

**Healthcare-Associated Infections Advisory Committee Meeting
January 13th, San Diego, California. 10:00 a.m. to 3:00 p.m.
DRAFT MEETING MINUTES**

Attendance:

Members: Kim Delahanty (Chair), Mike Butera, Raymond Chinn, Alicia Cole, Enid Eck, Annemarie Flood, Brian Lee, Lisa McGiffert, Mary Mendelsohn, Roberta Mikles, Carole Moss, Frank Myers, Terry Nelson, Shannon Oriola, Debby Rogers, Dawn Terashita, Francesca Torriani, David Witt

Guests: Chris Cahill, Sue Chen, Debra Edmunds, Debbie Emmerl, Sherilyn F, Barbara Goss-Bodorff, Brenda Hahn, Margot Hudson, Vikki Keller, Margot K, Tracy Lanier, Myra Laurino, Lana Lo, Karen Maceno, Valerie Martinez, Tina Menasian, Sheri Morgan, Karen Myers, Teresa Nelson, Daniella Nunez, Dawn Palatino, Mike Pfeiffer, Anne Marie Robinson, Joanne and John Sanchez (public story presenters), Jeanne Shirley, Cynthia Stuart, BZ

Staff: Loriann DeMartini, Jon Rosenberg, Sam Alongi, Kate Cummings, Roberto Garces, Lynn Janssen, Patricia McClendon, Jorge Palacios, Kavita Trivedi

Agenda Items/Discussion	Action/Follow-up
<p>Call to Order and Introductions: HAI AC Chair Kim Delahanty (Chair) convened the meeting.</p> <p>First of all, thank you to Sharp HealthCare for providing the meeting room, set up, lunch and refreshments for today's meeting.</p> <p>We have had a lot of success in the HAI Advisory Committee because of all the hard work that we have completed; this will be another exciting and productive meeting.</p> <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 San Diego and on the teleconference lines.</p> <p>Review of the Bagley Keene Open Meeting Act of 2010: Subcommittee procedures include:</p> <ul style="list-style-type: none"> • Meeting is to be publicly noticed 10 days prior to meeting; • Complete offsite address/line published; • Agenda posted 10 days prior to the meeting; and, • Written update for the HAI AC to review 48 hours prior to the next HAI AC meeting. 	<ul style="list-style-type: none"> • HAI Program to send Thank You letter to Sharp HealthCare for hosting the meeting.
<p>Public Story: Cole - Today, we have Joanne and John Sanchez with us to share their experience. This Committee invites members of the public to share their stories to remind us that we are here for the public benefit. We talk a lot about metrics and statistics and risk adjustment but we want to keep in the forefront that numerators are people.</p>	<ul style="list-style-type: none"> • HAI Program to send a Thank You letter to Mr. and Mrs. Sanchez for sharing their story.

Joanne Sanchez - John had a knee replacement in August of 2007. He went into the hospital on the 25th and was released on the 28th. He worked for a moving company and was a very strong man. To this day, he can't walk from the car to a Kaiser visit without being out of breath and without having to receive breathing treatment or having to rest. One year he had to go to the hospital about eight times. When I picked him up on August 28th, 2007, his knee bandage was soaked in blood and I thought that was strange. I asked the nurse to change the bandage and by the time we drove home, I had to change it again, and then the next morning. His leg looked swollen and blotchy, and was worse and warmer the next day. His knee was stiff and still bleeding. It seemed to get more painful as well. When we went in the following day, the receptionist looked at his knee and called for an orthopedic doctor. We were sent to our hospital and he was sent to surgery.

We were told John could have one of four things, and he ended up with three of the four. He had a hematoma, he was bleeding from the bone area, and he had Staph. He stayed seven more days in the hospital, in intense pain part of the time. Since that time, John and I have lost our home. I had worked for thirty six years for the same bank. Retirement was supposed to happen last year, but we have no income for that now. He has what is called an allergic Bronchial Pulmonary Aspergillosis. He never had asthma but has a constant cough. He has had nasal surgery.

If someone had known his knee shouldn't have been stiff and warm or bleeding or blotchy, maybe they would have kept him another day, and would have realized by the next day that something was wrong with his knee. For a receptionist to know that, even she knew something was wrong. This has impacted all our lives and he can't walk or breathe.

I am grateful that this committee knows how serious these infections are and that you are working to help to improve the situation.

Chair - I just want to thank you for your bravery in coming here to tell your story. We are sorry for your pain and suffering. An experience like yours is the reason we are here, to prevent this from happening to anybody. We are all consumers of healthcare as well and we take this very seriously. Everyone on this Committee knows that these are peoples' lives and not just numerators and statistics. We are fighting the battle with you. Thank you for helping to keep us focused in this fight.

Chinn - I would like to say that great strides have been made since 2007 in reducing staph infections, in that we have garnered the assistance of patients to prevent such complications. For example, by washing the leg at home before the surgery and by checking the nose as a carrier of Staph, we are able to decrease the risk of infection.

Rosenberg - Five years ago I had a hip replacement and lived in fear of every twinge or pain for a year. Knowing what I know, I scrubbed myself starting a week before the surgery with antiseptic, used disinfectant shampoo, used medication on my nose, shaved the area, and selected a surgeon by reputation for low rate of infections. One of my goals for this program is that every patient has access to that kind of knowledge and opportunity.

<p>Moss - Thank you so much for sharing your story. The only way we will be able to make improvements is by people like you sharing your challenges and being strong and diligent in preventing these errors.</p>	
<p>Approval of Minutes:</p> <p>November 2010 meeting minutes:</p> <ul style="list-style-type: none"> • Motion to approve November 2010 HAI minutes (with minor corrections provided). <ul style="list-style-type: none"> ➢ Motion—Flood ➢ Second—Eck ➢ Motion Passed by unanimous vote <p>December 2010 meeting minutes:</p> <ul style="list-style-type: none"> • Motion to approve December 2010 HAI minutes (with minor corrections provided). <ul style="list-style-type: none"> ➢ Motion—Flood ➢ Second—Eck ➢ Motion Passed by unanimous vote 	
<p>HAI Program Update: Jon Rosenberg</p> <p>In the last week of December, the Program cleared and posted three reports. During that week these reports moved from the Department through the Agency level and then back down. It was the Influenza report from 2009/2010 for healthcare personnel; the bloodstream infection report; and the C-diff report. There was a tremendous amount of work at all levels of the Program represented in that report. Because the Program wanted to enable anyone with questions to address those today, the two principle leads for those reports, Trish McClendon for the Influenza and C-diff and Kate Cummings for the BSI report are here today.</p> <p>The reports represent the best the Department could do with the information provided at the time. There were months of verification and correction processes with the 383 reporting facilities in California, and trying to verify any lack of reported information. There was a very narrow window of time to work with that information, and the Program is proud of the work that went into this. Kate Cummings will now discuss the BSI report.</p> <p>Cummings - I would like to thank the Committee for the opportunity to provide some brief comments on the HAI Program technical report on healthcare associated bloodstream infections, which was released on December 30, 2010. The report has garnered a lot of attention and interest, with the subsequent comments reflecting the range of expectations about the scope and content of the report. Among these comments, those of State Senator Elaine Alquist remind us that, as we have seen with other legislation, it takes time to refine the data collection process, and that this is a good first step, but that it takes time. The Department hopes that the comments of Senator Alquist help to broaden the lens about what was accomplished with this report. Despite the range and tenor of some of the comments, the Department considers it a positive sign that there is interest and support in the topic as the Department works toward our goal of increasing patient safety in hospitals.</p> <p>CDPH strongly supports public reporting of quality information and data on</p>	<ul style="list-style-type: none"> • HAI AC members with infection control data concerns should forward these concerns to the Program. • CDPH is considering methodologies for data validation as part of its process for upcoming data reports; CDPH is considering addendums for errors/omissions/corrections for the technical report. • CDPH to consider county specific reports for future reports. • Members with suggestions for website formulation and educational documents should submit these suggestions to the Program and to Public Reporting and Education Subcommittee. • Program to provide the White Paper

(from previous versions of HAI Committee/Working Group) to the Title 22 Subcommittee.

HAI rates as these data offer incentive for collaboration between hospitals and prevention experts based on benchmarking, and this collaboration will be the bridge between the barriers the hospitals face and the practices to meet their goals. It provides information to hospitals to improve care and to help consumers make more informed decisions about their healthcare choices. As has been widely noted, there are important caveats about the reported HAI rates, and the federal healthcare infection control practices. The developers of reporting systems should avail themselves to established improvement methods for collecting and reporting data. Publicly reported HAI rates can mislead stakeholders, including the public, if inaccurate information is disseminated.

CDPH evaluated the HAI data quality for the reporting period of 2009 through the first quarter of 2010; as a reminder, this reporting period was prior to data being electronically reporting using NHSN. Given limited guidance during this period, this assessment identified some key limitations, including non-standard definitions and protocols. For example, some hospitals reported primary bloodstream infections while others reported all laboratory detected infections including both primary and secondary infections. Quality assurance and control affirmed this at a point when the corrections could not be made. There was insufficient information to risk adjust. For example, for central line days, the data was not recorded to identify the type of unit. CDPH identified incorrect and insufficient as well as incomplete data, and had insufficient means to risk adjust and ensure that fair and accurate comparisons between hospitals could be made.

Despite these limitations, there were some key findings from the data. Of 383 reporting facilities, nearly 88% reported complete MRSA and bloodstream infection grids. Nearly 80% reported complete CLABSI rates. Only 5% reported no complete quarters of data.

Working with hospitals and reviewing their data provided important information about the internal hospital specific surveillance systems and reporting structures, and in some cases, the lack thereof. These structures are the foundation for quality data; they are recommended by national experts as a standard for technical analysis. Without a context for interpreting the data, a low or a high rate might reflect non-standard data. Strong or weak surveillance systems may reflect in varying rates.

Given this context, comparing rates for this set of data may be misleading. For this report, it is *not* appropriate to conclude that low rate hospitals are more successful in preventing infections, and are therefore safer.

Key lessons were learned and important strides were made on reporting, and the Department needs to build surveillance capacity to support quality data collection and reporting. Using the NHSN electronic reporting system is an important step, but not the only one, in making sure that the healthcare system, including CDPH, uses standard definitions, protocols, data entry and risk adjustment capabilities, especially for outcomes like central line associated bloodstream infections. Timely quality assurance and quality control helps to identify systematic data issues early when revisions can still be made. Data validation should begin as soon as possible. Because of these limitations, these rates are better thought of as a starting point, and should generate questions about quality care and patient safety in hospitals.

CDPH is committed to reporting HAI rates based on quality data that will serve as tools for comparing hospitals. Given that context, and this commitment, what is needed to produce rates that are comparable across hospitals? Elements include clear, uniform definitions for infections and populations at risk, consistent case finding strategies, data for risk adjustment, standard data collection reporting, quality assurance and control by the hospitals and by CDPH, and data validation by both. The action steps for CDPH and hospitals to take include using NHSN software implemented in April 2010, consistent application of NHSN definitions and protocols, and identification of the barriers and best practices for application to help hospitals that are more challenged in getting up to speed. Implementation of timely quality assurance and quality control is essential. Hospitals will need to submit timely and complete data complying with NHSN standards. CDPH will assist in identifying systematic errors.

Chair – The Committee recognizes that the HAI Program went to great lengths to provide a useful report from flawed data, and applauds the efforts of you and your colleagues. I look forward to future reports which will include risk stratification, because that is an important tool for hospitals and for the public at large to understand what the numbers mean and the groupings.

Eck - I want to acknowledge all of the work done by CDPH. The opportunity to validate and resubmit data was very important to the facilities. The timeliness of that and corrections made too late in the process did pose a problem for the public report. One of our concerns was the public being misled by the data and thinking something inaccurate about their hospitals. Kaiser has been impacted by multiple sources, and it has been helpful as there were issues with our data, that whatever limitations there are need to be identified clearly. It will take us time to get this right so that families can make choices about their care. Issues that need to be corrected, like hospital classifications, how should this be handled?

Cummings – Please email any issues to the infection control mailbox.

Myers – This was an incredible attempt at risk adjustment given the poor quality of the data. For small corrections, will those be corrected or not?

Rosenberg – Send any corrections to the infection control mailbox.

Myers – Will there be an attempt for data validation by CDPH for the next set of data; and for the MRSA and VRE report, will the local liaisons review the data for questionable data issues?

Rosenberg - I hadn't heard that for MRSA or VRE, but it is certainly true for some hospitals. There are 383 hospitals, 382 of which are enrolled in NHSN. Most have complete data reported into NHSN in an appropriate manner. There are some hospitals that have reported only hospital onset. Lynn (Janssen) will speak to the validation issues.

Janssen – The Program is planning to perform data validation; it is important for reporting and is a condition of the federal funding. Doing so through the consultants is really for educational purposes to work with the hospitals. That is not scheduled to start until after there has been one full year of data

collection. The Program is planning to validate the January through March 2011 data. There will be more information in the coming months; this is all still in the concept phase.

There will be pre-validation work to help hospitals with what their data should look like.

Chinn - Even within an institution, it is difficult to compare rates reported in this session to the future. For example, an institution that reports a zero rate this time and goes up to 5% next time because of better case finding and definitions, this comparison isn't relevant because the baseline data isn't useful.

Oriola – Can corrections be posted for data that was inadvertently omitted?

Rosenberg – An addendum for omissions and corrections is being considered.

Mikles - As a patient advocate, I appreciate the work that CDPH has done, because I know how many hours they have put into this, and it wasn't easy. Consumers have to be given information that they can use and if they can't use it or it is misleading, it is no good and damages everyone. I really appreciate the work the providers have done and CDPH and feel strongly about having clear information provided.

Terashita - A number of hospitals have been contacted by media sources (regarding the report). I was wondering if you had any thoughts on dividing this up by county. Local Health Officers have had discussions about the reports and have a desire to see the data by county for the hospitals in their jurisdictions.

Rosenberg – Will the Committee make a formal request for presenting the data by county? For future reports, the Program is considering sorting by county or by zip code grouping; though there will be structural limitations based on the structure of the website. With data that is comparable, ideally the information can be provided in ways to facilitate the comparisons that people would like to make, and not just display long lists of hospitals.

Eck - For consumers, the tables with all 383 hospitals listed in alphabetical order are unwieldy; if the options are limited to 'by region' or 'by insurance', then to structure the data by county would be helpful. The data and presentation format has to be useful for the public as well as health officers.

Cummings - For this first report, because of the data limitations, this had to be a technical report. But for future reports, that is the purpose of public reporting, to present information that is useful to health professionals and to the public. Better conformance to NHSN protocol, and consistent application of protocols will mean CDPH will be better positioned for the next report.

Chair - Is it the Program's understanding that when MRSA and VRE information is entered, that you do not withhold those that are not healthcare associated? Are *all* of the positives included?

Rosenberg - You are talking about MDRO module, the Lab ID? Then yes.

Chair - So there is no more evaluation of whether the patient had (MRSA or VRE infection) on admission? Even if it was present on admission, it gets entered in as healthcare associated?

Cummings - According to the date the specimen was identified.

Chair - Some of the epidemiologists review the data case by case and determine those that are healthcare related.

Rosenberg - I assume that means that they haven't read the NHSN protocols? Or they have chosen to ignore them?

Flood - They are probably looking at the way the law is written which says 'healthcare associated', and are making the assumption that they only report healthcare associated. But if you are using the NHSN module, any positive means that it is positive for NHSN requirements, and gets entered.

Rosenberg - Some hospitals had substantial numbers of facility onset and no community onset. There is no way that was the case; these facilities are selectively reporting. The State needs to get the message out that facilities need to conform to the NHSN reporting. If facilities are clearly not reporting community onset, Lab ID events, NHSN recognizes that as 'off manual' and will not accept that data. CDC is in the process of developing risk assessment methodology for CDI, and *possibly* for MRSA or VRE. One of the things CDC is considering is using the number or rate of community onset cases as a way to adjust for risk based on colonization pressure in the hospital. So if hospitals under-report or don't report, they are only going to hurt themselves since reports will be risk adjusted to include community onset.

Myers - I can see the legal argument that in order to comply with NHSN you have to report all cases, yet there has been some confusion about this issue among the facilities. On risk adjustment and local data, one of the challenges CDPH is going to have going forward is that there needs to be a way for the public to discern what a 'good rate' is for their hospital based on facility *type*. There may be a premier cancer hospital but the rates appear high against a local community hospital with a lower case mix index. We have to find a way to communicate the population factors and facility type.

Flood - Clearly this is very complicated, because no hospitals are exactly the same. There needs to be context so that people looking at the report know the reasons for the differences.

Chair - In light of this development, I would suggest that CDPH push out this education sooner than later, via the liaison or otherwise. We need to get this out to the hospitals. The data sets and differences now will affect the quality of the data a year from now.

Torriani - With the CDI data, the commitment to risk adjust data was clearly done on one of our calls with the CDC. On our BSIs, we need to check with the CDC whether the same risk adjustment can be made.

Rosenberg - I think there is still a basic principle that hospitals have to follow NHSN protocols.

Torriani - The issue is to have the discussion regarding the risk adjustment and its importance. We have to go a little further for the risk adjustment to happen.

Rosenberg - It will happen for CDI. I am sure we will hear that they haven't yet considered this for the MRSA data.

Torriani - Let's be proactive and approach that discussion with CDC so that it gets discussed now rather than later.

Rosenberg - If there are no legal limitations, it could possibly be put into regulation, that facilities must follow NHSN protocol whenever there appears to be a discrepancy between NHSN protocol and statutory requirements, but it probably wouldn't happen until the end of this year. That would specify that facilities *must* follow the NHSN protocol. If the State is required to follow NHSN to meet mandates, hospitals will need to be required to meet the same requirements.

Rogers - I appreciate the conversation. There are several ways to get to the hospitals, but I think an AFL would guarantee that the State can clearly communicate this to all the hospitals. I appreciate the liaison infection preventionists but they only have so much bandwidth to reach their thirty or forty hospitals.

Myers - When facilities sign up for NHSN those requirements can be reinforced.

Cole - Is it possible to post online the spreadsheet and information that is given to the media who call and ask for information, so that anyone interested could view the information?

Rosenberg - I don't think so right now. It is accessible through a public records act request which is a process people have to go through. I don't believe it would be possible otherwise.

Eck - A follow-up on the communication piece: with C-diff it is a challenge, particularly on a patient who you know came in with C-diff, but a positive test can't be obtained until the fourth day. I agree with Debbie that CDPH could issue an AFL with CHA as they usually do, to send additional communication to hospital leadership to reinforce that notion. It would be important to do that relatively quickly, and I would like to make the motion.

- **Motion requesting CDPH to create an AFL reinforcing the expectation that all hospitals participate in NHSN and follow the NHSN protocols specifically emphasizing the MDRO module and the requirements to report all positive results, date of hospitalization and other relevant fields.**
 - Motion—Eck
 - Second—Mikles
 - Motion Passed by unanimous vote

Rosenberg - Statutory requirements started with SB739 and reiterated in SB158 required CDPH to update infection control regulations, taking into

account CDC recommendations for prevention of infections. CDPH has initiated the rulemaking process to revise Title 22 of the California Code of Regulations Section 707.39 entitled "Infection Control Program". Except for service-specific regulations like laundry and cleaning, as far as the infection control program, that is all there is: 707.39 down to the number of infection control practitioners.

There are two aspects. One is an open opportunity to update, add and revise any aspect of those regulations or anything that should be included in this section. It is the only section of Title 22 that is open for changes in this round. There were aspects of infection control that could be in regulations that were part of the original white paper from the advisory working group that many of you were part of that was published in 2005. Some of the language of 707.39 was lifted from that, including program resource assessment to address inadequacies of the designation of the number of infection control practitioners based on bed size.

This is an opportunity to reconsider that and revise any part of 707.39 that is considered necessary for updating. On February 3rd in Sacramento, there will be a hearing where any stakeholder may make proposals prior to CDPH drafting the proposed revisions to rulemaking which will come back to the public for public comment. The State is not *required* to hold a public hearing unless there are requests, but given the nature of the rulemaking it is likely the Department will hold additional public hearings. This would be a three part process: receiving information from stakeholders; drafting the proposal and internal and legal reviews; then, publishing the proposed regulation for public review and final rules and regulations.

For any aspect of SB739, SB158 or SB1058 that fits into an infection control program, this is an opportunity to clarify or add to the statutes of all three bills. You cannot modify or change or reduce a statute through regulations.

(Refers to attachment from Licensing and Certification)

Chair - For example, it says that facilities are supposed to report 'all deep and organ space surgical site infections'; could the language reflect that the hospitals will use NHSN procedures to report that?

Rosenberg - There are going to be a number of proposals that Legal will look at to determine whether they represent clarifications or modifications. If HAI AC is uncertain, the Program could ask for a legal determination. This is a window to work through the process efficiently to update the regulations.

L&C feels that if the HAI AC produces a consensus set of regulations for infection control practices, then assuming that the language adopted doesn't cross certain lines, the L&C interpretation would be that the Committee has the authority to make recommendations that L&C can cross reference. HAI AC may suggest adding something to the regulation that is two or three pages long, so L&C could refer to and require conformance to the recommendations in that document at that point in time. If there are practices/elements that the Committee feels should be followed 100% of the time, those practices/elements can be cross referenced. We need to ensure that added elements are elements that hospitals are not currently at 100% compliance.

<p>Chair - This review would require formation of a new subcommittee.</p> <p>Flood - I am willing to chair if that subcommittee is created.</p> <ul style="list-style-type: none"> • Motion to create a subcommittee (to be known as Title 22 Subcommittee) to review the white paper written by the previous HAI Working Group to produce, as soon as possible, a consensus set of recommendations for infection control practices, with the Subcommittee to be chaired by Annemarie Flood. <ul style="list-style-type: none"> ➤ Motion—Eck ➤ Second—Torriani ➤ Motion Passed by unanimous vote <p>Rosenberg - The plan is to get the formal proposal out this summer, so it is a reasonable timeline but this needs action as soon as possible. February 3rd is the public commentary.</p> <p>Chair - For anyone interested in joining, please contact Annemarie Flood and copy Alongi, Kalson and Delahanty. The Program will help to develop the conference call schedule.</p> <p>Public Comment: None.</p>	
<p>Pediatric/SSI Procedures:</p> <p>Lee – Per the last HAI AC, the subject of discussing pediatric SSI issues was raised, given that the SSI issues of the pediatric subpopulation are inherently different than the SSI issues of the general population. The formation of a subcommittee was discussed, as well as the need for pediatric expert participation.</p> <p>Myers - Can non-HAI AC experts who are brought on to participate in a subcommittee vote as a part of that subcommittee?</p> <p>Chair - No, only the HAI AC members. I think a number of HAI members would join the Subcommittee regardless of their particular areas of expertise.</p> <p>Rosenberg - Subcommittees provide proposals to the HAI AC. Regardless of the nature of who is on the subcommittee, the HAI AC would like to know if this is a unanimous or contentious point of view. Once a subcommittee comes up with a recommendation it should prepare to discuss with the HAI AC how it came upon that recommendation.</p> <ul style="list-style-type: none"> • Motion to create a Pediatric SSI Subcommittee to consider pediatric SSI issues, mechanisms and methodology, with the Subcommittee to be chaired by Lilly Labar. <ul style="list-style-type: none"> ➤ Motion—Lee ➤ Second—Flood ➤ Motion Passed by unanimous vote <p>Lee – This Committee (HAI AC) needs more representation from pediatric hospitals.</p> <p>Chair - There is a process for that. Submit a formal request to myself and Jon with a list of the credentials of the people and who they represent. Then it</p>	<ul style="list-style-type: none"> • Dr. Lee to submit recommendations for increasing pediatric specialty participation on the HAI AC.

<p>goes to Dr. Horton, who has the discretion of inviting new members via a formal letter.</p> <p>Eck - (To Lee) Do you feel that you have contacts you could reach out to for participation? There are major (pediatric) centers that would be helpful and we could offer suggestions.</p> <p>Chair - Those who have contacts, please submit them to Dr. Lee and to the HAI Program. Thank you.</p> <p>Flood – A colleague recently shared a project looking at ways to standardize isolation signage. Persons working from place to place would know what they needed to do based on these standardized signs. This would simplify education. So a colleague suggested considering standardizing certain colors, wording on precautions, and the like. The White Paper may be a good place to start with this. Some of the work has already been done. Does the Committee feel this would be value added?</p> <p>Oriola - The recommendation was to start with color because of the varying isolation practices in the state. For example, hospitals are trying to standardize armband colors. This would help if a nurse is going from one hospital to another.</p> <p>Cole - Thank you for bringing this up. It is very important; I suggest it be included in the tasks of the Title 22 Subcommittee to facilitate standardization. Through my experience as a patient, and in talking to survivors or family members, consistently they have not been put in isolation, even without gowns or masks, so it is critical to standardize the identification process (through armband color, specific signage, etc).</p> <p>Chair – The Committee believes this standardization process is an important aspect of infection prevention strategies; it will be included with the Title 22 Subcommittee.</p>	
<p>Antibiotic Stewardship: David Witt</p> <p>The Subcommittee met in December and discussed a means of reporting capacities of facilities; the group recommended that if a region is defined broadly enough, we would support reporting on a voluntary basis. Facilities would have a choice of how to report when filling out a spreadsheet of sending in biograms. The recommendation is made to follow CLSI requirements, and to report the grade point where possible. We feel that antibiogram reporting is of value, and this would address the concern regarding discovery and disclosure of this sort of data.</p> <p>We also examined the elements of antibiotic stewardship. We agreed that an antibiogram should be produced and utilized according to the CLSI requirements. Antibiotic utilization should be monitored DOT (days of therapy) or DDD (daily dosings) and to use this as a measure. Institutions would measure antibiotics determined to be of importance to that facility.</p> <p>The language is reasonably broad, and the Subcommittee felt the breadth of the language was needed to permit the facility to adjust depending on what kind of institution it is and what kind of resources it has.</p>	<ul style="list-style-type: none"> • Per motions approved today; HAI AC formed three new subcommittees; SSI Subcommittee, Enid Eck, Chair; Title 22 Subcommittee, Annemarie Flood, Chair, and Pediatric SSI Subcommittee, Lilly Labar, Chair. These subcommittees will be given time on the February agenda. • All subcommittee Chairs are requested to submit electronic versions of their subcommittee

<p>We also recommended that there be evidence of the antibiogram being disseminated for use and education of the medical staff.</p> <p>Discussion:</p> <p>Myers - One of the questions we have heard in the past is standardizing on DDD or DOT so that surveyors would have an idea what usage looks like in each facility. The decision was <i>not</i> to standardize.</p> <p>Witt – In facilities with an electronic pharmacy either can be done, but in a smaller hospital it would be more difficult to get pharmacist records.</p> <p>Rosenberg - Could one or more elements of that (antibiotic stewardship program) be clearly stated, easily understood and implemented by all hospitals, agreed upon as a minimum standard that some are currently in compliance with, and easily enforceable? Then the final question is should that be put into the regulation?</p> <p>Witt – That is our recommendation to the Committee.</p> <p>Torriani - I thought there was agreement in the Subcommittee of what—at a minimum—should be included in an antibiotic stewardship program. However, the Subcommittee did not make that leap to say that these are enforceable standards, and that we request L&C monitor or enforce.</p> <p>Rosenberg - If the subcommittee makes a recommendation saying that X and Y are the minimum standards, L&C could potentially use that as an enforcement tool under the patient safety licensing survey. It would make it much more clear that this is enforceable if the Committee (HAI AC) makes the recommendation.</p> <p>Witt – At our first meeting, we concluded that antibiotic stewardship is not being done at many hospitals, and that the issue is big enough to require defining clear minimum standards.</p> <p>Chair - I think the point is that it is not for L&C to do, and it did sound that way, so it is a clarification point.</p> <p>Terashita - Is this meant to be reported to the State or is this all internal (for the individual facilities)?</p> <p>Witt – The antibiotic stewardship program is internal to the hospital. The antibiograms we encourage reporting to the State. The antibiotic utilization is for the internal use of the hospitals.</p> <p>Terashita - Have you explored any method of reporting, like NHSN? We have tried to do the paper reporting at the local level, and it is very difficult.</p> <p>Rosenberg - Kavita (Trivedi) is in the process or revitalizing the California antibiogram project, so that is going to go forward. If a sufficient number of microbiology laboratories can be recruited to voluntarily report, a statewide antibiogram will again be produced. If recruiting isn't successful, it is a different issue. The last time it was both community and healthcare associated pathogens. From the State's perspective this would be restricted to healthcare pathogens. If there are others who want to include community</p>	<p>reports 48 hours before HAI AC meetings.</p>
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pathogens they will need to take some of the responsibility for the workload. There are 60 to 75 labs reporting; the issue was the delay in reporting when those susceptibilities were reported and generated. The latency period must be shortened with a more reasonable number that could even be manually reported.

Chair - This is expanding beyond our focus. What are you asking from the Committee?

Witt - The last two reports have really been status updates. I hope in our final meeting we can include all the necessary elements which include the prior report, this one and any other yet undefined elements that would define the antibiotic stewardship program.

Myers - Part of the reason the Subcommittee was formed was to give guidance to the L&C on the interpreted standards. L&C has cited institutions for not having the infection preventionist ensure that antibiotics are appropriate for patients because that was that surveyor's interpretation. The Subcommittee is to help provide clear guidance there. As to the public antibiogram, we have in San Diego created a public antibiogram which we have shared with hospitals. I do have concerns with the State putting one together, given that the information is discoverable and that antibiograms have been used for marketing to physicians. We could provide some regulatory protection for that so that it is non-discoverable and so that we don't end up driving drug resistance because pharmaceutical companies use the information to market certain antibiotics. Or we limit it to generic drugs.

Lee - These were agreed upon as minimum elements of antibiotic stewardship, but not the only minimum elements.

Witt – The Subcommittee has determined these minimum elements, and will discuss additional minimum elements at our next meeting.

Butera - The mandate is to have a method for surveillance, and the task is to define those elements that fulfill the requirements of the law, which is vague. We do need some statutory definition that can be taken back to review with hospitals and pharmacists to have an effective program. Also, we do not want this to be too restrictive on facilities.

Rosenberg - It sounds as if, from your perspective (to Butera), in some hospitals, the people responsible for these programs would like it to be enforceable; that way they can say to their administration "we *have* to do this". As soon as it becomes known that they won't be cited for not doing it, they would respond that it (antibiotic stewardship program) is not necessary. If there is going to be an official recommendation from the HAI AC that will have an impact on the patient safety licensing surveys, it would have to be done now.

Chair - The Patient Safety Licensing Survey tool just says that you have to have an antibiotic stewardship program. The interpretation in San Diego is that there is infection prevention oversight and that is clearly not the case. The surveyors are saying that the infection preventionists have to manage it.

Witt - If the Committee doesn't come up with a program that is concrete

enough to go to a program administrator and state that it *has* to be done, this will not be enforced. In our original meeting we defined that our program would be supervised by someone with confirmed expertise in antibiotic stewardship. I am not sure what body would have the authority for antibiotic stewardship.

Chinn - At the original meeting we wanted to define the antibiotic stewardship program. IDAC is going to have a one day course that is like a toolkit of how to do a program. There is also a metrics committee for the antibiotic stewardship program. Kavita had mentioned that NHSN has a module that will promote the use of DOT.

Trivedi - What I have been hearing from hospitals, is that they would appreciate if the statute could be revised to be a little more prescriptive, but not overly prescriptive. Facilities want help in figuring out what the stewardship program should entail. They are asking questions that relate to the law as to whether we have a program that looks at the judicious use of antibiotics. They are not specifically asking about the stewardship program.

In terms of metrics, I had put together a metrics committee of physicians and pharmacists, and in the process, CDPH came to us and pitched the Antimicrobial Use and Resistance (AUR) module in NHSN which would allow hospitals to automatically put information into this module to generate metrics for CDPH. It would be beneficial for the Subcommittee to more clearly define the elements of the stewardship program.

Torriani - It is premature to make prescriptive statements, particularly when the requirements of CDC or CDPH are unknown.

Butera - I have access to a project where SHEA and IDSA are developing a statement regarding antibiotic stewardship. I strongly feel there needs to be a collaborative, physician directed antibiotic stewardship program. It needs to be a collaborative physician and clinical pharmacist interaction.

Witt - I believe we all agree. When you consider the breadth of the 400+ hospitals, and how many have no ID specialists, as we look at our recommendations it is to permit someone who is not board certified in infectious disease to pick up this responsibility. I work in hospitals that will never have an ID specialist.

Butera - But all hospitals have a pharmacy committee that is a *medical staffed* committee run by a physician who can be trained in antibiotic stewardship. It doesn't have to be an ID trained specialist, but it should be physician directed and in collaboration with the pharmacy.

Chair – Will the Subcommittee make a motion on antibiotic stewardship?

- **Motion proposing that an Antibiotic Stewardship Program is considered as a physician directed, multi-disciplinary team in collaboration with pharmacy that supervises antibiotic stewardship and is administratively supported.**
 - Motion—Witt
 - Second—Butera
 - Motion Passed by unanimous vote

<p>Public Comment: None.</p> <p>Chair - C-diff Subcommittee report is deferred until next HAI AC meeting.</p>	
<p>Public Reporting and Education Subcommittee: Carole Moss Since the State has posted the first reported data through the website, it is probably an appropriate time to hear from CDPH their goals for the website. Our Subcommittee would like to know what goals and areas to focus on, and would like the input of the HAI AC as a whole to establish target goals and line items that will have timelines attached, so that we can enhance the site to make it the most educational possible.</p> <p>Rosenberg - With helpful input from the members of the Public Reporting and Education Subcommittee, the Program had a good starting point to, in three to five days, draft internally and post information for the public. At the same time, the Program was working to get the reports cleared and posted.</p> <p>The State did realize that there needs to be a way for any member of the public to communicate with the Program, so a public mailbox for the HAI Program, has been created. The address is cdphhaiprogram@cdph.ca.gov but you can just click on the link, which is on virtually all pages of the website.</p> <p>In terms of what is next, the HAI Program requests some input from the Committee and the Public Reporting and Education Subcommittee, between now and when we gear up for re-crafting the website to meet the needs of the next data report. That could include elements of the website and reporting data. There needs to be much more explicit education for the public about the reporting, whether it is in the report or on the site, for example what risk adjustment is and what the steps are, SIRs, and most of that material can be borrowed from existing websites.</p> <p>CDC has announced the process of syndicated material, which is material oriented toward the public, in which they invite state departments to adopt as their own and not just as a link to the CDC sites/material.</p> <p>The Program would like some input about what people like or don't like, what is missing, etc. For example there is a section below each disease where Jorge (Palacios) highlighted what patients or patient advocates can do to prevent infection. There is a lot that could be there that isn't there. Given that it is a public site, the infection protection component to the site rests with the liaison team. For those of you who are IPs, if you want to see more specific material on the site for IPs, send those to the infection control mailbox. For the public site, I don't want to presume what the public would need.</p> <p>Chair - What is the timeframe for making these suggestions?</p> <p>Rosenberg - This is an ongoing and iterative process.</p> <p>Moss - So with that why don't we put out this kind of request: the Subcommittee meets at 7:00 Thursday mornings, and the next meeting is next Thursday. If I could ask everyone on our Subcommittee to pull together some ideas by walking through the site as it is. Give us your thoughts and establish a few targets or goals of what you think is missing and we can work</p>	<ul style="list-style-type: none"> • CDPH will post a CMS link to the SCIP data on the HAI website. • Program (Palacios and Kalson) will contact OPA regarding public service announcements; Program will also work with the Public Reporting and Education Subcommittee for ideas and discussions on PSAs. • CACC is requested to send out communication to all members on the SSI (regarding CABG and Hip surgery).

with the Committee and the State on a timeline to deliver the key changes. We will work with the Department to discuss resources. Send the ideas to me and to Jorge (Palacios) by next Wednesday, and feel free to join the Subcommittee call on Thursday.

Rosenberg – Regarding the development of the site: the State tried to follow a train of information seeking that someone would follow, such as what an HAI is, then if they are interested in one of the reportable HAIs, it goes to that. The Program also tried to link it to the report in spite of the data limitations. It would be helpful to the Program to have insight to the train of thought a consumer might have based on their interest in HAIs.

Moss – The Subcommittee meeting scheduled for next Thursday will have to be rescheduled for the day after, Friday.

Eck – Could the website facilitate a similar list of questions to those listed on AHRQ? It lists the top ten questions you should ask (healthcare related questions to ask your doctor). Those are more generic questions, but could be modified for HAI issues. This way, a surgical patient going to the doctor could be prepared to ask the right questions. I am specifically thinking about surgical site issues.

Rosenberg - We could possibly link to AHRQ. There is a link already, for example, to NIH some patient information. Approved links can be added within a day.

Chair - Based on the Open Meeting Act you can't change the meeting date because the proposed meeting date is fewer than 10 days out. Either it has to remain with the original date or be moved to 10+ days out for proper public noticing. I would ask that you determine that meeting date through the Subcommittee and notify the Program to post the rescheduled date/time.

The Public Education and Reporting meeting was rescheduled—revised date/time to be posted on the website in accordance with Bagley Keene.

Alongi – As a reminder to the subcommittees: any pieces that you are developing through a subcommittee either then come up to the full Committee for review/approval, or may be passed on to the Department with the understanding that they are not actual vetted recommendations of the full Committee.

Chair - Make sure you come back through the full Committee with the subcommittee edits instead of going straight to CDPH for the website posting. It has to come back here first.

Moss - Absolutely, no problem.

Oriola - My question is related to a comment by Jon (Rosenberg). You stated, for example, that you would want to put up recommendations to prevent hip SSIs. During the last HAI AC meeting there was an approved motion to target SSIs for reporting to begin collecting data in January. Was that recommendation accepted by the Department and if so will an AFL be going out soon to facilities regarding that requirement?

Rosenberg - As soon as the Program can get it approved. Because of the delicate language in SB1058, it is going to need to undergo legal review. It is in draft form and will undergo review soon.

Oriola - Would it be safe to say that CACC could communicate to its members to suggest that surgical site infection surveillance be reported through NHSN for hip and CABG beginning January 1st?

Rosenberg - For their use, yes. For April 1st go-live for reporting. It is not that different from the CDPH recommendation made last year to start tracking hip and CABG, with pediatric recommendations to be determined.

Nelson - As we target consumer information on the website, we might parallel that with the surgeries that come into focus for statistical studies. Secondly, I hope the Public Reporting and Education Subcommittee will take an opportunity, now that there is attention being paid to the website, to expose the consumer to things they can do to protect themselves as well.

Rosenberg – Right; that is posted for each disease, but you are saying we could take all of those things consumers can do to prevent infections as a separate topic.

Nelson - I know that people will be going to the website for the report. Somewhere along there it would be useful to show what the consumer can do, perhaps on a pop-up, such as "What can you do to prevent a family member from getting an infection?"

Rosenberg – This type of suggestion is very useful; the Program would like to develop links to this type of information.

Chair - What Carole (Moss) needs is for these suggestions to be forwarded to her and the Subcommittee so that she can compile that information.

Chinn - The law stipulate that you do not report 'superficial' or 'contaminated', so when you report to NHSN, who is going to be separating those from, say, CABG and hip?

Rosenberg - I was looking at report functions, and there is a specific report that gives you only 'deep and organ space'.

Janssen - I asked this question specifically to the CDC. By NHSN protocol, facilities have to report all. Part of that report that is showing only 'deep and organ space' infections is only attributing those infections to those found during the same admission or readmission to the same hospital. If you weren't looking at admissions to other hospitals following surgeries, the data may be comparable only for that subset that are deep or organ space, you still have to follow NHSN protocol to enter all.

Myers - Are you saying that these be excluded if I find the case was admitted to another hospital. It would only be if the patient was readmitted to my facility?

Oriola - You could identify the person post-discharge. I believe CMS will be doing the same thing in 2014 when they will be teasing out the same data we

are required to collect.

Eck - As a system with members who predominantly get their care within our system and our admitted within our system, our system could be significantly impacted and our data misunderstood because our capacity to identify a surgical site infection is much greater than a community hospital where a procedure is done and a patient goes home and develops an infection. I am concerned with how this will be structured, because we will put everything in NHSN and we will own all of it because our system captures more data.

Rosenberg - It could work in the other direction. It could be that a Kaiser member is more likely to be admitted to a different Kaiser hospital than the one they had the surgery in, than that a patient who had surgery in a community hospital may only return to that hospital. They are *only* counting readmissions to the *same* hospital, not to all Kaiser hospitals in the system. If you don't count non-readmission post-discharge surveillance, that levels the playing field. New York found there were not that many patients readmitted to other hospitals.

Eck - It would be different if we contract with the community hospital to do the surgery if we don't have space at the Kaiser facility. Then they would likely be readmitted to the Kaiser hospital.

Rosenberg - We will have these discussions as we move toward the fall. This would be an appropriate issue to discuss in an SSI Subcommittee.

Eck - We (Kaiser) know what our post-discharge surveillance finds in comparison to others, and our capture is much greater because those patients stay within our system.

Chair - If the Committee would like a subcommittee, please make that motion.

- **SSI-A: Motion to create an SSI Subcommittee to work on the details of the SSI reporting mechanism/methodology.**
 - Motion—Eck
 - Second—Myers
 - Motion Passed by unanimous vote
- **SSI-B: Motion to name Enid Eck as Chair of the SSI Subcommittee.**
 - Motion—Oriola
 - Second—Myers
 - Motion Passed by unanimous vote

Rosenberg – CDPH recognizes the great amount of work this Committee and subcommittees are doing, and that this takes time away from your positions in your organizations. The State greatly appreciates your help with these issues.

Chair - And there is momentum. When there is a mandated law, this is the trickle-down effect.

Oriola - I don't understand some of Enid's comments. For example, Sharp Coronado here does hip surgeries for Kaiser patients. But if a Kaiser patient develops an infection, it is attributed to Sharp Coronado. We call our patients a year out to see if they have gotten an infection. I think it might be a false

assumption to make that Kaiser is the only group with due diligence.

Eck - The chart was not representative of all the hospitals that do those procedures. The follow-up you do is probably not the same as at all hospitals.

Rosenberg - I encourage everyone interested in this area to read other state reports. There has been an inordinate amount of concern about post-discharge surveillance and the under-collection of infections when there is potential for under-reporting of CLABSI's and that isn't a post-discharge issue. 40-60% of infections happen during the current hospitalization and most of the remainder happen on readmission to the same facility. The goal cannot be to capture 100% of everything all the time, especially if you want to look at the incidents with the greatest morbidity.

Flood - There is a standard for communication between hospitals when you discover an infection that may have occurred at another institution. I recognize it may be difficult through the medical records to identify that institution. That might be a topic in the White Paper review. It would have to be something that could be surveyed.

Rosenberg - If we have personal identifiers, we can potentially do that for you. It may not be 100% but CDPH could increase the post-discharge surveillance to close to 90+% and do all of the work for you. The latency period from OSHPD for that data has been reduced to under three months, but CDPH would require the personal identifiers.

Myers - Would that be discoverable?

Rosenberg - Personal patient information is *not* discoverable. Certainly it is not subject to the Public Records Act.

Mikles - If my insurance sends me to hospital 'A', I have surgery and go home and then I am not feeling well so I go to hospital 'B' which is not within my health insurance coverage, and my hospital 'A' does not have a bed available, how is that infection credited?

Oriola - Technically 'A' owns it. Hospital 'B' by Joint Commission is supposed to inform 'A' of the infection. It is not formal, but the Infection Control group would contact 'A'. If you are a Joint Commission surveyed hospital, you are required to have a process of notifying other hospitals.

Flood - It isn't a clear approach, because often it is not listed or documented what the hospital was that did the surgery in the notes, or we are not alerted to it because it missed the radar.

Rosenberg - Ultimately this has to be done electronically. This part could be done electronically if the State has the patient identifiers. If the Committee so recommends it, CDPH could figure it out, but would need that formal request.

Chair - And that would be worked through the Subcommittee.

Moss - Regarding a topic that was forwarded as an approved motion: the PSAs. I would like to establish an organized method to compile messaging that we can begin to pull together in a PSA, such as what HAI's are, and

where you can find results of how your hospital is doing on prevention. Who from the Department would we be working with on this?

Rosenberg – The Subcommittee should contact Jorge (Palacios). PSAs are under the control of the Office of Public Affairs (OPA); recently that has been tighter and it clearly was not going to happen around the report itself. But that doesn't mean that we can't continue to work with the OPA. There are members of that office who have been responding a lot to issues around HAI, so perhaps Jorge can get an idea from OPA if the State can do something proactively.

Moss - Let's review the motion that was approved at the last Committee meeting. The recommendation was to begin to develop and produce these preventative public service announcements to educate the public and alert them to the report coming out so that they would know where to go to find it. Has that changed, or is there something back from the Department that they have not taken the recommendation to announce the report and direct people on where to find it?

Rosenberg - Right, the Department made the decision to issue the press release only. That was a departmental decision.

Chair – The motion reads “that the HAI AC requests the CDPH develop PSAs before each technical HAI report is issued”.

Moss - That was it, the report that you issued that said that this is bad data and that we will do a better job next time? That is the message that you feel this Committee should stand behind?

Rosenberg - That was the decision of CDPH.

Moss - So what about the next report? So everyone will be doing all the work, will be putting in the time, and will we be expecting that it will be advertised and announced to the public, or will we again be subject to the decision that we are not sure how you are going to promote the report?

Rosenberg - We will never be sure because it is beyond our control, but I am confident that if we have a report consistent with what Kate (Cummings) has described, that the Department will be behind it. Given the current budget situation, a Department doing something good is going to want to publicize it. This was clearly a report that the Department decided to present the way they did based on the limitations of the data. In future report it should be different.

Moss - We should begin work on producing and pulling together PSAs that are ready to roll for that next data report so that there is no timeline issue.

Chair - Yes, working with Jorge (Palacios) and engaging public relations at CDPH is the recommendation.

Moss - So Jon, does that mean we will get a letter from you that supports our efforts to the powers that be in the Office of Public Affairs?

Chair - I am not sure of the question Carole.

Moss - To make this move we all know how a bureaucracy works. For Jorge to get the kind of support he needs, he is going to need something coming from you (to Jon) as the leader of the Program that says 'this is our plan; can you help the Program get it done'. Are you ready to do that?

Rosenberg - When the Program is close to releasing something and would like input and support from OPA, the Program could do that.

Moss - I will work with Jorge to get that moving even though it's early.

Myers - Regarding public reporting: SB739 1288.8 says that when we report through the CMS website that we will annually report to the Department, the CLIP rates, the surgical prophylaxis Influenza vaccination rates. Does CDPH plan to generate that as a report?

Rosenberg - CLIP is definitely an upcoming priority.

Myers - People don't have clear access to the antimicrobial prophylaxis data; that would be something to get out there.

Rosenberg - The first thing to say is that this is the California requirement and that those individual hospitals that report to CMS are at this site. We may have the opportunity for some analyses on the SCIP data with HSAG.

Myers - That is data that we have confidence in, its publishing would raise awareness.

- **Motion to recommend that CDPH, as soon as possible, provide a link to CMS for SCIP information (for information required under 1288 in SB739) on the website. HAI AC recommends a press release announcing this information.**

- Motion—Myers
- Second—Oriola
- Motion Passed by unanimous vote

Oriola - Is there a possibility now that we need to confer rights to chart hospitals that the hospital could possibly publish information sooner than CDPH on infections reported through NHSN? My facility has asked me to confer rights, and they could put it out sooner.

Chair - Yes, CHART sent out to all hospital systems requesting that we confer rights to them for their NHSN data even if you are not a CHART hospital.

Rosenberg - And that makes it public?

Oriola - In terms of publicly available data.

Janssen - Anyone who is part of the group can pull and analyze the data. The data is only as good as the day the data is pulled and analyzed. The data evolves and changes are made by hospitals *every day* in NHSN; it is something everyone is going to have to get used to. The positive message is that everyone is reporting to the same site, so that will improve the data with the different groups looking at the data.

Moss - Going back to the reporting, what is the plan for consequences that are official for those hospitals that don't comply with the legislation? And what is the official process to implement those consequences?

Rosenberg - There is no penalty specified in the law. The only penalty that L&C can impose is the general deficiency, but I don't know what the consequences are of getting that or not correcting it.

Moss - Kathleen (Billingsley) had responded to that in the document she sent back to Senator Alquist. If we could put that as an action item, I think it is critical that hospitals understand that there are consequences to not complying with the legislation and this Committee needs to make them aware. This Committee can make a recommendation to put out an AFL to those hospitals that haven't complied and feel that they don't need to. There are confirmed regulatory violators who need to face fines and penalties.

Rosenberg - A letter is planned prior to Influenza vaccination reporting specifically. Even recently, that was a disappointing compliance rate for something that is mandatory and not as complicated as enrolling in NHSN, conferring rights. It is stated in the Influenza report that CDPH plans to send a letter to hospitals reminding them that this is the law and that there will be consequences to the hospitals for not complying with the law this year.

Moss - This isn't just about conferring rights with NHSN. This is about reporting their infection rate, and I know that at least 20% did not. I ask for that to be an action item on the next agenda. If you (to Program) could research that and come back with your findings on the consequences that we can spell out in a letter.

Chair - The HAI AC is an advisory committee outside of L&C. We are *not* making recommendations to L&C. It is not the purview of this Committee to make those recommendations. We are here as an advisory body for implementation of the law. As far as L&C there is a firewall between us and them, and that is addressed in a different venue. Loriann DeMartini has asked if you have those concerns, please contact her in those matters.

Moss - Well this is related to the public and public gathering of data; so it absolutely has a perfect place in the agenda of this Committee.

Chair - No, it does not.

Moss - Because of all the work everyone in this Committee is doing to make sure we get the complete data and posting it to the website. I will reach out to Loriann but it needs to be a topic for everyone in this room; if there is no compliance follow-up then we are all here sitting in a room meeting and whatever happens at the end just happens. This is a very big part of what we do on this Committee and should not be pushed off onto L&C.

Rosenberg – Carole (to Moss), a major component of this Program, with substantial funding from the federal government, is to produce a robust and sustainable reporting system through NHSN. There is a tremendous amount of work and energy, some of which is being done by people in this room. Maybe it is a matter of semantics to say that we are assisting hospitals and trying to improve their capacity to collect this information, but the information

needs to be collected. We need to come up with accurate data to report. We are making progress.

I don't think it is fair to go back to rates of reporting or compliance. On the one hand you say 'punish for not doing it', and in the other hand you provide support and assistance to get it done. We all agree everyone should be reporting. When I read other state reports, one thing that struck me is the consequences in year one from January 2009 to suddenly start extending surveillance from ICUs for CLABSI to outside the ICU. It sounds very simple, but to suddenly extend that surveillance is extremely complicated. We have talked about the technical details to report on line days in all of the different wards in the hospital where you have people with permanent lines. In January 2009, all patients with all lines suddenly had to be under surveillance.

The total number of line days is greater outside of the ICU. No one is saying that we should ignore all patients with lines. But it was not a good thing to start doing that on January 1st when there was no *program* to assist all of these hospitals with the processes of collecting information in non-ICUs and no practical guidance from the State. To criticize hospitals for missing some components of reporting because they weren't sure how to report it does a disservice, and doesn't recognize that this was groundbreaking and unique when it happened. Added to that was surveillance on MRSA and VRE and C-diff. No other state is doing C-diff.

Chair - To reiterate, the charge of the HAI AC is to make recommendations to CDPH on implementation of the senate bills on HAIs and to decrease morbidity and mortality in patients. It is not a punitive body and it is not under the purview of L&C.

Eck - In regards to the proposal Jon (Rosenberg) mentioned and the opportunity to change that regulation so the appropriate staffing and resourcing of infection prevention programs is part of the solution in ensuring that hospitals are able to do surveillance and reporting: when those changes get made and hospitals are held accountable for appropriate resourcing, what will flow from that is the surveillance we are working for. I heartily support continuing with this 'carrot' approach rather than Carole's (Moss) 'stick' approach.

Mikles - In the SB1058 language, there is nothing that says that the State can impose any civil monetary penalty. The state is only able to do a deficiency report. Loriann addressed, in the last meeting, that there were only a few hospitals that had not reported. CDPH can't impose a fine unless it is mandated through legislation.

Moss - That is incorrect. We can talk offline (to Mikles).

Mikles – (To Moss) Some of the providers will want to know, so that they can tell another provider that if they haven't been reporting they are either going to face a deficiency from the State. It is only fair for the Committee to hear what Loriann (DeMartini) has to say because *you* brought it up.

Moss - Based on the review of the output of the data that and on the feedback that Kathleen Billingsley gave to Senator Alquist, there are penalties and consequences that hospitals will and can be charged for missing the

requirements of SB1058 and not reporting their data. My question to Jon was to clarify what consequences are to be shared, perhaps through an AFL to the hospitals so that they will know there are penalties for not complying with the legislation and not providing the data that is requested in a timely manner and in reporting for all the different quarters that are required. What is the process to implement the fines against the hospitals?

DeMartini - Thank you Carole for restating the question and to the Committee I apologize that I haven't been able to listen in for the entire meeting. You are referring to Kathleen's testimony before the Senate hearing on October 20th?

Moss - Right, and her responses back to the Committee with questions regarding the hearing. In that statement, she did clarify that yes, there are regulatory fines that L&C planned to assess and that can be assessed for hospitals that don't comply with the legislation.

DeMartini - There is a degree of accountability. Where it is unclear is the issue of civil money penalties. In terms of accountability, yes, the facilities must comply with the mandates and statutes such as reporting. We did identify a number of hospitals that were not reporting to NHSN. Through the efforts of those programs and in concert and collaboration with the providers, we have that number down to two hospitals that have not yet reported through NHSN. Both of those hospitals were cited for non-compliance, and I am handling that piece of the enforcement piece separate from the HAI Program. The penalty piece, where CDPH does have the ability to issue civil money penalties, is under our authority of identifying an immediate jeopardy. An immediate jeopardy is a situation whereby there is likeliness to cause harm to an individual in a hospital secondary to non-compliance. Those fines start at \$50,000 and go up to \$100,000 with repeat violations. Now, would a situation where a hospital does not report rise to the level of immediate jeopardy; probably not.

Moss - What about in the event of an outbreak, and to add to the question, we were not just talking about not just those that did not comply with the registration on NHSN; we were also talking about the 20% of hospitals that did not give complete information or did not report at all. Those are also not in compliance with legislation. So, number one, if there is proof of an outbreak, that would actually put patients in immediate jeopardy, and the second part of this is, what is the plan to follow up with the hospitals that did not comply?

DeMartini – There are two pieces in that response. One: will there ever be a situation when a failure to report would constitute an immediate jeopardy? I would rather not say yes or no, because, in part, the immediate jeopardy statute is still relatively new, and it results in the issuance of penalties. Close to 200 of these penalties have been issued and are listed on the internet, if anyone is interested in what constitutes an administrative penalty or deficiencies. It is possible where there may be a situation regarding HAIs that do rise to the level of immediate jeopardy.

That situation has not come to our attention. That would then go forward with issuing an administrative penalty (AP). Administrative penalties do go through a rigorous review process and it is done by L&C, not the HAI Program. I am not trying to skirt the question; if it rises to the level of an AP, it would be identified by L&C, by a district office, and then that district office manager

would make a determination on whether he or she feels that it rises to the level of statutory definition of immediate jeopardy and they would start the process for the issuance of an AP.

To the second part of the question. Yes, we are, in the issuance of this report, looking at those hospitals that failed to provide complete information to be presented in the report. That is somewhat separate and distinct of from the HAI Program and is being looked at by L&C, similar to the manner in which L&C investigated when some hospitals were not reporting through NHSN. If I have not adequately addressed your question (to Moss), I will certainly entertain further discussion.

Moss - Actually, I do have one more topic I would like to bring up. This point has to do with the very important issue that has come up at least three times that I know of, and I know that we are very focused on the Bagley-Keene Act. This has to do with a secret meeting that was planned, a private meeting that took place just before the release of the data. The Bagley Keene Act completely prohibits the gathering of more than one AC member and I would like to bring up the meeting that took place with Loriann DeMartini, with Kim Delahanty, and Annemarie Flood, and someone else from CDPH. And I think it is important that this Committee knows that there are meetings that take place that this Committee is not privy to. I think it is a great disappointment. I heard about it and I joined the call. I know it was a shock that I was on the call. What I listened to was something that I think the entire Committee needs to hear, that these meetings take place, and that it is completely against the transparency that a *public* committee should be reporting.

The Act says that there should be no meeting of two or more people. And we have reviewed it copious times in the beginning of this Committee.

Rosenberg - The definition of a meeting is what is critical there. Because obviously people on ACs have phone conversations, for instance. To enable members of ACs to talk to each other, whether it is about information in the area the AC advises on or not, there is a fairly detailed and specific definition of what a meeting is.

Moss - There is really no way to get around it. Today we all know that even our subcommittee meetings need to be posted, the public needs to be aware, the minutes need to be taken, the notes need to be published, and that is not what took place in a meeting that incorporated three members and a participating executive. That is not the way this Committee should operate. It should be transparent, and everyone should know that this meeting is taking place just like every other meeting and every other discussion.

Chair - Thank you for bringing it up. Actually, the Committee was alerted to the meeting through Annemarie's email when I was out of the country. She submitted it to all the HAI AC members.

Moss - And then she pulled it back and said "Whoops, nobody is supposed to be on the call. It's just supposed to be a private call." And then she recalled the message. So that is a little different than alerting everyone to the meeting and allowing them to join the call.

Flood - I serve at the direction and pleasure of CDPH and the people who

serve there. I was instructed CDPH that there not be a Committee meeting, but that she wanted to get in touch with Kim because of the release of the report. I asked if this was to be shared and she said yes. There was a miscommunication, and I was asked to pull back the invitation. And the 'other person' you (to Moss) are referring to on the call was Pamela Dickfoss who is the Acting Director of L&C and CDPH. That was my understanding. And it was very clear to me, and Pamela Dickfoss was only interested in giving the report to a representative of the Committee. We were able to get a hold of Kim, a member from CHA, and a third party, and I can't remember who that was. So there were three entities, local public health officers, and those three entities were the only representatives they were interested in sending the report to.

Rosenberg - I didn't even know about this and wasn't invited myself. I wouldn't have known about it if Annemarie hadn't mistakenly sent the notice to everybody. My understanding is that it wasn't a meeting. It wasn't even supposed to be a discussion. It was supposed to be the mechanism whereby an embargoed copy of the report was going to be distributed. The Department didn't want to take responsibility for sending it out to all the parties, all the individual members of those organizations that had requested an embargoed copy. So they decided to go through one contact at each one of those organizations, CCLHO, CHA and the HAI AC and simply communicate to them that they were asked to be the point of contact to distribute the embargoed copy to their members. *There was no intent to involve two members of the Advisory Committee.* The goal was to get to one, and with Kim out of the country it eventually ended up that two participated.

Moss - She (Delahanty) was in LA. She was able to get back to San Diego and send that out to everybody. There were fifteen hours before I asked her what she planned to do with the report.

Rosenberg - Carole, that is a second issue.

Moss - It has to do with transparency and trust. This Committee asked for a preview copy for months. They asked "Please, let us have a chance to review this before the public sees it. Let us take a look. We don't even need to know what hospitals they are". And after all of those requests, this was given to Kim, and she decided not to send it out to this committee. And I believe that was very disrespectful and she has no right to do that. I know that Annemarie will try to back her up and say that she was traveling. She was in LA and had plenty of time to get to San Diego and send out the attachment just as Annemarie did the night before and offered to the night before. This is a matter of trust. And this Committee needs to know that these meetings are taking place and there are things that are going on that are really disrespectful to everyone who participates.

Chair - Carole, what is your concern about you getting it fourteen hours later, as you say, and what difference would it have made if you had gotten it at midnight of the night before? I sent it out the next morning. I was still on vacation, actually, but I did take the time to make sure I took that call. So please tell me what your concerns are and what would have changed if you had gotten it at midnight as opposed to the next morning at 10:00 AM?

Moss - *It didn't really matter to me*, but I can see in many of the meetings how

much each and every one of these people wanted to review the data before it was sent out. It wasn't my need to look at it.

Chair - They were able to review it before it was posted.

Moss - It was up to you to distribute it to the Committee. That was your job.

Chair - And I did that; they were able to review it prior to it being made public.

Moss - After I sent a letter and let people know. You could have done that when you got home, which is what you had said you could do; "I'm driving from LA to San Diego". This is a discussion that is very disappointing simply because she is the leader of this Committee and we are all committing a lot of time and that was something that was disrespectful to each and every one of us sitting at the table today.

Alongi - Carole, I have to remind you, two minutes comment please. And now we have a number of people in the queue.

Moss - I'm finished.

Witt - There are a couple of things to take from this. There is a reason for the basic rules, so even if things are well intended they don't give the appearance; so this was a little blundering. I don't think there was any ill intent. By the same token, we also have the premise that we treat each other with the assumption that we all have good intent. We make blunders. But the good intentions are there.

I think there is a lesson to learn that we were really looking for this information, but I disagree with Carole and I don't think we can accuse another member of the Committee of doing things deliberately. I think there is a lesson here that when there was a piece of information we were looking at, it didn't come as forthcoming as it might have.

We will have to read the language of Bagley-Keene to know, but the argument is always to follow the rules so that there isn't any perception of secrecy. I think we have got to assume that no one on this Committee is trying to sandbag anyone. And the point of the rules here is that we can always bring it up publicly if we wonder about it, we bring it to the Committee. So I think it is good that you brought that up Carole, because it is a bit of a concern. But I think the way we can deal with it is to scrupulously adhere to Bagley-Keene, and mutual respect.

Myers - Playing by the rules is important. But, treating each other with respect and not accusing people of things outside the Committee is another good sign of respect. And one thing I would like to reiterate as a final piece of the minutes is the reason why the Committee asked for the report ahead of time was to have input, so that we could see the format of the data to see if there were things that were not risk adjusted. That is part of the reason we said we would see the data blinded. I do have to say that I am a little disturbed that the Committee, once the data was embargoed, would put itself before the public and say that we deserve to see it first now that the data is finished and we don't have any input. The goal of seeing it beforehand was to see if anything was missed. Once it was put together, there was no real reason for

<p>us to see it before the general public got to see the report.</p> <p>Rosenberg – Another error on our part, some hospitals got to not only know there was a report coming, but to see the report coming. One of the things OSHPD always does that the Program will always do in the future; when there is a report coming, they send out a notice to the hospitals.</p> <p>Chair - I would just like to make one comment Carole, to you, and I hope you take this with all due respect. I can't imagine your pain and what you have been going through due to the loss of your son. I can't imagine it. I am also sorry through your mourning that you cannot see that we are all here fighting the battle with you, not against you, but with you. And together with you, and everyone else in this room, we are the only ones who can make patient safety improve, and that is what we are here for.</p> <p>Moss – Well, that's good to hear.</p>	
<p>Action Items</p> <ul style="list-style-type: none"> • All reports presented to the main body of the Committee will be posted on the HAI website. To assist the Program with this process, members are to submit all materials to the Program. If a member has presented a report or data that has not to date been posted to the website, member should inform the Program. • HAI AC members with infection control data concerns should forward these concerns to the Program. • Program to send ‘thank you’ letter for John and Joann Sanchez (public story presenters). • Program to send ‘thank you’ letter for Sharp HealthCare for providing the facility, refreshments and lunches for today’s meeting. • CDPH is considering methodologies for data validation as part of its process for upcoming data reports; CDPH is considering addendums for errors/omissions/ corrections for the technical report. • Local Health Officers request to CDPH county specific reports for future reports • Dr. Lee to submit recommendations for increasing pediatric specialty participation on the HAI AC. • Program to provide the white paper (from previous versions of HAI Committee/Working Group) to Annemarie Flood, as she is the Chairperson for the Title 22 Subcommittee. • CDPH will post a CMS link to the SCIP data on the HAI website. • Members with suggestions for website formulation and educational documents should submit these suggestions to the Program (Rosenberg). Members may also contact the Public Reporting and Education Subcommittee (Moss—Chair) to offer suggestions and discuss ideas. • Program (Palacios and Kalson) will contact the Office of Public Affairs regarding public service announcements; Program will also work with the Public Reporting and Education Subcommittee for ideas and discussions on the public service announcements. • CACC is requested to send out communication to all members on the SSI (regarding CABG and Hip surgery). • Per motions approved today; HAI AC formed three new subcommittees; SSI Subcommittee, Enid Eck, Chair; Title 22 Subcommittee, Annemarie Flood, Chair, and Pediatric SSI Subcommittee, Lilly Labar, Chair. These 	

subcommittees will be given time on the February agenda.

- Subcommittee Chairs are requested to submit electronic versions of their subcommittee reports 48 hours before HAI AC meetings.

Future Meetings:

- Next meeting is **February 17th in San Diego.**

Chair—Thank you everyone for your time and commitment.

Meeting Adjourned

Acronyms

AFL	All Facilities Letter
AHRQ	Agency for Healthcare Research and Quality
AJIC	American Journal of Infection Control
APIC	Association for Professionals in Infection Control and Epidemiology
ARRA	American Recovery and Reinvestment Act
AUR	Antimicrobial Use and Resistance
CACC	California IPAC 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
CLSI	Clinical and Laboratory Standards Institute
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
ICHE	Infection Control and Hospital Epidemiology
ICU	Intensive Care Unit
ID	Infectious Disease
IDAC	Infectious Disease Association of California
IDSA	Infectious Disease Society of America
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
SHEA	Society for Healthcare Epidemiology of America

SIR	Standardized Infection Ratio
SSI	Surgical Site Infection
VRE	<i>Vancomycin-resistant enterococci</i>