Preventable Adverse Event Reporting: Status Update

August 19, 2016

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Texas Preventable Adverse Event Reporting 3 Tier Phase-In Implementation

First Tier PAE Reporting Beginning January 1, 2015

1. Surgeries or invasive procedures involving a surgery on the wrong site, wrong patient, wrong procedure.
2. Foreign object retained after surgery.
3. Post-operative death of an ASA Class 1 Patient.
4. Discharge or release of a patient of any age, who is unable to make decisions, to someone other than an authorized person.
5. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, wrong gas, or are contaminated by toxic substances.
6. Abduction of a patient of any age.
7. Sexual abuse or assault of a patient within or on the grounds of a health care facility.
8. Patient death or severe harm resulting from a physical assault that occurs within or on the grounds of a health care facility.
9. Patient death or severe harm associated with a fall in a health care facility resulting in a fracture, dislocation, intracranial injury, crushing injury, burn or other injury.
10. Patient death or severe harm associated with unsafe administration of blood or blood products.
11. Patient death or severe harm resulting from the irretrievable loss of an irreplaceable biological specimen.
12. Patient death or severe harm resulting from failure to follow up or communicate laboratory, pathology or radiology test results.
13. Patient death or severe harm associated with use of physical restraints or bedrails while being cared for in a health care facility.
14. Perinatal death or severe harm (maternal or neonate) associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility.

Second Tier PAE Reporting Beginning January 1, 2016

1. Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) after total knee replacement or after hip replacement.
2. Iatrogenic Pneumothorax with venous catheterization.
3. Stage III, Stage IV or Unstageable pressure ulcer acquired after admission/presentation to a health care facility.
4. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider.
5. Patient suicide, attempted suicide or self-harm that results in severe harm, while being cared for in a health care facility.
6. Patient death or severe harm associated with patient elopement.
7. Patient death or severe harm associated with an electric shock while being cared for in a health care facility.
8. Patient death or severe harm associated with a burn incurred from any source while being cared for in a health care facility.
9. Patient death or severe harm associated with the introduction of a metallic object into the MRI area.

Third Tier PAE Reporting Beginning January 1, 2017

1. Surgical site infections following a spinal procedure, shoulder procedure, elbow procedure, laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery or cardiac implantable electronic device.
2. Artificial insemination with the wrong donor sperm or wrong egg.
3. Poor glycemic control: hypoglycemic coma.
4. Poor glycemic control: diabetic ketoacidosis.
5. Poor glycemic control: nonketotic hyperosmolar coma.
6. Poor glycemic control: secondary diabetes with ketoacidosis.
7. Poor glycemic control: secondary diabetes with hyperosmolarity.
8. Patient death or severe harm associated with the use of contaminated drugs/devices or biologics provided by the health care facility.
9. Patient death or severe harm associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
10. Patient death or severe harm associated with intravascular air embolism that occurs while being cared for in a health care facility.
11. Patient death or severe harm associated with a medication error.

545 PAEs Reported in 2015 Type of Event	Number of Events
Patient Death or Severe Harm Associated with a Fall Resulting in a Fracture	202
Foreign Object Retained After Surgery or Invasive Procedure	121
Wrong Site Surgery or Invasive Procedure	66
Patient Death or Severe Harm Associated with a Fall Resulting in an Intracranial Injury	43
Wrong Surgery/Procedure	29
Patient Death or Severe Harm Associated with a Fall Resulting in Other Injury	17
Perinatal Death or Severe Harm (maternal or neonate) Associated with Labor or Delivery in a Low-Risk Pregnancy	17
Patient Death or Severe Harm Resulting from Failure to Follow Up or Communicate Laboratory, Pathology or Radiology Test Results	11
Sexual Abuse or Assault	8

545 PAEs Reported in 2015 Type of Event	Number
Any Incident in which Systems for O2 or Other Gas Contains No Gas, Wrong Gas, or are Contaminated by Toxic Substances	8
Surgery or Invasive Procedure on Wrong Patient	7
Patient Death or Severe Harm Associated with a Fall Resulting in a Dislocation	6
Patient Death or Severe Harm Resulting from a Physical Assault that Occurs within or on the Grounds of a Health Care Facility	3
Intra-operative or Immediately Post-operative Death of an ASA Class 1 Patient	2
Patient Death or Severe Harm Associated with Use of Physical Restraints or Bedrails	2
Patient Death or Severe Harm Associated with Unsafe Administration of Blood or Blood Products	1
Patient Death or Severe Harm Resulting from the Irretrievable Loss of an Irreplaceable Biological Specimen	1
Discharge or release of a Patient of Any Age, who is Unable to Make Decisions, to Someone Other than an Authorized Person	1
TOTAL	545

2015 PAE Report

Type of Facility	# Reporting ≥1 PAEs	# of Facilities in TxHSN	% that Reported ≥1 PAE	% of All Facilities in TxHSN That Reported ≥1 PAEs
Hospitals	175	439	40%	19%
ASCs	32	464	7%	4%
All Facilities	**207**	**913**	**N/A**	**23%**

Type of Facility	# That Reported ≥1 PAEs	Total # of Events	Average # of Events per Facility
Hospitals	175	503	2.9
ASCs	32	42	1.3
All Facilities	**207**	**545**	**2.6**

Second Tier PAE Reporting January 1, 2016

SURGICAL OR INVASIVE PROCEDURE EVENTS

1. Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) after total knee replacement or after hip replacement.
2. Iatrogenic Pneumothorax with venous catheterization.

PATIENT PROTECTION EVENTS

1. Patient suicide, attempted suicide or self-harm that results in severe harm, while being cared for in a health care facility.
2. Patient death or severe harm associated with patient elopement.

Second Tier PAE Reporting January 1, 2016

ENVIRONMENTAL EVENTS

1. Patient death or severe harm associated with an electric shock while being cared for in a health care facility.
2. Patient death or severe harm associated with a burn incurred from any source while being cared for in a health care facility.

POTENTIAL CRIMINAL EVENTS

1. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider.

Second Tier PAE Reporting January 1, 2016

CARE MANAGEMENT EVENT	RADIOLOGICAL EVENT
1. Any Stage III, Stage IV or Unstageable pressure ulcer acquired after admission/presentation to a health care facility.	1. Patient death or severe harm associated with the introduction of a metallic object into the MRI area.

Pressure Ulcer Reporting Guidance

On Admission and Documented	Progresses to	Reportable?
Skin intact	Stage 3, 4 or Unstageable	Yes
Stage 1	Stage 3	Yes
Stage 1	Stage 4	Yes
Stage 1	Unstageable	Yes
Stage 2	Stage 3	No
Stage 2	Stage 4	Yes
Stage 2	Unstageable	Yes
Stage 3	Stage 4	Yes

Preliminary 2016 Q1 PAEs — Type of Event	Number of Events
Stage III, IV or Unstageable Pressure Ulcer Acquired after Admission	161
Patient Death or Severe Harm Associated with a Fall Resulting in a Fracture	38
Foreign Object Retained After Surgery or Invasive Procedure	24
DVT/PE after Total Knee Replacement/Hip Replacement	20
Wrong Site Surgery or Invasive Procedure	18
Patient Death or Severe Harm Associated with a Fall Resulting in an Intracranial Injury	12
Iatrogenic Pneumothorax with Venous Catheterization	8
Wrong Surgery/Procedure	8
Patient Death or Severe Harm Associated with a Fall Resulting in Other Injury	6
Perinatal Death or Severe Harm (maternal or neonate) Associated with Labor or Delivery in a Low-Risk Pregnancy	4

Preliminary 2016 Q1 PAEs — Type of Event	Number of Events
Patient Death or Severe Harm Resulting from Failure to Follow Up or Communicate Laboratory, Pathology or Radiology Test Results	5
Patient Suicide, Attempted Suicide, or Self-harm that Results in Severe Harm	4
Patient Death or Severe Harm Associated with a Burn Incurred from Any Source	3
Surgery or Invasive Procedure on Wrong Patient	2
Sexual Abuse or Assault	2
Patient Death or Severe Harm Associated with Use of Physical Restraints or Bedrails	2
Patient Death or Severe Harm Resulting from the Irretrievable Loss of an Irreplaceable Biological Specimen	2
Any Incident in which Systems for O2 or Other Gas Contains No Gas, Wrong Gas, or are Contaminated by Toxic Substances	2
Patient Death or Severe Harm associated with patient elopement	1
TOTAL	322

2016 Q1 Preliminary PAE Report

Type of Facility	# Reporting ≥1 PAEs	# of Facilities in TxHSN	% that Reported ≥1 PAE
Hospitals	109	426	26%
ASCs	5	463	1%
All Facilities	**114**	**885**	**13%**

Type of Facility	# That Reported ≥1 PAEs	Total # of Events	Average # of Events per Facility
Hospitals	109	317	2.9
ASCs	5	5	1
All Facilities	**114**	**322**	**2.8**

2016 Q1 PAE Compliance Report

	Hospitals	ASCs	Total Facilities
Currently Licensed*	422	463	885
Non-Compliant— No PAE contacts	1.7% (7)	5.4% (25)	3.6% (32)

***As of March 31, 2016**

Note: This is % of total Hospitals or ASCs that did not provide a PAE contact. This % also includes any newly licensed facilities.

Third Tier PAE Reporting January 1, 2017

PRODUCT OR DEVICE EVENTS	PRODUCT OR DEVICE EVENTS
1. Patient death or severe harm associated with the use of contaminated drugs/devices or biologics provided by the health care facility.	1. Patient death or severe harm associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.

Third Tier PAE Reporting January 1, 2017

CARE MANAGEMENT EVENT	CARE MANAGEMENT EVENT
1. Artificial insemination with the wrong donor sperm or wrong egg. 2. Patient death or severe harm associated with a medication error.	Poor glycemic control: 1. hypoglycemic coma 2. diabetic ketoacidosis 3. nonketonic hyperosmolar coma 4. secondary diabetes with ketoacidosis 5. secondary diabetes with hyperosmolarity.

Third Tier PAE Reporting January 1, 2017

SURGICAL OR INVASIVE PROCEDURE EVENTS	SURGICAL OR INVASIVE PROCEDURE EVENTS
1. Surgical site infections following spinal, shoulder, elbow procedure; laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery or cardiac implantable electronic device.	1. Patient death or severe harm associated with an intravascular air embolism that occurs while being cared for in a health care facility

TxHSN Reporting Schedule

Reporting Quarter	Q1: Jan 1 – Mar 31	H1: Jan 1 – June 30	Q3: July 1 – Sept 30	H2: July 1 – Dec 31
Facility data submission deadline	Within 60 days of end of reporting quarter			
DSHS takes preliminary data snapshot	1-Jun	1-Sept	1-Dec	1-Mar
DSHS sends email to facility users review data	~15-Jun	~15-Sep	~15-Dec	~15-Mar
Facility data corrections due ✶ Last day to verify no PAEs to report for half year	30-Jun	30-Sep✶	31-Dec	31-Mar✶
DSHS takes final data snapshot	1-July	1-Oct	1-Jan	1-Apr
DSHS sends email to facility to review data summary and make comments	NA	15-Oct	NA	15-Apr
Facility comment period deadline	NA	30-Oct	NA	30-Apr
DSHS reviews comments	NA	15-Nov	NA	15-May
Public posting of data summary with approved comments	NA	1-Dec	NA	1-Jun

PAE Resources Updated

Preventable Adverse Events

Preventable Adverse Events

Home > Infectious Disease Control >Health Care Safety

Preventable Adverse Events (PAE)

Health Care Safety

Revised Definitions and Guidance Document

Sign up for e-mail updates

HCS Home | FAQs | Data | Reporting | Resources | Advisory Panel | Education Training

New FAQs

Preventable Adverse Events, also known as PAEs, can happen in health care. They are not supposed to happen. An example would be surgery on the wrong body part, or a bad injury from a fall. Health care workers try hard to make sure PAEs don't happen.

The State of Texas decided that most hospitals and surgery centers must report PAEs. As of January 1, 2015, PAEs that happen are reported to the State Department of Health.

EMAIL

Ask us your PAE questions!

Contact Information

Help Desk Email

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512-776-7676

Fax 512-776-7616

Emily Engelhardt, TxHSN Administrator

Nesreen Gusbi, TxHSN Administrator

Vickie Gillespie, PAE Clinical Specialist

THE HELP DESK EMAIL is the FIRST and BEST PLACE TO CONTACT FOR QUESTIONS or ASSISTANCE.

Upcoming Education

- PAE Fall Update Webinar Series http://www.dshs.texas.gov/IDCU/health/preventable-adverse-events/Education-and-Training.doc
- DADs/DSHS Infection Control Conferences with IC Toolkit
  - Sept 15, Houston Food Bank; Sept 21, Pickle Center, Austin; Sept 28, Juliette Fowler, Dallas
  - http://www.questionpro.com/t/AH0hnZU3EG
- Annual East Texas APIC Conference
  - Oct 7, Tyler Junior College, Tyler http://apiceasttexas.com/conference/
- APIC DFW 2016 Annual Conference registration not available yet http://www.apic-dfw.org/calendar-of-events/2016/10/20/2016-annual-conference
- TSCIP – CIC Review Course October 24-25, Amarillo Nursing College, Amarillo
  - http://www.tsicp.org/wp-content/uploads/2015/03/tsicp_cic_brochure_1016.pdf
- Winter Essentials of Infection Control & Prevention
  - January 19-20, Moody Gardens, Galveston http://www.tsicp.org/educational-opportunities/winter-essentials-of-infection-control-and-prevention/
- Houston APIC conference, pending
  - http://apichouston.org/meetinginfo.php?id=44&ts=1452111863

Questions?

PAEs Reportable in Texas--SREs

- Serious Reportable Event (SRE) "Never Event"
  - List of 29 events developed by the National Quality Forum (2002)
  - https://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx
- Most begin with "Death or Severe Harm".
- Some SREs are also HACs.
- There is not a list of associated ICD-10 codes for the SREs.

PAEs Reportable in Texas--HACs

- Hospital Acquired Conditions (HAC)
  - List of 14 Events/Event categories for which Medicare will not provide additional payment to the facility (2006)
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html
- Condition not present on admission but is present on discharge
- PAE events that are only HACs are to be reported if they would meet HAC ICD-10 Coding.

Poor Glycemic Control

See ICD-10 codes for these:

- Hypoglycemic coma
- Diabetic ketoacidosis
- Nonketonic hyperosmolar coma
- Secondary diabetes with ketoacidosis
- Secondary diabetes with hyperosmolarity

Pressure Ulcers—SRE and HAC

- HAC codes—include Stage III and IV
- SRE—includes Unstageable
- There are no ICD-10 codes for Unstageable (considered Stage III or IV)
- Unstageable Ulcers are to be reported as a PAE—
  - "Stage III or Stage IV or Unstageable pressure ulcer acquired after admission/presentation to a health care facility.

HACs Currently Reported to NHSN for Texas Reporting

- CAUTIs in ICUs
- CLABSIs in ICUs/NICUs (VCAIs)
- SSIs following CABG
- SSIs following CIED in Children's hospitals
- SSIs following spinal fusion in Children's hospitals

Other Tier 3 PAEs

Artificial insemination with the wrong donor sperm or wrong egg.

- Must report the event when you are made aware of it.

Intravascular Air Embolism
(Death or Severe Harm)

- Excludes death or severe harm associated with certain high risk neurosurgical procedures (head ↑ heart)
- Includes but not limited to:
  - Head and neck procedures
  - Vaginal and C-section deliveries
  - Spinal instrumentation procedures
  - Liver transplants
  - Low risk procedures e.g. line placement or IVs

Use or Function of Device
(Death or Severe Harm)

- Report defects, failures, incorrect use
- Report irregardless if the use is intended or described by the manufacturer.
- Includes implant, medical equipment, medical/surgical supply, HIT device

Use or Function of Device continued (Death or Severe Harm)

- Includes, but not limited to, catheters, drains, and other specialized tubes, infusion pumps, ventilators, and procedural and monitoring equipment.

Contaminated drugs/devices or biologics (Death or Severe Harm)

- Report irregardless of the source of contamination or product
- Contaminants –physical, chemical, biological
- Report events involving medications, biological products, vaccines, nutritional products, expressed human breast milk, medical gases or contrast media.

Contaminated drugs/devices cont' or biologics (Death or Severe Harm)

- Includes:
  - threat of disease that changes patient's risk status for life
  - contaminations both seen and unseen
  - serious infection from contaminated drug/device
  - occurrences r/t improperly cleaned / maintained device.

Medication Errors
(Death or Severe Harm)

- Includes but is not limited to:
  - Over or under dosing
  - Administration of med if known allergy or contraindication
  - Drug-drug interaction if no known potential for death or severe harm
  - Failure to administer prescribed drugs
  - Improper use of single or multi-dose vials if leads to dose adjustment problem
  - Wrong administration technic

Medication Errors continued (Death or Severe Harm)

Excludes:

- reasonable difference in clinical judgment on drug selection/dose
- events associated with allergies that could not have been known or discerned in advance.

ECRI 2016 Top 10 Health Technology Hazards

- Inadequate Cleaning of Flexible Endoscopes before Disinfection
- Missed Alarms
- Failure to Effectively Monitor Postoperative Patients
- Inadequate Surveillance of Monitored Patients in a Telemetry Setting
- Insufficient Training of Clinicians on Operating Room Technologies
- HIT Configurations and Facility Workflow that Do Not Support Each Other
- Unsafe Injection Practices Expose
- Gamma Camera Mechanical Failures
- Failure to Appropriately Operate Intensive Care Ventilators
- Misuse of USB Ports

Adapted from: Health Devices 2015 November. ©2015 ECRI Institute www.ecri.org/2016hazards

ECRI 2016 Top 10 Safety Concerns

- Health IT configurations and organizational workflow that do not support each other
- Patient identification errors
- Inadequate management of behavioral health issues in non-behavioral-health settings
- Inadequate cleaning and disinfection of flexible endoscopes
- Inadequate test-result reporting and follow-up
- Inadequate monitoring for respiratory depression in patients prescribed opioids
- Medication errors related to pounds and kilograms
- Unintentionally retained objects despite correct count
- Inadequate antimicrobial stewardship
- Failure to embrace a culture of safety

ECRI Institute's Risk Management eSource April 2016

HACs Reported to TxHSN as PAEs

- Events that are only HACs are to be reported if they meet or would meet the HAC ICD-10 Codes--
  - ✓DVT/PE after hip/knee surgery (2016)
  - ✓ Iatrogenic Pneumothorax with Venous Catheterization (2016)
  - ✓Poor Glycemic Control (2017)
  - ✓SSIs for certain events (2017)

HAC SSIs for PAE Reporting in TxHSN (2017)

- Certain spinal, shoulder, elbow procedures
- Laparoscopic gastric bypass
- Gastroenterostomy
- Laparoscopic gastric restrictive surgery
- Cardiac Implantable Electronic Device (exception Childrens Hospitals)
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html

ICD-10 Codes for 755 Surgical Orthopedic HACs

0RQJXZZ	Repair Right Shoulder Joint, External Approach
0RQK0ZZ	Repair Left Shoulder Joint, Open Approach
0RGJ04Z	Fusion of Right Shoulder Joint with Int Fix, Open Approach
0RGJ07Z	Fusion of Right Shoulder Joint with Autol Sub, Open Approach
0RGJ0JZ	Fusion of Right Shoulder Joint with Synth Sub, Open Approach
0RGJ0KZ	Fusion of R Shoulder Jt with Nonaut Sub, Open Approach
0RGJ0ZZ	Fusion of Right Shoulder Joint, Open Approach
0RGJ34Z	Fusion of Right Shoulder Joint with Int Fix, Perc Approach
0RGJ37Z	Fusion of Right Shoulder Joint with Autol Sub, Perc Approach
AND	
K6811	Postprocedural retroperitoneal abscess
T814XXA	Infection following a procedure, initial encounter
T8460XA	Infect/inflm reaction due to int fix of unsp site, init
T84610A	Infect/inflm reaction due to int fix of right humerus, init
T84611A	Infect/inflm reaction due to int fix of left humerus, init

Texas Healthcare Associated Infection (HAI) Investigation Team

Jessica Ross, CIC
HAI Epidemiologist for Texas
Texas Department of State Health Services

HAI Epidemiologist

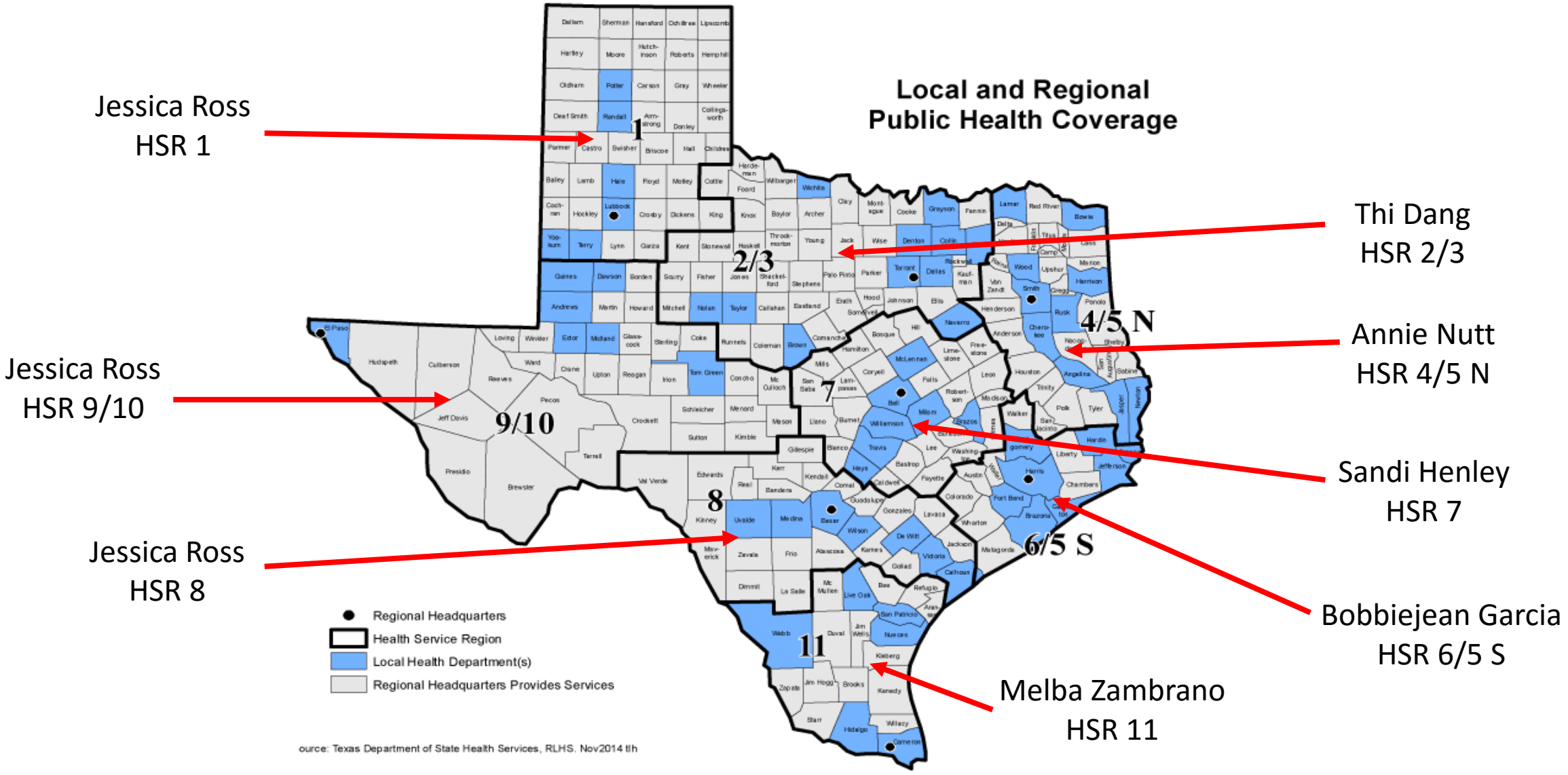
Covers a multitude of Infectious Diseases and situations

- Team of certified Infection Preventionist (CIC)
- Bloodborne Pathogens
- Meningitis, Influenza
- Emergency preparedness
- Multidrug-resistant organisms (MDROs)
  - MRSA, CDIFF, VISA/ VRSA
  - More emerging and urgent threats: CRE, MDR-Acinetobacter (MDR-A)
- High consequence diseases
  - Ebola or other VHF
- Outbreaks in many different types of settings: acute care, LTC, dialysis, dental facilities, ASC, and more.

Texas HAI investigation team

- Jessica Ross, CIC
  - HAI Epi for TX
  - Currently covering HSR 1, 9/10, and 8
  - Phone: 512-776-6356
- Bobbiejean Garcia, MPH, CIC
  - HSR 6/5 S Regional HAI Epi
  - Phone: 713-767-3404
- Thi Dang, MPH, CIC
  - HSR 2/3 Regional HAI Epi
  - Phone: 214-632-3480
- Annie Nutt, MPH, CIC
  - HSR 4/5 Regional HAI Epi
  - Phone: 903-533-5317
- Sandi Henley, RN, CIC
  - HSR 7 Regional HAI Epi
  - Phone: 254-750-9387
- Melba Zambrano, RN, CIC
  - HSR 11 Regional HAI Epi
  - Phone: 956-444-3208

HAI Investigation Team



TX Notifiable Conditions

TX Notifiable Conditions

- Multidrug-resistant Acinetobacter (MDR-A) and Carbapenem resistant *Enterobacteriaceae* (CRE)--CRE-*E. coli* and CRE-*Klebsiella* species are notifiable conditions in TX as of April 2014 and are reportable with in 1 working day as of January 2016.
- VISA / VRSA still remain notifiable conditions and are immediately reportable.
- Remember to also report: any outbreak, exotic disease, or unusual group expression of disease that may be of public health concern

MDRO Data

Reported MDRO cases per organism identified in 2014 - 2015 (rates per 100,000)						
	MDR-Acinetobacter (MDR-A)	CRE	CRE Organisms			TOTAL
			CRE-*K.pneumoniae*	CRE- *K.oxytoca*	CRE-*E.coli*	
2014*	860 (3.13)	541 (1.97)	452 (1.65)	12 (0.04)	77 (0.28)	1401 (5.10)
2015	978 (3.53)	875 (3.16)	722 (2.61)	28 (0.10)	125 (0.45)	1853 (6.69)

MDRO Data

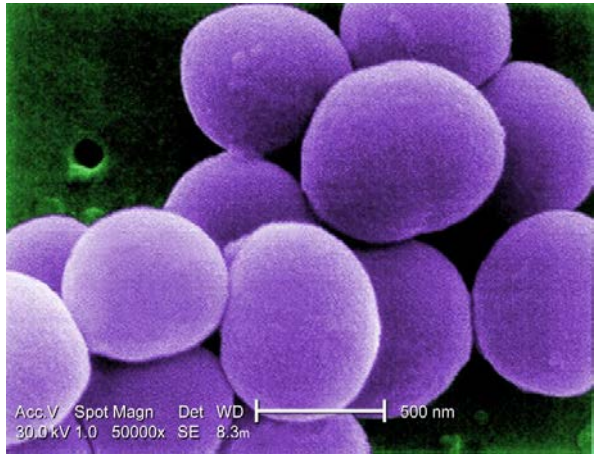
Specimen Source for each Reported MDRO Organism, 2015					
		CRE			
	MDR-*A*	*E.coli*	*K.oxytoca*	*K.pneumoniae*	Total
Blood	80	10	0	39	129
Bone/Tissue	28	1	1	7	37
Other	47	13	2	27	89
Sputum	219	7	6	112	344
Urine	132	73	12	419	636
Wound	472	21	7	118	618
Total	978	125	28	722	1853

MDRO Data

Carbapenem Resistant Enterbacteraceae (CRE) Cases by Age Group in Texas, 2015		
Age Group (Yrs)	Year	
	2015	
	Count	IR
0-4	4	0.20
5-9	3	0.15
10-14	2	0.10
15-19	4	0.20
20-24	13	0.64
25-29	9	0.46
30-34	11	0.55
35-39	19	1.01
40-44	34	1.83
45-49	43	2.46
50-54	60	3.35
50-59	77	4.57
60-64	83	5.90
65-69	112	9.80
70-74	103	12.83
75-79	111	20.28
80-84	78	20.52
85+	110	31.24

Multiple Drug Resistant Acinetobacter Cases by Age Group in Texas, 2015		
Age Group (Yrs)	Year	
	2015	
	Count	IR
0-4	3	0.15
5-9	3	0.15
10-14	2	0.10
15-19	3	0.15
20-24	14	0.69
25-29	18	0.92
30-34	24	1.20
35-39	34	1.81
40-44	53	2.86
45-49	55	3.14
50-54	60	3.35
50-59	124	7.36
60-64	106	7.53
65-69	128	11.20
70-74	117	14.57
75-79	94	17.18
80-84	69	18.15
85+	70	19.88

MDRO Data



Reported VISA/VRSA Cases by Year in Texas, Years (2007-2015)																		
	2007		2008		2009		2010		2011		2012		2013		2014		2015	
	Count	IR	Count	IR	Count	IR	Count	IR	Count	IR	Count	IR	Count	IR	Count	IR	Count	IR
VISA	3	0.01	2	0.01	4	0.02	10	0.04	6	0.02	23	0.09	8	0.03	5	0.02	9	0.03
VRSA	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00

Other projects

Ebola Assessment Centers

- TX received funding in 2015 to conduct assessments in healthcare facilities that chose to be an “Ebola Assessment facility”.
- Part of this funding included:
  - Mandatory pre-assessment tool to be completed by Ebola Assessment Centers.
  - On-site survey conducted by a multidisciplinary team from DSHS including Lab, Preparedness, and Epidemiology.
- 10 facilities across TX have already completed these on-site assessments

Targeted Assessment for Prevention (TAP) Strategy

- Also work with the HAI audit team and conduct site visits
- Starting in 2017 DSHS will begin the **Targeted Assessment for Prevention (TAP) Strategy** as another means to look at HAI data.

What is the TAP Strategy?

- The Targeted Assessment for Prevention (TAP) strategy is a method developed by the CDC to use data for action to prevent HAIs.
- The TAP strategy targets healthcare facilities and specific units within facilities with a disproportionate burden of HAIs so that gaps in infection prevention in the targeted locations can be addressed.

Who is using the TAP strategy?

- CDC is working with partners such as CMS Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs), State Health Departments, healthcare systems, and facilities to incorporate the TAP strategy into their quality improvement work.
- DSHS HAI investigation team will be utilitzing the TAP strategy to identify and reach out to facilities within their jurisdictions to assist them with prioritizing HAI prevention throughout facilities or within specific locations.

Where does the data come from?

- Data used for the TAP strategy are reported by healthcare facilities to CDC's National Healthcare Safety Network (NHSN).
- Healthcare facilities can also generate their own TAP reports to look at their own data for different HAIs and patient care locations.

The best defense is a good offense…

- **Prevention, prevention, prevention**
- Use common sense and be prepared for the unexpected
- Hand Hygiene
- Appropriate PPE for the situation
- Get vaccinated
- Remember the Environment as a reservoir for transmission and infections
- Know what to do for occupational exposures

Texas Healthcare Associated Infection (HAI) Reporting and Validation Updates, 2016

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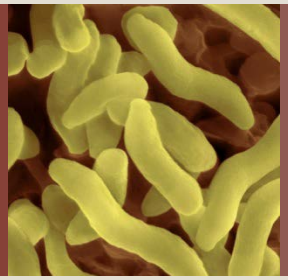
512.776.3773

Objectives

1. Review the 2016 National Healthcare Safety Network (NHSN) updates related to HAI reporting in Texas.

2. Describe the HAI data validation process.

NHSN Update: 2016

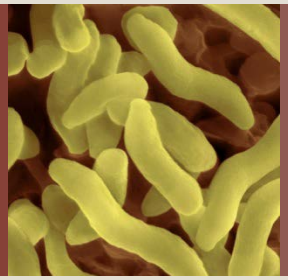


2016 NHSN Updates: Patient Safety Component

- VASC – If pus from the peripheral IV site is positive for a matching organism from the blood during the IWP, it would be an LCBI but not a CLABSI.

- Exclusion of *Blastomyces, Histoplasma, Coccidioides, Paracoccidioides, Cryptococcus and Pneumocystis from all NHSN definitions.*

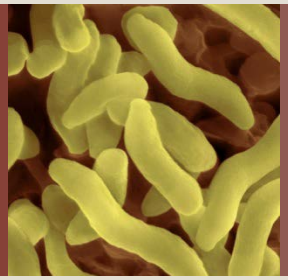
- If the date of culture collection is on or after the date the patient is declared brain dead AND the patient is being supported for organ donation purposes, the event should not be reported as an HAI.



Note about 2015 Re-baseline

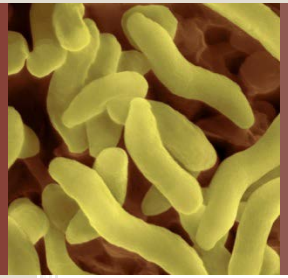
- NHSN will address the following questions/ concerns:
  - Exclusion of MBI-LCBI from future CLABSI rates and SIRs
  - Use of new risk models for CAUTI and CLABSI
  - Updated risk models for SSI SIRs to address PATOS (will be excluded for CMS 30 day SIR)

HAI Data Validation



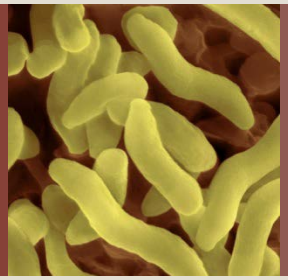
Data Validation: 2015

- Audit data for 6 month period:
  - H1 (Jan – June): Facility selected in October 2015
  - H2 (July – Dec): Facility selected in April 2016
- Selected facilities based on Standardized Infection Ratio or using NHSN Facility Selection procedures
  - SSI and CAUTI: Significantly high SIR
  - CLABSI: Facility selected using NHSN Guidelines



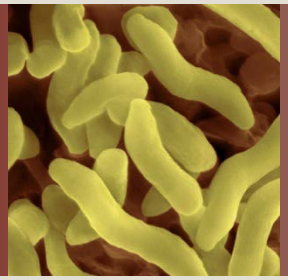
Data Validation

Texas HAI Reporting Deadlines				
Reporting Quarter	**Jan 1 – Mar 31**	**April 1 – June 30**	**July 1 – Sept 30**	**Oct 1 – Dec 31**
Facility Data submission deadline	According to NHSN rules: within 30 days of end of reporting month			
Departmental data reconciliation (DSHS pulls data from NHSN)	1-Jun	1-Sep	1-Dec	1-Mar
Facility NHSN data corrections due in NHSN	30-Jun	30-Sep	31-Dec	31-Mar
DSHS sends email to facilities to review data summary	NA	15-Oct	NA	15-Apr
Facility comment deadline: Facilities will have until this date to enter a comment related to their facility's data display	NA	30-Oct	NA	30-Apr
DSHS review of comments: DSHS will review comments by this date	NA	15-Nov	NA	15-May
Public posting of summary: Public Data Display will be posted on a public website	NA	1-Dec	NA	1-Jun



CLABSI Audit: Facility Selection

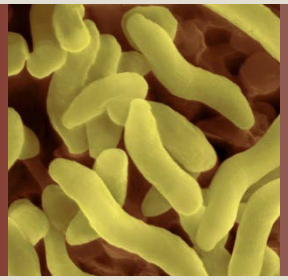
- 21 in the top third of facilities with highest number of expected/predicted infections are selected.
  - Top 7 facilities with SIRs above the median
  - Top 7 with SIRs at or below the median, but above 0
  - Top 7 with SIRs = 0
- 5% of all remaining facilities are randomly selected (~15).



Record Selection

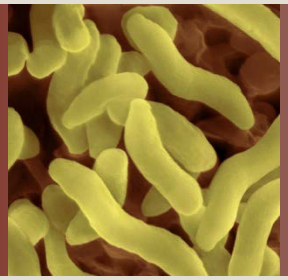
Selected facilities will be required to submit a line list of all positive blood cultures from the given audit period (6 months). Line list should include:

- MRN
- Gender
- DOB
- Admission Date
- NICU/ICU
- Name/Type of ICU (optional)
- Lab Specimen # (optional)
- Specimen Collection Date
- Organism Name



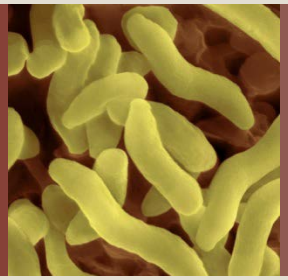
Record Selection

- From the line list, DSHS will select:
  - Up to 20 records of NHSN reported CLABSIs
  - 40 records of unreported candidate CLABSI events
    - 10 from NICU setting (if applicable)
    - 30-40 from adult/pediatric ICUs



Summary of CLABSI Validation Process

1. Notify facility and request line list of positive blood cultures
2. Select medical records for review and notify facility
3. Select site visit date and send Facility Audit Survey for completion by facility prior to site visit.
4. Notify CEO/Administrator, DSHS Regulatory and Regional/Local Health Departments about upcoming visit
5. Review Facility Audit Survey and perform site visit
   - Introductions/Entrance Interview
   - Partially “Blind” Chart Review
   - Debriefing/Conclusions
6. Send Validation Summary Report to IPs, CEO/Admin and other staff as needed.



2015 Validation Findings*

- CLABSI:
  - 723 records reviewed for CLABSI
  - 25 (3.5%) Discrepancies noted (24/25 were initially missed by the facility)
- SSI:
  - 205 records reviewed for SSI
  - 12 (6%) Discrepancies noted (11 were over-reported)
  - 11 (5.4%) events were miscoded
- CAUTI:
  - 30 records reviewed for CAUTI
  - 1 (3.3%) Discrepancy noted (over-reported)

**Findings are preliminary as of 7/26/2016*

DSHS Validation Team

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DSHS Regulatory Section
Patrick Waldron, M.Ed., LMSW

Branch Manager

Health Facility Compliance

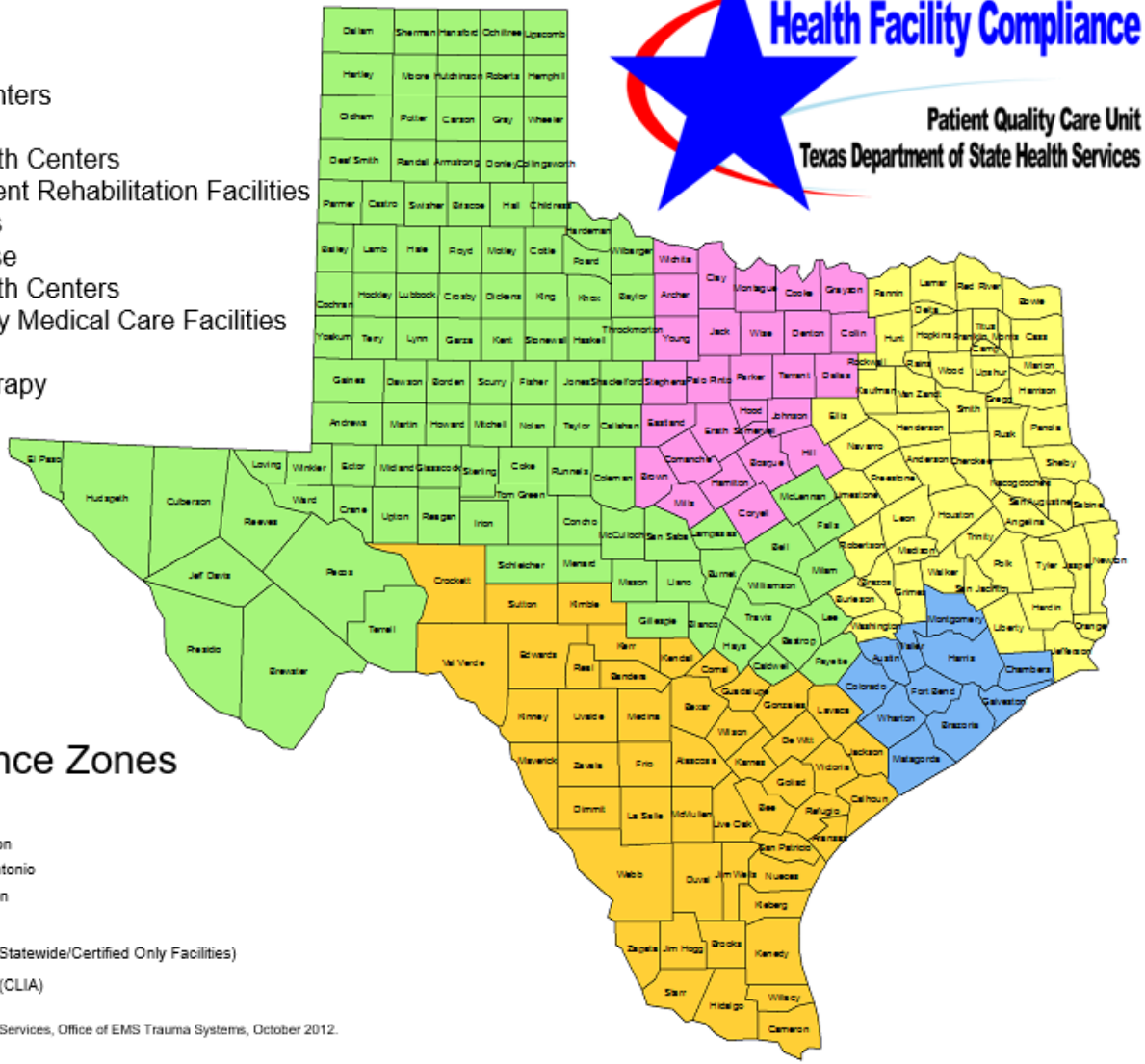
Patient Quality Care Unit

Facility Types

- Abortion Facilities
- Ambulatory Surgical Centers
- Birthing Centers
- Community Mental Health Centers
- Comprehensive Outpatient Rehabilitation Facilities
- Critical Access Hospitals
- End Stage Renal Disease
- Federally Qualified Health Centers
- Freestanding Emergency Medical Care Facilities
- Hospitals
- Outpatient Physical Therapy
- Portable X-Ray
- Psychiatric Hospitals
- Rural Health Centers
- Special Care Facilities

Health Facility Compliance

Patient Quality Care Unit
Texas Department of State Health Services



HFC Compliance Zones

- Zone 1: HFC Group - Austin
- Zone 2: HFC Group - Arlington
- Zone 3: HFC Group - San Antonio
- Zone 4: HFC Group - Houston
- Zone 5: HFC Group - Tyler
- Zone 6: HFC Group Austin (Statewide/Certified Only Facilities)
- Zone 6: HFC Group - Austin (CLIA)

Source: Texas Department of State Health Services, Office of EMS Trauma Systems, October 2012.
Mapped by Tracy Haywood, October 2012.

Health Facility Programs

Below is a guide highlighting the appropriate channels for communicating with DSHS Regulatory when you need technical assistance, have questions, or have concerns.

Group Managers should be your first point of contact

Health Facility Compliance
Hospitals, Ambulatory Surgery Centers, Community Mental Health Centers, End Stage Renal Disease (dialysis), Comprehensive Outpatient Rehabilitation Facilities,, Outpatient Physical Therapy, Rural Health Centers, Freestanding Emergency Medical Care Facilities, Abortion Facilities, Birthing Centers, Special Care Facilities, Portable X-ray, CLIA (labs).

Group Managers:
Austin- Wanda Wilson 512-834-6700, x 2685
Arlington- Marsha Wall 817-264-4751
San Antonio-Larrie Collier 210-531-7319
Houston- Frank Arch – 713-767-3360
Tyler- Jeanette Potter 903-533-5381
Austin2- Rachel Turner 512-834-6700 x 2639

Substance Abuse Compliance
Substance Abuse Treatment Facilities, Faith Based Programs, Opioid Treatment Facilities.

Group Manager:

Rachel Ashworth-Mazerolle

512-834-6700, ext 2126

Health Facility Licensure
Hospitals, Special Care Facilities, Freestanding Emergency Centers, End Stage Renal Disease (Dialysis) Facilities, Birth Centers, Abortion Facilities, Crisis Stabilization Units

Substance Abuse Facilities, Faith Based Programs, Opioid Treatment Facilities

Group Manager:

Janet Luebner
512-834-6639

Health Faicility Architecture Review
Hospitals, Ambulatory Surgical Centers, Dialysis Facilities, Freestanding Emergency Medical Centers, Special Care Facilities, Crisis Stabilization Units.

For New Construction, additions, major renovations, alterations or moderations of existing structures.

Group Manager:
Rebecca Read
512-834-6649, ext 2661

Consumer Safety Enforcement

Previous, current, or pending disciplinary actions and enforcement process against the licensed health facilities

Group Manager:
Ademola Olufemi

512-834-6670 ext. 2817

If Needed, contact Unit Directors for assistance with:

Health Facility or Substance Abuse Compliance:
Patrick Waldron
Branch Manager
512-834-6700, ext 2625

Health Facility Licensing and Architectural Review:
Charlotte Sullivan, Director
512-834-6600

Enforcement Programs:
Chris Drews
Unit Manager
512-834-6665

Contact the Section Director if further assistance is requested:
Renee Clack
Health Care Quality Programs
512-834-6700

What does regulatory do?

Our staff conducts on-site inspections and complaint investigations to ensure that facilities are in compliance with the regulations set forth in the Licensing Regulations for Health Care Facilities.

We seek evidence of compliance, which are the minimal standards set forth in rule and regulation.

Voluntary compliance is the goal; although the health and safety of the patients in paramount. When necessary, enforcement action for violations of statutes and rules will be taken to achieve compliance.

DSHS staff proactively assists the regulated community and the general public in their understanding of and compliance with regulatory requirements in order to protect the health and safety of all Texans.