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SUMMARY OF STATE LAWS ON HOSPITAL-ACQUIRED INFECTIONS

25 state laws require public reporting of hospital-acquired infection rates.
2 state laws require confidential reporting of infection rates to state agencies (NE, NV).
1 state law permits voluntary public reporting of infection information (AR).

LAWS REQUIRING PUBLIC REPORTING OF INFECTION RATES
Click on the state name to link to the actual law

California (2008) SB 1058/Chapter 296, SB158
These bills require public reporting of hospital infection rates; screening of certain incoming patients for MRSA, plus follow up prevention; disclosure to patients when diagnosed with MRSA infections and information on how to prevent transmission; hospital-wide reporting of MRSA, VRE, and c. difficile infections; improved oversight by the licensing agency; training on prevention of infections at the hospital level, including physicians.
2006: Requires hospitals to have policies in place to prevent infections, which will be checked by the Department of Health Services once every three years after 2009. The public will not know whether the hospitals are actually following their procedures. It requires public reporting based on the CDC "Guidance to Public Reporting," but only includes process measures, relating to the rate at which prevention practices are used, including surgical infection prevention practices already published on CMS Hospital Compare and vaccinations of health care workers.

Colorado (2006) Article 3, Part 6 The Colorado **Health Facility Acquired Reporting** statute requires hospitals, ambulatory surgical centers and dialysis centers to report incidents of hospital-acquired infections to the CDC to be analyzed and risk adjusted. The Colorado Department of Public Health and Environment will use that information to issue facility-specific infection rates to the public. An advisory committee, including consumer representatives, assists the department. The law requires that a certified infection control professional collect the data for facilities with more than 50 beds. Physicians who diagnose a hospital-acquired infection upon follow-up with patients are required to report those infections to the facility in which the reportable procedure was done. These reports are to be included in the facility report to the Department. The first report will include infection rates for cardiac and orthopedic surgical site infections and central line-related blood stream infections. The advisory committee can recommend additional measures later. The first **report** was issued in January 2008.

Connecticut (2006) The Connecticut Act Concerning Hospital Acquired Infections requires hospitals to report infections to the Connecticut Department of Health. A committee, which includes consumer representatives, will advise the department on specifics regarding the types of outcome and process measures to be collected, as well as how these are to be collected and reported. The department will then make hospital-specific infection information available to the public. The first report is to be issued by October 2008.

Delaware (2007)
Requires hospitals to report on infection rates, the specifics of which are to be established by the Department of Health and Social Services, with assistance of an advisory committee (includes a consumer representatives, purchasers and a union representative). Additional types of infections may be required to be reported after June 30, 2010. Hospitals are to report Infections to the CDC NHSN on a quarterly basis. All hospitals must join NHSN by December 31, 2007. The initial report is to cover an entire year, to be issued by June 30, 2009; thereafter, quarterly updates will be available to the public at each hospital and by the department. A physician who diagnoses an infection following a patient's hospitalization must report this to the department and it will be included in the public report if it meets NHSN specified definitions. The law also requires correctional facilities to report hospital-acquired infections related to specified procedures as established by the department and infection rates shall be publicly reported.

Florida (2004) The Florida law is a general directive to collect and report on hospital-acquired infections. The Agency for Health Care Administration (AHCA); advised by a committee of stakeholders, is in charge of implementation. They issued the first hospital-specific report in the US in November 2005, using the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSI) scale. This was included within a comprehensive report of other quality indicators, such as mortality rates connected to specific procedures. The report indicates significant variations among hospitals. It compares hospitals by indicating if the rate of infection was as expected, lower than expected, or higher than expected. The report includes a rate which reflects each hospital's unique population, but has not been risk adjusted. The PSIs include several infection-related measures along with other hospital-acquired conditions that should not occur. The PSI tool culls out likely hospital-acquired infections using administrative/billing data. The advantage of using administrative information is that it is in electronic form, supplies a record for almost every patient, and typically contains information that can be used to risk adjust and assess the patient's condition and treatment in the hospital. Many hospitals state that their own billing records are so inaccurate that the data should not be used for quality assessments, however, the hospital is ultimately responsible for the validity of this information. AHCA's initial plan was to eventually report hospital infection rates using the CDC NHSN collection and analysis process, but no progress has been made on that to date.
To access hospital information, go to reports about Florida hospitals, and follow the instructions to get information about "Hospitals" and "Complication/infection rates."

Illinois (2003) The Illinois reporting law initially passed in 2003, but several changes made by the 2005 legislature pared down the reporting. The new law requires two or more infection measures to be reported as determined by the state Department of Public Health to include process or outcome measures relating to surgical site infections and ventilator-associated pneumonia, and central vascular bloodstream infection rates in designated critical care units. The measures are to be based on those developed by national quality organizations and agencies. Reporting is to occur quarterly, with the annual report due on December 31 of each year; presumably the first report was to be available in early 2007, but the agency failed to implement the law. The initial law required reports to include selected hospital-acquired infection rates (surgical site infections, ventilator-associated pneumonia, central line blood stream infections), using the CDC National Healthcare Safety Network methods. The original bill also required reporting of nurse staffing ratios.

Maryland (2006) Requires the Maryland Health Care Commission to include hospital-acquired infection information in the existing reporting system on hospital quality. The information is to be presented in a manner that will allow comparisons among hospitals. Both versions of the hospital infection reporting bills passed; the Senate version went into law without the Governor's signature and the House bill was vetoed by the Governor as duplicative.

Massachusetts (2008)
Requires hospitals to report infection rates and prohibits payment for some hospital acquired conditions.

Minnesota (2007) (Scroll to line 400.8: Hospital Information Reporting Disclosure.)
Requires hospitals to report hospital-acquired infection measures endorsed by the National Quality Forum by January 1, 2009. At the time of passage, NQF had not yet endorsed hospital infection measures. The state has an arrangement with the MN Hospital Association and Stratis Health to collect and report these measures. These organizations report other quality measures for the state.

Missouri (2004) Requires hospitals to report risk adjusted rates for surgical site infections, ventilator-associated pneumonia and central line-related bloodstream infections; it allows other categories of infections to be added by rule later. The initial report was issued on bloodstream infections, and surgical infections for total hip replacements, CABG and abdominal hysterectomies were released in the next report. **MO reports are available** on the Department of

Health and Senior Services' website.

New Jersey (2007)
Requires hospitals to report infection measures to the Department of Health and Senior Services, to include process quality indicators and hospital-acquired infection rates. The specific measures are to be selected by the Commissioner of Health in consultation with the already existing Quality Improvement Advisory Committee. Reports shall be available on the agency website.

New York (2005) This law was significant in that the states' hospital associations worked with consumer organizations in support of the public reporting required in this bill. The bill allows for a long implementation period (2 years) and requires the first year's data collection to be considered a "pilot" with no hospital-specific information revealed. However, the data can be released without identifying the hospitals, e.g., aggregate statewide data or hospital level information without the hospital name, which would enable the state and the public to look at the variations among hospitals or in various regions of the state. The initial report will include surgical site infections, central line related blood stream infections; ventilator associated pneumonia rates in critical care units are expected in later reports. The law allows the health department to require additional reporting after consulting with technical experts. The National Conference of Insurance Legislators (NCOIL) adopted this law as their model act.

New Hampshire (2006) Requires hospitals to report their infection rates as well as measures they use to prevent infections. The first report's outcome measures are to include the rate of central line related blood stream infections; ventilator associated pneumonia and surgical site infections. The rate at which the hospital uses certain processes to prevent these types of infections is also be included. The Department of Health and Human Services is to implement the law in consultation with technical experts. The department has the authority to add other measures to these reports in the future. The law's effective date is July 2007; annual reports are to be issued June 1 of each year. The first report should be out in June 2008, however, in June 2007, although the law's sponsors requested $138,000 dollars to fund the program, the NH Ways and Means Committee only budgeted $1 for reporting; consequently public reporting will be delayed at least until 2009 as budget votes only occur every two years.

Ohio (2006) Creates a hospital measures advisory council that will recommend how the state will collect and report hospital quality measures, including hospital-acquired infection measures. The law specifically calls for the council to consult with consumers, nurses, and infection control professionals on infection reporting. The law requires various price and performance data to be collected from hospitals beginning in 2007 and reported to the public on a website within 90 days of receiving the information from the hospitals. The director of health must adopt rules that will include "measures that examine infections" as well as other measures of quality of care.

Oklahoma (2006)
This law gives the Oklahoma Hospital Advisory Council, which is appointed by the state Commissioner of Health and which includes 3 public members, the duty and authority to recommend and approve new quality indicators to include the Agency for Health care Research And Quality (AHRQ) Patient Safety Indicators (which include some hospital infection related measures) and ventilator associated pneumonia and device related blood stream infections in ICU patients. These measures are to be included in facility specific reports.

Oregon
Requires the Office of Health Policy and Research (OHPR) to implement hospital infection reporting. The law does not specify the infection measures, but the legislature clearly directed the agency to report infection rates, as well as process measures. An advisory committee was created to assist OHPR in determining the specific measures and methodology for reporting. The first public report is to be available no later than January 1, 2010.

Pennsylvania (2004) Section 6(f)(3)(vi) and Section 7(a)(1)(i) Under a general law on hospital

quality, the Pennsylvania Health Care Cost Containment Council (PHC4) was given the authority to collect and report hospital-acquired infection rates. PHC4 published numerous reports, based on aggregate data collected in 2004 and 2005. These were the first reports on hospital-acquired infections in the US. In 2006, PA published the most extensive hospital specific report on infections which included infections occurring throughout the hospital, including surgical site infections, central line associated blood stream infections, ventilator associated pneumonia and catheter associated urinary tract infections. In 2007, the PA infection reporting law was changed to require hospitals to use the CDC NHSN system for reporting their infections. Future reports will include the same measures as before, but with a different source of data. The following links will take you to the reports:

Public Report: Hospital-specific patient infection rates, mortality and cost in Pennsylvania (11/06)
Hospital-acquired infections, March 2006
Reducing Hospital-acquired Infections, The Business Case
Hospital-acquired infections, July 2005
MRSA in Pennsylvania Hospitals August 2006

Rhode Island (2008): Two bills (S2382 and HB7962), passed and signed into law, require the Department of Health to issue public reports comparing infection rates among RI hospitals. An advisory committee will help to develop the infection reporting system and will serve as a permanent subcommittee to an already existing steering committee on health care quality. The majority of the advisory committee members must come from the infection control community, but representatives of consumers, labor and employers who purchase health care are also included. Through regulations based on the advisory committee's recommendations, the department will establish which types of infections rates are to be reported. The law allows for reporting on the four major types of hospital-acquired infections -- surgical site infections, ventilator associated pneumonia, central line blood stream infections, and urinary tract infections -- and allows for the advisory committee to recommend additional reporting. Surgical infection reporting must include post-discharge surveillance. The state may also report measures that indicate hospitals' compliance with infection prevention practices. It is unclear when the first annual report will be public as the law includes two publication dates: no later than October 2010 or no later than December 2010 (a report to the legislature). Hospitals must also make these reports available at their facility.

South Carolina (2006) Article 20 Requires hospitals in the state to report the rate at which their patients develop surgical site infections, ventilator assisted pneumonia, and central line bloodstream infections to the Department of Health and Environmental Control by February 2008. A committee, which includes consumer representation, will advise the Department on the methodology for collecting, analyzing and disclosing the information. The department has the authority to add measures in the future. The first annual report was issued in August 2008. View the report: **South Carolina Hospital Acquired Infections Report.**

Tennessee (2006) The Department of Health will publish on their website infection rates for central line associated blood stream infections in intensive care units. The reports will be updated every six months with the most recent four quarters of data. The department will report only aggregate statewide CABG surgical infection rates. Data will be reported through the CDC National Healthcare Safety Network (NHSN). A task force will advise the department on infection reporting system and as national consensus standards are developed it may recommend additional reporting measures.

Texas (2007)
The Department of State Health Services will publish health care acquired infection rates at hospitals and ambulatory surgical centers, for seven types of surgical procedures and central line associated blood stream infections in ICUs. The law establishes special reporting requirements for pediatric and adolescent hospitals and major pediatric units in general hospitals. Hospitals that do not perform a sufficient number of the specific procedures for which SSI rates are to be

reported, will report on the three most frequent operations performed. An advisory committee was created to assist the department and has recommended to use the CDC National Healthcare Safety Network. The law specified that hospitals would begin reporting infection information to the department by June 2008, but the Legislature's failure to fund this program has delayed implementation. Funding will be considered during the 2009 legislative session.

Virginia (2005)
The law is a simple mandate for acute care hospitals to report nosocomial infection rates through the CDC National Health Safety Network. No advisory committees, no specifics on what will be collected or how the board of health will specify details. Information is to be available to the public upon request which is not advised, web based reports are the best way to go. The bill is not effective until July, 2008.

Vermont (2006) In late 2005 a state committee recommended public reports on certain hospital-acquired infection information and the state's health agency (Health Care Administration) began implementing those recommendations after getting approval from key stakeholders and legislators in early 2006. Meanwhile a bill was filed to put the mandatory reporting into law; the language from that bill was eventually added to an omnibus health care bill (SB310). A work group, including consumer representatives, advise the agency. The first report, issued in 2006, covered only process measures, specifically the rate at which hospitals use procedures that prevent surgical site infections. Hospitals are also required to complete the LeapFrog survey on hand washing and numerous other patient safety and quality-of-care measures will be included about each VT hospital. The following links will take you to the reports:
2007 report on blood stream infection rates
2007 report on surgical infection prevention practices.

Washington (2007) Requires hospitals in the state to disclose the rate at which patients acquire certain infections during treatment. The law will be phased in so that hospitals first will be required to collect data on central-line associated bloodstream infections in intensive care units (beginning July 1, 2008), then ventilator-associated pneumonia (beginning January 1, 2009), and then surgical site infections for certain procedures (beginning January 1, 2010). By December 1, 2009, and every December 1 in future years, the Department of Health will publish a report on its web site that compares the health care associated infection rates at individual hospitals in the state using the data reported in the previous calendar year.

West Virginia (2008)
The law requires hospitals to report hospital-acquired infections to the West Virginia Health care Authority using the CDC National Healthcare Safety Network. An Infection Control Advisory Panel will work with the Authority in developing the details of the reporting system and advising on the manner in which the information should be made available to the public. The Panel does not include any consumer representatives. The law is not specific regarding the type of infections that are to be reported, rather that will be developed by the Panel and the Authority. Hospitals are to begin reporting in July 2009 and the first public report is to be issued in January 2011. The law includes enforcement – assessing fines for failure to report – and allows the Bureau of Public Health for hospital oversight and disease surveillance activities.

HOSPITAL INFECTION –RELATED LAWS, OTHER THAN PUBLIC REPORTING

New Mexico. A legislatively created **task force** issued recommendations in November 2007 to initiate a **pilot program** for reporting hospital-acquired infections. During the year-long voluntary and confidential pilot phase, six hospitals will report central-line associated bloodstream infections and influenza vaccination rates of their health care workers using the CDC National Healthcare Safety Network. Reporting began in July 2008. At the end of the pilot, an advisory committee, created as recommended by the task force, will review the results and determine the best methods for making information public and for expansion of the reporting program. The six hospitals participating are: the University of New Mexico Health Sciences Center, the Heart

Hospital of New Mexico and Presbyterian Hospital in Albuquerque, Gerald Champion Regional Medical Center in Alamogordo, Memorial Medical Center in Las Cruces, and the San Juan Regional Medical Center in Farmington.

Nebraska & Nevada (2005)
These states passed laws mandating collection of hospital infection information but not to share with the public. The Nebraska law requires health care providers to track and report hospital infections as an aggregate number to the health department. Nevada requires certain medical facilities to report hospital-acquired infections as sentinel events to the Health Division of the Department of Human Resources.

STATES WITH STUDIES ABOUT HOSPITAL-ACQUIRED INFECTION REPORTING

Alaska (2006) The Legislature adopted a resolution to create a task force to develop recommendations for hospitals to disclose their infection rates, however, a we find no evidence that a report has been issued.

Georgia (2006) The Health Care Standards Commission for Prevention of Hospital Acquired Infections will study safety standards, best practices, infection rates and causes. No public members are included. The commission may, but is not required to, make recommendations and was to be abolished at the end of 2007. There is no evidence of a report or recommendations on the website of the Georgia Division of Public Health.

North Carolina (2007)

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