

**California Department of Health Services  
Healthcare Associated Infections Advisory Working Group  
August 25, 2005  
10:00 a.m. – 4:00 p.m.  
1500 Capitol Avenue, Conference Rooms B&C, Sacramento, California**

**Final Minutes**

**Members Present:** Raymond Chinn, Kim Delahanty, Enid Eck, Warner Hudson, Mary Mendelsohn, Shelly Morris, Fran Myers, Shannon Oriola, Jonathan Teague, Anvarali Velji, Lisa Winston, Elizabeth Bancroft, Dorel Harms, Justin Graham, and Gilberto Chavez.

**Others Present:** Howard Backer, Chris Cahill, Sue Barnes, Marian McDonald, Nancy Mikulin, Mark Starr, Mike Hughes, and David Stoebel.

**Welcome**

Kim Delahanty and Dr. Gilberto Chavez called the meeting to order at 10:00 am.

Kim Delahanty asked the group for their comments and any corrections to the minutes of the July 25, 2005 meeting. One typographical error on page 5 was noted by one of the members (through instead of thorough). The typo has been corrected on the final version posted on the Department's web site.

It was moved by Oriola and seconded by Myers that the minutes be approved. The motion was approved unanimously.

Dr. Chavez introduced Dr. Howard Backer, State Health Officer. Dr. Backer had been unable to attend the July meeting. He welcomed attendees stressing the importance of this work. Dr. Backer asked that the Working Group craft recommendations based on data but also shaped by what is practical and acceptable. He urged the group to look at specific options and examine both pros and cons of recommendations so that the recommendations are defensible.

Dr. Backer also responded to questions from Working Group members:

Q (Dr. Velji): Should the Working Group look at HAIs as they might exist in the future (e.g. SARS or Avian Flu)?

A: Evidence shows what factors exist in the chain of events leading to an infection in a Healthcare setting. The Working Group is looking for ways to interrupt that chain of transmission so its recommendations should be effective with emerging infections.

Q: (Shannon Oriola): Is this group tasked only to address hospitals?

A: The Working Group should make recommendations wherever there is evidence of a problem (e.g. ambulatory surgery centers) although hospitals are the major sites and the most pressing. Dr. Chavez commented that the mandate is broader than just hospitals although hospitals are the most important. He pointed out that the group has already included ambulatory surgery centers.

Q: (Shannon Oriola): May the Working Group make recommendations to the legislature of other policy makers?

A: Yes, it is reasonable to make such recommendations and to suggest the best means of implementing them.

## **Introductions by Advisory Working Group Members, members of the public and technical consultants**

Working Group members, staff members and members of the public introduced themselves.

Dr. Chavez reminded the members that the Working Group's meetings might be covered by the Bagley Keene Open Meeting Act of 2004, which governs all state board and commission meetings. The act requires these bodies to publicly notice their meetings, prepare agendas, accept public testimony and conduct their meetings in public. The act also limits participation during discussion to Working Group members only unless non-member participants are specifically asked to give input. Each meeting must have a time for public comment about matters not on the agenda. **NOTE: After the meeting, Dr. Chavez sought clarification from the Department's legal counsel regarding the applicability of the Bagley Keene Open Meeting Act of 2004 to our Advisory Working Group. The Department's legal counsel determined that because "this committee is not created by executive order or statute, or required by law to conduct official meetings, then you are not subject to the statute, and you may conduct the meetings under alternative procedures of your own making".**

The Working Group discussed its schedule and agreed to hold monthly meetings on September 29, October 27 and December 2. There may also be need of a meeting in late December to finalize the report. In response to a question, Dr. Chavez said that it would be difficult to conduct whole Working Group meetings by teleconference but that such formats might be appropriate for meetings of smaller Work Teams.

## **Discussion and Prioritization of the Workgroup's Possible Focus Areas**

Dr. Chavez gave an overview of the priority areas identified in the July 25th meeting. The present task will be to prioritize them and to begin developing recommendations. Recommendations should be based on evidence, the group should distinguish between consensus and non-consensus recommendations and each recommendation should be accompanied by an analysis of the "pros" and cons" of the recommendation.

In response to a question, Dr Backer said that it would be acceptable for the Working Group to continue past December 31, 2005 if there is momentum.

The group discussed some basic criteria for prioritizing focus areas and listed the following:

1. Degree of Impact (both efficacy and unintended consequences)
2. Implementability (including a cost/benefit analysis)

3. "Political Pressure" (for example issues like reporting which have political momentum and issues for which there is a regulatory authority demanding compliance)

In this discussion, Dr. Velji introduced a motion for the "Working Group to pick five areas of intervention that we will agree upon and doing so improve quality of care and decrease morbidity and mortality in all hospitals in California." The following intervention areas were proposed for consideration:

**Outcome-based Focus Areas:**

1. Ventilator-Associated Pneumonia (VAP)
2. Bloodstream Infections (BSI)
3. Surgical Site Infections (SSI)
4. Antimicrobial Resistance
5. Influenza

The motion was second by Dr. Hudson.

There was considerable discussion of the motion as it would shift the structure of the Working Group from process to outcome. Arguments in opposition included the idea that ultimately patient safety is improved when hospitals improve their processes and the Work Group should focus on processes rather than outcomes. As a result of this discussion a friendly amendment was introduced to link the process-based focus areas proposed at the last meeting (as listed below) to the five outcome-based focus areas. The amendment suggested that the process-based focus areas provide a framework for making recommendations in each of the five outcomes selected.

**Process-based Focus Areas**

1. Incentives
2. Adaptation of Quality Improvement Standards
3. Reporting
4. Accountability
5. Resources
6. Evidence Based
7. Public/ Prof Education and The Public's role in prevention
8. Facilities Non-licensed

The friendly amendment was accepted. The motion as amended carried (8/7).

Subsequently, a motion was introduced by Graham and seconded by Oriola that the Working Group create a separate work team to address the following including but not limited to:

1. Incentives

2. Recommendations regarding internal and public reporting
3. Standardization of surveillance
4. Sources of specific quality measures and their appropriateness
5. Statements regarding process versus outcomes measures

The motion failed (7/7/1).

## **Divide up and Work on Teams according to Prioritized Focus Areas**

The Work group decided to act as a single group to elaborate on the process areas so that the work teams can use them in considering recommendations for each outcome area.

The group brainstormed the following examples and ideas for each of the process-based focus areas: **(Please note that these are examples of possible recommendations for illustration purposes ONLY and NOT final HAI Working Group recommendations)**

### **1. Incentives**

#### Negative

- Sanctions regarding licensure
- JCAHO sanctions
- Decreases in reimbursement by payors for facilities that don't meet standards of Infection Control

#### Positive

- Increases in reimbursement by payors for facilities that do meet standards of Infection
- Seed money
- Technical assistance

#### Both

- Public reporting
- An internal reporting system incorporating cost to the facility of HAI
- In all cases, pay attention to cost implications of recommendations

### **2. Adaptation of Quality Improvement Standards**

- Based on Standards of national infection control and infectious disease organizations (National Healthcare Safety Network/Centers for Disease Control and Prevention, Association for Professionals in Infection Control-based on evidence, Society for Healthcare Epidemiology of America, Infectious Disease Society of America)
- DHS will convene an expert group as needed to review changes recommendations & will notify hospitals

### **3. Reporting**

- Internal & external
- Surveillance, case finding, analysis
- Minimize burden of measurement
- Evidence-based
- External process measures only
- Consider reporting protocol
- Recognize purchasers will be interested
- Public may require education
- Standardized ways of measuring
- Tie together hospital and public health systems
- Note that outbreaks always reportable
- Make reporting non-punitive
- Give specific rates back to surgeon
- Get data back to bedside care providers
- Establish minimum levels of reporting and minimum thresholds for internal reporting

### **4. Accountability**

- Facilities shouldn't be held publicly accountable for meeting standards until they have had an opportunity to internalize them e.g. 1 yr
- Develop a structure so each member of healthcare team is held accountable (physician, nurse, leadership)
- Infection control responsibilities should be described in job descriptions of all clinical employees
- Establish a requirement that top person in the organization sign off on the facility's infection control program.
- DHS should educate surveyors doing hospital site visits about infection control.
- Recommend to the legislature to enact criminal liability laws for a physician not washing hands
- Requiring an annual CME course on infection control (e.g. 1 hour on line course)
- Ask the California Medical Board to develop an action plan to increase physician compliance with hand hygiene
- Create consequences if physicians and leadership do not comply

### **5. Resources**

- Staffing information systems analysts
- ID physician support
- Leadership attention
- Ongoing QI group

- Staffing ratios for IC
- Training of IC staff
- Allocate resources for ID physicians
- Alternative ways to bolster resources (e.g. light duty personnel)
- Appropriate allocation resources to address essential functions (consensus panel report)
- Surge resources (Facility resources/supplies)
- Consider ways to “painlessly report” e.g. an automated system
- Expert input:
  - Education regarding infection control for leadership
  - Infrastructure for collaboration within a facility

## **6. Evidence Based**

- Use AHRQ structure for clinical areas
- Rate recommendations on basis of how rigorous the evidence is.

## **7. Public/ Prof Education and The Public’s role in prevention**

- DHS to conduct a public campaign on public’s role in prevention HAI
- Educate the public on the distinction between processes vs. outcome
- Educate the public on how to assess their provider
- Develop infection control curriculum at professional schools
- Develop direct to consumer marketing program teaching people to ask providers to e.g. wash hands
- Educate the public about the fact that despite best precautions, the risk is not zero
- Educate the public that there are things they can do to prevent HAI e.g. wash hands

## **8. Facilities Non-licensed**

- Recognize that non-licensed facilities have licensed personnel
- Bring facilities doing procedures under licensure
- Create incentives applicable across settings
- Note that potential for HAI exists wherever patients are being seen
- Support California Medical Board in taking action where appropriate

## **Other Notes**

- Each sub group should describe resources required to implement each recommendation
- There was a suggestion that this be seen as an overarching issue affecting all of the others

## Creation of Work Teams

The members present volunteered for one of the work teams as follows:

### Ventilator-Associated Pneumonia (VAP) Team

Enid Eck (temporary point of contact)  
Sue Barnes

### Bloodstream Infections (BSI) Team

Mary Mendelsohn (temporary point of contact)  
Frank Myers  
Dorel Harms

### Surgical Site Infections (SSI) Team

Anvarali Velji (temporary point of contact)  
Shelly Morris  
Justin Graham

### Antimicrobial Resistance Team

Kim Delahanty (temporary point of contact)  
Jonathan Teague  
Shannon Oriola

### Influenza Team

Elizabeth Bancroft (temporary point of contact)  
Lisa Winston  
Raymond Chinn  
Warner Hudson  
Gil Chavez

## Next Steps

- Dr. Chavez will e-mail the list of Work Teams to all HAI Advisory Working Group members on Monday 8/29 asking to sign up for membership in one of the five Work Teams.
- **The temporary point of contact for each Work Team will convene a meeting via conference call to select permanent leadership (including a Team Leader, Secretary, and Reporter) and develop a work plan.**
- Each team will start reviewing the available evidence-based information on their subject area. When the evidence supports it, develop recommendations by consensus or non-consensus (majority vote) for active steps to reduce HAI by public and private entities. Identify issues that need follow up action including needs for additional information. **Each team must present to the full HAI Advisory Working Group membership a report on their progress during the month of September to be discussed and acted upon at the September 29<sup>th</sup> meeting.**
- Dr. Chavez will e-mail electronic copies of the forms developed for use by the Teams in their decision making.

- Sara Stoots, Dr. Chavez' assistant, will provide support to the Team leaders in setting up teleconference phone bridges on an as needed basis.
- Dr. Chavez will discuss with the Department's leadership the need for professional writing support for editing the work of the five Teams and producing the HAI Advisory Working Group's final report.
- Dr. Chavez will check on the possibility of recording the group's proceedings.

## **Public Comment**

The following were comments made by members of the public:

### 1. Marian McDonald, RN, MSN, CIC

- I recommend that the working group recommend an evaluation of every Infection Control program in the state, so that the group can have a clearer assessment of the condition of your patient before you prescribe treatment. I believe that the members of the working group, who all represent facilities with strong IC programs, would be greatly surprised at the extreme variability in methods and effectiveness that I have seen as a consultant. Clearly the assessment cannot be completed by the end of this year, and it is likely that an assessment tool may not even be completed in that time frame, but the recommendation for assessment can be put forward in that time frame. I believe the group would be misguided to propose improvements without making efforts to know the current conditions in place. I would like to see this assessment address the entire IC program of each facility as a whole, so that recommendations are not limited to specific infections.
- As an addition to the brainstorming efforts on being evidence-based: When the group makes recommendations not supported by evidence, that it consider producing evidence resulting from its activities.

### 2. Nancy Mikulin (California Department of Health Services, Medi-Cal Managed Care Division).

- Emphasis should be on standardized quality measures and reporting tools
  - Medi-Cal experience has shown that comparisons between entities is difficult if the measures used to quantify outcomes are developed by the entities themselves or if every entity uses the same poorly-designed measure
  - Develop outcome measures that don't exceed the IT capabilities for data collection of the facilities
- Pay for performance - consider Pay For Performance over questionable methods such as Continuing Medical Education that don't change behavior

## **Adjourn**

The meeting was adjourned at 4:00 pm