

Minutes
Texas Department of State Health Services (DSHS)
Healthcare-Associated Infections (HAI) and
Preventable Adverse Events (PAE) Advisory Panel Meeting
April 5, 2013, 10:00am
Brown Heatly Room 1410-1420

Panelists attending: Sharon Dorney, Charles Lerner, Bruce Burns, Mary Smith, Susan Mellott, Jane Siegel, Gary Heseltine, Charlotte Wheeler, Darlene Adams, Judy Prescott, Susan Sebazco, and Edward Septimus

Telephone attendance: Richard Bays

Chairperson Jane Siegel led the meeting.

Meeting was called to order at 10:00 AM and attendees made introductions.

December 14, 2012, meeting minutes were approved with the addition of the name of one attendee (on file).

HAI/PAE Personnel Positions:

The Houston area Epidemiologist, Bobbiejean Garcia was introduced. Panel members were notified that Jeff Taylor, Emerging and Acute Infectious Disease Branch Manager had retired.

Legislative update:

The advisory panel was briefed on the state of HAI/PAE related bills that were under discussion at the legislature and/or filed. One added the reporting of deaths associated with HAI. Another was a requirement for a plan of correction to be completed for HAIs resulting in death. Another would remove the distinction between required reportable surgical procedures for children's hospitals and adult general hospitals.

A few members of the public commented that they and/or their organizations' have some concerns in regards to the prosed legislation regarding the issue of reporting for children hospitals' and adult general hospitals'. The concerns included issues regarding data reliability, risk adjustments, and standardized infection ratios.

Another comment addressed the concerns in regards to the proposed bill concerning plan of corrections. The discussion before the AP centered on the definition of "violation" within the proposed legislation.

Data review process:

DSHS provided a handout and discussion regarding the recent on site reviews of several reporting facilities. Further discussion addressed how facilities were chosen for review (standardized infection ratio (SIR) data was used as the criteria), the process for contacting the facility and performing the review, the final report to the facility chief operation officer, and reviews of hospitals.

The annual report that will be published at the end of 2013 will include data and documentation regarding all of the facilities reviewed. Discussion also addressed subsequent reviews and how it might be good to use the readmission rate as a validation tool.

DSHS staff also explained what was learned through the process of actually completing each review. This included the time spent on each review (6-8 hours), time spent with facility staff, (infection professionals, medical record techs, and administration), and the writing of the report. The actual time spent by DSHS staff overall, was approximately 3 days per facility.

Next steps for future reviews will also include looking at denominator data compared to discharge data and targeting specific surgical site infections due to high SIR. Further reviews will take place periodically with nine more scheduled for the next series. It was also discussed that future reviews might include follow-up with DSHS epidemiologists, involvement of the local and regional state staff, and providing assistance to facilities on reporting.

It was reported that almost all of the facilities reviewed to date had already begun corrective actions regarding the high SIRs. In addition, that it appeared that the high SIRs were largely due to very complicated cases.

Suggestion was also made by the AP to post some of the infection related tools on the DSHS website and to look at addressing “best practices”.

Other discussion surrounded:

- Possible contract with a quality improvement organization to assist
- Resources for validation
- CMS validation study
- Looking at the number of IP per facility
- Doing desk reviews as opposed to on site
- Reporting issues as the relate to facility staff turnover

HAI/PAE web:

It was suggested that DSHS look into putting some type of marker on item on the web that were new or had changed. When a person receives such a notice, it does not indicate

specifically what is different. Recommendation was made to mark what is different so the public will be better able to find it.

Carbapenem-resistant Enterobacteriaceae (CRE) reporting:

It was reported that DSHS found a number of clusters of CRE (10) in the first quarter of 2013. Also, found a number of CRE cases associated to central line associated blood stream infections and that those found in neonatal intensive care units were more gram positive.

Other issues:

Discussion was held around the role of long-term care (LTC) facilities and their effect regarding these infections as people move for LTC to acute care and back. How DSHS could work with the Department of Aging and Disability Services in this regard. In addition, how the state can best work with LTC administrators on reducing infections. DSHS staff provided handouts about this issue.

Discussion was also held in regards to healthcare acquired conditions and how these are included in the Texas definition of preventable adverse events and how they relate to the CMS value based reporting program.

Further discussion centered on DSHS support to increase the use by the public of the CMS patient survey. This included discussion of how the survey was used by the public, whether it was a primarily paper based system or did the public access the facility survey electronically.

Facility compliance:

DSHS staff reported on the incidence of facility compliance as it relates to ongoing reporting. It was discussed that there are a few facilities that should be reporting that still had not granted rights to the required data as dictated by statute and rule. This list is provided to the DSHS Regulatory Services Division on a quarterly basis. New facilities have 90 days to enroll and grant rights to DSHS for their data. It was also discussed that there are some facilities that may not have a CMS number since they are owned by a physician or physician group. These facilities can get a NHSN Registration number by emailing the staff at the National Healthcare Safety Network.

Action Items

1. Send a list of states that already report some form of preventable adverse events (PAE).

2. Next AP meeting, have the discussion on PAE reporting early in the agenda.
3. Send the PAE white paper to the AP members.
4. Keep the Legislative update on the agenda.
5. Keep the rule update on the agenda.
6. Schedule next meeting (August).

Adjournment: 3:30pm