

Healthcare-Associated Infections Advisory Committee (HAI AC)
July 8, 2010, 10:00 a.m. to 3:00 p.m.
Location: Sacramento

MINUTES

Attendance

Members: Kim Delahanty (Chair), Mike Butera, Ray Chinn, Alicia Cole, Enid Eck, AnneMarie Flood, Lilly Guardia-Labar, Michael Langberg, Tom Jackson, Brian Lee (alternate), Mary Mendelsohn, Lisa McGiffert (alternate), Carole Moss, Rehka Murthy (alternate), Terry Nelson, Shannon Oriola, Debby Rogers (alternate), Todd Stolp, Jonathan Teague, Dawn Terashita, Francesca Torriani, Kathy Wittman, David Witt

Guests: Rebecca Cederi, Tamar Foster, Hattie Hanley, Holly Harris, Tina Menasian, Roberta Mikles, Daniella Nunez, Michelle Ramos, Sayd Sayeed

CDPH Staff: Kathleen Billingsley, Jon Rosenberg, Sam Alongi, Melissa Anastasio, Sue Chen, Roberto Garces, Mauro Garcia, Lynn Janssen, Cheryl Kalson, Kavita Trivedi, Carol Turner

Agenda Items/Discussion	Action/Follow-up
<p>Call to Order and Introductions HAI AC Chair Kim Delahanty convened the meeting.</p> <p>Introductions were made at Sacramento and on the teleconference lines.</p> <p>Thank you all for joining us today.</p>	
<p>Approval of Minutes Chair called for approval of the May 27, 2010 meeting minutes.</p> <p>Motion (Flood) – Move to approve the May minutes Second - Eck</p> <p>Discussion [Minor edits noted by Eck; these were passed on to staff to update the May 27 meeting minutes.]</p> <p>All ayes; Motion passed</p>	<ul style="list-style-type: none"> • HAI Program staff to post revised and approved minutes from May 27, 2010 meeting.
<p>Public Story Alicia Cole Ms. Cole shared her experience in acquiring a HAI after having surgery in August 2006. Ms. Cole described the long term effects that her HAI has had on the quality of her life including constant pain, the inability to work even four years after the HAI, and medical care still necessary several times per week.</p> <p>Ms. Cole recalled numerous unsanitary practices she witnessed in her hospital both for the initial surgery as well as during her hospitalization for the HAI. She noted that even though the hospital has been repeatedly cited for unsanitary conditions in their operating rooms and for failing to adhere to their own infection control policies and procedures, a review of</p>	

<p>infection reporting available on several web sites all reported “no data” in the infection control/patient safety section since reporting is done voluntarily.</p> <p>Ms. Cole urged for mandatory public reporting and the need for transparency.</p> <p>Discussion</p> <p>Moss – Alicia is here to speak for those who did not make it. The importance of getting this information quickly is life saving.</p> <p>McGiffert - Would like to put it in the parking lot for the Committee to discuss the implementation of the requirements in the law to give patients notice and information. One of the things not clear is how CDPH is ensuring these policies of notifying patients when they have infections and giving them information are being followed through with.</p> <p>Chair – Thank you Alicia for your strength and bravery. We are all here to do what we can to make hospitals safer.</p>	
<p>Proposed Change in Subcommittee Rules</p> <p>Chair - Chair read the Proposed Change in Subcommittee Rules document [this handout is available on the HAI AC website]</p> <p>McGiffert – Please distribute the document to the group.</p> <p>Chair – CDPH will post it on the HAI AC website.</p> <p>Langberg – Point #4 assumes that the way a quorum can be created is only by conference call; is that the intent? It seems a quorum ought to be whether a person is participating in person or by conference call.</p> <p>Chair – Correct; a quorum of a subcommittee must be in attendance of the subcommittee meeting whether in person or by conference call.</p> <p>Langberg – Given the confidentiality issues mentioned here, what are the rules regarding audio or video taping of the meetings and the use of those tapes?</p> <p>Chen- HAI program staff puts out minutes with the assistance of the subcommittee Chairs. There is no taping or audio except by HAI program staff in the subcommittee meetings; these are used only to put together summaries of the subcommittees’ proceedings.</p> <p>McGiffert – Would the tapes be retained if there was a challenge on the veracity of the minutes being produced to the Committee?</p> <p>Alongi – Yes, until the minutes are approved by the full Committee.</p>	<ul style="list-style-type: none"> • HAI Program to post revised Subcommittee Rules on HAI AC website.

Langberg – Audio taping is only done by staff for the purpose of creating and validating minutes? Can any of us tape the full Committee meeting if we wish?

Alongi – Yes; Committee meetings are public and may be taped by anyone attending the meeting.

Witt – If staff can record a subcommittee meeting, there is no reason to preclude anyone else from recording it.

Flood – Open sharing of ideas is the intent behind the “no recording” idea. If people wish to tape or record for their own personal use, that may be appropriate. Recordings should not be shared in a public forum.

McGiffert – If something is decided in the subcommittee and is submitted to the full Committee, the full Committee is entitled to a full vetting of the issues discussed. If the subcommittee conversation is deemed confidential, no one will be able to talk about it. Issues will arise that will require the full Committee to know some of the discussion that occurred in the subcommittee. These rules are saying those subcommittee members can’t talk about it; it is confidential?

Chair – The (Proposed Rules) says, “this is to further clarify that subcommittee meeting content is to be handled as confidential *until* reported by the subcommittee Chair to the full Committee.” At that point, it is open for discussion.

Eck – A clarification that may be helpful in rule #4 is by adding on a (d) that spoke to a topic on which there was inability to reach consensus.

Nelson – To the effect “If the consensus cannot be achieved, the discussion, recommendation and vote count would be brought forward.”

Teague – Have these rules been reviewed by counsel?

Rosenberg – No; under Bagley-Keene subcommittees are informal working groups that the HAI AC has created to aid in moving the process along.

Moss – To clarify, representatives on the subcommittees that are representing hospitals cannot go back and share the discussion of what went on in the subcommittee?

Chair – Correct; until it is presented to the HAI AC. Once it has been presented here, it is public under Bagley-Keene.

Motion (Oriola) - Move to approve the revised guidelines for subcommittee meetings with the following two changes:

- **# 4 - a quorum two-thirds of subcommittee members must be**

in attendance of the subcommittee to forward a recommendation to the full Committee.

- **#4-C- If a consensus cannot be achieved, the discussion, the recommendation and the vote count would be brought forward.**

**Second - Eck
Discussion**

Hanley – Has this been cleared with the Attorney General’s office because it does seem to be a different intent than the Bagley-Keene?

Chen - The whole point behind this is to allow uncensored discussion in the subcommittees that cannot be taken out of context and potentially misused. That is why all subcommittees are less than a quorum; so information is not required to be shared. Subcommittee do not fall under Bagley-Keene.

Rosenberg – Subcommittees are not officially mandated meetings. Any member of the Committee can bring a subject matter to the Committee and ask for the Committee to consider the following information and make a recommendation based on that information. In the same sense, a member of a subcommittee brings the subcommittee’s information to the Committee to consider and make a recommendation under Bagley-Keene.

Billingsley – Jon’s point is the subcommittee structure exists outside Bagley-Keene; the concept moving forward is to establish a structure upon how the subcommittees should handle their responsibilities.

Witt – The purpose of a subcommittee permits us to work more efficiently but I have a vague discomfort in how it is phrased. The issue of confidentiality; to require it creates the image of a lack of transparency.

Rosenberg – You are right; ask instead of saying, “this is a rule.”

Nelson – This process that we are addressing right now is an example of how this all works. The subcommittee had an issue, they brought it up to the full Committee, and we are discussing it in open forum. It is not secretive; it is a way to get work done.

Chair – In addition to the motion the Committee would suggest two changes:

- **Change “subcommittee rules” to “guidelines”**
- **Change the last statement to read “this is to further clarify that subcommittee meeting content is recommended to be handled as confidential until reported by the subcommittee Chair to the full Committee.”**

[Revisions to Motion accepted by Oriola, Eck]

Labar – To make a point in a subcommittee discussion, it was important that I used examples from my hospital for the better good of the state of

<p>California. I would like it handled as confidential and not just a recommendation.</p> <p>Teague – The confidential information items you are talking about; is that information of patient privacy?</p> <p>Labar – No; it pertains to processes and procedures that may differ from other organizations.</p> <p>Witt – There is no statutory protection for confidentiality. There is no protection beyond courtesy. I recommend as keeping it as a courtesy among subcommittee members.</p> <p>[Chair reads revised motion] Majority ayes, four nays; Motion passed</p>	
<p>HAI Program Updates</p> <p>Rosenberg – The HAI Program is waiting for the final Human Resource’s approval to hire a Staff Program Analyst, a key position with moving forward with NHSN data. CDPH is interviewing for the Research Program Specialist, who will be working under the Staff Program Analyst.</p> <p>The other key vacancy is the Health Education Consultant which is being reclassified to an Associate Health Program Advisor. This position will become the principal program HAI AC liaison. This position will also handle the program’s outreach and messaging activities including education of the public in regards to reporting and infection prevention.</p> <p>The HAI Program has built itself up to nine full-time or part-time field IPs including refilling the Los Angeles’ position with a highly experienced and respected IP who will be beginning in August.</p> <p>Staff is in the very final stages of finalizing the 2008-2009 Employee Influenza Vaccination/Declination report that was presented in preliminary form in the previous HAI AC meeting. The report is entering the L&C clearance process. Staff is looking at all 2009 and Q1 2010 data that was collected in paper form and the data for CLABSI. The challenge with CLABSI data was there were already over 180 hospitals reporting some CLABSI in NHSN; an attempt to accommodate them by offering a combination paper and NHSN reporting was made. HAI Program staff is also initiating a data verification process; staff has identified 393 reporting hospitals and will do data verification on all 393, including those hospitals who do not have data and those who have data for some quarters but not all. For the 2010, April 1 onward NHSN data, HAI Program staff is working with hospitals to ensure the flow that has to happen from having monthly plan, data entry, and rights conferral allowing staff to verify what is there or potentially not there. This is a joint responsibility of the program’s epidemiology group and field IP group. The final stages of putting out a rudimentary program webpage will be done by the end of next week. The pages that follow the homepage are under construction.</p> <p>From April 1- June 30, the field IP team consulted with 87 hospitals, 43 LHOs, and every local chapter. The HAI Program collaborated with CHA to put out a joint letter to all on their list which includes all member</p>	<ul style="list-style-type: none"> • HAI Program to have the HAI webpage up and running by August 1, 2010. • CDPH L&C to email Cole (mizcole2@aol.com) the job description for the liaison position. • Staff to collect membership information for <i>C diff</i> subcommittee • Staff to assist <i>C diff</i> Subcommittee Chair in scheduling <i>C diff</i> Subcommittee meetings • HAI Program to email Committee members the survey and article for NHSN definitions (as shared by Flood).

hospitals' CEOs.

Rogers – We also sent the joint letter to all the Quality Directors and IPs that we have on different lists.

Rosenberg – The letter was an introduction to the HAI Program, the program's general goals and objectives; an introduction to the ARRA grant; and that there are field staff who are in the process of exchanging information with hospitals statewide.

Cole – May I get the job description and requirements of the Associate Health Program Advisor? (Rosenberg – Yes)

Wittman - To follow up on who received the letter, I got it forwarded from my CEO; the letter *is* getting out there.

Chen – Staff will send it out to the members of the Committee.

Rosenberg – The field IPs are in the process of assisting local hospitals' IPs by assessing and making recommendations for successful intervention strategies to reduce HAIs; assisting in all the necessary steps in NHSN to submit the required data using a program information exchange; and working with hospitals in their assigned counties to better understand their infection control infrastructure surveillance activities and priorities. Each of the field IPs is responsible for approximately 60 hospitals.

Jackson – Do you know how many hospitals have been visited?

Rosenberg – Eighty seven.

Janssen – That includes any hospital that needed consultation as well as those that received the initial visit.

Rosenberg – Correct; most, but not all, were onsite visits.

Murthy – At the previous meeting, there was a question raised for discussion about the LabID Reporting Module being introduced for *C diff* and MDRO. The decision for the AFL to have hospitals use the LabID even though many hospitals are probably doing surveillance for nosocomial *C diff* and MRSA; does this take into account testing differences between facilities or even the definition being used?

Chen – An IP did a survey on how many definitions were out there and in that one chapter there were seven different definitions of *C diff* infections being reported to CDPH. The decision to use LabID is to make the definitions consistent and also in anticipation by the end of the year, NHSN will be coming up with an electronic transfer methodology where the data goes directly from the lab into NHSN.

Rosenberg – If the clinical surveillance is used according to NHSN rules, the numbers should not differ.

Murthy – It may; versus PCR testing, in hospitals that have studied it, there is a 20% difference.

Rosenberg – There is no difference whether you use clinical surveillance or laboratory surveillance; NHSN criteria are still a positive test for patients who have signs and symptoms consistent with disease. If it is a work load issue, HAI AC can discuss that.

Motion (Murthy) – Move to create C diff subcommittee
Second – Witt
Discussion

McGiffert – To be clear, the purpose of this subcommittee is to establish a standardized method for reporting *C diff*?

Chair – As I understand, there is some disparity in the definition and reporting of *C-diff*, so the *C-diff* Subcommittee is going to research the issue and make recommendations for a standardized reporting methodology.

Majority ayes, two abstentions; Motion passed

Chair – If you would like to be on the *C diff* Subcommittee, please contact Sam, Sue, or myself.

Motion (Eck) – Move to appoint R. Murthy as Chair of the C diff subcommittee
Second – Nelson
Discussion
All ayes; Motion passed

Terashita – The way HAI data is being reported is quite different from the way things have been reported historically. Usually things are reported to LHDs, then to the State and on to the CDC. This is going backwards; it is going to the CDC first. The State has a mandate so the State gets the data but the LHDs are fighting to even get the data. Does CDPH have concerns regarding LHDs getting NHSN data; would the HAI AC consider putting out a statement saying that LHDs could get NHSN data while putting in some protection saying this data cannot be published by the LHDs before the State does its publishing?

Rosenberg – We cannot set rules without statues or going through regulations. LHDs could potentially have a local ordinance saying this. There may be precedents out there.

Oriola – In addition to the testing differences in *C diff*, for those that don't do surveillance, Dawn (Terashita) is correct about healthcare onset and

the definitions. But what the NHSN methodology misses are those patients that have been in skilled nursing facilities, long term acute facilities or other acute care facilities. The assumption is the patient comes in and on day three of being on an antibiotic now has diarrhea and that hospital is going to have to put on their billboards that the *C diff* happened at their facility, when it could have been from another healthcare facility. There are distinctions between healthcare *associated* verses healthcare *acquired*; I hope the *C diff* Subcommittee will make a clarification.

Rosenberg – That would also go to the Metrics Subcommittee.

Chinn –It goes back to the intent of monitoring *C diff*; if it is just to see the HAI number then fine. But if you are going to hold hospitals accountable, there are significant issues with that. We need to know the intent of the reporting.

Eck – The intent of public reporting legislation is to equip the public with information that would allow them to make choices about where they get their healthcare. The concern from a health agency perspective, if there are multiple mechanisms in which technically the same data is published but under different assumptions or definitions, how is the public going to be equipped to make informed decisions? The differences are a disincentive for transparency. That is a discussion for the Metrics Subcommittee to participate in. Transparency is critical and the data has to be valid for it ultimately to be meaningful to the public.

Stolp – To follow up on the question about precedence in reporting to the State bypassing LHDs, yes there is precedent; West Nile Virus testing went directly to the State, and eventually was returned to LHDs. In investigations, LHDs *can* require reporting in their jurisdiction to facilitate their investigations of outbreaks. Is it not reasonable for LHDs to obtain that information from the website that displays the public information? I think I heard the word about a delay and that may be the reason there is an issue.

Terashita – One of the issues is delay. In LA, we hope to get the data to be able to troubleshoot; to see trends in areas of our community. Hopefully LHDs can work something out where we talk to our hospitals and get them voluntarily to confer rights to us.

Chen – There was a presentation recently at the California Communicable Disease Control meeting on the HAI Program. One of the issues mentioned in the feedback from that meeting is that LHOs are sometimes so overwhelmed with the other issues that HAIs are not high on their priority list. One of the things both Todd (Stolp) and Dawn (Terashita) can help us with is how do we integrate what the HAI Program is doing out into the community

<p>Stolp – One of the primary objectives of every LHO is getting information that can benefit the public health as quickly as possible into the heads of the public. Jon (Rosenberg) has done a great deal of that with his presentation of the HAI Program to a number of CCHLO committees and subcommittees. That ongoing representation has already raised the profile of HAIs.</p> <p>There is a reluctance of physicians to devote a lot of effort to attack a problem unless a solution seems within reach. Emphasizing the benefits of the program and steps to be taken to resolve HAI problems in those facilities that have statistics they would like to improve is critical part of the message.</p> <p>Lee – The <i>C diff</i> concern brought up the issue of comparable reporting; comparable reporting with CLABSI reporting is another difficult challenge. Depending on how the NHSN definition is interpreted, a particular infection may or may not be reported as a CLABSI.</p> <p>Witt – There is a disparity between the purpose of state reporting and the purpose that a LHO would have. Although a LHO would love to get the data, mandated reporting is really designed for a different purpose. To comment on Brian’s issue, part of reporting is the auditing function, the validation. If we do things poorly, we create opacity. When we look at our recommendations from the Committee and the subcommittees, we need to have some sort of validation function.</p> <p>Flood – There is an article in AJIC this month that speaks to the concerns about how to use NHSN’s definitions. There is also a survey associated with this piece. [Link to be provided on HAI Program website]</p> <p>Cole – In regards to the transparency in the collection of the data, it is extremely important when we are doing the education component for the public that we do everything we can to encourage the public that they can report their own infections to the LHD.</p>	
<p>NICU Data Rosenberg-[Handout provided on HAI Program website]</p> <p>Lee – One of the challenges we struggle with when the law came down about surveillance testing is trying to figure out what site to culture. Nares are the primary site of culture in the adult-world, but in the pediatric population, especially neonatal, culturing the nares results in missing a fair percentage of colonization. Testing the rectum increases your positivity rate; testing the umbilicus increases your positivity rate. One question that doesn’t seem to have been asked of these hospitals is what site did they culture?</p> <p>Chen – There were a lot of questions on that particular issue. The law</p>	<ul style="list-style-type: none"> • HAI Program to email committee members NICU data handout and post on Program website.

does not say where to culture but the law does not say where not to culture.

Rosenberg – I believe the vast majority of them did only cultured nares.

Moss – It is important that whatever is presented to the Committee be posted.

Rosenberg – Documents presented to the Committee will be posted as soon as the minutes for that particular meeting are approved.

Chen – The document was attached to the email that came out with the meeting minutes. It was there for review and it will be posted now because the minutes have been approved.

Nelson – Are you aware of any studies that would indicate of what the curve looks like in colonization?

Rosenberg – Those studies have been done for *staph aureus*. Babies become colonize mostly with their mom's staph very quickly in the first week of life so there is a very high prevalence of colonization. It would be reasonable to think that if the mom is colonized with MRSA there would be a similar, rapid rate of colonization. But I don't think studies have been done in the community for MRSA yet.

Lee – Community MRSA has a different pattern especially in pediatrics. A study was done where kids were admitted with Staph abscesses. Cultures were compared to controls that did not have Staph abscesses. The rate of colonization in the nose was pretty much the same. But the rectal colonization was significantly higher in the patients with Staph abscesses. There is a different pattern with community MRSA; now that we are required to do surveillance testing, the nares just may not catch all the colonization that we are looking for.

Rosenberg – MRSA colonization in the general population is about 1.8%. If moms are the only source of colonization, over time that percentage perhaps would lower but very few of those are going to be positive in the first 24 hours that SB1058 mandates the baby be tested in.

Murthy – To clarify the methodology, the denominator is all admission to the NICU?

Rosenberg – They are tested; we don't know if 100% of babies born in the hospital and admitted to the NICU were tested. The assumption is that the facilities complied with the law.

Murthy – Is there analysis on whether hospitals reported all the admissions?

Rosenberg – No; we just asked the facilities to state the number tested and the number positive.

Oriola – Thank you for including the article; it really shares our experience. This is not a cost effective intervention to control or prevent the spread of MRSA; it does not have a yield.

Motion (Oriola) – Move to request CDPH to review the current interpretation of who meets the definition (inborn is infants born into a facility and transferred directly to the NICU; excepts infants born and then transferred to an outside NICU) and request the State to discontinue requiring testing of inborns within the first 24 hours of life for this specific population

Labar – I understand the rationale; but as a receiving hospital, I say this helps receiving hospitals. When the hospital understands there is a positive culture coming to our neonatal; it protects other babies in the unit.

Rosenberg – The law only mandates at 24 hours. Do you know how many positive babies you received that were tested in the first 24 hours?

Labar – I was tracking it for some time when this law first started. Within the first 24 hours it is a small percentage; nonetheless if it is just 1 out of 300 that is important to know to isolate and care appropriately.

Oriola – That is why JCAHO requires hospitals, when transferring a patient positive with a MRSA, communicate that information with you.

Labar – But the motion is to not test at all?

Oriola – No; we do test, we had MRSA in my unit, and we do communicate 100% of those to the children’s hospitals when we transfer but those were not positive within the first 24 hours of life. For this intervention, it is not helpful in reducing the transmission or spread when you have a zero. You have to look at the yield of what you want to do in the overall scheme of things.

Labar – Are you basing your recommendation on this handout?

Oriola – And my experience, yes.

Rosenberg – The study shows that six out of 7,997 tested positive for MRSA in the first three days of life.

Restates Motion (Oriola) – Move to request CDPH to review the current interpretation of who meets the definition (inborn is infants born into a facility and transferred directly to the NICU; except infants born and then transferred to an outside NICU) and request the State to discontinue requiring testing of inborns within the first

24 hours of life for this specific population.

**Second – Murthy
Discussion**

Murthy - If it is agreeable with Shannon, I would like to amend the motion to indicate targeted screenings in high-risk infants as the language of the law indicates. This is an area with limited data.

Chair – For the motion, you are only making the motion on inborns within your facility; that you would still be doing active surveillance testing on transfers from other facilities? These are two different populations; the motion is about inborns born within your facility and then transferred to NICU. Any baby who is being transferred from one facility to another facility NICU is still being screened?

Oriola – Yes; that would be the targeted, high-risk population so we don't need to amend the motion.

Wittman – I'm trying to understand your concern. If you are receiving a baby from me, you would have to screen that baby on arrival, true?

Labar – Yes.

Wittman – So you would not be losing the screening information; I am not sure where the concern is.

Labar – Because if the baby is screened in another hospital, we can prepare appropriately for when that baby is admitted to us.

Rosenberg – What do you do with the other 99% plus of babies transferred? Do you screen everybody on admission?

Labar – Yes.

Rosenberg – What do you do with those babies until you get the test results? What do you do differently from those that you know are positive?

Labar – The ones that we know are positive, we are ready to treat appropriately in those three days we normally wait for the culture.

Wittman – When I receive someone and have to screen, I assume they are positive until it is ruled out; those precautions are already being taken. I am trying to understand your concerns (to Labar). It is a lot of money that I would like to have designated elsewhere.

Labar – It is important to know what the organism is so the baby is not compromised.

<p>Lee – From a cost effective standpoint, it is a burden and I can understand why you would not want to do those cultures for such a low yield. My only concern is this is not enough data; things are changing with community MRSA and there may be new information that comes out.</p> <p>Eleven ayes, three nays, four abstentions; Motion failed.</p> <p>[break for lunch]</p>	
<p>Antibiotic Stewardship Subcommittee Report</p> <p>Witt – The subcommittee discussed and agreed on several general issues:</p> <ol style="list-style-type: none"> 1. Antibiotic Stewardship is proper use, use when indicated, and for the proper duration. 2. The guidance of this Subcommittee (and subsequently the Committee) should be evidence-based where possible. 3. Antibiotic Stewardship needs to be a mandated activity, needs regulation to get over inherent budgetary inertia in funding the issue, requires negotiating solutions with health care providers, and requires some incentive for hospitals to actually do this. 4. Strong enforcement is required. <p>The first important monitoring would be outcome measures. Dr. Trivedi has a group of experts forming a Metrics Subcommittee [outside the HAI-AC] to discuss Antibiotic Stewardship (AS); this subcommittee is waiting to get the report from the AS Metrics Subcommittee and will use what is adaptable.</p> <p>The other metric indicated is process. The Subcommittee agreed there should be some demonstration of capability in the field. For those that are not trained formally either as an infectious diseases pharmacist or an infectious diseases clinician, there needs to be a training program via a certification program; there are discussions taking place on exactly that will constitute. The Subcommittee is in consensus to expand this where possible into long term care facilities. To do this within the context of acute care hospitals and ignore the feeders for antibiotic resistance would be futile. The Subcommittee is going to meet again after receiving the AS Metrics Report to formalize the recommendations.</p> <p>Butera –As a CMA representative I remind everyone there are models out there to take a look at the IP role, the pharmacist’s role in antibiotic stewardship.</p> <p>Witt – Where it becomes difficult is in the multiple small hospitals that do not have an ID staff. The hesitation is: can you train the one general surgeon you have there to serve this function?</p> <p>Oriola – To clarify, the AS Metrics Subcommittee is going to be discussing measurement around some of the antibiotics that might be suggested for surveillance?</p>	<ul style="list-style-type: none"> • HAI Program to email Committee members the language for antibiotic stewardship legislation (HR1549 and SB619) and sample endorsement letter. • Eck, Stolp, and Witt will draft a letter of support addressed to the legislators who submitted HR 1549 and S 619. This draft will be presented at the next full meeting of the HAI AC on August 30.

Witt – The AS Metrics Subcommittee deals with the complex issue of *what* gets measured; the Antibiotic Stewardship Subcommittee chose not to discuss this issue.

Oriola – Another clarification, you mentioned long term acute care and skilled nursing; would that in the offering be an option or be required?

Witt – Looking at long term care, the question is: where does the authority of the Committee go and where does the authority of the CDPH go? From the Subcommittee’s viewpoint, they should be inextricable.

Eck- One of the other things the HAI AC previously talked about is the wide use of antibiotics within the food supply. Was there any discussion on how the Committee could go upstream from an epidemiological perspective and look at other agencies within the State to consider this?

Witt- No; we have not examined it. The Subcommittee can put it on the agenda; it would be a good topic.

Eck- It really is not within the Committee’s scope. But, the Committee is in a unique position to make the case, shine the light on it, and identify whose scope it is within.

Rosenberg- There is a lot of activity at the federal level on this; I will look into the issue of federal preemption over the State’s authority over the use of antibiotics in agriculture. With all the environmental groups active in California, not having seen any pressure on the State to regulate the use of antibiotics makes me suspect there is a federal preemption.

Stolp- HR 1549, the Preservation of Antibiotics for Medical Treatment Act, continues to be moving through the House. And S 619 is the mirror bill in the Senate. So there is still active federal legislation that is being scrutinized that evidently does have some preemptive influence.

Eck- In the past, the Committee has sent letters speaking in support of different initiatives that were ultimately in support of improved patient care. Could the Committee send communication in support of the passage of HR 1549 and S 619?

Motion (Eck) – Move to draft a letter to each of the authors of HR 1549 and SB 619 expressing the Committee’s support for those pieces of legislation and urging their passage. This draft letter will be presented at the next full HAI AC for consideration.

**Second – Stolp
Discussion**

Butera –The sponsors will certainly be happy to have the Committee’s endorsement. But is it in the power of the charge of this Committee?

<p>Chair – The Committee can vote on the motion and CDPH can weigh in because it would really be a collaborative of the HAI AC along with CDPH’s endorsement to write the letter.</p> <p>Witt – If it is acceptable, that would be fine. But the Committee is autonomous from the CDPH; we certainly have authority to write a letter.</p> <p>Rosenberg – The CDPH HAI Program would be precluded from signing on that letter.</p> <p>Motion (Eck): Move that the HAI AC draft a letter to each of the authors (for HR 1549 and S 619) expressing our support for those pieces of legislation and urging their passage.</p> <p>Second—Stolp</p> <p>Labar – My concern is that I haven’t read these pieces of legislation so we are being asked to vote on something I have not seen presented to the Committee.</p> <p>Stolp – If HAI AC would like a delay in the sending of the letter until the Committee has a chance to review it, I would not object to that.</p> <p>Eck – I would not object to that at all; I assumed it would have to come back to the Committee for approval.</p> <p>Majority ayes, one nay; Motion passed</p> <p>Note: Eck, Stolp, and Witt will collaborate in drafting the letter.</p> <p>Note: Rosenberg will email a sample endorsement letter to members of the committee.</p> <p>Note: Stolp will email copies of the language of the HR 1549 and S 619 legislation to Witt and Eck.</p>	
<p>Public Reporting/Education Subcommittee Report</p> <p>Moss – The Subcommittee has built groups as follows:</p> <ul style="list-style-type: none"> • Customer Focus Group (led by Cole), on how to explain the data to consumers; how to interpret and use the presented data. • Patient Centered Messaging Group (Cole), on messaging prospective patients; what one can do to aid in the prevention of infections before going into the hospital. • Clinician Focus (Myers), on how to present the data and the caveats to the healthcare professional. • Content and Visual Display of Data (Cole), on how the image is portrayed on the HAI website. <p>The Subcommittee will be adding additional groups dealing with public relations and the different ways we can optimize the website and its usefulness to the public. Once the HAI Program has completed its</p>	<ul style="list-style-type: none"> • Committee members to email links (to Cole) to any state’s HAI websites and attach information on why they are recommending this site for consideration. Links to be emailed to Cole at mizcole2@aol.com. • Committee members to email (to Flood) educational tools and samples of what

<p>timeline, the subcommittee will maintain an aggressive approach to meet the deliverables and commitments in the legislation. The Subcommittee gathered the data that was presented last year and is in the process of updating that flowchart. By the next HAI AC meeting, the Subcommittee will have a better idea for what the main goals are and what the subcommittee will have to do to meet the targets in the timeline.</p> <p>Cole – If any member of the Committee comes across a website that has really good educational materials and information or if you like the way the information is displayed, please send me a link and reasons why you like that particular website (mizcole2@aol.com).</p> <p>Flood – If there are educational tools in HAI prevention that anyone likes, please send those to me (aflood@coh.org).</p> <p>Moss – The subcommittee looks forward to everyone’s input.</p>	<p>particular information they are recommending for consideration. Links, tools and samples to be submitted to Flood at aflood@coh.org.</p>
<p>Influenza Reporting Subcommittee Report (3:35:11) Chinn – [presentation available on HAI website] Dr. Chinn’s slideshow presents the influenza subcommittee recommendations and describes options discussed for the three years of data (2008/09, 2009/10, 2010/11) under discussion.</p> <p>Motion (Chinn) – Move to approve the recommended format for 2008-09 reporting. Second – Eck Discussion</p> <p>Cole – When you talk about professionals who were vaccinated elsewhere, is there any way of validating? Do they have to bring in documentation or is it on the honor system?</p> <p>Chinn – The honor system.</p> <p>Eck – Given the challenges that we have with this data, this is the best we are going to do. By focusing on employees, recognizing that other groups were not clearly delineated, will allow us to do some comparisons between 2008/09 and 2009/10. There is so much of this that we are never going to have controls for; we need to face that and put it on the list of the limitations of the data.</p> <p>All ayes; Motion passed</p> <p>Motion (Chinn) – Move to approve the recommended format for 09-10 reporting. Second – Eck Discussion</p> <p>Nelson – Could you clarify the April 30 – July 1 grace period as that time period has already passed?</p>	

Trivedi – Yes, we just finished collecting that data; the grace period is over.

Witt – Is this is going to be divided by seasonal strain and H1N1 strain?

Chinn – Yes.

All ayes; Motion passed

Moss – The plan is to post the 2009 -2010 data to the HAI website by October 30?

Chair – Correct.

Moss – And we will have the 2008-2009 posted when?

Chair – Before October 30, 2010.

Chinn —For the 2010/11 season, we have divided the recommendation into two sections, employee and non-employee personnel. This first motion is referring to health care facility employees.

Motion (Chinn) – Move to recommend to CDPH the presented format for 2010-11 reporting for employees

Second – Nelson

Discussion

All ayes; Motion passed

The second part of the 2010/11 discussion involves the requirement for non-employees.

Nelson – With this category of non-employees, would we use the same date of March 31? The date is not phrased again in this section.

Chinn – Yes that makes it more consistent; we could articulate that.

Chen – This is predicated on assistance from the Medical Staff Office; how does that come into play because that has been a sticking point in hospitals?

Witt – To address that issue by mandating a process for them providing that data; I don't see the Committee doing that.

Chen – After two years of trying to explain this, this is better articulated than the first time around but is essentially in some of the outreach is the same. There is still going to be that confusion between who is considered “employee” and who is considered “healthcare personnel”. What was demonstrated at the previous HAI AC meeting is that when you use similar language and have it mean two different meanings, the common understanding and our special definition, it creates confusion that we have not yet been able to overcome.

Trivedi – The Subcommittee went over options and forms with hospitals. Do you know how many hospitals we got information back from?

Janssen – We received information back from 33 hospitals.

Trivedi – Half of them said they could do the group approach and the other half said they could do the patient care area approach. Everybody had different ways of going about this. One of them works in one setting while the other works better in another setting; we do not have a perfect answer. We just need to go with one way otherwise we will not get this information. Definitions we used are different in comparison to the other form. We did not use the CDC’s healthcare personnel definitions; we shortened it and made it more understandable. Our intent was pilot-test the form, see where our problems were, and then come up with a final form after testing.

Chinn – Once public reporting becomes available, it is guaranteed that hospitals will be paying attention to those. There is some traction there; we have to start somewhere. And for the public, they always ask why doctors are always excluded from initiatives.

Eck – I would be hesitant to dictate to the hospital how they have to get this data; what we need to say is you have to provide us with this data.

Labar – The subcommittee wanted some kind of documentation of immunization and attestation was one of the ways considered.

Flood – There are still three buckets: those vaccinated, those attesting to vaccination elsewhere, and unknown. In 2010/11 reporting, in the measurement of one hospital’s buckets against the hospital down the street’s buckets, that comparison will drive the process.

Butera – The statute requires reporting compliance by hospitals among employees and also healthcare personnel that require physicians be included in that. The point of public reporting of this endeavor is the fact that the aim is to have as many people vaccinated as possible that have contact with patients. If that is the aim, then healthcare personnel should include all physicians having patient contact, not just patient care areas. Our definitions need to be clear about what is required in terms of reporting for medical staff.

Chinn – Under the definition of healthcare personnel, that is captured.

Moss – If we just take the overriding theme of all healthcare personnel with patient contact as the title and then underneath it could list the details. Then they would know all healthcare personnel with patient contact will be required to check a box; there will not be confusion. That

is all the public wants to see; the results of those that have contact with patients.

Wittman – That is what we are trying to accomplish. From an operational perspective, we really do need to have the specifications listed in Option 1 where it states we have a Medical Staff Office which is going to be our guiding light to ensure physicians have the attestations. Our challenge from the hospital's operational perspective is getting that data for the non-employee.

Garcia – The contract employees are going to be the hardest part for the hospitals.

Chinn – That is why we asked for a separate way of doing it; we asked all contract agency registries to write in their contracts that anyone who comes into the hospital fulfill the requirement. That is the best you can do with the contracts and still catch this whole pool.

Eck – Contract employee agencies can be audited.

Witt – To clarify, Option 1 is talking about a targeted, subset of the medical staff?

Chinn – No; what we discussed in Subcommittee was the question of all LIPs and IPs defined as healthcare personnel verses targeting them. The group felt targeting them would be too difficult.

Nelson – Carole (Moss) made a statement about only collecting data on only those healthcare personnel that had patient contact because that would be simpler. In my experience, to make that division and let them *decide* if they have patient contact or not makes it very complicated.

Janssen – To be clear, you would ask the contract agencies to sign an attestation that they have vaccinated all their contract employees?

Chair – Yes, that they have had a vaccination or have a signed declination on file.

Janssen – In the rates of reported individual hospitals, they will not be included?

Chair – Correct.

Chinn – Not in the denominator or numerator of vaccinations reported.

Motion (Butera) – Move to recommend to CDPH the presented format for 10-11 reporting for non-employee healthcare personnel under option #1
Second – Flood

<p>Discussion</p> <p>Eck – Terry had proposed putting in March 31 but I do not think we should, particularly for the contract registry; the registry should have information on everybody they send.</p> <p>Nelson – Then hospitals could take any time during the year to make that audit?</p> <p>Eck – Yes; we do not need the date.</p> <p>Chair – The motion does not include a date.</p> <p>Nelson – Did the motion designate procedurally how to reach medical staff?</p> <p>Chair – No; health care facilities can select for themselves how they operationalize this.</p> <p>Flood – Registry is required by Aerosol Transmissible Disease Standards to take care of their employees for Aerosol Transmissible Diseases; auditing can be easily done for that subset.</p> <p>Wittman – Speaking from the operational perspective, we need the March 31 date so we know by March 31 anyone on the medical staff roster as of March 31 is included in the report for 2010-11.</p> <p>Chinn – Suggest putting the date on the LIPs and the volunteers and leave the contract employees alone?</p> <p>Chair - In addition to the motion the Committee proposes two changes:</p> <ul style="list-style-type: none"> • Adding the date of March 31 to LIPs • Adding the date of March 31 to volunteers <p>[Revision acceptable to Butera and Flood]</p> <p>Chen – When you say “require hospitals to provide along with data or attestation confirming they required all of their employment agencies to get this data on all of their personnel” and then they sign “yes” or “no”?</p> <p>Chinn - Yes</p> <p>All ayes; Motion passed</p>	
<p>Metrics Subcommittee Report</p> <p>Chinn – [presentation available on HAI website]</p> <p>Moss – The Metrics Subcommittee will be working with the Public Reporting subcommittee; are there things the Public Reporting Subcommittee needs to get from the Metrics subcommittee in order to get</p>	<ul style="list-style-type: none"> • Public Reporting subcommittee and Metrics subcommittees will coordinate timelines and information to ensure that crosscutting issues are included in

<p>the timeline together?</p> <p>Chen – The most important information that needs to be coordinated is to begin the educational material that will go around the specific types of data reported. The subcommittees do not need the specific data to get that process started; specific data is only needed for fine-tuning.</p> <p>Chinn – Other than Influenza Reporting, there has not been much movement in the Metrics Subcommittee; it is still in the exploration stage.</p> <p>Moss –January 1, 2011 is getting closer.</p> <p>Chinn – The Metrics subcommittee is trying to work on the CLABSI Infection Reporting.</p> <p>Chen – There are other areas, like Patient Centered Messaging, that are not dependent on any other subcommittees to start on.</p> <p>Moss – That is information that is not in the legislation; that is an <i>enhancement</i> to what we are required to deliver. The priority needs to be what is required to be delivered in order to meet the January 1, 2011 deadline.</p>	<p>timelines and that timelines all match to January 1, 2011 rollout</p>
<p>Action Items</p> <ul style="list-style-type: none"> • HAI Program to have the HAI webpage up and running by August 1, 2010. • CDPH L&C to email Cole (mizcole2@aol.com) the job description for the liaison position. • Volunteers interested in the <i>C diff</i> subcommittee should notify Chen, Delahanty, or Alongi or their interest to participate. • HAI Program to email Committee members the survey monkey for NHSN definitions (as shared by Flood). • HAI Program to email Committee members the language for antibiotic stewardship legislation (HR1549 and SB619) and sample endorsement letter. • Eck, Stolp, and Witt will draft a letter of support addressed to the legislators who submitted HR 1549 and S 619. This draft will be presented at the next full meeting of the HAI AC on August 30. • Committee members to email links (to Cole) to any state’s HAI websites and attach information on why they are recommending this site for consideration. Links to be emailed to Cole at mizcole2@aol.com. • Committee members to email (to Flood) educational tools and samples of what particular information they are recommending for consideration. Links, tools and samples to be submitted to Flood at aflood@coh.org. • Public Reporting Subcommittee and Metrics Subcommittees will coordinate timelines and information to ensure that crosscutting issues are included in timelines and that timelines all match to January 1, 2011 rollout. 	<p>Detailed listing of Action Items at left.</p>

Next Meeting: ~~Monday, August 23, 2010~~
Note: Meeting was subsequently changed per online vote to August 30, 2010.

Chair - HAI AC will look into the possibility of the August meeting being held in San Diego. Thank you everyone for your time and commitment.

Meeting Adjourned

Acronyms

AFL	All Facilities Letter
AJIC	American Journal of Infection Control
APIC	Association for Professionals in Infection Control and Epidemiology
ARRA	American Recovery and Reinvestment Act
CDC	Centers for Disease Control and Prevention
C-diff	<i>Clostridium difficile</i>
CDI	<i>Clostridium difficile</i>
CDPH	California Department of Public Health
CHA	California Hospital Association
CHQ	CDPH Center for Healthcare Quality
CID	CDPH Center for Infectious Diseases
CLABSI (BSI)	Central Line Associated Bloodstream Infections
CLIP	Central Line Insertion Practices
CMS	Centers for Medicare and Medicaid Services
GAC	General Acute Care Hospital
HAI	Healthcare Associated Infections
HAI AC	Healthcare Associated Infections Advisory Committee
HICPAC	Healthcare Infection Control Practices Advisory Committee
H1N1	H1N1 Pandemic Influenza
HSAG	Health Services Advisory Group
ICU	Intensive Care Unit
IP	Infection Preventionist
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MRSA	<i>Multiple-resistant staphylococcus aureus</i>
NHSN	National Healthcare Safety Network
PPO	Preferred Provider Organization
QIO	Quality Improvement Organization
SCIP	Surgical Care Improvement Project
SIR	Standardized Infection Ratio
SSI	Surgical Site Infection
VRE	<i>Vancomycin-resistant enterococci</i>