

Healthcare-Associated Infections Advisory Committee
April 17, 2008, 10:00 a.m. to 3:00 p.m.
Location: California Department of Public Health, Sacramento

Attendance

Members: Attendees: Kim Delahanty (Chair), Raymond Chinn, Letitia Creighton, Enid Eck, Donna Fox, Jennifer Hoke, Lilly LaBar, Marian McDonald, Carole Moss, Terry Nelson, Amy Nichols, Shannon Oriola, Debby Rogers, Jonathon Teague, Dawn Terashita, Francesca Torriani, Mary Tran, Anvarali Velji, Pat Wardell, Lisa Winston, David Witt

Guests: Suzan Shinazy, Robert Berg, Tanya Dodd

Staff: Sam Alongi, Sue Chen, Roberto Garces

Agenda Items/Discussion	Action/Follow-up
<p>Call to Order and Introductions Committee Chair Kim Delahanty convened meeting at 10:00 a.m. Introductions made at Sacramento and on teleconference lines.</p>	
<p>Approval of Minutes The Chair called for approval of the March 2008 meeting minutes.</p> <p>McDonald – Motion to approve Eck – Second All ayes Motion Passed</p>	<p><input type="checkbox"/> Staff to make minor revisions to March minutes based on member notes and comments.</p>
<p>Public Story</p> <p>Shirley Holderness (story told by Suzan Shinazy, daughter, RN)</p> <p>Mrs. Holderness developed a post-operative infection after placement of a cardiac stent. When Suzan queried the physicians because her mother had developed progressive signs and symptoms of infection, a physician denied that her mom had an infection despite being in possession of confirmatory cultures, refused to order an Infectious Diseases consultation, and did not treat the infection. Mrs. Holderness died shortly thereafter.</p> <p>Chair—Thank you for sharing your story with us today.</p> <p>Discussion Moss—Along these lines there are challenges, but this is plain, old fashioned medical care, and there is no excuse for what keeps happening. I talk to people daily, that this happens, the rooms are filthy. The way they treat people, it's disgusting. They have lost the care in healthcare. And so, it's not this big huge enormous issue. It is basics like showering or bathing the patients as they come in. What can we do, quickly, we have had many, many meetings; we have had so many subcommittees, subcommittee meetings. We've spent copious hours; we're all working very hard, but to be honest, we have done nothing in the whole time I've sat here. We have proposed solutions to CDPH. We have not heard one response back for our hours of commitment and experience. We are due the respect of a response and</p>	<p><input type="checkbox"/> Thank you letter to Suzan Shinazy</p>

a deadline for when we're going to start doing public reporting and that we're going to start cleaning up these hospitals, because we're the experts, you're the experts, sitting around these tables, working in all these hospitals. I keep bringing victim after victim; I hear little comments here or there; I don't hear any sense of urgency with anyone in this room. And I speak for all of California, people, so I am mad, and I think that everything we're doing is a waste of time, because we don't have a commitment from the CDPH, from Dr. Horton, Kim Belshe or the Governor. We have nothing – we don't even have a budget. So all of the things we do in this room, to be honest, are a waste of time unless we have a commitment back from the CDPH.

Chen--I'm sorry that you don't feel like you have had a response. As the representative from CDPH today, we do have a commitment; we have been doing the best we can with what we have. We do not have control over the budget – the money is in the budget – we don't get any money until budget passes, which may be, which is whenever the Governor signs the budget. In response to "nothing has been done", I am a L&C decision away from sending out a document that says, "This is when California hospitals will start public reporting." If you don't think that there has been any response from CDPH, all infection control practitioners (ICPs) have had the opportunity to see firsthand, and get firsthand, the education surrounding public reporting. From no resources, California hospitals will begin mandated reporting on July 1. That's a huge accomplishment for this Committee, ICPs, and CDPH. Sometimes, as we sit here in this committee, it's almost like a sterile environment compared to what must be done to actually implement this program. To implement the process of moving California and its 450 hospitals to begin mandatory reporting is not a small event. And, we control what we can control. What we can control is the assistance that I've gotten from ICPs throughout the state, the support I've gotten from members of the committee, the support I've gotten from other people in licensing and certification, two of whom are sitting on your right, to work on this. And while we don't sit there and blast out, "Well, we've just done this and we've just done that," it's happening. We cannot move faster than the ability of the ICPs in the hospitals to move forward. We can push them, and we are pushing them, but there's only so fast you can push them. And they are all responding. I've got proof sitting right up here.

Torriani—No one on this Committee is sitting on their hands. This committee has empowered us, but also empowers many other people in California to do the right thing, and to focus on those things, things that are not rocket science. Which is: hygiene, looking at signs of infection, and the ability of practitioners to understand the difference between something that is there but is not causing an infection and something that needs treating and quick action. I think that we as committee members have been able to influence, and bring about a better kind of sense in what practitioners do, not only public education, but also the education within the hospital. While it might appear that what we're doing here really doesn't actually get into the minds of people or get other things done, it does. We've in some ways profited from this Committee because we've been able to carry points to our institutions

and changes. Changes are step by step and take time. We cannot expect that all of these things will just happen because we're California. California is a very progressive state, but we really have to have a sense that what we're doing will be accomplished in a few years from now while we are accomplishing all of these other things step by step in our own institutions.

Moss—Do you honestly think that our Governor and our leadership have done enough to help end these deaths and these people from suffering? Do you honestly think that we have the support of our state government, honestly?

Torriani—I do think that we have more support in this state than in other states. Do I think we have much more work to do? Yes. Do I think the whole healthcare debate should be revived? Yes, I do think that the country and this state has a big problem with health. So, do I think there should be more effort put in? Yes.

Moss—Let's get Sue and the people here enough help to do a good job. Let's get people here. That's what...

Chen—It's a matter of education though also, and I think that public opinion is pushing, it's too fast for some and never fast enough for others.

Moss—Is the budget approved or is it not approved?

Chen—No, the budget doesn't go until June 30, and then the Governor can sign it any time after that. Last year he signed it on August 26.

LaBar—There has been action on the part of the hospitals. Back in the year 2006, the Children's Medical Services, which is part of the California Services, CDPH had an initiative of a collaboration of 22 hospitals; these are NICUs, tertiary NICUs, throughout the state of California. Since 2006, this collaboration of NICUs has worked together very hard. You can look at our minutes, it's online, on part of this collaborative, and what it brings in is ICPs, NICU practitioners, nurse practitioners, physicians, and we have worked very hard to decrease bloodstream infections. We have posted all kinds of alerts to healthcare providers, because providers need to be educated. They need to know what their MRSA incidence is, and they need to be able to openly communicate with families about that, and you as a nurse know that. We've worked very hard, this collaborative, and we have seen an immense decrease in infections, and we're working even harder. This is 2008; it's two years later. Since SB739 has passed into law, there has been another collaborative of NICUs that are not tertiary. This is part of CPQCC (CPQCC is an organization made up of neonatologists throughout the state of California). We have, as part of this initiative, included SB739, all of the requirements there. We are looking right now in the NICUs, not tertiary NICUs, just the NICUs from well babies that go into a NICU for maybe a one or two, three day stay, looking at practices there, trying to decrease infections in those NICUs. There's been a lot of work around this; these hospitals report regularly. On the

first collaborative I spoke of, they report every other week what their rate is to all these other hospitals. We compare, we look at best practices, we try to implement those best practices, and then with the CPOCC, we report every month. So there's a lot going on. We know this is happening. The ICPs are the ones who report it; we report it out, we're trying to disseminate it.

Rogers—I wanted to report some progress that the CHA Board of Directors – and I've talked to them in advance of the Board's next meeting. There's a proposal in the Board packet that the Board endorsed reducing hospital acquired infections, which will be the first time that level of conversation has happened with our Board of Trustees, so I'm delighted. It has been the work, and the steady progress of this group, and the synergy of this group that has really helped move that forward. And the recommendation is that the first one we start with is central line bloodstream infections.

Witt—I've noticed in our public story cases that we've picked cases that are not the result of a lack of modern technology; they're the result of bad practice, and we haven't voiced that. These are things that are not dependent on screening. Your mom may have had MRSA when she came in. She may or may not have brought it in with her. Most of the infections we've dealt with are catastrophic, and they may not have been hospital transmitted. They are hospital acquired because they're related to procedures, but over and over, and I think with maybe one exception, but I think all of them, have been the result of bad practice. I don't think this has to do with screening; it has to do with cleaning, hand washing and the real basics. I'm really concerned where we run and add another thing that's un-established to fix the things that should have been fixed a long time ago. I'm concerned we're diverting resources pointlessly, as opposed to cleaning the rooms, cleaning the environment, making sure hand washing happens with earnest. I'm concerned that there is pressure to focus on the newest technology supported by advertising from the new technology companies. I'm concerned that we need to have all the expertise in the group to do something that's effective. It is slow, absolutely, and to answer Carol's question – I don't think anyone means to.

Chinn—Overall, HAI rates, at least in the intensive care unit, when we look at the last NHSN data shows that actually the incidence of those infections are decreasing. And I have to second Witt's comments, and that is, by doing everything, focusing on everything you should do, those MRSA rates are going to come down. If we focus solely on MRSA, we may lose sight of all the other infections that can occur with line-related bloodstream infection. Also remember that, at least for the community acquired/associated-MRSA, nasal carriage is not the place that people carry it. A third of the patients will carry it, sometimes a third will not have it and a third will have it. The focus and all the attention should be paid to insertion technique and maintenance of the lines, or the result will be that you're going to bring everything else down.

Chair—I have three comments relating to how infection prevention has

<p>made an impact on decreasing healthcare-associated infections, and getting things back to the basics. We have an artificial nail policy whereby no direct patient care provider is to wear artificial nails. This in and of itself is back to the basics, getting down to the details of what transmits these organisms. That has been done nationally. We've done a hand hygiene campaign nationally which has shown to improve compliance; we're not 100% where we need to be, but we are definitely making strides there. People talk about hand hygiene – it's in your grocery stores. It's the wipes available at the stores to wipe down your carts. There is an impact that we have had a mark on. I would say having this Committee, and the sustainability of this Committee, with all of these expert people taking time out to sit around the table to do something that's very, very important, is a very good use of people's time, and I take exception if people think that we are not trying and making a difference in infection prevention strategies across California. Let's get back to the agenda.</p>	
<p>Committee Updates</p> <p>Chen—Program Implementation: The second round of statewide classes for ICPs for NHSN compliance is set to begin next Tuesday. Classes will be presented to all chapters and any corporate or public health group as scheduling permits. As of April 1, I am pleased to announce that California has 172 NHSN hospitals. That's out of 1,340 nationally and represents about 12.8% of the national volume. 38.2% of California hospitals have already completed the registration of their hospital into NHSN, so that's past the digital certificates. Compliance with the notification of who the NHSN facility administrator has gone from 38% all the way up to 69% and compliance with getting the SCIP survey back has gone from 44% up to 64%. I would like to thank Licensing & Certification for a lot of phone calls they made. I would like to thank corporate collaborations: Sutter; Kaiser; Adventist Health; Catholic Healthcare West; Los Angeles County and the floor level infection control/ quality people.</p> <p>All Facilities Letter (AFL) 08-10, named CDPH Groups, is ready for distribution. Once I get the OK, I can send it out. The content is how to join the CPPH group, details on CLIP reporting, details on SCIP reporting, a special note for long-term acute care facilities and surgery centers, and a request for secondary identification for future collaboration between CDC and CMS. Yesterday's Waxman hearings discussed the "silozation" under HHS as far as groups not talking to each other. This is California's proactive step to ensure that when they do say, "Okay, you can download CMS data directly into NHSN," we will already have the common denominator, California is taking the lead in this use of a common identifier. I would like to say thank you to all for the suggestions for more effective routing of this directive. The CDPH group is formed and it has it's first member. There are plans for a future AFL on how to give permission for CDPH to see the CLIP data. I can't release that before NHSN actually releases the CLIP module. We've had a draft of that, which is the actual module, but I can't ask for you give me permission to see the data if NHSN doesn't have a module to report data through. So I have the draft of that fairly far along; it</p>	<p>Chen to distribute AFLs once approved</p>

will not take long. If NHSN does not release the module before July 1, hospitals can begin reporting anyhow and enter that data retroactively. Whether or not CDC releases the module in May as they're hoping to, California will start reporting CLIP data effective of July 1, 2008.

The third issue is influenza vaccination/declination reporting. I thank the Subcommittee for the many hours they put in, and I thank you for all your discussion. We passed what we thought was the final piece at the last meeting, but I felt it was really important that the Committee see it as a whole. Once the Committee finishes today, I will compose the AFL to alert facilities on how to comply with influenza vaccination/declination reporting requirements.

The last item is the reporting of the MRSA bloodstream infections. A subcommittee is working right now to suggest ways for that to be reported. When the recommendation has been approved by the full Committee, an AFL will be written and sent out. The CDC is not expecting either the influenza vaccination reporting or the MDRO module to be available before sometime in the fall. This means we may be starting some reporting before NHSN support is ready. [Question re whether AFLs would be sent to Committee members.] Committee members are already on the email distribution list and, whenever something of that magnitude comes out, the document is posted to the HAI-AC website as soon as possible.

Eck —If NHSN does not release the CLIP module before July 1 so we can actually start, how exactly is it that we would be able to submit data?

Chen—You have the form, so what you would be doing is creating, filling out, and collecting manual forms. They will need to enter data collected beginning July 1 retroactively. As long as the hospital has joined NHSN within this year, data can be reported retroactively all the way to January 1. As long as NHSN releases the CLIP module in 2008, data can be entered back to July 1.

Eck—If the module is not released, then what you are suggesting is that they just collect it all on the paper form at whatever point they enter that data. Given the size of this state, given the number of hospitals we have here, given the work that this group has been going and the legislation that has been passed, that we have so little influence over what's happening with NHSN, is frustrating.

Member—The burden would be to sit with hundreds and hundreds of pieces of paper collected while waiting for NHSN to (release the module) – then to enter it in December because that's when NHSN releases the module. Meanwhile, we have all this data that we have no way to even doing anything with.

Chen—I've passed around the room the actual AFL. There have been questions about the letter to the CDC on whether or not California can provide input. I spoke to Dr. Dan Pollock, who is the head of NHSN, and I asked him if California could provide input. He said he thought

that that was reasonable and suggested putting it in writing. Therefore we completed the letter; it is signed and ready to be put in the mail.

Eck—We're all trying to get ahead of the curve so when somebody says go on July 1, we're all ready to start entering data. The way to get the data distributed to the people who are asking for it, the bottleneck, is the database. [Chen - This is the best we could make of that situation and I'm sorry that you have the potential impact of accumulating lots of data points for somebody to sit down and enter.] At some point there will be capacity for data to be electronically downloaded from electronic medical records because many health care agencies and hospitals are going to electronic medical records. By pulling electronic data and then manually typing it in, there's a huge potential for human error; the last thing the public needs is inaccurate data.

Oriola—An email that was sent out regarding an expectation of what units will need to be reported, but I thought that there was going to be a grace period from when this letter goes out and then facilities start collecting it and then there's a time they'll have to report. Are you saying that at July 1 the form is going to have to be filled out retrospectively and then reported?

Chen—The form was originally sent out on January 3, so I have considered the intervening time a grace period. Starting July 1, hospitals will be required to fill out that piece of paper. If the module is out in May, there's no issue. If the module comes out after July 1, then there's an issue and that is that anything collected from July 1 forward will have to be retroactively entered back to July 1.

Oriola—For CLIP, as far as July 1, if a line is inserted that data will be collected and entered. So it really won't begin entering – I mean, there's not a mandate saying, lines inserted in May you have to retrospectively enter. [No. If the line was started July 1 or after, CLIP data will need to be collected and entered.]

There was discussion about whether hospitals would be dropped from NHSN if they didn't begin reporting on July 1. A facility would not be dropped prior to January; they must enter six months of data into NHSN during the calendar year. There was other discussion on the specifics of options for CLIP reporting.

Fox—Are we as a state going to have process measures in the public reporting? If so, is it our link to NHSN or is CDPH or another state agency going to have a public reporting website of those process outcomes?

Chen—There will be public reporting of these process measures. The actual format is what the public reporting subcommittee is addressing. Facilities will have to enter whatever data if they can. If they started entering it on July 1, facilities would have to enter it. Being as they can't start, whenever they can do it, they still have to enter it. L&C is working collaboratively to begin putting other elements of SB 739 requirements in, as both (Creighton) and (Hoke) are working on the

<p>insertion of infection control education into L&C surveyor training.</p> <p>Creighton—Much of how the surveyors will be trained can't be determined until this committee makes their recommendations. So based on committee recommendations, as soon as the basic elements are together, L&C will begin training at the district offices.</p> <p>Chair—I would make a recommendation because basic infection control training practices, Epi 101 or Foundations Course, is what is really going to be essential for these surveyors regardless of the recommendations that come from the HAI AC. It will cover everything, and to wait until the HAI AC makes a recommendation for training, and not have L&C trained and ready to survey may be problematic.</p> <p>Creighton—A part of SB 739 says every three years they're going to have their plan, revise their infection control plan. And then it talks about surveyors going in annually and looking specifically for these key elements that SB 739 and this Committee is going to make the recommendation. So that'll be part of when we do our training, emphasizing to them, this is what you need to look for. That's why we're waiting to see what the recommendations are going to be.</p> <p>McDonald volunteered to share a presentation on the basics of epidemiology.</p> <p>Fox—I'd like to make the request that environmental health is a priority [Yes] because there's a lot of pressure, pushing patients up to the hallways. We have lots of documentation, which I've been sharing with the district about pushing patients into dirty beds, the "get them up, get them out" mentality. That's not really even a training issue the way we might think of it, but it's so fundamentally basic and we're going in the wrong direction.</p> <p>Rogers—Can I just say that on the recruitment of hospitals, if the group or Sue decides it's appropriate for CHA to send out a letter to the hospitals that have not signed up yet, we're happy to partner with you in that way.</p>	
<p>Influenza Subcommittee Recommendations Chinn (reviewing the Influenza Subcommittee Recommendations) At the recent SHEA meeting in Orlando, Florida, we had the opportunity to meet with different people who are starting with the reporting as kind of a state initiative. California by far is the furthest ahead in that arena. So, they're just in the planning stage, nothing like this particular Committee has done.</p> <p>I wanted to call your attention to B3A. Last meeting we wanted to close a loop. The item under discussion is B3, we have a timeline there, and under A, this is what we passed the last meeting: "Each acute care hospital shall have a written process to establish targets to increase inform declination/ immunization rates over the 2007/2008 baseline rates for healthcare personnel, including but not limited to, physicians, nurses, those in training for healthcare professions and other workers in</p>	<p>Influenza Subcommittee will revise declination form and present at May HAI</p>

the acute care setting.” The problem that arose from this was that we do have baseline information from 2007-2008 for employees, but this does not set baselines for healthcare providers. I would like to revisit this issue by proposing that we approve as follows: “Each acute care hospital shall develop a list of healthcare personnel not included in the facility’s roster of employees and not included in the group as outlined in B.”

If you would digress a little bit, go look under B, and that is where we say that, “Acute care hospitals should establish a process that ensures contract agencies can provide evidence of or documentation of influenza vaccination and/or verification of declination for all contracted healthcare personnel.” This group would include people that are registry nurses, registry RCPs, environmental services. Where it says it would not include in the group in group B, would be those that have frequent contact such as volunteers, such as LIPs. As an initial step, we had proposed that before, we could include a list of those that have frequent patient contact and also work in the healthcare environment where patients are cared for as an example. I would like to open that for discussion, because the main thing is that we don’t have a baseline vaccination rate of healthcare personnel. We do have it for employees. As a bridge, can we use what I just outlined as a bridge for the 2008/2009 influenza season? The definition for ‘frequent contact’ would be left up to the hospital. One of the other advantages of focusing on this type of healthcare personnel is in the event we have to ration vaccine, this would streamline into that process because key people in the healthcare setting are already identified.

Moss—So the highlighted section is kind of a conduit between the 2008-09, and in 2009-10 it will be all personnel?

Chinn—If you look on the back of the 2009-10 influenza season, I propose that each acute care hospital should have a written process to establish targets to increase immunization rates over the 2008-09 rates for healthcare personnel. What we’re proposing in the interim is a bridge between the two years.

Moss—In that point then all will be included in the baseline?

Chinn—The recommendation is that they should increase the baseline rates for all personnel.

Rogers—Is there any rationale in breaking out hospital employee versus physicians/others with the theory being that perhaps the others might be less inclined?

Chinn—One of the challenges is capturing information on non-employees. The Committee originally used employees because that was a number that was easy to obtain from human resources. We want to make sure that LIPs were held to the same standards as employees. There’s not really much argument, especially if you have a physician that has a lot of patient contact. At the last meeting, (Gross) made a point that some of these LIPs come to the hospital rarely, so we felt it

would be appropriate to initially contact high contact LIPs then roll it out to others.

LaBar—My concern is volunteers. I believe it should be mentioned, and it should clearly say “volunteers.”

Chinn—I understand. Anyone that has other examples we can put them in. Remember when I first made my statement I said groups like volunteers. We can certainly include it. I think they are a very important group and from my experience they are one of the highest compliance groups.

Eck—With our “including but not limited to” we were trying to get away from having to try and remember everyone else. When you put “including but not limited to,” it really says, “Take a look at who needs this and do the right thing.”

Chinn—I think the most important thing is to identify those with frequent contact, not only with patients but also in the patient care environment. I think that is in the first tier. If that was successful then they would go to the second tier, which is a little more comprehensive. It’s incumbent on each institution to do more or less a risk assessment. By identifying those that are really targets, who kind of have a sense of who really needs a vaccination, so that in the event of vaccine shortage you then have a tiered approach to it. The intent of our wording was to make it more generic as well as comprehensive. We have to look at the data and see how it is best displayed; this involves a learning curve because no one has done it before, and we just have to see how the data flows and displays in a way that is meaningful. I like the way that if you target things you might find the LIPs are worse than the group. So you’re going to have to do work in that arena.

Winston—I recommend not making it a requirement that hospitals need to separate out the groups, because sometimes it’s a gray area within hospitals where you have groups of people who may not be strictly employed but have a very close affiliation and only work there, and I think it’s going to be hard sometimes for hospitals to tease that out, will make the record keeping more complicated. I recommend letting the facilities work it out themselves, that they have to include all these people, but they could separate it or not as they desired. And I think it’s supposed to say “frequent patient contact” in that paragraph but “contact” was inadvertently omitted.

Chair—If we don’t require it to be separated out, we’ll never find the problem areas, so we need to be very specific. For employees it’s very easy for institutions to do that through the HR system. We need to be able to receive and analyze where our problem areas are so we can teach, re-educate, focus.

Winston—If you try to mandate separating the reporting, it may not make sense for every facility to say, “Here’s our employees and here’s our LIPs,” because looks different in different hospitals.

Chair—That's the point of why we're trying to get to this, is because LIPs have not been captured, and may not have been as compliant.

Chen—I would just like to put into this discussion; that that's a detail that can be worked out later. It will require discussion at CDPH and possibly re-involving the Committee.

Chinn—This is obviously a dynamic process. We're not going to be able to figure out how to report unless we have some indication of what the data looks like. This would be useful to define.

Witt—We changed the tone in revisions, eliminated all healthcare personnel, and I think that actually has some impact, at least to me. I think it makes it very clear that in 2010 everyone will be reported. The issue of physicians/LIPs is important, because we have the highest risk epidemiologically of transmission to many patients and staff because we have the most unique contact with patients, so we are more likely to transmit than a nurse who spends all day with five patients.

Eck—I would request, because what we're really going for is increasing immunization rates, not necessarily declination rates, that wherever we are putting the declination and immunization that immunization comes first.

Moss—I was going to touch on lack of "all personnel" as we discussed last time being added. (Yes)

Fox—I would just like to reinforce that we want subcategories because our overall goal, much of what we are going is transparency and accountability.

Chinn—The last item has to do with Item E1D. What we originally mentioned was that facilities that do not participate in the CMS reporting like in HospitalCompare, go through the same rigor of filling out the forms that hospitals that participate fill out. The number of hospitals would be small and that it would be kind of an arduous thing for them to have to initiate, and if you look at item E2, in 2009-2010, CMS will be redesigning the requirements. Why not just have the institutions that are not participating in CMS start reporting screening on patients 50+ admitted who do not have a diagnosis of influenza; that would at least get them started in the right direction. If you had them fill out the same form as the CMS participating hospitals now, this is arduous; they would have to relearn how to screen their patients when the 2009 standards come out.

For Attachment A, all healthcare facilities know that it is a requirement to get the vaccination data; hence we had made a deadline of March 31, 2008. This particular form does not include what (Myers) had wanted, and that is that the declination form only be obtained and signed during influenza season, and that is because we didn't have an opportunity to notify healthcare facilities of that requirement, so that would be an inclusion in next year's reporting. Remember, attachments B1 and B2 are just examples. Each facility can come up with whatever

consent and informed declination that they want, whatever education they want. These are just examples. These are not the actual forms that CDPH is going to endorse.

Rogers—We should clearly state that it is only an example.

Witt—I do think there's a strength that if we don't have a specific form, we do put elements that we want in the form, because the range between the two forms is huge.

Chinn—Yes, the reason is one form uses as an education in addition to authorization for vaccination and declination. The second form says all the employees are required to do a web-based education type module and sign that they've done it. That's why none of the components of education are on that particular form. So there's two ways of doing it, and I don't know that we want to get in the business of creating one for the institutions, because I think that they know what should be in the component.

Witt—Right, although that's why I'm suggesting the elements. We know the strength of the declination; it's making clear to healthcare workers that this is not an issue of autonomy but an issue of jeopardy to the patients. That's the only element I would like to see included in the declination form, that I realize that by declining this form that I am creating a risk to the patient. That's the one thing I think people would have a hard time signing without thinking about it.

Chinn—I know in the second example, where all employees are required to go on the computer and read the substance, you have it under the second paragraph, (page 7), where it says that the flu is associated with 36,000 deaths each year in the US, that the flu can be prevented by annual vaccinations, and so on. So we can certainly highlight that. Are there any other things that really are pressing in terms of being highlighted?

Chair—If you go into the consent B1 and you go to the last bullet under influenza vaccination declination, it says that "my declination of vaccination may endanger my own health and that of my family, my patients and my community."

Chinn—Each hospital has its own way of defining things so I don't think we should make it so confining that hospitals don't have the latitude to choose their own type of wording. But we can certainly make a case for making a statement that all your declination forms include a comment about threat to patients and coworkers.

Torriani—It would be very useful to have examples. Once again we enter this space where people don't want to reinvent the wheel. They want to take a format and then adapt it, and you could make key elements not adaptable.

Chinn—(Witt), I think that your point is good, so in the AFL just mention the fact that we want, number one, that declination is a means

to make sure that every employee and healthcare provider is approached with the process of getting vaccinated. And the second point would be that employees understand that by not vaccinating they pose a threat to family, coworkers and patients. We can certainly do that in the AFL.

Witt—Is that ‘understanding’ or ‘attestation’, which is different. It would be on the attestation form is what I’m proposing. The other reason for that is you can imagine a lot of in-house attorneys being very concerned about – this would be a conflict, this would be a conflict with your staff, having it come from the state may really remove a lot of the difficulties. I would support having attachment B1 be our form.

Chair—So are we making a motion to give no examples, and just attach B1 as the form?

Witt – Motion for B1 to be the form

Eck – Second

Discussion of motion

Moss—There is a larger issue, that there are no penalties if the hospitals decide not to do this. If people say, I’m not going to do this, where can we start to put a penalty for non-compliance?

(739 is the law) So what happens, what is the penalty if they don’t?

Creighton—At this point it hasn’t been determined. There some discussion of, for those of you who are familiar with SB 1301 – that’s a \$25,000 fine per event – there’s been some discussion of rolling that into this. So it’s being discussed at levels higher than us.

Chair—That’s beyond the scope of this Advisory Committee. We’re not here to assign penalties or to drive process. We need to keep our focus on SB 739 implementation.

Member—My suggestion is that maybe in six months we can revisit it as a thing on the agenda to find out what the progress is, but right now we need to let the process work.

Fox—There are two pieces of paper; I agree that one piece is always preferable. However, they are very different. I think the educational items listed in the bulleted form, each of these is important. Lots of people will say, and everybody’s heard it, I know if I’m sick, if I’m sick I don’t go to work. Well, according to this you don’t know if you’re sick. We’re on a slippery slope in terms of the tone that we’re going toward in terms of holding employees responsible for making patients sick. It’s one thing to list risk factors, be fully informed, to sign a form. It’s a whole other thing to sign an attestation that could become, “This patient got the flu, this nurse took care of this patient, this nurse caused that patient’s death.” The point is, in the context that this is two pieces of paper, one is educational and one is an attestation, it is a good package.

Chinn—I think we should allow hospitals the latitude to design their own

with some suggestions that we incorporate; one of the reasons some organizations elected to do it two ways was because no employee is going to read all those bullets and really have it sink in. And the purpose of having a web-based mandatory review is that all of the information is taken outside of the context of having to do the declination at that particular time, because you can't do the declination unless you read all that information and signed off. It is a double type of duty where you acknowledge all these facts and then you go and sign an informed consent. If we can stress certain points, that you should incorporate these items into your education, let the facility decide whatever they want to do.

Nelson—I like the idea of it being packaged, where as a practitioner I call pull a form down and I don't have to go through that creative process. My concern is that some of these facts change. It puts us in a place where I think we prescribe what elements we think need to be in the document, say reference to current rates, just some examples of things that could be used, and the wording in the attestation that we're most comfortable with—that middle road. It means more work on my Committee's part in coming up with that form; that might be a healthy thing for us to be thinking about.

Chinn—I second that as well because all these forms have to go before the legal department at the hospital, and sometimes they want it phrased certain ways.

Nichols—I would only want a form to be required by the state if it were electronically compatible with our electronic databases. Otherwise we are back to transferring from paper to computer and all of the errors that that suggests.

Chair—What I hear being said in different ways is that the institution should have the opportunity to create their own form giving these examples.

LaBar—I believe that most hospitals, at least accredited hospitals, do have a form. There's JCAHO standard IC4.10; if you're accredited, you have a form for declination/attestation. In addition to that, it is very important that employees know, especially in a children's hospital, that yes, influenza can cause high morbidity and mortality. We do say that in our declinations. It's important that those who come to the hospital sick know the responsibility of what they are doing when they come in sick. I believe in strong language and that hospitals should be allowed to make their own form. Also, the science changes, we'll change our forms as the science changes.

Witt—What I am wedded to is this central section wording, so the motion I had, fine, I'm willing to look at it, but I'm not willing to leave this wording up to the facility.

McDonald—I propose that this group prescribe certain elements, and I've got two points: that we prescribe certain elements that the hospitals can meet those elements using their own wordings using their

<p>own wording and their own forms, and also that we have certain specific required wording that's going to meet (Witt's) conditions, whether its, "My refusal of vaccine may endanger my own health," we decide what required wording, and that required wording should be right above the signature. So, required elements and specific required wording for a small component of the form.</p> <p>Witt—Part of why I said all these bullets should be here is because the bullets provide a context, and they're all important.</p> <p>Chinn—When you have a form full of bullets, do you think that an employee engaged in their workday will read it?</p> <p>(Original proposal to use B1 is withdrawn.)</p> <p>McDonald – Motion to prescribe elements for the document and some specific required wording.</p> <p>Chair—The current bullets that are on B1 is the required wording that we would like on a form for every facility, regardless of how the facility puts the form together.</p> <p>Member—They need to be current facts. Because sometimes we get regulatory statements that this is the prescribed wording. For instance, some of the Hepatitis B statements, and now twelve years later I'm having to explain how that works in this context. In this case, there are statistics here, and they're going to change, so we need to word it so that it's not these exact words.</p> <p>Rogers – Motion to approve the content that's already been approved so we don't have to rework the content.</p> <p>Eck – Second</p> <p>All ayes</p> <p>Motion Passed</p> <p>Chair—The subcommittee will revisit the form and will bring that back in May.</p>	
<p>MDRO Subcommittee</p> <p>LaBar (review of MDRO Subcommittee recommendations) The MDRO Subcommittee Advisory Report was distributed. It's a one page simple form. The goal is simplicity and conciseness. So we looked at the MDRO module from the NHSN which references other documents. It was a goal of this committee to review the NHSN MDRO module as well as other documents that were referenced in this module so that we could have a complete understanding of this module. What we found out is that it is very complicated. The expectation from the NHSN is to complete this module when reporting MDROs, which includes gram-positive and gram-negative organisms.</p> <p>The Subcommittee, upon review, assessment, and critique of this module decided that this module is helpful in creating a guideline but is</p>	<p>Subcommittee will create a draft data reporting form and present at May HAI</p>

not necessarily helpful in the implementation in the use of this guideline. The reason is that we felt it took many readings of this document first to understand it, to understand the expectation, and to then implement this expectation throughout the hospital. Most of it, like hand hygiene is already being done, but to actually implement in the entire module and to input it and to send it to NHSN would require a dramatic amount of work while not necessarily giving us the information we need. In applying this MDRO module in the reporting of MRSA, we decided that reporting simplicity will mean that hospitals will report and the comparability and the validity of the data will be assured. We want hospitals to report first and foremost, and we want what they report to be data that is understood and data that can be used to create risk-reduction strategies that can be used to decrease the incidence of this organism in our community. We have reporting specifics, community onset, and we identified what would be expected to be reported.

MRSA bloodstream infections would be reported as a whole number. For those deemed community onset, there is no denominator; there is only one number, the incidence number. Reporting for those deemed to be hospital-onset would be by rate, which would be the number of MDRO bloodstream infections over the number of patient days. In this situation it's important that we get information from all the hospitals. We know that patient days are available to hospitals, so the ICPs would have ready access to that information. Now we have asked also that CDPH mandate that hospitals have information on patient days available to ICPs.

We have here we adopted the module's definition of a new bloodstream infection event. We know many times that the culture result is repeated, sometimes two weeks later we will get that same culture report, so we did adopt the MDRO module bloodstream infection event as an MDRO, in this case MRSA, isolated from blood in a patient with no prior positive blood culture for that same organism in less than or equal to two weeks. We've identified what the new event is, and that's using the NHSN definition in the MDRO module. The process measures as stated in the MDRO and CDAD module also includes associated disease currently being utilized. That's why I mentioned the hand hygiene as well as PPEs in California state hospitals are not applicable at this time. This is not to discount that we may be asking for process measures because the beauty of process measures is that they're not risk-adjusted. Looking at actual processes may be the best way to prevent infection as opposed to retrospectively looking at infection rates, so we kept that here as part of this document. Monitoring interval was briefly mentioned, and we are still unclear what it should be. Should we ask the hospital to report their annual rate, should we ask them to report it quarterly, etc? Lastly, what we are considering to bring to the Committee next time is the data form for your consideration and input.

Oriola—Is this exclusive of MRSA bacteremia? (Yes) So just for simplicity, you should take out MDRO and put MRSA, and then take out MDRO at the beginning. We need to define the community onset and hospital onset. Community onset is probably a blood culture collected within the first three days and hospital onset is collected greater than

three days.

Rogers—I have a question about the ‘strong’ recommendation that the department require hospitals that they provide the number of patient rates to ICPs. Is there an expectation that hospitals would just do this in their own internal process? SB 739 has certain requirements and certain recommendations that will come forward; we’ve not had that in the past. Now we do have it and it’s the mandate of all hospitals through licensing that hospitals comply; I just don’t think it’s appropriate to mandate or strongly suggest that hospitals have to give the information to ICPs.

Torriani—What would be the downside on not giving this information to ICPs? We know that this is very difficult to obtain and that this information will be used by the IC units to normalize data for other bacteria, infections or other things.

Rogers—So it will be the ICPs that will create the rate based on the patient days as opposed to using for example using OSHPD data, which has a validation process, and it has the number of days.

LaBar—One of the considerations is that first of all, there’s a real shortage of ICPs and those coming in are young ICPs. Here is a mandate telling me that the hospital is mandated, all I have to do is ask, where can I get patient days. The intent was just to make things simple for the practitioner.

McDonald—Small and rural facilities are stressed in many different ways, and speaking for the ICPs at small and rural facilities, they need the help. It may be easy in big and well-organized places, but small and rural facilities struggle.

Chen—We asked “could you please evaluate the MDRO module as a means of reporting?” The consensus seems to be similar to what other subcommittees have found, that it is so complex, there is too much to do, that no, it is not feasible. I went and printed it out. For the MDRO module, for an infection event, the minute it hit a BSI it said, “Use the BSI form.” And so what I did is I took the BSI form and I cut a whole lot of pieces out of it, I have it down to one page, what I would like is to hear some discussion on the feasibility of doing this form. Also in preparation for this, I sent a bunch of questions to NHSN, like, “Can CDPH pulled out only the MRSA data, etc.?” Approaches like that would protect the privacy of hospitals but still allow us to have some sort of automated system to collect this data.

Eck—If you go back to what Labar presented as her recommendation from this group and what we had previously agreed to as it related to MRSA, it’s three basic elements, all of which are reasonable to accomplish. How do we get these three to CDPH?

Torriani—We are ready to do a mock-up of a form that could be used by all facilities to enter the number, and we can definitely do it at the next call.

Chair—So what is the action item on this?

LaBar—We will put a form together. NHSN is an entity we can report to, we can get data, that's very important. At the same time, how is the state going to be able to get to use this data, to incorporate all this data from all the hospitals so that we can identify risk-reduction strategies, because we do want to reduce the incidence of MRSA bloodstream infections. The action item is to develop a draft form for reporting.

Teague—Around the idea of this kind of infection reporting, one of the things we're aware of is that it's not just infection reduction within the facility, although clearly that's the paramount goal. It's also informing consumers so people can choose their healthcare facilities and so that payers can choose which facilities they're going to contract with. This becomes a decision for both parties. In terms of being mindful of our audience and what their interests are as we put this out there.

LaBar—So, our goal is to look at our MRSA BSIs. But NHSN isn't even going to report it back.

Eck—This data, to some degree, might help in the component about hospital onset, but the bigger question is that the burden within the community is not well quantified. In various places around our state that burden is significantly different. Part of what we were attempting to do with this is to define that piece because then that can also be addressed and focused by education, public awareness and the like. For the public to necessarily be able to say, "I have four choices in my community, this is the hospital I'm going to go to"; across our state, the number of MDROs, and specifically MRSA, in Los Angeles County versus a small county in Northern California, it's hugely different. That's an important piece that I think the public hasn't necessarily had solid information on. I just don't want us to in any way mislead that this approach is going to purely provide, "I'm going to go to hospital A instead of hospital C" because the community burdens are different.

Teague—The point is well taken, when thinking about the particular audiences for this kind of information, there's clearly a constituency in public health arena, community health planning. But we also get inquiries from people, consumers, and the larger aspects of the healthcare market that want to know, how are hospitals performing? There is inevitably a hospital performance aspect to this, even though this isn't going to address that.

Chair—There is an assumption we haven't addressed, and that is that everyone gets to pick their healthcare. That is not a reality, and even though of us who are healthcare workers and have insurance, we only get to pick certain things. We need to talk about that, because it's an assumption that we all get to pick and chose whatever we want; it doesn't work that way in healthcare.

Teague—I would also acknowledge that point. OSHPD in particular has been asked to publish various kinds of data on its website in the theory that it's going to inform consumer choice. We're acutely aware that

consumer choice is very narrowly circumscribed; nevertheless, we get the directives, and we also get the requests to put this information out there.

Torriani—If we start thinking that quality institutions have a low rate of MRSA bacteremias that is also misleading to the public because we know that the institutions who have the most resistant bugs are those who also do transplants, who treat patients who are more prone to these infections. If I get into a big trauma, I want to go to the best trauma center nearest to where I get hurt. I am not going to have at hand the rates to look up of infection. I want them to get me there as soon as possible, and to have the best trauma and the hospitals that have the worse cases so that I get the best care. And that is a point that people – we may go down a road that we don't want to go down because we may mislead them.

Member—Given that you will now have quite a bit of disparate information, how will those calls be handled, and what gets done with that information. If I call you up and say, "I'd really like to know, where's the hospital that passed?" what's going to happen with this information, and how do the limitations of any data set get explained to any members of the public who call in so that they really are given information from which to make a better decision. If I get a Consumer Reports on washing machines, I know exactly how to read that report. But this doesn't work that way. I think what the public is really asking for, what they desperately want, is that kind of a report. And there are many ways in which it would be wonderful if we could do that, but so much of what we are doing here, it's not that simple.

Chair—To that point, we've got our Public Reporting Subcommittee who's going to get us up to speed on that, so let's just talk MDRO for now.

Flood—What it really comes down to is that each hospital is its own risk pool. And even by reporting this, that's going to change those risk pools because all those people who said we're going to go to Hospital A because that's what those reports said, they're going to take all their stuff with them. This is going to be a moving target. Everything else being the same, and all the actions being the same, these things can move back and forth so incredibly quickly that the data that we publish can change to be worthless.

Public Reporting Subcommittee

Moss—Thank you to all the members of the Subcommittee, because we've been on an accelerated schedule. We've been working toward a good first step - a model that we can emulate as far as the possible site for California, and we'd like to share our great results on infection prevention. We know that our charter was to identify a portal that we could use as an interface with the public that would be easy to use and user friendly and accurate. We agreed that the number one priority is that it states up front very clearly the age of the data that we're reporting. Number two, since we're going to be reporting on separate things, what number is the best number to be at for the things we're reporting. Do we want a large number or a small number? Francesca will walk through the site for the Committee.

Torriani—I think that the proviso is that this subcommittee, we did not decide about the content, because the content was already decided by the whole Committee. So to be clear, this demo is only to look at format. Basically, this is the site for Missouri. They started this process in 2004 and they went live in 2006 and so it took a little while to get it going. As a consumer, I look at different things.

(Torriani and Moss presented details of the following components)

- Site organization
- Search components
- Ease of use
- Graphical presentations/visualization of data
- How the site meets the goal of sharing information and results in several different ways. A narrative, a chart, a graph, with color; certain people read things differently
- The importance of sustainability, and the ability to update frequently
- Usefulness of comparison data for multiple hospitals, or a profile for the individual hospital
- Utility of having the address and the number and the individual website
- Statewide down to hospital to hospitals comparison
- Rates by size of hospital
- Drill-down to various levels of detail
- Timeframe of data collected

Wardell—A section for notes on the page is important because that's there to tell people that even though there may be a higher or a lower comparison, it might not be statistically significant. I think when you're talking to consumers, that's helpful.

Torriani—What I really like about this site is that it has two purposes. One is to inform and one is to educate. And they're hitting the nail right on the head. The other thing that I find very telling is that they are not inundating the consumer with a lot of information. They are concentrating on two things, essentially, which are central line infections and surgical site infections.

Eck—If you go back to that central line page again, they had the

Subcommittee will formulate a proposal to CDPH and present at May HAI

national rate, it's gone down. There is a difference, and that is one of those consumer education pieces, there is a difference between a teaching hospital and a non-teaching hospital, and for the 45 bed hospital, St. Mary's, it's probably not teaching, but Barnes certainly is. And that would be, if I have a big trauma, take me to the trauma center. Those are other important pieces.

Oriola—It may be helpful to do percentile of participating hospitals if NHSN is a benchmark versus an actual rate that may be difficult to understand. How do you compare yourself to your peers for insertion practices, like for central lines?

Chair—So outcome and process measures can be modified to this format, we just have to figure those out. This is an example of a way we could do it, just showing you a template. It's not final.

Torriani—The site is well-presented and not "dumbed down". Hospitals do have the opportunity to make comments in comment section.

Witt—I have a couple of concerns when we're talking about 'dumbing it down'. I want to ensure that we don't equate making it understandable to someone with less education as equivalent to dumbing it down. I think we need someone who isn't looking at this stuff all the time like everyone in this room to tell us if this is understandable. I think it needs to have the education, it needs to be usable for us as well, but it needs to have meaning for the public.

Rogers—I really like the website a lot and I agree that it needs to be easily identifiable by the consumer, but we've all said, "Who is good or bad, is it good to be high or low?" We might consider doing some focus testing when we get closer to what the elements will look like. I agree with some of the words that we might need to change to a more understandable way for the public site.

Teague—In the site, generally the hospital comments field was not populated; whether or not it is used, it seems like it's important to offer it. With the outcome reports that we publish, we always have an opportunity for the hospitals to submit letters. They get to review the findings in the reports, but at the end of the day the findings are set. The hospital still has an opportunity to submit a letter that presents any explanation that they would like to offer, and often there are circumstances that can't really be captured in the data that require some narrative. It's important in my view that that comment field be available. The other thing that we really liked about this was that it had information layers, depending on what level you wanted to get to in terms of understanding the data, you could drill down to that, but you could still find the site intelligible at a relatively superficial level

Eck—Empowering the patient as part of this is really valuable.

Hoke—Sometime in the process, I think it may be wise for the committee to start pulling in CDPH IT web support person to help guide your thought process in this. They are already developing standards for

the new website, so they may be able to guide you to what sort of may work and fit their standards.

Torriani—The last point on this website that I wanted to make is that once again it doesn't try to do everything. They have related links, such as to the CDC page.

Rogers—Part of SB 739 is for this task force to make recommendations to CDPH, and should the department decide to go through with any or all of them, which is our hope, does the department submit a new budget change proposal because the bill's already been signed and we're already charged with the work? Or does it need to go into the budget cycle again as new funding, or do you need a bill? So I'm looking procedurally as the department moves forward and decides to implement these things, what's the process for getting money?

Chen—When SB 739 was passed as an unfunded mandate, a budget change procedure, or BCP, was immediately written that requested X amount of people and X amount of money, with the general categories of what they should be doing. That recommendation is currently in the 2008-2009 budget. It is not a certainty, but we do believe we will get the money that we requested last year for this year. As the Committee comes up with new recommendations, as CDPH discusses those recommendations, if more resources or money is needed, we have to write another BCP, and it then has to go through the whole budget committee, budget process and one of the more difficult things is finding out how we can get it paid for. Some of that's being strategic, what pot of money will it come from, so that if there is a general 10% cut across the Board, of the general fund, that we don't lose the money. You may need another budget battle in the next year for a website. Right now it's requesting 14 positions: I think two physicians, one nurse, two epidemiologists, some number of laboratory personnel, X number of personnel for L&C and money to support them, with some money to support this Committee. I think there's a little leeway to be creative with the position, so for instance, if we trade perhaps a physician for a nurse and administrative support, which would be very useful, to try and get the correct mix of people with that pot of money. At this point there isn't any money to do this kind of thing.

Chair—I think we should go through the draft document as recommendations from the public reporting team and get some input from the bigger group.

Moss—The two most important pieces were the real-time data and then the key of what's a better grade, a zero or a larger number. Talking with our group and also with other states and focus groups, ease of accessibility was the number one priority, the definitions which would be easily imaged on a tab, a quick glance at graphics, the demographics, and comparability of CLIP data, etc. and the last bullet point, I think it one of the most important, and that is education. It's not just education of the public but it's also education of others. We're looking forward to working with an educator who's a trainer, who's worked with the consumer that can help us make things very simple.

The potential ways that we reach consumers is unlimited.
Velji—This is an excellent tool, but I was trying to figure out, if there is no money in the budget already allocated, we don't know when this will come to fruition. Obviously, there is a fast track way to get it online and start working on it, because other states already have some of this. The other aspect is who will maintain it and who will record was useful, how many years, what areas. And who will update the information, who has control over what goes on the website, to make it really an official website

Chair—These are questions that our group has in to CDPH.

Member—I assume our customers want to see a proposal before they start approving or giving things. I assume that our next step is we're going to get together and put together a proposal, which your input will be required because of the scope of work that we deliver. We'll put a proposal and present it to CDPH. All of us need to think about how we can participate with the assets that we have. Over the next couple of months I think we could get a good idea of the cost just by working with the people in Missouri.

Chen—Claudia Erickson, the person who's actually on the committee as a consultant, is the person who designed the HAI AC website. When she has the specific questions, she can then go and look for the information. She is also a health educator, so she really is an important person to have on your subcommittee.

Chair—Our question is, does this look reasonable, are we on the right track?

Torriani—On page two, we have what we would be proposing as a subcommittee to put on the website. We might want to start with some of these, pick a few and concentrate on how these would appear. I would propose to delete some of these, not because we want to forget them, but just because we want to say that for now, these are the items that we want to concentrate on.

Eck—There is a difference between providing information and education. Education really is tapping into that individual empowerment piece. I would encourage us to really link that piece in, and having a health educator is part of this.

Chair—Our next item of business is formation of further subcommittees, and some of those subcommittees in the back of your minutes were for Public Education, SSI, and VAP. Is now the time to formulate those subcommittees, or do we put them in the parking lot until May?

Review of active subcommittees:

Influenza

MDRO

Public Reporting

Nelson – Motion to defer any other subcommittee formation

<p>until May meeting Wardell – Second All ayes Motion Passed</p> <p>Discussion among members regarding definitions of “maximal barriers” and facilities’ experiences with drape size.</p>	
<p>Discussion</p> <p>Discussion among members regarding definitions of “maximal barriers” and facilities’ experiences with drape size.</p>	
<p>Action Items and Upcoming Meetings</p> <p>Chair—Action Items</p> <ol style="list-style-type: none"> 1) We will have a health educator on the Committee. 2) All AFL (restatement) will go to all Committee members via email. 3) (McDonald) will forward to Licensing and Certification a canned infection control foundations education program to educate staff. 4) CHA to partner with CDPH for letters to hospitals as it relates to AFLs. 5) Email suggestions to (Chen) on the AFL (but the AFL is going out) and there will be an FAQ attached to the AFL. 6) The Committee to set guidelines for Committee membership criteria; Chen and Delahanty will look into the issue, draft a document, and include it as an agenda item for next time. 7) Send thank you letter to our public speaker <p><u>Review of Subcommittee Action Items:</u></p> <ol style="list-style-type: none"> 8) Influenza – Will bring a declination form (with key elements as discussed today) to the May meeting. 9) MDRO – Formulate a draft data entry form and reporting mechanisms. 10) Public Reporting – Will draft a proposal to CDPH to include budget, website masters, public education, and additional items. <p>Thank you for taking time out of your busy schedules, coming together and working together to drive patient safety.</p> <p>Flood – Motion to have the HAI-AC meeting the 4th Thursday every other month. McDonald – Second Motion dropped after brief discussion</p> <p>Next meeting May 29, San Diego 10:00 a.m. to 3:00 p.m. Members to be notified of site.</p> <p>Future meetings July 31, Sacramento (or San Diego) September 18, Sacramento</p>	<p>HAI will have a health educator on the Committee.</p> <p>All AFL (restatement) will go to all Committee members via email.</p> <p>(McDonald) will forward to L&C an infection control foundations education program to educate staff.</p> <p>CHA to partner with CDPH for letters to hospitals as it relates to AFLs.</p> <p>Email suggestions to (Chen) on the AFL (but the AFL is going out); an FAQ will be attached to the AFL.</p> <p>The Committee to set guidelines for membership criteria; Chen and Delahanty will draft.</p> <p>Send thank you</p>

Adjourned

letter to our
public speaker.

Acronyms

AFL	All Facilities Letter
ARDS	Acute Respiratory Distress Syndrome
BSI	Bloodstream Infection
CART	CMS Abstraction and Reporting Tool
CDIF	<i>Clostridium difficile</i>
CDPH	California Department of Public Health
CLIP	Central Line Insertion Practices
CMS	Centers for Medicare and Medicaid Services
DIC	Disseminated Intravascular Coagulation
ED	Emergency Department
HAI AC	Healthcare Associated Infections Advisory Committee
ICP	Infection Prevention and Control Professional
ICU	Intensive Care Unit
IHI	Institute for Healthcare Improvement
JAMA	Journal of the American Medical Association
L&C	Licensing and Certification
LIP	Licensed Independent Practitioner
MRSA	Methicillin-Resistant <i>Staphylococcus aureus</i>
MSSA	Methicillin-Sensitive <i>Staphylococcus aureus</i>
NHSN	National Healthcare Safety Network
NICU	Neonatal Intensive Care Unit
OR	Operating Room
PICC	Peripherally Inserted Central Catheters
RN	Registered Nurse
SA	<i>Staphylococcus aureus</i>
SB 739	Senate Bill 739
SCIP	Surgical Care Improvement Project
TB	Tuberculosis
UVC	Umbilical Venous Catheter
VAP	Ventilator-Associated Pneumonia
VRE	<i>Vancomycin-Resistant Enterococcus</i>