Flex Monitoring Team
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Reporting of Healthcare-Associated Infections by Critical Access Hospitals

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KEY FINDINGS

- A review of state statutes and regulations indicates that 34 of the 45 Flex states require hospitals to report data to the state and/or the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) on one or more Healthcare Associated Infections (HAIs).
- In 12 of these 34 states, the HAI reporting requirement only applies to Prospective Payment System (PPS) hospitals or to hospitals with Intensive Care Units (ICUs); specifically excludes Critical Access Hospitals (CAHs) or low-volume hospitals; or includes a waiver or exemption process.
- Among the six HAIs reported to Hospital Compare via NHSN, CAHs were most likely to report data on CDI (283 CAHs, 21.2%) and MRSA (227 CAHs, 17%), followed by SSI for colon surgery (189 CAHs, 14.1%), SSI for hysterectomy (153 CAHs, 11.4%), and CLABSI and CAUTI (147 CAHs, 11% each).
- Although many CAHs do not have the minimum number of cases to calculate facility-level risk-standardized infection ratios, analysis of pooled data from groups of similar facilities can help track infection trends and identify potential targets for HAI prevention and quality improvement initiatives at the state level or among groups of CAHs providing similar services.

INTRODUCTION

Healthcare-Associated Infections (HAIs) in hospitals have garnered considerable attention in recent years and are the focus of multiple national and state reporting requirements and prevention initiatives. An estimated 5-10% of hospitalized patients experience a HAI every year, resulting in significant morbidity and mortality.[1] HAI measures indicate how often patients in a hospital contract certain infections during their medical treatment. These infections can often be prevented when healthcare facilities follow guidelines for safe care.

The Centers for Medicare and Medicaid Services (CMS) require Prospective Payment System (PPS) hospitals to report data on six HAI measures: central line-associated bloodstream infections (CLABSI); catheter-associated urinary tract infection (CAUTI); surgical site infections (SSI) from colon surgery; SSI from abdominal hysterectomy; methicillin-resistant staphylococcus aureus (MRSA) infections; and clostridium difficile (CDI) infections.[2] PPS hospitals report HAI data to the CDC NHSN, which shares the data with CMS. CMS does not require CAHs to report data on the HAI measures, but CAHs may choose to report on a voluntary basis. CDC reports that 404

CAHs contributed data to NHSN in 2013, up from 324 CAHs in 2012.[3-4]

Four HAI measures (CLABSI, CAUTI, CDI, and MRSA) are optional patient-safety measures for the Medicare Beneficiary Quality Improvement Project (MBQIP) in FY 2015-2017. State Flex Programs may choose to assist CAHs in their states with reporting data on these four measures and implementing quality improvement activities to improve patient outcomes on the measures.[5]

PURPOSE

The purpose of this policy brief is to describe state HAI reporting requirements and the extent to which they apply to CAHs, and analyze data reported by CAHs on publicly-reported HAI measures in Hospital Compare. A second policy brief in this series will describe evidence-based programs and strategies for reducing HAIs in CAHs.

DATA AND APPROACH

We used multiple approaches to identify state HAI reporting requirements and the extent to which they apply to CAHs. We reviewed information on overall state HAI reporting requirements and state health care infection plans from the CDC website[6] and on state statutes and recent legislation regarding HAI reporting from the Association of State and Territorial Health Officials (ASTHO).[7-11] Key contacts for the State Health Care Infection Programs in the 45 Flex States were identified from the CDC website, and these individuals were surveyed via email about whether small rural hospitals in their state (including CAHs) were required to report HAIs to the state and/or NHSN, and whether small rural hospitals (including CAHs) were included in HAI reporting and prevention initiatives. Thirty-four of the 45 State Infection Program contacts responded to the survey. We also surveyed the 45 State Flex Coordinators by email, asking about the same issues and for additional information about HAI reporting and prevention activities involving CAHs. After multiple contacts, State Flex Coordinators in all 45 Flex states responded to the survey; three states had two State Office of Rural Health survey respondents each. To resolve missing or conflicting information from the above sources, we checked state health department websites, and analyzed state statutes and regulations regarding HAI reporting.

Next, we analyzed data for January 2013 through December 2013 reported by CAHs on the six HAI measures in Hospital Compare (CLABSI; CAUTI; SSI from colon surgery; SSI from abdominal hysterectomy; MRSA blood infections; and CDIs). CAHs that reported data on one or more procedures (the denominator for the SSI infection rates), patient days (the denominator for CDI and MRSA blood infection measures), or device days (the total number of days that all patients had a central line or urinary catheter, the denominator for the CLABSI and CAUTI measures) were counted as reporting that measure.

According to CDC, the minimum numbers needed for calculating facility-specific Standardized Infection Ratios (SIRs) are 1 expected event or 50 device days annually.[3,12] A SIR compares the number of infections that occurred in a facility or a state to the number of infections that were expected based on previous years of reported data. Few CAHs have the minimum 50 device days or 1 expected event for calculating SIRs at the individual hospital level. (For the last six months of 2013 and the first six months of 2014 Hospital Compare data, the number of CAHs nationally with calculated SIRs was 0 for CLABSI and SSI-hysterectomy, 1 for MRSA and SSI-colon surgery, 2 for CAUTI, and 170 for CDI.)

No longitudinal data were publicly available to calculate state-level expected events for the two SSIs, so we analyzed performance for CLABSI, CAUTI, MRSA, and CDI. We followed CDC methods for calculating pooled mean infection rates for CAHs nationally and by state by summing the numerators for all CAHs with data for each measure in each state and dividing it by the sum of the denominators for those CAHs.[3-4] We were not able to calculate separate infection rates for critical care and non-critical care locations within CAHs, as the Hospital Compare HAI data do not include this information. Some states did not have enough CAHs reporting data to have the minimum denominators for all CAHs combined; infection rates for those states are not reported in this brief, but data for the CAHs in

those states were included in the national CAH rate calculations.

RESULTS

State HAI Reporting Requirements and Applicability to CAHs

According to the CDC, 27 of the 45 Flex states require some type of HAI reporting to NHSN.[6] ASTHO reports and legislative summaries indicate that 24 Flex States either had an HAI law or considered HAI-related legislation in 2012-2014.[7-11]

In our surveys, State Infection Program Contacts and Flex Coordinators in the same states did not always agree about the applicability of HAI reporting requirements to CAHs. State Infection Program contacts in 15 Flex states and State Coordinators in 12 Flex states reported that CAHs in their states are required to report HAIs to NHSN. State Infection Program contacts in 13 Flex states and Flex Coordinators in 20 Flex states reported that CAHs in their states are required to report HAIs to the state health department or another state organization, such as a health care or patient safety authority.

Based on our review of state statutes and regulations and information from state health department websites, we identified 34 Flex States that have a state statutory or regulatory requirement for hospitals to report data on one or more of the six CMS HAIs to the state and/or NHSN (Table 1). In 12 states, the requirement only applies to PPS hospitals; excludes CAHs, low volume hospitals, or non-ICUs; or includes a waiver or exemption process. The remaining 11 Flex states either describe their hospital HAI reporting initiatives as voluntary (e.g., on health department websites) or were presumed to have voluntary reporting in the absence of any evidence regarding mandatory reporting.

In addition, several states require HAI reporting by laboratories and/or health care providers under communicable disease requirements; HAIs covered by these requirements include infections caused by antibiotic-resistant organisms such as MRSA, Vancomycin-resistant Staphylococcus aureus (VRSA); Vancomycin-resistant Enterococcus (VRE); Vancomycin-intermediate Staphylococcus aureus (VISA); and Carbapenem-resistant Enterobacteriaceae (CRE).

A growing number of states require hospitals to allow the state health department to have access to their

Table 1. State Statutes / Regulations Applying to HAI Reporting by CAHs (N=45 Flex States)

State statutes and/or regulations require hospitals to report one or more of the following HAIs to the state and/or NHSN: CLABSI, CAUTI, SSIs, MRSA, CDI[a]	Alabama, Arkansas, California, Colorado, Illinois, Indiana, Kentucky (effective 10/1/16), Maine, Massachusetts, Mississippi, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas, Washington, West Virginia
State HAI reporting statutes and/or regulations apply only to PPS hospitals or hospitals with ICUs, exclude CAHs or low-volume hospitals, or include a waiver or exemption process	• Georgia (PPS hospitals reporting to CMS via NHSN) • Hawaii (PPS hospitals reporting to CMS via NHSN) • Minnesota (CLABSI in neonatal and pediatric ICUs) • Missouri (low-volume providers may request exemptions) • New York (minimum thresholds for public reporting) • Nevada (applies to facilities with 25 or more patient days) • North Carolina (PPS hospitals reporting to CMS via NHSN) • Oregon (low-volume providers may request exemptions) • Tennessee (excludes CAHs) • Utah (PPS hospitals reporting to CMS via NHSN) • Vermont (CLABSI in adult, neonatal, and pediatric ICUs) • Virginia (CLABSI in adult ICUs)

[a]CLABSI: central line-associated bloodstream infection; CAUTI: catheter-associated urinary tract infection; SSIs: surgical site infections; MRSA: Methicillin resistant Staphylococcus aureus; CDI: Clostridium difficile.

Data source: Authors' review of state statutes and regulations and information from state health department websites. For additional details on specific state laws and regulations, see Table A-1 in Appendix.

NHSN data. In states with mandatory HAI reporting requirements, CDC provides health departments with access to the reported NHSN data for facilities in their state. States that do not have a reporting requirement in state law may access NHSN data for facilities in their state for surveillance and prevention activities through a Data Use Agreement with CDC.

Table 1 shows the classification of the Flex states according to their HAI reporting requirements. Table A-1 in the Appendix has additional information about the specific state statutory and regulatory requirements.

CAH Reporting of HAI Data to Hospital Compare via NHSN

Table 2 (next page) shows the number of CAHs by state that reported data to Hospital Compare via NHSN on one or more device days for the CLABSI and CAUTI measures, one or more procedures for the SSI infection rates, and one or more patient days for the CDI and MRSA blood infection measures. Of the 45 Flex states, 42 states had at least one CAH that reported CDI data; 41 states had at least one CAH that reported MRSA data; 36 states each had at least one CAH that reported CLABSI data and SSI data for colon surgery; 34 states had at least one CAH that reported CAUTI data; and 32 states had at least one CAH that reported abdominal hysterectomy SSI data.

Overall, CAHs were most likely to report data on CDI (283 CAHs, 21.2%) and MRSA (227 CAHs, 17%), followed by SSI for colon surgery (189 CAHs, 14.1%), SSI for hysterectomy (153 CAHs, 11.4%), and CLABSI and CAUTI (147 CAHs, 11% each). The percentage of CAHs reporting each HAI measure varied by state. The states with the highest average percentage of CAHs reporting across all 6 HAI measures were New Hampshire, Oregon, California, Indiana, and Illinois. (Some HAI measures may not apply to some CAHs, e.g., the SSI measures would not be relevant for CAHs that do not perform colon surgery or abdominal hysterectomies).

Table 3 (page 6) presents national pooled-mean infection rates for all reporting CAHs for the four HAIs, and statewide rates for each state that had the minimum number of device days needed to calculate them. The national CAH CLABSI rate was .054 per 1000 central line days. The national CAH CAUTI rate was .074 per 1000 urinary catheter days. CAHs had a national rate of .002 for MRSA and .029 for CDI per 1000 patient days.

DISCUSSION

State HAI infection reporting requirements vary in terms of the hospital settings to which they apply. Several states have statutes or regulations that reference the CMS requirements for PPS hospitals to report HAIs to NHSN, including a number of states that have recently added language requiring PPS hospitals to allow the state health department to have access to their NHSN data for surveillance and prevention purposes. Some state HAI laws and regulations specifically include or exclude CAHs, while others include exemptions or waiver processes that may apply to CAHs. In some cases, the requirements may technically include all hospitals, but in reality may not be applied to lower volume hospitals such as CAHs that do not have a minimum number of eligible patients.

State HAI infection reporting requirements also vary in terms of which types of infections are covered. Some state requirements specifically refer to the CMS HAI measures or NHSN HAI definitions, while other states refer to healthcare associated infections in general or only include one or two types of HAIs such as CLABSIs or SSIs in their reporting requirements.

The five states with the highest average percentages of CAHs reporting across the six HAIs in Hospital Compare all have state HAI reporting requirements, although one (Oregon) allows low-volume providers to request exemptions.

CONCLUSIONS

Lack of clarity in some state HAI reporting requirements and recent changes resulting from implementation of the CMS requirements for PPS hospitals may partially explain the fact that State Infection Program contacts and State Flex Coordinators in some states either did not agree or were not sure about whether HAI reporting requirements applied to CAHs in their states. Some State Infection Program contacts may not have

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Table 2. CAH Healthcare Associated Infection Reporting to Hospital Compare (N=1,338 CAHs)

State has a HAI reporting requirement that applies to CAHs

State has a HAI reporting requirement that only applies to PPS, ICUs, excludes CAHs / low-volume, or includes a waiver of exemption

State has no HAI reporting requirement

State	Total CAHs	CAHs Reporting to Hospital Compare via NHSN[1]					
		CLABSI	CAUTI	SSI:C	SSI:H	MRSA	CDI
Alabama	3	0	0	0	0	2	2
Alaska	13	1	1	1	0	2	2
Arizona	15	0	0	1	1	1	1
Arkansas	29	0	0	1	1	1	1
California	32	11	9	14	13	21	21
Colorado	29	3	3	7	6	5	5
Florida	13	1	1	1	0	1	1
Georgia	33	2	2	2	1	4	4
Hawaii	9	1	1	1	1	0	0
Idaho	27	2	2	6	4	8	7
Illinois	51	14	11	13	9	42	42
Indiana	35	14	16	25	19	9	9
Iowa	82	2	4	2	0	7	21
Kansas	84	3	3	3	2	6	9
Kentucky	29	1	2	0	1	1	1
Louisiana	27	2	2	2	3	2	2
Maine	16	4	4	2	1	2	12
Massachusetts	3	2	2	0	1	1	1
Michigan	36	4	4	3	2	6	6
Minnesota	79	2	2	1	0	0	2
Mississippi	33	0	0	0	0	2	3
Missouri	37	1	1	2	0	2	2
Montana	48	1	1	2	2	2	3
Nebraska	65	0	0	1	1	1	1
Nevada	11	1	1	1	1	1	1
New Hampshire	13	10	9	12	9	8	8
New Mexico	9	2	2	1	1	2	3
New York	15	0	0	0	0	0	0
North Carolina	23	2	2	6	6	6	6
North Dakota	36	0	0	0	0	2	2
Ohio	34	5	5	3	3	4	4
Oklahoma	34	0	0	0	0	1	1
Oregon	25	13	13	16	15	13	21
Pennsylvania	13	4	5	6	4	5	5
South Carolina	5	1	1	1	0	5	3
South Dakota	38	1	0	0	0	0	0
Tennessee	16	1	1	1	1	1	1
Texas	80	6	6	9	7	7	7
Utah	11	0	0	1	1	4	4
Vermont	8	1	0	0	4	5	5
Virginia	7	1	1	1	0	1	1
Washington	39	12	12	18	15	7	8
West Virginia	19	7	7	5	4	6	7
Wisconsin	58	6	8	17	11	18	22
Wyoming	16	3	3	1	3	3	16
All States	**1338**	**147**	**147**	**189**	**153**	**227**	**283**

[1]Reporting defined as a denominator of 1 or more: urinary catheter days (CAUTI); central line days (CLABSI); surgical procedures (SSIs); patient days (CDI, MRSA).
Data sources: Number of CAHs as of 12/31/13 from FMT CAH database; HAI data for 2013, downloaded from CMS Hospital Compare website January 2015.

Table 3. Pooled Mean Infection Rates for CAHs Reporting to Hospital Compare via NHSN (N=1,338 CAHs)

State	CLABSI[1]	CAUTI[2]	MRSA[3]	CDI[3]
Alabama	a	a	0	0.41
Alaska	0	0	0	0
Arizona	a	a	0	1.49
Arkansas	a	a	0	1.20
California	0.53	1.27	0	0.28
Colorado	0	0	0	0.22
Florida	b	b	0	0
Georgia	b	0	0.09	0.35
Hawaii	0	0	a	a
Idaho	0	2.46	0.05	0.18
Illinois	0	1.56	0.04	0.38
Indiana	1.24	0.64	0	0.29
Iowa	b	0	0	0.31
Kansas	0	0	0.10	0.58
Kentucky	b	0	0	0
Louisiana	0	0	0	0
Maine	0	0	0	0.17
Massachusetts	b	0	0	0.27
Michigan	0	0	0	0.20
Minnesota	0	0	a	0.29
Mississippi	a	a	0	0.30
Missouri	0	0	0	0.39
Montana	0	0	0	0
Nebraska	a	a	0	0
Nevada	11.36	0	0	0
New Hampshire	1.26	0.54	0	0.10
New Mexico	0	0	0	0.11
New York	a	a	a	a
North Carolina	0	0	0	0.21
North Dakota	a	a	0	0
Ohio	0	0	0	0.07
Oklahoma	a	a	0	0
Oregon	1.49	0	0.06	0.33
Pennsylvania	0	0	0.04	0.51
South Carolina	b	0	0	0.18
South Dakota	b	a	a	a
Tennessee	b	0	0	0.19
Texas	0	0	0	0.48
Utah	a	a	0	0.35
Vermont	0	a	0	0.30
Virginia	0	2.10	0.16	0.47
Washington	0	1.38	0	0.35
West Virginia	0	0.89	0	0.33
Wisconsin	0	2.09	0	0.35
Wyoming	0	0	0	0.19
All states	**0.54**	**0.74**	**0.02**	**0.29**

[a]no data
[b]too few cases (< 50 device days or patient days for all CAHs reporting in state)
[1]Per 1000 central line days
[2]per 1000 urinary catheter days
[3]per 1000 patient days
Data source: HAI data for 2013, downloaded from CMS Hospital Compare January 2015.

(Continued from Page 4)

been as knowledgeable about CAHs as they were about larger hospitals that have been the traditional focus of infection control programs; conversely, some State Flex Coordinators may not have been as familiar with HAI reporting requirements as they are with other types of quality reporting.

These results suggest that State Flex Coordinators should familiarize themselves with any HAI statutory and regulatory reporting requirements in their state that may apply to CAHs, as well as voluntary reporting efforts involving CAHs. State Flex Coordinators should also prepare to assist their CAHs as necessary to report the HAI measures and to use the data to determine quality improvement needs. A second policy brief in this series describes evidence-based programs and strategies for reducing HAIs in CAHs.

HAI quality measures have become more relevant to CAHs as older measures such as CLABSIs are expanded from ICUs to non-ICU settings such as general medical and surgical units, and newer measures such as MRSA and CDI, which apply to the overall patient population, are adopted. The increased number of CAHs reporting HAI measures and their adoption as optional patient safety measures for MBQIP reflect their growing importance for CAHs.

Although many CAHs do not have the minimum 1 expected event or 50 device days to calculate facility-level SIRs, analysis of pooled infection rate data from groups of similar facilities (e.g., CAHs that provide similar services) can help track infection trends and identify potential targets for HAI prevention and quality improvement initiatives. ■

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APPENDIX 1

Table A-1. State Healthcare Infection Reporting Requirements for Flex States

State	Statutory / Regulatory Language
Alabama	Code 420-4-5 (PDF: http://bit.ly/1LkStFY) requires healthcare facilities, including CAHs, to report inpatient HAI data to the Department of Public Health via NHSN by 1/1/11, including CLABSI[c] (adult, pediatric and neonatal critical care units), SSI[g], and CAUTI[b] (general medical/surgical wards, adult and pediatric critical care units).
Alaska	Code 7AAC 27.019 allows the Division of Public Health access to HAI data that federal agencies require hospitals to submit via NHSN effective 12/29/13. Hospitals are also required to report VRSA[j] and CRE[d] (PDF: http://bit.ly/1Pm7ogO)
Arizona	Code requires laboratories and healthcare providers to report selected organisms to the Arizona Department of Health Services including MRSA[e], VISA[h], VRSA[j], VRSE[k], and Streptococcus pneumonia. http://1.usa.gov/1Pm7tkP
Arkansas	Code § 20-9-1203 (PDF: http://1.usa.gov/1Ji95Yf) requires health facilities to collect HAI rate data in categories as added by Department of Health (DOH), allows them to submit reports to the Department of Health, and requires health facilities participating in the CMS Hospital Inpatient Quality Reporting Program to allow the Department of Health to access data submitted to NHSN. Reporting was expanded to include CLABSI[c] & CAUTI[b] in ICUs, SSI[g], MRSA[e], and CDI[a] (PDF: http://1.usa.gov/1fp3sjb).
California	Code 1288.45-1288.95 1288.55 (http://bit.ly/1gXL4yN) requires each health facility to report cases of MRSA[e], CDI[a], VRE[i], CLABSI[c], SSI[f] (deep or organ space, orthopedic, cardiac, and gastrointestinal designated as clean and clean-contaminated) on a quarterly basis to the Department of Health and NHSN on a quarterly basis.
Colorado	Statute 25-3-602 (http://bit.ly/1LkV02R) requires health facilities to submit HAI rate data for cardiac/orthopedic SSI[f] and CLABSI[c] to NHSN, and requires individuals who collect the data at hospitals with > 50 beds to meet national certification requirements.
Florida	Rules 64D-3.029 (http://bit.ly/1WES7NM) require VISA[h] and VRSA[j] reporting within 72 hours.
Georgia	HAIs that are reportable to the CMS Quality Reporting Program (http://1.usa.gov/1fp6X9m) were added to the Department of Public Health (DPH) Notifiable Disease List in January 2013. Health facilities required to report for CMS are required to join the Georgia NHSN Users Group and allow DPH HAI staff to access the data. This requirement only applies to PPS hospitals, but CAHs are encouraged to submit data.
Hawaii	HRS §325-2.5 (http://1.usa.gov/1NuDpoB) requires each CMS-certified health facility to report HAI data to NHSN, provide data access rights to the Department of Health. The HAI annual report prepared by the Department (PDF: http://1.usa.gov/1USZ9g2) does not include data from hospitals that are not part of the CMS IQR program, including CAHs.
Idaho	Laboratories are required to report MRSA[e] to public health authorities (http://bit.ly/1gXQx8V).
Illinois	Code 77 § 255.250 (http://bit.ly/1TViL0L) requires hospitals to prepare a quarterly report including data on SSI[f], CLABSI[c] (critical care units), and VAP[l]. Hospitals are required to report MRSA[e] data to the Department of Public Health (http://bit.ly/1hp8ePJ).

[a]Clostridium difficile
[b]Catheter-Associated Urinary Tract Infection
[c]Central Line-Associated Bloodstream Infection
[d]Carbapenem-resistant Enterobacteriaceae
[e]Methicillin resistant Staphylococcus aureus
[f]Surgical Site Infections
[g]Surgical Site Infections for Colon Surgeries & Hysterectomies
[h]Vancomycin intermediate Staphylococcus aureus
[i]Vancomycin-resistant Enterococcus
[j]Vancomycin resistant Staphylococcus aureus
[k]Vancomycin-resistant Staphylococcus epidermidis
[l]Ventilator-Associated Pneumonia

Table A-1, continued.

State	Statutory / Regulatory Language
Indiana	410 IAC 15-4 (PDF: http://bit.ly/1MxZ8Lt) requires all licensed hospitals, including CAHs, to submit CLABSI[c] (ICUs), CAUTI[b] (ICUs), and SSI[g] data to the NHSN and provide access rights to the Department of Health effective 1/1/12.
Iowa	Voluntary reporting of HAIs to the Iowa Healthcare Collaborative.
Kansas	Voluntary reporting of HAIs to NHSN. In 2011, 65 Kansas hospitals voluntarily shared their NHSN data with the Department of Health and Environment (PDF: http://bit.ly/1WF2p0e)
Kentucky	902 KAR 2:020 (http://1.usa.gov/1Nv3lAr) requires health facilities that report HAI data to CMS via NHSN to allow the Department of Public Health to access the data. Effective 10/1/16, health facilities will be required to report data for VISA[h], VRSA[j], MRSA[e], VRE[i], CRE[d], and CDI[a].
Louisiana	Voluntary reporting of HAIs. According to the Department of Health & Hospitals' MRSA[e] Guidelines, hospitals are not required to report individual cases of MRSA[e], but clusters should be reported.
Maine	Rules 90-590 Chapter 270 (http://1.usa.gov/1hpBFB7) require all hospitals to submit data related to CLABSI[c] (ICU), MRSA[e], CDI[a], central line compliance, and ventilator compliance to the Maine Health Data Organization (MHDO), or to NHSN and allow MHDO access to the data.
Massachusetts	105 CMR 130.1701 (http://1.usa.gov/1E4jCuo) requires hospitals to submit HAI data to the NHSN and grant data access to the Health Department. State HAI reports include CAHs.
Michigan	Voluntary reporting and sharing of NHSN data with the Michigan Department of Community Health. In 2013, 14 CAHs voluntarily shared their data. (http://1.usa.gov/1K6mtUs)
Minnesota	Rules Chapter 4654 (PDF: http://bit.ly/1HWjPdF) requires hospitals with neonatal and/or pediatric ICUs to report CLABSI[c] data to NHSN. Rules Chapter 4605.7040 (http://bit.ly/1NFiqNC) requires reporting of VISA[h] and VRSA[j] data.
Mississippi	Code § 41-3-17 (http://1.usa.gov/1NFiD3D) requires any facility including acute care hospitals required by CMS to report to NHSN to share their NSHN data with the Dept of Health. Laboratories are required to report VRSA[j] and VISA[h].
Missouri	Code 19 CSR 10-33.050 (PDF: http://on.mo.gov/1KweKLb) requires all hospitals to submit HAI rate data on CLABSI[c] (ICUs), SSI[f], and VAP[l] (ICUs) to the Department of Health (or to NHSN and allow the DOH access). Low-volume providers may request exemptions annually but must have an infection control program in compliance with applicable statutes and regulations.
Montana	Voluntary reporting. Hospitals subject to CMS reporting requirements must share NHSN data with the DPPHS, but are not required to publicly report hospital-specific data. HAIs are not considered reportable diseases. (http://1.usa.gov/1TTNWyO)
Nebraska	173 NAC 1 (PDF: http://1.usa.gov/1E4onE8) requires hospitals to report MRSA[e], VISA[h], and VRSA[j].
Nevada	Statute §439.847 requires each medical facility with an average of 25 or more patients per day to report CLABSI[c], MRSA[e], and several types of SSI[f] to NHSN. Facilities with fewer patients may choose to participate. (http://bit.ly/1TTOyUV)

[a]Clostridium difficile
[b]Catheter-Associated Urinary Tract Infection
[c]Central Line-Associated Bloodstream Infection
[d]Carbapenem-resistant Enterobacteriaceae
[e]Methicillin resistant Staphylococcus aureus
[f]Surgical Site Infections
[g]Surgical Site Infections for Colon Surgeries & Hysterectomies
[h]Vancomycin intermediate Staphylococcus aureus
[i]Vancomycin-resistant Enterococcus
[j]Vancomycin resistant Staphylococcus aureus
[k]Vancomycin-resistant Staphylococcus epidermidis
[l]Ventilator-Associated Pneumonia

Table A-1, continued.

State	Statutory / Regulatory Language
New Hampshire	Statute §151:33 (http://bit.ly/1JiJoXl) requires any licensed hospital (including CAHs) to identify, track, and report HAIs to the Department of Health and Human Services, including CLABSI[c], CAUTI[b], and SSI[f]. (PDF: http://1.usa.gov/1E5WiMi)
New Mexico	7.4.3.11 (http://bit.ly/1WFibs7) requires acute care hospitals to submit data for CLABSI[c] and CDI[a] to NHSN and provide access rights to the Department of Health.
New York	State Public Health Law § 2819 (http://on.ny.gov/1gXULNl) requires each hospital to report CLABSI[c] (at least 50 central line days), SSI[f] (at least 20 patients), and other types of HAI as required. CDI[a] and CRE[d] were required in 2015. All indicators must be reported via NHSN. (PDF: http://bit.ly/1E5X7ET)
North Carolina	Statute § 130A-150 (http://bit.ly/1MDzdUn) requires hospitals to electronically report all HAI data required by the CMS Inpatient Prospective Payment System through NHSN.
North Dakota	Rules Article 33-06 (PDF: http://1.usa.gov/1J4TpIB) requires hospitals to report MRSA[e], VRSA[j], VISA[h], and CRE[d] data.
Ohio	Code § 3727.33 requires each hospital to submit information on hospital performance measures to the Ohio Department of Health. The measures that must be reported are specified in Ohio Administrative Code rule 3701-14 and include CDI[a] and MRSA[e] infection rates as defined by the CDC. (http://bit.ly/1NFoTbC)
Oklahoma	Statute 63 § 1-707 (PDF: http://1.usa.gov/1J4xEL7) requires hospitals to publicly report HAI data for VAP[l] and CLABSI[c] (ICUs). Administrative Code Title 310 Chapter 667 – 310:667-1-3(h) and (i) require licensed hospitals to utilize NHSN to report these data.
Oregon	Rules 333-018-0110 (http://bit.ly/1MDBcrQ) require hospitals to report CLABSI[c] (ICUs), MRSA[e], CAUTI[b], CDI[a], and SSI[f] data to the state's Health Care Authority (or report via NHSN and provide the HCA with access rights). Facilities that perform less than 20 specific surgical procedures may request an exemption from reporting that SSI[f]. Facilities with less than 50 central line days per year may request an exemption from reporting CLABSI[c]. (http://1.usa.gov/1WFk1sZ)
Pennsylvania	Statute 40 § 1303.401–411 requires hospitals to report HAI data including CAUTI[b], CLABSI[c], and SSI[f] to the NHSN. The Department of Health accesses the submitted data prepares annual reports, which include CAHs. (http://bit.ly/1E4uZlV)
South Carolina	Statute § 44-7-2410-2460 (http://bit.ly/1E4vf4t) requires hospitals to report SSI[f], VAP[l], CLABSI[c], MRSA[e], and CRE[d].
South Dakota	SDCL 34-22-12 requires mandatory reporting of communicable diseases by physicians, hospitals and laboratories. SD 44:20:01:03 (http://1.usa.gov/1J4XQTT) includes HAI, but does not specify types of infections.
Tennessee	All acute care hospitals, excluding CAHs and long-term acute care facilities, are required to report CLABSI[c], SSI[f], MRSA[e], CDI[a], and CAUTI[b] to the Dept. of Health through the NHSN. (http://tn.gov/health/topic/hai)
Texas	Health and Safety Code Chapter 98 and Administrative Code §200.2 require all hospitals to submit HAI data to NHSN including CLABSI[c] and various SSI[f]. (http://bit.ly/1K6yOYE)

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Table A-1, continued.

State	Statutory / Regulatory Language
Utah	Code (http://1.usa.gov/1Jj7wgQ) requires facilities that are required by CMS to report HAIs to NHSN to share this data with the Department of Health.
Vermont	Hospitals required to report data on CLABSI[c], SSI[f], VRSA[j], VISA[h], and CRE[d] to NHSN (PDF: http://1.usa.gov/1K6BIg5). Regulation 4-203 (PDF: http://1.usa.gov/1J4Dtby) requires facilities to report VRSA[j] data.
Virginia	§ 32.1-35.1 requires hospitals to report data about nosocomial infections to NHSN and release their data to the VA Board of Health. 12VAC5-90-370 (http://bit.ly/1hpUHHo) specifies CLABSI[c] in ICUs as the HAI to be reported. (http://1.usa.gov/1PmAs80)
Washington	RCW 43.70.056 (http://1.usa.gov/1hpVbNN)requires hospitals to report data on CLABSI[c] and SSI[f] to NHSN and allow the Department of Health to access the data. RCW 70.41.430 (http://1.usa.gov/1E65j85) requires hospitals to report MRSA[e].
West Virginia	§16-5B-17 (http://bit.ly/1K6Fg1K) requires hospitals to report HAI data in the manner prescribed by NHSN to the Infection Control Advisory Panel. CAHs are exempt, but must report CAUTI[b] rates in medical and surgical units and ICUs.
Wisconsin	Hospitals required to report laboratory-identified CRE[d] (PDF: http://1.usa.gov/1LIl3qv). Statute Chapter 252, and DHS 145 (http://1.usa.gov/1KwmlcH) require lab-confirmed reporting of VRSA[j] and VISA[h] to the health department.
Wyoming	Statute 35-4-107 requires report from both the attending healthcare professional and laboratory that diagnoses MRSA[e], VRSA[j], VISA[h], and VRE[i] (PDF: http://bit.ly/1UTutez).

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