

## Legislative Initiatives and HAI

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As the issue of hospital-acquired, or nosocomial, infection becomes increasingly dominant on the radar screens of health care professionals, it is attracting the attention of lawmakers, as well. At least 11 states have passed legislation requiring hospitals to disclose hospital-acquired infection rates. Other states have convened study committees to evaluate the feasibility of public reporting, while a host of other states have failed to pass legislation in their most recent legislative sessions.

The Centers for Disease Control and Prevention estimates that an average of 250 people a day die from hospital-acquired infection in the United States.<sup>1</sup> And those who survive these infections pay on average seven times more for their course of treatment. The CDC has projected that nosocomial infections add more than \$5 billion to the nation's health care bill each year.<sup>2</sup> Hospital-acquired infections result in longer stays and more complicated recoveries requiring additional and expensive treatment.

These numbers are attracting a critical eye from lawmakers across the United States.

Pennsylvania is considered by many to be a trailblazer in this legislative movement. Legislation in the Keystone state gives the Pennsylvania Health Care Cost Containment Council authority to collect and relay hospital-acquired infection rates to the public. The organization already has made public information from the data it has collected.

Other states have followed suit, and have passed legislation similar to that in Pennsylvania mandating public reporting of nosocomial rates.

Momentum is catching on, as still more states are moving increasingly closer to passing similar legislation in states such as Texas and Vermont.

For example, On May 3, the New Hampshire Senate passed HB1741, which requires hospitals in the state to report infections to the Department of Health and Human Services.<sup>3</sup> The commissioner of the department is then required to post the information on a statewide database. The bill is picking up support and is awaiting the governor's signature.

On May 4, the Alaska Legislature adopted a resolution to create a task force to develop recommendations for hospitals to disclose their infection rates, to be presented in the form of legislation in 2007.<sup>4</sup>

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<sup>1</sup>"Hospital Infection Reporting Laws Spread Across the Country; Concern Over Patient Infections Prompting States to Take Action." U.S. Newswire. 9 May 2006.

<sup>2</sup>"Hospital Infection Reporting Laws Spread Across the Country; Concern Over Patient Infections Prompting States to Take Action." U.S. Newswire. 9 May 2006.

<sup>3</sup>HB 1741-FN 2006 Session. 7 March 2006.

<sup>4</sup>2006 Legislative Session. "Hospital-acquired infection public reporting bills." 25 May 2006.

Other states, such as California and Washington, have rejected similar reporting legislation. In 2004 California Governor Arnold Schwarzenegger cited a financial burden on hospitals and a lack of a standardization system of data as a justification for rejecting the bill. A new bill has since been introduced and is being considered by state legislators. Hospitals in Washington have opposed a bill largely due to the increased time and cost it would take workers to extract data and fill out additional paperwork.

In addition to state initiatives, the Federal Deficit Reduction Act of 2005 will go into effect in 2007 and will require more reporting from hospitals or they'll risk reductions in Medicaid payments.<sup>5</sup> If hospitals do not report certain hospital-acquired infections that could have been reasonably prevented by following certain evidence-based guidelines, they can be penalized for up to 2 percent of inpatient Medicare costs. Currently, they only can be penalized by a reduction of 0.4 of a percentage point for the same offense.<sup>6</sup>

While reporting infection rates is at the top of legislators' agendas, many hospitals are wary of reporting these statistics, primarily because the risks of infection can vary wildly. A patient who has undergone a routine or elective surgery, for instance, faces a much lower risk of infection than one who may have third-degree burns over a large portion of the body. These risk deviations make it difficult to establish a realistic baseline for accurate and useful data.

What's your organization's position on mandatory reporting of infection rates? Is it even possible to achieve standardization of reporting that makes sense? And more importantly, can mandatory reporting actually be effective in reducing hospital-acquired infection?

To weigh in on this critical issue, please visit [knowledgeisinfectious.org](http://knowledgeisinfectious.org) and click on "share" to join the online discussion.

This podcast has been presented as an educational resource by Cook Medical.

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<sup>5</sup>Conference Agreement on Key Medicare Provisions of The Deficit Reduction Act of 2005 (s. 1932). American Hospital Association. 23 January 2006.

<sup>6</sup>Conference Agreement on Key Medicare Provisions of The Deficit Reduction Act of 2005 (s. 1932). American Hospital Association. 23 January 2006.