

SOUTHWESTERN NEWS

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UT Southwestern professor supports development of report cards on hospital infection rates

DALLAS – July 20, 2005 – Health-care officials should work collaboratively with consumer groups to develop report cards on hospital infection rates, a UT Southwestern Medical Center professor urges in the July 21 issue of *The New England Journal of Medicine*.

“Public reporting can be a good thing if it’s done right,” said Dr. Jane Siegel, professor of pediatrics who chairs the Infection Control Committee at Children’s Medical Center Dallas. “If it’s done right, we’re talking about improving the quality of health care and patient safety in hospitals. As health-care professionals, we want to see that. As consumers, we want to see that.”

There’s a growing appetite for infection-control report cards that the public could use in selecting hospitals and that hospitals could use to lower infection rates: Thirty-nine states have introduced legislation, and six have passed laws requiring reporting of certain data. In Texas, legislators created an advisory panel in their June session to study the issue.

Every state is likely to have some standard within the next couple of years, predicted Dr. Siegel, a co-author of the journal’s Perspective article.

Consumers Union, which initiated public reporting of hospital infection rates, the Centers for Disease Control and Prevention (CDC), and professional societies are working together to define elements for a successful public reporting system.

It’s not as easy as handing out A’s or F’s or rating the performance of automobiles or refrigerators, said Dr. Siegel, who served eight years on the CDC Healthcare Infection Control Practices Advisory Committee. Health-care officials must decide what infections hospitals should track and what benchmarks should be used, she said.

Reporting systems need to account for, among other factors, differences in patient populations and ensure that hospitals are using similar methods to report the data.

“A hospital that doesn’t have very many patients and does not perform high-risk procedures has fewer patients at risk for developing infections and, therefore, may have a low

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infection rate,” Dr. Siegel said.

Similarly, a hospital without an infection control team will have a low infection rate because patients who acquire infections from hospitals aren’t identified. “The quality of care at the hospital with the low infection rate may not be better than the hospital with the higher infection rate,” Dr. Siegel said.

Many patients who undergo complex, high-risk procedures today would not have survived long enough to acquire an infection 10 or 20 years ago. Other challenges exist as well. Sometimes patients are discharged from the hospital before the incubation period for the infection, making it difficult to determine whether the patient acquired a disease associated with a procedure performed while hospitalized. And there are not always uniform clinical definitions of conditions.

Nevertheless, Dr. Siegel and her co-authors, Dr. Robert Weinstein, professor of medicine at Rush University Medical Center in Chicago, and Dr. P.J. Brennan, chief medical officer at the University of Pennsylvania School of Medicine and Health System in Philadelphia, wrote, “We know that informing surgeons of their wound-infection rates can lead to reductions in those rates, presumably by reinforcing the use of sensible interventions (e.g., limiting the amount of movement in and out of operating rooms in order to lower bacterial loads).”

Dr. Robert Haley, chief of epidemiology at UT Southwestern, conducted a landmark study on controlling hospital infection when he worked at the CDC in the 1970s. That study found that hospitals adopting combinations of standardized infection control measures and having trained professionals dedicated to infection prevention experienced a 32 percent reduction in infection rates.

The authors of the Perspective article suggest including health-care epidemiologists and infection-control professionals early in the formation of standards and phasing in reporting requirements to give hospitals time to develop, refine and validate the data collection system. Bad data is worse than no data at all, Dr. Siegel said.

“Research is needed to identify the most meaningful metrics, determine the best way to report them, and access whether such reporting improves patient safety,” the authors conclude. “These challenges present unprecedented opportunities to improve patient care, if we can only put our anxieties to rest and move forward.”

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