hospitals that have stepped up efforts to more thoroughly clean hospital wards have effectively controlled the spread of *C.-diff.*
  - Unfortunately hospital cleaning budgets are frequently cut and cleaning staff are often inadequately trained.
- Hand washing must be with soap and water; commonly used alcohol-based hand gel is ineffective against this bacteria.
- Very difficult to get rid of - so prevention is best defense
- Vaccines are being researched

# Federal/national Issues:

- Bills and hearings in Congress on reporting infection rates and MRSA prevention/screening (CDC-NHSN)
  - Durbin reintroducing, Waxman interested
- National Quality Forum - Endorsed measures, priority area
- Joint Commission accountability - loses deeming status in 2 years
- HHS “Eliminating Hospital-acquired infections”
  - Response to GAO study
  - Workgroups, setting goals for reduction, what’s “preventable”
- CMS reporting – Hospital Compare
  - Only process measures for hospital infections
  - Significant expansions proposed in the next 5 years - more outcome measures

# Federal/national Issues - Cont'd:

- CMS no-payment rule – 10 hospital-acquired conditions
  - ripple effect with other payers
  - UTIs already being affected
  - Protects against patient billing
  - More to be added later
- Pending patient issues with hospital-acquired conditions
  - Protection against losing coverage due to Medicare limits
  - Protection against bankruptcy; out-of-pocket costs
  - Protection against quick discharge

CMS webpage on nonpayment rules: [http://www.cms.hhs.gov/HospitalAcqCond/01\\_Overview.asp#TopOfPage](http://www.cms.hhs.gov/HospitalAcqCond/01_Overview.asp#TopOfPage)



Actress and patient safety advocate Alicia Cole still healing from an MRSA infection acquired in 2006.

Alicia portraying a doctor in a California obesity prevention ad.

Childhood obesity.  
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## Nile's Project

Carole and Ty Moss, CA advocates were instrumental in passing "Nile's Law," a strong 2008 state law that bears the name of their son who died of MRSA in 2006 at the age of 15. They organize concerts to raise public awareness about MRSA, with Ty - a professional musician - and his friends performing.



## Hospitals will have to pay for their mistakes

In 2004, the very hospitals where Dorothy Etheridge picked up infections and a bed sore were reimbursed by Medicare for the extra care she needed to recover from them. Etheridge, 73, a retired mental-health-care worker from New Hampshire, had a diagnosis of treatable lung cancer. The bed sore and infections added to her suffering and required significant hospital care in the last year of her life.

Consumers Union estimates that more than 2.4 million Americans suffer each year from an error or infection that occurs while they're in the hospital for something else. Medicare, private insurers, or the patients are typically billed for the additional care they need to recover from hospital mistakes.

That's about to change for the more than 40 million Medicare enrollees. Congress passed a law requiring the Centers for Medicare & Medicaid Services to start identifying preventable "hospital-acquired conditions" for which Medicare would no longer pay. The idea is to push hospitals to improve care by making them foot the bill when they err.

Medicare has listed eight preventable conditions for which it will not reimburse hospitals after Oct. 1, 2008, and is pro-

posing nine more conditions to be added in 2009. The effects could widen as private insurers and state-funded health insurance programs begin to follow Medicare's lead.

Some of the eight have been dubbed "never events" because they should never happen. They include leaving sponges or implements in a patient after surgery and giving the wrong type of blood.

Several hospital-acquired infections are also on the list. In 2007, almost 500,000



**VICTIM** Lori Nerbonne and Kelly Grasso with photo of mom, Dorothy Etheridge.

hospitalized Medicare patients were hurt by the eight preventable events.

While the new rule bars hospitals from passing the bill on to the patient, it addresses only charges accrued in the initial hospital stay. But patients might need continuing treatment that adds up to a bundle. Consumers Union has asked Medicare to clarify that patients who are harmed by these preventable conditions will not be billed for any of the additional care they need.

### Hospital errors and their cost

Problem	Medicare cases in 2007	Charge to Medicare per hospital stay in 2007
Surgical objects left in patient	750	\$ 63,631
Air embolism	57	71,636
Blood incompatibility	24	50,455
Serious bedsores	257,412	43,180
Fractures, burns, etc.	193,566	33,894
Urinary tract infections from catheters	12,185	44,043
Vascular infections from catheters	29,536	103,027
Infection after heart-bypass graft	69	299,237

Source: Centers for Medicare & Medicaid Services

PHOTOGRAPH BY NANCY CALVERT FOR CONSUMER UNION

Sisters Kelly Grasso and Lori Nerbonne started "New Hampshire Patient Voices" after their mother died from an MRSA infection in 2004. They are working on numerous patient safety initiatives: funding for the NH hospital infection reporting law, hospital errors and physician accountability.



Ed Lawton at the US House Committee on Oversight & Government Reform hearing on hospital acquired infections. Ed is a survivor of a hospital infection and has been educating patients and professionals about preventing infections.



# Patient issues

From more than 2000 stories told to Consumers Union

10. No one paid attention to my pleas for help
9. My requests for prevention were spurned
8. I wasn't informed about my infection
7. I had to take responsibility for the care of my loved one
6. I was told infections are expected
5. I have suffered immensely
4. I lost my job, my insurance, my way of life, my home
3. No one would accept responsibility
2. No one told me I could spread MRSA to my loved ones.
1. I don't want this to happen to anyone else