

**Healthcare-Associated Infections Advisory Committee Meeting
November 12, 2015, Oakland, CA 10:00am-3:00pm**

Summary Meeting Minutes

Committee Members

Present: David Witt (Chair), Carole Moss, Brian Lee, Catherine Liu, Enid Eck, Jeffrey Silvers, Karen Anderson, Salah Fouad, Dawn Terashita, Samantha Tweeten, Stanley Deresinski

Participated by phone, at a posted public meeting site, able to vote: Deborah Wiechman

Participated by phone, not at a public meeting location: Marsha Barnden, Alicia Cole, Rae Gruelich

Members Absent: Michael Langberg, Paige Batson

Liaison Representatives -

Present: CACDC/Matthew Zahn, CACC/Schulye Beal

Members Absent: CHA/David Perrott, CMA/Michael Butera

Department Staff

Present: Lynn Janssen, Neely Kazerouni, Lori Schaumleffel, Erin Epon, Janice Kim, Lanette Corona, Carla Cueva, Zoe Langdon, Sue Chen, Vicki Keller

Agenda Item/Discussion
<p>Call to Order and Introductions Chair, D. Witt, called the meeting to order @ 10:11 am</p> <p>Introductions</p>
<p>Review of Rules of Order The Chair reviewed the rules of order per Bagley-Keene and the Committee by-laws. Voting members were reminded that they represent their individual expertise; Liaison Members represent the organization that appointed them.</p>
<p>Approval of the Minutes – August 13, Meeting It was noted that the summary of the public story was felt to be too abbreviated.</p> <p>Discussion:</p> <ul style="list-style-type: none">• It is not customary to include names of specific facilities in these Committee meeting summaries. The release of specific facility names might cause undue anxiety for patients at those hospitals.• Events noted in these narratives are ‘unverified claims’.• General recommendation by members was to refrain from publishing the name of the facility in the meeting summary because documentation of events was not presented or evaluated by the Committee. It was felt that each public story could be challenged by the named companies, thereby placing the presenter in potential legal jeopardy.

Motion: (C. Moss) That the statement she had prepared upon request from K. Bleything (who read the story about her mother at the May meeting) be inserted into the meeting summary with inclusion of all details presented including institution name.

Second: S. Fouad

Motion did not pass: (one for, six against, 5 abstentions)

Motion: (C. Moss) That the statement be amended only to leave out names of specific institutions.

Second: (S. Fouad)

Motion did not pass (six in favor, two opposed, four abstentions)

Motion: (S. Fouad) That the minutes be approved as written but with correction of two typos identified by E. Eck

Second: (J. Silvers)

Motion passed (eight for, one opposed, four abstentions)

May 14, 2015 meeting

Motion: (D. Witt) Motion to approve the May meeting summary as written

Motion passed (nine for, none opposed, 3 abstentions)

Public Story

Andy Armenta, a biomedical engineer, shared his observations and concerns over the past four years. He described his use of adenine triphosphate (ATP) technology, which measures protein left on surfaces after cleaning and disinfection and is used by some hospitals to measure cleanliness. Mr. Armenta used ATP to monitor the cleanliness of equipment in the ICU, including hand sanitizer holders and anesthesia machines. Based on data collected over a period of a year (30 tests performed per month), he estimated a 60% pass rate in his facility for high touch objects. He noted that some equipment such as heart-lung machines do not have someone specifically assigned to clean them so are more contaminated. The facility engaged a vendor to professionally decontaminate, however high levels of ATP were found in the setting upon completion of their work. Mr. Armenta was unable perform cultures to identify organisms left behind and stated the facility didn't want to know.

Discussion:

- Consideration should be given to forming a subcommittee to focus on deep environmental cleaning of healthcare facilities. Cleaning activities should be validated.
- A member asked what tasks the subcommittee would perform. Suggestions included identifying 'low hanging fruit,' eliminating organism reservoirs, determining 'best practices,' and promulgation of an AFL.
- Many hospitals already use ATP weekly on high touch surfaces and use results to educate staff.
- CDPH HAI Program regional prevention initiatives are focusing on a clean environment. Dr. Erin Epton recently presented the importance of environmental cleaning at the quarterly meeting of the Orange County CDI prevention collaborative. CDPH efforts have not considered the 'insides' of equipment such as would be found by a biomedical engineer.

Motion: (C. Moss) To establish a subcommittee to focus on deep environmental cleaning of hospitals and healthcare facilities, so that we can begin to come out with some answers and solutions for hospitals in the State of California.

Second: (J. Silvers)

Motion accepted by unanimous roll vote

Prevention Progress Story – Rosenbert T, “[For VA Hospitals \(and Patients\), a Major Health Victory](#)”, *New York Times*, Jan 30 2015

In 2007, the Department of Veterans Affairs (VA) implemented a bundled approach to decrease methicillin-resistant *Staphylococcus aureus* (MRSA) in their facilities. Interventions included rapid screening for MRSA on admission and transfers, improving hand hygiene, increasing use and improving compliance with contact precautions, and changing organizational culture. An MRSA coordinator was hired for each VA facility. By 2012, MRSA rates had dropped 68.7% from baseline. The Hospital Corporation of America (HCA) instituted a similar intervention, with results tied to executive bonuses. Infections dropped by 30%. Overall improvement has been linked to non-reimbursement by CMS for specified infections.

Discussion-

- This is an excellent example of the importance of isolating patients with MRSA and rapid-test screening on admission. Recommendation that CDPH should get in touch with the VA and tour a facility.
- Does rapid screening for MRSA imply causality (that the screening itself will decrease MRSA infections)? The vertical impact was less important than the horizontal impact for decreasing infections overall as it was organism non-specific. The staff improved hand hygiene rates. The project may also be biased as it coincided with the introduction of alcohol-based waterless hand cleaner in healthcare facilities.
- There is a commercial aspect to universal rapid testing. VRE is actually a much greater problem but is not specifically screened for.

CDPH HAI Program Updates – L Janssen, Chief, HAI Program

HAI Program posters presented at the IDWeek Conference in San Diego were submitted in conjunction to the Program’s update.

- An update on validation activities was provided. 2014 was year two of a three-year HAI data validation endorsed by the Committee. The objective of 2014 validation was to improve case-finding. 245 hospitals were visited and a sample of data audited. Smaller volume hospitals (111) also participated using a self-directed process and submitted results via an online form. In 2015, HAI Program Liaison IPs are visiting the 86 hospitals where CLABSI were missed or sensitivity for MRSA- and VRE-BSI and CDI was lower than 85%. The objective for 2015 validation is to improve SSI surveillance and reporting. A workbook, posted on the CDPH website, directs hospital IPs through a self-directed process. SSI validation findings are due December 4, 2015. Webinars have been presented to assist IPs.
- A quality review of reported HAI data is performed by the HAI Program Epidemiology Unit, specifically looking for denominator data that doesn’t make sense. 57 hospitals were recently contacted to correct their CDI denominator data. Quarterly QA/QC reports were posted on CalHeart in October. Future postings will include an assessment of denominator data.
- The Liaison IPs are also performing prevention assessment visits to hospitals with statistically high rates of HAI as indicated in the last published reports.
- The HAI Program received Ebola Supplemental funding from CDC that supports CDPH onsite assessments to evaluate designated hospitals’ readiness to care for Ebola patients in California.
- The HAI Program is involve in a number of activities to address antimicrobial resistance are:
 - Participation in the ASP Collaborative remains robust with over 150 member hospitals.
 - 25 hospitals have been targeted to begin reporting antimicrobial use and using comparative metrics in NHSN.
 - Senate Bill 361 was passed requiring skilled nursing facilities to have antimicrobial stewardship policies by January 2017. The HAI Program will begin webinars in March 2016.
 - The Orange County CDI Prevention Collaborative continues to meet quarterly since June 2015; the year-long project will conclude in May 2016. A second CDI collaborative will begin in the

Sacramento metro area after the start of the new year.

- Discussion is under way to form a regional CRE prevention collaborative in the San Francisco Bay metro area.
- A survey was sent to all hospital laboratory directors to seek information on antimicrobial resistance and lab capacity for testing for resistance mechanisms.
- New HAI Program staff members were introduced: Adam D’Amico, Cal EIS fellow; Kyle Rizzo and Laura Blum, HAI prevention coordinators/epidemiologists; Zoe Langdon, injection safety coordinator), and Aileen De Los Angeles, liaison IP for the San Francisco Bay Area). The HAI Program is still recruiting for a liaison IP to cover smaller volume hospitals and help with HAI-related outbreak investigations. This position is based in Richmond.
- An update to the 2009 State HAI Prevention Plan was submitted to CDC by the October 1, 2015, deadline. Recommendations from the HAI -AC were included and incorporated.
- Dr. Erin Epsom and Dr. Janice Kim are leading HAI outbreaks with support from Dr. Jon Rosenberg who is working part-time.
- CDC suggests that HAI advisory committees in each state consider having representatives from hospital preparedness groups. California has 58 healthcare coalition representatives.
- The HAI-AC members suggested L&C participation in future meetings.

Discussion

- Is it within the scope of activities and appropriate for HAI-AC to enter into discussions on emergency preparedness? Such a conversation might be desired if there were another pandemic.
- CDPH L&C staff previously participated in the Committee.
- It was noted that Los Angeles PH Department hospital outreach efforts were initially funded with federal preparedness monies.
- HAI prevention and hospital emergency preparedness are parallel yet disparate. Infection control bridges both.
- A discussion of preparedness would be helpful if it includes local public health and emergency medical services. Front line staff can provide invaluable insights. If the Committee were to engage in such conversations, it would give all a better idea of barriers to preparedness.
- It was noted that CDPH HAI Program staff have been invaluable in working with the Local Public Health (LPH) department on the CDI Collaborative. This has resulted in LHD having conversation about HAI prevention and capacity.
- Hospitals learn from LPH. LPH establishes expectations and best practices for performance that CDPH cannot do, and has authority to act on recommendations that CDPH might not have.
- Recently CDC disseminated a letter requiring hospitals to adhere to NHSN event definitions. If cultures are not taken, an event doesn’t have to be reported. It is important to remember that not practicing testing for this reason is not acceptable; deliberate non-reporting of events is not acceptable.

Discussion: Determining What Issues the HAI Advisory Committee Will Address and How To Address Issues More Efficiently: D. Witt

A history of the California HAI Advisory Working Group and how decisions were made was presented. The group was formed in 2004 as a voluntary working group to address how to advise the Department of Health Care Services on how to prevent healthcare-associated infections. A White Paper was submitted in December 2005. Formation and scope of the HAI-AC was legislatively mandated by Senate Bill 739 in 2006 and the Committee began meeting in 2007. The role then was to advise the Department on how infections should be publicly reported. The Committee considered reporting process versus outcome measures, discoverability of information, and reporting methods. Some of the meetings were non-productive because of tension and a lack of mutual respect.

The Committee was placed on hiatus during 2009, restarted in 2010, and member representation changed to its current format in 2013. The issue of lack of respect again came up at the August 2015 HAI-

AC. Rules are needed not for when things are going well, but for when they are not. The HAI-AC has a narrow statutory mission. Recommendations are advisory, meaning CDPH does not have to accept them.

Discussion:

- The initial goal of the Advisory Working Group was to create recommendations of what could be done to prevent infections; what would be the 'right' thing to do. The speaker is aware that all recommendations are advisory. All Committee members serve voluntarily. It is ill-advised for the Department to ignore the expertise and wisdom that goes into making the recommendations. The speaker would like to see an atmosphere where collaborative partnership could improve.

Motion: (S. Fouad) To script what the Chair would say at the beginning of meetings stating we are an advisory committee and our role is to help and recommend; however recommendations are not something that the Department has to follow.

Second: (no member second the motion)

- There are many assets in the room. With the current Committee structure, individuals do not have time to share ideas. It was proposed that the next meeting be set up for each member to put three ideas in a basket to share information from all members.

Motion: (C. Moss) To set aside time next meeting from all members to share HAI prevention ideas and goals for discussion anonymously and without fear of retaliation.

Second: D. Witt

Motion passed by unanimous roll vote

- It was suggested that all future motions be put on the screen to view.

Subcommittee Presentation Reports

Antimicrobial Stewardship/Antimicrobial Resistance Subcommittee – B. Lee ([see slides](#))

- The Subcommittee met in September and agreed to expand their role to include antimicrobial resistance issues. This included a motion "Refer to a subcommittee to investigate the feasibility to develop a recommendation for reporting CRE" that was passed at the August 2015 HAI-AC meeting.
- Two members were added to the Subcommittee, Matthew Zahn and Samantha Tweeten
- Because of the complexities of defining CRE resistance, the Subcommittee instead recommends the Department look into creating a public health registry to enable identification of patients with CRE. The registry would be for use by healthcare facilities. Illinois currently has this type of registry, as described in article

Trick WE, "Electronic Public Health Registry of Extensively Drug-Resistant Organisms, Illinois, USA", *Emerging Infectious Diseases*, 2015

Discussion:

- Suggested a timeline of 2-3 years to begin reporting, then to be made public. This would align with the CDC sharing data and put California ahead of the curve. CRE is a major health issue.
- LHD desire accurate data. What would be done with the data if made reportable? Individual follow-up of patients with CRE exceeds LPH resources. Reporting the name of the patient does not present an accurate picture of where the patient became colonized or infected. Other concerns about bi-directional communication and patient confidentiality were expressed.
- While this may be a future direction, if the state proceeds, the project should first be piloted.

Motion: (B. Lee) The Antimicrobial Stewardship/Antimicrobial Resistance subcommittee recommend that CDPH look into creating a public health registry to enable identification of CRE patients for healthcare

facilities to use. Due to the difficulties in gathering accurate data, we do not recommend pursuing public reporting of CRE at this time.

Motion passed by unanimous roll vote

Safe Injection Practices Subcommittee: D. Terashita ([see slides](#))

The Subcommittee has met four times since its inception. In addition to HAI-AC members, we have outreached to key organization and now have subcommittee members from the California Ambulatory Services Association, California Medical Board, and the President of the Institute of Medical Quality. The Subcommittee will continue deliberation to prioritize focus on certain facility types and HCP for injection safety messages, education, and materials. A more formal report will be available at the next HAI-AC meeting.

Discussion:

- The Department is encouraging anyone from the public to join the “[One and Only One](#)” campaign and would like recommendations from the Subcommittee for ideas on activities for participants.

New Items / Updates

Hospital Infection Prevention Data from 2014 NHSN Annual Facility Survey: L Janssen

The Department would like input on how this data presented should be used while trying to avoid risk for IPs. Should it be used internally? The CDC has developed assessment tools, which have been sent out by the Program to hospitals as part of Infection Control Week.

Discussion:

- Trepidation was expressed should the data be widely distributed. IPs feel stressed, understaffed, and do not have sufficient time to complete their work. Data is showing 50% time spent on surveillance, leaving 50% for all other responsibilities and tasks such as infection prevention.
- How are composite rates measured? There is currently no correlation between IP staffing and hospital infection rates. A confounder to this is if hospitals with infection issues hire more staff.
- A tool was recommended to assess processes but was not used. Are there other means to capture this information? The APIC Mega Survey does not provide this information. As broad surveys do not capture individual facilities, it was suggested that a narrative be started.

HAI Public Outreach Plan: An Update: L Janssen for J Palacios

The public outreach strategy includes a goal of 99 messages on social media prior to the end of 2015, most of which are currently going through the approval process. Data from the website is used to drive Program activities, such as an upcoming webpage on environmental cleaning in healthcare. A “GoAnimate” presentation, developed by HAI Program staff member, Lanette Corona, demonstrated how short videos can be used to directly reach members of the public with HAI messages; the cartoon video was well received by the Committee.

Selection of New HAI Advisory Committee Chair, 2016-2018

Two nominations were made, J. Silvers and C. Moss.

Jeffrey Silvers received 11 votes for

Carole Moss received 1 vote for

Congratulations to the new nominated Chair, Jeff Silvers

The HAI Program Chief recognized and thanked each one of the HAI-AC members, particularly those whose terms will be ending after today’s meeting, including Dr. David Witt, Chair; Marsha Barnden, Dr. Stanley Deresinski, Rae Gruelich, Dr. Samantha Tweeten

- The Program Chief also acknowledges the 10 years of effort and valuable input from Committee

members. Suggestions for how there can be more dialogue that also complies with the Bagley-Keene Open Meeting Act would be welcomed.

Announcements

Meeting dates for 2016 are
February 11 – Sacramento
May 12 – Oakland
August 11 – Sacramento
November 10 – Oakland

The meeting was adjourned at 2:35 pm.

Acronyms added

AAMI	Association for Advancement of Medical Instrumentation
ABS	Antibiotic Stewardship
AFL	All Facilities Letter
APIC	Association for Professionals in Infection Control and Epidemiology
CACC	California APIC Coordinating Council
CACDC	California Association of Communicable Disease Controllers
CAUTI	Catheter-associated Urinary Tract Infection
CDC	Centers for Disease Control and Prevention
CDI	<i>Clostridium difficile</i> infection
CDPH	California Department of Public Health
CHA	California Hospital Association
CMA	California Medical Association
CNA	California Nurses Association
CHCQ	Center for Health Care Quality
CHG	Chlorhexidine gluconate – a topical antimicrobial used for hand hygiene, patient bathing
CLABSI	Central Line-Associated Blood Stream Infection
CLIP	Central Line Insertion Practice
CMS	Centers for Medicare and Medicaid Services
CRE	Carbapenem-resistant Enterobacteriaceae
CSTE	Council for State and Territorial Epidemiologists
CUSP	Comprehensive Unit-Based Surveillance Program
HAI AC	Healthcare-Associated Infections Advisory Committee
HCP	Health Care Personnel
HICPAC	Healthcare Infection Control Practices Advisory Committee (CDC)
HSAG	Health Services Advisory Group - California's CMS-funded Quality Improvement Network
ICU	Intensive Care Unit
IDSA	Infectious Diseases Society of America
IP	Infection Preventionist
L&C	Licensing and Certification
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>
NHSN	National Healthcare Safety Network
NICU	Neonatal Intensive Care Unit
PD	Patient Days
PDSA	Plan Do Study Act – a quality improvement approach
QA/QC	Quality Assurance/Quality Control
QIO	Quality Improvement Organization
SIR	Standardized Infection Ratio
SSI	Surgical Site Infection