SUBJECT: Reporting of health care associated infections

COMMITTEE: Public Health — committee substitute recommended

VOTE: 9 ayes — Delisi, Laubenberg, Jackson, Cohen, Coleman, Gonzales, S. King, Olivo, Truitt

0 nays

WITNESSES: For — Shelton Green, Texas Association of Business; Robert Haley, Texas Medical Association; Suzanne Henry, Consumers Union; Rebecca Ross Colvin, Sid Peterson Memorial Hospital; Dan Stultz, Texas Hospital Association; Starr West, Texas Hospital Association; Thomas DeChant; Lynda Watkins; (*Registered, but did not testify:* Carolyn Belk, The Methodist Hospital System; Ed Berger, SETON Family of Hospitals; Pamela Bolton, Texas Watch; Marsha Jones, Texas Children's Hospital; Carrie Kroll, Texas Pediatric Society; Glen Maxey, National Nurses Organizing Committee; Michele O'Brien, CHRISTUS Santa Rosa Healthcare; David Pearson, Texas Organization of Rural and Community Hospitals; Sarah Sinclair, Memorial Hermann Healthcare System; Bryan Sperry, Children's Hospital Association of Texas; Charles Stuart, Blue Cross Blue Shield of Texas; Matthew Wall, Texas Hospital Association; Dorrine DeChant)

Against — None

On — Tom Betz, Texas Department of State Health Services; (*Registered, but did not testify:* Jane Guerrero, Neil Pascoe, Department of State Health Services)

BACKGROUND: Health care-associated infections are infections that patients acquire during the course of receiving treatment for other conditions. The enactment of SB 872 by Nelson by the 79th Legislature in 2005 created the Advisory Panel on Health Care Associated Infections, which produced an interim report studying emerging practices for the prevention of hospital-acquired infections.

DIGEST: CSHB 1398 would require the Department of State Health Services (DSHS) to establish the Texas Health Care-Associated Infection Reporting System within the infectious disease surveillance and

epidemiology branch of the department. The reporting system would allow health care facilities to report health care-associated infections to DSHS, which would make this information publicly available. The reporting system also would allow for education and training of health care facility staff.

At state expense, data would be collected through a secure, electronic interface with health care facilities to accurately report on patients allowing for a risk adjustment of the facilities' infection rates. DSHS would review the infection control and reporting activities of health care facilities to ensure the data provided were valid and plausible.

The bill would specify the types of infections that health care facilities, pediatric and adolescent hospitals, and general hospitals would be required to report to the department. Alternative reporting requirements would exist for health care facilities that did not perform at least 50 reportable procedures per month to report infection rates on the three most common surgical procedures. Facility reporting would not be required more frequently than once per quarter.

At least annually, DSHS would make a risk-adjusted summary of infections reported by each facility publicly available. Health care facilities could attach written comments to the summary. Summaries or other disclosures could not contain the name of a patient or anyone associated with a health care facility in connection with a specific infection incident. The summary would be available on the Internet and through other publicly accessible means.

DSHS would educate and train health care facility staff regarding use of the reporting system. Except for the summaries and information shared within DSHS, information gathered by DSHS or a health facility would be confidential. Such information would not be subject to disclosure requirement or other legal compulsion and could not be admitted as evidence in a legal action. This would not limit a patient's access to the patient's own records.

Publicly reported information could not be used to establish a standard of care in a civil action. A general hospital in violation of this bill, with the exception of those providing medical rehabilitation services, would be subject to the enforcement provisions of the Hospital Licensing Law.

Ambulatory surgical centers would be subject to enforcement standards in the Texas Ambulatory Surgical Center Licensing Act.

The bill would create the Advisory Panel on Health Care-Associated Infections within DSHS to guide the implementation, development, maintenance, and evaluation of the reporting system. The advisory panel could recommend modifications to the list of infections that would be reported. The bill would specify the composition of the 16-member panel to include infection control professionals, physicians, performance improvement professionals, officers of certain health care facilities, consumers, and DSHS non-voting representatives. Lobbyists and individuals paid by a Texas trade association could not participate on the panel. Members of the panel would not be compensated but could have travel expenses reimbursed.

HHSC would adopt rules and procedures necessary to implement the bill, and DSHS would appoint the advisory panel members as soon as practicable following the effective date. DSHS would have to establish the reporting system by June 1, 2008

This bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2007.

SUPPORTERS SAY:

CSHB 1398 would benefit the health of Texans and save the state millions in health care costs. The Centers for Disease Control and Prevention (CDC) estimates that two million Americans acquire health care associated infections each year, and 90,000 die from these infections. CSHB 1398 would implement the expert recommendations provided by the Advisory Panel on Health Care-Associated Infections, which included agency, health care, and consumer representation. Sixteen states have enacted legislation regarding public reporting on health care-associated infections.

The bill would give hospitals a mechanism to compare their infection rates to those of similar facilities. In exposing hospitals with a relatively higher incidence of health care associated infections, the bill would encourage these facilities to more actively pursue ways to decrease infection rates. CSHB 1398 also would identify hospitals with relatively low rates of infection, so these hospitals could be studied to develop best practices for decreasing infection rates. A long-term decrease in infection rates would

spare Texans costs not only in monetary terms but also in terms of human welfare. The bill would provide a fundamental measure of patient safety allowing consumers to compare infection rates before choosing the facility at which they would undergo a procedure.

CSHB 1398 would be unique among other states' legislation on reporting of health care-associated infections because it would recognize that children often receive different treatments than adults. The bill would help health care facilities and consumers gain insight into infection rates for treatments specific to children.

The bill would take an appropriately measured and phased approach to adding reporting requirements for health care-associated infections. While in the long term it would be beneficial to require reporting requirements on all types of infections, a more expansive program would take longer to implement. CSHB 1398 would allow more infection types to be added as the reporting system proves stable and effective in addressing the current infection types.

The bill appropriately would exclude reported infection rates from being used to establish a standard of care in civil cases, because the reported rates would be risk adjusted to account for different procedures that inherently have higher risks of infection. While the risk adjustment does speak better to the relative infection rates at different facilities, there is no way to make a comparison that is certain enough to establish a standard of care. Civil suits instead should rely on the facts of the specific case under consideration.

Finally, the legal protections in the bill would provide a solid balance between encouraging health care facilities to report all required health care-associated infections, yet not going so far as to preclude patients from being able to use all information pertinent to their cases in legal actions

OPPONENTS SAY:

CSHB 1398 should not prevent civil litigants from using publicly reported infection rates as the standard of care in a civil action. If the information to be provided by public reports was accurate enough to be used as a comparison between infection rates at various facilities, then this information should represent a valid basis for standard of care. The government should not restrict the use of public information. If reporting reflects that a facility has a relatively higher incidence of a particular type of infection, it would be a reasonable argument for a litigant, combined

with other case-specific facts, to suggest that a health care facility was liable for causing a patient's infection.

OTHER OPPONENTS SAY:

While this bill would be a positive step toward curbing the incidence of some types of health care associated infections, the bill would be of greater benefit if it required reporting on all types of health care-related infections. Such legislation has been enacted in Pennsylvania. In addition, it would be more cost effective to incorporate reporting for all types of infections in the initial development of the reporting system than restructuring the reporting system later as other types of infections were added.

Finally, the bill should contain absolute privilege for information submitted by health care facilities pertaining to health care-associated infections. Such information should not be used in any form against the facility or related persons in a legal action. Failure to provide adequate legal protections of information submitted by hospitals and health care facilities would violate patient confidentiality and could cause some facilities to withhold information about health care-associated infections and hinder accurate and complete reporting.

NOTES:

HB 1398 as introduced would not have provided for risk adjustment of infection rates or DSHS review of infection control and reporting activities through trend analysis. The original bill did not include enforcement provisions under the Hospital Licensing Act or the Texas Ambulatory Surgical Center Licensing Act. The bill as introduced would have provided absolute privilege for information submitted by health care facilities, and this information could not have been used in any form against the facility or related persons in a legal action. The original bill would not have specified that all definitions would be based on those provided by the CDC.

A similar bill, HB 1885 by Vo, was left pending in the House Public Health Committee. Another similar bill, SB 288 by Nelson, passed the Senate by 30-0 on April 4 and was reported favorably, as substituted, by the House Public Health Committee on April 23. CSSB 288 is almost identical to CSHB 1398.

The fiscal note indicates CSHB 1398 would cost $2.3 million in general revenue-related funds during fiscal 2008-09. The cost would include the development of the Texas Health Care Associated Infection Reporting

System, reimbursement for advisory committee member travel, salary for five FTEs to develop a training program in fiscal 2008, and salary for 13 FTEs in 2009 and each year thereafter for training and report compilation.