California Department of Health Services
Healthcare Associated Infections Advisory Working Group
October 27, 2005
10:00 a.m. – 4:00 p.m.
1625 Stockton Boulevard, Sacramento, California

Minutes

Members Present: Kim Delahanty, RN, BSN, PHN, MBA, CIC; David Witt, MD (for Anvarali Velji, MD); Mary Mendelsohn, RN, CIC; Frank Myers, CIC; Shannon Oriola, RN; Justin Graham, MD,MS; Jonathan Teague; Lisa Winston, MD; Vicki Bermudez, RN; Chris Cahill, MS, BS, RN; Elizabeth Bancroft, MD, SM; Lois Richardson and Barb Glaser (for Dorel Harms); Marian McDonald, RN, MSN, CIC; Beth LaBouyer; Shelly Morris, RN, CIC; and Gilberto Chavez, MD, MPH;

Others Present: Jean Iacino, Sara Stoots, and David Stoebel

Call to Order/Agenda Review

The meeting was called to order at 10:10 AM. Dr. Chavez welcomed the participants and asked that the minutes reflect that he provided all refreshments to be served during the meeting at his own personal expense**. No state funds were used to purchase lunch or other refreshments.**

The group reviewed and approved the day's agenda.

Introductions by Healthcare Associated Infections Advisory Working Group (HAI AWG) Members

Working group members introduced themselves and identified the organization or constituency that they are representing on this working group.

Approval of Minutes from September 29, 2005

The following additions/corrections were noted:

1. Page 5: Issues for Further Literature Review: Efficacy **OF** (not or) preplanning.
2. Page 3: Antibiotic Surveillance Team-Stewardship: Prophylaxis: **REMOVE** Surgical, dental, implants (use the SCIP/SIPS Model).
3. Page 2: Recommendations Requiring Further Discussion: Enid Eck questioned the difference between this paragraph and the VAP group's first recommendation which was adopted by consensus. After discussion, it was agreed that Enid would draft a clarifying paragraph to clarify the issue.

The group unanimously approved the minutes (Moved Oriola/Seconded Macdonald)

Member Updates

1. Mary Mendelssohn announced that the Hospital Association of Southern California has formed a task force on HAI reduction. The group met on

October 26 to develop recommendations for Los Angles County only. The LA Board of Supervisors is interested in the problem and local media have also focused on the issue. The Board of Supervisors is stressing the importance of the "public's right to know" and has expressed interest in developing a rating system for hospitals similar to one developed for restaurants. The restaurant rating system is process-based. The LA task force will not begin major action planning until the HAI AWG's report is available.

2. Barb Glaser of the California Hospital Association (CHA) announced that Senator Jackie Speier's SB-739, which places certain infection control requirements on acute care hospitals, failed passage in the Assembly and became a two-year bill. This provides an opportunity for the current language in the bill to be modified. The CHA is opposed to the bill in its present form. Upon group's discussion, it was proposed that members of the HAI AWG make contact with Senator Speier's office and possibly invite a staff member to attend a subsequent meeting. Later the group agreed that it would be more appropriate to meet with Senator Speier in January and to brief her on the completed report.

Focus Area Teams Updates

Antimicrobial Resistance

The team indicated that they had additional recommendations for the HA AWG to consider. See recommendations in the following section of the agenda.

Influenza

The team had held further discussions regarding vaccination of Healthcare Workers. While truly mandatory vaccination may be problematic, there are some additional issues to consider within the framework of the group's original proposal to recommend that facilities be required to offer vaccination. The following points were made in discussion:

1. Start with required tracking for those on payroll.
2. Require facilities to report department specific vaccination rates.
3. The California Adult Immunization Coalition in the Department of Health Services should be a resource for any effort of this type.

Ventilator-Associated Pneumonia

1. The group has not met since the last meeting. The group will continue to clarify that surveyors should assess variations from hospital standards based on a review of the individual patient's nursing plan of care. The surveyor cannot know if an apparent deviation from standard protocol (e.g. elevating the head by 30º) is in keeping with that individual's care plan and therefore in compliance or if the observed deviation is not based on modification of the

standard protocol based on identified nursing concerns such as pressure ulcers .

Bloodstream Infections

1. Dr. Torriani has been unable to attend meetings but did participate on the conference call. She stressed that lack of resources is not an excuse and that part of the task is to educate administrators that preventing HAIs is critical and that infection control teams need to have the resources to do their job. The group also stressed the importance of educating surveyors about HAI. In response, the Working Group discussed and adopted recommendation D in the following section.

Surgical Site Infections

The team indicated that they had additional recommendations for the HA AWG to consider. See recommendations in the following section of the agenda.

New Recommendations Presented by the Prioritized Focus Areas Teams

The working group reviewed several issues not completed in the September meeting and adopted the following recommendations with full consensus:

Anti-Microbial Resistance

A. ***DHS should encourage healthcare facilities to share comparable data to determine if there is an anti-microbial resistance problem within the community in collaboration with local county health departments. Purpose: To identify trends, foster communication and develop strategies for interventions***.

B. ***Healthcare facilities will adopt measures for discontinuation of anti-microbial prophylaxis as per national standards of their choosing. DHS surveyors will ensure that:***

   a. Facilities have chosen a standard;
   b. They are adhering to the standard that they have chosen; and,
   c. ***Facilities provide feedback to individual providers and their departments.***

   Discussion: It will be challenging for facilities to ensure compliance by individual physicians who choose an approach that deviates from the set standard. Therefore, this recommendation only holds the facility accountable for adopting the standard and ensuring compliance by their employees.

Influenza

C. ***Require healthcare facilities to offer flu vaccinations to staff with an opt-out option via a signed declination.***

   Discussion: Requiring employees to receive vaccinations without an opt-out option may be difficult for a variety of reasons. Therefore, this recommendation requires only that facilities offer the vaccination and that any employee who

declines signs a declination form. Marion Mac Donald presented a declination form developed by SHEA, which may be used as the basis for developing one for this purpose.

Bloodstream Infections

D. ***Surveyors need to be educated on processes for the prevention of HAI's and a process for evaluating deviations from standards as defined by the facility.***

Discussion: The group discussed the basis for standards and concluded that there are several possibilities. Each facility should be left to adopt its own standards so long as they are consistent with one of the nationally recognized sets of standards. Surveyors should evaluate the facility based on the standard adopted. This recommendation is one that should be crosscutting and apply to all outcome areas perhaps under infection control.

Discussion of Process-Based Focus Areas (per August 25 meeting)

The group addressed recommendations to policy makers related to process issues. As this discussion moves forward, the group should consider how to develop general guidelines and apply them to the five clinical topics areas already addressed.

Reporting/Surveillance

There was a wide-ranging discussion of the reporting issue. Key points made:

1. The argument for outcome reporting is that patients will tend to choose facilities with lower incidences of HAI and the marketplace will create pressure for poorer performing faculties to improve. However, the group expressed concern about differences in reporting capacities. For example: a patient could acquire an infection in one hospital but not develop symptoms until after release. If the patient seeks treatment at another hospital, there would be no system for attributing the HAI to the first hospital. In contrast, if a patient were to acquire an infection at a Kaiser facility and seek treatment at a second Kaiser facility, the integrated record keeping system at Kaiser would track and correctly attribute the infection. In this scenario, Kaiser would be penalized.
2. There is no common structure for doing outcome measurement reporting. It is nearly impossible to do adequate risk adjustment between various types of facilities and across individual facilities.
3. Outcome reporting could also provide an incentive to send high-risk patients out of state or to shift them away from the ICU to reduce the ICU's apparent infection rate. A member indicated that there was some evidence that the Pennsylvania reporting law had led to shifting patients out of state.
4. If reporting is done on the basis of the facilities' adherence to specific processes, it is important that all facilities use the same definitions in order to prevent "gaming of the system". Lisa Winston noted that there is a degree of

subjectivity in the interpretation of data. Depending on definitions a set of data might or might not identify a case of HAI.

Following the discussion, the group agreed by consensus to approve the following:

1. A recommendation to require public reporting of process measures that are standardized across facilities.
2. A recommendation that all facilities should report outcome and process measures internally.
3. A recommendation of guiding principles for public reporting of some outcome and process measures

An ***ad hoc*** work group composed of Enid, Shannon, Dorel, Dr. Witt, Dr. Velji and Dr. Graham will more fully discuss the issue of reporting/surveillance and will draft more specific language for review by the full membership via e-mail. This group will also write a section on reporting/surveillance for inclusion in our final report.

Infection Control Infrastructure

Enid Eck presented an ad-hoc report developed by some members of the HAI AWG. The report calls for provision of adequate resources and infrastructure for Infection Control teams to be effective. Given the length of the report the group took no action at this time. Members are asked to review the report before the next meeting and to provide comments to Enid via e-mail. The HAI AWG also agreed to carefully review the recommendations on page 12 of the report for possible adoption or modification.

Comments during the discussion included the following:

1. Cost estimate should be updated to 2005 dollars.
2. The HAI AWG's final report should address accountability for an infection control program. That accountability should be at all levels of the organization. For example, monitoring workers' hand washing should be the responsibility of each unit managers, not the Infection Control Nurse.
3. The report should make it clear that not all resources are financial. A manager's attention to the issue and collaborating in addressing it are also resources.
4. The infection control document, as agreed upon, could be included as an appendix or referenced in our final report as a template on infrastructure standards for hospital infection control.

During the discussion, Marian MacDonald proposed the following recommendation:

DHS should develop and publish a reasonably simple standardized method for cost analysis of resources currently expended in managing HAIs. Her reasoning was that with such a methodology, facilities could understand the current costs of HAI and therefore justify increasing resources for infection control. The group requested that she provided this suggestion to Enid as part of her comments on the report.

Discussion of Final Report Format

The group held a discussion about the final report format and time frame.

1. **Format:** Given the current progress, the report might be written to focus on the five clinical areas plus the two process issues, Reporting and Infection Control Resources. A report with this content would cover most of the issues identified to date. The balance of the issues could be held off for continuing work after January 2006.

   The five sections should have a constant format and the recommendations should be organized so as to specify the target of the recommendation. Several of the groups did organize their recommendations in this way the remaining two (Anti-microbial Resistance and Surgical Site Infections) will need to specify. Each section should contain some introductory narrative and all should specify the evidence on which recommendations are based. Gil will circulate a general format for the sections and ask committees to place their recommendations and narrative in that format.

2. **Time Frame:** The group asked whether or not the timeline could be extended beyond December 31. Jean Iacino responded that this date resulted from the Little Hoover Commission's recommendation that DHS convene a task force to study HAI by that date. She will enquire as to whether or not the date can be extended. The group agreed that we have enough material to issue some report by December 31.

Meeting Evaluation and Next Steps

It was agreed that the HAI AWG will spend the better part of the December 1st meeting review and discussing a preliminary draft report. Gil asked each team to submit a draft of its chapter to him and Kim by November 15. They will collate the drafts and submit it to the group for review prior to the next meeting.