110TH CONGRESS
1ST SESSION

S. 2278

To improve the prevention, detection, and treatment of community and healthcare-associated infections (CHAI), with a focus on antibiotic-resistant bacteria.

IN THE SENATE OF THE UNITED STATES

OCTOBER 31, 2007

Mr. DURBIN (for himself, Mr. OBAMA, and Mr. SCHUMER) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To improve the prevention, detection, and treatment of community and healthcare-associated infections (CHAI), with a focus on antibiotic-resistant bacteria.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Community and Healthcare-Associated Infections Reduction Act of 2007''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Effective antibiotics have transformed the practice of medicine and saved millions of lives, but

the emergence and spread of antibiotic-resistant bacterial pathogens poses a significant threat to patient and public health.

(2) Although many antibiotic-resistant infections occur most frequently among individuals in hospitals and other healthcare facilities, they also affect otherwise healthy individuals in the community.

(3) According to the Centers for Disease Control and Prevention (referred to in this Act as the ''CDC''), healthcare-associated infections (referred to in this Act as ''HAI'') are one of the top 10 leading causes of death in the United States.

(4) In American hospitals alone, HAI account for an estimated 1,700,000 infections and 99,000 associated deaths each year. In 70 percent of these deaths, the bacteria are resistant to at least one commonly used antibiotic.

(5) Dr. John Jernigan, Chief of Interventions and Evaluations at the CDC, estimates that HAI in hospitals result in up to $27,500,000,000 in additional healthcare costs annually. The growing problem of antibiotic resistance, which affects the most common and least expensive antibiotics first, also shifts utilization toward more expensive antibiotics.

(6) Methicillin-resistant Staphylococcus aureus (referred to in this Act as ''MRSA''), one of the most dangerous forms of antibiotic-resistant staph infections, highlights the magnitude of the problem. A recent study by the CDC estimates that nearly 95,000 people became infected with invasive MRSA in 2005 in the United States, resulting in 19,000 deaths, more than the number who died from HIV/AIDS, Parkinson's disease, emphysema, or homicide. A vast majority (85 percent) of these infections were associated with healthcare treatment.

(7) MRSA also affects individuals outside the healthcare setting and in the community. Recent weeks have seen an increase by health and education officials in reported staph infection outbreaks, including antibiotic-resistant strains. These infections have occurred in New York, Kentucky, Virginia, Maryland, Illinois, Ohio, North Carolina, Florida, and the District of Columbia.

(8) The problem of antibiotic-resistant infections is not limited to MRSA. High levels of resistance in enterococci, Klebsiella pneumonia, Pseudomonas aeruginosa, and E. coli have also been reported.

(9) Antibiotic-resistant infections have been discovered in troops coming back from Iraq and Afghanistan. A CDC study showed that between March and October 2003, 145 United States service members at military treatment facilities were infected or colonized with a multidrug-resistant gram-negative bacterium called Acinetobacter baumannii. The most likely source of this outbreak was bacteria within deployed field hospitals.

(10) Despite this significant public health threat, information on community and healthcare-associated infections (referred to in this Act as ''CHAI'') is incomplete and unreliable. Policymakers, healthcare providers, and individual consumers have little information about hospital infection rates, making it difficult to diagnose the scope of the problem and evaluate current infection prevention efforts, and assess potential remedies.

SEC. 3. DEFINITIONS.

In this Act:

(1) ADMINISTRATOR.—The term ''Administrator'' means the Administrator of the Centers for Medicare & Medicaid Services.

(2) AHRQ.—The term ''AHRQ'' means the Agency for Healthcare Research and Quality.

(3) CHAI.—The term ''CHAI'' means community and healthcare-associated infections.

(4) DIRECTOR.—The term ''Director'' means the Director of the Centers for Disease Control and Prevention, unless otherwise specifically designated.

(5) HAI.—The term ''HAI'' means healthcare-associated infections, which are infections that patients acquire during the course of receiving treatment for other conditions within a healthcare setting.

(6) HOSPITAL.—The term ''hospital'' means a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))).

(7) INTERAGENCY WORKING GROUP.—The term ''interagency working group'' means the interagency working group on community and healthcare-associated infections established under section 9.

(8) MRSA.—The term ''MRSA'' means Methicillin-resistant Staphylococcus aureus.

(9) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 4. COMMUNITY AND HEALTHCARE-ASSOCIATED INFECTION CONTROL PROGRAM.

(a) ESTABLISHMENT OF BEST PRACTICES GUIDELINES FOR INFECTION CONTROL.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, AHRQ in collaboration with CDC shall develop best-practices guidelines for internal infection control plans to prevent, detect, control, and treat CHAI at hospitals.

(2) REQUIREMENTS.—In carrying out paragraph (1), AHRQ shall—

(A) establish a set of best practices with supporting justification of their appropriateness and effectiveness based on nationally-recognized or evidence-based standards, which practices may include—

(i) the establishment of an infection control oversight committee; and

(ii) the establishment of measures for the prevention, detection, control, and treatment of CHAI, such as—

(I) staff training and education on CHAI prevention and control, including the monitoring and strict enforcement of hand hygiene procedures;

(II) a system to identify, designate, and manage patients known to be colonized or infected with CHAI, including diagnostic surveillance processes and policies, procedures and protocols for staff who may have had potential exposure to a patient or resident known to be colonized or infected with a CHAI, and an outreach process for notifying a receiving healthcare facility of any patient known to be colonized or infected with CHAI prior to transfer of such patient within or between facilities;

(III) the development and implementation of an infection control intervention protocol that may include active detection and isolation procedures, the alternation of the physical plan of a hospital, the appropriate use of anti-microbial agents, and other infection control precautions for general surveillance of infected or colonized patients;

(B) work in collaboration with other agencies and organizations whose area of expertise is the identification, treatment, and prevention of infectious disease;

(C) publish proposed guidelines for internal infection control plans;

(D) provide for a comment period of not less than 90 days; and

(E) establish final guidelines, taking into consideration any comment received under subparagraph (D).

(b) CONSULTATION OF BEST PRACTICES GUIDELINES.—The Administrator shall consult best practices guidelines in evaluating hospitals infection control plans as a condition of participation in the Medicare program.

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2008 through 2012.

SEC. 5. COLLECTION, REPORTING, AND COMPILATION OF COMMUNITY AND HEALTHCARE-ASSOCIATED INFECTION DATA.

(a) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, hospitals shall report information about CHAI to the CDC National Healthcare

Safety Network (NHSN), which shall be used by the CDC to develop a national database of infection rates in hospitals. With respect to reporting such information, the following shall apply:

(1) Hospitals shall meet data reporting standards as required by the NHSN, including timeframes, case-finding techniques, submission formats, infection definitions and other relevant terms, methodology for surveillance of infections, risk-adjustment techniques, or other specifications necessary to render the incoming data valid, consistent, compatible, and manageable.

(2) Hospitals shall submit data that allows the CDC to distinguish between—

(A) infections that are present in patients upon their admission to the hospital;

(B) infections that occur during a patient's hospital stay; and

(C) infections caused by multiple drug resistant organisms and nondrug resistant organisms.

(3) The CDC shall have the authority to make such orders, findings, rules, and regulations as necessary to ensure that hospitals accurately and timely track and report data.

(b) CONSULTATION.—The CDC shall review and revise NHSN standards as appropriate, working in consultation with the Centers for Medicare & Medicaid Services, AHRQ, and national organizations engaged in healthcare quality measurement and reporting.

(c) DATA HARMONIZATION.—The Director shall work in collaboration with the Administrator to support the harmonization of data for purposes of developing a national database of infections rates in hospitals and other purposes determined to be appropriate.

(d) DISSEMINATION OF DATA.—Not later than 1 year after the date of enactment of this Act, subject to the confidentiality of patient records, the CDC shall—

(1) make data available to interested researchers;

(2) make data available to interested State Health Departments;

(3) produce useful and accessible reports for the public to allow for comparisons of HAI rates across hospitals; and

(4) use data to assist hospitals in evaluating and formulating best practices strategies to reduce infection rates.

(e) PRIVACY OF DATA.—Notwithstanding any other provision of Federal, State, or local law, the infection data

collected pursuant to this Act shall be privileged and shall not be—

(1) subject to admission as evidence or other disclosure in any Federal, State, or local civil or administrative proceeding; and

(2) subject to use in a State or local disciplinary proceeding against a hospital or provider.

(f) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2008 through 2012.

SEC. 6. QUALITY IMPROVEMENT PAYMENT PROGRAM.

(a) PAY FOR PERFORMANCE INITIATIVES REPORT.—Not later than 90 days after the date of enactment of this Act, the Administrator shall submit to Congress a report studying the feasibility of reducing HAI rates through a Quality Improvement Payment Program.

(b) PROGRAM.—The report under subsection (a) shall consider such factors as—

(1) patient demographics, such as—

(A) the median income of patients;

(B) percentage of minority patients; and

(C) disease condition;

(2) hospital characteristics, such as—

(A) median income;

(B) population density of the hospital zip code locale;

(C) university affiliation; and

(D) hospital size as indicated by the number of beds; and

(3) other factors as determined to be appropriate by the Centers for Medicare & Medicaid Services.

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2008 through 2012.

SEC. 7. PUBLIC AWARENESS CAMPAIGN.

(a) IN GENERAL.—The Director shall award grants to States for the purpose of enabling the States to carry out public awareness campaigns to provide public education and increase awareness with respect to the issue of reducing, preventing, detecting, and controlling CHAI.

(b) REQUIREMENTS.—To be eligible for a grant under subsection (a), a State shall provide assurances to the Secretary that the State campaign to be conducted under the grant shall—

(1) provide information on the prevention and control of CHAI, including appropriate antibiotic use, causes and symptoms, and management, treat-

ment and reduction methods, in healthcare settings and non-healthcare settings;

(2) provide information to healthcare providers and the public, including schools, non-profit organizations, and private-sector entities; and

(3) work with members of the community to promote awareness and education, including hospitals, school health centers, schools, local governments, doctors' offices, prisons, jails, and other public- and private-sector entities.

(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2008 through 2012.

SEC. 8. EXPANSION AND COORDINATION OF ACTIVITIES OF THE NATIONAL INSTITUTES OF HEALTH REGARDING COMMUNITY AND HEALTHCARE-ASSOCIATED INFECTIONS.

(a) COMMUNITY AND HEALTHCARE-ASSOCIATED INFECTIONS INITIATIVE THROUGH THE NATIONAL INSTITUTES OF HEALTH.—

(1) EXPANSION AND INTENSIFICATION OF ACTIVITIES.—

(A) IN GENERAL.—The Director of National Institutes of Health (referred to in this

section as the ''Director''), in coordination with the directors of the other national research institutes (as appropriate), may expand and intensify programs of the National Institutes of Health with respect to research and related activities concerning CHAI.

(B) COORDINATION.—The directors referred to in paragraph (1) may jointly coordinate the programs referred to in such paragraph and consult with additional Federal officials, voluntary health associations, medical professional societies, and private entities, as appropriate.

(2) PLANNING GRANTS AND CONTRACTS FOR INNOVATIVE RESEARCH IN CHAI.—

(A) IN GENERAL.—In carrying out subsection (a)(1) the Director may award planning grants or contracts for the establishment of new research programs, or the enhancement of existing research programs, that focus on CHAI.

(B) RESEARCH.—In awarding planning grants or contracts under paragraph (1), the Director may give priority to—

(i) collaborative partnerships, which may include academic institutions, private

sector entities, or nonprofit organizations with a focus on infectious disease science, medicine, public health, veterinary medicine, or other discipline impacting or influenced by emerging infectious diseases;

(ii) research on the most effective copper-based applications to stem infections in military and civilian healthcare facilities; and

(iii) research on new rapid diagnostic techniques for antibiotic-resistant bacteria.

(b) REPORT.—Not later than 6 months after the date of enactment of this Act, the Secretary, in collaboration with the Director, the Commissioner of Food and Drugs, and the Director of the National Institutes of Health, shall prepare and submit to the appropriate committees of the Congress a report that describes the obstacles to anti-infective, especially antibacterial, drug research and development. Such report shall—

(1) identify, in concurrence with infectious disease clinicians and appropriate professional associations, the infectious pathogens that are (or are likely to become) a significant threat to public health because of drug resistance or other factors;

(2) identify those incentives that may already exist through Federal programs, such as Orphan Product designation, including an explanation of how such programs would apply to infectious diseases and in particular resistant bacterial infections;

(3) recommend strategies to publicize current incentives available to encourage anti-infective, especially antibacterial, drug research and development;

(4) recommend additional regulatory and legislative solutions to stimulate appropriate anti-infective, especially antibacterial, drug research and development;

(5) update the progress made in response to the ''Public Health Action Plan to Combat Antimicrobial Resistance'' to include a narrative summary of activities in addition to tables provided in existing progress reports, highlighting where gaps remain as well as obstacles to future progress; and

(6) recommend strategies to strengthen the Federal response to antimicrobial resistance, as outlined in the Action Plan, in particular additional actions needed to address remaining gaps or obstacles to progress in implementing the Plan, as well as Federal funding needs.

(c) PUBLIC INFORMATION.—The coordinating committee shall make readily available to the public information concerning the research, education, and other activities relating to CHAI, that are conducted or supported by the National Institutes of Health.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary for each of fiscal years 2008 through 2012 to carry out this section.

SEC. 9. INTERAGENCY WORKING GROUP ON COMMUNITY AND HEALTHCARE-ASSOCIATED INFECTIONS.

(a) ESTABLISHMENT.—The Secretary, in coordination with the Administrator, shall establish an interagency working group on CHAI to consider issues relating to the reduction and prevention of these infections.

(b) MEMBERSHIP.—The interagency working group shall be composed of a representative from each Federal agency (appointed by the head of each such agency) that has jurisdiction over, or is affected by, CHAI including—

(1) the Centers for Medicare & Medicaid Services;

(2) the Centers for Disease Control and Prevention;

(3) the Health Resources and Services Administration;

(4) the Agency for Healthcare Research and Quality;

(5) the Food and Drug Administration;

(6) the National Institutes of Health;

(7) the Department of Agriculture;

(8) the Department of Defense;

(9) the Department of Veterans Affairs;

(10) the Environmental Protection Agency; and

(11) such other Federal agencies as determined appropriate.

(c) DUTIES.—The interagency working group shall—

(1) work in collaboration with the Interagency Task Force on Anti-microbial Resistance;

(2) facilitate communication and partnership on infection prevention and quality health-related projects and policies;

(3) serve as a centralized mechanism to coordinate a national effort—

(A) to discuss and evaluate evidence and knowledge on infection prevention;

(B) to determine the range of effective, feasible, and comprehensive actions to improve healthcare quality related to CHAI; and

(C) to examine and better address the growing impact of CHAI in communities throughout the United States;

(4) coordinate plans to communicate research results relating to CHAI prevention and control to enable reporting and outreach activities to produce more useful and timely information;

(5) consider and determine the feasibility of establishing an active surveillance program involving other entities (such as athletic teams or correctional facilities) for the purpose of identifying those individuals in the community that are colonized and at risk of susceptibility to and transmission of bacteria;

(6) develop an appropriate research agenda for Federal agencies;

(7) develop recommendations regarding evidence-based best practices, model programs, effective guidelines, and other strategies for promoting CHAI prevention and control;

(8) monitor Federal progress in meeting specific CHAI prevention and control promotion goals; and

(9) not later than 2 years after the date of enactment of this Act, submit to Congress a report that describes the appropriateness and effectiveness

of best practices guidelines developed by the Centers for Disease Control and Prevention for infection control plans.

(d) MEETINGS.—

(1) IN GENERAL.—The interagency working group shall meet at least 6 times each year.

(2) ANNUAL CONFERENCE.—The Secretary shall sponsor an annual conference on CHAI prevention, detection, and control to enhance coordination and share best practices in CHAI data collection, analysis, and reporting.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 10. GOVERNMENT ACCOUNTABILITY OFFICE REPORT ON COMMUNITY AND HEALTHCARE-ASSOCIATED INFECTIONS.

Not later than 2 years after the date of enactment of the Act, the Government Accountability Office shall submit to Congress a report on the impact of this Act on—

(1) the prevalence of CHAI; and

(2) the quality and availability of data about CHAI.

SEC. 11. PREEMPTION.

Nothing in this Act shall be construed to preempt existing State laws, except to the extent that such State laws would result in the establishment of duplicative or conflicting surveillance or reporting requirements.

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