

**Healthcare Associated Infections Advisory Panel
May 12, 2008**

Attendees: Cathy Gleasman (scribe), Jan Patterson, Bruce Burns, Alyson Hight, Marilyn Christian, Gary Heseltine, Glen Mayhall, Lisa McGiffert, Barbara Plummer, Jane Siegel, Charlotte Wheeler, Nance Stearman, Linda Stephens; **Guests:** Starr West, Sky Newsome, Tjin Kay, Neil Pascoe, Wes Hodgson, Debra Slapak, Emily McCallum, Matt Wall, Nnenna Ezekoye, Trish Bode, Rebecca Herron, Cindy Wesch, Susan Penfield, David Lakey

Agenda:

Welcome and Introductions (Jan Patterson)
Review of Minutes from April 15, 2008 meeting (Jan Patterson)
Commissioner or Assistant Commissioner to discuss healthcare associated infections
Review of Draft healthcare associated infection reporting budget (Susan Penfield)
Legislative Appropriation Request public comment (Lisa McGiffert)
Survey of facilities' infection control and information technology resources (Jane Siegel)
Review of panel motions/recommendations (Jan Patterson)
Other (Discussion of MRSA tracking project, plans for the panel for the summer)

Motions Approved during Meeting:

**TWO MOTIONS FROM HAI ADVISORY GROUP
FINALIZED MAY 12, 2008**

1. Motion Made:

This Advisory Panel recommends that the Texas Department of State Health Services establish a system for surveillance and public reporting of healthcare associated infections using the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) system as the data collection program, subject to the following requirements:

- Newly allocated and permanent funding for a public reporting system;
- IT infrastructure (including hardware, software) and maintenance;
- Support in the form of new 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
- Permanent funding for validation and auditing of data

Motion seconded, and carried.

2. Motion Made:

Contingent on newly allocated and permanent 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 facility level data reporting in the second year.

Motion seconded, and carried.

Welcome and Introductions (Jan Patterson)

Cindy Wesch provided a personal story of her sister, who died from HAI (sepsis).

Barbara Plummer is filling remaining consumer seat on the panel. She is an occupational therapist and she contracted MRSA (*methicillin resistant staphylococcus aureus*) on the job. She ended up with a below-the-knee amputation due to infection in a broken foot.

Margaret Orman is filling the QA position, but she is not available for the meeting today.

Review of Minutes from April 15, 2008 meeting (Jan Patterson)

A copy of last meeting's minutes was handed out upon reconvening after lunch. The panel and guests were given an opportunity to review them before comments were solicited.

Corrections: Note that the budget is \$3 million per ANNUM, not biennium (page 1 and page 8). The speaker misspoke. (See addendum).

Page 5: Change "Medicaid" to "Medicare and Medicaid".

Page 2: Nick Dauster is with the Office Government Relations, not OGC.

Corrections will be made and the notes redistributed.

Commissioner or Assistant Commissioner to discuss healthcare associated infections

Dr Lakey responded to Jan's letter, and he will come speak to the panel this afternoon. The Department of State Health Services (DSHS) is interested in providing funding; the legislature and the governor are supportive. Funding will be pursued in the January 2009 session and not in a special request.

Jan also wrote a letter to Albert Hawkins. Charles Bell responded. He expressed appreciation for the panel, and acknowledged that funding was not appropriated. Dr Hawkins cannot attend the meeting, but will be updated by Dr Lakey after the meeting. A contact person, Mr. Valentine, was provided at Dr Hawkins' office.

Lisa and Linda went to the hearing on May 6th, and testified in support of funding. It wasn't very interactive, but it was good to have representation. There was an email that written comments could be sent up to May 16th. Sending an email would be a good idea, to show broader support. Four Infection Control Practitioners (ICPs) attended the meeting in Harlingen, and were able to speak and show support. There's a link on the DSHS webpage showing where to send written comments.

It does not appear that this issue is a priority with the Health and Human Services Commission (HHSC). However, Dr Lakey seems to hold it in high priority. Senator Nelson also seems to find it a priority and states she'll pursue funding.

Has anyone seen anything about Texas withholding payments from Medicaid for Healthcare Associated Infections (HAIs)? Lisa is going to look and see if she can find anything, and will share with the panel.

Dr. Lakey, who is an infectious disease physician by training, feels that this is a very important matter. He stated that we need to make sure we do this right, and do not divert people from doing infection control to entering data. That can just exacerbate the problem. DSHS is committed to it being done right. We've been trying to educate people about how important it is for us to get funds. There're quarterly legislative meetings, and in several of them he's brought up this panel and its work. He's told them that it'll be difficult to put into effect without funds. Last week, he briefed them again about

keeping it on the radar for the next legislative session. He's also committed to keeping it in the mind of the executive branch. Dr Hawkins discussed the issue with the governor. We have buy-in with the governor's office, he believes. It's being worked through both the legislative and executive branches. On May 20, Dr Lakey will discuss the challenges with the Senate Finance Committee and discuss how important it is that we have funds for this process. The main focus is hospital budgets, but he will take the opportunity to discuss this issue. The only way to get funds is through the legislature, but we're prepared to push it come January. They appreciate the work of this panel in figuring out what program is the best one for this system. It's helpful for them to know how the National Healthcare Safety Network (NHSN) system has improved, and to know the cost of getting it set up. We need to make sure we have the people and the quality control to make sure it's accurate data and data that can be used to make the right choices. Our challenge over the next several months is getting a true picture of what this system entails, so that we can make the legislature and governor see the importance.

Question: What would Dr Lakey like from us as a committee, to help educate people and communicate with those who control the finances?

Answer: Needs to have the information to sell. Needs to have a picture of the needs of Texans, which can be sold to the legislature. Needs to know the technology and the people needed, in order to have an accurate system. The things that would be best to monitor and how to step that up. What does the system look like in the implementation plan, so it can be sold as a thoroughly thought out plan. He needs to be able to show them that if we have the funds, the system will work.

Comment: We were asked to provide short term recommendations by June, and we've created those recommendations today. We're recommending NHSN, and making sure we have the right infrastructure. Today, we'd like to work on the specific protocol and what it looks like-we'll discuss through the summer and reconvene, ready to campaign, in September.

Dr Lakey: We have buy-in through the executive side. We need buy-in from Senator Nelson on the legislative side. Do expect to have support from Senator Nelson. The senate finance committee should be a receptive group. We have a lot of issues in this agency that need additional funding, and we can only have twelve or so exceptional items. So we need to be clever about 'bundling' the budget requests together. So HAI registry might not stand on its own, it may be incorporated into another item. But it will be there. It probably cannot just be added to the budget, it'll need to be an exceptional item. It's doubtful additional funds will be added next week, but he'll use the opportunity to get it before the committee.

Question: What is your timeline to get the information for the exceptional item?

Answer: Currently listening to stakeholders throughout Texas, showing them the strategic plan, which includes HAI. We are getting feedback. The last two weeks, there have been general presentations about the things being considered. There have been stakeholders from this group who have made presentations. Over the next several weeks, that will be refined into more 'meat on the bones'. In August, we'll need well thought out plans to present to the Legislative Budget Board (LBB). They'll be further refined between August and October. He'll need a clearer picture of what this looks like, with more specific a budget, well thought out plan, etc by October. He'll need to sell the idea that we're good stewards of those funds.

Legislators listen most to people in their own districts, so we need to make sure the information is reaching them in their 'own backyards'.

Question: About the 'bundling'-it's going to be very important to know where it's bundled. Strategically, it's a very high profile, 'hot' issue-you might get more response for the things bundled with it, if you stress the HAIs instead.

Answer: He has around five minutes to say everything, then each item is explained in a committee in chambers. As an infectious disease physician, he feels he can sell this and create interest.

Comment: This proposal is more than just reporting, it's an integrated prevention and reporting system, and it's important to make sure the legislators know that.

Answer: You have to read the room. Each agency testifies, and then there's testimony from supporters. We need to get better at getting supporting testimony for public health issues. It's hard for legislators to see how these issues save lives and money, since someone doesn't know that they were saved because it was in place.

Comment: Everyone on the committee knows someone who had an HAI. We need to get that information before the legislature. We've started every meeting with someone with a story of a loved one who died of an HAI. We can help provide supporting testimony, as long as we know when they are needed.

If Dr Lakey has a good estimate of the necessary budget before the legislative session, that should be sufficient.

Review of Draft healthcare associated infection reporting budget (Susan Penfield)

This issue has been looked at extensively, more so than most things Dr Penfield has dealt with in the last ten years. There is a lot of interest. Initially, after the legislation, we brainstormed on what could be done without any money. The appropriation process starts very early-this year it was in January. When it was originally looked at, the Centers for Disease Control and Prevention (CDC) system did not seem like the best way, and neither did creating our own. The Center for Health Statistics (CHS) plan, modified, seemed like the best plan, during the months this panel was being formed.

When CHS got the contract approval to work with IT, it turned out there were practical problems that made it more difficult to make the modifications than previously thought. Also, this panel had strong interest in using the CDC program (NHSN), which was expressed in the second meeting of the panel. The official presentation to Dr Hawkins was postponed, while the NHSN system was looked into. In the meanwhile, a very rough draft of a budget was created, showing what would be needed to use the NHSN system.

Legislative appropriation requests are made each session, and we can act for exceptional items. Exceptional items are generally requests for new programs, rather than modifications of programs that already exist. We put in a 'place holder' request, as we entered the process of determining which program was the best fit. The numbers were based on the CHS program. This information will be replaced by a refinement based on the committee's recommendations, and practical recommendations. The commission will work out what goes forward, and what will end up in the final request. We fully anticipate that this program has an excellent chance of going forward in our final request, which would mean DSHS would request funding for this project. However, should we get this money, it doesn't actually mean any money coming in until the beginning of FY10. It is possible, but difficult, to get funding before this point. The first opportunity to do actual work is probably Fall '09.

Using NHSN instead of CHS is a more massive undertaking, as it's a new program and not a modification of a system in use. The timeline is similar, and we don't know if it's practical to push it to take effect earlier than FY09. The time to actually request money is less than a year away.

Question: What would the staff listed on the budget be doing?

Answer: The department identified funding for one position- a senior program specialist who would be a project manager; someone who would facilitate and walk the program through its early stages. Depending on Information Technology (IT) requirements, there might also need to be an in-house IT program manager as well. Even though NHSN is free, in order to do reports and analysis there is a need for an IT program manager. The amount in '08 is small, because it's a partial year. We'd be hoping to get someone on board in the summer. In '09 it would be a full year. In 2010, we would add the IT person. The other staff salary in Central office in Dec '09 would be the people who would work with IT on development, working with the regions and stakeholders. They would do analysis and trouble-shooting as time went on. In March '09, we would add regional staff. These positions would do quality assurance, work with ICPs, and would most likely be program specialists and possibly nurses. At that time, administrative support staff would be added. All these dates are approximate. New York has 12 people covering their state. We've scaled the numbers up proportionally to meet Texas' greater need/size.

Comment: It's important in the legislative appropriations request (LAR) to stress that this is not just a public reporting model-it's reporting and prevention. The public reporting will stimulate change in the hospitals, not just reveal the information. The training, validation, and education in the hospitals that are monitoring the infections beyond their current level will make them change in a way that prevents infections. We need to stress that. And stress that it's not just a simple reporting system-it's a much more active model. People are the ground have to change how they use the information.

Question: What is the money allocated for software development?

Answer: It is the database in which we can manipulate the data. Part of it is the web-development and query system for people who are searching for the information, so they can do a look-up by region, county, facility, etc. We're going to download the NHSN data file, but we need a way to work with the data. We can see what other states are doing, and possibly modify what they are doing, rather than developing our own system. There will still be parts that need to be developed. And we will also want to be able to use this data with other datasets, to build the patient safety model. It is critical that we understand that we cannot be columnar with this data, and keep in mind we need to be able to connect to other datasets.

Question: Do we have any idea what kind of software would be needed?

Answer: We will need to discuss with IT. Some things will be standardized for us, but other parts will need to be created for us. It is not a large budget, in IT terms, but this panel needs to be able to understand and explain what the money is for.

Question: Did we look at other states and what they are doing, in order to create the budget?

Answer: It was based on the experience of the IT people here, from working with tasks of similar size.

Question/comment: This should not be that big a project. Was this number set on a standardized idea or approximated based on this specific project? Did we compare to other states and what it cost them? What are we getting for \$480,000?

Answer: This is a start-up draft budget; it's not based on the level of refinement being discussed. They based it on approximate man-hours, and the average cost per man-hour. It will be looked at closely and refined to meet this specific project prior to being presented to the legislature. Bear in mind that IT programs are very expensive in general. We are certainly open to looking at other states' programs and how they did things, and the costs. The difficulty is that in order to do an exceptional item, we need to be ready when the legislature convenes. As more detail is presented to the panel, the panel will be able to refine the budget. We need to avoid both asking for too much and spending more than necessary, but we also need to avoid asking for too little and ending up with a program that doesn't do what we need it to do.

We will look at what is more cost-effective: hiring staff or using contractors. There are many variables that affect which choice is better. The IT salaries are separate from man-hours. The salaries are also not all IT people- they may be administrative help, or project assistance, or various other types of employees.

Question: Can you explain “Start up training contracting” in the budget?

Answer: We wanted to get everything in to the budget if possible. It would be useful and helpful to have training on interacting with the system. There is also a lot of set-up that needs to be done to get certificates and get the machines set up for NHSN. So this would be start-up issues and issues of using the system itself.

Question: In terms of FY08 and FY09, is that funding in place?

Answer: Yes, we have the funding for one fulltime equivalent (FTE). The travel money listed will come down. One FTE to lead the program, plus we are able to use parts of other FTEs’ time. We need to refine the job description based on using NHSN instead of CHS, then classify the position. It will hopefully be posted this summer, and on board before the next legislative session.

Question: While we’re waiting for funding, would we encourage hospitals to get on board with NHSN and start using it?

Answer: We would help the hospitals be aware of NHSN, and would encourage them to become familiar with it. We could use the time to educate and promote good infection control practices.

Comment: It could be a good ‘cushion’ for hospitals to begin looking at NHSN and getting trained on it. Perhaps the one staff person who was on board next summer could work on getting that word out. Most hospitals know NHSN is coming, so it would make sense to encourage them to start the long process of getting their certificate. It’s being discussed in the regions. DSHS staff can help with that process.

Comment: We need to set up a specific program to alert hospitals to this process coming up, and help them to get set up.

Comment: We need to think about what to do if this program isn’t funded. What other benefits can the hospitals get with interaction with NHSN? NHSN isn’t set up for Ambulatory Surgical Centers (ASCs) at this time. Would there be a need to make a rule that NHSN be used? That may help prevent laggards and resisters to the system.

If we move forward with our work, and adopt recommendations, and started through the rule-making, would it be possible to do that before funding was approved? That would make it faster, if we didn’t need to wait until we had the funding. But then if it’s not funded, we have a rule that hospitals must follow, but without money.

NHSN is a positive thing, it gives a measure on how you’re doing compared to the rest of the country. This results in better control of infection, even without the reporting factor. Hospitals need to be pushed to provide funding to put NHSN in place and use it in infection control, lower their infection rates-that’s the point of this, rather than the reporting. We need something that can be organized aside from public reporting.

If the program is funded, the ICPs and hospitals will get other benefits for their additional work-the comparing to other hospitals. If it’s not funded, it’ll be a lot of work for not a lot of extra benefits.

A lot of hospitals have other infection control systems, and there is a fear that they won't be willing to step up and do NHSN until they know there'll be funding.

Texas does not appear to be bowing to 'peer pressure' that other states are using NHSN. Many states are early on, and struggling. The Texas mandate is broader, and we're a tenth of the country. We have a lot of voices and we're going to get a lot of data from every size of facility possible-from small rural hospitals to large urban hospitals.

If Texas comes on board with the CDC system, we may have more voice in changes they make in the system, because of our large size and varied environments.

Jan was recently in Baltimore discussing this issue. A physician from Colorado pointed out that only two states have gotten extra funding for implementing this system. Lisa states that's incorrect. She will get the correct number of states. Our legislature is most likely going to look at what other states are doing, in deciding what we should do. We need to make sure we understand this budget and can defend it. We also need to know what other states are doing, so we are not comparing apples to oranges, when they have a lower budget but are doing much less.

Lisa stated that she does not believe Texas hospitals will do NHSN unless they are required to. We have ten hospitals participating now, even though it's available. We can promote it, but until there's a rule we can't enforce it.

Dr Penfield: When the time comes that we know what we're doing, and whether or not we have funding, we can set up the rules. If hospitals know the rules are on the way, they may be willing to start before that point. There also may be things we can make mandatory without funding.

Charlotte: We need to be realistic and look at both ways-funded and unfunded- and figure out what we really can do.

Dr Penfield: The input that the members of this panel bring is very valuable. The department appreciates it, and recognizes that even separate from the issue of NHSN/reporting.

The Texas Medical Association (TMA) Infectious Disease Committee meeting-attended by Susan Penfield, who is a consultant to the committee. This issue was brought up, and the executive committee was asked to support getting funding for this project. Texas Hospital Association (THA) is also supporting this issue, and working with Senator Nelson and Representative Delisi to get funding. That support will be on-going, although Representative Delisi will not be returning, and a new chair has not been appointed.

Another group that would be helpful would be Texas Pediatric Society. They will be contacted and asked for their support. The Texas Infectious Diseases Society will also be asked for their support. A diverse group of organizations supporting this project is a good idea, and it's a good idea to start collecting these endorsements. It could be helpful to tell the legislature "These organizations all support us."

Legislative Appropriation Request public comment (Lisa McGiffert)

See above-comments are within the previous section

Survey of facilities' infection control and information technology resources (Jane Siegel)

A short survey could possibly be done, to see if there's been progress or changes. Things may have changed, but also it's valuable to know if nothing has changed. The previous survey only had a 25%

return rate, so it may not be worth it to do it again, if NHSN has been chosen. APIC did a study recently that showed the respondents are doing more than they were, but still less than they should be doing, specifically on MRSA prevalence.

The ICPs are probably doing more surveillance, without receiving more resources.

Neil Pascoe and Gary Heseltine will discuss outside the meeting whether or not things will have changed enough to make it worth the effort to redo a survey. The panel feels that it's up to DSHS to decide whether or not it's worthwhile. Bruce and Jane will be involved in deciding what questions, if any, are needed.

The APIC chapters and Panhandle Infection Control (PANIC) chapters could put out a survey at their meeting, which might be cheaper and would result in a better response rate.

In the long term, this information could be included in the DSHS AHA annual national hospital survey. We could add a couple of questions on infection control, since Texas always adds an addendum anyway. If we feel the information is important enough to track over time, adding questions to an existing survey may be a good way to go about it.

The previous survey had fifteen questions, but it could be cut down to just a few (such as the number of ICPs per 100 beds or other staffing ratio issues, whether or not there was an infection control program in place, etc). Two questions is the maximum that should be added to the hospital survey.

We have a baseline from the previous study, and it would be interesting to do another study after reporting begins. There can be some 'report card' type questions.

Review of panel motions/recommendations (Jan Patterson)

Five comments on the motion, two requested changes. Gary and Glen requested changes.

The word 'sustained' was changed to 'permanent' in all motions. The panel disagrees on whether permanent or sustained is a better choice of words. Upon discussion, 'permanent' was chosen.

The word 'new' was interjected before 'FTEs' in motion 1.

These recommendations are our first goal, set on the first meeting of this panel. We are recommending NHSN, and recommending that funding needs to be in place for this to be a meaningful system.

We need to spell out NHSN as "Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN)."

Make the bullets past the first one in Motion 1 sub-bullets.

Need a new bullet for supporting the IT infrastructure, including maintenance, hardware, software, and servers (first sub-bullet).

The final sub-bullet had "Permanent funding for" added to the beginning.

Motion made and carried to accept the changes.

New Motions:

Motion 1:

This Advisory Panel recommends that the Texas Department of State Health Services establish a system for surveillance and public reporting of health care-acquired infection using the Centers for Disease Control and Prevention's National Health Care Safety Network (NHSN) system as the data collection program, subject to the following requirements:

- Newly allocated and permanent funding for a public reporting system,;
 - IT infrastructure (including hardware, software) and maintenance
 - Support in the form of new 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
 - Permanent funding for validation and auditing of data

Motion seconded, and carried.

2. Motion made: Contingent on newly allocated and permanent 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 facility level data reporting in the second year .

Motion seconded, and carried.

Process for the Panel, discussion

The panel feels they're in a holding pattern until they see what happens with the funding situation. Perhaps a break for the summer would be appropriate. It might be good to do a summary of the two motions and incorporate them with the measures to be reported, and put them in an official statement to be sent to the leadership.

The law is very specific about what's reported first. There are some other decisions the panel could make, but it's questionable if it's worth it to make those decisions before knowing if there will be funding (logistics, etc). Two years from now, it could be a whole new group, who could make different recommendations.

This panel is meant to stay together for another year, and there may be some other things that can be done in the meanwhile.

The panel might want to review the web-board from New York. This would provide a rationale and talking points. A draft could be circulated over the summer and input could be solicited-a brief and concise version of the panel's vision of how NHSN would work in Texas.

Nothing can be finalized without the budget, but the panel has to start somewhere. Creating a document that lays out arguments, etc is a good place.

Jane Siegel, Marilyn Christian, and Lisa McGiffert will take the lead on beginning the document. The document should be as dynamic as possible. The panel will look at it during the summer.

In the fall, when the panel reconvenes, there will be a program person on board.

Strategies for Lobbying for Funding Request

Have already discussed some agencies that could help. Need to translate the budget into “English” so it’s more understandable. Dr Penfield will be working on that, and will be asked to email it to the panel. Need to look at the budget for FTEs-the amount listed for an ICP may not be realistic.

If we share our vision with the whole community, we may be able to get more support.

The budget will need to be reviewed by people who will actual need to implement it, to see if it’s realistic.

In July and October, there are trainings for new ICPs. The information could be presented at those meetings, possibly.

There are several representatives of APIC chapters on the panel.

Possibly a slide set could be developed, to be presented at local APIC chapters, in order to gather support for funding this project.

All hospitals should be encouraged to sign on to NHSN and get started.

We wait to focus our energy on slide-sets, etc for when funding is approved.

The Texas Society of Infection Control and Prevention (TSCIP) has been trying to push for hospitals getting on NHSN. Talking to APIC chapters about NHSN would be valuable. We still want the community to know the recommendations of the panel, even before we know what the legislature decides.

New DSHS FTE to come on board this summer, s/he should talk to Texas Medical Foundation (TMF) about how to get more hospitals to join NHSN (relationship developing, etc).

Need organization around support for funding, regional APIC chapters and other organizations, could be given a letter that they can use to support funding (to be sent to legislature). This should begin during the summer, but take place in the fall. Jan Patterson could be the receiving person for letters of support, and then she could distribute the packet for distribution. She will draft a template letter, listing organizations that support the panel’s recommendations. She will keep track of new organizations, and will add them to the letter as needed.

MRSA Pilot Program authorized by law last year

Is DSHS playing a role with the program?

The rules are proposed and the comment period just ended. Reporting is not just at the hospitals. All clinicians (hospital, individual, lab, etc) who have knowledge of a MRSA case report it to the local jurisdiction (local health department, generally). Demographics and lab-based reporting. Starts July 1, 2008 and runs through June 30, 2009. Limited to three areas of Texas.

The CDC study on invasive MRSA showed a wide variation on the incidence (looked at both community and hospital acquired MRSA). If demographics aren’t being tracked, it may be hard to tell that there are differences. There are areas in the state or in the country where community prevention should be stepped up and targeted at specific communities with high incidence.

It’s good for this panel to know what’s going on with this law, as it could affect the reporting requirements.

Randall/Potter county found that most individuals hadn't been told that they had MRSA, and weren't told how it was spread or how to prevent it. ICPs are going to triple or quadruple their reporting with the new rules, but just reporting numbers won't necessarily change anything. There is no funding for this project. It was originally created for Bexar county specifically.

Not all cultures will be infections, and it'll take an ICP to determine which it is in a lot of cases. Colonization is not included in the program, just infection. A lot of the huge numbers will be due to colonization, but they're only asking for those who are infected.

How are the data going to be interpreted? A year's worth of data collection will be looked at by the legislature, and they may say "Look at how much we have! Everyone should do this!". Someone who is more knowledgeable should be looking at the data. A research protocol is needed.

This could require long chart reviews on all these patients. There is no protocol currently, but is starting in less than two months. The timeline for the data to be available is after the next legislative session. They will probably not want to go through another session without some MRSA legislation. If the data isn't available, the legislature may be making laws without the information.

MRSA's been around for a long time, but the public is only newly aware of it. Most of the worst infections, the fatal infections, are taking place in a healthcare setting. Around 100,000 people a year die from HAIs. We need to do what we can in this committee, but keep in mind what else is going on.

A prevalence study would be useful, but it doesn't need to be a law.

Next Meeting:

The meeting for May 27, 2008 is cancelled. The panel will adjourn until Tuesday, September 9, 2008. The location will be determined and announced over the summer, but an effort will be made to keep it in the DSHS boardroom.

Next steps:

Gary Heseltine will work with Susan Penfield to refine the budget.

A thank you and one page summary of the process will be created and sent to Dr Lakey within the next week.

The specifics of New York state's program will be looked into further.