Consumers Union
Nonprofit Publisher of Consumer Reports

Policy Brief:

Public Disclosure Will Encourage Hospitals to Improve Infection Practices

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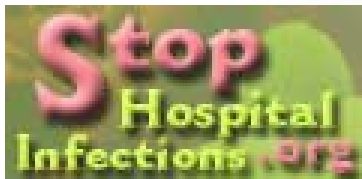


A Project of Consumers Union

If consumers can choose a hospital based on good information about the quality of care, including hospital infection rates, hospitals will quickly implement better practices. Studies show significant improvement in states with public data on mortality rates and other indicators of quality. Yet Congress is about to implement a new reporting law that will make hospital infection rates and other important quality data confidential. Consumers won't know which hospital has the best track record, and won't be able to make an informed choice.

Hospital infection is a leading cause of death

About 90,000 people each year die from infections they contract while in the hospital for other health problems—infections that add nearly $5 billion to our nation's health care bill.[1] More people die of hospital acquired infections than from auto accidents and homicides combined.[2]

An additional 1.9 million or so get an infection that does not cause death, but depending on the type of infection, these patients spend from one to 30 extra days in the hospital getting treated.[3]

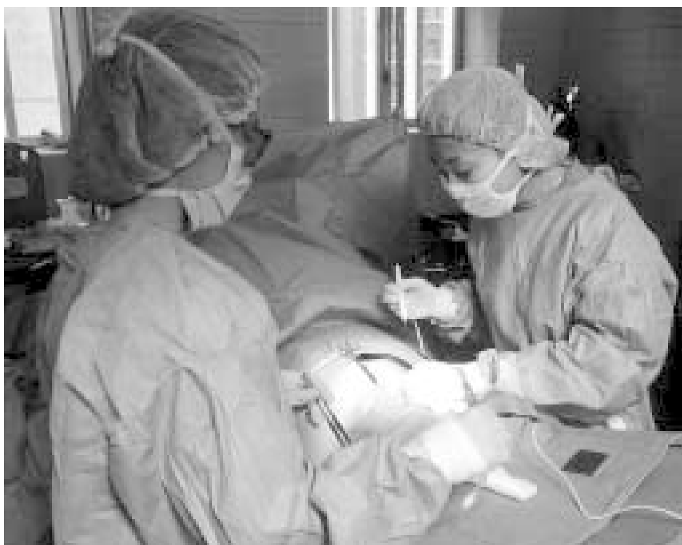
Increasingly, the infections that spread in hospital settings are resistant to common antibiotics,[4] and these resistant strains have begun to spread from hospitals into the community. A 2002 Chicago Tribune investigation found that at least 200 people in Illinois died of drug-resistant infections that they contracted at home or at work, infections rarely found outside of hospitals five years ago.[5] Doctors found a methicillin resistant staph infection (MRSA), common in hospitals, in a patient who had not had any contact with a hospital in 1997, and the CDC has since confirmed other cases. The CDC recently reported the spread of MRSA among people in competitive sports, prisoners and others.[6]

Preventing Hospital Infection

Hospitals treat a lot of very sick people—people who are both more likely to contract an infection due to their already weakened state, and people who are more likely to carry an infection into the hospital with them. On top of that, invasive procedures like surgery bypass the body's defenses against infection, creating natural pathways for disease.

Even so, most studies show that hospital infections can be reduced by implementation of infection control practices—especially hand washing. And infections can be reduced significantly when hospitals commit to well organized infection control programs.[7]

By definition, any infection that you don't bring with you into the hospital is a hospital-acquired infection. Hospitals and infection control experts call these "nosocomial" infections. These infections are most common among patients using invasive devices like intravenous tubes (IVs), catheters, and ventilators—and among surgical patients, elderly patients, infants, and ICU patients (who generally are more likely to be on IVs, catheters and ventilators).[8] Depending on the specific type of infection or infection control practice under study, researchers find that improved infection control



According to the CDC, hospitals can reduce the number of surgical site infections by ensuring that patients recieve antiobiotics prior to surgery (unless contraindicated), improving hand washing techniques and operating room practices, and monitoring patients after discharge.

practices can reduce the spread of hospital infections by anywhere from 10 percent to 70 percent.[9] Studies of comprehensive hospital programs designed to to reduce all types of infections find reductions of over 50 percent.[10]

In 2002, the CDC issued new hand-washing guidelines for health care workers—advising that hospitals use alcohol based hand products rather than plain soap and water because busy employees found them easier to use.[11] Although studies show that improved hand washing in hospitals reduces infection rates significantly, hand washing compliance rates are generally less than 50 percent.[12]

For the areas of the hospital most prone to the spread of infection, a number of other infection control practices have been proven effective. A study of neonatal ICU infection found that a campaign of aggressive monitoring and education dropped the infection rate from 42 percent to 12 percent in five years.[13] Studies indicate that the use of catheters coated with antimicrobial or antiseptic agents can reduce infections, although they cost slightly more.[14] Surgical site infections, the second most common hospital-acquired infection,[15] can be reduced through careful application of antibiotics before surgery, changes in preoperative anti-infection procedures, attention to operating room ventilation and procedures, and post-surgical surveillance.[16]

Keeping Secrets

Hospitals and the CDC identified the growing problem of preventable hospital-acquired infection more than three decades ago. Today many hospitals track their own infection rates, especially in units like the ICU or neonatal ward where infections are common or patients are particularly susceptible. But most do not currently report infection rates to any regulatory agency or accreditation body. They cannot compare their performance to other area hospitals, and their patients cannot know if they are getting the best available care.

This year, the nation's leading hospital accreditation organization (the Joint Commission on Accreditation of Healthcare Organizations) chastised hospitals for under-reporting deaths due to hospital-acquired infection. Since JCAHO implemented reporting of "sentinel events" (death or serious injury) in 1996, only 10 infection-related reports had been reviewed. "Numerous high profile media reports of incidences of patient death resulting from hospital-acquired infection indicate that such cases are seriously under-reported to JCAHO," the organization wrote in January, 2003.[17] Unfortunately, reports to JCAHO are entirely voluntary. The agency sent a special advisory to hospitals "to clarify that nosocomial infections resulting in death or serious injury should be voluntarily reported."[18] Nine months later, JCAHO had seen no increase in reporting of sentinel events related to hospital infection.[19]

Where hospitals do report, the information is typically held in secret. The JCAHO information is only reported to the public in aggregate form. The CDC launched a confidential, voluntary reporting program in 1970. But by 2000, only 315 of the nation's 4,900 hospitals had joined.[20] The program gives hospitals a standardized way to measure infection rates and compare their own infection rates with the average of all the hospitals in the program. Participating hospitals together reduced their infection rates significantly during the 1990s—proving that hospital infections can be prevented.[21] But patients and employers cannot distinguish the best from the worst rates, and for the thousands of non-participating hospitals, virtually no information exists about infections or infection control practices.

Mandatory Public Reporting Works

Several states have instituted data systems that report hospital-specific quality of care information to the public—and in those states, hospitals have worked hard to improve their outcomes on the publicly reported indicators.[22]

Most of these quality reports focus on mortality rates for selected surgical procedures like coronary artery bypass grafts (CABG). The mortality rates are adjusted to account for the differences among patients, and consumers can see whether patients die at a higher rate at one hospital compared to another. News organizations have not been shy about reporting the differences either.

New York was among the first states to compare hospital mortality for CABG. When the early reports were issued, hospitals with substantially higher mortality rates responded by examining their surgical systems and identifying areas of improvement. Winthrop University Hospital on Long Island fared poorly among heart programs, so it hired a renowned cardiologist to overhaul its program, hired additional staff, and created a new database system to monitor quality of care. Within two years, the cardiac program had one of the state's lowest mortality rates.[23]

According to Dr. Ed Hannan of Albany's School of Public Health, hospitals reviewed the timing of surgery, monitored post-operative and ICU care, and created systems to prevent post-operative bleeding. While mortality for this surgery declined by 13% among all patients in the U.S., mortality declined in New York hospitals by 28%—and the declines are partly related to public dissemination of outcomes data.[24]

Recent data published in Health Affairs "provide strong evidence that making performance information public stimulates quality improvement in the areas where performance is reported to be low." Researchers specifically site the hospitals' concern for their public image as a key motivator for improvement.[25]

Public reporting laws have spread across the country and now include hospital infection rates, the adequacy of nursing staff, and sometimes medical error information. Texas issues an annual analysis by hospital of 25 different hospital outcomes indicators.[26] Illinois recently enacted legislation to mandate hospital infection reporting on a quarterly basis, and the state will annually publish infection rates by hospital.[27]

Congress Introduces Voluntary, Confidential Reporting

But now Congress is stepping in—not to create mandatory public reporting, but instead to create a voluntary, confidential program that is likely to pre-empt existing state efforts (see Consumers Union bill analysis). Quietly making its way through both houses, the "Patient Safety and Quality Improvement Act" (HR663 and S720) authorizes complete confidentiality of patient safety information, such as serious medical errors and hospital-acquired infections, for hospitals that voluntarily report the information to "patient safety organizations." But voluntary reporting programs suffer from three serious flaws.

- Hospitals don't have to join in the first place. Very few hospitals joined the existing voluntary reporting system for hospital infection at the CDC over its 30 year history. California's voluntary patient satisfaction survey effort also suffers from poor participation by hospitals.

- No one will ever know if a facility has problems and doesn't try to improve. Data collected by the new patient safety organizations cannot be used for any enforcement purpose.
- Hospitals will be able to "game" the system by withdrawing voluntary participation if their data looks bad. The "patient safety organization" may report overall improvements in the quality of health care, but base that report on the data of only the best facilities electing to continue their participation. By contrast, mandatory public reports focus public pressure on the lowest performing facilities.

Conclusion

Consumers Union opposes the federal effort to close down access to information about your local hospital's performance, and supports the expansion of state reporting laws—especially where they include hospital infection rates. As antibiotic resistant infections begin to move from hospitals into the community, it is imperative that hospitals reduce their infection rates by all available means. And the best way to make that happen is to give consumers the quality of care tools to use to pick the best hospital.

To take action on federal legislation making hospital information confidential, go to www.StopHospitalInfections.org and email your U.S. Senators and Representatives.

For tips on shopping for the best hospital, avoiding medical errors, and getting the most out of your hospital stay, take a look at Consumer Reports on Health, the health and medicine special publication of Consumer Reports Magazine. You can find a link to Consumer Reports on Health at ConsumerReports.org.

Footnotes

1 U.S. Centers for Disease Control and Prevention, Office of Communication, "Hospital Infections Cost U.S. Billions of Dollars Annually," 3/6/00, "CDC Releases New Hand-hygiene Guidelines," 10/25/02.
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10 "CDC's Seven Healthcare Safety Challenges," http://www.cdc.gov/ncidod/hip/challenges.htm. The challenges specifically include reducing by 50% drug resistant bacterial infections in hospital settings.
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15 Perencevich, Eli N. et al, "Health and Economic Impact of Surgical Site Infections Diagnosed After Hospital Discharge," Emerging Infectious Diseases, February 2003.
16 U.S. Centers for Disease Control and Prevention, National Center for Infectious Disease, Hospital Infections Program, "Guideline for Prevention of Surgical Site Infection, 1999." The National Quality Forum, Safe Practices for Better Healthcare: A consensus report," p. 45.
17 Joint Commission on Accreditation of Healthcare Organizations, "Sentinel Event Alert," Issue 28, January 22, 2003.
18 Joint Commission on Accreditation of Healthcare Organizations, "JCAHO Taps Expert Panel to Strengthen Infection Control Standards," January 22, 2003.
19 Charlene Hill, JCAHO Communications Director, information by phone, September 23, 2003.
20 "By the Numbers: Hospitals and Healthcare Systems," Modern Healthcare, December 2002, p. 12. U.S. Centers for Disease Control and Prevention, Division of Healthcare Quality Promotion, "About NNIS," download date, 9/8/03. The agency recently closed the program to new hospital participants.
21 Richards, Chesley et al, "Characteristics of hospitals and infection control professionals participating in the National Nosocomial Infections Surveillance System 1999," Am J Infect Control 2001; 29:400-403.
22 States with public reporting or public access to hospital-specific outcome or incident information include Texas, California, Ohio, New York, New Jersey, Colorado, Pennsylvania, Maine, and Connecticut. The specific information that is collected, reported or available differs by state.
23 Huff, Charlotte et al, "Vital Signs," Ft. Worth Star Telegram, July 28, 2002.
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