SJR

19

SESSION ADDRESS:
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Senator Gary Stevens
Alaska State Legislature

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Memo

To: Senator Fred Dyson, Senate HESS Committee

From: Senator Gary Stevens

Date: 2/16/2006

Re: Committee hearing request

I would like to request a HESS Committee hearing on Senate Joint Resolution, "Relating to creating the Task Force to Assess Public Reporting of Health Care Associated Infections " at your earliest convenience.

Thank you for your consideration of this request.

Senate District R
Senator_Gary_Stevens@legis.state.ak.us

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
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Juneau, Alaska 99801-1182
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MEMORANDUM February 16, 2006

SUBJECT: Summary of SJR 19 (Work Order No. 24-LS1657\A)

TO: Senator Gary Stevens
Attn: Doug Letch

FROM: Jean M. Mischel
Legislative Counsel

You have requested a summary of the above-described resolution.

As a preliminary matter, note that a summary of a resolution should not be considered an authoritative interpretation of the resolution and the resolution itself is the best statement of its contents.

The Whereas clauses state the findings of the legislature regarding the rate and costs of hospital acquired infections and other infections associated with health care.

The Resolve clauses establish a 10 member task force to conduct a review of and report on infections associated with health care and hospitals and reporting mechanisms.

JMM:med
06-135.med

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Sponsor Statement for Senate Joint Resolution 19
(February 16, 2006)

Some 2 million infections a year are acquired in hospitals and an estimated 90,000 people die as a result of these infections, making it the sixth-leading cause of death in the country. The cost to the consumers is between $4.5 and $11 billion a year. Given these alarming statistics, it is vital for consumers to have full knowledge of how medical facilities fare with infection rates. Passage of SJR 19 can help accomplish this goal by providing lawmakers, state health officials and medical professions the opportunity to craft workable legislative recommendations for the collection of data on hospital-acquired infection rates.

SJR 19 creates the Task Force to Assess Public Reporting of Health Care Associated Infections. This eleven member panel will consist of two senators, two representatives, the Chief of Epidemiology for the State of Alaska, one healthcare consumer from rural Alaska, one healthcare consumer from urban Alaska, a representative of the Alaska Native Tribal Health Consortium, a representative from the Alaska Chapter of the Association of Professionals in Infection Control and Epidemiology, and a representative of the Alaska State Hospital and Nursing Home Association.

During the 2006 Legislative Interim, the Task Force will be asked to:

(1) Review experience to date with public reporting of hospital-associated infections.
(2) Develop a white paper to be used for drafting legislation for reporting of healthcare associated infections. The white paper will address the unique healthcare challenges of Alaska and would encompass:
    (a) Mechanism(s) for reporting;
    (b) Identifying data sources and possible outcome and process measures to be reported;
    (c) Timeline for implementation;
    (d) Infrastructure needs for supporting a robust ongoing reporting system for dissemination of accurate data.

I ask for your support of this important legislation.

Senate District R
Senator_Gary_Stevens@legis.state.ak.us

Doug Letch

From: Jane Alberts
Sent: Monday, January 16, 2006 10:37 AM
To: Doug Letch; Katrina Matheny; James Shine; Sen. Gary Stevens
Subject: Kenai Peninsula Online - Alaska Newspaper -

another story on the same topic, in the same issue!
is it a slow newsday?
ha

Web posted Monday, January 16, 2006

Some care can threaten your health

By HAL SPENCE
Peninsula Clarion

At least a third of infections acquired in U.S. hospitals are considered preventable, according to the Center for Disease Control and Prevention.

Sen. Gary Stevens' bill (SB 208) would require hospitals to make public the rates of occurrence of five categories of infections named in the accompanying article.

Medical sources available on the Internet, including the CDC, define these "nosocomial infections," a term that literally means infections acquired in a hospital.

According to the CDC, approximately 500,000 surgical site infections occur per year. There are an estimated 27 million surgeries performed in the United States annually.

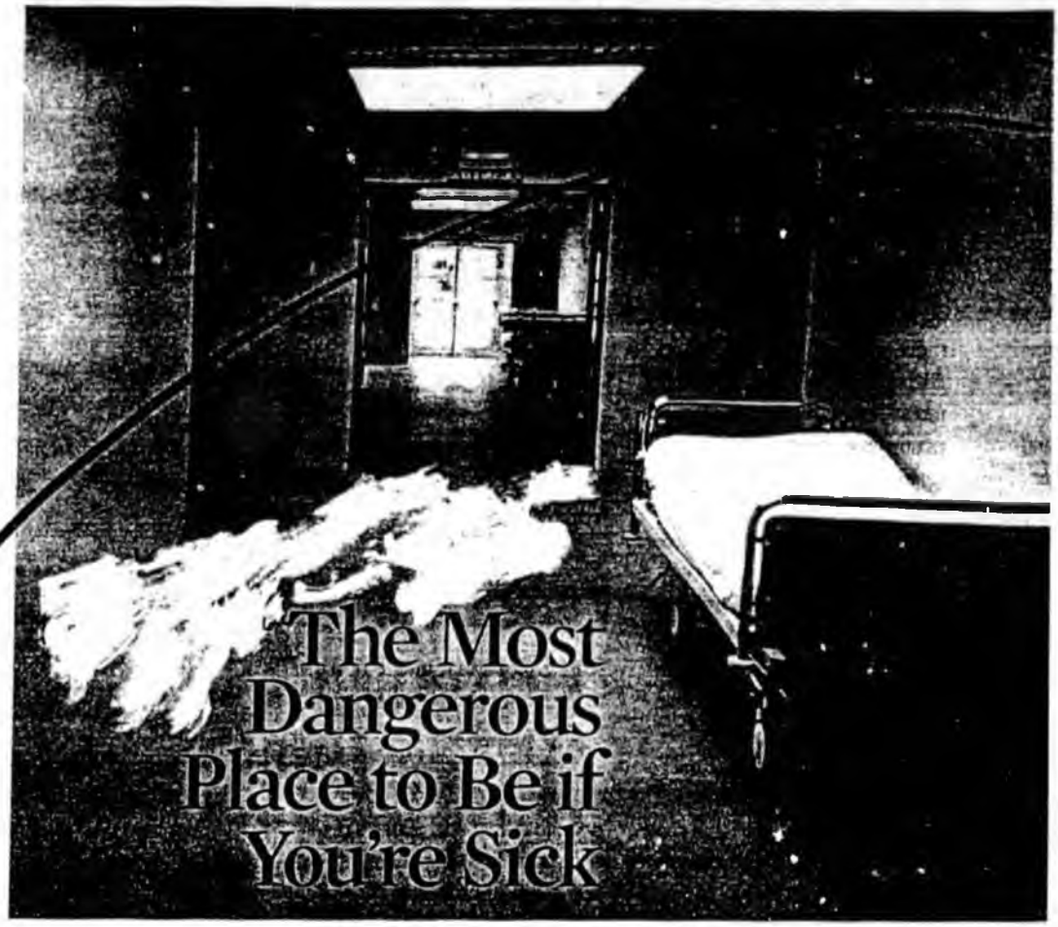
Pneumonia associated with ventilation — that is, mechanically assisted breathing — is another major source of in-hospital infections, accounting for about 15 percent of all hospital-associated infections. Better than half of those are associated with treatment in intensive care and coronary care units, according to the CDC.

Central line-associated blood infections are related to the use of venous catheters. An estimated 250,000 such infections occur each year in U.S. hospitals. One-eighth to 1/4 of infected patients die, the CDC said.

Urinary tract infections are the leading cause of nosocomial infections, accounting for more than 40 percent of the total reported and affecting an estimated 600,000 patients a year, said the CDC. Most (66-86 percent) follow use of urinary tract catheters, Brief use results in a low number of incidents, but infection is "virtually 100 percent" for patients with urethral catheters draining to open systems used longer than four days. Most infections clear up by themselves and some show no overt symptoms, the CDC reported.

The fifth category delineated in Stevens' bill provides room for future regulations adopted by the Department of Health and Social Services covering other infection sources.

[BULLETINBOA



The Most Dangerous Place to Be if You're Sick

When Leroy Rickabaugh had surgery to remove a bladder tumor at Mercy Medical Center in Des Moines, Iowa, last October, he expected to be in the hospital for just a few days.

Instead, he ended up staying for nearly three weeks after he contracted a bacterial infection that also hit several other patients on his ward. "I didn't get more seriously sick," Rickabaugh, 74, says, "but they wouldn't let me out until it cleared up."

In a way, Rickabaugh was lucky. Of the 2 million or so Americans each year who contract infections while in the hospital, about 90,000 die because of them. Hospital infections, in fact, are the nation's sixth-leading cause of death.

Health care and consumer activists have been pushing for laws that would require hospitals to publicly disclose their infection statistics, in the hope of pressuring them into adopting more effective anti-infection measures. So far they've scored victories in five states: Florida, Illinois, Missouri, Pennsylvania and Virginia. About 30 other states are considering similar legislation.

"It's a problem begging for attention, one that costs a lot of lives and money," says Lisa McGiffert, director of the Stop Hospital Infection Project for Consumers Union. "Clearly, hospitals aren't doing all that they can."

Now, with efforts in the states accelerati for a nationwide standard.

"We have an information shortage about h says Kenneth W. Kizer, M.D., president of th Forum, a Washington-based nonprofit organ have 50 different standards for measuring t have informat

First the bad news: About 90,000 Americans die each year from infections they contract while in the hospital.

Most infect ures aren't ne they're not lowed. Hun Ignaz Semm 1847 that the infections in reduced by hand washing. But many doctors staff members still do not wash their hands. Another simple but often overlooked precau surgery patients receive the correct antibiot before incisions are made.

"Doctors and nurses get so caught up in th don't even realize how far their own practic they see the data out there," says David Washington-based American Health Quality need to get that data to them."

CDC Department of Health and Human Services Centers for Disease Control and Prevention

Infectious Diseases in Healthcare Settings

The following are infectious diseases that may be transmitted and/or acquired in healthcare settings and therefore are possible Healthcare Associated Infections (HAIs).

Infectious Diseases that may be acquired in Healthcare facilities

- *Acinetobacter*
- Bloodborne Pathogens
- *Burkholderia cepacia*
- Chickenpox (Varicella)
- *Clostridium Difficile*
- *Clostridium Sordellii*
- Creutzfeldt-Jakob Disease (CJD)
- Ebola (Viral Hemorrhagic Fever)
- Gastrointestinal (GI) Infections
- Hepatitis A
- Hepatitis B
- Hepatitis C
- HIV/AIDS
- Influenza
- MRSA - Methicillin-resistant *Staphylococcus Aureus*
- Norovirus
- Parvovirus
- Poliovirus
- Pneumonia
- Rubella
- SARS
- *S. pneumoniae* (Drug resistant)
- Tuberculosis
- Varicella (Chickenpox)
- Viral Hemorrhagic Fever (Ebola)
- VISA - Vancomycin Intermediate *Staphylococcus aureus*
- VRE - Vancomycin-resistant *enterococci*

Date last modified: January 3, 2006
Content source: Division of Healthcare Quality Promotion (DHQP)

Hospital-Acquired Infections

Last Updated: September 1, 2004

Synonyms and related keywords: nosocomial infection, vancomycin-resistant enterococcus, VRE, methicillin-resistant *Staphylococcus aureus*, MRSA, *Pseudomonas*, candidiasis, *Legionella*, respiratory syncytial virus, thrush, *Clostridium difficile*

AUTHOR INFORMATION

Section 1 of 10 Next

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Quoc V Nguyen, MD, is a member of the following medical societies: American Association of Immunologists

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Disclosure

INTRODUCTION

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Background: Hospital-acquired infections encompass almost all clinically evident infections that do not originate from patient's original admitting diagnosis. Within hours after admission, a patient's flora begins to acquire characteristics of the surrounding bacterial pool. Most infections that become clinically evident after 48 hours of hospitalization are considered hospital-acquired. Infections that occur after the patient's discharge from the hospital can be considered to have a nosocomial origin if the organisms were acquired during the hospital stay.

Pathophysiology: Within hours of admission, colonies of hospital strains of bacteria develop in the patient's skin, respiratory tract, and genitourinary tract. Risks factors for the invasion of colonizing pathogens can be categorized into 3 areas: iatrogenic, organizational, and patient related.

- Iatrogenic risk factors include invasive procedures (eg, intubation, indwelling vascular lines, urine catheterization) and antibiotic use and prophylaxis.
- Organizational risk factors include contaminated air-conditioning systems, contaminated water systems, and staffing and physical layout of the facility (eg, nurse-to-patient ratio, open beds close together).
- Patient risk factors include the severity of illness, underlying immunocompromised state, and length of stay.

Frequency:

- **In the US:** Nosocomial infections are estimated to occur in 5% of all acute care hospitalizations. The estimated incidence is more than 2 million cases per year, resulting in an added expenditure in excess of $2 billion. The National Nosocomial Infections Surveillance (NNIS) System of the Centers for Disease Control and Prevention performed a survey from October 1986 to April 1998. They ranked hospital wards according to their association with central-line bloodstream infections. The highest rates of infection occurred in the burn ICU, neonatal ICU, and pediatric ICU.

Mortality/Morbidity: Nosocomial infections are estimated to more than double the mortality and morbidity risks of any admitted patient, and they probably result in about 20,000 deaths a year.

Respiratory Syncytial Virus Infection

Rhinovirus Infection

Staphylococcus Aureus Infection

Thrush

Toxic Shock Syndrome

Urinary Tract Infection

Continuing Education

CME available for this topic. Click here to take this CME.

Patient Education

Yeast and Fungal Infections Center

Yeast Infection Overview

History:

- Nosocomial infections are caused by viral, bacterial, and fungal pathogens. These pathogens should be investigated in all febrile patients who are admitted for a nonfebrile illness.
- During their hospital stay, many patients acquire viral respiratory infections in the winter (eg, influenza, parainfluenza, respiratory syncytial viruses), rotaviral infections in winter, or enteroviral infections in the summer. Viruses are the leading etiologies of nosocomial infections.
- Bacterial and fungal infections are less common. However they are significantly associated with more morbidity and mortality. Most patients who are infected with nosocomial bacterial and fungal pathogens have a predisposition caused by invasive supportive measures such as intubation and the placement of intravascular lines and urinary catheters. Fungal infections more likely to arise from the patient's own flora; occasionally, they are caused by contaminated solutions (eg, those used in parenteral nutrition).

Causes:

- Among 6,290 pediatric ICU patients surveyed between 1992-1997, the incidence of nosocomial invasive bacterial and fungal infections were as follows:
  - Bloodstream infections, 28%
  - Ventilator-associated pneumonia, 21%
  - Urinary tract infection (UTI), 15%
  - Lower respiratory infection, 12%
  - Gastrointestinal, skin, soft tissue, and cardiovascular infections, 10%
  - Surgical-site infections, 7%
  - Ear, nose, and throat infections, 7%
- Nosocomial etiologies in bloodstream infections include the

ıegative staphylococci, 40%

, 11.2%

%

:cus aureus, 9.3%

ır species, 6.2%

ads, 4.9%

ıgies in UTI include the following:

ive enterics, 50%

, 10%

ıgies in surgical-site infections include the

0%

ıads, 16%

negative staphylococci, 15%

, fungi, *Enterobacter* species, and *Escherichia*
ən 10% each

ıgies in fever include the following:

ɔns are most common causes of nosocomial

the second most common cause of nosocomial
ə hospitalized child.

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ıical Differentials Workup Treatment Medication Follow-up Miscellaneous

Croup
Endocarditis, Bacterial
Endocarditis, Fungal
Enteroviral Infections
Hepatitis C
Influenza
Legionella Infection
Parainfluenza Virus Infections
Pseudomonas Infection
Respiratory Syncytial Virus Infection
Rhinovirus Infection
Staphylococcus Aureus Infection
Thrush
Toxic Shock Syndrome
Urinary Tract Infection

Other Problems to be Considered:

Sepsis
Streptococcal infection, group D (enterococcus)

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Lab Studies:

- A detailed physical examination and review of systems most likely reveal the involved organs or systems. Workup should be focused on these abnormal areas. Studies should be centered on infections of the bloodstream, UTI, and pneumonia, unless an obvious source (eg, surgical-site infection) is readily identified.
- Bloodstream infections
  - Quantitative blood cultures with samples from the intravenous line and peripheral vein are recommended to aid in differential diagnosis of line-associated bacteremia.
  - Fungal cultures should be requested, if they are suspected. The laboratory should incubate cultures longer for fungus detection than for other pathogens.
  - In immunocompromised patients, special studies such as cultures for nocardia and atypical mycobacteria, cytomegalovirus, and antigenemia detection, occasionally are requested.
- Pneumonia
  - Radiography, oxygenation, and hemodynamic status determination are required

in the evaluation of nosocomial pneumonia.

- Examination of the sputum, endotracheal aspiration material, and pleural effusion fluid with Gram staining and culturing may be useful.
- A rapid diagnostic test may be uniquely useful. Examples include the direct fluorescent antibody test for *Legionella* organisms or those causing pertussis; immunofluorescence tests for influenza, respiratory syncytial virus (RSV), which is transmitted by contact, and *Pneumocystis carinii;* and modified acid-fast stains for mycobacteria.

ıary tract infection

- UTIs are expected in patients who require an indwelling urinary catheter.
- Efforts should be made to differentiate colonization, cystitis, and frank pyelonephritis by means of urinalysis, urine Gram staining, and culturing.
- Early removal of the urinary catheter is always helpful in the treatment of catheter-associated UTI.

itis

- A stool Gram stain should be performed to detect white blood cells.
- Tests for *Clostridium difficile* toxin are useful in the workup for nosocomial fevers and loose stool. (Rotavirus spreads among susceptible infants during local epidemics in cold months. In infants, colonization with *C difficile* often does not cause problems.)

er laboratory studies

- General viral cultures from the throat and rectum can be helpful in management.
- Acute and convalescent titers against viral agents also can be helpful.
- Antigen for *Legionella pneumophila* serotype 1 can be detected in the urine.

Studies:

ecial imaging techniques (eg, sonography, CT, or MRI) may be helpful in evaluating icure site infections.

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Care:

f shock, hypoventilation, and other complications is provided,
tion of empiric antibacterials, antifungals, and antivirals.

hicillin-resistant *Staphylococcus aureus* (MRSA) are not
by susceptible *S aureus*. MRSA requires treatment with a
pathogenicity does not differ from that of susceptible strains

d be considered if the line is suspected in the cause of sepsis.

tibiotics should be selected according to the local
:rns of microbial susceptibility.

:onazole, amphotericin B) are added to empiric antibiotics in

:iclovir, acyclovir) could be used in the treatment of suspected
infections.

ıtibiotics are used, with guidance of the results from rapid
sputum, endotracheal suction material, and bronchial lavage

:s are indicated in legionellosis.

ntadine and rimantadine for influenza A, and neuraminidase
nfluenza A and influenza B) are used if viral pneumonia is

mantadine can be used for either prophylactic or therapeutic
have not been approved for use in infants younger than 1
lack of data.

the use of neuraminidase inhibitors in children have not been

apy has been used to treat symptomatic patients and patients
ɜncy or chronic lung diseases to limit morbidity and mortality.

:ost-effective prevention measure is vaccination against

rs should be removed, if feasible.

- Empiric antibiotic and antifungal therapy is based on the preliminary results of urinalysis and urine Gram staining.
- Surgical-site infections should be managed with a combination of surgical care and aggressive antibiotic therapy that is guided by the results of deep-tissue Gram staining and culturing. Of special concern is fasciitis, which is associated with mucoid group A streptococci and high morbidity and mortality rates.

Surgical Care:

- Surgical debridement is an integral part of management of surgical-site infections or superinfected decubitus ulcers.

Consultations:

- Many nosocomially infected patients require expert care from an ICU team.
- Infectious disease specialists, burn care specialists, and surgical teams usually are involved in the care of these complicated cases.

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Pharmacologic treatment depends on the underlying etiology.

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Patient Education:

- For excellent patient education resources, visit eMedicine's Yeast and Fungal Infections Center. Also, see eMedicine's patient education article Candidiasis (Yeast Infection).

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Medical/Legal Pitfalls:

- Outbreaks of nosocomial invasive infections may become the subject of adverse publicity and legal suits against institutions and medical personnel.
- Many states have adopted educational courses emphasizing infection control, as well as strict enforcement and reporting of violation of hand washing codes. Many hospitals have reorganized the physical layout of hand washing stations and have adopted

THE
FOLLOWING
DOCUMENT(S)
ARE
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›revent the spreading of pathogens. They also have restricted the ny antibiotics that are used to combat nosocomial infections.

ltiple-resistant organisms, such as vancomycin-resistant ptide-resistant *S aureus*, and inducible beta-lactamase gram- are a constant threat.

›id spread of respiratory syncytial virus (RSV) among pediatric SV epidemic poses a threat to susceptible children who require ; winter months.

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Differentials Workup Treatment Medication Follow-up Miscellaneous Bibliography

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FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SJR 19
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Legislature
Title: Task Force on Hospital Infections
RDU
Component
Sponsor: Stevens, G
Requester: Health, Education, & Social Services
Component No.

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Prepared by: Jason Hooley
Phone 465-3762
Division: Office of Senator Fred Dyson
Date/Time 2/27/06 3:38 PM
Approved by: Senator Fred Dyson
Date 2/27/2006
Agency: Chair, Senate Health, Education, & Social Services Committee

(Revised 9/7/2005 OMB)

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/14/06

FURTHER: Finance

Date of 5-Day Notice: _____
(In accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2,27,06

Health, Education and Social Services Committee considered SENATE JOINT RESOLUTION NO. 19

SJR 19 TASK FORCE ON HOSPITAL INFECTIONS

Relating to creating the Task Force to Assess Public Reporting of Health Care Associated Infections.

and recommends:

[ ] be **replaced** with _____ **CS** _____ (_____)

[ ] adopt **previous** _____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

CS Senate Bill:
[ ] Same Title
[ ] New Title

SCS House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

LEG	2/28		S	X

PREVIOUS FISCAL NOTE(S):

[ ] **APPROPRIATION - no fiscal note**

			✓	
	✓			
	✓			
CHAIR:	✓			