# Healthcare Acquired Infections Advisory Panel Meeting
March 18, 2008

Attendees: Cathy Gleasman (scribe); Patti Bull, Bruce Burns, Marilyn Christian, Patricia Grant, Gary Heseltine, Alyson Hight, Glen Mayhall, Lisa McGiffert, Jan Patterson, Jane Siegel, Nance Stearman, Linda Stephens, Charlotte Wheeler, Gail Van Zyl,
Guests: Jeff Taylor, Thomas DeChant, Thanh Dao, Judy Holmes, Kay Tjin, Lisa Eltzroth, Emily McCallum, Starr West, Monty Waters, R. Schirmer, Debra Slapak, Neil Pascoe, Minnie Malone, Kevin Warren, Sky Newsome, Lynda Watkins, Trish Bode, Letha Mosely

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**Agenda:**
Welcome and Introductions- Jan Patterson
Personal Story
Review of Minutes from Feb 19, 2008 meeting- Jan Patterson
Review of potential data sets for reporting from Center of Health Statistics system- Bruce Burns
ICP Training and certification for standardized surveillance-Charlotte Wheeler
Consideration of NHSN

a. CDC teleconference- T. Horan (or designate)
b. ICP Perspective- Glen Mayhall and Galveston ICP

TMF infection related activities- Kevin Warren
Clarification of legal and compliance issues- Monty Waters
MDRO Module Overview-Dr Gary Heseltine

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**Personal story of Thomas Cullin DeChant (from son, Thomas)**

May 06, in hospital –got Legionnaire's and developed MRSA plus other infections. Died 42 days later. Family does not expect loved one to die of something totally different from what they were admitted for. Distressing things were done-no one gowned up or wore gloves, few masks, even though infection was known. Family did not use personal protection either, since the healthcare workers weren't, they didn't think it was necessary. The Respiratory Tech flushed his medication with tap water. Very shocking to family, who didn't know if that was standard or dangerous. Mr. DeChant recommends that all of us be on the same page, understand what needs to be done. As a citizen of the state, we're appreciated. Most Americans don't know anything about HAI's. There is a Senate resolution in memory of his father- SR 1076 (handout provided). This is a Senior citizen issue-most seniors have immune system issues. Without consideration for this, people are going to die. The family knows that it's a struggle to get this far, and appreciates the work the advisory committee is doing.

**Review of Minutes:**
Additions or corrections? No. Stand as written.

**Clarification of legal and compliance issues-Monty Waters**

Issues: The law was passed in the last Legislative session, 2007. The most important thing that struck him-how much work was required to implement the law, and no money to do it. There is a rider in the state appropriations act, which says that no state agency is required to reallocate funds if there is not specific money appropriated. This means that if the legislature doesn't appropriate money, the agency is not required to do the work. We've done a lot already. There are a lot of 'shalls' in the act, which make it look as if we actually do have to do the work. This is being clarified.

The first thing the law does is establish this panel. The normal law on advisory panels does not apply to this group. We do not need rules to conduct meetings. This exemption saved us time and trouble. The panel was established with specific slots for membership, voting and non-voting, department and not. This is the same as for most panels. The specific thing we have to do to implement the chapter, and establish a Texas healthcare reporting system within the epidemiology branch. The law is very descriptive, very detailed-there are specific infections, and different rules for different facilities. The charge is unusually detailed. In the communicable disease world, the rule was that diseases needed to be reported, but it was up to the department to decide which diseases, and how to report them. This is different, it's very specific. We're required to make the rules consistent with federal guidelines and rules for reporting these diseases. Monty doesn't know of any rules, asks if anyone knows of any. The point is to make sure we're not contradicting them, but if there aren't rules we can't contradict them. Based on recommendation of advisory panel, modifications can be made, based on CDC recommendations. Panel can modify list in the state law, but it must stay consistent with federal rules, guidelines, and law.

CDC maintains a strong interest in communicable diseases, but all information collecting is done on the state level and then reported to the federal level, who compiles the data. Another function of the advisory panel is to give guidance to the department in publishing the findings. The panel establishes frequency of reporting. Facilities cannot be required to report more frequently than quarterly. What about a pilot program? Due to lack of resources and funding, a pilot program should be allowed. Full implementation isn't possible without funding. There should be no legal problem with setting up a pilot program.

Question/Comment: A pilot program is a violation of purpose and intent of the law- if it's only selected hospitals, you are not giving full information to the public.
Answer: We don't have to have just selected facilities. It could be community based approach, and be limited to a region or area instead of only certain facilities. If the goal is zero infections, wherever we start is a step in the right direction.

Voluntary programs result in skewed data, but this could be a stage of implementation.

Comments: In the Senate Bill- page 5, lines 10-12-the Executive commissioner cannot make recommendations that conflict with federal guidelines. That was put in place so that if the federal government ever puts in place guidelines, Texas facilities won't need to double report. There is legislation in process to create this. (In reference to potential future law) Section 103D Page 7, lines 10-13, Healthcare Associated Infections-this is protection against using strictly administrative data. Hospitals will use the CDC's protocols and definitions to identify HAIs , regardless of how reporting will take place.

Question: In terms of the proposal for state appropriations - what is timing of that? Is the HAI program included in the amount of funding requested?
Answer: The process of budgeting is already well underway. This Legislative Appropriations Request (LAR) would be for next session (2009). The committee is expected to make recommendations regarding funding to the DSHS, not directly to the Legislature.

Question: Can Monty provide committee with the request made for the HAI program (In LAR)?
Answer: It is unknown if this committee is directly part of LAR. The Infectious Disease Control Unit is putting it forward to Dr Lakey, who will decide which requests go to Commissioner Hawkins, who decides which requests go to Legislature. There are hundreds of requests.

Comment: The committee could help to bring this to the attention of the commissioner, so we will need to know what is included in LAR, when are meetings during which the committee members could weigh in, etc? Dr Heseltine will get the information.

Recommendations can be made to the legislature *by individuals* who are on the committee, but it must be clear that the role is of individuals.

Comment: The earliest the money would be available, if there were any money, is September 2009.

Any other questions to Monty Waters should be submitted through Dr. Heseltine.

Comment: If the choice is 'Pilot or nothing', we should choose Pilot. If the choice is 'Pilot or everything', we should choose everything. This isn't going to start happening right way, the numbers won't start coming in until some time in 2009. The advantage of a Pilot is to work it out in a small category instead of all at once, so we can see how it works on all spectrums. Problems are more easily tweaked. If we're using NHSN, it shouldn't cost that much to implement.

**Review of potential HAI data sets for reporting through the Center for Health Statistics: Bruce Burns**

The handout of the Excel document contains a list of factors that could be added. We could include those data elements. We had to change how we looked at the issue because there are only two NTE fields, and the ASCs need more than that. Looked at different segments into which data could be put. May need to go to newer versions. K3 segment requires ANSI approval to be used.

There would be codes for different kinds of infections, and types of procedures could be added. On the right side, right hand column, it says 'new', which would be new datasets to be added. From state data tapes. Senate Bill 1731 included funding to include outpatient data from hospitals and ASCs. All data elements need to be included, need to make sure funding available. Once identified, would need to allow for NCA Professional to be included, which changed focus of data elements. We could still collect hospital infection data under the same file structure. There are different forms which allow for different data elements. There is a pilot at the Mayo Clinic, Bruce trying to get in contact to find out what data they are collecting. They use a different format, goes into XML file structure, through which the hospitals and ASCs will need to learn how to submit data, which will be an issue, especially for the smaller ASCs.

No current cost estimate for adding HAI reporting in this new format, because system hasn't been built and there's no federal requirement as to how to do this; we'd be on leading edge. If we could adapt and use the Mayo Clinic's system, that would help. Standards are being developed as we speak, and may be released in the near future.

Gary and Bruce went through MHIRS system, took data elements, and added RSV and MRSA infections, so that they could be captured. Also added decubitis ulcers. Bruce can provide more detail as needed, but the system would be expandable as far as he knows, under this file format structure. It's narrative and clinical notes now, but as it becomes more standardized with formatting and structure, specific terminology and structure will have to be used.

Question: This is data for each individual patient?
Answer: Yes, and that is needed for this file structure.
Question: Would this information be given directly by the facility?
Answer: Yes. Facilities would provide the patient level information.

Question: The ICPs would be giving information at the hospital level, which would be submitted to the department? Would the ICPs be sending information directly? Would the actual data elements be inputted into the HAI system?
Answer: The facilities will be entering patient level information, which will be documented by the ICP.

Comment: Information on central line days could possibly be provided in a different way. We need to collect central line days to calculate the hospital infection rate. Same with surgical site infections; we do over 1000 a month. Having information for the denominator would be great. If there's an infection, the information about that person could be put in.

Need enough information to do risk-adjustment using patient specific data. A user supplied denominator, with patient level data for each infection, would be the best scenario. The way it's being suggested seems very involved and difficult to provide.

Some information may be available by ICD or CPT codes, but not central line days. You would want to enter that the person had a central line, but including the insertion and removal dates would be too much data entry. At the patient level, someone would have to code that the patient had a central line. There's a code for central line, but it's very broad, and depends on the hospital. It's not as standardized as it should be, in implementation.

Some of the ICPs should get together with the data people at the hospital and discuss how to resolve this. There may be things that are being put automatically on the discharge forms and this would not increase labor. Discussing it would reduce the anxiety about it.

This information is post-discharge, which makes it even more difficult. Using administrative data isn't very accurate, may be better with electronic records, but difficult to know.

Comment: The entire CHS system is based on administrative data, and is put on public website. The Center envisions a totally separate track on infections, with information provided by ICP by some mechanism. Includes patient level data for actual infections, and denominator provided 'in bulk'. The patient identifier for administrative data and infection data could be matched up in database.

The information is downloaded into a statistical package, which figures the rates, etc. You can look at many different variables connected with the patients.

Patient level data for events is a must. Specific pathogen tracking is a must. Could susceptibility be tracked as well? Is there capacity? Yes. More data elements can be added. The clinical data architecture hasn't been established yet. The Mayo Clinic has been using the system since September of 2007. We only learned of it a couple of months ago.

If there was a simple way to get the denominator, that would really help. It is do-able but we would need a place to put it. The ICP could send in the number of patients within a specified time frame.

The information going out to the public will be old- the database is a year old before there's a full year. The rates won't match up with current information. Is there a way to fix this? The question will be asked. If it's a year's worth of data, it will be difficult to provide the denominators.

Question: The patient has to be discharged before any information is added about them to the database? Answer: Under the current system, we do not generate an encounter record until they're

discharged. But we could change that. Comment: If we don't need to wait until the patient is discharged, we'd have a more accurate denominator.

Question: Neonatal ICU data- collection of data by birth weight? How will that be included? Central line vs. umbilical.
Answer: Could still give the denominators by birth weight, but definitely would be more complicated.

Training will be required no matter which system we choose.

**ICP Training and Certification for standardized surveillance- Charlotte Wheeler**

A phone conference with Texas Society for Infection Control and Prevention (TSICP) -10 people, including Neil Pascoe. Discussed possibility of TSICP providing training. If talking about Bruce's system, not NHSN, could have web conference or hands-on training on computers. TSICP has provided education across the state, twice, bioterrorism and PanFlu, very successfully. Not an APIC entity, a Texas entity. They have a focus on rural areas. Have training for beginners on up, and have national conference (coming up next week). Go to 8-10 locations in state, to do training. ICP in Panhandle Infection Control (PANIC) said 'why can't we do something where we don't leave the office?' So they are investigating web conferences. Already have class on standardization of guidelines for surveillance. Have a training with scenarios and discussion. TSICP would need funding to provide the training. Depending on which program we choose, DSHS may be able to help as they help with bioterrorism and PanFlu training. For next meeting, Charlotte will provide estimates for cost of training.

Question: Can there be collaboration on training? Local APIC chapters? Could have webinar during monthly meetings. Person teaching from APIC chapter should go to standardization training, so that everyone gets the same training, everyone on same page. Certification for training would be helpful. Going through Chapters works for metro areas, but rural areas would need to use computer training, probably. Do not have resources to send people to every location, even if it were mandatory.

**Texas Medical Foundation, Health Quality Institute, infection related activities-Kevin Warren**

Tasked with working with hospitals currently submitting data to NHSN, on how to submit data on MRSA model. Based on data from CMS, 8 Texas facilities are submitting but TMF doesn't know which ones.. CMS contract is to focus on two areas: working with NHSN hospitals to increase submission of data and encourage more hospitals to report to NHSN. In Texas, we want to avoid duplication of effort. Important to TMF to hear ultimate outcome. In August will begin training to hospitals through workshops. Trying to understand best practices and what's going on. How are the rates? If they are good, what are they doing? Since CMS has not released which eight hospitals are reporting, TMF would like them to contact us, so that they could be approached. There's a federal law preventing the CDC from disclosing which hospitals are submitting data. Individual hospitals can disclose their own information.

Want to work with reporting hospitals to find out if they're reporting on all of the modules, our directive is to get at least 30% to report on MRSA/MDRO model, work with hospitals to improve their performance with reporting the data. Since TMF does not know which hospitals they are, they do not know where room for improvement exists. Is there a range within those eight? TMF would like hospitals that are doing the best to work with hospitals that are not reporting. Mainly interested in MDRO/MRSA module, only one defined in the RFP. Challenge- there are a lot of unanswered questions from CMS. Too much ambiguity.  The primary goal is to work with hospitals currently

reporting to NHSN to report the MDRO module, secondary goal is to increase the number of TX hospitals reporting to NHSN.

How many hospitals nationwide are using MDRO module? It's just being rolled out, so not many yet. Existing modules are being adapted. In the process of testing. As the module comes out, TMF trying to assist people in using the MDRO module. The module has several components-CDAD, MRSA, all patient safety focused. Not posted yet on NHSN, can't be seen yet. Discussed on call earlier this month. Can be discussed on call with CDC.

Does not have much to do with central line.

Question: What is training through collaboratives?
Answer: Strategy being used is to pull providers together and share learning in a collaborative format. Not having hospital learn on its own. Look at lessons learned together. Avoid spending time 'recreating the wheel'. Get hospitals to work together instead of TMF or others providing onsite assistance, which will take place, but will not be main method. In collaborative training, there could be training on more modules than just MDRO.

Question: How much training are you prepared to do?
Answer: Doesn't begin until August, when recruitment starts. The actual training should be sometime in the fall, will be working on it for three years. Will work with ICPs, and others who actually work with the NHSN system.

Question: What are the benefits ? What do hospitals get from being trained?
Answer: Networking with other hospitals, learning how to improve . Will learn how to identify infections better, which will help to reduce them.

Another component is a separate training program: working with hospitals and physicians, nursing homes, home health agencies, and continuing the surgical site infection training. Working with providers to get specific issues supported, as they relate to the particular environment.

- re what does the MDRO module do? We already report the pathogen to NHSN when reporting the infection; is it "whole house" component?

Question: Is this a total house surveillance component? Answer: Allows selection. Choose what to report on, commit to particulars and timeframes.

Once we know exactly what the module looks like, it'll be easier to see the benefits.

No specific goal as to how many hospitals we will be trying to get to report. Just looking to improve the number reporting, and to improve the reporting itself.

Comment: Getting this committee to choose NHSN for the mandatory reporting will increase the number of hospitals participating in NHSN.

Standardized software for hospitals would help make NHSN easier to use. CDC NHSN is available to vendors who choose to participate with certain specifications. Currently NHSN is accepting demographic data from hospitals as a download. The best possible scenario for ICPs would be to have data transfer capability using their current infection control software, then they can download the surgical denominator data. If the system creates an export report, then the user would be able to log into NHSN and use a browse button to locate the file and bring it in as an import file. It will prevent ICPs from having to enter individual patient data for each infection site that they are tracking. Allowing

the existing hospital infection control system to download into NHSN avoids having to sit and type in all the information. Surgical denominator data is currently accepted by NHSN, a recent pilot was done to accept central line data. Planning to make it possible to import both BSI data and surgical site infection data.

Question: If a hospital is transitioning to EPIC for electronic data, will it need another program to transfer the data to NHSN?
Answer: No, you just need to create a report in an Excel report in an exportable format. That can be imported into NHSN.

A member commented hearing that at some point, the CDC may stop accepting downloaded Excel reports. This issue was addressed on the CDC call.

Comments on data validation: Data validation will have to be trusted at ICP level; the hospital would have to purchase any download packet. All vendors do not use the same definitions, etc. It will be up the hospital or healthcare facility to make sure it's validated.

All modules need to be validated and audited, so there's consensus in data collection.

There has been some trouble with validation - overall on some infections. The ICP must look over the data. For example, NSQIP data cannot be compared directly with NHSN data.

Follow up phone calls to patients required.

**Consideration of NHSN**
**ICP Perspective-Glen Mayhall, UTMB/Galveston**
**Ellen Sanderson, UTMB ICP-presentation- What is NHSN, How is it used**

Handouts not provided, but will be sent out with the minutes.

UTMB collects data on all infections that occur in the ICU, at every site for each patient. We send this data into NHSN; NHSN does not send the data back – but we have the information. Our submissions are done for our own benefit.

NHSN does have the option of putting in large denominator. Can submit the totals at the end of the month.

NHSN is bringing out a demo to allow facilities to use the application for a day; add everything you would need to see if it works for your facility. All data is deleted at midnight of that day.

There are online courses-20 to 30 courses available, each lasts about a half an hour.

There is also an online toolkit available: www.cdc.gov/ncidod/dhqp/index.html

Support on using NHSN at the state leve:
CSTE, SHEA, APIC, IDSA (professional organizations)
NHSN State Users Group
Training and webinars

System is somewhat slow-takes 3-5 minutes to add each patient's data. This is a capacity issue for NHSN, which must increase its capacity to handle the number of hospitals coming into the system. A

400 bed hospital, would require 1-3 FTEs to do two modules plus surveillance, data entry and associated activities. UTMB/Galveston is 900 beds, and they have six FTE ICPs and an administrative assistant who inputs our data.

Question: Can you use NHSN as the sole log of infections? Or do you need your own Excel spreadsheet as well?
Answer: You do not need a separate database. Reports and graphs can be generated from NHSN. You can also overlay your facility over national data and do comparisons. Facility can do all of its own analyses. However, UTMB/Galveston uses NHSN as sole database.

Question: For data analysis, do you have to complete full sign on process every time you want to access NHSN?
Answer: Yes. But it doesn't take that long.

Question about post-discharge surveillance: UTMB only collects readmissions because so many of their patients come from out of town.

NHSN uses a basic risk index for SSI: operation duration, wound class I-III, ASA score greater than 3.

Web-based system is user-friendly, and will be getting better as time goes on. More classes are being added.

For microbial resistance modules, you may need to work with your micro lab to get set up.

**CDC Teleconference Call-Theresa Horan**

**Questions previously provided to the CDC NHSN Team:**

1. Does NHSN provide the download software so healthcare facilities don't have to double-enter everything? OR do they have to purchase from the vendor of their software?
2. Is NHSN download compatible with all vendors' IC software?

   Answer: CDC has been working for last couple of years with the vendors to develop a way that users of their software can also be members of NHSN and provide data that was already captured and move it over to NHSN. The idea is that the facility would join NHSN, and then use their vendor product to enter and analyze data. Have adopted standard space approach for that work. Clinical document architecture. Vendors have done pilot test with created clinical documents (CDA files for CLBSI), and have transferred data in NHSN format to CDC. Second test in August-surgical site infections. Implementation guide being written and validated thorough health level VII group. Work will continue and CDC will provide infrastructure and implementation guide to vendors. Any vendor who wants access through NHSN will be able to do so. The other answer is that it's not something that's ready now. It's a work in progress, don't know when it'll be ready. Implementation guides are not yet on the website, but that is the intention. Only recently accepted at HLVII. Not sure what exact plan is for making it available. The idea is that the vendors will have access. Another piece of the question- would an individual hospital have to purchase anything from the vendors? That's up the individual vendors to decide. CDC and IC software vendors will continue to work to make a way for hospitals using a vendor product to be able to move data from their vendor product to NHSN, so no double entry would be required.

   There are other ways to get data into NHSN-other vendor software, Excel spreadsheets, etc ,which predate HLVII. Didn't feel there could be a new product unless it had the

capability of old product. That capability will continue and will not go away in the foreseeable future. They can also import a patient demographic record, even though most hospitals wouldn't need to. Outpatient dialysis centers are the ones who need that capability, mostly. But want new application to do everything that the old application did. Outpatient dialysis centers are primarily a stable population. Not in a hospital situation, with HAI's. There's no sense in daily demographic data in those cases.

3. Do you have to enter each SSI (procedure and infection) or just the infection?
    a. Procedures and infections. Procedures are denominator. Facilities can import operating room (OR) records for the number of procedures. If you follow procedure record module, you need to enter both. If the hospital does not choose to follow that module, then individual SSIs can be entered and there's no requirement to enter procedures. Of course, you couldn't figure rates that way.

4. Do you have to enter each central line inserted? Or is there an option to simply enter central line days? Each CLABSI?
    a. A Central Line Practices adherence monitor is going to be conducted. If that module is chosen, then every central line inserted in that location that month is required to be entered. If it's only CLBSI option for particular location, then any central line associated bloodstream infection will need to be entered, along with patient days and central line days for the month. Each option is by location. In a given month, one or more locations are chosen for monitoring and then you choose the event or outcome that you want to follow. This is for cutaneously placed and surgically placed central lines, depending on the location of insertion. The facility chooses-module could be done in an OR or not.

5. Dr Haley was very concerned about confidentiality being maintained in 2005 and was worried that if fed back to the state. Has that changed?
    a. No change to confidentiality. Legal counsel at CDC and HHS feel that the assurance of confidentiality that NHSN can provide is iron-clad. The only way to challenge it is to take it to the Supreme Court. When working with NY State, deciding on whether or not to use NHSN, CDC was asked about the privacy act. Every individual has the right to request their own information from any facility. One worry in a public reporting state- if all of the hospitals have to belong to NHSN, that would become public knowledge. An individual patient would know that their data was reported to NHSN, and could request it. This could be used in litigation. If they could specify enough information, CDC might be physically able to find the data. But CDC does not want to have to release it , due to confidentiality with the hospital. Legal counsel has stated that NHSN system is not a privacy act system of record. Therefore no information would need to be released under FOIA. CDC does not use the data under the rules associated with the privacy act, so confidentiality is even more solid. CDC does not provide the state with data, the hospitals can (if the state is part of their 'group').

6. Is CDC NHSN program able to accommodate patient level reporting directly from hospitals? What are the IT requirements for this?
    a. See answer to 1 & 2

7. What would be the turn around time and mechanism for reporting back to the state?
    a. Data entered is immediately available to CDC, the facility, and any groups the facility belongs to. As long as they have the appropriate rights. Would not be an aggregate data. You cannot see other members' data. Only the group can see, and only if it's published somehow.

8. Will NHSN cover all patient safety issue from reconciling medications to falls and transfusion reactions?
    a. Nothing with medication errors or falls, currently. Haven't' had time to decide if they need it. Concentrating on infectious diseases being translated into NHSN. Working with AABB to create a new component related to blood and blood product transfusions. New pilot, beta test with hospitals later this year. After OMB clearance hurdles, will be made available. Is the architecture such that other things besides infections could be monitored? Yes. Just need resources and interest.

9. How many facilities in Texas currently use NHSN?
    a. As of today, there are 9

**If the proposal is for all hospitals to join NHSN, and then Texas would get state-specific data from NHSN, here are some questions that arise:**

1. Would Texas specify what components of NHSN protocols would be mandatory? If so, which ones? How would specialty hospitals be handled?
    a. Yes, you can specify, depending on what your legislature requires.

2. Could hospitals elect to add other components from NHSN?
    a. Yes. If they're not mandatory they will not need to give rights to group to look at data. Look at the protocols and requirements and see if that matches the kind of data you want to report. If it matches, it makes sense to use NHSN. If they don't match, it may be a square peg/round hole and not a good fit. Look at requirements, methodology, frequency, definitions. Whole picture. No module for nosocomial viruses, such as RSV in children's hospitals. Ambulatory Surgical centers, long term care, surgical hospitals are going to be added. There are facilities using NHSN right now who have need of these modules. CDC has been able to accommodate them, if they are affiliated with a hospital.

3. Given the guarantees of anonymity in NHSN, how would that reconcile with Texas responsibilities of accountability to consumers and the state legislature? Won't all individual Texas hospitals' rates have to be public? If there's an outlier hospital, won't there be expectation for someone (DSHS?) to investigate or intervene? Would that set precedents for consumer groups to try to get disclosure on NHSN participating hospitals in other states?
    a. That's up to you. If you tell your hospitals that they're required to provide certain information, which will be provided publicly, they will need to do that. If a lawyer wanted the info, we'd need some way to be protected. (Dr Heseltine says we're protected already). Brought up at recent meeting-you have a responsibility if you have the data. Would that set precedent for consumer groups? CDC wouldn't be able to give them the data, and hopefully hospitals and state would have protection against it or would give them data, depending on what was best.

4. Would NHSN be able to provide training and/or inter-rater reliability studies?
    a. There is a series of archived webcasts that are required for anyone enrolling. Soon there will be interactive web modules, with CEUs available. You can have training by local APIC chapters. Not a lot of progress on inter-rater reliability training. CDC supports users and state health departments, and there is a phone and email box for technical questions. Texas is not expecting to get funding for training. There is interest and motivation.

5. What type of resources will be needed to comply with NHSN regarding 1) at the ICP desk, 2) from the hospital standpoint i.e. server (some ICP do not have computer systems)
    a. In the ICP perspective, a computer is required, Windows XP or Windows 2000, high-speed internet connection, email access, and a printer. From hospital computer standpoint- only need to provide above. Nothing is loaded onto hospital's computer. Each user has digital certificate, but beyond that nothing that the hospital has to provide. There are plans to increase server capacity-in final stages of getting them, will make it faster for everyone. Constantly attempting to optimize the system and give the user the best experience. There are over 1200 facilities enrolled right now, almost all are hospitals. There are fifteen states using it for mandatory reporting, some in the process of implementing. New York has been on the longest. Then Vermont and South Carolina. Pennsylvania and Colorado are on. Tennessee and California are nearly there. Several states are aiming at July. There are also a few states who are online but are not using NHSN for mandatory reporting.

6. Describe the time resources involved for data entry for a typical ICP. Do individual patient denominators need to be entered or can the denominator be entered as a collective number?
    a. Depends on what is chosen. Voluntary vs. mandatory, etc. As long as six months of protocol data per year is provided, it's up to them. That is the minimum commitment to be allowed to use NHSN. Most hospital ICPs do a lot more than that routinely, for their own purposes. So it depends on the requirements of the facility. Data entry itself for an event isn't really that bad. Takes a minute or two. But if you are entering all procedures, and have a high volume, it can take a while. That's why the import is available. They do not accept data directly from the OR system, they have to put out data in the specified format (ASCI file, the format is available on the CDC website). It does require that IT person creates the file. Once it's successful, then it's more or less automatic after that. It's not about the OR vendor. CDC encourages everyone to do that, they're there to help make it happen. What translation is required from surgery system? The IT person would make sure it translated to the appropriate NHSN alphabetic procedure code, which would be imported. Post-discharge surveillance would be decided by the state board advisory board, who would decide the challenges and how to level the playing field in comparing one hospital to another. NHSN hospitals are encouraged to do post-discharge surveillance as best they can. There's a field for when the SSI was detected. Could be post-discharge, readmission, etc. Will not know if there's under-ascertainment, which makes comparison a challenge. New York limited theirs to detected on admission or on readmission. A trained ICP is someone who has been through a real training course, a recognized course, but not required to be a certified ICP (although that would be nice). CDC expects that everyone who uses the system will also use the CDC training courses and complete training.

7. I am an ICP working two days a week, have other responsibilities besides IC. Is NHSN realistic for a small rural hospital ICP that has limited time to complete the job? Is NHSN set up with a FTE ICP in mind?
    a. It depends on what is selected for monitoring. If it is BSI in the ICU, they hopefully don't have many and it shouldn't take an inordinate amount of time. The more things monitored, the more time it'll take. With the influx of new facilities, NHSN is seeing more situations like this. There is no specific FTE requirement for NHSN, per the CDC.

8. When will we see an annual report?
    a. CDC is working on the analysis right now. Shooting for May 15, so it will be in August issue. For June issue, the infection definitions will be published. Right now, those definitions are in two places. Most of the current ones are in Dr. Mayhall's book, but some have been modified. You'd have to go to the Mayhall chapter and then to the NHSN manual to get a complete definition. The next report will not include antimicrobial resistance information. There's a document going through clearance process now that will be the first NHSN microbial resistance report. Do not know what journal it is slated for yet. The plan is to procedures and devices included in the next NHSN manual, and the antimicrobial report will be separate.

9. Tell us about the MDRO module.
    a. The MDRO module and CDAD module has several options. Essentially, there will be a basic requirement by location, picked within a facility, and pick an organism, then all infections in that location caused by that organism will be required to be reported. Beyond that, in that same location, you can choose to report 'laboratory identified events'. This would let you get a proxy measure for community acquired infections, as

well as hospital incidence of prevalence, and transmission. If you choose to do exit surveillance testing in that location, you can choose timing- admission or admission, discharge, transfer. You can also look at adherence to hygiene such as gown and glove. There's a lot of flexibility. The forms have been made available to Neil Pascoe, including the protocol and instructions.

10. What's happened to ICARE?
    a. Still exists, facilities reporting. Will be revamped over the next couple of years. Suggestions welcome.

**MDRO Module Overview-Dr Gary Heseltine**

Document will be sent out to participants. Dr Heseltine spoke to New York, they're doing subset of what we were asked to do. Biggest problem is getting the denominator from the OR. Most demanding task, timewise. Asked NHSN to include medical record numbers to allow linking back. They have 5 regional staff people doing audits. Initial budget was a little over a half million dollars, but they couldn't get anyone qualified. The budget had to be increased to $700,000. This is their pilot phase. The regional people are all ICPs.

Do not know if NY had difficulty getting hospitals enrolled.

No good surveillance methods for post-discharge information. Made it mandatory for the facility at which someone presents with an infection to notify the previous facility.

The module centralizes and aggregates data that is probably already being collected by hand.

**Next meeting agenda**:
More specifics of legislative agenda request. Dr Heseltine assigned.
Other state reporting programs, e.g. NY. Starr West assigned.
Discuss MDRO module. Dr Heseltine will send out the handout.
Discuss Mayo experience collecting data?
Have 8 major infection control regional areas give input on which program they prefer (NHSN vs. CHS)? ICPs present can give an update at TCIP meeting. Their input will be expressed at the next meeting.
Jane Siegel, Patti Grant and Charlotte Wheeler will create a table with pros and cons of each system, to be presented at next meeting, Bruce Burns will assist.
Dr Heseltine will work on setting up a conversation with Dr. Lakey for next time.

**Next meeting: April 15th, held at DSHS main campus. Room to be determined.**

**May 12th following meeting and last meeting on May 27th (if needed)**