

AN ACT relating to health-facility-acquired infections.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

As used in Sections 1 to 3 of this Act:

(1) "Health facility" means an acute or critical care hospital, physical rehabilitation hospital, surgical center, tuberculosis hospital, nursing facility, ambulatory care center, skilled nursing facility, or nursing home;

(2) "Health-facility-acquired infection" or "HAI" means a localized or systemic condition:

(a) That results from an adverse reaction to the presence of an infectious agent or its toxin;

(b) The timing of which indicates it was contracted while the person was a patient at a health facility; and

(c) Of which there was no evidence that the infection was present or incubating at the time of admission to the acute care setting, unless the infection was related to a previous admission to the same facility; and

(3) "Multidrug-resistant organism" or "MDRO" means any bacterium resistant to three (3) or more classes of antibiotics. In addition, MDRO includes:

(a) Methicillin-resistant staphylococcus aureus (MRSA);

(b) Vancomycin-resistant enterococci (VRE);

(c) Clostridium difficile;

(d) Acinetobacter baumannii;

(e) Ceftazidime-resistant klebsiella; and

(f) Any other organism identified by the federal Centers for Disease Control and Prevention or Kentucky Cabinet for Health and Family Services as a multidrug-resistant organism.

➔ SECTION 2. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

- (1) Within ninety (90) days of the effective date of this Act, each health facility shall implement an infection prevention program for, at a minimum, its intensive care units, surgical units, or other units or areas where there is a significant risk of health-facility-acquired infection. By July 1, 2012, each health facility's infection prevention program shall be implemented throughout the facility.
- (2) As a condition of licensure, a health facility shall implement effective strategies for an infection prevention program in accordance with subsection (1) of this section to prevent the spread of MDROs and any other pathogens designated by the secretary. The strategies shall include but are not limited to:

 - (a) Contact precautions as specified by the federal Centers for Disease Control and Prevention for patients found to be positive for MDROs;
 - (b) Strict adherence to hygiene guidelines that include but are not limited to health facility staff hand-washing prior to and after patient contact;
 - (c) The development of a written infection prevention and control policy with input from front-line caregivers, and the posting of public notices regarding the infection prevention and control policy; and
 - (d) A worker and staff education requirement regarding modes of transmission of MDROs, use of protective equipment, disinfection policies and procedures, and other preventive measures.
- (3) Data regarding health-facility-acquired infections that are publicly reported by the cabinet shall not be used to establish a standard of care.
- (4) The cabinet shall make data publicly available on its Web site at least annually in understandable language with sufficient explanations to allow consumers to draw meaningful comparisons between health facilities as relevant data becomes available. The data shall include but not be limited to:

- (a) The facility's rate of health-facility-acquired infections;
- (b) The rate of health-facility-acquired MDRO infections; and
- (c) The total number of MDRO infections and colonizations found on surveillance testing on admission.
- (5) Health facilities shall report in a timely manner all HAI and MDRO infections and the number, type, and percentage of MDRO infections and colonizations found on surveillance testing. Health facilities shall use the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) reporting system or other data collection method as determined by the secretary for implementation of Sections 1 to 3 of this Act.
- (6) The secretary shall, by July 1, 2012, implement a method for patients to report HAI and MDRO infections to verify the data reported by health facilities.
- (7) The secretary shall serve as chief administrative officer for the health data collection functions under this section. Neither the secretary nor any employee of the cabinet shall be subject to any personal liability for any loss sustained or damage suffered on account of any action or inaction related to this section.
- (8) The secretary shall report by January 30 each year to the Legislative Research Commission and the Governor on the rate and trend of health-facility-acquired infections, the effectiveness of the requirements of this section and Section 3 of this Act on reducing the rate of health-facility-acquired infections, and recommendations for improvement.
- (9) The secretary shall promulgate administrative regulations to implement Sections 1 to 3 of this Act. The administrative regulations shall include a time schedule for health facilities reporting infections to the cabinet.

➔SECTION 3. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

A health facility that violates any provision of Section 2 of this Act shall, for the first

violation, be cited and shall submit a corrective action plan to the cabinet within ten (10) business days of the citation. For a second violation within a six (6) month period, a health facility shall be fined up to one thousand dollars (\$1,000) per day until the violation is corrected. For three (3) or more violations within a six (6) month period, a health facility shall be fined up to ten thousand dollars (\$10,000) for each violation and shall be fined up to one thousand dollars (\$1,000) per day until all violations are corrected.

→ Section 4. The General Assembly finds and declares that:

(1) Over 1.7 million patients in the nation become infected after entering health facilities each year, and about 100,000 die as a result of those infections;

(2) Methicillin-resistant staphylococcus aureus (MRSA) is a common staphylococcal infection that is resistant to powerful antimicrobial agents and is increasingly prevalent in health care settings;

(3) Because it can survive on cloth and plastic for up to 90 days, MRSA is frequently transmitted by contaminated hands, clothes, and noninvasive instruments, and the number of patients who can become infected from one carrier multiplies dramatically;

(4) The federal Centers for Disease Control and Prevention estimates that one in twenty patients entering a health facility carries MRSA and reports that MRSA accounted for 60% of infections in American hospitals in 2004, an increase from 2% in 1974, and still increasing. In 2007, the Association for Professionals in Infection Control and Epidemiology reported that the prevalence of MRSA was increasing eight times more than expected;

(5) The Association for Professionals in Infection Control and Epidemiology reports that the incidence of clostridium difficile is increasing ten times more than expected, and the American Journal of Infection Control reports that Kentucky has the sixth highest rate of infection in the United States;

(6) The nationwide cost to treat hospitalized patients infected with HAI is

estimated to be between 28 to 45 billion dollars. The CDC estimates the increase in cost for ventilator-associated pneumonia, surgical site infections, and catheter-associated bloodstream infections to range from \$28,404 to \$34,670 per patient;

(7) Multidrug-resistant infections are preventable, and recent data support a multifaceted approach to successfully combating infections, including routine screening, isolation of colonized and infected patients, strict compliance with hygiene guidelines, and a change in the institutional culture to ensure that infection prevention and control is everyone's job and is a natural component of care at each patient encounter each day;

(8) Virtually all published analyses that compare the cost of screening patients upon admission and the adoption of effective infection control practices with the cost of caring for infected patients conclude that caring for infected patients is much more expensive;

(9) Routine screening and isolation of all patients with MRSA in hospitals in Denmark and Holland have reduced their MRSA infection rate to 10% of their bacterial infections, and following a pilot program by the United States Department of Veterans Affairs' Pittsburgh Healthcare System that reduced MRSA infections in its surgical care unit by 70%, all Department of Veterans Affairs health facilities have been directed to develop and implement similar procedures, Northwest University reported that the aggregate hospital-associated MRSA disease prevalence density decreased by 69.6% after universal surveillance was instituted;

(10) The federal Centers for Disease Control and Prevention reports that the number of cases of health-facility-acquired infections exceeds the number of cases of any other reportable disease, and more deaths are associated with health-facility-acquired infection than several of the top ten leading causes of death reported in the United States;

(11) The Association for Professionals in Infection Control and Epidemiology (APIC), Society for Healthcare Epidemiology of America (SHEA), Infectious Diseases Society of America (IDSA), Council of State and Territorial Epidemiologists (CSTE),

and Trust for America's Health (TFHA) support public reporting; and

(12) It is a matter of importance for public health and sound fiscal policy that patients in Kentucky's health facilities receive health care that incorporates the best practices in infection control, not only to protect their health and their lives, but also to ensure the economic viability of Kentucky's health facilities.