

Healthcare-Associated Infections Advisory Committee

October 9, 2008, 8:00 a.m. to 11:00 a.m.

Location: Conference Call

Attendance

Members/Alternates:

Kim Delahanty (Chair), Ray Chinn, Alicia Cole, Letitia Creighton, Enid Eck, Annemarie Flood, Lilly Guardia-Labar, Jennifer Hoke, T Warner Hudson, Lisa McGiffert, Mary Mendelsohn, Shelly Morris, Carole Moss, Rekha Murthy, Frank Myers, Terry Nelson, Shannon Oriola, Debby Rogers, Julia Slininger, Todd Stolp, Jonathan Teague, Dawn Terashita, Francesca Torriani, Anvarali Velji, Pat Wardell, Lisa Winston, David Witt

Guests: Cynthia Franco (Vista Hospital, Riverside), Les Hanover (Cepheid), Jean Paul Buchanan (Senator Alquist Office)

Staff: Sam Alongi, Sue Chen, Roberto Garces, Jon Rosenberg

Agenda Items/Discussion	Action/Follow-up
<p>Call to Order and Introductions Committee Chair Kim Delahanty (Chair) convened meeting at 8:00 a.m. Conference call rules (attached) discussed Introductions made</p> <p>Thank you all for joining us today.</p>	
<p>Updates</p> <p>Progress on Program Implementation – Chen 317 of 465 California hospitals are registered in NHSN, or 68%. This comprises 18.5% of NHSN hospitals nationwide. Of the 317, 177 (55%) have registered into the CDPH group.</p> <p>CLIP module was released on September 19, 2008; hospitals can now input their CLIP data.</p> <p>Influenza Module: AFL 0817 was released in August. 45% of facilities have reported vaccination data from the 2007-2008 influenza season. Employee vaccination rates ranged from 28 to over 90%.</p> <p>Committee Personnel: We still need a representative from California Association of Health Plans (CAHP).</p> <p>Senate Bills 158 and 1058: were signed on September 25 and chaptered on September 28. They will take effect on January 1, 2009 unless otherwise specified.</p> <p>For January 1, 2009 (under SB158):</p> <ul style="list-style-type: none"> • Facilities must have patient safety committees in place to consider all HAIs. Every HAI would require a root cause analysis. • Environmental sanitation section of infection control policies must be updated to contain required wording. <p>Under SB 0158,</p> <ul style="list-style-type: none"> • MRSA testing program must be put in place. • Reporting of healthcare associated MRSA and VRE BSIs, C diff 	<ul style="list-style-type: none"> • Rosenberg to seek legal clarification of language relating to SSI definitions – clean and clean-contaminated; deep organ space; denominator; and breadth of reporting: will facilities need to report all SSIs or defined orthopedic, gastrointestinal and cardiac surgeries. • Rosenberg to clarify with CDPH that recommended SCIP process measures already being reported can be used.

infections, central line, bloodstream and surgical site infections as specified in SB1058 must start at January 1.

Oriola—MRSA testing and screening implemented on January 1, 2009?

Chen—Yes per our reading of the Bill.

Oriola—Does that include NICU?

Chen—Yes per our reading of the Bill. Some of the language is up for further discussion.

Murthy—Regarding the patient safety committee (PSC):

Chen—The wording in 158 describes many other events that would be covered; this is separate from the infection control committee.

Hudson—What is the verbiage in SB158 on what is encompassed by the term 'healthcare facility'?

Chen—Acute care facilities, long term care facilities, specialty care hospitals, and acute psychiatric hospitals, so it is broader than just acute care hospitals.

Chair—If we already have a Patient Safety Committee, can we use that?

Chen—Yes.

Oriola—Does this have to be facility specific, or can it be system-wide?

Chen—Consider - would one centralized committee would work for your system?

Oriola—So at this point, until it is clarified, we do not have to do MRSA screening in our ICU in our acute psychiatric hospital?

Chen—Correct.

Chen—So starting in January 2009:

1. Hospitals not having an existing Patient Safety Committee must set that up, and the events to be looked at are specified in the Bill.
2. Hospitals need to set up an MRSA testing program as specified in SB 1058.
3. Per 1058 hospitals need to update their infection control policies to ensure the required verbiage on environmental cleaning.
4. The reporting of MRSA and BSI bloodstream infections that are healthcare associated, C diff infections that are bloodstream associated, central line infections throughout the facility, and the various surgical site infections as described in SB 1058 must begin.

Chinn—The requirements for surgical site infections are nebulous? Does the Committee have the ability to modify the language so that it makes more sense?

Rosenburg—Neither CDPH nor the Committee can modify. So for this section, the Bill requires that all orthopedic, gastrointestinal and cardiac surgical site infections be reported. Second, the Bill creates a category of organ and deep space infections that stands on its own. This cannot be modified without new regulation or legislation. There can be legislation to modify this, but even if that were to happen there would be a period of time in which the language stands as it is now. What

CDPH needs from the Committee is explicit language regarding the impact of this language and legislation, so if everyone can send these letters stating what they believe the impact of trying to implement these statutes will be...

Oriola—I believe the burden will be large for those who are not on electronically. The data for these would be overwhelming.

Rosenberg—The legislation (1058) states: “Each facility shall report quarterly to the Department...all healthcare associated surgical site infections of deep or organ space surgical sites,” that is one phrase.

Chinn—Is there a requirement for a denominator, or just number of cases?

Rosenberg—The denominator is the number of surgeries involving deep or organ space.

Chen—The Committee does have the right to make comments on what is the impact of this legislation.

Morris—What are the steps for creating emergency or offsetting legislation?

Rosenberg—This is a very explicit process which is to completely prohibit any requirement on any sector of the state without full public comment and exact knowledge of what is required. So even if the legislation granted the Committee the authority to change it, this would still have to go through the full and public process used by the state. And that would involve a major expenditure of resources and time.

Myers—Would this require active surveillance, or is passive surveillance acceptable? And what is the punitive measure under the law if institutions do not comply with the law?

Rosenberg—The legislation just says “all”; CDPH cannot specify as a requirement; we can only make recommendations for hospitals to report to us, all the surgical site infections and all the surgeries for those categories. Since there is no category “deep and organ space” surgery, the intent of that appears to be a type of infection. How the hospitals count or determine “all” is going to be up to the hospitals.

Murthy—Because the legislation doesn’t specify the methodology of NHSN, or active or passive, there is a potential for a broad array to be used, and inconsistent information may result.

Chinn—The saddest thing here is that it doesn’t do the patients any benefit. The original intent of the reporting of infections was to focus in on certain infection types, develop strategies to decrease them, and if we don’t have a common playing field for comparison, this will defeat the purpose.

Eck—We need clarification from the CDPH attorneys on what this really means; is it restricted to “deep or organ space” surgical site infections for orthopedic, cardiac, or gastrointestinal?

Rosenberg—If in fact we are permitted to say they are deep or organ space infections of orthopedic, cardiac, or gastrointestinal...what is the impact?

Eck—The impact would still be huge. The disparity in reporting between electronic systems and other systems, this will be very difficult.

Rosenberg—I will continue to talk with the attorneys today.

Slininger—Could we simplify this by just reporting cases on a regular basis and then offer the denominator perhaps annually.

Rosenberg—CDPH has been advised that because there is no specification of what are the parameters of a case. Therefore it is essentially rate reporting. Nothing in the Bill gives CDPH the authority to require specific information or NHSN data, so CDPH cannot specify this.

Stolp—The intent was to restrict this to deep or organ space infections. If we don't do that, much of the reporting will become essentially meaningless.

Teague—In paragraph 3, a lawyer would interpret that as deep and organ space AND orthopedic, cardiac, and gastrointestinal.

Eck—I do believe that the intent was to look at serious infections. I wonder if we're making this all more difficult than it needs to be, so we should take this to the attorneys for their take.

Eck—So from an action item perspective, CDPH will speak with the attorneys and get the final word on this?

Rosenberg—Yes. Let's assume that the deep or organ space refers to orthopedic, cardiac and gastrointestinal. And further qualified by clean or clean contaminated categories. Otherwise unqualified orthopedic, cardiac and gastrointestinal. So what I need today is information on implementing this legislation, what is the impact

Chinn—Who would generate the list of procedures to be reported?

Rosenberg—If it follows under the deep or organ space infection under orthopedic, cardiac or gastrointestinal, it has to be reported.

Chinn—So the denominator will be, for example, all gastrointestinal surgeries; in that case the comparative data is useless, the numbers will be all skewed. The denominator is where all the trouble will stem from. If the intent is just to report the number of deep or organ space infections, then that is fine.

Rosenberg—The legislation calls for the incidence rate.

Torriani—Even if we attempt to determine the size of the impact...there is no real definition. Defining the numerator and denominator, as well as defining infections...

Murthy—Referring to the language—paragraphs 1 and 3 under section 2, it seems to be fairly clear about the denominator being patient days. The clarification needs to be obtained as to what is the desired intent of the legislation.

Rosenberg—In section 2, I believe 'patient days' is a mistake and should have been number of surgeries. But what is written is what is written.

Murthy—So it seems to be within our prerogative as a Committee to get this clarification from legal.

Rosenberg—So what I need to know from the Committee is "is this workable?" The Committee's job is to advise CDPH on how to implement this as it is written, how to comply without changing the language at this time. How would the Committee recommend that hospitals proceed.

Mendelsohn—On behalf of ICPs, the impact of this is huge. Most of these practitioners are not looking at this broad set of infections. IF we

<p>can't change the wording, the AFL will have to be very specific in codes and what needs to be done. In the meantime we will have to be active in trying to correct what has been done by this legislation.</p> <p>Eck—I'd like to go back to the intent, and suggest that we get the clarification from CDPH legal. Given SB 739, SB 158 and SB 1058, the focus is to prevent healthcare associated infections. If we recommend that clarification on procedure categories be given on the areas in which we are already collecting and reporting (process measure data), therefore we would be reporting those data which are reported in SCIP. This would narrow the list of procedures, we'd have the process data, and we'd be looking at the question of are those process measures working? The intent of this is 'are we making a difference in healthcare' and by narrowing it this way we could have a better answer to that question. As written, this legislation is not doable, it is too wide a range of procedures, there's no comparability, and it doesn't reflect the intent of what the legislation was meant to cover.</p> <p>McGiffert—The intent very explicitly in 1058 is to use NHSN.</p> <p>Rosenberg—Where does it show the authority?</p> <p>McGiffert—This is in 4.D. of 1058 (1288.55): "Health facilities that report data pursuant to the system..."</p> <p>Chen—The legal interpretation is in section A. The interpretation from legal is that CDPH can require NHSN for anything in section A, in 1288.55.</p> <p>Rosenberg—Section D also says <u>shall</u> report using NHSN.</p> <p>Chen—The bill does say "as appropriate". I would interpret this (we will check with legal) as if it is not appropriate to report through NHSN, CDPH does not have to require it, but where it is appropriate, say with BSIs, CDPH can require it.</p> <p>Oriola—There are different reporting of rates, such as overall versus targeted, and this legislation seems to blur some lines, so it would be nice to have some clarification.</p> <p>Chinn—This has not been tested, it makes me nervous to put forth in public forum something that is not tested and may have unintended consequences. Given that we use NHSN definitions, we also would include denominator information. I believe this gives us the latitude to modify or interpret the legislation. By putting the strategies into the key targeted infections, we will have a better outcome.</p> <p>Murthy—By default, it seems that we would use NHSN. That could be a way to define the set of procedures within the frame of NHSN. The reporting is a different question.</p> <p>Eck—We must use NHSN or there will be no comparability whatsoever. Bear in mind that since the majority of hospitals are now in NHSN, we need to keep the consistency going and not throw this huge new workload on hospitals.</p> <p>Chen—Please members, submit your written comments to Jon and me.</p>	
<p>Review of Draft AFL 0819 Mandated Reporting of Central Line Associated Bloodstream Infections</p> <p>Chen—I wrote up the work of the BSI Subcommittee. What this requires is "will report via the NHSN modules for ICUs".</p> <p>Terashita—This is similar to what we reported at the last meeting. We</p>	<ul style="list-style-type: none"> • Chen to clarify NHSN reporting requirements and definitions for comparability and consistency

divided this into ICU patients and non-ICU patients. So for ICU patients we decided to go with NHSN reporting. Non-ICU patients under 1058, we decided to do this separately, reported directly to CDPH, aggregate reporting of numbers of infections and the denominator of line days.

Morris—Line days outside of the ICU will be onerous to collect.

Terashita—That is the Subcommittee recommendation; it is up to the full Committee to accept or reject this.

Morris—I thought we were looking at admissions or patient day data.

Torriani—Using patient days doesn't make as much sense. The risk is discovered through using line days.

Terashita—The subcommittee also discussed that CLIP will be daily line assessment hospital wide, so hospitals will have to be keeping track (eventually) of all lines in the hospital. The NICU piece is more difficult: it can't be phased in. So we need to make a recommendation on NICU for the AFL that CDPH is developing right now.

Oriola—[Issue on catheters]

Myers—Given the burden that SB 158 and SB 1058 are bringing, adding additional responsibilities may not be a good idea at this time.

Labar—Many NICUs do participate in CPQCC using NHSN definitions. The only clarification is that we look at temperatures and we created our own definition because we thought NHSN was really not specific to what we see in the clinic. For NICUs, getting data on birth weights and line data is problematic; this will take time to implement for those NICUs not already collecting this data.

Nelson—All the legislation involving HAI looks to this Committee for practical and professional insights. I suggest the Committee checks itself a little bit in recommending things right now until we have more clarification. We're asking a lot of training to go on; my suggestion is that we focus on specialized areas, and a smaller subset of employees who would be logging line days and other data. I suggest that we really stay focused on those things that can really give us information on interventions, where outcomes and processes can be monitored.

Terashita—It is written in the Bill that we use total hospital.

Chinn—Bloodstream infection is one of the things we could attempt to 'get to zero' on.

Nelson—Doesn't monitoring of ICUs give us that information? We need to look at designing something that gives us a good return on investment.

Oriola—The National Patient Safety goal (under the Joint Commission) is requiring focus on central vascular associated infections as well; there is a phase-in of one year on this.

Witt—What we can contribute is how to make this legislation reasonably doable; I think line days are what is required here.

Labar—Are hospitals required by the first of the year to report on BSI? So the AFL and some clarifying criteria have to go out as soon as possible, so NICUs can get this together.

Chen—With help from L&C, we will get the AFL out as soon as possible. The hospitals are depending on us to provide recommended guidelines on implementation.

Terashita—Do we need to decide today whether the Committee will use NHSN or other for this?

across California hospitals

- Chen to modify the BSI AFL based on the passed BSI Subcommittee recommendation; the start date for public reporting will be included.
- Chen to clarify MRSA (in an AFL dealing only with central line BSIs) on the question of births outside vs. inside your hospitals

<p>Chen—The CDPH recommendation is to use NHSN. A motion on this would be appropriate.</p> <p>Terashita—Motion for the Committee to accept the BSI Subcommittee recommendation as written, with the clarification that NICU data will be entered into NHSN following NHSN guidelines.</p> <p>Oriola—Second</p> <p>Discussion</p> <p>Torriani—Can you provide clarification on the ICU versus non-ICU?</p> <p>Terashita—Yes, the ICU will be reported through NHSN and non-ICU reported directly to CDPH.</p> <p>All ayes</p> <p>Motion Passed</p>	
<p>AFL Letter</p> <p>Chen—I will write the AFL to correspond to the motion, with ICU reported through NHSN, and all other areas reported quarterly with an appropriate numerator and denominator. I will run this by the BSI Subcommittee before it gets submitted to L&C.</p> <p>Stolp—The document didn't indicate that information would not be publicly released until sometime later.</p> <p>Chen—The data will be publicly reported by 2011.</p> <p>Stolp—The whole point in the postponed public release is an opportunity for us to understand the interpretations of the data.</p> <p>Chen—The Public Reporting Subcommittee will be looking at this issue, as well as many other public reporting issues.</p> <p>Murthy—The draft letter, given this discussion, for ICUs, the device days denominator doesn't seem particularly difficult, but may require a mandate or special note for non-ICUs. It may be necessary to spell out in the letter for the administrators.</p> <p>Chen—These Bills put such a reporting burden on infection control practitioners that we cannot accomplish it without massive help, so administrators will have to get involved if facilities are to comply.</p> <p>Morris—What is the frequency of reporting?</p> <p>Chen—Quarterly.</p> <p>Morris—Should reporting deadlines be spelled out?</p> <p>Chen—We can include the reporting deadlines.</p> <p>Torriani—So the letter to be put forward will be completely revised, so there won't be option 1 and 2 etc?</p> <p>Chen—Correct.</p> <p>Torriani—I think it is also important to mention the upcoming requirements of public reporting.</p> <p>Chen—The Subcommittee will see the letter before it goes to L&C.</p>	<ul style="list-style-type: none"> • CDPH will disseminate an AFL to administrators regarding new CLABSI reporting requirements and associated timelines that will start January 1, 2009.
<p>Other Discussion</p>	<ul style="list-style-type: none"> • Myers to send article to HAI

<p>Oriola—On the MRSA screening in the NICU environment, since there are no studies on perinatal transmission, could the screening on the NICU population come from those babies transferred from another facility or from home rather than those delivered in the hospital?</p> <p>Labar—The incidence is so high in the community, whenever a baby is transferred in, it is screened. We do find MRSA even in the very newest born. I would strongly recommend including this screening, including babies born in the facility.</p> <p>Chen—Your question Shannon is whether to do this screening on babies born in your facility who transfer to the NICU? (Yes) CDPH will discuss this and let you know the interpretation. This may come down to the wording in the law.</p> <p>Moss—Any baby going into the NICU should be screened.</p> <p>Myers—I would like the Committee to be aware of a recent article on active surveillance.</p> <p>Chair—Please send this out and we will distribute.</p> <p>Morris—In talking about testing within 24 hours of admission, what if patient has been screened previously (say during pre-op which could be several weeks before the patient is admitted), would those patients need to be re-tested?</p> <p>Chen—1255.8 Section B does specify ‘within 24 hours of admission’. So if pre-op testing occurs outside of that window, those patients would need to be retested.</p> <p>Oriola—Is there a letter to submit to CDPH for a waiver?</p> <p>Chinn—One way to save resources would be to not re-screen those who tested positive outside the 24-hour window.</p> <p>Rosenberg—The legal opinion on just sub-section A: “if the patient is scheduled for inpatient surgery and...” the legal opinion is that the requirement is only to screen patients who have a documented medical condition (based on CDC or committee finding). I will ask CDC if they have any findings on documented medical conditions making patients susceptible to MRSA infections when they undergo inpatient surgery. If there is no finding through CDC, then there is no requirement here.</p> <p>Labar—Risk factors for post-operative infection is clearly well defined.</p> <p>Rosenberg—But this is referring to medical condition.</p> <p>Myers—We would also need a clarification on the requirement for follow-up on and education for patients’ awareness of their MRSA status. What would the expectation be on the hospitals here, particularly for non-emergent situations around MRSA status?</p> <p>Chinn—My sense is that if we are looking at risk reduction for patients, you would screen patients in certain surgical groups for MRSA and MSSA. There is some data around this. So if we want to say which groups would be beneficial to screen, that is reasonable. It is unclear whether the intent is that, or to just capture all patients at-risk?</p> <p>Winston—Studies have shown it to be scientifically controversial whether screening is beneficial. What would be most beneficial is for this Committee to be as clear as possible on exactly what the requirements are...regardless of the merits of the science (or lack of science) around the legislation.</p> <p>Cole—The comment I wanted to make was with regards to MRSA education of patients and following up how we explain to the patients</p>	<p>staff for distribution to Committee.</p> <ul style="list-style-type: none"> • Rosenberg to ask CDC if there are any findings on documented medical conditions making patients susceptible to MRSA infections when they undergo inpatient surgery. • Chen to clarify requirement for follow up education to individuals on their MRSA status • Chen to continue to obtain legal opinion on the MRSA issue for surgical patients and communicate those to HAI-AC.
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about their infections. What we need to do is that under all circumstances look at the intent of the law – which is to protect patients and MRSA education and follow up is very important for patients to know what is going on with their health and care.

Chen—CDPH will continue to get legal opinions and communicate them to the Committee as we get them.

Chen—We need to look at the table of legislative duties of the HAI Committee, so we can get workgroups moving and figure out how this Committee can assist.

For legislative duties on page 2 under legislation of 158. Under D it has the duties of the HAI AC. Under the 8 squares on the table, we need to fill in what we are doing and where we want to place our focus. CDPH will fill in the information for page 4. What CDPH needs here is, for 158, what is the Committee looking for, how can CDPH best help hospitals implement these two bills.

Chair—This may be the time to review the action items.

Action Items

1. Rosenberg will clarify with the legal department the specifications that relate to language of the SSI definitions – clean contaminated; deep organ space; denominator; total numbers; are we looking at everything or specific as defined: orthopedic, gastrointestinal and cardiac surgeries.
2. Rosenberg will clarify with CDPH that recommended SCIP process measures already being reported can be used.
3. Chen will:
 - a. clarify NHSN reporting requirements and definitions for comparability and consistency across California hospitals
 - b. modify the BSI AFL based on the passed BSI Subcommittee recommendations; the start date for public reporting will be included (based on the legislation)
 - c. clarify MRSA (in an AFL dealing only with central line BSIs) on the question of births outside vs. inside your hospitals
 - d. clarify requirement for follow up education to individuals on their MRSA status
 - e. continue to seek legal opinion on the MRSA issue for surgical patients and communicate those to HAI-AC.
4. CDPH will disseminate an AFL to administrators regarding the new reporting requirements and associated timelines that will start January 1, 2009.

Flood—Wasn't there an action item for members to examine the burden of SSI?

Rosenberg—I have enough information for today, but please do send comments in writing as you are able.

Hudson—The Joint Commission is looking at influenza vaccination rates. Will hospitals be able to use the data we collect through this legislation to address the Joint Commission's interest in this information?

Creighton—Without knowing the specifics, I believe you could use SB 739 data for the Joint Commission.

Chinn—Agreed, it seems like that data would stand on its own merit.

<p>Duties of this Committee under the new Bills</p> <p>Chen—Looking at SB 158, the first requirement is to review legislation federal and state legislation, regulation, etc., and communicate to CDPH how infection prevention programs will be impacted. Could we form a subcommittee here?</p> <p>Note: I would like to keep our subcommittees under 20 members, to give people a chance to make comments off record.</p> <p>Torriani—Once we've determined a person is colonized or infected, what is the requirement? Should that be addressed by this Committee?</p> <p>Witt—This would be very difficult for this Committee to address.</p> <p>Torriani—We should have this in meeting minutes that we understand this needs to be considered but cannot consider it as a Committee at this time.</p> <p>Murthy—Another point for clarification, under item C, "Commencing January 1, 2011, patient who tests positive...shall again be tested immediately before discharge." So again there is a comment about demonstrating some special level of risk for MRSA.</p> <p>Chen—This will be a very difficult road. These are excellent points, but we are not yet at a point to address them. I feel we need to form these subcommittees in order to move.</p> <p>Chen—Volunteers for Legislative Impact Subcommittee?</p> <p>Members—Myers, Nelson, Delahanty, Torriani, Mendelsohn, Moss, Rogers, Chen (staff).</p> <p>Chen—A second Committee can recommend a method by which the number of infection prevention professionals/resources can be assessed in each hospital. So we need volunteers for this Subcommittee:</p> <p>Members—Delahanty, Flood (volunteered as alternate to Chair), Labar (volunteered as Chair), Morris, Murthy, Torriani, Chen (staff).</p> <p>Torriani—Infection control physicians need this Committee to be a voice for them.</p> <p>Chen—Do we want a third subcommittee to look at MRSA issues and questions?</p> <p>Myers—Yes to addressing this, but don't know if it requires a subcommittee. But this set of questions does need to be addressed.</p> <p>Chair—We will put this in the 'parking lot' until the November meeting.</p> <p>Chen—We will also begin retiring subcommittees. MDRO Subcommittee is hereby retired. BSI may be disbanded after its last upcoming look at the AFL. Membership may be done and retired by the November meeting. The old Legal Subcommittee remains retired.</p>	<ul style="list-style-type: none"> • Form subcommittees based on volunteers
<p>Action Items and Upcoming Meetings</p> <p>Chair—Wrap up and action items and dates.</p> <ol style="list-style-type: none"> 1. Rosenberg will clarify with the legal department the specifications that relate to language of the SSI definitions – clean contaminated; deep organ space; denominator; total numbers; are we looking at 	

everything or specific as defined: orthopedic, gastrointestinal and cardiac surgeries.

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 - e. continue to obtain legal opinion on the MRSA issue for surgical patients and communicate those to HAI-AC.
4. CDPH will disseminate an AFL to administrators regarding the new reporting requirements and associated timelines that will start January 1, 2009.

Thank you to all of you for participating and keeping patient safety your focus.

Next meeting in Sacramento on November 6.

Adjourn

Acronyms

AFL	All Facilities Letter
APIC	Association for Professionals in Infection Control and Epidemiology
ARDS	Acute Respiratory Distress Syndrome
BSI	Bloodstream Infection
CACC	California APIC Coordinating Council
CART	CMS Abstraction and Reporting Tool
CCLHO	California Conference of Local Health Officers
CDIF	<i>Clostridium difficile</i>
CDPH	California Department of Public Health / Department
CLIP	Central Line Insertion Practices
CMS	Centers for Medicare and Medicaid Services
DCDC	CDPH Division of Communicable Disease Control
DIC	Disseminated Intravascular Coagulation
ED	Emergency Department
HAI AC	Healthcare Associated Infections Advisory Committee / HAI Committee / 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

PSC	Patient Safety Committee
RN	Registered Nurse
SA	<i>Staphylococcus aureus</i>
SB 1058	Senate Bill 1058
SB 158	Senate Bill 158
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>