

DR. SARA COSGROVE

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## Making a Financial Case for Infection Control

At a recent conference of the Association for Professionals in Infection Control and Epidemiology, Dr. Sara Cosgrove, associate hospital epidemiologist at Johns Hopkins University School of Medicine, spoke about the role finance plays in fighting health care-acquired infections. In this podcast, Cosgrove discusses the financial impact of HAIs—particularly those caused by multidrug-resistant organisms, or MDROs. She also talks about the challenges hospital administrators and infection control practitioners (ICPs) face in funding infection control programs, as well as tools they can use for overcoming those challenges.

INTERVIEWER: The title of your presentation was “The Clinical and Financial Impact of Multidrug-Resistant Organisms in Healthcare Facilities.” Can you tell me, first off, why it’s important to understand the financial impact of MDROs, and what you think that will help people understand about this epidemic, and how it can arm them with information that they need?

S. COSGROVE: I think institutions are driven to make decisions about what kinds of programs to fund on the basis of: “Is a particular problem harming a patient? Is it leading to increased hospitalization?”—which pretty much by definition would lead to an inability to admit newer patients to the hospital—if you still have a patient occupying a bed for a long period of time. And that kind of indirectly leads to increased cost. So it’s important to know if those kinds of increased costs—length of stay, and increased mortality—are happening, because then you can direct interventions toward areas where those are of the biggest magnitude.

INTERVIEWER: Do you find that a lot of hospitals are having difficulty calculating that cost because it’s not (a hard cost)? It’s not like you’re buying a bed and you know how much that costs. It’s something that happens over time. What are the challenges in calculating that cost?

S. COSGROVE: I think it’s very challenging at the individual hospital level to calculate those costs. Mortality, strangely enough, can sometimes lead to increased cost, and sometimes lead to decreased cost; if a patient dies very early in the hospital stay, then they may potentially have a lower cost. But that’s still a bad outcome, and

you don't want that to happen. But, on the other hand, sometimes patients who have a complicated hospital course and then die have the highest expenses of any group of patients in health care.

But it really comes down to understanding how hospitals are reimbursed. That financial understanding is complicated and unique to individual institutions. But the easiest way, I think, to think about it really is: If you have a patient who comes in for an elective surgical procedure and everything goes as it should and there are no complications, then you have the best outcome for the patient and the best outcome for the hospital, because that bed time has been used to the greatest advantage. But if you have a person who comes in for an elective procedure and they go on to have some complication involving a resistant organism or an infection or *Clostridium difficile* colitis, then instead of being discharged when expected, they're discharged four days later or five days later—even if there is some reimbursement back for that time period in addition to what would be expected, it's not going to be as much as if another patient could have come in and had an elective procedure during that five days and been discharged. And then two patients would have had good outcomes instead of one patient with “not a good outcome.”

INTERVIEWER: It seems to me, and something that happened—I don't know if it was during your presentation or a subsequent one—but Dr. Jarvis had talked about the fact that hospital leaders and administrators really need to lead the charge here. And it seems as though the finance side of things is really where the administration does have a lot of say. So do you see a disconnect between the science of preventing MRSA and the finances of preventing MRSA?

S. COSGROVE: I think, traditionally, infection-control programs and antibiotic-management programs are viewed as things that cost money, and they do, because there's a chunk of money that's put forth in a hospital budget for those activities, and those functional units are not making money for the hospital. I mean, obviously they're not directly making money. They're not seeing patients and billing for that. They're not doing procedures and billing for that. So it's not the typical dynamic.

Usually, we have a surgeon who does a procedure, and the surgeon bills for her time, and the hospital bills for the procedure, and money flows in. And infection control, when you're not visionary about it, looks like just some regulatory thing

that you must do and you have to pay for. And, unfortunately, there haven't been huge increases in the money that institutions have given over to infection control and antibiotic management because money's tight in all hospitals.

The truth is: With additional mandates from state government and other sources, there hasn't been a cash flow into the hospital to help support those mandates, and I think that's a real critical issue because there's an expectation now that we'll do everything possible to prevent infection. And we'd like to do that—absolutely. No one wants infection. But [fighting] it costs money. And then we have to consider: Where do we want to spend that money?

INTERVIEWER: When you're thinking of the infection-control professional and you're thinking of the hospital CEO and the CFO who handle the finances, what can the ICP do to maybe get some of that money? Is there an argument that they can make to free up some of that money so that that is a priority in the administration's mind?

S. COSGROVE: I think that most hospital administrators are not cold people, and so if you can at a minimum bring the data from the literature that we know these infections are associated with mortality, increased hospitalization, increased cost, generally that will make some headway.