

**Healthcare-Associated Infections Advisory Committee Meeting**  
**May 14, 2015, Oakland, CA 10:00am-3:00pm**

**Summary Meeting Minutes**

**Committee Members**

Present: David Witt (Chair), Alicia Cole, Stanley Deresinski, Salah Fouad, Rae Greulich, Brian Lee, Jeffrey Silvers, Dawn Terashita, Samantha Tweeten

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

*Absent:*

Marsha Barnden, Enid Eck, Michael Langberg, Catherine Liu, Carole Moss, Zachary Rubin

**Liaison Representatives**

Participated by phone, not at a posted public meeting site: CHA/David Perrott, CMA/Michael Butera

*Absent:* CACC/Cheryl Richardson, CACDC/Matthew Zahn, CNA/Kathy Dennis, HSAG/Suzanne Anders

**Department Staff**

Present: Lynn Janssen (HAI Program Chief), Jorge Palacios (Staff Lead), Sue Chen, Lanette Corona, Carla Cueva, Erin Epton, Vicki Keller, Janice Kim, Neely Kazarouni, Teresa Nelson, Jon Rosenberg, Lori Schaumleffel

<b>Agenda Item/Discussion</b>
<p><b>Call to Order and Introductions</b> Chair David Witt called the meeting to order @ 10:05 am.</p>
<p><b>Review of Rules of Order</b> 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><b>Public Story</b> Lorraine Schwartz relayed the story of her husband, a 72 year old former CDPH employee who ultimately passed from an HAI. She stated that what matters now is that changes must occur in healthcare so that conditions will be safer for patients entering the hospital.</p>
<p><b>Approval of the Minutes – February 12, 2015 meeting</b> <b>Motion (J. Silver)</b> Second (S. Fouad)</p> <p>In the IPA Subcommittee Report section, change the wording to “It was noted that the presentation <del>provided</del> included some analyses of pilot study data (small sample size) rather than a focus on summary of changes to the survey tool.”</p> <p><b>Motion approved without opposition</b></p>

### Prevention Progress Story –

A summary of “Prevention of Colonization and Infection by *Klebsiella pneumoniae* Carbapenemase-Producing (KPC) Enterobacteriaceae in Long-term Acute Care (LTAC) Hospitals by Hayden et. al. (2015) was presented by Carla Cueva.

- An infection prevention bundled intervention was evaluated in a longitudinal study in Chicago, following 2951 patients during the intervention period.
- The bundle consisted of four practices: screening patients for KPC colonization upon admission and every other week; contact precautions and geographic separation of KPC-positive patients in ward cohorts or single rooms; bathing all patients daily with chlorhexidine gluconate; and healthcare worker education and adherence monitoring.
- The conclusion noted “A bundled intervention was associated with clinically important and statistically significant reductions in KPC colonization, KPC infection, all-cause bacteremia, and blood culture contamination in a high-risk LTACH population.”

### Discussion:

- Infection control can work, but is very labor-intensive. Is that effort sustainable? Which part of the bundle impacted the reductions?
- The meat packing industry has higher compliance with hand hygiene than healthcare.
- One member relayed that patients are cultured upon admission in her LTAC hospital after two patients were found to be positive for KPC on admission cultures two years ago. Stringent precautions were put in place and there have been no new positive cultures since. Compliance with hand hygiene is 95% with manager involvement. Many patients are colonized or infected with resistant bacteria upon admission. LTAC hospitals are not skilled nursing homes; they are like ICUs. Antimicrobial stewardship is an absolute necessity. LTAC hospitals can rise to these new challenges.
- Hospital culture must change so that there is enforcement and consequences for non-compliance with hand hygiene.

### HAI Program Updates – L Janssen, Chief, HAI Program ([see slides](#))

- The HAI Program organizational chart was reviewed. All funded positions are filled.
- Program applied for CDC Ebola supplemental funding and received three year funding.
  - Written in a way to support Ebola preparedness and also build infection control capacity broadly.
  - These funds will allow retention of the Liaison IPs through March 2018, expansion to non-hospital care settings, and add up to five new positions.
- Data for Action strategy implemented with consultation offered to 112 hospitals with high HAI incidence.
- Hemodialysis BSI Prevention project has been started with hiring of Sheila Segura as our dialysis Liaison infection preventionist;
  - Meetings were held with ESRD Networks 17 and 18 to get their support and willingness to collaborate.
- The California Safe Injection Practices webpage was launched. Thoughtful input from HAI-AC members is requested to provide direction for this program; Formation of a subcommittee was suggested.
  - Dr. Janice Kim provided an update on an outbreak of hepatitis B in Santa Barbara County, an example of unsafe injection practices resulting in patient harm.
- Validation Update
  - Reminder of three-year validation plan approved by the HAI Advisory Committee: Year 1, 2013 data, hospitals were asked to attest to performing six core surveillance practices; Year 2, 2014 data, the objective was to help hospitals assess and improve case-finding (results to be presented); and Year 3, 2015 data, developing a process to help hospitals assess and improve SSI surveillance, looking at both infection events and select denominator data elements important for accurate risk adjustment. Will present the SSI validation plan at the August meeting.

- 2014 validation findings:
  - All hospitals had opportunity to participate. Larger volume hospitals received a site visit and validation performed by an HAI Program Liaison IP. Smaller volume hospitals (average daily census 42) used a workbook to perform a self-validation process and submitted results electronically.
  - Participation rate was 92% among larger volume hospitals and 81% among smaller volume hospitals. In total, 345 hospitals participated in 2014 validation.
  - Summary validation results presented.
- HAI Program is following up with hospitals to determine on a case-by-case basis how to assist hospitals that are not reporting completely or accurately. HAI Liaison IPs are making appointments with these hospitals for separate one-day visits to provide consultation for improving surveillance practices.

Discussion:

- How many hospitals with high HAI rates are actually participating in consultation? Is there tracking of progress to measure improvement? Names of hospitals with high rates are published in the annual report of key findings.
- Does CDPH have a gap analysis of unsafe injection practices? Is the problem due to a knowledge gap or as a cost-savings measure?
- Can the Committee work on issues outside of acute care facilities? Injection safety is an issue in outpatient facilities.
- Why were infections missed? Are there any patterns to the misses? It was requested that the 'why' infections were missed be shared.
- Request for validation data for larger hospitals be presented in numbers instead of percentiles.
- Clinicians are unhappy with the CLABSI surveillance definition. This may affect continuing low sensitivity with CLABSI case-finding. Infections based on lab-based definitions are less likely to be missed.
- Concern that hospitals doing poorly may have an incentive not to report all infections. Because each SSI is related back to the surgeon, there is incentive not to report.
- It is hard to find infections once the patient leaves the hospital system.
- From prior validations, many missed infections occurred during the initial hospitalization.
- Could there be a mandate for surgeons to report SSIs?
- The organizational culture does not favor surgeons reporting infections.
- Antibiotic use for more than 24 hours postoperatively might be flag for further follow-up.
- ICD 9/10 diagnostic codes for each of the 29 reportable surgery types was distributed to hospitals for applying to 2015 surgical cases for performing surveillance. These codes help to identify the medical records to review for SSI. CA is the first state to use this extensive use of codes for SSI case-finding.
- It is hard for IPs to get data to look for SSI via flag code.

**Motion (Terashita): That the HAI Advisory Committee assembles an Injection Safety Subcommittee.**

Seconded: J Silvers

There was no further discussion.

**Motion approved unanimously.**

**Motion (J Silvers): That Dr. Terashita chair the Injection Safety Subcommittee.**

Seconded: B. Lee

There was no further discussion.

**Motion approved unanimously.**

## Subcommittee Presentation Reports

### Antimicrobial Stewardship Subcommittee – Brian Lee ([see slides](#))

Accomplishments of the Subcommittee were reviewed, including the compilation of materials for and recommendation of an ASP toolkit, with CDPH adopting and publishing an ASP toolkit on the CDPH HAI Program webpage in April. Recognized that CDPH has a lot of ongoing ASP activities, including the ASP Collaborative. The ASP Subcommittee is looking for ideas on what might be a future role and goals for an ASP Subcommittee.

Discussion: The collaborative from Intermountain Health was discussed in terms of what could be applied for ASPs in small hospitals.

### Infection Preventionist Assessment Subcommittee – Karen Anderson ([see slides](#))

Reviewed the three charges to the Subcommittee:

- 1) Review and evaluate federal and state legislation, regulations, and accreditation standards and communicate to the department how hospital infection prevention and control programs will be impacted;
- 2) In accordance with subdivision (a) of Section 1288.6, recommend a method by which the number of infection prevention professionals would be assessed in each hospital; and
- 3) Recommend a method by which all hospital infection prevention professionals would be trained to use the NHSN HAI surveillance reporting system; a table of resources available to hospital IPs for training on to use the NHSN surveillance system is submitted as part of this report.

Regarding the first charge, it is difficult to objectively review and evaluate the impact of regulations and accreditation standards and how infection prevention and control programs will be impacted if something like a survey tool is not used. In order to determine how regulations have been affected, need to know the time being spent on each of the requirements. Asking the Committee how to go about having an objective method to determine impact of regulations on IPs.

Discussion:

- Committee members are encouraged to share their thoughts on how to move forward with how to evaluate impact of regulations on IPs; email suggestions to Jorge.
- No one has found a way to evaluate the issue of what would constitute adequate IP resources.
- APIC is doing a mega survey that will evaluate IP practice but will not be specific to California infection control laws or requirements.
- Studies have already been published by Dr. Pat Stone looking at changes in infection control programs in California before and after the law.
- For the first charge, the Committee could consider taking a longitudinal view, looking out for policy changes, federal regulations, accreditation standards, and guidelines that are coming, and advise CDPH on how California IC programs may be impacted and what CDPH might do to assist IC programs. Examples: The transition to pay-for-performance is a new requirement that could impact IC programs by placing more pressure to not report infections; what should CDPH do to prepare for or address that policy change? Could the Committee provide insight to CDPH regarding how the requirements for hospital ASP programs going into effect July 1, 2015, is impacting IC programs?
- The Department will provide to Committee members the Dr. Stone articles evaluating California infection control programs
- The issue of IP resources will be further discussed at the next meeting.

### Public Reporting and Education Subcommittee (PRES) – No formal report was submitted to the HAI-AC

Discussion:

- An evaluation of the CDPH Center for Health Care Quality released last year, with results and progress shared at stakeholder meetings. What activities have resulted from this report?

**State HAI Prevention Plan Subcommittee** – No formal report was submitted to the HAI-AC. No new recommendations have been made by the Subcommittee. CDPH is waiting for final recommendations. The final will be brought back to the Committee at the August meeting.

#### **New Items / Updates**

##### **Developing a Comprehensive HAI Antimicrobial Resistance Program** – Erin Epton ([see slides](#))

Reviewed progress of the CDPH-convened ASP Collaborative and how this is interrelated with an approach to support regional collaboratives, including the Orange County CDI Prevention Collaborative and planned CRE prevention activities. A state clinical laboratory director's network able to monitor antimicrobial resistance prevalence and trends is proposed along with an evaluation of laboratory capacities.

##### Discussion:

- What is threshold for CDI testing? At Stanford, 35% patients are tested for CDI without clinical evidence that would support testing.
- There is a correlation between proton pump inhibitor (PPI) use and increased CDI.
- Outpatient antibiotic use contributes to CDI.
- MRSA incidence is declining both in CA and nationally due to prevention activities and stewardship.
- The epidemiology of CRE, some with a different mechanism of resistance, was presented at a recent IDSA meeting in LA. Is CRE coming from LTAC hospitals or being fed into LTACs?
- Senate Bill 361 proposes antimicrobial stewardship policy in skilled nursing facilities. Guidelines are to be consistent with national guidelines but the bill may be difficult to enforce.
- Hand hygiene difficult in SNF due to lack of well-placed gel
- It was noted that CRE control strategies should match endemicities.
- Screening testing for CRE has a sensitivity of CRE 75-80%. Collection technique is important.
- Hospitals want assistance overcoming implementation obstacles for prevention activities.
- It was proposed that CRE be part of next meeting agenda.

##### **Infection Preventionist Staffing in California Hospitals** – Lynn Janssen ([see slides](#))

Except for the SENIC Study from 1985, there is no demonstrated association between number of IPs and hospital infection rates. New York State has not been able to find such an association; will continue to publish infection preventionist staffing every other year, highlighting the 15% of hospitals with lowest IP staffing levels.

California hospitals provided information on IP staffing via the NHSN 2014 annual facility survey in February/March 2015. Data presented showing the mean and percentile distributions of hospital IP staffing by hospital category. Hospital category rankings of IP staffing changed depending on the presentation of data, number of IPs vs. IPs per staffed beds. These data may enable California hospitals to benchmark their IP staffing. As a precaution, however, hospitals could use the data and determine they have high IP staffing compared to other hospitals. The Program will bring back final 2014 NHSN survey data to the August meeting, including analysis of time IPs spent on surveillance vs. time spent on activities other than surveillance.

CDPH also continues to assess the detailed time-task questionnaire of hospital IPs recommended by the Committee in February. Considering whether to evaluate for use as a toolkit to support local discussions between IC programs and hospital administration.

##### Discussion:

- IPs lack sufficient support to accomplish their work. Their workload in terms of what they do and what someone else can do should be evaluated. How does one capture that an IP "could do with assistance?"
- Could hospitals with adequately resourced IP programs be spotlighted like the ASP Spotlight Program based on levels of IP support?
- Size does not indicate complexity and intensity of IP programs. Influence is needed to increase the

number of IPs. IPs have the best idea of how to do this and know the evidence.

- If hospitals with high IP staffing resources also have high infection rates, what can a facility say?
- Many IPs in small hospitals are listed as full time but have many other duties such as employee health, staff nursing, etc.
- Was there a definition for how to fill out the number of IPs in the NHSN annual survey? Was the number of hours spent on surveillance arbitrarily decided by the person filling out the survey?
- IP activities vary from week to week. Numbers of IPs haven't changed much over the past few years.
- NHSN IP staffing numbers do not give an accurate picture of what is actually happening in a hospital. IPs don't spend all their time performing surveillance. IPs have myriad of other responsibilities such as emergency management, flu vaccinations. IPs are accessible, do research, and called on for more than tasks. A flat picture does not accurately capture the complexity.
- Numbers are so irrelevant to what IPs do. Consider setting up process measures that indicate whether a job is being accomplished.
- CMS can find gaps where basic elements of infection control requirements are not being met. Interpretive guidelines for processes can measure/support whether the job is being done.
- CMS holds IPs responsible everything – Food Services, environmental services, MD vaccinations, etc.

#### **Overview of the Hospital Regulatory and Survey Process – Scott Vivona (Acting-Assistant Deputy Director, CHCQ)**

The vast majority of hospitals are not routinely surveyed by CDPH Licensing & Certification (L&C), but are deemed in compliance with CMS requirements by an accreditation organization such as The Joint Commission (TJC). L&C performs 5-8 validation surveys/year to validate the findings of the TJC. L&C receives over 3,000 complaints/year and approximately 8,000 facility-initiated incidents, including unusual occurrences, medical breaches, or adverse events. If a facility is visited in response to a complaint, surveyors will initially go in wearing their 'state' hat and survey for compliance with Title 22. Discovery of more serious issues can trigger a CMS survey. CDPH will call CMS who can then approve a full survey of 21 elements or a focused survey of three to five elements related to the allegation. The surveyor changes to a federal mode for this survey. In 2014, of 50 such calls, CMS authorized 10 full surveys and 23 limited surveys.

State surveys include:

- Medical Error Reduction Process (MERP) survey – pharmaceutical issues
- Patient Safety Licensing Survey (PSLS) – about 100 are performed annually
- A new, more intense protocol for surveying general acute care hospitals has been developed and is ready to be piloted. It will be used more frequently than the PSLS, with surveys of general acute care hospitals planned for every three years.

L&C is in the process of looking at all regulations, with a goal to update all within three years. This is a large, complex undertaking.

To survey for compliance with the new law requiring an antimicrobial stewardship program, the hospital will be surveyed to their own protocol. L&C cannot tell a hospital how to implement the program; it is up to the facility to adopt their own processes. L&C will learn from this process and expand their survey specificity over time.

Discussion:

- The new CDPH three-year survey will be in addition to an accreditation survey (i.e. TJC) cycle. This is a separate and distinct survey, therefore additive. Currently the MERP survey is separate. It is anticipated that it will be disbanded and incorporated into other protocol.
- There will be added training for surveyors for the new survey protocols.
- The new survey tool will likely be made public following the pilot. There may be a future opportunity to roll out the tool, maybe through the California Hospital Association, to ensure hospitals are prepared.
- CMS requires surveying a percentage of dialysis facilities on an annual basis. CDPH surveys 72 of 610 (12%) facilities annually.
- Recommendation to have a presentation of L&C survey findings at an upcoming meeting.

**Action Items**

1. Subcommittee to be formed for providing recommendations for a statewide Safe Injection Program.
2. From validation results, the HAI Program will report back at a future meeting the findings on missed infections.
3. Discussion on IP resources will be brought back by the Infection Preventionist Assessment Subcommittee at the August meeting. Committee members are to email Jorge Palacios ideas of how regulations and guidelines impact IP programs. The Dr. Stone article referred to by L Janssen will be forwarded to the Committee to be included in the August discussion.
4. Recommendations from the State HAI Prevention Subcommittee will be formally summarized and presented to the Department at the August meeting.
5. CRE will be placed on the August meeting agenda for discussion.
6. The Program will bring back final 2014 IP staffing data collected from hospitals via the annual NHSN survey, and include the analysis of time IPs spent on surveillance and time spent on activities other than surveillance.

**Announcements**

- The meeting was adjourned @ 3:00 pm
- The third quarter meeting will be held August 13, 2015 in Sacramento, CA

DRAFT

## Acronyms added

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