isolates of biofilm-forming and/or multidrug-resistant bacteria is observed in urine samples analyzed by a UF-500i.

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Legionella Hospital Laboratory Testing Practices in Georgia

To the Editor—We read with interest the excellent article by Garrison et al[1] titled "On-Site Availability of *Legionella* Testing in Acute Care Hospitals, United States." The authors' call for more on-site testing for *Legionella* is of critical importance for patient care.[2] In addition, legionellosis is a nationally notifiable disease, and public health would benefit from rapid diagnosis as well as rapid reporting.[3] Increasing in incidence in the United States, Legionnaires' disease is one of the leading causes of community-acquired pneumonia and requires a higher public health priority.[4-8]

An earlier study by Brzozowski et al[9] on diagnostic testing practices for infectious diseases supports the findings of Garrison et al.[1] Brzozowski and colleagues (R.L.B. is a coauthor) conducted a survey of hospital microbiology laboratories in Georgia to assess diagnostic testing practices in 2006 for selected infectious diseases, including *Legionella.* In that study, only 4 (11%) of 36 hospital laboratories that received a request for *Legionella* urine antigen testing reported the ability to perform the test on site.[9] Among 15 hospitals that received a request to culture, only 1 hospital laboratory reported culturing *Legionella* on site.[9] Of note, only 66% of the Georgia hospital laboratories reported receiving a request for any *Legionella* diagnostic testing in 2006. Urban hospitals were more likely than rural hospitals to receive requests for testing (on-site or send-out testing) for *Legionella* ($P = .0002$).[9] Larger hospitals were significantly more likely than midsize or small hospitals (those with less than 100 beds) to receive requests to test for *Legionella* (either on-site or send-out testing; $P = .001$).[9] Both Garrison et al[1] and Brzozowski et al[9] found that larger hospitals were more likely to offer on-site testing.[1,9]

Garrison et al[1] speculate that turnaround time is greater with send-out specimens, and this was supported by the Georgia study.[9] The median turnaround time for results for *Legionella* urine antigen from commercial laboratories was 3 days, in stark contrast to 0.75 days for on-site testing ($P = .0073$).[9] We agree with Garrison et al[1] that turnaround time for results is a likely barrier to testing for legionellosis. Interestingly, the Georgia study found similar results for other rapid molecular tests with most specimens sent for off-site testing; for meningococcal polymerase chain reaction, the turnaround time for results of specimens sent to commercial laboratories was 2.5 days.[9]

Should hospitals be incentivized to provide on-site laboratory testing capacity, particularly as new rapid molecular tests are being developed and approved for use? Relevant professional organizations and advisory groups may want to review the issue. Certainly, the government and insurance companies should consider the cost to the patient and society when inadequate reimbursement practices hinder the use of diagnostic tests. Perhaps timeliness of reporting results should

be taken into consideration with reimbursement policies for diagnostic testing. Both the hospitalized patient and the population benefit from rapid and accurate diagnosis.

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