

Healthcare-Associated Infections Advisory Committee
November 20, 2008, 9:00 a.m. to 11:00 a.m.
Location: Conference Call

Attendance

Members/Alternates:

Kim Delahanty (Chair), Raymond Chinn, Alicia Cole, Enid Eck, Marian McDonald, Shelly Morris, Carole Moss, Rekha Murthy, Terry Nelson, Shannon Oriola, Debby Rogers, Todd Stolpe, Jonathan Teague, Dawn Terashita, Francesca Torriani, Lisa Winston, David Witt

Guests: Kathleen Billingsley, Monica Waggoner, Chris Cahill, James Marx, Kathy Wilson (for Frank Myers)

Staff: Sam Alongi, Sue Chen, Roberto Garces,

Agenda Items/Discussion	Action/Follow-up
<p>Call to Order and Introductions Committee Chair Kim Delahanty (Chair) convened meeting at 9:00 a.m. Conference call rules discussed Introductions made</p>	
<p><u>Professional Education Components of SB 185</u> <i>R Chinn reviews professional education initiatives of SB 185.</i></p> <p>R Chinn - The bill stipulates that the chair of the infection control committee shall participate in a CME program tailored to infection surveillance prevention control offered by CDC at SHEA or other recognized professional organizations. The second piece has to do with all staff and contract submissions, basically that the whole cadre of healthcare professionals that should be trained in the methods to prevent transmission of healthcare associated infections. And the third is that all permanent and temporary hospital employees should have hospital specific infection control education. Number one and two have been in discussions with CDC and SHEA as well as the Infectious Disease Association of California. All three groups are obviously very interested in this initiative because it will be the first in any state that will kind of more or less mandate education for the chairs of infection control. In discussions with SHEA and CDC they're very interested in perhaps tailoring a course for this purpose, in conjunction with the State Infectious Disease Association. And the format they would be choosing would be something similar to a SHEA course but pared down, as well as having some form of webinar where they can give a certificate of attendance.</p> <p>This would within the purview of this committee to stipulate the number of hours and possibly content and I think that the best thing that we could do is perhaps discuss with CDC and SHEA just to get a sense of what they feel the most important components are.</p> <p><i>Potential content for CDC/SHEA infection control course tailored to infection control chairs, participation hours, and mechanisms of education delivery to all staff on infection control methods are discussed.</i></p>	

M McDonald - I think it would make a lot of sense for us to become clear on the content before we attempt to address the time requirement. I'd like to suggest that a sub-committee work with SHEA, work with IDSA and whoever else is appropriate to identify and clarify, and come to agreement on content, then we can work to address how deep into the content do we want to go, what are our outcome measures, and at that time then address time requirement.

R Murthy - In terms of the CME that the SHEA/CDC training, I assumed that that was primarily geared toward the infection control committee chairs, and that the second piece of all medical staff who have privileges at a particular hospital. There's some precedent set or some examples of Healthsteam or other kind of education programs that could be used centrally for all physicians.

R Chinn - I think that's correct. There are two different components. The second one I think may be a little easier because for our staff, for our hospital, we're going to mandate that certain physician education done via email or whatever, so that this would satisfy a requirement for credentialing and re-credentialing.

We could certainly talk to the CDC and SHEA, because it would be nice to have some kind of consensus with how to approach it. I just wonder whether we shouldn't take on a sub-committee and then enter into the discussions with SHEA and the CDC. Because once you realize that the CDC / SHEA courses are like four days of intensive work but I don't know that every infection control chair requires that because these particular courses are geared toward epidemiology. There are a lot of webinars that CDC has created and we could probably develop something that would be acceptable to healthcare institutions, rather than recreate everything.

E Eck - I would like to suggest that we can't resolve this on this call this morning, we have an hour dedicated or so to this, [MOTION] so I move that a subcommittee be convened to look at the education requirements, both for the committee chair and med center epidemiologist, and general physician and staff education requirements, and bring a recommendation to the committee as a whole for how that education could be addressed, building on the work that Ray has done, with a potential adaptation of the SHEA and/or CDC courses.

S Morris - SECOND

Rural concerns, costs, and unintended consequences are discussed.

T Stolpe - I think that it would be important in the committee to have representation from the frontline physicians, particularly from the rural communities where resources might be a little slim, so that input and being sure that the decisions about what sorts of training are going to necessary are practical for those communities.

R Chinn - Oh, I think that's a point well taken. For the rural areas it

would make sense to provide some guidance there, and I certainly will take that when I go to SHEA and decide on, after discussions with them and CDC because what we're looking at is something that's fairly universal, particularly in terms of at the epidemiology. I fully support the motion and we could work on it offline.

T Stolpe - I do believe there are very serious risks of cost increases that may not translate into improved patient care - costs in terms of epidemiological interpretation, demand upon the staff, number of cultures obtained, which populations are cultured, what we do with those cultures, what sort of resistance patterns are done in rural communities where those cultures tend to establish those resistance patterns.

All in favor? All Ayes. No opposition.

Members asked to contact Sue, Sam, Roberto and Kim to be on the subcommittee facilitated by D Witt (volunteered). Nominations to be sought for a rural physician who would be interested in participating in the subcommittee.

Cleanup Language for SB 1058

S Chen – Just to start this off, what we did is, Sam provided the pertinent language from this discussion from our last meeting, I then put in the quote for the actual language in the legislation, some thoughts from CDPH, some questions that need to be answered when we're looking at potential cleanup language, and then the commentary from a group led by Francesca. And I think that they're all relatively similar, and I would like some commentary on this.

R Chinn – I think we should separate this into two sections. The first is to kind of discuss the over-all language of the legislation, and the second is to recommend the component that Francesca has outlined. I think that it's very important to voice the fact that the original legislative language is not in company with any of the surveillance systems that we know of, and that as much as we, the public are looking at us to be transparent, we should also look at the law in that same manner, so that if, for lack of a better phrase, there are unintended consequences of doing this type of surveillance that end up with basically no information to drive healthcare improvements, and I think that the legislative mandates should be viewed in that light. We should make a statement that this is just legislative mandate, and despite recommendations to refine this type of surveillance, it remains the language it is.

K Delahanty – The whole purpose of this particular conference call was to submit some cleanup language that we felt as an advisory committee needed to be submitted to the author for review.

D Witt – We recognize there's unworkable language, or we see as unworkable language. The reality is that this is an edict, and we depend on the Senator, on making a compelling case to the Senator, to open up

Professional Education subcommittee formed and will be chaired by David Witt. Volunteers to participate contact Sue, Sam, Roberto, Kim.

Nominations for rural physician to participate on subcommittee being sought.

the bill for change. That's our purpose here. So I think we need to be very explicit with the intent of the bill and propose language that will make the bill as written more workable, and not to try in essence to re-legislate, because I think that [*if the legislation is reopened*], that will not happen. I think we really need to be sensitive even when there's parts that we don't think are the best legislation; it has been legislated, so we just need to make it something workable. I think that I feel compelled, I plead to make it useful and useful to the public.

R Murthy - I think that it would be very important given that we are trying to clarify language, if that's the direction we choose, that we expand on the rationale, and part of that rationale is that as the intent is to reduce complication from surgical procedures, that we really demonstrate that by choosing to track and report the process and outcome measures on new procedures for which there is good evidence.

C Cahill - My question is to the committee, has anybody spoken with the author's office to see if, what they're amenable to as far as cleanup language, and the time that would be proposed to submit the cleanup language?

S Chen – A representative from the author's office was at the last Advisory Committee meeting. There is a window of opportunity right now for cleanup language if submitted from the committee within the next two weeks. The earliest it could be introduced would be in early January.

M Waggoner – I had a discussion with the author's office. They are willing to entertain technical amendments that allow the department to best implement the legislation. They would like to hold off if possible on things that may change the scope or the intent of the law at this time. That being said, December 1 is when they start introducing bills but don't really get going until January. I think what the author wants to entertain at least at this time are the things that prohibit implementation such as a definition that is wrong, or impediments to at least starting down the path of getting information into the department.

E Eck – I very much support what Reyka said earlier, and I think we do need to focus on the fact that as currently worded, this legislation is essentially unimplementable, because the sentence structure in the area that speaks to the reporting of surgical site infections is convoluted, and the qualifiers are not really aligned with the surgical procedures in a way that's clear on what should be reported. In our discussion at the last meeting, and summarized on the document that Sue sent out, under the heading "HAI Advisory Committee Thoughts" was what we attempted to do in that discussion. I think this was captured really quite well given how that discussion went. To be able to get anything started and be able to provide data to the department in a way that would be comparable and consistent with NHSN definitions, we need to have specific procedures that are reported, not an "all" that would lump a wide disparity of and large number of procedures together in what would not be a meaningful, nor a way in which we could evaluate whether any intervention that could have been implemented did in fact

prevent HAI. I would like to suggest that we focus on what has been captured as the thoughts that were shared in that meeting and see if we can get agreement on the procedures that are identified here that are specific procedures.

S Chen – It's my understanding that we can only write, we can only mandate what is written in the legislation, the way it is written. We cannot expand or contract it. If we cut this down to the proposed surgeries, that would be contracting the legislation, and we're not allowed to do that.

R Chinn – A couple comments. I thought at the last meeting, we had passed a motion that was in two parts. One was to go ahead with the legislative mandate and have each institution create their list and then report it to the state to fulfill that mandate. And the second part is what Dr. Toriani et al. had discussed, and stipulate that certain surgical site infections are voluntarily reported. Now, I don't know what's happened to that. So are we trying to modify that now? But we passed that motion. So that was the first comment. The second comment is that we submitted a lot of comments to the Senator's office in regards to this specific topic. Dr. Toriani and I wrote a letter to them outlining why this mandate for all surgical site infections makes no sense, and offered the suggestion that the specific surgeries should be followed because they have the SHEA and CDC recommendations. I would be happy to forward that letter to you, because it has all of the explanation why we don't think that the "all" should be included. So I'm a little confused now. Are we able to submit something to the legislature to say that we agree with the intent but disagree with the "all" because it makes no sense, and these are proposals, but what I'm saying is that we already sent a letter on behalf of the Infectious Disease Association of California when this whole legislative movement was in action and they chose to ignore. We could send the committee the letter we sent them that outlines why we felt it would make no sense. If they weren't willing to listen then, will they be willing to listen now? And what do we do with this motion that we just passed, saying that each care hospital has to submit all surgical site infections as stipulated from the legislative mandate because the last time I had asked, was that each institution create their own list and submit the garbage to the state. So can I get some clarification where that motion stands right now?

S Chen – The motion stands.

L Winston - I suggest a parallel process, that we both go ahead with developing our individual lists, because the law is what the law is, and with the suggested surgeries, to have it have more clarity, and then as a parallel process, recommend the cleanup language to Senator Alquist's office, so that perhaps the law could be improved in the future.

R Chinn - I think it's very critical that we have something in there that says that we don't agree with it, because if this goes out and the Senator's office is not willing to change this "all" thing and it goes out to all the facilities, mandating that they collect all the infections mandated by Senator Alquist, then the hospitals would feel that this committee

[*recommends it*]. I don't understand why the committee would recommend it. So I feel there should be some sentence in there saying that we don't agree and that this is done because of legislative mandates.

F Torriani - I agree with Dr. Chin and think that if indeed we cannot strip the "all" then there should be a clear dissent from this committee saying this does not have a rationale and therefore this committee opposes the law as written. If each hospital has to come up with what "all" is and then report the whole rate, it will not help anybody.

K Billingsley – I think Monica Waggoner, who's my partner here in the Department of Public Health, has been very clear that we have an opportunity to submit information that would entertain technical amendments to basically define or illuminate the word "all" and better specify according to our recommendations, what your recommendations are as to what should be implemented. I think the focus should be on making sure that we can clearly articulate what those proposed technical amendments would be at this point in time. I think that at the last meeting, it was quite beneficial that a member of the author's staff was in attendance and very clearly heard the level of concern that the committee members had with this implementation. I don't think anyone could look at what was being stated and ignore that. And based on the fact that I do believe that the staff for the author as well the authors are very reasonable individuals and very much respect what the committee will propose, so I think the focus should be on what technical assistance and amendments can we go ahead and articulate and give to the author?

S Chen (as submitted in writing by R Murthy) - I support Lisa's and Enid's recommendation to make the attempt to provide cleanup language as developed and presented to the committee as soon as possible. I would also recommend that our committee prepare a submission that CDPH could provide within the two week deadline to the author of the bill that would provide the technical changes as allowed by the author based on the committee's input and careful review of current language not being clear. Thank you.

M McDonald – I would like to suggest that we consider a two layer approach to this. First, do some good solid scientific specific surveillance and reporting using whatever procedures we decide to choose according to NHSN protocols and definitions, in other words, do some good science for certain specific procedures. We could certainly discuss which procedures which procedures those might be so that we make sure that we get good representation from smaller facilities but that would be the first layer. Secondly, if we must, and I say if, if we must continue with the word "all" if we are not able to amend the scope of the legislation, the second layer would be essentially a rough measure reporting simply the numerator for all the deep organ space surgical site infections for each of the three categories, the three symptoms that they specify, report a denominator of cases. This is certainly far from NHSN rigor, it's a rough measure, but it would meet the intent and the spirit of the law. And what this would do is that it would give us first compliance with the

spirit of the law, and second, an opening into some rough data that would meet the concerns of the author to say, "Let's look at this. Is it rigorous? No it is not. Is it a beginning of rough data?" It would actually break new ground to just simply say "How are we actually doing in these big things." Maybe we find problems that we need to zero in on. So consider then please two layers, the NHSN rigor and a less rigorous meeting the spirit of the law rough measure category.

D Witt – I would really say our role is not to oppose the legislation; the legislation is what it is. I know we're all frustrated and I totally agree with Ray's comments - this is not workable - but I think our role is to explain what would make it workable and to make that transition. I would think that opposing the legislation would diminish the value it would serve [*not serve a constructive purpose*]. Not even opposing the legislation, just the disparaging statements of this committee are really not appropriate. I think it is what it is, and we can give the best advice we can. On the other hand, I think it was Kathleen who identified that this is really an opportunity to make this law workable. I think the Senator's staff certainly indicated they were receptive, and that we really need to think about what we're asking for, because like the law, what we ask for may become somewhat inviolate. This is a chance to make what may be inviolate changes for the better.

F Torriani – MOTION for 12.88.55 (A3). "Each health facility shall report deep and organ space surgical site infections to the department quarterly, using CDC definitions and methods. The following operative categories have been selected: knee prostheses and arthroplasty, hip prostheses and arthroplasty, CABG, cardiac valve replacement/bariatric gastrointestinal surgery." And then, the number 2 is "The exercise for the aforementioned surgeries would be reported as risk stratified rates per 100 surgeries within the surgical categories to CDPH through NHSN."

E Eck – Second.

A Cole - I keep hearing how difficult and how impossible, this is not going to work, and there is no way this is going to work, and I'm coming from the perspective of the public who many of which I'll give you, and please pardon my breaking this down to such a rudimentary example. I used to be a business owner and I had shop, a retail shop. Now at any point, you could ask me as a store owner how many items did you sell this month? And I could tell you a total for how many pieces of merchandise went out of my inventory. If you asked me how many t-shirts did you sell this month? I could give you an answer. I could give you an answer of how many pairs of earrings; I could give you an answer because I did surveillance in the way of inventory. So I think this committee needs to consider you're going to have a hard time selling to the public that hospitals don't track their inventory, they don't track their losses, and they don't track their infections. I don't think the general public, and those who legislate it and authored this, are under the impression that hospitals like other businesses track their progress, their pluses and their minuses, their losses, what they do well and what they don't do well, and so what I'm trying to understand here is what

makes this so completely, completely, vehemently opposed and just impossible, because it would be my understanding that hospitals do have infection control professionals, who know the infections in their hospitals? And the law is saying we want to make that information available to the public. If you have ten infections, you had ten infections. How many infections did you have in this facility? And I think where we're getting caught up in is in breaking it up into the categories and we're making it a little bit more difficult semantically than it has to be. On page 3, the CDC NHSN definitions table 1, it breaks out UTI, SSI, it breaks out organ space, I mean, I just think that we're getting up in semantics and not wanting to see the possibility of how to make it work. That's my comment.

R Chinn – A couple of things. Colon resection was mentioned previously and I think that would capture the clean contaminated GI surgery, and most hospitals would do this type of elective procedure. The other thing is that under cardiac surgery, we have three different types of cardiac surgery that you have to include if you want to capture those surgeries. That's the CABG, that's the valve, and that's the bypass not using the venus graph. And then the other thing is, now when you talk about NHSN definitions, they report all surgical site infections, that would include superficial, and the reason we chose to do deep and organ space is that these are the most important and critical, so that it would capture the whole playing field for all institutions. I want to make a point that sometimes it's very difficult if you want to compare Toyota's to Cadillacs. If you want to use the examples of cars, it would be combining the performance of a Toyota and a Mercedes in that type of setting, and that's why it's so important to kind of look at each individual surgery differently, because the improvement interventions may be different.

I think one of the things we have to remember is that any improvement effort in the department will be translated to other departments because institutions don't like to do different things, they like to do one thing. So if there's a quality improvement, improved prophylaxes antibiotic in this surgery that will prevent infections, it's going to be through the entire spectrum of surgeries.

A Cole – I agree with you. And trust me, I'm not, I want this to be doable for both the public and the professionals. I'm not saying that. But what I just keep hearing is such a visceral negativity with just approaching the situation, and that's all I'm saying.

R Chinn – But Alicia, we're not all negative. We have proposals that can be expanded upon as we track more infections. That's the view behind all of this. Because we have an alternative that we're offering to the writers of the bill. And we have a lot of support, from SHEA, CDC, to say that this is the method that we should use, because the other method of "all" has never been tested. And you're throwing things out to the public that may actually be damaging.

M McDonald – Alicia, I hear your point about how many t-shirts you sold. The first thing I'd like to say is it's really easy to count t-shirts,

they are all really easy to count in sections. So the error I think in your assumption is that infection control practitioners know about every infection. They do not. To do that, tracking and identifying every infection is called total health surveillance and very few facilities are able to do total health surveillance, they do instead what's called focused surveillance. They actually find and track the infections that they consider to be the most significant, the most valuable to know about. So total facility surveillance is exceedingly rare. If we had the resources to do that, I'm sure we would all be happy to. But with the resources that we have at this time, and that's not only person hours and financial resources, but also resources of attention and collaboration which I think are important to consider. Having said that, the proposal that I believe what's currently on the table, that we look at total knee replacements, total hip replacements, CABG, and bariatric GI surgeries, meet the current scope of the law that we look at some way at all of the surgical site infections and deep surgical site infections from those three categories. I do support those categories with the possible exception that it would leave only orthopedic surgeries being monitored for smaller facilities, but if we do have to meet that intent of the law for "all" looking at the specific NHSN categories, would not meet that "all" requirement as is presently in the law.

D Witt – Our opposition that you hear is to lousy reporting for the public. Let's be clear. My business sells gumballs and Toyotas. I sold forty units last year. I'm great. Now if they are gumballs, that's deceptive, but for Toyotas, I have a great business. And as we see public reporting an infection rate of all surgeries, it's really like that. So in order to have useful information, we have got to take on things that are significant. I agree, the staffing needs to be increased, and this was clearly an unfunded mandate planned by the legislation. That is just a fait accompli. We cannot do selective procedures; we need to do broad, important GI procedures, but not all. I don't want to put a procedure, monitor abscess removals. I think we want to monitor colectomies, we want to monitor bariatric surgeries. Third, when we look at unintended consequences, there are plenty of them in public reporting. If you look at New York's cardiac mortality, it's gone down dramatically since they started doing public reporting, and everyone's so happy, but if you actually look at it, what's happened is no one does high risk interventions on seriously ill MI's, and what it leads to is probably about two hundred deaths a year in New York due to people unwilling to perform a riskier procedure. So if we look at publicly reporting data, it is absolutely vital that we report something that means something to the public and is believed by the hospitals. And if we are sloppy in our definitions or try to be broad so that it sounds good, we are doing everyone a disservice.

S Oriola – Alicia to your comment, I think we all want to have transparency and report meaningful information to the consumers so they can guide their healthcare choices and do it in a scientific way. We're just trying to clean up the language, because if you get things that don't even make sense, you can't guide your consumer choices. And my last comment, the concept of tracking bariatric surgeries, vs. colon re-section, I believe, and I need to double check my facts, but I

believe there is no comparative data in the NHSN system for bariatric or gastric bypass surgery. There is for colon re-section. So if the law states that we have to compare data to NHSN, there would only be comparison in California, and not to the NHSN standards, so I'm not sure if that would have to factor into our decision.

K Delahanty – I would like to make one blanket over-arching statement. We are all consumers of healthcare. We on the committee get healthcare, just like the consumers get healthcare. We all want what's best, we all want positive outcomes, we all want patient safety initiatives. So I just want to focus and make sure that everyone keeps that in mind that we all are here to do what's best for patients because we ourselves or our loved ones are patients.

S Oriola - I would echo Kim's comment, what I think you're hearing is our struggle to do exactly what you're saying needs to be done, and that is to compare valves to valves. What we have as it's currently worded is just a mish mash that wouldn't help anyone.

F Torriani (restates MOTION) - So the language would read. 12.88.55 (A3). Each health facility shall report deep and organ space surgical site infections to the department quarterly using CDC definitions and methods. The following operative categories have been selected: knee prostheses/arthroplasty, hip prostheses/arthroplasty, CABG, chest only, cardiac valve replacement via sternotomy,." So it could be CABG, chest only, and cardiac valve replacement via sternotomy, and cardiac valve replacement via sternotomy, elective colon re-section.

E Eck - SECOND

C Moss - Before we vote on anything, I really think we need to see that in writing. Just based on the complexity of what we're talking about. Second of all, what happens to the people who have elective surgery or knee surgery or ankle surgery? I don't hear those being included.

K Delahanty - We've had this roundabout discussion about incorporating "all: vs. us making a recommendation as an Advisory Committee to the author to see if we can modify that, and that's what this is about. We can't go back and talk about "all" anymore. So when we call the question you can vote how you feel you need to vote, but we really need to stay focused on the motion. When we call for the vote we'll have a name vote, so that we'll have that listed out, who is approving and who is not approving.

R Chinn - We are trying to start moving forward on implementation of the bill. As an Advisory Committee based on science and evidence, we believe that we need to move forward with some recommendations that will be transparent, sustainable, and beneficial to the public. These infections and the infection rates should be as stratified by the CDC, otherwise it's a bunch of mish mash stuff that may not do any good and may cause harm. The other thing is that as long as the foot and ankle surgeries are done as an outpatient, right now we're trying to focus on the inpatient, because you know that foot surgery is outpatient.

C Moss – You know you're missing so many infections with this. I mean, it is counter to what you are trying to do. It is absolutely, you know it's not your best effort. You all know it's not your best effort.

M McDonald - We do want to have a complete and comprehensive program when we are able to do that. I think our goal in the short term is to get started in solid science. Rather than trying to do a whole bunch of stuff that we cannot do well at the outset, let us do well what we begin now, and then as we have gained skill, add those other things that do need to be looked at.

C Cahill – We have only a few minutes left to decide and vote, what it is that our hospitals are going to be reporting. I would suggest that we move on and any comments that Carol has she address them in writing to the committee.

S Chen - Some of the basic language for getting started is there. I think the committee has not addressed the issue of what to do with the "all" because I didn't hear it in Francesca's language. And if you go back to Terry's comment earlier, the intent is not to miss things, the intent is to get started and then if the committee would like to put in some language that would allow them to ask for wording that will allow us to expand this list, because we're also missing one of Alicia's points in that some of the abdominal surgeries, either hysterectomy or C-section which has not yet been addressed. Those are some things to consider for the motion on the floor.

D Rogers – To piggyback on what Carol and Sue were both saying, it sounds like the motion limits us to those particular things that are well-defined now, but I think that we might need an option to open that door to other things, phasing in of infections related to surgery.

E Eck – Debby, in SB 739 there is language that addresses the HAI advisory committee to be able to identify surgical site infections that should be reported, and we could put a phrase in, "and other surgical procedures as identified by the HAI Advisory Committee in the future."

T Nelson – My concern is if we're going to suggest language that specifies those specific surgeries that I understand are representative, are high impact, we have systems in place that allow us to stratify and analyze that data and make it something that we would term useful, I have difficulty in specifying those, and would prefer that we use language that would enable the committee to determine what those are because once that's put into law, it would take another piece of legislation to make that adjustment, and if indeed we accomplish what we're after, we'll want to be able to add or delete things to the list. I heard very specifically from the representatives from Senator Alquist's office, that they were looking to us as a committee not to discuss whether or not this is workable, but to come forward with the suggestions of what would make this practical and workable. And I think if that's truly the case, then we could give our, could go for that option which would allow us kind of a body which is now a permanent fixture to

determine that. And then Carol's concern about adding additional surgeries, Alicia's concern for having representative Ob/Gyn surgery should also be considered and it would even extend from these three categories. So I have difficulty in supporting specific surgeries and then have them put into the legislation.

D Witt – What Terry just said I think makes enormous sense. I think we've got to address in our motion something to the senator that addresses "all" in the future. And it may be practical, it may be all significant, it may be "all" on a rotating basis to use resources widely, but it really can't be just bariatric surgeries. Or colon surgery. Or gallbladders. I don't think that we're meeting the intent of the law.

K Delahanty - I want to remind everybody that the motion from our last meeting is still a motion that we unanimously voted on which is that we would voluntarily report "all gastrointestinal, cardiac, ortho" in a lump sum to NHSN, and then voluntarily using NHSN definitions on the specific categories of total hip, total knee, and CABG, colon re-section surgeries.

T Nelson - I made that motion, and that was for us in recognizing that we needed, that's what we're going forward with, but today's meeting is about the cleanup language that would perhaps bring it into alignment with what we have in front of us that we have to deal with now.

K Delahanty - Well here's what it says, "recommend the CDPH should the committee designate specific deep and organ space procedures to request that data be submitted for total hip, knee, colon re-section, CABG, as well as for the over-all category for which they fall, and cardiac, gastro, and ortho to be reported to NSHN. This would include CDPH recommendation to report all to comply with the law and voluntarily report using NHSN definitions on the specific categories of total hip, total knee, CABG, and colon re-section surgery, and that this be reported to NHSN." And it was seconded and it was unanimously approved.

T Nelson - But today we're meeting about the cleanup language that we're going to submit. That's different. That was the context of what was going to go out in the AFL to give guidance immediately, people were waiting, that was "yes, you're going to have to report all of them, but go ahead and set up these primary categories because we're anticipating that the cleanup language will direct that we will be doing those".

K Delahanty - My point of bringing it up again is to assure Alicia and Carol that that motion is still a motion that we intend to do, so it does capture the "all" component that they were concerned about that would not be addressed when we're talking about cleanup language and giving specific surgical procedures.

R Chinn - This is an introduction, there is nothing to say that we can't expand on the surveillance of surgical site infections. One of the problems is if we throw in a hundred thousand different surgeries, the

<p>physicians are not going to be able to do that. What we're trying to do is just trying to stipulate a couple examples, and then the committee as per SB 739 can expand on the reporting requirements. Initiatives made to improve certain surgeries will be across the board. It will have an impact on all surgeries done at that institution. I think the language is there, you just stipulate these are the beginning venues, and then there is a clause in there that will allow, per 739...</p> <p>T Nelson - I didn't hear that as a part of the motion.</p> <p>F Torriani – [restates the MOTION with amendment] - The motion would be 12.88.55 (A3) Each health facility shall report deep and organ space surgical site infections to the department quarterly using CDC definitions and methods. The following operative categories have been selected to start; these could be amended in the future: knee prostheses/arthroplasty, hip prostheses/arthroplasty, CABG, (chest only), cardiac valve replacement via sternotomy, elective colon re-section.."</p> <p>K Delahanty – We have a motion on the floor. We need a second on the motion. And we're past 11 o'clock time, so we're exiting. Does that mean we need to table this and reschedule another conference call? This is such and important issue that we don't want to rush.</p> <p><u>Next conference call meeting Monday at Noon, November 24th.</u></p> <p>K Delahanty - The purpose of the call will be to define the language that is being submitted for cleanup, and that is all.</p> <p>End call.</p>	<p>S Chen will distribute via email the language for the motion regarding 12.88.55 (a3).</p> <p>Next conference call set for November 24th @ noon.</p>
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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>