

**Healthcare-associated Infections Advisory Committee Meeting  
June 9, 2011, Sacramento, California 10:00am-3:00pm**

**Meeting Summary**

**Attendance**

**Members Present:** Kim Delahanty (Chair), Mike Butera,\* Raymond Chinn, Enid Eck, Annemarie Flood, Lilly Guardia-LaBar, Holly Harris (alternate), Mike MacLean, Mary Mendelsohn, Roberta Mikles, Carole Moss, Rehka Murthy, Frank Myers, Shannon Oriola, Debby Rogers, Dawn Terashita, Francesca Torriani, Lisa Winston, David Witt, Kathy Wittman

**Guests Present:** Cheryl Bright, Chris Cahill, Elizabeth Cook, Jan Emerson-Shea, Julia Hallisy, Lisa McGiffert, Michelle Monserrat-Ramos, Daniela Nunez, Terry Nelson, Maria Sperber,

**Members Not Present:** Alicia Cole, Eric Frykman, Daniel Gross, Michael Langberg

**Department Staff:** Linda Becker, Elizabeth Cook, Kate Cummings, Loriann DeMartini, Pam Dickfoss, Lynn Janssen, Cheryl Kalson, Vickie Keller, Tracy Lanier, Ralph Montano, Terry Nelson, Theresa Nelson, Jorge Palacios, Jon Rosenberg, Dirk Winston

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

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<p><b>Call to Order and Introductions</b></p> <p>HAI-AC Chair Kim Delahanty convened the meeting.</p> <p>Introductions were made of those present and on the teleconference lines.</p> <p>It was noted that the meeting was being filmed by Channel 5 San Francisco News, San Francisco</p>
<p><b>Public Story</b></p> <p>Cheryl Bright relayed her story, followed by a discussion concerning the nuances of effective infection control information for patients and advocates. Ms. Bright stated that although she had read the hospital signs reminding patients and visitors to ask healthcare workers about their hand washing, she wished there had been more clarity as to why this message is so important.</p> <p>Advisory Committee members discussed the importance of explaining the rationale behind hand washing, and suggested it would be important to enhance brochures, FAQs, and signage with additional information. Consumers Union recommends that CDPH provide more information relayed by professionals that is directed to families and patient advocates, for example, a website link entitled "If You're in the Middle of an Infection."</p> <p>Ms. Bright stated that she received more information from online support groups including people with MRSA infections. As her mother often changed the gauze on her wound and was careful about her daughter's infection they did not consider the mother's susceptibility to infection until information from a support group raised their awareness.</p> <p>CDPH gave Ms. Bright the HAI Program website address, which includes a link to an infection control video targeted to patients, patient advocates, and clinicians and requested feedback on the video.</p>

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### Review of Rules of Order

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.

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.

The public will be invited to comment after each topic today.

### Approval of Minutes

The Advisory Committee reviewed the April 14 Meeting Summary. Members expressed their preference that all comments and votes be identified by member name in the interest of full disclosure. CDPH's decision to summarize the meeting minutes (as opposed to transcribing), was based on limited available resources and no mandate requiring that CDPH provide a verbatim meeting record.

- **Motion to resume what we've been doing in the past of recording an edited version of the transcripts with names of comments and all votes that are requested to be identified by name, direction of vote, and who voted that way.**

- Motion—Moss

- Second—Flood

- Motion Passed by Unanimous Vote (19 yes, 0 no, 0 abstentions)

**Yes:** 19 (Harris, Flood, Moss, Witt, Terashita, Rogers, Eck, McLean, Torriani, Myers, Wittman, Delahanty, LaBar, Winston, Mendelsohn, Murthy, Chinn, Mikles, Oriola)

**No** – 0

**Abstain** – 0

### HAI Program Update – Rosenberg

Dr. Rosenberg announced that Terry Nelson, RN, has stepped down as an Advisory Committee member. Terry will continue to attend the HAI-AC meetings as a guest. CDPH and the Committee acknowledged Terry's contributions to the Advisory Committee since 2007, and thanked him for his service on behalf of the people of California.

**UCOP letter to Advisory Committee—Follow-up.** The University of California Office of the President sent a letter to CDPH requesting changes as to how CDPH counts CLABSI cases on the first 3 days of hospital admission. Although the letter alleged that the proposal was consistent with CDC guidelines, those guidelines do not apply to CLABSI; rather, the three-day rule applies to infections other than CLABSI. Further, CDPH discussed the proposal with the NHSN Director who determined that it is not consistent with NHSN protocols. Therefore, CDPH has chosen not to accept the recommendation. Dr. Rosenberg acknowledged that CDPH needs to identify more specifically what the variability in the different practices is in order to more accurately define consistent practices for hospitals. CDPH believes that changing surveillance criteria was not an appropriate way to address variability.

**Bagley-Keene and Teleconferencing:** Bagley-Keene language is somewhat vague in regards to teleconferencing, as the law was written prior to widespread use of this technology. To address uncertainties, CDPH had relied on Bagley-Keene guidelines which were generated from the California Department of Consumer Affairs; however, other agencies have interpreted the statute

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differently concerning the definition of an appropriate public meeting space. CDPH advises that members wishing to retain voting rights must call from a meeting location that has been identified in the HAI-AC Meeting Notice and Agenda, and is publically accessible.

**CLIP Data:** CLIP data will be completed soon. It is CDPH's practice to define and identify outliers. CDPH will contact every hospital so that no hospital that is an outlier (good or bad) will be surprised by the interpretation of their data. CDPH will discuss with each hospital how verification was conducted to determine whether the data is fairly represented, thus providing hospitals with the opportunity to evaluate their results prior to reporting.

The CLIP data QC/QA process is ongoing. NHSN issued its new version, which includes a significant change in how rights to data are conferred to CDPH. CDPH now has a reliable email list with at least one, and in most cases, two e-mail addresses for every hospital in the state. Hospitals will receive a picture of the CDPH template with the choices to stay or leave the group, or stay in group but deny conferral rights. CDPH will not address conferral rights for SSIs at this time, but only for those subjects for which there is a very clear statutory mandate with accompanying AFLs. CDPH needs to address an issue relating to identifiers, so there will be future templates. This has the potential to cause confusion and Infection Preventionists may believe that since they've already conferred rights they will not have to do it again. Therefore, CDPH needs to be very clear about this change.

(Note: It is the HAI Program's intention to provide an SSI report for January 2012.)

#### **Liaison Team Update – Janssen**

**Overview:** The goals for the Liaison Team are to 1) increase the use of NHSN in order to help hospitals use surveillance data for their own HAI prevention purposes; 2) validate NHSN data; and 3) work on HAI prevention initiatives throughout the state. The Team is providing ongoing consultation to hospitals, and working with the Epidemiology Unit to ensure completeness of data as viewed through NHSN.

**Prevention Activities:** The Liaison Team is working with collaboratives, using the peer-to-peer learning model. As a requirement of the federal grant, the Liaison Team is also required to work with existing prevention collaboratives, and therefore have provided subject matter expertise and information to the Regional Hospital Association and Patient Safety First Collaboratives. The Team also started a collaborative with the prison hospitals in California, and, in the fall of 2011, will expand to jail units to look at infection prevention needs of prisoners. A collaborative with 26 long-term acute care hospitals was launched in February 2011 to target reductions in catheter-associated UTIs, and CDI, with some CLABSI process issues included.

The Team has initiated work with small and rural hospitals and has partnerships with the HHS regional office and the Hospital Council of Northern and Central California. The Liaison Team will be initiating a series of tracts for small and rural hospitals to participate in CDI reduction, CAUTI prevention, and anti-microbial use, which is of primary concern to these facilities.

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**Data Validation:** The Liaison Team is currently piloting the process of communicating with hospitals and evaluating the feasibility of that process. Materials will be piloted in hospitals in the next few weeks with onsite visits. A notice will be sent out advising hospitals that want to participate in on-site data validation to sign up by the end of this month. The limit is 100 hospitals to allow for thorough evaluations. A letter will contain what the expectations are for hospitals who agree to participate. The protocol is to look at identifying infections in an effective and appropriate way.

The data validation process is not a scientific study and no data will be collected for the Department with hospital identifiers. Rather, it will help the Liaison Team understand where to target education, and focus on improvement in preparation for disseminating information more broadly. This is not a mandated program, the HAI Program is nonregulatory and the goal is to improve surveillance in California.

Funding for the Liaison Team is available through October. There may be more funding available but only for prevention initiatives.

### **Public Reporting of CLABSI Data – K. Cummings**

#### Background

CDPH Senior Epidemiologist Kate Cummings presented the proposed standard measures for public reporting of CLABSIs in California as recommended by the CDPH Metrics Work Group. (A separate copy of the Metrics Work Group recommendations is attached to this Summary.) While the Advisory Committee was on hiatus in 2009-10, CDPH convened a panel of experienced leaders in hospital epidemiology to recommend to CDPH standard measures or metrics for reporting HAIs, including CLABSIs, to the public. The panel met monthly and in the spring of 2011 provided recommendations for CLABSI reporting.

#### Presentation

CDPH's goal for public reporting is to produce quality CLABSI data that are valid, fair to hospitals and useful to the public, CDPH faces several challenges to achieving these goals in that the choice of standard measure (or metric) for presentation must successfully address the complexities of a fair comparison, must minimize distortion which can occur with rates, and must be easy to understand. Selecting the appropriate standard measure that preserves simplicity and validity is challenging.

The proposed standard measures are based on The Metrics Group recommendations and consistent with NHSN methodology. The goal of the presentation is to enlist the HAI Advisory Committee's support in adopting these measures and in managing reasonable expectations for public reporting based on what the standard measures (and the 2012 CLABSI Report) can and cannot do.

California Statutes require CDPH to post CLABSI rates (Ref: **Slide 4**) and central line days acquired at each facility in California. To accomplish this goal, CDPH must follow a risk adjustment process. In order to address key limitations in data previously reported in a passive paper-based system, hospitals were required to report CLABSI data using the CDC NHSN web-based reporting system beginning April 1, 2010. Today's discussion focuses on data reported on or after April 1, 2010 via NHSN.

There are constraints that must be considered when choosing appropriate standard measures for CLABSI (Ref: **Slide 5**): by statute, CDPH must include a denominator (i.e., central line days or CLD) and the rate by hospital. Risk adjustment is essential to account for different patient care locations when comparing hospitals. Rates of infections vary by types of patient care location and types of patient care locations vary by hospital. Most importantly, the measure must be acceptable to hospitals and the public, so not only must it be fair but easy to understand.

(Ref: **Slide 6**) Rates based on observing infections in patients have all the attendant practical and ethical constraints and are inevitably subject to error. Rates vary due to random error, distortion, or

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chance, or real differences. The distortion of rates is of concern to CDPH.

(Ref: **Slide 7**) The following challenges must be considered when making the choice of a standard measure: simplicity vs. validity, complexity vs. ease of use/understandability.

(Ref: **Slide 8**) CDC uses stratified rates as its primary measure, by publishing CLABSI rates for specific patient care locations (units). CDC chose to publish by unit because the rates of infection vary by patient care location or unit. As a secondary metric for comparing states, CDC uses the Standard Infection Ratio (SIR), which is a somewhat more controversial metric for risk adjusting. CDC uses the indirect method to calculate SIR. Unit-specific rates of the national cohort are applied to the unit structure (i.e., central line days per unit) of each hospital to derive an expected number of events. The observed number of events is then compared to the expected number and is expressed as a ratio of observed infections to expected infections. **Slide 9** gives an example of this calculation. An SIR under 1.0 means the hospital had fewer infections than expected, based on the national average; an SIR over 1.0 means the hospital had more infections than expected.

(Ref: **Slide 10**) The SIR can be easily presented graphically and appears easy to understand. The layperson's perception is that an SIR <1 is "good" and further below 1 is "better." Conversely, an SIR >1 is "bad" and further above 1 is "worse." (Ref: **Slide 11**) However, the SIR can be misleading and is more complicated than it appears.

(Ref: **Slide 12**) The example slide uses age groups, but the same applies to unit names. In population A, the rates (depicted by bubbles) are much higher in the first two units (groups) – 39 vs. 11, but because of the distribution of central line days, the observed number of infections for the hospital as a whole is lower than the expected number. It would be misleading to say that Hospital A is "better" than the reference group as the distribution of central lines days masks the unit-specific rates and distorts the SIR.

When comparing across hospitals, Hospital B looks better than Hospital A, as unit-specific rates are lower. Yet Hospital A has a lower SIR (the lower the better). This is an example of distortion error.

CDPH Metrics Workgroup Standard Measures Recommendations:

1. **Rates should be reported annually.**
2. **Rates should be sectioned by subgroups of units or "strata."** Stratified rates are CDC NHSN methodology. Collating subgroups ensures an adequate sample size in each stratum, which in turn ensures more stable estimates. Strata use also reduces the number of units that the public would have to review. Units were reviewed for consistency in the type of care provided and similarity in national rates before being consolidated into strata.
3. **Provide for each stratum an alpha list of hospitals, number of infections, line days, and patient days.** For hospital strata with >100 CLDs CDPH would report the rate; hospital strata with <100 CLDs would not have a rate or statistical testing. In the interest of full disclosure, and in a modest departure from work group recommendations, CDPH will report the numbers of infections, line days, and patient days (PD) for hospitals with < 100 CLDs and will list the central line utilization ratio (i.e., CLDs/PDs). Device utilization is a proxy to the complexity of care provided in specific units ( (Ref. **Slides 18** through **21** for proposed reporting strata and data flow.)
4. **The Work Group strongly recommended against rank ordering of hospitals by point estimate (rate).** (Ref. **Slide 22.**) CDPH agrees with this recommendation; the rationale is to avoid the misconception that adjacent ranks are meaningfully different from one another. Even if confidence intervals are provided and overlap, the lay reader is still likely to perceive that one hospital is worse than the one that comes before it and better than the one that comes after it.
5. **Secondary adjusted measures, including the SIR, are not recommended pending further**

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**evaluation** CDPH will convene experts to explore the value of additional adjusted measures, although the primary concern is not to mislead the public. CDPH is also concerned that the public may have difficulty sorting through the many tables of patient care locations. Therefore, independent of the work group, CDPH is proposing for 2012, an additional table which provides a tabular summary of strata-specific statistical testing results. The table would be similar to Consumer Reports rating tables and would replace the SIR in providing a single summary snapshot of hospitals. (Ref. **Slide 24** for an example.)

### 6. Ensure clear communication about changing surveillance criteria.

7. **Give each institution the opportunity to review reported data prior to publication.** The HAI Program Epidemiology Unit (EU) has distributed two quality control reports to all hospitals and will continue to work with hospitals to identify systematic errors in their reported data. The EU will also contact hospitals with strata that are significantly above or below the state average to help hospitals identify potential systematic errors in reporting or potential barriers to infection prevention, as appropriate.

(For a summary of this proposal, ref. **Slide 29**.)

### Discussion

Members were interested in why CDPH may want to do a comparison within California and wondered if there is value in comparison to the CDC published data, which is the national standard. CDPH intends to do an aggregate analysis of the units in California, and then compare to the national average. California rates frequently appear to be lower than the national average. Those analyses, which are not under the purview of the mandate, will be done after January 2012. At the aggregate level, the HAI Program EU wants to look at the data to see the differences but at the hospital level it's best to hold to the California average at this time. If rates go up it may be better to compare to the national average.

A member was concerned about not using the SIR measurement; however, thusfar, CDC has never published SIRs at the facility level (although a facility SIR is calculated for facilities for their individual use in NHSN) the published SIRs have only been used for comparing between states. As a result of the publication from Washington State that shows distortion of hospital specific data using the SIR, CDPH is concerned about what is present in the actual hospital data. CDPH's greatest concern is to ensure the public is not misled.

The next CDC state-specific report for SIRs will incorporate data since April 1, 2010. There will be a state SIR for California, which will be another measure of how California hospitals in the aggregate are doing compared to hospitals in other states. While there could be some controversy over validity, publishing SIRs on a state level is a very different issue from publishing a list of individual hospitals with individual SIRs. There may well be a national trend over the next year for states to stop publishing hospital-specific SIRs.

The question was raised as to why CDPH is not focusing on zero as the benchmark. Currently, the national precedent is to compare against the average for each stratum, and the public can click on the table that gives the stratum specific results where they can see the actual number of infections. An Advisory Committee member noted that everyone agreed in concept that the target is always zero--zero tolerance for poor processes and ongoing improvement. This data will enable the HAI-AC and CDPH to identify opportunities for improvement.

The issue was raised as to how many hospitals in California are specific to pediatric rehabilitation; there are only two units. It was pointed out that a pediatric patient transferring from a Pediatric Intensive Care Unit (PICU) to a rehabilitation unit represents an at-risk population. CDPH agrees with this assessment but at the moment the charge of the EU is to determine if strata may be published as "stand-alone." The data suggests that there are infections occurring in these locations and those are

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going to be published. They will not, however, be published against an average and are not going to be averaged into a general pediatric ward because their risk is different.

There are many ways that patients are overlapped when mapping acute care hospitals in California. However, if a facility has a purely or 80% pediatric rehabilitation unit in an acute care setting, it would not be designated as a pediatric rehabilitation unit. A participant also noted concern that the pediatric rehab units may be misclassified (that nonacute care rehab units have been mistakenly been classified as inpatient acute care rehab units).

CDPH outlined the reporting schedule: The previous reporting period covered data submitted through March 31, 2010. CDPH and hospitals has moved to a separate surveillance and reporting system beginning April 1, 2010-March 31, 2011 – CDPH will issue a report that will be delivered in January 2012 and covers the period April 1 2010-March 31 2011.. CDPH proposes to release a report in July 2012 that will cover data from January 1, 2011 through December 31, 2011. Reports thereafter would be issued every July 1, which allows time to clean the data. Each July will produce data from the previous calendar year.

It was noted that CMS will begin to use the SIR when they publish rates in 2013.

CDPH may look at the state as compared to the national average for the technical report only, and does not feel this is the time to test a specific California hospital against the national average.

### Public Comment

A guest was interested in how interactive the final report will be and whether CDPH has the resources to create for example, pop-up balloons that provide additional information. It is CDPH's intention to make the report informative and accessible to the public and will do whatever possible, within the parameters of the Department's resources and technology, to make the report visually attractive, useable, and informational.

### • **Motion to accept the CDPH's proposed standard measures for public reporting of CLABSI data**

- Motion – Myers
- Second – Wittman

Yes – 16 (Flood, Witt, Terashita, Rogers, Eck, McLean, Torriani, Myers, Wittman, Delahanty, Winston, Mendelsohn, Murthy, Chinn, Mikles, Oriola)

No – 3 (Harris, Moss, LaBar)

Abstain – 0 (Motion Passes)

## **HAI-AC Bylaws**

### Background

The HAI Program has been charged by CDPH to develop written bylaws for the HAI Advisory Committee based on SB 739 directives. The purpose of bylaws is to formally address issues such as structure and membership, define Committee rules such as what constitutes a majority and how a quorum is defined, and to address the categories and balance of representatives who sit on the Committee, as outlined by SB 739. The bylaws are a natural continuation of the discussions that began when the Advisory Committee was a working group in 2003, but were set aside to address the urgent need to advise CDPH on public reporting of HAIs

Prior to drafting the Advisory Committee bylaws, CDPH reviewed bylaws from other Committees within and without CDPH, relying primarily on the HICPAC model, which is the HAI-AC's national counterpart. CDPH also studied the Bagley-Keene Open Meeting Act of 2004 to ensure that all

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provisions of the statute are being followed.

The bylaws will be helpful to new members by enhancing and accelerating the orientation process.

### Discussion

CDPH asked the Advisory Committee to focus particularly on the Committee's composition as required by SB 739 and definition of the categories, the transition process from the existing membership structure, and term limits.

**Article II Section A Page 3 – Number of Members:** Discussion ensued as to the size of the Committee. The minimum would be eight (8) members based on the eight required representative categories. However, the group was divided on the maximum number of members. Proponents of reducing the membership felt the Committee would be more manageable. Opponents opined that a smaller membership body will make it more challenging to populate the subcommittees and there would be less of a body of expertise. CDPH reminded the members that although recommendations will be taken under consideration, final approval rests with the CDPH Director.

- **Motion: In order to complete the work of the HAI AC and adequately staff the HAI AC Subcommittees, the HAI AC recommends that maximum number of members be 24, excluding liaison members.**

- Motion – Mendelsohn
- Second – Eck

Yes – 9 (Harris, Witt, Terashita, Eck, MacLean, Wittman, Winston, Mendelsohn, Chinn)

No – 1 (Moss)

Abstain – 9 (Flood, Rogers, Torriani, Myers, Delahanty, LaBar, Murthy, Mikles, Oriola)

(Motion does not pass)

**Article II Section B Page 3 – Appointment Process:** Members suggested clarifying criteria that would constitute grounds for dismissal from the Advisory Committee. It would be very difficult to cover all criteria for dismissal, but a member expressed that, although there are some justifiable reasons for dismissal, there is concern about dismissal based on hearsay or a comment taken out of context. The Chairperson pointed out that serving is at the pleasure of the CDPH Director's and is not within the Advisory Committee's purview. It was decided to strike the last sentence, "The Director may exercise the right to ask a member to resign at any time."

**Article II Section C Page 3 – HAI AC Composition:** Members reviewed the membership categories. An ID pharmacist and a CFO were two specific suggestions to enhance the HAI AC membership. CDPH stressed that the categories are specific to SB 739 and CDPH wants to avoid members who function as organizational representatives, as that is what the liaison category is for.

One of the challenges of populating the Advisory Committee with the mandated range of expertise is finding hospital administration professionals. It is difficult to get a CEO to commit to HAI AC membership as it may not be their core interest. However, a Deputy Officer who directly represents the CEO may be a way to circumvent this challenge. Another suggestion was to recruit a recently retired CEO who remains well-informed and has the time to sit on the Advisory Committee. However, a retired expert is less likely to have current ties to the HAI community unless s/he is consulting.

The Committee agreed that a healthcare consumer could be a healthcare activist or advocate.

**Article II Section E Page 4 – HAI-AC Chairperson:** The members expressed concern about a 2-year membership term for the chairperson, based on the complexity of the issues that the Advisory Committee addresses and how long it takes to get up to speed on those issues, and the Chairperson

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should be a seasoned Advisory Committee member. It was suggested that the Chairperson be excluded from term limitations.

Members also questioned whether the term “coordinate” is the best way to describe how the Chairperson works with CDPH to produce the agenda and meeting summaries. The Chairperson stated that she was voted in by the Advisory Committee members and collaborates with CDPH; however, it is CDPH who has the final say in all Advisory Committee activities. The Chairperson advises CDPH in regard to the meeting agenda and the meeting agenda is a coordinated effort. CDPH always takes under consideration the needs and suggestions of the Advisory Committee in setting the agenda.

CDPH stated that a new leadership team was coming on board very soon, including the new California Department of Public Health Director. Although the HAI AC has done a phenomenal job without bylaws, the new bylaws are needed to direct the composition and activities of the Advisory Committee and will be reviewed and approved by the new Director. The Advisory Committee recommendations will be captured and taken to the Director; however, he will be the one who actually determines the final set of bylaws. Although there is a section in the bylaws for amendments, the Director will determine if any amendments are necessary.

**Article II Section J Page 6 – Transition Plan:** CDPH stated that the starting date for the transition plan will take a bit of time to determine, but the Advisory Committee will be informed as soon as a date is set. There will be an application process, applications will be reviewed by the CDPH Director, and appointments will be made.

**Article III Section B Page 7 – Voting Rights:** A member stated that voting should be guided by a 2/3’s consensus as opposed to a majority vote. Another member requested that CDPH clarify “public location” and voting by phone, which is not included in the Bylaws.

A member questioned why there was no provision for alternate members. Alternate members will not be considered for the Bylaws as CDPH could not find any Committee which had a provision for alternates. Further, another complication is that there is a process for appointing members and that will be the CDPH Director’s job; otherwise an HAI AC meeting could potentially be completely represented by alternates.

CDPH thanked the Advisory Committee for their input on the bylaws and asked that additional comments be sent to the Department by the end of the week.

#### Final Comments and Conclusions

Subcommittee reports will be deferred until next meeting. At this time it is unclear when the next meeting will take place, given that the Executive Order to curtail all non-essential travel remains in effect. CDPH stated that it went to extraordinary measures to have this meeting determined “mission critical.”

#### **Action Items/Next Steps**

- CDPH will resubmit the April 14, 2011 Meeting Summary revisions and depict voting by name, for a vote to approve at the next meeting.
- CDPH to send a thank you letter to Terry Nelson
- HAI AC members to advise CDPH of specific messages that are being sent to hospitals regarding CLABSI surveillance
- CDPH will ask the Metrics Working Group to look into comparing hospitals in California to the national average.
- Agenda items for next meeting: CLABSI public reporting update, Subcommittee reports
- CDPH to seek legal clarification regarding the rights of meeting attendees (members and public) who teleconference
- CDPH will research whether it is legally feasible to duplicate the Consumer Reports method

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| <p>for depicting variance; CDPH will consider the issue of further discrimination of results</p> <ul style="list-style-type: none"><li>• The next HAI-AC meeting is tentatively scheduled for August 18 from 10:00 AM to 3:00 PM. Location to be announced.</li></ul> |
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## Acronyms

<b>AFL</b>	All Facilities Letter
<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>CLD</b>	Central Line Days
<b>HAI AC</b>	Healthcare Associated Infections Advisory Committee
<b>HICPAC</b>	Healthcare Infection Control Practices Advisory Committee
<b>IP</b>	Infection Preventionist
<b>MRSA</b>	Methicillin-resistant Staphylococcus aureus
<b>NHSN</b>	National Healthcare Safety Network
<b>PD</b>	Patient Days
<b>QC/QA</b>	Quality Control/Quality Assurance
<b>SIR</b>	Standard Infection Ratio
<b>SSI</b>	Surgical Site Infection