

Public Reporting and Inter-hospital Comparison of Health Care-Acquired Infections

**Association of Medical Microbiology and Infectious Diseases -Canada
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This statement has been reviewed and endorsed by CHICA-Canada.

Health care acquired infections are a significant public health problem and patient safety issue. In Canada an estimated 220,000 infections acquired in health care facilities and 8,000 deaths attributable to these infections occur annually (1). Collection, analysis, and interpretation (surveillance) of these infections is an essential element in their control. All hospitals should carry out surveillance for health care acquired infections. The primary purpose of surveillance is to allow front line health care providers to understand the frequency and distribution of infections, including emerging and changing pathogens, and take steps in their control and prevention.

The general public, in recent years, has rightly begun to expect more information on risks that patients may be exposed to in the health care setting. Given the interest in and importance of this issue, the Association of Medical Microbiology and Infectious Disease (AMMI) Canada has developed this position statement on the public reporting of health care-associated infections.

In summary, no evidence was identified that decision making by patients with respect to health care acquired infection risks is improved by public reporting of health care-associated infection rates from individual institutions, nor is there evidence that the rate of these infections will fall if individual hospitals' infection rates are publicly reported.

Background

In February 2005, the Healthcare Infection Control Practices Advisory Committee (HICPAC) in the United States published guidance on public reporting of healthcare-associated infection, providing a number of recommendations to guide and assist in this process (2). The Society for Healthcare Epidemiology of America (SHEA) published a position paper on public disclosure of healthcare-associated infections (3). In their documents, both groups discuss the forces driving public disclosure and the potential drawbacks of mandatory reporting of healthcare-associated infections. The major concerns relate to the choice of valid indicators, accuracy and consistency of data collection, and lack of validated risk adjustment methods to allow interfacility comparisons. Given these significant limitations, there is considerable concern regarding any conclusions that may be drawn from comparison of publicly reported surveillance results. HICPAC and SHEA also point to the success of the National Nosocomial Infections Surveillance (NNIS) System in the United States. A critical success factor of the NNIS Program has been the ability to provide confidential data on hospital-associated infections back to participating facilities. This principle of confidentiality has given more than 300 hospitals the confidence to participate in NNIS, with demonstrable reductions in infection rates (4). HICPAC is very careful to point out that, on the other hand, there is

no evidence that public reporting systems reduces these infections. Thus, in keeping with evidence-based guidelines, at this time there is insufficient evidence to recommend for or against public reporting of healthcare associated infections.

In Canada a surveillance network for hospital-acquired infections, the Canadian Nosocomial Infection Surveillance Program (CNISP) was established in 1994. This program is a collaboration between the Public Health Agency of Canada and the Association of Medical Microbiology and Infectious Disease (AMMI) Canada. Its objectives are to provide national rates and trends on nosocomial infections in Canadian health care facilities, establish “bench mark” data that will enable comparison of rates by Canadian health care facilities, and provide evidence based data that can be used in the development of national guidelines on clinical issues related to nosocomial infections. CNISP data provide a very useful overview of nosocomial infections in Canada. However, differences in surveillance and laboratory detection methods and patient populations in individual CNISP hospitals preclude direct hospital to hospital comparison.

Pending evidence of effect on consumer choice or frequency of infection, AMMI – Canada neither recommends nor discourages public reporting of individual hospital infection rates, but if such reporting is carried out advocates that the following principles be followed:

- the goals, objectives, and priorities of a public reporting system are clearly specified,
- established and, where possible, validated public health and infection control surveillance methods are used consistently to collect, analyze, and report the data,
- the processes and/or outcomes to be monitored are measurable,
- the data (process and/or outcome measures) are useful to the public and the facility for its quality improvement efforts,
- there is a multidisciplinary group composed of public health officials, consumers, health care providers, and health care infection control professionals to monitor planning and oversight of the system,
- publicly released reports convey scientific meaning in a manner that is useful and interpretable to a diverse audience, with potential limitations of data and methodologies noted,
- there is a mechanism to provide regular and confidential feedback of performance data to health care providers, and
- patient privacy and confidentiality are maintained as per hospital policy and privacy legislation

Currently, infection control programs in Canada may be insufficiently resourced to allow for these principles to be met. At this time AMMI advises against using individual hospital generated reporting of infection rates as a way of comparing or “ranking” hospitals. Surveillance and laboratory detection methods are not standardized under such circumstances, making comparisons invalid.

References:

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- 4.Monitoring hospital-acquired infections to promote patient safety – United States, 1990-1999. MMWR 2000; 49:149-53.

Prepared by:

Geoff Taylor, MD FRCPC
Lynn Johnston, MD FRCPC
Andrew Simor, MD FRCPC

Reviewed by:

CHICA-Canada Board of Directors
Principal Reviewer:
Bonnie Henry MD MPH FRCPC, CHICA-Canada