NYC Hospital Group to Publicize Error Rates

BY MICHELE G. SULLIVAN
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You might not expect a hospital to advertise its errors, but that's what the public wants. And that's what the New York City Health and Hospitals Corporation is doing, according to Alan Aviles, the group's president.

The group's 11 hospitals plan to publicize their overall mortality rates, heart attack mortality rates, and rates of nosocomial infections, including central line, ventilator-associated, and surgical site infections.

Nineteen states, including New York, have legislation requiring the public reporting of nosocomial rates.

Legislation adopted in 2005 requires New York hospitals to report to the state health department their incidence of central line bloodstream infections, and coronary artery bypass graft and colon surgery site infections. It's unclear when that information might be made public and whether it will appear as aggregate or facility-specific information. But Mr. Aviles has taken the bull by the horns, because hospitals can't do a better job until they can see the job they're already doing, he said in an interview.

"One of the biggest problems in this industry is the extent to which we keep this kind of quality-related data close to the vest. The practical result of that attitude is that we expect our physicians to make improvements while they're groping around in the dark."

Publicly disclosing what has always been considered a hospital's deepest secrets is the only way to fix them, he said.

Mr. Aviles has faced naysayers, including those within his own system who worried that public scrutiny could nick their competitive edge among the city's 60 hospitals. "There was concern that we could be impacted competitively if the public either misinterpreted the data or if the numbers aren't as good as those of the competition," he said. "But people know that medical errors and hospital-acquired infections cause thousands of needless deaths each year. … Transparency can only help."

To that end, Mr. Aviles and his team have set a lofty goal: By 2010, they want to have the safest hospitals in the country.

There's no mistaking the single-mindedness behind that goal, said Jim Conway, senior vice president of the Institute for Healthcare Improvement (IHI). "It's extraordinarily courageous and extraordinarily hard," he said in an interview. "They're willing to be held accountable not only to their own staff, but to consumers, patients, and families."

The nonprofit IHI supports transformational change in health care quality and safety, both in the United States and internationally. Its "Five Million Lives Campaign," launched in 2006, aims to protect patients from 5 million incidents of medical harm by the end of 2008. To achieve that, at least 4,000 hospitals will have to commit to improving patient safety. At present, 3,500 are involved.

The lofty goals set by the IHI and Mr. Aviles' group are a hallmark of successful change, Mr. Conway said. Another example is Ascension Health System, which comprises 65 hospitals across the United States and aims to eliminate all preventable harm in all of their hospitals in 2008. "We're seeing the fruits of that goal. In almost every tracked indicator, their performance is much better than almost any other system in the country. For pressure ulcers, for example, the rate in their lowest-performing hospital is one-sixth that of the national average," Mr. Conway added.

Cincinnati Children's Hospital is trying to eliminate 80% of preventable serious harm, including hospital-acquired infections, by July 2008, according to Mr. Conway. Beth Israel Deaconess Medical Center in Boston has become the first hospital to post its 2007 Joint Commission Accreditation Survey findings on its Web site. The center also publicly posts its commitments to quality improvement, including the complete elimination of ventilator-associated pneumonia and central line infections.

"What drives organizations to accomplish goals like these?" Mr. Conway asked. "They have a great vision, and they have a solid sense of their current reality. They understand the gap between where they are and where they need to be, and they use that tension to drive change."

Goals in these organizations are specific and measurable—eliminating 100% of central line infections by a certain date, for instance, as opposed to a broader aim of delivering the best health care.

"We've come to understand that 'some' is not a number and 'soon' is not a time," Mr. Conway said. Just as important, everyone from the chief surgeon to housekeeping is considered responsible, he added.

Such efforts may be unusual now, but they are the wave of the future, Mr. Conway said. The public wants the information, states are requiring its disclosure, and the federal government is now refusing to pay for illnesses that could have been prevented—including hospital-acquired infections.

"We're going to see more and more hospitals taking responsibility like this," he predicted. "This is the end of the beginning, and the beginning of something new." ■

Advocates Want National Reporting Law

States may prove an invaluable laboratory for the eventual adoption of a national law requiring all hospitals to publicly report their rates of nosocomial infections, according to Lisa McGiffert, manager of the Consumers Union's Stop Hospital Infections campaign.

To date, 19 states have adopted such laws, which vary widely in the type of data collected and in their dissemination, Ms. McGiffert said in an interview.

There is some benefit to having the states figure out the best method for collecting and sharing this information, she said. "We feel that it's very important to engage in this exercise before there are any national standards created. When that does happen, we want the law to be based on real-life experience, not someone's theoretical ideas of how it should go."

The nonprofit Stop Hospital Infections project, run by the same company that publishes Consumer Reports, works to enact state laws that publicly disclose hospital rates of nosocomial infections. But the group's ultimate goal is a national law that would enact a uniform data collection and reporting system.

A prototype bill, the Healthy Hospitals Act of 2007, was introduced into the House last February, Ms. McGiffert said. Sponsored by Rep. Tim Murphy (R-Pa.), the bill would require public reporting of health care–associated infections data by hospitals and ambulatory surgical centers.

H.R. 1174 implies a stick but offers a carrot. Hospitals with poor results could suffer if consumers choose a competing facility that has a better rating, but they would also be eligible for financial incentives or grants under Medicaid if they improved their infection rates.

Just when such a bill might come up for voting is unknown. In the meantime, the group continues to promote legislative action on the state level. All but four states (Arizona, Montana, North Dakota, and Wyoming) have at least debated legislation requiring some form of public disclosure of hospital infection and error rates. New Jersey has adopted a public reporting bill that awaits the governor's signature.

An overview of the existing legislation may be found at www.stophospitalinfections.org. Some bills stipulate a time for the issuance of the first report; others don't. "But you can usually count on at least 2 years between the adoption of the law and the first report," Ms. McGiffert said.

MRSA Studies Highlight Importance of Infection Control

BY BRUCE K. DIXON
Chicago Bureau

CHICAGO — Transitional care facilities may need to consider placing incoming surgical patients in private rooms to prevent the transmission of methicillin-resistant *Staphylococcus aureus*, according to a poster study presented at the Interscience Conference on Antimicrobial Agents and Chemotherapy.

The study, conducted at the MeritCare Medical Center in Fargo, N.D., revealed that methicillin-resistant *S. aureus* (MRSA) nasal colonization was 1.6%, which is double the national estimate reported for 2001-2002 (J. Infect. Dis. 2006;193:172-9).

The MeritCare Medical Center is a private hospital that serves as a "step-down" facility for patients awaiting nursing home placement, said Stephanie M. Borchardt, Ph.D., of the Fargo Veterans Affairs Medical Center.

Swab specimens were collected from the anterior nares of 550 transitional care unit (TCU) patients between September 2003 and November 2004. "These were older patients, most of whom were coming off a surgical service, and [they] were significantly more likely than others to be colonized with MRSA," she said.

The median patient age was 78 years, and 64% were female. Of those positive for MRSA, more than half were being cared for by orthopedic surgery service at the time, one-third were on the cardiology or cardiothoracic surgery service, and 11% were on the general surgery service, the authors reported at a meeting sponsored by the American Society for Microbiology.

"These findings highlight the need to consider lodging surgical patients in private TCU patient rooms to prevent transmission of MRSA," Dr. Borchardt said.

A second surveillance culture study found high rates of both MRSA and *Acinetobacter baumannii* colonization in patients at a long-term acute-care facility in Baltimore. Nose, perirectal, sputum, and wound cultures were collected from 35 patients; cultures were retrieved from one or more of those sites in an additional 114 patients, said Jon P. Furuno, Ph.D.

The prevalence of MRSA was 30% and of *A. baumannii,* 28%, said Dr. Furuno of the University of Maryland, College Park.

Anterior nares and sputum cultures were the most sensitive in identifying MRSA and *A. baumannii* respectively, and most *A. baumannii* were susceptible to ampicillin/sulbactam (93%), imipenem (90%), amikacin (80%), or trimethoprim/sulfamethoxazole (30%).

It was not surprising that over a quarter of the cultures were positive, because most of the patients in the Baltimore facility are in poor condition and have been at high risk of pathogen exposure, Dr. Furuno said in an interview.

"If a large portion of your patients are transferred from facilities where they might pick up these organisms, it's important that you have a team-based infection control system in place and that you assess the overall burden of colonization in these patients," he concluded. ■