II

116TH CONGRESS
2D SESSION

S. 3380

To improve patient safety by supporting State-based quality improvement efforts and through enhanced data collection and reporting, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 3, 2020

Mr. WHITEHOUSE introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

---

A BILL

To improve patient safety by supporting State-based quality improvement efforts and through enhanced data collection and reporting, and for other purposes.

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 ''Patient Safety Improvement Act of 2020''.

SEC. 2. SUPPORTING STATE AND LOCAL COLLABORATIVES TO ADDRESS HEALTH CARE-ASSOCIATED INFECTIONS.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by adding at the end the following:

"SEC. 320B. EFFORTS TO REDUCE HEALTH CARE-ASSOCIATED INFECTIONS.

''(a) GRANT PROGRAM TO REDUCE HEALTH CARE-ASSOCIATED INFECTIONS.—

''(1) IN GENERAL.—The Secretary shall award competitive grants to eligible entities to support State-based collaboratives in implementing evidence-based, regional approaches to infection prevention, control, and reporting.

''(2) PURPOSE.—Amount awarded under grants under paragraph (1) may be used to support the following activities:

''(A) Inter-professional and inter-facility learning activities.

''(B) Building statewide learning collaboratives.

''(C) Conducting a needs assessment to identify gaps in health care-associated infection prevention and reporting in a State or region.

''(D) Other activities determined appropriate by the Secretary.

''(3) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an entity shall be a public or private nonprofit entity that submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including—

''(A) a description of the activities to be carried out under the grant, including the participants in any collaborative established to carry out such activities;

''(B) a list of the specific goals of the entity for the regional or statewide reduction of health care-associated infection rates;

''(C) an assurance that the entity will publicly report performance on a set of quality and outcomes measures in carrying out activities under the grant to reduce health care-associated infections; and

''(D) any other information determined appropriate by the Secretary.

''(4) PRIORITY.—In awarding grants under this subsection, the Secretary shall prioritize applicants

that collaborate with multiple stakeholders across a region or State.

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

''(b) PREVENTION EPICENTER PROGRAM EXPANSION GRANTS.—

''(1) IN GENERAL.—The Centers for Disease Control and Prevention shall expand the Prevent Epicenters Program to up to five additional sites. New sites shall work with State or regional prevention collaboratives to develop tools, strategies, and evidence-based interventions to—

''(A) prevent or limit infection rates in health care facilities across the continuum of care and in community settings;

''(B) facilitate public health research on the prevention and control of drug-resistant organisms and emerging microbial threats; and

''(C) assess the feasibility, cost effectiveness, and appropriateness of surveillance and prevention programs in different health care settings.

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

SEC. 3. IMPROVING COMMUNICATION DURING CARE TRANSITIONS.

(a) IMPROVING PROVIDER COMMUNICATION REGARDING PATIENT INFECTIONS IN MEDICARE AND MEDICAID.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this Act as the ''Secretary'') shall award competitive grants to support the development and evaluation of programs aimed at improving inter-facility communication about health care-associated infections, multidrug-resistant organisms, emerging microbial threats, and antimicrobial use during transitions of care.

(2) ELIGIBILITY.—To be eligible for a grant under paragraph (1) an applicant for such grant shall be composed of two or more health care providers or facilities that regularly transfer or refer patients to each other.

(3) REPORT TO CONGRESS.—Not later than 1 year after the end of the grant period under this subsection, the Secretary shall submit a report to Congress on lessons learned by grant awardees, in-

cluding best practices and recommendations for guidelines, policies, or payment reforms to improve inter-facility communication during care transitions.

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

(b) GUIDANCE ON INTER-FACILITY COMMUNICATION.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Administrator of the Centers for Medicare & Medicaid Services, in collaboration with the Director of the Agency for Healthcare Research and Quality, shall convene a working group to develop guidance for standardized communication between health care facilities upon the discharge and transfer of individuals who were diagnosed and treated for health care-associated infections.

(2) TOPICS.—The working group convened under paragraph (1) shall identify—

(A) types of information related to health care-associated infections that should be communicated when an individual is discharged and transferred from one health care facility to another, including—

(i) the type of infection or colonization acquired by an individual, including whether or not such infection or colonization is caused by a multidrug-resistant organism; and

(ii) the type of antimicrobial drugs, if any, that the individual received for the infection from the discharging or transferring provider and the stop date for those drugs;

(B) methods for transmitting information;

(C) timeframes for transmitting information; and

(D) any other information determined appropriate.

(3) WORKING GROUP PARTICIPANTS.—The working group under paragraph (1) shall be composed of representatives from—

(A) patient groups;

(B) hospitals;

(C) long-term care facilities;

(D) accreditation agencies;

(E) State and local health departments; and

(F) other stakeholders as determined appropriate by the Secretary.

(4) GUIDANCE.—Not later than 1 year after the working group has been convened under paragraph (1), the Administrator of the Centers for Medicare & Medicaid Services shall issue guidance on standardized content and structure for transmitting information regarding individuals who were diagnosed and treated for health care-associated infections.

SEC. 4. IMPROVING DATA ACCURACY AND SURVEILLANCE.

Subpart II of part D of title IX of the Public Health Service Act (42 U.S.C. 299b–33 et seq.) is amended by adding at the end the following:

"SEC. 938. HEALTH CARE-ASSOCIATED INFECTIONS AND ANTIMICROBIAL USE.

''(a) IDENTIFYING BEST PRACTICES.—The Centers for Disease Control and Prevention, in collaboration with the Agency for Healthcare Research and Quality and the Centers for Medicare & Medicaid Services, shall convene stakeholders to identify best practices for the collection and electronic reporting of data on health care-associated infections to the National Healthcare Safety Network by 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))).

''(b) DATA COLLECTION PILOT PROGRAM.—

''(1) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, in consultation with the Director of the Centers for Disease Control and Prevention, shall establish and implement a pilot program to identify best practices and innovative approaches for the collection and electronic reporting of data on the incidence of health care-associated infections by long-term care facilities, ambulatory surgical centers, and dialysis facilities. Such pilot program should incorporate applicable data validation methodologies and other recommendations described in the framework developed under subsection (c).

''(2) REPORT.—Not later than 6 months after the completion of the pilot program under paragraph (1), the Director shall submit to the Secretary and the appropriate committees of Congress a report on the best practices identified through the pilot program, including the lessons learned and challenges encountered with respect to data collection and electronic reporting in long-term care settings, ambulatory surgical centers, and dialysis facilities as well as

any recommended health care-associated infections surveillance methods for those settings.

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

''(c) DATA VALIDATION METHODOLOGY.—The Centers for Disease Control and Prevention shall work with State and local health departments to develop a standard methodology for validating data reported by long-term care facilities to the National Healthcare Safety Network.

''(d) STUDY AND REPORT.—

''(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study to evaluate the adequacy of State health departments' and other State oversight agencies' methods for external validation of data reported to the National Healthcare Safety Network by health care facilities.

''(2) CONTENTS.—In conducting the study under paragraph (1), the Comptroller General shall—

''(A) assess the types and frequency of external validation strategies conducted by State departments of health;

''(B) identify barriers to adherence with the Centers for Disease Control and Prevention's external validation guidance; and

''(C) recommend strategies to improve the consistency and reliability of data that is reported to the National Healthcare Safety Network.

''(3) REPORT.—Not later than 18 months after the date of enactment of this section, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations, if any, for such legislation and administration action as the Comptroller General determines appropriate.''.

SEC. 5. STRENGTHENING ANTIMICROBIAL STEWARDSHIP.

(a) IN GENERAL.—Section 320B of the Public Health Service Act, as added by section 2, is amended by adding at the end the following:

''(c) GRANT PROGRAM FOR STATE ANTIMICROBIAL STEWARDSHIP ACTION PLANS.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award grants to States

for the development and implementation of State antimicrobial stewardship action plans.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including—

''(A) an assurance that development of the plan under the grant will be led by an infectious disease-trained physician with experience in antimicrobial stewardship or a pharmacist with expertise in infectious disease and antimicrobial stewardship; and

''(B) an assurance that the plan will focus on collaboration across health care settings and include a summary of resource gaps and challenges.

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

(b) ADVANCING HOSPITAL REPORTING ON ANTIBIOTIC USE AND ANTIMICROBIAL RESISTANCE.—Not later than 1 year after the date of enactment of this Act, the Administrator of the Centers for Medicare & Medicaid Services shall issue a notice of proposed rulemaking that

requires acute care hospitals to report antibiotic use and antimicrobial resistance using the National Healthcare Safety Network's Antimicrobial Use and Resistance Module as part of the Hospital Inpatient Quality Reporting Program.

(c) IN GENERAL.—Section 320B of the Public Health Service Act, as added by section 2 and amended by subsection (a), is further amended by adding at the end the following:

''(d) PROMOTING THE APPROPRIATE USE OF ANTIBIOTICS.—

''(1) IN GENERAL.—Beginning on January 1, 2021, and annually thereafter, the Centers for Disease Control and Prevention shall conduct at least one antimicrobial stewardship workshop in a State or region where annual prescriptions for antimicrobial drugs per capita exceed the national average.

''(2) REQUIREMENTS.—The workshop under paragraph (1) shall identify regional strategies to support collaboration across the care continuum to promote the appropriate use of antimicrobials. In implementing such workshop, the Director of the Centers for Disease Control and Prevention should seek participation from relevant public and private

stakeholders with expertise in health care, quality improvement, and consumer engagement.

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

''(e) STUDY ON PRESCRIPTION DRUG MONITORING PROGRAMS.—

''(1) IN GENERAL.—The Centers for Disease Control and Prevention shall conduct a study on the feasibility of requiring ambulatory and outpatient health care providers to report prescriptions for antimicrobial drugs to a State prescription drug monitoring program, if such a program is available in the practitioners' States.

''(2) REPORT.—The Centers for Disease Control and Prevention shall submit a report to Congress on the findings of the study under paragraph (1) and make recommendations for the use, improvement, or expansion of State prescription drug monitoring programs to capture information on prescriptions for antimicrobial drugs.''.

SEC. 6. IMPROVING SAFETY IN PEDIATRIC CARE.

(a) PEDIATRIC SAFETY ADVISORY COUNCIL.—The Secretary shall establish a Pediatric Safety Advisory Council (referred to in this section as the ''Council'') to

advise and make recommendations on policies to improve pediatric safety and reduce the incidence of health care-acquired conditions in children's hospitals and other pediatric care settings.

(1) MEMBERSHIP.—The Council shall include at least one of each of the following providers:

(A) Neonatologist.

(B) Pediatrician.

(C) Pediatric infectious disease specialist.

(D) Pediatric intensive care specialist.

(E) Pediatric hospitalist.

(b) STUDY ON THE FEASIBILITY OF CHILDREN'S HOSPITALS REPORTING TO THE NATIONALHEALTH CARE SAFETY NETWORK.—

(1) IN GENERAL.—The Centers for Disease Control and Prevention shall conduct a study on the appropriateness and feasibility of requiring freestanding children's hospitals to report information on health care-associated infections to the National Healthcare Safety Network.

(2) CONTENT.—The study under paragraph (1) shall evaluate the applicability of National Healthcare Safety Network modules, risk adjustment methodologies, and case definitions to freestanding children's hospitals.

(3) REPORT.—The Centers for Disease Control and Prevention shall submit a report to Congress on the findings of the study under paragraph (1) and make recommendations for—

(A) increasing the number of children's hospitals that report to the National Healthcare Safety Network; and

(B) an alternative means to collect data on health care-associated infections that occur during a patient's stay at a children's hospital.

SEC. 7. OTHER PATIENT SAFETY IMPROVEMENTS.

(a) IN GENERAL.—Section 320B of the Public Health Service Act, as added by section 2 and amended by section 5, is further amended by adding at the end the following:

''(f) CONTINUING EDUCATION ON INFECTION CONTROL AND PATIENT SAFETY.—

''(1) IN GENERAL.—The Secretary shall establish a program to provide incentives (in the form of grants or other assistance) to State medical boards that require health care professionals (as defined by the medical board) to complete accredited coursework or training in infection control or other patient safety topics as a condition of receiving a new or renewed license to practice in the State.

''(2) EXEMPTION.—A State medical board that receives assistance under paragraph (1) may provide an exemption from the coursework or training requirement under such paragraph for those health care professionals who have specialized training in infection control (such as an infectious disease specialist or certified infection control practitioner), who are not actively practicing in the State, and who do not provide direct patient care.

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

(b) ENGAGING HOSPITAL LEADERSHIP IN PATIENT SAFETY IN MEDICARE AND MEDICAID.—

(1) MEDICARE.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) in subparagraph (X), by striking ''and'' at the end;

(B) in subparagraph (Y), by striking the period and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(Z) in the case of hospitals, including critical access hospitals, to require that, not less

than once every 5 years, all members of the board of such hospital receive training (which may include coursework at an accredited institution of higher education) on patient safety topics relevant to a hospital (or critical access hospital, as the case may be) setting.''.

(2) EFFECTIVE DATE.—In the case of the requirement imposed by the amendments made by paragraph (1), such requirement shall apply to agreements entered into or renewed on or after the date that is 30 days after the date of the enactment of this Act.

(c) CORE QUALITY MEASURES COLLABORATIVE.—

(1) IN GENERAL.—The Administrator for the Centers for Medicare & Medicaid Services shall establish a Core Quality Measures Collaborative to harmonize quality measure reporting requirements across public and commercial quality improvement and reporting programs.

(2) STAKEHOLDER INPUT.—Administrator for the Centers for Medicare & Medicaid Services shall seek input from a broad array of stakeholders to identify priorities for clinical areas and care settings that could benefit from core quality measure sets

and to inform the quality measures that are included in core sets. Stakeholders shall include—

(A) commercial health plans;

(B) Medicare and Medicaid managed care plans;

(C) physician and other provider organizations;

(D) patient groups; and

(E) quality improvement groups.

(3) FRAMEWORK AND GOALS.—Not later than 1 year after the date of enactment of this Act, the Administrator for the Centers for Medicare & Medicaid Services shall publish a framework and goals for the Collaborative under paragraph (1).

○