Healthcare Acquired Infections Advisory Panel Meeting
April 15, 2008

Attendees: Cathy Gleasman (scribe), Patti Bull, Bruce Burns, Marilyn Christian, Gary Heseltine, Alyson Hight, Glen Mayhall, Lisa McGiffert, Jan Patterson, Jane Siegel, Linda Stephens, Charlotte Wheeler, Patti Grant
Guests: Jane Smith, Becky Heinsohn, Neil Pascoe, Stan West, Debbie Martin, Debra Slapak, Lynda Watkins, Trish Bode, Thomas DeChant, Dinah Welsh, Matt Wall, Rebecca Herron

Agenda:
Welcome and Introductions-Jan Patterson
Review of minutes from the March 18, 2008 meeting-Jan Patterson
Dr David Lakey-cancelled
Legislative Appropriation Request/Exceptional Item Information- Gary Heseltine
Summary New York State Department of Health HAI reporting implementation- Gary Heseltine
CHS Reporting System new requirements information, CHS Mayo Experience-Bruce Burns
New York Hospital Association Report-Starr West and Mary Therriault
Comparison of Reporting Systems-Jane Siegel and Charlotte Wheeler
Cost of Education Training TSCIP, local APIC chapters- Charlotte Wheeler
ICP's Perspective on Pennsylvania's HAI Reporting-Gary Heseltine

Review of minutes from the March 18, 2008 meeting-Jan Patterson
Corrections needed, will be made by Cathy Gleasman and re-distributed. Minutes approved with corrections stated.

Dr David Lakey
Unavailable, due to situation with Eldorado/San Angelo.

Legislative Appropriation Request/Exceptional Item Information- Gary Heseltine
Forwarded the request for information and the answer is that at this time DSHS plans to request funds in the next Legislative session. The request will need to be approved by Dr Hawkins, and then moved through the process. If approved, the money would be available September 2009. Development costs would vary, but the number of FTEs required is similar. The budget would be 2.6 to 3 million dollars per biennium (see addendum). These are rough numbers, but things have been in flux for at least a year. Therefore, this is the best estimate. We would need two FTEs in each region, and hopefully at least one person would be certified in infection control, and the other would be an administrative person. For DFW and Houston, we'd request an additional FTE, due to higher workload. Post discharge surveillance would be a particular challenge. Adequate resources in terms of trained personnel would be key. There would also need to be 4-5 new people in the central office. There are functionally 8 regions. Each choice would have variables, including the amount of IT help needed. This is a provisional exceptional item, a placeholder, which will allow flexibility in what is eventually chosen.

Grassroots pressure from those impacted and from infection control community will be the most help getting the exceptional item accepted. This panel can reinforce those positions. The pivotal person is the executive commissioner-Dr Hawkins. The specifics of allocating the funds comes from the Legislature.

Nick Dauster with the Office of ~~Governmental Counsel (OGC)~~ *Government Relations* states that hearings on exceptional items are scheduled at 3pm for May 2 (on main campus) and May 9 (a teleconference) to discuss the issues. Comments are welcome. The meeting will be posted and publicized and Nick will make the information available to the committee.

Members of the panel can go and testify. Comments can be verbal, but will be limited to three minutes. Written testimony is also allowed, and can either be handed in at the meeting or sent ahead of time. An email process will be in effect to receive comments. Nick will find out the email address and the process and get the information to the panel. If you go, plan to stay the entire time to get your opportunity to speak. Anyone who wants to submit a comment, but who cannot come to the meeting, submit your comments to Lisa McGiffert. Jan Patterson will create a summary comment. Someone from this committee will be there and will hand over all the comments.

Dr Hawkins will be invited to the next meeting of the panel, but it is not seen as highly likely that he would attend. It would be more feasible if Jan Patterson offered to meet with him separately. She will write a letter inviting him, and offering a separate meeting as an alternative. Nick states that he knows Dr Hawkins has been briefed on this issue.

The announcement concerning whether the money is awarded or not will be made at the end of the next Legislative session, June 2009.

Summary of New York State Department of Health HAI reporting implementation- Gary Heseltine
An outline was handed out to panel and guests. This conversation took the form of a teleconference with Rachel Stricof. The main topic was the experience of Pilot Year Implementation. What were the key things getting it off the ground? Funding and staffing issues were discussed as well.

Rachel Stricof:
Met with the Legislators from the beginning, and they were receptive to providing resources. They were told that NYSHD was very willing to develop a system, but only if they had the resources and were going to do something useful with the information. They gave the department resources, but did not fund an outside entity to do development. They asked for money to develop statewide system, but were not given that money either. New York State wants to have all the data, but the goal is not usually to feed the information back to the hospitals.

When they didn't get the money to create their own system, they were already leaning toward using NHSN. NHSN allows users to customize data fields and add elements. Most importantly, they realized their hospitals were part of networks who may have facilities in other states. If each state had a different system, it would be very problematic. The looked at how to make the system useful to everyone, and not have anyone be conflicted. Here was a system already being used by 10% of facilities, and which was seen as valuable by those using it. By adding New York State to the mix, they would enrich the data. They also knew that the hospitals could use the system for all their infection surveillance needs, not just what the state mandated. The system also didn't charge, and the state wasn't willing to mandate the use of a system that the hospitals would have to pay for. NHSN enhanced feasibility and ease of using the data.

They were very lucky to get staffing. There were two very critical positions to fill: data manager, who could help hospitals with enrollment, and who was very computer savvy; and the program manager who could make sure everyone was using definitions in a standardized way and who could help with technical issues. There was also a need for secretarial staff and other administrative staff. The Program manager also has regional staff.

Comments from Carol (Program manager)-A critical piece is consistency, being consistent with NHSN system, but also being flexible and able to add elements as needed by the state health department. Having infection control staff to divide up work helped to get the hospitals on board and helped to use the data effectively.

Rachel Stricof: The whole system got up and running before regional staff was added. The data manager and program manager did that alone. Between the two of them, they were able to use communication skills to reduce 'the whining factor' and just get people to get down and start using the program. There was huge variation in what hospitals were using for surveillance, even amongst hospitals using NHSN. They tried to standardize it. They worked closely with NHSN to create consistency. They trained using components they created, using available NHSN slides modified for their needs. This enhanced the clarification and validation of what they needed to do. An ongoing log, an Excel spreadsheet, was kept on all the hospitals, which helped with continuity and helped them to help the struggling hospitals. They originally received $560,000 for positions.

They've been doing medical record reviews, blind on whether or not infection had been reported, until the end of the process with each record. This provided a bi-directional learning experience with hospital staff. This led to further refinement of the systems within the hospitals. There was also a half-time data manager, and then 5 regional positions, each with 20 hospitals that they're responsible for. They look for cluster events, both within hospitals and within geographic areas.

Question: Do you look at records without an infection reported to look at compliance with reporting? How do you choose the records looked at? Answer: We focused on cases reported in the first quarter, selected an internal control within the same hospital, matched to duration of surgery, procedure, age, etc and also selected an external control, someone not reported, and from another hospital. If they matched cases, they'd be more likely to detect an event that wasn't reported. The information was used for Quality Improvement purposes at the facility level, as well. They looked at both risk factors and/or prevention strategies used, to see if additional factors could be identified. There were two controls for every case-one internal and one external. In the ICUs, they asked for medical records for 5-10 individuals who had a particular culture while in care, and compared for consistency of definition and reporting. They also looked at risk factor and prevention factors used in the ICU, and looked at documented evidence. They wanted to know how to make the program more useful for hospitals, and not just something mandated by the legislature.

Facilities in general welcomed this dialogue and discussion. People received them very well, both up- and downstate. The facilities were nervous about what problems would be found, but the pressure was on both sides, as the health department had to be sure they were consistent and not confusing. When discrepancies were found, both sides discussed why and whether it was a misinterpretation or a problem. The health department also sent out surveys to the facilities about how their information was collected, etc, and to verify the facilities were doing collecting the information correctly. If it was not, the health department would have an opportunity to teach them how to do it correctly. This resulted in a richer and better understanding, and a better database. The health department received letters from facilities, praising them for what was learned at the audits. By the end of the year, there were only eight facilities that were not cooperating. These were cited, fined, and required to come up with a plan of correction. The hospitals who weren't cooperating wanted their infection rate listed as 'zero', and this was not allowed. The health department released the information on which hospitals had been fined and cited for non-compliance. But this was only facilities that were not willing to cooperate and collaborate. Any hospital who seemed to be non-compliant due to misunderstanding, etc were met with early enough to fix the problem, rather than waiting for the audit.

Post-discharge surveillance was made difficult by over-interpretation of HIPAA laws. The state passed a law stating you WILL share this information with each other. That helped to alleviate the anxiety and fear that the facility could be in trouble for sharing. They are not using POA data. There's no funding, so hospitals are being told not to waste resources tracking it. They want a useful system for reducing infection, which means on-going reporting. Looking back does not help with patient safety in the here and now.

Patients who are re-admitted to a different facility may come in already infected with a specific organism. If the hospitals can't share this information, it has a negative effect on treating the patient. The law change reinforced that the hospitals were allowed to share the information with each other. There is a HIPAA waiver for public health issues which applies to this surveillance, but the hospitals were concerned that sharing the information could be viewed as a breach of the HIPAA laws and that they could be fined. The tweak in the state law made it clear that it was legal to share information, and alleviated the worry. The law specifies that if a second facility has a patient who is diagnosed with an infection associated with the first facility, they must notify the first facility and keep a record that it was done.

There are around 186 hospitals with ICUs and who perform the surgeries associated with these infections. These are the hospitals who report.

Question: What is the recommendation for ICPs per bed? Answer: NYS is reluctant to set a minimum, as it tends to become the maximum. They have two indicators instead, available to the public, with no value-judgment. However, they send letters to the hospitals with the lowest ratios, to let them know their status. The worst case scenario was one ICP for over 600 beds.

This first year is aggregate data only. It has been very valuable, as it's allowed the hospitals to get expertise in using the system, and become consistent in using the definitions. It gives hospitals an opportunity to find out what needs to be modified in their surveillance systems and to communicate with the different systems within the hospital, and allows them time to learn and they'll therefore be much more consistent next year.

It's written into the law that the whole first year was a pilot program. A pilot year gives an opportunity to 'steady the ship'.

From the beginning, they had training from people who have actually used NHSN in their own facility.

They did not do anything different for pediatric facilities, although they have many NICUs. There are only three PICUs, due to the 'certificate of need' program, which requires anyone wanting to build or open a hospital to show that it's needed in that particular community. Texas does not have a program like this, so anyone can build any kind of hospital, regardless of the community's actual needs.

Question: Were local health departments involved? Answer: Very minimally. They were told what was going on, but since they did no play a large role in infection control in the hospitals, they were not actively involved. The State Health Department is given that task. The local health departments did not wish to be further involved; they preferred that the State Health Department handle it all.

Lisa McGiffert suggested that it would be helpful if NYS documented how they set up the program, etc. Rachel Stricof stated that this information will be provided in the first year's report. There is also a web-board with the training and audit materials, which all participating states know about and can access. They're more than willing to share experiences and pitfalls, and feel that it would be a very good thing if those experiences allowed other states to improve the process.

Discussion of teleconference:
The rich part of the discussion is that this isn't just public reporting or 'us against them'. This is everyone coming together to improve patient safety. There is an element of public reporting, and there are hospitals who say 'we're not giving anything'. But the way the NY program is described makes it clear how important this program can be. The external controls are a nice feature. New York State has gone out of their way to make sure the data is trust-worthy and not misleading. Collecting data for data's sake is confusing and will make the situation worse instead of better. Using the program for continuing education and to improve patient safety is a much better use of the data.

The New York State Health Department has made a good relationship with the ICPs. Texas would be looking at bringing up hundreds of hospitals to do better surveillance and to help their patients, and a good relationship with the ICPs will be critical. Rachel's vision can be replicated, but it does cost a lot of money. Texas should be paying close attention to their experience.

We do not know what's the best way to influence the thinking of the legislature, but the experience of New York State could be helpful. We do need to make sure there is no issue or fear of consequences of data-sharing. This will need to be addressed with the legislature while we're trying to get funding. It would help to have specific legislators who would take on the issue. We need to be able to articulate the morbidity and mortality costs if we do not do this. We need to make the public health argument, the bigger picture argument in terms of the community. What does it take to persuade someone? Personal experience. Family and friends who have been affected by HAIs and who would have benefited from this system.

The work is with the appropriations committee-to have them see this project and feel it's important enough not to be crossed out. And the committee has to balance all the requests, and it may turn out this one is the one that has to be crossed out.

We need to reiterate that this project is of no help unless it's funded.

The legislature in New York didn't create the vision, it was brought to them and they were made to see the importance of it.

CHS Reporting System new requirements information, CHS Mayo Experience-Bruce Burns
The Mayo Clinic never got back to him to answer his questions. The new requirements are being discussed by HL7, and the Mayo clinic did a pilot using the CDA architecture, Bruce contacted them to discuss layout of data elements. The HL7 format is being talked about, but may not have been formalized at this point. It will become a viable option in the near future. It's an open-text field now, but they want to have HTML tags that would enable it be read by computer. The current hardware won't be supported for CHS. The current system is an older system, developed in 1998. The manufacturer has gone out of business since that time (Compaq), so they can't support the hardware or back up the software. CHS will need to rebid the process and make changes in the hardware and software systems. The impact on this project will be significant. Looking at 2010. Bruce is still working on it for SB 1731, on the patient data side. He will need to go through the same process for that, so he's working on it now. The contract ends in 2011, and it will need to be rebid. There are multiple confounding issues coming. It will remain a Tier I project, which means bid process will take 18 months to get started.

The inpatient payment rules proposed by Medicaid and Medicare include hospitals reporting all payor data to CMS. If all the states authorize that, then there will be additional pressure to get the data to CMS in a timely fashion, and in the format they request. The rules are only proposed at this time, but

there are 1200 pages of rules. We don't know yet what the mandate will be exactly-hospital level, or state level.

New York Hospital Association Report-Starr West and Mary Therriault (teleconference)
Mary Therriault works for Hospital Association of New York State (HANYS), and has worked with NHSN. Has been working with HANYS for around eight years, she's an RN, works in Albany. Has worked extensively in Long Term Care, and in infection control.

Questions for conference call:

1. What infection types are the NY hospitals reporting through NHSN?
    a. Colon surgery
    b. Central line infections in ICU
    c. Jan 2008 on hip replacements, full or partial
    d. Surgical sites-coronary artery bypass surgery. NYS is a certificate of need state for coronary bypass surgery. There are only 37 hospitals that do the surgery.
2. When did reporting begin?
    a. The law was passed in 2007, with a year of a piloting. There was a lot of money from the legislature, which strengthen the program. The first year of aggregate data will be this year. Next year the information will be reported, facility specific, for 2008.
3. What types of facilities are mandated to report to NHSN?
    a. All acute care hospitals only, do not include ambulatory centers at this time
4. Was there any exemption for very small hospitals such as critical access hospitals?
    a. There are small hospitals, but they all must report. There are only 4 critical access hospitals. The technical committee and the state tried to be very sensitive and only choose infections that every hospital would have within the year. All small hospitals have some sort of ICU, so they may have a central line. The numbers are just coming out for 2007. There is some preliminary information now, but the numbers can't be given publicly.
5. Did all hospitals start reporting at the same time or was reporting phased in?
    a. All started together-189 hospitals. There have been hospitals targeted for closing and more will close this year, so the number could be off depending on closures.
6. Was the NHSN training adequate or was additional training provided? By whom?
    a. Training from CDC was outstanding.
    b. At first very few hospitals embraced NHSN. There was a large learning curve to get on board with NHSN system. Many hospitals had the infrastructure to use any software system; they were able to roll out quickly. The smaller hospitals used consultants for their IT, and it took longer to roll it out. Some took over 6 months to be able to get information into NHSN system, due to technical issues. HANYS had great difficulty with Explorer v7 downloading digital certificate, despite talented IT people. There are technical people you can call at CDC, but it does take a day or so to get called back.
    c. Clinical help for NHSN, have a wonderful RN who will take phone calls and assist.
    d. The dept of health hired many people to get the program up and running. They've hired 6 more RNs in the regions to help with issues. A wealth of information in the NYS Dept of Health has helped.
    e. Question: There would be a six-month lag before all hospitals could be on NHSN? Answer: Yes, if you have small hospitals without IT help. HANYS continues to recommend to CDC that they look to vendors who have done Core Measures previously, as the digital certificate is the same. The digital certificate secures data, tells CDC that you're on your computer, entering patient data. It's a matter of infrastructure,

IT, and money. NHSN needs to look at other vendors who do patient level data at the same level of security, but who aren't using digital certificates.

     f.   Question: ICPs just went on website and downloaded information to join? Or was there more training? Answer: There was a day of training on how to download a digital certificate. CDC NHSN could then be called for help. There was already help at the state level.

     g. Question: The ICPs who help in the region, do they do clinical support only or do they analyze data? Answer: Analysis is done by ICP RN and epidemiologist in Albany.

     h. Having national APIC people who could work with local APIC groups in South Carolina was very helpful. They were very successful in implementing NHSN.

7. Other comments:

     a. It helps to have the data entered as it occurs instead of afterwards.

     b. Do not do post-discharge surveillance. Need to look at it at some point. It was decided that the process was too mammoth already.

     c. Hoping to capture readmissions down the line, by date. None looked at during this first year.

     d. NY State using the system is helping to pave the way for other states to use NHSN.

     e. If the NY group could put together tips, that would be very helpful.

     f. Question: Is New York better at having FTEs per bed than Texas? Answer: Depends on the hospital. Some use secretarial staff put in the information, some upload from surgical suites for denominators. The server tends to be slow, and get hung up, which makes data entry very difficult, especially in the middle of the day. Some hospitals have had to change what time of day the information is uploaded, to get around that.

     g. Having a secure website for the Dept of Health is helpful. All the new ICPs can get the history of what's been done, and it's password protected.

     h. Question from DSHS: Confidentiality and privacy-was it an issue (with NHSN)? Answer: No, that was the digital certificate and they are all HIPAA compliant.

     i. You can give rights to only certain data, depending on what's required and reasonable.

Comparison of Reporting Systems-Jane Siegel, Patti Grant, and Charlotte Wheeler
A handout was provided with the findings. The first five pages are 'null and void' due to Bruce's report. There are pros and cons on the remaining system (NHSN), starting on page 6.
Summary: Biggest concern with NHSN is the ability of the server to keep up. The server is in the process of being upgraded. All systems will require a learning curve for the ICPs. Most ICPs are familiar with NHSN and are familiar with the terms and definitions. They just need to join. Reducing the difficulty of the security system (digital certificate) will make it easier. NHSN has been very responsive to our requests, but have not interfered with our committee's decision or solicited our participation. A lot of the issues which were concerns previously have been fixed. There is not currently a way to accommodate RSV, but it may become available or the rates could be simply faxed in quarterly since it's a short season. Many hospitals do not have pediatrics and would not need to ever report RSV. For the ones who need to report it, it could be listed as an 'additional organism'.

In principle, NHSN would meet the scope of the legislation. The general format needs to be looked at and verify that this is correct. Another question is whether or not it could handle ASCs? (They are not part of the system at this time, although hospitals can accommodate day surgeries and non-overnight stays).

A pilot year would help give the hospitals time to iron out the difficulties.

Smaller hospitals might have trouble getting up and going, but once they are reporting should not be a burden, as their numbers will be small. The issue will be whether or not they have internet access at all.

The legislators will most likely come up with other things that we need to do surveillance on, which may not be possible on NHSN. However, the current legislation seems covered. There is not currently another system that will allow unlimited modification. And it is difficult to think of anything specific that might need to have surveillance done, but that NHSN cannot handle.

Another pro is that there are so many other states already using the system. Why would we want a system that couldn't be used across states?

There was a study in Boston that identified the total denominator off all cases of infection that occurred after surgery. Over 84% of infections occurred after discharge. Surgeons don't tend to keep track of anything post-discharge. It's very difficult to get the surgeons to cooperate. Their system tightly captures information, because it's necessary for reimbursement. It enabled them to look at sensitivity of post-discharge information.

The committee was asked to move to recommend that the NHSN is the system that will be recommended, but part of the motion should be that funding should be required for the program to go forward. There's a fear that the Legislature will see this as a 'free system' unless the committee is specific in their recommendations.

Motions suggested: If there is funding in the amount of $3 million per biennium (see addendum), and technical support for the use of the program in the regions, the NHSN program is the recommended system for data collection.

A system that includes NHSN as the data collection program, which includes funding allocated and sustained, and support in the form of employees in the regions and central office is essential to the implementation and maintenance of a valid surveillance and public reporting system.

Question: Is part of our recommendation, once we pick a system, to have a phasing in program? Or is that getting too far ahead? The start up is one issue, and another issue is whether to go straight to facility level data or start with aggregate data. This needs to be thought about as the panel moves forward. Answer: We might address this in a second motion. We chose the system we think is best, but the issue of implementation is separate.

Question: Do we have to follow the same format at the last time a recommendation was made? Answer: Probably not, but it will need to be checked into. We can use their language to get our point across. Using the same format may make it easier for them to follow.

Jan Patterson requested a motion be made by consensus, officially:

Motion Made:
This Advisory Panel recommends that the Texas Department of State Health Services establish a system for surveillance and public reporting based on the NHSN system as the data collection program, subject to the following requirements:
- Newly allocated and sustained funding for a public reporting system;
- Support in the form of FTEs dedicated to administrative, IT, and infection control expertise in the regions and central office;
- Education, training, and clinical support for healthcare based infection control professionals available on a continuing basis; and
- Validation and auditing of data

Motion seconded, and carried.

Cost of Education Training TSCIP, local APIC chapters- Charlotte Wheeler
See handout provided. Talked with executive directors and board, and have two options. The first is TSCIP travels and does training on location, in selected areas of the state. The first day would be to validate CDC definitions, look at case scenarios from CDC working groups, and make sure everyone is using the same definition. The training will be divided between large and small group work, to ensure that everyone feels their questions can be heard and addressed.

This education is not meant to replace the CDC's training; it's an added personal touch. We have such big areas, there are going to be people who are overwhelmed and this will help them. Not everyone is computer savvy, and using experts who are already users can help do the training.

The second option is web or video conferencing. The ICP would be able to remain in their facility, and there would not be travel costs associated.

There will be a Train the Trainer class to make sure that all presenters are consistent with each other and with CDC's recommendations.

There are areas without APIC chapters. And some people cannot travel.

It is very important to keep the message the same, and even though APIC is larger, it's more scattered.

No need to develop a whole new training system, as CDC has NHSN training created already. This training would be additional, not a substitute. It's not to 'reinvent the wheel', it's to make the 'wheel' more accessible and easier to use. Money can be put into the budget to cover training.

Would Texas Hospital Association support the training? They normally charge for training, as their training program is self-supporting.

Are we completely opposed to asking the facilities to pay for training? Even at the rate of $200 per attendee? Hospitals may object and will not allow ICPs to go to training; they may only allow them to do the free training online. If we make it state-funded we will get more people trained.

The public is tired of the appearance that nothing is being done on infection control. Hospitals may need to just put up the money for training and personnel. The object is to get hospitals to do more for infection control. If we have training mandated, we need to have it be under the auspices of the state, not THA.

We should put something in the funding request for funding, even if it's not enough to cover the whole amount. The better hospitals will always be more involved and more proactive, but we need something basic there for the others. ICP turn over is huge, there are new ICPs frequently, who will require training.

There should also be money included for travel for audits.

Webinars could be an attractive option, for those who don't miss the one-on-one. However, face to face is still preferable. Webinars are better for reinforcement and follow up, but not as good for initial indoctrination.

Should we discuss a phase in approach with only aggregate data the first year? Yes, much better than going straight to facility level data.

Motion made: Contingent on newly allocated and sustained funding for a public reporting system, the data should be presented as state-level aggregate data for the first year of the program (for data validation, evaluation, and analysis purposes), followed by phasing in of facility level data reporting.

Motion seconded, and carried.

ICP's Perspective on Pennsylvania's HAI Reporting-Gary Heseltine
Teleconference with Lisa Knack, in Pennsylvania, which was one of the first states to implement NHSN.

They had six weeks notice to start reporting, mandated by their legislature. They were using the UB format. Surgical site infections were the beginning, and they were only to be counted if they occurred during the current hospitalization. They also wanted CLABSI, Foley catheter associated UTIs, and ventilator associated pneumonia. The education came in May 2004, although they'd started in January 2004.

In fourth quarter, they started reporting 'device days'. If a patient came in with a UTI but also had ventilator associated pneumonia, they were coded '14'. Information was not consistent.

In fourth quarter 2005, they added more and more data. In the first quarter of 2006, there were 14 definitions and they all became reportable, except ENT procedures. Oral thrush didn't need to be followed.

Still using the denominator data of patient discharges, not stratified by device days, they decided psychiatric patients shouldn't be included. And neither should transplant patients.

For 2006 and 2007, were reporting 100% of hospital acquired infections. Changed several times what was reported and under what circumstances.

Last summer, new legislation was passed (referred to as "52"), and they had to start reporting all infections through NHSN. Very overwhelming experience. They also have to report MRSA, and long-term health care facilities.

They now include ENT infections, including oral thrush. All hospital acquired infections must be reported within seven days.

Infection control committee has to have a non-affiliated community member.

Physicians need education, too.

Act 52 empowers three government entities to tell hospitals how to report, and all three give different interpretations of what they want. Once they signed onto NHSN, you can sign on to transfer data automatically to various entities. All three entities empowered in Pennsylvania get this information.

It's all an unfunded mandate. Two ICPs for 200 bed facility. With all data entry, they could use another half-time employee and they may get someone in July. They're' required to do a feasibility study for implementation.

The data flow has gone from retrospective to prospective, have 24 hours to report an infection once identified. She has been putting in 60 hour work weeks since this started. They must review all records immediately.

They haven't worked out enforcement yet, that starts May 1. They'll have to go to court more often, too. There has been an increase of 20% reported, with a commensurate increase in lawsuits.

The parameters have changed in the middle of the year several times. The numbers of reported infections have gone up every time, but they've added infections to BE reported several times, and in the middle of the year.

The public isn't really using this data, as far as she knows. The data is mixed for all hospitals and there's no way to really compare. She does know the public is reading the information, but it seems patients choose their hospital based on popularity and advertisements, rather than the data.

Last week the hospitals were interviewed on data comparing 2005 to 2006, which is so old, it is history, and you have to talk to it. The one hospital who derided the quality of the data was ridiculed. There have been protests, asking for reasonable denominators. Only hospital sizes have been compared in peer groups.

They did MRSA screening by itself for about a year, and reduced it 15%. Then did a hand-washing campaign, and reduced it 67%.

ASCs are in the plan, and so are nursing homes, but they are not reporting yet.

Lessons learned: It made everyone focus and made everyone aware of their data.

They are still reporting everything, but hoping that at some point soon some infections won't be reportable anymore.

NHSN, if you stay within the modules, works well.

The state health department decided that between 10 and 12% of patients should have hospital acquired infections, and if your rate is lower you must be under-reported. So they ask you to pull charts and re-evaluate and re-report.

The majority of facilities augmented their staff to accommodate the changes in the law. But they only had 120 days to implement, and that was too fast to get staff on board.

Being bogged down with paperwork keeps her from going out and doing prevention, which is a shame. Hasn't even had time to start annual education campaign. Hoping that she can catch up once she gets the new half-time employee.

Suggestion: Be very judicious in what we require reported. Do not require reporting of non-device related UTIs.

Discussion of the teleconference:
Data needs to be close to real-time in order to be helpful. The Pennsylvania legislature went ballistic against the Pennsylvania Hospital Association, and they rejected assistance of epidemiologists.

The board they set up had only one doctor, and no other medical personnel. No infection control expertise. In early discussions, there was resistance from infection control people, so they were kept off.

Pennsylvania: A big lesson in how NOT to do this in Texas.

The first official recommendation should be CLABSI. That will get the hospitals into NHSN (assuming we're funded) and get their feet wet.

Post-discharge surveillance is not included in the law. It's doable, but only if there's enough money. Readmissions should be looked at first.

With phase-in, you can always do more, you just can't do less. Starting with CLABSI would be a good start to phasing in. Even if a hospital doesn't do Central Lines, they could start looking at NHSN and maybe pick another one of the eight infections to start with it.

There is disagreement-some feel that all infections covered by the law should be begun at once.

For Next meeting:

Look at draft of funding proposal/budget. Dr Heseltine will send a copy out ahead of time for review.

Discuss what the format of our report should be. Should it be like the report from last time? This may be a question for Monty Waters. Dr Heseltine will check if there is a specific rule about how it has to be formatted, and send out a template if one is available. Finalized at next meeting.

Hold further discussion of implementation, including aspects of phase-in.

Discuss whether or not to send out another questionnaire, similar to the one from two years ago, to address IT support available. It may have changed in the last three years. Neil and Jane will review the old survey prior to the meeting.

Dr Lakey will be invited again. Jan will write a letter inviting him. She will also write to Dr Hawkins and invite him.

Dr Heseltine will get information about the May 2 and May 9 Exceptional Item meetings and provide the information to the panel.

Date: May 12, 2008. Location: DSHS boardroom

Motions made at this meeting:
1. Motion Made:
This Advisory Panel recommends that the Texas Department of State Health Services establish a system for surveillance and public reporting based on the NHSN system as the data collection program, subject to the following requirements:

- Newly allocated and sustained funding for a public reporting system;
- Support in the form of FTEs dedicated to administrative, IT, and infection control expertise in the regions and central office;
- Education, training, and clinical support for healthcare based infection control professionals available on a continuing basis; and
- Validation and auditing of data

Motion seconded, and carried.

2. Motion made: Contingent on newly allocated and sustained funding for a public reporting system, the data should be presented as state-level aggregate data for the first year of the program (for data validation, evaluation, and analysis purposes), followed by phasing in of facility level data reporting.

Motion seconded, and carried.

Addendum: The amounts listed should be per year, not per biennium.