

Healthcare-Associated Infections Advisory Committee
January 12, 2009, 10:00 a.m. to 3:00 p.m.
Location: Sacramento

MINUTES

Attendance

Members: Kim Delahanty (Chair), Ray Chinn, Alicia Cole, Letitia Creighton, Enid Eck, Annemarie Flood, Jennifer Hoke, Lilly Guardia-Labar, Marian McDonald, Lisa McGifford, Mary Mendehlson, Shelly Morris, Carole Moss, Rekha Murthy, Terry Nelson, Shannon Oriola, Debby Rogers, Julia Slininger, Todd Stolp, Jonathan Teague, Dawn Terashita, Francesca Torriani, Anvarali Velji, Pat Wardell, Lisa Winston, David Witt

Guests: Mary Ader (Assembly Appropriations), Kathleen Billingsley, Chris Cahill, Alfred Mitchell

Staff: Gilberto Chavez, Sam Alongi, Sue Chen, Roberto Garces, Jon Rosenberg

Agenda Items/Discussion	Action/Follow-up
<p>Call to Order and Introductions HAI Committee Chair Kim Delahanty (Chair) convened meeting. Introductions made at Sacramento and on teleconference lines. Thank you all for joining us today.</p>	
<p>Approval of Minutes Chair called for approval of the November 2008 meeting minutes.</p> <p>Oriola-Request was made to add a section to the minutes regarding the determination of which surgical patients are at risk for developing an MRSA infection and that it has not been interpreted by the CDC or CDPH, therefore it is not enforceable. Had some minor corrections, given to staff.</p> <p>Oriola—Motion to approve November minutes (with minor corrections) Eck—Second All ayes Motion Passed</p> <p>The Chair called for approval of the November 2008 teleconference minutes. November 20, 2008 Oriola—Motion to approve November 20 minutes Eck—Second All ayes Motion Passed</p> <p>November 24, 2008 Eck—Motion to approve November 24 minutes Oriola—Second All ayes Motion Passed</p> <p>November 26, 2008 Eck-Request was made to add to the minutes clarification language regarding motions and voting process. Eck—Motion to approve November 26 minutes (with minor corrections) Oriola—Second All ayes Motion Passed</p>	<ul style="list-style-type: none"> • Staff to make minor revisions to November minutes based on member notes and comments.

Public Story
Dr. Alfred Mitchell

Dr. Mitchell presented on the problem of infection in hospital settings from a surgeon's point of view. On record, there are 1.7 million infections and 90,000 deaths per year as a result of infections, but all indications are that the numbers are greater than that. Resistance of the organism to treatment limits options to treat infections. If an infected limb is not detected early, many times the only option is amputation. Patients are suffering every day due to delays. Educating surgeons and doctors on the nature of infection, and the need for aggressive treatment, including using surgical consult, is needed.

Prevention is the key, and simple technologies such as copper surfacing can greatly reduce transmission of infectious material in the hospital setting. Stainless steel surfaces can be coated allowing bacteria to die upon contact rather than staying on surfaces from three days up to several weeks. Masks, clothing, and sheets are also available.

Oriola-Your presentation captured the suffering that is going on out there. I wanted to clarify that, other than the urinary catheter associated infections presented, it appears that the patient was admitted to the hospital with an infection and they were inappropriately managed by the health care team.

Mitchell-These are patients that were in house and then I was brought in for a consult. Some of these infections are healthcare-associated. One on the leg was an arthroscopy and then these problems started. The other person was in the hospital for a fall, and the other was an infection from an IV. There are others that are coming into the hospital through the ER and are there for an extended period of time. These examples show what is happening in the hospital and how aggressive treatment is taking care of these infections.

Murthy- While we are discussing prevention, there is clearly a need to identify these problems in patients early and get aggressive care and consulting the appropriate healthcare professional team members, including surgeons, microbiologists, and the pharmacist early on is critical for management of these patients. Certainly, the spectrum of illness and the disease severity of some of these infections has really increased because the bugs are changing much faster than we can keep up with antibiotics.

Chen-You made a comment to me earlier about the role of surgeons and also you made an analogy to the airline industry. Could you repeat that please?

Mitchell-Yes. While I was flying up here the other day, I was looking at the plane and noticed how the pilot walked around and checked on everything to make sure we were safe before taking off. As a surgeon, I asked: what are we doing for our patients? We should be checking the operating room to make sure it is clean before my patient goes for surgery. Not just operate on the patient but make sure that everything is set up right to prevent that patient from getting an infection. If you go through any of your facilities and get a swab culture from the operating table, it is amazing what you will find. Remember the restaurants and food processing plants are checked. They have to do cultures. We don't do surface cultures in hospitals and this is something we have to do.

Witt-What you are presenting are battles we have always had. It doesn't matter if it is MRSA or not, these have always required effective and aggressive clinical care. It is not a new problem; it is an old problem. One thing that is a little ambiguous is that you have community-acquired infections and hospital-acquired infections, and the ambiguity between those two has created a lot of inappropriate directions. Treatments for community-acquired aggressive strains may be confused with what is acquired in the hospital. Because of that, policy is often not ideal.

Mitchell-If you look at what is going on in the community, it's called the

USA 300 strain. It is always a mixed bag because patients are coming in from different facilities. After two or three days, another surgical patient may move into that room. So the treatment is still the same. You have to get them on the appropriate antibiotics and aggressively treat it. So different strains but if you get the right cultures and treat it aggressively, you can take care of it. It is right to be able to identify the strain to know where it is coming from, but the treatment is still the same.

Moss- Time is of the essence for these people and today, many of the hospitals are just doing three-day blood tests. In three days, these people could be dead. This just really does focus on the importance of speed and implementing faster testing for the people that are in these hospitals.

Mitchell-Just like you have seen, in three days, you have missed the boat. That is where we need to identify it right away, and make sure that the cultures reflect the antibiotics that you are treating the patient with.

Rosenberg-Most of the strains of MRSA that are circulating in hospitals are not going to cause those kinds of aggressive skin infections as opposed to USA 300. There certainly has been some concern for a while about the potential for USA 300 to move into hospitals and replace some of the strains; an article published last week explores that potential. Most of the studies that have been done were in large urban hospitals and don't reflect what necessarily is going to happen in community hospitals. It could be just very different environments. This is something we need to be aware of. Our primary focus, of course, is preventing the infections from the traditional hospital acquired strains.

Moss-There are so many different chiropractors and health personnel that are using colloidal silver. So my question for people in the room today is whether anyone has been investigating this or anyone has heard of this. I think it is very interesting and worth investigating. They take water, a stick of silver and a battery. They drip it into the water and do it with copper as well. Dr. Mitchell did his own study and found the benefit of copper. As this group is focusing on prevention, I think it is something we should look at.

Stolp-One of the issues we are struggling with is patient-specific risk factors. One of the patients was morbidly obese. I'd be interested to know what patient-specific risk factors, whether it's social, metabolic, historical, do you see contributing to the population you are encounter.

Mitchell-Hands down, if someone is a diabetic, immunosuppressed, has liver problems, is on any immunosuppressant drugs, or has any other pre-existing problems, it impacts on that infection. If you have a simple lesion, that infection just goes rampant; it is certainly harder to treat these patients.

Program Updates

Billingsley-I wanted to thank everyone for being so welcoming and giving me the opportunity, as part of the Center for Healthcare Quality, to be a part of this Committee and to learn about everything that you've done. This experience has broadened my horizons a great deal and has made me a better advocate for everything going forward. Unfortunately, we don't have funding from January 1st to be able to go ahead and support the Committee.

It is regrettable that we cannot continue for the present, but the Center for Healthcare Quality and especially Licensing, wish we were able to use the licensing fees to go ahead and support this. We are very transparent with the hospitals, skilled nursing, home health, and other facilities about how we use that money. We do not have the authority to use those monies to support this Committee. We've been trying to figure out what we could do. This doesn't mean that we won't look at other funding sources going forward, and it doesn't also mean that we'll be able to get funding. We will continue to pursue that through the

state side and will also continue to pursue it through other avenues. I feel very committed that, even though I have to announce today that we are going to put the Committee on hiatus, CDPH will continue trying to secure the funds to bring the Committee back. The annual report you have really does reflect all the extraordinarily good things that have come out of this. Looking at the legislation and implementation of SB 158 and SB 1058 in just this brief period of time, I really have seen the incredible value of what you are bringing to what we need to do together as a group. You have our commitment that as a department, we will continue to look at funding from a variety of resources to bring the Committee back in its current format.

Chavez-This Committee has been functioning with you for a long time and the Center for Infectious Disease (CID) has done so with really no additional funding and we have, thanks to creativity and people like John and Sue who put 150% effort into this Committee been able to continue to keep the Committee working. You have been a great group of leaders to work with. Our chairwoman has been amazing. Unfortunately, we have a tough budget situation and starting on the sixth of February CDPH will be furloughing staff and closing down the department for two days per month. CID lost 22 positions last budget year. People are really doing more and more with less and less. We have been having conversations about how we can continue to support and work with the Committee and continue to implement the bills that are so important for the prevention of infections. As Kathy said, we are not giving up. Kathy, Dr. Horton and I will continue to advocate for being able to continue doing this. But, in practice, we just don't have the funds to continue to support the work of the Committee.

Moss-How will the work be done as it relates to bringing on all the hospitals to NHSN for the reporting? Will that just continue?

Chen-It is my understanding that a contract is being sought to hold me over until at least July which means that I will be continuing to provide support to the hospitals so that we don't lose ground during this hiatus as far as the program. The most important thing is that CDPH continue to support the hospitals and keep the trust that the hospitals have developed in the department. CDPH will use this hiatus constructively for consolidation purposes to catch up on some of the loose ends and continue to lay groundwork so that when the Committee does come back together, we will have some of the pieces together.

Moss-With the legislation that went into place January 1, 2009, there are several things that are now the law, and that hospitals should be doing. They were not notified; they don't know. So, today when Kathleen sends in an inspector to find out if a high risk patient was screened before surgery, what will these hospitals know?

Billingsley-We're sending out additional information in terms of an AFL to clarify this. We cannot interpret the law, but we can send out information out about what the law requires. Debby Rogers at CHA sent out correspondence to all of the facilities; that will be very helpful.

Moss-That would be good to see that letter.

Billingsley-We will be glad to send that out to everyone here.

Moss-Now that we have data that you've collected at CDPH, that data needs to be reported on the website. We need to make sure that these hospitals who have done all this work, and who have been collecting and sending you data, see the results of their efforts. I understand that there are regulations in there that say no more than six months after the data is collected that it needs to be posted. So I know you are short handed and you have members here who are committed to helping. So, if there is data that needs to be tallied up and put in an Excel spreadsheet, this might be a good time for all of us to stand up and volunteer to help you. These are important pieces of information that the public deserves to see and we don't need to do anything fancy like a website. We can go onto L&C and post the results.

Chen-We have two sets of data. One set is the 2007-2008 influenza data for immunization of healthcare workers. We've only taken a preliminary look at that but I don't see where, after an epidemiologist looks at it and we get some approval from the department, that it can't be posted in the required six month time frame. It's not going to be on its own portal; it will probably be on the L&C site.

Billingsley-There is an infrastructure within L&C that will allow us to post a lot of different kinds of information and we need not have an expensive portal to be able to do this. This is our opportunity to start thinking outside of the box about how can you do it at no cost.

Chen-The second piece of data is the CLIP data and that is July through December 2008; that is not due into NHSN before the end of January, so we don't quite have that yet. We do have an epidemiologist that has been working with us part time. As soon as that data is into the system, we will be able to begin analyzing it. That is also probably about six months down the road.

Chavez-We need to be honest and transparent. The work that needs to be done is important; the issue is implementation from our perspective. Epidemiological review and posting of data takes a lot of staff and manpower, so without having the resources to do it, it becomes almost impossible in this case. We are trying to do it and do it right. The department needs to have the resources and we are trying to find creative approaches to it. I can tell you that Sue alone is not going to be able to implement SBs 739, 1058, and 158.

Moss-I understand that the legislative process, and the way that it was approved in the budgets, does not have to do with the general fund. It was set up so that you have the funding. L&C pays for the processes in all the things that are implemented in SBs 158 and 1058. We have a challenge here understanding when we know that the legislature was designed so that budgets won't affect it; it is through licensing and certification. Do we work directly with Kathy on this? I know that there is funding but these are now laws that came through the department and through the governor, that understand the cost to do these things, and they made it a priority for the people of California. It is not the standard budgets.

Billingsley-L&C has to be given the authority to go ahead and increase revenues and increase the fees in order to be able to cover this. At this point in time, we don't have the authority to make that change. We will continue to seek that authority to be able to fund this. But, at this point in time, I can't just all of a sudden decide which facility types are the ones that will receive our resources and then increased fees.

Chavez- Just to clarify, I think part of the issue is that the bills say that we can use L&C funds, but the only body that appropriates funding in the state is the legislature.

Moss-It's already in the legislation.

Labar-As I recall, the HAI-AC is mandated in the writing of these laws, is it not? How do you get around that? How can you say that this Committee does not exist based on budgetary deficiencies when the law is saying it should be there?

Billingsley-The Committee can exist and 1058 and 158 call out the Advisory Committee. What I was saying is that we do not have the funding to be able to support the infrastructure. Granted you fly here yourself and you come to a state building, but the process of recording the minutes and generating the minutes, that contract, I cannot extend beyond January 1, 2009.

Labar-So you are talking about our support?

Billingsley-Yes. There are no funds to go ahead and continue that piece.

Labar-Then you would do what we do in our hospital and each of us

would take turns and we would all take on the responsibility.

Billingsley-The Committee can look at this and have that discussion. I just needed to let you know that part is not funded.

Chavez-When you have a committee established by statute, they are very specific steps that have to happen for people to meet, as you know. It is very labor intensive. You have to post minutes on the internet, you have to post an agenda so many days before time, and you have to have availability for the public. That takes support at our level. That is what we can no longer support based on the budget.

Labar-We know about the timeframes because most of us have worked on subcommittees before. I think most of us are familiar with the process. I was hearing that this Committee is being disbanded.

Billingsley-No, I said it was going on hiatus until such time as the funds become available again and we can go ahead and support the required infrastructure. We will still have the website.

Chair-I just wanted to clarify that there will not be a physical building or any administrative support.

Billingsley-That is correct

Murthy-Is data collection, analysis, and posting affected? Regardless of the hiatus, do we need to have specific actions today to reflect these circumstances and then kind of reset the clock a bit. Do have hospitals continue to report without having expectation that there would be follow up in a known timeline?

Chavez-The most critical element is actually working with hospitals, collecting the data, making sure people are screened and all of that, but that takes staff resources that we don't have. The largest concern of ours is to be able to get the authority to get licensure fees spent so we can actually hire the staff to do the work when it needs to be done. Like I said, even with Sue working over 100% time, we still are not going to be able to do everything that's set forth in those pieces of legislature.

Murthy-So is there a timeline for that piece? Does it go back to the legislature or how does that work?

Rosenberg-Those points and Carol's points support the ideas of the hiatus for the Committee. There is a tremendous amount of work that goes into the process of trying to generate resources to support the Committee's meetings and all of the mandates. If we had to, we could squeeze out the Committee meeting, if we really had to. Given the extent of the effort that it takes just to support the Committee, we just can't do both.

Oriola-I remember sometime in the last six months, Senator Elaine Alquist who chairs the Senate Health Committee, actually pulled the funding and she is the author of the legislation. So it is a legislative mandate but then the legislator that submitted the legislation actually pulled the funding. Is that true?

Rosenberg-She pulled the funding for SB 739, that is true.

Billingsley-The reason she pulled it was because it wasn't all for this Committee. It was also for things that go on outside of hospital acquired infections. They were things that go on outside of hospital acquired infections. They did keep in and approve funding that was for the HAI component which was about \$40,000-\$60,000.

McDonald-I have two questions. First, can the total dollar cost to support the committee be made available to the Committee, and can it be split out into existing costs and potential costs such as the website? Second, is it possible for L&C or CDPH to accept funding from an outside source and if so, what conditions would have to be met for that to be acceptable.

Billingsley- Both L&C and the Center for Healthcare Quality receive funding and grants based on proposals that are received. As far as receiving donations from other entities, we would have to check with legal to see how that would work. I can say that there are several programs in the CDPH that are funded through federal grants and other grants that are given to the program for specific purposes. As for as the breakdown of the fiscal for the cost of the Committee, we will have to get back to you on that as well.

Eck-One of the issues with all three of these bills is that there is language that the hospitals are looking at and saying "What exactly are we supposed to do?" I know that I have a list of questions from our executive directors that commission me to come and ask them today because it's not clear. The concern going forward is that the timelines in that legislation are not changing and the mechanism for clarifications about what is required has now been cut off. Without the input of the Committee to CDPH there is no means to express what is needed to make the work doable. You have your side of making this operational and we have our side. Without a consensus process by this Committee, and recommendations that come to CDPH that influence the AFLs that come out to the hospitals, we are going to be at the mercy of surveyors' interpretations of the language in the legislation at any given point in time. Everyone around this table represents a hospital and is going to be able to give you detailed examples of where surveyors have interpreted legislation in very different ways than the hospital has. Requirements are forging ahead, there is no hiatus for January or July 1st. What are the hospitals to do during this hiatus when in fact surveyors come in and there isn't clarity?

Billingsley-CDPH and the surveyors are really challenged with the same issue that you are in that they cannot take the law and interpret that.

Eck-But they do in their enforcement process.

Billingsley-At this point in time, they truly cannot do that. I will say that there are 600 surveyors out there everyday and 600 surveyors are not going to look at issues in exactly the same way. Standardization is the number one challenge for L&C. I think we are a lot better than we were before because we communicate a lot more, we conduct training, we provide more internal clarity where we can, and so we will continue to do that. We will be a good listener for anything that occurs that is outside of what is written in the law. The technical amendment was a good thing and a good action in the fact that the legislative staff asked for clarity from the Committee. That goes through its own process and timeline. I don't know where it is but I can get back to you on that.

Moss-I will have to correct that. It wasn't met. The legislative office did not see or receive an official document with the technical language until it was seen on our website on Friday. There wasn't anything official sent in between the hours we spent coming up with the language and this last Friday. As it relates to surgical, it's very well defined in an NHSN document as it relates to surgical code numbers.

Creighton-When we go out and we survey and you asked specifically about the screening process. Just like when we go into any hospital, we ask them what their process is, and then we ask them to demonstrate them to us. If they do what they say they are doing, then they are in compliance. We don't mandate to any facility how they are going to do it. That is how the surveyors should be approaching this.

Eck-I agree with you and I understand that's the process. My concern is that one of the major benefits of this legislation was that we would finally have comparable standardized processes statewide. Now, there is no comparability whatsoever and the majority of the benefit of this legislation is lost. This Committee sought to leverage these learning's and improve care. Those pieces are going to be at risk. Any hospital that has set up a whole system to do it their way will suffer a huge impact to go back and modify it in eight months when the hiatus is over and all reporting has started. I understand why the decision is what it

is but I think we as a group need to be very clear about what is at stake and what could be lost.

Billingsley-I think Sue and Jon had a very good point in that we have very limited resources and that they will be able to continue to move forward in some areas but with what we have, we cannot do everything. When you can't do everything, some things will be lost. The message that I want to say is that CDPH is committed to doing whatever we can.

Torriani- Before we go on hiatus, we should decide what the priorities should be. If we can have any priorities in clarifying language in specific parts of the law that we want to continue working on. I am very concerned about the data gathering, analysis and interpretation process. I would caution this group to think about it because I would not want this data to be lost into some venture with a grant where someone interprets the data for us. This has been over four years working with experts from the field and you lose that knowledge, that history. Somebody else who might have better politics gets into the process and that would really be a pity for us as a group but particularly for the people of California.

Moss-As it relates to what's happening now and this Committee, Kathleen, what are the months that you will go back into the legislature for the licensing fees? Does that come out in July?

Billingsley-What happens now is that there will be a proposed fee schedule that will be posted on the L&C website on February 1, 2009. Based on what we have approval to do at this time, those fees will reflect that. If there is any decision with respect to the governor's budget or any further action taken, the fees are adjusted and the final fees are posted within 10 days of the governor signing the budget. So there can be modifications in the fees between February 1, 2009 and when the governor signs the budget.

Moss-Just so everyone in the room knows, three people at this table had the final sign off of what the language was going to be in the legislation. The governor would not sign off until Sue, Jon and Dr. Chavez changed the language. The language you have has been approved by CDPH through the people you are sitting here with. So before you blame it all on the legislation. I learned how this whole process worked and I was amazed to find out it comes right back here for the final legislation. So before you place blame on our legislature, understand that through the challenges of our bureaucratic set up and find out where the legislation came from and who had the last sign off. It was three people sitting at this table.

Chen-I would beg to differ.

Ader-I am on the sub-appropriations committee. I am happy to answer questions about the subcommittee process or the emergency fiscal session. As far as the question about if outside support can be received, there is a code section that authorizes the department of finance. So if someone wants to write a personal check to the Committee, there is a code that authorizes that.

Slininger-In the light of the fact that hospitals still really don't have clear implementation instructions, how will the surveyors be instructed when they are in the facilities? Unless I am remiss, there is nothing in there about best practice. I don't believe that we were given the right to say a hospital's going to do it a certain way. We were told that they needed to have a process in place. So while we can recommend that these are best practices, we don't have a mechanism to enforce it. The questions are there all the time, what is their process and do they follow it?

Eck- The implications are that down the road, when this group gets back together, and if we are able to achieve a consensus, and create a process whereby the surveyors could go out and say that these are the things that are expected, you need to have a policy around this, and

then are you meeting that policy. That piece will be a much harder climb because hospitals will have already figured out what they want in their policy, and they will already have processes and mechanisms to comply with that policy.

Billingsley-If there is ever future legislation that mandates specific things that the surveyor must survey to, you'd be surprised at how quickly people will develop those standard processes.

Witt-If you have the opportunity to send the letter to all facilities, my biggest concern about this hiatus is we actually had a bully pulpit. Infection control gets no credibility. No one listens to us. The only impact we have had is through the regulatory environment that requires it. I think these bills have given us a bully pulpit to actually demonstrate that infection control is not only required by regulation, it has this level of attention by the public, by the legislature, and by the hospital industry. I am really concerned that we had a drum roll and no one shows up on the stage. As we look at what we send the facilities, if you can address that this is a hiatus, that there is no diminishment of the importance of this legislation, I think it would really serve us well. The fact that this is a temporary hiatus is such an important concept to them. That explanation would really change the ability to develop things before it becomes very visible again.

Rosenberg-This goes back to Enid's points. The MRSA screening is the only thing you mentioned specifically and I know it is just one example. For the most part, those are specified as they are in the law. We don't have the authority to interpret them and the Committee doesn't have any authority to influence how they are interpreted. I think you are overemphasizing what might be lost or not lost in the next six months in terms of the hiatus.

Eck-It wasn't related to the surveillance; that was a minor piece. I think it's the reporting of surgical site infections which is going to be a major piece of what's required starting now. We did a huge amount of work to try and come up with some clarity around language on what should be reported so we would have some comparability, and that's not there. There's a whole series of other things that are not terribly clear in that legislation that we discussed in this Committee. Surveillance is pretty straight forward. The surgical patients are not clear.

Rosenberg-The law is still the law whether it is clear or not. From our perspective, if something comes up where we feel there is a critical recommendation from the Committee that we need in order to move forward on something, and something really substantial is going to get lost, then we can address a way to convene an emergency meeting. A lot of the recommendations of the Committee are piling up for future work and direction, which is all very good and important, but isn't what we are trying to implement in the next six months with the staff that we have.

Murthy-The support that those of us in the institutions have received because of the work can't be overemphasized. The hospitals are in the same situation as the state is, in terms of budget constraints and decreasing reimbursements, etc. To the extent that the Committee had the ability to review the best practice recommendations for the purposes of helping to make the application consistent, that is where the real value still lies. I am concerned about the current language which hospitals are stuck with, that the expanded screening that is listed in bullet form for all those indications of patients including patients recently discharged within the last 30 days from any acute care hospital. The level of resources and effort to focus on screening and identifying patients for this one organism, while we know we are being challenged by multiple other resistant pathogens, is really still mind boggling. Granted, we are going to be doing all this work, there's going to be a phasing period, so we won't be able to realize the value of it for some time to come. I would really appreciate to hear some specific comment on the screening issue which is pretty wide in scope. For some hospitals it may be easier to screen everybody rather than

just select out. Should we understand from today that regardless of what's happening in terms of funding, the hospitals are still going to be required, based on licensing and regulation inspection, to carry out what's in that language to the letter.

Billingsley-Yes

Chen-In order for us to respect the effort that is going into providing this data, I think one of our biggest pieces is to get clarification on how things should be reported. Hospitals could start out one way and not have to change midstream. So, if there were one priority, that's what I would like it to be. How these infections are going to be reported is through NHSN or some mechanism through the state. As I go around the state, people are starting to figure out how they are going to be doing things, but the clarity on where they are going to be reporting and what they are going to be reporting is probably the number one issue.

Member-So you're saying that will be your priority?

Chen-As we're moving this HAI program forward, that has to be done. Just out of respect if nothing else.

Member-Has any discussion occurred whether private funding could assist?

Billingsley-Yes, we have discussed that further and private funding can assist. I will make sure that we clarify this and make that information available.

Hoke-I just want to point out that when you are talking about the surveyors coming out, don't forget that the surveyors are not going to be looking at the reporting piece. that goes through NHSN. They're going to be looking at the processes. For instance, when they are going out and they're talking about the system that's going on, and they're asking about surveillance testing, they will look to see that you are doing that according with what the law says. But whether you are reporting into NHSN or not, that is pulled from the data that we get from NHSN.

Eck-Here are some examples. We have a patient that comes into the hospital in preterm labor, and is admitted into labor and delivery. Then she goes home not in labor, and comes back two days later. Based on the legislation, every time that patient would come back in the hospital, whether it's 24 hours, 48 hours, or 72 hours, that woman would have to be screened for MRSA because she would have been in the hospital, in the acute care setting, within the preceding 30 days. If I'm a patient, that makes no sense. This is what the hospitals are saying. What is the point of that? You would be right in saying to a hospital that this is the law and you must comply with it. It makes absolutely no sense from a resource use, from a patient perspective, an infection prevention perspective, none at all. I have a patient that is admitted to the ICU and they are going to have cardiac surgery. They get admitted to the surgical ICU, gets screened, go to the OR, and come back to the cardiac surgery ICU. Well now they were screened on the ICU, but now this is a different ICU. Now, I am going to have to screen them again on that ICU even though it was eight hours after their first admission but they went to the OR and now they are someplace else. Those are the kinds of real questions that the hospitals are struggling with. Jon, with all due respect, I hear your commitment to convene and solicit input but I do not believe that those kinds of things that hospitals, including my hospitals, are dealing with even remotely represent, what Kim deals with or what Francesca deals with, or the rural community hospitals. The vast majority of people around this table would be willing to do phone calls to have the dialogue about what needs to be done and the kinds of clarifications necessary.

Rosenberg-All of the legislative language in discussion in the version of those bills that were submitted over many months and were at risk even if the Committee didn't go on hiatus of turning this into a post

legislative review committee. There was ample opportunity for parties to testify or submit whatever. The legislative process happened and most of the MRSA screening language wasn't all changed at the last minute. It was there. To be frank, I think hospitals failed to participate. It may be appropriate at this place and time to say let's devote some Committee time to reviewing the screening requirements of the bills to discuss the merits, plus and minus, pros and cons of screening, different kinds of screening and how it's selected. Even with full resources, that would become the major focus of this committee or a subcommittee, for quite a long period of time. This is not one of the pieces of legislation that directly impacts the CDPH-HAI program because we're not receiving the results of the screening. Given the explicit mandates in this legislation for what the program is supposed to be doing (and the hospitals are a part of that program) I don't know that even now today that we necessarily want to keep going on about the MRSA screening. You're talking about ultimately like, with the surgical site infections, wanting to propose changes in the legislation. Again, we can't interpret that.

Chavez-The department, with or without your input, cannot interpret the law. The law is what it is. We cannot divert from that. There are processes such as regulation that are extensive processes that take years where there is public input and debate and make changes. But we cannot change that; it is what it is. So, whether we have a debate here or an agreement on what is the best thing on screening, that in and of itself cannot be something that Kathy and her folks can take and use for implementing the law.

Billingsley-What the Committee can do, as it is advisory, is to give the department advice as to the lack of clarity regarding some of the language, and the Committee can make recommendations as to what that language should be. Then it is incumbent upon the department to take that forward and draft regulations based on that recommendation.

Rosenberg-The department is concerned about the readmission and placement of patients in SNFs and other facilities after they've been identified as MRSA positive; we will look to see what we can do to try to deal with that issue. That's another example of a priority for us to deal with that's going to take time. We would like to look at what the department could do in terms of addressing environmental cleaning and disinfection which is an important priority in SB 1058. Given the law says what it does, we see the potential to actually make that more effective. But again, that's going to take time and work.

Hoke-And I think that we already have something in one of the documents about controlling positive numbers in long term care facilities in California that says that they're like on a seven day bed hold and the facility cannot refuse them just because they have a positive result.

Chair-I've let this discussion go because these are all important issues, but we need to complete our agenda and then prioritize next steps. We have left in the morning session progress on program implementation and reviewing of the draft annual report.

[BREAK FOR LUNCH]

Program Updates

Progress on Program Implementation - Chen

Chen-We now have 335 of 444 California hospitals registered into NHSN, 200 of which have added during this year. Calls for assistance are still being received from hospitals that are just beginning the registration process; we are all over the map as far as compliance with this particular piece. Many of those hospitals involve 25 or fewer bed facilities and the outreach to bring these hospitals into compliance is really resource intensive. Many facilities of this size do not currently perform the mandated reporting procedures so as to maintain a good standing with NHSN. This means CDPH is having to craft different solutions with what we put in the report in order for them to stay in NHSN. They also don't have denominators that reach levels of significance for use by NHSN. Of note, New York state did not actively pursue their last 25% of their 270 hospitals.

California hospitals comprise 16.5% of the over 2,000 NHSN hospitals nationwide. The Committee asked NHSN for input into proposed modules prior to the modules becoming final. NHSN is in a dilemma over mandated use of their modules that were designed for voluntary participation. While this is not in the formal report, the CDC has been querying California on issues related to the NHSN. Specifically, most recently, on the employee influence of vaccination module, and there may be a change in some of their policies going forward.

201 of the CA's 335 NHSN hospitals that have joined the CDPH group, or 60%. So there is 40% that are members of NHSN who have not joined our group. Of the 242 hospitals who voluntarily submitted employee influence vaccination data, preliminary analysis shows a bell curve of the mean vaccination rate in the 50-59% range, with 76% of the facilities within the middle of the bell curve, which would be the 40-69% range. When you look at the outreach, however, the outreach was 14% of their employees all the way up to 188% of the employees. When you look at 188% of the employees, actually facilities were reporting more than employees. When you adjust for people who are offered the vaccination over a denominator of those offered and those who declined, our rate is within national standards, or 41% of our healthcare workers who were offered the vaccination accepted it. I would like to request that the Committee recommend the use of the patient employee safety module off plan to collect the pre- and post-influenza survey that was recommended by this Committee in May of 2008. It was an error in the way we were looking at that. On the second page, where there was a lot of data that was supposed to be gathered, that element is actually optional. So we can go back at some point and say 'please use this'. The module is not out yet, so it would have to be for next year and have people report those pre- and post-surveys off plan. That would enable us to have all the data in one place.

Finally, I would like to say that CDPH is still working with legal counsel on interpretations of the legislation that will guide how the legislation can be enforced. The department has developed the database and the statewide email list for tracking and communication purposes. We have used this list three or four times now and L&C will be asked to provide guidance on issues regarding noncompliance. More specifically, less than half of the California hospitals have returned attachment E, which was the pre survey, so what we have done is provided a list to L&C of those hospitals who have not complied. L&C will be contacting these hospitals to assist them to comply. Education and individual consultation has been provided statewide to chapters, corporate groups, district offices and consulting groups on registration and implementation; those efforts are ongoing.

Active Subcommittees—We have the Public Reporting and Education Subcommittee with Carol Moss. We have met to strategize how this should go and when the Committee comes off hiatus hopefully we will have a more cohesive plan. We will be working to create the structure we had originally envisioned; this means providing information to the

public in a way that it is going to be intelligible for consumers and useful for clinicians. We have our Committee Guidelines Subcommittee with Frank Myers. That group is close to putting a recommendation together. As soon as we get that recommendation, we will forward it to Committee members. Finally, there was a Curriculum for Infection Control Committee Chairs chaired by Dr. Witt. We will address that when we go over subcommittees. Subcommittees that we have formed but not yet activated are the Legislation and Evaluation Subcommittee. We have volunteers but we don't have a chair for that subcommittee. The Infection Preventionist Resources Subcommittee, with Lilly LaBar as chair, has not been activated, it is only named.

Our inactive subcommittees from this year are CLIP with Enid Eck, Influenza with Ray Chinn, SCIP with Shannon Oriola, Legal with Debby Rogers, MRSA Reporting with Terry Nelson, MDRO Module Evaluation with Lilly LaBar, and CLABSI with Dawn Terashita. We have several membership gaps going forward. One of them is our representative from health payers. We no longer have a representative from a union because Donna Dorsey Fox took a different position and is no longer on the committee. We also have several members who have retired or changed positions, and there is at least one other group where there has been fairly minimal participation. This may be reevaluated during this hiatus.

Projects in process—The membership satisfaction survey is still in process. We will need the subcommittees to address other mandates of SB 158. We're looking for a website to support a blog group for hospitals with less than 100 beds which is a third of California hospitals. While we have a moderator and a backup moderator, we don't have a landing site for this blog. Small facilities have to handle things so much differently that it makes sense that they have their own problem solving support group. We need to finalize the analysis of the 2007-2008 employee vaccinated flu data that was voluntarily reported, so we can put that information out. Finally, the analysis of the six months of CLIP data that should be available within NHSN by January 31st will also need to be completed.

Flood-Regarding to the CLIP data, did we ever send out clarification on the long term device?

Chen-We brought it here and it was approved by the committee. It has gone out only informally. It has not gone out formally because when we think about opening Title 22, you might get some unintended consequences. If we reopen AFL 08-10 which is the data file there, it was better not to open that up. We would have to revise that, which means it would be reopened to scrutiny again internally.

Flood-So surveyors moving forward have been instructed to do what specifically?

Chen-Follow your policies. It's no different.

Flood-The other question regarding CLIP is, currently the only area that we're looking at for CLIP data is the ICU? We were supposed to be rolling that out.

Chen-When we started out, we said we would rotate this every six months, but when I talked to infection preventionists recently, the reaction to a rotating option was not positive. Considering all the requirements that came down effective January 1st, it would be an undue burden to make everybody do that. The intent would be to eventually rotate this to different sites; to rotate it second to the radiology, emergency department, and pre-operative areas which I think is a huge potential problem, and last to the units. However, this doesn't seem to be good timing. The clarification would need to be, if you rotate it to another site, can you stop doing it formally in the first site, so that your work is not piling higher and higher with no relief? Right now, it is still ICU only. CLIP reporting is a continuous process. We originally said six months because it was going to be six months in the ICU and then we were planning on rotating it. A lot of people do

not feel that they really have their CLIP data as good as they would like it to be, so this is ongoing.

LaBar-It does include critical care areas?

Chen-Yes, including NICU.

Eck-There is a big difference between having checklists and people using them at insertion. The infection control person having to sit and enter all of that into NHSN. The infection control people will end up doing nothing but sitting and entering data into NHSN, not out on the units.

Torrani-I am asking for clarification on CLIP. Are we saying that the CLIP has to be done in all units but will be entered into NHSN module only as of a certain date?

Chen-CLIP data must be collected in all ICUs and entered into NHSN; there is no cutoff. We did not extend it to all other units. In 2010, the Joint Commission will require a rollout.

Eck-Regarding the Legislation Subcommittee, given the hiatus of the Committee, will CDPH ask subcommittees to continue to go forward during the hiatus? That subcommittee probably would be a valuable one to convene.

Chen-Their job description is the line in the legislation that says the Committee will look at the impact of legislation and regulations on hospitals.

Review Draft of Annual Report

Chen-The first part is the introduction. Next, I put an overview of recommendations made, projects in process, the status of mandatory reporting in California, and future directions. Status of mandatory reporting is merely the numbers we discussed earlier. The piece that's going to need the most input is future directions. What I put down is to continue the public reporting; this should be public education project and I didn't specify what it would entail. Next, begin moving through the mandates from SB158, look at the reported data, and make recommendations.

Oriola-Motion to accept annual report as submitted by Sue and Kim

LaBar-Second

Murthy-Was the work regarding the technical clarification language reflected here?

Eck-My concern is that this implies that something got accomplished and what did get accomplished was a ton of work on the part of this group of people to create that language, but in terms of any real corrective language making its way through any process that would clarify with hospitals legislation...

Chen-I don't know that any of that would have started before January anyhow.

Eck-We were all told in November that it all had to be done because it had to be submitted by December 1st.

Chen-I will have to get back to you because I don't know the status of this process.

Eck-This language does not accurately describe what this Committee did. By the lack of clarification, one could think that corrective language was somehow going to be forthcoming. That is not correct.

Chen-I don't know how to answer that question.

Oriola-I understand what you are saying. We still can't distribute an AFL on those four surgeries because we need legislative language to back up that language. So what's going to happen this year is chaos.

Chen-We are still seeking legal clarification on how this legislation can be enforced.

Flood-We could add "timelines for technical clarification remain uncertain."

Moss- Then it is clear that we did the work and it is someplace to be released at some point but, in the meantime, hospitals are supposed to start reporting per the legislation, but we're unclear as to what needs to be reported.

Eck-I would recommend the NHSN manual Patient Safety Component Protocol, last updated on January 2008; it lists surgeries covered under NHSN and ICD-9 codes.

Moss-That is not the point of this question. I am absolutely familiar with the NHSN list. That does not speak to the risk adjustment, the risk calculation, or the methodology for reporting. That is a laundry list of surgical procedures that everybody in this room probably has memorized. You cannot put hip and knee and bunionectomies in the same pot and calculator rate, but that is what we are looking at right now. That is what we are facing.

Murthy-I recommend that the status of this particular piece be reflected; that the section from the crafted language (November conference calls) be moved to either "in process", "pending" or some other header so that it reflects it was work that was accomplished and recommendations made and status of that in the pipeline.

Oriola-I think we were clear on the call that "all" would be reported at some point in time but it had to be meaningful for the consumer, for the surgeon, and to the hospital. The legislation doesn't specify a methodology for reporting, so a hospital can interpret that they are going to throw all their surgical denominators together and all their infections together and that's what one hospital would consider reporting, versus another hospital separating them out. This is a stepwise fashion so we can start with the four main surgeries and grow out to all surgeries. I wanted to clarify that the Committee recognizes the value of reporting not just those four.

Chair-The consensus amended language reads: "Each health facility shall report quarterly to the department all healthcare associated surgical site infections that meet CDC and NHSN definitions and methodology for deep incisional or organ based infections following orthopedic, cardiac, and gastrointestinal surgeries. The number of surgeries for each category of procedures shall be reported for the same period. Infections are defined in the following: Any prosthesis arthroplasty, hip prosthesis arthroplasty, CABG and cardiac valve replacement via median sternotomy, and colon resection shall be reported separately to the department via NHSN. On an annual basis these selected procedures being reported will be reviewed by the HAI Advisory Committee who will make recommendations to the department." That is what we all agreed on the last time we met.

Oriola-Move to approve the report as is with the amendment and removing future directions.

Slininger-Second

All ayes

Subcommittee Updates

Public Reporting/Education Subcommittee - C Moss

Moss-I want to thank everyone who has participated to this point. We have had some good feedback from meetings we have had with people who are very knowledgeable about how to report to the public. We've been able to gather data from them. While on hiatus, we can work together with Sue and the department, and with Kathleen in L&C, to at least make sure we get some things posted that are on our site, so that all of the hospitals can take a look and see that all their work was worth this; that they're registered on there and they are being reported. As it relates to the public education component of it, we were able to identify several people that have access to user groups that will help us begin to draw people from the community to our site. We will continue to talk with people who have databases of community public people that we can reach out to and drive them to our website.

Chen-Thank you for your work. Honestly, this is the most complex subcommittee. It's different from all our other committees because it is ongoing.

Oriola-I had a question on 'education to the community'. When you say that, you are trying to draw those people into the website for the resources that we're going to impose?

Moss-Yes because we don't advertise on commercials so we need to find a way to get people to come to our website.

Oriola-Are we just drawing them to the CDPH website or our HAI website?

Moss-To our HAI website. As we develop, we will put things on their like the 15 steps, things like Enid talked about such as preparations a patient going into the hospital would take to help prevent infections. We can gather data and put it on there and we can all add to it; those things will be filtered through the Committee but that is down the road.

Committee Guidelines Subcommittee - Chen

Chen-We will get an update from this subcommittee and email it out to the Committee.

Clinician Education Subcommittee - Witt

Witt-Ray and I met with some representatives for SHEA and assessed with them the possibility of them sponsoring and helping develop a course. They have agreed. Our discussions involved mostly what the curriculum should be, what kind of time requirement there would be, and what the format would be. The SHEA meeting is in San Diego this March so they offered to have a one day course preceding the meeting directed at all California clinicians. After that we took it to the group electronically, and we do have consensus for this. It is in the summary there, we felt that those are the critical aspects of the SHEA course as well as some aspects we thought wouldn't be needed in addition for California clinicians. There is some tension between SHEA, which is used to an academic setting, and the needs of rural practices; these may be very different. There is still a little bit to be worked out in the curriculum as far as how much time per which parts of the topic; hopefully creating that curriculum could be done by experts or professional society groups. If we have agreement with the Committee, we can start publicizing this. There are issues that they came up with on their curriculum that need to be part of the curriculum. They excluded antibiotic stewardship and employee health issues, both of which are really critical. It is a lot to fit in eight hours. In their preliminary schedule, they have two hours on MDRO and zero hours on antibiotic stewardship and employee health; my view is that this can be better allocated. I don't think SHEA is opposed; I do think they are looking at this from a big hospital perspective.

Oriola-Are they involved because they are going to sponsor the course? (Yes) So they would be giving out the CME's? (Yes)

LaBar-You will advocate for antibiotic stewardship?

Witt-I think it has to be included. We would actually declare what will be in this course if it is going to meet the California specifications and so we have the opportunity to really require this. Regarding the items that we put in our proposal, do we feel that they all need to be included in this course? That is what I am asking the Committee to endorse.

Moss-Is this something you'll be able to put online so people can actually get a certificate after they've completed the course and answered the questions?

Witt-It's not a certification course. To make it a webinar would definitely be good. The other thing is, it's going to be an influx this year for a fairly large number of people and then after that, it's not going to be 427 a year. It's going to be a trickle of new staff. One of their interests is to draw people to attending SHEA meetings.

Murthy-I agree with the list. Because it is California based, it would be helpful to put the employee health issues—to perhaps emphasize on the influenza issues and the exposure because I think it is going to be challenging in eight hours to manage that huge list. Antibiotic stewardship is clearly a priority among all the other items, and employee health as it relates specifically to post exposure follow ups and influenza vaccine management issues. There might be some room for either mentioning or adding on as a handout or something the disinfection sterilization. In terms of the depth that SHEA goes into maybe incorporate that into some of the MDRO piece. They could emphasize the disinfection sterilization.

Witt-They currently have one hour devoted to disinfection sterilization/environment.

Chair-There is a concern about this meeting the intent of the law. The law says that the hospital epidemiologist/infection control chair will participate in CME. It doesn't say how many, but it does say infection prevention surveillance and something else, and specifically names the SHEA CDC program. Do we feel that this eight hour course will meet the intent and then the person going can then say 'now I can be a hospital epidemiologist'?

Witt-Two things. The language, if I recall, actually didn't reflect the SHEA CDC course. When I went back to read it, it was really quite odd. It was a course put on by recognized professional organizations such as SHEA and CDC. So what we figured is, "what's the target?" The target is to give people basic epidemiological tools. Do you have all the nuts and bolts you need to run a reasonable program? Is eight hours enough? Probably. Would more be good? Yes, but should it be mandated to every 20 bed hospital? So this is kind of where we came up with this is what could be reflective of the SHEA course by the aspects of it, and really provide someone that can speak knowledgeably from that point on to function as a hospital epidemiologist.

Slininger-Part of, or all of the idea of including something about employee health actually meaning to get at letting the physicians understand how important it is not only to support the hospitals effort to have all the employees vaccinated, but the physicians need to be vaccinated too, and understand their role in not spreading flu in the hospital. If that's the case maybe we want to title it a little differently. As it is, the title employee health may not interest them.

Witt-I think the purpose is not to do education on employee health. The purpose is to create someone who can then be that interface to identify what's important and receive all of the reports regarding employee health. The flu is incumbent in that but so is measles exposure and needle sticks and everything that comes down the line.

Murthy-Part of the overarching emphasis in the SHEA education program is to illustrate for the people being trained that the concept of

healthcare worker is not just the employee, it's also for anybody in the facility.

Morris-Are you also going to address safe injection practices? Nationally SHEA is going to be putting a lot of emphasis on that.

Witt-I brought up patient safety and overall background. My inclination is it does fit. This is something that's important but not immediately and directly integral.

Member-There are a number of places that it could be worked in, but simply getting it on people's radar screens is important. You are going to miss a big opportunity because I think a lot of it affects not only hospitals, but practices in all these places that are not even surveyed at this point, doctors' offices, outpatient clinics, etc.

Chinn-Do you think the list is too long? We have a lot of items there.

Torriani-What's missing, as Ray pointed out, is antibiotic stewardship and employee health issues. Of all of these, that's what is missing. But, it could be crafted in.

Murthy-I wonder if antibody stewardship would be part of the MDRO's section. So that could be added as one of the goals of that section; in that case the two hours might be reasonable.

Witt-The only reason I personally favor the antibiotic stewardship is this is really vague language in the law, is really vague in practice, and even the [IDSA] guidelines are not clear. 'We should do what we should do' is not the best clinical practice guidelines. I advocate having it as a topic is because that becomes critical. As you were saying, we are going to be using broader and broader antibiotics starting on admission, and we are going to get worse and worse organisms. I think it needs the bullet point of standing at least on par with disinfection.

Moss?-Our guest talked about what he sees downstream as (in)effective antibiotics.

Chinn-It gives them a guideline which is very important.

Moss-I think it would be helpful to have illustrations of the realities like Dr. Mitchell did today. If you are working with SHEA on this, if they can provide illustrations that get to the reality of this.

Chinn-The most cogent type of presentations are the ones that present all these examples.

Oriola-If a physician went to the CDC SHEA course on hospital epidemiology would that preclude them from having to do demonstrate competency?

Murthy-As far as I understood from this discussion there wasn't specific language about California. It was meant to be reflective of things that are included in the California legislation, but it wasn't geared specifically to California.

Eck-I understand why you'd want to do this but I'm also wondering why it is we would not want to take advantage of the opportunity to say 'you know what, if you are going to be a medicine epidemiologist and chairing an infection control committee, you need to spend three days and actually go to this SHEA course and really do it. The difference between what they would get from that three days, and as good as this eight hour day might be, the depth of knowledge and the improved expertise is not the same. I understand not everyone can get there but my concern is that this could be sort of a fall back rather than taking the complete training.

Moss-It could be an alternative because you are going to have some people that aren't going to be an epidemiologist but they want to know this information.

Eck-But that's different because what we are saying is this would meet the intent of the requirement in the law.

Morris-About 1/3 of the hospitals are really tiny. Those of us at larger hospitals have probably been to the SHEA course. So this is really directed at where the real lack of knowledge is. But, you are absolutely right. This was the compromise between four hours which is clearly not enough and the full course which is probably not needed for your 18 bed hospital that has two person outbreaks.

Creighton-While it may be wonderful for physicians to attend the three-day course, their resources are just not there. However, the regulation says that they need to be trained and this would obviously provide them with the intent of the regulation.

LaBar-I'm going back to antibiotic stewardship only because the ID physicians in my hospital have been struggling for years prior to this senate bill to get a program in. Since the senate bill passed, they finally have some clout. For my infectious disease chairman to go to this and come back bulletted and highlighted would really help.

Velji-The intent of the curriculum as I see it is to give some competency to highly experienced people who just need to brush up on certain new developments. The idea is to give them new developments, not just the basic statistics. The idea is that there could be competency. Then to have something like antibiotic stewardship and what's new in that field. All of us have worked with order sheets and talked to pharmacists but now there are computerized models to help do this. A lot of it is pharmacy driven. Antibiotic stewardship in reality is not physician driven but pharmacist driven because you need to have also the calculations with the liver functions, and so forth. We are starting a program with the pharmacist, and we are going around and doing rounds with them, so we are teaching them and they are teaching us about a complicated patient. The idea is to focus on what is new and developing, not on what you can find in any book or any textbook. The other material can easily be covered in the syllabus that comes with this course. People can do some homework before they go in to the course. I am opposed to three-day courses because all of us are committed to doing so many other things. We don't want to make it a cumbersome thing because we are not trying to create an examining body.

Oriola-I move to adopt the report with the recommendation that this is minimum curriculum, and that providers can go to the three-day if they want to, and that under the MDRO section that it is highlighted that antibiotic stewardship should be part of that.

Moss-Second

Witt-I actually still oppose it because I think antibiotic stewardship has got to have its own leg.

Oriola-Retracts motion

Oriola-Moves to submit the recommendation of this report as a minimum requirement for a hospital epidemiologist or infection control committee chair to take and that in addition to MDRO's that antibiotic stewardship will have its own billing.

LaBar-Seconds

All Ayes

Motion Passed

Chinn-SHEA is planning webinars for advanced epidemiology so if you wanted to go more than just the course, they will make it available to whoever wants to sign up.

Infection Preventionist Resources Subcommittee-Chen

Chen-Nothing has happened and legislative impact has not been clarified.

Torriani-What has the law has mandated now in terms of CLABSI reporting.

Chen-There was a recommendation made from this group that was to the department. Because we are unable to move past some of the legal interpretations that information was actually folded into one all facilities letter. I don't know when they will be discussing it. We are constrained by not being able to interpret how hospitals are to report. Not being able to report, we can't say 'you must report this through NHSN.' All we can do is suggest. It is suggested that hospitals report ICU CLABSI's through NHSN and suggested that if they don't wish to report all through NHSN that they report them to the department in two numbers. It would be ICU through NHSN and then house-wide and the rest of the house-wide denominator to the department. Use of the NHSN CLABSI module is out as a suggestion.

Torriani-As of 1/1/09, facilities have to do surveillance on house-wide CLABSI?

Chinn-The denominator is line days.

Chair-There are two mechanisms for reporting. NHSN for the ICU CLABSI rates and a house-wide rate to the department.

LaBar-Are we entering this via the NHSN module?

Chen-There's a choice. In theory, all hospitals could report all of their CLABSI's and all of their line days from their facility to the department in two numbers. CDPH is asking is that you report your ICU's through NHSN with numerator and denominator. You can do as much reporting through NHSN as you want to. Minimally we would like ICUs through NHSN and everything else as two numbers to the department. You are required to do whole-house regardless of how you report it.

Oriola-I'm doing it through NHSN because I have specialty care units and I want to be able to compare my apples to someone else's apples.

Eck-Could I encourage the department to get that AFL out as soon as it is possible. In the onslaught that hit the hospitals starting January 1st, to have that come out in July with a mandate to retroactively enter all of this data... The fact that that communication did not go out, data may have already been lost in some places. When the dates that something is due precedes the notification that they are supposed to do it, it is brutal.

Chen-I understand your concern and what I would say is that if the AFL were to come out tomorrow, it would not answer most questions because we do not have sufficient legal clarity to answer those questions.

Eck-But, I thought you said the AFL recommendation from this committee to the department about what was required was embedded in the AFL that's coming out.

Chen-We cannot make hospitals do that. It is only a recommendation.

Eck-I understand that, but that isn't even out there.

Chen-I know.

Rosenberg-There's complications in that. For instance, are we required to provide an alternative means for reporting? Even if you say it is just a recommendation, it is not that simple.

Moss-What is it going to take to get the hospitals a letter that will give them direction?

Rosenberg-That is a question for Kathleen. There are people at certain policy and legal levels at L&C who need to review this, and this issue is

not their priority. We have a problem going back to the SB739 with something that never came up until now and that has to do with the reporting of the process measures. The precise language of the bill which is that hospitals must report on the implementation of the CDC recommendations for prophylaxis before surgery, influenza vaccination, and central line insertion. The problem now is the word implementation. There's people in policy positions at L&C that looked at it and said 'you're not authorized to require the success rate of implementing those measures, you are only authorized to require the reporting of the implementation.' It even goes beyond what surveyors might do. SB739 did not go through the legal review that 1058 and 158 did. If it had, we probably wouldn't have CLIP data or influenza vaccination rates because that's not implementation, that's the success rate; the outcome of the implementation. We could go through regulation and take another year or two, we could talk about amending SB739, or just continue as we are now but pointing out to facilities that this is all voluntary.

Flood-To meet compliance with SB739, as is currently written, we essentially have to hand you a policy and we would be in compliance.

Rosenberg-You must report to CDPH on the implementation of these guidelines.

Flood-I could hand you a policy and say this is my policy.

Rosenberg-This is how we are implementing it and I can't argue with them.

Flood-I just want to make sure.

Velji-Regarding Dr. Mitchell's presentation this morning, I believe all of us give those types of presentations at our infectious disease conferences we have annually for the last 25-30 years, and the morbidity/mortality conferences and infectious disease rounds ongoing. Most of us here are presenters and are aware of this. However, what would be very useful, like when we started this project two years ago, we said the most important thing is education of the consumer, such as the knowledge base as to not neglect minor wounds, cuts, etc. We see people with multiple scrapes that they had, but those are neglected. These are the people that end up, unknown to them, could be diabetics or otherwise compromised. Somehow we need to educate people, particularly now with MRSA, this is becoming a place that you do not neglect these types of early infections. We can put it on the website or wherever without causing hysteria because we don't want everyone lining up outside of the hospital doors. I am glad we continue to do those messages. In fact, over the last 25-30 years, we have noticed that the surgeons have become very aggressive with the infectious disease providers.

Mitchell-Yes. The best thing is to have someone push you saying 'you need to go to surgery, you have to come and do something.' A lot of times surgeons will say 'no, let's wait.'

Velji-Three days ago we had our Infectious Disease Society of Northern California meeting which is with the Greater Sacramento Epidemiologists Society; I presented SB 1058. One of the main concerns was that as we start screening too many people who qualify according to our criteria, what is going to happen is people will end up jamming emergency rooms while all this is going on with the screening and so on. People who need to be discharged, people who need to be transferred, cause extra steps to the whole process. Since our goal for the Committee is to improve quality, decrease morbidity and mortality, and help with the healthcare issue here in California, we need to have enough time also to discuss what is happening at the hospital level and at the clinic level. Things we do in the hospital like wash our hands with alcohol, it is not being done equally well in the clinic. The same MRSA people can be walking around shaking everyone's hands in the clinics. There are a lot of issues that are practical which are hospital based and clinic based, that we need to discuss here next time if and

when we convene.

Mitchell-You brought up a fantastic point; there are such basic things that we need, the practical things that are not being done. Hand washing, little practical sterile techniques from surgeons and doctors and staff. We need to get back to the basics.

Slininger-Education to the primary care physicians is also something that if it could find a way in so that the consult is not delayed. Somehow if we can impact education at the level of the primary care admitters who are treating something all together other than that seemingly minor infection that they are not paying attention to. Secondly, I am hoping that patient safety goals, that are becoming so strong for hospitals in particular, maybe not enough for the clinics, but that whole hand washing issue including residents that hospitals all around the state are paying so much attention to hand washing campaigns involving clinicians, physicians, and residents that I should hope we are going to see that improve.

Chair-Other unintended consequences that I think Dr. Velji is getting at is treating colonization versus infection. We have so many clinicians that don't even know what that means and now with these mandates and this pressure, I fear we're going to see an increase in emerging pathogens that are more resistant than we ever saw before which is going to create even more of a problem than what MRSA is already causing.

Morris- We have a process at our facility where we are looking at the CMS cases that fall out because of coding and we're finding that things being treated and called central line infections or UTIs that clearly aren't, yet they're being treated. All types of infections where antibiotics are used that didn't need to happen.

Moss-Dr. Velji, in response to your comments on the legislation, I can assure you that the legislator made every attempt to include all locations-clinics, nursing homes, because that is the right thing, but that's not what happened. That that was the intent. Everything other than outpatient was included from the very beginning, so it wasn't disregarded at all.

Murthy-The limitation we're still finding in the clinical setting is that the knowledge for the rapid diagnosis of other infections is really not there to the point that we get the care. So, while we might find MRSA, we may not have a diagnosis on other infections so there's this question of having to wait for three days for the final cultures. It may not be the right antibiotic but it only tells us if there is MRSA or not.

Torriani-These tests prove for colonization, not for detection of infection. Clinical disease which is really important. If you have peeling abscesses, the first thing that you have to do is a gram stain. That doesn't cost much. At least you'll see if the gram stain is gram positive or gram negative. You will have, at least, a presumptive diagnosis. It's very rapid but rarely done.

Future Directions and Prioritization

Witt-Are hospitals going to know that their hospital epidemiologists are going to need this course in time to sign up for the course??

Chair-Could we pair up with our professional organizations and send an FYI out?

Torriani-I think we need CHA.

[discussion ensued about the various ways in which the information could be disseminated and several people volunteered to get the information out through their specific channels]

Chair-I am opening up the floor to discuss prioritization and where we as a committee want to focus until such time that we reconvene.

Slininger-With the understanding we have now with the bills, our priority needs to be to communicate with hospitals the best we can regarding exactly what and how to report. I think that's the most important thing. As much information that can go out in one correspondence will be helpful to the hospital to have that resource in one place.

Chen-One thing that you could do is send me questions so we can get the answers. That might be the format that we can put some of this out while we are waiting for more definitive answers. I don't have a problem with that - whatever I can do to help.

Torriani-APIC and CACC are excellent places to disseminate. The problem is that the information doesn't filter down to all the physicians. Our organizations are not as well organized as CACC and APIC. The point is that we need to be involved. Maybe we need to be thinking of another way. I think working closely with CHA so that information gets disseminated at the medical level.

Terashita-All of our chairs are on email lists.

Chen-The list of 444 hospitals that we have is a more efficient way to get it out but my concern using that list is that it comes in to the facility administrator for NHSN or the infection preventionist, whichever one is on the list. So it doesn't go up to CEO's and that's where the CHA comes in. Remember that CHA only covers 3/4 of the hospitals in California. I am not aware of another entity that covers all the rest of the little hospitals, which is where a lot of the problem comes in and is why we are trying to get a blog for them.

Torriani-As you said previously, is this pool, 15% of hospitals, worth a lot of effort? At some point you have to decide.

Chen-Communicating basic requirements to them and really getting them online are two different things. There is an intent to comply there. It's just that the word does not get to them or to them in a timely fashion. Small hospitals also may not have the resources. The most ideal way to communicate to small hospitals would be through the LHDs. Every LHD has a list of the hospitals in their area and they can go to the CEO. When I tried to institute this a year ago, the health officers were not willing to cooperate with that approach.

Eck-One of the things we have talked about is a timeline and requirements for each of these bills. They are all rolling together now and people are lost. That would be a very valuable tool, especially with some of the dates for which we are already past and the notification hasn't gone out. That could go out without an AFL because it is just a summary of the requirements for each of these pieces.

Chen-Actually, there was an intent not to reinvent the wheel. Someone actually did that and gave me it on a graph. I printed out the graph and taped it together and it was 3 feet by 8 feet. The people in my APIC chapter are equally confused. The San Francisco Bay Area chapter is going to put on a webinar in exactly two weeks. What we are going to try to do is combine best practices. What you're talking about has already been done by Sutter Health so we will be distributing that table and it will be posted on a website closer to two weeks from now.

Eck-For people that can't participate in the webinar, the timeline would be helpful.

Chen-So maybe what I should do is put that out through the statewide facility list.

Oriola-I know we talked about education to the consumer and maybe doing that in the future. Did you recommend how to display this information?

Moss-We have to do a 'Plan B'. We will probably use the existing

website and it is going to be on a tab on L&C's section, or the HAI, we don't know yet. Before it gets posted, we would bring it to the Committee for approval.

Chen-You are going to see it many places. I don't know how the release of that first data will come out. I know that CDPH will be analyzing it and maybe it will just be in paragraph form on that one because we don't really have a committee.

LaBar-Is the HAI website dead/frozen?

Chen-It may be somewhat frozen after the posting of this set of minutes but it will be there. Any communication to you will come as an email to you rather than you having to guess when something new is put on the HAI site.

Flood-How are we going to certify these minutes today?

Chen-Email. If you look at the hiatus in terms of not formally going forward with subcommittee work, we really don't have the subcommittee support for a period of time that we have enjoyed. So, setting up the meeting, calling everyone, taking the minutes. That doesn't mean that there can't be some specific input. It's just not going to be the formal like we have. Anything that you need to know, I will email to you.

Flood-Motion to formalize that a mechanism be created, such as an email to review and formalize these minutes so at least these minutes can be posted on the HAI website while this committee is on hiatus.

Member-Isn't there a requirement for public comment before we vote on anything?

Chen-Yes, there is. There is the HAI email where people can make public comment that flies a little bit into our face in that we have not posted drafts before. Maybe post something that has been approved by the Committee, then put it out for public comment, or put something on the website that it is open to public comment for 30 days. We can take care of it like that. I would prefer not to post any content before Committee members have seen and approved the content.

Staff-There is a motion to review the January minutes (and if it's acceptable to Annmarie) with some component of public comment.

Flood-I approve that

Eck-Second

All ayes

Motion Passed

Chair-What I have offered to do is to make sure that today's activities like a state of the state go out electronically just to say where we are at so that the ICP's know in any event. Then Sue can forward that out. That's what I can offer to do for CACC.

Oriola-That would be helpful. I guess the people in this room have the luxury of knowing but there are many other people out there that want to know that aren't here. It seems like word of mouth gets out but then it's diluted.

Eck-Could the website have posted something that explains that the Committee will not be formally meeting for a period of time. That way the people who are used to looking at the website will know.

Chair-Do we have any more next steps besides prioritization of what and how it gets reported and sent out as soon as possible to the hospitals?

Moss-I'm sure the public would like to know when they're going to see postings of the things that have been collected.

Chair-If there is nothing else, we are adjourned.

(Thank you's all around to Committee members for their hard work, Kim Delahanty for chairing, and to Committee staff.)

Chen-David (Witt), you are going to be moving forward with your piece of the subcommittee. That will continue.

ADJOURN

Acronyms

AFL All Facilities Letter
APIC Association for Professionals in Infection Control and Epidemiology
ARDS Acute Respiratory Distress Syndrome
BSI Bloodstream Infection
CACC California APIC Coordinating Council
CAHP California Association of Health Plans
CART CMS Abstraction and Reporting Tool
CCLHO California Conference of Local Health Officers
CDIF *Clostridium difficile*
CDPH California Department of Public Health / Department
CLIP Central Line Insertion Practices
CMA California Medical Association

CMS Centers for Medicare and Medicaid Services
DCDC CDPH Division of Communicable Disease Control
DIC Disseminated Intravascular Coagulation
ED Emergency Department
HAI AC Healthcare Associated Infections Advisory Committee / HAI Committee / Committee
HECC Healthcare Educators of Central California
ICP Infection Prevention and Control Professional
ICU Intensive Care Unit
IDSA Infectious Diseases Society of America
IP Infection Preventionist
IHI Institute for Healthcare Improvement
JAMA Journal of the American Medical Association
L&C Licensing and Certification
LIP Licensed Independent Practitioner
MDRAB Multidrug-Resistant *Acinetobacter baumannii*
MRSA Methicillin-Resistant *Staphylococcus aureus*
MSSA Methicillin-Sensitive *Staphylococcus aureus*
NHSN National Healthcare Safety Network
NICU Neonatal Intensive Care Unit
NISS National Nosocomial Infection Surveillance System
OR Operating Room
PICC Peripherally Inserted Central Catheters
QIO Quality Improvement Organization
RN Registered Nurse
SA *Staphylococcus aureus*
SB 158 Senate Bill 158
SB 739 Senate Bill 739
SB 1058 Senate Bill 1058
SCIP Surgical Care Improvement Project
TB Tuberculosis
UVC Umbilical Venous Catheter
VAP Ventilator-Associated Pneumonia
VRE *Vancomycin-Resistant Enterococcus*