

**Healthcare-Associated Infections Advisory Committee**  
**November 24, 2008, 12:00 – 1:00 PM**  
**Location: Conference Call**

**Attendance**

**Members/Alternates:**

Kim Delahanty (Chair), Raymond Chinn, Alicia Cole, Letitia Creighton, Enid Eck, Annemarie Flood, Lilly Guardia-Labar, Jennifer Hoke, T Warner Hudson, Lisa McGiffert, Marian McDonald, Mary Mendelsohn, Shelly Morris, Carole Moss, Rekha Murthy, Frank Myers, Terry Nelson, Shannon Oriola, Debby Rogers, Julia Slininger, Todd Stolp, Jonathan Teague, Francesca Torriani, Anvarali Velji, Pat Wardell, David Witt

**Guests:** Kathleen Billingsley, Monica Waggoner, Chris Cahill

**Staff:** Sam Alongi, Sue Chen, Roberto Garces, Jon Rosenberg

Agenda Items/Discussion	Action/Follow-up
<p><b>Call to Order and Introductions</b>            Committee Chair Kim Delahanty (Chair) convened meeting at 12:00 noon. Introductions made.</p>	
<p>K Delahanty announces that the December 11, 2008 meeting has been cancelled and that the purpose of the conference call is to develop cleanup language based on submissions from C Moss, C Cahill and F Torriani et al.</p> <p><u>Cleanup Language for SB 1058: 3 Amendments</u></p> <p>C Moss – We have reached out to the CDC and feel that there is some additional insight to clarifying language so I'll just go ahead and read through. New language is underlined in what has been sent out and then there's a line through things that are being deleted or what we're suggesting are being deleted.</p> <p style="padding-left: 40px;">Each health facility shall report quarterly to the department:            (1) all health-care-associated surgical site infections <u>that meet CDC criteria for deep incisional or organ/space infections following</u> [of deep or organ space surgical sites, health-care-associated infections of] orthopedic [surgical sites,] <u>and</u> cardiac [surgical sites] <u>designated as clean and clean-contaminated operative procedures;</u>            (2) all gastrointestinal [surgical sites] <u>operative procedures</u> [designated as clean and clean-contaminated, and the number of surgeries involving deep or organ space, and orthopedic, cardiac, and gastrointestinal surgeries designated clean and clean-contaminated.]; <u>and</u>            (3) <u>the number of operative procedures of each of these types must also be reported for the same period.</u>  <u>The Department, with advice from the Committee, may develop specific directions needed to enable effective reporting and have the authority to require hospitals to adhere.</u></p> <p>C Cahill - The language that I have suggested is:</p>	<p>December 11, 2008            HAI-AC meeting cancelled.</p>

(a)(3) No later than (insert date) each health care facility shall quarterly report all of the following healthcare-associated (HAI)surgical site infections (SSIs)to the department or to the National Health Care Safety Network (NHSN)of the Centers for Disease Control and Prevention (CDC)

- (A) KNEE PROSTHESIS/ARTHROPLASTY
- (B) HIP PROSTHESIS/ARTHROPLASTY
- (C) Mediastinitis following STERNOTOMY
- (D) ELECTIVE COLON RESECTION

We would have to submit data to NHSN on all cardiac surgeries performed so they could risk adjust it, is that not true?

S Chen - We would really like the data submitted through NHSN because of the risk adjustment piece.

C Cahill - OK, so anyway, I've given an option because many of our hospitals are small and don't have the ability to input all of that data. Anyway going on to (a)(4):

(a)(4) Health care facilities that elect to submit surgical site infection data directly to the department must receive prior written authorization from the department.

(a)(5) Surgical site infection data submitted directly to the department shall include, but not be limited to, the following information: the patient's medical record number, the date of hospital admission, the primary ICD-9 code assigned to the procedure and the title of the procedure as identified in the surgeon's operative summary, the date the procedure was performed, the identifier number assigned to the primary and secondary surgeons by each hospital, the site deep incisional or organ/space)of the infection, the onset date of the infection, the date the culture of the infection was obtained, the microorganism or microorganisms identified by the laboratory as the causative agent or agents of the infection, the length of the surgical procedure (cut time as defined by the NHSN) in minutes, the American Society of Anesthesiology (ASA) score assigned by the anesthesiologist, and shall designate if the procedure was determined to be categorized as clean or clean-contaminated according the CDC/NHSN definitions.

(d) Each hospital shall quarterly submit to the department the total number of procedures performed in each category of surgery identified in subdivision 1288.55(a)(3.)

(e) SSIs reported to the public shall be risk stratified by rate per 100 surgeries within each surgical category indentified in subdivision 1288.55 (a) (3).

(f) The department may annually delete from or add to subsection 1288.55 (a) (3) a category or categories of surgical

site infections to be reported to NHSN or the department. Health care facilities shall be notified of any changes no later than January 31 of each subsequent year.

F Torriani - The intent of this was to simplify the language and then to go into the details once the legislation was simplified.

12.88.55 (a)(3) Each health facility shall report deep and organ/space surgical site infection (SSI) rates for specified clean and clean-contaminated procedures to the Department quarterly using CDC/NHSN definitions and methods. The SSIs will be reported as rates per 100 surgeries. Infection rates are to be reported for the following procedures:

KNEE PROSTHESIS/ARTHROPLASTY  
HIP PROSTHESIS/ARTHROPLASTY  
CABG AND/OR CARDIAC VALVE REPLACEMENT VIA MEDIAN STERNOTOMY  
ELECTIVE COLON RESECTION

As the intent of the legislation is to prevent surgical site infections in general by reporting outcome measures, the above list of surgical procedures may be amended and additional procedures may be added upon recommendation of the HAI-AC without further individual legislative action.

#### Discussion of Three Amendments

K Delahanty - The purpose of this call is to define and clean up the language in the bill that we feel needs that and submit that, come to some sort of consensus and submit that.

L McGiffert - OK, so my understanding is there is a window of opportunity during which technical amendments can be made but they can't be substantive. If they're substantive they will be kicked out. So they have to be sort of technical amendments to clarify what's there. But there is this window, where legislators are allowed to make technical changes that do not have to go through the whole hearings and all of that process.

R Chinn - Lisa, what would be an example of a technical...

L McGiffert - Well, I think that is one of the reasons why we, in our proposed amendment from the consumers, suggested that we make it clearer, that we express the intent of the author, that the department and the committee would specify exactly how things are to be done. As that's not spelled out in the actual legislation, and then that would be sort of a technical amendment. If you went from reporting all to report four [*surgeries*], that might be more than a technical amendment.

S Chen - I think that the question that Ray asked was very germane, i.e., that means we essentially cannot remove "all". Then the question is, in part of the technical language, can we make any suggestions on

how it can be implemented? Is that correct, Lisa?

L McGiffert - I don't know this, but it could be that a technical correction would be that you keep the all in but then you allow a phase-in schedule or something like that. And again, I think the only way we're going to know one way or another is for us in the Advisory Committee to submit something and then have it up for review.

D Witt - And I think again you know, what we've been asked is technical clarifications, we've not been asked for new legislation. And given that, I think we really do not conform to what we were asked by the author to do with our original proposal speaking to, how do I identify these, Francesca's proposal. On the other hand, while the consumer's proposal does help clarify somewhat, I think it does still have some significant gaps. The problem with the language as it existed is that we need to have some viable identification to these procedures and some viable comparing apples to apples and I think the consumer's language helps, probably my biggest concern with it would be again gastrointestinal procedures really would need deep and organ space infections only, superficial sites is a trivial matter that is background noise and I actually like this that with the exception that it would permit clarification and implementation from the committee, I think that if it broadened that directive to the committee, I think that this actually makes more sense and reflects the Senator's initial intent better.

S Oriola - I liked the Torriani amendment. And I'm not quite sure, are we to start reporting in January 2009? Because I think that's possible with this amendment. And then my other question for clarification is with the other language Carole that you submitted, is that an over-all rate per gastrointestinal infections or is it group stratified by each particular type of procedure in those categories, I'm not quite clear the language that was presented.

C Moss - Previously, I believe it would be risk adjusted already.

S Oriola - To each procedure in those categories or an over-all rate in those categories, it wasn't very clear to me in the language that was submitted.

C Moss - Well maybe we can clarify that a little bit better. This came from the CDC itself.

L McGiffert - There is another place in the legislation that talks about reporting information out to the public and that being risk adjusted.

S Oriola - Right, but you can't risk adjust something that, using NHSN methodology, is just an over-all rate for gastrointestinal procedures, so the Torriani amendment is a little more specific and still gives the committee the latitude of adding more on, and I think that was doable with the given number of procedures.

F Torriani - The trouble is, if within this report, even directly to the state, and a whole range of procedures, let's say knee procedures, and

this is not risk assessed at the time of the analysis, then that risk adjustment is completely gone. And that is what NHSN does. It's because you risk adjust by the time it takes for the surgery, the type of wound, and that gives basically an adjustment for an infection.

D Witt – Again, in the consumer's language, we have to risk adjust this; if we don't report this with useful numbers we report rubbish that benefits no one. And again I mention the consumer's language addresses that, maybe with a little fleshing, that the department with advice from the committee may develop specific directions needed to enable effective reporting. I think that's what we have to do. We have to have the flexibility to not make this inviolate legislative language but to create some flexibility to make sure that we aren't reporting just because we can't think of everything at this point. We need to develop some technical advisory capabilities.

R Murthy - I agree with Dave's comment about the language in the consumer's representative issue about the department with advice from the committee may develop specific direction. The one point I would make is for item two where it talks about all gastrointestinal operative procedures and would remove the "clean and clean contaminated," I think it is important to have that [*those words*] remain mainly because when we get to the risk adjustment piece, in the interim you may have defined some general numbers. The problem is if we don't have that qualifier, it would add dirty procedures [*to the general number*]. Trauma centers that perhaps do more of the contaminated trauma surgeries may be skewing the overall numbers and interpretation. So when we talk about the language for stratification and risk adjustment, we need to do our best to provide the means to be able to perform those adjustments.

L McGiffert - The reason we took that out was because of the conversation with CDC that there are no clean operations, gastrointestinal operations, and that limiting that would be difficult for data collection and make it subject to (unintelligible) and so that was why we suggested removing that. But again, that actually might be more of a substantive change, but I think that if you removed it you could still specify that you want to collect the type of procedure it was, whether it was clean contaminated or dirty or what are the others; anyways, you could still specify those be reported to the department.

F Myers - Yes, I'm looking at both of these and on the consumer version that Carol submitted, my concern, and what the Torriani amendment attempted to address, was actually the whole issue of operationally defining these, because by saying orthopedics, we've had discussions about whether a laminectomy is an orthopedic versus a neurosurgical procedure, and functionally it leaves those ill defined. I think it was attempted with the Torriani approach to actually come up with firm definitions of those. Certainly I would agree there are no clean gastrointestinal surgeries, but there are clean-contaminated surgeries that you do see. Representing trauma hospitals in the Scripps System, I think that the issue of traumas is a major one. When comparing a trauma surgery to any other procedure, even a colon resection, whether

it's a trauma or an elective surgery, there are very different ramifications as to the likelihood of a surgical site infection and complications. I think Carole's suggested approach loses those important differences. I believe that Dr. Torriani's language is an attempt to operationally define the intent of the original, which was to get surgical site infection rates that were meaningful and comparable for those types of surgeries. If we go with the consumer version, we're going to have non-operational definitions – what is an orthopedic procedure – and we could argue all day about what that means. I'm not sure if that gets answered by bouncing it back again to this Committee.

L McGiffert - The intent is that those operations would be listed and determined through the department with the advice of the Committee. So, and I want to be clear, the CDC did say you would need to have a mechanism whereby there would be specific procedures listed so that everybody is reporting the same procedures, so that was the intent of the last sentence in our amendment and if it needs to be clarified, that it's more broad language rather than a specifically listing, because if a specific listing, you would have to go back every time and change it.

R Murthy - The language that Francesca and group worked on does point out the flexibility to incorporate other procedures. This is an important starting point because it gets to the common definitions and procedures. Also, these are procedures for which there are already publicly available reported process measures that can be linked with outcome measures so that the public can see the relationship between surgical prophylaxis and appropriate antibiotic usage data and surgical site infections. While we are still battling the details of the language, this at least begins our process. I don't believe there's a lot of disagreement in the intent. The goal for us as a committee has to be how can we make this work and we can make it work in a way that actually everybody can understand and it has some meaning, and then yes, we can keep adding to it as we go along. I think that it's okay to keep adding as we go along. You gave the example about clean procedures. If you leave the language broad for all GI procedures, there is a danger of getting lost in the forest. For example, hernia procedures may be clean but are considered gastrointestinal procedures. We need to start somewhere and I would propose that at least between these two, that Francesca's is at least clean, clear and it opens the opportunity to continue to expand.

S Oriola - I'd like to follow up from what Frank and Reyka said. I think the intent is to ultimately reduce surgical site infections in California hospitals and I think Dr. Torriani et al. does that with a good start. There are some questions that I have for Carole regarding the language because it says criteria that meets these four organ space infections that it doesn't state that it's NHSN ICD9 code procedures. For example in gastric surgeries there are twenty four codes that you would actually have to follow, which seems to be overwhelming and a lot of time with data entry with little yield probably, and it would have to include clean and clean contaminated, although, at least clean contaminated because we know there are no clean gastric surgeries so the clean contaminated would have to be added in, so if you report to NHSN, risk stratify, and

compare your data, then it would have to be an NHSN procedure. For example you can't track infections and compare, so my question again goes back to was it an over-all rate of all gastric procedures or is it risk stratified and do you have to track 24 of the procedures that you do and provide rates for all twenty four surgeries that you may perform. This gets to be very diluted. It must be started in January 2009. I think the Torriani amendment actually is a good place to start.

C Moss - The whole point of what we're trying to do right now is to get something that everyone can agree upon and I think at this point the more we take the time to go back and forth we're never going to have anything to submit over to Senator Alquist's office. And, the broad discussion that we were told that this was all about is that the definition and the fact of the matter is that we are going to be reporting on all, it will be all, so all that we're doing right now is defining which ones are going to be specifically identified, but the bottom line is all infections will be reported so I really do think, you know, this isn't the first thing that needs to be reported. This isn't going to be publicly reported until 2012. There are other things we need to be spending a lot of time on, the languages and fine tuning and everything, so what we have received and the information that we have gotten back from the CDC specifically states that the way that the wording is today. When it says in effect clean-contaminated, you're going to get very few infections reported and that's not the purpose of what we're doing today and what we're doing for this information. So, bottom line is we're supposed to be reporting and gathering data for all, and no matter how we end up dividing it up on the illustrations, we probably should just go ahead and look at what other states are doing; California's no different than other states, and to make sure that we are able to be compared to other states. So I really do think that the way that it's spelled out in Francesca's and the whole group that got together that wrote that in support of it, it's not illustrating what other states are doing and I really think that we should be able to take the information that we're gathering now and be able to compare it across the line with what other states are reflecting as well so we probably need to have that enter into the discussion.

S Chen - When you look at all the other states, we are the only state that seems to be requiring specific types of infections to be in our own legislation. Every other state has put some other mechanism for some decision making that does not require legislation every single time it changes. Is that helpful?

L McGiffert - Most of the states are listing, many of the states are listing specific legislation. We've worked in those states on that, but they have an expansion provision similar to the one that's been proposed although it's a little bit stronger than the one proposed.

C Cahill - On the language where it says the department with advice to the committee may develop specific directions needed to enable effective reporting, I'm wondering if that language isn't leaving us dangling out there like we are with the "all" clause and so that's one thing that occurred to me is that the language is not specific and

without being specific in the language should we get any other alterations in the language as we move on through the years?

R Murthy - I just wanted to pick up on something. Maybe this is for clarification. Carole had mentioned one of the reasons for including all procedures and specifically not leaving out dirty, infected, or clean was that if we didn't include all of those, there would be very few infections reported. I just want to make sure I understood that was what she said or meant, and if so, I would like to raise a discussion point that we are trying within this framework to make this not necessarily numbers of infections reported, and I know the question about (? 34.50) came up but it is I think difficult to say that if we have a trauma center that is doing a lot of trauma cases that is reporting a lot more infections, there is a danger of actually not having that clearly defined and the potential for misinterpretation. By using the category of clean-contaminated, setting apples to apples, you're removing some of those qualifications. So I just want to be sure that I understood that.

E Eck - I guess what I'd like to do is offer a friendly amendment to the language proposed by Carole and apparently with recent input from the CDC, and would request to address the concerns that have been raised by the group and make sure that we have a consistent process for reporting all of these by category. That despite the CDC input that there are no clean gastrointestinal surgeries, there are, because of how things get defined by CMS and what gets put in the category of gastrointestinal as a category of surgery, there are clean procedures. And so, what I would suggest as a friendly amendment is that for each of these categories, the category of clean and clean contaminated, and deep or organ space procedures be included for all of the categories and in the last sentence which based on Lisa's description of the intent of that, that there be more clear language such that the phrase "may develop specific direction" could perhaps be altered to say something like "may develop and/or identify specific procedures" that would enable effective reporting so that we could be very clear, the department could identify the specific ICD codes that would need to be reported and then we would have the capacity to truly compare on a risk adjusted basis all of the procedures that are reported across the state.

It would have to be in each category, they would have to be risk-adjusted for each category, because the process for risk adjusting, although it is similar for each, you would not want to have an over-all rate because the types of facilities we have across the state and what they do, a trauma center vs. a not, you would have to do risk adjustments by each category.

L McGiffert - I think what you're suggesting is that we don't go back to the original deep or organ space and clean contaminated, and certainly there is a question as to whether that would be substantive change if we take out those on gastrointestinal, I just wanted to be sure everybody knew what the CDC said. As far as the changing of the last language, I think it's fine except I think you should keep in "may develop specific directions and identify specific procedures needed to enable effective reporting" because there may be other clarifications

that are needed besides the procedures that you would want the committee and the department would be able to work together on.

Yes, I think that's fine, I think that has to happen, to come up with a list, and as long as it stays "all" it's going to truly be all that goes, as a list, well it may not be all, I don't know, it'll be a list that is developed based on what's possible. The other thing I wondered is - does the CDC or NHSN require these to be categorized as clean, clean contaminated, etc?

S Oriola – No. They have certain procedures that they trend and follow; it depends on how the procedure is rated in the operating room and how the surgeon's rates it.

L McGiffert - Yes, but doesn't that have to be reported to CDC with the data?

S Oriola - Yes.

L McGiffert - So that information is going to go into the reporting process.

E Eck - Right. But if we eliminate it from this then there's no reason to collect it. So that's what I'm saying. It needs to be in there for every one of them.

C Moss – [MOTION] I want to make a motion to approve Enid's suggestion and changes.

A Flood - Second.

S Oriola - OK, my only question is that do you need to eventually go to "all"? I think that the Torriani amendment gives us a really good start with expanding it eventually to "all." If you look at where the hospitals are right now, for a start, 24 gastric procedures would have to be reported, risk stratified, and then a rate calculated. There will be possibly two or three different rates for each of those 24 gastric procedures because when you look at the rate it gives you a category for risk category zero, and one, and two, and three, and that's just for gastric alone. I'm not sure how that will be initially meaningful, so if we at least start with a more defined group that should be very low infection rate, and then it would trickle down to the others, that would be a good start. I think it would be difficult looking at all this information; you would get lost just looking at it on a website and it would be pages and pages of information.

D Witt - If we think about this process I just want to really reiterate this, in that we are not being asked to revise legislation. A technical amendment is a clarification of existing legislation. As the Committee, we seriously encumber our credibility if when asked for technical clarifications we present revised legislation. I really like the proposed motions and I think they would address flexibility needed as well as answer the question for the Senator's office as well as provide a flexible

and usable system that has value in terms of reporting.

F Torriani - I just think that this would not include with the amendment the Moss amendment which I don't disagree with necessarily would not give us the ability to add procedures that are important such as EUN procedures, hysterectomies, or other procedures which are not included in this category, and that is why we offer very simple language that would allow us as a group to add these procedures as we go. This is just a start. The intent clearly of this group is to widen as soon as possible and I think that in the amendment, the health care basically says that we are back to square one. Orthopedic surgery would be difficult to define; people would not report in the same way. When you go back to public reporting, what is being publicly reported and what methodology is being used? This is not the NHSN methodology. Missouri reports out infections and they have limited them to hip, and GYN procedures, so hysterectomies. All the other states require basically the surgeon to self-report, they are not using NHSN methodology which I think is key into getting a symptomatic review and data that is quality driven and that is meaningful.

S Chen - OK, and just a couple of things, really quickly. Number one, we do need to recognize that if this is only technical language, we have to keep the "all" in, but one of things it doesn't say is that we can't ask for some of these to fit definitions. What I would propose is that we go back to C Cahill's language under F on the second page. "The department after consultation with the HAI-AC may annually delete or add to sub-section ... a category or categories of surgical site infections to be reported to NHSN or the department. Health care facilities shall be notified of any changes no later than...." That kinds of gives us flexibility both up and down. We're keeping the "all" in and it should be absolutely be tied by the HAI-AC, which is what we're asking. We're not asking for everything on it because I think we all recognize that's not a viable way of starting reporting and we do have to get started. Thank you.

E Eck - I think that the proposed language from Carole and Lisa et al in each of the categories if it was made very clear, I think under number one where it says it would meet CDC criteria, that same language needs to be in place for all three categories and probably it could say CDC/NHSN criteria to address the issue that Francesca raised. If there was a need to clarify that we would follow NHSN definitions then those criteria for deep incisional or organ space, that needs to be spelled in every one. I was reading that, Francesca, as being applicable to all, but you are probably correct in that that should be inserted into every one of them. And I think in the last sentence if it gives the committee the opportunity to advise the department to identify specific procedures we could in fact begin with the ones that have been already identified in Francesca's proposal which I actually participated, so in principal am supporting. I do like Sue's suggestion about adding some language that would allow us to very explicitly, the committee and the department, add and/or delete especially if we are finding things that everyone is reporting on and it is not useful in helping us intervene and prevent infections. So adding Chris's letter F may be very helpful. I don't know if that would be perceived to be substantive changes to the legislation,

and I wouldn't want to jeopardize the whole clarifying language with something that is perceived to be substantive.

C Cahill - Yes, I just want to reiterate something I said previously. When you're talking about all of these surgeries, all hospitals, all surgeries, all categories of surgeries, this is a tremendous amount of data that has to be entered into the NHSN database by a single inspection control practitioner and I'm wondering if any of you, I know most of you NHSN hospitals, and I know a lot of you are used to entering the data, all of the data into the NHSN or NNIS databases but most of our hospitals that perform two or three hundred surgical procedures a year when you consider orthopedic, gastrointestinal and not all hospitals perform cardiac surgery, but I think some accommodation needs to be made to recognize that a single infection control practitioner working .5 or .75 will not ever have the time to enter all of this data into NHSN.

C Moss [restates MOTION] - The motion is Enid's revision, but we began with "Each health facility shall report quarterly to the department all health care associated surgical site infections that meet CDC/NHSN criteria, or deep incisional or organ space infections following orthopedic and cardiac designated as clean and clean contaminated operative procedures and all gastrointestinal operative procedures. The number of operative procedures of each of these types must also be reported for the same period." And the language, Enid maybe can help...

L McGiffert - And I think I understood her amendment was the department with the advice from the committee may develop specific directions and identify specific procedures needed to enable effective reporting. And I think I sent it to everyone on the list.

K Delahanty - I'm going to go ahead and read it because I received it, so this is the proposed motion. **Each health care facility shall report quarterly to the department all health care associated surgical site infections that meet CDC and [we're going to add in] NHSN criteria for deep incisional or organ/space infections following health care associated infections of orthopedic surgical sites, cardiac surgical sites, and gastrointestinal surgical sites, designated as clean and clean-contaminated operative procedures and the number of surgeries involved in deep or organ space and orthopedic cardiac and gastrointestinal surgeries designated clean or clean-contaminated.**

S Chen - One thing we need to ensure is that this is reported to the department in a sensible manner.

L McGiffert - OK, but at least that's the intent of this language that it would be specific directions to enable effective reporting.

R Murthy - Could we perhaps pull up while Lisa's pulling up that language pull up the Torriani language and see if there's, we talked about adding "all" back in there. Can we see if there's anything needed to be adjusted to that so that we can have both of them ready to be voted on?

S Chen - When you look at Francesca's it takes out the "all" intent and so I think we need to make sure that that intent stays in.

R Murthy - So if we add the word "all" back in but less the rest of it seems to get to the same point and maybe gives us a starting point. And if we needed to add something about the...

F Torriani - But I agree with Reyka. I mean, and I'm just floating this possibility, maybe we should start with, as of January, putting in the language that Sue said that as of January 1<sup>st</sup>, 2009, the procedures, these procedures would be reported. And then at least we have a phase-in that we're saying concentrate on these and then we'll get to the rest. Because clearly, I hear you, that we want to do all of them but we will not be able to do all of them as of January 1<sup>st</sup>, so we just have to start somewhere, and then test it, and then add. So I think that maybe one of the solutions would be to add wording to Carole's language saying that. That as of January 1<sup>st</sup>, 2009, the health care facilities will start with reporting of these processes. Would that be a motion that could be entertained?

What I'm trying to say is we are all working toward the same goal, we all want the same thing basically, that we want to make it workable, possible, and once again we don't want garbage, we want data that we can then make changes in our practices and continuing improving. So how about adding that as of January 1<sup>st</sup>, 2009, the health care facilities will start surveillance and reporting on the following procedures and then we add in knee procedures, arthroplasty, hip procedures, arthroplasty... And at least we have a starting point with the language that Carole proposed.

L McGiffert - I think everything's fine. It certainly was in the intent, the general language that we proposed, that the committee could come up with a risk to start with, but I think it would be worth if you want to start, with that language actually in the statute, we can try. I don't know if it will fly with the substantive change, but if it doesn't then I think that would be acceptable.

Because I think that would be technical assistance. If some were saying "Look, we cannot as of January get all of our shit together and start surveillance of all of this and reporting to NHSN," you know, it's simply not going to happen, right? So what we're saying is that we're offering technical assistance, start with this, and then we will develop, you know, the time line, which we can.

D Rogers - Phasing in is something that we had talked about during the process and I think that if that's agreeable I think that that might be a way to go. I think that the language that Lisa just sent out looks good and maybe if we could tweak it slightly for the phase-in as new things come along I think that that would be good.

T Nelson - I have to agree with the most recent proposal that by adding "all" back into the initial statement, then that the surveillance should

start with the following procedures concept, I think that in order to enable that, I would like to, I see it as an expansion on this list concept developing to have a section F from Cahill's proposal put there as an explanation of the process, of how this list will continue to develop. I think I'm a little bit concerned that it will dead end with these four if that's all that's put into the technical clarification, and I don't think that's anyone's intent. I think that we do want to continue to adjust the list, expand it, eliminate those that don't seem to be productive in terms of reducing infections, or we have actually eliminated them in that category, and now it's time to stop reporting them and putting our resources toward those that do, so I'd like us to look back again at that section F at the end of Cahill's present proposal as a tag to what was just discussed.

**K Delahanty - As of January 1<sup>st</sup>, 2009, each health care facility shall report all deep and organ space surgical site health care associated surgical site infection rates for clean and clean contaminated procedures to the department quarterly using CDC/NHSN definitions and methods. The SSI's will be reported as risk stratified rates per one hundred surgeries within the surgical categories the department using NHSN. Surveillance should start in the following surgical categories but not limited to: knee prostheses, arthroplasty, hip prostheses, arthroplasty, CABG, chest only and cardiac valve replacement via sternotomy, elective colon resection. The department may in consultation with the HAI advisory committee annually delete from or add to subsequent section.... a category or categories of surgical site infections to be reported to NHSN or the department. Health care facilities shall be notified of any changes no later than January 30<sup>th</sup> for each subsequent year.**

L McGiffert - OK, I think that the language about adding new categories is too soft to get to "all" for the intent. I think it should either say "shall add new" ones or something a little bit stronger. On "may annually delete or" is too soft.

F Torriani - Why don't we say "shall annually modify"...Based on the data received, right? The department shall annually modify, right? Because that's what we want is basically we look at the data, we say "oh, oh this is what we're not capturing, this is where we have to go next... right?"

L McGiffert - Well, if you're adding a whole new category you wouldn't be modifying based on information that's come through.

K Delahanty - Modify or add...

T Nelson - I have something I would like to add to that. When you say categories, I think in some cases we're talking about procedures rather than the broader term when we were using categories for cardiac and gastrointestinal. Secondly, to make the language a little firmer, "surveillance shall start," rather than "should start."

L McGiffert - I was thinking to keep the language like we had it, and then add a section that says "As of January 1<sup>st</sup>, you shall start with these procedures."

D Rogers - Can I ask one more thing? I'm unclear about the January 31<sup>st</sup> notification. Because I don't know when the year starts at hospitals. Do you know what I mean? I think if we want to give lead time to hospitals which is probably a really good idea that we might specify it in a different way, like the hospitals are notified six months in advance of when new procedures need to be reported or something like that.

L McGiffert - The paragraph that began "January 1<sup>st</sup>?" I was going to suggest that we keep the language as we had modified it with advice from the committee may develop specific directions and identify specific procedures needed, and then in another subsection, maybe a (b), as of January 1<sup>st</sup>, 2009, the following surgical procedures shall be reported, or, and then list the four that were in the Torriani amendment. And then the language of the, I didn't get the full language of the modification.

C Moss - At the end, when it talks about the department?

S Chen - I just sent something out. It's "the department after consultation with the HAI-AC shall annually modify or add to subsection 1288.55. etc. specific surgical site infections to be reported to NHSN or to the department including development of specific directions in order to enable effective reporting."

L McGiffert - Sue, do you think that gives the department the authority they need to require hospitals to follow those procedures that you come up with?

S Chen - Well, I would need to run that by powers that be to make sure that if I had the leeway...

C Moss - Let's just go ahead and add the language that the department has the authority to require hospitals to follow these procedures and processes.

D Rogers - I don't think that's necessary and I don't think that we've even talked about it before this meeting. I think that that's implicit in the law and ...

C Moss - Well, we need to be very clear. So, in my first motion it had, it did cover the authority.

K Delahanty - Does the department need to have the specific authority to be able to require hospitals to follow procedures that are not spelled out in the law?

K Billingsley - I don't have that many legal representatives today, in the short term, but I'm sure that we could write down the question and have someone respond this afternoon.

S Chen - Will the committee give us the leeway to, once Kathleen gets language that would be enforceable that we could actually do something with, that it would be put into the motion.

Carole, in your amendment, and Lisa, is it only the procedures that are reported into NHSN, because cardiac procedures I don't believe NHSN tracks valve replacement surgeries and pacemakers; there is not separate national data. That would be one of the clarifying issues, because you're using the NHSN. If NHSN only reports on half of the cardiac procedures, that may be a little confusing as well.

Member – Well, that is why you have the language of the committee to define the specific procedures so that is specifically what that's for.

Member – I think it would be acceptable to look at NHSN and see what procedures they separate out in those categories that should be reported out, so facilities can report it out.

F Torriani - Yes, so because I think that what we want is specify what kind of rate we want, and we want to make sure that not only the definitions of which procedures need NHSN criteria, but also the methodology and the way we report them needs CDC/NHSN criteria. And I think that is why I repeated it again. Because I think that one is we pick which surgeries we're going to do surveillance on, and then we find the SSI's, and then we want the SSI's to be found using the same methodology of NHSN and then we want them to be reported and stratified as much as we can with NHSN. So that is why I repeated it.

Member – You don't want the facilities to calculate the rates. So you'll probably just change that sentence “Each health care facility shall report all deep and organ space surgical site infections.”

*Additional discussion regarding “deep incisional or organ/space” and “methodology” language...*

D Rogers - This one needs some work. It does not include giving the Department of Health authority.

E Eck - And I would agree with Debbie that if there is a need to input, insert language that would give the department authority, which I think is more than explicitly spelled out in this legislation.

K Delahanty - OK, what I'm hearing is we are not going to be able to vote or come to consensus, so we need to decide in the next two days can we reconvene.

***Next call set for 7:00 AM, November 26, 2008. The latest iteration to be emailed out with clarification on the language for authority if that is needed.***

End call.

HAI-AC staff will distribute via email the latest iteration of cleanup language.

Next conference call set for November 26<sup>th</sup> @ 7:00 A.M.

## 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
CART	CMS Abstraction and Reporting Tool
CCLHO	California Conference of Local Health Officers
CDIF	<i>Clostridium difficile</i>
CDPH	California Department of Public Health / Department
CLIP	Central Line Insertion Practices
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
ICP	Infection Prevention and Control Professional
ICU	Intensive Care Unit
IHI	Institute for Healthcare Improvement
JAMA	Journal of the American Medical Association
L&C	Licensing and Certification
LIP	Licensed Independent Practitioner
MRSA	Methicillin-Resistant <i>Staphylococcus aureus</i>
MSSA	Methicillin-Sensitive <i>Staphylococcus aureus</i>
NHSN	National Healthcare Safety Network
NICU	Neonatal Intensive Care Unit
OR	Operating Room
PICC	Peripherally Inserted Central Catheters
PSC	Patient Safety Committee
RN	Registered Nurse
SA	<i>Staphylococcus aureus</i>
SB 1058	Senate Bill 1058
SB 158	Senate Bill 158
SB 739	Senate Bill 739
SCIP	Surgical Care Improvement Project
TB	Tuberculosis
UVC	Umbilical Venous Catheter
VAP	Ventilator-Associated Pneumonia
VRE	<i>Vancomycin-Resistant Enterococcus</i>