

*Editorial: The Charleston Gazette*

*Public Reporting of Hospital-Acquired Hospital Infections*

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The July 21, 2005 *Charleston Gazette* editorial concerning hospital infections provides the opportunity to discuss some of the important steps that West Virginia hospitals are continuing to take to improve quality of care and ensure patient safety. It also presents the opportunity to explain why public reporting of hospital-acquired infections (HAI) is more complicated than it sounds, requiring a standard, centralized approach rather than a patchwork of different state laws and regulations.

Preventing hospital-acquired infections is a top concern of West Virginia hospitals; so is identifying, controlling and eliminating hospital infections. Through their infection control programs, hospitals continuously strive to improve care and create a safe environment by using the most current science, techniques and products to reduce the risk of getting an infection while in the hospital. We see that dedication to doing the right thing in every health care professional, in every hospital, every day.

This commitment toward quality improvement was reaffirmed in 2003 when West Virginia became the first state to have all eligible hospitals agree to participate in a new national effort to improve care through public reporting of this information. This groundbreaking initiative, titled *Hospital Compare*, was created through the efforts of the Centers for Medicare and Medicaid Services (CMS) and organizations that represent hospitals, doctors, employers, accrediting organizations, other federal agencies and the public.

*Hospital Compare* calls for hospitals across the nation to volunteer to publicly report data on their quality efforts. Publicly available through the website <http://www.hospitalcompare.hhs.gov/>, those that are interested are able to view hospital-specific quality information on 17 measures for three common medical conditions – heart attack, heart failure and pneumonia.

Within the next year, the CMS measures will be expanded to include outcomes such as patient satisfaction and surgical complications. One of the measures that may be

added in the future is surgical site infection. This will provide another dimension to the existing national programs and state initiatives already focused on quality improvement. All of these efforts are aimed at making hospitals accountable for demonstrating the effectiveness of prevention and control programs by standardizing what is tracked and providing more information to consumers.

Hospitals recognize they have a responsibility to their communities and the patients they serve to ensure that any data collected are meaningful, reliable and can be used in a manner that will improve quality. There lies the problem of mandatory state reporting. On the surface, mandatory collection and public reporting of hospital acquired infections appears to be a good step toward providing consumers with useful decision-making information about hospitals. However, one of the unique challenges we face in West Virginia is that the average size of our hospitals is so small that it is very difficult to develop a comparative database to ensure publicly reported rates are interpreted fairly and accurately. Also, if consumers live on a border community, they can go to hospitals in each state and it will be impossible to compare measures if the states have different measures or the measures are defined differently or reported in a different fashion.

Standards for reporting performance improvement data, such as hospital acquired infection rates, need to be based on sound scientific principles endorsed by federal and state infection control experts, such as through the federal Centers for Disease Control and Prevention (CDC), and collected on a national basis. Largely in response to inquiries from states that have implemented or are considering mandatory reporting statutes, the CDC, through its Healthcare Infection Control Practices Advisory Committee, issued guidelines on public reporting of health care-associated infections. The Advisory Committee concluded there is insufficient evidence to support mandatory public reporting at this time and that more research was necessary to assess the comparative effectiveness of public and private reporting systems, their consequences and validity. The point being: any effort toward public reporting should be based on a standardized national reporting system with industry-wide collaboration so that the benefit of public reporting is not lost.

It's also important to point out that unlike other health care quality indicators or measures, hospital infection rates alone are not necessarily accurate indicators of

quality care. Many hospital-acquired infections (HAI) are due to patients' underlying diseases and other factors that put them at risk for developing infections. For example, a large number of hospital patients, by the nature of their illnesses and injuries, are extremely vulnerable to opportunistic—and otherwise harmless— infections. Thus, such rates are not accurate reflections of the processes hospitals have in place to ensure the delivery of quality health care.

Quantifying and analyzing HAI is a complex process. Definitions of hospital infections vary, as do the methods by which infections are identified. In addition, the type of hospital (e.g., small rural vs. large teaching) and the types of patients in each hospital affect infection rates. If comparisons across hospitals are to be made, surveillance methods and definitions must be standardized and adjustments for population variables must be made. This may be possible but would require significant financial and personnel resources from both the facilities generating data and the particular government agency responsible for collecting, analyzing and distributing the information. In fact, mandatory reporting has the potential to shift limited hospital resources from targeted prevention strategies to using them for additional surveillance activities, that in and of themselves, do not lead to reduction of hospital acquired infections. Moreover, what might be required at the state level will ultimately be superseded by a federal system.

Infection control and monitoring in hospitals remains a constant challenge but hospital infection control professionals are vigilant 24/7 as they tackle this complex issue. While sound requirements for a national infection reporting system are being developed, hospitals are focused on ways to reduce hospital-acquired infection and, to that end, have embraced a variety of prevention efforts. We are very proud of the many quality and patient safety initiatives now underway. West Virginia's hospitals will continue their efforts to reduce the number of infections through the implementation of proven clinical practices and make reliable information publicly available as the science for collecting this information becomes more advanced.