In the wake of what appears to be underreporting of nosocomial infections, a Pennsylvania state agency is poised to use its leverage to force hospitals to divulge more accurate and full information.

This summer, the Pennsylvania Health Care Cost Containment Council issued a report to the public showing that there were 11,668 confirmed hospital-acquired infections among 1.5 million discharges from 173 general acute care hospitals in 2004. The infections were associated with 1,793 deaths, 205,000 extra hospital days, and $2 billion in charges.

Pennsylvania is the first state to make such numbers public. As firm as the numbers may sound, however, the data are rife with omissions and invalid reports, and several hospitals reported no infections at all, said Marc Volavka, executive director of the council, which is a state-funded, independent agency. What was reported may only be the tip of the iceberg, Mr. Volavka said in an interview.

Since January 2004, hospitals in Pennsylvania have been required to submit quarterly data to the council on surgical site infections in orthopedic surgery, neurosurgery, and surgery related to the circulatory system; de-vice-related infections, including urinary tract infections from Foley catheters; ventilator-associated pneumonia; and bloodstream infections from central lines. Starting in 2006, hospitals will have to submit data on all hospital-acquired infections.

The council has the authority to release data on a hos-pital-by-hospital basis, but so far, it has not. “As we start-ed down this uncharted path, we said from the beginning that it would take time to get accustomed to this reporting process,” said Mr. Volavka in a statement, adding that many facilities had been given “lenient time frames and extensions.”

“Unless reporting gets more accurate and more complete, the council will start to use [its] authority” to name names, he said.

Doing that now could potentially harm hospitals that are complying with the reporting guidelines, according to Mr. Volavka. For instance, 17% of hospitals in the state (29 facilities), which account for only 25% of the admis-sions, reported more than half of the total infections. Sixteen hospitals reported no infections at all.

“There was no transparency between the number of infections reported to the state (11,668) and the number billed to payers: 115,631. The council said the higher number indicates there may have been more hos-pital-acquired infections than were reported to the state.

On the basis of the $29,000 that insurers actually paid for each infected patient, compared with $8,300 for an in-patient without an infection, the council estimated that third-party payments for the 11,668 infections amounted to nearly $390 million.

In a statement, Carolyn Scanlan, president and CEO of the Hospital & Healthsystem Association of Pennsylvania, said the council’s data on third-party payments was somewhat misleading because it made no distinction between infection-related costs and those costs associ-ated with the patient’s entire time in the hospital.”

Ms. Scanlan also defended hospitals’ response to the council’s requirements, noting that the number of infecc-tions reported had increased each quarter. She said the increase in reporting indicates that hospitals are becoming more familiar with reporting requirements.

The Centers for Disease Control and Prevention has said that 3%-10% of hospitalized patients will acquire an infection, Mr. Volavka pointed out. So, while the numbers reported in Pennsylvania jibe with that CDC esti-mate, “it frankly ought to be a wake-up call to health care professionals and to purchasers and consumers who ul-timately are paying the bill,” he said.

If the Pennsylvania data were extrapolated nationally, the figures indicate at least 100 people per day die from noso-comial infections, at a cost of about $90 billion a year.

Clinical Trials Need Minority Participation to Close Gap

BY NANCY WALSH
New York Bureau

New York — Racial disparities in access to health care will disappear only when adequate and representative samples of mi-norities participate in clinical trials, Winston Price, M.D., said at the annual meeting of the National Medical Association.

That disparities in delivery of health care exist is not in question. The Institute of Medicine report “Unequal Treatment: Con-fronting Racial and Ethnic Disparities in Healthcare” revealed the extent of the prob-lem, showing that disparities remain even af-ter adjustment for factors such as insurance coverage and socioeconomic status.

But a widespread mistrust of the U.S. health care system among minorities—not least because of past abuses such as the Tuskegee Syphilis Study, in which blacks went untreated for many years despite the activists’ efforts—is a roadblock to an unwillingness among African Amer-i cans to participate in the clinical trials that might directly benefit their own health.

An increasing understanding of genetic and racial differences in response to medications makes it imperative that minori-ties be included in studies aimed at developing new drugs.

“You had 1,050 African Americans who enrolled in the study, and the attrition rate was zero,” Dr. Price, who is also pres-ident of the National Medical Association, said at the annual meeting of the National Medical Association. "We make ourselves available for interviews on television, religious radio, and pop radio. In one creative marketing plan, we placed advertisements for one of our studies on the side of 20 city bus es, and have seen a significant number of patients responding,” he said.

“The strategy of information dissemina-tion is to go where the patients are, and not to rely on them to come to us, he said. “With the bus advertisements, the demo-graphic we were recruiting was reliant on public transportation,” he added. And the ads provided phone numbers, not e-mail addresses or Web sites because those would not be helpful for any potential par-ticipant who did not own a computer.

In the Duke program, the relevant stakeholders are at the table when re-cruiting programs are being designed. “If we are recruiting college students, we have students who sit on review panels and ad-visory boards to give us guidance as to what they would respond to, how, and in what setting,” Dr. Edwards said.

“Another panel member, Rahn K. Bailey, M.D., said throughout his career he has been interested in issues such as differ-ences in drug metabolism between African Americans and other patients. For example, about 40% of black patients are slow or intermediate metabolizers of the type II antipsychotic medications, said Dr. Bailey of the department of psychiatry and human behavior, University of Texas, Houston, and chair of the NMA psychiatry and behav-iorsal sciences section. As a result, black patients tend to experience more toxicity, and efficacy may be compromised.

“It’s not surprising to me now that many of my patients over the years have had great difficulty getting better, relapsed a lot quicker, and have done worse.”

Dr. Bailey said. “More often than not, the hospitals are demonstrating that minorities participate in clinical trials, Winston Price, M.D., said throughout his career he has been interested in issues such as differ-
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