74th OREGON LEGISLATIVE ASSEMBLY - 2007 Regular Session **MEASURE: HB 2524 A**
STAFF MEASURE SUMMARY **CARRIER:**
House Committee on Health Care

REVENUE: No revenue impact
FISCAL: Fiscal statement issued

Action:		Do Pass as Amended, Be Printed Engrossed, and Be Referred to the Committee on Ways and Means
Vote:		8 - 0 - 1
	Yeas:	Bonamici, Bruun, Cannon, Flores, Kotek, Maurer, Richardson, Greenlick
	Nays:	0
	Exc.:	Gelser
Prepared By:		Sandy Thiele-Cirka, Administrator
Meeting Dates:		2/15 (policy sub), 3/15 (policy sub), 3/22 (policy sub), 3/27 (full), 4/6 (full)

WHAT THE MEASURE DOES: Requires health care facilities to collect data on health care facility acquired infection rates. Establishes the Oregon Health Care Acquired Infection Reporting Program in the Office for Oregon Health Policy and Research (OHPR). Specifies program directives. Directs OHPR to adopt rules for the reporting program. Establishes the 16-member Health Care Acquired Infection Advisory Committee, specifies the committee's membership and terms of office, and directs the committee to develop and present recommendations to the OHPR Administrator. Directs the OHPR Administrator to present an annual report to the Legislative Assembly and the public. Declares January 1, 2010 as the first report effective date. Declares emergency, effective July 1, 2007.

ISSUES DISCUSSED:
- Growing concerns associated with hospital acquired infections
- Current activities of the Oregon Patient Safety Commission
- Voluntary versus mandatory reporting requirements
- Current infection surveillance and prevention programs throughout Oregon
- Review of other states with mandatory reporting requirements
- Joint Commission on Accreditation of Healthcare Organizations standards and requirements
- Public access and flexible reporting program
- Proposed amendments

EFFECT OF COMMITTEE AMENDMENT: Replaces original measure.

BACKGROUND: Healthcare associated infections (HAI) are defined as infections contracted in healthcare settings while receiving treatment for other conditions. The U.S. Centers for Disease Control and Prevention (CDC) estimates that healthcare associated infections contracted in U.S. hospitals account for approximately two million infections, 90,000 deaths and an estimated $4.5 billion in excess costs annually.

While there is little doubt that HAIs have serious clinical, financial, and policy implications for patients, hospitals and the state of Oregon, to quantify the extent of those implications is difficult. Currently, there is no consensus about how to define and measure HAIs, and existing methods may not accurately and consistently detect HAI cases.

Patient safety advocates assert that mandatory reporting and the publicizing of the rate of hospital-acquired infections and other medical errors in health facilities will encourage hospitals to share data, identify emerging trends and develop systems to prevent the occurrence of medical errors. Opponents of mandatory error reporting assert that state-mandated systems to make data public do not guarantee improvements in patient safety, but could lead to increased lawsuits, a decrease in reporting and would foster a system of blame rather than patient safety.