

**Healthcare-Associated Infections Advisory Committee Meeting
December 9th, Sacramento, California. 10:00 a.m. to 3:00 p.m.**

Attendance:

Members: Kim Delahanty (Chair), Mike Butera, Annemarie Flood, Holly Harris (alternate for Cole), Lilly Labar, Michael MacLean, Mary Mendelsohn, Roberta Mikles, Carole Moss, Terry Nelson, Shannon Oriola, Debby Rogers, Francesca Torriani, Kathy Wittman

Guests: Jane Burkhardt, Enid Eck (member offsite from non-posted phone), Debby Long, Rehka Murthy (member offsite from non-posted phone), Ralph Montano, Daniella Nunez, Pam Pyres, Kimberly Radcliffe, Deborah Shoch, Lynn Wilkins, Melissa (last name not provided)

Staff: Loriann DeMartini, Jon Rosenberg
Sam Alongi, Roberto Garces, Lynn Janssen, Cheryl Kalson, Jorge Palacios, Dirk Winston

Agenda Items/Discussion	Action/Follow-up
<p>Call to Order and Introductions:</p> <p>HAI AC Chair Kim Delahanty (Chair) convened the meeting.</p> <p>This is an important endeavor we have taken on and we are coming down to the last of the review of the data.</p> <p>I appreciate everyone's hard work in the room and outside of the room. There is a lot of work done in subcommittees outside of this meeting.</p> <p>Introduction of Roberta Mikles-</p> <p>Chair - I want to introduce Roberta Mikles. She is a new HAI AC member and I will let her tell you about herself and her background and experience with issues of healthcare associated infections.</p> <p>Mikles- Thank you. It is a real honor for me to be part of this. I started as a consumer, just listening, and became very interested. My background is in dialysis and I analyzed surveys from 2003, noting major problems in infection control.</p> <p>I bring to this committee an objective standpoint because I have been on the side of the provider; I have been a patient; I have been a family member of those dealing with these issues. So I appreciate things differently than some of the consumer advocates, some of the providers, some of the CDPH people here. I hope what I bring is appreciated.</p> <p>(Ms. Mikles described family experiences dealing with medical errors and infections.) I have also been very outspoken about dialysis issues. Dialysis patients have an average of two hospital visits per year, so are a key subgroup in this fight against preventable infections. I appreciate being on this Committee.</p> <p>I see state employees working extremely hard. I know that budgets were cut so their hands were tied at some point. The advocates are focused and the providers are dedicated and sincere. I hope I bring something to this.</p>	<ul style="list-style-type: none"> • HAI AC staff to have November 2010 and December 2010 draft minutes for HAI AC review at the January 13, 2011 meeting. • Standing action item: each HAI AC subcommittee Chair will prepare and send a report of subcommittee information presented during the current HAI AC for HAI Program distribution to HAI AC members.

<p>Review of Rules of Order: Chair briefly reviewed the active rules of order used by HAI AC, including following the queue and respecting speaker opinions, as well as limiting comments to two minutes and not repeating statements which have already been made.</p> <p>Note that there will be public comment after each topic today.</p> <p>Introductions were made at Sacramento and on the teleconference lines.</p> <p>Chair - We will defer approval of the November minutes to the January meeting. Also, changes in Committee membership have not yet received final approval, so those membership changes will be announced in January.</p>	
<p>Public Story: Moss - Today we have Kimberly Radcliffe to share her story. Ms. Radcliffe described her family's experience with healthcare associated infections and other issues of hospital care which led to the loss of her two year old daughter.</p> <p>Ms. Radcliffe's daughter, Charlie, was identified as having an atrial ventricular septal defect which required corrective surgery. Due to her weakened immune system and health issue, prior to surgery the family was careful to limit Charlie's exposure, and were careful with washing, sanitizing and other practices. After surgery, numerous care issues and infections kept Charlie in the hospital until she died, 95 days after admission.</p> <p>"We will never understand how this could have happened. Her immune system had been fine when we had her at home for five and a half months. I was so angry after she passed, I just wanted answers. I sent emails to everyone I could think of asking how this could happen. I got one response that told me that the hospital she was at, the Director of Infections and Disease Control was one of the country's best researchers and that this person was sure they had a great program. That scares me that my daughter can get this at one of the <i>best</i> hospitals. Where does that put the rest of the hospitals?"</p> <p>I was also told that her case was not reportable by identifier. I'd like to say that it only takes one less to make a big difference. I appreciate everyone's time and I know everyone is here to work on this."</p> <p>Chair - We are here for those reasons to prevent that from happening to anyone else. We really believe that one less <i>is</i> very important. Thank you for keeping us focused and we are very sorry for your loss.</p> <p>Rosenberg - I have spent more time in neonatal and pediatric intensive care units than any other place in hospitals and if anyone wants to understand where the front line is, that is the place to go.</p>	<ul style="list-style-type: none"> • HAI Program to send a Thank You letter to Kimberly Radcliffe for sharing her story.
<p>HAI Program Update: Jon Rosenberg I want to start by introducing Dirk Winston. Dirk is orienting himself with NHSN and will be the program manager for the CDPH group for NHSN</p>	<ul style="list-style-type: none"> • CDPH to ensure that the data tables for 'Trauma Centers' include all levels (1 through 4) and that the

issues. He will be the key point of contact going forward for the provider community and interfacing with CDC and NHSN over group issues.

Dirk has been in state service since 2004, initially with the state compensation insurance fund, but for the last five years with the Department of Corrections both for Sacramento and Fresno, and involved with two different start-up programs there, and has had data management responsibilities in those programs. We are happy to have him here.

This does leave us with one key vacancy in the epidemiology unit, so we are still shorthanded and for two months; the Program has focused all efforts on forthcoming reports, so we haven't been able to pay as much attention to NHSN going forward as we would have liked, but we will from this point on.

Moss - When you say that you are still shorthanded, how many more positions do you have to fill?

Rosenberg - One vacancy; that is 20% of the unit.

Moss - When do you think you will have that resource?

Rosenberg - We have no information on when the current hiring freeze might end.

Moss - In the hearings with Senator Alquist there were discussions on filling that position with a consultant. It sounds like you are able to fill that position with a consultant.

Rosenberg - That will take some months. Any contract would have to go out to bid. I am hoping we can fill the permanent position before the contract is done.

There was a request from the Committee to visually see the format of the data presentation in the report. I did bring a hospital redacted example of two of the tables in the report. Keep in mind that this is a draft report that is undergoing Departmental review; therefore, the presentation may be different in the final report.

Chair - This was emailed last night to Committee members.

(Tables displayed for review)

Rosenberg - There are two types of tables. Table one (there are thirteen additional tables by condition of interest and type of facility) is the number of complete quarters of healthcare associated bloodstream infections surveillant data reported by California facilities and patient care locations between January 2009 and March 2010.

The first column is the hospital licensee or campus name. In recent years many hospital systems have consolidated a number of formerly independently licensed acute care hospitals under a single license.

The reporting laws state that the reporting must be by licensed general acute care hospitals. That may have several campuses under a single

data carved out of the other tables is carved out for all levels (1 through 4) of trauma centers as well.

licensee. CDPH does not have the authority to direct hospitals to report by individual campus or licensee. Some reported separately, while most reported as a single unit. Throughout the report entities are referred to as reporting facilities. There are 375 licensed general acute care hospitals during this period, but 383 reporting facilities, so there are eight individual campuses that reported separately. The campuses are grouped under the licensee.

The Program stratified the bloodstream infection data according to whether the facility is a teaching hospital, a pediatric hospital, or a hospital with a trauma unit.

There are footnotes on the left side and gaps on the right column. The footnote marks are the licensees with multiple campuses.

There are five quarters of reporting for each category; MRSA bloodstream infections which are facility wide; VRE bloodstream infections which are facility wide; and Central Line associated bloodstream infections for which hospitals could report ICU data, non-ICU data or facility wide, or some combination of all three. This report documents the number of quarters the facilities reported for each of those categories. Many hospitals did report all five quarters for all of the categories. There is no hospital on this page with all zeros, but there were nineteen that reported no data.

Chair - To clarify, there are numbers on the right-hand side of the form that represent the number of quarters reported by facility.

Rosenberg - The reporting requirement went into effect January 1st, 2009. For the next five quarters, until CDPH was able to require hospitals to report into the NHSN via electronic reporting with patient specific information, for these five quarters, reporting was done by paper form, with two numbers for each of these quarters by category. The numerator was the number of patient infections, and the denominator was the number of patient days for MRSA and VRE and line days for ICU and non-ICU.

In the report, there are more hospitals that reported ICU data than reported non-ICU data. The Program also recorded whether they had an ICU or not. Any hospital that recorded a numerator or denominator for any one of the quarters for any infection category would get a value of one through five.

McLean - Regarding the quality function of the reports, some reports are presumably more complete than others. Do they need to meet certain criteria to be counted in the report?

Rosenberg - They have to report a numerator and a denominator to be considered. For the bloodstream infections, the Program went through two sets of processes of data verification and data correction. The first process was providing back to all hospitals what had been received from them; enabling verification of receipt and allowing facilities the opportunity to verify their information. For those hospitals told that a report had not been received for a certain quarter or category, those facilities then had the opportunity to then report that data. There were a number of hospitals who claimed to have sent in reports; in some cases these were found,

and in others the hospitals could report missing data.

Once the Program verified receipt of the data, the data was reviewed for evidence of errors and quality of data. The Program called the hospitals with the highest rates of infection to validate the data. If anomalies occurred, such as a numerator larger than the denominator, the Program contacted the hospital to assist with correction of the information.

McLean - Some hospitals do a better job of verifying and reporting than others.

Rosenberg - There is *data accuracy* and then there is *data validity*. Validation is planned for the near future but was not part of this process.

Flood - So the first line (on the example, posted to the HAI website) is the hospital licensee with multiple campuses that chose to report as a single entity. That licensee reported MRSA for all campuses for four of five reporting quarters, five out of five for VRE. They did not separate ICU or non-ICU. It is just a number over a number for each of those.

Rosenberg - The law only requires the reporting of all central line associated bloodstream infections and their number of line days. From a statutory basis, they are in compliance if they reported facility-wide. Because of the need to segregate ICU and non-ICU, in the absence of NHSN which will segregate by all units, on the forms CDPH provided the opportunity to report both by ICU and non-ICU.

Flood - Question: Even though they had the opportunity to report, they chose not to?

Rosenberg - Right. Many hospitals at the beginning of 2009 did not have a process in place to monitor central line associated bloodstream infections outside of ICU's. The tables show more complete reporting from ICU's than non-ICU. There were other issues; for example, many hospitals reported three sets up numbers that didn't add up. The Program then went back to them and explained that non-ICU means all non-ICU units combined. The ICU and non-ICU should add up to one number that represents the facility wide number.

Labar - In the first quarter of 2009 where many acute care units did not have a system of counting line days. It is a little more difficult for smaller hospitals that do not have computerized EMR; it is one person counting one by one. Consumers will scrutinize that, but the law went into effect and facility staffs scrambled to meet that law.

Rosenberg - You will see the number of line days in the non-ICU section is significantly larger than the ICU days. There are more patients with more lines for more days in non-ICU. When they are in an oncology or dialysis unit, there are a number of different units with patients with lines, so someone needs to count the line days each day. You cannot do that retroactively. If it wasn't done on that day, unless you have a record system set up to track that, it cannot be done retroactively. If they didn't have that, they were unable to report.

Pyres - Why are surgical site infections not listed?

Rosenberg - Not until 2012. That is what the law states.

Pyres - With all of this information, it will be posted so that average person like me can choose the right hospital? We need to have all the information posted. This is people's lives. Where are we at now?

Chair - Based on the mandatory public reporting on a public report card vs. what actually is happening in hospitals, we have been doing surgical site infection prevention and monitoring for twenty or thirty years in an internal process, and bringing that up to our quality departments to make process improvements. We have been implementing strategies to prevent infections from happening, whether it is surgical site, central line, urinary tract, ventilator associated. The law that was passed relates to *public reporting*. We are here to make sure that data gets onto the public report card and that there is an education process for the public so that you know what you are looking at. As we go through our agenda today we will discuss how we are going to develop that program.

CDC documents surgical site infection data and posts it on their website. Anyone can go to the site and see that. It is blinded by hospital, but breaks down the types of hospitals and facilities and gives the rates of surgical site infections. We are going to be on the cutting edge in California because we are going to be able to directly show the rates for our state and the patient population will be able to see this information.

Moss - Where are you going to identify what the headings mean?

Rosenberg - There will be footnotes to describe terms and categories and make any other clarifications.

Chair - At the November meeting Enid (Eck) volunteered her group's educational component to help with formatting for public education. We didn't have a process because we didn't know what the data looked like. Now that we have a format, we will be going forward with the public education plan and be discussing that in the committee today and also getting feedback from Enid.

Eck - Carole, we will need to work on this offline. There were a number of issues that the health education group found in terms of reading level and compliance. We started working on it and I think we probably need to do some work offline.

Chair - I just wanted to assure everyone that we are looking at the reading level, the key words and definitions, and all of that will be wrapped up in this Public Education and Reporting Subcommittee.

Wittman - Facilities that have the electronic records are trying to find ways to extract that. Just because it is in a medical record does not mean it can be extracted.

Rosenberg - A human being still needs to record each day that a line is in place. If that doesn't happen, it doesn't matter whether the record is paper or electronic as there is no record of a line on that day.

Torriani - This form we are looking at is not data. It is the completeness of the data. Are we going to see the data?

Rosenberg - Yes, on the next slide. There will be a technical report on the website. There will be additional material. But the only data will be contained in the technical report that is under review with the Department.

Torriani - And the data will be reviewed by the Committee before it is released? If this is going to be released to the public, there has to be a check and balance.

Rosenberg - There is a request that the Committee see an embargoed copy of the report before it is released but not to review it. There will not be time for the Committee to provide input. The data is in review now.

Torriani - We are used to seeing the data. How are we assured that the public will understand what the data is?

Rosenberg - That is the purpose of showing you the tables today.

(Next slide is displayed)

Rosenberg - All of the subsequent tables for MRSA bloodstream infections, VRE bloodstream infections, and CLABSI in and out of ICU's and facility wide by hospital type, with a table for teaching, a table for pediatric, a table for hospitals with trauma units, and a fourth table for hospitals that are not teaching, not pediatric and do not have trauma units, will be presented for each category.

(Rosenberg highlights information within the slide)

The Program found it unreasonable to rely on data reported for three or fewer quarters, because of how hospitals would have selected which of the quarters to report, but the group agreed that reporting four out of five quarters was sufficient. CDPH has provided a crude rate for the central line associated bloodstream infections for each facility.

The first column displays the case mix index (an index that generally reflects the acuity of the patients). This is a number produced by the Office of Statewide Health Planning and Development (OSHPD). They receive from hospitals information about the nature of the patients and the services provided. Based on that coding information, they generate the case mix index. A '1' would be an average mix, anything above '1' is higher acuity, and anything below '1' is a lower level of acuity. A limitation with the case mix index is that there is dependence on the hospital resources and sophistication of the coding. Hospitals with more resources might provide more coding data, and a hospital with a higher level of acuity but less coding resources might have a lower case mix index.

Within the categories of teaching, pediatric, trauma and none of the above, the case mix index is useful as a point of reference for the hospital's level of acuity. This tells you that the hospitals are not all the same.

Then there is the actual rate of infections per thousand line days. For

example, the third hospital has a below '1' case mix index and a high rate of infection at 5.70 (per thousand days). But when the 95% confidence limits are included, you can see the lower limit could have an infection rate of .15 days and as high as 31. If you look at the total line days, you can see why. This is a very small hospital. One more or less infection can have a tremendous effect on the rate. You may ask, given that range of confidence, why would we show this hospital at all. One hundred line days is the typical limit used by CDC and other states as the cut-off point. This was a hospital with too few patient days and too few line days, but most hospitals had sufficient days to meet those criteria. But given that this applies to all California hospitals, 100 line days is a very small number, so there are some small hospitals with low number of line days whose numbers are going to jump around because of the effect of a single infection. That is why the confidence limit will be included.

For larger hospitals, with more line days, the range on the confidence limits is much smaller. You can also look at hospitals that reported zero infections, and see whether the confidence limit includes zero.

Oriola - Would the Committee have an opportunity to look at the embargoed report with the data to make modifications to the report and an interpretation? The Committee's input could make the report more meaningful to the consumer.

Rosenberg - CDPH has requested permission to send out an embargoed report. But the report cannot be modified. Even if an embargoed copy is allowed, it will be the final report. This is a technical report and the Program is working with the Public Education and Reporting Subcommittee in preparing the material for the website with a link to the technical report, with an explanation for the public. CDPH will post as much as possible on the website at the same time the technical report is posted. There will be a page for MRSA infections, for central line infections, and VRE infections, with explanatory material.

Oriola - But in terms of getting that report in enough time to interpret that for the layperson, I don't know how much time will be there.

Rosenberg - This is going to be the format of the report and the difference will be that it will include the name of the hospitals, unless we are instructed to change the format.

Murthy - You (to Rosenberg) mentioned the tables would represent the different type of hospitals. Would a hospital that has teaching and a trauma center show up on multiple tables?

Rosenberg - Yes. Wherever the hospital meets the criteria, it will be included in the table. It is possible that a facility could be included on three of the four tables.

Chair - That needs to be clarified in the report, that there is nothing wrong with appearing in the report three times.

Rosenberg - There are separate tables for MRSA, VRE and CLABSI. Let's leave C diff out of this for right now. There are four tables for each infection; teaching, pediatric, trauma and none of the above. There were

hospitals that continued to use patient days for CLABSI, and that was considered to be non-reporting. CLABSI reporting is to be by line days. MRSA is by patient days.

McLean - When you were reading the title, you said that it was level one through three trauma centers, and that is not what that says. What is the status of the level three trauma centers? All trauma centers should be dealt with the same. You have some high risk groups that are going to be handled on a different table, but if it is a trauma center, it should be dealt with the same.

Rosenberg - I don't know. We used whatever licensing categories were available to us.

Chair - Regardless of what level it was, it is under the trauma report, correct?

Rosenberg - I don't want to answer that right now because I was not personally involved. The person who handled that is in Indianapolis right now.

Moss - Why are we not adding these rates. Why can't we show the numerator?

Rosenberg - The principal reason is that all larger hospitals, regardless of rate, are likely to have higher numerators. The point of comparison is the rate or the risk adjusted rate, not the numerator. You can multiple the rate times the central line days if you want to.

Moss - We are doing this for the consumers, not for the clinicians and not the hospitals. It would be beneficial to divide it so that the consumer can understand the charts better.

Chair - This is just for these five quarters, and going forward will be NHSN risk adjusted data. I think that is a reasonable recommendation.

Moss - You mentioned that there was a problem with receiving the data and that people faxed it, and we don't know where it went. How do you rectify that going forward to verify receipt and confirmation?

Rosenberg - Since April 1st, all HAI data that is presented in these reports, it has all been reported in electronically through NHSN, so it cannot get lost. Also, CDPH is in the process of instituting a continuous quality control and quality assurance process, just as CDC does to a limited extent already. There are also certain errors that the system will not allow to be made. There are error messages to guide people to enter the correct information. This doesn't mean it is perfect, but it simplifies the process. Even though the law requires quarterly reporting, NHSN requires monthly reporting. CDPH has staff in Richmond who can do reports and analyses for data quality. There are nine IP's in a liaison staff in the field who have used NHSN who can go to sit with a hospital's staff to help them enter the data. So CDPH can look at the data both remotely and onsite with the people processing the information.

Moss - There were two things we had asked for. We need to be able to

review and approve the minutes, and we had requested a list of hospitals that had registered for NHSN and had given authority for the CDPH to report. There was a document from Senator Alquist's office requesting the list of hospitals that have not conferred authorization to the CDPH to access their information through NHSN. We would like to see the list of the hospitals that have had two years to register and have not.

Rosenberg - 99.5% of California hospitals are enrolled or providing data. There are two hospitals that have not provided that. There were 24, and now 22 of those are in compliance.

Moss - Who are the two who are non-compliant?

Rosenberg - 373 of 375 licensed acute care hospitals are enrolled. It has taken a major effort on the part of the staff in Richmond and the liaison staff to complete this.

Chair - In our letter to Senator Alquist we will provide the names of those facilities. The HAI AC requested this information from CDPH, but it was not provided.

Regarding the minutes: this is the first time we have had such a quick turnaround—three weeks between meetings—as the Committee usually meets every four to six weeks. Proper completion of the minutes and meeting the Bagley Keene rules for posting means that the minutes were not ready for this meeting. They will be posted this week and then we will approve them in January. This is the first time we have had a three week turnaround between meetings.

Moss - You are going to post minutes that are not approved yet?

Chair - Which is what we do; yes, they are stamped 'Draft'. The Committee will approve (or modify and approve) the minutes in January.

Wittman - I appreciate the format of this report (referring to the technical report), especially Table 13. I have been looking at what Washington put out; I like the fact that there is a risk stratification component. Adding an absolute number *is* important from a consumer point. I would hope that if we put an absolute number, that we put a note for the consumer that an absolute number should never be the single component for hospital comparison, but that it can be used in addition to line days and case mix

Nelson - We work hard to express the rates, but there is no way to compare just using raw numbers. When you express things as a rate, you can have an understanding of how often something happens based on what exposure people have to a circumstance. When we say a rate is two per thousand line days, that thousand line days represents the amount of exposure the patient had to that risk, so it is important to express this in a rate. As infection preventionists, we are always cautious to express things as rates. This is all before the period of using NHSN, and there were a number of different interpretations. Once we move past that, we will be able to express things more clearly. Because this takes so much technical language, we wanted to keep this in a technical report and provide additional education to the public regarding what hospitals are doing to prevent infections and what the consumers can do to prevent infections.

Rosenberg - NHSN is moving toward expressing data as a single number, the Standardized Infection Ratio, or SIR. The intent for the consumer is to be able to put that into a single number; the number of observed infections divided by the number predicted for that facility given the nature of the patients and the kind of unit information available that impacts the rates of infection. An SIR of one would mean that the number of infections equals the number predicted, more than one would be higher than predicted, lower than one would be less.

Torriani - I ask that the Public Education and Reporting Subcommittee include language *explaining* to the public the method used to determine the range of acuity and the index.

Chair - For further discussion on the public reporting, please contact Carol Moss to assist the Subcommittee as they work through these issues.

Rosenberg - From a technical standpoint, this is the only data for these infections that has been collected in this fashion. The Program did not find any relevant benchmark for these infections to compare them. There was some uniformity in how the data was reported, but not how it was collected, which is why the CDI data is separate. There simply is no other dataset to compare with this data.

Mikles – I have the same document sheet, and it was mentioned in there that the CDPH would be citing those facilities that had not reported by November 30th. Has that been done, or is that going to be done?

Chair - Those two facilities have been reported.

Moss - Why are we not reporting C diff?

Chair - We are, but not in this format. We will be discussing that issue later in the meeting.

McLean - I understand the consumers concern to make this real and to share that we are actually talking about people. If you decide to do that, you need to have a lower limit of the number you report per hospital. For example, in my community, if there is one case in this hospital, everyone is going to know that I have C diff. The notion that you need to protect the privacy of people, if you are going to report the number of people, there needs to be a lower limit, probably around ten. If it is ten or under, we should *not* report by facility, because then someone can trace it back and make inferences about an individual's medical problems.

Pyres - The average consumer needs to see a number. I need to see the hospital and if they are doing badly. If I need to go back to a hospital, I am going to look on there. How is anyone else going to know to look there. I can't do that with rates. The average person needs to see how many hospital acquired infections there were in a hospital.

Chair - There are numerous ideas on the floor, but no motion.

Motion: The HAI requests CDPH to add Numerator column to the technical data tables being prepared for January 1, 2011 release.

- **Motion—Labar**
- **Second—Flood**

Discussion:

McLean - There needs to be a lower limit on the number for hospitals for the purpose of protecting individual privacy, and without that I would not support the use of a numerator.

Harris - The report is not where we need to be for the consumer. When I hear 'two years in the making', that is not satisfactory. Maybe there would be a glossary or an explanation. How would a person know that a certain person's infections were part of these statistics?

Chair - There isn't a way to pull that data out. There is no way to know that infection #1 was a particular person.

Harris - But is there a way to know that the hospital reported every infection?

Chair - No, there is not.

Eck - Does that include the recommendation on the limit?

Chair - No, all numbers.

McLean - If you report one, a lot of people in that person's small community will figure out the identity of that particular person.

Chair calls for the vote.

Restatement of Motion: The HAI AC requests CDPH to add a Numerator column to the technical data tables being prepared for January 1, 2011 release.

- **Motion Passed by (13 yes – 1 no – 0 abstention) vote**

Vote Tally

In Favor: Labar, Eck, Oriola, Moss, Mikles, Butera, Nelson, Torriani, Flood, Wittman, Moss, Rogers, Delahanty

Opposed: McLean

Abstained: Murthy

Moss - Enid is not at a site listed on the agenda. She cannot vote.

Chair - Enid, we did not list the San Diego site. We have to retract your vote. (Additional discussion: Murthy vote also retracted as she participated from a non-agendized site)

Chair - The revised vote count is 11 to 1.

- **Motion Passed by (11-1-0) vote**

Rogers - My concern is that many hospitals cannot be differentiated from each other but the numbers can. Has there been talk about displaying data similar to what OSHPD does where there are categories such as 'average', 'better than expected' and 'worse than expected'? One hospital might have fifteen infections and another two, but because of factors they cannot be differentiated from each other.

<p>Rosenberg - There is no expected number for this data, because there is nothing to compare it with.</p> <p>Chair - We cannot do that with these five quarters because of the way the data was collected. Going forward with data collected since April 2010, this will have been corrected. Please keep in mind when making comments that this is a <i>one-time issue</i>.</p> <p>Eck - If CDPH follows the HAI AC recommendation to include numbers, the table should be formatted so that the numbers are placed in columns immediately before the total number of line days. The consumer would then be able to see if a facility had twenty-five hundred line days and two infections; that is very different from a hospital with one hundred and fifty line days and two infections.</p> <p>Chair - Yes, agreed.</p> <p>Break</p>	
<p>Public Reporting Update: Carole Moss (Mock-up of web layout displayed)</p> <p>This is a revised submission of the layout of a consumer friendly format with colors. We have made some changes based on the feedback from our last meeting. We have also broken out the different sections to show "stellar performance", "better than average" and "worse than average" with different colors to make it easier to read.</p> <p>I think that this format solves many of the problems we discussed earlier. We have grouped facilities into trauma, non-teaching, and so on as discussed.</p> <p>Rogers - So what we don't see is the average category, but there are going to be dozens of hospitals in that category.</p> <p>Moss - Right. And at the bottom, this is for non-teaching, and then we have the pediatric. The last is teaching. At the bottom, it talks about the numerator over the denominator and this can be illustrated in the clearest way possible.</p> <p>Oriola- It should be very clear on each graphic what is being reported. For example, if the table regards the reporting of MRSA bloodstream infections, that should be clearly identified at the top of the graphic.</p> <p>Moss - Right, we are just looking at format here.</p> <p>Chair - The percentage here would be the rate that would coincide with the technical report?</p> <p>Moss - Right. The consumers could look at this and easily understand how the hospitals compare.</p> <p>Nelson- I wonder if it would be interesting to the public if the center bar indicated how many hospitals were represented in that category.</p>	<ul style="list-style-type: none"> • Public Education and Reporting Subcommittee to continue working on public presentation of data, and continue to work with Eck's group to consider appropriate formats, reading level, and other requirements. • CDPH (Janssen) to propose a revised methodology (such as inclusion of confidence intervals) applied to the data tables presented (and approved), subject to approval of the HAI AC.

Chair - They will all be listed. This is just a mock-up.

Rogers - The zero infection facilities being 'stellar', we agree with that, but I am conflicted because all of the other words we have chosen to describe hospitals are objective statistical terms, 'average'; 'above average'; 'below average'. With 'stellar', we are making a judgment and putting a valuation word on it. Having said that, it is stellar. I would like to get a sense of what others think.

Oriola - With zero, if you have one hundred and fifty line days, is that really stellar? So it is up for interpretation.

Moss - That would be a recommendation for us all to think about.

Oriola - Are we using standard deviations?

Moss - Can anyone address that for the group?

Labar - The categories refer to standard deviations around a mean. For example, 'better than average' refers to a number that is one standard deviation above the mean. If we use 'stellar', that is subjective and the public will form an opinion of whether it really is or is not. And can we really say that? I don't think so.

Moss - So for the consumers, would you suggest changing 'stellar' to 'better than average'?

Labar - The mean would be the average, and then there is a gradient up or below that that would represent above or below average.

Moss - So the top would be 'zero', then 'better than average', then "average", and then "worse than average".

McLean - If this is representing the first five quarters, I am concerned about making distinctions that are not real.

Moss - This is simply converting the report into consumer friendly language and determining how best to display it for the consumer.

Chair - This is not interpreting the data. It is complementing the technical report in a format the public will understand.

Butera - This format comparing to national data will be more germane once we *have* national data. The first five quarters will not be germane, but going forward will fit better into this format. We can also look at having a ranked order from 'best' to 'worst' and this will engender healthy competition between hospitals.

Oriola - Some hospitals will not ever be able to achieve a zero. Oncology hospitals, for example, will not have those outcomes because of the definitions, so if we can have explanations about that.

Moss - They could fall into the 'better than average' category.

Chair - When we say "zero", it is zero tolerance to bad behaviors. That is what we talk about in epidemiology. We cannot achieve zero 100% of the time with white blood cell counts, etc. but we never want to tolerate bad behaviors.

Rogers - We have the 'better than average' category and in this example there are three hospitals there with 40%, 41% and 42%. From a statistical percentage, there is probably no difference in the rating of that hospital, but if a consumer looks at that, will they decide that 40 is in fact different than 42 and make decisions based on that? For hospitals in a category (such as 'average' or 'better than average'), there is likely not a statistical difference.

Rosenberg - Thinking ahead to the SIR and how the CDC and other states portray data, showing the confidence limits would show how the hospitals stack up and/or overlap. If they overlap, they are not statistically significant differences. You may also recommend, for this data set, just showing the point (rate) or showing only the confidence limits. There are different ways to display the data that are more or less informative on the differences between hospitals.

Nelson - One more point on the 'zero'. There is a report today from Connecticut's data validation study for CLABSI that over the state as a whole, CLABSI's were under-reported by over 50%. Now that they are validated, their SIR's are one of the five highest states. There have been three other reports in the last month looking at the hospital data, and one was a collaborative study. The central line associated infections rate is a surveillance proxy for the real rate, which would be central line related bloodstream infections. The patients who have a central line who have a positive blood culture have two possibilities; an infection from the central line, or a secondary infection such as pneumonia or a urinary tract infection.

There are surveillance definitions for when you can call it a secondary infection, and this is where there is a big source of variability in the data studies, when there is validation that hospitals are following the definitions. And with children, it is not so clear cut; there is gray area as well as room for not following definitions strictly. If you *accurately* use the definitions in any hospital, there will always be some bloodstream infections that are caused by another site, but you cannot find the other site. In substantial size hospitals, there will be patients with a central line where it is not related to the central line, but is associated if you follow the definitions. You should not be able to get down to zero, because you have to count the secondary infections. Every hospital should have some secondary associated bloodstream infections. You can prevent every related infection, but still have some associated infections in spite of your best efforts.

Rogers - I like the idea of making it landscape. Helping to identify which way to display what is better and worse, sometimes when you see a chart, you assume which (top or bottom) represents better or worse; we may want to do a focus group.

Moss - Yes, we have reviewed this with many people and this is the format they liked the best, and this way you get more on the page.

When I look at the NHSN benchmark, it is below that that I want to reach. So this makes sense to me.

Chair - Most importantly, if it makes sense to the consumer, that is what is important.

Motion: HAI AC requests CDPH adopt the tables presented at the December 9, 2010 meeting by the Public Reporting Subcommittee as the format for presenting data to the public (to accompany the technical report), with the following changes:

-The heading "Stellar" to be replaced with "Zero" or "None"

-The category of "Average" is to be added to the tables

- **Motion—Moss**
- **Second—Flood**

Discussion:

Moss - I will revise the motion to include the reporting date.

McLean - Will it include confidence intervals?

Chair - The first five quarters is going to be what it is because of how it was reported and the inability to risk adjust. This will dovetail to the technical report.

Rosenberg - It is the Program's understanding of the November HAI AC meeting's vote that there not be a graphical display of the information.

Chair - Part of that is because we didn't have data to look at. So we didn't know how we could graph it or how it would look.

Moss - We also did not have the categories, so the challenges were the categories, the colors, and several other items.

McLean - I voted with the majority with respect to this last meeting. The issue for me is that it is not responsible to provide rankings which are misleading in a graphic form. That remains my concern today. I have no objection to trying to do something graphically, but when I look at rankings based on this data, they are not meaningful distinctions.

Eck - Our agreement at the last meeting was that because the first five quarters of data could not be risk adjusted, that we would only have the technical report, and would not have a graphical display of the data, particularly one with "below average", "average" or "above average", because there is no benchmark or risk adjustment possibility for MRSA, BSI or VRE BSI's. I thought for the first report we would only have the technical report and when we are all reporting NHSN risk adjusted data, that would be the point when we would display the data with a graphical display to make it clearer, and that we agreed to have language on the website that would explain what was being displayed in the technical report and build on that for the future data displays.

Chair - You are correct on your recollection of what we agreed upon last meeting.

Eck - I would move that we do not try to graphically display the non risk adjusted data for the first five quarters and that we plan and develop a process to graphically display that when we are all reporting the NHSN data.

Alongi - This motion cannot be opened as the Moss/Oriola motion is still on the floor.

Moss – In response to Enid, you are right, the last vote, every person on the committee voted to not provide the consumers with a report that they could understand, with the exception of Lilly (Labar) and myself. We are here to make sure the consumers can understand what this report means. We have gone back to the drawing board to make the changes that fit the requirements. The consumers deserve, even if it is the first five months, to see how the hospitals stack up.

Chair - To clarify, the members of the HAI AC voted against the *format* that was presented to us, not that we did not want the public to have the data and understand the data. We did not vote for that type of format; now you have made a motion on a revised format.

Moss - The language was that they voted 'to not have a graphical format to accompany the data'. It wasn't just that format. Instead, they would provide simply the technical document which none of the consumers could understand. That is why we have made the changes to meet the needs of the Committee. We already have some people in agreement.

Rogers – (to Rosenberg) For the low volume hospitals, there are huge confidence intervals. Do we have a lower limit where there are too few cases to rate them?

Rosenberg – There was a determination based on preexisting determinations for those infections, it is a very low threshold. Those facilities are credited for reporting but there is no rate presented. That was for three hospitals. Looking at line days for a facility with 100 to 150, if it goes from one infection to two infections, that facility's rate skyrockets. But, that is the accepted standard; those facilities will have very large confidence intervals.

Rogers - If the hospital is too small to report, we still want the consumer to see that they did report.

Rosenberg – It was only three hospitals. The threshold was 150 line days and 100 patient days.

Rogers – How do we determine 'better than average'?

Rosenberg – That has not been done for this data. There is a table and the facilities are listed alphabetically. They are not ranked by rates. The report does provide a state median, but that is not an average and it is not a benchmark.

Member - OSHPD has been reporting for years in a scientific methodology, 'better than average', 'average' and 'below average', that there is some sort of criteria. The concern revolves around just putting the

raw numbers out there.

Rosenberg - Missouri has also done that. There are other states that have done it for CLABSI. I don't know that anyone has done it using the SIR yet but there is a statistical method to divide groups into categories. HAI AC could also recommend quartiles.

Member - If you use a bell curve, you do have a statistical difference showing that the care is different in one place or another.

Rosenberg - Right, the Program has not done any of those analyses with this data. [limitations of the data again described]

Mikles - I am hearing that if something similar to this (technical report) is on the website, that there will not be any explanations for consumers?

Chair - No, if this is voted for, it will dovetail with the technical report. And the technical report is also going to be put onto the public website with educational materials on what all of this means that they are working on with the Subcommittee.

Nelson - All this discussion points out the difficulty expressing this set of data from five quarters. Last meeting, we agreed that because of all the difficulties in comparing and the conditions with this data, we passed a motion that we do not have a graphical display, so that we can describe the data using words, and there would be a detailed report if they want to go into that level of information. I still have the same opinion.

Chair called for a vote on the motion.

Restatement of Motion: HAI AC requests CDPH adopt the tables presented at the December 9, 2010 meeting by the Public Reporting Subcommittee as the format for presenting data to the public (to accompany the technical report), with the following changes:

-The heading "Stellar" to be replaced with "Zero" or "None"

-The category of "Average" is to be added to the tables

- **Motion—Moss**
- **Second—Flood**
- **Motion Does Not Pass by (7-2-4) vote**

Vote Tally

In Favor: Moss, Delahanty, Labar, Torriani, Flood, Butera

Opposed: Nelson, McLean,

Abstained: Wittman, Oriola, Mikles, Rogers

Motion that the (just failed motion) is amended to include including an OSHPD type of stratification/formatting.

- **Motion—Moss**

Discussion:

Labar - We are not going to use the OSHPD format, but are going to use it as a model? (Affirmed)

McLean - There is a principal that there is no statistic to correct bad data. If your fundamental problem is flawed data, there is no black box to correct that, so I have an issue with the motion in that we continue to have

compromised data. The closest you can come to doing what you want, is to publish the data with the point estimate and the confidence limits, and that will demonstrate that there is no quality to this data.

Labar - We know looking at clinical publications that bad data gets published with disclaimers. We could have a disclaimer on this data set. We want them to at least know there has been an effort, and there are things that are not perfect, but there are also things that are very good about this.

Rogers - We all agree that we have bad data, but that we are going to publish it in January with a technical report. I think that giving consumers a page where they can look at something, this speaks to what the consumers desire and deserve even though it is not perfect.

Chair called for a vote on the motion.

Rosenberg - I just wanted to point out one issue. I don't have copies of the whole tables here. I think the only groups that fit on a page are the pediatric hospitals. For the teaching and not otherwise categorized, there are between 150 and 250 hospitals. I can't quite conceive of what you could see visually. For some hospital comparison sites, using the term "like hospital" compare, there are too many hospitals to display, so you can select the hospitals you want to display by zip code or some other selection criteria. You are not going to be able to visualize more than a fraction on any one page.

Chair - The consumer is going to go to their hospitals or consortium and look from that, not look through all California hospitals.

Rosenberg - I don't think you can get a continuous graph on a website for one hundred and fifty hospitals.

Moss - There are definitely ways to illustrate this on a single page. You can put sections. There are creative things an artist can do. You can scroll down on the report...

Alongi - The vote has been called. No further discussion.

Restatement of Motion: HAI AC requests CDPH adopt the tables presented at the December 9, 2010 meeting by the Public Reporting Subcommittee as the format for presenting data to the public (to accompany the technical report), with the following changes:

-The heading "Stellar" to be replaced with "Zero" or "None"
-The category of "Average" is to be added to the tables
-The five-quarter reporting period to be added to the table headers
In addition, HAI AC recommends that CDPH include the statistical methodology (OSHPD methodology or similar) in categorizing data (for example using standard deviations to develop the categories 'better than average', 'average', and other categories)

- **Motion—Moss**
- **Second—Oriola**
- **Motion Passed by (9-2-1) vote**

Vote Tally:

In Favor: Moss, Oriola, Delahanty, Labar, Torriani, Flood, Mikles, Butera, Rogers

Opposed: McLean, Nelson

Abstained: Wittman

[FOLLOW-UP to Motion: In subsequent discussion (below), the Program, citing time and the exhaustive nature of OSHPD analysis, determined it could develop a methodology for the tables in an expedited timeframe, and requested that the HAI AC remain open to this proposal, with the CDPH proposal to be subject to a vote of the HAI AC.]

Eck - As I offered to do after our last meeting, I brought all of the information that was shared with us for the website to one of our health education specialists and asked her to review it and compare it to the requirements CMS and CDPH have within the state, and there were several areas that did not comply. We summarized those and made some edits to the text on the graph that we had received to make it comply. There were enough changes that it wasn't doable for her. This really belongs in the Public Education and Reporting group to work on this. Gail (health education specialist with Eck) could participate in one of the Subcommittee meetings to walk through the issues including the reading level and the font size and the use of upper and lower case letters, etc. We have tools we use internally to assess materials to make sure they comply. Gail supplied me with those, so I can share them with the Subcommittee and would be glad to work with them.

Moss - That would be great; if you would have her call me, we can coordinate.

Oriola - The Committee does advise the Program, and if this recommendation is in fact adopted, we are going to run afoul of our statutory mandate to report by January 1st because of the complexity of identifying the OSHPD methodology and applying that to our data, so we need to understand what we are up against with three weeks left.

Moss - We have many talented people here who will offer their assistance in meeting that deadline to the state. If you submit just the technical report, it will be pretty meaningless to the consumer. All of us at this table would be willing to reach out to OSHPD to get their assistance and advice.

Oriola - I would agree if we can put something out two to three weeks after so that we can still meet the mandate and get something out timely. Is it all or nothing?

Chair - The question is: can we put out the technical report on January 1, and take a couple of weeks to add the graphic? Is that amenable to everyone?

Moss - If we have exhausted all the avenues. We have a lot of resources between us. I can't see that happening, but if it is within two weeks of the posting of the technical report then that would be acceptable.

Chair - If that happens, we can put a note on the technical report, to

indicate that the information is coming out soon. I would like the expertise of the Public Education and Reporting Subcommittee to guide and facilitate that.

Rosenberg - I am familiar with the OSHPD data that people are referring to. It tends to come out one to two *years* after the data is submitted and you are talking about doing a statistical analysis with three hundred and eighty three reporting entities for five different quarters for four sets of infections by five categories of hospitals. There is one on cardiac mortality which is well established and it still takes them a year. I don't think the Department can make any commitments on doing this let alone the time constraints involved. And they do allow hospitals an opportunity to respond to the data. I am not talking about plugging the numbers into a spreadsheet and doing a graph, I am talking about a statistical analysis on this data. It is a lot of data.

Eck - This is in relation to the time and the surgical site infections. I was wondering where we are with that piece?

Rosenberg - If it was a graphical display without any statistical analysis it could be done at some timeframe, but it won't be in three weeks, and this would need to go through some kind of clearance process. The Program has a backlog of other data that needs to be reported to the public. NHSN doesn't operate automatically; there needs to be a continuous quality assurance process. Every piece of work on this negatively impacts something else. Senator Alquist asked the Committee for guidance on reporting of surgical site infections and I don't know if the Committee is going to have time to deal with that today...

Chair - A few more comments and then we need to move on our agenda.

Moss - What I am hearing is that you are not willing and are not going to at least try to put together a report that consumers can read and which the Committee just voted on. From your tone and your message, you are not planning on making an effort to go forward and present a report a consumer can understand. A technical report will be meaningless to consumers. Am I mistaken?

Rosenberg – That is an unfair accusation. What I am saying is that we have gone in two meetings from a vote not to do a graphical representation, so we have not done any work in the past three weeks on doing a graphical representation. That was the advice of the Committee. Now it is December 9th and the advice of the Committee is not only to provide a graphical representation of the data but also to take a very complex methodology and apply that to MRSA, VRE and CLABSI infections, and in two weeks put these 14 different tables into a graphical representation doing a statistical analysis using this methodology.

DeMartini - I think the Department has heard loud and clear the necessity of presenting this data in a way that is consumer friendly, and it is a matter of balancing all the mandates that we have and how we do that in a conscientious fashion. It is not incumbent upon us to provide something that is not going to be of value, and also meet our statutory requirements. What I heard was a slight modification to the motion, if that would be considered, where we would issue the technical report and work with the

Committee on presenting the data in a consumer friendly methodology given the time constraints we have.

Moss - That would give CDPH the ability to keep pushing it (the reporting date) out. The only way that we should even think about that is if you have a deadline within a couple of weeks. We are offering our services. We can do a lot of work you need to do. Let's make an effort to see if it is doable before we make a motion not to do it.

DeMartini - I don't believe we said that we wouldn't investigate it. We will do additional research on the OSHPD methodology. But we are confronted with our statutory mandate to get this report by January 1st, and the vetting process also needs to be taken into consideration. We are just acknowledging the timeframe we have and our conscientious commitment to introduce user friendly information. I cannot make a motion. I heard discussion that if it is not ready January 1st, we could do that a couple of weeks later.

Rosenberg – If, in what is agreed on by the Committee as a reasonable timeframe, CDPH can do a graphical representation without further statistical analysis, is that preferable to doing nothing if in a reasonable timeframe there can't be any more statistical analyses to differentiate the data?

Member - That motion failed.

Rosenberg - So it means presentation *only* if a statistical analysis can be done.

Mikles- In California, things don't happen overnight; there are barriers and obstacles. I am here for the consumer, what I heard in the Senate Health Committee I don't want to hear again. Hearing you say that this is not something that can be done overnight, maybe it is not. Maybe it takes a different degree of people to work to develop it. Maybe we should keep it simple and do a different motion to keep it simple and in a way that can meet the deadline rather than put ourselves in a position that it may not happen.

Chair - If I could ask Loriann or Jon, if January 3rd is when the technical report will be posted, is it reasonable that within three weeks from that time you would have been able to meet this motion?

DeMartini - In part there is the degree of statistical application that will be necessary to present the information in a way that lends validity to it. It is also an opportunity for the Committee to look at the technical report and be a part of how that should be graphically presented to the consumer.

Chair - If they were to say that a three week time period to post would work, would that be amenable?

Moss – If they would commit, then we can open it up for another motion. If they can't commit, I don't think we should open it up again.

Labar - Do they (OSHPD) do their calculations based on a simple mean?

Nelson - It is probably based on some standard deviation.

Labar - I do my own standard deviations and means all the time. I wonder if there is a lot of difficulty. There may be. We didn't say we wanted to use the OSHPD methodology, but to use it as a model, as a framework.

Rosenberg - There is no statistical difference between any two hospitals for which their rate overlaps in the 95% confidence limit. Doing further statistical testing isn't going to do anything. You are going to end up saying that 80% of the hospitals are in the same group, because of the 95% confidence limits, and if we do that you are going to come back and say you are very unhappy with it and that that is not what we wanted to tell the consumer. The vast majority of hospitals have overlapping confidence limits. Applying a different statistical test is not going to yield a different answer. It is easier to see it with a point estimate and to put the confidence limits in, and rate them according to the point estimate and point out to the consumer that there isn't a statistical difference between any two hospitals with overlapping 95% confidence limits.

DeMartini - I want to acknowledge that the Department is committed to making this consumer friendly. For us to do it in the next three weeks, it is not that we are not committed, but how we present that information, there may be a graphical way to present that data that give consumers some understanding of the range of the data based on the confidence levels.

Janssen - (offer to provide to the Committee a format including statistical methodology that could be included with the graphical presentation)

Chair - Once we get Lynn's (Janssen) example, Carole (Moss) would have to retract/decline her motion that we voted on, and will have a new motion with voting to adopt this.

Moss - We would like to go ahead with that with a January 3rd commitment.

DeMartini - It is hard to visualize, but we will review it and send it over to you and will also tell you if we can do it by January 3rd. If it is something the Department can do, we will make it happen. We will also honestly tell you if we have to apply statistical modeling based on OSHPD if we cannot meet the January deadline.

Moss - And we will spend the time to assist in doing that, so before you say "no", please ask us.

Nunez - It would be good for CDPH to create an easy to understand and easy to remember URL for the infection reports, and what is known as a 'vanity URL' is a domain that points to something that is related. They are easy to remember and give the public an idea of what they will find. They can be connected to key words that would come up in search engines. An example would be californiahospitalinfectious.com or similar. That would redirect to another CDPH site, to the correct landing page rather than the CDPH homepage. Buying a domain name is relatively cheap.

Motion: HAI AC requests CDPH consider a 'vanity URL' to trigger hits to the HAI website.

- **Motion—Moss**
- **Second—Oriola**

Discussion

Oriola - I know it's minimal, but there has to be some marketing and I don't know if we have the budget.

Moss - It is inexpensive to start the website.

Nunez - Part of the outreach we have talked about would go hand in hand with reaching out to different media outlets, blogs and things like that.

McLean - As a public official at a local level, if the CDPH says that we need a vanity website for health acquired infections, then what about birth defects, and childhood cancer, etc.? CDPH has a huge number of concerns and they may have a problem advocating for one over another.

Chair - Our focus is the HAI piece. We are not discussing other programs.

Mikles - I was going to mention that California will do a PSA with no problem.

No additional discussion

- **Motion Passed by (11-0-1) vote**

Moss - We know there are ways to do PSAs at minimal cost. Many of us who have been touched by this wish we heard something from our leadership on hospital infections. We would ask that the CDPH put together, before each report comes out, a public service announcement. We have access to producers and actors. We are asking the Department to step up, in a very simple way, and help lead people to our website.

Motion: HAI AC requests CDPH develop Public Service Announcements (PSA) before each technical HAI report is issued.

- **Motion—Moss**
- **Second—Labar**

Discussion:

Oriola – It would make better sense going out when we have better data to display because we know the first five quarters of data is very contentious. It would be nice to go out when the data is more robust.

Labar - I think we should be more proactive than reactive. Data is reactive. I think what Carole (Moss) it talking about is more proactive.

- **Motion Passed by (11-1-0) vote**

Moss - We would be happy to extend our help to put that together.

Surgical Site Infections Update: Jon Rosenberg

I assume everyone in the Committee is intimately familiar with the language of the statutes regarding surgical site infections, but because we have some visitors, I am going to present some of this in the order that CDPH interprets them to have meaning. Please let me go through three different stages here. The middle stage might cause a little consternation.

- Labar to work on NHSN procedures to phase in for pediatric facilities.

As many of you know, it has been a struggle to deal with Senate Bill 1058 language in regards to surgical site infections. To a certain extent, it hasn't been as urgent as it is now, because the first date for public reporting is January 1st 2012. But that now approaches, and in 2012 the Center for Medicare and Medicaid Services (CMS) will add some surgical site infections to the national mandatory reporting. We do not know the procedures or how many. They are doing it for CLABSI starting in January. SB 1058 requires all general acute care hospitals who perform these procedures to report all deep and organ space surgical site infections following clean and clean contaminated cardiac, gastro-intestinal, and orthopedic surgery.

In order to provide an opportunity for hospitals to comply with that, CDPH have provided, along with the forms for bloodstream infections and C diff, a form for hospitals to enter a numerator and denominator for these surgical site infections. They are not mandatory. That data has not yet compiled that data, but hospitals use the forms in a tremendous number of ways. When CDPH did the end of March revision of reporting to accommodate NHSN, at that time anticipating using NHSN for surgical site infections, hospitals were asked to voluntarily begin using NHSN for one or more surgical procedures. CDPH didn't know about CMS' rule, but anticipated a rule that would further clarify reporting procedures. That was just an advisement. CDPH doesn't know the extent to which hospitals are using NHSN for this, as it is completely voluntary.

For those of you who are not providers, there are a few things to keep in mind about surgical site infections. There is risk adjustment methodology for NHSN and that has changed since October. There are some changes in how groups will be having the risk adjustment done. The new SIR for surgical site infections requires some very specific data to be put into it for every single patient who undergoes that procedure. It is very different from all the other infection data. You have to have about a page worth of information including information that would be considered a personal identifier, such as gender, age, height and weight. Depending on the type of procedure may or may not be used. It has to be done for every single patient. It can be thousands. I don't know of any major hospital information system to transfer that data into NHSN.

Chair (regarding comments about methods of uploading the data) - It is a manual process for someone to intervene and input that information.

Rosenberg - At some point, things will progressively become electronic. I know there are hospitals that do high volume cardiac surgery, so that would be one thousand pages that would have to be looked at item by item to be entered into NHSN.

Wittman - This would have a tremendous impact on a large hospital; I have minimal staffing as it is.

Rosenberg - But CDPH needs to look to move away from forms that do not serve the public. We would rather not be sitting here in January 2012 reviewing this. There is no definition in NHSN for orthopedic or cardiac, there are specific procedures, and those were distributed. From a legal perspective, the first consideration is how to provide guidance to hospitals

on compliance with the requirement.

The first step is to look at surgical procedures in NHSN that qualify as clean or clean contaminated from orthopedic, cardiac or gastro-intestinal. Neurosurgical procedures are not in SB 1058. The first step is going from “all” to those procedures that qualify in NHSN.

I anticipate that is still going to produce a list of procedures that is not going to be feasible starting January 1st for most hospitals. But once CDPH hears from the Committee on your guidance on which procedures under the NHSN list fall under the clean or clean contaminated surgeries, the Program can take that and provide guidance, not a mandate, to hospitals. CDPH has been advised that because of our mandate to risk adjust data using NHSN methodology, once we have advised hospitals on procedures to be reported, we can eliminate the need for paper reporting. That is not viable without guidance from the Committee on what to do.

The first step was moving from paper reporting to NHSN. The second step is providing a list of NHSN procedures that fall within the “all” in SB 1058 and take that guidance to hospitals. If it is six procedures, and you do all six procedures, that is not going to be feasible. CDPH is not certain how to deal with that. The Program will have to look at the feasibility if we learn that many or most cannot comply. If nothing gets done, California will be stuck with paper reporting that does not provide the consumer with rates of surgical procedures using a valid risk adjustment methodology to compare hospitals.

(Slide displayed with NHSN surgical site procedures)

There is a list of procedures from which CMS has said it will pick ‘one or more’ for reporting. CMS is receiving input from various sectors to phase these in. CMS will dictate the use of NHSN.

Chair - To clarify, this is for reporting of surgical site infections. Hospitals are already looking at surgical site surveillance for surgeries not listed here. This is what will be reported to the public on a report card.

Rosenberg - This is reviewing individual patients with different criteria like body weight who have different risks following a certain procedure.

Janssen - This is a document that has not been published yet but it shows the SCIP procedures aligned next to the ICD 9 based categories of NHSN.

Rosenberg - There are as many as 15 and 25 ICD 9 codes for some of these procedures. Identifying the patients, you have to look for as many as 25 ICD 9 categories.

Janssen - The new SIR is based on a multivariate risk model. It says that each of these factors account for different levels of risk. Those data have to be available through NHSN. They have looked at thousands of surgeries and applied risk models.

Rosenberg - If the recommendation of the Committee is to pair the list of procedures in NHSN down to these, that is one thing, but if your starting

place is the ones in NHSN, we are going to have to work with OLS on the relationship for what is considered clean or clean contaminated.

Chair – Unless there is strong opinion otherwise, we will defer C diff and Antibiotic Subcommittee reports until January. (accepted)

Murthy – The point was about ICD 9 codes. If that is a reliable way to identify a sample of procedures, NHSN methodology to define the set of procedures, that would go a long way to helping with what should be reported.

(procedures from slide are listed)

Rosenberg - One of the questions is whether any of the surgeries listed here include procedures where the definition of clean and clean contaminated is problematic.

Members - Yes, colon surgery.

Rosenberg - So that doesn't fall under SB 1058 right from the start. It could apply to clean contaminated, not clean.

Murthy - Jon, are you providing direction or asking for a recommendation or request for the Committee to review the list.

Rosenberg - There is a standing recommendation from the Committee previously (2008) about what procedures should be reported; this recommendation happened *before* the passage of SB 1058. The Program is looking at whether that needs to be revised. If CDPH is to advise hospitals on what to report into NHSN regarding what is feasible, is that still the recommendation? There is a CAC recommendation for Senator Alquist on how to amend the bill; I do not believe the recommendations are the same.

Flood - We recommended starting with CABG and hip because of some of the issues with colon surgery and definitions. Most hospitals do hip surgeries, so that was the thought behind that reasoning.

Oriola - It is imperative that in January we start putting one or two surgeries into NHSN so that we can report something to the public for the mandate in 2012, and we will have some good data to report in 2012. Hopefully in the next six months, CMS will select some surgeries to report and we can phase in to be in alignment with CMS.

Motion: HAI AC recommends CDPH report Hip and CABG infections, for NHSN.

- **Motion—Oriola**

Labar - It is premature to do a motion. Many hospitals probably think that the ICD 9 codes mean the same as NHSN. We need to start the education now. We have to look at high risk in the pediatric population; we don't do CABG in pediatric hospitals. We also need to talk about the denominator. It is a lot of work from the ICD 9 code to the NHSN. We need to prepare hospitals to do this, especially if you do a lot of a certain type of surgery.

Chair - The Committee will recommend carving out pediatric, so there will be adult and pediatric recommendation.

Revised Motion: HAI AC recommends CDPH report Hip and CABG infections, for NHSN, for the adult population only, [pediatrics to be carved out and appropriate measures determined separately for pediatrics] and that facilities receive guidance from the HAI Program Liaison, with CDPH collecting data April 1, 2011 and forward. [Note: other procedures to be phased in over time.]

- **Motion—Oriola**
- **Second—Labar**

Rogers – If we are looking at where to start, it would be where the highest infection rates are, so I am assuming it is with those.

Chair – Yes, high risk, high volume.

Wittman - I agree we need to identify procedure codes, not just SCIP procedures. If we are doing SCIP reporting now, will that roll in? We do a sample.

Rosenberg - The legislation says “all”. This doesn’t affect your SCIP report.

Nelson - My concern for the motion is regarding the phasing and the timing of this. If we expect hospitals to be ready to do this manually, it is impossible.

Rosenberg - It is both the timing and the practicality.

Janssen - January 1st is a logical goal for hospitals that are already doing surveillance. The issues of preparing to enter and collect that data has been planned for regarding SSI methodology and where CDPH can connect infection preventionists with their codes to develop these electronic files. That is planned as a phased-in process. I understand the legislation is for “all” procedures and CMS is going to phase them in. In the multivariate risk model, there is data required to calculate each procedure that the state will not have access to until the next release of NHSN in March. If we are saying that hospitals immediately need to enter data into NHSN that was previously reported on paper for the purposes of risk stratifying, the Program will not be able to do that. CDPH has no information on age and gender, which are risk factors for most of those surgeries. Hospitals have access to that data, but CDPH will not be able to see those factors because those rights have not been conferred.

There are two things that are going to happen before April. One is the March release with NHSN, even if the State doesn’t have those risk variables, we will be able to calculate with those included in the risk models. The system calculates based on the data available. It is in the calculation of the SIR even if we won’t have access to that data. Then if we decide to confer rights to age and gender, this is a way to confer rights to those two criteria. I think you know the complexities in getting the hospitals to do the rights conferral. There is another fix NHSN has, which is the rights conferral process will change to be done by the group

administrator instead of the facility administrator, so when you join a group like CDPH, it will say: "Here is the template of the data you are giving the state rights to". In that template, the state determines the rights to be conferred. We won't have the ability to risk adjust most of these procedures until after March.

Oriola - We would have the data from April through December to report in 2012.

Janssen - We need to provide the avenue to help them input that data.

Motion restated

HAI AC recommends CDPH report Hip and CABG infections, for NHSN, for the adult population only, [pediatrics to be carved out and appropriate measures determined separately for pediatrics] and that facilities receive guidance from the HAI Program Liaison, with CDPH collecting data April 1, 2011 and forward. [Note: other procedures to be phased in over time.]

- **Motion—Oriola**
- **Second—Labar**

Labar - I would also like to say that hospitals have up until April to look at their denominator data, so there is a grace period. It is hard to pull and correlate.

Rosenberg - CMS and the federal government will select the procedures, and CDPH will match those with the ones in 1058, so once CDPH uses this first year's data, we will have experience in doing them correctly. It gives us something to report to the consumer in 2012.

Chair - You have to do it a year out, so what you will see in 2012 is 2011 data. If it is implantable, it is a year out post surveillance discharge review. If it is non-implantable it is 30 day post surveillance discharge review. Hospitals have their own quality people looking at surgical site infections as well.

No further discussion:

- **Motion Passed by (9-1-1) vote**

Vote tally:

In Favor: Flood, Wittman, Rogers, Delahanty, Labar, Mikles, Oriola, Butera, Torriani

Opposed: Moss

Abstained: McLean

Next Steps:

- HAI Program to send a Thank You letter to Kimberly Radcliffe for sharing her story.
- HAI AC staff to have November and December draft minutes for HAI AC review at the January 13, 2011 meeting.
- Standing action item: each HAI AC subcommittee Chair will prepare and send a report of subcommittee information presented during the current HAI AC meeting for HAI Program distribution to

HAI AC members.

- Public Education and Reporting Subcommittee to continue working on public presentation of data, and continue to work with Eck's group to consider appropriate formats, reading level, and other requirements.
- CDPH to ensure that the data tables for 'Trauma Centers' include all levels (1 through 4) and that the data carved out of the other tables is carved out for all levels (1 through 4) of trauma centers as well.
- CDPH (Janssen) to propose a revised methodology (such as inclusion of confidence intervals) applied to the data tables presented (and approved in Motion 3), subject to approval of the HAI AC.
- Labar to work on NHSN procedures to phase in for pediatric facilities.

Future Meetings:

Agreement on **January 13th in San Diego**

Subsequent meeting to be held February 17th, also in San Diego

Chair—Thank you everyone for your time and commitment.

Meeting Adjourned

Acronyms

AFL	All Facilities Letter
AJIC	American Journal of Infection Control
APIC	Association for Professionals in Infection Control and Epidemiology
ARRA	American Recovery and Reinvestment Act
CACC	California APIC Coordinating Council
CDC	Centers for Disease Control and Prevention
C-diff	<i>Clostridium difficile</i>
CDI	<i>Clostridium difficile</i>
CDPH	California Department of Public Health
CHA	California Hospital Association
CHQ	CDPH Center for Healthcare Quality
CID	CDPH Center for Infectious Diseases
CLABSI (BSI)	Central Line Associated Bloodstream Infections
CLIP	Central Line Insertion Practices
CMS	Centers for Medicare and Medicaid Services
CRNA	Certified Registered Nurse Anesthetists
EIA	Enzyme immunoassay
GAC	General Acute Care Hospital
HAI	Healthcare Associated Infections
HAI AC	Healthcare Associated Infections Advisory Committee
HICPAC	Healthcare Infection Control Practices Advisory Committee
H1N1	H1N1 Pandemic Influenza
HSAG	Health Services Advisory Group
ICU	Intensive Care Unit
IP	Infection Preventionist
JC	The Joint Commission
MDRO	Multiple drug-resistant organism
MRSA	<i>Multiple-resistant staphylococcus aureus</i>

MUE	Medical Use Evaluation
NCSL	National Conference of State Legislators
NHSN	National Healthcare Safety Network
NQF	National Quality Forum
OLS	CDPH Office of Legal Services
OSHPD	Office of Statewide Health Planning and Development
PPO	Preferred Provider Organization
QIO	Quality Improvement Organization
SCIP	Surgical Care Improvement Project
SIR	Standardized Infection Ratio
SSI	Surgical Site Infection
VRE	<i>Vancomycin-resistant enterococci</i>