PREVENTION: PUBLIC EXPECTATIONS

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Hospital acquired infections
722,000
1 in every 25 patients
75,000 deaths
(every 9 patients with HAIs will die during hospitalization)

Deaths related to Antibiotic Resistant Infections
or Antibiotic overuse
MRSA – 11,285
C. difficile – 14,000
3 key components to prevention

Public Reporting
Training – Education – Best Practices
Financial incentives and financial penalties
Outbreaks

- Notify patients who are affected & their doctors
- Notify public health authorities: local, state, federal
- Notify patients who may be affected
- Notify the public
- Foodborne Outbreak Online Database (FOOD Tool)

Mary Brennan Taylor, NY: "Our health department has been ineffectual; minimizing when any type of infection outbreak occurs is infuriating"
Who Should be Informed When a Hospital Outbreak Occurs?

- Patients who were directly affected by the outbreak: 75%
- Doctors treating the patients who were infected: 71%
- State public health authority: 64%
- Doctors who are admitting patients into the hospital: 63%
- Federal agency that oversees the nation's public health issues: 62%
- Patients who are being admitted to the hospital: 56%
- Patients currently in the hospital: 53%
- The public: 43%

Please indicate the extent to which you agree or disagree with…
Engaging patients through 2-way communication

(1) Inform re exposure, educate re colonization
   • Heater-cooler devices; Duodenoscopes

(2) Patient reporting of healthcare-acquired infections
   • FDA MedWatch: Adverse events for drugs, devices
   • CDC Vaccine Adverse Event Reporting System
   • Health Dept reporting systems for food poisoning
   • NO system for reporting infections
“Firewall” v. Collaboration

- Experts in infection control + inspectors/regulators
- Use all tools in the toolbox
- Review HAI data before inspections & investigations
- Year of significantly high infection rates = complaint
- Enforce prevention improvements: corrective action plans based on history & with the help of experts

Kathy Day, Maine: *There was an outbreak and the state had to get “permission” to go into that facility.*
Mandates Work

• Hospital staff: if it is not mandated, it will not get done.
• VA MRSA experience
• Missed opportunity: no mandated antibiotic stewardship programs and no tracking of whether the voluntary ones are working
• Medicare payment policies tied to doing the right thing – providing the right antibiotics, using Rx’g data to identify when and where overuse and inappropriate use is happening