

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

**Attendance**

**Members:** Kim Delahanty (Chair), April Alexander, Ray Chinn, Letitia Creighton, Enid Eck, Donna Fox, Dan Gross, Jennifer Hoke, T Warner Hudson, Lilly Labar, Marian McDonald, Mary Mendehlson, Shelly Morris, Carole Moss, Rekha Murthy, Frank Myers, Terry Nelson, Amy Nichols, Shannon Oriola, Julia Slininger\*, Jonathan Teague, Dawn Terashita, Francesca Torriani, Anvarali Velji, Pat Wardell, Dave Witt

**Guests:** Chris Cahill, Cindy Gaston, Brandi Lazork, Patricia Mueller

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

\* Julia Slininger called in from a non-posted site and was considered a member of the public for this meeting.

Agenda Items/Discussion	Action/Follow-up
<p><b>Call to Order and Introductions</b>            Committee Chair Kim Delahanty convened meeting at 10:00 a.m.            Introductions made at Sacramento and on teleconference lines.</p>	
<p><b>Approval of Minutes</b>            The Chair called for approval of the January 24, 2008 meeting minutes. Minor wording changes will be forwarded to staff. Members noted that the minutes read like a transcript; Sue Chen explained that more complete minutes help to maintain the flavor of the discussion and give detail to key points of the meeting. Minutes are condensed where possible.</p> <p><b>Motion to Approve January Minutes (as submitted with minor editorial corrections) (McDonald)</b>  <b>Multiple Seconds (Membership)</b>  <b>Motion Passed by Unanimous Vote</b></p>	<p><input type="checkbox"/> <b>Staff to make minor revisions to January minutes based on member notes and comments.</b></p>
<p><b>Public Story</b>            Carole Moss introduced Cindy Gaston, wife, mother of four, and survivor of Methicillin-Resistant <i>Staphylococcus aureus</i> (MRSA).</p> <p>Ms. Gaston gave a detailed account of her experience with MRSA. She pointed out that even with her experience working in healthcare, she had difficulty obtaining information, and experienced many problems obtaining consistent, appropriate and careful (infection prevention) treatment. She described the fear caused by misinformation she received, the inconsistencies in her care (some providers wore gloves and masks, some did not), and how she eventually left the hospital to complete her treatment and therapy on an outpatient basis because of the poor inpatient care she received.</p> <p>Chair—Thank you for your story and for having the courage to share your story with us today.</p>	<p><input type="checkbox"/> <b>Thank you letter to Cindy Gaston</b></p>

## Committee Updates

Chen—

1. The California Department of Public Health (CDPH) has presented the National Healthcare Safety Network (NHSN) class 14 times and presented to 11 of 12 Association for Professionals in Infection Control & Epidemiology (APIC) chapters. Training for the last chapter will be rescheduled.
2. As of March 3, 139 of 449 hospitals have enrolled into NHSN. 38% have notified CDPH of who the Facility Administrator will be, and 44% have returned the Surgical Care Improvement Project (SCIP) questionnaire.

Reliable communication to appropriate persons in all general acute care hospitals remains an ongoing issue. Formal education has been given to most chapters, but informally, a huge number of Infection Control Professionals (ICPs) haven't heard of this process. CDPH is trying to develop list of all hospital (staff) we need to communicate with. There is ongoing problem of reliable communication with the appropriate hospital staff. CDPH will be unable to accurately ascertain compliance with Senate Bill 739 (SB739) until this issue is successfully resolved.

### Discussion

Members noted being aware of these All Facilities Letters (AFLs) because of their work on the HAI AC, but that there were significant communication shortfalls internally in hospitals, including a possible assumption that "cc" was interpreted as the letter had already been distributed. Suggestions were made for alternative ways to address these AFLs; they will be incorporated into upcoming letters.

3. There is an upcoming meeting to discuss other requirements of SB739 with Licensing and Certification (L&C). A draft of an AFL is being prepared for general acute care hospitals to join the CDPH group, confer rights, and begin Central Line Insertion Practices (CLIP) and SCIP reporting. Sometime this week, CDPH will likely be nominated as a group.
4. MRSA progress:
  - CDPH has spent much time with the new requirement for reporting of severe cases of *Staphylococcus aureus*, and differentiating that from the HAI AC reporting recommendation.
  - The justification memo that was asked for in the January HAI minutes has not been assigned.
  - The draft of the Multi-Drug Resistant Organism (MDRO) module became available from NHSN February 28. An NHSN conference call for states will occur on March 5 to explain use of the module. Post-call, this will be discussed internally. CDPH currently intends to make MRSA reportable through NHSN. A subcommittee is requested to review the module and make a recommendation as to its use. L. Labar

- **Licensing and Certification will check addresses for AFL letter validation.**
- **CDPH will look at how the AFL is addressed and modify the next AFL letter based on Committee recommendations.**
- **Staff will write a letter to NHSN to ask if California can have input in production of future reporting modules.**
- **NHSN/MDRO Subcommittee was formed with L. Labar as facilitator.**

volunteered as chair.

**NHSN MDRO Subcommittee:**

1. Lilly Labar--Facilitator
  2. Ray Chinn
  3. Enid Eck
  4. Marian McDonald
  5. Shelly Morris
  6. Carole Moss
  7. Rekha Murthy
  8. Terry Nelson
  9. Shannon Oriola
  10. Dawn Terashita
  11. Francesca Torriani
  12. Anvarali Velji
  13. Pat Wardell
  14. Dave Witt
- A. Consultant: Henry Chambers  
B. Consultant: Amy Nichols

Moss—Why limit the number on the subcommittee?

Chen—To encourage frank discussion. The subcommittee chair always has the option to publicly post minutes if they determine that is appropriate. The subcommittee can not make any decision on behalf of the Committee.

There was discussion on the value of CDPH participating in the development of NHSN modules and how California might better partner with NHSN.

Eck—At some point, reporting on surgical site infections (SSI) will happen. It may be a year or two down the line, but it will happen. So HAI AC should consider the impact on hospitals having to report data, (NHSN mandated data elements), for which there are no additional resources. The data elements may be interesting as topics of research but have minimal immediate impact on improving patient care. A letter should be drafted on behalf of the HAI AC, which strongly conveys our interest in assuring that NHSN collaborate with CDPH and/or HAI AC members in the development of future NHSN modules to promote patient safety and HAI prevention.

Witt—This needs to have a parallel effort from the business sector, from different sectors to build interest from the consumer side.

Chair—This group does encompass many sectors, so as the Chair signing it would be putting forward the collective voice of the Committee and its wide membership.

Chen—The next item is potential conflicts of interest (see attached for

clarification and language). This wasn't on the agenda but via Bagley Keene and the need for immediate action we can bring this up today. The question was raised in January and sent to legal: are there potential conflicts of interest for Committee members here--is committee business covered under the Political Reform Act, an example might be if the Committee made a recommendation to use a certain type of technology and a voting member owned stock in, and could therefore benefit financially from the use of that technology, such as technology for active surveillance cultures). CDPH has been inundated with communications about testing technology. The conclusion is that SB739 created HAI AC as a classic non-decision making body; this Committee is not given any authority in connection with making or compelling a government decision. One exception could be Section C— Does the Committee make substantive recommendations that could be approved without significant amendment or modification by another public official or government agency? So thinking about our recommendations, CDPH sent an example to see if any business would fall under Section C. Since decisions are not rubber stamped and CDPH relies on its own conclusions, there does not appear to be a conflict. If a member does have conflict of interest, because of review, there is no bearing on the final decision. Does conflict arise if state staff own mutual funds related to matters here? The answer is that the Political Reform Act exempts broad based mutual fund. Conflict could potentially arise if a decision-maker has access to information that no one else has access to; CDPH can only ask that members excuse themselves from voting on any issue with which they might have a conflict of interest. CDPH concludes that HAI AC cannot mandate disclosure. We will attach this with the meeting minutes.

**Discussion**

Teague—Footnote: Form 700 is the Fair Political Practice Committee Statement of Economic Interest for state employees, boards and commissions.

There was no further discussion.

**Influenza Subcommittee Recommendations**

[The Influenza Subcommittee Presentation follows as an attachment. The discussion following that presentation is included here.]

Chinn—Reviewed consensus recommendations from the January meeting.

Presentation of Item A (Chinn)

There was discussion on whether [the requirement for reporting on the 2007-08 flu season] was too early, but it appears that most facilities were aware that this was coming, so it isn't a surprise to most hospitals. There was discussion that January wasn't enough time, so we moved the date to March 31. The reason for using the January cutoff for 2008-09 was that the impetus for vaccination occurs before the end of January in a typical year.

Presentation of Item A2 (Chinn)

**Discussion**

Moving the date to January 31 next year is inconsistent with Center for Disease Control and Prevention (CDC) recommendations (recommends through March); vaccinations are pushed for new and existing employees. The flu season usually peaks on average, mid-February.

Chinn—Does the Committee find it acceptable to move the date to March 31 for 2009 as the only change for A1 and A2? (Membership—Yes)

Myers—The subcommittee suggestion is to leave it up to CDPH how hospitals will define whether someone is vaccinated outside their facility, and how stringent CDPH wants to be with the ‘proof’ of vaccination.

□ Presentation of Item B (Chinn)

**Discussion**

Chinn—Remember, NHSN has a long list of elements; what the subcommittee chose was to tailor for our needs to satisfy SB739, so we won’t get credit for the Influenza Module according to NHSN.

Form B is the pre- and post- reporting as handed out at the January HAI meeting.

Presentation of Item D (by Chinn and Slininger)

D.1.a.

Each participating institution would send their information to a vendor, and the vendor will transmit the data to the Centers for Medicare & Medicaid Services (CMS). Current requirements for immunization of patients with community acquired pneumonia only will be expanded the following year.

D.1.b.

There are very few facilities that do not participate; they will be assisted to begin reporting by Lumetra and will have the option to use paper forms.

Item D.1.

[Influenza Subcommittee Presentation]

**Motion to approve A, B1 and B2, and D (with minor revisions) (Oriola)**

**Second (Hudson)**

**Motion Passed by Unanimous Vote**

Items B3, B4, C (Chinn)

Chinn—There was interest at our last Committee meeting in expanding ‘employees’ to ‘healthcare workers’ because there are contractors, licensed independent practitioners (LIPs), registry nurses, and others. There was no general consensus, so we broke it down to these categories, B.3.a and B.3.b.

**Discussion**

Chen—Page 16 of January minutes. Restated motion was *[From January 24, 2008 HAI AC minutes: In 2009, all healthcare personnel are to be screened and included in the rate; and the rate included in reporting and available to the public. Motion Seconded (Witt). Motion passed.]*. So if we vote to rescind that, you are overturning something already voted on.

Myers—Yes, that’s why we are using this to operationally define what healthcare workers include.

Chinn—This is to clarify that motion and create definitions to help operationalize these ideas.

Rosenberg— The Advisory Committee on Immunization Practices (ACIP) uses the term ‘healthcare personnel’ in its immunization recommendations.

[Discussion on using the term ‘worker’ or ‘personnel’.]

McDonald—When trying to track groups with amorphous borders like LIPs, it is very difficult to provide vaccine, document, and collect denominator and rate information. I would suggest our consensus is practical and doable with available resources.

Nelson—The crux is, do we try to remove all possibility of bringing an infected person into our facility, or do we focus on what the experts estimate would bring herd immunity, and a balance point between that and what is practical. Examples that come to me would include registry nurses. We have to direct resources to the most effective solution given that the resources are limited.

Chinn—Pointing out to the Committee the difference between LIPs and other contractors.

Myers—We do know that if the hospital can focus on the finite set of personnel, it can chase down those high risk contacts and do what is known to be most effective and makes a difference. By including everyone, a hospital could ‘look good’ in public reporting by immunizing more people rather than focusing on those with lots of patient contact. So the rate looks good but the risks increase for patients. This is why we looked toward those with frequent and close patient contact.

Moss—I see less value in picking and choosing. If you do one you should do all.

Chinn—When you measure something (vaccination/declination) you would look good if you had 100% of LIPs, but they could all be declining, so you then have unintended consequences. Fulfillment of the rate or number and you don’t focus on the real target. With epidemiology, you always target the high risk people so you get the most effective use of resources. Don’t forget herd immunity; if you get people with constant contact you do develop herd immunity.

Chair—Comment to the Moss response: because we are giving options of how we want to collect data is not saying that we are not offering the influenza vaccine to all health care personnel in the hospital—regardless of what they do. So as to clarify, all the law requires us to do as far as data collection is to capture employees. Hospitals should? still provide everybody the opportunity to either decline or get their immunization.

Moss—But only reporting on a handful is not enough for the public. If you're going to offer and going to measure, it must all be done the same way.

Chair—We try to do what we can to help the greater good. It is not possible for every hospital to prevent every infection or bad outcome although, we would like to. When we look at prevention, we must consider the greater good and what we can control.

Torriani—This year we're seeing (because the vaccine 'missed') that despite increases in immunization rates, there will be vaccine failures and other ways for infection to occur. This year is a reminder for both Option A and B. The second comment is that we know where the risk of spread of infection is, and those areas are the ones we have tried to target with Option A, to cover those highest risk. There are certain areas of entrance (emergency department (ED), intensive care unit (ICU)) where the risk is greatest for infection to be spread. From a public health point of view, going after vaccination on a provider who is only in the hospital once every two years is not effective.

Witt—It seems that the January motion covered healthcare personnel. There is nothing I see in here that pushes increasing the rate of vaccination among those who are the targeted personnel (Option A). The 'vaccination and/or declination' doesn't mandate that the vaccination rate goes higher.

Hudson—Suggest pushing efforts toward targeted groups and those with frequent contact. We don't want to shoot excellence in the foot with the pursuit of perfection. To chase LIPs who don't ever come to the hospital runs the risk of taking effort away from important efforts for vaccination. Outside of vaccination, there are other ingredients including early antiviral use (within 48 hours), hand hygiene, staying home when ill. A focus on chasing down those LIPs may limit these other education efforts.

Chen—If our goal is patient safety, the chase of ALL sets a double standard as it does not control visitors who might come in with the flu. I have listened to this ongoing conversation for the past three months. We have had little or no movement on opinions in the last three months between the two sides. It may be time to agree to disagree and move on. That said, there is an outside-the-box solution from Seattle. A hospital adopted a policy so that persons can choose not to get vaccinated, but then they must wear a mask throughout the flu season. This is effective, efficient, and in Seattle's case encouraged 98% vaccination rates this year. The legality of the policy was upheld by the

Washington State Supreme Court.

**Discussion**

Chinn—Witt made a good point on how do we improve LIP vaccination; included in the recommendation, in addition to the vaccination/ declination form, we had asked for vaccination rate as well. That should be used for internal tracking, to create internal pressure. There is no science behind the vaccination/declination form; we are trying to follow the intent of SB739 to offer every employee, free of charge, vaccination. The science is in the making of the vaccine available.

Labar—I strongly advocate using “healthcare personnel” as this gives me leverage to put this into practice and into bylaws. What helped in practice is that CDC recommendation on tuberculosis on other issues included “all healthcare personnel”. Option A would put practitioners at a disadvantage.

Murthy—SB739 does not mandate taking of the vaccine. The intent was to provide vaccine, document those who decline, and find focused ways to improve vaccination rates. The other piece is that this year’s experience shows us that the vaccine itself is not necessarily the key issue; this year there is a huge burden of several respiratory illnesses. Reduction of infection is important, so clarifying how to deal with employees who are actively symptomatic—how to tell symptomatic people to stay home, etc, that is important as we move forward. We should make sure we don’t deflect from the intent of reducing the burden of illness.

Oriola—Even with 100% compliance, this does not completely protect the facility. There is nothing in the legislation regarding enforcement of the recommendations.

Eck—I agree with Labar, to use “healthcare personnel” as outlined by ACIP. There is more to it, such as 3A which defines LIP. The key areas are those with significant contact with patients. The original (HAI) working group recommended the declination piece, because there was evidence that with the offer of declination, more people took the vaccine. With these recommendations, we have a solid baseline. Language that speaks to targeted continued improvement is important; CLIP is a good example of starting with a manageable target then expanding it in future years. I propose that we modify the language to include healthcare personnel, and that for this coming flu season we consider concerted effort to capture the high risk areas. And as a part of this recommendation we make it clear that this is a phased-in approach, for 2009/10 we will continue to expand, and the facilities must have a process of knowing who is coming into their facility, capture this data, and promote vaccine. This timeline would give facilities the time to fully consider all these elements. An education component would be very useful. So this year will focus on healthcare personnel (departments such as 3A), and in subsequent seasons expand to others including considering not only their EDs and intensivists, but, for example: contract employees, registry personnel, even visitors, etc.

Chen—Taking #3B and delete the word “all” would mean we can focus on incremental improvement. The second piece could be visitors. Then #3 could include any healthcare worker. Those without vaccination would either have to wear a mask or go home. This policy is used frequently in nursing homes.

Chair—Mandating and enforcing is difficult; the buy-in has to come from the staff, programs, and administration. They have to prioritize.

Murthy—Consider the public relations issue. A worry about influenza in the community may be that without education, seeing masks around the facility may lead to unintended consequences.

Chen—But gloves used to be optional too...

Eck—Given everything, its hard enough collecting survey data, but now we are requiring facilities to take these significant steps on limited resources. Facilities can only be stretched so thin before you may see diminishing returns. Another piece to consider is that every time we have a flu vaccine that misses the mark, immunization rates fall the following season. We will already be challenged next year to keep above this year’s baseline; so the Committee must be reasonable in our next steps in what we ask facilities to do. We are all here to improve patient safety. For the near future, we need very clear targets for increasing vaccination.

Chinn—As written, for 2008/09, this was just for institutions to have a process developed. It is for 2009/10 to design a method for public reporting. So the recommendation is already staged.

Moss—There are no penalties in the law for not following these recommendations. Consider making a recommendation to CDPH to have stiff penalties in place. Based on the vaccination missing the mark this year that is all the more reason to push hard. Wearing a mask if they won’t get a flu shot is how it should be. Labar stated that, “if it’s in writing I can get it done” in terms of dealing with providers and administrators; so that’s the direction the Committee should work.

Chinn—There are benefits to having a tiered structure. On years of shortages, you have to know the high contact/high risk areas.

Witt—We talk about legislative intent, which is to vaccinate, not to educate. This had to be watered down to what we can do, which is attempting to get people vaccinated. But the expediency issue can’t be resolved by looking at targeted units, as people pick up the virus in the ward, clinic or waiting room and not in the ICU. So require declinations, but report vaccine percentages. Vaccination rates are the only rates that have value to the public. There are ways to target, to enhance vaccination rates; target the vital core personnel, as an accommodation, and make sure vaccination rates are reported.

Chinn—The intent of the declination is to put the onus on the

administration.

Gross—Hold administration for that which they can be held accountable to; you can hold administration accountable to making certain they bring forward the opportunity for vaccination. That is why you separate attestation. It is worse when you move on to physicians in systems that have no influence over those physicians. You can't therefore hold the hospital accountable for making sure the vaccination rates increase.

Chinn—This first year we can get the baseline data.

Rosenberg—Consider the limitations of SB739. The Committee could consider scaling back the reporting of 'personnel' because of practicality, resource and implementation issues. Some of these proposals are going beyond SB739; are these recommendations that CDPH seek ways to implement, because at this point CDPH does not have the authority to do certain things. The Committee could recommend that CDPH seek the authority to recommend under SB739, or the Committee could request CDPH seek authority to do things outside of SB739, or the Committee can issue its own recommendation to hospitals.

Chinn—The Committee will make its recommendations to CDPH.

Murthy—Perhaps consider as a Committee, focus on the language of what we're expecting for the next year, as a follow-through of what's the baseline from this year. Asking for not only evidence of declination/vaccination rates, but to show there's been an improvement. Then ask for other aspects down the road.

Eck—We've focused on staged implementation, and including a real-world recommendation of "employee" including contractors, LIPs, and others.

Chair—Is there a motion? (Eck volunteered to restructure the motion given the discussion and present it later in the meeting.)

Eck—The place we're stuck is the language of 3A and 3B.

Myers—ACIP guidelines aren't as functional based on the fact that they were considering the entire continuum of care...where would we cleave that? Paramedics, people outside the facility?

Member—739 includes this language: "Section 1288.8: Initially these process measures shall include the CDC guideline for influenza vaccination of patients and healthcare personnel." Keep that in mind.

Chinn—Defining healthcare personnel has been key to this. Anyone working in a hospital is a 'healthcare personnel'. This was not accomplished at our last Committee meeting.

Witt—Yes, the sense of the discussion was that it would include all healthcare personnel.

Member—We already have the priority screen established (i.e. when there's a vaccine shortage) so it seems a small step to ensure that progress is made on these core groups.

**Motion**

**Motion to adopt 3A 4A and C1 as recommendations (Oriola)**

**Second (Gross)**

[Discussion regarding the process of making motions and appropriate consideration of concepts leading to motions.]

Rosenberg—Are you recommending broadening the process over time?

Wardell—Does it include LIPs? (Yes)

Witt—Point of order: Does CDPH have authority over the hospitals' contracts with contracted agencies? (Yes) Comment that this motion would be better to replace 3A with 3B. Then we've included concerns about LIPs.

**Motion Restated by Chair—3A, 4A and C1 as a package to adopt.**

Nelson—Call for question on this motion.

**Chair—Vote on the current motion:**

**Yes: 8**  
**No: 11**  
**Abstain: 5**  
**Motion does not carry.**

**Motion 3B, 4A and C1 as a package to adopt (Witt)**  
**Second (Terashita)**

**Discussion**

Eck—Does this have a phase-in period?

Witt—Yes it does give us the option on reporting. Public reporting would be the following year.

**Chair—Vote on the current motion:**

**Yes: 4**  
**No: 15**  
**Abstain: 6**  
**Motion does not carry.**

Witt—The distinction seems to be around LIPs. Is there a definition that is not all-inclusive but would cover the majority.

Gross—Regarding LIPs. What if the Committee considered using an Admit Number? This gets to those providers who are having contact with our patients. As an example, for our facility the cut point is 25

<p>admits; this resulted in about 425 of 1,200 physicians/300 bed facility.</p> <p>Nelson—We'd need to apply it as a percentage to consider different sized hospitals or systems. Perhaps apply it to number of beds in the facility.</p> <p>Myers—This is supportable as long as we have another mechanism by which to add to this people who we can consider high-risk.</p> <p>Moss—The public wants it for <u>all</u> the people who come into the hospital.</p> <p><b>Motion to move down the agenda while Eck drafts an Influenza subcommittee motion (Nelson) Second (Witt) Motion passed with no opposition (See Influenza Subcommittee Recommendations II below).</b></p>	
<p><b>Future Committee Direction</b></p> <p>Chen—Issues that need to be addressed; these can be considered in detail in future meetings.</p> <p>1. Does Committee have authority to make recommendations on preventive measures? The CDPH conclusion is that the word 'prevention' is sprinkled throughout, used in white paper, etc, so that is an open avenue for future activity.</p> <p>2. Presentation of public reporting. A charge of the Committee is, when data is generated, how should the data be presented. Is this worthy of a Subcommittee? (Membership—Yes)</p> <p>Nelson—Educational components are often targeted to specific groups; it may be better to wait, so that when we have a particular issue, we're better able to develop it with members who have expertise on the issue.</p> <p>Chen—This is more general. What we're looking at is data from <i>HospitalCompare</i>, and not specific issues.</p> <p>Rosenberg—Referenced the CDPH Healthcare Consumer Quality website and other states as examples of presenting data for the public. Public Reporting Subcommittee: Volunteers were sought. It was suggested that a CDPH health educator be added, and that the California Hospital Association (CHA) be invited to participate. Carole Moss volunteered and was accepted to facilitate this group. It was agreed that the subcommittees should be convened sooner as opposed to later.</p> <p>3. In speaking with ICPs, this Committee is working fairly rapidly. So we probably want no recommendations for implementation for six months to a year to allow them to catch up as they will be doing the majority of reporting.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Public Reporting Subcommittee was formed with C. Moss as facilitator.</b></li> <li><input type="checkbox"/> <b>Evidence-based research around public reporting will be provided for Public Reporting Subcommittee by Rosenberg.</b></li> </ul>

**Public Reporting Subcommittee Members**

- 1. Carole Moss--Facilitator
- 2. April Alexander
- 3. Kim Delahanty
- 4. Donna Fox
- 5. Lilly Labar
- 6. Marian McDonald
- 7. Frank Myers
- 8. Jon Teague
- 9. Dawn Terashita
- 10. Francesca Torriani
- 11. Pat Wardell

A. Consultant (Sue will enlist)

Action Item: Recommended to invite Dorel Harms and Debby Rogers

Chair—And possibly with the Committee formulating this communication to CDC on these modules might help slow the process and get some traction on what all the modules might look like. Should we form the SSI, Ventilator Associated Pneumonia (VAP) subcommittees or do we wait? (Membership elects to wait) We'll put this in the 'parking lot' then.

Chair—Under future direction, it has been brought to our attention that we need to do some collaboration with local public health departments; what does this all mean for them, and particularly MRSA? So we need to discuss education of the public.

McDonald—There are at least two sets. One is people diagnosed with MRSA. In looking for resources, it is very difficult to access useful information. One resource in the public domain is the Tacoma, Washington "Living with MRSA" patient education booklet. It is very good, is in the public domain, appears to have no deficit, and is already done. The second group, although less motivated, is the general public, the person without MRSA, learning how to protect themselves and their families. This may be a media issue, but there is a great need.

Moss—Public should also include doctors. They should be addressed as a subset. MRSA is preventable, and healthcare professionals should be aware of the success stories as well.

Rosenberg—CDPH does have an MRSA website. Please take a look and feel free to recommend improvements to us. Second, there is a project called AWARE, Alliance Working for Antibiotic Resistance Education, through the California Medical Association Foundation. [www.aware.md](http://www.aware.md) AWARE has focused on appropriate antibiotic prescribing, and has many strong and active partners. This has been effective at working with consumers and doctors. But be aware that "the state" does not have the resources to provide guidelines, standards, and information.

Chair—The suggestion is that we work together as an advisory committee to create some kind of public education recommendations to

<p>CDPH. This subcommittee will be developed at the next HAI AC mtg.</p> <p>Rosenberg—Yes, and we should consider some of these other partnerships to join forces with. For example, this Committee and AWARE can complement each other.</p> <p>[Discussion on status of recommendations that Committee has made, including:</p> <ul style="list-style-type: none"> <li>• Holding on letter of justification</li> <li>• Education to state’s ICPs</li> <li>• Differentiation among requirements</li> <li>• Just received MDRO module; within a week will know how state will proceed with implementing the reporting of HAI. MDRO module must be in place, running and assessed before any reporting can be mandated.]</li> </ul> <p>Chair—Do we develop a public education subcommittee at this time, yes or no?</p> <p>Membership—Defer to next meeting.</p> <p>Chair—Last discussion item is #5 (terms/renewal of membership to the Committee).</p> <p>Chen—The Committee may wish to consider a term or renewal for Committee members as members may wish to opt off or their ‘representational area’ may change, leading to imbalance.</p> <p><b>Discussion</b></p> <p>Issues such as the importance of attendance were noted. There are no governing by-laws, and ground rules for participation with this committee were never set. There is just the Bagley Keene Act and the charge of the Committee based on SB739, which helps with who to include but not with how to manage membership. Rules of participation for the Advisory Working Group will be brought to the next meeting for discussion as an agenda item. A question was asked “Was there an intention to make this a permanent body?” (Yes)</p>	
<p><b>Influenza Subcommittee Recommendations II</b></p> <p><b>Motion (Eck/Chinn)—</b></p> <p><b>1. By September 1, 2008 (for the 2008-09 <i>Influenza</i> Season)—</b></p> <p><b>A. Each acute care hospital should have a written process to establish targets to increase immunization rates over the 2007-08 baseline rates for health care personnel, including but not limited to: physicians; nurses; those in training for healthcare professions; and other workers in the acute care setting.</b></p> <p><b>Initial targets for increasing vaccination should focus on patient care areas providing care to patients at increased risk for Influenza, including but not limited to: EDs, ICUs, Cardiology Units, Oncology Units, and Pediatric Units.</b></p>	

**B. Acute care hospitals should also establish a process that assures contract agencies to provide flu vaccine and/or verification of declination for all contracted health care personnel.**

**2. For the 2009-10 *Influenza* Season—**

**Acute care hospitals should focus the increased vaccination rates for that season to include all healthcare personnel and support staff working in acute care hospitals.**

**3. By September 1, 2009—**

**CDPH should design a method for public reporting of immunization rates for all healthcare personnel.**

**Second (Moss)**

McDonald—Clarification: At one point it talks about patients at increased risk for Influenza; should it be at increased risk of influenza or increased risk of complications of influenza?

Eck (and members)—Increased risk of influenza.

Chinn—Intent was to define high risk areas, then in time add in the other areas.

Witt—The motion seems very broad, which is fine. I'm not sure of the point of emphasizing the high risk areas.

Eck—Its more the timing, and getting it implemented strongly in one area then widening the net. As we also talked about, providing education, developing strategies, figuring out how to target all the various providers, and we just need to give facilities time to figure this out.

Chen—Under 1B, consider language that requires physicians to get vaccination or provide declination as part of their credentialing process.

Eck—That could be the process hospitals choose.

Member —If you include credentialing, physicians will think its for every other year.

Eck—Care must be taken not to get too prescriptive with this language.

Moss—Consider including all people who come into hospital...

Labar—Our facility does screening as part of our etiquette to control for cough, cold and rash in the hospital.

Myers—Declinations work when they are done face-to-face, when given by a person highly motivated to vaccinate. No data supports behavior change from just sending out declination forms. We should also make

sure we don't lose focus on the core groups in subsequent years. What is clinically important is the rate on those crux individuals.

Eck—In 1A, the language will change from “initial targets...” to “initial and ongoing or subsequent targets...”

Rosenberg—Word carefully around who you are asking to do what...

Eck—So re-word to say “CDPH should recommend that acute care hospitals...” or similar language...

Chair—requested restatement of the motion prior to more discussion.

**Restatement of Motion (Eck)**

**1. By September 1, 2008 (for the 2008-09 *Influenza* Season) CDPH should communicate [by whatever mechanism CDPH chooses] the recommendation to acute care hospitals that—**

**A. Each acute care hospital should have a written process to establish targets to increase immunization rates over the 2007-08 baseline rates for health care personnel, including but not limited to: physicians; nurses; those in training for healthcare professions; and other workers in the acute care setting.**

**Initial and ongoing/subsequent targets for increasing vaccination should focus on patient care areas/services providing care to patients who are at increased risk for *Influenza* or complications from *Influenza*, including but not limited to: EDs, ICUs, Cardiology Units, Oncology Units, and Pediatric Units.**

**B. Acute care hospitals should also establish a process that assures contract agencies to provide evidence of or documentation of flu vaccination and/or verification of declination for all contracted health care personnel.**

**2. For the 2009-10 *Influenza* Season—**

**Acute care hospitals should focus the increased vaccination rates to include all healthcare personnel and support staff working in the acute care hospitals.**

**3. By September 1, 2009—**

**CDPH should design [and enforce/ask for data specific to the targeted areas] a method for public reporting of immunization rates for all healthcare personnel.**

**Second—Moss**

**Discussion**

[There was discussion on specific inclusion of Pediatrics as a category. The categories mentioned in the motion are intended as examples, not to be taken as the inclusive list.]

<p>Nichols—Is it correct that the baseline rates are from 2007-08 as reported to state as a result of SB739? (Yes) Will there be language about the declination being done in a particular way?</p> <p>Eck—How the declination should be done has already been approved in a previous motion.</p> <p>Nichols—Seems that the recommendation...we're already required to do a risk assessment in every facility as part of infection control as part of Joint Commission requirements. There is no standard way of doing that. It seems that the recommendation suggests things that are already required.</p> <p>Eck—The distinction is that we're saying "improve and continue to improve your vaccination rates". We're saying the hospitals need to have a plan and a process to do this.</p> <p>Fox—The level of specificity doesn't yet exist in the hospitals from the Joint Commission requirements; that is why we're asking CDPH to consider these recommendations.</p> <p>Morris—How will we know the individual baseline?</p> <p>Eck—Hospitals need a process for 2007-08. The hospital may have to go back and determine who received the vaccine.</p> <p>Chair—There is a motion on the table.</p> <p><b>All in favor: 18</b>  <b>All opposed: 2</b>  <b>Abstentions: 4</b>  <b>Motion passed.</b></p>	
<p><b>Action Items and Next Meeting</b></p> <p>Chair –Action items are:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Licensing and Certification will check addresses for AFL letter validation.</b></li> <li><input type="checkbox"/> <b>CDPH will look at how the AFL is addressed and modify the next AFL letter based on Committee recommendations.</b></li> <li><input type="checkbox"/> <b>Kim, Sue &amp; Jon R will write a letter to NHSN to ask if California can have input in production of future reporting modules.</b></li> <li><input type="checkbox"/> <b>NHSN/MDRO Subcommittee was formed with L. Labar as facilitator.</b></li> <li><input type="checkbox"/> <b>Public Reporting Subcommittee was formed with C. Moss as facilitator.</b></li> <li><input type="checkbox"/> <b>Evidence-based research around public reporting will be provided for Public Reporting Subcommittee by Rosenberg.</b></li> <li><input type="checkbox"/> <b>Thank You letter to Cindy Gaston for public story.</b></li> </ul> <p><b>Tabled</b></p>	<p><b>Action Items are listed in bold font under the "Action Items and Next Meeting" section on the left side of this table row.</b></p>

- SSI Subcommittee formation**
- VAP Subcommittee formation**
- Public Education Subcommittee formation (separate from Public Reporting)**
- Membership criteria**

Meeting adjourned at 3:00 p.m.

**Acronyms**

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

Respectfully submitted,

Third Sector Strategies