

**Healthcare-Associated Infections Advisory Committee Meeting
November 18, 2010
Sacramento, California. 10:00 a.m. to 3:00 p.m.**

Attendance:

Members: Kim Delahanty (Chair), Ray Chinn, Enid Eck, Annemarie Flood, Lilly Labar, Michael MacLean, Mary Mendelsohn, Carole Moss, Rehka Murthy (alternate), Frank Myers, Terry Nelson, Shannon Oriola, Dawn Terashita, Lisa Winston, David Witt, Kathy Wittman

Guests: Chris Cahill, Becky Siiteri, Mia Orr, Anthony Way

Staff: Kathleen Billingsley, Loriann DeMartini, Jon Rosenberg
Sam Alongi, Robyn Alongi, Letitia Creighton, Mauro Garcia, Lynn Janssen, Cheryl Kalson, Jorge Palacios

Agenda Items/Discussion	Action/Follow-up
<p>Call to Order and Introductions:</p> <p>HAI AC Chair Kim Delahanty (Chair) convened the meeting.</p> <p>Introductions were made at Sacramento and on the teleconference lines.</p> <p>Thank you to all our Committee members and guests for making time to work on these important issues.</p> <p>We have a few new things to go over before introductions. Jorge Palacio is here with us. He is the CDPH HAI Program's Associate Health Program Advisor and will be working with HAI AC going forward. For today, Jorge will also be collecting any travel invoices and documents. Cheryl (Kalson) will continue to collect the documents going forward.</p> <p>Review of Rules of Order: Chair briefly reviewed the active rules of order used by HAI AC, including following the queue and respecting speaker opinions, as well as limiting comments to two minutes and not repeating statements which have already been made.</p> <p>Note that there will be public comment after each topic today.</p> <p>Please take a moment to review the minutes from the October HAI AC meeting.</p> <p>Public Story: Chair-Carole (Moss) has informed me that there will not be a public story for today's meeting.</p> <p>Approval of Minutes: Motion to accept October 2010 meeting minutes (with minor edits provided). <i>[Note for November 2010 meeting: not all members present voted on each vote. All passed motions met established quorum requirements]</i></p> <ul style="list-style-type: none"> ○ Motion—Flood ○ Second—Mendelsohn ○ Discussion: No additional discussion 	<ul style="list-style-type: none"> ● Approved minutes of October 2010 HAI AC to be posted to HAI website ● Members to send suggested changes or clarification language on the MRSA screening in the NICU and/or discharge screening to HAI AC Chair or CDPH ● All approved motions to be presented to HAI Program for consideration ● Subcommittee chairs to submit their reports/presentations to Chair (ongoing)

- **All Ayes, Motion Passed by unanimous vote (11-0-0)**

Jorge Palacios Introduction: Jon Rosenberg

I am happy to introduce Jorge Palacios as the HAI Program's new Associate Health Program Advisor. One of the job specifications is to serve as a liaison with external advisory committees. Because this is the position we converted from the Health Education Consultant position, Jorge's principal liaison activity will be working alongside Cheryl with this Committee, with particular focus with the Public Reporting Subcommittee. Jorge will be leading our public education outreach and messaging activities, covering those three separate categories; education, outreach and messaging.

Jorge's most recent tenure was with UCSF working on a variety of healthcare quality improvement projects.

Palacios- I have been working in quality improvement for about 10 years and lucky enough to partner with California Healthcare Foundation managing one of the projects called Team Up for Health which is implementing tools for self-management in the area of chronic disease.

Rosenberg- The HAI Program feels Jorge brings a strong capability to think about this whole emerging era of informing patients to manage their own care and participate in the prevention of infections, to become aware of what the appropriate prevention measures are for whatever condition they have, and work in an advocate role for that.

Program Update: Jon Rosenberg

This week is 'Get Smart on Antibiotics' week and CDPH is packaging some messages around that topic. Yesterday was Hospital Antibiotic message day. Each day of the week has been given a specific designation by CDC. Dr. Horton issued a press release citing the CDPH HAI Program as having the only state-wide program for antibiotic stewardship in hospitals. There is a link on the CDC website to the antibiotic stewardship program, so the Program is very proud of that accomplishment.

The first week of December will be National Influenza Vaccination Week so the Program is moving toward having the 2009/2010 influenza report available that week and working with the Office of Public Affairs and with the California Hospital Association to release a joint statement on the importance on healthcare worker vaccination. Debby Rogers and Frank Myers have been discussing this topic.

CDPH is on track for publishing the HAI specific rates January 2nd. Various risk stratification measures are being considered. Kavita (Trivedi) and Kate (Cummings) are working with that data. There will be some risk stratification based on hospital characteristics; different ways to differentiate facilities are also being considered. Matching up a program with a hospital by license is difficult, and classifying hospitals as--for example, teaching--is difficult, but Kate and Kavita are doing a great job of doing that.

Lynn (Janssen) and I attended a meeting in Atlanta of all the state HAI programs. Nearly all of the 49 states who have federally funded HAI

- Chair to facilitate formation of a group to meet with Senator Alquist on issues of infection prevention

programs were represented. There was a very strong presence by CMS at those meetings. Just a few years ago those agencies were really not talking to each other. Now, when we have a meeting talking about eliminating HAIs, CMS is participating very actively from the enforcement side and other aspects. One of the key connections is the prospective payment system. Almost all hospitals receiving Medicare money will have to report CLABSI information to NHSN. I believe NHSN participation has grown from 3,000 to 6,000; NHSN is doubling the number of servers to handle the volume. The terms of the agreements with hospitals are being reviewed, in order to create templates of each hospital's mandatory reporting requirements. NHSN will then designate those rights. When a facility re-enrolls in NHSN, it will then agree to confer all the rights required for mandatory reporting.

Chair- I don't think those things are happening at exactly the same time. All the hospitals will be asked to sign the new agreement which describes the new data sharing that has to occur. The change of conferral of rights is coming with one of the releases in NHSN toward the beginning of the year.

Rosenberg- You will have the opportunity in the beginning of December to sign the new agreement and then sometime after that the new conferral process will go into effect. This is such a strong ongoing commitment and really highlights CDC's listing HAI prevention as one of five winnable battles.

With the two MRSA screening issues, the Program has a reaffirmed legal advisement that the Department does not have the authority to change the requirement for MRSA screening as it was interpreted to exclude NICUs. The State still requires the screening of neonatal intensive care patients; it would require a legislative amendment to change that.

The communication on the MRSA screening upon discharge, given that there is no standard definition of increased risk of invasive MRSA, is still being worked out. That communication is forthcoming. Exactly how hospitals will be advised to act upon that is still being worked out.

Winston- So this is supposed to go into effect January 1st?

Rosenberg- Correct.

Winston- What we are struggling with is this definition; the clinicians would like a definition. There is a mandate to have this process in place, but we need to get agreement from our medical staffs. If CDPH is looking for a definition, what is the timeline? What are we to do in the meantime?

Rosenberg- We cannot provide a definition without going through regulations, so this is out of the Program's hands. How CDPH will advise remains to be determined.

Committee Member- Given some of the issues we have had with AFL's, it would be nice to offer some guidance which could be taken or not taken so that it would be a fairly clean flow to the acute care hospitals.

Rosenberg- The request at the last meeting was to have the opportunity

to review AFLs pertaining to infection control. This particular AFL pertains to statutory requirements.

Committee Member- There are certain implementation barriers that often occur in acute care hospitals.

Rosenberg- The problem with the review of any AFL, and this requires legal review, is whether we can share it with you without it then becoming a public document, and basically once it becomes a public document it has technically been released. This is going to be up to legal services, whether or not, given the nature of the HAI AC, pre-release sharing can be done or not.

Winston- I presume in the meantime, since this will take place January 1st, what we should be doing in our institutions is looking at what our own risks are, based on who we have been screening, and who has MRSA in our facilities and coming up with something that we think is going to work in our institutions that would be appropriate until further guidance can be given.

Rosenberg- That would be a reasonable approach.

Nelson- The assumption that we would have, for something that is not necessarily clear, is that facilities can develop their own internal process, policies and procedures.

Rosenberg- If screening upon discharge is seen as one element of ongoing surveillance, then you could look at the CDC guidelines for the management of MDROs which does have a recommendation for how to go through the process of determining when it is appropriate to do ongoing surveillance.

Committee Member- We have had some discrepancies with the CDPH surveyors on our MRSA active surveillance testing and the requirements, and the interpreted requirement of the law. How are the surveyors who are going to the acute care facilities going to be educated in this 'reasonable approach' concept, that each hospital will be developing a thoughtful process until further guidance becomes available. We are being asked right now to show compliance with documentation of patient information, and it clearly does not state that in the law.

Billingsley- That is an excellent point and Loriann (DeMartini), as my successor to this Program, will work to clarify that.

Committee Member- It is a CDPH Cal Survey, but the surveyor is trying to wrap up Patient Safety Licensing within the Cal Survey.

Rosenberg- The licensing survey does focus about 60% of its oversight related to infection control. If there is ever any discrepancy or difference in that, I ask that you immediately contact Loriann, who handles the survey process, and if there are other questions, there is a questionnaire that you are given as a facility that you can give responses to regarding this survey process.

Flood- (To Billingsley and DeMartini) A colleague was cited for not

reporting patient vaccination rates to the state in the void of not being given instructions on how to appropriately report those rates. Yes, this is in the law, but there has been no instruction on how to appropriately do that. We know how to do this with employees, but this person had a citation regarding a patient.

Rosenberg- We would rather not be in the line of communications around regulatory and enforcement issues, but if we do get that information we will pass it along.

This is a new process, so anyone who does receive information, please immediately give that back. Loriann would be the best point person for that.

Committee Member- My comment is tied to what Frank (Myers) was requesting in terms of AFL input from infection preventionists who would be able to see these difficulties with implementation and/or language. Is it a possibility, with the HAI Program, which does have a team of infection preventionists, to run AFL language past them as a function of that program.

Terashita- Regarding the discharge and MRSA screening, I know a large group of facilities in Los Angeles has decided to take no guidance or definition for increased risk on MRSA and have chosen to not do anything. They can choose to take no action, so they have done that. They have been told by CDPH that will be acceptable at this time. These staff noted that multiple people have told them that, and that they also heard it at the NHSN definition workshop.

Billingsley- We have made sure that our infection preventionists have the right message.

Terashita - Question- But can the hospitals choose to do nothing?

Rosenberg - Let's wait for OLS to advise us on this.

Witt- Certainly it would be the opinion of the HAI AC to offer to OLS that the statewide GAC system would be ill-served not to have this Committee reviewing, in advance of their release, AFLs pertaining to infection control issues. Rules and regulations are very difficult to implement if the AFL is not phrased correctly.

Rosenberg- There are probably ways to bring the subject to the table and discuss various approaches without saying "This is the draft AFL and it is going out next week". For example, what are we going to do about nursing homes refusing to admit?

Murthy- I wanted to pick up on something Jon said about the MRSA screening of NICU patients and that the implementation has occurred without any clear guidance. Now Kathleen (Billingsley) has mentioned that the focus of L&C would be to look at the hospital's *processes*. Is it correct, then, that although the language may be interpreted from CDPH as having been adopted for the screening of newborns, if a hospital process has with deliberation evaluated the risk, and has re-evaluated a lack of contribution or low finding, is there a rule within the hospital process to re-

evaluate the need for continued screening? I want to make sure we are allowing hospitals to comply with the law and also have a process to assess the ongoing risk options for screening versus safety issues.

Rosenberg- We may be mixing two different issues. The first issue has to do with newborn screening. That really is clear in the law and is not subject to interpretation. The expectation is that facilities abide by the law. What is clear to CDPH is that the law is not open to the State's interpretation. That puts the onus on you (healthcare organizations) to decide as an organization what you are going to do. CDPH can't determine whether you did this correctly. You can certainly make a decision not to do it, but if the law states that you are required to do it, the requirement is clear.

Murthy- It is unclear why the implementation took place without the benefit of the Committee's review before implementation because the Committee was disbanded due to budget limitations.

Rosenberg- The Committee was active during the SB1058 deliberation processes. I don't recall anyone raising the issue regarding newborns at that time.

Billingsley- Yes, it was raised and there was discussion.

Oriola- The Senate office is possibly entertaining a legislative solution. My original comment was regarding the urgency of getting that piece of paper on letterhead, because of the continuing patient safety surveys that will continue. It would be helpful to have some clear direction. It is very challenging to operationalize this in a short period of time when you are dealing with both physician notifications and a screening process to determine who you are going to test.

Myers- I understand the budget issues; I also recall that there has always been a certain amount of discretion regarding enforcement. Case in point, the law requires facilities to look at every invasive procedure, but CDPH has recognized that is not doable and has looked at the institutions to determine that. I would ask that given we have documentation of no value for neonatal MRSA screening that CDPH consider the same level of enforcement on this issue.

Committee Member- There was some vigorous back and forth on SB1058 and there was a blackout period in which we saw a draft, and the final draft had several substantive changes, which brings us to where we are today.

Moss- The last people to look at the language were Jon Rosenberg and Sue Chen. They had input into the language and that was the time to make the changes. They were the last ones to review the language before it went for approval.

Rosenberg - That is not true.

Moss- The legal process goes through you so that's where these changes should have been made.

Rosenberg- This is not a CDPH sponsored bill. Those decisions in acts of legislature are independent of acts the Department can make.

Billingsley- CDPH was not the author of that bill. I don't think that the Senator (Alquist) would appreciate me taking responsibility for her actions and decisions. That is not our role. Our role, when asked, is to provide input.

Winston- The good thing about a law is that you have to abide by it. The problems occur in the implementation, when issues like the neonatal issues resulting in unintended consequences become harder to change going forward. I suggest that if the HAI AC will have input on MRSA screening, it would be an opportunity to include some of the other things that have been challenging to clarify so that it can be a stronger and more useful piece of legislation going forward.

Eck- Moving forward with the screening process, it would be helpful if there is a mechanism to revisit the positivity rates we are finding with all the screening. Just as with the NICU there was low positivity, we are seeing in my system unexpectedly low positivity with certain patient populations. Some of this undoubtedly has to do with work done in the community to reduce transmission of MRSA. Using the CDC's guidelines for screening would be helpful. Maybe there can be a legislative process with less black and white, with systems and processes for hospitals to monitor and review. And it will be helpful if this Committee can participate in that review.

Billingsley- I took one of the recent Senate informational hearings as an opportunity that was welcomed by the Senator to submit CDPH suggestions for modifications. I would encourage those who have suggestions for language changes to bring them forward so that the State will have a comprehensive outline considering Department, community and healthcare facilities issues to suggest changes and modifications to the bill language. I have encouraged people to send in those ideas so that we will have a comprehensive document with specificity and oversight to drive what we are going to do going forward.

Chair- We did submit suggestions for language such as calling out using NHSN surgical site definitions for treatment, and using risk assessment for MRSA discharge testing as well as a sunset clause that would enable this Committee to look at the data to advise the necessity of adding or subtracting elements based on the data moving forward.

Oriola- Do all the comments get filtered through the Department to the Senator or does the Senator get comments directly as well?

Billingsley- The Department would go ahead and send those forward. If the Department has questions for the Committee, it would ask the Committee for clarification.

Orr- At any point people can submit information for consideration.

Winston- Is it possible to disseminate the language to the HAI AC so that we don't start from scratch.

Chinn- You can submit all these recommendations but there is really no response. If the Senator's office had addressed some of these issues, like that it makes no sense to have a global surgical site infection rate after GI surgery, we wouldn't be in this state. If you offer these recommendations, is there a time for response and interaction with the office to articulate our points? It takes a lot of time and thought to submit these letters and it is a shame when there isn't response back regarding why they didn't follow such guidance.

Billingsley- The Department has had a good relationship with Senator Alquist and we have had dialogue and the opportunity to explain concerns.

Orr- Moving forward, Senator Alquist wants to see the best possible outcome so whatever information is helpful to us should be sent. It is key that the information is given to us in a timely manner and in a way that makes sense with the goal of the legislation. She is not interested in repealing any of the measures, but if you would like to consider the details of any of the specific measures, please send these suggestions directly to us (Senator Alquist's office, Mia Orr's email is mia.orr@sen.ca.gov).

Chinn- It is just a matter of refining, not repealing. My frustration is that we *did* provide input.

Orr- She is very open to your input now and that is why she held the hearing.

Chair- Copies of all three documents—California APIC Coordinating Council (CACC) letter, the HAI AC letter that Annemarie submitted, and the Infectious Disease Association of California (IDAC)—will be distributed and sent out via email.

MacLean- I was aware there was data out there that the screening of newborns in NICU's doesn't accomplish anything, however I hadn't heard it would be potentially harmful to children. I was concerned when I heard that and that we have legislation that says that this screening will happen.

Cahill- I did listen to the hearings, and believe there is an education opportunity here regarding infection control and epidemiology. I was wondering if a delegation of infection preventionists from the Committee has a meeting with Senator Alquist to discuss the issues that are being brought up.

Motion for HAI AC to form a voluntary group of infection preventionists to meet with Senator Alquist on issues of infection prevention.

- **Motion—Flood**
- **Second—Mendelsohn**

Discussion

Committee Member- I would hope these would be preventionists of varied thinking, not be of one way of thinking, and that different opinions are shared with the Senator.

Billingsley- Agreed. There are a number of challenges and opportunities

the State is facing, and real concerns that regulation is taking a front burner and that prevention strategies are falling behind as these regulations move forward. I would hope we can get the voice of the infection preventionists from the small hospitals as well as the large hospitals.

Orr- So would that be a survey, something the HAI Committee could send to the infection preventionists of California using CACC to ask for people interested, and we (Senator Alquist's office) would be the funneling to facilitate that?

Committee Member- That's an action the Committee can take, to seek input that would be representative of the infection preventionists of California.

Amendment (amendment accepted by Flood and Mendelsohn) that the Committee put together a delegation by surveying first CACC membership, looking for diversity representing small, large and specialty hospitals and other groupings that the Chair feels appropriate.

Discussion:

Chinn- It is also important to include the hospital epidemiologists because we do work together with the infection preventionists.

Amendment (amendment accepted by Flood and Mendelsohn to include hospital epidemiologists in the delegation.

Discussion:

Winston- I have a suggestion potentially to make this simpler. I have no objection to sending out a survey but I think there is wide representation by the Committee; is it possible to ask for volunteers from the Committee and then, if the group feels that particular expertise is missing, HAI AC could send out a specific query asking for that level of expertise?

Eck- It might also be possible to survey to get a better handle on the critical elements that are challenges to hospitals. It could even come from CHA what they as a group think. I am sure the senator's staff time is limited and it might help to come with data, i.e. that 50% of the hospitals had a specific issue, and it might facilitate what happens with the comments.

Myers- The State has already produced data, presented yesterday, which showed a significant increase in the amount of time infection preventionists are spending on surveillance and the time spent actually doing interventions to prevent infections, so there is already data available.

Chair- Due to limited resources, we will probably use data already provided. I am committed to facilitating that and organizing it with a conference call working with CACC and IDAC and the Advisory Committee to get that together.

Orr- I am hoping this will be an ongoing process to set something up. If you want a coordinated effort with the Senator that would need to be coordinated soon.

<p>Restatement of motion: HAI AC recommends formation of a voluntary group of infection preventionists and hospital epidemiologists to meet with Senator Alquist on issues of infection prevention. This group is to be comprised of qualified participants from HAI AC, CACC, or other members vetted through the Chair.</p> <ul style="list-style-type: none"> ○ Discussion: No additional discussion ○ All Ayes, Motion Passed by unanimous vote (11-0-0) 	
<p>Appreciation and farewell for Kathleen Billingsley: Jon Rosenberg</p> <p>Rosenberg- I am sure I can express for everyone in the Committee that we appreciate everything Kathleen has done, for moving this process forward. I can't conceive what the past few years would have been like without her. With Loriann's help we are going to move forward with the strong, sustainable process and program in place. But we will miss you. As you moved around the State and were present at the meetings, it was a first for someone in your position and we recognize the depth of your commitment to patient safety and understanding of the processes, some of which you have learned from participation in the committees.</p> <p>(additional thank you comments expressed by other members)</p> <p>Billingsley- The good outcome from the hearing was that there is an opportunity to clarify a lot of things and to highlight that. We have come this far, and have a lot more to do. I have had good discussions with the Senator on that and pointed out that we can't perform miracles overnight but will make dramatic change. I feel that I leave you in very good hands. This is the time to leverage all of this and elevate the issues. Thank you for the opportunity.</p> <p>Rosenberg- I am happy that Loriann (DeMartini) is taking on the role of oversight for the Committee. She has been with the Department for 18 years and for much of that time has been the chief pharmacy consultant. I have had numerous opportunities to interact with her over patient safety issues, and am impressed by her knowledge and interest in patient safety. I don't think there is anyone better for the role.</p>	<ul style="list-style-type: none"> ● Program to provide official Thank You letter to Kathleen Billingsley for her dedication and service with HAI AC
<p>Public Reporting Update: Carole Moss <i>(presentation available on the HAI website)</i></p> <p>Moss- The first document is the one Alicia reviewed with the full Committee at our last meeting with the exception of some information added about VRE and C diff. This document was sent out to everyone in the Committee for any edits or comments and returned to us. Everyone should have seen the HAI and MRSA page samples. This has not been changed or revised. The next document on consumer reporting has also been sent out to everyone. The third document has the changes.</p> <p>This gives you an idea of the comments and changes we have received and will make within the sample website. There were just a few changes and edits to our proposed website. The comments were just compiled last night from several different emails, and that is the summary.</p>	<ul style="list-style-type: none"> ● Program will send comments on the modification of the education piece of the HAI AC webpage for HAI AC member review ● Eck's organization to review the proposed public reporting education website pages to ensure these pages meet Medicare and other guidelines ● Program to review the proposed public reporting education

Chair- We will send this out to everyone on the call after the meeting in case there is anything else you need to email to Carole.

Moss- We have the recommendations and changes. What is the process to formally submit this to you Jon? Will you be doing changes or edits?

Rosenberg - The Program's focus right now is going to be the January 1st report which is not NHSN data or risk adjusted. The only thing we know for sure now is that there will be a technical report similar to the one for influenza vaccinations with tables as part of that report. We have limited options of what to do with that. We can have a page with some information and a link to the report, or we could take some of the tables and reproduce them as pages separate from the report, and I don't think there is much else we could do between now and January 1st.

This is really a one-time reporting format. The reporting for NHSN data will likely be substantially different. Some of the recommendations look like they pertain to changes further down the road when we have very specific tables of data to present. That data would remain on the website and be updated. We appreciate the recommendations for permanent public reporting, but right now we can only focus on how we are going to present the January 1st data.

Moss- I am confused. This Subcommittee has been meeting weekly to come up with educational documentation that will accompany the data, with input from all Committee members.

Rosenberg - Yes, that piece is fine and we need to have as much as possible ready before the January 1st report. For example, what is a CLABSI, why is it important, etc. I was referring to the presentation of that data which is in reference to the second slide.

Moss- That is a format that has been consumer tested and is easy for them to understand.

Rosenberg - Clarification- Our focus will be on the first set of information, the educational information on the infections, which is important regardless what data is being presented.

Moss- So the first slide that we sent to everyone, compiling format and data, will that accompany the data when it is posted? Or at least something close to it, based on the changes and edits proposed? My question is when you will be looking at the recommendations and making any kind of edits to the website; what is the process for the final format?

Rosenberg - The Committee is going to meet December 9th. We will have reviewed and commented and return to the Subcommittee well before December 9th.

Chair- That will be on the agenda December 9th.

Flood- My comment is more about the content and what will be published January 1st. This Committee did request to see the blind data prior to it being published because we wanted to be able to say how this might be more useful for the consumer. We want to put it out in a format that is

website pages before December 9th to review and validate the information therein

- Prior to November 25, 2010, Program will give HAI AC an answer as to whether the collected data can be presented to the HAI AC in advance of its release to the website/general public, and/or the way in which the data/analysis can be presented to the HAI AC

useful for the consumers.

Rosenberg - I will have to sit down with the people doing the data analysis and go over the proposals for that. The data will not be ready in format for the December 9th meeting, but it is possible that the blind data will be available by then. We have one epidemiologist principal doing all of the work for this report under supervision of one other person. Producing tables let alone graphs with data from over 300 hospitals and five quarters of data can be a major workload and that would be just doing it for one infection. That is why I can't make a commitment regarding other peoples' time. Our focus is on completing the report for January 1st. There might be a window to produce that material for December 9th.

Moss- We want to be sure that the format is useful and understandable by the consumer.

Rosenberg - CDPH will do everything possible to put this in the most understandable, user friendly format possible.

Chair- To reiterate from our minutes for the October 7th meeting, there was a motion for the HAI AC to be presented the last five quarters to April 1st, 2010 in a blinded data for review and comment at the November 2010 HAI meeting. That was our request.

Rosenberg – The Program couldn't do that.

Labar- Kim, you said at the next meeting is when the comments on the powerpoint would be reviewed?

Chair - No, CDPH has to validate and review the information for clarity and will comment back. That will be reviewed in December.

Rosenberg- Within the next couple of days the Program will respond on what can be shared and what the capabilities are regarding the graphic presentation that the Committee recommends for the presentation of that data.

Mendelsohn- I think we only want to put on the website only the slides that are relevant to the data that will be provided, or it would be confusing. We don't know what to prepare for public education because we are not really sure what is going to be out there and how self evident it is.

Moss- We are highlighting the bacterial infections that are going to be reported on January 1st, so everything is applicable to what is being reported. Everything in there is applicable and the data is focused on what is being presented January 1.

Chair - Some of the slides are not related to what is going to be reported in January. For example, the NHSN slide. We want to make sure the communication methodology matches the infectious data we are reporting. As it gets better stratified, we would include that information. Are there any comments or questions on the website mock-up?

Labar- I did show this to a children's hospital physician and he was confused by the format. This is a physician. I think we should try to make

it as simple as can be.

Moss - The format just follows the format of the HAI Committee website today. When they put this in, they will follow that format.

Rosenberg- It's one thing to talk about the formatted text; it's another to talk about the formatted data presentation.

Chair- So the education piece just needs to match the data that will be presented.

Rosenberg- There are five quarters of data. The Program has generated rates for the average of those five quarters. We haven't discussed options of looking at it other than a single point estimate for the entire five quarters. You are talking about the point estimate put into percentiles for the average for the five quarters.

Committee Member- And the data will be listed on the header with what five quarters those are.

Rosenberg- And for CLABSI, MRSA, BSI. CDI is another issue. There was a recommendation to defer reporting on CDI. We are not going to have the resources to do individual data correction for anything that looks odd to us for the CDI data, which we did for CLABSI. All of this went through the data verification and quality assurance process. You will still have data sets that look problematic and it is very significant expenditure to call each hospital and go over the data. I don't know whether the Committee has a recommendation whether would be appropriate for CDI.

Eck- Earlier there was a question that medical centers earlier thought they had reported everything the way they should have. Then when for example the flu data was hot-washed there were big chunks of data missing. My concern would be if we could verify that everything that should have been submitted has indeed been submitted, and that there are no holes.

Rosenberg - Hospitals that CDPH records showed did not submit five quarters of data were all contacted for verification. There are a number of hospitals which reported one to four quarters of data. The analysis including those with three or more quarters of data. There will be a table that reports by infection the number of quarters reported by hospitals. Hospitals reporting less than three quarters will be indicated. The Program doesn't believe a valid rate of infections can be produced for facilities reporting three or less quarters, particularly why they chose not to report the others.

Flood- Regarding C diff, it may have some value in terms of simple numbers, having the endemic rate of C diff infections, with all of the caveats, just as one number, for example one percent rate of healthcare associated infections of C diff in the State for this time period. If we can use the data in any format, we shouldn't put the data to waste. We could show a state rate vs. a hospital rate.

Myers- On the C diff data, I would ask CDPH that if there is something obvious—such as the number of infections exceed the number of patient

days—call the hospital to find out the answer. Otherwise, put the data out there. However, we don't want to have a situation like with influenza with hospitals with a 140% vaccination rate.

[Clarification from CDPH added post-meeting—*In the 2008-9 influenza vaccination report there are no hospitals with over 100% vaccination percentages. There are a few hospitals with over 100% total vaccination and declination percentages (the highest is 131.9%) as a result of double reporting of employees vaccinated elsewhere, as explained in the text.*]

Myers- With the small hospitals, if you have zero infections from 150 line days, there has to be some kind of cut-off there as well. The technical report is one thing, but the graphic images may be confusing to the public who may make wrong decisions and choose hospitals with limited number of line days. If they can graphically show the difference between facilities and risk adjust it, I would have no issues. People are going to assume this means something more than it really means if it is put into a graphic. The zero rate 150 line days hospital is not necessarily the best.

Labar- I don't think an endemic rate is possible, especially for a children's hospital where C diff is really in one population. Rates for children are very different from rates for adults, and yet they are lumped together here with other hospitals, some of which never see children. And we are looking at this as though the children's hospitals are low down in this. I am wondering about our education to the public. The time intervals are very important. Many hospitals work hard to obtain the zero. Also, the definition of what a CLABSI is very nebulous and can be left to individual hospitals' interpretations.

Chair- The rate for the C diff would be reported for the State of California, not by individual hospitals. This is the Public Reporting Subcommittee submitting a report to the bigger Committee. Now, with the Subcommittee presentation, we as the full Committee need to make a decision on whether we agree with this or not and where we are going forward. This has not been blessed or voted on by everyone. Please keep this in mind during your comments.

Moss- In any working group, you need to establish a sample and then ask for comments. We asked for comments, received comments and edits. At this point in time, based on those comments, we will incorporate them into what we have today.

Chair- We still need to vote on it. We need to bring that compiled work back to the Committee, and there needs to be a motion on the floor to accept what the Subcommittee has submitted, a second, discussion, and a vote. That does not change because of the work behind the scenes.

Moss- Based on the comments and edits, on our (Public Reporting and Education Subcommittee) review, the Subcommittee expects all of these changes and will make the edits in the document you see.

Motion (Moss)- Motion to submit what is being presented by the Public Reporting and Education Subcommittee as the format and the educational information to CDPH for their vetting and approval, with the goal of posting the educational information on January 1 to

accompany the data in the technical report.

Second- Flood

Myers- You are asking regarding the educational part for review today?

Moss- And the charts for the format where a consumer can understand and read.

Chair- That would be two different motions. The first motion would be what you stated regarding the educational element. Then we need to make a motion about methodology. So the first motion on the floor is what you stated. Do I have a second?

Discussion:

Eck- The text of that educational material and the format of headers and paragraphs is driven by the content on the website, correct? Does it have to be that way or can it be modified to make it more accessible and easier to read.

Rosenberg- No, we are stuck with very strict rules.

Eck- For any Medicare patients there are strict criteria regarding font size, reading level, etc. It may be important to have someone with that expertise to review it.

Rosenberg- If there are concerns about the language, we have limited personnel and time between now and finalizing.

Moss- We are open to having people review the font sizes and format.

Eck- I have people who can help with that. My concern was what our restrictions are from the Department side, and whatever we do in the next few days, it may not be possible to get it done by the January report.

Amendment to Motion: Moss—revise to add to that changes discussed today will be incorporated into the document along with modification of the font and any other CMS readability requirements.

Labar- The material also needs to be at fourth grade literacy level.

Chair- Enid has already volunteered to use her health education component to work with CDPH to look at format, font and meeting the requirements for the Medicare request. Please include that review in your motion.

Amendment to Motion: Moss--revise to include health education staff to review format, font and meeting CMS requirements.

Vote called:

In favor: Winston, Terashita, Witt, Flood, Wittman, Myers, Labar, Oriola, Delahanty, Moss, Mendelsohn

Opposed: Nelson

Abstained: MacLean

Motion passed by vote of (11-1-1)

The Committee may now consider a motion for methodology.

Moss- We are looking now at the format. We are reviewing consumer education on the format for the report.

Motion: Moss—Motion to submit to CDPH, this format, which has been used in many consumer reports, to be accepted with the revisions of the color coding and adding the timeframe and a specific header.

No second.

Motion does not proceed to vote.

Discussion:

Terashita- Is the idea to break it down by geographic area? Is that how the State intends to publish the findings from the data?

Moss - Yes, by area for all hospitals.

Chair- The HAI AC needs to make recommendations to CDPH. CDPH can take those or do their own thing. The Subcommittee is recommending this format. It did not get a second so now we need to go into something else for discussion to give the CDPH the big picture recommendation from this Committee.

Oriola- There is a concern with a 150 line day hospital, or a children's hospital, or an oncology hospital. As a consumer, you don't see the (relative) risk in the format. I am wondering if we want to separate both geographically, but also by teaching hospital, children's hospital, oncology, etc. or at least risk stratify a little differently and include line days. As a consumer you really can't tell looking at that why one facility is 300% worse than another. That may be, for example, a low volume facility that had one infection in a year, but that one inflates the apparent risk of that facility unfairly.

Moss- That would be addressed by Jon and CDPH, how they decide to handle the caveats and how they decide to group hospitals. Those categories (children's, oncology, etc.) could easily be added to this format. My submission is purely on format, the graph format. All the other details will need to be decided on within the Program.

Rosenberg- Whether you want to take this data, irrespective of the time and technical capabilities to do it, the issue is whether we want to present the data to the public in a way that emphasizes comparisons between hospitals or not. And how you do that is where we are looking for recommendations from the Committee. We are looking at the technical report which will take the rates by hospitals, stratify the tables presenting the rates, and I think what the Committee is looking for whether that should be presented graphically in a way that increases the ability for the public to compare hospital "A" to hospital "B" regardless of geographic

region, hospital type, and differences between hospital. There is also the question of what is better or worse than averages given the limitations of the data. Average could be the average for the hospitals or a national benchmark, which I don't believe we have done this way. We have tried to separate ICU's to non-ICU's so the rates will be divided in that way. Some of the hospitals were not able to do that separation.

Nelson- With the acceptance of the education designation of these infection rates, because of the nature of this data, which we are all aware has faults, and that the report can describe the limitations better than a simple graphic, I am not comfortable displaying it any way outside of a technical report indicating those limitations. Future data sets will also be compared back to this report.

Motion: Nelson--Motion that this data be displayed and only discussed in a technical report that is linked with the education piece.

- **Motion—Nelson**
- **Second—Witt**

Discussion

Moss- This is supposed to be for the public. The public consumers need this at a sixth grade education level. A technical document, written in a technical manner, is not going to meet that requirement.

Rosenberg- Someone at a sixth grade level education is not capable of understanding this data if the folks around this table are having trouble understanding it. We need to get it out there, and look at it moving forward.

Mendelsohn- My concern is representing an area that is not a great metropolitan area where in two counties my hospital is the largest. So to compare on a graphic the three hospitals in my county with two hospitals in another parallel county is a fruit salad without some sort of disclaimer piece. We need that explanation.

Chair- I reiterate this is one time, for one five-quarter period, and then we will be using the NHSN stratified information going forward.

Eck- Has the Program looked at how Leapfrog displays their data, because they have a process with bars that has a visual potential, but there are critical benchmarks, so that if you don't have enough data points, the data is not there. To Frank's (Myers) point, with the 150 line days, that is substantially different than a larger hospital. Comparing this data without everyone even having five quarters is an issue. I understand the desire to have something people can review critically to make healthcare choices.

Myers- If something is a statistical outlier, it should be noted. We need to try our best to make the data understandable, but it is like explaining oncology radiation to a patient. I would be comfortable going with the Consumer's Union methodology of 'better than expected', 'worse than expected', or 'as expected' with a notation that the data is not validated.

Rosenberg- There may be analyses that cannot be completed by January

2nd that can be completed in subsequent reports. It doesn't mean the door is closed January 2nd. This touches on the purpose for public reporting. If you look at what has been done to date, there is no consensus. There have been technical reports, raw data without risk adjustment, and some graphical comparisons.

Witt- There are a few things here to guide us. There are the statutory obligations; then there is the readable, reasonable representation of the data that this Committee has endorsed, and that the public can readily access. It sounds like the January 1st date and the second concept (the readable, reasonable representation of data) are mutually exclusive, and we need to recognize that. Publishing bad data is the worst disservice we can do to the public. It is wrong-headed to go ahead and do something that is going to give the consumer the wrong message.

Garcia- There is a lot of talk about how it should not look, but we need to discuss how to show it with what we have. Does it have to be in one chart? Can it be multiple charts? One with valid data and a secondary chart that shows secondary smaller hospitals.

Chair- I think we are saying that it can't be in a chart format because of inconsistencies in the type of reporting that happened. The experts in the room are saying that it can't look like a chart for the first five quarters, but that a technical report with clarifying language and education around the report is the reasonable course of action.

Restatement of motion.

Nelson - Motion that this data be displayed and only discussed in a technical report that is linked with the education piece. And that the technical report would include explanation of the limitations.

(Amendment accepted by Witt)

Vote called:

In favor: Terashita, Winston, Witt, MacLean, Nelson, Flood, Myers, Wittman, Oriola, Delahanty, Mendelsohn, Eck, Chinn

Opposed: Labar, Moss

Abstained: None.

Motion passed by a vote of (13-2-0)

C diff Update: Ray Chinn

The recommendations echo the concerns that were brought forward in the previous presentation. We had requested that NHSN modify their reporting module so that, beginning in first half of 2011, they are going to ask institutions to list the type of tests that are done for C diff. One of the issues is that if traditional tests are used, up to 25% of the cases may be missed, so that is one way to risk-adjust. NHSN was asked to go back to the original NHSN definitions for facility onset, that is, if a patient was in the institution thirty days before re-admission and diagnosis of C diff, then that C diff should be attributed to the facility. The Subcommittee would like to have the relevant NHSN module have an area for noting if a patient was sent to other facilities (for example, to a skilled nursing facility for dialysis), so that it is not facility onset but healthcare onset. None of this is

mandated. Finally, the Subcommittee is considering how to get a handle on other risk adjustments, such as if the facility is a teaching hospital.

Because the data before April 2010 is so flawed, the Subcommittee recommends that none of that data be reported. It is invalid information. We would like to delay the reporting to June 2011 and begin reporting on the data submitted April 2010, when the validation process started. We do want to credit the hospitals that did report data, even though the data is flawed. If the State is compelled to provide some kind of information, the Subcommittee would recommend posting a California CDI rate, acknowledging that it may be facility onset, healthcare onset, etc. just to get a sense of the data, and indicating that it will not be related to anything reported in the future. This would also note that any data prior to April 2010 cannot be validated.

For the education piece, when the public sees the name of a hospital next to a rate, they will assume it is a facility onset unless there is better information that other hospitals entered into that thirty day period. The Subcommittee would recommend providing education there.

Motion: Move to accept C diff Subcommittee's recommendations; that the hospitals that have reported 2009-2010 data are listed to acknowledge they submitted information; if the Department is compelled to report something, that it would be a global California CDI rate acknowledging that it could be facility or healthcare onset; that CDI rates are reported beginning June 2011 with data from April 2010 onward; that we have to insure the educational component to clarify that the rate is really healthcare associated and not facility onset; that hospitals would list test types used for CDI infections and a box to check whether the patient was in another healthcare facility in the past thirty days.

- **Motion—Chinn**
- **Second—Winston**

Committee Member- So the laboratory test element will be in the spring version of NHSN?

Committee Member- It will be in the facility survey.

Rosenberg- So the motion is for *all* the hospitals to do that. NHSN is not planning on introducing an element for facility admissions other than the reporting facility. The only option would be to create a custom field. There are a number of details to take into consideration if that is decided. Custom fields only work if every hospital uses them.

Chinn - It is a yes or no question, 'Was the patient in another facility?'

(reiteration and additional comments regarding what constitutes facility or healthcare onset and how to filter that data. Chinn accepts reconsidering terms of the motion.)

Committee Member- The goal of the initiative is to reduce C diff infections.

Chinn- The problem is that if you hold a facility responsible for improvement, if you are talking about healthcare associated and not

facility specific, the strategies for improvement will not be as robust. The suggestion would be changing the nomenclature to 'healthcare associated'. If you are able to tease out the facility onset, that would be even better.

MacLean- Ray indicated that the data we have prior to April is bad. The Department should confirm or deny that on the record for us. I am concerned you have made a two-part suggestion and I am not convinced you can produce on the second part. If it is not going to happen we should not agree on it today. I do not think the general community understands what we need to do to address C diff. When we address the rate we need to talk about what we can do to decrease the rate, talk about how C diff is a societal issue.

Amended Motion (Chinn and Winston): Move to list the hospitals that have provided CDI data from 2009 to March of 2010 to acknowledge their participation and that CDPH publish a California rate of CDI acknowledging the fact that this includes community onset, healthcare onset and facility onset and will not be used for future comparison.

Discussion:

Committee Member- This is the time to add in the public education component, because if the CDI rate is published, that is where the information for the public would be most useful. I recommend amending the motion to include the public education component.

(Amendment accepted by Chinn and Winston.)

Eck- I would disagree with doing a roll up of some grand CDI rate. This is invalid data. This is too large of a state, with too many variables, all of which have implications for wide variations. I agree with listing the hospitals and the education regarding unnecessary antibiotics.

Chinn- There is always a push to provide something, so rather than have CDPH release the hospital data, the Subcommittee is just offering an option so that the State doesn't release hospital specific information. The original recommendation was just to provide the list of hospitals.

Restatement of Motion:

HAI AC recommends CDPH list the hospitals that have provided CDI data from 2009 to March of 2010 to acknowledge their participation and that we publish a California rate of CDI acknowledging the fact that this includes community onset, healthcare onset and facility onset and will not be used for future comparison. Hospitals that have provided CDI data from 2009 to March of 2010 will be listed in order to acknowledge their participation.

Discussion: no further discussion

Vote called:

In favor: Terashita, Winston, Witt, Labar, Nelson, Flood, Myers, Wittman, Oriola, Delahanty, Mendelsohn, Eck, Chinn

Opposed: Moss and MacLean.

Abstained: None.

Motion passed by (13-2-0)

Motion: The report of 2011 will include data from April 2010 forward using NHSN data.

- **Motion—Wittman**
- **Second—Flood**

MacLean- Are you reasonably certain that data will not have a number of caveats with it?

Chinn- It is NHSN data with specific definitions.

Vote called:

In favor: Terashita, Winston, Witt, Labar, Nelson, Flood, Myers, Wittman, Oriola, Delahanty, Mendelsohn, Eck, Chinn, Moss, MacLean.

Opposed: None.

Abstained: None.

Motion passed by unanimous 'Aye' vote

Winston- There is still a question of how the data is going to be stratified, healthcare onset vs. community onset. In the community, that is pretty clear. Less than three percent of adults have C diff toxin as outpatient. But once you get to inpatient with surgical units, somewhere between 30 and 40 percent of adults have C diff toxins, so identifying when symptoms are due to C diff or not, when you are talking about more than 1/3 of people being colonized, is going to be challenging. I recommend we do not get caught up in the details. It is reasonable to include an explanatory note in that this is the definition of what this (healthcare onset) is, but it doesn't necessarily mean that you picked it up at that particular facility.

Chinn- Part of this discussion is to get to the education piece. Granted it is linked to a facility, but this is a healthcare onset possibly.

Oriola- Can we make a recommendation that the Department report only the healthcare facility onset defined by NHSN. That would be a good start.

Chair- Isn't that what the law already says? It says healthcare associated C diff.

Oriola- We are talking about hospital onset, not community onset.

Chinn- I think the legislation is very specific. All it says is healthcare associated. That is the rate we put up. We can put the hospital in but really it is healthcare associated, not facility. We are using healthcare associated, not onset.

Wittman- Perhaps what we need to do is ensure is that adequate education is provided by the Department to educate consumers and healthcare administrators regarding what we are talking about with healthcare associated and hospital facility associated.

MacLean- C diff is becoming more of an issue in society; it is not just what is happening inside the facility. Whether or not this is hospital acquired or not, when looking at this data, we need to look at what we need to do as a society to deal with this.

Chinn- That is something for the Public Reporting and Education Subcommittee to review.

Witt- I agree that healthcare onset should be what is reported. I looked at 152 C diff cases in my hospital, and 140 could be linked to a documented facility within a six month period. So even if it doesn't meet the criteria for community onset, when we are tying it to a hospital, it is not pertinent to that hospital. Many of the patients I looked at were not hospitalized in my hospital or even in the Kaiser system. I am concerned that is confusing reporting. Useful but not connected to a hospital.

Janssen- If everyone doesn't know the algorithm that Lab ID puts into place, it is either community onset or hospital onset, one to three days, four days or after. Then the community onset is further evaluated if the patient has been in this facility. It is called community onset healthcare associated. The reporting has to be thoughtful because they do mean different things. I like what Mike had to say in that the goal is prevention. CDC wants to roll this up into NHSN to show a reduction over time. As long as we are consistent we will show that reduction. Even the discussion about 2009-2010 has been about comparison to each other and what the public is going to do with that data. If you make an assumption that every hospital has done surveillance the same way, looking at each hospital's efforts in reductions could be equally important to reducing the over-all burden.

Antibiotic Stewardship Subcommittee Report: David Witt

We have reviewed the elements of the antibiogram and came to unanimous agreement on what should be necessary elements. I will generate minutes and circulate. Greater than thirty isolates per year should be reported. We specified MSSA and MRSA should be subdivided into resistant, organisms of note should be reported. We permitted smaller hospitals to use a greater than one year denominator for their reporting period (to smooth variation in rate that could occur with one or two cases per year in that hospital). The elements are standard. The Subcommittee recommends that this antibiogram be used as an assessment and directed to formal education of the medical staff.

The elements of antibiotic stewardship are that you have evidence of performing that assessment and education. We also began to discuss reporting to the CDPH. We have reservations in that reporting. There was agreement that we would all report but we understood there would be no guarantee of anonymity and we had concerns that reporting in a way that could be discovered to use any facility specific data is a real impediment to a recommendation to report. Facilities may do it and we encourage

them to do it, but on a voluntary basis.

Labar- I don't understand. When we see our antibiogram, it is talking about organisms and sensitivities in that population. What is about them that you don't want anyone to know? Our antibiograms are available for anyone to see.

Witt- It depends on how contorted adversarial relationships are. This could be discovered to show something; we feel the information should be shared if we can assure protection for that report.

Chinn- The problem is that mandating it doesn't give that protection. Making it voluntary, you still don't have the protection, but you could code it.

Myers- The problems with public reporting includes not only public issues of how it could be used against another facility, but also pharmaceutical companies acquiring and using antibiograms as a marketing tool to further sales, but potentially driving up drug resistance. You have to develop a governmental body to review the data. It should be encouraged to be done but to keep the facility out of it.

Flood- Antibiograms are valuable tools. There may be times when you want to share them within the county. If the Committee were to recommend this, it would be a document to present during the patient licensing survey, that kind of concept. The bugs change, so it doesn't really tell you anything. Six months from now, all the bugs could change.

Janssen- There is probably value in comparing antibiograms by geographic regions, and if the Subcommittee would consider taking them in from each region and taking all the identifiers off, that would be a thought.

Response- We would support that.

(reiteration of suggestions to use anonymous data at a county or state level)

Committee Member- Some states do a statewide report; the Committee may want to look at their methodology for protecting the hospitals. For example, in Nebraska they do a statewide antibiogram because they have certain resistant organisms that are reportable. But it takes an ELR (electronic laboratory reporting) system because otherwise it is hard to standardize the cut-off points for resistance. As the State moves toward that we could address it because there is value in seeing geographic patterns.

Motion tabled until January HAI AC meeting.

Committee Member- To have a county-wide or regional antibiogram to work off of might be more reliable for a facility than its own facility data.

Committee Member- In our county, the hospitals gave us their MRSA susceptibilities and we published them for the community so the practitioners could pick the best drug for our county.

<p>Chair- Review of Senate Health Committee Hearing and Next Steps: <i>(document submitted is available on the HAI website).</i></p> <p>The hearing included discussion on what some of this might look like in coming months, including the difficulties involved with using NHSN and what happens if you miss any of the buttons.</p> <p>Next Steps:</p> <ul style="list-style-type: none"> • HAI AC members to send suggested changes or clarification language on the MRSA screening in the NICU and/or discharge screening to HAI AC Chair or CDPH (MRSA screening in NICU or discharge screening or the SSI). • Chair will post/email to HAI AC the letters requesting reconsideration of elements of SB1058 and other infection prevention related legislation, specifically the California APIC Coordinating Council (CACC) letter, Infectious Disease Association of California (IDAC) letter, and the HAI AC letter (as presented by Annemarie Flood on behalf of the HAI AC Chair). • HAI related issues and information which members wish raised to Senator Alquist, including concerns about the language of the law, can be emailed to Mia Orr with California’s Office of Legal Services. • Motion was passed to enable a voluntary delegation of infection preventionists, hospital epidemiologists and HAI AC members to convene and to meet with Senator Alquist on infection prevention issues. • The HAI Program will send comments on the modification of the education piece of the HAI AC webpage for HAI AC member review. • CDPH will review the proposed public reporting education website pages before December 9th to review and validate the information therein. • Enid Eck has offered the resources of her organization to review the proposed public reporting education website pages to ensure these pages meet Medicare and other guidelines, specifically for appropriate formatting and reading level, prior to the information’s release on the website. • Prior to November 25, 2010, CDPH will give HAI AC an answer as to whether the collected data can be presented to the HAI AC in advance of its release to the website/general public, and/or the way in which the data/analysis can be presented to the HAI AC. • HAI AC and CDPH to send a formal Thank You letter to Kathleen Billingsley for her leadership with the HAI AC. • The next meeting of the HAI AC will be held in Sacramento on December 9th • Subsequent HAI AC meeting is scheduled for January 13th 2011. 	<ul style="list-style-type: none"> • Chair will post/email to HAI AC the letters requesting reconsideration of elements of SB1058 and other infection prevention related legislation
<p>Future Meetings: Agreement on December 9th as meeting date. Meeting to be held in Sacramento. Membership requested consideration of a Southern California location for an upcoming meeting.</p>	

Chair—Thank you everyone for your time and commitment.

Meeting Adjourned

Acronyms

AFL	All Facilities Letter
AJIC	American Journal of Infection Control
APIC	Association for Professionals in Infection Control and Epidemiology
ARRA	American Recovery and Reinvestment Act
CACC	California APIC Coordinating Council
CDC	Centers for Disease Control and Prevention
C-diff	<i>Clostridium difficile</i>
CDI	<i>Clostridium difficile</i>
CDPH	California Department of Public Health / the Department
CHA	California Hospital Association
CHQ	CDPH Center for Healthcare Quality
CID	CDPH Center for Infectious Diseases
CLABSI (BSI)	Central Line Associated Bloodstream Infections
CLIP	Central Line Insertion Practices
CMS	Centers for Medicare and Medicaid Services
CRNA	Certified Registered Nurse Anesthetists
EIA	Enzyme immunoassay
GAC	General Acute Care Hospital
HAI	Healthcare Associated Infections
HAI AC	Healthcare Associated Infections Advisory Committee
HICPAC	Healthcare Infection Control Practices Advisory Committee
H1N1	H1N1 Pandemic Influenza
HSAG	Health Services Advisory Group
ICU	Intensive Care Unit
IP	Infection Preventionist
JC	The Joint Commission
MDRO	Multiple drug-resistant organism
MRSA	<i>Multiple-resistant staphylococcus aureus</i>
MUE	Medical Use Evaluation
NCSL	National Conference of State Legislators
NHSN	National Healthcare Safety Network
NICU	Neonatal Intensive Care Unit
NQF	National Quality Forum
OLS	CDPH Office of Legal Services
PPO	Preferred Provider Organization
QIO	Quality Improvement Organization
SCIP	Surgical Care Improvement Project
SIR	Standardized Infection Ratio
SSI	Surgical Site Infection
VRE	<i>Vancomycin-resistant enterococci</i>