

**Healthcare-Associated Infections Advisory Committee (HAI AC)**  
**May 27, 2010, 10:00 a.m. to 3:00 p.m.**  
**Location: Sacramento**

**MINUTES**

**Attendance**

**Opening Remarks:** Mark Horton, Director, California Department of Public Health (CDPH)  
 Kathleen Billingsley, Deputy Director, Center for Healthcare Quality  
 Gil Chavez, Deputy Director, Center for Infectious Diseases

**Members:** Kim Delahanty (Chair), Mike Butera, Ray Chinn, Alicia Cole, Enid Eck, AnneMarie Flood, Kelly Green, Dan Gross, Lilly Guardia-Labar, Tom Jackson, Brian Lee (alternate), Lisa McGiffert (alternate), Mary Mendelsohn, Carole Moss, Rehka Murthy, Frank Myers, Terry Nelson, Shannon Oriola, Debby Rogers, Todd Stolp, Dawn Terashita, Francesca Torriani, Mary Tran, Lisa Winston, David Witt, Kathy Wittman

**Guests:** Reneta Ancion, Jeanne Burkhart, Saul Fingold, Tamar Foster, Lynn Wilkins, Melissa Dyers, Chris Cahill, Bruce Holden, Brian Lee, Tina Menasian, Roberta Mikles, Amy Nichols, Daniella Nunez, Sayad Sayeed, Debbie Wong

**CDPH Staff:** Sam Alongi, Melissa Anastasio, Kathleen Billingsley, Gilberto Chavez, Sue Chen, Letitia Creighton, Kate Cummings, Roberto Garces, Cheryl Kalson, Tricia McClendon, Jon Rosenberg, Kavita Trivedi

Agenda Items/Discussion	Action/Follow-up
<p><b>Call to Order and Introductions</b>            HAI Committee Chair Kim Delahanty convened meeting. Introductions were made at Sacramento and on the teleconference lines. Thank you all for joining us today.</p> <p>Dr Horton- I wanted to join the excitement and enthusiasm of this group. I would also like to credit the Little Hoover Commission and the work they did in stimulating the first advisory working group focusing on HAI and acknowledge the tremendous work that was done by that group to establish the framework for the legislation that was passed soon after that mandated reporting and created the program here in California. There was a hiatus because of a lack of resources. The American Recovery and Reinvestment Act (ARRA) has provided the funding to allow CDPH to move forward, put the program together, and reconstitute this working group. I want to particularly thank Dr. Gil Chavez and Kathleen Billingsley for their leadership and commitment in working together. It was important that there be close collaboration between the Center for Infectious Diseases (CID) and Center for Healthcare Quality (CHQ) in establishing this program. I want to specifically single out Dr. Rosenberg who in some cases has been our sole resource and expertise in this department. Thank you all for your commitment to this effort; count on the fact that CDPH will listen and will act on your direction on moving forward.</p>	

<p>Billingsley- I can't tell everyone here just how pleased we are to bring this committee back. We are very fortunate to be one of the few programs to be approved by the Governor to have funding to build up this program. Staff positions were just established in December of this last year and excellent staff are in place. But we also need your suggestions, your input, your recommendations, your thoughts and your intelligence. I welcome the opportunity and thank you for allowing me to be part of this.</p> <p>Chavez- We really need to celebrate where we are now. Five years ago, there were only two persons in CDPH tasked with working on healthcare associated infections (HAI) and that was Jon Rosenberg and Chris Cahill. There were only a handful of hospitals in the NHSN pilot program; there was no hospital data to look at; no capacity to work with hospitals; and no standing group with the expertise that we have now at this table to advise CDPH on direction. Fortunately, in the early stages, CDPH also recognized that consumer input was very important to advise CDPH on their experiences and expectations. CDPH has made strides; certainly there is a long way to go, but we are moving forward so that healthcare infection rates go down in California. Thank you.</p>	
<p><b>Public Story</b> <b>Bruce Holden</b></p> <p>Mr. Holden shared his experience in acquiring a HAI after receiving full knee replacement surgery three years ago. Mr. Holden recounted that he first noticed red spots with itching on his chest the very first day which proceeded to get worse in the days after. He was dismissed from the hospital and was later diagnosed by his primary care physician with a Staph Infection. Mr. Holden shared that he was not bathed in the hospital as well as his concern for being given a lot of antibiotics for his knee, his chest, and Staph Infection that resulted in burning his stomach and intestines. Mr. Holden shared that he now lives with the long-term effects of pain and discomfort.</p> <p>[Mr. Holden provided copies of his experience to Committee members and guests]</p> <p>Moss- There are hospitals that do a good job bathing but more often than not, we are hearing of people not getting bathed before surgery. This topic should be included on the next agenda.</p> <p>Cole- When I was in ICU, I was not bathed. Did you or your family report your infection to the health department? Do you know if your hospital reported it?</p> <p>Holden- Possibly my primary physician did. I do not know.</p> <p>Moss- Reporting is a huge topic; maybe we can come up with ideas on how to let people know how to report infections.</p> <p>Whitman- Are you talking about bathing before or after</p>	

surgery? These are two different things.

Moss- Before.

Chinn- Preoperative bathing has many protocols. All patients that have joint-replacement elective surgery are instructed to bathe before coming into the hospital.

Moss- It is the patient's responsibility?

Chinn- For the preoperative bathing, yes. There is research coming out that frequent bathing with a certain kind of soap decreases the incidence of MRSA. Based on this research many hospitals are moving forward with implementing the findings.

Member of public- Pam (a guest here today) had surgery after which she acquired a HAI. While in her room, which was set aside for a patient with an infection, I was witness to a healthcare provider who did not wash his hands. In the room there was antibacterial lotion and gloves; however, he did *not* wash his hands, use antibacterial lotion or wear gloves. He proceeded to insert a line and Pam realizing he did not take precaution told him "I have a staph infection." It is fine to have rules but we have to make sure people follow them. We have to remind patients to insist that anyone who enters your room to wash their hands.

Chair - I applaud you and all the advocates here. No one in this room in healthcare would say that the behavior you described is appropriate. The enforcement is a multiple prong approach from the State Enforcement Agency, the HAI Program and Licensing and Certification; then it trickles down to the actual administration of each individual hospital. We build in tools, education, and monitoring. But we don't always get 100%; one of our goals is to partner with the patients and the advocates for patients so we can have a culture change and we can make it safer for all of us.

Whitman- Pam, I like your flyer idea for empowering the patient. All of us as IPs preach that same message; please continue your fight to spread your message. We have already had the benefit of meeting with our field IP along with our County Health Officer. It is very important that you make the time to meet with those field reps in a joint session; we only have through 2011 to take advantage of what the State is offering us. The support my field IP is offering me differs from what he is going to do for the other two hospitals at the meeting. They need help with computer-based stuff. I'm having him come into my facility to do assessments. Take advantage of it.

Rogers- We are delighted to have this extra layer of support; CHA is working with CDPH on getting a letter out to our PPOs. We are working on a combine letter to introduce our field staff and hopefully we will get that out in the next week.

<p>Chair- Thank you Bruce, for coming here and sharing your story with us today.</p>	
<p><b>Review of Rules/Charge to the Committee</b>  Chair – An e-copy of the handout with any revisions made today will be available on the website.</p> <p>Moss- I noticed there is nothing on the agenda for public comment. There should be two areas for public comment.</p> <p>Chair- Right; we are going to give time after each agenda section for any public comments and questions and any Committee member comments and questions.</p> <p>Moss- Going forward, will that be noted on the agenda?</p> <p>Chair- Yes.</p> <p><b>Motion (Cole) - Move to post HAI Committee transcripts verbatim on the HAI website.</b>  <b>Second - Moss</b>  <b>Discussion</b>  Cole- I've noticed some of my comments and responses have been left out of the past minutes.</p> <p>Witt- The process that has been developed is that minutes are approved after Committee review, so that if there is substance left out you can bring it up as part of the approval.</p> <p>Chair- Each committee member is responsible to verify that their input on the minutes represents what they would like it to reflect.</p> <p><b>Two ayes, majority no; Motion failed.</b></p>	
<p><b>HAI Program Updates</b>  Rosenberg – The HAI Program was created with the passage of three pieces of legislation: SB 739, SB158 and SB1058 which were incorporated into the Health and Safety Code Sections 1288.45 – 1288.9. The legislative mandates for CDPH to implement a program for surveillance prevention of HAIs, to acquire general acute care hospitals to report their implementation of specified section process measures and rate specified HAIs for CDPH to post on our website along with current infection prevention and control information. The legislation specifies incident rates of infections be posted and be adjusted for risks using a method that is consistent with NHSN methodology or methodology that is recommended by the HAI AC for that particular section. All of these factored into the changes instituted regarding the methods by which hospitals report data to CDPH starting April 1, 2010.</p> <p>The HAI Program was authorized in December 2009; CDPH hired to the current level of staffing at the end of March. The</p>	<ul style="list-style-type: none"> <li>• Collect membership information for Antibiotic Stewardship subcommittee</li> <li>• Schedule Antibiotic Stewardship subcommittee meetings</li> <li>• Convene Antibiotic Stewardship subcommittee</li> <li>• Antibiotic Stewardship subcommittee to report on progress at next HAI AC</li> </ul>

program is supported 60% through designated state funding and 40% through the federal Department Health and Human Services (HHS) grant for the next year and a half. There is an expectation that the federal funding will be continued; appropriations cannot address that year in advance so CDPH won't have that in writing until sometime in 2011. The CDPH HAI Program has two vacancies; a data management position that is the key to accessing and analyzing data from NHSN, and a healthcare education consultant designated to manage the website and implement the actual process of public reporting. This position also is intended for outreach and messaging, an interface with all the different public advocacy groups. CDPH is working to fill both of those positions. The HAI Program is situated within the Center for Healthcare Quality (CHQ), work directly with Kathleen Billingsley, and maintains a distinct program separate for L&C. Information we acquire from hospitals is not shared with L&C. The requirement for data reporting started in 2009. In the absence of a program, the data submitted to CDPH was stored; it was not examined, evaluated or analyzed. As of March 2010, the HAI Program has sufficient staff to begin the process of accessing and evaluating this data. The Influenza Vaccination Data is the only data that CDPH is not logistically able to collect through NHSN at the time. There is a process being initiated at CDC to address that but currently there is none so this data has been collected through a standardized form since 2008. The results of the initial evaluation will be presented by the HAI program's Epidemiology Team. CLIP data was collected starting in July 2008 by form; the NHSN module to collect that data had not been implemented. That module was implemented in January 2009 so that data has been submitted and stored in NHSN and will be analyzed in the future. SCIP data is collected by HSAG, the California QIO; HSAG is something CDPH will have to deal with in the future. CLABSI data was previously submitted by form and this data cannot be appropriately evaluated due to locations in which this data was collected, the completeness of the data, and some data being reported by form and in NHSN by the same hospitals. Since the reporting mandate began, CDC implemented a risk-adjustment methodology called the Standardized Infection Ratio (SIR). This morning, CDC released a report which is the first National and State Report of CLABSI data. California data was not included in that report because during the timeframe the report covers, from January to June 2009, California hospitals were not mandated to use NHSN. The criteria for states to be included was that the state mandate reporting of CLABSI through NHSN. CDI data previously submitted by form also cannot be evaluated because of discrepancies over the definitions that were used; this will also be corrected by the use of NHSN which relies on laboratory data and not clinical surveillance data to collect CDI information. MRSA, bloodstream and SSI infection data previously submitted by form has not been evaluated. CDPH obtained a grant that provided an opportunity to fund eight field IPs to facilitate the contact between the HAI program,

local departments of public health, and local hospitals. They will be supporting local, regional, and statewide Infection Prevention Collaboratives.

Tamar- What is the duration of the grant supporting field staff?

Rosenberg- Through the end of 2011. The grant required every applicant to describe the process in which those positions would be permanent so that process is in place. The intent is if the job is done as written and done well, you will not want them to go away. The only way that is going to happen without federal grant support is that hospitals agree to an increase in their L&C fees.

Rogers- The fees are included in the budget; I am not sure how this part of the HAI program was written in, if it would automatically be included.

Rosenberg- It is not in the legislation of the L&C Special Fund. It may take another piece of legislation to continue funding these positions. The program was a seven percent increase to licensing fees last year. The hope and expectation is that the federal government will continue the funding.

Murthy- Jon, a question for you regarding *c diff* reporting and the change to laboratory-based reporting. Some hospitals have adopted PCR Testing which is more sensitive and many hospitals continue to do CDC-defined nosocomial determination for *c diff* rate; how will that be adjusted now that we use laboratory-based reporting and how will the differences in testing be captured?

Rosenberg- They can't be adjusted now because CDC doesn't have an item for reporting what laboratory test was used; they are in the process of implementing that change. CDC recognizes that as there is a shift towards molecular testing, there is a need to know what test was used for the surveillance. Once that piece is in place, then CDPH can determine how to adjust for it.

Murthy- For hospitals currently doing ICP-based surveillance determination for nosocomial *c diff*, are they going to be able to continue to report in that way?

Rosenberg- Not to CDPH; but you are also going to have use the Laboratory ID module. If you are already reporting each one of those patients as events, all you're adding on is your laboratory data.

Murthy- So you know there is a discrepancy of about two-to-three fold?

Rosenberg- Right. The only way to ensure consistency in respects to the laboratory test used is to have one method of

reporting, and the only one that makes sense is to require all hospitals to use the Laboratory ID Event.

Myers- There are questions about the seeming contradictions in regards to the laboratory reporting. The law originally says that facilities have to report all HAIs and asks for these to be reported at NHSN, which also asks about non-Healthcare Associated Infections. Some of the information entered is classified based on the CDC definition which is requiring facilities to report *non*-healthcare associated infections. If facilities exclude those, they are clearly violating the NHSN agreement. Has the State looked at that from a legal prospective? Is there clear resolution that systems and facilities are not overstepping the letter of the law by asking hospitals to enter the data in this particular way? Basically, facilities are either being forced to report beyond what's required by the law, or forced to violate the NHSN agreement if they decide to edit those data?

Rosenberg- CDPH has a legal opinion that supported the decision before it went out. CDPH is not reporting to the public community onset cases that are not associated with the facility; those will disappear.

Myers- In the first quarter of 2010 there are cases that are recurrent cases, but as the prior data is not entered, the only recurrent cases being entered are those which are clearly attributable to other facilities.

Rosenberg- That is always an issue; the only response is that there has to be a start point for the data.

Cole- Is there a way for a patient advocate to meet with any of the field IPs to have a brief meeting to bring a patient perspective or possibly shadow a field IP. It would be helpful to get true and valid information from a patient perspective of what is witnessed from the patients' side.

Rosenberg- Yes, that is possible. The vacant Healthcare Education Consultant when hired will be the contact person for our Patient Advocacy Groups and individual patients.

Wittman- The field IP supervisors want to make sure that everyone is doing standardized surveillance, looking at things the same way, so that hospitals can use their data. From the field IP supervisor perspective, our role is helping hospitals understand what their baseline infections are and where their problems are so they can work toward and realize reductions in infection rates. We are meeting the state requirements but we are also out there to work with the hospitals. We can meet with the patient advocacies in the interim until we have that position filled.

Chinn- Going back to CDI reporting, there are separate issues to consider within facility-onset CDIs. If a particular hospital treats many nursing home or respiratory care

patients, that facility is going to have a much higher rate of CDIs than other hospitals. The way reporting is currently done, that hospital is cited as having higher CDI rates, as these are not adjusted in any way; this would not be useful as comparison data.

Rosenberg- How CDPH reports the rates will be an issue for the Metrics subcommittee to look at. Once CDPH has that data, there will be discussions to determine how the public should look at it and understand it.

Witt- If we don't get good data, we don't get hospitals that are doing their very best by implementing advanced technology. When we move forward on data collection and reporting, this Committee should be careful with what it recommends be reported so that the resulting data is accurate. Reporting solely because it is required to be reported does everyone a disservice.

Rosenberg- I would just like to ask for a deferral of any further discussion of that because we have two presentations following lunch that will be a good starting place to begin developing these concepts.

Chair- Jon, are we going to discuss under the HAI Program Updates Antibiotic Stewardship and the Issue of Consolidated Licenses?

Rosenberg- Not today.

LaBar – I would like to see the issue of Antibiotic Stewardship put on the agenda. Hospitals support HAI prevention and the reporting of HAIs, but in dealing with MRSA, Antibiotic Stewardship is a critical issue. There needs to be, with this Committee, a strong support for that coalition

[Member]- Facilities have been struggling with Antibiotic Stewardship and assessing how best to preserve antibiotic effectiveness to deal with future infections. Even though such a program is considered the best practice by many professional organizations and CDC, cost is a major struggle. It is clearly a part of California law that hospitals be required to practice stewardship and monitoring. This issue needs to be on the table; for hospitals to implement a program, there needs to be a push from above.

Rosenberg- SB 739 had a provision that didn't get a lot of notice but in an AFL sent by to hospitals notifying them included in SB 739 required all hospitals to have a process to evaluate and monitor use of antibiotics. There is no specific charge to the Department; there is no reporting element. The need for this is motivated by the increasing resistance of Gram-negative bacilli, with development of resistance to the very last line of antibiotics. Gram-negative bacilli as a group represents about 20% of all HAIs. The number of antibiotics in the regulatory pipeline is zero; Dr. Trivedi is leading the

HAI Program's Antibiotic Stewardship Program and considering these issues.

Trivedi- I spend 75% of my time focusing on this issue of Antibiotic Stewardship; setting up different aspects to the program but the first information being collected is finding out from hospitals what they are currently doing in this area. After only two weeks of surveys being online, 200 facilities out of the 432 have responded. This is a hot topic for both consumers and healthcare professionals.

Rosenberg- Antibiotic Stewardship cannot just be confined to hospitals because many of the highly resistant Gram Negative strains are coming from long term acute care hospitals, sub-acute facilities, and skilled nursing facilities. CDPH will be actively involved with this and hope that by setting up regional collaboratives there will be sharing of those resources with these other care settings.

Rogers- Hospitals that had access to the Hospital Patient Safety Collaborative are probably a little further along on this continuum than hospitals that haven't had that level of access. Along with CHA, the Regional Associations' goal is to reach 95% of hospitals in the State. One of their planks is HAI. Those hospitals that have not had geographic access to the Hospital Patient Safety Collaborative yet will be more touched by this in the next year. In the future when you are looking for more information from hospitals, CHA will be happy to help you facilitate that in any way that we can.

Eck - In Southern California, there has been a concerted effort for Antibiotic Stewardship in the hospitals, but as an integrated system, more work is needed on the outpatient side as well. There is also concern about the amount of antibiotics use in the food sources and other places where antibiotics are inappropriately used. That could be more important; consumers have no idea the sources of antibiotics they are being subjected to. The problem cannot be stopped at the hospital level without thinking about this bigger picture. California is a position, as a major food provider for the nation, to impact Antibiotic Stewardship to people all across the country. The messaging around antibiotic use and inappropriate use would help on hospital side as well as this process as a whole.

Stolp- I was going to emphasize that 75% of antibiotics used are in the food industry. There is special legislation at this point to prevent the use of antibiotics in the food industry that is supported by the CCLHO.

Murthy- I am certainly glad to hear about the position of California to address and tackle this very complex problem not just from the hospital side but certainly from the nursing homes, the long-term care facilities, and the public in terms of unnecessary, inappropriate antibiotic use. Is there a role for this Committee through a subcommittee to formulate some

kind of consensus around a recommendation to come from the HAI AC?

Trivedi- I am constituting an Antibiotic Metrics Committee of a couple of physicians throughout the state who have a lot of expertise of Metrics Issues; we are looking at it so that as a State we can recommend Metrics that hospitals can follow in antibiotic use.

**Motion (Flood) - Move to create a subcommittee on Antibiotic Stewardship**

**Second - Eck**

**Discussion**

**All ayes; Motion passed.**

[break for lunch]

**Chair- Guidelines for Subcommittee Meetings**

- According to the Bagley-Keene Open Meeting Act 2004, all meetings of the Healthcare-Associated Infections Advisory Committee (HAI AC), when attended by a majority of members, shall be open and public when subject matter is within the jurisdiction of committee. The word "majority" is used in Section 11122.5. (a) "meeting" includes any congregation of a majority of the members of a state body at the same time and place, ..."
- Meetings also include situations where information is received or an issue studied prior to its placement on the body's agenda. In the interpretation of the Act by the California Attorney General's Office, study sessions are allowed. Under such circumstances, "However, if a quorum is involved, the study session should be treated as a meeting under the Act." A quorum was defined by the HAI AC at the August 27, 2007 meeting to be two-thirds of the committee membership.
- So long as HAI AC subcommittees maintain membership of fewer than 16 committee members, they are considered as an opportunity for exchange of information and study of issues prior to presentation to the full committee. As such, subcommittees are not subject to the Bagley-Keene Open Meeting Act requirement to be open and public.

**Subcommittee Rules:**

- Subcommittee meetings will not be open to the public.
- Guests invited to consult with the subcommittee will be cleared through the subcommittee chair and in consultation with CDPH staff. Subcommittee members should arrange the participation of guests through the chair in advance of the meeting or teleconference. Criteria for inclusion of a guest or

<p>consultant will be based on the charge of the subcommittee, to fill gaps in member expertise, and chair/staff discretion.</p> <ul style="list-style-type: none"> <li>• If an unauthorized person is found to be on the call, they will be asked, at the discretion of the Subcommittee Chair, to remove themselves from the call.</li> <li>• If the unauthorized person(s) do not follow a request to recuse themselves, the meeting may be immediately adjourned by the Chair.</li> </ul> <p>Witt – I would like to chair the antibiotic subcommittee.</p> <p><b>Motion (Nelson) - Move to appoint Dave Witt as Chair of the Antibiotic Stewardship Subcommittee</b>  <b>Second - Eck</b>  <b>Discussion</b></p> <p><b>All ayes; Motion passed</b></p> <p>Note: Dr. Witt will work closely with Dr. Trivedi on this subcommittee.</p> <p>Chair – If you would like to be on the Antibiotic Stewardship Subcommittee, please contact Sam, Sue, or myself.</p>	
<p><b>Metrics Subcommittee</b>  Rosenberg- Metrics deals with how data is selected, what data is actually selected and how that data is risk adjusted. Legislation says that our risk adjustments must be consistent with NHSN methodology. Because CDC looks at the data from a macro perspective when risk adjusting, the HAI program saw the need to have a subcommittee. Legislation does specify that the Committee may recommend a completely different method of risk assessment and risk adjustment. The subcommittee focus is just on the methodological issues of how to measure things and how to risk adjust for those measurements. The subcommittee is not dealing with how best to present the data to the public; they are most focused on methodologically, epidemiologically, and statistically what are the best, sound principles for measuring and adjusting for risks.</p> <p>The HAI program is lucky to have one of the country’s leading experts on metrics and on risk adjusting, Dr. Susan Huang, UC Irvine, to Chair the subcommittee and to find HAI AC members who are appropriate to be on the subcommittee. They will be studying the issues and developing a report, and that will be presented to the HAI AC with any recommendations. Then the HAI AC will have the opportunity in a public meeting to discuss those recommendations. Additional members of the subcommittee are: Dr. Andrew Noymer, Francesca Torriani, Ray Chinn, Frank Myers, Kavita Trivedi, Dr. Lauren Miller, David Birnbaum.</p> <p>The strength of this subcommittee is if they make a strong</p>	<ul style="list-style-type: none"> <li>• Collect membership information for Metrics subcommittee</li> <li>• Continue Metrics subcommittee meetings</li> <li>• Metrics subcommittee to report on progress at next HAI AC</li> </ul>

recommendation that the HAI AC adopts that is inconsistent with NHSN methodology, it has the potential to influence NHSN methodology. California hospitals represent more than 13% of the total hospitals registered in NHSN so the contribution to the National Database of HAIs is very important to CDC. The subcommittee had one meeting in which Susan reviewed the charge, the group discussed some particular issues, and chose CLABSI and the Standardized Infection Ratio as the first item on the agenda because that's likely to be one of the first metrics that CDPH reports beginning on January 1, 2011.

Chair- Recognizing the limitations of the data collection California hospitals have been submitting to CDPH for the last year and first quarter of 2010, I would like to give those general care acute hospitals recognition and thanks for complying with the law, even though some of the submitted data is not going to be usable.

LaBar- Although the data isn't usable, hospitals did put processes in place...that is an accomplishment in itself.

Rogers- Is a motion required to memorialize this subcommittee; how were the members chosen?

Chen- It is appropriate to go back and do this retroactively. We would like to entertain a motion for Susan Huang to be recognized as the Metrics Subcommittee Chair.

Moss- I noticed there is no consumer representative on that committee and I think there needs to be.

Rogers- To clarify, the regular procedure would be that it would come through us and we would discuss it? I know that time is of the essence so CDPH brought together a panel of experts. I just want to establish the process now that we are reestablished.

Chair – Yes.

Moss- Could you list the committee members again?

Alongi- Susan Huang, Andrew Noymer, Francesca Torriani, Ray Chinn, Frank Myers, Kavita Trivedi, Dr. Lauren Miller, David Birnbaum, Kate Cummings, Jon Teague.

Rogers- As a standard operating procedure, should there always be consumer representation on each subcommittee?

Alongi- All subcommittees are open to volunteers, although members do have to be vetted through the subcommittee chair.

Rogers- When there is a need to develop a subcommittee between Committee meetings, members should be notified and given the opportunity to participate.

Chair- Going forward, there won't be a retroactive subcommittee issue.

Rosenberg- At the time of the subcommittee's formation, CDPH had not yet determined the HAI AC membership.

Witt- This (Metrics) is primarily a technical subcommittee. For the validity of this entire committee, what is being presented needs to be explained to consumer as to how the Committee developed the technical issues.

Rosenberg- There is an interface between the two subcommittees and there could be joint meetings so that the technical issues could be explained. But the intent was for this subcommittee to be an entirely technical committee consisting of people who are expert and understand the methodology being discussed. The downside of getting people like Susan (Huang) and David (Birnbaum) is that their time is extremely limited; between now and December 31 they're going to have a significantly large number of meetings for a group separated by hundreds of miles. The intent is to create the best environment for them to get this work done. That is the sole intent for our considerations for membership and participation.

Oriola- To clarify, it is a technical committee but you want a consumer on each panel; would the consumer participants be non-voting?

Chair- They have to volunteer to be on the subcommittee and participate, but it is open to all members. I suggest we make a motion to have the subcommittee and determine who will be the Chair. Then we can discuss subcommittee membership.

**Motion (Torriani)- Move to create subcommittee on Metrics**

**Second - Eck**

**Discussion**

**All ayes; Motion passed.**

**Motion (Torriani) -Move to appoint Susan Huang as Chair of the Metrics Subcommittee**

**Second - Oriola**

**Discussion**

**All ayes; Motion passed**

Chair – If you would like to be on the Metrics Subcommittee, please contact Sam, Sue, or myself.

Torriani- This is a technical committee; the people on this committee have a very short timeframe to make decisions and make recommendations. We can always explain what

the decisions are at a meeting with the public.

Chair- To recap what happens with subcommittees, those are formed to do their work outside of this Committee. Then the Chairs of those subcommittees come back to report, there is open discussion, and public comment with questions and answers. The subcommittees themselves cannot forward any decisions to CDPH; they can only make recommendations for the full Committee to consider.

Rosenberg- To someone who is interested in being on the committees, get all the information you can find on Standardized Infection Ratio. This is very technical, biostatistical information.

Chair- Per Committee rules, the subcommittee Chair, along with CDPH has the discretion to accept or reject members who volunteer for any given subcommittee.

Eck- Because the Committee was disbanded for such a long period of time, momentum that we had around what would be useful information for consumers to make decisions has been lost. I suggest that progress that had been made up to the hiatus be reviewed and updated concurrent with the work of the technical subcommittee. That (Public Reporting) work has to be done so that whatever information is provided to the public is valid and reliable, and should be done concurrently so that the Committee maintains its credibility.

Chair- Those issues will be discussed during the 1:30 (agenda item) presentation of the Reporting Subcommittee.

Nelson- Dr. Huang, as Chair of the subcommittee, is she a member of the HAI Committee?

Chair- No. And subcommittee Chairs do not need to be members of the Committee.

Cole- I would like to ask that Committee members who have a medical background not assume that just because a person is here as a public representative doesn't mean that that person doesn't have knowledge of the issues being discussed. Please don't assume public equates with unknowledgeable. Where the Committee doesn't have a public member on a technical subcommittee, can the public representative bring in an official consultant onto the subcommittee who is an objective member of the public to bring in both public perspective and the technical aspects of the subject?

Chair- Per the Subcommittee Rules, guests are invited to consult with and to provide knowledge-based expertise.

Cole- If I am able to find someone in the general public who has that expertise and who is willing to volunteer to assist this subcommittee, how do we have that person appointed to the

<p>subcommittee?</p> <p>Chair- Such a nomination would need to go through the Chair of the Metrics. So you, the HAI AC member, would bring that information to the Chair of the Metrics subcommittee; you would volunteer to be on that subcommittee until that time, discuss it with the Chair; then that subcommittee Chair would have the oversight to make a recommendation.</p>	
<p><b>Presentation on Flu Vaccination in Hospitals</b> McClendon – (presentation available on HAI website)</p> <p><b>Presentation on Facility Specific Employee Influenza Vaccination Data</b> Cummings – (presentation available on HAI website)</p> <p>Rogers- How did we not have the right definitions?</p> <p>Cummings- We're coming into this late; when we came into this program in January, there was already a sense there was a misunderstanding. From my experience, I don't know if this was an unexpected outcome. Surveillance is a very labor intense endeavor. Classic surveillance is built upon processes and procedures; it is a very clear process where you verify you suspect, you verify your case, and the purposes of reporting are very clear. This is a little bit of a new thing.</p> <p>Rogers- Was it that there was no definition on the form or there wasn't a corresponding AFL?</p> <p>Chen- There is a lot of people in this room who worked very hard on the Influenza Subcommittee. The subcommittee and full Committee struggled to define the difference between employee and healthcare personnel; the subcommittee arrived at a definition that appeared would work. There also was discussion about the outreach of the program. The AFL was released August 15 and the program was to start September 1 so this left little time to educate. The definitions were in the AFL and the definitions were on the form. CDPH condensed the definition down to people who get their paycheck from the hospital as a separate group from healthcare personnel, but even with providing those words, there was confusion and inconsistency with the definition.</p> <p>Cummings- When considering Influenza and Vaccination research, the issue of quantifying what is going on among independent licensed practitioners who the facility doesn't have direct control over is difficult. The spirit of the language in this case was to capture what was going on there, but looking at it from an Epidemiologist's perspective, there will be double counting across all facilities. This makes it clear that the facilities didn't have the right sampling frame of who those healthcare practitioners are. When going back to the drawing board and thinking about what is the best way to quantify the level of vaccinations in the sampling frame of</p>	<ul style="list-style-type: none"> <li>• Collect membership information for Influenza subcommittee</li> <li>• Schedule Influenza subcommittee meetings</li> <li>• Re-convene Influenza subcommittee</li> <li>• Influenza subcommittee to report on progress at next HAI AC</li> </ul>

independent practitioners, how do we include them if the facilities aren't the right place to collect that data?

Rogers- In the options of public reporting, I would be opposed to a simple rank order because the physical difference between a hospital who has a 50% rate and another who has a 51% rate is insignificant. There would be no difference between those two rates from a statistical perspective. and we need to be clear that we differentiate hospital performance only when that difference is statistically significant.

Moss- Who can explain why NHSN can't do this?

Chen- The module did not come out until this year.

Rosenberg- The NHSN module is created to be the Employee Health Data Management System. It wasn't intended to be a data collection tool; it was created as a stand-alone data management system. There are six different independent commercial vendors of employee health software. Most hospitals have invested a lot of money into one or another of those systems and have manually entered all of that information into their database. Right now there is no method or no plan in the immediate future to create a connection between the commercial software systems and NHSN. It is technology possible but most hospitals would have to hire an additional person just to do the data entry.

Moss- I saw your AFL and it looked very clear to me; are you saying the AFL that went out to everyone was incorrect?

Chen- The AFL was not incorrect. As CDPH reviews that AFL now, several different places where it could have been more clearly directed have been recognized. That is hindsight. What CDPH found when communicating back to a limited outreach, different people interpreted the AFL differently. The final language was not understood in the same way even among members of HAI AC.

Moss- What is the plan now?

Cummings- The plan is to get a team together to develop a data reporting tool with clear instructions, inclusion criteria, a clear case definition, and bring that to a pilot group of facilities. The HAI program is looking for best practices in the field; there are many thoughts on that. Those are the things that can be done and be done quickly; this will be accomplished as part of the preparations for the coming flu season.

Chen- CDPH has borrowed a best practice from another state and that is to hold a series of statewide webinars where multiple people can hear the same information at the same time. As people ask questions, the program can come up with answers and improve through iterations of the session; the presentations get more comprehensive and better quality.

CDPH hopes this will improve communication and comprehension. There are have field staff out there now who can handle some of these issues on an individual basis.

Myers- There were multiple discussions around the definitions on the forms. I remember the Committee scrutiny over the language to make it as clear as possible. There are still going to be issues around healthcare practitioners; there are institutions that outsource their employees in their ICUs which is a very important group. Maybe going forward the language should say "if you get your paycheck here, then X" and forget the rest. You listed off what is my preferred option for public reporting, the general rate. I would offer two amendments to that one. 1. Could we consider feedback from institutions? The only way to improve your surveillance is to get feedback; if the individual institution knows that maybe they can explain themselves. 2. Let's thank those institutions that did report, the people who put the time in, and let's acknowledge their work in complying with the law. It is unfortunate to have spent a lot of time on this when the resulting product wasn't perfect, but it was the ultimate statewide pilot and much was learned from it.

Flood- Since we started this Committee another thing has come into play: the Aerosol Transmissible Disease Mandate that went into effect last fall states that people who work in hospitals are at greater risk exposure to Aerosol Transmissible Diseases of which Influenza is one. It is a California mandate under 5199 that we have a record of immunizations or declinations for all employees at risk in California, which might help decrease the confusion. For contractor employees, that employer would be responsible for doing that report and hopefully knowing that the report exists.

Witt- The caveats for the consumer on statistical significance, the ranks, the confidence intervals; my colleagues don't get it; I'm not sure I get it, so I don't think the caveats are going to help. It should be straight forward and there should be validity. In addressing that we don't have to have a rank order, we can have a percentile order. For example, a particular facility would be 'in the top 25%' and then you get around the issue of if you are at 51% or 50%. Finally, the answer is that if you cross this threshold of this hospital to make your living, you need to be vaccinated and have proof of vaccination.

Nelson- Representing the Infection Preventionists of California, I do want to acknowledge the tremendous amount of work that was done and it being a best effort in spite of what appears as confusion. This is what happens when a regulation is written and there is no funding there to support everything that makes it meaningful. The institutions I have contact with, when asked if they feel that their participation in vaccinations has increased because of this mandatory sense, it has. They are much more aware. Those institutions that were paying attention to their numbers saw an improvement;

the effect is there. Regardless what gets done today and moving forward, I want to keep a positive focus on what effect this group had on individual institutions.

Chinn- Going back to the reporting of healthcare personnel, in the subcommittee meeting we wanted to capture everyone involved in the healthcare setting, but may have done too much, too quickly. The original spirit was to capture groups that are definitely important, like licensed independent practitioners; everyone knows what that group consists of. It may be beneficial to have some structure in reporting and then in time build on it. The problem was that perhaps too much was attempted, too quickly.

McClendon- That is a very good point. On the reporting form the definition could include license independent practitioners and examples that will capture what we are trying to capture.

Chair- I'm hearing a resounding call for bringing the Immunization Subcommittee back together. This subcommittee went on hiatus after completing the work for the prior flu season. Now that we have some data and some recommendations, does the Committee favor reconvening the Influenza Subcommittee to work through some of these points that have been brought up? If that is the case, I suggest using the HAI program Epidemiologist that we now have available to the Committee, the data now available and go forward in subcommittee instead of using up Committee time today.

**Motion (Flood) - Move to reconvene the Immunization Subcommittee**  
**Second - Nelson**  
**Discussion**

**One opposed, majority ayes; Motion passed.**

**Motion (member) - Move to retain Raymond Chinn as Chair of Immunization Subcommittee**  
**Second - member**  
**Discussion**

**All ayes; Motion passed**

Chair- Anyone who would like to volunteer contact Sam, Sue, or myself.

Moss- The intention of the law was to protect patients. Everyone in this room is in agreement, if you have the flu and you are in a hospital touching patients, you are putting patient lives at risk. As it relates to the information in the data, we all have gone through and clarified the information. Sue did a great job of training people how to get on a NHSN; you do webinars and teach them. This Committee doesn't need to spend any more time on what the definition is. There should be a single line that says patient caregiver.

Trivedi- The subcommittee tried to emphasize that in any surveillance system there is time for growing and time for learning to do things better. We totally agree that all healthcare providers should be vaccinated; it's the way we collected the data that did not work these last couple of years. We thought it was clear; that is why we send these forms out to pilot testing. The subcommittee must be reconvened to discuss how to make this data valid for future consumer use. This will involve simply making up a form and pilot testing it to see what works and what doesn't.

Rosenberg- Consider the whole process that happens. There are Employee Health Services in hospitals. They are not *personnel* services; they are in charge of vaccinating *employees*, not in charge of vaccinating *personnel*, so we are starting with Employee Health Services. Their target in a large hospital may not even be ensuring they have information on every single employee in their hospital; they may be targeting nurses and emergency personnel in ICU to make sure that they have the highest immunization rates. But there must be a threshold on what's the target. Everyone agrees the goal should be 100% of immunization of everyone who carries a risk of infecting someone. But in terms of what data is collected and how that data is reported, because a hospital may decide it is only going to look at employees doesn't mean that the hospital doesn't care about everyone else. The question is what is an appropriate, reasonable representation of data that reflects the quality of that hospital's Influenza Program.

Oriola- The 2009-2010 data collection will have the same problem, because the form did not change. The subcommittee should focus their efforts on the pilot and improve the form so that there can be meaningful data moving forward instead of looking backwards.

Chair- Once again, I would like to open it to members to contact Sam, Sue, or myself if you would like to be on that subcommittee with your input.

Butera- It is my interpretation of SB 739 that the definition is hospital *employees*. The law requires hospital employees to have the influenza vaccination. Hospital employees include those people employed under the hospital administration; it doesn't include the physicians and it does not necessarily include the contract employees. We all agree that we want all people in the hospital environment who could put a patient at risk or their colleagues at risk to get immunized. My background as representative to the CMA, I'm a patient advocate. I advocate for my patients and I'm an advocate for our community. It has been a CMA position to endorse all healthcare worker immunization to be 100%. Furthermore, it is the position of the Infectious Disease Society of America to endorse a mandate for all healthcare workers as a condition of employment, as a condition of participating in patient care.

<p>Either get the vaccine or demonstrate a medically justifiable reason not to be vaccinated. That was presented to the AMA to make it AMA policy; this is still being worked through. We are all patient advocates, but the law as it is worded doesn't achieve the goal; it says hospital <i>employees</i> and what we want to do is immunize those people who are not just hospital employees but <i>anyone</i> in the hospital who is going to have patient contact. We need to have a process to encourage or mandate immunizations but we have to understand the way hospitals work. The subcommittee is appropriate. Reporting is important. Reporting is important in my hospital in pushing administration to make patient safety a goal and make it a priority. We need to put some teeth into our program where there would be some consequences to nurses and physicians if they didn't comply. Even for facilities that have improved, to move to 60, 70, 80% compliance to immunization by physicians and nurses is unacceptable.</p> <p>Chinn- I just want to clarify somewhere in that law, beneath it is "healthcare personnel". The wording is in the law, and is something we went back and forth on both in subcommittee and here at full Committee.</p> <p>Menasian- I've been a patient advocate for about seven years after being injured by a doctor and acquiring an infection. Every doctor and nurse in California is licensed by a Licensing Board. Why don't you go through the Licensing Board?</p> <p>[Members]- There is not a uniform standard across these professionals. To accomplish what you're talking about would require new legislation.</p> <p>Rosenberg- California is confronted by logistical situations in California that no other state is confronting. We're going to have ongoing quality control and ongoing quality assurance issues around all of the data no matter how it is supported. Quality control and assurance will be better when data can be reported through an automated system.</p> <p>Chair- That is another reason why we get our information through this subcommittee, to get the expertise and knowledge-base together to form recommendations to the HAI Committee. This process is one of continual reassessment, to the point of returning to the drawing board, if need be, on those issues.</p>	
<p><b>Reporting Subcommittee</b>  Chen- Because the HAI program does not have a health educator, Cheryl and Sam will be helping the subcommittee with putting the data up. The ultimate goal of public reporting is always to improve patient safety by decreasing morbidity and mortality. Public reporting will enable stakeholders to make more informed choices on healthcare issues by making quality measures related to infection prevention processes and infection events transparent. The goal of the HAI</p>	<ul style="list-style-type: none"> <li>• Collect membership information for (additiona) Public Reporting subcommittee</li> <li>• Schedule Public Reporting subcommittee meetings</li> <li>• Re-convene Public Reporting subcommittee</li> <li>• Public Reporting subcommittee to</li> </ul>

program and HAI AC is to make data accessible to stakeholders including feedback to healthcare providers. CDPH intends for this data to be used by facilities for their quality improvement efforts. Market factors may motivate some hospitals to excel or achieve the same standards as competing facilities. The Public Reporting subcommittee needs to be able to articulate its own principles to guide the presentation of information and education to the public. The subcommittee was formed to make recommendations related to methods of reporting HAIs. It will be through formulation of public education, formulation of messages for clinicians, and the mechanics of how the public data will be presented on the website. The last iteration of this subcommittee, chaired by Carole Moss, looked at different formats in 2008. We would like to solicit your input on how the HAI AC would like the subcommittee to proceed.

Moss- The good news is we are doing public reporting so California is going to be a safer place. We're not the first state to do it; there are other state examples we can learn from. Leadership at CDPH said they are committed to make the deadline of January 1, 2011. Today we are all focused on accurate data being shared with the public, and we are going to do that as a phase-in approach. The key piece is to get the news out on the great results that are happening in hospitals from all the work that has happened in this area.

The commitment of the subcommittee is to make sure the data is accurate and on time; data will be phased-in by posting spreadsheets identifying the hospitals and presenting the information that the HAI AC recommends for inclusion. There are great things to work on; we just want to make sure we have plenty of time to verify the data before we post it in January. Education is a huge piece on the site and also the distribution of the information. I'm relying on all of you (HAI Committee members) to help build that network of resources where can really push the information out and inform the public.

Chen- There is a commitment on the part of the State and on Carole's part that anything that comes out must be intelligible to the public. There will be a group looking at specifically that issue.

Kalson- An HAI website is in development; it is likely that a skeleton website can be piloted within the next week. As information becomes available and is vetted through the Committee and through CDPH, the site can be changed. I am soliciting suggestions from the HAI AC, our Infection Preventionists, and CDPH staff as both professionals and consumers. The approach to the website is to make it user-friendly and accessible to as many people as possible.

Billingsley- One of the key things is the public reporting; we are all here for the exact same mission. I would encourage all those who feel public reporting is important to participate

report on progress at next HAI AC

on the subcommittee. There will be many data challenges; this Committee and CDPH have many determinations to make on what kind of information will be shared. I encourage you to give your input now rather than later, as a great deal of work has to happen in the next six months.

Eck- The Public Reporting subcommittee had done a lot of work in 2008, showed the Committee some websites and examined ways the data was being displayed in different states.

Moss- The subcommittee *will* be reviewing all that again. But because of the rapidly approaching deadlines, things have to happen. We don't have to have a full-blown website to roll-out initially; this will be ever-evolving. In order to meet what needs to happen, the plan is to come up the content, determine the best way to present the data visually in a logical and understandable way, and then post it on a website. This will not require a lot of time and resources. The tool is the information, and the public needs the information.

Eck- Yes; and some of those websites were much clearer in the presentation of the data (reference to 2008 meetings in which the Public Reporting subcommittee presented a review of websites in use in Missouri and other states). This Committee had agreements in terms of the importance of empowering the consumer with that information. That is a critical role. I'm not suggesting spending tons of resources but rather getting that information posted in a way that anyone is able to understand and use that information. We also had agreements to post information on how patients themselves could reduce their infection risk, explaining how they could make choices to help take care of themselves as well.

Moss- That is a component of the education piece.

Eck- But our agreements were that those would be used together on the site. I will absolutely volunteer to be part of the group but I am hearing and am concerned that agreements this Committee had eighteen months ago have been lost or are being moved around. The information being posted because of time urgency does not seem to include the information that we all committed to provide. That would be a major disservice to the public.

Moss- We will pull up the minutes to review what we did last time, and present that information again. We will also be meeting at least once a week to move forward.

Chair- To reiterate the processes, the subcommittees work offline; they come back to the HAI AC with recommendations, input, and consensus.

Oriola- There is a lot of good in hospitals that is happening

and we're excited to share the information. I know some of you are testament to the damage caused by medical errors and this Committee believes that the reporting of information will help improve health and healthcare.

Moss- Everyone has worked really hard; it will be good to see the results.

Fingold- People who contact their legislators are important to those legislators; if you're bound to call, you're bound to vote. Along with Lisa McGiffert and Carole Moss, I proposed HAI legislation that in October 2007 that became SB 1058 (2008) thanks to Senator Alquist. The Governor received phone calls, letters, and emails from people, urging him to sign. It takes personal contact to those legislators.

Sayed- Where is the Influenza data from the 2009-10 season? Will there be rapid turnaround to access the data in public reporting?

Chair- Dr. Rosenberg went through a full assessment in the beginning of this meeting describing of what the data looked like that was actually collected over the last year and first quarter 2010 and where we are now with that data. Basically starting April 1, 2010, that data is being reported in a manner that we probably are going to be able to use. The prior data will not be useful to assess or analyze.

Rosenberg-The CLIP data was started to be reported in NHSN in 2009 as well. That data has not yet been evaluated.

Cummings- CDPH is still in the process of getting all the hospitals properly enrolled in NHSN.

Rosenberg- Earlier I noted that some key staffing positions that we need to fully perform NHSN roles are still vacant; we are doing the best we can. The priority now is getting all hospitals enrolled in NHSN. Going forward, the data can be loaded, reviewed, quality controlled and evaluated.

Oriola- The answer to your question (to Mr. Sayeed) is where Carole said public reporting would be available in 2011. Or are you asking to see the data earlier than that?

Sayed- I wanted to see the Influenza data from 2009-2010 to compare it to 2008-2009 and see if these inaccuracies are consistent.

Rosenberg- The 2009-2010 data will be completely different because of the pandemic; there were two different vaccines. That data will not be comparable to 2008-2009 data. Information collection focused on supply issues, to determine whether hospitals would say that their available supplies affected their vaccination rates. This information may be more useful in preparing for the next pandemic.

Chen- Some of the limitations in the way the data was collected are going to continue in the 2009-2010 data. There will not be process changes or improvements until the 2011 season.

Myers- Nationally, there is recognition that there is trouble with collecting CLIP data that was initially expected to be a relatively trouble-free process. If an observer fills out the form, the result is one CLIP compliance rate; when the physician inserting the CLIP fills out the form, the result is near perfection. In the case of one institution practicing self-reporting physicians doing the inserting, is that really comparable to an institution that has a third party observer documenting what is happening?

Stolp- 2009-10 is going to be a critical year for shedding light on what can happen with a massive educational effort. The fact that the local health department was the point source for the H1N1 vaccine will make for accounting 2009-2010 quite different. There will be conclusions that will be important in comparing that data. The data was more thoroughly collected because it *had* to be sent back through the local health departments.

Flood- There were many difficulties with flu and H1N1 vaccine and confounders to the data. There were issues with roll-out; with prioritizing and describing prioritized groups for vaccine; there were media pieces such as a peer reviewed journal video posted on U-tube showing a girl running backwards from the flu shot. There were also those who refused H1N1 vaccine because they felt it was processed too quickly. Data from this year will be aberrant.

Stolp- We (the Committee?) should be seeing ourselves as an advocacy program, a partnership with patients and a partnership with hospitals to diminish HAIs. This entire program should be known as a place to aid hospitals, physicians and medical staff, where they know they can come here seeking a way to improve their HAI program. The website should be used not just to penalize the ones at the bottom of the list but also recognize and reward those at the top of the list. That is a resource that is extremely valuable in promoting our efforts.

Wittman- I'm representing Infection Preventionists. I represent a hospital that has over 500 beds with one practitioner on the floor and I'm doing all the paperwork. Every time a new reporting mechanism that comes out, the queue of priorities has to be reconsidered in order to meet that mandate. The California law requires one (infection prevention) staff for every 200 beds. Convincing facility administration that more staff is needed to accommodate more paperwork is not possible when the law sets the minimum at one for 200. This group can talk about many issues and goals, but until there is pressure to support the IPs and get more IPs in the hospitals, there will not be real

<p>progress.</p> <p>Trivedi- There are only a few supported epidemiologists reviewing the collected data; it is a resource issue for the State as well.</p>	
<p><b>Action Items</b></p> <p>Chair – Next meeting’s agenda to include:</p> <ul style="list-style-type: none"> <li>• Antibiotic Stewardship Subcommittee Report</li> <li>• Metrics Subcommittee Report</li> <li>• Immunization Subcommittee Report</li> <li>• Public Reporting Subcommittee Report</li> <li>• Agenda to clearly list time allowed for public comment</li> </ul> <p>The bathing issue of patients, preoperative verses daily washes, is in the parking lot.</p> <p>[Repeated motions to select a standing meeting date. Motions withdrawn after no consensus on meeting date.]</p> <p>CDPH staff agreed to email group members to select meeting dates based on majority availability.</p> <p>Chair- Thank you everyone, for your time and commitment, and for coming together to help reduce the rate of healthcare associated infections.</p> <p><b>Meeting Adjourned</b></p>	<ul style="list-style-type: none"> <li>• Antibiotic Stewardship subcommittee to report on progress at next HAI AC</li> <li>• Metrics subcommittee to report on progress at next HAI AC</li> <li>• Influenza subcommittee to report on progress at next HAI AC</li> <li>• Public Reporting subcommittee to report on progress at next HAI AC</li> <li>• HAI program staff to email HAI AC members to determine date for next full Committee meeting</li> </ul>

**Acronyms**

AFL	All Facilities Letter
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
GAC	General Acute Care Hospital
HAI	Healthcare Associated Infections
HICPAC	Healthcare Infection Control Practices Advisory Committee
H1N1	H1N1 Pandemic Influenza
HSAG	Health Services Advisory Group
ICU	Intensive Care Unit

IP	Infection Preventionist
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MRSA	<i>Multiple-resistant staphylococcus aureus</i>
NHSN	National Healthcare Safety Network
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>