

Public health law for the collection and reporting of health care-associated infections

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Background: State-based laws for reporting of health care-associated infections (HAI) have developed and changed dramatically in recent years, affecting the costs of reporting and impact on infection rates. It is necessary for practitioners of infection control to understand these changing legal frameworks and their application to practice.

Methods: Employing systematic state-based research, the researchers have documented legislation and administrative regulations for institution-specific HAI reporting, using this information to create a comprehensive resource on state-based laws for mandatory HAI reporting.

Results: As of August 27, 2007, 24 states have adopted laws requiring reporting of HAI rates, with an additional 7 states currently considering legislation that would require HAI reporting and 19 states employing detailed regulation in the absence of any current legislative authorization specific to HAI. This study documents (1) which states require reporting of HAI and, if so, whether this is done by legislation or administrative regulation; (2) whether the specific HAIs to be reported are identified in state law or codified generally as “diseases of public health importance,” with reporting specified by administrative regulation; and (3) what reporting policies and procedures are detailed in law.

Conclusion: Through analysis of the collected information, the researchers have examined the degree to which states have modernized their respective public health laws to approach mandatory reporting by way of general legislation regarding “matters of public health importance” and subsequent detailed administrative regulation to specify those matters. (*Am J Infect Control* 2008;■:■■■-■■■.)

Although health care-associated infection (HAI) rates have continued to rise over the last 30 years,¹ there is widespread agreement that most HAIs are avoidable^{2,3} and that HAI reporting mechanisms—as a system for public health surveillance—can lead to improved medical procedures, infection control best practices, and consequent prevention of HAIs.^{4,5} In this study, the researchers have reviewed relevant legal documents and analyzed current state public health legislation and regulation regarding mandatory collection and reporting of HAIs. Through analysis of the collected information, this study examines the degree to which states have modernized their respective public health laws to approach mandatory reporting by way of general legislation regarding “matters of public

health importance” and subsequent detailed administrative regulation to specify those matters. As a result, this study of both legislation and administrative regulations adds detail missing from existing databases of state reporting requirements while complementing these resources. This comprehensive examination of state-based regulation of HAI reporting will prove useful in evaluating the costs of mandatory reporting and the impact that the various types of regulations/legislation have on infection rates.

HAI, formerly known as “hospital-acquired infection” or “nosocomial infection,” occurs when a patient receiving treatment in a health care setting develops an infection secondary to the patient’s original condition. Because of their central status in providing medical care for infections, hospitals are often focal points of infectious disease epidemics. Within hospitals, these diseases can spread easily among immunocompromised patients,⁶ often as a result of the hospital’s failure to employ known means of HAI prevention, including washing hands fully, wearing proper infection-preventing attire, and prescribing antibiotics more selectively.⁷⁻⁹ There are an estimated 2 million HAIs annually in the United States, resulting in more than 90,000 deaths and leading HAI to become the fifth leading cause of death in acute care hospitals.¹⁰ Beyond these mortality and morbidity figures, HAI has become a major source of multiple drug-resistant organisms (more than 70% of the bacteria that cause

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HAI are resistant to at least 1 commonly used drug), most prominently methicillin-resistant *Staphylococcus aureus* (MRSA), contributing to the spread of disease beyond the walls of the hospital.^{10,11} As compared with other causes, HAI represents the most common complication in health care settings, affecting 5% to 10% of all hospitalized patients.¹² With increased days of hospitalization and direct health care costs, these HAIs add to American health care expenditure by at least \$4 billion annually.¹³⁻¹⁵

Although infection control professionals have long collected data on HAI on a voluntary and confidential basis (eg, the National Healthcare Safety Network (NHSN), formerly the National Nosocomial Infections Surveillance System¹⁶), hospitals have remained resistant to any mandatory or public reporting of HAI rates.¹⁷ Until recently, public health authorities only collected information on and investigated large outbreaks of infectious conditions in health facilities on a case-by-case basis. Facing civil tort liability for negligence in infection control policies, hospitals have opted to defend individual lawsuits, often successfully challenging the causation of HAIs (ie, whether the hospital “caused” the resulting harm), rather than change the practices of medical personnel.⁶ Despite the continued use of voluntary standards, infection control processes, infection rates, and multiple drug-resistant organisms prevalence vary widely even in NHSN hospitals.¹⁸ Even federal guidelines to track processes associated with infections (as part of the hospital accreditation procedures of the Joint Commission of Accreditation of Healthcare Organizations) have done little to ameliorate HAI, lacking any specified “best practices” guidelines and compliance mechanisms necessary to mandate improvements.¹⁹

Despite commitments from the national public health community to reducing the rate of HAI by 2010,²⁰ hospital regulation falls solely under the constitutional purview of state authorities, and it was not until 2004 that any state specifically *required* hospitals to report HAIs. This Pennsylvania law, mandating that hospitals report information solely on specific surgical site and device-related infections,²¹ has since been followed on and expanded by several other states. In 2005, Florida’s creation of “Florida Compare Care” made it the first state to require Web-based publication of hospital-specific infection rates.²² In the wake of these preliminary efforts to regulate HAI, advocacy organizations—arguing for publicly available data on the basis of a “right to know”²³—have lobbied for mandatory public reporting of individual hospital infection rates in an effort to raise public awareness and motivate hospitals to make infection prevention a top priority.²⁴ Because of public attention to the magnitude of the HAI, drug resistance problems in hospitals, and

increasing demand for health care information, these organizations have recently been successful in pressing state and national initiatives that mandate hospital disclosure of performance and outcome data with regard to HAIs.²⁵

In building the evidence base to assist states in developing best practices for procedures to require public reporting of HAIs, the Centers for Disease Control and Prevention (CDC) instituted a Healthcare Infection Control Practices Advisory Committee to develop guidance documents that would specify principles for reporting systems.⁵ This was followed by a position paper from the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC), which, based on the CDC guidance documents, enumerated 9 recommendations to guide the development of a reporting system based on mandatory, publicly available, and standardized (by organism and infection site) data for meaningful hospital comparison.²⁶ Extending this effort toward uniform legislative prescription for HAI surveillance, the APIC, in collaboration with the Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America, has developed standardized model state legislation for collecting and reporting HAI data that balances patients’ right to know and hospitals’ need for uniform reporting standards.²⁷ This *Model State Legislation for Collecting and Reporting Healthcare-Associated Infections* (or a similar effort through the *Consumers Union Model Hospital Infections Disclosure Act*) does not dictate specific legislative methods for collecting and reporting infection data; rather, it recommends drafting administrative regulations with reference to the panoply of voluntary reporting standards. In advocating the codification of these measurement systems, both the APIC and the Consumers Union have undertaken Web-based surveys of state HAI reporting laws, listing pending and passed legislation.^{25,28} These Web-based resources have proven instrumental in galvanizing advocacy, but they have not compared the content of each state’s HAI regulation, provided legislative language, or analyzed political processes for regulatory reform, comparisons necessary in developing legal and political best practices for HAI reporting.

METHODS

To develop a descriptive database of state laws for the prevention, surveillance, and control of HAI, the researchers first identified state HAI legislation and administrative regulations across the states. (In this context, “legislation” refers to law developed by the legislative branch and promulgated by executive signature, and “regulation” consists of legal requirements developed by executive agency pursuant to its enabling

Table I. Summary of state HAI laws

| Adopted legislation | | Proposed legislation | Adopted regulations | |
|---------------------|----------------|----------------------|---------------------|---------------|
| Alaska | Missouri | Alabama | Arizona | New Mexico |
| | Nebraska | | | |
| Arkansas | | Massachusetts | Hawaii | North Dakota |
| | Nevada | | | |
| California | New Hampshire | Michigan | Idaho | Ohio |
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| Colorado | New York | New Jersey* | Indiana | Oklahoma |
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| Connecticut | Oregon | North Carolina | Iowa | South Dakota |
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| Delaware | Rhode Island | Pennsylvania* | Kansas | Utah |
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| Florida | South Carolina | Washington | Kentucky | West Virginia |
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| Georgia | Tennessee | | Louisiana | Wisconsin |
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| Illinois | Texas | | Maine | Wyoming |
| | | | | |
| Maryland | Vermont | | Montana | |
| | | | | |
| Minnesota | Virginia | | | |
| | | | | |
| Mississippi | | | | |

*Indicates states that have both existing and proposed legislation.

statutory authority.²⁹) Building on (1) data collected through a Joint Task Force of the Society for Healthcare Epidemiology of America and APIC³⁰ and (2) procedures developed by the Healthcare-Associated Infection Working Group's Tool Kit for reporting HAI,³¹ the researchers systematically examined Web databases (eg, Lexis-Nexis, Westlaw, state legislative Web sites) and personal resources (in select cases in which Web-based information was not readily available) to develop a comprehensive summary of the substance and procedures of states' mandatory HAI reporting.

Following this documentation, the researchers categorized the data collected for each state reporting process on the basis of (1) general authority requiring reporting of "diseases of public health importance" or specific, detailed legislative authority regarding the reporting of HIAs; (2) organisms and infection sites specifically enumerated (ie, case/intervention definition); (3) required hospital reporter; (4) detail in the report (aggregate for hospital vs individual case report); and (5) extent to which reports are released to the public with individual hospital identifiers. Based on previous studies of health regulations³² and experience in hospital-based infection control procedures,³³ these categories were deemed by the researchers as most likely to highlight the types of information of interest to those accessing the database, either to understand what is currently required in a given state or to consider possible regulatory reforms. This categorization was then analyzed from a comparative legal perspective to identify common

themes among legislation and/or regulation governing the collection and reporting of HAI, to examine these similarities and differences to understand political context, and, as a result, to uncover general empirical relationships among state legal efforts.

RESULTS

The state data have been organized in a Web-based table conducive to interstate regulatory comparison on the Web site of the Columbia Center for Health Policy (http://www.nursing.columbia.edu/chphsr/projects/law/public_health.html) and included as an Appendix to the present article. Based on an analysis of the categorizations of these laws and regulations, several patterns in hospital-based reporting become apparent.

Legislation has been proposed in almost all states, with several bills having now passed out of committee to receive the support of the legislature and become codified in state law. As of August 27, 2007, 24 states have adopted laws requiring the reporting of HAI rates, with an additional 7 states currently considering legislation that would require HAI reporting and 19 states employing detailed regulation in the absence of any current legislative authorization specific to HAI. (Additionally, New York City has become the first city to disclose HAI rates, albeit in the absence of legislation, for all public hospitals.³⁴) Table 1 lists the states with adopted legislation, proposed legislation, and adopted regulations. It is important to note that some states

331 categorized as “proposed legislation” already have
332 adopted legislation or regulations on mandatory report-
333 ing (eg, Pennsylvania); however, because superseding
334 legislation has been proposed, they were listed in this
335 intermediate category.

336 States, based on experiences with voluntary report-
337 ing mechanisms since the 1970s, have moved in the
338 last decade to institute systems of mandatory reporting
339 through legislation. Every state that has passed legisla-
340 tion on HAI reporting has made that reporting manda-
341 tory by all regulated health care facilities. Beyond that
342 commonality, states have instituted myriad legislative
343 and regulatory frameworks to assure and specify man-
344 datory reporting of HAI.

345 Among the legislative schemes created through this
346 process, the regulating agency responsible for HAI report-
347 ing is most often the state’s department of health
348 (or equivalent agency). There are exceptions to this,
349 however, whereby the state has created an independent
350 agency to monitor HAIs. In Pennsylvania, for example,
351 the Pennsylvania Health Care Cost Containment Council
352 had been established in 1986 but was reauthorized
353 in 2003 to include nosocomial infections in its existing
354 review of hospital-based reporting.³⁵ In cases in which
355 the state has declined to assume authority as the regu-
356 lating agency (eg, Arizona, Colorado, Tennessee, and
357 Virginia), laws have simply regulated the mandatory re-
358 porting of HAI by requiring participation in the CDC’s
359 voluntary National Healthcare Safety Network.

360 Within these reports to the regulating agency, regula-
361 tion often mandates a delineation of reporting by orga-
362 nism and by infection site. In instances in which the
363 legislation is specific, legislators have specified these or-
364 ganisms to include pneumonia, MRSA, *Clostridium diffi-*
365 *cile*, and *Vancomycin-resistant enterococcus* (VRE) and
366 infection sites to include surgical sites, blood stream,
367 and the urinary tract. In most cases, however, legislation
368 delegates authority to the regulating agency to determine
369 (and revise when necessary) both the reportable orga-
370 nisms and infection sites through subsequent regulation.

371 States that have successfully mandated HAI reporting
372 have, with certain exceptions (eg, Nebraska, Nevada),
373 also required the release of that information on HAI
374 rates to the public. Where they have done so, this publi-
375 cation of infection data has been done by the way of
376 both hospital-based data and aggregate state statistics.
377 Although many states have accomplished this release
378 of information through Internet posting, some state-
379 regulating agencies are permitted to release the infor-
380 mation only upon specific request (eg, Virginia).

382 DISCUSSION

383
384 Reviewing the legislative history of the laws specific
385 to HAI reporting, bills have been more likely to become

386 legislation where they give broad authority to the
387 health department to design specific reporting regula-
388 tions based on a general statutory language. This was
389 the case among the 5 states that adopted enabling lan-
390 guage from the Turning Point Model State Public Health
391 Act,³⁶ which provides legislative language that the state
392 should develop regulation on any “disease or condition
393 of public importance.” Among those states that have
394 successfully legislated mandatory HAI reporting, legis-
395 lation was often preceded by the legislative empanel-
396 ling of task forces or committees to study the issue.
397 For example, Texas created an Advisory Panel on
398 Health Care Associated Infections, which recommen-
399 ded a mandatory reporting system.³⁷ As in Texas,
400 state-specific reports created through this expert col-
401 laboration³⁸⁻³⁹ would propose principles upon which
402 mandatory reporting bills could then be drafted and
403 legislation promulgated. Many states (eg, Alaska) that
404 have not yet considered specific legislation have al-
405 ready convened an expert panel to study legislative
406 proposals.

407 The most detailed legal requirements for the report-
408 ing of HAI have derived from a prolonged period of
409 consideration of reform with the cooperation of hospi-
410 tal associations. Pennsylvania highlights this trend,
411 employing a phased reporting requirement on hospi-
412 tals, beginning in 2004 with specific surgical site infec-
413 tions and expanding reporting categories each year
414 until hospitals were required to report all HAIs.⁴ De-
415 spite the promise of rapid change for this clear public
416 health benefit, state hospital associations have often
417 opposed these laws during their drafting and acted to
418 slow or stop their implementation once regulations
419 have been enacted. Three documented reasons appear
420 to drive this resistance: fear of liability, reporting logis-
421 tics, and questions of efficiency. First, public reporting
422 is thought (often without justification) to lead to an in-
423 crease in liability for hospitals in HAI cases.⁴⁰ Second,
424 hospitals are concerned that data on hospital infection
425 rates will not be reported or publicized in a way that
426 presents an accurate picture of individual risk of infec-
427 tion, with hospitals conceivably varying in their report-
428 ing diligence and patients conceivably varying across
429 hospitals in their propensity for infection.⁴ Finally,
430 many in the health care and public health community
431 fear that resources spent on inefficient surveillance
432 may divert resources from patient care and preven-
433 tion.⁴¹ Consequently, with the infrastructural changes
434 necessary to meet new state data requirements,²⁶ it
435 would be advantageous to incorporate health care or-
436 ganizations in the planning of reporting procedures
437 to understand better the complexity and laboriousness
438 of data collection and reporting and develop commit-
439 ment from health care organizations through “owner-
440 ship” of the resulting legislation.

441 In light of the range of approaches developed by
 442 states in addressing HAI reporting, regulatory reform
 443 efforts could benefit from the recent development of
 444 model legislation. With states having each previously
 445 approached this issue de novo, federalism has not
 446 led to improvements in public health protection be-
 447 cause hospital associations have divided states in
 448 an apparent effort to weaken legislation and regula-
 449 tion. Model legislative language, analogous to the
 450 Turning Point Model State Public Health Act,³⁶ would
 451 allow for the incorporation of best practices for pub-
 452 lic health in every state's laws, providing baseline
 453 protections in infection control legislation and re-
 454 quiring pressing justification for deviating from this
 455 language.⁴² The APIC's *Model Legislation on Public*
 456 *Reporting of Healthcare-Associated Infections* should
 457 facilitate the improvement and standardization of
 458 state HAI regulations, a process that has begun in
 459 several states that have drawn on the APIC's work
 460 in drafting state legislation (eg, New Jersey). These
 461 model templates notwithstanding, current model
 462 legislation initiatives specify only the process of cre-
 463 ating regulations, not the substance of that regula-
 464 tion, providing more of a general statement of
 465 principles than an enumeration of specific organisms
 466 and sites of infection to be collected and reported.
 467 For states to develop best practices in HAI control,
 468 substantive legislative and regulatory provisions for
 469 mandatory HAI reporting, based on the current state
 470 of HAI epidemiology, would make an even greater
 471 contribution.

472 Finally, whereas early adopting states employed
 473 legislative specificity in HAI reporting, current law-
 474 making practices give flexibility to the regulating
 475 agency through broad legislative delegation. For
 476 many states, regulation has proved to be a less politi-
 477 cally cumbersome approach to law reform than statu-
 478 tory change, providing necessary legal specificity
 479 without the risk of legislative retrenchment inherent
 480 in opening a state's public health statutes to amend-
 481 ment. With this delegation to the regulating agency,
 482 this general legislative authority has expanded health
 483 department public health surveillance into the realm
 484 of quality control for the practice of medicine.⁴³ In
 485 confronting this uncharted terrain for health depart-
 486 ments, it will be necessary to develop consensus on
 487 best practices for infection control in model regula-
 488 tions, providing an improved understanding of what
 489 state agencies must do to assure standardized report-
 490 ing methods. Rather than simply giving token refer-
 491 ence to the wide range of voluntary standards, model
 492 legislation should provide the normative judgments
 493 to select among standards and allow for uniform and
 494 consistent state approaches to key infection control
 495 activities.

CONCLUSION

496 This research allows examination of whether regu-
 497 lations specifying mandatory reporting are able to
 498 deal more effectively with the evolving issues of HAI
 499 or whether the interest in reporting institution-specific
 500 data requires specific legislation, either to support the
 501 reporting or to stymie countervailing lobbying in the
 502 disclosure of information. The present results provide
 503 researchers with additional information to facilitate fu-
 504 ture research on questions of regulatory efficacy for
 505 HAI prevention and control. This project has created
 506 a Web-based system amenable to regular updating as
 507 regulations are promulgated, communicating its re-
 508 sults and analysis to the public health community to
 509 assist in improving future regulatory reform efforts
 510 for HAI prevention and control. Because these laws
 511 have only recently been developed, with many bills
 512 currently pending in state legislatures or with regula-
 513 tions not yet enacted, it will be necessary to keep this
 514 legal tracking updated frequently, with real-time up-
 515 dates through Internet dissemination. With periodic
 516 updating of these nascent regulations and communica-
 517 tion to the public health and infection control commu-
 518 nities, this project will inform policy makers of the
 519 various regulatory mechanisms that can be utilized as
 520 templates for mandatory reporting of HAI.

521 Given the dearth of research on the effect of manda-
 522 tory hospital reporting systems on rates of infection,
 523 additional research is needed to assess the political
 524 and policy efforts undertaken in states to translate
 525 best practices for infection control into law and prac-
 526 tice. With these mandatory reporting laws rapidly com-
 527 ing into force across the country, there exists a unique
 528 window of opportunity to assess the impact of manda-
 529 tory reporting on infection control programs, practices,
 530 and infection rates over time. Through future analysis
 531 and ongoing legislative tracking in all 50 states, re-
 532 searchers can investigate how (1) HAI reporting is cod-
 533 ified into state law (eg, obstacles to legal reform) and (2)
 534 modernized state HAI regulations can influence or
 535 change medical practice. In this latter consideration,
 536 despite enthusiastic support for the public release of
 537 performance measures and extensive adoption of qual-
 538 ity measurement and reporting, there is little evidence
 539 of the effect of public reporting on the delivery of
 540 health care, and even less is known about how this re-
 541 porting may improve HAI rates. Future research will be
 542 necessary on the longer term effects of mandatory HAI
 543 reporting on infection control departments' practices
 544 and their consequent effect on HAI rates.

545 It is a tragic irony of our health care system that pa-
 546 tients have found harm in places of healing. In the past
 547 30 years, however, thinking has evolved from fatalism
 548 about the inevitability of HAI to hospital-based efforts
 549 550

to control infection and to legislative requirements to inform patients. Although institutional medical care can never be free of risk, there is growing awareness that the risks of HAI can be greatly diminished through improved processes of care and that the law may be the impetus for abating these infections that cut into the public's health.

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APPENDIX: State HAI Reporting Guidelines

| Jurisdiction | Regulatory authority | Citation of authority L=legislation (L)=pending R=regulation N=neither | Hospital-Acquired Infections | | | | | | | Details of report (Required hospital reporter/ role of infection control dept) | Public access to information contained in report | | Comments | |
|--------------|----------------------|--|------------------------------|------|--------------|-----|-------------------|------|--------------|--|--|---------|--|-------------|
| | | | By organism | | | | By infection site | | | | Determined by agency | General | | By hospital |
| | | | Pneumonia | MRSA | C. difficile | VRE | Surgical site | UTIs | Blood stream | | | | | |
| AL | Dept. of Health* | (L) SB 409, Reg. Sess. (AL. 2007) | X | | | | X | X | X | | X | X | Active bill currently before the Senate Health Committee Hospitals required to collect data and will face civil sanctions for failure to comply Both voluntary and mandatory reporting requirements Legislature put forth a resolution stipulating the creation of task force for the development of recommendations for hospitals to disclose infection rates One of 5 states that have adopted the Turning Point Model Health Act. Required to report any "disease or condition of public importance". | |
| AK | Dept. of Health | L 2007 AL SJR 19, LR038 | | | | | | | X | Reporting by any health care provider as determined by the Dept. of Health | | | Have neither considered HAI reporting laws nor passed any legislation taking this matter into consideration Director of clinical laboratories must report MRSA under R9-6-204 Table 3 However Dept of Health, through the Arizona Administrative Code requires reporting of diseases as defined by the CDC. | |
| AZ | Dept. of Health | R AZ Admin Code §R-9-6-201-SR9-6-207 (Supp 93-04) | | X | | | | | X | Reporting by health care providers and clinical laboratories | X | | Both voluntary and mandatory reporting requirements | |
| AR | Dept. of Health | L AR Code Ann § 9-1201-§ 9- 1206 (2007) | | | | | X | | | | X | | | |

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| Jurisdiction | Regulatory authority | Citation of authority L=legislation (L)=pending R=regulation N=neither | Hospital-Acquired Infections | | | | | | Details of report (Required hospital reporter/ role of infection control dept) | Public access to information contained in report | | Comments | |
|--------------|---|--|------------------------------|------|--------------|-----|-------------------|------|--|--|---------|--|---|
| | | | By organism | | | | By infection site | | | Determined by agency | General | | By hospital |
| | | | Pneumonia | MRSA | C. difficile | VRE | Surgical site | UTIs | | | | | |
| CA | Dept. of Health Serv. | L CA Code Health & Safety §1288.5 §1288.9 (2006) | X | | | | X | X | X | | | The public reporting is based on the CDC's "Guidance to Public Reporting," but only includes process measures, relating to the rate at which prevention practices are used. The reporting requirements do not include the Guidance "outcome" measures, such as hospital infection rates which would reveal whether hospital policies are actually reducing infections. | |
| CO | Dept. of Public Health* | LCO Rev. Stat. § 25-3 601-§25-3 607 (2006) | | | | X | | X | X | R | X | X* | *An advisory committee will assist the department *Physicians who diagnose HAI, upon follow-up with patients must report those infections to the facility in which the reportable procedure was done. One of 5 status that have adopted the Turning Point Model Health Act. Required to report any "disease or condition of public importance". |
| CT | Dept. of Health* | L 2006 CT Pub. Acts 102 (Reg. Sess.) | | | | | | | X | | X | X | *A committee 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. |
| DE | Dept. of Health and Social Serv. | L H.B. 47 14th Leg. Reg Sess. (DE 2007) substituted by HS I | | | | | X | X | X | | | X | HB47 substituted by HSI, which passed the House and the Senate, and was signed by the Governor on July 12, 2007. |
| FL | Agency for Health care Admin* | L FL., Stat. Tit. XXIX ch. 408.5 (2004) FL. Stat. Tit. XXIX, ch 408.061 § 1(a) | | | | | X | X | X | | | X | *Florida issues hospital-specific reports using the Agency for Health care Research and Quality (AHRQ) Patient Safety Indicators (PSI) scale. |
| GA | Hospital Health Care Stand. Comm. for Prevention of HAIs* | L S.J. Res. 22 36th Leg. Gen. Sess. (Ga. 2007) | | | | | | | | X | | | All proposed bills have failed to pass. However, the Georgia senate created the Health care Standards Commission for Prevention of HAIs. *The commission will study safety standards, best practices, infection rates and causes |

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| Jurisdiction | Regulatory authority | Citation of authority L=legislation (L)=pending R=regulation N=neither | Hospital-Acquired Infections | | | | | | | Details of report (Required hospital reporter/ role of infection control dept) | Public access to information contained in report | | Comments |
|--------------|-----------------------------|--|------------------------------|------|--------------|-----|-------------------|------|--------------|--|--|--|----------|
| | | | By organism | | | | By infection site | | | | General | By hospital | |
| | | | Pneumonia | MRSA | C. difficile | VRE | Surgical site | UTIs | Blood stream | | | | |
| HI | Dept. of Health | R HI Admin Rules ch 11-156 (2001)* | | | | | | | | | | All proposed bills have failed to pass. Both proposed bills would have required public reporting. *Only listed communicable diseases and those that represent a risk to the general public are mandated to be reported by health care providers, laboratorians, and hospital administrators. | |
| ID | Dept. of Health and Welfare | R ID Admin. Code IDAPA Section 16.02.10 (supp. 2007)* | | | | | | | | | | Have yet to consider and/or pass any pertinent legislation. *State makes provisions for certain listed diseases to be reportable by health care providers, laboratorians, and hospital administrators. | |
| IL | Dept. of Health | L 210 IL Comp. Stat. 86 (2005)X S.B. 0233 95th Leg., Reg. Sess.(IL. 2007) enacted P.L. 95-0312* | X | | | X | | X | | X | X | Requires 2 or more infection measures to be reported as stipulated by the state's Department of Public Health. The report should include process of outcome measures relating to infection rates in designated critical care units. The measures are to be based on those developed by national quality organizations and agencies. The bill also requires reporting of nurse staffing ratios. *Makes provisions for the screening and reporting MRSA. All hospitals are required to establish an MRSA control program. | |
| IN | Dept. of Health | R IN Admin. Code tit. 410 (2007)* | | | | | | | | | | All proposed bills have failed to pass. Of the proposed bills SB513 and HB 1592 required public reporting of infection rates . SB 531 gives a committee and agency the authority to determine what infection information should be reported. * State makes provisions for certain listed diseases to be reportable by health care providers, laboratorians and hospital administrators. | |

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| Jurisdiction | Regulatory authority | Citation of authority L=legislation (L)=pending R=regulation N=neither | Hospital-Acquired Infections | | | | | | | Details of report (Required hospital reporter/ role of infection control dept) | Public access to information contained in report | | Comments |
|--------------|---|--|------------------------------|------|--------------|-------------------|---------------|------|----------------------|--|--|--|----------|
| | | | By organism | | | By infection site | | | Determined by agency | | General | By hospital | |
| | | | Pneumonia | MRSA | C. difficile | VRE | Surgical site | UTIs | | | | | |
| IA | Dept. of Public Health | R IA Admin. Code tit. 641 (2007) | | | | | | | | | | Have yet to pass any pertinent legislation *State makes provisions for certain listed diseases to be reportable by health care providers, laboratorians and hospital administrators. | |
| KS | Dept. of Health | R KS Admin. Regs. 28-1-2(supp. 2007)* KS Admin. Regs. 28-1-4(supp. 2007)* | | | | | | | | | | All proposed bills have failed to pass before crossover deadline. *State makes provisions for certain listed diseases to be reportable by health care providers, laboratorians, and hospital administrators | |
| KY | Cabinet for Health and Family Services | R 214 KY Admin. Regs. 214.010 (2005)* | | | | | | | | | | Have yet to pass any pertinent legislation. *Physicians and families are to report certain diseases as determined by the Cabinet for Health and Family and Services. | |
| LA | Dept. of Health and Hospital, Office of Public Health | R LA Admin. Code. tit. 51,101-119 (2007)* | | | | | | | | | | Have yet to pass any pertinent legislation *State makes provisions for certain listed diseases to be reportable by health care providers, laboratorians and hospital administrators. | |
| ME | Dept. of Health and Human Services | R Code ME. R.§10-144 ch. 258 (2007)* | | | | | | | | | | Have yet to pass any pertinent legislation *State makes provisions for certain listed diseases to be reportable by health care providers, laboratorians and hospital administrators. | |
| MD | Health-Care Commn. | L MD Code Ann. Health §19-134 (2006) | X | | | | | | X | | X | | |
| MA | Dept. of Health | (L) H.B. 2207 Leg. Reg. Sess.(Ma. 2007)* | X | | X | X | X | X | X | X | | Active bills currently under consideration *Proposed act promoting disclosure of HAIs | |
| MI | Dept. of Health | (L) H.B. 4158 Leg. Reg. Sess. (Mi 2007) | | | | | | X | X | | X | General Provisions for reporting HAIs | |
| MN | Dept. of Health/ MN Hospital Assn. | L 2007 Minn. Laws ch. 147, Art. 9, 144.565 Subd. 5, § 17 | X | | | | | | X | | X | Reportable infections will be those endorsed by the National quality Forum State will additionally required quality of care and patient safety reports | |

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| Jurisdiction | Regulatory authority | Citation of authority L=legislation (L)=pending R=regulation N=neither | Hospital-Acquired Infections | | | | | | | Details of report (Required hospital reporter/ role of infection control dept) | Public access to information contained in report | | Comments | |
|--------------|--|--|------------------------------|------|--------------|-----|-------------------|------|--------------|--|--|---------|---|-------------|
| | | | By organism | | | | By infection site | | | | Determined by agency | General | | By hospital |
| | | | Pneumonia | MRSA | C. difficile | VRE | Surgical site | UTIs | Blood stream | | | | | |
| MS | State Board of Health | L MS Code Ann. §41-23-1 (2000)* | | | | | | | | | | | Have yet to pass any pertinent legislation *State makes provisions for certain listed diseases to be reportable by health care providers, laboratorians, and hospital administrators | |
| MO | Dept. of Health & Senior Services | L MO Rev. Stat. § 192 (2006) | X | X | X | X | X | X | | | X | X | | |
| MT | Dept. of Public Health & Human Services | R MT Admin. R. 37. 114 (2006) | | | | | | | | | | | *State makes provisions for certain listed diseases to be reportable by health care providers laboratorians, and hospital administrators | |
| NE | Dept. of Health | L 2005 NE Laws 301 §41 | | | | | X | | X | | | | Reports not to be shared with the general public | |
| NV | Health Division of the Dept. of Human Res. | L NV Rev. Stat. Ann. §441A.(2005) | | | | | | | | | | | Reports not to be shared with the general public. Certain medical facilities are required to report HAIs as sentinel events | |
| NH | Dept. of Health and Human Services | L NH Rev. Stat. Ann. §151:33 (2006) | | | | | X | X | X | | | X | Required hospitals to report infection rates as well as measures they use to prevent infections | |
| NJ | Commissioner of Health and Senior Services | (L) S.147/919 212th Leg. Gen. Sess. (Nj. 2007) | X | X | | | X | X | X | | X | X | S919 was combined with S147 on June 6, 2007, S147 passed the Senate and the Assembly on June 21, 2007. Not only would it require public reporting of HAIs rates, it would also require disclosure to the public of each hospital's numbers on certain medical errors known as "never events." | |
| NM | Dept. of Health | R NM Admin. Code tit. §7 4.3 (2006)* | | | | | | | | | | | All bills failed to pass before crossover deadline. *State makes provisions for certain listed disease to be reportable by health care provided laboratorians and hospital administrators | |
| NY | Dept. of Health | L NY Pub. Health Law §2819(2005) | | | | | X | | X | X | | X | | |

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| Jurisdiction | Regulatory authority | Citation of authority L=legislation (L)=pending R=regulation N=neither | Hospital-Acquired Infections | | | | | | | Public access to information contained in report | | Comments | |
|--------------|--|--|------------------------------|------|--------------|-----|-------------------|------|--------------|--|---------|----------|--|
| | | | By organism | | | | By infection site | | | Details of report (Required hospital reporter/ role of infection control dept) | General | | By hospital |
| | | | Pneumonia | MRSA | C. difficile | VRE | Surgical site | UTIs | Blood stream | | | | |
| NC | Dept. of Health | L H 1738, Leg. Gen. Sess. (NCX 2007) | | | | | X | X | X | | * | * | *Bill creates an advisory commission to make recommendations in 2009 for a public reporting system and proposed legislation for public disclosure. |
| ND | State Dept. of Health | R ND Admin. Code Health and Safety §208 (2003)* | | | | | | | | | | | Have yet to consider any pertinent legislation. *State makes provisions for certain listed diseases to be reportable by health care providers, laboratorians and hospital administrators |
| OH | Dept. of Health/ Hospital Meas. Advisory Council | R OH Admin. Code §3727.312 (2006) | | | | | | | X | | X | X | Creation of a hospital measures advisory council to oversee collection and reporting of hospital quality measure and Hospital-acquired infection measures. |
| OK | Dept. of Health | R OK Admin. Code §310.515 (2006)* OK Admin. Code 310:667-40-11(C)(2)(E)* | | | | | | | | | | | Have yet to consider any pertinent legislation. *State makes provisions for certain listed diseases to be reportable by health care providers, laboratorians, and hospital administrators. **State emergency hospital must document HAIs, but disclosure is restricted and only made consistent with state or federal laws, or pursuant to court order. |
| OR | Dept. of Admin. Services | L H.B. 2524 74 th Leg. Gen. Sess. (Or. 2007) | | | | | X | X | X | X | | X | HB2524 was signed by the Governor on July 27, 2007. |
| PA | Health Care Cost Containment Council | L, (L) PL. 31 No. 14 (PA 2003)* H.B.700. Leg. Reg. Sess. (PA 2007)* | X | | | | | | X | X | | | *Enacted legislation designed to decrease and/or contain health care costs by collecting and disseminating data that would make the participants of the health care system publicly accountable **Comprehensive provisions aimed at eliminating HAIs and medical errors. Requires hospitals to track and report infection and medical error trends and to use evidence based universal surveillance |

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| Jurisdiction | Regulatory authority | Citation of authority L=legislation (L)=pending R=regulation N=neither | Hospital-Acquired Infections | | | | | | | Details of report (Required hospital reporter/ role of infection control dept) | Public access to information contained in report | | Comments | |
|--------------|--------------------------------------|--|------------------------------|------|--------------|-----|-------------------|------|--------------|--|--|--|----------|-------------|
| | | | By organism | | | | By infection site | | | | Determined by agency | General | | By hospital |
| | | | Pneumonia | MRSA | C. difficile | VRE | Surgical site | UTIs | Blood stream | | | | | |
| RI | Dept. of Health | L RI.Gen. Laws. 23-17.17(2006) SB0650 (2007)* | | | | | | | x | | | Voluntary reporting only Requires existing hospital quality steering committee to consider adding measures associated with HAls,to the state hospital quality of care reports. *Bill required public reporting of HAls held and recommended for future study | | |
| SC | Dept. of Health and Environ. Control | L SC Code Unann. §44-7-2410 (2006) | x | | | | x | x | x | | | *A committee, which will include consumer representation, will advise the Dept. on methodology for collecting, analyzing, and disclosing information | | |
| SD | Dept. of Health | R SD Admin. R 44:20:02:0 (2006)* | | | | | | | | | | Have yet to pass any pertinent legislation. *State makes provisions for certain listed diseases to be reportable by health care providers, laboratorians, and hospital administrators | | |
| TN | Dept. of Health | L TN Code Ann. 68-11-263 (2006) | | | | | X* | | | X** | X | *Surgical infection rate data to be reported through the CDC. **The department will only publish central line bloodstream infection in intensive care units | | |
| TX | Dept. of Health | L TX. HB 1398 amending TX. Health & Safety Code Ann. 98-001 et. seg. (2007) | | X | | | X | X | X | | X | | | |
| UT | Dept. of Health. | R UT Admin. Code §26-6-1 (2007) | | | | | | | | | | Have yet to consider any pertinent legislation. *State makes provisions for certain listed diseases to be reportable by health care providers, laboratorians and hospital administrators | | |
| VT | Health Care Admin. | L VT Stat. Ann. tit.18 § 9405b (2006) | | | | | X | | X | | X | | | |

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| Jurisdiction | Regulatory authority | Citation of authority L=legislation (L)=pending R=regulation N=neither | Hospital-Acquired Infections | | | | | | Details of report (Required hospital reporter/ role of infection control dept) | Public access to information contained in report | | Comments |
|--------------|----------------------|--|------------------------------|------|--------------|-----|-------------------|------|--|--|---|----------|
| | | | By organism | | | | By infection site | | | General | By hospital | |
| | | | Pneumonia | MRSA | C. difficile | VRE | Surgical site | UTIs | | | | |
| VA | Board of Health | L VA Code Ann. § 32.1-§35.1 (2005) | | | | | | | X* | X** | *Only acute care hospitals must report nosocomial infection rates through the CDC. There are no specifics on what will be collected or how. **Information made available to the public upon request | |
| WA | Dept. of Health. | (L) HB. 1106 60th Leg. Reg. Sess. (WA 2007) | X | | | | X | X | | X | Requires disclosure of rate at which patients acquire certain infections during treatment. Data will initially be obtained on central line associated bloodstream infections in intensive care units (from July 1,2008), then ventilator-associated pneumonia (from January 1,2009), and then surgical site infections for certain procedures (from January 1, 2010). By December 1,2009, the Dept. of Health will start publishing a report comparing HAIs rates at hospitals in the state | |
| WV | Dept. of Health | R WV Code ST. R. | | | | | | | | | All proposed bills have failed to pass before crossover deadlines. *State makes provisions for certain listed diseases to be reportable by health care providers laboratorians and hospital administrators | |
| WI | Dept. of Health | R WI Admin. Code HFS §145 (2003) | | | | | | | | | Have yet to enact any pertinent legislation. *State makes provisions for certain listed diseases to be reportable by health care providers, laboratorians and hospital administrators. | |
| WY | Dept. of Health | R WY Rules and Regs. ch. 11 §5289 (2006) | | | | | | | | | Have yet to enact any pertinent legislation. *State makes provisions for certain listed diseases to be reportable by health care providers, laboratorians and hospital administrators | |

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