

**ANTIMICROBIAL STEWARDSHIP/ANTIMICROBIAL RESISTANCE SUBCOMMITTEE  
HEALTHCARE-ASSOCIATED INFECTIONS ADVISORY COMMITTEE**

**Thursday March 24, 2016  
1pm-2pm  
Teleconference**

**Attendance:**

**Members of Subcommittee:**

Brian Lee, MD, Subcommittee Chair, Infectious Disease Specialist, UCSF Benioff  
Children's Hospital Oakland  
Karen Anderson, MT, MPH, CIC, Infection Control , University of California, San  
Francisco  
OlgaDeTorres, PharmD, FASHP, BCPS-ID, Department of Pharmacy, O'Connor Hospital  
Jeff Silvers, MD, Infectious Disease Specialist, Medical Director Quality Management,  
Sutter Eden Medical Center  
Matthew Zahn, MD, MPH, California Association of Communicable Disease Controllers  
Carole Moss, Patient Advocate  
Michael Butera, MD, California Medical Association

**Absent:**

Dan Uslan, Associate Clinical Professor, Infectious Diseases at University of California  
Los Angeles  
Conan MacDougall, PharmD, MAS, BCPS, University California, San Francisco  
Dawn Terashita, MD, MPH Acute Communicable Disease Control, LA County  
Department of Public Health  
Catherine Liu, MD, Infectious Disease Specialist, University California, San Francisco  
Samantha Sweeten, PhD, MPH, San Diego County Department of Public Health  
Stan Deresinski, MD, Infectious Disease Specialist, Stanford University

**CDPH Staff:**

Lanette Corona, Associate Healthcare Program Analyst

**ACTION TAKEN:**

**See Attached Minutes**

**ACTION REQUIRED BY HAI ADVISORY COMMITTEE:**

**ACTION REQUIRED BY ADMINISTRATION:**

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**Brian Lee, MD, Subcommittee Chair**



| TOPIC  | DISCUSSION   | ACTION/ OUTCOME | NEXT REVIEW |
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|  | <p>each school/program.</p> <p>3. CDPH request that the Medical, Dental, Pharmacy, Physician Assistant, Registered Nursing, Podiatry, and Optometry Boards of California (and/or support legislation to) require that all licensed practitioners (including physicians, dentists, pharmacists, nurse practitioners, physician assistants, podiatrists, and optometrists) complete at least 10 percent of all mandatory continuing education hours in a course in the field of antimicrobial stewardship, prescribing, and resistance.</p>  |                 |             |
| <p>V. Discussion Items: Antimicrobial stewardship education for future prescribers via curriculum requirement in medical/dental/pharmacy/nursing/veterinary/podiatry/optometry schools and residency training programs and for current practicing clinicians (physicians, pharmacist, dentists, nurse practitioners, physicians assistants, podiatrists, optometrists, etc.) via continuing education requirement in antimicrobial resistance/stewardship for licensure</p> <ul style="list-style-type: none"> <li>• List of Schools</li> <li>• List of residency training programs</li> </ul> | <p>Questions were raised regarding whom will the SNFs be sending their progress reports to every two and five years and who will be responsible for reviewing them and what will be done with the information? Discussion ensued regarding CDPH would be reviewing the progress reports and advising the ASP programs of what they should be or should not be doing. CDPH would decide what should be done with the information to ensure programs are complying and to share progress being made as well.</p> <p>A suggestion was made to have the clinicians that complete the suggested 10% of ASP continuing medical education (CME) featured somewhere to inform the public they are “certified” It was noted, the way the recommendation was written was taken from existing legislation that requires physicians to complete a certain amount of pain and geriatric units of continuing education which the medical boards oversees. Physicians must attest they’ve completed this requirement prior to getting their license renewed. Therefore, for our recommendation it would be the California medical, dental, pharmacy, nursing, physician assistant, veterinary, podiatry and optometry boards that would be responsible for overseeing this requirement for 10% of ASP CME and ensure compliance.</p> <p>A question was raised if members feel as if CDPH would be sufficient to work with the California boards to adopt this requirement or if other stakeholders should be included in this negotiation with the boards. It was noted, adopting stewardship practices in the outpatient settings have been looked at by IDAC and CMA. Outpatient facilities that are licensed by the state are under CDPH in terms of regulation and inspection. For private physician practices, they are licensed through the state licensing board for licensure. Implementing a</p> |                 |             |

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|       | <p>requirement for education and adopting stewardship programs in private offices is giving power to the state medical board in terms of renewal of licensure to meet this condition in order to get their licenses. It could be considered a barrier to the ease of licensure. Discussion ensued regarding the previous experience with the pain continuing education requirement the California Medical Association (CMA) passed resolutions and policies basically opposing any mandated CME requirements for maintenance of licensure in any one specialty area and left it up to the individual specialties to determine how to best meet their continuing education needs. The official policy of the CMA would be to oppose any sort of mandated CME activity for maintenance of licensure in any one particular specialty category. However, infectious disease physicians and other interested stakeholders feel that antibiotics are unique agents and unique in terms of their public health impact, and there should be more education. IDAC would not be opposed to some type of mandated CME but to come up with 10% of total CME, does not seem reasonable and would not be anything CMA would ever go for. More power would be handed to the state medical board in terms of overseeing licensure process which seems to be cumbersome enough. Many ID physicians at IDAC and at the board level as well as CMA would probably be opposed to these kinds of mandates and not be supportive of it. Although they would be very supportive of facilitating education but maybe not with a mandate. To change CMA policy would require a resolution that is adopted by CMA and IDAC has been considering doing such. The appropriate numbers of hours for CME for each specialty is unclear. Meaning if you are a pain doctor, you're not prescribing antibiotics in general and won't need to take 10% of your total CME in antibiotic stewardship.</p> <p>Discussion ensued regarding there would be overlap with other specialties. The 10% would not be totally unreasonable when you realize it does not have to be 10% of just antibiotic stewardship alone, It will cover more than antibiotics but it has to include antibiotic stewardship as part of it. The previous pain mandate for one-time education was totally ineffective and outdated and is why we are recommending the ongoing CME as a way to provide</p> |                 |             |

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|       | <p>better care for patients and safer medication management. It was noted, even with our support, the medical board must be compelled to do this probably by legislation, and CDPH may not have the ability to compel the medical board to make this a requirement. CDPH would be cut from the process because the only entity that has legal licensing authority is the state medical board which is a whole different entity outside our subcommittee’s sphere of influences that needs to be given legislative authority to do this. Physicians may consider this as affecting their ability to practice in California. One of the purposes of passing this motion was to make the statement of the importance of this and hope that there are ears out there making changes that are consistent with what are recommendations are.</p> <p>Next steps would be to create a list of schools and residency training programs CDPH may need to survey to gather information about their stewardship programs from. A suggestion was made to contact Alicia Cole who has been working with the Combating Antibiotic Resistance Bacteria (CARB) taskforce who has been looking into these professional schools.</p> <p>A suggestion was made to have this subcommittee draft a template letter/survey questions that CDPH could use or edit for contacting these schools/residency training programs. Discussion ensued regarding getting more stakeholder buy-in on the motion from various professional medical associations. If this is done, when CDPH is ready we can begin including and talking with the medical board to find supporters on this topic. That way all decision makers are on the same level to have more than just a one-sided view of only certain experts supporting us and attempt to limit issues later in legislation.</p> <p>Members were informed; Senator Hill will be formally introducing his legislation next week that will run concurrently with this subcommittee’s recommendation. Experience has been that legislation is required to mandate medical education due to the medical board does not have authority to create such mandates on their own.</p> <p>It was noted, although this subcommittee nor CDPH may not have authority to mandate AS CME, perhaps Senator Hill will be well informed of this</p> | <p>Alicia Cole to be contacted for potential list of schools and residency training programs she has obtained from working with CARB.</p> <p>Create a letter CDPH can send out to programs and residencies as well as, developing survey questions.</p> <p>Outreach to various groups that may be stakeholders in this process to ensure all are on board.</p> |             |

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| <p><b><i>Components of ASP for skilled nursing facilities: SB361: On or before 1/1/17, each skilled nursing facility, as defined in subdivision © of Section 1250, shall adopt and implement an antimicrobial stewardship policy that is consistent with antimicrobial stewardship guidelines developed by CDC and CMS, SHEA or similar recognized professional organizations</i></b></p> | <p>group of experts that are advocating for it regardless of the opposition for it. Members were informed IDAC is considering working with CMA to use their year-around resolution process for the purposes of looking for a policy change that would be supportive of some type of effort in having CME requirement for antibiotic appropriate use education. Current policy does not support this but that doesn't mean it can't be changed and CMA can support that.</p> <p>The requirement for AS policies in skilled nursing facilities as discussed in the previous meeting, was to continue to work towards developing guidelines to implement effective stewardship programs similar to the acute care facilities; a tiered definition of a stewardship program (basic, intermediate, advanced). The purpose of this is to provide guidance to facilities as they are developing their programs and give them an incentive to want to do more. Several of our subject matter experts of skilled nursing facilities have helped us develop tiered definitions for stewardship programs; we now have 5 submissions for review.</p> <p>A question was raised whether or not skilled nursing facilities will see value in the tiered approach. Will the facilities that are in the advanced tier get credit for it somehow? It could be similar to the acute care facilities, in that they can be included to the "Spotlight on ASP" on the CDPH website. Many members voiced they believed the SNFs will consider this is a worthwhile endeavor to work towards building an advanced program.</p> <p>Members agreed simplicity is the best way to work towards for the tiered definitions. As far as the basic tier, a policy is a requirement. Discussion ensued regarding who can be identified as a trained ASP professional. It was noted, physicians and pharmacists are usually the SME, nursing staff or an IP may be practicing outside of the scope of their license in terms of making decisions about antibiotic treatment of individual patient situations. It should be a physician or a physician director overseeing this responsibility about antibiotic usage (when to stop, change or de-escalate). It was suggested to tease out the management of the program from a quality prospective and consider an IP or nursing staff. Program support from an IP is the language that was agreed to be used for the definition. Our aim is to</p> | <p>Members to review the draft tier definitions and continue the discussion at the April meeting. Members can cut and paste from the definitions and resubmit for future review.</p> |             |

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|                                      | have trained and experienced professionals manage and form an appropriate program. |   |             |
| VI. Action items to bring to HAI-AC: | None discussed.  |   |             |
| VII. Tabled Items                    | None discussed.  |   |             |
| VIII. Next meeting                   | TBD – April 2016   | Doodle poll to be sent to members to suggest April 2016 meeting dates |             |
| IX. Adjournment                      | A motion for adjournment was made.   | Meeting adjourned at 4pm  |             |