FIRST REGULAR SESSION

HOUSE BILL NO. 286

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES SCHAAF (Sponsor), SANDER AND COOPER (Co-sponsors).

0460L.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 192.667 and 197.150, RSMo, and to enact in lieu thereof two new sections relating to infections, with a penalty provision.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 192.667 and 197.150, RSMo, are repealed and two new sections enacted in lieu thereof, to be known as sections 192.667 and 197.150, to read as follows:

192.667. 1. All health care providers shall at least annually provide to the department charge data as required by the department. All hospitals shall at least annually provide patient abstract data and financial data as required by the department. Hospitals as defined in section 197.020, RSMo, shall report patient abstract data for outpatients and inpatients. Within one year of August 28, 1992, ambulatory surgical centers as defined in section 197.200, RSMo, shall provide patient abstract data to the department. The department shall specify by rule the types of information which shall be submitted and the method of submission.

2. The department shall collect data on required nosocomial infection incidence rates from hospitals, ambulatory surgical centers, and other facilities as necessary to generate the reports required by this section. Hospitals, ambulatory surgical centers, and other facilities shall provide such data in compliance with this section.

3. No later than July 1, 2005, the department shall promulgate rules specifying the standards and procedures for the collection, analysis, risk adjustment, and reporting of nosocomial infection incidence rates and the types of infections and procedures to be monitored pursuant to subsection 12 of this section. In promulgating such rules, the department shall:

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

(1) Use methodologies and systems for data collection established by the federal Centers for Disease Control and Prevention National **[**Nosocomial Infection Surveillance System**]** **Healthcare Safety Network**, or its successor; and

(2) Consider the findings and recommendations of the infection control advisory panel established pursuant to section 197.165, RSMo.

4. The infection control advisory panel created by section 197.165, RSMo, shall make a recommendation to the department regarding the appropriateness of implementing all or part of the nosocomial infection data collection, analysis, and public reporting requirements of this act by authorizing hospitals, ambulatory surgical centers, and other facilities to participate in the federal Centers for Disease Control and Prevention's National **[**Nosocomial Infection Surveillance System**]** **Healthcare Safety Network**, or its successor. The advisory panel shall consider the following factors in developing its recommendation:

(1) Whether the public is afforded the same or greater access to facility-specific infection control indicators and rates than would be provided under subsections 2, 3, and 6 to 12 of this section;

(2) Whether the data provided to the public are subject to the same or greater accuracy of risk adjustment than would be provided under subsections 2, 3, and 6 to 12 of this section;

(3) Whether the public is provided with the same or greater specificity of reporting of infections by type of facility infections and procedures than would be provided under subsections 2, 3, and 6 to 12 of this section;

(4) Whether the data are subject to the same or greater level of confidentiality of the identity of an individual patient than would be provided under subsections 2, 3, and 6 to 12 of this section;

(5) Whether the National **[**Nosocomial Infection Surveillance System**]** **Healthcare Safety Network**, or its successor, has the capacity to receive, analyze, and report the required data for all facilities;

(6) Whether the cost to implement the nosocomial infection data collection and reporting system is the same or less than under subsections 2, 3, and 6 to 12 of this section.

5. Based on the affirmative recommendation of the infection control advisory panel, and provided that the requirements of subsection 12 of this section can be met, the department may or may not implement the federal Centers for Disease Control and Prevention **[**Nosocomial Infection Surveillance System**]** **National Healthcare Safety Network**, or its successor, as an alternative means of complying with the requirements of subsections 2, 3, and 6 to 12 of this section. If the department chooses to implement the use of the federal Centers for Disease Control Prevention **[**Nosocomial Infection Surveillance System**]** **National Healthcare Safety Network**, or its successor, as an alternative means of complying with the requirements of

subsections 2, 3, and 6 to 12 of this section, it shall be a condition of licensure for hospitals and ambulatory surgical centers which opt to participate in the federal program to permit the federal program to disclose facility-specific data to the department as necessary to provide the public reports required by the department. Any hospital or ambulatory surgical center which does not voluntarily participate in the National **[**Nosocomial Infection Surveillance System**] Healthcare Safety Network**, or its successor, shall be required to abide by all of the requirements of subsections 2, 3, and 6 to 12 of this section.

6. The department shall not require the resubmission of data which has been submitted to the department of health and senior services or the department of social services under any other provision of law. The department of health and senior services shall accept data submitted by associations or related organizations on behalf of health care providers by entering into binding agreements negotiated with such associations or related organizations to obtain data required pursuant to section 192.665 and this section. A health care provider shall submit the required information to the department of health and senior services:

(1) If the provider does not submit the required data through such associations or related organizations;

(2) If no binding agreement has been reached within ninety days of August 28, 1992, between the department of health and senior services and such associations or related organizations; or

(3) If a binding agreement has expired for more than ninety days.

7. Information obtained by the department under the provisions of section 192.665 and this section shall not be public information. Reports and studies prepared by the department based upon such information shall be public information and may identify individual health care providers. The department of health and senior services may authorize the use of the data by other research organizations pursuant to the provisions of section 192.067. The department shall not use or release any information provided under section 192.665 and this section which would enable any person to determine any health care provider's negotiated discounts with specific preferred provider organizations or other managed care organizations. The department shall not release data in a form which could be used to identify a patient. Any violation of this subsection is a class A misdemeanor.

8. The department 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 upon the information obtained pursuant to the provisions of section 192.665 and this section. The department shall allow all health care providers and associations and related organizations who 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

use. The department shall include any comments of a health care provider, at the option of the provider, and associations and related organizations in the publication if the department does not change the publication based upon those comments. The report shall be made available to the public for a reasonable charge.

9. Any health care provider which continually and substantially, as these terms are defined by rule, fails to comply with the provisions of this section shall not be allowed to participate in any program administered by the state or to receive any moneys from the state.

10. A hospital, as defined in section 197.020, RSMo, aggrieved by the department's determination of ineligibility for state moneys pursuant to subsection 9 of this section may appeal as provided in section 197.071, RSMo. An ambulatory surgical center as defined in section 197.200, RSMo, aggrieved by the department's determination of ineligibility for state moneys pursuant to subsection 9 of this section may appeal as provided in section 197.221, RSMo.

11. The department of health may promulgate rules providing for collection of data and publication of nosocomial infection incidence rates for other types of health facilities determined to be sources of infections; except that, physicians' offices shall be exempt from reporting and disclosure of infection incidence rates.

12. In consultation with the infection control advisory panel established pursuant to section 197.165, RSMo, the department shall develop and disseminate to the public reports based on data compiled for a period of twelve months. Such reports shall be updated quarterly and shall show for each hospital, ambulatory surgical center, and other facility a risk-adjusted nosocomial infection incidence rate for the following types of infection:

(1) Class I surgical site infections;

(2) Ventilator-associated pneumonia**; provided that, upon the recommendation of the infection control advisory panel one or more other quality indicators designed to better measure the risk of acquiring ventilator-associated pneumonia can be substituted for a risk-adjusted nosocomial infection incidence rate**;

(3) Central line-related bloodstream infections;

(4) Other categories of infections that may be established by rule by the department.

The department, in consultation with the advisory panel, shall be authorized to collect and report data on subsets of each type of infection described in this subsection.

13. In the event the provisions of this act are implemented by requiring hospitals, ambulatory surgical centers, and other facilities to participate in the federal Centers for Disease Control and Prevention National **[**Nosocomial Infection Surveillance System**] Healthcare Safety Network**, or its successor, the types of infections to be publicly reported shall be determined by

the department by rule and shall be consistent with the infections tracked by the National Nosocomial Infection Surveillance System, or its successor.

14. Reports published pursuant to subsection 12 of this section shall be published on the department's Internet web site. The initial report shall be issued by the department not later than December 31, 2006. The reports shall be distributed at least annually to the governor and members of the general assembly.

15. The Hospital Industry Data Institute shall publish a report of Missouri hospitals' and ambulatory surgical centers' compliance with standardized quality of care measures established by the federal Centers for Medicare and Medicaid Services for prevention of infections related to surgical procedures. If the Hospital Industry Data Institute fails to do so by July 31, 2008, and annually thereafter, the department shall be authorized to collect information from the Centers for Medicare and Medicaid Services or from hospitals and ambulatory surgical centers and publish such information in accordance with subsection 14 of this section.

16. The data collected or published pursuant to this section shall be available to the department for purposes of licensing hospitals and ambulatory surgical centers pursuant to chapter 197, RSMo.

17. The department shall promulgate rules to implement the provisions of section 192.131 and sections 197.150 to 197.160, RSMo. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.

197.150. **1.** The department shall require that each hospital, ambulatory surgical center, and other facility have in place procedures for monitoring and enforcing compliance with infection control regulations and standards. Such procedures shall be coordinated with administrative staff, personnel staff, and the quality improvement program. Such procedures shall include, at a minimum, requirements for the facility's infection control program to conduct surveillance of personnel with a portion of the surveillance to be done in such manner that employees and medical staff are observed without their knowledge of such observation, provided that this unobserved surveillance requirement shall not be considered to be grounds for licensure enforcement action by the department until the department establishes clear and verifiable criteria for determining compliance. Such surveillance also may include monitoring of the rate of use of hand hygiene products.

2. Beginning January 1, 2010, the department shall require every hospital licensed in this state to establish a methicillin-resistant staphylococcus aureus (MRSA) control program. The program shall be developed by the hospital's administrative staff, medical staff, and quality improvement program, and shall:

(1) Establish procedures to isolate identified MRSA-colonized and MRSA-infected patients or use alternative methods to reduce the risk of MRSA transmission when private rooms are not available;

(2) Establish procedures, protocols, and education for staff known to be MRSA-colonized or MRSA-infected;

(3) Establish an infection-control intervention protocol that includes at a minimum the following elements:

(a) Infection control precautions, based on nationally recognized standards, for general surveillance of infected or colonized patients;

(b) Intervention protocols based on evidence-based standards;

(c) Physical plant operations related to infection control and environmental cleaning;

(d) Strict hand washing hygiene protocols and the use of contact barriers;

(e) Appropriate use of antimicrobial agents; and

(f) Mandatory educational programs for personnel.

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