

## **Mandatory Public Reporting of Hospital Acquired Infections**

The non-profit Consumers Union (CU) has recently sent a letter to every member of the Texas Legislature urging them to pass legislation mandating the public reporting of hospital acquired infection rates. Accompanying that letter was model legislation for the state legislature to consider when it comes into session in January. The Texas Department of State Health Services has received several inquiries from the public as well as the legislature on this issue. It seems likely that the legislature will consider legislation similar to that introduced in other states. Currently, Illinois, Missouri, Pennsylvania and Florida have legislation for this reporting enacted. New Jersey and New York have legislation pending in their legislatures. While the Governor of California vetoed this legislation as an undue burden on the healthcare industry, it would be imprudent to rely on a similar outcome should this legislation be passed in Texas.

TSICP, with TMA, THA and other parties have initiated dialogue to best address this issue.

CU has this initiative as a featured campaign on their website. For additional information refer to the web site: <http://www.consumersunion.org/>



## **What Hospitals Are Doing to Enhance Patient Safety**

### ***Medicare Requirements***

The Medicare Conditions of Participation regulating each hospital that serves Medicare patients require an active program for the prevention, control and investigation of infections and communicable diseases. This regulation requires the hospital to develop, implement and maintain an infection control program for the prevention, control and investigation of infections (which includes, but is not limited to health care-associated infections) and communicable diseases and personnel. The hospital must have an active surveillance program that includes specific measures for prevention, early detection, control, education and investigation of infections and communicable diseases in the hospital. There must be a mechanism to evaluate the effectiveness of the program and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases (e.g., the Centers for Disease Control and Prevention Guidelines for Prevention and Control of Nosocomial Infections, etc.)

In 2004 CMS issued data submission requirements for an initiative entitled *Reporting Hospital Quality Data for Annual Payment Update*. Full Medicare payment to hospitals is contingent on reporting the mandated data. These tools are designed to prevent certain known problems in hospitals, deemed by CMS to be sufficiently important as to link the reporting with the payment of federal funds. Fully 100 percent of hospitals in Texas eligible to participate in the program have agreed to comply and have submitted data. Additionally, CMS is scheduled to include surgical infection prevention measures in the next set of measures. While all of the data suggested by the Consumers Union draft legislation is not required to be reported at this time, this national initiative to standardize quality data is a good start.

### ***Joint Commission Accreditation Requirements***

The accrediting body that reviews most Texas hospitals – the Joint Commission on the Accreditation of Healthcare Organizations – convened an expert panel last year to revise its infection control standards, with the goal of reducing the risk of health care-associated infections. The revised standards, which become effective Jan. 1, 2005, raise the expected performance of hospital leadership in this area and of the hospital infection control program itself.

In addition, several years ago the Joint Commission began announcing National Patient Safety Goals. Effective January 2003, compliance with the goals and associated recommendations has been incorporated into the accreditation survey process. Effective January 2004, a new goal was added: Reduce the risk of health care-associated infections. This goal requires hospitals to: 1) comply with current Centers for Disease Control and Prevention hand washing guidelines; and, 2) manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

In addition, as part of the Joint Commission's ORYX initiative – an initiative that integrates outcomes and other performance measurement data into the hospital accreditation process – the Joint Commission has developed a new measure set on surgical infection prevention. These measures became available for data collection this past summer. The data will be made available to the public late next year.

### ***Hospital Report Cards***

The Texas Health Care Information Council already has been charged with providing hospital-specific information to the public via hospital report cards. As part of this effort, the Texas Hospital Association and Texas hospitals have been working with state regulators to identify and make available valid, reliable and consistent measures that are meaningful to consumers. The council releases annually the *Indicators of Inpatient Care in Texas Hospitals*, a report on the performance by Texas hospitals on 25 measures of quality. The report provides consumers of health care with reliable and comparable data on hospitals throughout the state. In addition to bar charts and tables for each of the measures, the database also can be searched by hospital or metropolitan area for any of the procedures or conditions included in the report, allowing the reader to observe a hospital's improvement over time.

### ***New Texas Patient Safety Law and Regulations***

With the passage of a new state patient safety law last legislative session, Texas is taking a good first step to address medical errors and make hospitals more accountable to the public. As a result of the passage of House Bill 1614 in the 78<sup>th</sup> Regular Session of the Texas Legislature in 2003, hospitals and ambulatory surgery centers must report aggregate numbers of nine specific medical errors. The law also requires hospitals to have a comprehensive patient safety program in place. While all of the data suggested by the Consumers Union draft legislation is not required to be reported at this time, this state initiative to standardize quality data is a good start.

*September 30, 2004*

**Consumers Union**  
**Model Hospital Infections Disclosure Act**  
**August 25, 2004**

Section 1. Short title. This Act may be cited as the Hospital Infections Disclosure Act.

Section 2. Definitions. For purposes of this Act:

(a) "Department" means the Department of \_\_\_\_\_ [Note to advocates: your state may have several possible agencies to collect the data. These could be your state hospital licensing agency, your state health care data collection agency, or your state public health agency. If it exists in your state, we recommend using the agency that currently collects patient discharge data from hospitals. This will minimize the state's cost to implement the bill, as the hospital-acquired infection data can be gathered in the course of collecting other patient data.]

(b) "Hospital" means an acute care health care facility licensed under the Hospital Licensing Act [Note to advocates: insert a cross-reference and/or citation to the definition of "acute care hospital" in your state hospital licensing law. You may also consider including hospital-affiliated and freestanding outpatient surgical centers.]

(c) "Hospital-acquired infection" means a localized or systemic condition (1) that results from adverse reaction to the presence of an infectious agent(s) or its toxin(s) and (2) that was not present or incubating at the time of admission to the hospital.

Section 3. Hospital reports.

(a) Individual hospitals shall collect data on hospital-acquired infection rates for the specific clinical procedures determined by the Department by regulation, including the following categories:

- (1) Surgical site infections;
- (2) Ventilator-associated pneumonia;
- (3) Central line-related bloodstream infections;
- (4) Urinary tract infections; and
- (5) Other categories as provided under subdivision (d) of this section.

[Note to advocates: we recommend also collecting information about patient race, ethnicity and primary language to be able to assess racial and language disparities. Your state may already be collecting such information in its patient discharge database.]

(b)(1) Hospitals shall submit quarterly reports on their hospital-acquired infection rates to the Department. Quarterly reports shall be submitted, in a format set forth in regulations adopted by the Department, to the Department by April 30, July 31, October 31, and January 31 each year for the previous quarter. Data in quarterly reports must cover a period ending not earlier than one month prior to submission of the report. [Note to advocates: This is to ensure that the information is timely. For example, the report for the quarter ending March 31st should be submitted to the Department no later than April 30th of that same year.] Quarterly reports shall be made available to the public at each hospital and through the Department. The first quarterly report shall be due in 2006. [Note to advocates: we propose making the first report due in the year after the bill becomes effective. For example, if the bill becomes effective Jan. 1, 2005, the first quarterly report would be due on April 30, 2006; the first annual report from the Dept. would be due in 2007. Adjust the year for the quarterly report being due to your legislative calendar if the effective date of the bill is other than Jan. 1, 2005.]

(2) If the hospital is a division or subsidiary of another entity that owns or operates other hospitals or related organizations, the quarterly report shall be for the specific division or subsidiary and not for the other entity. [Note to advocates: When a hospital system or corporate parent of numerous hospitals uses a centralized data collection system to file hospital-acquired infection rates, the system should not be permitted to report its system-wide rates aggregately, but should report each facility's rates individually.]

(c) (1) The Director of the Department shall appoint an advisory committee, including representatives from public and private hospitals (including from hospital infection control departments), direct care nursing staff, physicians, epidemiologists with expertise in hospital-acquired infections, academic researchers, consumer organizations, health insurers, health maintenance organizations, organized labor, and purchasers of health insurance, such as employers. The advisory committee shall have a majority of members representing interests other than hospitals.

(2) The advisory committee shall assist the Department in the development of all aspects of the Department's methodology for collecting, analyzing, and disclosing the information collected under this Act, including collection methods, formatting, and methods and means for release and dissemination.

(3) In developing the methodology for collecting and analyzing the infection rate data, the Department and advisory committee shall consider existing methodologies and systems for data collection, such as the Centers for Disease Control's National Nosocomial Infection Surveillance Program, or its successor, however the Department's discretion to adopt a methodology shall not be limited or restricted to any existing methodology or system. The data collection and analysis methodology shall be disclosed to the public prior to any public disclosure of hospital-acquired infection rates.

(4) The Department and the advisory committee shall evaluate on a regular basis the quality and accuracy of hospital information reported under this Act and the data collection, analysis, and dissemination methodologies.

(d) The Department may, after consultation with the advisory committee, require hospitals to collect data on hospital-acquired infection rates in categories additional to those set forth in subdivision (a).

#### Section 4. Department Reports.

(a) The Department shall annually submit to the Legislature a report summarizing the hospital quarterly reports and shall publish the annual report on its website. The first annual report shall be submitted and published in 2007. The Department may issue quarterly informational bulletins at its discretion, summarizing all or part of the information submitted in the hospital quarterly reports. [Note to advocates: we propose making the first report due in the year after the bill becomes effective. For example, if the bill becomes effective Jan. 1, 2005, the first quarterly report would be due on April 30, 2006; the first annual report from the Dept. would be due in 2007. Adjust the year for the annual report being due to your legislative calendar if the effective date of the bill is other than Jan. 1, 2005]

(b) All reports issued by the department shall be risk adjusted.

(c) The annual report shall compare the risk-adjusted hospital-acquired infection rates, collected under Section 3 of this Act, for each individual hospital in the state. The Department, in consultation with the advisory committee, shall make this comparison as easy to comprehend as possible. The report shall also include an executive summary, written in plain language, that shall include, but not be limited to, a discussion of findings, conclusions, and trends concerning the overall state of hospital-acquired infections in the state, including a comparison to prior years. The report may include policy recommendations, as appropriate.

(d) The Department shall publicize the report and its availability as widely as practical to interested parties, including, but not limited to, hospitals, providers, media organizations, health insurers, health

maintenance organizations, purchasers of health insurance, organized labor, consumer or patient advocacy groups, and individual consumers. The annual report shall be made available to any person upon request.

(e) No hospital report or Department disclosure may contain information identifying a patient, employee, or licensed health care professional in connection with a specific infection incident.

#### Section 5. Privacy.

It is the expressed intent of the Legislature that a patient's right of confidentiality shall not be violated in any manner. Patient social security numbers and any other information that could be used to identify an individual patient shall not be released notwithstanding any other provision of law.

#### Section 6. Penalties

A determination that a hospital has violated the provisions of this Act may result in any of the following:

(a) termination of licensure or other sanctions relating to licensure under the Hospital Licensing Act [Note to advocates: insert the name and citation of your state hospital licensing act here].

(b) a civil penalty of up to \$1,000 per day per violation for each day the hospital is in violation of the Act.

#### Section 7. Regulatory oversight.

The Department shall be responsible for ensuring compliance with this Act as a condition of licensure under the Hospital Licensing Act and shall enforce such compliance according to the provisions of the Hospital Licensing Act. [Note to advocates: insert the name and citation of your state hospital licensing act here].

#### Section 8.

The Hospital Licensing Act is amended as follows: [Note to advocates: Amend your state hospital licensing act to add that violations of the Infections Disclosure Act is a grounds for license termination or sanctions in your state licensing act]



October 5, 2004

*Senator/Representative Name*

*Address - City, State Zip*

Dear Senator/Representative (*name*):

The Texas Hospital Association has become aware of the national effort led by Consumers Union to require the public reporting of health care-associated infection rates. Fighting infections within the health care setting is an ongoing battle that hospitals, nurses, physicians and others take very seriously. The battle has become more difficult as hospitals take care of sicker patients and fight infections resistant to the best medicines.

Consumers and purchasers have a right to expect quality health care and effective public reporting of performance indicators. Health care providers support public disclosure, but are dedicated to accomplishing it in a meaningful way. One approach would require public reporting of a facility's infection rate. This approach is based on the idea that consumers would consider such infection rates when seeking care, and that facilities would strive to lower their rates in the hope of keeping and attracting patients.

While many would agree that public reporting of facility infection rates makes sense conceptually, there are a number of implementation issues that must be considered. They include:

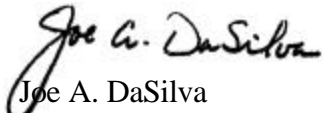
- how to account for differences in patient populations and therefore the likelihood of infections in those patients;
- how to rank and group the types and kinds of infections (so-called "denominator" issues);
- the lack of standardized definitions for types of infections;
- the lack of a standardized method for case-finding, which would reduce "surveillance bias" (the reporting of higher rates at institutions that do a more complete job of identifying events); and
- the resources required for surveillance and reporting.

A state law requiring infection-rate reporting also would entail additional software data capture systems at the Texas Department of State Health Services. While the industry is moving toward tracking and reporting clinical outcomes, the Centers for Medicare and Medicaid Services and the state Quality Improvement Organizations have not mandated these specific indicators yet, as they have no clear measurement definitions and collection guidelines. Thus, the information collected would be unreliable as far as an "apples to apples" comparison for differing types of hospitals (acute care, long-term acute care, rehabilitation, psychiatric, children and adolescent, hospice, etc.).

Legislation mandating the reporting of infection rates passed in Missouri this year. The fiscal note was estimated to affect that state's general revenue fund by more than \$500,000 per year – in a state with only 125 hospitals. When extrapolated to the approximately 500 hospitals in Texas, the cost to the state for such a program could well exceed \$2 million per year. I know you need no reminder as to the stress the state budget faces in fiscal years 2005-06, particularly in the Medicaid budget.

THA looks forward to working with Consumers Union and other interested parties to address citizens' concerns on this important issue. In the meantime, we have attached a basic fact sheet regarding the numerous patient safety initiatives that currently are in place. If you have any questions, please do not hesitate to contact Starr West, Director Health Care Quality at 800-252-9403 ext. 1042 or [swest@tha.org](mailto:swest@tha.org).

Sincerely,

A handwritten signature in black ink that reads "Joe A. DaSilva". The signature is written in a cursive, flowing style.

Joe A. DaSilva  
Senior Vice President  
Advocacy and Education

JAD:SW:das  
Attachment