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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1552 Session of 2007

INTRODUCED BY DeLUCA, MICOZZIE, SHIMKUS, THOMAS, DeWEESE, EACHUS, KENNEY, BELFANTI, BIANCUCCI, BLACKWELL, CALTAGIRONE, CREIGHTON, FABRIZIO, FRANKEL, FREEMAN, GIBBONS, GRUCELA, GOODMAN, HALUSKA, JOSEPHS, KORTZ, KOTIK, KULA, LENTZ, MAHONEY, MANDERINO, MARKOSEK, McILVAINE SMITH, MUNDY, MYERS, SAYLOR, SOLOBAY, TANGRETTI, J. TAYLOR, R. TAYLOR, WALKO, YUDICHAK, WANSACZ, KILLION, JAMES AND MELIO, JUNE 13, 2007

AS AMENDED ON SECOND CONSIDERATION, HOUSE OF REPRESENTATIVES, JUNE 26, 2007

AN ACT

Establishing the Pennsylvania Infection Control Advisory Committee; providing for duties of the committee, the Department of Health, the Pennsylvania Health Care Cost Containment Council and the Patient Safety Authority; requiring health care facilities to develop and implement infection control plans; and imposing penalties.

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The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the Health Care-associated Infection Prevention and Control Act.

Section 2. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Antimicrobial agent." A general term for drugs, chemicals or other substances that kill or slow the growth of microbes, including, but not limited to, antibacterial drugs, antiviral agents, antifungal agents and antiparasitic drugs.

"Authority." The Patient Safety Authority established by the act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act.

"BEST PRACTICES." NATIONALLY RECOGNIZED STANDARDS DEVELOPED BY ORGANIZATIONS SPECIALIZING IN THE CONTROL OF INFECTIOUS DISEASES SUCH AS THE SOCIETY FOR HEALTHCARE EPIDEMIOLOGY OF AMERICA (SHEA), THE ASSOCIATION FOR INFECTION CONTROL AND EPIDEMIOLOGY AND THE INFECTIOUS DISEASES SOCIETY OF AMERICA AND THE PROFESSIONALS IN METHODS RECOMMENDATIONS AND GUIDELINES DEVELOPED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION AND ITS NATIONAL HEALTHCARE SAFETY NETWORK THAT SHOULD BE USED BY <—

HEALTH CARE PROVIDERS TO REDUCE THE RISK OF HARM TO PATIENTS.

"Collaborative." An organized collaborative designated by the Department of Health in each region of this Commonwealth. An organized collaborative shall include at least one hospital and one nursing facility and may include Federal, State and local entities, other health care facilities, physician practices, academic institutions or any other organization that may assist in efforts to reduce or eliminate health care-associated infections.

"Collaborative partner." A health care facility that partners with a collaborative and uses and accesses the resources that the collaborative offers in accordance with this act.

"Colonization." The first stage of microbial infection or the presence of nonreplicating microorganisms usually present in the host tissues that are in contact with the external environment.

"Committee." The Pennsylvania Infection Control Advisory Committee established under section 3.

"Consumer Price Index." The Consumer Price Index for All Urban Consumers (CPI-U) for the Pennsylvania, New Jersey, Delaware and Maryland area for the most recent 12-month period for which figures have been officially reported by the United States Department of Labor, Bureau of Labor Statistics, immediately prior to the subject date.

"Council." The Pennsylvania Health Care Cost Containment Council.

"Department." The Department of Health of the Commonwealth.

"Fund." The Patient Safety Trust Fund.

"Health care-associated infection." 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 within 48 hours after admission;

(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.

"Health care facility." Any health care facility providing clinically related health services including, but not limited to, a general or special hospital, including psychiatric hospitals, rehabilitation hospitals, ambulatory surgical facilities, long-term care nursing facilities, abortion facilities, cancer treatment centers using radiation therapy on an ambulatory basis and inpatient drug and alcohol treatment facilities, both profit and nonprofit and including those operated by an agency or State or local government. The term shall also include hospice. The term shall not include an office used primarily for the private or group practice by health care practitioners where no reviewable clinically related health service is offered, a facility providing treatment solely on the basis of prayer or spiritual means in accordance with the tenets of any church or religious denomination or a facility conducted by a religious organization for the purpose of providing health care services exclusively to clergy or other persons in a religious profession who are members of the religious denominations conducting the facility. FOR THE PURPOSES OF <—

REPORTING, THE TERM SHALL ONLY APPLY TO HOSPITALS AND NURSING HOMES.

"HEALTH PAYOR." AN INDIVIDUAL OR ENTITY PROVIDING A GROUP OR INDIVIDUAL HEALTH, SICKNESS OR ACCIDENT POLICY, SUBSCRIBER CONTRACT OR PROGRAM ISSUED OR PROVIDED BY AN ENTITY SUBJECT TO ANY ONE OF THE FOLLOWING:

(1) THE ACT OF JUNE 2, 1915 (P.L.736, NO.338), KNOWN AS THE WORKERS' COMPENSATION ACT.

(2) SECTION 630 OF THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921.

(3) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT.

(4) THE ACT OF MAY 18, 1976 (P.L.123, NO.54), KNOWN AS THE INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS ACT.

(5) 40 PA.C.S. CH. 61 (RELATING TO HOSPITAL PLAN CORPORATIONS) OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN CORPORATIONS).

"Mcare Act." The act of March 20, 2002 (P.L.154, No.13), known as the Medical Care Availability and Reduction of Error (Mcare) Act.

"MEDICAID." THE PROGRAM ESTABLISHED UNDER TITLE XIX OF THE SOCIAL SECURITY ACT (49 STAT. 620, 42 U.S.C. § 1396 ET SEQ.). <—

"MRSA." Methicillin-resistant staphylococcus aureus, a more serious form of bacterial health care-associated infection that is resistant to commonly used antibiotics.

"Multidrug resistant organisms" or "MDROO." Microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents.

~~"Safe practices." The set of standards endorsed by the~~ <—

~~National Quality Forum that should be used by health care providers to reduce the risk of harm to patients.~~

Section 3. Committee.

(a) Establishment.--The Pennsylvania Infection Control Advisory Committee is hereby established.

(b) Membership.--The advisory committee shall consist of the following members who shall serve until the expiration of their terms, membership or employment or until their successors are appointed:

(1) The Secretary of Health.

(2) The executive director of the authority or a designee.

(3) The executive director of the council or a designee.

(4) The director of the Office of Health Care Reform or a designee.

(5) The following members chosen by the Governor:

(i) A representative of each collaborative from a list submitted by the respective collaborative.

(ii) Two individuals representing hospitals who are members of the Hospital and Healthsystem Association of Pennsylvania.

(iii) One individual representing a nonprofit nursing home.

(iv) One individual representing a for-profit nursing home.

(v) Two individuals with a background in infection control who are members of either the Association of Professionals in Infection Control (APIC) or the Society of Healthcare Epidemiology of America (SHEA).

(vi) One individual who is a patient advocate.

(vii) Two individuals with a background in epidemiology.

(viii) Two individuals representing other licensed health care facilities.

(IX) ONE INDIVIDUAL FROM A LIST OF TWO RECOMMENDED BY THE PENNSYLVANIA CHAMBER OF BUSINESS AND INDUSTRY CHOSEN FROM THE BUSINESS COMMUNITY REPRESENTATIVES APPOINTED TO THE COUNCIL UNDER SECTION 4(B)(4) OF THE ACT OF JULY 8, 1986 (P.L.408, NO.89), KNOWN AS THE HEALTH CARE COST CONTAINMENT ACT. <—

(X) ONE INDIVIDUAL FROM A LIST OF TWO RECOMMENDED BY THE PENNSYLVANIA AFL-CIO CHOSEN FROM THE ORGANIZED LABOR REPRESENTATIVES APPOINTED TO THE COUNCIL UNDER SECTION 4(B)(5) OF THE HEALTH CARE COST CONTAINMENT ACT.

(c) Chairperson.--The Secretary of Health shall be the chairperson of the committee.

(d) Meetings.--The committee shall meet quarterly and at other times at the call of the chairperson.

(e) Organization.--The committee shall be organized within the department for organizational, budgetary and administrative purposes.

(f) General powers and duties.--The committee shall do the following:

(1) Encourage cooperation among Federal, State and local government agencies, academic institutions and the private sector to assist in improving best practices ~~and promoting those~~ WHICH INCLUDE IMPLEMENTING NATIONALLY RECOGNIZED STANDARDS THAT PROMOTE practices and programs ~~that~~ TO reduce or eliminate health care-associated infections. <— <— <—

(2) Serve as a forum for presenting information and

studying programs being used within this Commonwealth.

(3) Develop recommendations regarding best practices to effectuate screenings of high-risk patients consistent with the provisions of this act and other means of reduction and elimination of health care-associated infections and how these practices may apply to health care facilities.

(4) Identify financial and technological needs of health care facilities regarding infection control and prevention.

(5) Develop recommendations on how best to implement an outreach process that includes notifying a receiving health care facility of any patient known to be colonized prior to transfer to another facility.

(6) Develop recommendations regarding evidence-based screening protocols of patients and residents for MDROO. ~~upon admission and randomized screening of inpatients and residents for MDROO after admission.~~ <—

~~(7) Recommend process for establishing benchmarks based upon a uniform database that identifies and quantifies health care-associated infections and will be based on actual observed experiences of health care facilities in managing infections to evaluate health care-associated infections for the department's use during licensure or inspection of a health care facility. The uniform database shall be established using payment claims data that is currently submitted to the Commonwealth and shall be an extension of the base categorical DRG structure and be based on standard administrative data. No additional data elements or changes to the current claim form shall be required. Benchmarks will be reviewed and updated annually.~~

(7) RECOMMEND A METHODOLOGY AND A DEFINED PROCESS USING <—

NATIONALLY RECOGNIZED STANDARDS FOR DETERMINING AND ASSESSING THE RATE OF HEALTH CARE-ASSOCIATED INFECTIONS THAT OCCUR IN HEALTH CARE FACILITIES IN THIS COMMONWEALTH. THE PROCESS SHALL INCLUDE ESTABLISHMENT OF BENCHMARKS TO MEASURE HEALTH CARE FACILITIES' MANAGEMENT OF HEALTH CARE-ASSOCIATED INFECTIONS, WHICH THE DEPARTMENT MAY USE DURING LICENSURE OR INSPECTION OF A HEALTH CARE FACILITY. METHODOLOGY, PROCESS AND BENCHMARKS SHALL BE REVIEWED AND UPDATED ANNUALLY.

(8) Provide recommendations to the department on the distribution of any available funds to collaboratives.

(9) Issue reports on health care facility infection control and prevention in this Commonwealth.

(10) Develop annual infection control and prevention priorities.

(11) RECOMMEND SYSTEM REQUIREMENTS AND ELEMENTS FOR <— HEALTH CARE-ASSOCIATED INFECTION ELECTRONIC SURVEILLANCE SYSTEMS TO BE USED BY HEALTH CARE FACILITIES. CONSIDERATION SHOULD BE GIVEN TO ELEMENTS WHICH PROVIDE:

(I) EXTRACTION OF EXISTING ELECTRONIC CLINICAL DATA FROM HEALTH CARE FACILITIES SYSTEMS ON AN ONGOING BASIS.

(II) TRANSLATION OF NONSTANDARDIZED LABORATORY, PHARMACY AND/OR RADIOLOGY DATA INTO UNIFORM INFORMATION THAT CAN BE ANALYZED ON A POPULATION-WIDE BASIS.

(III) CLINICAL SUPPORT, EDUCATIONAL TOOLS AND TRAINING TO ENSURE THAT INFORMATION PROVIDED UNDER THIS SUBSECTION WILL LEAD TO CHANGE.

(IV) CLINICAL IMPROVEMENT MEASUREMENT AND THE STRUCTURE TO PROVIDE ONGOING POSITIVE AND NEGATIVE FEEDBACK TO HEALTH CARE FACILITIES STAFF WHO IMPLEMENT CHANGE.

(12) RECOMMEND UNIFORM REPORTING REQUIREMENTS FOR HEALTH CARE FACILITIES TO REPORT HEALTH CARE-ASSOCIATED INFECTIONS TO THE DEPARTMENT, THE COUNCIL AND THE AUTHORITY. THE RECOMMENDATION SHALL INCLUDE THE FORM AND CONTENT OF THE REQUIRED REPORTS.

Section 4. Duties of department.

The department ~~shall~~ MAY do the following: <—

(1) Designate six infection prevention and control regions within this Commonwealth.

(2) Issue grants to collaboratives.

(3) Designate at least one collaborative in each region.

(4) When reviewing applications for designating a collaborative, the department shall give preference to groups that are currently meeting the requirements of this act and are implementing best practices to reduce health care-associated infections.

(5) In cooperation with the authority, develop a public outreach program on health care-associated infections. The program shall:

(i) Provide information to the public on causes and symptoms of health care-associated infections, prevention methods and the proper use of antibiotics.

(ii) Encourage that individuals receiving treatment or admitted to a health care facility ask health care professionals about efforts to control and eliminate health care-associated infections within the health care facility.

(iii) Determine the process to be used by health care facilities for notifying a health care facility of any patient known to be colonized prior to transfer

within or between health care facilities.

(6) Develop programs that inform facilities of the purpose and function of collaboratives and encourage the use of collaboratives for assistance.

(7) Publish in the Pennsylvania Bulletin, within 45 days after receipt of the committee's recommendation on METHODOLOGY, PROCESS AND benchmarks, the specific benchmarks <—— the department shall use to measure the progress of health care facilities in reducing health care-associated infections.

(8) Require best practices to effectuate screenings of staff and patients based on suspicion of transmission of an infection.

(9) In cooperation with the authority, act as a repository for information on current health care-associated infections and for newly identified infections and treatment protocols.

(10) PUBLISH A NOTICE IN THE PENNSYLVANIA BULLETIN <—— STATING THE UNIFORM REPORTING REQUIREMENTS, INCLUDING BOTH FORM AND CONTENT, FOR HEALTH CARE-ASSOCIATED INFECTIONS BASED ON RECOMMENDATIONS MADE BY THE COMMITTEE. THE UNIFORM REPORTING REQUIREMENTS SHALL APPLY AND BE UTILIZED FOR REPORTS MADE TO THE DEPARTMENT, THE COUNCIL AND THE AUTHORITY. THE EFFECTIVE DATE FOR THE COMMENCEMENT OF REQUIRED REPORTING BY HEALTH CARE FACILITIES CONSISTENT WITH THIS ACT, AT A MINIMUM, SHALL BEGIN NO LATER THAN 120 DAYS AFTER PUBLICATION OF THE NOTICE. REPORTING REQUIREMENTS CONTAINED IN SECTION 6 OF THE ACT OF JULY 8, 1986 (P.L.408, NO.89), KNOWN AS THE HEALTH CARE COST CONTAINMENT ACT, AS THEY RELATE TO HEALTH CARE-ASSOCIATED INFECTIONS SHALL REMAIN

IN EFFECT UNTIL 120 DAYS AFTER PUBLICATION OF THE NOTICE.

Section 5. Collaboratives.

To receive grant funding, a collaborative shall do the following:

(1) Establish an advisory body that includes, but is not limited to, the following:

(i) An epidemiologist with a background in health care-associated infections.

(ii) An infection control professional.

(iii) A professional from a laboratory that tests samples for testing of microbial infection or the presence of nonreplicating microorganisms.

(2) Establish an educational structure that can work with the authority and other organizations to offer various options for training in best practices.

(3) Identify effective measures for the detection, control and prevention of health care-associated infections that include, but are not limited to, the following:

(i) An active culture surveillance process and policies.

(ii) A system to identify and designate patients known to be colonized or infected with MRSA or other MDROO in accordance with the requirements of this act.

(iii) An infection control intervention protocol which, at a minimum, addresses:

(A) Infection control precautions based on best practices for general surveillance of infected or colonized patients.

(B) Treatment protocols based on evidence-based standards.

(C) Isolation procedures.

(D) Physical plant operations related to infection control.

(E) Educational programs for personnel.

(F) Fiscal and human resource requirements related to infection control and prevention.

(4) Use grant money to provide financial assistance to health care facilities to invest in technologies and infrastructure designed to reduce health care-associated infections.

Section 6. Health care facilities.

(a) Development and compliance.--Within 120 days after enactment, a health care facility shall develop and implement an internal infection control plan that shall include, but is not limited to, the following:

(1) A multidisciplinary committee including representatives from each of the following IF APPLICABLE TO THAT PARTICULAR HEALTH CARE FACILITY: <—

(i) Medical staff, including the chief medical officer.

(ii) Administration, including the chief executive officer and the chief financial officer. For a nursing home the committee shall include the director.

(iii) Laboratory personnel.

(iv) Nursing, including the director of nursing.

(v) Pharmacy, including the chief of pharmacy.

(vi) The physical plant manager.

(vii) A patient safety officer.

(viii) Members from the infection control team.

~~(2) In addition to standards adopted by the department:~~ <—

(2) HEALTH CARE FACILITIES SHALL ADOPT: <—

(i) Effective measures for the detection, control and prevention of health care-associated infections.

(ii) An active culture surveillance process and policies.

(iii) A system to identify and designate patients known to be colonized or infected with MRSA or other MDROO.

(iv) Procedures for identifying other high-risk patients admitted to the health care facility who shall receive routine cultures and screenings.

(v) An outreach process for notifying a receiving health care facility of any patient known to be colonized prior to transfer within or between facilities BASED ON <— RECOMMENDATIONS MADE BY THE COMMITTEE.

(vi) A required facility-specific infection control intervention protocol which, at a minimum, addresses:

(A) Infection control precautions based on nationally recognized standards for general surveillance of infected or colonized patients.

(B) Treatment protocols based on evidence-based standards.

(C) Isolation procedures.

(D) Physical plant operations related to infection control.

(E) Appropriate use of antimicrobial agents and antibiotics.

(F) Mandatory educational programs for personnel.

(G) Fiscal and human resource requirements

related to infection control and prevention.

~~(3) Any other requirements that the department shall require through rules and regulations.~~ <—

(b) Department review.--The department shall review each health care facility's infection control plan to ensure compliance with this act in accordance with the department's authority under 28 Pa. Code Ch. 146 (relating to infection control) during its regular licensure inspection process.

(c) Notification.--Upon approval of its infection control plan, a health care facility shall notify all health care workers and medical staff of the health care facility of the infection control plan. Compliance with the infection control plan shall be required as a condition of licensure, employment or credentialing at the health care facility.

Section 7. Authority.

(a) Duties.--In addition to its existing responsibilities, the authority is responsible for all of the following:

(1) Providing nursing homes with patient safety advisories issued by the authority pursuant to section 304(a)(7) of the Mcare Act.

(2) Issuing alerts and reports to health care facilities as required by the board.

(3) Including a separate category for providing information about health care-associated infections in the annual report under section 304(c) of the Mcare Act.

(b) Training.--The authority shall as recommended by the board create and conduct training programs for infection control teams, health care workers and consumers about the prevention and control of health care-associated infections. Nothing in this act precludes the authority from collaborating with the

department, collaboratives or other organizations in conducting these programs.

(c) Monitoring.--Health care facility patient safety plans will identify how the facility will distribute patient safety advisories, alerts and reports required under this act so that they are easily accessible and widely distributed in each health care facility to administrative staff, medical personnel and health care workers.

Section 8. Nursing homes.

~~(a) Reporting.--Nursing homes shall report to the council~~ <—

(A) REPORTING.-- <—

(1) NURSING HOMES SHALL REPORT TO THE COUNCIL the same infections and in the same manner that hospitals are required to report to the council under the act of July 8, 1986 (P.L.408, No.89), known as the Health Care Cost Containment Act. Reporting shall begin within 30 days following the effective date of this section. For purposes of this section, nursing homes shall be additional data sources as defined in the Health Care Cost Containment Act, and covered services as defined in that act shall include those services provided by nursing homes.

(2) NO LATER THAN 120 DAYS FOLLOWING THE DATE THE <—
DEPARTMENT PUBLISHES THE UNIFORM REPORTING REQUIREMENTS IN THE PENNSYLVANIA BULLETIN, PURSUANT TO SECTION 7(A)(1), NURSING HOMES SHALL REPORT INFORMATION PERTAINING TO HOSPITAL-ASSOCIATED INFECTIONS TO THE AUTHORITY IN THE FORM SO REQUIRED BY THE AUTHORITY. FOR THE PURPOSES OF THE REPORTING REQUIREMENTS CONTAINED IN THIS SECTION, THE CONFIDENTIALITY PROTECTIONS CONTAINED IN SECTION 311 OF THE ACT OF MARCH 20, 2002 (P.L.154, NO.13), KNOWN AS THE MEDICAL

CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) ACT, SHALL APPLY TO NURSING HOMES.

(b) Analysis of nursing home data by authority.--

(1) At the request of the department or the ~~board~~ COMMITTEE, but no less frequently than once per year, the authority shall analyze data without patient identifying information reported ~~to the department by nursing homes with respect to events compromising patient safety as required by 28 Pa. Code § 51.3 (relating to notification)~~ TO THE DEPARTMENT, THE COUNCIL AND THE AUTHORITY BY NURSING HOMES.

(2) A nursing home may request the authority to conduct an analysis of the data collected under paragraph (1) in order to provide information to nursing homes which can be used to improve patient safety and quality of care.

(c) Surcharge.--Commencing January 1, 2008, each nursing home shall pay the department a surcharge on its licensing fee as necessary to provide sufficient revenues to operate the authority for its responsibilities under this act. The following apply:

(1) For each calendar year, the department shall determine and assess each nursing home its proportionate share of the authority's budget for its responsibilities under this act. The total assessment amount shall not be more than $1,000,000 in fiscal year 2007-2008 and shall be increased according to the Consumer Price Index in each succeeding fiscal year.

(2) THE ANNUAL ASSESSMENT AMOUNT PAID BY A NURSING FACILITY SHALL BE A REIMBURSABLE COST UNDER THE MEDICAL ASSISTANCE PROGRAM. THE DEPARTMENT OF PUBLIC WELFARE SHALL PAY EACH NURSING FACILITY, AS A SEPARATE, PASS-THROUGH

PAYMENT, AN AMOUNT EQUAL TO THE ASSESSMENT PAID BY A NURSING FACILITY MULTIPLIED BY THE FACILITY'S MEDICAL ASSISTANCE OCCUPANCY AS REPORTED IN ITS ANNUAL COST REPORT.

~~(2)~~ (3) Money appropriated to the fund under this act shall be expended by the authority to implement this act. <—

~~(3)~~ (4) In the event that the fund is discontinued or the authority is dissolved by operation of law, any balance paid by nursing homes remaining in the fund, after deducting administrative costs of liquidation, shall be returned to the nursing homes in proportion to their financial contributions to the fund in the preceding licensing period. <—

~~(4)~~ (5) If after 30 days' notice a nursing home fails to pay a surcharge levied by the department under this section, the department may assess an administrative penalty of $1,000 per day until the surcharge is paid. <—

Section 9. Electronic surveillance.

(a) Electronic surveillance of health care-associated infections.--By January 1, 2008, the department shall, BASED ON RECOMMENDATIONS OF THE COMMITTEE, identify qualified ~~systems~~ SYSTEM COMPONENTS AND ELEMENTS which can be used by health care facilities by July 1, 2008.~~, to report health care-associated infections to the council. Qualified systems shall include the following minimum elements:~~ <— <— <—

~~(1) Extraction of existing electronic clinical data from hospital systems on an ongoing basis.~~

~~(2) Translation of nonstandardized laboratory, pharmacy and/or radiology data into uniform information that can be analyzed on a population-wide basis.~~

~~(3) Clinical support, educational tools and training to ensure that information provided under this subsection will~~

~~lead to change.~~

~~(4) Clinical improvement measurement and the structure to provide ongoing positive and negative feedback to hospital staff who implement change.~~

~~(b) Classifications.--Hospitals shall report the following classifications of infections and, as to each infection acquired in the facility, whether the infection was caused by a multidrug-resistant organism:~~

~~(1) Patients with positive MRSA at admission or preadmission screening.~~

~~(2) Urinary tract infections.~~

~~(3) Surgical site infections.~~

~~(4) Ventilator-associated pneumonia.~~

~~(5) Blood stream infections.~~

~~(6) Bone and joint infections.~~

~~(7) Central nervous system infections.~~

~~(8) Cardiovascular infections.~~

~~(9) Eye, ear, nose and throat infections.~~

~~(10) Gastrointestinal infections.~~

~~(11) Lower respiratory infections.~~

~~(12) Reproductive system infections.~~

~~(13) Systemic infections.~~

~~(14) Multiple infections.~~

(A.1) NO LATER THAN DECEMBER 30, 2008, HOSPITALS MUST HAVE IN PLACE A QUALIFIED SYSTEM FOR THE ELECTRONIC SURVEILLANCE OF HEALTH CARE-ASSOCIATED INFECTIONS. <—

~~(c)~~ (B) Benchmarks.--~~The department shall establish reasonable benchmarks against which to measure the progress of health care facilities to reduce health care-associated infections.~~ All HEALTH CARE facilities will be measured against <—

the benchmarks ESTABLISHED BY THE DEPARTMENT PURSUANT TO <—
RECOMMENDATIONS OF THE COMMITTEE. Those facilities with rates of associated infections that are above the benchmark will be required to submit a plan of remediation to the department within 60 days after being notified of missing the standard. If after 180 days, the facility has shown no progress in reducing rates of infections, the facility is required to consult with the regional collaborative to further develop a plan of remediation. If after an additional 180 days the facility continues to fail to progress in lowering its rates of infection, the penalties in section 10 shall apply.

~~(d)~~ (C) Other technologies.--Nothing in this section shall <— prevent health care facilities from having the flexibility to use other technologies to manage infections as they see fit.

(D) PAYOR.--A PAYOR MAY REDUCE ALL PAYMENTS TO A FACILITY <— WHICH FAILS TO MEET THE ESTABLISHED BENCHMARKS FOR A GIVEN YEAR BY 2% FOR EACH PAYMENT OWED TO A FACILITY FOR SERVICES PROVIDED UNTIL THE DEPARTMENT CERTIFIES THE FACILITY HAS MET THE BENCHMARKS FOR THAT YEAR.

Section 10. Violations and penalties.

(a) General rule.--When appropriate, the department will work with the health care facility to rectify a violation of this act.

(b) Health care facility violations.--A health care facility that violates this act may be subject to sanctions by the department, which include:

(1) Suspension of its license.

(2) Revocation of its license.

(3) Refusal to renew its license.

(4) Limitation of its license as to operation of a

portion of the health care facility or to the services which may be provided at the health care facility.

(5) Issuance of a provisional license.

(6) Submission of a plan of correction.

(7) Limitation or suspension of admissions to the health care facility.

(c) Penalty.--A facility who violates this act may be subject to a civil penalty not to exceed $500 per day.

SECTION 11. PAYMENTS. <—

(A) PAYMENT FOR PERFORMING ROUTINE CULTURES AND SCREENINGS IN HOSPITALS.--THE COST OF ROUTINE CULTURES AND SCREENINGS PERFORMED ON PATIENTS IN HOSPITALS IN COMPLIANCE WITH THE HEALTH CARE FACILITY'S INFECTION CONTROL PLAN SHALL BE CONSIDERED A REIMBURSABLE COST TO BE PAID BY HEALTH PAYORS AND MEDICAID, SUBJECT TO ANY COPAYMENT, COINSURANCE OR DEDUCTIBLE AMOUNTS IMPOSED IN ANY APPLICABLE POLICY OR BENEFIT ISSUED BY A HEALTH PAYOR OR PROVIDED BY MEDICAID AND TO ANY AGREEMENTS BETWEEN A HEALTH CARE FACILITY AND A PAYOR OR MEDICAID.

(B) PAYMENT FOR PERFORMING ROUTINE CULTURES AND SCREENINGS IN NURSING HOMES.--THE FULL COST OF ROUTINE CULTURES AND SCREENINGS PERFORMED ON PATIENTS IN NURSING HOMES IN COMPLIANCE WITH A HEALTH CARE FACILITY'S INFECTION CONTROL PLAN SHALL BE PAID BY HEALTH PAYORS AND MEDICAID.

SECTION 12. INCENTIVE PAYMENTS.

(A) GENERAL RULE.--COMMENCING JANUARY 1, 2009, A HEALTH CARE FACILITY THAT EXCEEDS THE BENCHMARK PUBLISHED BY THE DEPARTMENT SHALL BE ELIGIBLE FOR AN INCENTIVE PAYMENT. 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 HEALTH CARE FACILITIES.

(B) DISTRIBUTION OF FUNDS.--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. INCENTIVE PAYMENTS TO HEALTH CARE FACILITIES SHALL BE LIMITED TO FUNDS AVAILABLE FOR THIS PURPOSE.

(C) FUNDS SEPARATE.--FUNDS APPROPRIATED FOR INCENTIVE PAYMENTS SHALL BE SEPARATE FROM AND NOT OTHERWISE UTILIZE, RELY ON OR DIMINISH FUNDS NECESSARY FOR PAYMENTS TO BE MADE TO LONG-TERM CARE FACILITIES FOR THE PROVISION OF NURSING FACILITY SERVICES AND SHALL BE PAID IN ADDITION TO SUCH OTHER PAYMENTS.

SECTION 13. MACHINERY AND EQUIPMENT LOAN FUND ELIGIBILITY.

(A) FUNDS AVAILABLE.--UP TO $25,000,000 OF THE FUNDS APPROPRIATED BY THE GENERAL ASSEMBLY FOR THE MACHINERY AND EQUIPMENT LOAN FUND SHALL BE MADE AVAILABLE FOR LOAN TO HEALTH CARE FACILITIES TO ASSIST IN ACQUIRING SYSTEMS OR TECHNOLOGIES THAT ASSIST THE FACILITY IN REDUCING HEALTH CARE-ASSOCIATED INFECTIONS. LOANS SHALL NOT EXCEED 50% OF A HEALTH CARE FACILITY'S COSTS, WHICH SHALL BE APPROVED BY THE DEPARTMENT OF COMMUNITY AND ECONOMIC DEVELOPMENT.

(B) CRITERIA.--THE DEPARTMENT OF COMMUNITY AND ECONOMIC DEVELOPMENT SHALL DEVELOP CRITERIA FOR EVALUATING APPLICATIONS FOR LOANS THAT CONSIDER THE FISCAL CONDITION OF THE HEALTH CARE FACILITY, THE ABILITY OF THE HEALTH CARE FACILITY TO IMPLEMENT THE TECHNOLOGY AND THE POTENTIAL SAVINGS THROUGH AVOIDED COSTS AND REDUCED HEALTH CARE FACILITY-ACQUIRED INFECTION RATES. THE CRITERIA SHALL BE FORWARDED BY THE DEPARTMENT OF COMMUNITY AND ECONOMIC DEVELOPMENT TO THE LEGISLATIVE REFERENCE BUREAU FOR PUBLICATION AS A NOTICE IN THE PENNSYLVANIA BULLETIN.

(C) ELIGIBILITY.--ADDITIONALLY, TO BE ELIGIBLE FOR A LOAN, A HEALTH CARE FACILITY MUST BE IN COMPLIANCE WITH HEALTH CARE-ASSOCIATED INFECTION REPORTING REQUIREMENTS CONTAINED IN THIS ACT, THE ACT OF MARCH 20, 2002 (P.L.154, NO.13), KNOWN AS THE MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR (MCARE) ACT, AND THE ACT OF JULY 8, 1986 (P.L.408, NO.89), KNOWN AS THE HEALTH CARE COST CONTAINMENT ACT.

SECTION 14. EXPIRATION.

THIS ACT EXPIRES DECEMBER 31, 2012.

Section ~~11~~ 15. Effective date. <—

This act shall take effect in 90 days.