

Healthcare-Associated Infections Advisory Committee
September 18, 2008, 10:00 a.m. to 3:00 p.m.
Location: California Department of Public Health, Sacramento

DRAFT MINUTES

Attendance

Members/Alternates:

Kim Delahanty (Chair), Ray Chinn, Letitia Creighton, Annemarie Flood, Jennifer Hoke, Shelly Morris, Frank Myers, Terry Nelson, Shannon Oriola, Anvarali Velji, Julia Slininger, Dawn Terashita, Francesca Torriani, Pat Wardell, David Witt

Guests:

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

Agenda Items/Discussion	Action/Follow-up
<p>BSI Reporting Terashita</p> <p><u>Reporting Requirements</u></p> <ol style="list-style-type: none"> On January 1, 2009, all California licensed acute care hospitals shall begin collecting data on all central line associated (CLA) BSIs in patients residing in an intensive care unit (ICU). By April 30, 2009, data for the first quarter (January 1 to March 31) will be entered into the National Healthcare Safety Network (NHSN) BSI Module. Reports thereafter shall continue to be entered on a quarterly basis or more frequently. Reports for the quarter must be entered no later than one month after the end of the quarter. <p>S Chen – When using NHSN, facilities have to enter all the data for that month by the 30th of the following month (so data has to be entered within 30 days for the month being reported.) It prevents hospitals from cherry picking their data. The only exception is for 2008 because most hospitals are enrolling this year; they can enter data all the way back to January 2008.</p> <p>S Oriola – NHSN aggregates this report once a year. I think it's reasonable if you end up getting it at the first month at the end of the quarter. Ideally it would be entered within 30 days of the end of the reporting month.</p> <p>D Terashita – in #2: "Reports thereafter shall continue to be entered on a quarterly basis or more frequently." Some hospitals may want to enter every day.</p> <p>S Chen – When you enroll in NHSN you agree to participate by their rules. I don't want to advertise not following their rules.</p> <p>S Oriola – What would an L&C surveyor do if when they survey our facility, the data was entered in April rather than February?</p> <p>F Myers – I agree I wouldn't want to advertise willful violation of NHSN</p>	

rules. But there are no NHSN police.

S Chen – NHSN goes through every January 30 and they check to make sure that all enrolled hospitals have at least six months of reported data. It would be up to CDPH to discover if data was entered in a timely manner, and no we do not and will not have time to do that monthly.

L Creighton – From a survey perspective, it would be difficult for a surveyor to determine whether or not the data was entered on time.

F Torriani – in #1 it says, “shall begin collecting data on all central line associated (CLA) BSIs in patients residing in an intensive care unit (ICU).” Is that one or all intensive care units? Also do we mean adult and pediatric?

S Oriola – In any ICU. We can put “any” intensive care unit.

D Rogers – So the patient has to be in an ICU when the infection is identified? What if they were in the ICU 2 days ago and now they’re on the floor...

R Chinn – NHSN has definitions...

D Terashita – A lot of these questions are answered by NHSN. It’s pretty spelled out in the NHSN module.

Chair – The intent is you follow the NHSN definitions for surveillance and reporting for central line associated bloodstream infections in all ICU’s in the state of California and stratifying them according to their individual populations as required by NHSN.

D Rogers – Does NHSN identify community-acquired versus healthcare-associated?

Chair – Yes.

D Terashita

3. Definitions for CLA-BSI will be based on Centers for Disease Control and Prevention (CDC) and NHSN guidelines, [*CDC/NHSN surveillance definition of health care-associated infection and criteria for specific types of infection in the acute care setting*. AJIC 2008; 36(5): 309-332] To calculate rates, the denominator will be device days.

A Flood – We wanted to make it clear that we use “device days.”

S Oriola – NHSN does not use true “device days.” What they do is put patients at risk for having a device-associated infection – so if you have 1 or 3 lines it’s just counted once. So it’s not really device days, but it’s patients in the ICU with a line or lines.

R Chinn – It’s called device days by NHSN. I think the reason Dawn put it in here, is that someone (me) raised the issue of using patient days because all the other metrics for MDRO use patient days. This issue

came up because at some point in the future, we'll be asking for all central line associated bloodstream infections, not only in the ICUs. A lot of hospitals don't have device days for anything other than the ICU. We wanted to make sure we used the same denominator for the ICU as for the non ICU.

S Oriola – We're going to have to do a lot of education on what device day means.

Chair – We should just put in "definitions according to NHSN for the collecting of device days. Numerators and denominators will be according to NHSN central line associated bloodstream infection module."

D Terashita – about housewide reporting...

4. The impact of reporting CLA-BSI data from outside of the ICU is unknown. Hospital-wide BSI data collection and risk assessment is a Joint Commission National Patient Safety Goal (07.04.01) by 2010 and a requirement of the proposed Senate Bill (SB) 1058. Subcommittee members acknowledge potential benefits of phasing in house-wide surveillance and will discuss at further Subcommittee meetings.

We thought we wouldn't tackle this at this point since we already have a requirement. We'll do a phase-in. Our first requirement will be ICU concentrated and then we'll reconvene to hash out the details for housewide data collection.

D Terashita
Public Reporting Requirements

1. CLA-BSI rates per hospital will be made publicly available. Public reporting will depend on the resources and readiness of the CDPH public reporting website.
2. The Subcommittee recommends that the data be stratified in the same manner as CDC/NHSN. Hospitals will be required to enter neonatal ICU birth weight data so data can be stratified by birth weight. The Subcommittee will consider further stratification beyond NHSN.

L Winston – Presumably you're putting in your birthweight data for the ICU on the infections you're reporting. But unless you have it for the denominator...are you suggesting that it's going to go in for everybody?

Member – Yes.

S Chen – Last time we had this discussion with CLIP, they said that capturing the denominator for NICUs was still a work in progress. Is it still a work in progress?

S Oriola – I think if it's a mandate the facility will find a way to do it. Now that it's a focus and an outcome measure and that we're going to

be reporting, then the hospital is going to have to figure out how to collect the birthweight data.

S Chen – Remember when L Labar said that they were still trying to figure out how to get this data and whether or not it was the most appropriate data etc? It was something that really wasn't firmed up as a recommendation.

S Oriola – I remember that we excluded them from outcome reporting, but if you do a phase-in like Dawn is suggesting, maybe 2010, then they have all of 2009 to figure out how to collect the denominator and then in 2010 you can report by birthweight category.

S Chen – But this reporting would start in 3 months essentially. If everything is to be posted by January 1, 2011 you need to give us 6 months to work on this. It took New York state about that amount of time to write their report. CDPH would need time to write the report. A reasonable amount of data is then needed before public reporting is initiated. If you back that timeline up a year, that's where I get July 1, 2009 for the beginning of much of the reporting.

S Oriola – Maybe for #2 you say that hospitals will find a process so that they can stratify by birthweight.

S Chen - There should be some system of being able to get the birthweight data and I didn't think that the process was worked out.

R Chinn –But we've been doing it for years.

S Oriola - The point of the subcommittee was that the facility had to figure out a way to stratify by birthweight so that data can be compared among all NICUs across the state. It's probably what the consumers would want. Since we have very limited children's data, this is a very big piece.

S Chen – I have a recommendation for a person who the subcommittee can consult with on this topic, Greg Pullen from central California. He is not a neonatologist but he is extremely knowledgeable on neonatology issues.

A Flood – There is the CA Children's Healthcare Collaborative that has been reporting NICU data.

E Eck – At one of our meetings we said that we should be following what they're doing.

A Flood – and I think they stratify by birthweight.

R Chinn – Is it voluntary?

A Flood – It's voluntary for right now, but it's pretty ubiquitous.

Member – It's all of the Children's Hospitals and all of the big pediatric...

E Eck – All the Kaiser hospitals participate in the Vermont Oxford.

Member – I don't know how they compare.

Chair – UCSD used to be Vermont Oxford but they just transferred into this collaborative this year. They're different but they do stratify by birthweight.

F Torriani – I don't know why we're complicating our lives. I defer to these groups for us to feed into their methodology for what they're reporting. We should consult with them before we make any decisions. We definitely have an obligation to the kids.

S Oriola – There's VON, NHSN and the CA Collaborative.

A Flood – They compare themselves within the group if you're part of the collaborative. But that's a big chunk of the neonatal population in California.

Chair – Why don't we make the recommendation to contact the VON (Vermont Oxford) and the CA Collaborative (not sure of the exact name) and bring them into the subcommittee as an expert consultant.

Amy could you assist Dawn in getting contacts to those groups?

Amy – Yes.

D Terashita

3. Since most hospitals experience small numbers of CLA-BSIs, the Subcommittee recommends that data be aggregated quarterly per hospital.

We recommended that the data be aggregated quarterly. In other words we report publicly, quarterly data.

S Chen – NHSN has a policy that data is not aggregated until the denominator reaches a certain level.

R Chinn – So for hospitals that don't reach the requirement, it should be left blank?

S Chen – Correct.

A Flood – The rationale behind a fairly vigorous turnaround was that the consumer would have an interest in that; we were looking at it from the point of view of what the consumer would be interested in.

L Winston – We actually talked about what Carole would say if we were going to be doing it nine months out, about her concerns about not getting that data out.

F Myers – How does CDPH envision releasing this data. I'm currently

sending in data for 4 ICUs; 1 med, 1 surg, 1med/surg, one of them being at a teaching institution, one does not have a teaching program. Does that mean my hospital now has 4 rates?

A Flood – Yes this would be the way to risk stratify; comparisons will be made apples to apples.

D Witt – My concern is that the majority of our hospitals are small and their denominators will be low. If we do it quarterly...our colleagues don't understand statistical significance, let alone the public. The reporting group needs to grasp how to make this remotely significant to the public.

D Terashita – We didn't know how much to leave this up to the public reporting subcommittee; it did seem to blur lines a little bit.

S Chen – I wanted to make a comment about quality of data. South Carolina was mandated by their legislature to post all of their data and it was unintelligible, difficult to interpret data. They spent the next X number of months trying to explain this to the public. We don't need to make that mistake.

Chair – That's why we have that subcommittee.

S Chen – If the subcommittee makes a recommendation that ends up with bad data online, we should probably pull executive privilege...

Member – Don't we always have to all agree anyways? If a recommendation was made that didn't make sense to the rest of you, it wouldn't get passed.

R Chinn – I don't feel comfortable with quarterly rates.

S Chen – I want to post a year out for the first time we post data.

D Terashita – That's actually the next bullet.

D Rogers – In the CHART process, its quarterly reporting with a year's worth of rolling data. If there are fewer than 25 cases in a quarter, then it's not statistically significant and it shows up as too few cases to report.

E Eck – The concern would be for a smaller hospital that's not going to have as many line days, but they could have every single one of those lines infected. Therefore the public in that community would never know that because of the current structure of how this could be reported. We need to drill down and think this through because not only could it be misleading but it could be detrimental because it could withhold information that should have a light shined on it.

We need to compare apples to apples and I get that. It's going to be the little 4 bed ICU that's hasn't implemented the IHI bundle. We just bought a small 100 bed hospital with a small ICU – they've never heard

of IHIs.

How do we get to the intent of this which is to empower the public to be informed about what's going on in the state and it helps us make better decisions in terms of recommendations for interventions.

A Velji – Since our original charge was to look at infection across all hospitals in California. We had our problems when we said that you can't compare trauma hospitals with Kaiser who doesn't do any trauma or burns etc. By the same token, we said we can't compare the little community hospital in a small town with the other hospitals. What we've addressed so far is the bigger picture. We need to hone down, specifically how do we judge infection rates in a smaller hospital; how do we improve the quality of data that's coming out of there and how do we make improvements to the quality issue?

P Wardell – We're really going need the help of a statistician. Any data you report is only as good as the person who's helping to make others understand what it is.

D Terashita

4. Once the public reporting website is functional, the Subcommittee recommends that data will be available to the public three months after the collection interval ends. For example, Quarter 1 data (January 1 to March 31) will be posted on the website by July 1; Quarter 2 (April 1 to June 30) data will be available by October 1, etc.
5. Consensus was not reached on how much data to collect prior to posting on the website. For example, should CDPH publicly report after 1 quarter of data versus waiting for 2 or more quarters of data in order to establish a trend?

Chair – Subcommittee will reconvene with invited experts and have an update for the next meeting.

L Creighton – Regarding #4, in 739 isn't there a stipulation that once CDPH receives the data it must be made public within 6 months?

S Chen – That's referring to the process measures.