

## SUMMARY OF STATE LAWS ON MRSA

Methicillin-resistant *Staphylococcus aureus* (MRSA), an antibiotic resistant bacteria, causes an estimated 95,000 infections each year and 19,000 deaths - 85% of these infections are acquired in a hospital or other health care setting (for example, a nursing home, dialysis center, or ambulatory surgical center). Many US hospitals and other countries (northern European and Western Australia) use comprehensive evidence-based prevention techniques that have significantly reduced MRSA related infections in the health care setting. The effective prevention strategies endorsed by the Centers for Disease Control and Prevention (CDC), the Society for Healthcare Epidemiologists of America (SHEA), and the Association for Professionals in Infection control and Epidemiology (APIC) include: screening selected high risk patients for MRSA using a nasal swab ("active surveillance testing") to identify incoming patients who are colonized or infected with MRSA, isolating patients with MRSA to prevent transmission to other patients, using contact precautions (gloves, gowns, masks) with these patients, strict hand hygiene, and disinfecting the hospital environment.

### STATE LAWS REQUIRING MRSA SCREENING

#### **Illinois (2007) SB 233**

The IL law requires all hospitals to establish an MRSA control program to identify all MRSA-colonized ICU patients and patients at risk of carrying MRSA. Hospitals must appropriately isolate MRSA-colonized or infected patients, monitor and strictly enforce hand hygiene compliance, and report MRSA cases to the Department of Health. The Department will produce a public report on MRSA cases.

#### **New Jersey – S2580**

The NJ law (effective 9-2-07) requires hospitals to implement best practices and effective strategies to prevent hospital-acquired infections in intensive care units (or other units at high risk of hospital-acquired infections if they have no ICU). These must be in place within one month of the effective date and include identifying patients colonized or infected with MRSA, isolating those patients to prevent transmission to other patients, using contact precautions as defined by the CDC, culturing patients for MRSA upon discharge or transfer, flagging patients who are readmitted, strict adherence to hygiene guidelines, and worker education. Ultimately the infection prevention program must be in place throughout the hospital. Each facility must report the number of cases to the Commissioner of Health and Senior Services. The law does not require a public report of the information.

#### **Pennsylvania – S968**

The PA law requires each hospital, nursing home and ambulatory surgical facility to develop and implement an infection control plan that includes screening incoming patients and to report health care-acquired infections to the state for public reporting [NOTE: Hospitals were already required to report infections, but this law changed the

way they report.]. The law specifies what the plan must cover and require facilities to submit plans to the Department of Health (DOH). The plans must include establishing a facility committee to oversee infection prevention; effective measures to detect, prevent and control hospital-acquired infections; processes and policies to use active surveillance cultures; a system to identify patients at high risk of MRSA colonization or infection or other multiple drug resistant organisms (MDRO) to be cultured; and infection intervention protocols that include nationally recognized evidence based protocols, isolation procedures, cleaning of the environment, appropriate use of antibiotics, educational programs for facility staff, and sufficient staff and other resources. Timelines in the bill are unclear as steps must be taken by one or more state agencies prior to triggering the infection control actions at the hospital level.

Nursing homes are required to submit infection cases to the DOH and will pay for this system through a fee added to their licenses; the state is seeking federal approval to make the fee reimbursable by the federal Medicaid program.

Hospitals must report infections using the CDC National Health care Safety Network, beginning 180 days from the law's effective date. Patient specific information is required to coordinate with information currently collected by the PA Health Care Cost Containment Council (PHC4) on hospital discharges. This will enable more comprehensive assessment of health care safety and quality. The Department of Health (DOH), PHC4 and PA Patient Safety Authority (PPSA) will have access to the data for public reporting, prevention, and public health purposes.

Infections are reported to PPSA as "serious events" as defined by previous law, 120 days after the PPSA publishes a notice on uniform reporting, and then reported annually with the state's other serious events. The PPSA reports are extensive but not facility-specific. The PPSA must appoint an advisory committee of experts – no consumer representation – and is responsible for training health care workers on infection control.

The Department of Health is responsible for a public awareness campaign on health care acquired infections, considering the benefits of using surveillance cultures to identify community acquired MRSA, developing best practices, and making recommendations regarding screening patients for MRSA and other MDROs.

All agencies (PHC4, PPSA, DOH) are to work together to develop methods for public reporting of hospital infection rates so that comparisons among like hospitals can be made and assessments can be made as to whether the facility is appropriately reducing infections over time. The agencies must establish benchmarks from which facility success in reducing infections will be measured beginning in 2010. The law lays out rather weak consequences if a facility fails to meet the benchmark.

It is our understanding that PHC4 will continue to report the facility-specific infection rates using NHSN data rather than the methodology used in its 2006 and 2007 reports. It is also our understanding that the measures to be reported to the public will remain the same as in the prior PHC4 reports: all hospital-acquired infections occurring in the facility, including surgical site infections, blood stream infections, ventilator associated pneumonia, and urinary tract infections.

Each hospital is required to use an electronic surveillance system, as approved by the Department, by 12-31-08, unless special circumstances exist. The PA Patient Safety Authority (PPSA) is responsible to establish definitions, protocols, standards and training for implementing the law.

The cost of surveillance cultures shall be considered a "reimbursable cost" by all payers. Beginning in January 2009, each year the state will make a quality improvement payment to facilities that reduce their hospital-acquired infections by 10% and are in

compliance with this law. These increments and payments may be adjusted in later years.

Enforcement: Facilities can be assessed up to \$1000/day administrative penalty if they “negligently” fail to report an infection to comply with the law

### **OTHER STATE LAWS RELATED TO MRSA**

#### **Minnesota (2007) HF 1078**

The MN law requires every hospital to establish a MRSA control program that meets standards set by the state Department of Health. These standards must be reviewed annually for needed updating. [Standards have been proposed](#) and were open for comment until November 1, 2007. The proposal closely follows CDC guidelines for MRSA prevention, recommending active surveillance cultures and enhanced contact precautions only when the “prevalence of hospital-acquired MRSA infections is not decreasing.” There is no requirement for hospitals to establish a baseline from which to measure this or to report cases or prevalence to the state agency. One section of the proposal titled “Review of Specific Infections Prevention and Control Interventions” is an informative summary of MRSA related issues.

[\[http://www.health.state.mn.us/divs/idepc/diseases/mrsa/rec/index.html\]](http://www.health.state.mn.us/divs/idepc/diseases/mrsa/rec/index.html)

#### **Tennessee – S 268**

The TN law creates an Infections Task Force to meet twice a year to analyze data on the incidence and trend for “invasive MRSA.” MRSA is [a reportable condition](#) in TN: To see the March 2007 report: <http://health.state.tn.us/Downloads/MRSAreport307.pdf>.

#### **Texas – HB 1082**

The TX law creates a pilot program in Bexar County (San Antonio) requiring labs to report cases of MRSA to the county with authority; info about MRSA, including location of the infections reported; will be made public. This may serve as a model for statewide reporting in the future.