Committee to reduce infection deaths

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Media contacts: Mark Coyle
(571) 276-1893
miramx1@aol.com

RID CALLS ON CONNECTICUT LAWMAKERS TO MAKE HOSPITALS COME CLEAN

Next time you hear an ad on the radio urging you to use a particular hospital because it has the best doctors or the latest equipment, keep in mind what you're not being told: How many patients get infections while in that hospital.

"Six states, including New York, where I served as Lt. Governor, have passed laws to provide the public with hospital infection report cards. The people of Connecticut deserve the same information," says Betsy McCaughey, founder of Reduce Infection Deaths (RID) [http://www.hospitalinfection.org]. "When you have to be hospitalized, you should be able to find out which hospital in your area has the worst infection problem, so you can stay away."

RID urges Connecticut lawmakers to give residents of this state the lifesaving information they need to help protect themselves and their families from this deadly problem.

Hygiene is so inadequate in most hospitals that one out of every twenty patients contracts an infection in the hospital. The danger is worsening because hospital infections, increasingly, cannot be cured with commonly used antibiotics. In 1974, 2 percent of Staph infections were MRSA (*methicillin-resistant Staphylococcus aureus*). By 1995, that figure had climbed to 22%, by 2003, to an alarming 57%, and still rising.

Denmark Holland and Finland once faced similar rates but brought them down below 1 %. How? Through rigorous hand hygiene, meticulous cleaning of equipment and rooms between patient use, testing incoming patients to identify those carrying dangerous bacteria, and taking the precautions to stop the spread of the bacteria on hands, gloves, stethoscopes, other equipment, lab coats, uniforms, and furniture to other patients who did not come in with the germs.

A few hospitals in the U.S. – too few – are proving that these precautions work here too. These hospitals have reduced infection rates by 85% to 90% in pilot programs, showing that nearly all hospital infections are preventable. Unfortunately most hospitals have not implemented these precautions. We have the knowledge to stop these infection deaths. What has been lacking is the will.

Many hospital administrators say they can't afford to take these precautions. They can't afford not to. Infections erode hospital profits, because rarely are hospitals paid for the added weeks or months patients must spend in the hospital when they get an infection. Infections are adding $30.5 billion annually to the nation's hospital costs. That's enough to pay for the entire Medicare Part D Drug Benefit in 2006.

"Infection reporting will motivate hospitals to improve hygiene and hospital procedures – saving lives and dollars," says Betsy McCaughey. RID, a nationwide not-for-profit, advocates for improved hygiene in hospitals, more attention to hygiene in medical and nursing schools, and public reporting of hospital infection rates.

RID's latest report, "Unnecessary Deaths: The Human and Financial Costs of Hospital Infections," provides a model bill for reporting and demonstrates that hospital accountability saves lives.

The good news is that Florida, Missouri, Pennsylvania, Illinois, Virginia, and New York recently passed laws to provide the public with hospital infection report cards. Publicly comparing hospital performance will motivate hospitals to improve.

New York's experience with another type of hospital report card proves this. In 1989, New York became the first state to publish each hospital's risk-adjusted mortality rate for cardiac bypass surgery. The results? Deaths from bypass surgery dropped 40 percent, giving New York the lowest mortality rate in the nation for that procedure. Critics of hospital report cards speculate that deaths went down in New York because hospitals avoided treating the sickest patients, fearing that high-risk operations would bring down the hospital's grade. However, the evidence proves that's untrue. Deaths declined for a different reason: hospitals forced their worst-performing surgeons—generally, those with low volume—to stop doing the procedure. Patients of the 27 barred surgeons were more than three times as likely to die during surgery. In technical jargon, the 27 surgeons had an average risk-adjusted mortality rate of 11.9 percent, compared with a statewide average of 3.1 percent. Wisconsin also found that report cards motivate poorly performing hospitals to improve, according to a 2001 study of 24 hospitals there.

Is there a reason not to have infection report cards? The hospital industry argues that publicly comparing hospital infection rates would be unfair to hospitals that treat AIDS, cancer, and organ transplant patients who are especially vulnerable to infection. Fair enough, but reports can be risk-adjusted to reflect these differences. What is unfair is keeping the public uninformed.