Health Care Associated Infection Advisory Panel
First Meeting
February 19, 2008

Attendees (Panel): Bruce Burns, Alyson Hight, Glen Mayhall, Lisa McGiffert, Jan Patterson, Jane Siegel, Nance Stearman, Charlotte Wheeler, Gail Van Zyl, Gary Heseltine

Attendees (Guests): Jeff Taylor, Starr West, Neil Pascoe, Susan McBride, Thomas DeChant, Lynda Watkins, Michael McElwain, Sky Newsome, Matt Wall, Tom Betz, Nnenna Ezkoke, Rebecca Barron, Marilyn Felkner, Monty Waters, Wes Hodgson

Cathy Gleasman, Scribe

Introductions, Background
Dr Heseltine: HAI are part of larger issue of patient safety. This is a very complex, very formidable problem- the morbidity and mortality of the public. Reducing HAI is a large goal, with many players, and is very challenging. The essential element to make when undertaking this work is transparency and communications. People have to have permission to change-to change culture, to change the way of doing business. There are a lot of balls in the air. It's good to know what others are doing, in order to accomplish the larger goal of increasing public safety and bettering public health. We need to be able to integrate what we're doing, effectively.

Need to discuss legislative charge
Synopsis of First Advisory Panel Activities (Neil Pascoe, IDCU)
Election of Panel Chairperson, Vice Chairperson, and Scribe
Discuss future meeting dates-discuss having some videoconferences

Patient Safety and Health Care Associated Infections
Presenter: Gary Heseltine MD MPH, IDCU

See handout for presentation slides. Copies of the Senate Bill are in the packets, as are lists of previous and current panel members, and other charts.

Discussion of presentation:
Lisa McGiffert, Consumers Union: Every state except Florida and Ohio are using NHSN. Missouri uses their own system, plus NHSN. The website from Florida looks great, the possibilities are great in a web-based format, however the information is misleading to the public. Using terms like "as expected", makes it seem that some infections are acceptable. Their risk adjustment information is difficult for the public to understand. Missouri also has similar problems-all hospitals have the same rating icons. It's important to distinguish variations between hospitals. Patient Safety Organization Laws-when law was being passed, Consumers Union was beginning hospital infection campaign – they worked to amend the law so it doesn't supersede state laws that allow information to be published. The Texas hospital infection reporting law clearly requires transparency.

Jane Siegel- asked how many states are using NHSN, and what is the performance?

Lisa-21 states mandate reporting, 2 aren't using it, MO uses its own system plus allows hospitals to also report through NHSN. States are in various phases of implementation, many new programs have decided to use NHSN but haven't' started yet. NY is furthest along-has submitted a year's worth of data. NHSN is new, not sure if it can handle all the data being submitted. It's beneficial to have a national system, will improve data available for research, etc. Several states, including CO, NY, and

ND are using it now. VA is supposed to start soon. The big question is if NHSN can handle the load if all states are reporting. NY has 500 hospitals. The person handling NY says no problems yet, but the problems may show up when it's 5000 hospitals instead of 500. These are issues that can be built up to since states are implementing at different times.

Jan Patterson- it's improved since when the idea first created.

Lisa- states are discussing issues. Validation of data is the current big question. Most states are planning to do their own validation.

Jan-NYC's report on presentation was process measures, so it didn't need risk adjustment.

Gary- they do put up rates, which are also not risk adjusted.

Lisa-hospitals should be grouped together with similar categories-size, etc, in order to appropriately risk adjust. When your goal is 'zero' it does create somewhat of a conundrum regarding how to risk adjust.

Gary-there are at least 9 hospitals using NHSN at this time, in Texas.

Neil Pascoe-Review of Legislation
The 79th Texas Legislature (2005) required Texas to create an advisory panel to make recommendations to the legislature on whether or not Texas should make reporting of HAI mandatory. The advisory panel for SB 872 submitted the report in 2006 and made the recommendation to 2007 legislature that HAI reporting should be mandatory. There is five person overlap with that panel and this one.

The legislative charge has changed, but SB 288 was passed in 2007. There is now a mandate for hospitals to report HAIs and for the state to publish reports, but no funding to do so. Been waiting for the panel to reconvene and decide how to proceed.

Question: What is the specific charge of this advisory panel?
Gary-we know what we need to do, it's in legislation. But how do we go about doing it? Reporting system, infrastructure-what are our next steps, since we have no funding. Case definitions and what needs to be reported are specified by legislation- the panel has to make decisions on where do we go from here? How to do reporting, in our present situation without any funding, but we have infrastructure tasks. How do we move forward with what Legislature asked panel to do? What kind of guidance can we provide? We know what we need to report, but the question is how?

Monty Waters-legal counsel to IDEAS branch and to this advisory committee. Our charge is to 'guide the implementation, development and maintenance of the reporting system. This panel needs to advise on these matters. There are specific things that must be discussed with panel, such as infections to be reported. The panel has the right to modify the infections reported. The way we are to publicize and format the report must be in consultation with the advisory panel, the frequency of reporting must be established in consultation with advisory panel. All specified in legislation. The advisory panel is independent of the DSHS, so has the prerogative to add on tasks. Decisions should be made by June 1, 2008.

Lisa- one of the theories was that in TX we delayed passing a law to create reporting system, by having a committee before we passed the law. It could be helpful to start where we left off & look at work that was done before. There may be things we don't want to deal with anymore. The biggest

cost right now is putting on these meetings. We could meet and create a template by June and know what we want to do and how we want to do it, but we may not be able to actually do more until we have some money.

Neil-The version of SB288 was incomplete and corrected copies were distributed later in the meeting.

Election of Chair, Vice Chair, and Scribe

Asked for volunteers. Lisa McGiffert nominated Jan Patterson for Chair. She's willing to accept it dependent on having a good scribe.

Jan Patterson accepts Chair position.

Vice Chair- volunteers? Charlotte Wheeler volunteers and is accepted.

Scribe- volunteers? Lisa McGiffert volunteers and is accepted. The request is made that a separate staff person take minutes, as well. She will review and accept those notes, as well as making her own.

Future Meeting Dates

Meet on average once a month. DSHS can provide meeting space, agency admin staff will reserve rooms for the upcoming meetings. (No stipulation that meetings must take place in Health Department facilities.)
March 18th will be next meeting.
April 15th
May 12th
May 27th reserved for additional meeting, if needed. Will attempt to utilize emails to reduce need for this meeting.

Other panel members will be notified of meeting dates, and they are subject to change if necessary.

Center for Health Statistics
Opportunity for collaboration. Bruce Burns is representing CHS. CHS was awarded money to prioritize the collection of inpatient outpatient and radiological data. Authority was increased to collect from imaging centers, which are distinct from radiology centers.

Surgical procedures collected from ASCs (ambulatory surgical centers) and expanding to outpatient data collection. Collecting same information this project will need. Approached IDCU and presented as a potential way to assist in collection of SB 288 information. Would reduce CHS efforts- one data collection system instead of two. Could possibly start looking at intermeshing data, have hospitals and ASCs look at data as well, add clinical data element. Some data elements have been identified for 1731, some potential placeholders within their system needed to be set aside for this panel. In order to avoid having to expand data elements, we can decide later on what needs to be collected exactly, with the 'placeholders'. Set aside relevant variables for each case definition-including as spot for lung code agents and accommodate 3 surgical site infections at the same time. Looked at MO and CDC data to decide how much room to leave in the file, and allocated space accordingly. This is clinical data. Administrative data is in the same file, but collected separately.

Lisa stated that she went to Pennsylvania meetings and they included the hospital infection reports on administrative data.

Bruce stated that PA did not do this - additional data elements were added onto administrative data, but that the Texas proposal he is making is different than PA. Use HIPAA required format. Some ASCs, according to some payers (MEDICAID, MEDICARE, SCHIP) have different guidelines. Most other payers use 837 Institutional, which means there's a difference in the data set. Still working to clarify location to report in. First one only had one available field. Now trying to figure out if it'll work with other systems, other places.

Billing information on inpatient side is already being sent, has been for 8-10 years. Timeline for ASC data has not been specified to contractors yet. This is an issue for the June 1 deadline, won't be able to collect the data by that time. Bruce is already working on how to collect it, needs to get that to the vendor to find out how much it's going to cost. Depending on data elements decided upon, the cost will be affected. Need to create enough space to handle internal data structure.

Lisa asked if this committee could decide which procedures could be put in as placeholders. Gary stated that a list has been examined and matrix has been created, which can be emailed out so the panel can see it.

All information needed to do a risk stratification will be included, including RSV. Everything the senate bill required is in the matrix. There are hospitals already doing data collection for IHI, which is being published.

Jan asked once the data is collected, how will it be processed and turned around for risk stratification? Bruce stated that it would be turned over to IDCU for the unit to do the data analysis. Gary stated that we are developing the resources, including at least one more FTE. There will be a need for more funding, but at least we'll have data coming in. The data can be reassembled any time for a bigger picture of infection data and billing data, etc. We will need more personnel for validation, how many depends on the technique being used. Some new steps depend on the previous step.

Jan asked for an explanation of how separating clinical and administrative components relates to transparency. Bruce stated that SB 1731 [legislation that authorized them to do this work] only afforded CHS the requirement to collect the administrative data and create a consumer report guide concerning charges vs. costs, and what discounts facilities can provide. This senate bill is huge in scope, because it affects posting of prices and costs, etc and therefore affects Texas Medical Board. This requires patients to be given cost estimate and itemized bills, at the patient's request. It will not be a publicly viewable database.

After the initial phase, can we add to the database or change the data requested? It's a possibility, but depends on how it's set up initially. The more we can unify the collection effort from facilities, the more data we'll have in the data file. And it will reduce their need to go to two to three different entities within DSHS to provide the information, which reduces effort on both the facilities' side and DSHS's side.

Lisa had a question about the hospitals' comments on adding another reporting element. Bruce stated that Texas Hospital Association was encouraging this and thought it was a good idea to have this additional data element. Susan McBride, president of DFW Hospital Association Education- suggests looking at NHSN database again. You can populate with only data needed. Some hospitals think the NHSN is the best route and some think the CHS program is preferable. All opinions need to be weighed. Look at pros and cons of both sides. Bruce stated that training goes on now, with the

hospitals and they have access to a helpline. Training is done on how to report the data, and how to download and upload the data. We need to discuss the terminology and how to standardize it. That would be something IDCU would do.

Lisa discussed PA issues. The hospital community passed a law last year to change their reporting through NHSN. There was definitely strong resistance on the part of ICPs and the hospital community as to how data was previously collected. We need to know how this proposal is completely different than what PA did. Most people had issues with how the information was reported to the public, but also how the data was submitted by the hospitals. The hospitals expected the ICD-9 codes would match, but it was a misconception on the part of PHC4. The administrative and clinical data was matched up, but there were issues with how it was done. Mortality data matched with clinical data. The reporting is still going to be done by the same agency (PHC4), that has not changed. It would be valuable for this panel to hear from PA 'lessons learned'. Susan McBride states that she thinks this plan is very different from what PA did.

Starr West with Texas Hospital Association- initially PA had no denominator for central line infections, so you couldn't make meaningful data out of it. The other part was that there wasn't a denominator for surgical site infections. Without that denominator, the information was not useful.

The number of ICPs varies by hospital, and are a very limited resource.

A discussion re NHSN: You can't get patient level data, there are no identifiers, and it's more aggregate data. Limiting in one aspect. When it goes to CDC, you can't submit the name, so it can't be tracked. No identifier, either. Patients cannot be tracked, if they have an infection that they suspect was caused in the facility, after they've left the facility. The committee needs to find out if this is accurate.

Further discussion about the proposal:
A download system would be very helpful, in order to get denominators, rather than requiring data-entry. Need to avoid making people do the same thing twice. If the facility has electronic record keeping, it can be mapped in and shipped up to IDCU, where it can be extracted.

CHS looking at hospitals setting up own internal data structures and decide how to get information into the file. Small ASC facilities, with only a few people in the facility, will have more difficultly. CHS is looking at making it web-based, so that they can go online and put in data. Won't need to develop IT infrastructure to share data. There will still be parameters that have to be met. This is new on the outpatient side, but 4 million plus records are collected per year on the inpatient side. This data has been collected for around 10 years. Quality of care reports are created from this data, as well as Patient Safety Indicators. Right now, Pediatric Quality Indicators are being compiled, and will be released to the public. The hospitals and hospital associations receive the data as well.

Control of the data within TX and the region will be easier if the data isn't piped up to the feds.

Gail VanZyl- Twenty states have already done this. Is there a report of pros and cons for that? So that we can avoid reinventing the wheel?

Lisa- there are four or five states with the information out, which might be useful to look at. But it might be more useful to get representatives from the data collection agencies to discuss usefulness of different plans, especially NHSN. We could learn nuts and bolts details. Florida uses AHRQ Patient Safety Indicators. SC uses NHSN, so does Vermont. Missouri uses a combination of NHSN and their own.

Gail asked about potential for using special codes which are not CPT or ICD-9, so that we could collect different data, such as surgeries that were longer than 90 minutes.

Charlotte stated that we are the only state without funding. It would make sense to use a system that is in every ASC and hospital. Avoiding having to learn new data entry, new system. Would save money and be common sense, if it would work.

Glen Mayhall- this whole idea of reporting is to force hospitals to put out more money for infection control, because they'll be in competition. But we're trying to keep them from spending any more money now.

Lisa stated that you want to be an agent for change in the hospitals-to make the act of reporting part of the work. That's had a significant impact on changing attitudes around the country about infection control. It's important for hospitals to have more resources for this problem; it's been a large problem for a long time.

Jan had questions about the process of training, so we can make sure there's a baseline quality of the information being submitted.

Charlotte says that TSCIP is trying to set up a standardized list of definitions, as that is very important to get the correct data. They're treating it similarly to bioterrorism training-setting it up so that everyone can take the training on line.

Glen stated that everyone should be using CDC definitions, but Jan stated that their survey did not reflect that this is what's happening. Need some way of having people certified, so we know.

Charlotte stated that hospital turnover for Infection Control nurses is very frequent, so standardized training is important.

Neil had a question for Bruce-what is the timing of the reports and analysis feedback to the hospitals? Bruce stated that under the current system, hospitals report on a 9 month lag (end of reporting quarter until data comes to them for release, under Chapter 108). In setting up web-based system, they are trying to shorten that lag, but that requires a rule change. There are restrictions on contract times with 3M, who does some of the scores for hospital inpatient data (six months). Even with the way the system is currently set up, we cannot get less than that.

Lisa stated that this is a problem, and not fair to the hospitals or the public, since it's not timely data. You can have a hospital that has implemented changes and improved greatly, but the report doesn't show it.

Gail- What are the data elements required by the feds and why can't we use the same ones (diagnosis present on admission, for instance). Bruce stated there have been some issues, and they are trying to add them back in. The problems were both logistical and political and came before the new law. There were issues around hospitals getting claims rejected based on POA codes being on records.

Starr West (THA) - When the discharge data is sent to Bruce, it's sent by hospital discharge date. But infections aren't usually calculated by discharge date, but by the date the infection was found. All infections found in that month need to be reported with that discharge date.

Charlotte asked would data be added monthly?
Bruce- it depends on the hospital. Not collected more often than quarterly, but some hospitals submit data more frequently, even daily in some cases.

Surgeons may not be able to give accurate reports, as people are sent other places after surgery.

If hospitals doing NSQuip- can be used as another measure hospitals can use to report. Not standardized.

NQF (National Quality Forum) includes one of the measures on the table. NQF uses different definitions and another problematic issue. It's not in the public domain.

Some of those data elements could be incorporated. Good to use any data element set already being used. (American College of Surgeons manages this program).

NSQuip is a pretty extensive data set, worth looking at.

Alyson Hight- if for some reason a hospital doesn't already use the database, the hospital has a slow process going through IT Steering committee, will be several months from being able to get the information.

Bruce-not all counties report under the current law that his program operates under. Rural counties, smaller hospitals in non-urban areas, hospitals that do not charge-exempted (about 100 facilities) Under HAI law, they would all have to submit. But it would be limited data, only enough to match up the records. CHS system would need to be updated, but that would be more of a help desk issue. Hospitals are sent back identified errors, based on standard criteria. They get a second chance to review data. However if a valid code is misattributed to a patient, they do not get that back as an error. There's an encounter file sent four months later that has all data and has to be signed off on, saying it's correct. This enables them to generate their own reports. Physicians are provided an opportunity to review the data, but it's up to the physician to do so. They sign off that they had an opportunity. There's over 120 different edits on the data itself.

Jan-General consensus that this is worth looking into further. Asked for a spreadsheet for the group to look at (all the data elements) before the next meeting.
An important component would be the training component. Charlotte asked to look at it, with TSCIP, and see what kind of process would be needed to certify people in some way.

Also looking again at NHSN to see if it could accommodate the number of hospitals that would be reporting. Would be easier to compare to the rest of the country if we used NHSN. Charlotte would like to see what involvement would be needed to incorporate NHSN reporting at the hospital. Data submitted electronically in a standard format, there are a lot of data sets. But it's not as simple as the way data is being collected now. Charlotte has heard it's very detailed and labor intensive and she would like to actually see what it involves.

Glen stated their ICPs put the data into the NHSN system for their unit, and that it works well. The people who do it go to CDC for training, and gets lots of newsletters and upgrades, and it seems to be a smooth system, which they like a lot. There are different elements that can be chosen and joined up. They've been doing it for a long time, and find the data very useful. Not only for infection prevention, but also for research. Their ICP will join the next meeting to discuss it.

Charlotte stated it may be fear of unknown.

Jane Siegel stated they started using NHSN recently at her hospital, and it included several hours of online training and that her ICP spends a fair amount of time entering data.

Charlotte expressed a worry about cost, including the problem of small rural hospitals not having computers or web access.

Each state designs their own data set, so not every possible element is used by every facility.

Glen- there are ways and rules on how to do things, so that you do not double enter people. We don't need patient level data, it's set up to handle things very well without that.

Lisa had questions about what we are losing when we don't have other information about patients when we don't have that information in the public area. Do we lose other characteristics of the patients on the public reporting side?

Glen stated that you can't report a lot of that personal information anyway, to the public. We're looking at hospital rates.

Next time we'll hear from Dr Mayhall's ICP, and we need to schedule a conference call with NHSN to discuss the program. It would be useful to have someone (Rachel) from New York at a future meeting to discuss their experience. Lisa will get the NY contact information to Gary, so that she can be invited. Need to ask her about staffing, and costs, and logistical issues-how are they validating? How many of their hospitals were reporting to NHSN before? How long did it take to get people trained?

Comments about NHSN?
Neil stated that NHSN has been looked at, but it should be looked at again for the benefit of the panel. It was not believed to be a viable option, but we can revisit it.

Gail VanZyl asked, since we're not funded, are these efforts timely now? Are we going to put all this work into choosing a reporting system, and just sit and wait until we're funded?

Can we do this on a volunteer basis without more funding? Big issue. But we need a roadmap. Things do change. But the potential is that we might get funded, not that we will get funded.

Would it be better to wait until funding is appropriated? Does Sen. Nelson realize that we only have time for 4 meetings? Are we going to ask for more time? Looking at it realistically, what do we do on June 1st?

Staff: We need to go ahead and look at how it can be best implemented. At the point it needs to be implemented, we can say we still need resources.

Evaluation of the options is the best we can do.

It would be worthwhile to hear from the Commissioner what DSHS is willing and able to do in terms of implementation, development, maintenance of the program, and what other funding is available, so we know what our recommendations should be. Only Commissioner Hawkins, of the HHSC, can shift funds. He's been briefed, but Gary did not attend the briefing, so he does not know what transpired.

Jeff Taylor- Would like to remind the panel that whatever system is used, be familiar with the law and make sure it collects the data the law requires. For the next budget cycle, we are preparing an

exceptional item request to request funds to implement the law. Recommendation of the panel will help to figure out how much to ask for in the exceptional item. This is for the January 2009 Legislative Session. The request has to go through IDCU, then DSHS, then HHSC before it can go to Legislature. If it goes through and is approved by Legislature, the funds would be available Sept 1 2009.

Jane Siegel asked if it would be possible to do a pilot program with a smaller number of hospitals. Maybe not start out with all 500 hospitals in the state, so we can build some success and make it easier for other hospitals to join. The law might not allow it, but it does say that the panel is in charge of guiding implementation, so it may be possible. Monty Waters will be asked, and Gary will bring the information to the group. Would need to be looked at, would possibly need a legal opinion. General hospitals have to report, according to the law.

The issue can be discussed as the implementation in general is discussed. It would be useful to hear from the Commissioner at the second or third meeting, to hear what resources might be available.

Texas Medical Foundation has contract with CMS to begin bringing Texas hospitals online with NHSN. Would be helpful to hear from TMF about the scope of their contract - how many hospitals does it pertain to? Want to avoid duplication of effort. THA says it's under the Scope of Work, for all QIOs. General assignment, must increase by certain percent number of hospitals participating, May be for whole NHSN system, which is more than just infection control. Starr West will ask someone from TMF to participate next time.

For next time-Better to have a working lunch. Order in food. Gary will set it up. Location to be announced, probably the Exchange Building.

Next meetings will be March 18th, April 15th, May 12th and May 27th. Start at 10am and go to 4pm.

Lisa suggested that each meeting begin with Opening Remarks by someone who had an infection or who has a family member who did. Consumers Union will set it up. The panel agreed.

Agenda for next time:
Patient Experience
CHS presentation
NHSN Conference Call
ICP from Galveston in person or by phone
TMF representative to discuss NHSN contract
Charlotte discuss training for ICPs
Gary will relay information from Monty on Pilot phase question.