MENU OF SELECTED PROVISIONS

In Healthcare-Associated Infection Laws

A Companion to the CDC-ASTHO Toolkit, *Eliminating HAI: State Policy Options*

August 2012

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

The Menu of Selected Provisions in Healthcare-Associated Infection Laws is a publication of the Public Health Law Program in the Office for State, Tribal, Local and Territorial Support, in collaboration with the Division for Healthcare Quality Promotion in the National Center for Emerging and Zoonotic Infectious Diseases, at the Centers for Disease Control and Prevention (CDC). For additional information or technical assistance on legal issues related to healthcare-associated infection laws, please contact the CDC Public Health Law Program at 404-498-0470.

To view this publication online, visit http://www.cdc.gov/phlp/.

Disclaimer: Information contained in this document does not constitute legal advice and does not represent the legal views of CDC or the U.S. Department of Health and Human Services. Use of any provision herein should be considered only in conjunction with advice from legal counsel. Provisions may need to be modified, supplemented, or replaced to ensure appropriate citation to, or compliance with, relevant laws or to otherwise address the needs or requirements of a specific jurisdiction.

CONTENTS

INTRODUCTION

In 2010, the Centers for Disease Control and Prevention (CDC) and its partners in the field of infection control proposed a call to action in both the *American Journal of Infection Control* and *Infection Control & Hospital Epidemiology* charging health care providers to eliminate healthcare-associated infections (HAIs) through increasing adherence to evidence-based guidelines. Responding to numerous governmental and private sector activities initiated following the publication of that white paper, CDC and the Association for State and Territorial Health Officials (ASTHO) began a collaboration to study and educate about HAI policies and programs in states. Because state health agencies are responsible for protecting patients across the healthcare system and serve as a bridge between private healthcare entities and the public, state-run HAI programs play a central role in HAI elimination.

CDC and ASTHO jointly released a toolkit resulting from this collaboration in March 2011 titled *Eliminating Healthcare-Associated Infections: State Policy Options* (the toolkit).[1] To support the development of the toolkit, ASTHO assembled an expert working group of leaders in HAI prevention from across the country, including state health agency staff, legislative liaisons, state health agency legal counsel, infection preventionists, epidemiologists, and consumer advocates. The resulting document assesses the landscape of policies employed by states to advance HAI prevention and describes the major topics that provide the foundation for policy-related work on HAIs. The toolkit may be used by policy-makers to inform the choices they make to select and promote HAI elimination policies in states.

This Menu of Selected Provisions in Healthcare-Associated Infection Laws (the menu) supplements the information provided in the toolkit. The menu provides useful examples of provisions among 33 existing statutes from states and 1 territory that authorize state action related to HAIs.[2] These statutes are categorized by the same major HAI topic areas (topics) discussed in the toolkit and rely primarily on laws in states where CDC and ASTHO engaged stakeholders in a second phase of the project to examine the early impacts of state programs. The menu does not discuss regulatory provisions and is not intended to provide recommendations concerning HAI legislation. Instead, the menu will be useful for legal practitioners involved in drafting HAI legislation who seek examples of state statutory provisions related to important HAI topics. Similarly, the menu will aid policy-makers who must apply administrative law principles to craft legislative language reflecting HAI topics chosen by state policy-makers using the toolkit as a guide.

[1] Association Of State and Territorial Health Officials, Eliminating Healthcare-Associated Infections: State Policy Options (2011) (hereinafter "Toolkit").

[2] As of December 31, 2011, the states with relevant HAI provisions were Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, and the territory of Puerto Rico. The District of Columbia and Indiana included HAI-related provisions in state health regulations, but the menu only reviews statutory provisions and therefore does not discuss these regulatory requirements in detail.

MAJOR HAI TOPICS IN STATE LEGISLATION

This menu relies on prior analysis and evaluation work conducted by CDC and ASTHO. It highlights provisions related to the major topics discussed in the toolkit and examines unique examples of statutes from many states with HAI laws in place. Where relevant, sections of the menu cite sections of the toolkit that highlight some of the choices available to decision-makers for each topic. The major substantive topics covered include:

- authorities granted to state health agencies;
- definitions for the infections and facilities covered under laws;
- advisory councils;
- pilot phases for state programs;
- reporting requirements;
- licensure and training requirements;
- financial incentives and disincentives; and
- protection of HAI data.

These provisions support discrete functions of state HAI programs and aid in program implementation.

The first section of the menu gives a brief description of how HAI statutes confer authority to state health agencies. The second section provides an overview of definitions in HAI laws. The third and following sections describe the establishment and function of advisory councils and pilot phases for new HAI programs.

The majority of the menu focuses on the reporting pathways detailed in HAI laws, beginning with reporting by facilities to the state health agency. In addition, the menu captures reporting from facilities to the National Healthcare Safety Network (NHSN), the online surveillance system managed by CDC that is the gold standard for collecting HAI surveillance data. Finally, the menu discusses reporting from the state health agency to the governor or legislature and to the public.

The menu also covers how different states sustain and enforce HAI programs, particularly including licensing and training requirements and financial incentives and disincentives. The discussion of the major HAI topics ends with an overview of protections for data identifying patients, providers, and facilities. The menu concludes with a short discussion of its limitations and other resources.

This document was drafted by researchers in the Public Health Law Program in the Office for State, Tribal, Local and Territorial Support,[3] with assistance from the Division of Healthcare Quality Promotion in the National Center for Emerging and Zoonotic Infectious Diseases,[4] and the Office of the General Counsel at CDC.[5] For further technical assistance on this menu or HAI laws, please contact the Public Health Law Program.[6] For all other technical assistance on HAIs, please contact the Division of Healthcare Quality

[3] Tara Ramanathan, J.D., M.P.H., Carla Chen, J.D., and Matthew Penn, J.D., M.L.I.S.
[4] Elizabeth Skillen, Ph.D., Elizabeth Mothershed, M.S., and Jeremy Goodman, M.B.A.
[5] Heather Horton, J.D., M.H.A.
[6] Public Health Law Program, Centers for Disease Control and Prevention, 4770 Buford Hwy. N.E., M.S. E-70, Atlanta, GA 30341. Telephone: (404) 498-0470. Fax: (404) 498-6882. E-mail: mpenn@cdc.gov.
Web: http://www.cdc.gov/phlp.

Promotion.[7] Quotations are taken from relevant state HAI provisions and abbreviated or contracted only where laws covered multiple topics and such edits would not be substantive.

HAI Program Authority [8]

HAI statutes describe the state health agency's authority to create and implement an HAI program. States choose to define these authorities in different ways. Twenty-two states provide broad or general statutes that confer discretion to the regulatory process, thereby avoiding a legislative determination of specific methods or procedures for tracking and reporting.[9] In New York, for example

> "The department shall establish guidelines, definitions, criteria, standards and coding for hospital identification, tracking and reporting of hospital acquired infections which shall be consistent with the recommendations of recognized centers of expertise in the identification and prevention of hospital acquired infections including, but not limited to the National Health Care Safety Network of the Centers for Disease Control and Prevention or its successor. The department shall solicit and consider public comment prior to such establishment."[10]

Other states, such as California and Colorado, opt not to delegate authority to the regulatory process, but instead outline detailed provisions in statute.[11]

Depending on a state's rulemaking procedures, delegating authority may be advantageous to the topic of HAIs, given that the pathogens, procedures, and programs rapidly change with scientific advances. Several states incorporate this into their statutes to ensure that the law stays current with the evidence base. For example, 12 states explicitly allow for incorporating new infections within the HAI statute as they arise.[12]

---

[7] Division of Healthcare Quality Promotion, National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention, 1600 Clifton Road, Atlanta, GA 30039. E-mail: eskillen@cdc.gov. Web: http://www.cdc.gov/HAI/index.html.

[8] For a broader policy discussion, *see* Toolkit, *supra* note 1, at 11.

[9] *See, e.g.,* Ala. Code § 22-11A-114(b) (2009); Ark. Code Ann. § 20-9-1204(e) (West 2011); Cal. Health & Safety Code § 1288.8(c) (West 2006); Colo. Rev. Stat. Ann. § 25-3-602(5)(a) (West 2006); 16 Del. Code Ann. tit. 16, § 1003A(a)(4) (2007); Fla. Stat. Ann. § 408.061(1)(a) (West 2006); Md. Code Ann., Health-Gen. § 19-134(e) (West 2006); Mass. Gen. Laws ch. 111, § 51H(b) (2008); Mo. Ann. Stat. § 192.667(12) (West 2004) (referring to categories of nosocomial infection incidence rates); Nev. Rev. Stat. Ann. § 439.847(4) (West 2009); N.H. Rev. Stat. Ann. § 151:33(III) (2006); N.J. Stat. Ann. § 26:2H-12.45 (West 2007); N.Y. Pub. Health Law § 2819(2)(c) (McKinney 2005); N.C. Gen. Stat. Ann. § 130A-150(b) (West 2011); Ohio Rev. Code Ann. § 3727.41(B) (West 2008); 2007 Or. Laws, Ch. 838, §3; R.I. Gen. Laws § 23-17.17-9(e) (2008); R.I. Gen. Laws § 23-17.17-6(a)(9)(ii)(a)(VI) (West 2011); S.C. Code Ann. § 44-7-2430(D) (2006); Tenn. Code Ann. § 68-11-264(b)(2) (2006); Tex. Health & Safety Code Ann. § 98.103(d-1) (Vernon 2007); Vt. Stat. Ann. tit. 18, § 9405b(a)(3) (2007); Va. Code Ann. § 32.1-35.1 (2005); and Wash. Rev. Code Ann. § 43.70.056(3) (West 2007).

[10] N.Y. Pub. Health Law § 2819 (McKinney 2005).

[11] Cal. Health & Safety Code § 1288.45 et seq. (West 2006); Colo. Rev. Stat. Ann. § 25-3-601 et seq. (West 2006).

[12] Ala. Code § 22-11A-114(b) (2009); Ark. Code Ann. § 20-9-1204(e) (West 2011); Cal. Health & Safety Code § 1288.8(c) (West 2006); Colo. Rev. Stat. Ann. § 25-3-602(5)(b) (West 2006); Del. Code Ann. tit. 16 § 1003A(d) (2007); Nev. Rev. Stat. Ann. § 439.802 and 439.890 (West 2005); N.H. Rev. Stat. Ann. § 151:33(III) (2011); N.M. Stat. Ann. § 24-29-5(c) (2009); N.Y. Pub. Health Law § 2819(2)(f) (McKinney 2005); R.I. Gen. Laws § 23-17.17-6(a)(9)(ii)(a)(VI) (West 2011); S.C. Code Ann. § 44-7-2430(D) (2006); Wash. Rev. Code Ann. § 43.70.056(3) (West 2007).

Definitions

States differ in their definitions and descriptions of terms important to HAI prevention. Typically, HAI laws name the types of facilities, providers, and infections covered, etc. States offer a variety of terms for defining the scope of an HAI, using "hospital-acquired," "facility-acquired," or "hospital-associated" to match the focus of the statute. To aid in statutory interpretation, jurisdictions have standardized the definition of an HAI over time. For purposes of reporting data for federal reimbursement, and due to a growing number of facilities interested in collecting and reporting data, CDC and NHSN have chosen to use the term "healthcare-associated infections." States such as Pennsylvania and Massachusetts specifically define a healthcare-associated infection as

> "[a] localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that: (1) occurs in a patient in a health care setting; (2) was not present or incubating at the time of admission, unless the infection was related to a previous admission to the same setting; and (3) if occurring in a hospital setting, meets the criteria for a specific infection site as defined by the Centers for Disease Control and Prevention and its National Healthcare Safety Network."[13]

Other laws incorporate NHSN definitions by reference rather than listing them in the HAI statute in order to facilitate the use of NHSN software for HAI data collection. For example, in Tennessee "[f]acilities shall meet data reporting timeframes as required by NHSN and shall utilize standard methods, including healthcare acquired case-finding techniques, CDC infection definitions and other relevant terms."[14]

Advisory Councils[15]

Twenty-two states chose to appoint an advisory council or similar committee of experts and stakeholders to oversee the development or continued functioning of HAI programs.[16] States may require the appointment of an advisory committee with a broad statement of purpose. For example, Colorado's HAI statute reads "the executive director of the department shall appoint an advisory committee. . . [to] assist the department in development of the oversight of this article and the department's methodology for disclosing the information collected[,] . . . including the methods and means for release and dissemination."[17]

Some statutes also establish Advisory Councils, define their membership, and describe their authority. Some jurisdictions define the membership of these committees with specificity, to ensure that numerous

---

[13] Mass. Gen. Laws ch. 111, § 51H (2008); 40 Pa. Cons. Stat. § 1303.402 (2007).
[14] Tenn. Code Ann. § 68-11-263(a) (2006).
[15] *See* Toolkit, *supra* note 1, at 21.
[16] Ala. Code § 22-11A-118 (2009); Ark. Code Ann. § 20-9-1204 (West 2011); Cal. Health & Safety Code § 1288.5 (West 2006); Colo. Rev. Stat. Ann. § 25-3-602(4) (West 2006); Conn. Gen. Stat. Ann. § 19a-490n(b) (West 2006); 16 Del. Code Ann. tit. 16, § 1003A(c) (2007); Fla. Stat. Ann. § 408.061(1) (West 2006); 210 Ill. Comp. Stat. 86/25(c)(1) (2004); Mo. Ann. Stat. § 197.165 (West 2004) (referring to nosocomial infection incidence rates); N.J. Stat. Ann. § 26:2H-12.45 (West 2007); N.M. Stat. Ann. § 24-29-3 (2009); N.C. Gen. Stat. Ann. § 130A-150(e) (West 2011); Ohio Rev. Code Ann. § 3727.32 (West 2008); Okla. Stat. Ann. tit. 63, § 1-707(C) (West 2006); 2007 Or. Laws, Ch. 838, §4; 40 Pa. Cons. Stat. § 1303.405(b)(7) (2007); R.I. Gen. Laws § 23-17.17-6(a)(9)(i) (West 2011); S.C. Code Ann. § 44-7-2430(c) (2006); Tenn. Code Ann. § 68-11-264(b) (2006); Tex. Health & Safety Code Ann. § 98.051 (Vernon 2007); Wash. Rev. Code Ann. § 43.70.056(5) (West 2007); W. Va. Code § 16-5B-17(b) (2008).
[17] Colo. Rev. Stat. § 25-3-602 (2006).

diverse stakeholders are involved in the decision-making for HAI prevention activities and reporting to the public. Texas law requires that

> "The advisory panel is composed of 18 members as follows: (1) two infection control professionals who: (A) are certified by the Certification Board of Infection Control and Epidemiology; and (B) are practicing in hospitals in this state, at least one of which must be a rural hospital; (2) two infection control professionals who: (A) are certified by the Certification Board of Infection Control and Epidemiology; and (B) are nurses licensed to engage in professional nursing under Chapter 301, Occupations Code; (3) three board-certified or board-eligible physicians who: (A) are licensed to practice medicine in this state under Chapter 155, Occupations Code, at least two of whom have active medical staff privileges at a hospital in this state and at least one of whom is a pediatric infectious disease physician with expertise and experience in pediatric health care epidemiology; (B) are active members of the Society for Healthcare Epidemiology of America; and (C) have demonstrated expertise in quality assessment and performance improvement or infection control in health care facilities; (4) four additional professionals in quality assessment and performance improvement; (5) one officer of a general hospital; (6) one officer of an ambulatory surgical center; (7) three nonvoting members who are department employees representing the department in epidemiology and the licensing of hospitals or ambulatory surgical centers; and (8) two members who represent the public as consumers. . . . Members of the advisory panel serve two-year terms."[18]

Statutes can also provide specific authorities to the advisory committee, requiring certain functions or prescribing various duties. Washington requires certain functions as follows:

> "The advisory committee shall make recommendations to assist the department in carrying out its responsibilities under this section, including making recommendations on allowing a hospital to review and verify data to be released in the report and on excluding from the report selected data from certified critical access hospitals. Annually, beginning January 1, 2011, the advisory committee shall also make a recommendation to the department as to whether current science supports expanding presurgical screening for methicillin-resistant staphylococcus aureus prior to open chest cardiac, total hip, and total knee elective surgeries. . . . In developing its recommendations, the advisory committee shall consider methodologies and practices related to healthcare-associated infections of [CDC, CMS], the Joint Commission, the National Quality Forum, the Institute for Healthcare Improvement, and other relevant organizations."[19]

A statute that prescribes specific duties for the advisory committee may still authorize the state health agency to expand those duties if necessary. For example, in West Virginia

> "The advisory committee shall: (1) [p]rovide guidance to hospitals in their collection of HAI; (2) [p]rovide evidence-based practices in the control and prevention of HAI, (3) [e]stablish reasonable goals to reduce the number of HAI; (4) [d]evelop plans for analyzing infection-related data from hospitals; (5) [d]evelop healthcare-associated advisories for hospital distribution; (6) [r]eview and recommend to the West Virginia Health Care Authority the manner in which the reporting is made available to the public to assure that the public understands the meaning of the report; and (7) [o]ther duties as identified by the West Virginia Health Care Authority."[20]

[18] Tex. Health & Safety Code Ann. § 98.052 (Vernon 2007).
[19] Wash. Rev. Code § 43.70.056 (2007).
[20] W. Va. Code § 16-5B-17 (2008).

Pilot Phases[21]

Six states introduced short-term requirements to test implementation and address challenges before expanding the operation of their HAI programs. These statutes differ in what they require. Alabama, Hawaii, and New York require an initial report to be produced before continuing the HAI program;[22] Arkansas seeks public comment on its proposed data collection and analysis methodology before beginning public disclosure of HAI rates;[23] Arkansas and New Hampshire require the tracking of an initial set of infections before expanding their reporting programs;[24] and Rhode Island requires hospitals to report before incorporating other healthcare facilities into the state program.[25]

Even within these pilot phases, states have found unique ways to begin their HAI programs. New York's statute authorized a pilot program to run for 1 year, with all data protected from public identification for 1 year in order to "ensure, by various means, including any audit process referred to in subdivision seven of this section, the completeness and accuracy of hospital acquired infection reporting by hospitals. . . . After the pilot phase is completed, all data submitted under this section and compiled in the statewide hospital acquired infection database established herein and all public reports derived therefrom shall include hospital identifiers."[26]

Rhode Island authorized and directed its director of health "to develop a state health care quality performance measurement and reporting program . . . [that] shall be phased in over a multi-year period and shall begin with the establishment of a program of quality performance measurement and reporting for hospitals. In subsequent years, quality performance measurement and reporting requirements will be established for other types of health care facilities such as nursing facilities, home nursing care providers, other licensed facilities, and licensed health care providers as determined by the director of health."[27]

States considering pilot phases should note that the new Centers for Medicare & Medicaid Services (CMS) Hospital Compare website may impact the type of information disclosed to the public automatically through NHSN and craft statutory language accordingly.[28] Hospital Compare discloses some of the HAI-related information reported to CMS as part of the reimbursement process. This public reporting through Hospital Compare of state HAI information may lessen the need or desire for certain aspects of a non-public, state-based pilot phase.

---

[21] *See* Toolkit, *supra* note 1, at 19.

[22] Ala. Code § 22-11A-113 (2009); see also Haw. Rev. Stat. § 325-2.5(c) (2011) (allowing for the first year of reporting to be a pilot test of the reporting system that is not reported or disclosed to the public); N.Y. Pub. Health Law § 2819 (McKinney 2005).

[23] Ark. Code Ann. § 20-9-1204 (West 2011).

[24] *Id.;* N.H. Rev. Stat. Ann. § 151:33(II) (2006).

[25] R.I. Gen. Laws § 23-17.17-3 (2006).

[26] N.Y. Pub. Health Law § 2819 (McKinney 2005).

[27] R.I. Gen. Laws § 23-17.17-3 (2006).

[28] *See generally* Centers for Medicare & Medicaid Services, *Hospital Compare* home page, http://hospitalcompare.hhs.gov/ (last visited March 30, 2012) (hereinafter *"Hospital Compare"*).

Reporting Requirements[29]

The central provisions in all HAI statutes currently relate to reporting. Typically, HAI data for certain healthcare facilities are collected, delivered to a single source, and then prepared for dissemination to various other entities. Reporting requirements may vary by facility, provider, infection, or frequency. The following information pertains to statutory requirements for reporting, including the objects and methods of data collection, data validation and risk adjustment, and defining the pathways for reporting information on HAI rates.

Statutes may identify the methods and objects for data collection and reporting. A typical HAI statute, such as South Carolina's, considers

1. the methodology for reporting, including the collection, format, method, and frequency of reporting and dissemination of information;
2. the regular evaluation of the methodology and the information reported and validated for quality and accuracy;
3. the information collected as the number of HAI cases reported or rates of HAIs, and, for rates, whether risk adjustment, comparative information from other facilities in the state, or national benchmarks will be included;
4. HAIs and related surgical procedures that must be tracked, whether specified, left to the state health agency to define in regulations, or suggested with an opportunity to phase in future types of HAIs as needed;
5. the criteria for determining which HAIs are reported that are used by the HAI advisory committee, national organizations, or other sources, and whether they are listed or referenced in the state statute; and
6. the use of an executive summary or plain or easily-understandable language for public education purposes in the reports published.[30]

These provisions will be described further in the following sections.

(1) Methodology for Reporting

States can mandate reporting methodology or delegate the responsibility for identifying reporting methodology to the advisory committee. Illinois' statute specifies that:

> "[n]one of the information the Department discloses to the public may be made available in any form or fashion unless the information has been reviewed, adjusted, and validated. . . . The advisory committee must be meaningfully involved in the development of all aspects of the Department's methodology for collecting, analyzing, and disclosing the information collected under this Act, including collection methods, formatting, and methods and means for release and dissemination. [] The entire methodology for collecting and analyzing the data shall be disclosed to all relevant organizations and to all hospitals that are the subject of any information to be made available to the public before any public disclosure of such information."[31]

[29] *See* Toolkit, *supra* note 1, at 14.
[30] S.C. Code Ann. §§ 44-7-2430, 44-7-2440 (2006).
[31] 210 Ill. Comp. Stat. 86/25(c) (2004).

In response to demand for more efficient reporting, the most recent HAI statutes specify that reporting must be done electronically through NHSN or where the means for electronic systems for reporting are available.[32] For example, in North Carolina,

> "By December 31, 2011, the Department, in consultation with the State HAI Advisory Group and in accordance with rules adopted by the Commission . . . shall establish a statewide surveillance and reporting system for specified healthcare-associated infections. [] The Commission shall adopt rules necessary to implement the statewide surveillance and reporting system established. The rules shall specify uniform standards for surveillance and reporting of specified healthcare-associated infections under the statewide surveillance and reporting system. The uniform standards shall include at least all of the following: (1) [a] preference for electronic surveillance of specified healthcare-associated infections to the greatest extent practicable [and] (2) [a] requirement for electronic reporting of specified healthcare-associated infections."[33]

(2) Quality and Accuracy of Methodology and Reported Data

Some states require audits or review of methodology and reported data, as in Oregon, where the state health agency and advisory committee "shall evaluate on a regular basis the quality and accuracy of the data collected and reported by health care facilities [under law] and the methodologies of the Office for Oregon Health Policy and Research for data collection, analysis and public disclosure." The Alabama state health agency also

> "shall allow all health care facilities that have submitted data which will be used in any report to review and comment on the report prior to its publication or release for general public use. The department shall include comments of a health care facility, at the option of the health care facility, in the publication, if the department does not change the publication based upon those comments."[34]

(3) Information Collected on HAIs

Statutes may specify directives on specific HAI information collected. While the number of HAIs may be collected by state health agencies, a clear majority of states choose to collect HAI rates for public reporting purposes.[35] Nevada requires that its state health agency report "the type of event, the number of events and the medical facility which reported the event" for facility-acquired infections in medical facilities located in counties with 100,000 or more people.[36] Texas requires that infection information reported "must be risk adjusted and include a comparison of the risk-adjusted infection rates for each health care facility in this state that is required to submit a report."[37] Vermont requires

---

[32] *See, e.g.,* Cal. Health & Safety Code § 1288.8(e)(3) (West 2006) (amended in 2008); Haw. Rev. Stat. § 325-2.5(a) (2011); N.M. Stat. Ann. § 24-29-5(c) (2009) (requiring the use of NHSN); N.C. Gen. Stat. Ann. § 130A-150(b) (West 2011); and Wash. Rev. Code Ann. § 43.70.056(3) (West 2007) (amended in 2010 and requiring the use of NHSN).

[33] N.C. Gen. Stat. Ann. § 130A-150 (West 2011).

[34] Ala. Code § 22-11A-117 (2009).

[35] In 13 states, facilities may be required to submit their HAI rates to the state health agency through a specific HAI statute, and additionally required numbers of HAIs through infection control statutes or regulations that include HAIs among other reportable events. For example, in Nevada, a sentinel event is defined as "an unexpected occurrence involving facility-acquired infection, death or serious physical or psychological injury or the risk thereof, including, without limitation, any process variation for which a recurrence would carry a significant chance of a serious adverse outcome" and falls under mandatory reporting requirements (Nev. Rev. Stat. Ann. §§ 439.830, 439.835 (West 2005)).

[36] *Id.;* Nev. Rev. Stat. Ann. § 439.840(1)(c) (West 2005).

[37] Tex. Health & Safety Code Ann. § 98.106(b) (Vernon 2007).

that rules adopted include "measures of hospital-acquired infections that are valid, reliable, and useful, including comparisons to appropriate industry benchmarks."[38]

(4) Tracking of Specific HAIs

States may allow considerable discretion to the state health agency or advisory committee for determining which HAIs must be reported and their definitions. In order to determine when more detailed HAI provisions may be included in statute, it is important to consult the state Administrative Procedure Act and its requirements for checks and balances concerning regulatory activity.

Twenty states list some specific HAIs in statute for the state health agency to track, consider tracking, or augment. For example, Washington's statute names three specific HAIs that the reporting program will track and specifies surgical procedures related to those infections,[39] but Delaware's statute merely provides examples of HAIs of current interest and allows the Advisory Committee the discretion to determine which HAIs it will track.[40]

Twelve states take the middle path between specifying HAIs in statute and determining all reported infections in later regulations.[41] For example, South Carolina's statute allows the expansion of a required list of HAIs tracked, providing that "[t]he Department may, after consultation with the advisory committee, require hospitals to collect data on hospital acquired infection rates in categories additional to those set forth in subsection (A)."[42] Similarly, in New York the statute required reporting of surgical wound infections and central line related bloodstream infections during a pilot phase, and thereafter authorized the department "from time to time [to] require the tracking and reporting of other types of hospital acquired infections (for example, ventilator-associated pneumonias) that occur in hospitals in consultation with technical advisors who are regionally or nationally-recognized experts in the prevention, identification and control of hospital acquired infection and the public reporting of performance data."[43]

(5) Criteria for Identifying Reported HAIs

States may also list criteria that identify specific HAIs that could be used or refer to national standards, such as in Alabama, where "the information required to be reported by healthcare facilities to the department shall be based upon the Federal Centers for Disease Control and Prevention National Healthcare Safety Network definitions of hospital-acquired infections and the guidelines for reporting."[44] Delaware requires reports to be submitted using NHSN definitions for HAIs, but "prevention and control data related to quality measures will be based on nationally recognized and recommended standards that may include those developed by the CDC, Centers for Medicare and Medicaid, and/or the Agency for Healthcare, Research, and Quality, to name a few."[45]

---

[38] Vt. Stat. Ann. tit. 18, § 9405b(a)(3) (2007).
[39] Wash. Rev. Code Ann. § 43.70.056(2) (West 2007).
[40] 16 Del. Code Ann. tit. 16, § 1003A (2007).
[41] *See supra* notes 9-12.
[42] S.C. Code Ann. § 44-7-2430 (2006).
[43] N.Y. Pub. Health Law § 2819 (McKinney 2005).
[44] Ala. Code § 22-11A-111 (2009).
[45] 16 Del. Code Ann. tit. 16, § 1003A(b)(1) (2007).

(6) Requirements for Public Information

Statutes frequently consider how to make reports understandable by the public. Rhode Island's statute specifies that the annual public report must be "as easy to comprehend as possible, [] include an executive summary, written in plain language that shall include, but not be limited to, a discussion of findings, conclusions, and trends concerning the overall state of hospital-acquired infections in the state, including a comparison to prior years. The report may include policy recommendations, as appropriate, [and the] department shall publicize the report and its availability as widely as practical to interested parties."[46]

Other states allow further analysis of data that is publicly reported. In Missouri, the state health agency "may authorize the use of the data by other research organizations . . . [and] shall undertake a reasonable number of studies and publish information, including at least an annual consumer guide, in collaboration with health care providers, business coalitions and consumers based on the information obtained."[47]

Reporting Pathways

Statutes direct the pathways for reporting that various entities must follow. Public reporting requires that facilities report the incidence of HAIs to a state health agency, which then reports aggregate HAI rates to the public. The state health agency is also frequently required to report annual HAI rates to the governor or legislature as an added measure of accountability. Additionally, many states require that facilities use NHSN, so that the same measures reported to NHSN and the state health agency may be used for national HAI surveillance, reimbursement procedures, and state reporting activities.

Reporting from a Facility to the State Health Agency[48]

The cornerstone for public reporting lies in effective reporting of HAI data to the state health agency for data analysis and HAI prevention. Among the 27 states and 1 territory where facilities are required to report HAI data to the state health agency,[49] New York requires that

> "Each hospital shall regularly report to the department the hospital infection data it has collected. The department shall establish data collection and analytical methodologies that meet accepted standards for validity and reliability. The frequency of reporting shall be monthly, and reports shall be submitted not more than sixty days after the close of the reporting period."[50]

---

[46] R.I. Gen. Laws § 23-17.17-6(9)(iii) (2006).
[47] Mo. Ann. Stat. §§ 192.667(7), 192.667(8) (West 2004).
[48] See Toolkit, *supra* note 1, at 15.
[49] Ala. Code § 22-11A-114 (2009); Cal. Health & Safety Code § 1288.55 (West 2008); Colo. Rev. Stat. Ann. § 25-3-602(3) (West 2006); Conn. Gen. Stat. Ann. § 19a-490o (West 2006); 16 Del. Code Ann. tit. 16, § 1003A(b) (2007); Fla. Stat. Ann. § 408.061(1)(a) (West 2006); Haw. Rev. Stat. § 325-2.5(a) (2011); 210 Ill. Comp. Stat. 86/25(a) (2004); Me. Rev. Stat. Ann. tit. 22 § 8761(2) (2009); Mass. Gen. Laws ch. 111, § 51H(b) (2008); Mo. Ann. Stat. § 192.667(2) (West 2004) (referring to nosocomial infection incidence rates); Nev. Rev. Stat. Ann. § 439.835 (West 2009); N.H. Rev. Stat. Ann. § 151:33(II) (2006); N.J. Stat. Ann. § 26:2H-12.45 (West 2007); N.Y. Pub. Health Law § 2819(2)(d) (McKinney 2005); N.C. Gen. Stat. Ann. § 130A-150(c) (West 2011); Ohio Rev. Code Ann. § 3727.33 (West 2008); 2007 Or. Laws, Ch. 838, §2(a); 40 Pa. Cons. Stat. § 1303.404 (2007); R.I. Gen. Laws § 23-17.17-6(b) (West 2011); S.C. Code Ann. § 44-7-2430 (2006); Tenn. Code Ann. § 68-11-263(a) (2006); Tex. Health & Safety Code Ann. § 98.102(a) (Vernon 2007); Vt. Stat. Ann. tit. 18, § 9405b (2007); Va. Code Ann. § 32.1-35.1 (2005); Wash. Rev. Code Ann. § 43.70.056(2)(e)(1) (West 2007); W. Va. Code § 16-5B-17(d) (2008); and P.R. Laws Ann. tit. 24, § 367 (2007).
[50] N.Y. Pub. Health Law § 2819(3) (McKinney 2005).

Other states are more prescriptive and more detailed in their reporting requirements. Nevada's statute requires annual reports that

> "[E]ach medical facility shall provide to the Health Division, in the form prescribed by the State Board of Health, a summary of the reports submitted by the medical facility pursuant to [the infection control statute] during the immediately preceding calendar year. The summary must include, without limitation: (a) The total number and types of sentinel events reported by the medical facility, if any; (b) A copy of the patient safety plan established pursuant to [statute]; (c) A summary of the membership and activities of the patient safety committee established pursuant to [statute]; and (d) Any other information required by the State Board of Health concerning the reports submitted by the medical facility pursuant to [the infection control statute]. [Further,] the Health Division shall submit to the State Board of Health an annual summary of the reports and information received by the Health Division pursuant to this section. The annual summary must include, without limitation, a compilation of the information submitted pursuant to subsection 1 and any other pertinent information deemed necessary by the State Board of Health concerning the reports submitted by the medical facility pursuant to [the infection control statute]."[51]

Reporting from a Facility to NHSN[52]

NHSN is the CDC surveillance system to which over 9,000 U.S. healthcare facilities report HAIs to track local prevention initiatives, provide data for state reporting requirements, and provide HAI and prevention practice adherence data to CMS to take advantage of federal payment mechanisms offered through the Hospital Inpatient Quality Reporting Program. States with HAI reporting laws that choose NHSN as the technical infrastructure through which they obtain HAI data may relieve facilities in their jurisdictions from the administrative burden of entering data in a second state reporting system.

(1) State Law Requirements to Report to NHSN

Twelve state laws require reporting of certain data to NHSN.[53] These laws may further require facilities to grant access to NHSN data to state health agencies. For example, Tennessee's statute states that

> "Each facility regulated under this chapter with an annual average daily census of at least twenty-five (25) inpatients based on the most recent JAR public data, where applicable, or an outpatient facility that performs an annual average of twenty-five (25) procedures per day shall join [NHSN] surveillance system within one hundred twenty (120) days of when it becomes open to the facility's type of license in order to unify reporting systems and to benchmark against a national standard. Facilities shall meet data reporting timeframes as required by NHSN and shall utilize standard

[51] Nev. Rev. Stat. § 439.843 (2002) (including HAIs under the definition of sentinel events).

[52] *See* Toolkit, *supra* note 1, at 16.

[53] Cal. Health & Safety Code § 1288.55 (West 2006); Colo. Rev. Stat. Ann. § 25-3-603 (West 2006); Haw. Rev. Stat. § 325-2.5 (2011); Me. Rev. Stat. Ann. tit. 22 § 8761 (2009); Nev. Rev. Stat. Ann. § 439.847 (West 2009); N.M. Stat. Ann. § 24-29-6 (2009); 40 Pa. Cons. Stat. § 1303.404(b) (2007); Tenn. Code Ann. § 68-11-263 (2006); Va. Code Ann. § 32.1-35.1 (2005); Wash. Rev. Code Ann. § 43.70.056(2) (West 2007); and W. Va. Code § 16-5B-17(d) (2008). *See also* 16 Del. Code Ann. tit. 16, § 1011A (2007) (requiring hospitals to "join" NHSN and grant the state health agency access to information contained in the NHSN database).

> methods, including healthcare acquired case-finding techniques, CDC infection definitions and other relevant terms, and NHSN software for data collection and reporting. Data submitted by the reporting facility shall be reported without any patient identifiers. . . . Facilities shall grant the department of health access to the NHSN database on: (A) [c]entral line associated blood stream infections (CLABSI) in intensive care units for hospital specific reporting on the department of health's website. . . . (B) [s]urgical site infections for coronary artery bypass grafts (CABG). . . . The department shall be granted initial access one (1) year after NHSN becomes open to facilities. Every six (6) months the department shall update information posted on the department website received from the NHSN database authorized for public review."[54]

Pennsylvania's statute also requires hospitals to report to NHSN, but is less specific. It states that "hospitals shall . . . [a]uthorize the department, the authority and the council to have access to the NHSN for facility-specific reports of health care-associated infection data contained in the NHSN database for purposes of viewing and analyzing that data."[55]

(2) Methods for States to Access NHSN Data

State health agencies may access NHSN data in two ways. First, state health agencies may obtain data from facilities by forming a Group in NHSN. Facilities may join the Group and share some or all of their individual- and institution-identified HAI data with the state health agency from within the NHSN application. The Group function permits secure data sharing, allows data from healthcare facilities to become available to the Group in real-time, and provides access to many useful analysis options that are available in the NHSN application to the Group. Furthermore, facilities can share their data simultaneously with multiple Groups – for example, a state health agency; their corporate office; and their Quality Improvement Organization – without entering data multiple times.

Second, in states without mandates, state health agencies may obtain data that is voluntarily reported to NHSN by facilities in their jurisdictions by entering into a data use agreement (DUA) with CDC. By signing NHSN's Agreement to Participate and Consent during the NHSN enrollment process, facilities acknowledge and agree to NHSN's purposes, one of which is to provide NHSN data to state agencies for surveillance and prevention purposes. By signing a DUA with CDC, state health agencies may gain access to future NHSN data that is voluntarily reported by facilities in their jurisdiction, provided that the state attests that it can comply with DUA requirements that protect the confidentiality of facilities and specifies how the data will be protected. The DUA requires that institution-identified data will not be publicly reported and that regulatory or punitive actions, such as fines or licensure actions, will not be taken against healthcare institutions on the basis of data made accessible through the DUA. However, as noted, the new CMS Hospital Compare website may disclose some of the HAI-related information reported to CMS through NHSN as part of the reimbursement process in spite of DUA protections.[56] Facilities that are enrolled in NHSN in states with health agencies that sign the DUA will be notified and allowed to opt out of any voluntary HAI reporting they do to NHSN.

However, facilities may continue to find it beneficial to use NHSN for HAI data collection and share HAI data with state health agencies in order to fulfill federal payment requirements and avoid reporting data

[54] Tenn. Code Ann. § 68-11-263 (2006).
[55] 40 Pa. Cons. Stat. § 1303.404(b) (2007).
[56] *See Hospital Compare, supra* note 28.

both to NHSN and state health agencies separately. States that receive HAI data through the Group function will be able to use the data obtained from NHSN to implement public health and regulatory provisions in their HAI laws.

Whether a state agency obtains NHSN data through the Group function or the DUA, the data may be subject to open records requests at the state level. States that receive data from NHSN for public health purposes may need to revisit their Freedom of Information laws should they want to protect identification of facilities in data reported.[57] States may confer extra protections to data received by state health agencies to mirror protections of NHSN data at the federal level.

Reporting from the State Health Agency to the Governor or Legislature

For accountability of the HAI program, 17 states require reporting of HAI data to the Governor or to the Legislature in a summary or full report.[58] In South Carolina, "[t]he department annually shall submit to the General Assembly a report summarizing the hospital reports submitted."[59]

New York's statute also requires that "[o]n or before September first of each year the commissioner shall submit a report to the governor and the legislature, . . . that includes, but is not limited to, hospital acquired infection rates adjusted for the potential differences in risk factors for each reporting hospital, an analysis of trends in the prevention and control of hospital acquired infection rates in hospitals across the state, regional and, if available, national comparisons for the purpose of comparing individual hospital performance, and a narrative describing lessons for safety and quality improvement that can be learned from leadership hospitals and programs."[60]

Reporting from the State Health Agency to the Public[61]

Twenty-seven states mandate public reporting of HAI data either from the facility or from the state health agency.[62] An HAI program's provisions for reporting from an agency to the public may be

---

[57] *See, e.g.,* 16 Del. Code Ann. tit. 16, § 1010A (2007) (exempting data provided by facilities from the state freedom of information law).

[58] Ark. Code Ann. § 20-9-1205 (West 2011); Cal. Health & Safety Code § 1288.8(e)(5) (West 2006); Colo. Rev. Stat. Ann. § 25-3-603(1) (West 2006); Conn. Gen. Stat. Ann. § 19a-490o (West 2006); 16 Del. Code Ann. tit. 16, § 1004A (2007); Haw. Rev. Stat. § 325-2.5 (2011); 210 Ill. Comp. Stat. 86/30 (2004); Md. Code Ann., Health-Gen. § 19-134(e) (West 2006); Mo. Ann. Stat. § 192.667(14) (West 2004) (referring to nosocomial infection incidence rates); Nev. Rev. Stat. Ann. § 439.843 (West 2009); N.Y. Pub. Health Law § 2819(5)(a) (McKinney 2005); N.C. Gen. Stat. Ann. § 130A-150(b) (West 2011); 2007 Or. Laws, Ch. 838, §6; R.I. Gen. Laws §§ 23-17.17-5, 23-17.17-6 (West 2011); S.C. Code Ann. § 44-7-2440 (2006); Tenn. Code Ann. §§ 68-11-264, 68-11-267 (2006); Wash. Rev. Code Ann. § 43.70.056(3) (West 2007); and W. Va. Code § 16-5B-17 (2008).

[59] S.C. Code Ann. § 44-7-2440 (2006).

[60] N.Y. Pub. Health Law § 2819(5)(a) (McKinney 2005).

[61] *See* Toolkit, *supra* note 1, at 16.

[62] Ala. Code § 22-11A-116 (2009); Ark. Code Ann. § 20-9-1205 (West 2011); Cal. Health & Safety Code § 1288.55(c) (West 2006); Colo. Rev. Stat. Ann. § 25-3-603 (West 2006); Conn. Gen. Stat. Ann. § 19a-490n (West 2006); 16 Del. Code Ann. tit. 16, § 1004A (2007); 210 Ill. Comp. Stat. 86/30 (2004); Mass. Gen. Laws ch. 111, § 51H(c) (2008); Minn. Stat. Ann. § 62J.82(1) (West 2005); Mo. Ann. Stat. § 192.667(8) (West 2004) (referring to nosocomial infection incidence rates); Neb. Rev. Stat. § 71-8720 (2005); Nev. Rev. Stat. Ann. § 439.840 (West 2009); N.H. Rev. Stat. Ann. § 151:34 (2006); N.J. Stat. Ann. § 26:2H-12.45 (West 2007); N.M. Stat. Ann. § 24-29-6 (2009); N.Y. Pub. Health Law § 2819(6) (McKinney 2005); N.C. Gen. Stat. Ann. § 130A-150 (West 2011); Ohio Rev. Code Ann. § 3727.312(D) (West 2008); 2007 Or. Laws, Ch. 838, §6; 40 Pa. Cons. Stat. § 1303.408 (2007); R.I. Gen. Laws § 23-17.17-6(5) (West 2011); S.C. Code Ann. § 44-7-2430 (2006); Tenn. Code Ann. § 68-11-263 (2006); Tex. Health & Safety Code Ann. § 98.106 (Vernon 2007); Vt. Stat. Ann. tit. 18, § 9405b (2007); Wash. Rev. Code Ann. § 43.70.056(2) (West 2007); and W. Va. Code § 16-5B-17 (2008).

stated in statute or regulation. Colorado's statute requires that an annual report summarizing the risk-adjusted health-facility data be posted on the department of health's website as follows:

> "The department shall issue semi-annual informational bulletins summarizing all or part of the information submitted in health-facility reports. . . . The annual report shall compare the risk-adjusted, hospital-acquired infection rates, collected under [the HAI law], for each individual health facility in the state. The department, in consultation with the advisory committee, shall make this comparison as easy to comprehend as possible. The report shall include an executive summary, written in plain language, that includes, but is not limited to, a discussion of findings, conclusions, and trends concerning the overall state of hospital-acquired infections in the state, including a comparison to prior years when available. The report may include policy recommendations as appropriate. [] The department shall publicize the report and its availability as widely as practical to interested parties, including but not limited to health facilities, providers, media organizations, health insurers, health maintenance organizations, purchasers of health insurance, organized labor, consumer or patient advocacy groups, and individual consumers. The annual report shall be made available to any person upon request."[63]

Illinois set up a regular public reporting system for risk-adjusted and validated data. In that statute, "[q]uarterly reports shall be submitted, in a format set forth in rules adopted by the Department, to the Department by April 30, July 31, October 31, and January 31 each year for the previous quarter. Data in quarterly reports must cover a period ending not earlier than one month prior to submission of the report. Annual reports shall be submitted by December 31 in a format set forth in rules adopted by the Department to the Department. All reports shall be made available to the public on-site and through the Department."[64]

Massachusetts is unique in having multiple reporting systems to allow consumers access to data through several sources. The state collects data for quality and cost analysis, and a patient safety center collects data for public reporting separately, so that the same data may be reported to two different places. The statute states that Massachusetts Health Care Quality and Cost Council:

> "shall, in consultation with the advisory committee established by section 16L, establish and maintain a consumer health information website. The website shall contain information comparing the quality and cost of health care services and may also contain general health care information as the council deems appropriate. The website shall be designed to assist consumers in making informed decisions regarding their medical care and informed choices among health care providers. Information shall be presented in a format that is understandable to the average consumer. The council shall take appropriate action to publicize the availability of its website. . . . The website shall provide updated information on a regular basis, at least annually, and additional comparative quality and cost information shall be published as determined by the council, in consultation with the advisory committee. To the extent possible, the website shall include: . . . data concerning healthcare-acquired infections and serious reportable events reported."[65]

---

[63] Colo. Rev. Stat. § 25-3-603 (2006).
[64] 210 Ill. Comp. Stat. 86/25(d) (2004).
[65] Mass. Gen. Laws ch. 6A, § 16K(e)

Additionally, the statute requires the Betsy Lehman Center for Patient Safety and Medical Error Reduction to collect data as follows: "[t]he department shall, through interagency service agreements, transmit data collected under this section to the Betsy Lehman center for patient safety and medical error reduction and to the healthcare quality and cost council for publication on its consumer health information website."[66] This second method of reporting allows an independent nonprofit center to transmit data to consumers through its website instead of the state health agency.

Licensure and Training Requirements[67]

Some HAI statutes provide detailed authorities for the enforcement of HAI laws through licensure and training provisions for facilities and providers. Statues may condition provider licensure on fulfillment of training requirements in HAI prevention, whereas facility licensure may depend on compliance with the HAI statute in its entirety. In Colorado, a broad provision reads as follows: "[t]he department shall be responsible for ensuring compliance with [the HAI statute] as a condition of licensure . . . and shall enforce compliance according to the provisions in [the hospital-related part of] this article."[68]

Fifteen states and one territory provide for reporting as a condition of facility licensure,[69] and four allow for reporting as a condition of professional licensure.[70] States may impose detailed requirements on licensed facilities and providers together. For example, New Jersey law states

> "In addition to authority granted to the department by this act or any other law, the department after serving the licensee with specific charges in writing, may assess penalties and collect the same within the limitations imposed by this act, deny, place on probationary or provisional license, revoke or suspend any and all licenses granted under authority of this act to any person, firm, partnership, corporation or association violating or failing to comply with the provisions of this act, or the rules and regulations promulgated hereunder."[71]

Seven states additionally mention training for healthcare professionals in HAI statutes.[72] Training requirements for providers may include courses, tests, and other educational methods. In Colorado, "[a] n individual who collects data on hospital-acquired infection rates shall take the test for the appropriate national certification for infection control and become certified within six months after the individual becomes eligible to take the certification test. Mandatory national certification requirements shall not apply to individuals collecting data on hospital-acquired infections in hospitals licensed for fifty beds or

---

[66] Mass. Gen. Laws ch. 111, § 51H(b) (2008).

[67] *See* Toolkit, *supra* note 1, at 24-25.

[68] Colo. Rev. Stat. § 25-3-607 (2006).

[69] Two states mandate using licensing penalties upon violation of the statute. Mo. Ann. Stat. § 192.067(16) (West 2004) (cross-referencing the state on nosocomial infection incidence rates) and S.C. Code Ann. § 44-7-2460 (2006). Thirteen other states allow the state health agency or its representatives to use licensing penalties upon violation of the statute. Colo. Rev. Stat. Ann. § 25-3-606 (West 2006); Conn. Gen. Stat. Ann. § 19a-494 (West 2006); 16 Del. Code Ann. tit. 16, § 1008A (2007); 210 Ill. Comp. Stat. 86/45 (2004); Mass. Gen. Laws ch. 111, § 51H(c) (2008); Minn. Stat. Ann. § 62J.82(3) (West 2005); N.J. Stat. Ann. § 26:2H-5.22 (West 2007); 40 Pa. Cons. Stat. § 1303.408(8) (2007); Tenn. Code Ann. § 68-11-207 (1947); Tex. Health & Safety Code Ann. § 98.151 (Vernon 2007); W. Va. Code § 16-5B-17(e) (2008); and P.R. Laws Ann. tit. 24, § 367 (2007).

[70] Cal. Health & Safety Code § 1288.95 (West 2006); 210 Ill. Comp. Stat. 86/15 (2004); N.J. Stat. Ann. § 26:2H-13 (West 1971); and Tenn. Code Ann. § 68-11-213 (1947).

[71] N.J. Stat. Ann. § 26:2H-13 (West 1971); N.J. Stat. Ann. § 26:2H-12.41 (West 2007).

[72] Cal. Health & Safety Code § 1288.95 (West 2006); Colo. Rev. Stat. Ann. § 25-3-602(1)(c) (West 2006); 210 Ill. Comp. Stat. 86/25(c) (2004); N.M. Stat. Ann. § 24-29-3(B)(6) (2009); N.Y. Pub. Health Law § 2819(8) (McKinney 2005); 40 Pa. Cons. Stat. § 1303.403 (2002) (including training in the infection control statute that cross-references the HAI statute); and Tex. Health & Safety Code Ann. § 98.107 (Vernon 2007).

less, licensed ambulatory surgical centers, and certified dialysis treatment centers. Qualifications for these individuals may be met through ongoing education, training, experience, or certification, as defined by the department."[73]

California specifies that the Advisory Committee shall "[r]ecommend an educational curriculum by which health facility evaluator nurses and department consultants would be trained to survey for hospital infection surveillance, prevention, and control programs."[74] Additionally, "[b]eginning January 2010, all staff and contract physicians and all other licensed independent contractors, including, but not limited to, nurse practitioners and physician assistants, shall be trained in methods to prevent transmission of HAIs, including, but not limited to, MRSA and Clostridium difficile infection."[75]

Finally, Illinois' statute specifies staffing requirements to support its Hospital Report Card Act, specifying that "[a]ll health care facilities shall have established an orientation process that provides initial job training and information and assesses the direct care nursing staff's ability to fulfill specified responsibilities. [] Personnel not competent for a given unit shall not be assigned to work there without direct supervision until appropriately trained. [] Staff training information will be available upon request, without any information identifying a patient, employee, or licensed professional at the hospital."[76]

States also may confer criminal penalties for certain violations of HAI laws, although the occurrence of this is infrequent and may be challenging for state health agencies to enforce. Fines may be used to encourage compliance.

Financial Incentives and Disincentives[77]

Some states seek to ensure an HAI program's sustainability through provisions for financial incentives and disincentives. Eleven states and one territory allow agencies to levy fines for violations of HAI statutes,[78] whereas only four provide reimbursements or incentives for implementing activities required by HAI laws.[79]

---

[73] Colo. Rev. Stat. § 25-3-602(1)(c) (2006).

[74] Cal. Health & Safety Code § 1255.8(d)(3) (West 2008). *See also* Tex. Health & Safety Code Ann. § 98.107 (Vernon 2007) (specifying that the state health agency shall provide education and training for facility staff regarding the HAI statute, including: implementation and management of a facility reporting mechanism; characteristics of the reporting system, including public reporting by the department and facility reporting to the department; confidentiality; and legal protections).

[75] Cal. Health & Safety Code § 1288.95(b) (West 2008)

[76] 210 Ill. Comp. Stat. 86/20 (2004).

[77] *See* Toolkit, *supra* note 1, at 23, 26.

[78] Ala. Code § 22-11A-122 (2009); Colo. Rev. Stat. Ann. § 25-3-606 (West 2006); 16 Del. Code Ann. tit. 16, § 1007A (2007); Mass. Gen. Laws ch. 111, § 51H (2008);); Mo. Ann. Stat. § 192.667(9) (West 2004) (referring to nosocomial infection incidence rates); Nev. Rev. Stat. Ann. § 439.885 (West 2009); N.J. Stat. Ann. § 26:2H-5.22 (West 2007); 40 Pa. Cons. Stat. § 1303.408 (2007); S.C. Code Ann. § 44-7-2460 (2006); Tex. Health & Safety Code Ann. §§ 241.055, 241.059 (Vernon 2007); W. Va. Code § 16-5B-17 (2008); and P.R. Laws Ann. tit. 24, § 367 (2007).

[79] Mo. Ann. Stat. § 192.667 (West 2004) (referring to nosocomial infection incidence rates); N.Y. Pub. Health Law § 2819(8) (McKinney 2005); 40 Pa. Cons. Stat. §§ 1303.407, 1303.409 (2007); and Tex. Health & Safety Code Ann. § 98.055 (Vernon 2007).

Pennsylvania's statute includes varied financial incentives and states

> "Commencing on January 1, 2009, the Department of Public Welfare in consultation with the department shall make a quality improvement payment to a health care facility that achieves at least a 10% reduction for that facility in the total number of reported health care-associated infections over the preceding year pursuant to section 408(7)(i). For calendar year 2010 and thereafter, the Department of Public Welfare shall consult with the department to establish appropriate percentage benchmarks for the reduction of health care-associated infections in each health care facility in order to be eligible for a payment pursuant to this section. . . . Nothing in this section shall prevent the Department of Public Welfare in consultation with the department from providing additional quality improvement payments to a health care facility that has implemented a qualified electronic surveillance system and has achieved or exceeded reductions in the total number of reported health care-associated infections for that facility over the preceding year. . . . In addition to meeting the requirements contained in this section, to be eligible for a quality improvement payment, a health care facility must be in compliance with health care-associated reporting requirements contained in this act and the Health Care Facilities Act. . . . Funds for the purpose of implementing this section shall be appropriated to the Department of Public Welfare and distributed to eligible health care facilities as set forth in this section. Quality improvement payments to health care facilities shall be limited to funds available for this purpose."[80]

Disincentives for failing to follow the HAI law may be financial in nature. In Pennsylvania, "a health care facility which negligently fails to report a health care-associated infection as required under this chapter may be subject to an administrative penalty of $1,000 per day imposed by the department."[81] In Nevada the amount of the sanction depends on the violation. "[I]f a medical facility commits a violation of any provision of [the HAI law], and does not, of its own volition, report the violation to the Administrator, the Health Division may, in accordance with the provisions of subsection 3, impose an administrative sanction: (a) For failure to report a sentinel event, in an amount not to exceed $100 per day for each day after the date on which the sentinel event was required to be reported pursuant to NRS 439.835; (b) For failure to adopt and implement a patient safety plan pursuant to NRS 439.865, in an amount not to exceed $1,000 for each month in which a patient safety plan was not in effect; and (c) For failure to establish a patient safety committee or failure of such a committee to meet pursuant to the requirements of NRS 439.875, in an amount not to exceed $2,000 for each violation of that section."[82]

Other statutes, such as New Jersey's, apply penalties to providers and facilities, specifying that "[a]ny person, firm, partnership, corporation or association who violates any rule or regulation adopted in accordance with this act as the same pertains to the care of patients and physical plant standards shall be subject to a penalty of not more than $5,000 as provided for by regulation for each day that he is in violation of such rule or regulation."[83]

Some programs may be supported by financial penalties levied on licensed facilities. In Massachusetts, "[a]ny facility failing to comply with this section may: (i) be fined up to $1,000 per day per violation;

[80] 40 Pa. Cons. Stat. § 1303.407 (2007).
[81] 40 Pa. Cons. Stat. § 1303.411(b) (2007).
[82] Nev. Rev. Stat. § 439.885(2) (2002).
[83] N.J. Stat. Ann. § 26:2H-14 (West 2003).

(ii) have its license revoked or suspended by the department; or (iii) be fined up to $1,000 per day per violation and have its license revoked or suspended by the department."[84]

Protection of Patient, Provider, and Facility Data[85]

State HAI statutes often include provisions regarding privacy, confidentiality, and privilege of information. States augment patient protections contained in federal privacy statutes, such the Health Insurance Portability and Accountability Act of 1996, with state laws that protect patient privacy and ensure confidentiality for providers and institutions that may not wish to be identified in public HAI reports. Similarly, state statutes may protect data from use in litigation through privilege from discovery.

Twenty-four states protect patient privacy through state law,[86] as in Colorado, where "compliance with [the HAI statute] shall not violate a patient's right to confidentiality. A patient's social security number and any other information that could be used to identify a patient shall not be released, notwithstanding any other provision of law."[87] Further, in New York, "[r]egulations under this section shall include standards to assure the protection of patient privacy in data collected and released under this section and standards for the publication and release of data reported under this section."[88]

Providers and other healthcare employees also can be protected under state laws from identification. In South Carolina, "[n]o hospital report or department disclosure may contain information identifying a patient, employee, or licensed health care professional in connection with a specific infection incident."[89]

Facilities also may be protected in some states from disclosure of the reports they make to state health agencies even though their individual, overall HAI rates may be identified by the public reports that synthesize that information. Under Colorado law,

> "[A]ll information and materials obtained and compiled by the department under this part 6 or compiled by a health facility under this part 6, including all related information and materials, are confidential . . . [which] shall apply without regard to whether the information or materials are obtained from or compiled by a health facility or an entity that has ownership or management interests in a health facility. . . . The transfer of information or materials under this part 6 is not a waiver of a privilege or protection granted under law. . . . The provisions of this section regarding the confidentiality of information or materials compiled or reported by a health facility in compliance with or as authorized under this part 6 shall not restrict access, to the extent authorized

---

[84] Mass. Gen. Laws ch. 111, § 51H(b) (2008).

[85] *See* Toolkit, *supra* note 1, at 12-13.

[86] Ala. Code § 22-11A-112 (2009); Ark. Code Ann. § 20-9-1205 (West 2011); Colo. Rev. Stat. Ann. § 25-3-603 (West 2006); Conn. Gen. Stat. Ann. § 19a-490n (West 2006); 16 Del. Code Ann. tit. 16, §§ 1004A, 1006A (2007); Fla. Stat. Ann. § 408.061(1)(a) (West 2006); Haw. Rev. Stat. § 325-2.5 (2011); 210 Ill. Comp. Stat. 86/25 (2004); Mo. Ann. Stat. § 192.667(7) (West 2004) (referring to nosocomial infection incidence rates); Nev. Rev. Stat. Ann. § 439.840 (West 2009); N.H. Rev. Stat. Ann. § 151:35 (2006); N.C. Gen. Stat. Ann. § 130A-150 (West 2011); Ohio Rev. Code Ann. § 3727.36 (West 2008); 2007 Or. Laws, Ch. 838, §6; 40 Pa. Cons. Stat. § 1303.311 (2007); R.I. Gen. Laws § 23-17.17-6 (West 2011); S.C. Code Ann. § 44-7-2440 (2006); Tenn. Code Ann. § 68-11-263 (2006); Tex. Health & Safety Code Ann. § 98.110 (Vernon 2007); Va. Code Ann. § 32.1-38 (2005); and Wash. Rev. Code Ann. § 43.70.056(3) (West 2007).

[87] Colo. Rev. Stat. § 25-3-604 (2006).

[88] N.Y. Pub. Health Law § 2819(9) (McKinney 2005).

[89] S.C. Code Ann. § 44-7-2440 (2006).

by law, by the patient or the patients' legally authorized representative to records of the patient's medical diagnosis or treatment or to other primary health records."[90]

Finally, 13 states treat information reported by facilities as privileged from disclosure during litigation in a criminal, civil, or administrative proceeding.[91] For example, in Washington state, "[t]he hospital reports obtained by the department . . . and any of the information contained in them, are not subject to discovery by subpoena or admissible as evidence in a civil proceeding, and are not subject to public disclosure."[92]

Other states are more specific in their privilege protections, such as Colorado, which states that "[i] nformation reported by a health facility under this part 6 and analyses, plans, records, and reports obtained, prepared, or compiled by a health facility under this part 6 and all related information and materials are subject to an absolute privilege and shall not be used in any form against the health facility, its agents, employees, partners, assignees, or independent contractors in any civil, criminal, or administrative proceeding, regardless of the means by which a person came into possession of the information, analysis, plan, record, report, or related information or materials."[93] Eight states further create immunity for providers or other reporting entities from civil liability as a further protection.[94]

CONCLUSION

This menu discusses the provisions that appear most frequently in current state HAI laws; however, there are other specialized topics states may include in their HAI laws, such as data validation requirements, which fall outside the scope of this document. The menu also does not attempt to incorporate all laws external to the HAI provisions — such as infection control regulations, facility or provider licensure regulations, or federal privacy protections — that may have an effect on the authority and enforcement provisions discussed. However, when creating an HAI program, it is imperative to examine the authorities that already exist in state infection control or other relevant public health laws. Additionally, searching in public health or other enforcement-related agency regulations may prove particularly useful for further research into the breadth and depth of authority that state laws may apply to each of the topics listed above.

To protect patients across the healthcare system and maintain a bridge between health care and the community, it is vital that state health agencies be authorized to implement comprehensive, patient-centered, and evidence-based HAI programs. The menu will help practitioners to understand some of the options for drafting statutory language to achieve this goal.

---

[90] Colo. Rev. Stat. § 25-3-605 (2006). *See also* Tex. Health & Safety Code Ann. § 98.109 (Vernon 2007) (requiring that materials obtained or reported by the state health agency are confidential, "without regard to whether the information or materials are obtained from or compiled and reported by a health care facility or an entity that has an ownership or management interest in a facility").

[91] Ark. Code Ann. § 20-9-1206 (West 2011); Colo. Rev. Stat. Ann. § 25-3-605 (West 2006); 16 Del. Code Ann. tit. 16, § 10010A (2007); Fla. Stat. Ann. § 408.061(9) (West 2006); Haw. Rev. Stat. § 325-2.5 (2011); Neb. Rev. Stat. §§ 71-8710, 8711 (2005); Nev. Rev. Stat. Ann. § 439.840 (West 2009); N.Y. Pub. Health Law § 206 (McKinney 2005); Ohio Rev. Code Ann. § 3727.38 (West 2008); 2007 Or. Laws, Ch. 838, §4; 40 Pa. Cons. Stat. § 1303.311 (2007); Tex. Health & Safety Code Ann. § 98.109 (Vernon 2007); Wash. Rev. Code Ann. § 43.70.056(2)(e)(II) (West 2007); and W. Va. Code § 16-5B-17 (2008).

[92] Wash. Rev. Code § 43.70.056 (2007).

[93] Colo. Rev. Stat. § 25-3-605 (2006).

[94] Colo. Rev. Stat. Ann. § 25-3-605 (West 2006); Fla. Stat. Ann. § 408.061(9) (West 2006); Mo. Ann. Stat. § 192.067 (West 2004) (referring to nosocomial infection incidence rates); Nev. Rev. Stat. Ann. § 439.880 (West 2009); N.Y. Pub. Health Law § 206 (McKinney 2005); Ohio Rev. Code Ann. § 3727.38 (West 2008); Va. Code Ann. § 32.1-38 (2005); and P.R. Laws Ann. tit. 24, § 367 (2007).