TO: Representative Bethell
FROM: Thomas L. Bell, President
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DATE: January 19, 2005
RE: Public Reporting of Hospital Infection Rates

The Kansas Hospital Association (KHA) has become aware of the effort led by a national consumer group 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 challenging as hospitals take care of sicker patients and fight infections that are increasingly resistant to even the best medications.

Though KHA is committed to supporting proactive measures to ensure quality health care in Kansas, we recognize that initiatives such as the one led by national organizations often fail to acknowledge existing local, state, and national efforts to address the problem and lack qualitative data that indicates a public benefit.

Under Kansas law, "nosocomial infection" means "an infection originating in a medical facility." Although certain infections manifest themselves during a hospital stay, it is not always clear where they originated. Some infections may be acquired long before admission by prior exposure to microorganisms such as bacteria and viruses that are already present in the patient's body or in the patient's environment. In addition, the type of infection, the care site where it was contracted and the overall health of the patient are variables that affect the ability to create a precise definition of "hospital-acquired infection." The lack of a universal measure for defining nosocomial infections makes it very difficult to effectively analyze information about such conditions without a solid clinical understanding of the nature of the organisms and the methods of infection and transmission.

**Current Kansas Law Requirements**

Despite these difficulties, Kansas hospitals and public health authorities are, and have been for many years, actively involved in many efforts to report and reduce all incidents of infectious diseases. First, health care providers, laboratories and hospitals are required by Kansas law (K.S.A. 65-118, 65-128, 65-6001 through 65-6007, K.A.R. 28-1-1, 28-1-4 and 28-1-18) to report selected infectious/communicable diseases and conditions. Local
health departments are then responsible for investigating the reports and instituting basic public health interventions. The Kansas Department of Health and Environment (KDHE) may disclose to the public certain statistical data obtained through disease reporting. To the extent some of the reportable infections are hospital-acquired, and thus, hospital reported, the reporting mechanism in Kansas already includes "nosocomial infections."

Moreover, even if nosocomial infections were separately tracked, the value of the raw data / information would likely be minimal. In its 2003 summary of Reportable diseases in Kansas the KDHE acknowledged that interpretation of the data may not be particularly meaningful in certain situations due to variables such as reporting patterns, disease variations, and random fluctuations. In addition, the KDHE has recognized that small case numbers of particular diseases often produces artificially high disease rates and unstable, widely fluctuating disease trends. Finally, it is difficult to accurately compare the data between hospitals. In a report of the National Nosocomial Infection Surveillance System, the Centers for Disease Control and Prevention recognized that certain acquired data must be "risk adjusted" in order to create a valuable comparison and that at times there was insufficient data to draw particular conclusions. These factors should be carefully considered before creating additional public reporting requirements.

Centers for Medicare and Medicaid Services

In addition to state reporting laws, many Kansas hospitals voluntarily participate in a program involving submission of performance data to the Centers for Medicare and Medicaid Services (CMS) to provide useful and valid information about hospital quality. The quality measurements are currently on a website for health professionals which can be found at www.cms.hhs.gov and will be made available to the public in late March at www.medicare.gov. Beginning February 15, 2005, the CMS quality initiative will expand beyond the initial 10 quality measurements to include hospital data on surgical infection rates. The new measures are aimed at reducing morbidity and mortality associated with postoperative infections. Specifically, hospitals will begin reporting data on the proportion of patients who received prophylactic antibiotics within one hour before surgical incision, the proportion of patients given prophylactic antibiotics consistent with current recommendations, and the proportion of patients who received prophylactic antibiotics whose antibiotics were discontinued within 24 hours after surgery.

Centers for Disease Control and Prevention

Also, as you may be aware, the Centers for Disease Control and Prevention (CDC), in conjunction with the Healthcare Infection Control Practices Advisory Committee, has developed extensive guidelines for infection control procedures in hospitals. Some examples include guidelines on environmental infection control, hand hygiene, and the prevention of surgical site infections. Through its National Nosocomial Infections Surveillance System, the CDC has also created a database to track nosocomial infections in demonstration hospitals. This data is used by the CDC and hospitals to review antimicrobial resistance trends and determine nosocomial infection rates to use for comparison purposes.
Finally, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which is the accrediting entity for 43 hospitals in Kansas and across the country, is addressing the issue in a number of ways. First, it 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 became effective January 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 JCAHO also 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 CDC 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. Finally, as part of the JCAHO’s ORYX initiative (an initiative that integrates outcomes and other performance measurement data into the hospital accreditation process) JCAHO has developed a new measure set on surgical infection prevention. That data will ultimately become part of the JCAHO public reports.

As you can see, there are numerous infection control activities and efforts aimed at reducing the incidence of nosocomial infections. Kansas hospitals remain committed to providing quality care and providing meaningful information for the population it serves. For all of the reasons cited above, KHA believes that state legislation to create new reporting requirements for hospital-acquired infections would waste precious healthcare resources by duplicating quality initiatives already underway, overlapping with existing regulatory requirements, adding costs to the state with very little return on the investment, and creating unnecessary confusion and fear among patients.