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:

For the purposes of Sections 1 to 3 of this Act:

(1) "Cabinet" means the Cabinet for Health and Family Services;

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

(3) "Health-facility-acquired infection" means a localized or systemic condition that:

(a) Results from an adverse reaction to the presence of an infectious agent or agents or its toxin or toxins; and

(b) Shows 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;

(4) "Multidrug-resistant organism" means any bacterium resistant to three (3) or more classes of antibiotics that includes but is not limited to:

(a) Methicillin-resistant staphylococcus aureus;

(b) Vancomycin-resistant enterocci;

(c) Clostridum difficile;

(d) Carbapenem-resistant Enterobacteriaceae;

(e) Acinetobacter baumannii;

(f) Ceftazidime-resistant Klebsiella; and

(g) Any other organisms identified by the United States Centers for Disease Control and Prevention or Cabinet for Health and Family Services as a multidrug-resistant organism;

(5) "Secretary" means the secretary of the Cabinet for Health and Family Services.

➔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, a 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 January 1, 2015, a 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 multidrug-resistant organisms 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 multidrug-resistant organisms;

(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 multidrug-resistant organisms, use of protective equipment, disinfection policies and procedures, and other preventive measures.

(3) Health facilities shall not use data regarding facility-acquired infections that are publicly reported to the state to establish a standard of care.

(4) The cabinet shall make data 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 become 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 multidrug-resistant-organisms infections;

(c) The rate of positive conversions of discharge testing at acute and critical care hospitals and long-term care facilities; and

(d) If performed, the total number of multidrug-resistant-organism infections and colonization found on surveillance testing on admission.

(5) All health facilities shall report to the cabinet all health-facility-acquired and multidrug-resistant-organism infections, and if surveillance testing is performed, the type and percentage of multidrug-resistant organisms found in surveillance testing and the rate of positive results on discharge testing in a timely manner.

(6) The secretary shall by July 1, 2014, implement a method for patients to report health-facility-acquired infections to verify the data reported by health facilities.

(7) Nothing in this section shall be construed as mandating a health facility to perform surveillance testing.

(8) 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.

(9) 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 Sections 1 to 3 of this Act on reducing the rate of health-facility-acquired infections, and recommendations for improvement.

(10) The secretary shall promulgate administrative regulations to implement Sections

1 to 3 of this Act.

➔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 twenty thousand dollars ($20,000) for each violation and shall be fined up to two thousand dollars ($2,000) per day until all violations are corrected.

➔Section 4. The General Assembly finds and declares the following:

(1) Over 1.7 million patients in the United States 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) MRSA can survive on cloth and plastic for 90 days and is frequently transmitted by contaminated hands, clothes, and noninvasive instruments and the number of patients who can become infected from one carrier multiples dramatically;

(4) The U.S. Centers for Disease Control and Prevention estimates that one in 20 patients entering a health facility carries MRSA and that MRSA has accounted for 60 percent of infections in U.S. hospitals since 2004;

(5) The Association for Professionals in Infection Control and Epidemiology states that the prevalence of MRSA was increasing eight times more than expected;

(6) The Association for Professionals in Infection Control and Epidemiology states that the incidence of Clostridum difficile is increasing ten times more than

expected;

(7) The nationwide cost to treat hospitalized patients infected with health-facility-acquired infections is estimated to be between 28 to 45 billion dollars;

(8) Multidrug-resistant infections are preventable, and recent data support a multifaceted approach to successfully combat infections that includes 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 daily patient encounter;

(9) The U.S. Centers for Disease Control and Prevention states that the number of cases of health-facility-acquired infections exceeds the number of cases of any other reportable disease and that more deaths are associated with health-facility-acquired infections than several of the top ten leading causes of death in the U.S.;

(10) The U.S. Centers for Disease Control and Prevention and other professional health care associations have stated that public reporting of health-facility-acquired infections should be a part of an infection control program; and

(11) It should be a matter of public health and fiscal policy that patients in Kentucky's health facilities receive health care that incorporates 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.