SB

62

SFIN

FILE

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 62
(S) Publish Date: 3/14/07
Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services
Title: TASK FORCE ON HEALTH CARE INFECTIONS
RDU: Public Health
Component: Epidemiology
Sponsor: STEVENS
Requester: SENATE (HES)
Component No.: 296

Expenditures/Revenues (Thousands of Dollars)

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

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services	140.8	176.3	176.3	176.3	176.3	176.3
Travel	20.0	20.0	20.0	20.0	20.0	20.0
Contractual	10.0	10.0	10.0	10.0	10.0	10.0
Supplies	15.0	5.0	5.0	5.0	5.0	5.0
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	185.8	211.3	211.3	211.3	211.3	211.3
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF	185.8	211.3	211.3	211.3	211.3	211.3
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	185.8	211.3	211.3	211.3	211.3	211.3

Estimate of any current year (FY2007) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS						
Full-time	1	1	1	1	1	1
Part-time	1	2	2	2	2	2
Temporary						

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

SB 62 establishes the Advisory Committee on Public Reporting of Health Care Associated Infections to develop specific recommendations for the type of data to be collected, the mechanisms for data collection, and the optimal system for synthesizing and disseminating data in a manner useful to all Alaska healthcare consumers. Since 2002, 15 states have enacted legislation that requires hospitals to report hospital acquired infections to state health officials or other state agencies. Advocates of mandatory reporting, including the Consumers Union, believe that making such information publicly available will enable patients to make more informed choices about their healthcare and will improve overall healthcare quality.

Prepared by: Jay Butler, M.D. Phone 465-3090
Division: Public Health Date/Time 02/08/2007
Approved by: Karleen Jackson, Commissioner Date 02/13/2007
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

COMMITTEE COPY

STATE OF ALASKA
2007 LEGISLATIVE SESSION

BILL NO # SB 62

ANALYSIS CONTINUATION

ANALYSIS (Continued)

The bill requires the Advisory Committee to disband by June 30, 2012. However, 1.5 FTEs will be needed to develop the initial program beginning in FY08. In FY09, a Microcomputer/Network Specialist II (Range 20, 0.5 FTE) will be added. (Continued on Page 2)

Details of FY08 costs:

PERSONAL SERVICES for staff to administer and run the program ($140.8): Public Health Specialist II (Range 20D, 1.0 FTE), Administrative Clerk III (Range 10, .5 FTE).

TRAVEL ($20.0): Quarterly 1-day meetings; 1 in Juneau, 3 in Anchorage.

CONTRACTUAL ($10.0): Printing of committee reports.

SUPPLIES ($15.0): Initial setup for two positions - office furniture, computers, printer and general office supplies. After FY08, supply costs would be approximately $5.0 annually.

SESSION ADDRESS
Alaska State Capitol
Juneau, Alaska 99801-1182
(907) 465-4925
Fax: (907) 465-3517
Toll Free: 1-800-821-4925

Senator Gary Stevens
Alaska State Legislature

INTERIM ADDRESS:
112 Mill Bay Road
Kodiak, Alaska 99615
(907) 486-4925
Fax: (907) 486-5264

Sponsor Statement for SB 62

"An Act establishing the Advisory Committee on Public Reporting of Health Care Associated Infections"

SB 62 is legislation recommended by the Task Force to Assess Public Reporting of Health Care Associated Infections, which met during the 2006 Legislative Interim to study the unique challenges facing Alaska with regard to tracking and reporting health care acquired infections. This bill creates the Advisory Committee on Public Reporting of Health Care Associated Infections under the Department of Health and Social Services.

The Advisory Committee will consist of one member of the Senate, appointed by the Senate President, one member of the House of Representatives, appointed by the Speaker of the House, the state official in charge of epidemiology, and nine members appointed by the Governor as follows:

1. two physicians with significant experience in the area of infectious diseases;
2. a representative of the Alaska Native Tribal Health Consortium;
3. a representative of the Alaska Chapter of the Association of Professionals in Infection Control and Epidemiology;
4. a representative of the Alaska State Hospital and Nursing Home Association;
5. a health care consumer from urban Alaska;
6. a health care consumer from rural Alaska;
7. and a statistician.

In the coming years, the Advisory Committee's role will be to develop recommendations for collecting, analyzing and distributing information related to health care associated infections. By January, 2009, the Advisory Committee will provide recommendations to the Department for establishing a pilot program for public reporting of health care associated infections. By January, 2011, the Advisory Committee will provide to the Legislature a report addressing the unique challenges in the state, as well as recommendations for ongoing reporting.

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 SB 62 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.

I urge your support of this important legislation.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM January 23, 2007

SUBJECT: SB 62; Sectional Summary (Work Order No. 25-LS0332\C)

TO: Senator Gary Stevens
Attn: Doug Letch

FROM: Alpheus Bullard
Legislative Counsel

You have requested a sectional summary of the above referenced bill draft. As a preliminary matter, please note that a sectional summary should not be considered an authoritative interpretation of the bill, and the bill itself is the best statement of its contents.

Section 1. Authorizes the Department of Health and Social Services to collect, analyze, and maintain databases of information related to health care associated infections.

Section 2. Requires health care facilities to report health care associated infections to the department. Requires the department to disseminate health information obtained under this section to the public. Requires the department to consider the recommendations of the Advisory Committee on Public Reporting of Health Care Associated Infections. This section takes effect in 2009 after the committee established in sec. 3 issues recommendations to the department.

Section 3. Establishes the Advisory Committee on Public Reporting of Health Care Associated Infections in the Department of Health and Social Services. Sets out the composition and duties of the committee.

Section 4. Requires the governor to consider appointing persons to the new committee who served on the previously established Task Force to Assess Public Reporting of Health Care Associated Infections.

Section 5. Requires the committee to provide certain reports in 2009 to the department and in 2011 to the legislature.

Section 6. Repeals all sections having to do with the committee in June of 2012.

Section 7. Provides that sections 1 and 2 of the Act take effect January 1, 2009.

Section 8. Provides that sections 3, 4, and 5 of the Act take effect immediately.

TLAB:med
07-038.med

SB 62

AARP Alaska

APR 02 2007

April 2, 2007

The Honorable Lyman Hoffman, Co-Chair
Senate Finance Committee
Alaska State Capitol, Room 518
Juneau, AK 99801-1182

The Honorable Bert Stedman, Co-Chair
Senate Finance Committee
Alaska State Capitol, Room 516
Juneau, AK 99801-1182

RE: SB 62 (Stevens)--Support

Dear Co-Chairs Hoffman and Stedman:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Finance Committee to support SB 62, authored by Senator Gary Stevens.

Nosocomial infections are infections that are acquired in a hospital. Depending on the facility, 6 to 17 % of hospitalized patients will acquire a new infection after hospitalization. Older patients are particularly at risk for contracting these infections due to the declines in their physiologic reserves and declining immunity, and because they commonly have longer hospital stays and multiple treatments.

SB 62, authored by Senate Majority Leader Gary Stevens, will create a task force to assess public reporting of health care associated infections. Consumers should have access to information about infection rates in health care facilities. The goal of SB 62 is not just to be able to provide helpful consumer information but to reduce infections. Some of these infections are systemic problems and, if known, our health professionals can address them and find ways to prevent them.

Reporting of and eventual reduction of medical infections is in the best interest of all Alaskans. SB 62 is good public health and good common sense.

AARP recommends an "AYE" vote on SB 62.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Charlie Huggins
Senator Kim Elton
Senator Donald Olson
Senator Joe Thomas
Senator Fred Dyson
Majority Leader Gary Stevens

April 2, 2007

Senators Bert Stedman and Lyman Hoffman, Co-Chairs
Senate Finance Committee
And Senate Finance Committee Members

Re: SB 62

Dear Senators,

SB 62, under normal circumstances would not have come under my radar, so to speak, however, a recent event highlighted to me how important it is for the State of Alaska to join others in the reporting of serious infections.

During the past week I've hosted a young lady from out of town, because her father developed a serious staph infection that landed him in the local hospital. They were both visiting homer from elsewhere in the state. And, it was a health care associated infection.

Because of the information I have since received, it is very clear to me, that it would be very helpful, especially to our medical community, to know where these infections occur and if there is a pattern to them. At this time, such reporting does not occur, and that is clearly to the detriment of the public, which the medical community serves.

Therefore, I urge your support of SB 62.

Thank you,

Sincerely,

Milli Martin
P/O. Box 2652
Homer, AK 99603
907-235-6652

AARP Alaska

March 5, 2007

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 62 (Stevens)--Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health, Education and Social Services Committee to support SB 62, authored by Senator Gary Stevens.

Nosocomial infections are infections that are acquired in a hospital. Depending on the facility, 6 to 17 % of hospitalized patients will acquire a new infection after hospitalization. Older patients are particularly at risk for contracting these infections due to the declines in their physiologic reserves and declining immunity, and because they commonly have longer hospital stays and multiple treatments.

SB 62, authored by Senate Majority Leader Gary Stevens, will create a task force to assess public reporting of health care associated infections. Consumers should have access to information about infection rates in health care facilities. The goal of SB 62 is not just to be able to provide helpful consumer information but to reduce infections. Some of these infections are systemic problems and, if known, our health professionals can address them and find ways to prevent them.

Reporting of and eventual reduction of medical infections is in the best interest of all Alaskans. SB 62 is good public health and good common sense.

AARP recommends an "AYE" vote on SB 62.

3601 C Street, Suite 1420 | Anchorage, AK 99503 | toll-free 866-227-7447 | 907-341-2270 fax | toll-free 877-434-7598 TTY
Marie F. Smith, President | William D. Novelli, Chief Executive Officer | www.aarp.org/ak

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Joe Thomas
Senator John Cowdery
Senator Kim Elton
Senator Fred Dyson
Majority Leader Gary Stevens

Last update 2/20/07

2007 Legislative Session
Hospital-acquired infection public reporting bills
Click on bill numbers to access bill text

Georgia - HB 61; SB 78; SB 150
Bill Status: HB 61 in House Committee on Health and Human Services; SB 78 and SB 150 in Senate Health and Human Services
Bill Sponsor(s): HB 61: Rep. Powell; SB 78: Sen. Hamrick and Hill (Judson); SB 150: Sen. Hill (Judson)
Other Information: HB 61 is based on the Consumers Union model act and is the best bill so far.

Hawaii – HB 1438; SB 1239
Bill Status: HB 1438: Introduced on 1/22; SB 1239: Introduced on 1/24.
Bill Sponsor(s): HB 1438: Rep. Belatti; SB 1239: Sen. Fukunaga.
Other Information: Both bills require public reporting of hospital infection rates.

Indiana – HB 1592; SB 513; SB 531
Bill Status: HB 1592: Introduced and referred to House Committee on Public Health on 1/12; SB 513: Introduced and referred to Senate Committee on Health and Provider Services on 1/23; SB 531: Introduced and referred to Senate Committee o Health and Human Services 1/23.
Bill Sponsor(s): HB 1592: Sen. Dvorak; SB 513: Sen. Alting; SB 531: Sen. Dillon
Other Information: HB1592 and SB513 require public reporting of hospital infection rates. SB 531 allows for a committee and agency to determine what infection information should be reported.

Kansas – HB 2342, HB 2271
Bill Status: HB 2342 and HB 2271: Introduced 1/29; referred to House Committee on Health and Human Services 2/2.
Bill Sponsor(s): Both bills sponsored by the House Committee on Health and Human Services

Minnesota – SF 755, HF 1076
Bill Status: SF 755: introduced 2/12; sent to committee on Health Housing and Family Security; HF 1076 introduced and referred to House Health and Human Services (2/19).
Bill Sponsor(s): SF 755: Sen. Berglin; HF 1076: Kahn; Huntley; Ruud; Fritz; Abeler; Murphy, E.

New Mexico – HB 165; HB 944
Bill Status: HB 165: Introduced 1/17; assigned to House Committee on Judiciary; then House Committee on Health and Governmental Affairs; HB 944: Introduced 2/6 and referred to House Health and Governmental Affairs..
Bill Sponsor(s): HB 165: Rep. Anderson; HB 944: Rep. Rodella

Oregon – HB 2524
Bill Status: Introduced 1/30; referred to Health Care Committee 2/6; assigned to subcommittee on Health Policy 2/8; public hearing held 2/15.
Bill Sponsor(s): Rep. Tomei, Greenlick, Barker, Barnhart, Boone, Buckley, Cannon, Clem, Cowan, Dingfelder, Galizio, Geiser, Gilliam, Holvey, Lim Nelson, Riley, Rosenbaum, Shields, Witt

Texas – HB 1398; HB 678; SB 288
Bill Status: HB 1398 introduced 2/13, referred to the House Public Health Committee 2/19; HB 678 introduced 1/22, referred to House Public Health Committee (2/6); SB 288: introduced 1/24.
Bill Sponsor(s): HB 1398: Rep. Delisi; HB 678 Rep. Davis; SB 288: Sen. Nelson
Other Information: HB 1398 reflects recommendation of a state advisory committee on hospital infections.

Washington – HB 1106
Bill Status: Substitute passed by Health Care and Wellness Cmte (11-2) on 2/8; referred to Appropriations Committee 2/12; scheduled for public hearing in the House Committee on Appropriations at 3:30 PM. (Subject to change) on 2/22.

Bill Sponsor(s): Rep. Campbell

West Virginia – HB 2234; SB 85
Bill Status: HB 2234 in House Cmte on Health and Human Resources 1/16; SB 85 in Senate Cmte on Health and Human Resources 1/15.
Bill Sponsor(s): HB 2234: Rep. Hamilton; Hrutkay, Hatfield; SB 85: Sen. Hunter and Foster.

Hospital-acquired infections take toll on bottom lines

Posted 11/21/2006 12:18 AM ET
By Julie Appleby, USA TODAY

Reducing the number of infections patients contract while in hospitals would not only benefit patients but also hospitals' profits.

Researchers say the finding in a study out Monday counters an assumption that hospitals make money on patients who fall ill with a hospital-acquired infection because they often receive higher payments from insurers for dealing with complicated cases. But the higher payments do not cover the additional costs.

"This adds economic strength to the notion that we ought to be doing away with infections," says Richard Shannon, co-author of the study and vice chair of clinical affairs in the department of medicine at the University of Pennsylvania.

"Not only is it the right thing to do from the patient perspective," he says, "but infections are in fact costing payers and hospitals lots of money."

His study showed an average $26,830 loss to the hospital for each patient who came down with one type of infection called a central-line-associated bloodstream infection. A central line is a catheter placed into a vein to provide fluids or medication. Of 54 patients who got that type of infection during a three-year period at the one hospital studied, only four resulted in a break-even or profit for the hospital.

That's because the costs of caring for a patient who gets an infection usually far exceed the amount the facility is paid by insurers, says the study, one of three studies on the effects of hospital-acquired infections published in the *American Journal of Medical Quality*.

The journal articles come as hospitals nationwide are being asked to provide more information on cost and quality, but many have balked at providing information on hospital-acquired infections. Debate is ongoing about what types of infections should be reported and how to tell whether patients got the infections while in the hospital, came to the facility with them or developed them after being discharged.

Hospital-acquired infections are estimated to affect about 2 million patients annually and cause an estimated 100,000 deaths, according to one of the studies.

About 16 states have laws covering a variety of infection-reporting requirements for hospitals, but only Pennsylvania has issued a public report that gives infection rates at individual hospitals. Last week, Pennsylvania reported that more than 19,000 patients got an infection while in a hospital last year, raising costs.

The two other reports in the same issue of the journal take issue with another assumption about hospital infections: that patients who get them may have higher risks that cause them to come down with infections.

"Hospital-acquired infection is not an anticipated byproduct of taking care of the very ill," says David Nash, editor of the journal and chairman of the Department of Health Policy at Jefferson Medical College in Philadelphia. "It's a failure in the process of how medical care is delivered."

State eyes hospital infection reports

By Jessica Fargen
Boston Herald Health & Medical Reporter
Wednesday, February 21, 2007 - Updated: 04:01 AM EST

Jessica Fargen
Boston Herald Health & Medical Reporter

» Recent Articles by Jessica Fargen

Patients may soon be able to shop for the safest hospitals thanks to a new $1 million public health plan that will make rates of deadly infections at Bay State medical centers readily available to the public for the first time.

The Department of Public Health team, which has enlisted 50 experts and surveyed 73 hospitals so far, expects to make recommendations in June on how to reduce life-threatening in-hospital infections and put in a place a plan to make the rates public, officials said yesterday.

Hospital-acquired infections kill 90,000 Americans each year, including about 2,000 Bay Staters, and some experts say those deaths are largely preventable. Patients contract the infections at the hospital in many ways, including surgery, bacteria-ridden catheter tubesand unwashed hands.

Paul Levy, president of Beth Israel Deaconess Medical Center, created a big stir recently when he posted the hospital's infection rates on his blog and encouraged other hospitals to follow suit without a complicated state mandate.

"Wouldn't it be easier to try it out voluntarily - see how it goes?" he told the Herald. "My point is these numbers are available in real time. We all keep track of it. All the state has to do is set up a Web site and let us enter our data."

Sen. Richard T. Moore, (D-Uxbridge), chairman of the Legislature's Health Care Financing Committee, has filed a bill that would add Massachusetts to the list of 16 states that have passed mandatory reporting of hospital infections.

But public health officials are taking a more measured approach, hiring experts, doing research and surveying hospitals.

"Just the nature of the patients, the case mix of patients means that there is not a one-size-fits-all solution to the problem," said Nancy Ridley, director of the Betsy Lehman Center, which is leading the project with the DPH.

Massachusetts General Hospital spokeswoman Valerie Wencis echoed that concern, saying the hospital won't post its rates until it's mandated.

"You have to have a standard across all the hospitals," she said. "That's something that needs to be taken into consideration before rates would be put online or made public."

jfargen@bostonherald.com

INSURANCE JOURNAL

East News

R.I. Lawmaker Targets Hospital Errors

February 27, 2007

Between 44,000 and 98,000 patients die each year in U.S. hospitals because of mistakes, infections and other adverse situations. That's more deaths than those caused by breast cancer, AIDS or car accidents.

Most of those deaths are avoidable, acoording to Rhode Island Sen. Charles J. Levesque (D-Dist. 11, Portsmouth, Bristol), who has introduced legislation aimed at reducing their occurrences in hospitals in his state.

Senator Levesque's "Patient Safety and Medical Error Reduction Act" (2007-S 0650) would require all hospitals in Rhode Island to participate in a program to increase patient safety by reducing medical errors.

Most of the hospitals in Rhode Island are among the 3,000 hospitals nationwide already participating voluntarily in a campaign run by the Institute for Healthcare Improvement to reduce medical errors, infections and other mishaps.

Their voluntary participation is excellent, said Senator Levesque, but he would like to see them all taking part.

"Everybody involved in the health care system wants patients to be safe and to receive proper care when they're in the hospital. I'm sure we can all agree that all hospitals in Rhode Island should be doing everything they can to reduce mistakes, hospital-acquired infections and medication errors so every patient can leave the hospital healthier than when he or she arrived," said Levesque.

The act specifically lists two national organizations □ the National Quality Forum and the Institute for Healthcare Improvement □ that have developed programs to help reduce medical errors, but hospitals would be allowed to use other programs as long as they are approved by the Department of Health. Each hospital would be required to report their progress in improving patient safety.

The act would also link hospitals' performance in terms of patient safety to funding by allowing the Department of Human Services to use it to determine their reimbursement rates.

Common ways hospitals can increase patient safety include standardizing safety, communication and sterilization procedures. Computerizing patient information to the greatest extent possible is also a way to reduce the possibility of human error.

According to a 1999 Institute of Medicine report, To Err is Human, costs of preventable "adverse events" in hospitals are estimated to be between $17 billion and $29 billion every year.

"Mistakes in hospitals hurt everyone. They tarnish the health care industry, they cost everyone money in the form of higher health care and insurance costs, and worst of all, they cost lives. I commend the hospitals in Rhode Island that are already taking the initiative to reduce errors and infections, and I hope this legislation formalizes this process and ensures every hospital's full compliance," said Senator Levesque.

Source: R.I. Legislative Press Bureau

Find this article at:
http://www.insurancejournal.com/news/east/2007/02/27/77190.htm

ASHNHA Position on SB 62

Prepared by: Jennifer Grogg, RN on behalf of ASHNHA

March 1, 2007

WHO DOES ASHNHA REPRESENT?

The *Alaska State Hospital and Nursing Home Association* membership includes 24 acute care hospitals, 2 behavioral health facilities, 6 assisted living facilities (Alaska Pioneer Homes), and 5 free-standing nursing facilities. Nine of our 24 acute care hospitals also provide nursing home services. We believe ASHNHA's rich composition of private, federal, state, and tribal health care facilities provides a balanced viewpoint on important health care policy matters. (Full membership is listed on page 2)

ASHNHA's POSITION ON SB 62:

ASHNHA's membership urges a cautious approach on SB 62 and supports the establishment of an Advisory Committee on Public Reporting of Healthcare Associated Infections; relating to reporting and dissemination of data concerning healthcare associated infections.

SUPPORTING TESTIMONY:

➲ This Advisory Committee will be able to review the status and success of States with similar legislation on the issue of mandatory reporting of Healthcare Associated Infections. Many States have yet to implement these regulations because of the difficulty in creating equitable guidelines for all the reporting agencies. This important issue should be designed with the nuances of Alaska in mind, there is no room for 'cookie cutter' legislation.

➲ Alaskans do not have a wide variety of choices in their selection of Healthcare Facilities, we need to be certain that Alaskans understand that the goal is to create the safest healthcare environment possible for all Alaskans.

➲ With more procedures and surgeries being performed in ambulatory or same day surgical facilities, these organizations should be included in the reporting process to give a broad base of information.

➲ The members of the Advisory Committee will require background knowledge and information to establish a foundation of mutually agreed upon definitions of infections that all Healthcare facilities in the State of Alaska will adhere to when reporting on Healthcare Associated Infections.

➲ This common base of definitions and terms will allow for the equitable formulation of reporting and maintain the confidentiality of the patients who are being served at these facilities.

➲ THIS LEGISLATION MUST BEGIN THIS PROCESS. SB 62 is a complicated issue. Alaskans would be best served with deliberate and quick actions.

➲ ➲

ASHNHA Position on SB 62

Prepared by: Jennifer Grogg, RN on behalf of ASHNHA

March 1, 2007

➲ ASHNHA urges your support of SB 62.

➲ Others either on the phone or in the room who could speak to the need of an Advisory Committee:

- Alaska Chapter of the Association of Professionals in Infection Control
- Alaska Department of Health & Social Services, Dr. Jay Butler

➲ Thank you for this opportunity to comment.

This Testimony is on Behalf of the Following Alaska Health Care Facilities

Alaska Regional Hospital, Alaska Native Medical Center, Alaska Pioneer Home System, Bartlett Regional Hospital, Bassett Army Community Hospital, Central Peninsula General Hospital, Cordova Community Medical Center, Denali Center Nursing Home, Fairbanks Memorial Hospital, Heritage Place Nursing Home, Kanakanak General Hospital, Ketchikan General Hospital, Maniilaq Health Center, Mary Conrad Center, Mat-Su Regional Hospital, Mt. Edgecumbe Hospital SEARHC, Norton Sound Regional Hospital, Petersburg Medical Center, Providence Alaska Medical Center, Providence Extended Care Center, Providence Kodiak Island Medical Center, Providence Seward Medical & Care Center, Providence Valdez Medical Center, Sitka Community Hospital, South Peninsula Hospital, St. Elias Specialty Hospital, USAF 3rd Medical Group- Elmendorf, Wrangell Medical Center, Yukon Kuskokwim Delta Regional Hospital, Alaska Psychiatric Institute, North Star Behavioral Health System, Wildflower Court Nursing Home.

An APIC Briefing

February 2007

Dispelling the Myths:

The True Cost of Healthcare-Associated Infections

AUTHORS

Denise Murphy, RN, BSN, MPH, CIC
Vice President, Chief Safety and Quality Officer
Barnes-Jewish Hospital at Washington University Medical Center, St. Louis, MO

Joseph Whiting, MBA, FACHE
Chief Executive Officer
JKW Consulting, South Elgin, IL

APIC's HAI Cost Calculator Development
Christopher S. Hollenbeak, PhD
Associate Professor of Surgery and Health Evaluation Sciences
Penn State College of Medicine, Hershey, PA

To obtain a copy of the HAI Cost Calculator, visit www.apic.org

APIC
ASSOCIATION FOR PROFESSIONALS IN INFECTION CONTROL & EPIDEMIOLOGY, INC.

APIC's mission is to improve health and patient safety by reducing risks of infection and other adverse outcomes. The Association's more than 11,000 members have primary responsibility for infection prevention, control and hospital epidemiology in health care settings around the globe, and include nurses, epidemiologists, physicians, microbiologists, clinical pathologists, laboratory technologists and public health practitioners. APIC advances its mission through education, research, collaboration, practice guidance and credentialing.

All inquiries about this document or other APIC products and services may be addressed to:

APIC Headquarters
1275 K Street NW,
Suite 1000,
Washington, DC 20005-4006

Phone 202.789.1890
E-mail apicinfo@apic.org
Web www.apic.org

APIC thanks its Strategic Partners for their support of the 2006 Futures Summit on "The Economics of Infection Prevention."

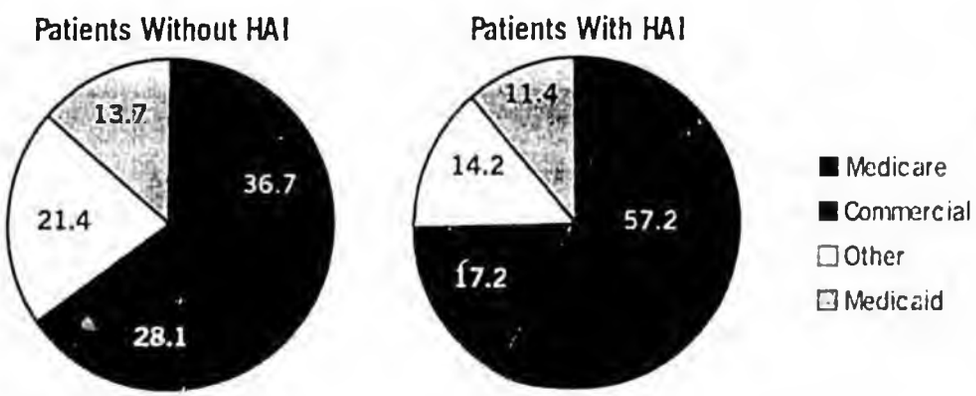
Bard Medical Division • *BD* • *Cereplex, Inc.* • *ChloraPrep* • *Clorox* • *Ethicon*
Medline Industries, Inc. • *MedMined* • *PDI* • *STERIS* • *Tyco Healthcare/Kendall*

Executive Summary

Hospital leaders are aware that healthcare-associated infections (HAIs) impact patients but many have no idea of the extent of the situation and the degree to which HAIs impact cost and operating margin. For example, some hospital executives believe the number of inpatients that acquire an HAI is far smaller than the actual rate. The purpose of this paper is to present the business case for reducing healthcare-associated infections from the perspective of the healthcare executive. Case studies of significant cost savings are presented along with a methodology for determining the cost of various categories of HAIs.

The large impact these cases have on costs and operating margins is even more significant. A recent study of 1.69 million admissions from 77 hospitals found that patients with a healthcare-acquired infection reduced overall net inpatient margins by $286 million or **$5,018 per infected patient.** The study found that the average additional incremental direct cost for patients with an HAI was $8,832[1].

HAIs erode the bottom line. Therefore in classes where reimbursement is lower, the loss impact is even greater. Figures 1 and 2 demonstrate that the average payer mix for patients without infections is 37% Medicare, 28% commercial payers, 21% other and 14% Medicaid. For patients with healthcare-associated infections, the mix changes to **57% Medicare**, 17% commercial 14% other and 11% Medicaid[2]. Closer examination of payer type for patients with HAIs brings the potential for net loss into greater focus.



Figures 1 and 2.
SOURCE: MedMined, Inc 1.69 million admission study September 2006

Healthcare-associated infections have long been considered a byproduct of healthcare, an outcome of treating an increasingly older, sicker patient

Contents

APIC's mission is to improve health and patient safety by reducing risks of infection and other adverse outcomes.

The Association's more than 11,000 members have primary responsibility for infection prevention, control and hospital epidemiology in health care settings around the globe. APIC advances its mission through education, research, collaboration, practice-guidance and credentialing.

Visit APIC online at ***www.apic.org.***

There is emerging evidence that reimbursement for infection does not cover the cost of the required additional care. In fact, HAIs result in considerable operating losses in almost all cases.

population with an increasingly invasive arsenal of interventions. The costs associated with these infections were thought to be largely offset by reimbursement. But as the methodology of accounting for the costs of HAIs has become more sophisticated, institutions are finding that HAIs are not revenue neutral or positive, that HAIs substantively erode the profit margin of the average hospital. Leading institutions are also finding that significant reductions in many categories of HAIs cannot only be reached but sustained, providing a substantive opportunity for improving patient outcomes and the bottom line as well.

This paper seeks to dispel three widely held myths where HAIs are concerned:

1. That HAIs are an expected byproduct of treating an older, sicker patient population with an increasing array of invasive techniques;
2. That the additional cost of an HAI is largely offset by reimbursement, making the infection revenue neutral or positive;
3. That the number of HAIs in most institutions is not significant, making the cost savings associated with reduction of HAIs not worth the investment.

Our goal is to aid healthcare executives in better understanding the true cost of HAIs and engage them in an evaluation of the costs in their particular institution. By clarifying the business case and providing a practical methodology to estimate the value of reducing healthcare-associated infections we are confident that hospital leaders will take a more aggressive approach to infection prevention.

Current Situation

The current system of reimbursement obscures the true cost of HAIs to health care institutions. There is emerging evidence that reimbursement for infection does not cover the cost of the required additional care. In fact, HAIs result in considerable operating losses to hospitals in almost all cases.

It is our position that pursuing perfection[3], setting HAI reduction strategies at the theoretical ideal (zero preventable infections), represents a substantial opportunity for hospital leaders to improve safety, quality and significantly reduce cost.

In 2005, the Top Issues Confronting Hospital CEO's survey conducted by the American College of Healthcare Executives ranked financial challenges as the number one concern of hospital CEOs[4]. Financial challenges had also been ranked number one in the 2003 and 2004 surveys. In addition to traditional financial challenges, the "C-suite" executives must respond to external pressures from regulatory and standard-setting agencies, consumer advocacy groups, and their own community boards to reduce adverse outcomes of hospitalization.

The pressure to keep patients safe and deliver high quality clinical outcomes will further impact reimbursement as pay for performance initiatives become a reality nation-wide. All this said, most executives would agree that keeping patients safe is the right thing to do regardless of financial implications. We hope to provide evidence to demonstrate that infection prevention is not only the right thing to do for patients, but is good business as well.

Healthcare-associated infections cost between five and six billion annually and result in almost one hundred thousand deaths in the United States.

Evidence

In the past decade there has been increasing activity in the measurement of the specific impact infection prevention has had on operating margins and excess costs associated with HAIs. Healthcare-associated infections cost between $5–6 billion annually and result in almost 100,000 deaths in the US[5]. This paper presents two notable examples of healthcare organizations that documented the economic value of eliminating HAIs and did it using validated economic analysis[6].

Allegheny General Hospital

Bloodstream infections are a risk for patients needing vascular access lines, especially if lines are placed in large central veins leading to the heart.

In 2004, the Jewish Health Foundation and Pittsburgh Regional Health Initiative launched an all-out assault on central line associated bloodstream infections (CLABs) through implementation of evidence-based prevention measures. With 40 hospitals working in concert, they set their theoretical goal at zero, meaning their target was no central line infections. With results audited by the Centers for Disease Control and Prevention, they were able to achieve an overall 63% reduction in these serious adverse outcomes of hospitalization.

One participant, Allegheny General Hospital, was able to achieve a 90% reduction in CLABs from fiscal year 2003 to 2004 (from 49 to 3 with an average savings of $14,572 per CLAB[7]. A summary of the Allegheny General's CLAB-related study, as reported in the Nov-Dec 2006 American Journal of Medical Quality Supplement on Hospital-Acquired Infection: Meeting the Challenge (Richard P. Shannon, MD), yielded the following information:

- Average reimbursement per case: $64,894
- Average cost per case with CLAB: $91,733
- Average Loss per case: $(26,839)
- Total Loss from operations associated with CLABs: $(1,449,306)
- Percent of total cost of care associated with CLABs: 43%

What price tag can be placed on the lives saved from successful prevention measures deployed by this organization?

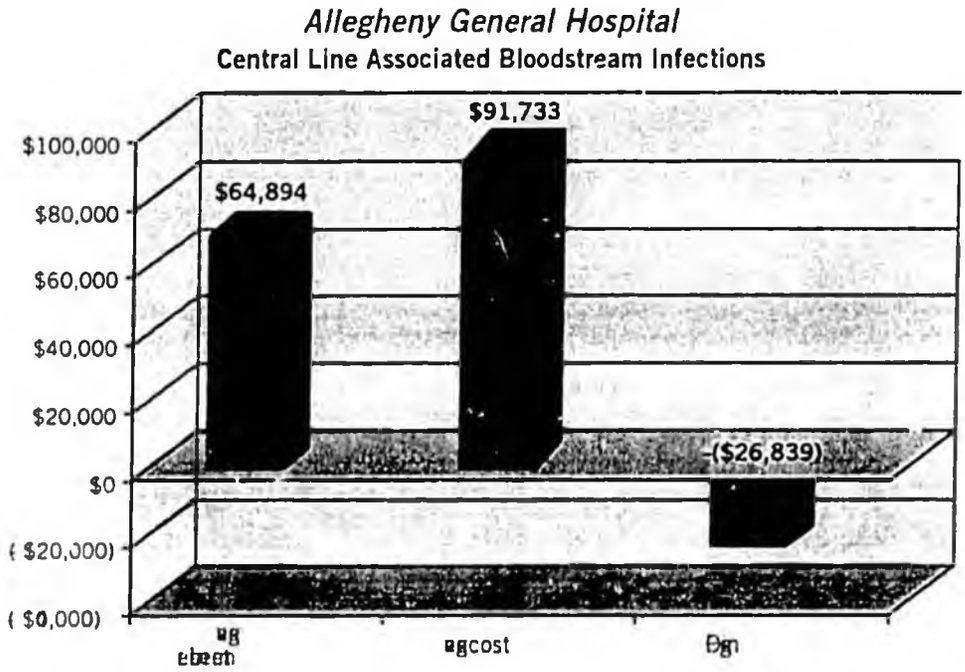


Figure 3.
***SOURCE:** Shannon, R.P. (unpublished data)*

In addition to their work on CLABs, AGH also demonstrated significant improvement in reducing ventilator-associated pneumonias (VAPs). Their results showed a reduction from 46 VAPs in FY 2003 and 45 in 2004 to 8 in FY 2005 (82% reduction). Their economic analysis for fiscal years 2003–2005 indicated that cases with a VAP resulted in lost revenue. VAP cases averaged a loss of $(24,435). The average reimbursement for VAP cases totaled $62,883 while the average cost was $87,318; therefore, the average loss for each case was $(24,435).

During the two year effort to eliminate CLAB's and the one year effort targeting VAPs, the total cost savings was $2.2 million. The cost to obtain this level of savings was just under $35,000. The cost per ventilated patient to achieve the targeted improvement was just $17. Note that the mortality associated with ventilator-associated pneumonia and central line associated bloodstream infections is 20–60%. What price tag can be placed on the lives saved from successful prevention measures deployed by this organization?

BJC HealthCare

In 1996, infection control leaders at BJC HealthCare, a 13-hospital, non-profit health care system based in St. Louis, Missouri, presented to their senior management and board of directors a formal business case for increasing

resources to eliminate HAIs. In 2000, they estimated the excess cost generated by just four categories of healthcare-associated infections (CABG surgical site infections (SSI), spinal SSI, bloodstream and ventilator-associated pneumonia infections) at **$8.2 million** across all BJC hospitals. Based on this information, leadership approved an investment of $350,000 to enhance system-wide efforts to eliminate HAIs. Individual hospitals also invested an additional $50,000–$150,000 to increase full time equivalents (FTEs) dedicated to infection prevention and/or medical direction during that same time period. By year end 2001, the same four categories of HAI were associated with excess costs of $6.4 million, an almost $1.8 million dollar reduction in excess costs.

Table 1 contains a summary of the impact of targeted interventions at Barnes Jewish Hospital, BJC's 1300 bed academic medical center, between 2000 and 2004. In a four year period, infection prevention efforts yielded a reduction of excess cost in just four HAI categories of almost $2.5 million. Studies

Table 1

Barnes Jewish Hospital—Impact of Interventions To Decrease Healthcare-Associated Infections

	2000	2004	Intervention Impact
CABG Surgical Site Infections (SSI)			
#SSI	43	18	-25
%SSI	6.8%	5.6%	-18%
Excess Cost	$825,000	$322,610	-$502,390
Spinal Surgical Site Infections (SSI)			
#SSI	20	5	-15
%SSI	2.07%	0.8%	-61%
Excess Cost	$301,327	$44,823	-$256,504
Bloodstream Infections (BSI)			
#BSI	309	87	-222
BSI/1,000 patient days	8.4/1000	1.5/1000	-82%
Excess Cost	$1,446,120	$459,690	-$986,430
Ventilator Associated Pneumonia (VAP)			
#VAP	166	73	-93
VAP/1,000 ventilator days	10.1/1,000	4.8/1,000	-52%
Excess Cost	$1,382,780	$632,180	-$750,600
Total Cost of all HAI tracked	**$3,955,225**	**$1,459,303**	**-$2,495,924**

SOURCE: Denise Murphy, Marilyn Jones, BJC Infection Control and Healthcare Epidemiology Consortium, St. Louis, MO.

evaluating "routine" processes such as changing of ventilator circuits every 24-48 hours also resulted in annual savings of $1 million in supply and equipment reductions associated with fewer ventilator circuit changes (with no adverse impact on patients).

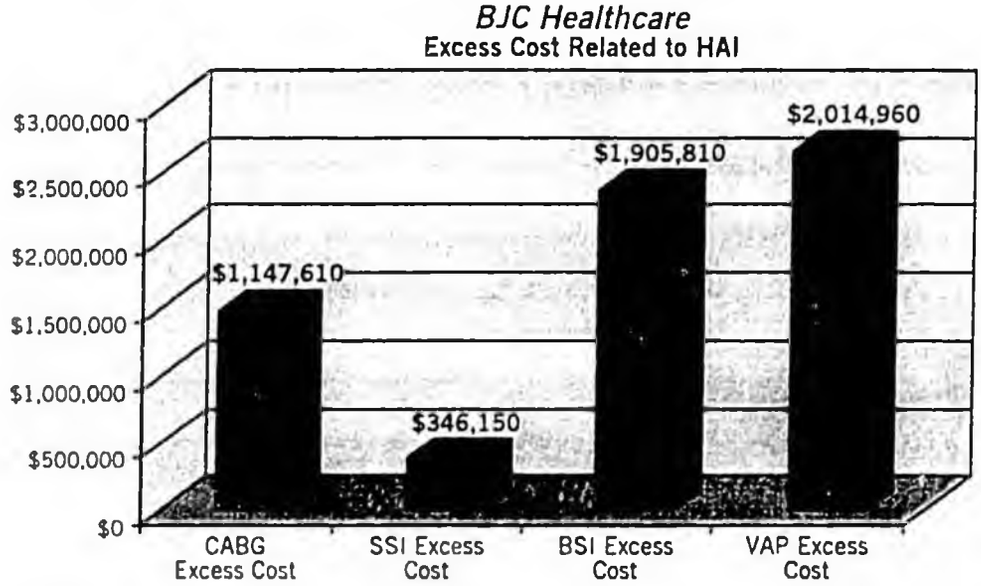


Figure 4.
SOURCE: Denise Murphy, Marilyn Jones, BJC Infection Control and Healthcare Epidemiology Consortium, St. Louis, MO.

In addition to the cost of infections, Infection Prevention Specialists also began sharing excess length of hospitalization with executives. In 2000, surgical site infections after coronary artery bypass graft surgeries alone resulted in 1,350 excess days (average of 27 days/SSI) over the expected stay for patients who did not acquire an infection. With volumes being the main driver of revenue, this information supported the need for enhanced prevention efforts.

Opportunity Cost

Based on the data submitted for the first nine months of 2005, it is estimated that HAIs added 227,000 extra hospital days in Pennsylvania alone.

As noted above, a largely hidden cost of HAIs is the additional patient days they consume. While many hospitals routinely run near or at capacity, the elimination of HAIs can provide the hospital with additional patient care capacity at little or no cost. A 1985 article estimated that HAIs add a total of 7.5 million excess patient days nation wide[9]. According to the Pennsylvania Healthcare Cost Containment Council (PHC4), the 1.9 million admissions in their state in 2005 without an HAI had an average length of stay less than 5 days[10]. For the 24,000 admissions that were reported with an HAI, the average length of stay

was **23 days**. Based on the data submitted for the first nine months of 2005, it is estimated that HAIs added **227,000 extra hospital days** in Pennsylvania alone. Pursuing zero tolerance for HAIs can free up a significant number of bed days that can be used for patients potentially bringing in a higher level of reimbursement.

The evidence is compelling that taking action to invest in prevention can have a profound positive impact on the organization's bottom line, patients' safety and satisfaction, and reputation.

The Business Case

The business case for pursuing perfection and eliminating HAIs is designed to identify the reasons for action and the expected benefits. The business case for quality can be defined as "an analysis aimed at determining the economic liabilities of preventable errors to ensure that an investment in quality will bring the greatest value"[11]. The evidence is compelling that taking action to invest in prevention can have a profound positive impact on the organization's bottom line, patients' safety and satisfaction, and reputation. Whenever possible, meaningful measurements should be expressed in operational terms. The importance of forming a partnership with the Finance Department at the outset in the development of the business case, in which the infection prevention and control specialist and a finan.. partner work together to quantify the economic impact of HAIs to the organization, is key. In this case, the focus is on demonstrating that operating margins can be improved as a result of targeted actions to reduce HAIs to zero.

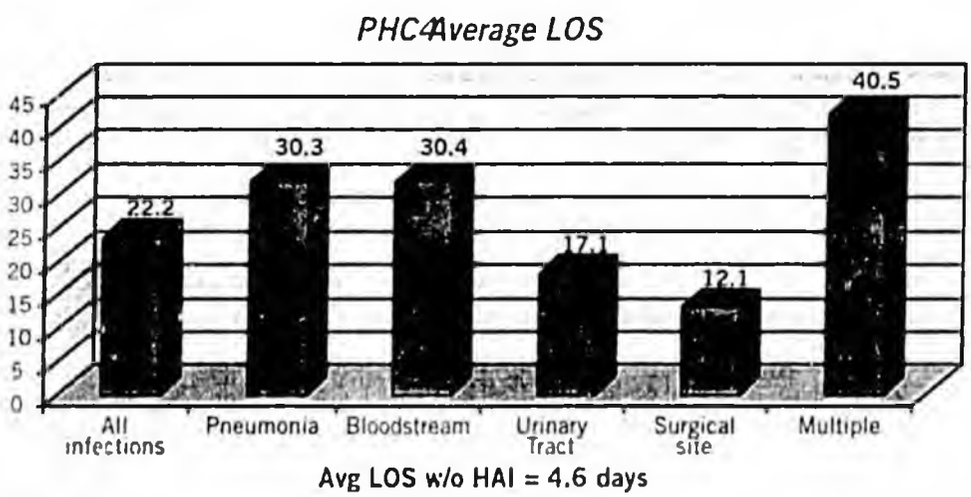


Figure 5.

Methodology

While it may be interesting to read the validated financial results from other organizations, our primary purpose is to provide the reader with practical guidelines to analyze how HAIs are impacting their bottom line. What follows is a simple and practical methodology that can be used to calculate the economic

value of reducing HAIs in your organization. Based on the cases outlined above, we believe that most if not all hospitals have a significant opportunity to improve the bottom line by eliminating HAIs. The following methodology will enable you to identify and quantify that opportunity by using your own organization's data.

To calculate the estimated value (excess cost or impact on margin) of eliminating HAIs in your organization, the following methodologies are suggested:

1. Select one of the following options for the population to be analyzed.
   a. Option 1 – select a number such as 10 patients who acquired a CLAB
   b. Option 2 – select a class of HAIs for the last year. (Include any case where a payer was billed for any service related to a healthcare-associated infection. DO NOT include a case if the primary cause of admission was for an infection; DO INCLUDE readmissions for HAI.)
2. Identify the actual or estimated reimbursement for each case
3. Identify the total costs associated with the case, based upon activity-based cost accounting, if available
4. Identify the costs attributable to the HAI
   a. This step requires clinical and financial expertise to identify which services provided were attributable to the infection AND the cost of these services

Table 2
The Impact of CLAB's on Gross Margin*[12]

	DRG 204/2721** (n=3)	DRG 191 (n=3)	DRG 483 (n=2)	
	Acute Pancreatitis	Pancreatitis w/ CC	Pancreatitis w/ tracheotomy	Case of Pancreatitis with CLAB
Revenue ($)	5,907	99,214	125,576	200,031
Expense	5,788	58,905	98,094	241,844
Gross Margin	119	40,309	27,482	(41,813)
Costs attributable to HAI				170,565
LOS	4	38	41	86

**CLAB – central line-associated bloodstream infection*
*** Complication/comorbidity*

SOURCE: Shannon, R.P., et al. ASMQ Supplement, Vol 21, No. 6, 2006

5. Calculate the Gross Margin for the case by subtracting the expenses (3) from the reimbursement (2)
6. Compare the gross margin for the case to the gross margin of similar cases without a healthcare-associated infection, matched for age, principal diagnosis, and admission severity
   a. See Table 2

When you have completed the analysis of the HAIs in your organization, use this information to target an area that has significant opportunity for improvement, and then "pursue perfection". Set the target for elimination of this HAI. This approach drives innovation, removes complacency, centers on patients' needs and spurs deep system change.

Continued research and performance improvement efforts must be dedicated to eliminating HAIs and providing a safer environment for patients and providers. These efforts must be supported, if not led, by executive leadership.

Call to Action

In an effort to enhance the attention and resources dedicated to the culture of zero tolerance toward HAIs, it is critical that organizations commit to the following actions:

1. Identify a financial partner to work with Infection Prevention and Control Specialists in your organization.
2. Quantify the economic impact of HAIs in your organization by using the methodology described above.
3. Based on the results of this economic analysis, target a high risk, high volume procedure or patient population and lead efforts to eliminate HAIs using a zero tolerance (or "pursue perfection" mentality).
4. Ensure that Specialists are educating healthcare workers about infection prevention and driving applicable evidence-based best practice recommendations.
5. Identify process defects and institute necessary systems or practice changes where indicated.
6. Measure the results of the efforts and repeat the process.

Conclusion

There is a finite supply of health care dollars in the United States. Regardless of whether health care coverage is managed by employers, insurance companies or the government, consumers fund the system. It is the responsibility of executives and clinicians to protect this investment. To accomplish this task requires an understanding of the risks and liabilities associated with entering the health care system and what it takes to improve health care delivery. Continued research and performance improvement efforts must be dedicated to

eliminating HAIs and providing a safer environment for patients and providers. These efforts must be supported, if not led, by executive leadership.

Because many deserving issues don't get attention unless executives understand their economic implications, APIC is committed to continuing to communicate and clarify the business case for infection prevention. We hope that the practical examples presented in this executive briefing will encourage hospital executives, especially financial executives, to develop a deeper understanding of the economic impact of healthcare-associated infections and, with that understanding, undertake the steps that will lead to healthier bottom lines and improved patient outcomes.

The dollars and infection rates are about people—our family, our friends and our neighbors, who are needlessly harmed every day, and the significant human and economic costs associated with these events.

An Actual Patient Account:

In February 2002, a 37-year old father of four was admitted to the hospital with acute Pancreatitis. Three days into his stay he developed abnormally low blood pressure and respiratory failure. On Day 6, his blood culture tested positive for MRSA (methicillin-resistant *Staphylococcus aureus*) after a femoral vein catheter had been in place for 4 days. The patient had multiple complications related to the infection which required an exploratory laparotomy (a surgical procedure to gain access to the abdominal cavity) and eventually a tracheostomy (a surgical procedure on the neck to provide a direct open airway). On the 86th day of his stay, the patient was discharged to a nursing home. He never returned to work.

The total cost of this patient's care was $241,844, 70% of which ($170,565) was attributable to the central line-associated bloodstream infection (CLAB) he acquired while in the hospital. This patient had commercial insurance which reimbursed the hospital $200,031. Despite this high level of reimbursement, **the hospital lost $41,818 on this case alone.** While this case represents a severe impact of a healthcare associated infection, it is an all too common occurrence.

This story and millions like it occur every year in American hospitals. While our primary objective is to increase hospital leadership attention to the economics of healthcare-associated infections, the dollars and infection rates are about people—our family, our friends and our neighbors, who are needlessly harmed every day, and the significant human and economic costs associated with these events.

***SOURCE:** Shannon, R.P., et al. ASMQ Supplement, Vol 21, No. 6, 2006*

APPENDIX

Definitions

Activity-Based Cost Accounting: A powerful tool for measuring performance, Activity-Based Costing (ABC) is used to identify, describe, assign costs to, and report on operations. A more accurate cost management system than traditional cost accounting, ABC identifies opportunity to improve business process effectiveness and efficiency by determining the "true" cost of a product or service.

Attributable Cost: The services provided and billed to a patient that were caused by a healthcare-associated infection.

Business Case: A business case addresses at a high level the business need that the project seeks to resolve. It may include the reasons for the project, the expected business benefits, the options considered (with reasons for rejecting or carrying forward each option), and the expected costs of the project, a gap analysis and the expected risks. The option of doing nothing should be included with the costs and risks of inactivity included along with the differences (costs, risks, outcomes etc) between doing nothing and the proposed project.

Excess Cost/Length of Hospital Stay: The cost/LOS the patient incurred as a result of a healthcare-associated infection over and above usual costs and LOS. The cost/LOS that would be avoided if an HAI did not occur.

Healthcare-associated Infection: A localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that:

1. occurs in a patient in a hospital, and
2. was not found to be present or incubating at the time of admission unless the infection was related to a previous admission to the same setting.

Operating Income: The amount by which total operating revenue exceeds total operating expenses.

Operating Margin: The ratio of operating income to total operating revenue. This measure places operating income in perspective with the volume of business realized by the hospital.

There is a finite supply of health care dollars in the United States. Regardless of whether health care coverage is managed by employers, insurance companies or the government, consumers fund the system.

Best-practice Examples

During the Futures Summit on "The Economics of Infection Prevention" sponsored by APIC in April 2006, several best-practices for the elimination of HAIs were shared. These practices significantly contributed to an organization's pursuit of a zero tolerance approach to HAIs. These practices are not absolute guarantees of success, and not all practices may work at every organization. They are, however, worthy of consideration as part of a comprehensive strategy to enhance infection prevention and patient safety.

Executives, especially financial leaders, can have more of an effect on elimination of HAIs simply by talking about zero tolerance, and making small incremental investments in prevention, than all the policies and procedures in the world.

Champions

A common denominator in achieving a zero tolerance strategy is the commitment of champions to this effort. Often champions become engaged in the fight to eliminate HAIs as a result of their involvement in an incident where a patient was severely injured by an HAI, or when a relative or friend had suffered the effects of an HAI. Successful transformation toward a prevention vs. a reactive culture is generally a result of the extraordinary efforts of a few dedicated people. Organizations should identify, invest in, and empower those people.

Leadership

Organizational leaders set the culture and language shapes it. Executives, especially financial leaders, can have more of an effect on elimination of HAIs simply by talking about zero tolerance, and making small incremental investments in prevention, than all the policies and procedures in the world.

Data and Human Focus

Several of the organizations who have been most successful in the fight to eliminate HAIs have found a way to present data to governing boards, quality committees and other groups that promote a bias toward action. For example, HAIs are often reported using rates. If an organization's rate is 5.1/1000 patient days and our competitor's rate is 5.4/1000 patient days, this may appear acceptable. Also, communicating rates does not define how many people are being injured and possibly killed by HAIs. No infection is acceptable despite the fact that, in hospitals, all infections are not preventable. Key decision makers must know numbers of people affected, rates, action plans and the resources it will take to get to zero.

Language Barrier

HAI-related information is often communicated using terms that are unfamiliar to many non-clinical leaders. To enhance the success of HAI elimination efforts, it is important to create an environment where non-clinical leaders

receive data and information they can understand. It is equally as important for Infection Prevention and Control Specialists to work with financial leaders and learn the language and terms of business and finance, such as payer mix, ROI and operating margin. The sooner we can remove language barriers, the sooner we can create better results together.

CFOs can help clinicians in Infection Prevention and Control to never assume that adding resources is the only way to improve care.

Results First

While resources are critical to support the fight, demonstrating success and return on investment makes a great case for enhancing resources. Succeeding first, THEN asking for more resources, is a good strategy. CFOs can help clinicians in Infection Prevention and Control to never assume that adding resources is the only way to improve care. Collaborate to find ways to enhance prevention program efforts even if additional FTEs are not possible. The Specialists, once successful in eliminating infections, may begin bargaining for a percentage of the organizational cost savings to further enhance prevention efforts.

---

[1] 1.6 Million Admission Analysis, MedMined, Inc. September 2006

[2] 1.6 Million Admission Analysis, MedMined, Inc. September 2006

[3] Reinertsen, James and Schellekens, Wm. 10 Powerful Ideas for Improving Patient Care. Chicago: Health Administration Press. 2005

[4] Top Issues Confronting Hospitals: 2005, American College of Healthcare Executives

[5] Public Health Focus: surveillance, prevention and control of nosocomial infections. MMWR Morb Mort Rep 41:738-787, Oct. 23, 1992.

[6] Reference Carnegie-Mellon validation of AGH and Hollenbeak validation of BJC.

[7] Shannon, Richard, MD, Hospital-Acquired Infections: Meeting the challenge. American Journal of Medical Quality, Supplement to Vol. 21, No. 6, Nov-Dec. 2006.

[8] Murphy, Denise and Christopher Hollenbeak, Economics of Infection Prevention, APIC Futures Summit, 2006

[9] Haley, RW et al. Am J Epidemiology 1985

[10] Pennsylvania Healthcare Cost Containment Council, PHC4 Research Brief, March 2006

[11] McGill, Doug, The Business Case for Quality, Economics of Infection Prevention APIC Futures Summit, 2006.

[12] Shannon, Richard, MD, Hospital-Acquired Infections: Meeting the challenge. American Journal of Medical Quality, Supplement to Vol. 21, No. 6, Nov-Dec. 2006.

APIC
ASSOCIATION FOR PROFESSIONALS IN
INFECTION CONTROL & EPIDEMIOLOGY, INC.
1275 K Street NW, Suite 1000
Washington, DC 20005

About APIC

APIC's mission is to improve health and patient safety by reducing risks of infection and other adverse outcomes. The Association's more than 11,000 members have primary responsibility for infection prevention, control and hospital epidemiology in health care settings around the globe, and include nurses, epidemiologists, physicians, microbiologists, clinical pathologists, laboratory technologists and public health practitioners. APIC advances its mission through education, research, collaboration, practice guidance and credentialing.

Visit APIC online at **www.apic.org.**

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/19/07

FURTHER: (Finance)

Date of 5-Day Notice: 3/1/07
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/12/07

Health, Education and Social Services Committee considered

SENATE BILL NO. 62

SB 62 TASK FORCE ON HEALTH CARE INFECTIONS

"An Act establishing the Advisory Committee on Public Reporting of Health Care Associated Infections; relating to reporting and dissemination of data concerning health care associated infections; and providing for an effective date."

and recommends:

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

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

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
HSS	2/8/07	✓			1

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Elton	✓			
	Thomas	✓			
	Dysart	✓			
CHAIR: Bettye Davis	DAVIS	X			