

Healthcare-Associated Infections Advisory Committee
July 31, 2008, 10:00 a.m. to 3:00 p.m.
Location: Sharp Mary Birch Hospital, San Diego

Attendance

Members/Alternates:

Kim Delahanty (Chair), Ray Chinn, Letitia Creighton, Annemarie Flood, Donna Fox, Lilly Guardia-LaBar, Jennifer Hoke, Tricia Kassab, Brianna Lierman Hintze, Marian McDonald, Shelly Morris, Carole Moss, Rekha Murthy, Frank Myers, Terry Nelson, Shannon Oriola, Anvarali Velji, Julia Slininger, Dawn Terashita, Francesca Torriani, Pat Wardell, David Witt

Guests: Jack French (presented public story), Chris Rainey, Megan Lewis, (two staff from Little Hoover Commission), Lynne Fiorica, Idamae Rolle

Staff: Sam Alongi, Sue Chen, Jon Rosenberg

Agenda Items/Discussion	Action/Follow-up
<p>Call to Order and Introductions HAI Committee Chair Kim Delahanty (Chair) convened meeting at 10:00 a.m. Introductions made at San Diego and on teleconference lines. Thank you all for joining us today.</p>	
<p>Approval of Minutes The Chair called for approval of the May 2008 meeting minutes.</p> <p>McDonald—Had some very minor corrections, given to staff.</p> <p>McDonald—Motion to approve minutes (with minor corrections to be made by staff) Myers—Second All ayes Motion Passed</p>	<ul style="list-style-type: none"> • Staff to make minor revisions to May minutes based on member notes and comments.
<p>Public Story Jack French was introduced by Carole Moss.</p> <p>Jack relayed his story regarding a five month period in which he endured four surgeries relating to avascular necrosis, hip surgery and severe subsequent infections and multiple surgeries, as well as a long period of relying on home health nurses and having to take strong doses of antibiotics. He requested that the Committee explore ways to increase publicly available information on hospital infections and endemic infection rates. "If a hospital had to post infection rates like the "A" on a restaurant, they would make sterilization of the facility and training of staff top priorities. We all should have the right to make the most informed decision possible."</p> <p>Moss—What about mandating sterilization? Isn't there something CDPH can do to make this happen</p> <p>Oriola—Items used in surgery are sterile; there are processes in place to make sure this happens.</p> <p>Chinn—Depending on the organism, sterile process may or may not be involved. There are steps to assure that sterilization is effective.</p>	<ul style="list-style-type: none"> • Thank you letter to Jack French

Moss—What about cleaning, can CDPH mandate better cleaning requirements for people and materials that touch patients? What can CDPH do to help us keep doctors, patients and the environment clean?

McDonald—Understand that endogenous flora come from the patient. So in addition to understand the operating area, it is also important to consider preparation of the patient.

Moss—There is a hospital in Long Beach that focuses on cleaning, including bathing every patient before surgery, with dramatic results.

Chinn—The healthcare system has engaged an entire strategy, including patient bathing in chlorohexadine, staph aureus decolonization, MRSA check with subsequent treatment. With all these treatments and antibiotics given and stopped appropriately, we would decrease these risks. So we have made significant strides in terms of infection prevention. And as a body, this group is gaining a voice. And we have evidence now that MRSA bacteremias are lower, likely due in some part to our work here. While these lag behind, say, Mr. French's experience, we are making strides.

Chair—As an overview, there are log books, a daily log tracking spores, controls and outcomes; if an instrument falls on the floor it is removed from the OR to be sterilized again; there are many safeguards, plus clinical engineering and facilities engineering which have their own requirements. All of this is logged, so that when an inspector or surveyor comes in, they review the logs, look for discrepancies, ask why and supporting documentation, otherwise there is a finding, and a root cause analysis. The facility must answer or face infractions. So there are stopgaps in place in California and nationally.

I am sorry for your experience Jack. And it does sound like human factors, rather than processes, may have influenced your outcome.

Chinn—Note that as organizations face budget restrictions, they may have reduced housekeeping or other staff including surveyors. This affects the environment and the cleanliness of the environment. The state is trying on multiple levels to address this and other issues.

Chair—CACC (California APIC Coordinating Council) works on sterile processing issues. Sterilization training and annual certification is an extensive effort they are driving.

McDonald—Apology for what happened to Mr. French. Title 22 does address monitoring and documentation of sterilization. I would like to note that we want to look at here are outcome measures rather than process measures.

Torriani—In the past two years, from a California and national point of view, JCAHO can now come unannounced. This has provoked change in preparedness of the facilities under JCAHO. This is a welcome change for those of us who want transparency in the healthcare environment.

<p>Chair—This is referred to as “continued readiness”.</p> <p>Fox—Question: what are the “penalties” that were referred to?</p> <p>Chen—This is for an immediate jeopardy solution.</p> <p>Creighton—Under SB 1301, if patient is placed into immediate jeopardy, the facility may be fined \$25,000 per event. This has occurred related to infections in hospitals. “Immediate jeopardy” includes hospital awareness or culpability, and that patients are at risk of serious harm, but not necessarily that the harm has occurred.</p> <p>French—My concern is that if there is an outbreak or a high rate of infections in the hospital, I would like to be able to see that.</p> <p>Chair—Is there a way for the public to know if there is an outbreak going on in a hospital?</p> <p>Rosenberg—It is the obligation of the local health department and the state to determine if the Public is at risk as a result of the outbreak. Generally, most local health departments, if we determine the public is not at risk and doesn’t have a need to know, the public is not informed. There have been instances where the hospitals have been required to inform patients coming in to a facility of an outbreak in that particular facility. So it is a case by case determination.</p> <p>Chair—Thank you Mr. French for being here today and sharing your story with us.</p>	
<p>Committee Updates</p> <p>Progress on Program Implementation – S Chen 272 of 455 California hospitals are registered in NHSN, or 65%; this is excellent. 136 hospitals registered into the CDPH group; that is 47%.</p> <p>January 30, 2009 is the drop dead date for entering into the system; after that date you cannot put data in for 2008. I do not recommend that hospitals wait until that date as they will be too far behind.</p> <p>Myers—Can we get a list of the names of the hospitals who have registered?</p> <p>Chen—I can pull the numbers of the 136 hospitals. I cannot ask if a hospital is registered.</p> <p>Revisit of CLIP Module Requirements – S Chen Staff was asked to provide changes to interpretation for this module. Slides are posted on the CDPH HAI public website; the changes discussed last time are incorporated into the slides. Everything that was agreed to at last HAI meeting is included.</p> <p>The most frequent question I hear is “why can’t I report CLIP data”?</p>	<ul style="list-style-type: none"> • Sue Chen will take the AFL (Influenza) back to CDPH legal staff for review. • SCIP Subcommittee will discuss pediatric populations around the three SCIP measures and the reportable surgical procedures, and bring a recommendation to the Committee.

You cannot yet report CLIP data into NHSN is because NHSN has not yet released the module. When the module is released you will all be notified so that you can begin entering data.

Chair—You'll need to keep your data through some sort of mechanism until NHSN releases the module, then you can enter the data into the system, starting July 1.

Chen—Another question is "How long must documentation of line assessment be maintained by the facility"? L&C has stated (through formal consult) that if the information is in the medical record it must follow medical record guidelines—seven years for an adult patient, and up to age 18 (or in some cases longer if the patient is a minor) for pediatric patients. If it is not in the medical record documentation it should be kept for the duration between CDPH surveys or three years, whichever is longer.

Another issue is the assessment of line necessity. According to ICPs, they are not comfortable asking physicians if they need to keep (long-term lines) each day. Committee can open this up for discussion.

For now, everything that is considered a central line according to the CLIP module has daily assessment of line necessity.

If it is, say a portacath which is implanted underneath the skin, does it have to be assessed daily? There are lines that may be in for years, and this would seem silly. I'd like guidance from this committee on what would be reasonable.

Flood—I have a bias; we're up to 87,000 transplants. Every single one of those had a central line placed prior to beginning of transplant process. Many cases (example: bone marrow transplant) have a central line places before a transplant process; its part of their therapy. In those instances, tunnel catheters or implantable devices, particularly when they are part of a treatment regimen, should not be included in this daily line assessment. On the other hand, if the patient has a PIC or some other central line, then I agree that this should be included in the daily line assessment standard.

Witt—I see that point. Speaking for small community hospitals, there is a value in making it uniform. I admit its silly for a facility like City of Hope, but for small facilities it doesn't seem to have a big consequence to include these. We are talking about the ICU to this point, so I think a simple protocol, making it broad.

Nelson—The prevention is geared to percutaneous, so I think we should add the term "percutaneous" central lines.

Oriola—In this capacity, we're only looking at ICUs, so that is correct.

Chen—Remember that ICUs are only our starting place, and it is usually going to be easier to do this in an ICU and less likely to be missed than, for instance, a med/surg floor. So keep in mind that whatever is

- Staff will send out links to Senate Bills 158 and 1058.

decided has to be applicable to other settings outside the ICU.

Myers—With the example of the seven day line, we are all wrestling with the best ways to address patient care without overburdening staff with checking more boxes. Keep in mind that if we make it a checkbox it becomes background noise and doesn't enter the consciousness of the caregiver.

Chinn—VasCaths are considered central line. So the question is whether in patients who need dialysis for a long time, shouldn't those lines be tunneled? The issues we have are bacteremias associated with percutaneous VasCaths and there are very specific guidelines for tunneling of lines. So that is indicated, but the leap would be, if this is indicated, why isn't there a transition to a tunnel?

Morris—It would help to have definite definitions of the line and line usage in relation to the CLIP guidelines and which should be assessed daily.

McDonald—Propose adding the word "percutaneous" to the language. Obviously, some lines are intended to be long term and are relatively lower risk. If we add the word percutaneous that might be a place to start.

Flood—Tunneled versus non-tunneled is the classic definition or implantable. There are standards.

Oriola—Suggest looking at inclusion criteria. If a patient is getting therapy or hemodynamic monitoring, for example, then they're automatically included in that inclusion criteria, and if they're no longer on that, then the line needs to be assessed by a physician. So the AFL says you have to have a process in place that you are assessing. So if they're on Vancomycin they need a central line; when they come off Vancomycin they no longer need that central line and it needs to be assessed that day. This is a process we're working on.

Labar—In regard to seven day therapy, I believe that that does necessitate daily line assessment. It is important through the seven days as the infection could occur any time. There could be criteria such as tunneled or non-tunneled, but I would suggest we include Broveac lines. It is important that physicians know how the line is on a daily basis. We need to inform them and sell them on the importance of checking those lines on a daily basis, so that we can decrease these infections.

Flood—Just so we're clear, when we're talking about line assessment, we're talking about the need for the line; line necessity versus need assessment. It's a different statement.

Myers—My point was that during the seven days of therapy, the necessity for the line is there, no one argues that; it's the assessment of that line that we are considering here.

Labar—There's so intertwined; what is the difference? If there going to do a line, why not do the assessment anyway?

Flood—Because someone with Endocarditis who will need six weeks of antibiotic therapy they are going to have a PIC. The necessity is for them to have a central line; that is their course of therapy; that line should be assessed for redness and inflammation at least every day, with every dressing change. The point is that there are some instances where people have a lower risk catheter in place for therapy that serves long term therapeutic needs; that is a little bit different than an IJ, an EJ and/or a PIC on someone who went septic and crashed in the ICU. There are regimens out there that necessitate long-term central venous catheter access.

Labar—To break that out; for hospitals to look at all those different issues, where its been placed, which assessment versus necessity to do, etc., the burden will be huge.

Oriola—I am not arguing that. Perhaps inclusion criteria would be a good way to go.

Chinn—This suggestion came from one of the critical care physicians, who suggested a list of inclusion criteria; if the patient doesn't meet those, then you move on with the appropriate course.

Chair—Is there a need to take this back to Subcommittee, revisit the language and bring it back? (Subcommittee doesn't feel need to meet again.)

Chen—Thank you for participating in this discussion.

Torriani—So what has just been decided? Did something just change?

Chair—This was an open conversation with the Committee, not to decide anything. Did Sue (Chen) capture everything in this draft?

Chen—The question was: should we require the continued daily assessment of line necessity as recommended by the Subcommittee and adopted by the full Committee, and the answer is yes, just as it was at our last full Committee meeting. I brought it up as I have been receiving pushback.

Murthy—My understanding was that line necessity was not a reportable issue but something that should be available for hospitals to demonstrate (Committee: that is correct).

Chair—There are no changes; now that the conversation has evolved into something else, does the Subcommittee need to take it back and draft it differently?

Torriani—So, for example, for someone that comes in with a portacath that is not being used and that person is admitted, are we saying that a daily assessment has to be done? (Committee—that is correct.) Okay.

Murthy—If the hospital can demonstrate their own process, does this Committee prescribe how this will be done? (Committee—No, the HAI Committee will not prescribe how it shall be done.)

Chair—Again, we're just making sure that there isn't anything that needs to be changed based on the conversation that just took place.

McDonald—Would it be helpful for the physician to write "this line will be needed for X days of therapy" and for that to be acceptable as documentation for those X days?

Chair—We are not prescribing how a facility will do this process. We are keeping it global and allowing the facilities to determine for themselves what that process is. Again, nothing has changed. Does the Subcommittee need to reconvene or are we adopting this document as our recommendation?

Torriani—So if a hospital has in place exclusion criteria, if they are able to demonstrate the criteria, they will not have to change their process.

Chair—If that is their process, then yes that is acceptable.

Okay, so we will adopt as is the CLIP module as decided upon last meeting, and that will go forward as the whole Committee's recommendation on the CLIP.

Torriani – Motion to approve and adopt CLIP document
Flood – Second
All ayes
Motion Passed

Influenza draft module -- S Chen

Legal has had us revise the report based on whether or not CDPH can mandate particular reporting. The changes essentially are:

1. CDPH cannot mandate vaccination reporting before January 1, 2008. So for 2007, we cannot mandate. So the letter asks for the data voluntarily.
2. The original version of the report said "must set up a mechanism for ensuring that contract personnel have proof of vaccination"; CDPH cannot do that because there is no statutory trail, so the language has been modified to "all healthcare personnel should be offered". The requirement is still for all personnel, but it is now a suggestion that hospitals do it a certain way.
3. The definition of "healthcare personnel" was taken directly from CDC June 2008 NHSN surveillance definition.
4. There is some minor clarification language.

Myers—Is there a possibility to include all contracts for personnel to require vaccination/declination?

Chen—The actual language is "Beginning with the 2008-09 season, each acute care hospital shall take the following actions to ensure that all

healthcare personnel are offered education on influenza and the opportunity to receive the vaccination during influenza season." In C on page 3, "As influenza vaccination is recommended by the CDC, it is suggested that hospitals establish a process ensuring that contract agencies provide evidence of influenza vaccination and/or verification of declination for all contracted health care personnel."

Moss—So in this version 'C' is now optional?

Chen—In 'C', it says recommended. However, under the major headline, I strengthened the language for the 2008-09 season so that it covers everything underneath it.

Fox—Issue: We cannot discuss things that are not on the agenda.

Chair—This is included in the agenda under the heading of "Committee Updates".

Chen—This AFL will come out in three days.

Moss—To clarify, what is the change that the language was changed to "recommended"?

Chen—The change is, that the legislation SB739 does not cover any mandated reporting prior to January 1, 2008. So the data we want to get from last influenza season must be gathered voluntarily.

Chinn—In the original draft it states that "each institution should have a process". In this draft, it is stated as recommended.

Chen—"Each acute care hospital shall take the following actions to ensure that all healthcare personnel..."

Members—What about 4C?

Chen—I will take it back to legal for further review.

Moss—But this is done for TB. Why can't we require it for influenza?

Creighton—We had a conference call with legal; there is nothing in the statute that discusses that we must make them do this. We cannot require that they do it based on the statute. TB is a different law. We have to be able to tie our actions here to a statute.

Chair—We will take it to legal and bring it back.

Chen—Show of hands for those who would like to be on a conference call for this? (Moss and Creighton raised hands.)

Budget issues – S Chen

The Department would like to thank this Committee for their hard and thoughtful work. CDPH is very much interested in the continuation of the HAI AC, primarily from a value-added standpoint to public health via

your output, but also because of the statutory mandate and the sensitivities surrounding that. Since the Department of Communicable Disease Control (DCDC) under Dr. Chavez has financially supported the HAI AC to date, L&C has been asked and will be stepping up for the remainder of this year to contribute to the continuation of the group, including the consultant position through December. CDPH has only made plans through December as we are waiting to see what might happen with SB 1058 and SB 158, which could become effective on January 1, 2009.

Committee Personnel – S Chen

April Alexander has left CAHP for another position. We will request another representative to be appointed. We have Breanna Lierman Hintze here as a representative today.

We are also seeking an active participant from the California Conference of Local Health Officers (CCLHO).

SCIP Reporting -- J Slininger

(SSI Reporting by Children’s Hospital handout)

The reporting that is being done by hospitals for CMS and JCAHO meet 739 requirements, so hospitals already doing that reporting don’t need to do anything different.

Since 739 doesn’t exclude any types of hospitals from the reporting, children’s hospitals must now follow these same tools and criteria who were not previously required to do this under CMS or JCAHO (this has been part of Lumetra’s role in assisting these hospitals who were not already reporting to create a mechanism to do so). Some questions about the appropriateness of the criteria to be applied in children when they are based on literature on the adult population has come into question by some children’s hospitals. Some facilities are doing fine and reporting results; some have experienced pushback on the antibiotics and duration of antibiotics.

What these facilities have been told (by me as liaison)

The CMS forms are being used with the exclusion of 18 years or younger.

Secondly, this is a new process, we’re starting with the best things available that we have, and we welcome input as we go forward.

They have also asked if there are adverse consequences from results of reporting. There are no adverse consequences for lower compliance on any of the measures; there is nothing in 739 regarding this. Eventually CDPH will post the measures for every California hospital, but that mechanism has not been formalized.

I contacted the national lead, Dr. Grassler (SCIP Program) and asked about the appropriateness of these guidelines, or if there are other guidelines to consider. I also reviewed the overall body of literature. I contacted our lead in the Subcommittee (Oriola) and we discussed whether the children’s facilities should be included or whether they should be exempted somehow.

We recommend that we bring back to HAI the question of “should we require pediatric hospitals to report or should they be exempted under SB 739?”.

Secondly, perhaps consider if a different guideline should be sought and be used around pediatric surgeries.

Third, the current process puts an undue burden of being seen as making clinical recommendations on CDPH. This could be perceived as CDPH telling providers how to treat.

Fourth, there probably will eventually be ramifications of public reporting. Even though there is a no plan to punish or reward, some hospitals will then look better than others, and is this an efficacious thing?

Lastly, should we exempt children’s hospitals from 739 requirements, just the SSI portion?

Chinn—Are you saying that there are no guidelines for pediatrics similar to those used for adults?

Labar—Facilities struggle, and there have not been benchmarks. They are looking at evidence-based components that are in keeping with the pediatric population.

Chinn—Perhaps we ask our pediatric colleagues what is consistent with the adult population (example: administration of antibiotics) and start with those? This gives you the latitude, the intent is to capture similarities for, say, cardiac surgery and vancomycin use.

Oriola—The Subcommittee felt it was very dangerous to have a mandate to apply adult specific guidelines to the pediatric population. It is important to not take the choice away from the pediatric practitioners.

Slininger—Even if we find out what the consensus is from the premier pediatricians, it still is not necessarily the standard of practice or guideline. I think we have to draw a strong line differentiating adults from children.

Murthy—There are facilities where physicians are operating on both adults and children, and treating them the same per adult guidelines. I think we need to learn from this, and also to ask what harm is being done by treating them as the same.

Myers—You can extrapolate logically, cut times and duration of therapy is not an issue. In fairness to pediatrics, anything else should be thrown off the table and just report on those two measures.

Slininger—There is a precedent for this in public reporting; while there is an indicator around which there is still some question, the public

reporting on that indicator can be suppressed.

But at such a time as the indicator goes to public reporting, pediatric hospital reporting would only post for indicators 1 and 3. As we go forward, that might be a clean recommendation, to suppress reporting on indicator 2.

Moss—What they're doing on public reporting portals is breaking out those who are treating only children. Many hospitals that treat both. I think it would be dangerous to eliminate children's hospitals from reporting. There are so many critical things to be shown regarding children that it should never be eliminated—comparing like hospitals.

Chair—They're not saying not to report, they are suggesting reporting like with like.

Moss—Why would you take out the choice of antibiotic from reporting?

Chair—Because its different from adults to pediatrics. There is no research to show that that particular antibiotic is best to use for the surgery for that particular child.

Oriola—There isn't research to support use of one antibiotic over another in those cases.

Torriani—The risks of infection may be different. Second, some antibiotics for adults may be contraindicated for children. So we don't want to get into a debate that hasn't been assigned for children.

Labar—Microorganism susceptibility is done at many facilities, and is done annually. This helps the facility figure out which organisms are resistant to which antibiotics, and which antibiotics are effective. So they will not be the same across hospitals.

Moss—The piece that will appear, for adults, are we showing the choices? Wouldn't it be helpful to show the antibiotics being used in different hospitals?

Chair—No. Just like Lilly just described, organisms and resistance are different per facility. SB 739 and sharing of information are totally separate issues. Information sharing is a wonderful idea, but it is outside the purview of this Committee at this time.

Flood—Pediatric hospitals should be considered different, and with a disclaimer that antibiotic therapy for the pediatric population has not been standardized.

McDonald—Would it be useful to consider a less prescriptive standard for pediatric facilities, for example, having these facilities write and adhere to their own evidence-based policies, and review these annually.

Slininger—I would recommend not going that route because it puts more work on SB739 administration than is designed.

Motion (Slininger)

The motion is to suppress children’s hospital reporting on 2, recognizing there is no national guideline in choice of antibiotic.

I think children’s hospitals would be comfortable with that as well.

Motion --For children’s hospitals, reporting on the SSI antibiotic prophylaxis measures, they will continue to use the current guideline they’ve been given, but when those performance measure scores are publicly reported, the results of infection measure 2 (selection of antibiotic) will be suppressed from public reporting until a national guideline for choice of antibiotic emerges.

**Second—Wardell
Discussion**

Oriola—suggest modifying the motion, you’re still guiding antibiotic therapy...I recommend modifying 1 and 3 and sending the letter out saying there is no evidence to support 2.

Murthy—Discussion point: duration of therapy. It may be worth checking in the pediatric literature for data suggesting 24-hour, 48-hour, or other duration, that is in the evidence.

Fox—This all seems premature. This should be in a larger discussion of public reporting. And there are certainly many children being treated in non-pediatric hospitals.

Slininger—One clarification: SCIP-reported data do not report on any pediatric surgeries at all (by exclusion of age under 18)

Chair—Does the SCIP group need to gather information from the pediatric provider population?

Slininger—Re-emphasize that that is a dangerous tack to take.

Chair—To clarify, we’ve made a motion of measure 1 and measure 3 and excluding measure 2. If we can’t come to a determination or vote, does the Subcommittee go back and get some input from pediatrics continuing on in this vein rather than taking more time discussing it here. So the SCIP Subcommittee can gather that input and bring this back to the next meeting.

Motion removed from the floor.

Chair—The motion is off the floor. The Subcommittee will get together off-line and bring this back in September to the full Committee.

[BREAK FOR LUNCH]

Chair—Reminder: when we’re talking about institutions and groups and doctors and people, please keep names out of the discussion.

<p>Update on Senate Bills 158 and 1058—Chen My constraint is that I can only discuss what is publicly available. So, there is much activity by stakeholders to try to finalize language of bills. In its current form,</p> <ol style="list-style-type: none"> a. There is language to set up a designated fund within L&C to finance the HAI Program; it would also include (at this point) financing travel for Committee members. b. The HAI-AC would continue in current form, but may have new tasks. <p>Myers—Given that both bills have a lot to do with direction of resources, do we want to take a position/make a recommendation on these bills?</p> <p>Fox—I don't think that's within the purview of the Committee.</p> <p>Witt—I think we're here at the behest of the legislature, so I don't think we take a position.</p> <p>Chair—We can make recommendations to CDPH, but that is all.</p> <p>Fox—I believe that members and organizations can take positions, but not as a Committee.</p> <p>Morris—CACC has been involved with the bills since their inception, and will continue to do so. We're just waiting to see what the final form of the bill will look like.</p> <p>Myers—Could members be sent the link to the two bills? (Yes, staff will e-mail this to the Committee members)</p>	
<p>Subcommittee Updates</p> <p>MDRO Labar and Torriani</p> <p>Subcommittee met via conference calls and focused on finalizing the staph aureus reporting method as proposed at the January 29 HAI meeting by the MRSA Subcommittee. We discussed how we wanted to report, and what was brought to our attention was what CDPH can and cannot mandate. What they can mandate per Title 17 is case reporting (CMR); we are not so sure that this report would give us all the necessary information that we need to intervene appropriately. So we decided not to go this way.</p> <p>We also considered reporting MRSA through the NHSN MDRO module; however that module was very complex. And we were not assured of when the NHSN MDRO module would be released online. We decided not to go this way either.</p> <p>Given that there is legislation that may change the complexity of reporting, we decided to go this route (document attached). We are talking about voluntary reporting; the incentives of voluntary reporting will benefit the hospitals in many ways, and we'll be able to recognize</p>	<ul style="list-style-type: none"> • MDRO Subcommittee will look at Phase 2, including: <ul style="list-style-type: none"> ○ Determine how hospitals will get back data from CDPH; ○ Reference CDC in their document; ○ Remove the term "incidence"

the burden of disease in our communities. Facilities would be expected to report community onset as a whole number, facility onset will be reported as number of bloodstream infections, and the hospital would provide the number of patient days.

The rationale, as seen in your handout (reads from document) Once the facility reports the data, the data will be routed through a third party who will de-identify the data. We can start this voluntary reporting right away; the key is that we want to start something rapidly to address the issue.

The key element is that CDPH strongly encourage hospitals to submit this data. The concept is that we really want a good idea of community and facility onset; that would give us a good picture of bloodstream infections. Data would be collected as of January 1, 2009 and reported through the third party as of May 1, 2009. That would be a good first step. Then we would have a rate for California divided by those two onsets (community and hospital). Since California hospitals are 18% of NHSN nationally, this would be a significant percentage of reported data.

Because CDPH will not have the ability to identify facilities reporting the data, it would be helpful for CDPH and for this group to understand the characteristics of the facility. So we thought by identifying the facility as public versus private, teaching versus non-teaching, would be a helpful grouping, without identifying the particular facility.

Morris—This is wonderful; you've done a great job. Two questions: one, on the community onset, you want just the number or the rate? (Just the number). Relating to that, this piece (handout NHSN) shows selected MRSA metrics available in NHSN, they talk about admission prevalence BSI rate, which they report as number of MRSA BSI per 1,000 admissions. So would this be a benefit, to use "per 1,000 admissions"?

Labar—The subcommittee has not thoroughly reviewed it, but it has not yet been decided upon. It has been accepted but not published. But we can definitely go back and consider this.

Torriani—So for community onset MRSA bacteremias, why not do what CDC and NHSN recommends which is reporting incident cases of bacteremias per 1,000 admissions.

Chair—This is 3B in the NHSN MRSA Surveillance Description.

Labar—So does everyone know how to access their admission numbers? (membership—yes)

Terashita—Regarding bypassing the local health departments, locals would like to see these reports prior to their release. Perhaps we could ask the local health departments if they'd like to receive the data first.

Myers—What is implied but didn't explicitly state is that the data be fed

; and,
o Use patient days and occurrence s per 1,000 admissions.

back to the hospitals. I suggest that the final recommendation spell out that the data will be fed back to the hospitals. So that the public, private, teaching and non-teaching rates be provided to the hospitals.

Torriani—This subcommittee addressed the reporting, but hasn't specifically addressed this yet as it wasn't part of the mandate for the subcommittee. I agree that the feedback is very important.

McDonald—Questions pertaining to definitions: "MRSA isolates...two weeks or longer".

Labar—These definitions are directly from the NHSN module.

McDonald—Day 1, 2 or 3. For this, is it midnight to midnight or 24 hours after admission? Example, admit a patient at five a.m. and they have a positive culture at three a.m. three days later.

Chen—Day 1 is any time during the 24-hour period of that day (midnight to midnight is the day).

Chinn—Most bacteremias that are community associated will occur within the first 48 hours. By extending to 72 hours (three days) instead of 48 (two days), you capture the right data.

Oriola—Midnight to midnight, i.e. calendar day. (Reads excerpt from recommendation and CDC language), so the document states this very clearly.

Fox—I found no statutory or regulatory definition of admission, so in the absence of that I think the clock starts when the patient walks in the door. All the time in the facility (even prior to admission such as when the patient is in the ED) should count on that clock.

Labar—This issue was covered by the portion of the document that Shannon (Oriola) just read.

Fox—What would be most helpful is to use what was discussed last time, for example: when a person sets foot in a healthcare facility that results in admission.

Chen—This was resolved in the last meeting by changing the 48-hour to 72-hour criterion, so that would be extra work for almost no gain.

Fox—If we're focusing on the patient's exposure and the data is secondary, why would we not count from the time the patient enters the facility.

Oriola—That was an extensive conversation. From the time they're admitted to the hospital was the way to go. This document has already been adopted by Illinois and other states. We don't want to vary from it now or we won't have comparable data.

Fox—But since there is no definition of admission, the burden is on us to

say why we wouldn't start the clock when the patient enters the ED. We are prioritizing patients and not data.

Labar—This is straight from the NHSN module: "Community onset is collected as an outpatient or an inpatient less than or equal to three days after admission."

Fox—But there is no definition of admission. So I am arguing that it is when the patient enters the facility, not when they are admitted.

Torriani—We understand your point; the discussion Shannon was referring to is the paper that led to the NHSN CDC definitions of when a MRSA bacteremia should be considered hospital versus community onset. We understand what you are trying to say, the way we have developed it doesn't take much away from the burden of healthcare onset infections, knowing that a lot of community onset infections are actually healthcare associated, so we are not detracting from the importance of healthcare associated in the community onset portion. We're just dividing them into community onset and healthcare onset. We also know that most infections are either there on arrival or will declare themselves well over day four, so that is where the eventual 23+ hours in the ED will really not sway the numbers by trying to define exactly when the patient entered the facility as opposed to just capturing the actual admission. Minimal events occur in that 48- to 72-hour period, and so we won't lose much strength of data.

Wardell—Note: On the denominator on hospital onset: Occupied bed days is different than patient days. Which are we using?

Labar—Yes, it should just be "patient days".

Moss—Did we include discussion on ED? Is that noted in the minutes? (Yes: members clarified that "ED" is short for emergency room or emergency department)

Chair—The recommendation is for the MDRO group to take this back for Phase 2, to determine how hospitals will get data from this report, and add the reference to the CDC NHSN module, and change to per 1,000 admissions. So the group will bring this back to the September meeting.

Member—Who is the third party for data de-identification?

Labar—That is to be identified later. It will not be CDPH.

Chair—Action items for MDRO: Put in the report how hospitals get information back from CDPH; reference CDC; remove incidence; make it patient days; and make it per 1,000 admissions; work on the second phase.

Labar—I'd like to invite all the subcommittee members to participate in this activity.

Chair—Great work. Thank you. On to Public Reporting.

Public Reporting

Moss—A reminder of who is on the Subcommittee: April Alexander, Kim Delahanty, Donna Fox, Lilly Labar, Marian McDonald, Frank Myers, Dawn Terashita, Jon Teague, Pat Wardell, Francesca Torriani and myself.

Chen—I thought we had nominated CHA (Rogers) and the health educator (Erickson). (Okay)

Moss—From last, one of our action items was to get more detail on costs, building the portal, acquiring the technology and equipment, and figuring out the people and hours necessary for the project (costs are detailed on the handout from the Subcommittee). This includes the setup and ongoing maintenance.

Just to review, on Missouri, they are not using NHSN at this time, so their budget includes building their own database. We would expect it to be less since we are using NHSN. Missouri has been very kind in walking through all this detail with us.

Wardell—What is the breakdown of the staff cost? Is it in-house staff or contractors?

Moss—They used different personnel at different times, some things were one-time or specialized that required a contractor, some were ongoing or required internal staff.

Chen—Is this showing costs for one year or another timeframe?

Moss—Their annual budget is the \$358,000, so the rest of the costs you see there were the one-time setup costs for the project.

Some of you had asked about the results as things moved over to public reporting. Missouri referred us to their annual report (see their website). We've talked to them directly to get their feedback. They saw most of the change in the period we're in now; when they implement the processes they see the biggest amount of change, even before implementation of the reporting. I spoke with six or seven people there; they were very helpful to us.

Oriola—Question: Will we make a recommendation to adopt this model, or ask for this amount of funding from the legislature? (At this point it is unclear what exactly will be stated in the recommendation to CDPH.)

Labar—We are encouraged strongly to use NHSN; why did Missouri choose not to go with NHSN.

Moss—At the time NHSN wasn't available, so they are dealing with the issues of migration. Please also see the back page of the handout; this includes more good information.

Member—How will the interface with NHSN work?

Chen—The way the data works is that when facilities give permission to see the CLIP module, CDPH can download the data directly from NHSN to be worked on appropriately.

Moss—Just to remind everyone again, we have an ongoing contest to develop a slogan, tagline and/or logo. Ask your family, your kids, and your friends for ideas.

McDonald—What about the person inside CDPH who did the CDPH logo? (group—good idea)

Chair—Great work Carole and Subcommittee, and thanks for keeping us on track with the contest as well.

Committee Membership

Chair—I'll give a brief report since we were devoid of a Chair until today. Membership is: Kim Delahanty, Frank Myers—who has volunteered to chair, Marian McDonald, Pat Wardell, Carole Moss, and maybe AnneMarie Flood. This Subcommittee will determine criteria for being on the HAI Committee. Frank Myers has volunteered to chair this Subcommittee (today). Thank you Frank. We haven't had any meetings or movement as yet.

There was a piece that went out with last meeting, but this was just a guideline to get us started. So the Subcommittee will review and bring a report for next time.

Volunteers for this Subcommittee? (Witt and Murthy volunteered)

BSI Reporting

Membership is Carole Moss, AnneMarie Flood, Shannon Oriola, Francesca Torriani, Ray Chinn, Lilly Labar, Rekha Murthy, Pat Wardell, and Dawn Terashita—who has offered to chair this Subcommittee.

This group will meet before the next meeting and bring some information for us.

Public Education

Chen—I believe there was discussion that this is hand-in-hand with public reporting. Carole did volunteer to chair this. I would like to hear discussion pro or con to merge these subcommittees.

Wardell—Motion Flood—Second

Chair—So the **motion on the floor is to combine these two functions into one Subcommittee.**

Oriola—So with the charge being broader, are there people who want to add themselves to the Subcommittee?

Myers—So is the public education about healthcare associated

<p>pathogens, or is it about the website, or... (group—yes)</p> <p>Chair—It is to assist in the public’s understanding of our database, website, definitions, etc.</p> <p>Oriola—With broadening the Subcommittee, are there more who want to join?</p> <p>Moss—Membership is: Pat Wardell, Shannon Oriola, Francesca Torriani, and Carole Moss, Dawn Terashita, Jon Teague, Frank Myers, Marian McDonald, Lilly Labar, Donna Fox, Kim Chair, April Alexander, AnneMarie Flood, and Claudia Erickson.</p> <p>Labar—That means the Subcommittee is very large. Should we narrow it down or revamp the group?</p> <p>Chair—Well, it is going to be a huge undertaking, so let’s meet first and see how productive it is in this iteration, and then determine what, if anything, we need to do with the membership. Carole, are you still willing to chair this group?</p> <p>Moss—I would be honored.</p> <p>Vote All ayes Motion Passed</p>	
<p>Other discussion</p> <p>Relating to Public Story</p> <p>Velji—My comment regards when Jon mentioned the responsibility of reporting outbreaks etc from public health. It behooves hospitals and institutions to do early reporting so that they are not seen as hiding the facts. We have always brought it to the public’s attention in Sacramento, and we’ve found this is a better way to do things, rather than bring it out at a later date from public health.</p> <p>Moss—So how would we start to focus on that? What would the process be to make this available to the public?</p> <p>Myers—Let’s do an example. Let’s say we have an <u>outbreak</u> at one facility, but that outbreak rate it is still only half of the <u>endemic</u> rate at another facility. So one facility may have only half the rate, but people won’t go there because there is an “outbreak”. Without knowing what is going on in the community, it is not a valid comparison and may cause people to choose another facility when there is nothing wrong with the facility experiencing the outbreak. In that case, a very good surveillance system will punish facilities which are good at identifying changes in the endemic rate. If you don’t know “compared to what” it doesn’t make sense.</p> <p>Moss—What is the definition of outbreak?</p>	<ul style="list-style-type: none"> • C. Moss requested that members bring their “Top 3” ideas to bring change and prevent hospital associated infections. • Committee will review accomplishments/summary of what’s happening in California around hospital associated infection prevention. • F. Myers will send out to the Membership

<p>Membership—More than expected, or more than the endemic rate.</p> <p>Moss—How do we warn the public?</p> <p>Myers—That is what public health dealt with: what constitutes a threat to the public? Public health makes that determination and decides on what is a threat, and decides when it is important to notify the public.</p> <p>Chair—1301 and 1312, through that process, those cases are reviewed under facilities’ risk management programs. So these issues are addressed and reported.</p> <p>Flood—So the concern is, is the hospital doing something wrong? Sometimes the hospital isn’t doing anything wrong but something has changed in the external environment, and in the process of going into those outbreaks, it wasn’t a failure on the part of the institution or the process, it can be a failure of products or just something that has changed in the external environment. And this can take days (or longer) so we have to be careful if we decide to report on this, that we are reporting correctly and providing enough time to find the answer and get local public health or even national (CDC) get involved. But in general it takes some time to determine the cause of the outbreak and determine whether it is appropriate to report on this.</p> <p>Moss—So how do we start the informing process?</p> <p>McDonald—The challenge for us is that these issues are very complicated; if we oversimplify things, they are not accurate or helpful. So in Public Education, we’ll have to determine what the information means, then translate it into information that the public can use. And is this information useful to the public? The public wants to know where they are safe. So we have to understand the baseline, what’s expected, and then move forward from there. How do we take complex data and make it useful for the public?</p> <p>Creighton—Hospitals report cases to CDPH. CDPH (L&C) goes in to investigate/ The information we find we cannot release to the public until we get a plan of correction back from the facility that CDPH accepts. Once it is accepted, the information becomes public. Prior to that, if that information it is released, it is released by the hospital or the local public health department, but L&C cannot release it. It is based on the population the facility serves and what its baseline is, and every facility is different. If there is an outbreak, L&C investigates it, but that doesn’t necessarily mean that there is deficiency in the hospital. The information on facility deficiencies is available on the state website. The link will be sent out and posted on the HAI website.</p> <p>Murthy—The work that’s being done now is starting the process of heading off the outbreaks, the preventable process-related ones.</p> <p>Labar—The public should know that under statements of authority, ICPs are able to shut down units whenever it is necessary.</p>	<p>Subcommittee a generic list of rules and terms, in order to generate discussion for upcoming conference calls.</p>
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Myers—There are some downsides of too much information. One institution called public health to ask for assistance on what they thought might be an outbreak. In that case, local public health and CDC said one thing, L&C said another, and things became very public. The institution got their name dragged through the mud for trying to do the right thing. So we don't want to make a punitive system that makes reporting punishable, because people will stop reporting. So we have to find that fine balance.

Terashita—Every outbreak that is reported to us, transparency is the motto. The key question is always is the public at risk, and if so, we report it to the public. Also, ongoing investigations may reveal a pseudo-outbreak. It takes a while to gather all the information, and something that appears at onset to be an outbreak may be background endemic or other. It is important not to blast the hospital; you want to validate the result. As an example, look at the salmonella outbreak investigation right now, which has harmed the tomato industry even though upon further investigation it was determined that tomatoes were not the cause.

Guidelines for Committee Membership

Chair—Open the floor to discuss Committee membership guidelines. Before that, though, just want to thank Sharp for hosting. (group applause). Everyone has in front of them the proposed guidelines.

Oriola—So who is "excused"?

Chen—Anyone who called and gave a valid reason.

Oriola—Do we have a track record of this?

Chair—Yes.

Myers—And we can operationalize this and formalize some rules through our subcommittee.

Flood—So we'll figure out what are the acceptable methods of "excuse".

McDonald—Suggest putting it on agenda (it is currently included on the meeting agendas).

Murthy—So what is the problem overall?

Chair—There are a few members who never show up or who have shown up once. We would like to maintain active participation, active leadership, participation in subcommittees, and accountability as members.

Oriola—What about key groups who don't participate? Let's say they go over the unexcused limit, do they get kicked off or what happens?

Slininger—It may be a good time to send out a letter inquiring as to who still wants to participate, and it might be a kind way to let people who

haven't been participating know that we'd like them here. And the annual participation letter could contain the rules of membership.

McDonald—We cannot hold people accountable for things that aren't clearly written.

Myers—We do need to get a better idea of who is at the peripheral sites, particularly those who show up late and perhaps don't get recognized. So we need a mechanism for this.

Chair—There was discussion about participation "on-site" only, but there is a lot of pushback around that idea, for issues such as travel, expense, etc.

Member—The agenda packet could include a list of attendance for the last X months.

Chair—We do keep this data, and can include this in the packet for future meetings.

Nelson—We serve at the pleasure of CDPH, so they must have an idea of constituencies they want represented. So will we consider the participation of additional groups? Are there holes to be filled? Or is that too detail-oriented; are we just looking to find a way to get steady participation from our members? I don't see this as a punitive approach but a way to know who is participating and set out an expectation of what participating means. Which is showing up, participating on subcommittees, and speaking up.

Chair—Administrative staff are just looking for some input on the questions on the guideline example form (attached).

Nelson—I would suggest adding that when people come in to the satellites after the start of the meeting that we pause and introduce those folks.

McDonald—Are people who do not attend but do receive minutes valuable; do they serve a function?

Chen—You'll want an active committee. My thinking is that a person who only shows up one time or two times in seven is not really participating. Perhaps someone whose schedule doesn't work for attending meetings but is active on subcommittees is still a valuable member.

Witt—My thinking is that people who can't meet minimal guidelines should be reconsidered as a member.

Chen—If someone is on the Committee to fill the role for a certain population, and doesn't participate...one of the things CDPH does is try to fill the gaps.

Another thing to consider is term limits? Is that something to institute?

<p>Slininger—Maybe this is another component to an annual letter.</p> <p>Murthy—Sometimes people may miss a meeting due to circumstances, but they are still active and who is participating on subcommittees.</p> <p>Flood—I would propose that evidence of participation be attendance at main meeting and/or participation in subcommittees, and that the chair of each subcommittee give attendance reports. That should help the Committee analyze participation.</p> <p>Chair—Administrative staff does keep notes and attendance of all HAI meetings.</p> <p>Flood—Recommend that staff give (at HAI Committee meeting) a brief report of subcommittee number of meetings and attendance at those meetings.</p> <p>Oriola—We’re talking about just a few people, and staff probably knows who they are. The majority of members are very committed and do participate regularly, so the focus should be on building the attendance or finding reasons for non-participation of those few.</p> <p>Chair—We will take this to Subcommittee. Thank you all for your input. If you have more comments, please email them to the administrative staff or subcommittee chairs.</p> <p>Moss—Could we take time at our next meeting...I think it important for each of us here to bring to the next meeting your top three things you would do if you could do them to make changes (to lessen healthcare associated infections and MRSA). So what would you do—and bring those to the next meeting.</p> <p>Nelson—It would be helpful for the whole group to be more aware of what different groups/institutions are doing around these issues. As a part of this group, we have a charge of knowing what’s going on in California, so to be able to summarize this for the state (i.e. for different hospital associations and systems and professional groups) would be very helpful.</p>	
<p>Action Items and Upcoming Meetings</p> <p>Chair—Wrap up and action items and dates. We’re going every six weeks from now through December, and we’d like to pick two dates now. Both the next two meetings will be in Sacramento from 10 a.m. to 3 p.m. Meeting details will be posted on the HAI website when they become available.</p> <p>Next: September 18, Sacramento</p> <p>Following: November 6, Sacramento</p> <p>A December or January meeting date will be set at the September</p>	<ul style="list-style-type: none"> • Committee will send a thank you letter to Sharp for hosting the meeting.

meeting. This will allow time to see what happens with the 158 and 1058 legislation.

Chair—Action Items

- Sue Chen will take the AFL (Influenza) back to CDPH legal staff for review.
- SCIP Subcommittee will discuss pediatric populations around the three SCIP measures and the reportable surgical procedures, and bring a recommendation to the Committee.
- Administrative staff will send out links to Senate Bills 158 and 1058.
- Committee will send a thank you letter to J. French for presenting public story.
- Committee will send a thank you letter to Sharp for hosting the meeting.
- MDRO Subcommittee will look at Phase 2, including:
 - Determine how hospitals will get back data from CDPH;
 - Reference CDC in their document;
 - Remove the term “incidence”; and,
 - Use patient days and occurrences per 1,000 admissions.
- C. Moss requested that members bring their “Top 3” ideas to bring change and prevent hospital associated infections.
- Committee will review accomplishments/summary of what’s happening in California around hospital associated infection prevention.
- F. Myers will send out to the Membership Subcommittee a generic list of rules and terms, in order to generate discussion for upcoming conference calls.

Chair thanked Sharp for providing meeting location and lunch. Also, a thank you to all of you for participating and keeping patient safety your focus.

Next meeting in Sacramento on September 18.

Adjourn

Acronyms

AFL	All Facilities Letter
APIC	Association for Professionals in Infection Control and Epidemiology
ARDS	Acute Respiratory Distress Syndrome
BSI	Bloodstream Infection
CACC	California APIC Coordinating Council
CART	CMS Abstraction and Reporting Tool
CCLHO	California Conference of Local Health Officers
CDIF	<i>Clostridium difficile</i>
CDPH	California Department of Public Health / Department
CLIP	Central Line Insertion Practices
CMS	Centers for Medicare and Medicaid Services
DCDC	CDPH Division of Communicable Disease Control
DIC	Disseminated Intravascular Coagulation
ED	Emergency Department
HAI AC	Healthcare Associated Infections Advisory Committee / HAI Committee / 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>