

## Clostridium *difficile* Subcommittee Recommendations

Meetings of July 29, 2010 and August 12, 2010

### Access Information:

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Recommendations discussed at the pre Aug 30 conference meetings (recs 1,2,3 were presented to 8/30 HAI AC I believe)

1. Subcommittee recommends using NHSN Lab ID Events reporting for C Diff with the following comments and caveats

Pros: Standardization and consistency of reporting

- \* Overall implementation would be standardized across all hospitals by using Lab ID events (no individual interpretation)

- \* Consistency of reporting likely to be higher

Cons: Problems with attribution of CDI to hospitals and terminology misleading

a. Data flawed due to lack of control for variations in hospital testing methods (toxin EIA vs. 2 step antigen + either culture vs. PCR vs. antigen vs PCR alone)

b. Data likely to misrepresent hospitals with higher at risk population admitted or transferred (who may be incubating or recently with CDI in another healthcare facility) as having higher CDI rates as the incubation period for CDI may be up to 4 weeks

b1. NHSN correlates hospital-onset, facility-associated with having been hospitalized in the facility within 4 weeks of positive test. This methodology does not take into account care provided at other healthcare facilities, e.g. outpatient clinics, infusion centers, outpatient dialysis units, skilled nursing facilities

c. Duplicative efforts required of hospitals already conducting chart reviews for CDI for institutional QI efforts (focused on probable nosocomial CDI)

d. Terminology of "Healthcare associated – Hospital Onset" will require significant education for public reporting

2. Recommend use of "facility-wide" reporting module and not unit specific in the NHSN Lab ID event reporting module

3. Recommend that CDPH collaborate with CDC to request additions or modifications to the Lab ID event reporting for CDI as follows:

- \* Remove unit specific info as mandatory

- \* Add testing methodology of facility (EIA, PCR, culture etc) to assist CDPH in stratification

- \* Add a field re recent healthcare associated risk factors (ie SNF, d/c from other hospital, dialysis, outpatient surgery, etc) see B1

(interim use adoption of Lab ID event not contingent on CDC action, but subcommittee endorsed deferral of reporting pending CDC-CDPH actions)

4. Subcommittee did not endorse CDI rates as a reliable proxy measure for abx stewardship given the many confounding issues contributing to CDI – e.g transmission factors and environmental factors etc

5. Subcommittee made a strong recommendation for an education program to explain the meaning of CDI data to public as distinct from the HAI due to MRSA/VRE
6. Specifically, subcommittee recommends caution when reporting is initiated to use "Healthcare associated, hospital onset CDI" (ie as facility specific) RATHER than "healthcare associated facility-associated" so as to avoid inaccurately attributing the CDI to individual facilities. The subcommittee strongly opposed use of the NHSN specified component termed "hospital-onset, facility-associated CDI" (see slide 47 in CDI training module), as per discussion above in B1. It would be reasonable to suggest that we relook at the data when 3c is up and running such that only if the answer is a NO (to being in SNF and other healthcare venues) and the patient was hospitalized in the facility within 4 weeks of the testing, that the CDI be considered facility-onset
7. Recommend "providing education to healthcare facilities not to obtain CD testing as a test of cure" since the toxin/pcr may be positive for a long time and a positive test on the same patient > 8wks would be considered a new case