Pa. Pushes for Hospital Disclosure on Infections

BY ALICIA AULT
Contributing Writer

In the wake of what appears to be underreporting of nosocomial infections, a Pennsylvania state agency is poised to use its leverage to force hospitals to divulge more accurate and full information.

This summer, the Pennsylvania Health Care Cost Containment Council issued a report to the public showing that there were 11,668 confirmed hospital-acquired infections among 1.5 million discharges from 173 general acute care hospitals in 2004. The infections were associated with 1,793 deaths, 205,000 extra hospital days, and $2 billion in charges.

Pennsylvania is the first state to make such numbers public.

As firm as the numbers may sound, however, the data are rife with omissions and invalid reports, and several hospitals reported no infections at all, said Marc Volavka, executive director of the council, which is a state-funded, independent agency. What was reported may only be the tip of the iceberg, Mr. Volavka said in an interview.

Since January 2004, hospitals in Pennsylvania have been required to submit quarterly data to the council on surgical site infections in orthopedic surgery, neurosurgery, and surgery related to the circulatory system; device-related infections, including urinary tract infections from Foley catheters; ventilator-associated pneumonia; and bloodstream infections from central lines. Starting in 2006, hospitals will have to submit data on all hospital-acquired infections.

The council has the authority to release data on a hospital-by-hospital basis, but so far, it has not. "As we started down this uncharted path, we said from the beginning that it would take time for Pennsylvania's hospitals to become accustomed to this reporting process," said Mr. Volavka in a statement, adding that many facilities had been given "lenient time frames and extensions."

"Unless reporting gets more accurate and more complete, the council will start to use [its] authority" to name names, he said.

Doing that now could potentially harm hospitals that are complying with the reporting guidelines, according to Mr. Volavka. For instance, 17% of hospitals in the state (29 facilities), which account for only 25% of the admissions, reported more than half of the total infections. Sixteen hospitals reported no infections at all.

There was also a glaring discrepancy between the number of infections reported to the state (11,668) and the number billed to payers: 115,631. The council said the higher number indicates there may have been more hospital-acquired infections than were reported to the state.

On the basis of the $29,000 that insurers actually paid for each infected patient, compared with $8,300 for an inpatient without an infection, the council estimated that third-party payments for the 11,668 infections amounted to nearly $350 million.

In a statement, Carolyn Scanlan, president and CEO of the Hospital & Healthsystem Association of Pennsylvania, said the council's data on third-party payments was somewhat misleading because they "made no distinction between infection-related costs and those costs associated with the patient's entire time in the hospital."

Ms. Scanlan also defended hospitals' response to the council's requirements, noting that the number of infections reported had increased each quarter. She said the increase in reporting indicates that hospitals are becoming more familiar with reporting requirements.

The Centers for Disease Control and Prevention has said that 5%-10% of hospitalized patients will acquire an infection, Mr. Volavka pointed out. So, while the numbers reported in Pennsylvania jibe with that CDC estimate, "it frankly ought to be a wake-up call to health care professionals and to purchasers and consumers who ultimately are paying the bill," he said.

If the Pennsylvania data were extrapolated nationally, the figures indicate at least 100 people per day die from nosocomial infections, at a cost of about $50 billion a year. ■

Clinical Trials Need Minority Participation to Close Gap

BY NANCY WALSH
New York Bureau

New York — Racial disparities in access to health care will disappear only when adequate and representative samples of minorities participate in clinical trials, Winston Price, M.D., said at the annual meeting of the National Medical Association.

That disparities in delivery of health care exist is not in question. The Institute of Medicine report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare" revealed the extent of the problem, showing that disparities remain even after adjustment for factors such as insurance coverage and socioeconomic status.

Duke University Medical Center

Dr. Christopher Edwards said investigators explain tangible benefits for patients themselves, and for future generations.

But a widespread mistrust of the U.S. health care system among minorities—not least because of past abuses such as the Tuskegee Syphilis Study, in which blacks went untreated for many years despite the availability of effective therapy—has led to an unwillingness among African Americans to participate in the clinical trials that might directly benefit their own health.

An increasing understanding of genetic and racial differences in response to medications makes it imperative that minorities be included and their needs addressed in the drug development process, said Dr. Price of the State University of New York Health Science Center, Brooklyn.

The experience with BiDil, a fixed-dose combination of isosorbide dinitrate and hydralazine approved specifically for the treatment of heart failure in black patients, shows it can be done.

"You had 1,050 African Americans who enrolled in the study, and the attrition rate was zero," Dr. Price, who is also president of the NMA, said in a press briefing. "Every single one stayed with that study until completion. The drug was approved by the Food and Drug Administration on June 23, not because it was the right thing to do but because it was pure science and evidence based." Other models also are demonstrating blacks can be recruited successfully, Christopher L. Edwards, Ph.D., said.

Programs that are successful tend to be well entrenched in the community; they have good outreach and education and relationships with local organizations such as churches and fraternities, Dr. Edwards said.

They do not pressure potential participants, but provide information and allow patients to process it at home and respond when they are ready, he said.

Successful investigators are available to the community not only when recruiting; they are able to articulate the tangible benefits of participation, not only for patients themselves but also for future generations. Dr. Edwards' program in the department of psychiatry at Duke University Medical Center, Durham, N.C., is an example.

"We make ourselves available for interviews on television, religious radio, and pop radio. In one creative marketing plan, we placed advertisements for one of our genetic studies on the side of 20 city buses, and have seen a significant number of patients responding." he said.

The strategy of information dissemination is to go where the patients are, and not to rely on them to come to us, he said. "With the bus advertisements, the demographic we were recruiting was reliant on public transportation," he added. And the ads provided phone numbers, not e-mail addresses or Web sites because those would not be helpful for any potential participant who did not own a computer.

In the Duke program, the relevant stakeholders are at the table when recruiting programs are being designed. "If we are recruiting college students, we had students who sat on review panels and advisory boards to give us guidance as to what they would respond to, how, and in what setting," Dr. Edwards said.

Another panel member, Rahn K. Bailey, M.D., said throughout his career he has been interested in issues such as differences in drug metabolism between African Americans and other patients. For example, about 40% of black patients are slow or intermediate metabolizers of many psychiatric medications, said Dr. Bailey of the department of psychiatry and human behavior, University of Texas, Houston, and chair of the NMA psychiatry and behavioral sciences section. As a result, black patients tend to experience more toxicity, and efficacy may be compromised.

"It's not surprising to me now that many of my patients over the years have had great difficulty getting better, relapsed a lot quicker, come back to the hospital frequently, and ended up in the legal system because of clinical issues that were not addressed medically," Dr. Bailey said.

Audience member William Lawson, M.D., brought up the work of Surgeon General David Satcher, M.D., Ph.D., in his 1999 report "Mental Health: A Report of the Surgeon General." One of the points made was that virtually all U.S. psychiatric studies included primarily white males, so almost all psychiatric drugs had less than 1% African American representation, said Dr. Lawson, chair of psychiatry, Howard University, Washington. "And the consequences have been awful." ■

Index of Advertisers