Health Watch USA Newsletter

www.healthwatchusa.org Dec 30, 2010

Member of the National Quality Forum and a designated "Community Leader" for Value-Driven Healthcare by the U.S. Dept. of Health and Human Services

Hospital Acquired Infections

Public Reporting of Healthcare Acquired Infections in Kentucky.

*"Dr. James Ketterhagen, chief medical officer for Jewish & St. Mary's, said his system is working toward creating a public reporting site once the merger occurs. "I'm a strong believer in transparency," he said." ***

*""Where data is available, we want to publish it," said Dr. Dan Varga, chief medical officer for the Saint Joseph system." ***

**Report in the Courier Journal, Louisville, KY - Laura Ungar Dec. 24, 2010
http://www.courier-journal.com/apps/pbcs.dll/article?AID=2010312240023

CDC Revamps their Healthcare Acquired Infections Website.

http://www.cdc.gov/hai/ State Reports and Plans are now easy for all to find.

New CDC data indicates that approximately 1 in 20 hospitalizations has a HAI.
http://www.cdc.gov/HAI/burden.html

Staph Aureus MRSA - Resistance -- Kentucky Top Four States with Highest Incidence.

Proper usage of antibiotics is stressed. Only use antibiotics when indicated and use the correct antibiotic.
http://www.cdc.gov/GetSmart/campaign-materials/week/overview.html
http://www.wired.com/wiredscience/2010/11/resistancemap-and-get-smart-about-antibiotics-week/

VA MRSA Data Shows MRSA Can be Controlled.

Using a bundle which included surveillance cultures, hand hygiene and contact isolation produced the following results:

"In unpublished data involving more than 1 million patients at 153 VA hospitals, MRSA infections have been reduced by a staggering 76% in intensive care units and 28% in non-ICUs, according to **Martin Evans**, MD, associate director of the VHA MRSA Prevention Program." (Source: Hospital Infection Control & Prevention. Dec. 2, 2010 Vol 7 no 48.)

This data is similar to the Data Obtained by Congressional Inquiry in May of 2010.
http://www.neverevents.org/downloads/MRSA-VA-Data-20100518-Redacted.pdf

---

State of Oregon Releases Their Hospital Acquired Infection Report.

http://www.oregon.gov/OHPPR/HAI_Report.shtml

Hospital Acquired Infections in Kentucky (KY. Hospitals Battling Infections – Courier Journal, Laura Ungar, Dec 24, 2011)

http://pqasb.pqarchiver.com/courier_journal/access/2228902561.html?FMT=ABS&FMTS=ABS:FT&type=current&date=Dec+24%2C+2010&author=Laura+Ungar&pub=Courier+-+Journal&edition=&startpage=A.1&desc=Ky.+hospitals+battling+infections

---

Keystone Project, resulted in zero catheter-related bloodstream infections for 18 months.

McClatchy Newspapers Online Reports:

> *Nancy Foster, vice president of quality and patient safety policy at the American Hospital Association, said the results changed the thinking of many who believed that a certain level of infections were inevitable in hospitals, considering the dangerous nature of the work and the large numbers of sick people.*
>
> *"Keystone has taught us that that's not true. If you figure out what the right steps are and how we can deliver them each and every time, we can get to zero or near zero," Foster said.*

http://www.mcclatchydc.com/2010/12/09/105047/hospitals-will-report-patient.html

---

Office of Healthcare Quality released their Meeting Report Summary: Progress Toward Eliminating Healthcare--Associated Infections.

In the MRSA section, it is stated that surveillance cultures "appear to work" but

controversial as to whether cost justifies results:
http://www.healthwatchusa.org/publications/201012-Documents/20100925-Meeting_Summary_Progress_Toward_Eliminating_HAI.pdf

Different approaches:

1) Collaboratives among facilities, public and private sectors, disciplines.
2) Involving state and local health departments helps improve communication across facilities in a region or locality.
3) Focus on basic infection control practices (e.g., barrier precautions, surveillance).
4) Focus on standardizing measures across facilities and settings for reporting and benchmarking.
5) Focus on decreasing device use by ensuring appropriateness for insertion and maintenance.
6) Active detection and isolation (ADI) appears to work remains somewhat controversial as to whether its costs justify its results.

In view of the low cost of cultures ($10) and rapid polymerase test ($30), it is hard to see how it is not cost effective when the average cost of an HAI is $42,000. This also does not take into account the cost of disability to the patient. How much is the dollar value of a lost leg to MRSA after a total knee replacement? Lee, et. al, in Infection Control and Epidemiology has found screening for MRSA to be cost effective.

Lee BY, Bailey RR, Smith KJ, Muder RR, Strotmeyer ES, Lewis GJ, Ufberg PJ, Song Y, Harrison LH. Universal methicillin-resistant Staphylococcus aureus (MRSA) surveillance for adults at hospital admission: an economic model and analysis. Infect Control Hosp Epidemiol. 2010 Jun;31(6):598-606. PMID: 20402588

Hospital Acquired Conditions

The OIG Report: How to Tell the Story (NQF-Endorsed ® SP 1-34) View Power Point Slides: http://www.safetyleaders.org/webinars/indexWebinar_December2010.jsp

The OIG report found an adverse event rate of 13.5% of all hospital admissions (this includes 0.6% of serious reportable events as defined by the NQF and 1.0 % of Hospital Acquired Conditions as defined by Medicare). In addition, there was a 13.5% temporary harm rate. All totaled there were 36 adverse events and temporary events per 100 admissions. This was very similar to the IHI data at 40 events per 100 admissions.
http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf

Joint Commission Releases Analysis of Sentinel Events Reported Each Year From 1995 to 2008.
http://www.jointcommission.org/assets/1/18/se_stats_trends_year.pdf

For-Profit Dialysis Centers Reported to Have Higher Complication Rates. http://www.propublica.org/article/new-study-shows-higher-mortality-risk-at-in-for-profit-dialysis-chains http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2010.01219.x/abstract

96 Hospitals in California Reported No Medical Errors. Questions Raised Regarding Self Reporting http://www.latimes.com/news/local/la-me-error-free-hospitals-table%2C0%2C6278146.htmlstory

---

Hospital Boards

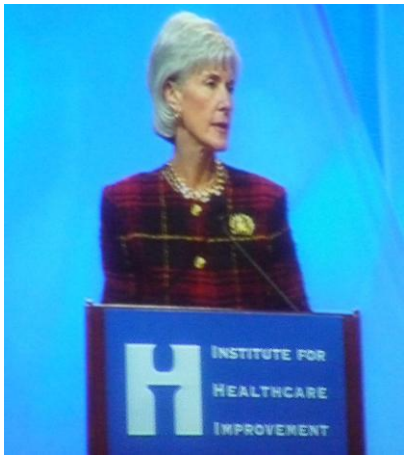
Institute for Healthcare Improvement (IHI) stresses the importance of Hospital Boards in hospital quality oversight. CMS requires hospitals to have a governing body (the board) which is responsible for hospital quality. In CMS survey complaints, the board is most commonly sited for a lapse in quality. Along with overseeing the functioning of the organization, the board also hires the CEO and medical staff. (Jim Conway - Far Left at IHI Seminar on Hospital Boards. Dec 2010 -- Click to Enlarge)

Additional references: http://www.compass-clinical.com/better-hospitals/2010/02/helping-your-board-ensure-patient-safety/

For more information on the responsiblities of hospital boards go to: http://www.healthwatchusa.org/publications/201012-Documents/20081110-HospitalBoards-RoundtableAcuteCare.pdf

---

Institute for Healthcare Improvement: National Forum



December 7, 2010
Remarks for Secretary Kathleen Sebelius

"As the world keeps growing smaller and more connected, America needs a strategy to compete and succeed. But that is hard to achieve when we spend 50 percent more on health care per capita than any other country in the world, when one in three children and two in three adults are overweight or obese, when experts say we may have the first generation of children with shorter lifespans then their parents." http://www.hhs.gov/secretary/about/speeches/sp20101207.html

---

Surgical Checklists Reduce Errors

Surgical checklists are reported to reduce adverse events by 39% and to reduce death rates by 50%.

de Vries EN, Prins HA, Crolla RM, den Outer AJ, van Andel G, van Helden SH, Schlack WS, van Putten MA, Gouma DJ, Dijkgraaf MG, Smorenburg SM, Boermeester MA; SURPASS Collaborative Group. Effect of a comprehensive surgical safety system on patient outcomes. N Engl J Med. 2010 Nov 11;363(20):1928-37. http://www.ncbi.nlm.nih.gov/pubmed/21067384

Gag Clauses Placed in Contracts by Device Manufacturers.

First it was the HMO's in the 1990s, now it is the Device Manufacturers. "Contractual gag clauses silence hospitals and prevent them from discussing price information and implications of medical-device choices, even with their own physicians." http://online.wsj.com/article/SB10001424052748704278404576038171368028098.html?mod=googlenews_wsj

---

Health Insurance Costs and Premiums are Rising - Impact on Employers & Workers.

Insurance premiums for family coverage is projected to increase 79% by 2020. From 2003 to 2009, business premiums have increased 41% and deductibles 77%. Greater than the increase in wages.
http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2010/Dec/State-Trends-Premiums-and-Deductibles.aspx

Tracking the contribution of the U.S. Health System to the Global Competitiveness of American Employers and Workers**:** 2010
Report: http://businessroundtable.org/uploads/studies-reports/downloads/2010_BRT_Report_10_07_10.pdf

---

Opinion Editorial: Courier Journal Op-Ed on Possible Difficulties Ahead of Healthcare Reform "A Health Care Storm Brewing".

http://pqasb.pqarchiver.com/courier_journal/access/2207911961.html?FMT=ABS&FMTS=ABS:FT&date=Dec+9%2C+2010&author=Kevin+Kavanagh&pub=Courier+-+Journal&edition=&startpage=n%2Fa&desc=Kevin+Kavanagh+%7C+Health+care+storm+brewing

---