

**REPORT OF THE INTERIM STUDY TO CONSIDER
LEGISLATION REQUIRING HOSPITALS TO REPORT
INFECTIOUS DISEASES TO THE PUBLIC**

Findings and Conclusions

January 31, 2006

Report of the Interim Study to Consider Legislation Requiring Hospitals to Report Infectious Diseases to the Public

TABLE OF CONTENTS

Introduction.....	4
Proposals from Other States.....	5-6
Interim Study Background.....	7
Findings.....	7
Possible Legislation.....	8
Conclusions.....	8
Appendix.....	9-11

INTERIM STUDY TO CONSIDER LEGISLATION REQUIRING HOSPITALS TO REPORT INFECTIOUS DISEASES TO THE PUBLIC

Membership

Senator Bernest Cain, Chair
Senator Judy Eason McIntyre, Vice-Chair
Senator Don Barrington
Senator Debbe Leftwich
Senator Mike Mazzei
Senator Angela Monson
Senator David Myers
Senator Susan Paddack
Senator Scott Pruitt
Senator Kathleen Wilcoxson

Senate Staff

Jennifer Christol, Legislative Analyst/Editor
Melanie Stucky, Attorney
Anthony Sammons, Fiscal Analyst
Sara Lassiter, Administrative Assistant

Report on Interim Study 05-06

Introduction

Hospital-acquired infections are one of the leading causes of death in the United States. The Centers for Disease Control and Prevention estimates that as many as 2 million infections are acquired each year in hospitals and claim approximately 90,000 lives per year. It is estimated that more Americans die each year from hospital-acquired infections than from auto accidents and homicides combined.

Hospital-acquired infections not only put the patient at risk, but also increase the days of hospitalization required for patients and add considerable health care costs. A survey based on data from 20% of U.S. hospitals revealed that patients who acquire an infection as a result of medical care in hospitals spend an average of almost ten additional days in the hospital and incur over \$38,000 in added health care costs.

Prevention of hospital-acquired infections is possible, however, through better hygiene and advanced scientifically tested techniques for surgical patients. Therefore, many health care consumers and organizations are calling for public disclosure of hospital-acquired infection rates. Proponents argue that public reporting of hospital-acquired infection rates provides the information health care consumers need to choose the safest hospitals. Public reporting, therefore, gives hospitals an incentive to improve infection control efforts.

Others argue that reporting hospital-acquired infection rates is misleading as a hospital's infection rate may not necessarily be indicative of the quality of care provided in the hospital, particularly when compared to other hospitals. One hospital may appear to have a higher infection rate than another hospital because that particular hospital practices better surveillance techniques or treats more high-risk patients. Further, there are existing local and national efforts to address hospital-acquired infections. New reporting requirements might duplicate or overlap initiatives already under way.

Proposals from Other States

Several states have considered legislation requiring public reporting of hospital-acquired infection rates. Figure 1-2 summarizes the status of proposals in other states:

**FIGURE 1-1
Status of Proposals in Other States**

State	Measure	Status
Alabama	SB 83	Failed
Alaska	SB 208	Active
California	SB 739	Failed
Colorado	HB 1045	Active
Connecticut	HB 5805	Failed
Delaware	HB 30	Active
Florida	SB 2910	Passed
Georgia	HB 417	Active
Hawaii	HB 287	Active
Illinois	SB 59	Passed
Indiana	SB 468	Failed
Iowa	HF 44	Active
Kansas	HB 2283	Active
Kentucky	HB 240	Active
Louisiana	SCR 86	Passed
Maryland	HB 78	Active
Massachusetts	SB 1308	Active
Michigan	HB 4504	Active
Minnesota	HF 87	Active
Mississippi	SB 2929	Active
Missouri	SB 1279	Passed
Nebraska	LB 361	Passed
Nevada	AB 59	Passed
New Hampshire	HB 1741	Active
New Jersey	S 147	Active
New Mexico	HB 934	Failed
New York	A 8698	Passed
North Carolina	SB 391	Failed
Ohio	HB 197	Active
Oklahoma	SB1098	Active
Oregon	SB 400	Failed
Pennsylvania	SB 387	Passed
Rhode Island	SB 20	Failed
South Carolina	SB 799	Failed
Tennessee	SB 441	Passed
Texas	SB 872	Passed
Vermont	HB 258	Active
Virginia	HB 1570	Passed
Washington	HB1015	Active
West Virginia	HB 2180	Active
Wisconsin	AB 811	Active

Figure 1-2 summarizes the proposals passed by state legislatures regarding hospital-acquired infectious diseases:

**FIGURE 1-2:
Current State Laws Regarding Hospital-Acquired Infectious Diseases**

State	Summary
Florida	SB 2910, passed in 2004, requires hospitals to report all instances of hospital-acquired infections. Additionally, each hospital must also detail the number of complications and readmissions occurring each year. The Agency for Health Care Administration is responsible for administering the provisions of this act.
Illinois	In 2003, the Illinois Legislature passed SB 59, the Hospital Report Card Act. This act requires hospitals to report all instances of hospital-acquired infections to the public. The Department of Public Health is responsible for administering the provisions of this act.
Missouri	SB 1279 creates the “Missouri Nosocomial Infection Control Act of 2004” to encourage health care facilities to take appropriate actions to decrease the risk of infection. The Department of Health and Senior Services holds the authority to collect, analyze and disclose nosocomial infection data from patient records.
Nebraska	LB 361, passed in 2005, requires that patient safety organizations release to the public non-identifiable aggregate trend data identifying the number and types of patient safety occurrences, including unanticipated death or major permanent loss of function due to nosocomial infection.
Nevada	The Nevada Legislature passed AB 59 in 2005. This act requires certain medical facilities to report hospital-acquired infections as sentinel events to the Health Division of the Department of Human Resources. This act does not make data publicly available.
New York	A 8698, passed in 2005, requires hospitals to report their hospital-acquired infection rates and make the information available to the public no later than 2007.
Pennsylvania	In 2003, the Pennsylvania Legislature passed SB 387, which gives the Pennsylvania Health Care Cost Containment Council the authority to collect and report hospital-acquired infection rates. Pennsylvania was the first in the nation to require that hospital-specific data regarding hospital-acquired infections be publicized.
Tennessee	The Tennessee Legislature passed SB 441 in 2005. This act requires hospitals to report all infectious diseases patients acquire while in the hospital. Quarterly reports are made to the Department of Health and then made available to the public.
Texas	SB 872, passed in 2005, authorizes the establishment of an advisory panel to conduct a study on the reporting of health care related infection rates and process measurements. Texas also uses software published by AHRQ to publicly report patient safety measures.
Virginia	HB 1570, passed by the Virginia Legislature in 2005, requires acute care hospitals to report information about acute nosocomial infections to the Center for Disease Control and Prevention’s National Healthcare Safety Network. Upon request, information regarding data may be released to the public by the Board of Health.

Interim Study Background

In July of 2005, Senators David Myers and Debbe Leftwich received approval for an Interim Study to consider legislation requiring hospitals to report infectious diseases to the public. On November 4, 2005, the interim study was held. The Senators invited several guests to present at the meeting. The agenda included a review of the Centers for Disease Control and Prevention's Healthcare Infection Control Practices Advisory Committee guidelines, a discussion of quality indicator data collection and public recording from Dr. Dale Bratzler of the Oklahoma Foundation for Medical Quality, and a review of current efforts underway in Oklahoma hospitals from the Oklahoma Hospital Association.

Findings

Section 1-119 of Title 63 of the Oklahoma Statutes provides for the reporting of discharge data from hospitals to the Division of Health Care Information within the State Department of Health. Such information includes billing data, patient demographics, diagnoses, procedures and charges, and contains information indicating whether or not an infectious disease was diagnosed. The Agency for Healthcare Research and Quality (AHRQ), a Public Health Service agency in the United States Department of Health and Human Services, has developed a set of patient safety measures based on discharge data sets, such as those already required pursuant to Section 1-119 of Title 63 of the Oklahoma Statutes. These measures may be computed on AHRQ software, which is available free of charge.

The State Department of Health, with legislative authority, could calculate and post publicly the AHRQ safety indicators as Texas does. Such information would highlight a number of patient safety areas, including infectious diseases. This approach would give the public valuable information. Further, this approach would require no additional work on the part of hospitals since the discharge data sets used to calculate the AHRQ safety indicators are already available.

The exact cost of such an approach is unknown. While the software would be provided free of charge by the AHRQ, additional funding may be needed for the State Department of Health to analyze the data and produce the reports.

Another consideration is the difficulty that may arise from adding hospital indicators to the data. Currently, the data are collected in aggregate and, thus, data from individual hospitals are not specified in any reports. The interpretation of existing state laws requires that only patients and physicians are not to be identified in any reports. The same protection is not provided for hospitals. However, the Health Care Information Advisory Board, authorized by Section 1-122 of Title 63 of the Oklahoma Statutes to set reporting requirements, has voted down the move to include hospital indicators in reports because of concerns from the Oklahoma Hospital Association and some facilities that the information might be misinterpreted or misused.

Possible Legislation

Possible legislative measures could include requiring the State Department of Health to analyze the discharge data received pursuant to Section 1-119 of Title 63 of the Oklahoma Statutes and to attach hospital identifiers to public reports of such data. This would allow the State Department of Health to access the free software provided by AHRQ to analyze several patient safety measures, including infectious diseases. A relatively minimal amount of funding would be needed for the State Department of Health and no additional information would be required from hospitals.

Conclusions

The interim study revealed much needed information on possible legislative measures to require hospitals to report infectious diseases. However, pursuing such legislative measures is not feasible at this time. More time is needed to study the costs associated with requiring the State Department of Health to calculate and publish AHRQ patient safety measures. Further, more effort is needed from several parties to negotiate such an approach. Legislation related to the reporting of hospital-acquired infections should be delayed until further study.

Appendix

Agency for Healthcare Research and Quality: Quality and Patient Safety

<http://www.ahrq.gov/qual/>

The Agency for Healthcare Research and Quality within the United States Department of Health and Human Services provides links to several websites and articles on quality and patient safety through this webpage. The site includes links to the National Quality Measures Clearinghouse and the National Resource Center for Health Information Technology.

Centers for Disease Control and Prevention: Healthcare Information Control Practices Advisory Committee

<http://www.cdc.gov/ncidod/dhqp/hicpac.html>

The Healthcare Information Control Practices Advisory Committee (HICPAC) provides information through this webpage about its charter, current roster, and meeting schedule. Additionally, publications authored by HICPAC are available in pdf format through this site. Publications include several guidelines and recommendations regarding hospital-acquired infections.

Centers for Disease Control and Prevention: Infection Control in Health Care Settings

<http://www.cdc.gov/ncidod/dhqp/index.html#>

This site, maintained by the Centers for Disease Control and Prevention (CDC), serves as the menu page for the CDC's information on infection control in health care settings. Links are provided on the webpage that lead to CDC infection control guidelines, articles on specific infections, and tips on improving hygiene in the health care setting.

Consumers Union: Hospital Infections

http://www.consumersunion.org/pub/cathealthsafetyhosp_infections/

The Consumers Union, a nonprofit organization that promotes the reporting of hospital-acquired infection rates, provides information on hospital-acquired infections through this website. In addition to providing links to current news articles on hospital-acquired infections, the website also provides links to information on state proposals regarding the reporting of hospital-acquired infection rates.

Oklahoma Foundation for Medical Quality: Hospital Data Collection

http://www.ofmq.com/display_hci_project.php?id=48

Sponsored by the Oklahoma Foundation for Medical Quality, this website provides information on the Hospital Quality Alliance, the Hospital Quality Initiative and QualityNet Exchange. Additionally, the site has information on the Hospital Compare website (www.hospitalcompare.hhs.gov).

Oklahoma Hospital Association: Quality and Patient Safety

<http://www.okoha.com/Content/NavigationMenu/InsideOHA/QualityRisk/default.htm>

The Oklahoma Hospital Association's webpage for quality and patient safety includes links to Oklahoma-specific information on patient safety, credentialing and a guide to health care quality. The website also includes links to other relevant websites, such as the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations.

National Healthcare Quality Report: 2005

<http://www.qualitytools.ahrq.gov/qualityreport/2005/browse/browse.aspx>

The 2005 National Healthcare Quality Report is a comprehensive national overview of quality of health care in the United States and is sponsored by the Agency for Healthcare Research and Quality. Quality measures include effectiveness, patient safety, timeliness and patient centeredness.