

## Editorial

# “And coming up next..... Mandatory Public Reporting”

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In his book detailing the events surrounding his survival of a night on Mt Everest, Lincoln Hall describes his disappointment in the manner in which an interview with him was broadcast in the popular media in Australia. In a clear case of creative editing, answers to questions were spliced to implicate the leader of the expedition as being at fault for Hall almost dying on the mountain. Hall notes the deliberate *misinformation* then led to multiple web reports that were ‘riddled with inaccuracies’. However, Hall acknowledges the double edged sword of the media by also being grateful for accurate reporting of other details of his adventure.<sup>1</sup>

Like a window to the future, we can observe the proceedings in the US regarding the issues of mandatory public reporting (MPR) of hospital acquired infections (HAIs). At the recent Society for Healthcare Epidemiology of America (SHEA) meeting in Baltimore, Carlene Muto from the University of Pittsburgh Medical Center presented a paper outlining the differences in HAI rates using traditional Centers for Disease Control and Prevention (CDC) methods compared to HAI data identified only during hospital admission as requested by state agencies. Data from the state agency were reported publicly and identified 75% fewer surgical site infections than the traditional CDC method.<sup>2</sup> Muto expressed concern regarding the *misinformation* being provided to the public. Also noteworthy is the fact that hospitals were given six weeks notice to the introduction of MPR.

As of July 2007, almost half of the states in the USA have MPR. In many other states there is much legislative activity moving in this direction.<sup>3</sup> In the USA, not only is there a powerful consumer demand for information regarding HAI rates, but an equally compelling requirement from pay for performance programs that request this information as a quality indicator.

Both of these areas are in their infancy in Australia. The calls for transparency and disclosure are becoming more frequent from consumers and the media. In Queensland, the pilot of a pay for performance program in public hospitals commenced in July 2007. The objective of this pilot is to test the effect of linking payment to safety and quality rather than funding models based on throughput.<sup>4,5</sup> And recently, the federal Minister for Health and Ageing, Tony Abbott, proposed hospital ‘league tables’ on safety and quality measures be included as part of the state and federal funding agreements.<sup>6</sup>

But what is the purpose of MPR and who benefits? Most importantly, does it improve patient outcomes? Does it provide consumers with useful and accurate information? Does it satisfy the needs of clinicians when reviewing their own performance? Does it provide meaningful information to hospital executives when making hospital-wide decisions? Does it satisfy the need

to appropriately measure overall hospital performance? Perhaps all it really does is provide politicians with agendas and popular media with tomorrow’s headlines.

The underlying assumption in MPR is that it will improve quality of care motivating improvement providing information that differentiates performance of health care providers.<sup>7</sup> It must be noted though that there is a distinct lack of evidence to support this hypothesis. In a systematic literature review, it was concluded that there was no strong evidence that demonstrated MPR prevented HAI, or improved HAI prevention or control practices.<sup>7</sup> What happened to the notion of voluntary participation as a key element critical to the success of HAI surveillance systems?<sup>8</sup> Should we be concerned that MPR might lead to ‘gaming’ or data ‘fudging’, especially if it is linked to funding?

The Healthcare Infection Control Practices Advisory Committee recommends the use of both process and outcome measures for MPR. Process measures are seen to have distinct advantages as they are unambiguous, do not require risk adjustment, predict outcomes (assuming strong evidence base), and potential improvements are the responsibility of the clinical service.<sup>5,9</sup> However, outcome data will always attract debate on appropriate risk adjustment and surveillance intensity (ie the more you look, the more you find). Risk adjustment requires the collection and analysis of more data, thus increasing the resources required to collect the data. Despite the National Nosocomial Infection Surveillance derived NNIS Risk Index being used worldwide, there remains discontent and a growing body of literature that suggest it does not perform well for several procedures and better indices are required.<sup>10</sup>

What sort of information do consumers want? Feedback from consumer focus groups conducted by the VICNISS (Victorian Hospital Acquired Infection Surveillance System) Coordinating Centre have indicated little interest in comparative international data. Consumers indicated they want local data that is easy to understand, simple and factual. Is it possible to provide simple, accurate and meaningful data not complicated by risk adjustment? Although HAI data would seem to attract major headlines in the media, consumers also indicated that the information is only going to be of interest to them if they, or a close friend or relative require hospitalisation. More generally, feedback indicated that consumers do not feel such information would empower them to make decisions about where they are to be treated, and so query the usefulness of such data being available.

How far away is MPR in Australia? Victoria is soon to mandate participation of acute care public hospitals in specific VICNISS activities. Presently de-identified hospital level data is fed back

directly to participants. Aggregated data is reported publicly in an annual report. Discussions have taken place at a departmental and consumer level on the introduction of MPR.

New South Wales (NSW) has had a mandated collection of targeted HAI data since 2003. The data are published in an aggregated format on the NSW Health website and reports are provided to area health services on their individual hospitals. The NSW HAI Quality Program is undergoing several changes, though there are no immediate plans for MPR of individual hospitals.

In Western Australia (WA), hospitals have been contributing data to a voluntary HAI surveillance program HISWA (Hospital Infection Surveillance WA) since 2005. Building on the success of HISWA, four key indicators have been selected to be mandatory for collection by WA public hospitals in 2007/2008. Discussions have taken place with contributors and health department executives on MPR, and whilst there are no immediate plans for its introduction, it is anticipated that hospitals will be identified in mandatory indicator reports fed back to all the contributing public hospitals.

In Tasmania hospitals are required to submit Australian Council on Healthcare Standards data annually and data is published in annual reports. Future state-wide surveillance options are presently being explored.

Whilst there are no immediate plans for MPR to be introduced into South Australia, there is an extensive voluntary surveillance program for methicillin resistant *Staphylococcus aureus* with high participation rates including public and private hospitals. Data are reported monthly in an aggregated format on their website. Hospital level data are reported back to hospitals directly.

In 2000, the Centre for Health Related Infection Surveillance and Prevention (CHRISP), on behalf of Queensland Health, established voluntary submission of HAI data, from twenty-three of the largest public hospitals in the state. Patient de-identified data are analysed by CHRISP individually for each hospital and aggregated. A hospital de-identified report is provided to Queensland Health and six-monthly reports, which include the aggregate as well as their own data, are provided to the participating hospitals. All other hospitals undertake signal infection surveillance, which is currently not reported to CHRISP. There are currently no plans for MPR.

At the SHEA meeting, when questioned regarding how the public had reacted to the release of HAI data in Pittsburgh, Muto responded that although it was not clear how much the general public would be able to understand, media organisations were quick to broadcast images of patients exhibiting scars from wounds that had resulted from an HAI. It was noted that this type of portrayal led to *misrepresentation* of the issue.

With the recent reformation of the Healthcare Acquired Infection Surveillance Expert Working Group under the auspices of the Australian Commission on Safety and Quality in Healthcare, perhaps it is timely to examine the objectives of MPR from a national viewpoint. We should observe developments in other countries and where appropriate apply the evidence locally. As McKibben et al comment, MPRs should be continuously evaluated for effectiveness and should be based on sound public health science.<sup>7</sup>

In exploring this issue, there are many more questions than answers. Consumers have a right to know what goes on in their publicly funded hospitals. Consultation with consumer groups is essential to identify appropriately framed information. Pay for performance programs are being piloted, and have a right to be made aware of the performance of their hospitals.

In many hospitals, infection control staff already possess accurate information on HAIs, often due to dedicated infection control resources allocated to surveillance. Much of this information is fed back to clinicians and other relevant stakeholders and is used to target areas for improvement. The challenge is in identifying appropriate data and its transformation into information that can be used by consumers and pay for performance programs. Whilst meeting this challenge, a major objective would be to avoid *misinformation*. Perhaps process measures are a good starting point for MPRs? Infection control professionals are well placed to lead this discussion.

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