

**2007 Annual Report of the Healthcare-Associated Infections Advisory Committee to  
the California Department of Public Health  
Covering Activities July 1 through December 31, 2007**

**History of the Committee**

In 2003 report, the Little Hoover Commission, an independent state oversight board, recommended that California bolster technical, scientific, and physical capacity to counter preventable healthcare-associated infections (HAIs), and that a scientific panel be convened to make recommendations. In 2005, an HAI Advisory Working Group (AWG) convened by the California Department of Health Services (CDHS) submitted a report to Sandra Shewry, CDHS Director, entitled “Recommendations for Reducing Morbidity and Mortality Related to Healthcare-Associated Infections in California: Healthcare-Associated Infections Advisory Working Group Final Report to the California Department of Health Services, December 31, 2005.” This report was used to develop Senate Bill 739, (Speier, Chapter 526, Statutes of 2006), which requires mandatory reporting of infection control and surveillance process measures. The California Department of Public Health (CDPH) used existing contract funds for one year of funding for a program coordinator and logistical assistance for an HAI program.

**Implementation of SB 739**

In June 2007, CDHS appointed a new Healthcare-Associated Infections Advisory Committee (HAI-AC), subject to the Bagley-Keene Open Meeting Act. Many members of the 2005 committee, including Chair Kim Delahanty, continued on the new committee. CDPH subsequently appointed additional experts to fill gaps in certain technical areas. CDPH’s Sue Chen served as program coordinator. The HAI-AC website at [http://www.cdph.ca.gov/services/boards/Pages/HAI\\_AC.aspx](http://www.cdph.ca.gov/services/boards/Pages/HAI_AC.aspx) contains meeting agendas, minutes, and additional information.

The full HAI-AC met in August, September, and November 2007. Per SB 739, reporting is to begin “on or after January 1, 2008,” so the committee’s first priority was to make recommendations regarding how hospitals will report data to CDPH. The HAI-AC recommends that hospitals report via the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). CDPH sent All Facilities Letter 07-37, dated November 27, 2007, to inform general acute care hospitals that they must enroll in NHSN. As of December 31, 2007, 55 of California’s approximately 400 general acute care hospitals are enrolled in NHSN. The HAI-AC anticipates that enrollment in NHSN will represent a significant increase in workload for infection control professionals, who will largely be responsible for implementing reporting. CDPH’s HAI program coordinator is providing education on reporting at Association for Professionals in Infection Control and Epidemiology (APIC) chapter meetings statewide. Four of 12 chapters have received education, with the remainder scheduled during January and February 2008. Because CDPH anticipates that NHSN will release process reporting modules with additional training requirements in February 2008, CDPH has encouraged hospitals to complete basic enrollment by the end of January 2008.

HAI-AC’s second priority was to recommend how hospitals should report on the process measures for: 1) central line insertion process (CLIP), 2) influenza vaccination for

employees and high-risk patients, and 3) the judicious use of antibiotics/surgical antimicrobial prophylaxis. HAI-AC formed subcommittees for each of the three process measures.

The HAI-AC CLIP Subcommittee felt that the amount of data required by the NHSN module for central line insertion practices is not the best use of surveillance resources and suggested that hospitals collect fewer data points. A major challenge is how to meet NHSN requirements for frequency of data submission. Certain fields in a module must be entered for the record to “count,” and at least one complete module must be submitted by a hospital in 6 of every 12 calendar months. Failure to meet NHSN reporting requirements could result in the hospital’s disenrollment from NHSN, which would put the facility out of compliance with SB 739. The CLIP Subcommittee continues to work to resolve this issue and will report to the full HAI-AC in January 2008.

SB 739 requires that general acute care hospitals offer employees influenza vaccination annually at no cost and require that employees be vaccinated or sign a declination of vaccination. SB 739 further requires that hospitals follow CDC guidelines for influenza vaccination of patients (not further defined or specified). The HAI-AC Influenza Subcommittee expressed concern regarding the amount of work required to report employee vaccination rates. Major issues include: 1) potential partial use of an NHSN module for demographics, which would lead to failure to meet NHSN reporting requirements for the influenza module, 2) whether reported vaccination rates should encompass hospital employees only or include other healthcare providers (such as licensed independent practitioners), and 3) lack of an identified process to report to CDPH an employee/healthcare provider vaccination/declination “rate.” The subcommittee may recommend that CDPH develop a reporting form for this purpose.

Some hospitals currently report immunization of inpatients to the Centers for Medicare and Medicaid Services (CMS), but not all acute care hospitals are required to participate. CMS targets only patients ages 50 or over that are admitted with a diagnosis of community-acquired pneumonia, while CDC identifies more patients as needing influenza vaccination. To fulfill the statutory requirement for reporting on vaccination of patients, the HAI-AC Influenza Subcommittee will explore using data that hospitals already report to CMS.

The HAI-AC accepted the recommendation of the Surgical Care Improvement Project (SCIP) Subcommittee to use data for surgical antimicrobial prophylaxis that hospitals already report to CMS. Approximately 75 percent of California hospitals report this data. Lumetra, the Quality Improvement Organization that holds the California contract with CMS, will aid hospitals not already reporting data to CMS, so that hospitals will comply with this portion of the required process reporting. Still unresolved is how to organize the data that CDPH downloads from CMS into a format that can be more readily analyzed. Lumetra and CDPH are working to resolve this issue.

The HAI-AC Legal Subcommittee, headed by the California Hospital Association (CHA), explored whether data reported to NHSN are protected from use in litigation (i.e., are the data discoverable?). NHSN data are protected from discovery, however data downloaded

from NHSN by CDPH are presumed discoverable. The Legal Subcommittee suggests that CDPH sponsor legislation to protect such data from discovery.

At the November 2007 meeting, CDPH requested the HAI-AC address mandatory reporting of healthcare-associated methicillin-resistant *Staphylococcus aureus* (HA MRSA) infections. Accordingly, HAI-AC formed a subcommittee and invited additional experts to participate. The subcommittee devoted its initial meetings to: 1) determining how surveillance data can best be used, 2) defining the category of MRSA (community-acquired, healthcare-associated, or nosocomial) that would be reported and 3) identifying options for surveillance. When the full HAI-AC reaches consensus on these issues, it will make recommendations to CDPH.

Respectfully submitted,

Kim Delahanty, RN, BSN, PHN, MBA, CIC  
Chair, Healthcare-Associated Infections Advisory Committee

Sue Chen, RN, MPH, CIC  
CDPH Healthcare-Associated Infections Program Coordinator