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 4 of this Act:

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

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

(a) Results from an adverse reaction to the presence of an infectious agent(s) or its toxin(s).

(b) There must be 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.

(3) "Multi-drug resistant organism" or "MDRO," means any bacterium resistant to three (3) or more classes of antibiotics AND including methicillin-resistant staphylococcus aureus (MRSA), vancomycin-resistant enterocci (VRE), Clostridum Difficile, Enterobactriaceae, Acinetobacter, ceftazidime-resistant Klebsiella, and gram negative bacilli (GNB) or other organisms identified by the federal Centers for Disease Control and Prevention or Kentucky Cabinet of Health and Family Services as a multidrug resistant organism.

(4) “ Secretary” means the Kentucky Secretary of the Cabinet for Health and Family Services.

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

The General Assembly finds and declares that:

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

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

(3) Because it can survive on cloth and plastic for up to ninety (90) days, MRSA is frequently transmitted by contaminated hands, clothes, and noninvasive instruments and the number of patients who can become infected from one (1) carrier multiplies dramatically;

(4) The federal Centers for Disease Control and Prevention estimates that one (1) in twenty (20) patients entering a health facility carries MRSA and reports that MRSA accounts for sixty percent (60%) of infections in American hospitals in 2004, an increase from two percent (2%) in 1974, and currently increasing, in 2007 the Association for Professionals in Infection Control and Epidemiology reported that the prevalence of MRSA was increasing eight times more than expected;

(5) The Association for Professionals in Infection Control and Epidemiology report that the incidence of Clostridum Difficile is increasing more than 10 times as expected, and the American Journal of Infection Control reports that Kentucky

has the sixth highest rate of infection in the United States;

(6) The nationwide cost to treat hospitalized patients infected with HAI is estimated to be between 28 to 45 billion dollars, the CDC estimates the increase in cost for Ventilator Associated Pneumonia, Surgical Site Infections and Catheter Associated Bloodstream Infections ranging from $28,404 to $34,670 per patient;

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

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

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

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

(11) The APIC (Association for Professionals in Infection Control and Epidemiology), SHEA (Society for Healthcare Epidemiology of America), IDSA (Infectious Diseases Society of America), CSTE (Council of State and Territorial Epidemiologists) and TFHA (Trust for America's Health) agree with the public reporting option in proposed congressional legislation ; and

(12) It is 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.

SECTION 3. 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, all health facilities shall implement an infection prevention program at least includes intensive care units, surgical units, or other units or areas where there is a significant risk of health facility-acquired infection. By January 1, 2011, each health facility's infection prevention program shall be implemented throughout the facility.

(2) As a condition of licensure, a health facility shall implement best practices and

effective strategies for an infection prevention program in accordance with subsection (1) of this section and implement best practices for preventing MDROs and other pathogens as the Secretary determines appropriate that include but are not limited to:

(a) Contact precautions as specified by the federal Centers for Disease Control
and Prevention for patients found to be positive for MDROs;

(b) Strict adherence to hygiene guidelines that include but are not limited to
health facility staff hand washing prior to and after patient contact;

(c) The development of a written infection prevention and control policy with
input from front-line caregivers, and the posting of public notices regarding the infection prevention and control policy; and

(d) A worker and staff education requirement regarding modes of transmission of MDROs, use of protective equipment, disinfection policies and procedures, and other preventive measures.

(3) Surveillance Cultures:

(a) Not later than 180 days after the date of enactment of this Act, each acute care hospital shall screen for MRSA infections, and such other MDRO pathogens as the Secretary deems necessary, for each patient entering an intensive care unit or other high risk hospital department (as defined by the Secretary).

(b) The Secretary, consulting guidelines established by the Centers for Disease Control and Prevention, shall establish a process and a timetable for extending the screening requirements of Section 3 (3)(a) of this Act to all patients admitted to a health facility or discharged from an acute or critical care hospital, or nursing facility not later than January 1, 2014.

(c) The Secretary may waive the requirements of Section 3 (3), if the Secretary determines, consulting guidelines established by the Centers for Disease Control and Prevention and after public hearing, that the rate of MRSA infections or other infections has declined to a level at which further screening is no longer needed.

(4) The Cabinet for Health and Family Services 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 becomes available. Data shall include but not be limited to:

(a) The facility's rate of health facility-acquired infections;

(b) The rate of health facility-acquired MDRO infections; and

(c) The total number of MDRO infections found on surveillance cultures on admission.

(d) The rate of positive conversions of discharge cultures at acute and critical care hospitals, and nursing facilities.

(5) Health facilities shall use the Centers for Disease Control and Prevention's NHSN (National Healthcare Safety Network) reporting system or other data collection method as determined by the Secretary for implementation of this Act.

(6) The Secretary shall by July 1, 2011 implement a method for patients to report HAI to verify the data reported by health facilities.

(7) The Secretary shall serve as chief administrative officer for the health data collection functions of this Act. 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 Act.

(8) The Secretary shall report by each January 30 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 4 of this Act on reducing the rate of health facility- acquired infections and recommendations for improvement.

SECTION 4. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

A health facility that violates any provision of Section 3 of this Act shall for the first violation within a six-month period, be cited and shall submit a corrective action plan within ten (10) business days of the citation. For a second violation within a six-month period, a health facility shall be fined up to one thousand dollars ($1,000) per day until the violation is corrected. For three or more violations within a six-month period, a health facility shall be fined up to $20,000 for each violation and shall be fined up to two thousand dollars ($2,000) per day until all violations are corrected.