Healthcare-Associated Infections Advisory Committee
Meeting Summary
August 9, 2018
Sacramento, CA

Voting Members Present

Dawn Terashita (Chair), Theresa Caughlin, John Culver, Jackie Daley, Jeremiah Darnell, Silvia Gnass, Marian Hollingsworth, Marisa Holubar, Patricia Kassab, Cristine Lacerna, Erica Pan, Matt Zahn

Voting Members Absent

Roy Boukidjian, Tim Clark, Sara Doernberg, Kim Erlich, Tashia Orr, Michele Ramos

Liaison Members Present

Debby Rogers

Liaison Members Absent

CHA/Kathy Dennis, HSAG/Howard Pitluk, CHA/Michael Butera, CAPICE/Mary Virgallito, CAAPA/Jeremy Elkins, IDAC/Phillip Robinson, CACDC/Ying-Ying Goh,

Department Staff Present

Lynn Janssen, Erin Epson, Lori Schaumleffel, Vicki Keller, Lanette Corona, Myesha Febres, Connie Chung, Janice Kim, Valerie Sandles

Call to order, introductions, and review meeting requirements

Chair, D. Terashita, called the meeting to order at 10:04 AM.

Item 1. Approve February 8, 2018 meeting summary

Meeting summary unanimously approved.

Item 2. Provide CDPH/HAI Program updates – Lynn Janssen, Chief, HAI Program; Vicki Keller, CDPH IP Coordinator; Lori Schaumleffel, IP Coordinator

Preview of the Annual Report of HAI in California Hospitals, 2017 *(currently in clearance).* 18-page narrative report with 5 appendices (38 pages total) plus detailed 2-page HAI summary profile for each hospital. "My Hospital's Infections" map with ability to perform side by side comparisons for up to 3 hospitals. HAI findings reported by hospital type: Statewide findings refer to majority (335) of California hospitals. Findings reported separately for 23 long-term acute care (LTAC) hospitals, 34 critical access hospitals, 75 rehabilitation hospitals and units. Report tracks hospital progress toward 2020 reduction goals. In 2017, hospitals made substantial progress compared with previous years. 2017 incidence for CLABSI, MRSA BSI, CDI, SSI lower than 2015 national baselines, and VRE BSI rates decreased for all hospital types except LTAC.

HAI incidence not decreasing in all hospitals for all infection types. CDPH action plan: Provide onsite assistance to hospitals with highest SSI incidence. Convene hospitals reporting highest numbers of CLABSI. Continue support to hospitals with high CLABSI and CDI incidence over multiple years. Work with select hospital group to learn underlying causes of MRSA BSI. Learn what hospitals are doing to reduce VRE BSI rates. Coordinate with others engaged in HAI prevention. Provide HAI trend data and support to

local health departments to address community HAI issues

> **Discussion:** Discussed ability of hospitals to review their data on the CalHEART website throughout and at end of year prior to data extraction by CDPH. Suggestion that hospitals be notified by the HAI Program liaison IPs when the Annual Report is about to be published. HAI Program to notify the HAI-AC via e-mail when the report is about to be published. Question about whether the report could be released sooner. HAI Program is working with hospitals to get data in sooner, within limits of the law.

Overview of the 2018 Roadshow, "Preventing Healthcare-Associated Infections: *Do You Know if Your Health Care Providers are doing the Most Important Things Consistently?* Primary objectives to review evidence-based practice known to prevent HAI, present HAI liaison IP observed gaps, and promote the establishment of facility-wide adherence monitoring programs. 371 attendees (IPs, front line staff, nursing leaders) in 22 classes, April-June 2018. Attendees aware that their hospitals' staff not consistent with adhering to evidence-based standards of practice. HAI Program staff will continue to promote hospital-established adherence monitoring programs.

> **Discussion:** It was noted from the Public that during a personal hospital visit, there were a large number of rooms that were in isolation. It was discussed that more important than the number of patients isolated is the staff and visitor adherence to care practices that prevent transmission. Question on what constitutes "leadership support" for the Infection Prevention Program in a hospital. Will bring this back to next HAI-AC meeting in November.

Updates on past committee recommendations

- CRE reporting *(Nov 2017)* - CDPH developing process to make CRE reportable via Title 17
- Antimicrobial stewardship in dentistry *(Nov 2017)* - CDPH collaborating with the California Dental Association to develop dental-specific guidance using the CDC Core Elements for Outpatient Settings
- Water management for Legionella *(Nov 2017)* - CDPH promoting CDC guidance for implementing a water management program. Exploring alternatives for reaching SNFs (not a widespread audience for HAI Program webinars).
- ASP toolkit for skilled nursing facilities *(May 2017)* - Toolkit is in clearance and will be posted on website soon

> **Discussion:** Question regarding CRE reporting. Clarified CP-CRE will be reportable. Question regarding AFL to mandate an inter-facility transfer form. Currently no California law or regulation to require. Local public health departments can require via a health order. Question about CRE data being made public. CDPH is neutral; no law to publicly report. Question on an update on the Committee recommendation for environmental cleaning and monitoring. CDPH stated was planned for inclusion in revised regulation; will confirm at November meeting.

Unfinished Business

Item 3. Review HAI trends and observational data from California long-term acute care hospitals

CDPH described prior HAI Program efforts to work with LTAC hospitals to reduce HAI rates. In 2017, California LTACs remain high in all HAI categories when compared to national baseline. Barriers to impacting on HAI in LTACs include historically low interest in collaborating with public health, high staff turnover, majority owned by single corporation, Kindred. LA County public health currently meeting with all 9 LTACs in the county. Each LTAC hospital is asked to work on process for reducing HAI. When convening, have more interest in a forum that addresses a very specific LTAC issue. CDPH seeking Committee input and make recommendations on further actions the Program could take to decrease HAI in LTACs.

Discussion: Comment that Kindred needs to be more involved with HAI Program staff for HAI reduction. Committee questioned if specific LTAC hospitals are more problematic than others. Eight continue to be highest focus for 2017-2018. Orange County public health would like to hear how LA LTAC Collaborative is making an impact; may encourage Orange County LTACs to participate.

Subcommittee Reports

Item 4. Antimicrobial Resistance/Stewardship Subcommittee – Marisa Holubar, Chair

- **Motion #1**: **Marian Holubar**

"CDPH modify the current inter-facility transfer form highlighting **the minimum necessary items** needed for inter-facility communication."

Discussion: Simplify existing form on CDPH website. Discussed two options 1) HAI Program can highlight the minimum fields to be completed on the current form, per the subcommittee recommendations, or 2) HAI Program will keep the existing form and another template.

No vote taken. CDPH accepted the recommendation.

- **Motion #2: Marisa Holubar**

"CDPH mandate communication of these minimum necessary items *(information fields)* upon transfer to another facility."

Discussion: CMS and The Joint Commission require inter-facility communication. Questioned how to mandate at the local or state level.

Voted in favor: Marian Hollingsworth, Jeremiah Darnell, Patricia Kassab, Silvia Gnass, Jackie Daley, Cristine Lacerna, John Culver, Theresa Caughlin, Matt Zahn, Erica Pan, Marisa Holubar
Opposed: None
Abstained: None
Motion Passed.

- **Motion #3: Marisa Holubar**

"CDPH conduct a needs assessment of hospital-based ASPs to inform efforts to support programmatic growth and reach. The AR/AS Subcommittee can develop the content for this needs assessment."

Discussion: None

Voted in favor: Marian Hollingsworth, Jeremiah Darnell, Patricia Kassab, Silvia Gnass, Jackie Daley, Cristine Lacerna, John Culver, Theresa Caughlin, Matt Zahn, Erica Pan, Marisa Holubar

Opposed: None
Abstained: None
Motion Passed.

Item 5. Environmental Cleaning in Healthcare Subcommittee – Jeremiah Darnell, Chair

- **Motion #1: Jeremiah Darnell**

"We recommend that the California Department of Public Health post, on the CDPH website, links to CDC and CMS guidelines and toolkits to assist California health care facilities with development and maintenance of comprehensive water management programs for the prevention of Legionella growth and transmission."

Discussion: None

Voted in favor: Marian Hollingsworth, Jeremiah Darnell, Patricia Kassab, Silvia Gnass, Jackie Daley, Cristine Lacerna, John Culver, Theresa Caughlin, Matt Zahn, Erica Pan, Marisa Holubar
Opposed: None
Abstained: None
Motion Passed.

Item 6. Public Reporting and Education Subcommittee – Patricia Kassab, Chair

The Public Reporting and Education Subcommittee reported on their review of sepsis as a topic for HAI Program website.

- **Motion #1 Patricia Kassab**

"Add the three web site links *(presented)* to the CDPH HAI "Me and My Family" web pages:
APIC Sepsis materials (https://apic/org/For-Consumers/Materials-for-healthcare-facilities)
CDC Get Ahead of Sepsis (https://www.cdc.gov/sepsis/index.html)
CDC Life After Sepsis (https://www.cdc.gov/sepsis/pdfs/life-after-sepsis-fact-sheet.pdf")

Discussion: Sepsis is not just an HAI; rather majority of patients with sepsis present to emergency department. Should consider the links in the Healthcare Professional page as well

Voted in favor: Marian Hollingsworth, Jeremiah Darnell, Patricia Kassab, Silvia Gnass, Jackie Daley, Cristine Lacerna, John Culver, Theresa Caughlin, Matt Zahn, Erica Pan, Marisa Holubar
Opposed: None
Abstained: None
Motion Passed.

New Business

Item 7. HAI as Adverse Events: Seeking Committee input for reporting HAI as an "adverse event" under (Health and Safety Code 1279.1(b))

California Health and Safety Code section 1279.1 (b) shared with the committee for review and discussion.

Discussion: Committee commented that requirements are in most hospitals' sentinel event policies. Hard to determine if HAI is the actual cause of adverse event. Most patients with poor

outcomes have co-morbidities, which may contribute more to adverse event than the infection. Need clearer definition of "cause" so that all facilities use and apply the same definition. Hard to prove causation and, if not clear difficult, difficult for L&C to cite. Reportable adverse events such as loss of limb or NICU outbreak already reported to both local health department (Title 17) and L&C (Title 22). Question about whether and how many facilities have been cited for HAI related adverse events. Difficult to pull information related to how many facilities have been cited for HAI related adverse events. CDPH uses CMS-mandated software and L&C unable to customize. Concern of over enforcement from a local health department standpoint that will be more difficult to work with facilities if over regulated. Other public reporting may be affected.

Item 8. Review national, state and local activities related to the disclosure of hospital outbreaks – Dawn Terashita

Presented public reporting of outbreaks in other states and some countries. Outbreaks of infections are a regular occurrence within healthcare facilities. Currently no standard policy for disclosure; generally based on ongoing risk. Type of disclosure and information disclosed varies based on situation. Described benefits and risks of full disclosure to the public and ethical issues around disclosure.

Discussion: Comment that if one hospital reports, then all should. Hospitals with more "aggressive" surveillance will be reporting more. Discussed question of "Are we protecting hospitals or the public?" Being forthcoming and balancing trust discussed.

Public comment: Concerned expressed about hospital leadership not being transparent and possible harm to HCW and patients. Patients/ parents should be notified if an outbreak is happening in their hospital.

Item 9. Discuss HAI Advisory Committee Liaison members providing regular scheduled updates of their organizations' HAI prevention and related activities

This item will be discussed at the November meeting.

Item 10. Public comments on matters not on the agenda

None.

Item 11. Review action items and propose agenda topics for future meetings

Committee asked to prepare suggestions monitoring adherence to CHG bathing. At November meeting, explore what leadership support looks like for the hospital infection prevention program. Discussed changing the standing meeting week/day for 2019. Discussed in-person attendance at HAI Advisory Committee meetings. Members reminded that participation is a commitment; please prioritize attendance.

Meeting adjourned at 2:54 PM