Healthcare-Associated Infections Advisory Committee
November 29, 2007, 10:00 a.m. to 3:00 p.m.
Location: Los Angeles County Health Department

Attendees: Kim Delahanty (Chair), April Alexander, Gil Chavez, Ray Chinn, Letitia Creighton, Charles Derby, Enid Eck, Annemarie Flood, Dan Gross, Dorel Harms, Warner Hudson, Marian McDonald, Mary Mendelsohn, Shelly Morris, Carole Moss, Rekha Murthy, Terry Nelson, Shannon Oriola, Julia Slininger, Jonathan Teague, Dawn Terashita, Francesca Torriani, Anvarali Velji, Pat Wardell, Lisa Winston, David Witt
Guests: Sandra Alvarado, Elizabeth Bancroft, Lauren Burwell, Alicia Cole, Betty Cole, Ron Cole, Chris Crater, Glenna Duke, Lindsey Hageman, R Jett, Glenn Leibowitz, Laurene Mascola, Lucy Rizo, Sandra Wood, Sharon Wood
Staff: Sam Alongi, Sue Chen, Roberto Garces, Jon Rosenberg

Agenda Items/Discussion	Action/Follow-up
Call to Order and Introductions Committee Chair Kim Delahanty convened the meeting at 10:00 a.m. Introductions of members and public attendees were made around the room and at satellites sites Sacramento and Richmond.	
Approval of Minutes **Motion to Approve Minutes (Hudson), Second (Oriola)** **Discussion** Minutes did not include discussion from the last Advisory Committee meeting regarding the provision of a teleconference bridge accessible to the public for the November 29th meeting. Chair reminded committee of their charge as outlined by SB 739 and presented meeting priorities: subcommittee reports and MRSA.	Motion to approve minutes accepted unanimously.
Public Story **Carole Moss** presented the story of her son Nile Calvin Moss and their family's experience with MRSA. DVDs and a handout outlining Nile's experience and death due to MRSA were distributed. Public comment: It seems that the extent of the problem of MRSA is not widely known even among healthcare providers/administrators	Thank you letter to Carole Moss
Subcommittee Presentations: **Central Line Insertion Practices (CLIP)** draft recommendations were presented by Subcommittee Chair Enid Eck. Recommendations were: 1) That all California hospitals be assessed, and offer attestation that they have implemented the CLIP guidelines from the CDC. 2) When NHSN CLIP data elements are released by the CDC, that modules be made available to hospitals to fully inform them as to the required data elements. This will enable hospitals to develop processes to collect the rest of the information to comply with NHSN submission.	CLIP subcommittee questions and concerns will be presented at the Dec 5 NHSN User's Call. The CLIP Subcommittee will refine their recommendations,

3) CDHS and/or CHA should assess and receive attestation that hospitals are implementing CDC guidelines for the management of central lines and verify that hospitals have process in place to collect required data on CLIP form for submission. If accurate data is not being submitted, establish a standardized process for submitting the data so that there is comparability among facilities. (See CLIP Subcommittee draft recommendations)	and present revisions at the next full Committee meeting.
Discussion Issues identified were assessment of the CLIP tool, compliance w/ NHSN rules to meet SB 739 reporting requirements, and how the process should be implemented . 1) How must the CLIP form be used? All data points asterisked are required fields before the data will be counted as meeting NHSN reporting requirements for that incident. 2) Can the form be modified? Not at present; any modification of the current draft would require NHSN to restart the whole approval process, further delaying its release. 3) What happens if only partial data is entered? There is no "spectrum of compliance" for reporting; either hospitals are in compliance or not. The current rule for data submission is all asterisked fields must be completed and data reported to NHSN per a plan at least six months per year. Minimally one unit (1 ICU) must be surveyed/month. Failure to comply can result in disenrollment from NHSN. HAI AC can consider starting with the current CLIP format and recommend modifications later. CLIP Subcommittee clarified that the CLIP form only relates to insertion practices, and recommended that a communication be sent to all hospitals for them to submit attestation that they have in fact implemented the CDC guidelines. The concern is that if hospitals were able to pick and choose which elements they would submit via the CLIP form is that there would be no comparability of the data. Standardization is considered necessary and desirable. The value of hospital attestation for implementation of CLIP elements was questioned. Federal legislation is gearing towards reporting to NHSN. HAI AC has determined that the key is to get the process measures out to the public and customize the tool. HAI AC is not concerned with aggregating data for CDC research purposes. It may be prudent to start with manageable recommendations and expand on them at a later date. Hospitals would submit what the Committee considers to be the critical elements to NHSN; this data is not compiled and published. It would be much easier to collect four elements than 40. This would count for reporting to the state. The committee does intend to follow the mandates of SB 739. There is no Subcommittee recommendation on frequency – such a recommendation would require something that is both reasonable and frequent enough to have value.	S Chen to get clarifications on issues from NHSN and present them at the next CLIP subcommittee meeting.

HAI AC was reminded to be cognizant of the impact on smaller hospitals/facilities when putting the recommendations into effect, and of the resources these facilities may lack in assembling/reporting data. Discussion over addition of daily assessment of line necessity: the subcommittee decided that since CDC was only looking at the NHSN form, the daily line assessment was not an option. Question for NHSN: If hospitals go through the process of enrolling in NHSN, choose to not submit outcome data so they're not using another module and do not submit all required elements of CLIP form and do a subset of data, will they be able to continue in membership of NHSN given the rules of participation? This needs to be confirmed. Question for NHSN: Is this only going to be ICU? Or you can pick a high risk area? Or is HAI asking hospitals to do it whole house? After review of the recommendations and lengthy discussion, the CLIP segment of the meeting was closed without a motion.	*[Per S Chen, added, this is a CDPH question.]*
Subcommittee Presentation: Influenza Influenza draft recommendations were presented by Subcommittee Chair Ray Chinn. A copy of his PowerPoint presentation will be posted on the HAI-AC website. 1) Vaccination of care providers is more efficient in preventing the transmission of influenza in a hospital setting than vaccination of patients. The intent of the legislation is to increase the number of healthcare providers vaccinated. 2) The legislative mandate is paraphrased as follows: annually offer onsite free vaccination to all hospital employees, requiring either vaccination or a written declination. SB 739 is clear about "employees". The NHSN module defines healthcare workers as including volunteers and licensed independent practitioners. The subcommittee decided that because this is an initial effort, the focus should be on facility employees, and not broadened to include healthcare providers at this time. 3) The Subcommittee recommends vaccinations by work unit for greatest efficacy, but actual vaccine administration processes should be left to institutional prerogative. NHSN would like data stratified by whether the employee has patient contact and/or works in a patient care environment. 4) The Subcommittee recommends phrasing declination language to document that each employee was approached and given the opportunity to receive the vaccine. A clause should be inserted that to fulfill the intent of the law and educate employees, declination statements should only be obtained during influenza vaccination season. 5) The Subcommittee felt that the NHSN employee influenza vaccination module requires more information than is needed to meet requirements of SB 739. Therefore, the Subcommittee elected to select key data elements and a preseason and	The Influenza Subcommittee will collect additional information, meet to refine their recommendations, and present revised recommendations to the next full Committee meeting.

postseason survey on influenza vaccination program for healthcare personnel for recommended use. 6) The second component of SB 739 mandates influenza vaccination for patients. CMS has a reporting system in place. The subcommittee recommended following CMS reporting requirements for this module. **Discussion** Data points reported to NHSN will be tabulated by NHSN and sent to the state. *[S Chen added correction: Data can be downloaded from NHSN by CDPH for analysis, but no tabulation is done by NHSN on the state's behalf.]* Influenza module documentation required by NHSN is considered onerous, so only key elements will be recommended for reporting. While module requirements will not be fulfilled, this is an evidence-based approach that can be used to provide CDPH with pertinent data. Discussion on other healthcare personnel such as consultants, outsourced employees, and licensed independent practitioners (LIP) who come into the facilities: [Request from membership: Please add to the minutes for the subcommittee to further consider adding to the category of "healthcare workers" employees, outside employees and other people working in the hospital. Response: Every influenza program within healthcare facilities includes offering vaccination to everyone. For monitoring purposes during program startup, not including LIPs would be easier.] It has been well documented that use of mandatory declination/ vaccination statements improves employee vaccination rates. The declination form should be strongly worded. There is already a declination form in the Advisory Group white paper that can be recommended but not mandated to facilities. Regarding education pertaining to declination forms: the Chair clarified for the Committee that the Subcommittee charge is to make recommendations on the implementation of reporting elements of SB 739, not on how the Committee is going to prevent influenza, and that HAI AC as a full group votes to approve, reject, or modify. Regarding recording baseline, documenting education, reporting on vaccination and declination: The fact that this focuses on employees makes the education component important; free is valuable to employees. The question was asked: "How will the baseline be documented in each facility for declination as well as the receipt of education?" Response: "UCSD uses a one-line check about receiving education on the declination/consent form." **Discussion / public comment** *Q: Are doctors and nurses not necessarily considered healthcare providers?* A: *They are not necessarily considered employees of the hospital. An*	

employee must be direct employee of the hospital. Interns and residents are employees of the hospital. If physicians (LIP) come in to do consults they are not considered an employee of the hospital. Q: *"My concern is that eight of my 10 doctors were not hospital employees, they were consultants brought in from other facilities".* A: *Regardless of the letter of the law, if you're a physician and you want a flu shot, you get the flu shot. It's the reporting piece that we're talking about that we include in the denominator, not whether you get the shot or not.* Q: *I think it would be imperative for doctors to be included in that. Are transport people included? (response: yes) radiologists? (response: yes)* A: *The only ones that aren't included are LIPs that have privileges; they are not employees of the hospital.* There was an at-length discussion on the definition of "employee" and the letter or intent of SB 739 with regard to this issue. Comment: *The ramifications of including all healthcare workers are great. For example, some hospitals have 3,000 physicians on their roster and maybe only 100 come to the hospital frequently. Which physicians should be targeted for vaccination/declination? Some institutions tally those physicians who have constant patient contact like the emergency room and ICU physicians and hospitalists. Perhaps after the Committee sees how the Subcommittee recommendations flow, they can revisit the issue of encompassing LIPs and others in the denominator data.* Comment: *"My point was I was trying to clarify whether doctors were included. And to put it on the record that doctors should be included because they have the most intimate contact with patients. I think it (the recommendation) needs to be inclusive of anyone that has intimate contact with the patient".* Comment: *"What you're saying is perfectly clear and correct. The question is how do we increase vaccination among employees/ healthcare providers?"* Comment: *"We certainly agree that physicians should be vaccinated; the reason the group put employees in the recommendation is that we have to have a denominator to get a rate. Vaccinate them all but count and report rates for employees."* The Influenza Subcommittee will continue to work on these recommendations.	
Subcommittee Presentation: Surgical Care Improvement Project (SCIP) SCIP/CMS draft recommendations were presented by Subcommittee Chair Shannon Oriola.	The SCIP Subcommittee recommendations

The SCIP/CMS Subcommittee presented a set of draft recommendations (the handout is attached/posted on the HAI-AC website). Not all hospitals/facilities perform SCIP surgery. If a facility already reports SCIP measures through CMS it will report SCIP Infection 1-3 measures to CDPH. If a hospital not currently submitting data does perform the required surgeries and has a Medicare provider number, the hospital can utilize the CART tool for electronic reporting. Lumetra will provide assistance free of charge. If the hospital does not have a Medicare provider number, they will be able to use a paper tool. The methodology and sampling are defined by CMS. Required elements are reviewed in the handout. The Subcommittee recommends that SCIP 1-3 measures for the first quarter of the calendar year 2008 be reported to CDPH by hospitals who do not currently report SCIP measures, with a reporting deadline of no later than July 1, 2008. Hospitals who currently report SCIP measures to CMS will continue to report on the 15th day of the 5th month following the close of the quarter. The hospitals currently reporting will input their first quarter 2008 data to their vendors by August 15. This timeframe was considered so that Lumetra would have enough time to help hospitals who have not currently been reporting. SCIP measures 1-3 were defined in the handout. The proposed solution covers smaller hospitals as well as larger hospitals and fulfills the intent of SB 739. The first set of measures could potentially be made public as early as July 2008. **Discussion** *Q: For these surgical prophylaxis measures, are you only looking at the CMS 10% sample?* A: *Yes. Using the CART electronic tool, CMS will look at the antibiotic entered and determine if it's appropriate or not. If a facility is using a paper tool, they will need to use a paper dictionary.* Issue example Q: *During a recent outbreak of surgical site infections, the hospital was asked for their surgical prophylaxis data for the specific type of surgery involved for which they had 100% data. On the Hospital Compare website, only one higher number was present. The compliance with surgical antibiotic prophylaxis for the specific type of surgery was significantly lower than what was reported on the Hospital Compare site not because it was inaccurate but because the website aggregated all the different types of surgery the hospital performed. This is not useful information. Some patients have said, "If I knew that there was this type of problem at this hospital, I would have tried to find another hospital." A hospital might rather know 100% than 10%, and to have this information stratified by type of surgery. Looking at the influenza module, perhaps what CDC wants is qualitatively different, not quantitatively different.* Response to issue: "*The SCIP intent is to look at a cross section of surgeries. The Subcommittee chose the initial 7-8 stratum to get a ballpark so that the facility is reporting out on its process overall. As an internal validation of data, if a hospital has one surgery that consistently scores low, they should be doing performance improvement for that*	were accepted by the full HAI-AC. *[Added by S. Chen on 1/28/08: CMS data cannot be downloaded by CDPH until nine months after it is entered.]*

surgery to bring performance up. The Subcommittee is trying to utilize a tool that's already out there being used by hospitals to get the reporting process started; maybe over time the process can be adjusted. *Hospitals/facilities have established this mechanism with CMS and The Joint Commission reporting. All hospitals are following their own surgery specific types of results on their performance measures because they know that each type reflects their overall score and they also know that soon Medicare reimbursement, the annual payment update will not just be credited for those who report but for those who are reaching a certain level or threshold of improvement. Using the same mechanism for reporting the necessary information for SB 739 is a true improvement process, and will help those hospitals who haven't already engaged in that.* *In terms of when to expect hospitals to report their data, this is patient specific data that has to be analyzed into numbers, and of course it takes CMS longer than that for the data to show up on Hospital Compare."* Q: *What will the Committee recommend to address the issue of hospitals that might be performing these sampling strata surgeries but not reporting? Essentially those hospitals will be out of compliance with SB 739.* A: *A draft recommendation has been written for the committee to be forwarded with the next AFL letter which will describe to hospitals how now Lumetra wants them to fulfill those steps, that there will be checkboxes for the SCIP measures and they'll either indicate:* 1. *Hospital reports to the Joint Commission;* 2. *Hospital reports to CMS;* 3. *I am not reporting and I'll call Lumetra; or,* 4. *I am a hospital that does not do these types of surgeries.* *There will then be a way and a requirement for the hospitals to identify the category they fall under.* *A facility without a Medicare provider number will have to use the paper tool. If the facility has a Medicare provider number but hasn't been reporting, it will have to start using the CART tool. It's clear that all hospitals in California will be submitting data to the state either directly or indirectly. The public can be directed to the CMS website, but those few hospitals simply won't be there. The spirit of the legislation is for the public to have access to all (mandatory) reported rates of hospitals; leaving us without a mechanism, for this year, to report those compliance rates with these measures for hospitals that don't appear on the Hospital Compare website.* Response: The Subcommittee realizes that that is going to be a next step; the Committee will need to look for a way to offer the public reporting for this additional margin of hospitals. **Francesca Torriani made the motion to accept report. Seconded by Warner Hudson.** **Committee voted unanimously to accept the report.**	

Subcommittee Presentation: Legal Legal draft recommendations were presented by Dave Witt. The Legal Subcommittee presented a set of draft recommendations (the handout is attached/posted on the HAI-AC website). The Legal Subcommittee addressed four questions: **1.** Does CA law permit hospitals to provide patient identifiable information to NHSN or other groups? A: Yes, California civil code permits healthcare providers to provide medical information. **2.** Is patient specific data submitted to NHSN discoverable and admissible in California court? A: Yes, it is discoverable and admissible. There is confidentiality protection. The Public Health Service Act only protects confidentiality but does not protect against discovery. **3.** Will fear of civil liability deter the reporting of information? A: Potentially. There is definitely a concern that the fear of liability would provide inappropriate incentives or unintended consequences, including non-reporting. **4.** What is the best way to protect this information? A) Can a unique identifier be modified in a way to prevent discoverability? Unclear but most counsel feel that as long as the unique identifier can still be linked back to a patient, it would still be a unique identifier. B) Legislation needs to be promoted. Right now there are very few states that mandate NHSN. There are several that mention it, but do not mandate or it has not been clear about the reporting. Among the states that mention it, Colorado has specific legal protection from discovery, subpoena or other means of legal compulsion. The subcommittee would recommend and ask CDPH to sponsor legislation to exempt reports from discovery or admission into evidence in California courts, hearings, etc. **Annemarie Flood made the motion to approve the recommendation of subcommittee as submitted.** **Discussion:** On the discoverability of records, unless there is a law saying something is not admissible, then it is discoverable and admissible at any point in time. Discoverability has a potential to be a disincentive for hospitals to participate in this system. Not every committee member necessarily feels that way, but it is a concern in terms of getting good data. CDPH rarely sponsors legislation; it is not appropriate for CDPH to recommend legislation. A point was raised that the charge of the Subcommittee was to discover what the status submitted data will be; this is informational and does not require a motion or action. Perhaps in finding the information a recommendation about that information naturally surfaces.	

Comment: *Transparency and reporting: Reporting should be fair, willfully participated in, so that it is reproducible and auditable and has validity. The concern about discovery is very different from the concern about reporting. This Committee supports the idea of reporting. The issue of discoverability is data mining; that a plaintiff's attorney goes to this source to retrieve individual cases that have been reported. That's a very different issue from individual malpractice or public reporting. There isn't an issue on transparency of the hospital; there is the issue of protecting the individual and that the nature and integrity of the reporting needs to be protected in some manner for hospitals, physicians and everyone to feel comfortable and actually embrace and give honest reports.* *There's no objection to reporting; but the report shouldn't be traced back to individual patients, individual providers. Traced back to hospitals yes. To make it an individual issue, then perverse incentives may happen. The Subcommittee wants facilities to feel comfortable reporting – to see the benefits to patients and improving care. That's been the core of peer review; the integrity therein – it can be done without having a fault issue in reviewing a colleague's case.* *The motion was made because there is ample precedent in the laws of other states who have passed public reporting laws and have in their laws exempted reporting from discovery. The goal here is honest, accurate reporting and that is facilitated by making this exempt from discovery as a hospital's internal quality program has been for years; exempting this from discovery will do that.* Q: *Based on the fact that an outside source for reporting could be considered because we would then be releasing the data, should we consider an outside source (NHSN) or will CDPH build its own system?* Public comment: *I didn't hear anything about laws or legalities or instituting cleanup legislation or contrary parallel legislation that would give an option out of the existing…* Comment: *At our first meeting that was one of the directives we were given, that we could recommend legislation from Dr. Horton. That is part of our charge.* Comment: *Bad and unfortunate things happen in hospitals; great things also happen in hospitals. How can this Committee eliminate/decrease/ prevent bad things. How do we go forward so that there is transparency? So that we do know how many bad things are happening in hospitals and where they are happening so that we can have the goal of making it better and preventing those things. If our spirit and goal is to make certain that we report data to make things better, we need to create methods to make certain that we create an environment that is harmless, blameless so that we can improve quality of care within our organizations. The reality of hospitals today – there are people out there who data mine to bring about litigation not for the purpose of improving quality of care – that is why hospitals will be sensitive to these issues. It's not about identifying the issues, it's not about quantifying, or it's not*	

about not reporting. It's about that unnecessary, unintended consequence from those people who don't share our collective goal. **Motion retracted.** Q: *Is there any information on the record of any kind of discovery issues that have emerged?* A: *There is no history of such activity but this process is still relatively new.*	
MRSA Discussion & Subcommittee Creation (Handout attached and posted on the HAI-AC website.) MRSA comments were presented by Jon Rosenberg. HAI AC has been requested to provide CDPH with a summary and recommendations for reporting of healthcare-associated MRSA. An introductory discussion on the requirements of, definitions for, and scope of reporting was given. **Community-Associated MRSA:** An ad hoc subgroup of California Committee of Local Health Officers has agreed to consider community-associated (CA) MRSA at a formal meeting in mid-December. The group agreed to one option for reporting: cases of severe illness defined as admission to an ICU or death in someone who is previously healthy (there are epidemiologic case definitions for previously healthy). Such a case would clearly constitute CA MRSA. Based on extrapolated data from another state, about 150-200 cases MRSA per year are anticipated to fit into that definition in California. This level of reporting would be manageable and reasonable for local health departments. **Healthcare-Associated MRSA:** CDPH has the authority without going through regulation or additional legislation to require any disease or condition to be reported. CDPH can implement individual case reporting such as is being done with CA MRSA. Such data will not be rates because there is no real denominator. A recommendation for case reporting by the Committee could be implemented rapidly without a more formal process. Any further requests such as rates of MRSA infection would require additional legislation to become mandated. **Discussion** *CDPH is requesting that this committee develop a set of recommendations for the implementation of reporting of healthcare-associated MRSA in California hospitals. The next agenda item is to frame questions. What question does the committee want the data to answer? What is the denominator of cases? What cases count in the subset? Do we want general data? Example: Tennessee has had reporting for invasive MRSA and their experience is that invasive bloodstream infections have the most impact. Do we want to be able to identify those hospitals with more cases or transmission and put resources there? If we have total reporting of MRSA as some groups*	MRSA Subcommittee to form and meet prior to the next full HAI AC meeting.

suggest, we could spend all of our time doing that and would neglect all of the other prevention activities we're trying to do. Yes there is a payoff, but it behooves us to modulate that payoff so that it's something doable while having an impact on improving patient safety. *NHSN is within a month of rolling out a multi-drug resistant organism reporting module that includes MRSA, CDIF and other resistant organisms. That is one potential option for reporting.* Q: *To be clear, we're to gather our recommendations and come up with an idea of what we want publicly reported from the hospitals? This is just to health departments? Where does the report go?* A: *This is for the reporting of healthcare-associated MRSA. The report goes to CDPH or wherever we decide it goes to, and most likely will become public.* Q: *Does California require MRSA, VRE, Staph, CDIF to be a reportable disease?* A: *None of those are reportable, unless there is an outbreak. There is no regulatory definition of outbreak.* Q: *Unless you're screening, how are you going to know how many patients have these diseases? As part of this conversation we need to discuss screening for patients or there's no way to measure where we are with an outbreak.* A: *Screening is one of the pieces that can be considered.* **Discussion** *(Carole Moss requested to be logged in minutes): This committee was put together to help prevent infections and there's legislation going on in other states and in California. If HAI AC wants to be a part of it, everyone needs to be a part of it and do it quickly. Screening is critical. There is no way to prevent infections unless we know. If people are coming in and walking into hospitals with MRSA, CDIF, VRE, staph infections…they can spread it around to patients and also the caregivers. Screening is a topic that I'd like to add to go into the minutes. Hospitals should report infections rates to the public for MRSA, VRE, Staph and CDIF. Today, guidelines for active surveillance are now being recommended by IHI. HCA, approximately 200 hospitals are doing AVI. All VA hospitals, approximately 150) are doing AVI (active surveillance (rapid testing)). This is a critical issue that we need to address very quickly; we can't wait until next year to look into this important component to prevent infections. Education of consumers and healthcare staff. I've been meeting with high schools, health classes. We need to make a big effort to educate the public.* *A recent JAMA article cited crude mortality (people who died with an MRSA infection.) We don't know if they died from an MRSA infection or other causes and had a concurrent MRSA infection.* *A hospital/healthcare system can't control what happens outside its doors. It is important from a quality point of view to be reporting healthcare associated MRSA, that's what happened on your watch within those 48 hours. And this is something for the committee to consider.*	

We can have labs dump all of the positive isolates. We can make MRSA isolates reportable, but what would you do with that data. *It might be reasonable to start with making MRSA isolates reportable to public health. That may help hospitals get a feel of the scope of the problem in their communities?* *We're all here to promote better health for the public. We've been doing this for most of our lives. But we're also consumers. My mother-in-law died from a nursing error; my brother was discharged from the hospital with MRSA septic joint. We all have the same goal. Only good legislation/regulation has improved healthcare. I'd like to make sure what we do will improve healthcare. We do have data on community cultures but there's disparity between what's going on in the community versus the hospital. When we look at what we want to do, we want to do things that have a benefit, that get us data that we can act on, that are things that have been shown to protect the patient. I feel we must carefully consider recommendations to be sure that they are as good as they can be, not frenetic to just get something done.* Decision was made to create an MRSA Subcommittee. A sign-up sheet for the MRSA Subcommittee was distributed. *We do need to bring the matter of the financial climate into this. I think for many, if finances were not an issue, the recommendations would be different. The fact of the matter is that finances are an issue – for CDPH, local public health departments, hospitals. If you want to talk about active surveillance cultures, who pays for those? If you're going to talk about public health, who's going to analyze the data?* Q: *Are recommendations on reporting of MRSA by CDPH going to be submitted to the hearing that's coming up?* A: *This will not be addressing all MRSA but again ICU death in a previously healthy person.* Discussion regarding questions and issues to consider around MRSA: A. Education for the community. B. How serious is community-associated MRSA? C. How many cases in California? D. It's important to be able to target our resources and educate the public. E. The other part of the question is HA MRSA. Looking for it doesn't mean the infection will be prevented. What we're trying to do with the bundled approach is to prevent the bug from getting into the patient regardless if it's a resistant or sensitive pathogen. F. As we get into the subcommittee it would be helpful to have a starting point of what we're going to look at and what we're going to try and prevent. *It is very important to come back to what questions need answering and not just what data can be submitted. A driving force is the numbers. In most institutions in California, 50-65% of their staph aureus isolates are MRSA. If it's proposed to report out all of those isolates, that's going to*	

be more information submitted than anyone can deal with. That should keep that separate from the discussion of screening. *Caution should be exercised before going down this road of acting too quickly. One of the key elements is not how much MRSA a facility has, but what is being done to lower incidence and keep it down. Merely measuring lab isolates or screening may not reflect the true value of knowing what hand hygiene compliance is, what's the isolation burden, etc. It may be worth looking at other surrogate markers. The common dilemma that we fall into when we're looking at this is what's the value of finding someone who's colonized versus actually finding the true infection burden?* *How can you fix a problem unless you have a measure? VA hospitals have effective screening. Yes you can check and screen each person as they come in and put them behind the line if they have MRSA. Protecting the other patients. If you don't screen how can you fix a problem? Regarding finances – we can't afford not to do this. As other states have proven, we have cases upon cases that will now get worse because of the ruling of CMS which will eliminate the payment on infections that come in hospitals. Consider the burden on our hospitals when Medicare and Medicaid are no longer paying for infections they get in the hospitals. These are key areas that now need to be addressed. Why would they take MRSA off an infection list for CMS?* *The principle that governs us as infection control practitioners is that we do transmission based precautions. We assume that a person might be infectious and therefore we protect with common infection control principles, we protect from transmission to surfaces and also patient-to-patient or provider-to-patient. We don't want to lose the focus which is to decrease infections. On top of all of the other comments that have been made, we also really have to think what is the effect of isolating the MRSA patient on the general care of this patient and the unintended consequences. Studies have shown that patients are not looked after, vitals are not taken, those are consequences we don't want to provoke. We need to go back to the principles – hand washing; personal hygiene practices; etc.* Item: *(requested to note in minutes by Carole Moss)* Carole Moss volunteered to be the MRSA Subcommittee Chair. *S. Chen: I'd prefer that Carole is not facilitator of the MRSA group. I'd prefer someone in the middle.* *C. Moss: Please record this in the minutes.* *T. Nelson: I'd like to be on the subcommittee.* *Chair: Terry would you like to facilitate it?* *T. Neson: Sure.* *There is a legislative hearing on this (MRSA) on December 20. There is no strict deadline yet for the MRSA group.* *I don't believe that the subcommittee can provide something to the CDPH. It would have to come from the Committee. By next meeting we should know what CDPH needs from the MRSA subcommittee and what we would recommend.*	

Action Items and Next Meeting per Chair K Delahanty:	
Action Items are summarized in the Action/Follow-up column of these minutes.	Committee staff will draft a letter to all California hospitals.
Item: The Committee made important recommendation to the California Department of Public Health to use NHSN to report measures of SB 739 that are available in NHSN. A letter will be going out to all hospitals. I'm proposing a short report to be submitted to the department of public health about committee progress, including MRSA issues.	Committee staff will draft a short report to CDPH regarding Committee progress, including MRSA issues.
Next Meeting: Consensus date for next meeting is January 24 in Sacramento. Time is 10:00 a.m. to 3:00 p.m. Location and agenda will be emailed to Committee members and posted to the web site two weeks in advance of the meeting date.	MRSA Subcommittee will form and work. CLIP will meet after consultation w/NHSN. Influenza subcommittee will work on second draft.

Acronyms

CART	CMS Abstraction and Reporting Tool
CDIF	*Clostridium difficile*
CDPH	California Department of Public Health
CLIP	Central Line Insertion Practices
CMS	Centers for Medicare and Medicaid Services
HAI AC	Healthcare Associated Infections Advisory Committee
ICU	Intensive Care Unit
IHI	Institute for Healthcare Improvement
LIP	Licensed Independent Practitioner
LUMETRA	Quality Improvement Organization that works with CMS in California
MRSA	Methicillin-resistant *Staphylococcus aureus*
NHSN	National Healthcare Safety Network
SB 739	Senate Bill 739
SCIP	Surgical Care Improvement Project
VRE	*Vancomycin-resistant Enterococcus*

Respectfully submitted,

Sam Alongi & Roberto Garces
Third Sector Strategies