Patient safety accountability

Lisa McGiffert
Consumers Union Safe Patient Project
lmcgiffert@consumer.org
www.SafePatientProject.org

Health Watch USA

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Public Reporting Works

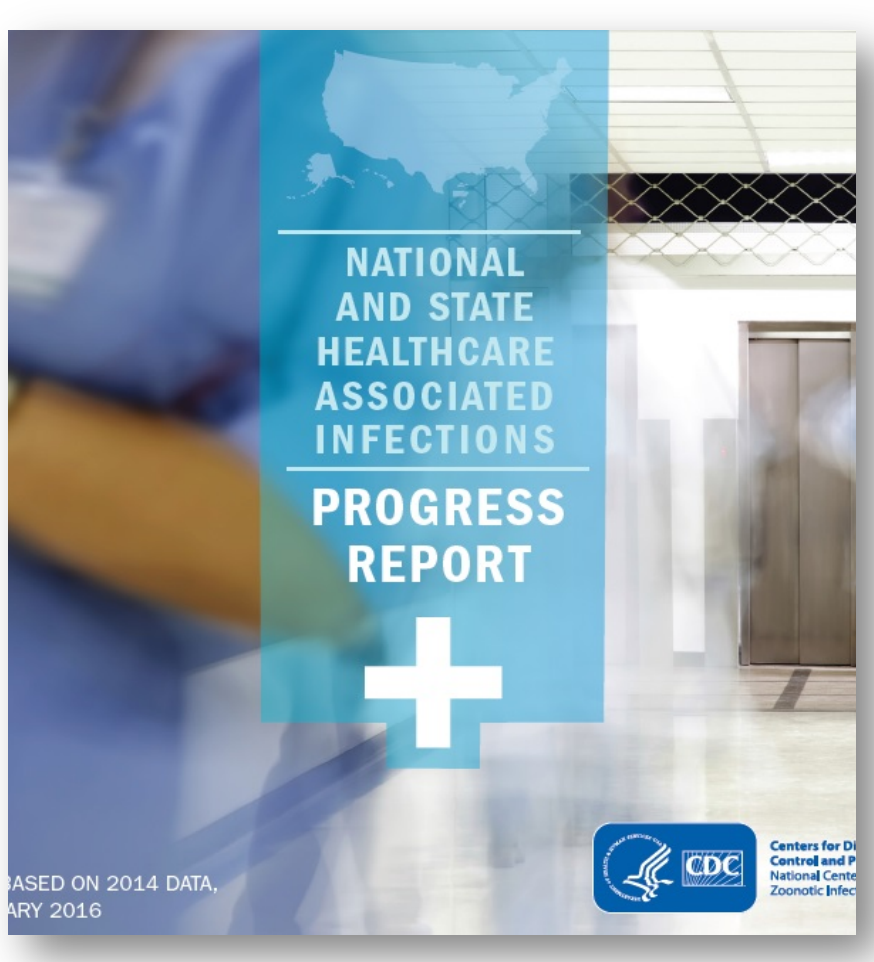
When the information is USED

- ✧ By providers to improve patient safety
- ✧ By regulators to enforce improvements when needed
- ✧ By researchers & public health experts to analyze trends and disclose those to the public
- ✧ By consumers to select providers, raise issues with healthcare providers and apply pressure when performance is poor

Public Reporting Works

- ✧If it is easily accessible
- ✧If it is presented in an understandable and relevant way
- ✧If it timely
- ✧If it shows progress over time
- ✧If it includes multiple sources of reports (e.g., death certificates, patient reporting)
- ✧If it provides complete information

Current public reporting hospital-acquired infections



- Annual reports: CDC, Hospital Compare, some states
- Not timely (2014 data in 2016; rolling 12 mo. Qtrs)
- Est 25% of hospital infections
- Superbug lab ID'd MRSA; *c.difficile* (mostly caused by antibiotic overuse)
- Device (UTI, CL) and surgery (limited) related

People want more information about medical harm

- ✧**82%** want hospitals to report medical errors (including infections) to the public. *(2011)*
- ✧**29%** of hospital patients said they experienced at least one of 16 listed medical errors (2015)

A Kentucky Example

Baptist Health Louisville

✧Hospital Compare

✧Overall rating for complications & deaths – 4 stars

✧# of HAIs: 204 HAIs in last CMS reporting period

✧But overall it was “no different than others” in all but 2 of these categories (one better & one worse)

U of KY of Lexington

- ✧Overall rating for complications & deaths – 3 stars
- ✧# of HAIs: 327 HAIs in last CMS reporting period (more than 6/week)
- ✧Overall it was “no different than others” in all but 2 of these categories (one better & one worse)

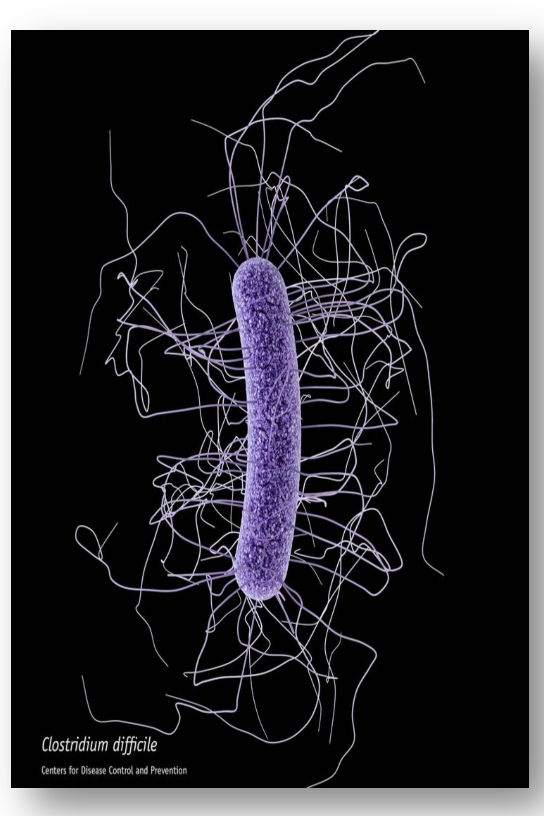
What's missing?

- 537,000 cases of hospital-acquired infections
- Millions of cases of health care-acquired infections in settings other than hospitals
- Outbreak and other real time information

Outbreaks

- ✧Who should be notified of an outbreak? *(2016)*
  - ✧**75%**: patients directly affected by the outbreak
  - ✧**71%**: doctors treating infected patients
  - ✧**>50%**: patients in the hospital and being admitted

Example of outbreak



"When I was able to walk down the hall in the hospital, I was horrified to see room after room with C. diff caution signs on their doors warning that the patients inside, like me, had been infected."

Kellie Pearson, Farmer, age 49

How Your Hospital Can Make You Sick, Consumer Reports

Example of outbreak

University of CA at Irvine – MRSA outbreak

- ✧NICU unit - 8 months before revealed 10 HAIs
- ✧County: no evidence of higher risk than elsewhere
- ✧Hospital: didn't notify incoming parents in labor because isolated infected babies & notified those whose babies were tested/treated
  - ✧One parent of infected baby disputed disclosure
- ✧Patients have right to know, even if source is not yet known – it is unethical not to do this

Example of outbreak - UCI

“**This story is disturbing because it leads me to believe that there was an effort to hide this MRSA outbreak.** Perhaps the idea is to not cause a panic among patient's relatives but I think if the information is presented clearly that people can understand this and realize that hospitals make every effort to prevent spread of MRSA and other lethal bacteria and viruses. **Covering up something is probably worse than reporting it to patients and relatives since the idea of covering up information causes people to distrust the hospital even more than having an infection control problem and treating it**. Covering up a problem only leads to speculation and disinformation if the truth is not being told up front.”

Accountability - Safety

- ✧Oversight systems in place to protect the public too often hide the problem
- ✧Information and disclosure
- ✧Public trust

A California Example

Cultural "firewall" among public health systems

- ✧HAIs data not shared before complaint investigations or regular inspectors
- ✧CDC contracts prohibit (KY and other states without a mandate)
- ✧Successfully petitioned CDPH in Jan 2017 to share information and use it to prioritize and inform

Focus on High Infection Rates

- Nearly 60% of CA hospitals had significantly higher infection rates in at least one type of infection in past 3 years
  - 38% of these had high rates over multiple years
- One had high rates 12 times in numerous categories over 3 years.

UCI drill down

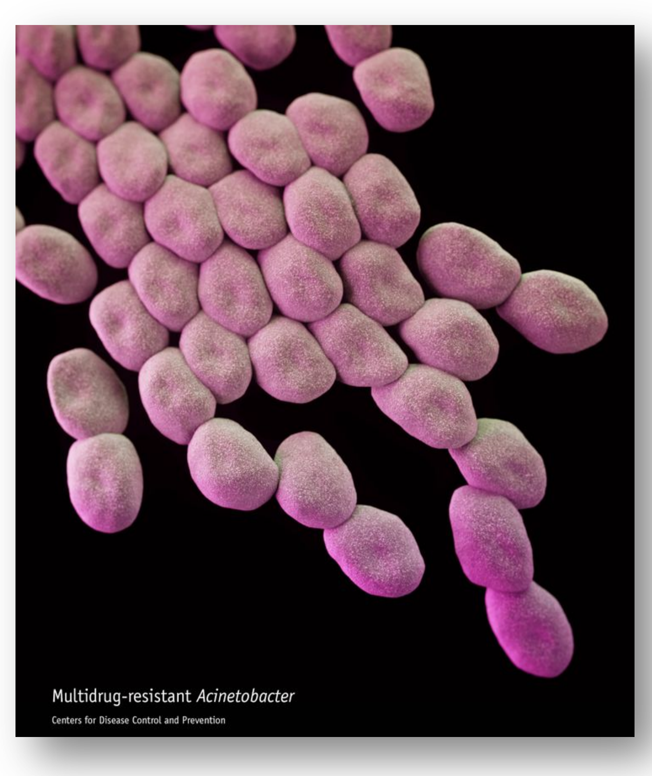
A clearer picture of problems

- ✧6 times in 3 years had high infection rates
- ✧C.difficile: high all 3 years – 406 patients total
- ✧CLABSI: lower or no different in all categories but one – temporary lines in hematology/ oncology units (SIR 4.57) – an outbreak?
- ✧SSI: twice had high rates in rectal surgery (SIR: 3.06, 3.79

Antibiotic resistance

- ✧Urgent situation
- ✧Consumer Reports – 22 years ago (1995):
  - ✧Tips that could have been given yesterday
  - ✧Called out doctors, drug makers, patients – same as now

Can someone explain this?



Federal websites for reporting all sorts of problems:

- ✧ Drugs and devices (FDA)
- ✧ Food-related illnesses (health departments)
- ✧ Vaccinations (CDC)
- ✧ Credit cards & banks (CFPB)
- ✧ Cars (NHTSA)

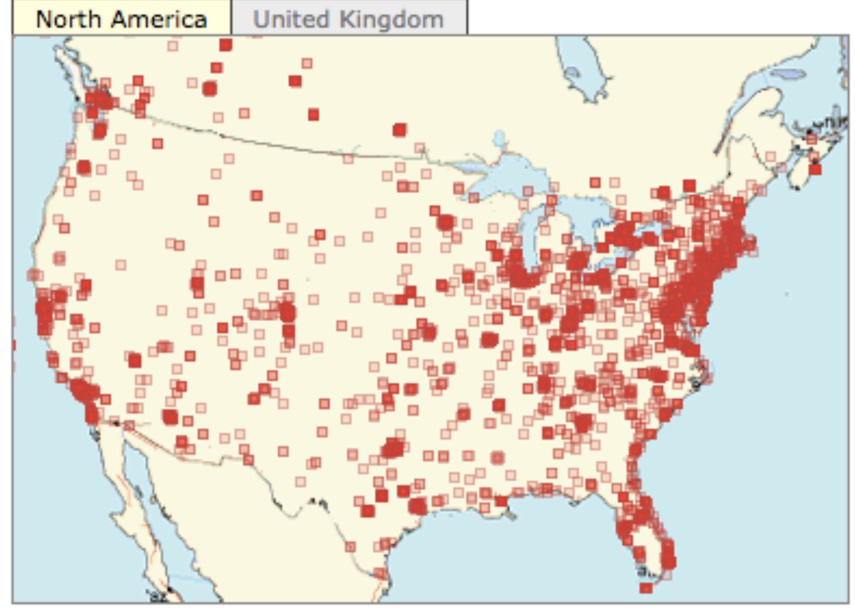
Bedbugregistry.com

The Bedbug Registry

look up + report | alerts | city maps | resources | about | faq

The Bed Bug Registry is a free, public database of user-submitted bed bug reports from across the United States and Canada. Founded in 2006, the site has collected about 20,000 reports covering 12,000 locations.

Download our official **iPhone app!**



click on any region to see an interactive map of infestations

Check For / Report Bugs:

Hotel name:

City and state

Check Hotel

Street Address

City and State

Check Address

What we need…

A national system for patients and families to report health care-acquired infections that is transparent to the public

Value of patient reporting system -

- ✧Motivate healthcare providers to improve; most outbreaks under the radar; little response for the poor performance
- ✧Patients need protection - have a right to know if they are walking into an outbreak; have a right to be counted
- ✧Researchers and epidemiologists are missing data; evidence that patients report > accurately, including events missed by healthcare system

Ways to improve

- ✧ More drill down analysis – especially locally
- ✧ More focus on appropriate antibiotic use
- ✧ Change health department culture to one of collaboration between infection control and enforcement.
- ✧ Understand & value the importance of patient reports in creating accountability for patient safety
- ✧ Patient centered care = full disclosure to patients