

The Abell Report

What we think about, and what we'd like you to think about

Published as a community service by The Abell Foundation

Hospital-Acquired Infections: A National Tragedy

ABELL SALUTES: Patterson Park Community Development Corporation and Executive Director Ed Rutkowski; for mastering neighborhood dynamics, for creating an “urban success story.”

In 1996, watching conditions in the Patterson Park neighborhoods worsening, Ed Rutkowski formed Patterson Park Community Development Corporation (CDC). His effort was strengthened by a \$40,000 grant from The Abell Foundation and a commitment from the Foundation to guarantee a portion of private bank loans for acquisition and renovation of area houses.

With the benefit of community representation, Rutkowski and his board defined the neighborhoods to be targeted as those lying north and east of the park.

In the first nine months of its operation, the CDC completed renovations on three houses. Initially, the market was flat. To create incentives designed to attract buyers, the CDC partnered with the Foundation and together created programs that offered free tuition to St. Elizabeth's Catholic school, and a Home Value Guarantee program that underwrote payment of property value declines for owner-occupants.

Under Rutkowski's leadership the CDC has created important market-set-

continued on page 8

Across America 90,000 people a year die from hospital-acquired infections, while hospitals, government and communities struggle for answers.

Gloria Bonaffini, a 71-year-old Connecticut resident, entered Bridgeport Hospital in 1996 for coronary artery bypass surgery. She expected to be home within a few weeks, but her stay extended for more than a year. The reason: her sternum was infected by a staphylococcus germ during the surgery. The infection spread through her body and eventually killed her, according to hospital records.¹

Six years later, in St. Louis, MO, 13-year-old Raymond Wagner III broke his left arm while sledding. He developed a staph infection in the hospital that grew serious. He then spent several grueling weeks in the hospital and had to endure several more surgical procedures. He survived, but faces a lifetime of worry about a recurrence of the infection.²

In the summer of 2006, dozens of people protested outside a Louisville, KY, hospital. The protesters included former patients (or their families) who said they had contracted an infection at the hospital. “I'm permanently scarred, my body is weak. It caused me so much pain and heartache,” said one demonstrator, who believes she was infected while hospitalized for cancer surgery in 2002.³

These incidents, involving both young and old, are far from unusual. Across the nation, hospital-acquired infections are a serious problem that demands increased attention. People who enter the hospital may end up with an infection that can extend their stay,

cause lasting physical problems and be fatal.

How serious is the problem? A definitive answer cannot be known because there is no rigorous, nationwide tracking of hospital-acquired infections, but what is known is disturbing.

According to the U.S. Centers for Disease Control and Prevention (CDC):

Each year nearly 2 million patients in the United States get an infection while hospitalized, known as “nosocomial” infections (from the Latin word for hospitals), but referred to in this report as “hospital-acquired infections.”⁴

Of those patients, about 90,000 – or 246 a day – die as a result of their infection.⁵ Those 90,000 deaths are more than the total deaths caused each year by AIDS and automobile accidents combined.

For patients who are infected, hospital stays can be extended by many days or weeks; some patients carry the damage from serious infections for a lifetime. One such patient, Neil Novin of Pikesville, MD, believes he was infected with a devastating bacterium known as MRSA (methicillin-resistant *Staphylococcus aureus*) while in the hospital for a hip replacement. The infection has led him to undergo 11 additional surgeries.⁶

Many of these infections, and the deaths they cause, are known to be preventable – through more aggressive testing of incoming patients and stricter

continued on page 2

hygiene standards. Other measures include the basic one of ensuring that doctors and nurses wash their hands between patient visits, and making more careful use of invasive medical devices, such as catheters. While some hospitals have made some progress, the overall response has not been proportionate to the problem, with tragic consequences.

Congress has not adequately addressed the issue, and only a few states have taken steps to force hospitals to better guard against infections. Hospitals in Canada, Europe and Australia have been far more aggressive and have reduced infection rates well below those here.

The stakes are rising with the appearance of quick-to-evolve pathogens that are hard to battle with antibiotics. These drug-resistant microorganisms are becoming the chief cause of hospital-acquired infections, posing an increasingly serious threat to patients, hospital personnel and the public.

While some researchers and consumer and healthcare groups agitate for change, many healthcare providers have been slow to respond to the crisis, despite the staggering death toll, the high infection rate and the ever-growing threat of drug-resistant strains.

“For years, we’ve just been quietly bundling the bodies of patients off to the morgue while infection rates get higher and higher,” Dr. Barry Farr, then-president of the Society for Healthcare Epidemiology of America, said in an interview in 2002.⁷

This report is the first part of a two-part study. Part I provides an overview of the problem and responses undertaken nationally. Part II will consider the issue in Maryland, as pertinent data become public record.

About the term “hospital-acquired infections”

There is some debate over the best descriptive term for the infections discussed in this report. Some in the healthcare field prefer the term “healthcare-associated infections,” taking into account that infections are a problem throughout the healthcare area, not just in hospitals. For example, Dr. Trish Perl, Associate Professor of Medicine and Pathology and Hospital Epidemiologist for the Johns Hopkins Medical Institutions, comments: “Experts in the field now recommend the use of the term ‘healthcare associated infections,’ of which ‘hospital acquired’ (is) a subset where most data are available. For example, clients in long-term care facilities are increasingly at risk; there is little or no surveillance, there are no infection control resources to speak of, little to no policies to prevent transmission and there is a potential significant problem.”

The American Hospital Association, according to spokesperson Richard Wade, prefers “healthcare-associated infections.” Mr. Wade says, “It’s hard to pin down where some of the infected people acquired

those infections. Many may acquire them in nursing homes, ambulatory centers, doctor’s offices or in the community, and then bring them into the hospital.” The federal Centers for Disease Control and Prevention uses the term “Healthcare Associated Infections” but also provides statistical estimates about the rate and costs of “hospital-acquired” or “nosocomial” infections, estimates that are referred to in this report.

Because this report focuses strictly on the problems and challenges confronting American hospitals, it uses the term “hospital-acquired infections,” while acknowledging the serious problem that infections pose for all types of healthcare facilities, including nursing homes, rehabilitation centers and outpatient centers. Additionally, *hospital-acquired infections*, under that rubric, are the most studied and best documented subset of the broader category of healthcare-associated infections

Studies of this problem, as well as the debate over how to best give a name to it, are ongoing.

A National Problem

Infection prevention and control experts have attempted to track the rate of hospital-acquired infections for many years. In 1998, it was estimated that there were roughly five hospital-acquired infections for every 100 hospital admissions, according to data compiled by the CDC.⁸ Experts estimate that the rate remains roughly the same today. In other words, about one out of 20 patients can expect to contract an infection while in a hospital.

Accounts of these infections are becoming more widely publicized; the details can be grim, as unforeseen illnesses strike patients of all ages and backgrounds. Hospital-acquired infections carry a heavy human toll, but they also generate enormous costs for our health-care system. One study estimated that treating an infection adds more than \$15,000 to each infected patient’s bill, and one advocacy group estimated that hospital-acquired infections carry a total cost of between \$28 and \$30 bil-

continued on page 3

lion.⁹ Others estimate that the added cost of such infections is far lower, but no expert disputes that the problem carries a significant financial cost.

Antibiotic-Resistant Infections

The issue of hospital-acquired infections has taken a disturbing turn in recent years with the appearance of more and more pathogens resistant to traditional antibiotics. These pathogens are difficult to treat and can spread widely. Many experts agree that overreliance and overuse of antibiotics has led to a deadly phenomenon. Between a quarter and a half of all hospital patients are given antibiotics, but, it is estimated, roughly half of these drugs are either inappropriate or unnecessary.¹⁰

According to the CDC, more than 70 percent of the bacteria that cause hospital-acquired infections are resistant to at least one of the antibiotics most commonly used to treat them. Furthermore, persons infected with drug-resistant organisms are more likely to have longer hospital stays and require treatment with second- or third-choice drugs that may be less effective, more toxic, and/or more expensive.¹¹

The most common types of drug-resistant infections are strains of staphylococcus, according to the CDC. Research has shown that such bacteria spread far more quickly than other bacteria. Three decades ago, only 2 percent of “staph” infections were caused by the drug-resistant strain known as MRSA. Today, an estimated 60 percent of staph infections are MRSA. Overall, the CDC estimates that 120,000 patients were infected with the MRSA bacteria in 2002.

The Causes

Data strongly suggest that the risk of infection rises for hospital patients undergoing the following procedures:

- **Urinary bladder catheterization.** Urinary tract infection is the most common type of hospital-acquired infection and has been shown to occur primarily after urinary catheterization.
- **Respiratory procedures such as intubation or mechanical ventilation.** Bacteria and other microorganisms are easily introduced into the throat by treatment procedures performed to treat respiratory illnesses.
- **Surgery and the dressing of surgical wounds.** An infection can be acquired from improperly cleaned skin, poor surgical technique, and inappropriately administered antibiotics, from contaminated surgical equipment or from the hands of healthcare workers.
- **Insertion of intravenous lines and other procedures.** Bacteria from the patient, the environment, contaminated equipment, or healthcare workers’ hands can enter the body at the site of catheter insertion.¹²

Patients can become infected in other ways.

Bacteria can be transferred from a healthcare provider’s clothes to a patient or the patient’s environment. This includes privacy curtains surrounding a patient’s bed, which can hold bacteria and are often the last thing a caregiver touches before touching a patient. A range of hospital equipment, including stethoscopes and blood pressure monitors, can carry bacteria.

Infection-causing pathogens also can be passed to patients by a doctor, nurse or other healthcare provider who fails to cleanse his or her hands between patients, using either an alcohol-based gel or hand washing. Studies reveal that a high percentage of hospital personnel fail to clean their hands between routine visits to patients.

At the Bridgeport Hospital in Connecticut, a surveillance tape showed

that as many as half the doctors failed to wash their hands before entering one of the operating rooms. This lax hygiene became particularly relevant after the hospital was hit with major lawsuits related to the death of Gloria Bonaffini as noted earlier in this report and other cases of patients’ infections. The lawsuits showed that the hospital resisted aggressive testing of patients for infection or for giving infected patients individual rooms because of the hospital’s concerns about costs.¹³

“Nobody here intentionally spread germs, but we’ve learned that even the smallest breakdown in infection control can have devastating consequences,” a Bridgeport Hospital spokesman said in an interview.¹⁴

Following the lawsuits, the hospital instituted an aggressive anti-infection effort that reduced the hospital’s infection rate following cardiac surgery from 22 percent to nearly zero in most months, according to the *Chicago Tribune*.

Staffing shortages can also be a factor in the rate of increase in infections. One study of 799 hospitals nationwide found that patients were more likely to contract urinary-tract infections and hospital-acquired pneumonia in cases where nursing staffing was inadequate.¹⁵

Another obstacle in some cases is the physical layouts of hospitals themselves. Many lack wards or rooms that can be used efficiently to house patients who are infected. Others lack the space to install needed hand-washing areas. New guidelines for hospital design issued this year will call for the first time for hospitals to be built with private, not shared, rooms – in part because infection rates are lower in one-person rooms.¹⁶

Progress Is Achievable

Hospital-acquired infections are not inevitable, according to many experts. The record is replete with examples of how some hospitals have brought down infection rates through a variety of efforts.

continued on page 4

A 2006 study by Johns Hopkins researchers showed that simple and cheap procedures reduced the rate of catheter-related infections in more than 100 Michigan hospital intensive-care units. The research project focused on rigorous hand-washing, thorough cleaning of the skin around catheters, and the wearing of sterile masks, gowns and gloves. The study found that the rates of catheter-related bloodstream infections dropped by 66 percent.

“We think this model really helps to advance the science of patient safety,” said Dr. Peter Pronovost, the lead author of the study and a professor of anesthesiology and critical care medicine at the Johns Hopkins University’s School of Medicine. “It shows what’s possible. We no longer have to accept the infections as inevitable.”¹⁷

The Institute for Healthcare Improvement, which presents itself as “leading the improvement of health care around the world,” released findings in 2006 showing that 20 hospitals around the country had had either no or very few cases of a particular type of infection, ventilator-associated pneumonia, in the preceding year.¹⁸ The hospitals achieved these results by following a six-step protocol to combat pneumonia. Among the steps: making certain that hospital personnel keep the head of a patient raised to an angle of between 30 and 45 degrees and weaning patients off ventilators as quickly as possible. One Maryland hospital that was part of the study, Atlantic General in Berlin, reported only one case of ventilator-associated pneumonia in the previous 13 months.

Dr. Donald M. Berwick, president and CEO of the Institute, said, “These results are truly remarkable. These organizations have shown that ventilator-associated pneumonia, which occurs all too frequently in U.S. hospitals, is by no means inevitable.”

The University of Pittsburgh Med-

ical Center-Presbyterian reduced MRSA infections in its intensive care unit by 90 percent between 2000 and 2003 after implementing a protocol that tested every patient entering the hospital’s intensive care unit. A separate initiative in the Pittsburgh region, which was focused on decreasing catheter-associated bloodstream infections, reduced the annual number of such infections from 37 to 6. From 2003 to 2004, the number of deaths associated with those infections in the participating hospitals dropped from 19 to 1.¹⁹

Mercy Health Center in Oklahoma City reduced its surgical site infection rate by 78 percent in patients receiving cardiac bypass, orthopedic, colon, and hysterectomy surgery. Its method: follow strict protocols for whether or not to prescribe pre- and post-surgical antibiotics and keep body temperatures at the desired level during surgeries. “Our longer-term goal is to spread and sustain effective system changes to all surgical procedures within our hospital,” an infection control practitioner at the hospital said.²⁰

Significant research into preventing hospital-acquired infections is ongoing. In one example, the CDC in May awarded \$10 million to five medical research centers to develop and test new approaches to reducing infections.²¹

Some hospitals have also taken the simple but potentially effective step of posting a reminder for patients to insist that their doctors and nurses wash their hands before treatment.

A Push for Public Information on Infections

The CDC is the lead federal agency reporting about prevention of hospital-acquired infections and antibiotic-resistant organisms. It issues guidelines for combating such infections and epidemiologically significant organisms and collects information provided voluntarily by hospitals about their hospital-acquired infections, through the National Nosocomial Infections Sur-

veillance (NNIS). (The CDC has renamed the data-collection effort as the National Healthcare Safety Network.) Information from that study, which dates back 30 years, is made public, but only on an aggregated basis; that is, information about infection rates at an individual hospital remains confidential. The last report was issued in October 2004. The 2005 NNIS report has been delayed by several months due to problems with a new web-based reporting system used by hospitals, according to the CDC.²² The identity of the 300 hospitals that reported data for the 2004 study remains confidential, and the number of hospitals represents a small percentage of the nation’s 5,700 hospitals. The CDC does not release information that publicizes individual hospital infection rates.

Some observers have criticized the data collected by the NNIS. One analysis found that hospitals failed to report large numbers of infections or mischaracterized whether a large number of infections were indeed acquired by patients while hospitalized.²³ Others have called for a greater reliance on automated analysis of lab, pharmacy, and clinical data to better identify the prevalence of hospital-acquired infections.

Given the number of infections, the deaths attributed to them, and the high healthcare costs they generate, many experts have been critical of the CDC’s reporting requirements.

“If collecting data in isolated hospital areas represents ‘best practice’ when 2 million Americans develop a hospital-acquired infection, resulting in 90,000 deaths, and \$5 billion in cost, then best is just not good enough,” the New England Journal of Medicine wrote in a 2003 editorial.²⁴

In addition to the CDC’s efforts, the federal Medicare program has taken steps to provide a modest amount of infection-related information to consumers. On its Hospital Compare website, the Medicare program provides data for 1,300 hospitals that voluntarily

report how often they follow practices related to preventing infections during surgery and preventing pneumonia. The data for those hospitals are compared to the national average and to the average for the hospital's home state. While that information may be useful to patients in assessing hospitals, it does not provide any information about infection rates.

Other countries have been more aggressive about monitoring hospital-based infection rates. In England, for example, the National Health Service has forced hospitals to display statistics about their infection records and aggressive steps were taken to promote hygiene. (Like the U.S., England has much work to do on this issue; officials estimate that hospital-acquired infections kill 5,000 people a year in England.²⁵)

Some experts contend that public reporting of infections will not generate better infection records. Hospitals, they say, will not diligently look to identify all reportable nosocomial infections. And there is little research evidence showing that disclosure leads to decreasing infection rates.

Some in the healthcare field have resisted public disclosure of specific information about hospital-acquired infections. Among their arguments: such data can be misleading because some hospitals treat more patients who are far more vulnerable to infection – such as AIDS patients or the elderly. Their rate of infection will be significantly higher than those of hospitals that do not treat such patients and will mislead the public about safety conditions within their respective facilities. Some hospital officials argue that it can be difficult under current conditions to be certain whether or not a patient acquired an infection inside the hospital or carried it in when he or she was admitted.

But Richard Wade, a spokesman for the American Hospital Association, said the group recognizes that hospital infection rates will eventually be made pub-

▲

***A significant number
of American hospitals
have implemented active
testing of incoming
patients, in an effort to
detect those carrying hard-
to-treat infectious agents.***

▼

lic, and that such disclosure will force hospitals to act. “Going public will make hospitals more aware of how they do things.”²⁶

Some hospitals have already embraced public disclosure. Marshalltown Medical and Surgical Center in Marshalltown, IA, for example, posts a quarterly summary of the incidence of nosocomial infections among its patients.

Why? “Because people have a right to know,” says a hospital vice president.²⁷

A Push For Wider Patient Testing

Central to the debate today is whether to do routine testing of incoming patients for infections, particularly such strains as MRSA and vancomycin-resistant enterococcus (VRE). In the testing that is proposed, the patients would be those most at risk for carrying dangerous infections, such as diabetics, dialysis patients and those who have come from nursing homes or other high-risk environments.

Under this protocol, patients in these categories would continue to be tested throughout their hospital stay, and those who test positive would be treated in isolated units within the hospital to reduce the chance of spreading the infection.

This approach was laid out in a special report of the journal *Infection Con-*

trol and Hospital Epidemiology in May 2003, co-authored by seven researchers for the Society for Healthcare Epidemiology of America (SHEA).²⁸ They point out that other countries, including Finland, Belgium, Denmark, and the Netherlands, have made strong progress toward eliminating the presence of MRSA, in part by aggressively testing incoming hospital patients. Some of these researchers have been sharply critical of the CDC for failing to call for wider patient surveillance testing for infections.

After five years of study, in October 2006 the CDC issued guidelines for dealing with drug-resistant pathogens that did not go as far as SHEA had sought. The guidelines note that aggressive testing of patients, known as “active surveillance culturing” (ASC), may be appropriate in some cases.²⁹ However, the CDC stopped short of calling explicitly for hospitals to undertake such testing; some members of the advisory board that issued the guidelines say more research is needed to determine the effectiveness of ASC.

Among those who have been critical of the CDC's stance on patient testing has been Betsy McCaughey, founder of the organization Committee to Reduce Infection Deaths, a nonprofit educational group. She wrote recently:

“Research shows that the only way to prevent MRSA infections is to identify which patients bring the bacteria into the hospital. The MRSA test costs no more than the H.I.V. test and is less invasive, a simple nasal or skin swab.... Can hospitals afford to screen for MRSA? They cannot afford not to. Infections wipe out hospital profits. When a patient develops an infection and has to spend many additional weeks hospitalized, Medicare does not pay for most of that additional care.”³⁰

A significant number of American hospitals have implemented active testing of incoming patients, in an effort to detect those carrying hard-to-treat infectious agents.

For example, in 2005, Evanston Northwestern Healthcare in Illinois began screening incoming patients at its three hospitals to detect MRSA. The testing allows doctors to immediately identify and treat patients who may otherwise be unaware of having MRSA, the hospital system announced. Once diagnosed, patients are treated with a nasal antibiotic ointment for five days. They also need to bathe using a special antiseptic soap on the first, third and last day of the nasal ointment treatment.³¹

It seems inevitable that many more American hospitals will pursue such an approach, following the lead of their counterparts in Canada and parts of Europe, taking more aggressive steps to identify and isolate incoming patients who are already infected.

States Take Up the Issue

The issue of hospital-acquired infections is beginning to be addressed at the state level. The debate is centered on the question of whether to make public the data about infection rates. To date, 14 states have passed laws requiring hospitals to report some information related to hospital-acquired infections, data that will be made public in various ways.³² New York, for example, is conducting a pilot project whereby the data reported will not be broken out by specific hospital. State officials, however, can release the data in its aggregated form, or data about a specific hospital, without the hospital's name attached. This will allow for analysis of the data on a statewide or regional basis.

Two other states, Nevada and Nebraska, now require hospitals to report data on hospital-acquired infections to state health officials. However, the data cannot be made public. Three other states, Alaska, Georgia, and Texas, are studying the issue this year. More than half the states have yet to address the problem.

Pennsylvania: A Case Study

Pennsylvania is one of the few states required to collect and report data on hospital-acquired infections. Beginning in 2004, hospitals in the state began to submit data on hospital-acquired infections to the Pennsylvania Health Care Cost Containment Council. Although some observers questioned whether all state hospitals complied fully with this collection effort, the data compiled by the Council and first released in 2005 are "eye-opening information for all parties involved in the delivery and payment of hospital care."³³

An updated report issued in March 2006 showed that the situation being reported by Pennsylvania hospitals had not improved:

- In the first nine months of 2005, hospitals identified 13,711 hospital-acquired infections, compared to 11,668 for all of 2004. The increase likely reflects hospitals' improved data submissions and an expansion of data collection requirements for infections in surgical units.
- 13 percent of those who acquired infections in the hospital died, compared to 2.4 percent without such infections.
- The average length of stay for a patient with a hospital-acquired infection was 21.1 days, compared to 4.5 days for patients without such an infection.
- The average hospital charge for patients with a hospital-acquired infection was \$197,717, compared to \$31,617 for other patients.

The Pennsylvania Council concluded that the extra cost of hospital-acquired infections in 2004 could be estimated at \$614 million. A more exact figure will be available when more data is provided by all the relevant parties.

At the time of the release of the 2005 data in March 2006, Marc Volavka, executive director of the Pennsylva-

nia Health Care Cost Containment Council, said the numbers cited above were underreported, calling them "just the tip of the iceberg."

Volavka also urged Congress to set a goal of reducing and, ultimately, eliminating hospital-acquired infections. With its major financial stake in health care (through Medicare payments, for example), the federal government could wield enormous influence over hospitals, he said.³⁴ While a perfect reporting system is not likely, Mr. Volavka urged action.

"There could be no more noble or compelling issue for Congress, and our nation, to tackle," he testified.

Maryland's Situation

In recent years, Maryland policymakers have begun to take the first steps in addressing the problem. In 2006, the General Assembly considered two pieces of legislation on the subject, passing one and rejecting the other.

The bill that did become law requires the Maryland Health Care Commission to collect and publish information on hospital-acquired infections.³⁵ Sponsors of the legislation expect that public reporting of infection data will spur hospitals to do a better job of preventing infections. "[The bill] will cause the hospitals to want to look good, and allow people to make informed choices," Del. Shane E. Pendergrass, one of the bill's chief sponsors, said in an interview.³⁶

The new law, which was passed with the support of the Maryland Hospital Association, also requires the commission to adhere, to the extent possible, to the CDC's recommendations on collecting and reporting such data to the public. The first set of infection data being collected by the Maryland Health Care Commission is expected to be released in 2007.

A second measure (cross-filed as Senate Bill 535 and HB 966) took a more aggressive approach. In its preamble the measure declared, in effect, a

public health crisis due to hospital-acquired infections. The bill would have required Maryland hospitals and nursing homes to implement a rigorous anti-infection program and to test patients for some infections, as called for in the guidelines set out by the Society for Healthcare Epidemiology of America.³⁷ The legislation, which would have required more intensive action by state hospitals and nursing homes than the reporting measure, was opposed by the Maryland Hospital Association (MHA) and was killed in Senate and House committees. MHA officials argued that hospitals should not be forced to undertake mandatory testing programs; rather, each should be allowed to decide what level of surveillance is appropriate for its patients.

The Johns Hopkins and Franklin Square Hospitals are part of a two-year study of efforts to use, among other things, more in-depth patient testing to combat MRSA, the drug-resistant bacteria. The two Maryland hospitals will work to improve hand hygiene practices, to screen incoming patients for the bacteria, and to isolate those who test positive.³⁸ The initiative is being sponsored by the hospitals themselves, the Robert Wood Johnson Foundation, the Plexus Institute, and the Maryland Patient Safety Center, which is affiliated with the Maryland Hospital Association. Organizational change is being promoted by use of a technique called “positive deviance,” which encourages healthcare workers to help develop solutions to problems associated with hand hygiene, isolation and active testing of patients.

Key legislators have promised to revisit the issue in 2007 in an effort to

force Maryland hospitals and other healthcare facilities to take more aggressive steps to stop infections.

Conclusion

Hospital-acquired infections constitute a crisis in the United States. At least one out of every 20 hospital patients acquire such an infection, and more than 90,000 patients will die from one of the infections each year. And the situation is only going to grow more challenging, as pathogens continue to quickly develop resistance to antibiotics.

Research has shown promising ways to combat such infections. But many policymakers and healthcare administrators have yet to fund or embrace the kind of aggressive testing and clinical responses that several European countries have used to successfully bring down their infection rates. This is a failure that plays out in unnecessary deaths, lingering illnesses and billions of dollars of extra costs to our already bloated healthcare system. Many hospitals and policymakers seem to accept the high infection rate and death toll as the price of doing business.

The issue is gaining traction around the country. Under pressure from a small number of consumer groups, some states have enacted laws to require hospitals to report infection data, but other states have not taken action and Congress has not stepped in.

About the Author

Tom Waldron is a Baltimore-based researcher and writer. He is a former reporter and State House bureau chief for the *Baltimore Sun*. This report is based on a review of documents, research, media coverage and interviews with experts in the field.

¹ “Infection epidemic carves deadly path; Poor hygiene, overwhelmed workers contribute to thousands of deaths,” Michael J. Berens, *Chicago Tribune*, July 21, 2002, Page 1.

² Testimony of Raymond T. Wagner Jr., House Energy Committee Subcommittee on Oversight and Investigations, March 29, 2006.

³ “Protesters: Jewish Hospital to blame for staph infections,” Darhiana M. Mateo, *Louisville Courier-Journal*, July 27, 2006.

⁴ This report refers to infections acquired in hospitals, but the information here is also applicable to other healthcare facilities, particularly nursing homes.

⁵ U.S. Centers for Disease Control and Prevention, Campaign to Prevent Antimicrobial Resistance in Healthcare Settings, <http://www.cdc.gov/drugresistance/healthcare/problem.htm>.

⁶ “Md. bill seeks data on hospital infections; Reporting is not mandatory in state,” David Kohn, *Baltimore Sun*, March 13, 2006

⁷ Berens, *Chicago Tribune*, July 21, 2002.

⁸ Robert A. Weinstein, “Nosocomial Infection Update,” *Emerging Infectious Diseases*, Vol. 4, No. 3.

⁹ Betsy McCaughey, “Hospital Infection Fact Sheet,” Committee to Reduce Infection Deaths, <http://www.hospitalinfection.org/infectionfacts.shtml#5>.

¹⁰ “Strategies for Preventing Nosocomial Transmission of Methicillin Resistant *Staphylococcus aureus*,” presentation by Dr. Carlene A. Muto, University of Pittsburgh/UPMC-P, director of Hospital Epidemiology/Infection Control

¹¹ U.S. Centers for Disease Control and Prevention, Campaign to Prevent Antimicrobial Resistance in Healthcare Settings, <http://www.cdc.gov/drugresistance/healthcare/problem.htm>.

¹² Surgery Encyclopedia, <http://www.surgeryencyclopedia.com/Fi-La/Hospital-Acquired-Infections.html>

¹³ Berens, *Chicago Tribune*, July 21, 2002, Page 1.

¹⁴ *Ibid.*, 1.

¹⁵ *Ibid.*, 1.

¹⁶ “New Standards for Hospitals Call for Patients to Get Private Rooms,” Laura Landro, *Wall Street Journal*, March 22, 2006.

¹⁷ “Simple Measures Reduce Infections,” Chris Emery, *Baltimore Sun*, Dec. 28, 2006.

“Hospital-Acquired Infections: A National Tragedy”
is available on The Abell Foundation’s website at www.abell.org or:
write to The Abell Foundation
111 S. Calvert Street, 23rd Floor, Baltimore, MD 21202

continued from page 7

- ¹⁸ Institute for Healthcare Improvement, press release, Feb. 21, 2006.
- ¹⁹ “Evolving a Culture of Patient Safety: Lessons from the Elimination of CLABS,” Allegheny General Hospital and Pittsburgh Regional Healthcare Initiative.
- ²⁰ American Health Quality Association, http://www.ahqa.org/pub/quality/161_1101_5381.cfm
- ²¹ Centers for Disease Control and Prevention, <http://www.cdc.gov/od/oc/Media/pressrel/r060504.htm>
- ²² Centers for Disease Control and Prevention, http://www.cdc.gov/ncidod/dhqp/nnis_05delay.html.
- ²³ Testimony of Marc Volavka, executive director of the Pennsylvania Health Care Cost Containment Council, House Energy Committee Subcommittee on Oversight and Investigations, March 29, 2006.
- ²⁴ New England Journal of Medicine, 348:7, 2003.
- ²⁵ “Greater patient power to fight superbugs,” James Meikle, *The Guardian*, July 12, 2004.
- ²⁶ Interview Oct. 31, 2006, by author with Richard Wade, senior vice president for strategic communications, the American Hospital Association.
- ²⁷ “Hospital Infections,” WHO-TV, Channel 13, April 2006.
- ²⁸ “SHEA Guideline for Preventing Nosocomial Transmission of Multidrug-Resistant Strains of *Staphylococcus aureus* and *Enterococcus*,” Carlene A. Muto, et al. “Infection Control and Hospital Epidemiology,” May 2003, page 362.
- ²⁹ “Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006, Centers for Disease Control and Prevention.
- ³⁰ “To Catch a Deadly Germ,” Betsy McCaughey, *New York Times*, Nov. 14, 2006.
- ³¹ “Patients, Community Benefit From Evanston Northwestern Healthcare Admission Screening Program to Reduce Rate of Potentially Fatal Staph Infection,” PR Newswire announcement, July 25, 2005.
- ³² Consumers Union, http://www.consumersunion.org/campaigns/learn_more_background/003544indiv.html.
- ³³ Pennsylvania Health Care cost Containment Council Research Briefs, Issue No. 5, July, 2005.
- ³⁴ Testimony of Marc Volavka, executive director of the Pennsylvania Health Care Cost Containment Council, House Energy Committee Subcommittee on Oversight and Investigations, March 29, 2006.
- ³⁵ Senate Bill 135, sponsored by Sen. Delores G. Kelley, passed both houses of the General Assembly and became law without the governor’s signature.
- ³⁶ “Tracking Hospital Infections,” David Kohn, *Baltimore Sun*, April 14, 2006.
- ³⁷ The measure would have required hospitals and nursing homes to establish an infection prevention and control program that follows the guidelines of the Society for Healthcare Epidemiology of America. Such a program includes active testing of patients for infections; isolation of patients with infections; and strict adherence to hand-washing and other hygiene guidelines.
- ³⁸ *Baltimore Sun*, “2 hospitals to test for bacteria,” July 22, 2006.

ABELL SALUTES:

Continued from page 1

ting renovations of vacant houses, and has sold nearly 200 houses to homeowners. Over 15 banks and lending institutions have provided financing for purchase and innovation, and funding support has come from all levels of government, and both local and national foundations. The organization now maintains a sizable rental portfolio of formerly vacant properties.

Over the past ten years, Rutkowski’s efforts have helped to stabilize and improve the neighborhoods of Patterson Park. In 1995, he joined neighborhood residents in purchasing and renovating properties for sale. Before the concept was fully tested, he created the Patterson Park Neighborhood Initiative to hire organizers to help define the issues affecting their neighborhoods: a high crime rate, insufficient city services, decreasing population. He became a careful student of neighborhood dynamics affecting Patterson Park, the increase in foreclosure and vacancy, and effects of rapid racial change and drug activity. He co-authored a book on his findings, *The Urban Transition Zone*.

Rutkowski identified the key to neighborhood revival – safety in the park. He felt strongly that the neighbors had to feel comfortable using it, day and night, and to that end he supported the development of the non-profit Friends of Patterson Park to help achieve the goal. Recognizing that the park was undervalued and under-programmed, the Friends became advocates for the park. They raised money for the redevelopment of the boat lake, the pagoda, the marble fountain, the playground, and perimeter lighting. At the same time, they developed a program of events, as many as 50 each year. The Friends are true stewards of the park, logging thousands of volunteer hours each year to staff the pagoda and participate in clean-ups and events.

The CDC has pioneered the design concepts of combining antiquated alley houses into spacious, state-of-the-art houses. The agency has worked with neighbors and the police on issues of crime, and has brought resources into the neighborhood that help keep the streets and alleys clean.

Ed Rutkowski’s energy and enthusiasm for the neighborhood over the past ten years are exemplary. The *Baltimore Sun* called the Patterson Park CDC “an urban success story.”

The Abell Foundation salutes Ed Rutkowski and the Patterson Park Community Development Corporation, for mastering neighborhood dynamics, for creating an urban success story.