

**Healthcare-Associated Infections Advisory Committee
 May 29, 2008, 10:00 a.m. to 3:00 p.m.
 Location: Sharp Mary Birch Hospital, San Diego**

Attendance

Members/Alternates: Jonathon Teague, Mary Tran, Marian McDonald, Jon Rosenberg, Donna Fox, Chuck Derby, Shelly Morris, April Alexander, David Witt, Pat Wardell, Dawn Terashita, Francesca Torriani, Jennifer Hoke, Carole Moss, Dan Gross, Frank Myers, Shannon Oriola, Annemarie Flood, Mary Mendelson, Kim Delahanty, Lilly Guardia-LaBar

Guests: Laurene Mascola, Ida (?), Michelle Zolinski, Peter Kim, Jun Kuo, Andrew and Jeri Bailey, Chris Cahill

Staff: Sam Alongi, Sue Chen, Roberto Garces

Agenda Items/Discussion	Action/Follow-up
<p>Call to Order and Introductions Committee Chair Kim Delahanty convened meeting at 10:00 a.m. Introductions made at Sacramento and on teleconference lines.</p>	
<p>Approval of Minutes The Chair called for approval of the May 2008 meeting minutes.</p> <p>P Wardell – Motion to approve S Oriola – Second All ayes Motion Passed</p>	<p>Staff to make minor revisions to May minutes based on member notes and comments.</p>
<p>Public Story</p> <p>Andrew Bailey Is a 69 year old triathlete who suffered a severe crushing injury to his right lower leg, including multiple fractures and loss of muscle tissue prior to Christmas 2006. Because he was an athlete, steps were taken to save his foot. He developed a post operative MRSA wound infection which he was told by hospital staff not to be concerned about. Andy was released from the hospital after seven weeks of antibiotic therapy. Every time he came off antibiotics, his wound would re-show signs of infection. In July 2007, a cat scan revealed non-healing of the fracture and a continuing infection, which progressed to the stabilization rod that had been inserted, necessitating removal of all hardware from the leg. Even after all this, the infection reoccurred in December 2007. Two months later, in February 2008, Andy's right lower leg and foot were amputated. He is now able to stand and walk with his prosthetic device but no cane for the first time in a year and a half. In his words, "I feel that I should have been told by the staff at the hospital that there was an outbreak of MRSA, and I feel that the MRSA prolonged my hospital stay. I was supposed to be in there for three weeks, I ended up being there seven weeks. All the treatment I've undergone since then, including the amputation, and all the medical expenses I've had because of this horrible infection. I've been in pain, suffering, fear, anxiety, discomfort, and a change of my lifestyle, since being diagnosed with MRSA."</p>	<p>Thank you letter to Andrew Bailey</p>

Committee Updates

Progress on Program Implementation – S Chen

Mandated reporting of the CLIP process module is set to begin on July 1. As of May 27, there are now 235/435 (54%, up from 38%) CA hospitals registered into NHSN. There has been a big push get names of facility administrators. Compliance is 391 (90%, up from 69%). For SCIP forms, compliance is 310, (71%, up from 64%). Significant progress has been made on this issue. All involved were thanked for their assistance, especially LA County of LA. As I travel around the state I see people getting closer and closer to being ready to report. I believe there will be significant compliance come July 1. Per informal count, 75 hospitals have joined the CDPH group (1/3 of the CA NHSN hospitals). A second round of talks to interested APIC chapters or groups is underway to discuss AFL 08-10 and upcoming influenza vaccination/ declination requirements. Three talks have been given, with three more scheduled.

Second, a letter was sent to Dr. Pollock of CDC asking for more input at a more preliminary stage on content of the modules. Our committee has been finding is that the modules are so work intensive as to not be practical for the hospitals to use. They may have excellent information but the workload is just too much. The letter in April and a response received in May. Dr. Pollock essentially said 'we understand your concerns about workload, we're grateful for your interest, we recognize that wider experience with use of the forms should inform decisions about any changes.' The CDC would like to see any of the modules that they currently have released used for a year before changes are considered. Dr. Pollock stated they do want to work closely with California and that he'd be pleased to discuss with us ways to further develop their working relationship with states to meet the rapidly increasing number of NHSN users of which we are now about 15%. We were invited to have a conference call with the CDC to see if how CA could have more specific input. Right now there's no point in doing that unless there's a new module that comes under development because the pending modules are set for at least the next year.

Chair – Any comments or discussion around that issue?

M Mendelson – I was on a phone call with APIC regarding staffing. There were some people on the call from PA who are now mandated to use NHSN, and they were commenting on the increased number of staff they're having to hire to accommodate the workload. So we should anticipate that with the work required to keep up with NHSN and we should communicate that out to hospitals, hopefully with the help of CHA, to administrators to give them a heads up.

R Chinn - PA is different than what we're doing because they require everything to be reported while we have the latitude to pick and chose what components of NHSN will best meet our needs. I think that we should temper the statement with that in mind.

F Myers - I'm a little disappointed with the CDC's response of "use it for

a year and find out if you still have the problem." I think anyone who would report a problem in healthcare and say to somebody, "Well, wait a year and then see if we still have the problem," would be admonished appropriately for that approach. So I'm a little disappointed that the CDC has basically said, "Well, see if you still have a problem in a year with it." That's a terrible suggestion for us.

S Chen - The response also needs to be looked at in terms of how long it takes the CDC to get something approved. I believe that they will accept input once a period of time has gone in. One of the objectives of the letter was to get us in before it went for OMB approval, and I don't feel that I got a totally satisfactory answer to that. I emailed Dr. Pollock a very pointed question back and I have not gotten a response. That aside, as we hear about new things in the pipeline (I understand there might be a couple of new things in the pipeline), we will try to position CA to provide input before the module goes to the OMB for approval. Of course, our other option is the one that the Committee has been using, and that is to not use the whole module, which is to the detriment of the CDC when they don't get our data because we're such a large population center.

L LaBar - We're getting ready for July 1 inputting to the CLIP form and there is no NHSN module, so we're going to go ahead and keep it in our drawers, and when the module is ready we'll input it. I think that that is highly irregular, and frankly, I'm disappointed.

F Torriani – I think that the answer of CA should be to only input what this committee has decided is reasonable, and then when 15% (50?) of the whole CDC or more basically inputs, that will derive changes. We have no other way of changing the system. We either all go with twenty questions or we put in what we think is really reasonable for a whole country as an example of meaningful data that will be robust. The other data is really extemporaneous and is really for research purposes. So I think that should be our answer.

M Mendelson – The problem for us is that if we don't do the complete module as written, we don't get credit, and if we don't get credit, we get kicked out of NHSN. So it does put those of who are inputting data in a bind.

F Torriani – But you do have the solution, and that doesn't mean that it's not a meaningful solution. You have the option to, which is basically to answer the five questions, and then to give six months of BSI data in the unit. That is a reasonable way of getting around that. And that also gives CA meaningful data. If we do option two, it really means that we're inputting two things, which in the end, we will get to, we all are interested in.

R Chinn – That was my point, actually, because I think institutions that have ICUs should be reporting BSI line related rates. I think that's a very easy way to stay in NHSN and yet allow us to do what we want to do.

Issues on Committee Membership – S Chen

Issues on the committee membership were raised a few meetings ago as there are some members who do not attend, and we would like their expertise and input into the committee. Kim and I got together, listed committee conduct issues, and then tried to sort them out into basic categories. That aside, specific guidance should come from the group. One of the issues is attendance. [Handout "Proposed Guidelines for HAI AC Participation" pointed out.] No more than two excused versus unexcused absences in a six-month time frame? What an unexcused absence? One of the things I said was non-notification of the program coordinator constitutes an unexcused absence, so we do have people that fall into that group. Per Bagley-Keen requirements, official attendance for voting purposes has to be from a posted teleconference site and if someone attends from a non-site, I would think that would be considered attending, but they just don't have a formal vote under that scenario.

M Mendleson – If someone has unexcused absences, I see if you have two excused, you're excluded, but if you have an unexcused, what happens?

S Chen – It actually is a question. Should it be two excused or unexcused?

A Flood – We all have jobs, I think if you have an excused absence, sometimes you might have a busy period of time, you might have surveys, you might have DHS walk up on your step, you might have any number of things, where you could have more than two legitimately excused absences in a two month period. If we have more frequent meetings, I think that missing two meetings as an excused absence may occur. I think it's the unexcused absences, I think that if you have more than two unexcused absences, that is not appropriate attendance. But I think that excused absences, especially because many of these people participate on subcommittees and bring value to the committee, and even though they can't physically be present is something to be considered.

Chair – I would counter that statement with the fact that because there is such viable information from that person, by not being there more than two times, is really going to stop possible forward motion.

S Chen – I want to counter that also. Everyone may have one alternate. Hopefully if they cannot attend, the alternate will be able to.

M McDonald – My issue is a question. Does the document as it exists now define excused and unexcused absences?

S Chen – The only thing I said was non-notification of the program coordinator constitutes an unexcused absence.

M McDonald – I just think that at some point we need to hash out language that people can agree on, because sooner or later, this will become contentious.

S Chen – We will never fit this discussion into the timeframe allotted. We could have a group work on this and then come back to the committee now that we have a framework.

F Myers – I would just like to add, with kind of a nebulously defined excused and unexcused, given the nature of many people’s jobs here, where one might find themselves, again, as I actually had happen at one of the meetings, I had the ticket, I was planning on being on the plane, and got a phone call from my facility, and had to go back to my facility. I know with a couple of the infectious diseases physicians, there can be a situation where somebody who is on call called out sick that day, they have to cover. We can be in a situation where there is very quick turnaround. It’s part of the nature of the beast. Obviously, you’re not going to see a ton of those, but I’m a little hesitant to say that there’s any defined number. I think we need to be real clear on what excused or unexcused is, and I’m not sure given the nature of the job, there are a whole lot of differences between the two.

Chair – I suggest we put together a small working group to work on this and come back with all of these details that have already been brought up and come back to the next committee meeting. I can’t make a motion, just as a reminder.

P Wardell - Motion for working group

M McDonald – Second

All ayes, motion passed

S Chen – Just to finish, numbers 2, 3, and 4 are guidelines for group representation, requirement for active participation, and a requirement to practice professional courtesy. More difficult issues are 1) Should there be term limits on participation? 2) How should changes in job status or location be handled? 3) In terms of general representation, should the state be voting members? 4) What constitutes an excused absence? This is only a start for the committee to work on.

Revisit CLIP Module Requirements – S Chen

The question was raised “Was the interpretation by CDPH of the committee recommendation for the implementation of CLIP overly prescriptive?” What I’ve done in this handout is to try to clarify the CLIP operationalization debate. The first paragraph contains a cut and paste of the CLIP recommendation to the state; there were no changes in words, and numbers and color were added. The second section contains a cut and paste of the parallel section from the AFL which is now a legal requirement, and again I put in numbers. The areas that are colored and numbers correspond to the only differences in language between the two versions. The first place language was changed was under issues in the table. CLIP Subcommittee recommendations were put in red, what was included in the AFL was colored black so that you can clearly see any differences in language between the recommendation and what actually went out in the AFL. The first one was that “hospitals are required to develop a process to complete a daily assessment.” This was changed that to “develop and implement a process,” because I don’t want facilities to just develop a process, it

should also be implemented. Is there an issue with that particular change in wording? The second one was "to have a mechanism to demonstrate the process." I changed it to "be able to present results." My question is if you're going to say, "have a mechanism to demonstrate the process," what is a surveyor supposed to look for when they come in to see if the facility is being compliant?

F Torriani - So this is a departure. If you say, "be able to present results," that implies to me that we are tracking the process of daily line utility. And that implies a whole other thing, while "be able to demonstrate the process" was what we were really trying to get to, which is, "Okay guys, here we're doing the review of your facility, show me how you address the daily line necessity." One is really, "show me how you have implemented this," and really...

S Chen - But what are they going to be looking at when they show you how it's implemented?

F Torriani - Any of these questions are the same questions that surveyors look at. Do you have, in your facility, something in place that – can people talk to this?

S Chen - It's not can people talk to it, if it's not documented somewhere, it's not done. Am I correct?

F Torriani - Right, but the question is, between something that is, "Show me all of your results in the past six weeks of how many times this was not done" which implies a whole other issue.

S Chen - Would you like to know how I teach it?

F Torriani - This is what we read. "Be able to present results" means, how have you checked the compliance with this measure? It's not, "Hospital, show me what is the process and whether you have it in your charts" which is really what we are trying to achieve.

D Witt - I would really agree with Francesca. I think I would expect you to come into my unit and see where we documented it, and not correct the documentation.

S Chen - This is how I teach it. It says, "Be able to present results," i.e. if a surveyor walks into your ICU and says, "Where is the documentation of line necessity for Patient X for last Sunday?" they only have to be able to show that single point of documentation. It has nothing to do with tracking it. There's no requirement for any tracking, presenting, anything other than that single data point that the surveyor asks for, but they do have to have something to look at.

Chair - I would like to make a comment about the wording and interpretation. When we write the language, I think that Dr. Torriani and Dr. Witt are saying, they want it to be just clear because of being able to do the right thing, get them what they would like to see, and not making busy work, because some people may interpret that

statement as being able to track and trend and they'll take it to the next level. The clearer we can be oftentimes the better. I think that's kind of where the thought is going.

R Chinn - I agree with that. I think that this follows what we are asked to do for the prevention of ventilator-associated pneumonia, and that is, have someplace in the chart where you document that the head of the bed is 30 degrees, and that you've tried the weaning criteria. I think that as long as we have a process, I think that will be sufficient.

A Flood - I'm in a new world right now as I am now at City of Hope, and we are in an interesting position in that essentially as part of the treatment plan for these patients' cancers, they often get lines placed in an out-patient setting, and carry that line through for weeks, years, months. So, as opposed to the ICU setting, which I think this is more geared to, where you have someone who is acutely ill who requires an intravenous access. It's just interesting, how would we approach that, because we have something that is clearly part of their treatment mechanism for the majority of the patients, and how do you address that in an easy fashion that's clear to the inspector coming onsite.

J Hoke - When we're going out there to teach the evaluators and surveyors, we're going to have them look at the process, and in addition, what are you doing with the results of that process. Perhaps that's where the confusion is coming in. There's a process they're going to look at, and then what are you doing with those results as well.

S Chen - There's no intent for anyone to have to aggregate that data whatsoever. To me, this does not read as, it just says, be able to present results. So maybe if we said, "Be able to present results of individual assessment." I think this is an assumption. We agree that we don't want to cause any extra work, but all I am training ICPs to do is, what I want to see is, if I ask for this particular patient on this particular day, I should be able to find that documentation somewhere, the somewhere not being specified. [That's what it should say.] That's how I teach it.

D Terashita - When we had made this recommendation it wasn't for the results to track and trend. But I had a meeting with all four of our LA County hospitals, and when they read this, they misunderstood it. So it turned into this long discussion that they thought they had to get results of every central line inserted, so since they're so confused, unless we specify.

D Gross - I was wondering if you could do a modification and say, "Hospitals are required to develop and implement a process to ensure daily assessment and documentation of central line necessity etc..." and do away with number two, and you have the clarity, and I think you all had consensus on that's what you were after.

S Chen - I need to be able to see that and think about it, but I don't have a problem. The intent was just to make sure that it gets done, and when a surveyor walks in they should be able to tell, yes, it has

been done for this patient on this day if that's what they want to find out. There's no intent to aggregate that.

M McDonald - Perhaps it would be helpful to specify in whatever written directions, and I think the key word here is written, as opposed to what Sue teaches. Of course, we can all listen and learn, but sooner or later we have to have it in writing, that there is no expectation of aggregate data.

F Myers - We have to be careful whenever we say, "It's taught this way." Unfortunately, many generations ahead of now coming on new won't have that learning process and will oftentimes just be forced to figure it out based on what's in writing, and that's where we get some really interesting interpretations and interesting practice patterns developed that may be sub-optimal for the organizations.

Sacramento - We want it to be very clear that this is not going to be surveyed when the surveyors come around – that there's not going to a rate associated with it.

Chair - Dan has given Sue some modification language, and we'll send it back out for everyone to review.

S Chen - The third piece is, "a licensed caregiver strongly associated with reducing, etc. etc.," and I interpreted that licensed caregiver as "a person with the authority to order insertion or discontinuation of a line." Of course, the reason for this decision is because registered nurses are not allowed to diagnose within their scope of professional practice. Deciding whether a line should stay in or not stay in would be diagnosing, so it is not within the nursing scope of practice. Is there any issue with that particular piece?

F Torriani - Who puts in this information? What we're hearing is that it should be done by a physician. Knowing how physicians are – this isn't going to happen.

D Witt - I think what we're directing this towards is a multidisciplinary decision. I think this will be "check" without thinking – which is not the outcome we want.

M McDonald - A thought for the future...as many hospitals are moving toward the electronic medical record, we might want to start thinking how this would fit into this system. Briefly, in the electronic medical record, if the nurse checks "yes" the patient has a central line, then the software would automatically generate the field for the physician to check "yes/no" the line continues to be needed (with that physician's identifier.)

L LaBar - I would hope that the physician would not need a prompt to know that there's a central line in the patient.

M McDonald - They might not need a prompt but they might need a reminder to chart the continued necessity of the central line.

<p>L LaBar - That's different. The intent is that the physician assesses the lines on a daily basis.</p> <p>S Morris - How does the IHI handle it?</p> <p>P Wardell - That question is not asked.</p> <p>R Chinn - It's left up to the institution. I think it will end up being a check box. At least in the ICU, the nurses are on the critical care physician to ask "do you still need the line?" Outside the ICU, I think that's where the problem would be. Maybe we could start this endeavor in the ICU, because we know the highest risk patients are in the ICU. If you want to go further, a list could be developed like "if the patient does not have hyperalimentation; lack of venous access; need for central line monitoring..." then you could ask for the line to be taken out. Just have a set of parameters so that you don't have to ask the physician because if they're on hyperal, if they need central line monitoring doing cardio outputs all the time – that's a given that the line will be left in.</p> <p>S Chen - It's not an independent nursing decision. We agreed on that already. What you're saying is that it can be a facility-specific procedure on who actually checks the box and I don't have a problem.</p>	<p>Edit CLIP document and send it back out to the HAI-AC.</p>
<p>Influenza Subcommittee Recommendations</p> <p>R Chinn reviews Influenza Recommendations (handouts)</p> <p>F Torriani Motion to accept attachments B1, B2 and D Witt second No discussion No opposition Motion passes</p> <p>R Chinn reviews recommendation B.2.</p> <p>L Mascola - Mismatches occur occasionally - add "occasionally" on B2 E. For item B2 F after FLUMIST "intranasal flu vaccine may be an option for certain individuals"</p> <p>R Chinn - "May be" is good.</p> <p>F Myers - My interpretation is that there will be some expectation that the organization supply Flumist to healthcare workers who do meet the criteria. That currently is not the practice by many acute care facilities. I think it may help with rates. This group has to recognize that by mentioning it as an option is to make the expectation that organizations provide it to some individuals. Obviously, we may not be able to accurately predict the number of individuals who will take it, but the organization should have some available.</p> <p>R Chinn - I think using "may be" would address that.</p>	

L LaBar - At Children's we have FluMist. When we brought it in a few years back it increased the compliance rate. People are afraid of needles. I think we should footnote that it may increase compliance rates.

F Myers - I'm comfortable being more prescriptive because there is data out there that shows it will increase vaccination rates. There's data out there that in years of mismatch that Flumist is a better vaccine. I also understand that the institution may run out because it can't predict successfully the first year, and doesn't want to get caught with holding a ton of extra vaccine.

R Chinn - Obviously this influenza program is going to be dynamic and every year we're going to be reassessing it. When rates come in and they're suboptimal, then we can go further and make it a little bit more prescriptive. Right now, I think what we'd like to do is enhance the injectible form and then see what the data shows.

T Nelson - For smaller facilities, to require keeping a range of vaccines available, might be a little bit of a challenge.

P Wardell - If you wanted to get an idea of how much (Flumist) is needed for the next year, in the declination you can add under the reasons for declination, "afraid of needles."

R Chinn - For my institution, we targeted those who were afraid of needles and we still didn't get the vaccination rates we expected.

M Zolinski - We worked with 15 hospitals one of which was Children's Hospital; we worked with UCSD, Scripps, Mercy, and all of the Sharps. The first year we did this in the 05/06 influenza season we had asked about Flumist in the survey - "if you're afraid of needles would you be willing to take Flumist?" We also gave out that year around 100 doses to those hospitals who wanted it. The usage and uptake was really poor that year but that was also the time we weren't ready to promote it and hospitals were a little leery of using it. The following year we did an entire promotional campaign but in general, there was still a lot of apprehension in introducing Flumist. For the population who had apprehension of needles and met the criteria, we provided them with an easy alternative (Flumist), but they still did not take it. It's an expensive vaccine - that the reason I get from the employee health people that I work with. It really needs a champion; it really needs a push and you need to have a population behind it. Some hospitals have had that momentum (Children's) but it takes a couple of years to build it.

S Oriola - There are barriers too - it needs to be refrigerated.

M McDonald - We're looking at a slope and gradual improvement over years. The work that we're doing now will lead to a better performance next year and improved performance the year after that. We need to take a multiple year perspective.

T Nelson - We need to keep our perspective on what we put in there. In my mind, a lot of this will take place at the local facility's discretion. To make it prescriptive in the declination or even in the document statement gets to be a little laborious for this group. For those out there waiting to get this document in their hands, have something that's a balance between simple to understand and have enough prescriptive elements so they know what to do.

R Chinn - The most important statement is the impact of not vaccinating on colleagues and patients. All these other complements (education) are really left up to the facility. These are just examples. We were asked to provide examples of statements that *could* be included in the educational package. The committee here really wanted that statement about potential harm to patients and colleagues in the consent form.

R Chinn - Reviews recommendation B5, c – definition of healthcare personnel from the National Foundation of Infectious Disease.

S Oriola - Do we know what the NHSN module definition will be?

R Chinn - This is the most comprehensive definition that I've found.

R Chinn - For recommendations 5a OR b – these allow you, if you want to generate a rate for all healthcare personnel or targeted a specific group, you can do that.

S Oriola - Motion to accept the final recommendations as discussed

L LaBar seconds

No Opposition

Motion Passes

S Chen - An All Facilities Letter will be sent to hospitals to get started on this process as outlined in recommendations 5a and b.

BREAK FOR LUNCH

S Chen will send out communication before AFL regarding the flu recommendations

Subcommittee Updates

MDRO Subcommittee Update – L LaBar

Since our last HAI-AC, the MDRO subcommittee met twice. At the first conference call, Dr. Rosenberg was concerned of the ability of the state to enforce the reporting of rates – that the requirement is the reporting of cases. At the second conference call, according to Dr. Chinn's reading of SB 739, we can make the reporting of rates and/or incident numbers mandatory. Going on that premise, we revised our recommendations. We have included reporting requirements to be: type of hospital; number of hospital beds; current number of ICPs; reporting whole number of community onset BSIs; number of hospital onset MRSA BSI's, number of patient days and a rate to be calculated by the state. We added a glossary.

A Flood - Is it just primary BSIs or also secondary?

L LaBar - Primary and secondary (all positive cultures) and separated out into community and hospital associated.

T Nelson - Question to Dr. Rosenberg – beyond reporting infections could you address our ability in requiring the other elements outlined in the recommendations (e.g. # of ICP's)?

J Rosenberg - When we require a condition to be reported, we specify the information that we require in that report. I don't think we explicitly have the authority, but if we have the authority to make anything reportable, then we can say as part of this requirement we need x, y and z pieces of information. We don't have specific authority to compel hospitals to report # of ICP's, but If we can justify it as part of our interpretation of rate reporting and/or require rate reporting, I think we could do it. I think we do need to ask if we can require rate reporting, and I've put a request in with our legal department. I'll get back to the committee as soon as we hear an answer.

R Chinn - If you read SB 739, it does say that our committee is required to make recommendations related to the methods of reporting cases of hospital acquired infections in general acute care hospitals. It goes on to say under section C: that the committee will make recommendations in phasing in the implementation and public reporting of additional process measures and outcome measures by January 1, 2008. You're saying, Jon, that CDPH has the final say in what we recommend? Even though it's our charge to say that it's consensus among the group that as part of an outcome measure we'd like to see MRSA bacteremia rates (numerator/patient days x 1000). How is that different from agreeing to use NHSN, where you actually do generate BSI line-associated rate?

J Rosenberg - I thought the subcommittee recommended rate reporting, not case reporting.

L LaBar - We're reporting numerator and denominator; CDPH is calculating the rate.

J Rosenberg - We make hospital patients with MRSA BSI's reportable then we tell hospitals how to implement that. We can add MRSA BSI in hospitalized patients to the list of reportable conditions and then we tell hospitals how to comply with it. I think they'll be happy to give numbers and not have to report each case. I think that's the solution and we may not need to get a formal legal consultation on that, but we might. We need to file a memo with office of administrative law and then they have to accept that memo before it actually becomes reportable. It takes about two months instead of a year.

F Torriani - Reporting requirements: type of hospital, # of hospital beds, # of ICPs...I'm not sure that helps in the information about MRSA BSI's in categorizing. It simply says this is the amount of work. The point I want to make is the sentence, "CA acute care hospitals shall classify each reportable MRSA bloodstream infection, including primary and secondary BSI, into one of the following categories." Why are we saying "each reportable", when we're really saying report MRSA bloodstream infections? "Each reportable" goes down the path of case reporting. We want to report unique events – so we should put that language in. We should consider the language (or some similar), "CA acute care hospitals shall report all unique or incident MRSA bloodstream infections, including primary and secondary, into one of two exclusive categories: community onset and hospital onset."

M Mendelson - I recommend quarterly reporting, because it's very easy to get behind.

L LaBar - Hospitals are already doing it monthly.

M Mendelson - The three month timeframe allows us some wiggle room. It's a more realistic deliverable with all the things that we have to do.

Chair - Quarterly gives us a bit of lag time. If you're asking for it monthly and the lab information system is not set up that way, it doesn't matter how much you ask. Some hospitals may not be able to report monthly.

C Moss - In a survey taken across the nation, the #1 critical point is that it's very current information. Every three months is not current.

S Chen - How do you define day 1? My thought is that it's the day patient sets foot in hospital. Do we agree with that?

Membership – No. It has to be tied to admission data; we need to be consistent with national definitions so that we have robust data.

S Oriola - Quarterly seems to be a better timeframe. With smaller hospitals their infection control committees may meet quarterly, monthly or even every other month. Three months vs. 1 month is not much of an issue – it's pretty much the same.

M McDonald - We can legislate monthly data, but it doesn't mean that it's going to be possible if the resources are not available. Quarterly is

reasonably timely and a lot more doable.

C Moss - Today they're collecting data monthly; why would we give more time?

Chair - For those doing it monthly and can do it should continue to do so.

S Chen - When we look at data, a month's worth of data doesn't mean anything. We're interested in data over time to look at trends.

C Moss - Can we extend the option that for those who want to can do it monthly?

D Gross – What about using the language “No less frequently than quarterly.”

S Oriola - We're making assumptions that the state can put the information on the website monthly. The hospitals won't be posting directly to the website; it's submitted to CDPH then posted correct?

P Wardell - Our monthly data is miniscule so it makes more sense to report it quarterly.

L LaBar - I like “no less frequently than quarterly.” but because a hospital has it's infection control committee meet quarterly doesn't mean they do their rates quarterly, is that true?

S Oriola - I think it depends on available resources (staffing etc.)

L LaBar - It's hospital's responsibility to have backup if an ICP is going to go on a leave of absence (e.g. 2 week vacation). Even if reporting is monthly, it doesn't mean they're not producing monthly.

C Moss - If you need to take your child to the hospital, I want current information. Wouldn't it be the goal of all of you to have the most current information? Honestly?

A Flood - Statistically, things will be high one month, low the next month but overall there's an average. I realize when an infection happens to you it happens to you 100%.

F Myers - I want the most accurate information. I don't want the most current. With quarterly, the sample size is sufficient at that point you can minimize random variation.

M McDonald - Resources do not exist. We need to temper our desires to the resources that are available both at a state level and at the institution level.

R Chinn - When we discussed reporting with the CDC, we felt even quarterly may be too soon. Actually they recommend a rolling 12 month rate to get a better sense of the institutional performance. We want

current meaningful data that you can interpret. Quarterly is reasonable.

Chair - Just because we're reporting quarterly doesn't mean that we're not doing things day to day for process improvement. Every day performance improvement is occurring.

C Moss - Why can't it be the goal to have it monthly?

D Witt - We are all consumers. I want something I can trust. I think we have to guide the consumer. If you do it month to month it's just background noise.

S Morris - We just started reporting out in this manner. We're a 500 bed hospital and we're seeing very low numbers for hospital acquired BSI's. I would support quarterly.

Chair - We all agree with "no less frequently than quarterly" under frequency?

Membership - Yes

F Torriani - On admission criteria - we should look at what are we reporting? We're reporting numbers of unique events of MRSA bacteremias occurring before day 4 (community onset) and day 4 on hospital onset. Both will be captured using standard definitions so that we will be able to compare to national standards. We know that a good part of the community onset cases will be in fact healthcare associated. There a good argument to use the set definitions.

C Moss - I agree with Sue 100% that it has to be once the foot hits the hospital (that ends up as an admission.)

M McDonald - How do you define "foot in the hospital"?

S Chen - When the person sets foot in a healthcare facility that results in admission.

P Wardell - We really do our data collection from the date of admission. If they're in the ED they get an ED number; if they get admitted they get a whole new number and that's their date of admission. I can electronically make sure that I have consistently accurate data.

C Cahill - How about when the patient is housed in the emergency room for 2, 3, 4 days?

S Chen - How often does that come up? How big a burden will it be? An MRSA bloodstream infection is not an instant thing.

C Cahill - The definition needs to be a little bit tighter. I think there are a lot of emergency rooms these days that hold ICU patients.

Chair - We are capturing the data - what's community onset and what's hospital onset using a standardized timeframe.

D Witt - As far as onset, fortunately day 4 – 5 is rarely when we see hospital onset infection. Defining it the same as everyone else is important.

T Nelson - Some facilities have admission begin when the service sequence begins. How are we going to use this data? That will help make this decision.

R Chinn - Because of the numerous tasks of ICPs – it would be reasonable to use the simplest which would be the date of admission. I think that's when billing begins.

R Chinn - Motion for criteria for admission is day 1 of inpatient admission.

A Flood seconds

Discussion

D Fox - My concern is that if we don't count when the foot hits the door, we may not be as vigilant.

L LaBar - Everyday the ICP gets report of all positive blood cultures hospital-wide. Nothing is going to be missed.

C Moss - When do we talk about having all MRSA BSIs be reported?

Chair - To clarify SB 739 does not address MDRO for reporting. MRSA has been added because it's timely.

Motion on table

All in favor.

No opposition.

Motion Passes

Chair - Now let's talk about number of ICP's as a reporting requirement.

S Chen - First I'd like to ask a question that I've been asked during my teaching: at what point is a person counted twice? Originally, in the recommendation, it after 14 days. The way I've been clarifying this as: somebody's blood clears; it's clear for 14 days; they have another positive blood culture; that would be considered a new event. Everyone OK with that?

L LaBar - That's the MDRO module definition.

R Chinn - I have a little trouble with that. Sometimes people do have endocarditis; they are negative and then they come back positive again. It's the same infection.

A Flood - IHI bundle is a 30 day window, after which it's a new infection.

D Witt - I think Dr. Chinn is right that the majority are probably a

reoccurrence, not an occasional one. This is going to count as a hospital acquired infection although the majority of them might not be. But I would favor not changing definitions from the standard so we can compare apples to apples.

Chair – Back to the discussion about the number of ICPs as a reporting requirement

D Witt - Do we have the ability to report these? If we do, is it ICP resources that we're interested in? Should it be total resources (clerical, administrative, and ICP's)?

J Rosenberg - My concern is that it's an item that's helpful in evaluating the information collected relative to MRSA BSI's but it's not directly an item of BSI's. The committee should decide if it's useful/important enough to have.

C Moss - I had suggested on the subcommittee call, what other information can we put on here to help consumers understand? The top of my list is how many people in the hospital are focused on infection prevention? It's critical that you can't anyone in a hospital to talk to about your husband who just acquired MRSA. It's critical to consumer and I can't imagine anyone in this room thinking any other way.

Chair - The philosophy is that infection control is everyone's responsibility. At our institution, we do not routinely talk to families. The physician and nurses and the team that take care of that patient are the ones who should be speaking to the family and the patient about their treatment, their diagnosis, and what they're doing to mitigate that.

C Moss - None of you talk to families? This is unbelievable.

F Torriani - As the hospital epidemiologist, I do not talk to the patient or the patient's family about a specific infection control issue unless – it's an issue that can affect family, caregivers, etc. I want to educate and mitigate panic. I trust those on the unit to be able to speak.

D Gross - The goal is to do benchmarking. Is there data out there, that tells us (in terms of a benchmark), how many ICP's per bed/patient visits etc. tells us if we're doing a good job or not? Unless we have that data that tells us what the right number is to benchmark if we're doing the right job or not, it becomes meaningless data. If you do go down that path, you might want to think how you might want to report it so that it's meaningful to consumers.

Chair - It sounds like a bigger issue than just a reporting requirement for MDRO. I think we should take it out of the MDRO subcommittee report and make it its own subcommittee.

M Mendelson - Motion that we pull hospital ICP program review into a separate subcommittee to devise some metrics.

P Wardell Seconds

<p>Discussion</p> <p>C Moss - All of you complain that you don't have enough time; you don't have enough people. the only way you're going to get more people is if you bring it to the forefront.</p> <p>F Myers - Having not heard any opposition to this (we can certainly work out the methodology later) but it seems that rather than spend more time talking about how we agree on it, maybe we can just go forward with the recommendation.</p> <p>M McDonald - Carol, no one has opposed reporting numbers. I agree that we do need to report numbers of ICP's.</p> <p>S Oriola - We need meaningful methodology to report ICPs.</p> <p>R Chinn - Original intent of including some of these parameters was to make it more meaningful for comparison among hospitals. I think it's a whole separate issue (# of ICP's) that can be put elsewhere.</p> <p>Chair - Motion on the floor is to remove the current # of ICP's out of the MDRO subcommittee and make it another subcommittee to discuss ICP ratios and it's effectiveness on infection prevention programs.</p> <p>For (11) M McDonald, S Morris, J Teague, D Gross, R Chinn, S Oriola, A Flood, M Mendelson, K Delahanty, A Alexander, D Terashita</p> <p>Oppose (8) C Derby, C Moss, F Torriani, J Hoke, P Wardell, D Witt, L LaBar, F Myers</p> <p>Abstain (1) T Nelson</p> <p>MOTION DOES NOT PASS</p>	<p>L LaBar will modify the MDRO report</p>
<p>Public Reporting Subcommittee Update</p> <p>C Moss reviews public reporting presentation at the last HAI AC meeting.</p> <p>C Moss - I talked to Missouri about cost and resources involved – Missouri has a budget of \$300K for 2 FTE IT staff and 1 writer consultant. Missouri is reporting for hospitals and small clinics and ambulatory (350 sites). We're looking at 435 facilities. They are not using NHSN and so their budget covers the reporting and licensing and certification as well. Once we get a green light, we can spend some time with Missouri on their project deployment.</p> <p>R Chinn - Can you give us a sense of their scope of reporting?</p>	

<p>C Moss - They do not publicly report MRSA. We're not exactly the same, but to give you an idea of what kind of a budget we would need each year to support this it would probably be in the area of \$400,000 to make up for the differences.</p> <p>F Torriani - Does that include the design of the website? There's a one time (upfront) cost for the design; then you have the servers; and then the maintenance.</p> <p>S Chen - I participated on some of the NHSN calls where they (Missouri) were describing that. I'm not quite sure about the \$300,000, as I recall Missouri noted that several part-time staff were working on it, but they spent many more hours than the budget.</p> <p>M Mendelson - Have they done studies on public usage? Have they seen any impact on infection rates as a result of public reporting?</p> <p>C Moss - Re-announced the contest for branding the website.</p> <p>C Moss – My action items to present at our next meeting are: public usage; impact of public reporting on infection rates; actual itemized costs of Missouri's website</p> <p>F Torriani - The MDRO module is not sufficient for the ICP issue. I think it would be relevant in the public reporting subcommittee. We're looking at how we get the information to the public; what is the meaningful information.</p> <p>D Gross - Can't we ask the subcommittee to explore all that is relevant and meaningful to try to achieve the goal of communicating in a meaningful way ICP's, etc. We're all after the same thing – meaningful information to the consumer.</p> <p>F Torriani - Instead of another subcommittee, why not pull it into something what will be presented to the public?</p> <p>C Moss Motion for ICPs to be discussed in the public reporting subcommittee. F Myers second All in favor No opposition</p>	<p>C Moss will work on usage and impact of Missouri website; review of implementation costs</p> <p>S Chen will find out CDPH budget for a public reporting website</p> <p>Public reporting subcommittee will work on ICP metrics et al. and their recommendations to CDPH.</p>
<p>Future Directions</p> <p>Formation of Further Subcommittees</p> <p>S Chen - Per SB739, we need to start addressing surgical site infections (SSI), bloodstream infections (BSI) at some point, ventilator associated pneumonia (VAP) process measures. The recommendation should come down this year, but I'm opposed to any other reporting requirements this year.</p> <p>A Flood - Can members send their wishes for the proposed new</p>	

<p>subcommittee participation to Kim and Sue?</p> <p>S Chen - We have MDRO, public reporting and membership criteria subcommittees still going. Another subcommittee would be public education. It's a matter of how many things you want to start right now. I would like to have recommendations for SSI, BSI and VAP by end of the year.</p> <p>Chair - What we should be focusing on are the membership subcommittee criteria, which should be pretty quick, because we already have an outline and starting point; BSI should be pretty quick because we already have the workings done; and public health education.</p> <p>Discussion of Potential Redundancies in Reporting Requirements</p> <p>J Rosenberg reviewed the formation and work of statewide/regional collaborative initiatives, a public/private coalition and the California Hospital Association; started with the release of the IHI bundle. The Gordon and Betty Moore Foundation and the Blue Shield Foundation funding BEACON initiative for rapid implementation of the IHI bundle with 44 Bay Area hospitals participating. There is also a southern CA initiative that involves around 137 hospitals. Each initiative reports to other organizations but the data reported is not public (although the data could be publicly reported voluntarily). CHA is starting a California Hospitals Patient Safety Organization (CHPSO) that they envision will become the umbrella of all initiatives in CA to reduce HAI's.</p>	<p>Subcommittees membership criteria, public health education and BSI; SSI and VAP will be talked about at the July meeting</p>
<p>Action Items and Upcoming Meetings</p> <p>Chair—Action Items</p> <ul style="list-style-type: none"> • Subcommittee membership criteria, public health education and BSI; SSI and VAP will be talked about at the July meeting • Sue will modify the CLIP form • Sue will send out communication before the Influenza AFL regarding the flu recommendations • Lilly will modify the MDRO report • Carol will work on usage and impact of Missouri website; review of implementation costs • Sue will find out CDPH budget for a public reporting website • Public reporting subcommittee will work on ICP metrics et al. and their recommendations to CDPH. <p>Chair thanked Dan Gross for providing meeting location and lunch.</p> <p>Next meeting in San Diego on July 31 at Sharp Mary Birch Hospital, San Diego.</p> <p>Adjourn</p>	

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
L&C	Licensing and Certification
LIP	Licensed Independent Practitioner
MRSA	Methicillin-Resistant <i>Staphylococcus aureus</i>
MSSA	Methicillin-Sensitive <i>Staphylococcus aureus</i>
NHSN	National Healthcare Safety Network
NICU	Neonatal Intensive Care Unit
OR	Operating Room
PICC	Peripherally Inserted Central Catheters
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>