

Healthcare-Associated Infections Advisory Committee Meeting
October 7, 2010
Sacramento, California. 10:00 a.m. to 3:00 p.m.

Attendance:

Members: Kim Delahanty (Chair), Ray Chinn, Alicia Cole, AnneMarie Flood, Brian Lee (alternate), Lisa McGiffert (alternate), Carole Moss, Rehka Murthy (alternate), Frank Myers, Terry Nelson, Shannon Oriola, Dawn Terashita, Francesca Torriani, Lisa Winston, David Witt, Kathy Wittman

Guests: Michelle Baass, Jean Burkhardt, Chris Cahill, Tina Menasian, Roberta Mikles, Michele Montserat-Ramos, Daniela Nunez, Mia Orr, Paula Pettit, Pam Pires, Kimberly Ratliff, Syed Sayeed, Martha Swaim

Staff: Jon Rosenberg, Sam Alongi, Letitia Creighton, Roberto Garces, Mauro Garcia, Lynn Janssen, Kavita Trivedi

Agenda Items/Discussion	Action/Follow-up
<p>Call to Order and Introductions HAI AC Chair Kim Delahanty (Chair) convened the meeting.</p> <p>Introductions were made at Sacramento and on the teleconference lines.</p> <p>Chair- We would like to start with accolades for Sue Chen who has moved on in California public health. We acknowledge her for her dedication, hard work and passion, with her concern for patients of California and their safety as well as her commitment to infection prevention in the epidemiology profession and provision of the education. Wherever we needed her she would provide education throughout the state. She was at the grass roots level for the HAI Program in public health and has catapulted infection prevention and safety to the forefront for CDPH and the patients of California. She will be missed as the HAI Program coordinator and we look forward to continuing to work with her in her new role as CDPH IC liaison.</p> <p>Rosenberg- What this recognizes is the extent that the liaison program is integrated into the entire program and the critical role in continuing the struggles with NHSN and the complexities. Moving forward on NHSN and improving the surveillance of infections in approximately four hundred hospitals and the ultimate goal of improving the prevention of those infections and being able to document the success of those improvements. Each liaison team is responsible for an average of sixty hospitals, and it is an increasingly important role. Sue's strength is as an infection preventionist and her understanding of how hospitals work and function and how they can be improved; this is the reason for her transition. The HAI Program has been approved to bring an additional person in for support. The start date is November 2nd.</p> <p>Chair- As a reminder, the charge of this Committee is to make recommendations to CDPH to decrease the morbidity and mortality as it relates to preventable healthcare associated infections. Everyone's voice is welcome here. If there are outbursts that person will be asked to recuse themselves from the meeting by the Chair.</p>	<ul style="list-style-type: none"> • Thank You letter for Sue Chen for her work with the HAI AC • Approved August minutes to be posted by HAI Program

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.

Note that there will be public comment after each topic today.

Please take a moment to review the minutes from the August HAI AC meeting.

Discussion:

Moss- Revision: Minutes to include the roll vote on legislative order.

Myers- Revision: On page four, the question wasn't whether to violate the data format, the question was whether to violate the law regarding the reporting dates.

Chair- Under action items we are requesting that subcommittee written reports be submitted to (Alongi, Delahanty, Rosenberg) 24-48 hours prior to the HAI committee so that we can have copies for everybody and send them off to the remote call-in locations.

Moss-The Committee and the public need to know how many hospitals have given the rights to access their data for NHSN.

Rosenberg- Kavita (Trivedi) can provide these numbers. It isn't just a 'yes' or 'no' process. CDPH isn't as concerned whether a hospital has given us rights to some data, but rather that the hospital has conferred rights to the correct data; that is going to take a number of months for some hospitals. Virtually all of the hospitals have conferred some rights, there are perhaps a few that haven't, but the work is going into getting the rights of all the specific elements and for something like central line related bloodstream infections, it is not just one set of rights for us. Those who are doing the work on conferring the rights can comment on that.

Wittman- I have been part of the NHSN process and I know that my rights have been conferred. I am still learning that just because you have conferred rights to your facility does not go across the board. There are growing pains that facilities are dealing with.

Janssen-This may be something to track on the website.

Trivedi-The Program has looked at the different rights. There are rights that need to be conferred for each of the infections and process measures. All of the hospitals in California that are required to report to us range from 70%-86% (rights conferred), so CDPH has a significant number of hospitals permissions for each of these data points, but all the hospitals are not yet on board.

Janssen-The part-time people have thirty hospitals. The full-time people have sixty hospitals. Some hospitals haven't been as quick to because of staffing issues or not being able to hire infection preventionists, there are almost no hospitals that have not joined NHSN or are not in the process

of getting up to date. The list would be dynamic as things are changing every day. In some cases the people have not been able to get to the people who have needs or have gotten to the people only to find out that they hadn't enrolled in NHSN. Our goal is to get every hospital on board by the end of the year. It is a process and we are completely committed to getting everyone on board and the performance.

Moss-This is an important issue. Hospitals were notified of this two years ago. If the deadline isn't enforced and there is no illustration of who is doing what is required, this is an uncompleted task. In order to be in compliance, there needs to be a deadline and it needs to be raised with non-compliant facilities.

Janssen- It will be coming out in a report as the hospitals are required to report certain metrics, the Program will be able to see which facilities are lacking. The facilities need time to do that. They confer rights back to CDPH when they are entering data. The important thing is that they are following the NHSN protocols; the data can be back-entered to the time they started entering the data.

Rosenberg- For most HAI data, they were only required to *begin* inputting it on April 1st, 2010. Compared with the experience of other states this is still a relatively short period of time. The only data that was required to be put into NHSN prior to that was the central line insertion data. There is no way to know, looking at NHSN, that a hospital hasn't conferred rights to CDPH. There are some two- and four-bed prison hospitals here. If they don't insert central lines, they are not required to confer rights because there is nothing to confer. When the Program looks at NHSN, the only way to know is to identify the hospital, contact them and find out why they haven't conferred rights. NHSN doesn't have any requirement to report to CDPH that a facility doesn't insert central lines. It is most likely that the facilities which haven't conferred rights haven't because they don't insert lines. For CLI-BSI and CLABSI they have no obligation to confer rights if they don't insert central lines. California is unique in the U.S. in having no exemption for any licensed general acute care hospital to be enrolled in NHSN and providing this access to this data. So many of the small facilities like prison hospitals have reporting requirements that do not apply to them.

Moss- Do you have a timeline of when this will be due?

Rosenberg- CDPH will issue a report on the status of the NHSN enrollment, rights conferral and data submission by January 1, 2011; this will report the state of NHSN in California. That report is going to require stopping at a certain point in time and assessing what is there. That process has to involve contacting every hospital for whom we don't see certain elements; this is very time-consuming.

Myers- HAI AC can follow CDPH's guidance in the way these need to be set up. I would ask that since at this point we are tracking MRSA and c-diff that went into effect in all facilities as of April 1st, it would appear we could look strongly at facilities that haven't joined 'group CDPH' as of that date. I understand that the collection of data is a separate issue. But there isn't a reason why, other than finding staff, that a facility shouldn't already have joined. Is there a way that this could be tracked?

<p>Janssen- It really is just a few facilities; those not yet involved are priorities for the Program. There is an evaluation going on to determine current status. It is a priority to get everyone on board. Of my twenty nine reporting agencies, there are none that have not enrolled.</p> <p>Wittman- Without the liaison resources which are 100% funded by the federal grant which expires at the end of next year, I don't know where we would be. We need to be able to sustain it beyond 2011.</p> <p>Motion to accept August 2010 meeting minutes (with revisions and minor edits provided). <i>[Note for October 7, 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—Oriola ○ Discussion: No additional discussion ○ All ayes, Motion Passed by unanimous vote. 	
<p>Public Story Introduction of Martha Swaim</p> <p>Swaim- I would like to thank the HAI AC for letting me speak on behalf of my mom. I would like to tell you about my mom, Eva Swaim, who went into the hospital for hip surgery and two months later was dead.</p> <p>[Ms. Swaim provided the text from her presentation, which is available on the website]</p> <p>Swaim- Hospital hygiene is important for all doctors, nurses and patients to protect patients from infections. The California Department of Public Health should insure that hospitals are clean and that the equipment is well maintained. Public reporting of hospital infections is important to me as someone who has lost a parent who suffered from hospital acquired infections due to poor quality healthcare. Public reporting holds hospitals and nursing homes accountable for harming patients and can improve patient care. I want to thank the Hospital Infection Advisory committee for its work to get information about hospital infections to the public.</p> <p>Torriani-I would like to commend you for your input and your description. This is because of bad hospital care that each of us in healthcare wants to fight.</p> <p>Moss- I would like to bring up a point that Ms. Swaim brought up that we hear over and over and that is death certificates are many times inaccurate; this is a key topic for us to focus on in this committee. The same thing happened with my son; his death certificate said that he had assepsis, while what he died of was an infection from MRSA. So this happens all the time. We need a more accurate process for reporting the deaths of loved ones.</p> <p>Chair- I just want to thank you for your bravery and we are all sorry for your loss. We don't want to see this ever happen to anyone. This is why we as infection control practitioners, infectious disease physicians, and HAI AC Committee members are vested in this process and are trying to</p>	<ul style="list-style-type: none"> ● HAI Program to send a Thank You letter to Martha Swain for presenting her story to the HAI AC.

<p>prevent from happening in healthcare today. So thank you for coming and sharing your heart and soul.</p> <p>Comment-Thirty-five years ago I was moonlighting at a hospital I won't identify and was very disturbed by the care I was seeing and that is why many of us are here today, because of experiences we have had.</p> <p>Myers- Do you know if the hospital reported this facility to Licensing and Certification or to the local health department? This is something I have been trying to encourage, for long-term care facilities is to report it and let the Department know, because one of the things those of us in acute care want to do is explain what we see in a way that the health department can understand a little bit better.</p> <p>Swaim-The hospital and the nursing home facility have a close working relationship and a contractual relationship, their own staff doctors and nurses also work at the nursing home. The facilities do have signs on the wall about reporting elder abuse and poor care, yet at the same time all of this is going on.</p>	
<p>HAI Program Update (Rosenberg): In addition to Sue's assignments the Program is bringing on Jorge Palacios November 2nd. He is an Associate Health Program Advisor. This is the reclassification of his position which was previously a health education consultant. He has completed the course work for a Master's Degree in Social Psychology and has been working for many years at UCSF in San Francisco General in support of research activities. One of his principal roles is to serve as the interface between patients that are enrolled in clinical studies and the research component of those studies. He has broad experience in working with patients and healthcare consumers and helping them understand the nature of the studies as well as the risks and the benefits. Mr. Palacios has experience going over consent forms with patients as well as assisting patients in making informed decisions about their care. His experience and training will be a great asset in terms of the public reporting aspects of the program.</p> <p>He will work with all of the committees and subcommittees and will work with Cheryl on the website issues. The Program has also received permission to hire one person to join the Epidemiology Unit as a research program specialist /data management person. At the same time, in August, the Program lost one of its three epidemiologists. With the freeze in effect it is unlikely that position will be filled in the near future.</p> <p>The HAI Program posted a 2008/2009 healthcare employee vaccination report on September 30th which included the hospital specific employee vaccination rates and a notation for those hospitals that did not report for that year. Posting of the 2009/2010 data this year is anticipated for December 1st, although the timing of the clearance process is uncertain. While a decision hasn't been made about posting specific hospital vaccination rates for that report, it is reasonable to expect that the same decision would be made for that.</p> <p>For January 1st, the HAI Program is in the process of cleaning up the data verification process for the data that was submitted by paper forms prior to April 1st. That is five quarters of data for MRSA and bloodstream</p>	<ul style="list-style-type: none"> • Motion approved for HAI AC to be presented the last five quarters (to April 1, 2010) of (blinded) data reported to the HAI Program for review and comment at the November, 2010 HAI AC.

infections as well as CLABSI and c diff. The plan is to report the hospital specific incident rates on those infections on January 1st.

Flood-Many facilities were taken aback about the hospital specific reporting sent out in the recent AFL. In the future, as a courtesy to the HAI AC, if CDPH is going to require something that the HAI AC advised against, could the HAI AC members receive a notification that these things are happening prior to the release of the AFL?

As far as the reporting of the quarterly data is it going to look like the format we received, with a numerator and a denominator for the institution or is there going to be some attempt at risk stratification? I am particularly interested in the CLABSI.

Trivedi- We are looking at ways to present the data in a risk adjusted way, but we have not determined yet how we are going to do that because the data we got in is just partitioned by ICU, non-ICU. We will be able to do risk adjustment on the NHSN data, but we are trying to find a basic way to do this.

Moss- A lot of time has been spent on how to report, employees, non-employees; CDPH decided not to go with the recommendation of the Committee. Will CDPH accept the recommendation regarding the breakdown of the whole worksheet? What is the intent of the next posting of the data?

Rosenberg- Going forward is a different process because there is extensive pilot testing of a variety of different ways of collecting that information. There is a form that the Committee reviewed and the hope is that this process results in a greater sense of confidence in the employee vaccination rates, clear definitions of employee and non-employee healthcare personnel, and data submission for those categories that have been included. The Program will have a better sense of the quality of data in March; it is not likely that there will be uniform complete reporting of all of the non-employee healthcare personnel. The hospitals know what is being asked for based on the pilot testing and input from over thirty hospitals. The Program has conducted four sets of webinars statewide to fully inform people of the process and the forms and answer their questions.

Moss- So this next report will not include nurses?

Rosenberg- The 2009/2010 report will not be any different than the 2008/2009 report. It still has many of the same problems. But there will be two sets of vaccines involved. CDPH did ask about the availability of vaccine. The Program doesn't yet know what that is going to look like; there may be some hospitals with limited availability of data.

Moss- There is a national registry of vaccines. Is there no way we can use that registry to incorporate all healthcare?

Rosenberg-That will not happen. That was a long and painful process. California is one of four pilots in a national program and information for this is posted on our website. There is a link to a new page called Healthcare Personnel Influenza Vaccination Pilot Project. This was part of

two processes linked together. One was the recognition on the part of CDC and NHSN that aggregate vaccination data from the NHSN module is not available.

Every person in the hospital is entered as an individual. The CDC recognizes the need for aggregate personnel reporting. Then they confronted the issue of 'which personnel groups can be defined and are feasible to collect?' The National Quality Forum (NQF) then proposed making healthcare personnel vaccination a national quality standard. But they confronted the same question of 'which personnel?' The National Quality Forum made a proposal for a standard. The Center for Medicare and Medicaid Services (CMS) may then adopt this as a reportable standard so all healthcare facilities would be required to report this. The decision was made to make this year a pilot project year to collect data electronically on the CDC website, and California is one of four areas in the country to be part of the pilot. This is a joint project with the CDPH Occupational Health Program. This week the Program started the recruitment process and sent out an email to our large mailing list with the recruitment information; within an hour, four hospitals responded as being interested in the pilot program. The target is seventy hospitals.

The elements in data selection in that program are slightly different regarding which personnel to select which is good because both processes will demonstrate the feasibility of collecting information on non-employee and personnel data categories. That pilot process will also include interviews about the barriers to collecting this information.

Myers- I have a question about the ICU CLABSI rates. I know we have looked at this issue, and the interpretation of the laws is that it the data has to be risk assessed in the NHSN process. If we are not going to follow the law, is the State going to say that ahead of time, so that if those systems lead to an injunction there will be an option?

Rosenberg- I don't have that answer at this time. There is obviously a severe time crunch.

Torriani-I would like to request that this Committee see the data that is going to be reported. This Committee's function also is to be able to see, review and comment on data.

McGiffert- Back on the healthcare vaccination, the new form would exclude any nurses, RN's, direct patient contact people who are not direct employees but are contract employees. I am assuming that your pilot is looking at that. I think there are many of those employees working in hospitals working in the state and that is a pretty large group to not insure they are vaccinated. I believe that through your study the facilities didn't have a way to document this.

Rosenberg- We emphasized that we want no hospital to mistake our limitations in reporting for freeing them from the obligation to follow all of the CDC recommendations in insuring that all those employees get vaccinated. There is a big difference between the hospitals' obligation and insuring as many employees get vaccinated as possible. Reporting is one thing and providing influenza vaccination is different. They will be required to report additional categories in future years. We will do whatever we can

to increase the rates of healthcare vaccinations. We will be collecting additional information, in-season online surveys of policies and practices including vaccination of non-employee personnel such as registry and contract personnel. The agreements can include vaccination consent and declination forms as well as vaccination requirements.

Mikles-I am hearing concerns from Ann Marie, Carol and Francesca. This is a room of experts. I am hearing that some recommendations are being given and are not being taken by the Department. So my question is whether the Department gets back to the experts in this room to say that they understand the recommendations but are not going to follow them? We don't know as patient advocates how to respond to concerns.

Moss- I would recommend that the Metrics subcommittee get together with Kavita (Trivedi) and CDPH staff to risk stratify the data and devise what that methodology will be.

Rosenberg- Frank (Myers) clearly outlined this in the last meeting based on the minutes. The mandate is to publicly report the incidence rates of those infections and to risk adjust. And the determination has been made that one mandate takes precedence over the other, that CDPH is not in a position to be in possession of data that we were mandated to collect and report and then choose not to report it. The primary problem now is time constraint. Additionally, if a certain number of members are involved in discussions around HAI AC-relevant issues, then it becomes an official Advisory Committee meeting and the Bagley Keene Act dictates rules for making those proceedings public.

Trivedi- When the Program originally came to the Committee to ask for help with the data collected prior to April 1st, the difficulties of risk adjustment was highlighted, and the Program asked for guidance. What came of that discussion is that there should not even be a January 1st report.

Torriani- move that CDPH present the data to the Committee before its publication.

Discussion:

Torriani- The facilities aren't proposing to look at their own (facility) data, only the aggregate dataset.

Chinn- The other thing to do is to look at the non-ICU infection rates because there is a significant problem with having for example an oncology ward compared to medical surgery. When you combine everything, the rates may be skewed and not useful. That would give us an opportunity to decide to just report the ICU rates for this year and build in more stratification for non-ICU units as it becomes available for reporting.

Murthy-The other issue is trying to reconcile the two mandates that Jon articulated. The role of this Committee is to close that gap and assist; that is a fundamental function. This should be reflected in the motion. It is our responsibility to make sure that the Department has the ability to meet the goal of the law as mandated. It is a disservice to the public to present useless data.

Myers-There are two priorities; one is risk adjustment of data and then the state deadlines. Reviewing the data especially in blind fashion, some of our fears may be allayed in the sense that we may find a normal distribution and could go ahead. Or we may find significant challenges with the data and need to put our comments into the minutes.

Chinn- I was lead author on this essentials of public reporting. There was a joint statement from the various organizations. Each hospital needs to be given the opportunity to look at the data and have a response. This was highlighted when we put out the influenza hospital data. No hospital was able to respond to what the challenges were and it gives the wrong public perception.

Moss- I want to be clear. In the minutes, the motion that was seconded and approved said "a motion to accept the surveillance form as presented with the amendments; the first non-employee category to read non-employee medical staff and allied health professionals as well as to include definitions for these including M.D., D.O., Dentist, Podiatrist, Nurse Practitioners, Assistants and others". When will that take place?

Chair-2010/2011. This flu season that we are in currently leads to that data to submit to CDPH and they will gather that data and report out in those categories.

Moss- So that will be posted in October of 2011?

Chair-Right, data must be submitted by April 30th of 2011, and there will be time to review and to post after that.

McGiffert- Some of the states have done grouping of hospitals by peer groups. When you look at risk adjusting data that you don't have anything to go by, that might be something to consider. From a consumer perspective, it allows them to compare like hospitals. Outside the ICU for example, you might report those with all the trauma centers together and the smaller hospitals together. South Carolina does that. Pennsylvania did it and it draws your eye to the higher risk hospitals.

Moss- This review should not cause any delays.

Rosenberg- Correct, this would happen at the November meeting.

Restatement of Motion: for the HAI AC to be presented the last five quarters (to April 1, 2010) of (blinded) data reported to the HAI Program for review and comment at the November, 2010 HAI AC.

- **Motion—Torriani**
- **Second—Myers**
- **All ayes, Motion Passed by (13 yes – 0 no – 1 abstention) vote**

Subcommittee report on Public Reporting/Education
(see detailed subcommittee report on HAI website)

[Introduction of Daniela Nunez from Consumer's Union, speaking on social media for the Public Reporting subcommittee]

- The Chair for each active HAI AC subcommittee (Public Reporting and Education, Antibiotic Stewardship, and C.

<p>Nunez- Here are some ideas considered to make sure that information will be presented in a consumer friendly way:</p> <ul style="list-style-type: none"> • Let the media know when the data is coming out in advance. • Invite health reporters to a briefing that will explain the data that they are going to be seeing. This will enable them to be more ready to write accurate stories about the data. • Plan a media alert a week before the report is to be issued. • Consider providing the report to the media for their questions in advance of writing their stories. • Assign as a spokesperson for radio media, such as morning radio shows. • Gather a list of Twitter and blog contents and links. CDPH can use its own Twitter account as well as California Association of Hospitals to alert through Twitter. • Establish a blog. For an example, CDC has a blog called State Healthcare which can link directly to public reports. This can be circulated to the media and other sources. It contextualizes the information in a way that the public can understand and comment. • Develop a short URL that is descriptive of what is being presented. One example would be californiahospitalinfectionreport.org or .gov so that there is an easy reference that can be communicated to the public. If the Department has an email list they can be alerted. • Use a graphic button on the homepage of the CDPH website that links to the infection report. <p>If any of you have Twitter accounts that you want to add, send us your email addresses and we can add them. Contact dnunez@consumer.org</p> <p>Consumers' Union has a Twitter account at twitter.com/cusafepatient</p>	<p><i>difficile</i>) will prepare and send a report of subcommittee information presented during the October 7 meeting for HAI Program distribution to HAI AC members.</p>
<p>Public Reporting and Education Subcommittee report part 2 (see detailed subcommittee report on HAI website) [Alicia Cole introduced]</p> <p>Cole-Our subcommittee worked hard through the education and reporting subcommittee to come up with information that we felt would be vital for consumers to know and to educate them on the data we will be reporting. Keeping in mind budgetary issues, we wanted to implement changes and updates to the CDPH website that could be easily cost effectively done to make the site both user-friendly and attractive to the public. We want to help foster more trust and credibility between the CDPH and our Committee and the public. We want to make sure they have enough information to see that it is presented in a way that is understandable and useful.</p> <p>In looking at the existing website, there was significant white space that that could be used to create banners and links that could fill up the space and create a more visually inviting website. By clicking on the icon "hospital infection rate public report" you can go to that information and know where to find it.</p> <p>[Presentation of the visual aspects of the website and reference to handouts from the San Diego meeting. Cole will email all those documents to HAI Program for distribution and review.]</p>	<ul style="list-style-type: none"> • Cole to email website sample documents to HAI Program

We created a site for the infection rate data with links to other pages within CDPH and CDC so that consumers can go to vital information and to get educated. There is also a link to the hand washing site. We included the history of the vaccination declination rate data collection process to give consumers and understanding of how and why the data was collected, risk adjustment and stratification at a basic level and letting them know the whole process as well as the importance of vaccination.

There is a consumer information center page as well as links to the hospital infection reporting and vaccination. They can put in their zip code to find out where to go for vaccine shots. We discussed how we are going to validate sources of information to include in links. With all the links that we have on the site, they all come from reputable sites like CDC, IHI and SHEA that have great information for consumers.

December 5th-11th is National Influenza Vaccination Week and we will include this information to encourage the public and healthcare workers to take part in this. We also have links and reports for healthcare professionals. We also have links and information in Spanish and text links to several other languages.

Healthcare workers can click on a link that brings them to a .pdf with information they can print out to give to their patients or to post in the offices. It is available in several languages. This will become a hub for information on how to protect workers and patients.

We have tried to be cognizant of all the aspects of healthcare that are impacted by this information. We also want to get the word out that if you are sick, stay home.

We have also included information on seasonal flu and staph infections. We want the public to be aware that the symptoms may mirror each other.

Chair- Did the subcommittee validate that the definitions are current and have valid information?

Cole-The definitions come directly off the CDC website. This is just a mock-up, but the actual text will be up to date, and the oversight group and webmaster will insure that.

(discussion regarding specific links and information and updating of information)

McGiffert-You found great information and content to include. It is hard to know when you are most up to date and to keep it updated. It will need to be maintained to be useful, especially the areas of most interest to consumers.

Cole- We will continually go to the source websites and keep them updated.

Chinn- Is it possible to find a place to explain the formal recommendations of the HAI? For our purposes as an advisory group, it would be good to have that.

Cole- We do have a page dedicated to the HAI AC, so that would be great to have the official recommendations up there. If someone would volunteer to propose that documented text, we can format it.

Rosenberg-Some of these things will take some time like the page construction. I would encourage everyone to look at the site as it stands. Sources of information can be added, and you can send the Program links to consider. If it is a government agency, it would be no issue. If it is something else it will have to be vetted for appropriateness. Just as an example of what can be done, there is a link to the CDC/SHEA patient guidelines. Note to the HAI AC that the HAI Program has no control over the tabs at the top or the left side of the page; these areas are controlled by the Department.

Question-Jon, are you going to be the editor of our website?

Rosenberg- If I have any questions or uncertainties about what should be posted I would review that with Kathy Billingsley.

Moss- We need to have someone verifying that the information is accurate.

Rosenberg- I would be responsible for that. Some things I do not need to approve, but new content I would need to approve.

Cole- The links are set up to be cut and paste to make this possible to do with few resources. Everything in there is already pre-packaged.

Chair- Do I hear a motion to ask for resource allocation for sustainability for this website, to have the right amount of CDPH HAI program staffing to continue updating the website.

Rosenberg- In Missouri, their website cost \$500,000 per year and they lost all their funding. They announced that they would remove all prior data and would only post new data. They road-tested that and you would only see one quarter of data. They rescinded that and left the old information.

Moss-There is funding set aside from this legislation. We need to ensure that the money that is guaranteed is set aside for this website.

Rosenberg- There is no money set aside for that. The money is set aside for this Committee. But the Program could ask for funding.

Cole-Motion: that the HAI AC asks CDPH to provide necessary resources for continuing the maintenance, verification and communication validation of the data for the HAI website.

Discussion:

Comment- It is not just about maintaining the website; it is about focusing on communication and how we keep the resources to have people develop communication and ongoing education for various sectors.

Rosenberg- The concern is that the websites do not get funded and there is attrition. If we do not fund the core the rest is superfluous. We need a

commitment to fund basic functions of this website.

Comment- It is going to be critical that the data that will drive the initial interest be easily available and that the data is reliable for our communication strategies.

Rosenberg- Looking at the future is one thing. The challenge in front of the Committee given that there are limitations to the data that will be posted in January, if the Committee wants to post advice or guidance in making the data available given that the initial recommendation was not to post the data...

Nelson- Can we make the statement stronger to "provide" than "look into".

Restatement of Motion with amended language:

Motion: HAI AC requests CDPH provide the necessary resources for continued maintenance, verification and data validation of the HAI AC website.

- **Motion—Cole**
- **Second—Myers**
- **Motion Passed by (15-0-0) vote**

Cole- There will be a space for public comment, to make suggestions, raise issues, or point out areas of concern. There is already a similar space on the CDPH website; this website would borrow that feature.

Rosenberg- I would like the subcommittee to consider the degree of interactivity that the program should have. At this point the HAI Program doesn't provide the public with a direct contact point. There is one for the Committee but not for the program.

Rosenberg- The Program hasn't had a chance to fully consider the extent to which Program resources should be a direct resource for people, or whether it makes better sense to direct them elsewhere. The Program could consider a mailbox. I would welcome your thoughts.

Murthy-I suggest that the Committee consider posting a calendar of events for the public. Facilities could see key dates and the public would have that information as well.

Myers-There should be a way for the public to report when they feel there is a data discrepancy. For example, if a hospital has reported no CLABSI data and a patient has had one, that patient should have a way to submit that information for review and validation.

Cole- There are complaint forms in Spanish and English available through CDPH to fill out information about a facility. We would need to add a section on HAI reporting. That mechanism is in place but we can give it more visibility.

Rosenberg- It could open a floodgate of people reporting in data without a means for our Program to validate what they are reporting. With the legislation, there is no way to determine (by patient name) if any person's infection was reported.

[review of handout and mock-up of additional site information and links regarding laws and reporting mandates]

Rosenberg- What are the steps whereby the Committee as a whole can make a recommendation that we adopt certain or all of the aspects of the site? It has to be a recommendation from the Committee. We could do that separately for the 2008/2009 and 2009/2010 data or just for the 2010/2011 data. Some of the suggestions for education material may fall into what we are going to be directed to do to increase influenza vaccination rates.

Chair- The Committee, by the next meeting, will have reviewed the subcommittee recommendations, revisions, additions and priorities. We have scheduled a November meeting, so by that point everyone needs to get back to (Moss/Cole). C. Moss will compile that information and present to the HAI AC in November. Then the HAI AC will make a decision going forward. By November 11th, everyone needs to have their input and suggestions in to the subcommittee.
[example of link to .pdf shown]

Cole-CDPH is having a contest and a film festival, so we want to also get the word out about that. They are trying to engage the public in reporting vaccinations. As the HAI Committee, we want to encourage anything the agency is doing to promote vaccinations. All the information is on the CDPH website.

The subcommittee suggests having information explaining what risk factors are and how the data is risk adjusted. The public needs to understand the factors so that there is a sense of trust and transparency of why certain infections are being counted in a different bucket.

Torriani- There should be some explanation for now of why the data is not being risk adjusted, not to give a false impression that the data is risk adjusted when it isn't.

Cole- The subcommittee recommends posting a history and information on NHSN and what they are, along with links to past reports they have done. We also want to explain how this Committee came to be, how SB158 and 1058 relate, and an explanation of Niles Law. There will be a link to the Bill itself. There will be information on SB 739 as well. There will be information on MRSA, c diff, bloodstream infections, etc.
[further review of links and pages planned for the website]

Description of web-pages and information links including:

- Catheter types
- Hygiene
- Hand-washing initiatives
- Healthcare worker resources

Rosenberg- Originally I was going to act as liaison between the Metrics subcommittee and this group and then Metrics was dissolved. There is a big challenge in writing recommendations about the data limitations of a report that hasn't been released. Originally the Program thought we were going to do the influenza report with the list of the non-reporting hospitals, but the decision was made to report each hospital's rates. The data is not

validated; the methodology in this report is not consistent; and there is a link to ways in which collections and reporting of data can be improved. I have heard a couple of references to what came out of CDPH subcommittees as something people want in that report, which is what was the original recommendation from the Influenza subcommittee and the Metrics subcommittee on what those reports should look like. CDPH will be doing that with your inputs. You can probably assume the influenza report is going to look the same as the prior report; work on the upcoming review will happen in November. At that time the Program will have a better idea about what the report will look like and what this group has said about it.

Moss- Is your plan to get this out and include it on the evaluation.

Response: Yes; that was sent out on October 6 with the presentation.

Member- There are a couple of different opinions on guidelines for the subcommittee meetings. What are the requirements for a quorum?

Chair- The same 2/3 requirement applies.

Subcommittee Report / Antibiotic Stewardship
(see detailed subcommittee report on HAI website)

The subcommittee discussed the value of something that would be 'surveyable', that will be viable, and considers different elements in what represents an antibiotic stewardship program. We felt that this is really what constitutes an antibiotic stewardship program and what is achievable by all hospitals. Hospitals need to do risk assessment and demonstrate that they monitor and evaluate the resistance traits. Usage of antibiotics needs to be examined, collected and available to evaluate whether an antibiotic is over-used. A rural facility is different than a hospital in the city. You need to define your own expectations for your facility in medical usage evaluations. This is a standard practice for many medications but needs to be performed for antibiotics as well.

The subcommittee suggests documentation that an antibiogram is not only produced but also used for education and distributed to clinicians. We will be looking to define the elements of the antibiogram. This isn't likely to be controversial; it will be rather boilerplate, just again: what are the elements at all the facilities it goes to, such as facilities that have intense IT capabilities? The stewardship program must be overseen by a trained individual.

We look at parameters that we expect to us to track usage patterns for broad spectrum antibiotics. These would include general categories, negative agents, positive agents. Your surgical care performance measures which everyone collects, the stewardship program should review if it is being done correctly; defining dosing and usage of antibiotics so that we can compare it to other facilities usage, and perform medical usage evaluations and actions required.

We did not have enough persons on the conference to make a quorum so this is not a recommendation. We are going back next month along with the tougher issues which would be outcomes and reporting.

Discussion:

Myers-There are several ways to enter antibiotic use. I would ask the subcommittee to decide whether it wants to be prescriptive and say X is the only way to measure this, or if we want to have several ways to measure antibiotics, all being acceptable. We are trying to give some guidance for Licensing and Certification when they do the evaluations. We also said that antibiotic steward positions for training are not IT specialists or pharmacists. It would behoove us to be more prescriptive with the legislation and outline the courses required.

Witt- Although I wouldn't say we have total consensus, the sense most of the subcommittee has is that we want people to use something that makes sense that is standard for their facility and it will need a little more discussion. If we are not trying to compare data it may not make sense to specify exactly what methods are being used, but if we are trying to compare outside, it would need to be more standardized. Some of these can be converted to be compared but will take a little work, using daily dosage or another method.

Moss- Please define daily dosage.

[Presented as average dose per patient for the average 60 lb. patient and divide it by the total usage. Days of therapy (DOT) you are actually measuring the days that someone was on therapy and accounts for pediatrics, renal failure patients, etc.]

Torriani- We should be very gentle because we don't want to be a mandate of "this is what you are going to do". There should be a minimum requirements guideline; then we may suggest additions to the minimum requirements. We should also think of what this means for licensing and regulatory issues.

Rosenberg-I don't think it has anything to do with enforcement of SB739 provisions, which are already underway. The patient safety surveys are under pilot now and all they are asking hospitals if they have a process in place. After a certain number of surveys, the entire experience is going to be reviewed and HAI AC will have an opportunity to participate in the review. The main requirement at this point is that the hospitals can provide documentation that they have a process.

This could be tasked by the Committee in different ways. This is how we publish our guidelines all the time and Licensing allows us to do that. This is intended to be advisory only, and as a tool to assist hospitals in developing their own policies and procedures. I am not aware of any facility that has been cited for being out of compliance. By the converse, we could say this is the minimum, and say to Licensing that they should be citing. We should indicate how this is intended to be used. Licensing is not obligated to enforce this.

Comment-There are some specialty hospitals that might not fit the classic rule. There has been a recent article indicating that customers are taking recommendations as regulations. If we use something like days of dosage, we need to understand that one size does not fit all.

Witt- Each IT capability is different. Some have no IT support. What we

would use is our definition of antibiotic use. If it winds up being a comparison between facilities its different that using it to look at your own. It is complex and the comments will be discussed next week.

C. difficile subcommittee:

[See detailed C. diff subcommittee report on the HAI website]

Murthy-There are several key issues in regards to C. diff that were discussed at significant length in our subcommittee. One of the drivers is the desire for standardized reporting to make it easier for interpretation and consistency of methodology. However, there are some significant limitations. The current methods don't really provide for risk stratification. There is a high level of risk variation between hospitals. Some hospitals we have a much higher rate, and nursing home patients by virtue of their underlying diseases have higher rates.

Another issue that has emerged relates to new technology that has become available, specifically the PCR technology which is much more sensitive than traditional methods still used by many hospitals. Hospitals using PCR technology would appear to have significantly higher rates because of better detection. There isn't a good way to reflect that stratification in the data.

Terminology in the CDC/NHSN Lab ID module is important to consider. The terminology used is "facility onset" and "community onset". The language makes it appear that the onset is attributed to the facility. There are some flaws with that. C. diff can have a fairly long incubation period, so somebody who was exposed to antibiotics may have the onset of disease after hospitalization. There is not a good way to screen for this. The Lab ID module asks for every positive test procedure to be reported. It misses out on hospitals to evaluate if the infection was contracted in their facility or is just a test result.

Although the Committee came up with some suggestions to CDPH to work with our CDC colleagues in modifying that to include some of the risk stratification fields, we do not know what the timeline would be if CDC agrees to do that.

I look forward to working with the Public Education and Reporting subcommittee; how we report this data would be significantly different than CLABSI and MRSA data.

The data interpretation for C. diff is complicated because of the epidemiology of the disease. There is a higher rate of recurrence of disease. Because of this and the timeline involved, there are issues with whether the disease was contracted at a different facility. We agreed that it would make the most sense at the moment to implement the lab ID reporting module but there were some caveats we felt strongly needed to be brought forward. The terminology that is used by CDPH should be reflective of the healthcare associated vs. facility onset category that we are referring to so that it is open-ended in terms of attribution. We should ask the hospitals for which testing processes are being used in the lab and that might help in stratification of differences in rates. There is a field that asks if the patient was recently discharged from

your facility within the prior two months. It does not ask the question as to whether they were in another healthcare facility such as a nursing home. This would address one of the gaps in the data.

We are awaiting input from CDPH as to whether the requests have been made to the CDC and NHSN programs and what the timeline will look like.

The last issue is the public education of both: a) how *C. diff* occurs, as well as B) how to understand this data. There is also a component of education to the healthcare providers.

Janssen- The methodology is on schedule. I don't know whether they can do things incrementally or if it has to be done as a package. I know the implementation of the password substituting the secure digital certificate is going to be delayed.

Rosenberg- The way NHSN is doing changes now is with a change control board. Anytime you change one thing it impacts another. Things are prioritized for what can easily be done. You have to schedule all of the changes to be done at the same time.

Comment- What about other risk factors other than your own facility?

Janssen- They said they would consider it with a formal recommendation.

Torriani- CDPH needs a recommendation, otherwise it will not happen.

[resumption of subcommittee report]

Murthy-The subcommittee has been asked to look at or identify the role of CDI as a surrogate marker or measure. We haven't made a formal recommendation on that. Another issue in collaboration with the Public Education subcommittee is how best to use the Lab ID Reporting module. And we will address how to focus in the absence of these fields if there is an opportunity to have CDPH have access to these fields.

Comment: We can look at adoption of PCR for 2010 after April 1st. That won't be picked up by NHSN once they institute that. Anyone can give us the date which they adopted PCR.

Flood- You have three sets of data. You have community onset, healthcare associated and healthcare onset. My question to CDPH is what to do with those data sets? If you use hospital specific it would be valuable for the community at large to see the community onset, such as community associated MRSA.

How is CDPH going to use the data to tie it to a facility?

Rosenberg-CDC will be in the process of developing risk adjustment for CDI during this next year. One consideration is the use of community onset cases as a measure of pressure on the facility. It shows the complexity of this. This is not a device or procedure associated measure. There is no measure of an acceptable rates level developed.

Motion for the C Diff subcommittee to make recommendations regarding the public reporting of *C difficile* data.

- **Motion—Oriola**
- **Second—Wittman**
- **Motion Passed by (12-0-0) vote**

Terashita- Regardless of the outcome with risk stratification, it would be beneficial to start collecting this data, so can we recommend that we start collecting this data at some point in time so that we can use it regardless of when CDC takes it on.

Janssen- I'll answer partially and ask Jon. One concern was the burden on hospitals. On the other hand there was significant interest from hospitals wanting this kind of approach. We did want the ability to have as a backup option, collecting this data so the CDPH would have the option. We can wait until the next meeting to see whether we get a response back.

[Question regarding the motion from last meeting regarding the MRSA screening of infants.]

Rosenberg- Look at the MRSA screening provision of SB1058. Read the last provision of that subdivision, # 2. "The Department may interpret this subdivision to take into the account the recommendations of the Committee or its successor".

I noticed that a week or so ago and asked the lawyer what authority was provided the Department given that the Committee has made a recommendation for one of those aspects. His initial determination is that it doesn't authorize us without going through regulation. His advice is that it doesn't provide CDPH the authority to eliminate a provision for screening that the Department has previously stated does apply. It doesn't allow CDPH to reinterpret.

Kathleen (Billingsley) will look at the lawyer's interpretation and move forward. CDPH still may be required to go through the regulatory process. There still needs to be an official statement on this. There are a number of elements in SB1058 where there are phrases such as "increased risk for invasive MRSA" that are not defined in the statute in the legislation.

Therefore the Department can not determine for the hospitals what constitutes risk of invasive MRSA. *Whether* the Department will tell you more than that I cannot say. If you make a determination for yourselves and develop a quality procedure on the basis, the Department cannot take issue with you and say that is the incorrect interpretation, because the statute does not give any guidance. Recall the screening for surgery issue; that was similar.

I don't know if the Department can tell you that doing *nothing* is acceptable. At least you will know that making a decision on the basis of your interpretation is better than doing nothing. As long as you are doing something you should be covered.

Member- I would ask the support of this Committee in reviewing AFL's before they are issued. They could be read to contradict each other. Since

<p>this subcommittee does advise the larger HAI AC, maybe we could have the subcommittee review the AFL's.</p> <p>Rosenberg-Since there may be a period of three months between meetings, I would ask for a clarification on the intent or desire pertaining to this motion.</p> <p>Member- I would say before release would be my expectation. I would be open to send this out for review for comments and not have a full meeting.</p> <p>There will also be things that other people will catch and can inform CDPH that there is an issue.</p> <p>Motion: that the HAI AC be allowed to review CDPH AFLs on issues of infectious diseases for licensed health care facilities one week prior to the release of the AFL.</p> <ul style="list-style-type: none"> ○ Motion—Nelson ○ Second—Wittman ○ Discussion: no further discussion ○ Motion Passed by (12-0-0) vote 	
<p>Action Items (Chair)</p> <ul style="list-style-type: none"> ● HAI Program to send a Thank You letter to Sue Chen for her work and dedication to this Committee and the Program. ● HAI Program to send a Thank You letter to Martha Swaim for sharing her story. ● HAI Program to report to HAI AC members on the number of California hospitals that have “joined CDPH” toward the goal of conferring rights for NHSN. HAI AC has requested list of those facilities that have not joined; this recommendation is under advisement within the HAI Program. ● Standing action item: each HAI AC subcommittee Chair will prepare and send a report of subcommittee information presented during the October 7, 2010 meeting for HAI Program distribution to HAI AC members. ● Add agenda item for November 2010 meeting: data review (collected data to be presented to HAI AC by HAI Program). ● HAI Program to distribute Danielle Nunez contact information: dnunez@consumer.org. ● HAI AC Chair and HAI Program to consider adding to future agendas: death certificate reporting; how health care complaints are addressed, particularly how the HAI Program will interact with the public; and, how to encourage health care facilities to report suspected deficient care (in long term care centers or other health care facilities). <p>Next Meeting: November 18, 2010. (Sacramento).</p> <p>Murthy-Is there still an opening for CDPH and the Committee to work with legislation to modify some of the elements? Is there recourse from a legislative aspect as we mobilize as a group and get public data to make it more meaningful?</p> <p>Rosenberg-There is not a formal process to do that within the Department. There is the Office of Legislative Affairs which is the liaison</p>	<p>[Listed to left under Action Items]</p>

between the Department and the legislative offices and it is the only interface available. The Program takes direction from that office. There is a hearing scheduled on October 20th on the HAI legislation, so that is one opportunity. There is often an opportunity to make comments at the hearings.

Comment- The Senate Health Committee is going to be having an oversight hearing of these programs and I believe there will be representatives from the Department. We have the due dates of when certain things are supposed to happen and the ongoing activities. A lot of it will clarify what changes are needed. I believe Kathleen Billingsley will be attending.

The responsibilities of the Department will be reviewed in that meeting.

Chinn- We had this issue with "all" GI surgery. I understand that the Department can't interpret the law.

Orr- The Senate Subcommittee has an agenda, but anyone who wants to speak or testify, or give out handouts can speak and address them.

Chair- Please put HAI AC in the queue for comment. HAI AC will be there to ask for clarifying language. K. Delahanty to send M. Orr a formal request to be on the agenda as HAI AC.

McGiffert- The HAI AC should consider being included on the agenda and not part of the public comment.

Future Meetings:

Agreement on **December 9th** as meeting date. Location to be determined.

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
CDC	Centers for Disease Control and Prevention
C-diff	<i>Clostridium difficile</i>
CDI	<i>Clostridium difficile</i>
CDPH	California Department of Public Health
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
MRSA	<i>Multiple-resistant staphylococcus aureus</i>
MUE	Medical Use Evaluation
NCSL	National Conference of State Legislators
NHSN	National Healthcare Safety Network
NQF	National Quality Forum
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>