DR. TAMMY LUNDSTROM

Reporting vs. Prevention: Keeping the Rules in Balance

INTRODUCTION: At a conference of the Association for Professionals in Infection Control and Epidemiology (APIC), Dr. Tammy Lundstrom, JD, chief medical officer of the Detroit area's Providence Hospital, spoke about the impact of legislation in the battle against *methicillin-resistant Staphylococcus aureus*, or MRSA, as well as other healthcare-associated infections. Legislation, Lundstrom notes, focuses on reporting infections as a means to transparency. While hospitals must accept this paradigm as a reality in today's healthcare arena, their primary focus should not be on simply counting today's infections, but preventing them. She also points out that though certain infections, such as MRSA, are in the public spotlight, each hospital should focus on its own unique challenges. In this podcast, Lundstrom shares insights on how healthcare organizations can adapt specific legislative mandates into organizational changes that lead to infection prevention.

INTERVIEWER: There's legislation both on the federal level as well as on the local level. Can you tell me, in your viewpoint, why this legislation has come about and what you think will be accomplished by this legislation?

T. LUNDSTROM: Well, I think it's come about because of a lot of consumer interest in knowing infection rates, among a host of other quality data on hospitals, and really looking at the whole transparency issue and providing consumers information that they can use to better choose where they want to spend their healthcare dollars—and also on the part of payers because they want to send their covered lives to hospitals that have higher quality and fewer complications. So I think there is that push. And then also some very recent cases of tragedies—deaths from community-acquired and hospital-associated infections that have really continued to bring this information forward to the public.

INTERVIEWER: What is the difference between reporting HAIs and MRSA data and legislating active surveillance?

T. LUNDSTROM: Well, I think in terms of active surveillance, as we heard earlier in the conference, MRSA is not the only resistant or problematic organism in town. Some hospitals have problems with *Acinetobacter*. Some hospitals have problems with *C. difficile*. The new *Klebsiella* that's resistant to most antibiotics is a real big problem in some hospitals.

So I think the goal is to do a real thorough risk assessment of your own hospital, your geographic areas, and hit on those organisms and infections that are problematic in your facility, with the goal to eliminate. If everybody does that, active surveillance cultures, as a mandate, are not necessary.

And certainly professional societies, including the CDC, think that active surveillance cultures have a role. That's really not what we're saying. We're saying they do have a role in certain instances. If you've done all of the Tier 1 recommendations from CDC, and you're monitoring compliance, you've got high compliance with the Tier 1 recommendations and your rates are not decreasing, then you would step-wise consider Tier 2 recommendations, which include active surveillance cultures.

That's a much different approach from saying everybody will do active surveillance cultures on everybody. It attempts to make a one-size-fits-all approach when there may be very local problems that are much more of a patient-safety issue at certain hospitals, and the concern is that resources will then be devoted to a mandate that's really not appropriate for that particular hospital.

INTERVIEWER: The new CMS rule in the DRG system, you talked a little bit about that. How should ICPs work to communicate with their hospital administrators about what the CMS rule means, not only to the patient but also to the hospital and its financial health?

T. LUNDSTROM: I think most hospital billers, coders and finance officers are really well aware of that information. So I think what it's done is help to bring infection control to the forefront in terms of programmatic resources. What the exact effect will be on hospitals I don't think is yet known.

But there are a couple of lessons we can take away. One is: the focus on counting infections should be minimal. The real focus should be on preventing infections. So looking at things that you can do to eliminate catheter-associated urinary tract infections, for example, like getting the catheter out quickly, assessing the need

for the catheter every day, are probably a lot more important and certainly, from a patient's perspective, will have a lot more impact than trying to figure out financially how hospitals will fare under these new rules.

So I think the message to infection control: It's an opportunity to open conversation with the board members and the finance committee as to the resources that are necessary based on your own facility's risk assessment. It's also an opportunity to get in front of physicians and talk to them about prevention and getting those catheters out—paying attention to hand washing, things that we know are going to work to really prevent infections. So I think it's a challenge, but it is also an opportunity.