

**Healthcare-associated Infections Advisory Committee Meeting  
June, 2012 Sacramento, CA 10:00am-3:00pm**

**Meeting Summary**

**Attendance**

**Members Present:** Enid Eck, Annemarie Flood, Rekha Murthy, Shannon Oriola, Dawn Terashita, David Witt, Kathy Wittman, Alicia Cole\*

**Members Not Present:** Michael Langberg, Carole Moss

**Department Staff:** Sue Chen, Loriann DeMartini, Jorge Palacios, Rosenberg, Karla Van Meter, Jennifer Hoke, and Lynn Janssen

\*Call-in from a private (nonvoting) location

Agenda Item/Discussion
<p><b>Call to Order and Introductions</b></p> <p>Acting Chair - HAI Program Jon Rosenberg convened the meeting.</p> <p>Introductions were made of those present and on the teleconference lines.</p>
<p><b>Public Story</b></p> <p>Video: by The Safe Care Campaign shown. The Power is in your hands</p> <p><b>Review of Rules of Order</b></p> <p>The Chairperson briefly reviewed the active rules of order used by the HAI-AC, including following the queue, speaking clearly, respecting speaker opinions, muting phones if on the teleconference line, limiting comments to two minutes, and, in the interest of time, not rephrasing statements which have already been made.</p> <p>The HAI Advisory Committee's mission is to give recommendations to CDPH on implementing the statutory mandates for prevention of--and the associated morbidity and mortality from--HAIs. The Committee is neither a regulatory nor a punitive body.</p> <p>The public will be invited to comment after each topic today.</p>
<p><b>Approval of Minutes</b></p> <p style="text-align: center;">No summary of March 2012 meeting available; summary will be presented for approval at the September 6 meeting in Oakland.</p>
<p><b>HAI Program Update – J Rosenberg</b></p> <p>(Note: Refer to HAI Program website <a href="http://cdph.ca.gov/hai">http://cdph.ca.gov/hai</a>)</p> <p>When reporting data from hospitals,</p> <ul style="list-style-type: none"><li>➤ Groupings will be for general acute care, critical access, prison, rehabilitation, community, major teaching, long term acute care, and pediatric hospitals.</li><li>➤ Table A will compare the percent change in individual hospital data between April-December 2010 and January-December 2011.</li><li>➤ CLABSI data will be compared to NHSN referent data (2006-2008), not the most recent data</li><li>➤ Data will be compared to CA state data if there is a sufficient baseline, or national data if not.</li></ul>

## Discussion

- E Eck would like statement in introductory report acknowledging hospitals w/ electronic medical records as that impacts thoroughness of reporting
- Question on how validated hospitals would be recognized; to be determined by CDPH
- A Flood requested asterisks for SSI data where multiple procedures are performed through one incision; this can falsely elevate a category (e.g., small bowel SSIs) because of the hierarchy for assigning SSI to a specified procedure. Will discuss w/ K Van Meter.
- Noted that some hospitals are uploading denominator data for up to 29 surgeries but lag with surveillance for numerators, thereby falsely lowering SSI rates. Per J Rosenberg, this may be a clerical error by the facility. Out-of-plan NHSN data will not be included in July public report. Hospitals w/ some months of surgical data in plan will be included in July report.
- E Eck requested a distinction between complete and partial reporting as partial reporting could be a method for 'gaming' the system; comparison would not be comparable.
- L DeMartini acknowledged the difficulties of SSI reporting. This issue will be re-discussed within the Program and an AFL issued in August 2012 for clarification.
- A Cole suggested a caveat for the public report for hospitals that may have "withheld data". Noted that hospitals are not in the beginning phases of public reporting. Hospitals should be regulated and fined if they fail to turn over data.
- Request made for county-specific data; see note below from March meeting:

Comment: Other suggestions regarding focus of the CLABSI report included reporting at the regional or county level (although this may be problematic due to variations in patient risk factors and hospital characteristics), and by hospital system (commitment to supporting infection control programs, and patient safety may vary among corporate entities). It was suggested that the CMS Hospital Compare site has a link where one may download all the data that is publicly available and that CDPH hospital reports might link to CMS Hospital Compare.

## HAI Liaison IP Team Update – L Janssen

The focus of the HAI Liaison IP Team has been to assist hospitals to enroll and become competent in NHSN. Data validation was done and surveillance gaps identified. A highly successful series of webinars (March Madness) taught facilities how to use data to define their progress. The team is currently teaching a three hour class at 18 sites throughout the state that presents 2011 results, teaches hospitals self-validation, and includes one hour of case scenarios of practice using NHSN definitions.

The team has been conducting a series of demonstration projects from hospital care settings in an attempt to develop model programs as to how public health would work in these settings. They are:

- *C difficile* infection (CDI) Project – Imperial County. Includes local acute care hospitals and long term facilities and public health
- End Stage Renal Disease (ESRD) – LA County, Northridge. Working w/ dialysis centers to better understand opportunities for prevention of CLABSI and readmissions to acute care.
- Long Term Acute Care (LTAC) Continuum of Care – LA County. Looking at transitions from acute care to other levels of care, working to prevent readmissions to higher levels of care
- Ambulatory Surgery Centers (ASC) – Sacramento area. Collaboration of three groups (APIC, AORN, CDPH) to ensure basic infection control practices in these settings

Much of the initial work has involved setting up lines of effective communication. Other collaborative activities continue:

- CAUTI/CUSP is nationally directed effort to reduce foley catheter-associated UTIs
- Prison hospitals – in addition to 3 state corrections hospitals, includes 20 hospitals with jail units.

If funding for the HAI Liaison Team is continued, collaborative activities will continue. Other prevention

activities under consideration are:

- Maintain regional IP model, including monthly regional calls (usually attended by 50%-to-60% of the hospitals)
- To highlight strengths of the liaison team, utilizing public health expertise, including ability to interface across all care settings
- Focus on activities and outcomes for which we have some data and measurement experience and to expand on that based on the demonstration projects. Offer these prevention programs to communities that are within our region e.g.,
  - SSIs and other postoperative infections and hospitalizations or re-hospitalizations as a result of SSI
  - BSI, CLABSI, MRSA and other vascular access site infections and also re-hospitalizations
- Consider SSI validation for up to 50 hospitals if funded
- Exploring ways to better support antimicrobial stewardship activities

Education Subcommittee – Chair S Oriola

Members – MB Shannon (CA Healthcare Foundation), C Moss, R Mikles, M Mendelssohn, J Palacios, J Rosenberg

<http://www.cdph.ca.gov/programs/hai/Pages/HAIAdvisoryCommitteeMeeting--June21,2012.aspx>

Educational Materials shown for possible posting on or link to CDPH HAI Program website

- Infection Prevention and You (for consumers)
- 20 Tips To Help Prevent Medical Errors (for consumers)
- Hand Hygiene, featuring Dr. John Jernigan from CDC
- [Video from Consumer's Union on patient safety](#)

**Motion made to post first three links on HAI Program website, [with links to corresponding Spanish language videos as available]**

- **Motion – Oriola**
- **Second – Wittman**
  - **Amended – Flood**
  - **Second – Eck**

**Motion carried unanimously**

Discussion:

Concept generally supported

- Approach for policing, staff member accountability considered novel. The Veterans Administration implemented an enhanced bundle and succeeded in decreasing MRSA/VRE. Surveillance alone did not seem to be a factor in decreasing infections.
- In one hospital system, after initiation of electronic HH monitoring for two months, weekly feedback to patient care units, and initiation of two person central line dressing process, a marked increase was seen in compliance w/ central line dressing change bundle (CLAMP) with a corresponding decrease in infection markers and positive cultures
- Decrease in MRSA/VRE and CLABSI associated with initiation of hand hygiene initiative. Videos considered useful; supports endorsement to hospitals for internal use
- Reinforcement of positive behavior and repetition of message results in better reception of the concept
- Dr. Rosenberg to check on whether these external links can be posted on the program website.

**Motion made to post link to fourth video on HAI Program website. [Posting this video does not constitute a CDPH recommendation]**

- **Motion – Oriola**
- **Second – Witt**
- **Amendment for Caveat – Terashita**
- **Second – Wittman**

**Motion carried unanimously**

Discussion on Video #4:

Concept generally supported

- Concern was expressed by one member that the video could be construed as portraying healthcare providers as the enemy, but agreement w/ the video is not grounds for not posting it.
- Consumers Union does not critique technical issues.
- Suggested that rather than the specific video, a link be created to [safepatientproject.org](http://safepatientproject.org).
- Concern expressed that posting this video not be interpreted as agreement with all content.

#### **Title 22 Subcommittee Update - Flood**

<http://www.cdph.ca.gov/programs/hai/Pages/HAIAdvisoryCommitteeMeeting--June21,2012.aspx>

Slide set reviewed by Subcommittee Chair.

- Much discussion about definitions of words used ('verify' <language for surveyor>, target audience for a regulation <the facility>, a regulation cannot limit a statute, meaning of 'shall', meaning of 'self-implementing' legislation).
- How specific should the recommendations be? Per CDPH, not too specific
- Interpretation of 'risk assessment' question remains unclear – is it impact on hospital from a cost perspective? To quantify impact of HAI on facility?
- Should designate NHSN as the data base for reporting to CDPH
- Issues w/ conflicting standards of care
- Request that wording be less vague for enforcement of MRSA requirements
- If patient already known to be positive for MRSA, that they not be re-screened
- Clarification on surgical site infections is not included in this document; the Subcommittee will be re-convened to address this issue.

**Motion carried 7-0. Flood will send clean copy to Dr. Rosenberg.**

#### **Antibiotic Stewardship Subcommittee – Dr. Witt**

Remains on hiatus. Metrics for antibiotic stewardship (process vs. outcome) need to be decided.

#### **By-Laws**

<http://www.cdph.ca.gov/programs/hai/Documents/HAIAdvisoryCommitteeBylawsJune2012.pdf>

A copy of HAI-AC bylaws was approved within the last couple of days and will be posted on the Program website.

The Program invites members of the current HAI-AC to apply to a reconstituted HAI-AC. The first meeting will be held on December 6, 2012. The meeting will be held in Sacramento.

#### **Announcements**

The HAI-AC has worked on making recommendations on how to and implementation of infection control legislation. Future work will be strategic planning and to take the data gathered and make recommendations for further infection reduction.

The next meeting will be September 6<sup>th</sup> in Oakland.

### Next Steps

- The March and June meeting summaries will be available for review before the next Advisory Committee Meeting
- The HAI Program will begin implementation of the by-laws. Recruitment for new members will be initiated. Current members interested in remaining on the Committee should apply.
- By-Laws will be posted on the HAI Program website
- Agenda items to be included for the next HAI Advisory Committee meeting:
  - SSI Reporting and potential SSI subcommittee formation
  - Subcommittee Updates

### Acronyms

<b>AAMI</b>	Association for Advancement of Medical Instrumentation
<b>ABS</b>	Antibiotic Stewardship
<b>CAUTI</b>	Catheter-associated Urinary Tract Infection
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CDPH</b>	California Department of Public Health
<b>CLABSI</b>	Central Line Associated Blood Stream Infection
<b>CLIP</b>	Central Line Insertion Practice
<b>CMS</b>	Center for Medicare and Medicaid Services
<b>HAI AC</b>	Healthcare Associated Infections Advisory Committee
<b>HCP</b>	Health Care Personnel
<b>ICU</b>	Intensive Care Unit
<b>IP</b>	Infection Preventionist
<b>MRSA</b>	Methicillin-resistant <i>Staphylococcus aureus</i>
<b>NHSN</b>	National Healthcare Safety Network
<b>NICU</b>	Neonatal Intensive Care Unit
<b>PD</b>	Patient Days
<b>SIR</b>	Standard Infection Ratio
<b>SSI</b>	Surgical Site Infection