Health Care Associated Infections Advisory Panel Meeting
November 11, 2008

Attendees: Wes Hodgson, Gary Heseltine, Cathy Gleasman (scribe), Patti Bull, Linda Stephens, Patti Grant, Naeanna Ezekoye Alyson Hight, Neil Pascoe, Minnie Monroe, Starr West, Bruce Burns, Sky Newsome, Linda Porter, Margaret Mendez, Honey Covin, Margaret Orman, Susan Penfield, Gail Van Zyl, Glen Mayhall, Matt Wall, Charlotte Wheeler, Marilyn Christian, Debra Slapak

Agenda:

I. Welcome and introductions
II. Review of minutes from Sept 2008 meeting
III. Legislative talking points and strategy update
IV. Data validation options
V. National Patient Safety Goal 7
VI. Unified approach to quality and patient safety
VII. Adjournment

I. Welcome and introductions
II. Review of minutes from Sept 2008 meeting

Comments received-pg 4, 4th paragraph down-for the sake of clarity, getting certificate for hospitals statewide takes a year (not individual hospital)

Pg 5, 4th paragraph down-third sentence-"other states not providing entire amount of training and feedback that would be ideal". Take out 'that would be ideal'.

Page 7, 4th paragraph- rephrase "MRSA is most important outbreak' to "one of most important pathogens in the community"

Page 5, bottom-related to Bruce Burns' statement, concerning valid records. Recommended changes-should state that submitted data will be audited or edited. (Will send actual phrases to be changed)

Gary will send out revised minutes and request approval.

No other changes requested.

III. Legislative talking points and strategy update

Patti Grant speaking for Dr Siegel. After last meeting there was a meeting with Lisa McGiffert, Charlotte Wheeler, Patti Grant and Dr Siegel discussing talking points to use with legislators. There is a handout.

Last bullet, page 2-talking about Hep A and vaccines in general in Texas- the point is that back in 2007 we were 22nd in the country, and in 2004 we were 47th. We jumped that high in 3 short years, and would like to use that example of how important funding is.

Page 4- Should establish HAI definition.

This document is to be used by any HAI panel members to discuss the HAI initiative with legislators and their staff.

Dr Mayhall asked why the legislators voted on this if they needed definitions. It was pointed out that there are new legislators.

Matt suggested adding "due to lack of (bill) funding" after "now we are stuck" on the 3rd bullet from the bottom on page 2.

Bruce brought up the 2nd bullet on page 2- and asked for clarification on 'can only expect what you expect'. Answer, unless there's a public reporting system for HAI, we don't know what to expect, there's no baseline. Patti suggests striking the comment, rather than trying to explain it. Could put in parenthesis "Data validation process".

Next to last bullet on page 2- 'Who supports' list should be spelled out rather than using acronyms.

Neil suggested that we should also spell out Hepatitis A and Hepatitis B.

Background point bullet-should also spell out acronyms (6th from the bottom, 2nd page)

Matt says thanks to the group for the hard work, and has a question on 7th bullet on page 2. Need to cross out "same standard of care" and replace it with "report same definition of health care associated infections".

Last bullet on 2nd page-what does NIS stand for? Probably "National Immunization Surveillance".

Patti will make suggested changes and get list back out to the group by tomorrow.

IV. Data validation options

Discussion of background items. Does it make sense to look at contracting for data validation component? If you divide reporting process, one of the key components is 'how good is the data?' We have a good handle on definitions. The current model requires hiring several people. Would it be a viable option to hire contractors instead?

If DSHS were to be involved with data validation, is it possible to hire a contractor to do some of the audits?

There are 9 centers in NHSN, and no one has validated them except the CDC. Are we going to say that those who join afterwards are going to have to be validated? Gary says that's not the issue he's trying to get at.

Starr brought up that it's not so much if the data is being accurately reported to NHSN; it's that some hospitals are doing a much better job of surveillance and will therefore be putting in more infections. This will make the hospitals doing better surveillance look worse than the hospitals that do surveillance less well.
It will be difficult to discern between low rates and poor reporting. We don't have enough people to go out and check on everyone. This is Gary's point.

In New York, they use NHSN and there is case control and case review to ensure that things are done accurately and correctly.

Dr Mayhall would like to see the background on that, since it's hard to do a case control if you do not have accurate data from the facilities. Virginia has a team that checks charts and pulls data and was able to verify that training was taking place.

Patti stated that as long as the company that we're using is trained in what it is we do (hospital epidemiologists or Infection control practitioners); we don't need to train anyone in the health department.

To really validate the system, teams will have to visit each hospital, which will be very expensive.

Throughout any program, it may be possible to game the system and it will be difficult to tell who is.

There are contractors who do chart review and who look at reliability and consistency. Too many things vary between sites for them to be compared to each other.

Could it be done in hospitals across a system, if the policies and procedures are the same? Possibly.

Are their triggers that could set off doing a validation, rather than trying to validate the data for 500+ hospitals? We could establish trigger-points in advance and that might work better than trying to validate all hospitals.

Could be done as a survey or spot inspection, where regulatory or epidemiologist did it. Could be done on a sample, rather than all the hospitals. Could also be complaint driven as well as spot checking.

How will we estimate for the legislature how much money is needed to hire contractors? Dr Mayhall thinks it's a viable concept, if we have enough money.

Originally were planning to have DSHS employees do the data validation, should at least discuss using contractors. The cost has not yet been explored, were only trying to open the door to the discussion.

We will always need a watchdog to make sure no one is gaming the system; it's not something we can do once and be done.

Pennsylvania and/or Florida-how are they addressing the issue of data validation? Dr Mayhall said he didn't think they were validating much of anything. There is no quality

control in effect. New York is a better example; they are using internal staff at the health department. But Texas is bigger geographically and has more hospitals.

There are 22 FTEs in the plan as written; the question is whether or not contractors would offset the cost of the FTEs.
The advisory panel thinks that the key is to have trained individuals, rather than it mattering whether they are DSHS employees or contractors. In today's economic climate, we may not be able to get full funding, so we should look at ways to minimize the cost. Dr Mayhall feels that there are more resources than we think, and it may not be an issue.

Gary stated that integration is an issue. If there are contractors doing data validation for HAIs, they might be able to do data validation for other regulatory issues. This could make it more cost effective, as well.

Matt asked if we were suggesting audits that might give the hospitals pause. We've only looked at cost effectiveness at this point.

This law specifically falls under infectious diseases and not under regulatory.

Expecting auditors to audit for other issues may mean they have a higher skill set and therefore command a higher reimbursement rate.

Validating is going to go on indefinitely-it must be on-going and recurrent if everyone is going to have to live up to the same standards.

The ultimate source of data is likely to be chart review. We would most likely start with what New York is doing and then go from there. The panel would decide what issues to look for, etc and how much was feasible.

The actual law does require validation (SB 288)-initial and on-going. The question is not whether or not we'll validate-it's to what extent and who will perform the actual tasks.

We are not finalized on this issue; there will be on-going dialog.

V. National Patient Safety Goal 7

There have been many changes through the Joint Commission. There is a handout, which was emailed to those who called in.

Particularly for Central line bloodstream infections, rates, compliance with best practices, etc-and making information available to key stakeholders, which could include the state health department. Gary feels there is overlap between these standards and what we want to accomplish with SB 288.

It's important to reduce the burden on health care facilities who are trying to compile with a variety of requirements.

Patti-the Joint Commission standards are 'voluntary', although the Joint Commission can shut you down; and SB 288 is mandatory, but they are complementary to each other. These standards would be a natural progression to help reduce rates of infections.

Charlotte stated it's challenging just to meet the Joint Commission safety goals, including central line infections. These standards might help meet the SB 288 regulations.

Parts of the rule may lend themselves to validating the information.
The major overlap has to do with outcome surveillance. SB 288 is more about outcome data, whereas the Joint Commission looks at process, which is not part of SB 288 right now.

Not all hospitals are included in the SB 288 legislation. Psych hospitals and hospitals that only do rehab are excluded. Comprehensive medical, some special hospitals, and LTACs are included.

The goals of the Joint Commission listed here are not dissimilar to the goals of SB 288.

Patti Bull-Until we have our plan in place, we are only hoping we are giving the Joint Commission the information they need.

Joint Commission issues RFI's, specific things they find that a facility isn't doing. Much more likely to compare themselves to NHSN at the CDC for a benchmark, rather than to Texas alone, at least until Texas is reporting as a whole.

A lot of hospitals choose their own definitions at this time, but once our plan is in place, it will have to be more standardized.

National Patient Safety Goals look more at process than rates. The rates aren't as important.

NHSN on Central Line has a place to look at what percentage is using correct process. As a member of NHSN, there's a program to enroll in for mainline nosocomial infections. This allows you to be in a database of hospitals that choose to enroll (stated by Dr Mayhall)

Gary is looking at the item (9) that discusses reporting results to stakeholders.

Neil reads 'key stakeholders' as internal rather than external. Gary feels that the state could define itself as a key stakeholder, by rule.

Dr Penfield said that if they're gathering the data, then we could collect it in the same format, if it's standardized for Joint Commission. Others stated that it is not standardized.

Gary was hoping to discuss how the two standards could be made congruent.

Because so much of the Joint Commission is about the process, when hospitals are all reporting to NHSN, they will be able to talk about definable outcomes, using the same language.

Charlotte felt it was good that we're starting with central line, as it's a 'never event'. That makes it a good place to start.

If CDC and Joint Commission sit together and come up with standardized rules, it would help with these efforts. Starr stated that this does not happen.

The GAO report found that at the federal level, there is not much integration of agencies looking at infections. The CDC is very slow to change.

Linda Porter has a worry about Joint Commission rules-she wanted to make sure we wouldn't limit our collection to sentinel events. We are not planning to.

Patti Grant- Sees the National Patient Safety Goal as a totally separate issue, even though there is overlap. She does not think we need to worry about it one way or another. Gary stated no one was meant to worry, he just wanted to discuss if we could integrate and unify the expectations of the hospitals.

VI. Unified approach to quality and patient safety

Looking to simplify things as much as possible. Starr will speak on it. A diagram was sent out to everyone. From a THA perspective, they are using this mental image for many things, including infection reporting.

Upper left hand corner, red circle- Accurate data drives the rest of the bubbles on this page. Want to make sure it's integrated. Encourage conversations about where data can come from, in a way that makes sure that there's not duplication of effort.

There are simplified guidelines being created, looking at SHEA and CDC and Joint Commission, to make it less difficult for hospitals to comply.

Need unified regulations. Facilities think that once they pass Joint Commission, they cannot fail state audits, and this is not true. It's a shock when a facility that passes Joint Commission is told they did not pass a state audit.

There will be three categories- 1st standards that have direct effect on patient safety, 2nd is indirect effect on patient safety, 3rd would be standards that are condition of participation.

In the long run, will make everyone's life simpler and will lead to improved provider improvement. Pay for performance is being used by many entities. The standards need to be simplified and standardized, or it's going to be a nightmare and will add more cost to the system instead of rewarding good performance.

Matt stated that we haven't discussed enforcement- even if the rules are similar, enforcement may not be. Will that be discussed? There may need to be communication and cross-training to avoid that issue. We need inter-auditor reliability.

Training comes in here-making sure that all training on data validation is the same. Has not been decided how it'll take place, but there needs to be certification. Interpretation needs to be very tight.

Is hospital licensing concerned about these issues? The hospital license rules were recently changed. This should not cause problems for regulatory-having state and CMS rules being similar is helpful. States will decide which issues are their biggest and state rules may be more stringent than federal rules. But the closer you can get it, the better.

Sometimes, the rules are totally different, not that one is more stringent than another. This is a bigger problem.

Hospitals would love to see CMS and Joint Commission and the state have the same criteria, per Charlotte. But consistent application of different rules would also be good.

Next Steps:

January 13 is the start of the Legislative session. The group is currently waiting to see if funding is approved, which may not be known until May or June. There will be hearings during the session; the group may need to meet to discuss them.

There is DSHS staff monitoring hearings, they could let Wes and Gary know and they could let the group know when they take place.

A reminder: You must represent yourself and not the Advisory group in any legislative hearings.

Another reminder: need seven working day lead time to set a meeting, as it has to be published in the Texas Register.

Educational efforts with regard to the Legislature may be the only upcoming tasks of the group.

Information about hearings and bills of interest will be distributed to the group.

Can a query email be sent out the second week of January to see if there's a reason for the group to meet? Charlotte, as acting chair, agrees that this should be done. Everyone needs to respond with any information they think the group should meet about. No meeting will be set at this time.