Health Care Associated Infections Advisory Panel Meeting
September 9, 2008

1. Welcome and Introductions
2. Review of minutes from May 2008 meeting
3. Review of LAR meeting (Susan Penfield)
4. Strategies for 2009 Legislative Session
5. Adjournment

Attendees: Lisa Giffert, Gail Van Zyl, Gary Heseltine, Bruce Burns, Jane Siegel, Susan Penfield, Cathy Gleasman (scribe), Sky Newsome, Starr West, Neil Pascoe, Mimi Malone, Marilyn Christian, Patricia Grant, Alyson Hight (on phone), Glen Mayhall (on phone), Margaret Orman (on phone), Barbara Plummer, Nance Stearman (on phone), Charlotte Wheeler (on phone), Doris Moran, Debra Slapak, Becky Heinsohn, Lynda Watkins

Motions:

**Review of Minutes**

There were questions on some of the acronyms, which were clarified.
Question on the last paragraph, page 2. "Do expect to have support from her" refers to Senator Nelson. Senator Nelson's name will be included in lieu of the pronoun 'her'.
The phrase about 'bundling the items' will be changed to 'bundling the budget items' or 'budget request'.
Suggestion made to move the motions to the beginning of the document. Idea approved and there will now be a section that lists all motions.
Minutes and amendments approved. Revised copy will go out later this week.

**Review of Legislative Appropriations Request Meeting (Susan Penfield)**
Dr Penfield handed out documents from the LAR, which is online. Found at :
www.dshs.state.tx.us/budget/lar/default.shtm

Each agency writes up the money they are requesting, including the money they are already receiving and the federal funds requested. Usually it's the same amount from the previous session, but sometimes something is added or subtracted. It is the base request. In addition, we have 'exceptional items', which are funds requested for specific projects, etc. It takes a long time, and requires justifications, planned budgets (including FTEs-full time employees), everything we think the cost will be for at least the first year of the next biennium, but frequently for several years in advance. The exceptional items are not the core budget. The core budget is generally the things we already have-salary, rent, travel, etc- the operating budget we've been working with. It includes grants, contracts, IT money. We include the federal money to show what's been appropriated.

Generally, anything new has to go on the exceptional item list. It's a complicated system. Sometimes we are required to cut our core budget and in order to get those funds back, we add them to exceptional items.

All the HAI money requests are in an exceptional item. This year, rather than having each item show up separately in the LAR, it was bundled. The front page of the handout is not on the web, it will be faxed to phone participants. The HAI item is under #3-Health Date Collection and Analysis, disease registries. It is higher in the second year because there are more staff to be hired for the second year. It takes time to get FTEs on board and that is reflected. Once everyone is on board, and full time, the amounts will go up. There are also IT costs associated. This document is an internal document, and a draft. The group is asked to please not share it outside our workgroup for now.

Full funding means that when we developed the exceptional item, we were asked what we would do if we got partial funding. We tried to cut as little as possible, and ended up not decreasing it. We've requested the full funding, but the legislature could cut it.

There may be subtle differences between the documents. It can depend on where particular costs end up. The question was brought up about IT costs- where is it in the exceptional item? It is under 3, even though 5 is "information technology". They asked for some FTE support, and that might be in IT-but it was moved back and forth, so we'll have to look at the detail to know.

The CHS line is additional funds for outpatient. It's important for everyone to realize this money is laid on top of other resources DSHS has, this is only the extra we're trying to get to implement new programs.

Behind this sheet is the same budget that was handed out earlier in the summer, except for some tweaking on the travel. The cost of the FTEs is not in IT.

Page 2.E page one of two-summary of exceptional items request-shows the bundled amounts. The numbers are slightly different, but are approximately the same.

We are approaching this as a data system separate from infectious disease control in order to help assure we get the most money.

Lisa McGiffert stated that the staffing is about more than health data analysis, otherwise we'd need fewer people. But we wanted to build in nurses to help the hospitals learn how to use the data and how to track, in order to reduce infections. Just because DSHS has put it under data collection doesn't mean we can't stress the prevention component when dealing with hospitals, etc. We need to work on a 'script' to make sure we accurately reflect what's in the budget, but that helps ensure this happens and happens well. Dr Penfield stressed that there is no restriction on content-we put it where we thought we could get the funding, but that was not meant to mean it had to just be data collection.

This is a relatively small portion of the appropriations request.

Looking for the actual description of health care associated infections- it's in 4.A "Exceptional Item Request Schedule" page 4 of 25. This is the breakout by type of funding, and there's a description on the very last line: "And operate the public health data collection and analysis for

healthcare associated infections. The back page, Page 7 of 25, the fourth or fifth line from the bottom: Senate Bill, describes the law that tells us we must do this.

The piece that is not online, but was passed out at the last meeting gives the breakdown by all the different pieces-cost to the state, whether IT or equipment, etc. That's where the .6 FTEs come from. We now have our servers outsourced, and that cost is there. Indirect cost is for overhead, and pays for pieces of the department which are not in other budgets.

Lisa McGiffert has questions on positions and salaries. Who are the program specialists, which are the majority of the positions? In the second year there are 8 of them. It is important for the workgroup to know who they are-are they nurses? They are infection control specialists, and may or may not be nurses. Using program specialists gives more flexibility than specifying nurses or epidemiologists. We're going to try to get ICPs, especially in the beginning. There's a shortage, however, so we may not be able to fill all the positions with someone certified. The admin assistants will assist the program specialists. Not all are based in Austin, only the ones who say "CO". The rest are in the region. We are going to pilot in two regions of the state, and that allows them to get a head start. In the largest areas, we'll need more coverage.

Dr Penfield stated we are going to roll it out in two regions, so we can get the bugs out and get it going. However, the workgroup decided against piloting at the last meeting, and feels strongly that it should be rolled out simultaneously across the state.

Dr Penfield: The money will not be available until September 1, 2009. We can't hire anyone or get the IT going until after the money is available. It will take nearly until the end of the year to get it going. The IT system feels it is necessary to test the system in a smaller area. If we decide to roll it out simultaneously, that may mean we have to push all the FTEs into the second year.

Lisa McGiffert stated that there are no states who have rolled it out in stages. The workgroup's ideas were taken at face value, but the DSHS was told there needs to be an alpha and beta testing. We do not have a Texas interface, which needs to be worked out.

There's nothing to stop a hospital from joining NHSN right away, and doing so would facilitate the 'liftoff' statewide. (Dr Heseltine)

Charlotte Wheeler stated she understands what Dr Penfield is saying-that everyone going on at once might not work. We will probably have to test the system in a small area first. If we prepare the area to do so, we can market it throughout the state. The ICPs throughout the state can begin getting on the system and get certified on NHSN during that testing year.

The first year goal is to get everyone signed up and using it. We'll collect the data, but not release it as hospital specific data. If we spend the year allowing people to sign up, but not requiring it, we'll have to catch up the next year (Lisa McGiffert)

Dr Penfield-Anyone can start reporting anytime.

Charlotte Wheeler- Signing on to NHSN is a big project, and ICPs just don't want to do it if it's going to be wasted effort. It's going to take some ICPs some time to get online, especially ones who aren't familiar with email, etc.

Patti Grant-need to make sure the data being reported is accurate. If we do have everyone sign on the first year with NHSN without the infrastructure in place at the DSHS and the regions, the information will be 'garbage in, garbage out'. What Texas is trying to do is a higher level of quality control. It's a balancing act. If we let everyone start out, we run the risk of bad data for that first year. We won't be able to trust the data. Having a phase in might allow better control of the data.

Charlotte Wheeler stated that we need to have one message going out, and then we can focus on one or two regions at a time, and make sure they're trained well.

Dr Heseltine stated that on a nationwide conference call on NHSN there was agreement that just getting the certificates for hospitals statewide takes a year. And that's only signed up, not necessarily trained on case definitions, etc. One question he has for CDC is if they have a contractor who will come to hospitals and do set up, so ICPs don't have the burden of setting it up. It takes a significant amount of time and energy. That would move toward process improvement.

Lisa McGiffert reiterated that this process needs to start all over the state all at once. There are hospitals with experience with NHSN, who can assist. There are 10 hospitals, including UTMB and UT Southwestern Medical Center. There are still no provisions for ASCs to sign up.

If we wait for all or nothing, we'll be paralyzed. Not everyone can be in front of the process.

There have been changes in definitions, and somehow we need to be sure people are doing everything correctly.

Dr Siegel stated that if our intent is to have all hospitals in NHSN, we need to start recruiting them from the beginning.

Dr Penfield stated that focused usage of the interface will be quicker if we start out with two regions-perhaps a rural and a 'harder one'. We can work on our testing with the hospitals who are already using NHSN.

Patti Grant had a question on implementation- at what point in time do we utilize some of our associations that we collaborate with to get the word out? Can we work with AHA or TMF to get the word out that this is coming, and what it's going to require? It would be a good idea to get the idea of resources out to the people in the hospitals who hold the purse strings, that's going to be crucial to make them aware.

Dr Penfield said that we do rules in January or February, and we could put this information in the Texas Register. Patti Grant stated that most people don't know much about the Texas Register or how to use it.

This is not supposed to take ICPs away from their day-to-day duties, and that will need to be in the rules.

It's agreed that if we do not get funded, the project will not get done. There's no way to do it without funding. States who have either not gotten funding or who lost their funding were unable to do it. All of the states who set up their own systems will end up going to NHSN, eventually.

Dr Siegel asked how many states have these systems? 24 laws in place, 7 produced reports, maybe another 5-8 in the process now. It'll be 2010 before we see their reports. California just passed a bill to use NHSN, it hasn't been signed by the governor yet, that is funding through fees.

Dr Heseltine asked if there's a middle of the road scenario? What if it's partially funded? There are other states which are not providing the entire amount of training and feedback. If we don't get full funding, we could do some data collection, but the training and feedback would suffer.

Patti Grant stated that consumers would get incomplete information, and the whole point is to get information to the consumer.

Dr Heseltine pointed out that the conversations with the legislature will make it clear that the data quality issue is crucial. Patti Grant stated that the only way to remove doubt about ICPs and data is to have a way to verify the quality.

All administrative data should be validated. Texas has a system for validation. Problems are identified. Our data ought to be better than that from a state that doesn't do validation.

There's a disjunction between administrative and clinical data, that's huge. Eventually, that should change.

It's disturbing that inaccurate data is being reported every year, year after year, and the hospitals say 'don't use it'.

If this is partially but not fully funded, some validation will be done, but it will be more of an honor system. There may be allegations of integrity issues, but it may be hard to prove.

If it's not pressing and urgent, the validation will not happen. Reality will push it away. Which is why the group needs to really press for full funding. (Patti Grant) Without that, we'll be back where we were in 2004.

Lisa stated that with limited resources, we can focus on problem data/problem hospitals. Bruce Burns stated that the submitted data will be audited or edited for correctness according to expected standardized codes and validated to that extent. This form of validation of data doesn't require the actual onsite verification by abstracting records to validate that the facility actually reported the data correctly. Validating through record abstraction is not practical and costly to the state and facilities.

Matt from TMA-you can have a bill that passes, and then have funding not pass. We need to keep on that we need funding, starting early. It also needs to be on-going, since you can get to the end of the process and lose the funding.

Lisa McGiffert pointed out that it's important for the legislative group making the decision to realize how important it is and that it has support from constituents.

Dr Siegel pointed out that the language describing why this is important needs to be more compelling. Dr Penfield stated that there are very specific limits on language and how many characters are allowed, so the compelling information needs to come in briefings, etc.

The whole LAR is dry, stated Lisa McGiffert, so we need to make sure we use compelling language.

The timeline for the approval – the session starts the second Tuesday of January. There will be briefings, etc before that. We don't know when exactly it will be decided. No one's said it's a bad idea, but it's in competition with a lot of other projects.

**Strategies for 2009 Legislative Session**

It would still be valuable to have letters from agencies and associations, to the legislature, explaining why this is so important. Perhaps a subcommittee can be formed. Should it be done before the legislative session? Or closer to the time when the decision will be made? Previously, Jan Patterson volunteered to draft a letter. Lisa McGiffert would be willing to work on the subcommittee to come up with talking points describing what the LAR does in a more compelling way, if it could be internet and phone. It's not too early to start, with a goal of having them all submitted just prior to the session. Possibly also address hospital administrators to bring the issue to their attention. This would personalize it and bring it to the front of their minds. If we don't have buy-in from the hospitals, it will be harder to implement.

Consumers in the state of Texas find this important, we've had a great deal of response. Now that we have the official LAR, we can maybe do something. THA can go back and talk about it in the weekly newsletter. They also have a lobby group that meets weekly during the session, that might be another avenue to get the message out. The message to the C Suite should be concerning how they're going to clean their own house to get compliance.

Dr Heseltine stated that we can accomplish this through force- ie 'we won't reimburse you' or by changing the culture. CEOs respond to positive competition better than negative. We can also meet with journalism and get January editorials in support. This is a 'report card', and if the hospital is the first one to get the information out, they'll see it as a marketing ploy and a way to get more patients.

What is the status of the MRSA funding? It was proposed, comments have been received, staff is writing up the final piece. At which time, the rules will become final. The bill has to do with health departments in Bexar, Potter, Brazos Counties, reporting. They have to report one month of MRSA lab results in March. It looks like because it's taken so long to get it up and running, they are only looking for a sample of data to show the legislature. Who in Amarillo is doing this? Dr Rush Pierce, at Potter/Randall County.

TMF is also starting an initiative on MRSA. They were told around a year ago that 8 facilities were reporting to NHSN. Their goal is to sign up at least 6 facilities in Texas to sign up for a workgroup with TMF to work on testing the MDRO tool on NHSN. There will be speakers and exchange of ideas to prevent the spread of MDRO, over the next three years. The module will still be available to everyone else.

Dr Siegel expressed confusion about why there's a big push to do MRSA surveillance, when other infections are more prevalent. Lisa McGiffert explained that a bill passed and did not require funding, so the project moved forward. The idea is to focus on one problem, and see what can be done to get a handle on it. It is not meant to say other organisms aren't important.

MRSA is one of the important pathogens we have in healthcare, throughout the country.

The bill was requested by a particular county, so there was particular interest in a specific place.

When the rules are finalized, this workgroup will be sent an email so they can look at them.

Question from Charlotte about NHSN-have we talked with Florida more about what has happened with their servers? They still are using the same ones, and it's still very very slow.

Lisa McGiffert will write down ideas and send them to everyone.

Patti Grant and Dr Siegel will help to come up with talking points and compelling language.

A small group of hospitals who will come out and support the initiative and who would challenge other hospitals to join will be identified.

Private insurance companies can be contacted and encouraged to get on board. They'll have visibility and be able to speak to CEOs etc, to encourage the outcome we're looking for. Individual vendor preferences cannot be part of the message, it will need to be a generic public health issue, and we'll need to convey that to the insurance companies.

C suite most interested with number of events, hospital acquired infection prevention efforts, present on admission issues.

California is charging a fee, is that something Texas can consider? A public/private partnership? Especially if we end up with the intermediate funding scenario.

Most people look at the federal government as a big entity they can't touch. But this Texas plan is more grassroots, much more personal to people of Texas. It will be much less abstract and global to the C Suite, and they'll see that it affects their bottom line. It's bare roots marketing and more user friendly to the consumer rather than going to the federal government's website and trying to wade through it.

Is there some way to grab the leaders of the institutions and show them that this will reduce their infections, and reduce their costs?

There is a lot of energy going to the frontlines about reducing other problems, and it's going to be difficult to get them to add more energy to think about HAIs.

We need to focus on how to present this as more than bean-counting.

Budget deficit act passed and that led to the tracking of 'present on admission'. Texas didn't pass this law to affect a budget deficit-it's a patient safety issue. But one of the reasons it passed was the potential for saving money. It's the difference between "We're saving money, and also reducing infections!" and "We're reducing infections, and also saving money!"

Implementing a system to prevent UTIs , that wasn't there before, is going to save money, but it's hard to determine just how much.

When we looked at the New York program, it was the best case scenario, that including state employees to assist. That's what we need to market-help us get this funding, and the state will be able to provide assistance to you. If there's no funding, you'll still need to report, but you won't get help.

If we could get someone to place an ad in the paper during the session, that could help. Where does the private insurance industry stand on this? They pass the cost on to consumers, so it doesn't hurt their profits. The subgroup will talk to them.

There is active lobbying talking about denied access to care, and we now have two legislators who were personally affected by HAIs, and they're going to testify in committee on the TDI Sunset, on Sept 19.

How do we compete with what's going on with CMS? Facilities are having to focus on Core Measurements and that's taking away funding from this. That's going to cause a problem with implementation at the bedside level.

Rebecca Herron with Government Relations arrived to answer questions. She stated that activity with the legislature has heated up more quickly than normal for this time of year, plus we're dealing with hurricanes. Senator Nelson has requested as legislation as possible, as she's in a competition with Senator Zaffarini to file as many bills as possible. Senator Nelson will most likely still be the chair, but Rep. Delisi will not, so there will be someone new as chair of the house committee on Public Health. The Senate committee will not change, but the house committee will. The staff may change for all legislators, probably.

Pre-filing starts November 10, the session starts January 13. Currently sworn in legislators can file bills before the session starts, and they do that for various reasons including trying to get a certain number or to keep their bills in consecutive order, etc. Sen Nelson wants to file the most bills on Nov 10, more than any other senator. Sometimes the pre-filed bills are 'shell bills' which means they change dramatically before the committee meets.
What is the schedule for the budget? Is there a way to find it? Rebecca stated that her understanding is that first cut will be in October of this year (the LBB). She does not deal specifically with the budget, but it can be found online. She suggests that this group strategize quickly.

The budget process is very long and tedious. You have to continually keep contacts and issues going, to keep them on the front burner with the committees and subcommittees which deal with DSHS issues. The committees haven't been announced yet.

The budget is not finally decided until the end of session, it always goes to conference committee, and it's pretty much the last thing done. It's important to find a 'friend' who will help to keep this issue to the forefront. And this is not the only issue they are concerned with . Develop a relationship with a staffer who works with a legislature who is on the committee, and do it as soon as possible-before the session if possible.

What we're focusing on now is not a stand-alone bill-it's in appropriations now. The job now is to shepherd the issue through the various committees, and make sure it stays in the front of their minds.

Neither the Advisory Panel nor DSHS can lobby. This funding isn't at the bottom of the list, but it's also not at the top of the list. It's at least above the middle. There's only so much pie to go around. Individuals on the Advisory Panel can act as individuals to talk to staffers, etc.

There is specificity within the budget request, very strategy specific. It is up to the department to decide exactly how it's divided up, if we don't get everything we ask for.

What if there's another public health related bill? Would it be possible to attach the HAI funding to that bill? No, not really. The budget is a bill itself.

Legislators can't get their bills set in committee or moved out of committee with any kind of speed, if it has a cost associated with it. Which is why many bills are submitted without cost attached, even if DHS has told them it will cost. Then we have to put it on an exceptional item, etc. That's how HAI got passed.

How can we get this funding a higher priority within the department? The head of the departments, etc can bring it up every time they speak. Does it carry weight with the legislature if DSHS thinks it's a high priority? Somewhat, yes. DSHS is asking for many more FTEs, in facility licensing, due to the reorg. How does that fit with this program? We don't know.

Dr Lakey finds this to be very important. But you have to put it in perspective with the other exceptional items. They're very important too, and they have to be balanced.

All of the associations have someone at the budget table-government relations. This panel needs to let the associations know, and let them shepherd it through. They have the contacts.

It needs to be communicated in as simple a way as possible, tell a story, 30-60 seconds. Legislators and their staff come from all walks of life, and some understand better than others. They understand hospital associated infections are terrible, but what needs to be conveyed is how this will help.

Lynda Watkins- at the last session, Dr Lakey talked about getting some kind of vision in writing (how to best implement the Panel's vision) from the Panel, and it hasn't been written. Dr Lakey still would like one, he brought it up recently to Senator Nelson's Senate Finance committee. Dr Siegel volunteered to try to draft some talking points, but they have not been written. She will do it as soon as possible, as it's critical. The same document can be used for the rest of the legislature-one page, with bullets.

Bruce Burns has the dates for the budget hearings: LBB meets on September 19 at 9:30, Reagan Bldg Room 140. These meetings run very long, and there will be many people testifying. They will probably be doing the first cut in October. Gail Van Zyl will let her government affairs people know. If anyone else can go and talk about it, that would be best. Short of someone going, letters could be sent or the staff could be contacted between now and then. Lynda might be able to go, but she can't commit right this moment as she doesn't have her schedule. There will be subsequent meetings, but they will only be about items that are accepted at this meeting.

Since it's a public hearing, they have to post an agenda. However, the agenda doesn't have to have specific times. If we have talking points written, they should be given to whoever is going to speak.

**Next meeting**
Ideas:
See how things are in early November, and meet then, possibly with call-in people.

We need to at least have a report from the committees, but that could be via email. The panel needs to know if there is money before any specifics are decided.

The strategy plan subcommittee can meet via email.

Schedule next meeting, with conferencing, for January, unless something comes up.

The committees won't announce members and chairs until January or February. Maybe wait until then to meet, and have a half day meeting as a Panel and then go as individuals to meet with legislators.

Have a conference call meeting between now and the beginning of the session, just for updates. Otherwise, it seems like a long time until another meeting. This could be the first or second week of November.

It's beneficial to talk to legislators in the interim between sessions. If you only talk to them during the session, then they know you want something. It would be beneficial to talk to Senator Nelson before the session so she knows it's important.

The group agreed on a conference call in early November, no face-to-face meeting, to touch base. Wednesday, November 12, in the afternoon was chosen. Those who can come in person can, and members can call in. Dr Heseltine will arrange the space and time and notify the group. The next meeting, possibly in January, will be scheduled then.

Meeting adjourned at 1:15pm.