Focusing on infections
Hospitals’ progress slow, reports says

Increased awareness and newly spearheaded improvement initiatives have done little to curb the number of healthcare-associated infections, according to a recent quality report from HHS’ Agency for Healthcare Research and Quality.

AHRQ released its 2009 National Healthcare Quality Report on April 13 alongside a companion report on healthcare disparities, which together “provide a detailed snapshot of how well the healthcare system is doing,” said Carolyn Clancy, the agency’s director. It is the first time that the quality report, now in its seventh year, has contained specific tracking information about hospital-acquired infections, which affect nearly 2 million patients each year, according to HHS.

Using CMS data, AHRQ found an 8% jump in the rate of postoperative sepsis and a 3.6% increase in the rate of postoperative catheter-associated urinary tract infections, signaling a problem that merits immediate attention, Clancy said. They also found no change in the rate of central-line bloodstream infections.

But despite these worrisome figures, it’s important to keep them in context, Clancy said. “The information in that report only applies through 2007, and a lot of it is Medicare data,” she said.

In other words, those numbers don’t take into account the latest efforts by the government and hospitals to make a significant dent in infection rates, HHS Secretary Kathleen Sebelius said in a conference call.

For instance, in late 2009, HHS awarded $17 million to combat hospital-acquired infections. Nearly half that amount went toward a nationwide expansion of the Keystone Project, an 18-month collaborative effort between Johns Hopkins University, Baltimore, and the Michigan Health & Hospital Association in Lansing, which lowered the rate of central-line bloodstream infections in more than 100 Michigan intensive-care units using checklists and staff training.

The biggest momentum will likely come from the recently passed Patient Protection and Affordable Care Act, which provides incentives to adopt protocols aimed at reducing infections, Sebelius said, and will eventually impose financial disincentives on providers that don’t lower their numbers.

The infection prevention landscape has changed significantly since 2007, agreed Rick Foster, senior vice president for quality and patient safety at the South Carolina Hospital Association. The state’s infection reporting and tracking requirements have helped providers notice patterns and develop strategies, he said, and have also moved away from the long-held notion that patient safety efforts should be led only by quality improvement staff.

“In our state, we’ve seen hospitals that have made infection prevention the responsibility of the whole unit,” Foster said. “That’s a big transition from the old, siloed approach. Now we have entire intensive-care units that are working together to prevent central-line infections.”

In fact, Foster credits that team-based approach with helping to achieve a nearly 45% drop in the number of central-line bloodstream infections.

Disparity >> Jessica Zignond
Lack of insurance is biggest problem

Not only do healthcare disparities continue to be a chronic problem in the U.S., but disparities for cancer, heart failure and pneumonia deserve special attention, the Agency for Healthcare Research and Quality reported last week.

The group’s annual National Healthcare Disparities Report was released simultaneously with its National Healthcare Quality Report on patient safety (See story, above). In its disparities report, the AHRQ said that in the measures that track both quality of care and access to care, disparities persist for all populations. And, as before, a lack of insurance continues to be a leading cause of healthcare inequalities among populations.

“We always think about a model that thinks about voltage drops,” said Carolyn Clancy, director of the AHRQ. “If you think about the transformer and the outlet in your house, there is a lot of potential for drops along the way,” she said, likening this model to healthcare.

“One is: Are you offered insurance? A second is: Can you afford it if you are offered it?” she added. “A third is: How generous is the coverage? Some of the coverage is like a hospital gown—depending on how you look at it, you’re covered.”
since they began the program in 2007.

The problem for many organizations stems from trying to accomplish too many goals at once, said Jodi Joyce, vice president of quality and patient safety at Legacy Health, a five-hospital system based in Portland, Ore. Two years ago, mired in safety initiatives that were failing to get traction, the system's leadership set two main goals: eliminate needless deaths and eliminate causes of preventable harm beginning with hospital-acquired infections.

Their first-year targets were a 5% reduction in mortality and a 10% to 20% reduction in healthcare-associated infections. Specifically, the system looked at incidences of ventilator-associated pneumonia, surgical-site infections, central-line bloodstream infections and catheter-associated urinary tract infections. "We found that if you tighten your focus, it makes it much easier to pull together resources and align efforts so you can really make strides," Joyce said.

Legacy's strategies included implementing bundles of evidence-based best practices and requiring daily conversations with key caregivers to ensure they had a clear and agreed-upon plan of care for each patient.

Finally, Joyce said, they worked on overcoming the cultural barriers that had hindered efforts, placing emphasis on communication issues such as shift-to-shift handoff conversations among clinicians, training and staff engagement.

For the second year of the initiative, Legacy Health bumped up its infection reduction goal to 50% and set its mortality reduction goal at 10%. Twenty-three months into the program, the number of hospital-acquired infections has decreased nearly 39% and mortality has dropped 14.3%. "We fell a little short of our infection goal, but we are continuing to make real progress. Next year, our goal is a 60% reduction and our long-term goal is zero."

There were some bright spots in AHRQ's report, including significant improvements in the rates of process measures for preoperative and postoperative antibiotics, and an 11.6% drop in the rate of postoperative pneumonia. Still, Clancy called those gains and the overall 2.3% increase in quality "unacceptably slow."

"Dramatic reductions in healthcare-associated infections are possible and they are occurring," she said. "

According to the report, blacks and Hispanics had worsening disparities in colorectal cancer mortality between 2000 and 2006; American Indians/Alaska Natives had worsening disparities in the recommended hospital care for heart failure from 2005 to 2007; and Asians and Hispanics both had worsening disparities in pneumococcal vaccination for adults aged 65 and older between 2000 and 2007.

"In the health reform bill, one of the things Congress did was to remove copayments and deductibles for many preventive screenings," said Georges Benjamin, a physician who serves as president of the American Public Health Association. "After that is implemented, we should see a marked improvement in access to preventive screenings to preventable cancers."

AHRQ researchers found that while the quality of hospital care for heart failure and pneumonia improved overall, care for whites continues to improve at a higher rate than for minorities, which shows that quality improvement has not translated to disparities reduction. As to why these disparities continue to persist, the AHRQ report offered a few reasons. "Low rates of colorectal cancer screenings may be due to cultural attitudes and patient perceptions, such as the belief that screening is not necessary," the report said. "In addition, patients may have problems paying for follow-up visits to complete screening and may have logistical problems getting to appointments."

Meanwhile, this year's report included a new section devoted to lifestyle modifications, with measures about counseling smokers to quit and advice to obese adults about healthy eating.

Benjamin said one way to improve obesity rates is through stronger relationships between doctors and the patients they treat.

"When you're being treated in the emergency department, you're being treated for an acute problem," Benjamin said. "Very clearly, one thing that having an insurance card will do is having a solid patient-physician relationship."

The report's findings support this need for greater awareness, as AHRQ found that there were more than 72 million obese adults in 2005-06; obese adults who are black, Hispanic, poor or who have less than a high school education are less likely to receive diet advice from their doctors; and most American children have never received counseling from their healthcare provider about exercise, and about half of those children have never received counseling about healthy eating. According to the Centers for Disease Control and Prevention, results of a 2007-08 survey showed that an estimated 17% of U.S. children and adolescents are obese.

First lady Michelle Obama has made the nation's childhood obesity epidemic her personal cause as she launched the Let's Move campaign earlier this year. As a member of the Obama administration, Clancy said she did not want to comment on the specifics of the program.

"As an individual and an American, I'm very excited about it," Clancy said. "I'm frankly thrilled we're focusing on it. "

Source: Agency for Healthcare Research and Quality National Healthcare Quality Report, 2009