

Healthcare-Associated Infections Advisory Committee Meeting
August 30, 2010
San Diego, California 10:00 a.m. to 3:00 p.m.

Attendance:

Members: Kim Delahanty (Chair), Mike Butera, Ray Chinn, Enid Eck, AnneMarie Flood, Dan Gross, Lilly Guardia-Labar, Michael Langberg, Mary Mendelsohn, Lisa McGiffert (alternate), Carole Moss, Rehka Murthy (alternate), Terry Nelson, Shannon Oriola, Debby Rogers (alternate), Todd Stolp, Dawn Terashita, Francesca Torriani, Lisa Winston, David Witt

Guests: Kelley Boston, Barbara Goss-Bottorf, John Bradley, Jack French, Brenda Hann, Lily Hu, Pat Inglett, Vicki Keller, Tracy Lanier, Roberta Mikles, Teresa Nelson, Daniella Nunez, Cynthia O’Keefe, Shilla Patel, Kerry Schultz, Reggie Smith

Staff: Kathleen Billingsley, Sam Alongi, Becky Siiteri, Sue Chen, Roberto Garces, Tricia McLendon, Sayd Sayeed, Kavita Trivedi

Agenda Items/Discussion	Action/Follow-up
<p>Call to Order and Introductions HAI AC Chair Kim Delahanty (Chair) convened the meeting.</p> <p>Introductions were made at Sacramento and on the teleconference lines.</p> <p>Thank you all for joining us today. Special thank you to Sharp Healthcare for hosting this meeting today, as well as for providing lunch and refreshments and the teleconference equipment for this meeting.</p> <p>Please take a moment to review the minutes from the July HAI AC meeting.</p> <p>Motion (Witt)—Move to accept July 2010 meeting minutes (with minor edits provided to staff).</p> <p>Second—Labar</p> <p>Discussion—None</p> <p>Motion Passed by unanimous ‘aye’ vote.</p> <p>Review of Rules of Order Chair briefly reviewed the active rules of order used by HAI AC, including following the queue and respecting speaker opinions, as well as limiting comments to two minutes and not repeating statements which have already been made.</p> <p>Note that there will be public comment after each topic today.</p>	<ul style="list-style-type: none"> HAI Program to send a Thank You letter to Sharp Healthcare for hosting the meeting, providing phone and computer setups, and for providing lunch and coffee.
<p>Public Story Presenter was unable to attend. Public story will be resumed at the next full HAI AC meeting.</p>	

<p>Bagley-Keene Open Meeting Act Review (Chen)</p> <p>[Please refer to the handout sent to email list regarding the Bagley-Keene Open Meeting Act (Act).]</p> <p>Chen—The Act was amended in 2010. All meetings of the HAI AC including subcommittees—if created by formal action of a State body or any member of the state body that consists of three or more members—are subject to the Act.</p> <p>CDPH legal counsel has confirmed that creation of a subcommittee constitutes a formal action, thus HAI Committee meetings as well as all subcommittee meetings are open and allow for public comment. These rules do also apply to teleconferences. The meeting or teleconference date and agenda must be posted ten days prior to the meeting. There must be opportunity for the public to address the body and all votes taken on a teleconference must be polled (recorded by name).</p> <p>Further details provided regarding the recording of meetings, which is allowed, and voting without a quorum: Meetings may be recorded by any attendee, so long as the act of recording is not disruptive to the proceedings of the meetings. If CDPH records the meeting, it is subject to the public records act, but recordings may be erased after thirty days. Also, members attending a Committee meeting via phone from a location that has not been posted ten days in advance do not have voting rights.</p> <p>Materials reviewed and/or issues discussed concurrently by more than two Committee members must be posted on the website within a reasonable timeframe.</p> <p>Overall, this will change the way we do things and will make the proceedings more open.</p> <p>Langberg— How are votes required for passage of motions tabulated; are abstentions counted as part of the total vote?</p> <p>Chen—Two-thirds of the voters present are required to pass a motion, so an abstention counts as a “no” vote as part of the two-thirds requirement.</p> <p>HAI Program Update (Chen): The website went live on August 6th with major links including legislation and AFLs, influenza information and education. The website is in its infancy and will continue to evolve.</p> <p>Beginning August 9th, six quarters of data—January 1, 2009 through June 23rd, 2010 was sent back to hospitals for verification and any needed corrections; CLABSI, <i>C. difficile</i>, MRSA and VRE bloodstream infections. Those forms are due back on September 3rd. The epidemiology unit will pull data on September 15th; this data will be analyzed and submitted in the six-quarter published report.</p> <p>Oriola— When you pull the data on September 15th will you be pulling NHSN data or the corrected data?</p>	<ul style="list-style-type: none"> • HAI Program to report to HAI AC members on the number of California hospitals which have conferred rights for NHSN. • HAI Program to send out to all HAI AC members the link to the HAI website. • HAI Program will post a table of timelines and due dates for HAI related activities; the HAI Program will build a live document on the website with this information (this document may be a calendar, timeline, or other format).
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Chen-- All corrected data will be included in that and the pull will be from NHSN. (Discussion that if facilities corrected data, subsequently CDPH pulls data again from NHSN, those corrections will not be in the new pull.)

Rogers—Are any hospitals left who have not received their data for verification?

Chen— Everyone should have received their data by now.

Staff—Please submit the data first to the infection prevention program leads and then they will be submitted to the administrators. Submitting first to the administrators may create a lag. The data needs to be verified by the infection prevention staff.

Flood—There are major concerns in the way the validation report is sent out, in that there are five quarters of data which some facilities made the effort to do unit-specific reporting, but it appears that it will be presented with no risk stratification, and limited category strata. Clarification requested on how this data will be presented to the public on the website, and how the presented data will be of value to the public?

Oriola—The understanding is that the 2009 data will be presented as aggregate because not all facilities provided their data through NHSN prior to that, but after April 2009, the data submitted has been risk-stratified. So there is no way to present it other than aggregate for 2009.

Myers—Metrics (subcommittee on Metrics) had many of the same concerns; during the subcommittee report this will be discussed.

Moss—Request for clarification: does this include the declination and the vaccination data? (Chen—Yes) On the 2008/2009 reports, what was the due date?

Chen—The original target date was August 30.

Moss—And what about 2009/2010?

Chen--October 30.

Moss—And for the influenza data? Verification is very important here; how will the data be verified?

Trivedi—For 2009/10, the process is that all hospitals were given a due date to submit influenza data. So there is no verification process. But that date has already past. It was July 8th.

Chair—Summary of comments and concerns regarding the collection and reporting of data:

- Multiple hospitals have found when CDPH returns the data to the hospitals for validation, the data is not accurate.
- There are still questions about what is required for infection data, how it is being extracted and reported, especially for 2009 data.
- Need to rely not only on the IPs but also the physicians for

data validation.

- Need to validate before posted to the website and that the right data is being presented just as is being done with the Influenza data.

Murthy—Are the errors CDPH are finding primarily with the data on the facility data entry side or retrieval related?

Chen—The regional IPs have been working with the facilities to assist them with NHSN and the rights conferral process. At least 90% of the hospitals are having issues with putting data in, conferring rights, etc. Please refer to the document “*Lessons from Pioneers Reporting HAIs*” released by the National Conference of State Legislators (NCSL) which shows that everyone is having the same types of issues and what was thought to be a straightforward process is fairly complex.

The IPs are finding that it requires site visits to help with the entry of data, and have so far gone to approximately 175 (50%) of the hospitals to work through these issues.

Labar—Is the September 3 deadline for dissemination of data? Or is that date just for submission of data to CDPH so that the liaison’s have that information and can speak with IPs regarding data issues?

Chen—The submission of the five quarters of data is due by September 3rd. CDPH will continue to work with the hospitals on the data and conferral of rights. The NHSN data and conferral of rights must be done by September 15.

The IPs need time to work with the data for the January report. Many site visits are scheduled over the next two weeks. The Program will not be able to visit all hospitals in time for the deadline. However, the Program has found other ways to reach out, including area meetings to bring many facilities together at one time.

Myers—Pieces of data may be missing when submitted to the state or that CDPH may not know where to look for the data. There should be a mechanism to communicate back and forth between facilities and the State to ensure that data has been received.

Moss—Do we have an updated count on hospitals that are on NHSN and have conferred rights to CDPH to review the data?

Chen—Yes, but the number isn’t as important as the number who have done this correctly.

Labar—April 1 was the due date for reporting on CLABSI and VRE, but NHSN didn’t make the modules available until April 30th, so the hospitals were not able to start working with this until May.

Stolp—What is the link to the public website?

Chen— Google “HAI Program, California”. Or go to the CDPH website, select “Programs” and look for the HAI section.

Chair—Staff will send the link out after this meeting as well.

Public comment—None.

Chen - HAI Program Update; Placement of Patients with positive *C. difficile* tests (released August 19th)

AFL 1021 was released on August 19th. CDPH advises against denying residence of patients unless the patient has had negative test for *C. difficile*. There has been a question as to whether this applies to pediatric facilities and the answer is yes. There will be an updated list of 2010 precautions written by Chris Cahill and distributed by CDPH and CAHF. This is an update of the 1996 ARM document.

Regarding the HAI Program: a data manager and a health educator have been added. The Program is also recruiting for another epidemiologist.

Oriola—Regarding the long-term care document, the recommendations are from the SHEA paper and not the CDC. Comment that HAI AC should recommend the CDC over the SHEA because of the prescriptive nature of SHEA.

Chen— What we are taking from the document is the section on mode of transmission. It is being used as a guideline. CDPH is considering that 20% or more might be colonized with *C. diff* even though they don't have an active infection. So SHEA 2010 is being used as a *guideline*.

Nelson—The deadlines are difficult to keep track of; suggestion that the HAI Program put together a summary document with deadlines and requirements.

Chair—Please verify if this is a motion.

Nelson—This is a recommendation to CDPH, not a motion. This is a suggestion to add a summary document to the website.

McGiffert—From the public perspective it is important to see those deadlines as well, so a document with a continually updated timeline will be very useful.

Chair—The Program will add a timeline to the website on when the hospitals are supposed to report data and when they will be published.

[There was consensus to update website with this information.]

Public comment—None.

McClendon / Siiteri - Influenza Vaccination/Declination Pilot Study for the 2010/2011 Influenza Season [slides with additional detail available on HAI website]

Influenza is a significant cause of morbidity and mortality, each year approximately 36,000 deaths are attributable to influenza in the U.S.

Healthcare personnel are an important source of transmission. The most effective strategy for prevention is annual vaccination.

All acute care hospitals should provide free vaccines and all general acute care hospitals should have mandatory vaccination. Mandatory report of vaccinations and declinations to CDPH.

Limitations of 2008/2009 and 2010/2011 data, pilot studies, and 2011/2012 options

2008/2009 and 2010/2011 limitations:

- Multiple versions of reporting form.
- Misinterpretations of employee/non-employee, declinations and vaccinated elsewhere.
- High unknown vaccination status.
- Low response rate (despite mandate).

For the 2010/2011 seasons the Influenza subcommittee solicited input from employee and occupational health advisors. The subcommittee determined it was difficult to obtain vaccination status information.

Two forms were developed; one focused on targeted groups and the other targeted patient care areas (emergency departments, ICUs and pediatric units). Recommendations were made to this Committee on July 8, 2010.

Summary:

- Use of aggregate data for 2008/2009 and 2010/2011 data will be used for reporting.
- Focus 2010/2011 data on healthcare employees and targeted groups.
- Recommend a pilot study be done by CDPH.

Pilot Study Focus:

- Test the clarity and comprehension of newly developed vaccination data collection.
- Demonstrate feasibility of collection of data on specific groups of healthcare personnel.
- Random hospital sample with varying demographics, size and type.
- Emailed invitation to pilot study (optional participation).
- Sent out the three data collection forms.
- Hosted call to explain the data collection.

(Survey collection data form displayed)

- Asked for number of employees on payroll.
- Non-employee physicians, non-employee nurse practitioners and non-employee physician assistants.
- Volunteers.
- Total number of each category (denominator).
- Vaccinated at the reporting facility, vaccinated elsewhere, and declinations.
- Total number declined/did not receive/unknown.

(Declination form displayed)

Attestation form displayed (new form for registry agency)

(Feedback form displayed)

Pilot Study Details:

- Twenty-one randomly selected hospitals plus three correctional facilities.
- Seven small, seven medium and seven large hospitals (mixed pediatric, non-pediatric, teaching, non-teaching).
- Ten of 24 submitted feedback questionnaire.

Summary of results:

- Eighty to 100% reported that the form is easy to use/read.
- Eighty percent reported data on employees is easy to collect.
- Fifty percent reported data on volunteers is easy to collect.
- Seventy to 80% reported that non-employee groups was **not** easy to collect.
- Sixty percent reported using the declination form.
- Fifty percent reported that they do not have an attestation process.

Summary of comments and questions posed in survey / Pilot study conclusion:

- *Paid* employee data is attainable
- Volunteer information is difficult but attainable in some institutions
- Non-employee information is difficult to obtain in many institutions
- May need two forms for declination and vaccinated elsewhere
- Many hospitals do not have attestation process in place

Options for discussion/motion/discussion

Surveillance Form

1. Option to keep the form as it is
2. Remove non-employee categories and include these categories in future years

Declination Form

1. Option to keep the form as it is
2. Option to provide two forms: a declination form and vaccinated elsewhere form

Attestation Form

1. Use the Attestation form as presented
2. Do not use the Attestation form

CDPH has scheduled webinars for September to review the surveillance form and questions.

Eck—Which staff responded to the survey?

McLendon—Primarily employee health.

Eck— Include/categorize Certified Registered Nurse Anesthetists (CRNA) and midwives as licensed practitioner data that should be captured due to clear direct patient contact. Only including nurse practitioners would miss inclusion of these categories.

Hospitals have contracts with registry agencies and should be able to pull contract data in the future.

Keep forms as simple as possible, suggest only one declination form.

Chair—the suggested motion is the option for Surveillance Form “as is”, which is Slide #12

Nelson—There is confusion in cases where declination is checked by the facility because vaccine was obtained elsewhere. So that person has been vaccinated but appears to be declining.

When thinking of the workload involved in keeping all those categories (CRNAs, midwives, etc) there is no need to break data down further than vaccinated onsite and elsewhere, employee (paid by hospital) or not an employee (paid elsewhere). It would be nice to have the additional data, but it is not reasonable to do.

Motion (Moss) to reconvene Influenza Subcommittee to reconsider Surveillance, Declination and Attestation forms, and to maintain keeping employees and non-employees in the analysis.

Second—No second

Motion failed to advance.

McLendon—A phased in approach for non-employees has been planned; this has driven these categories.

Chinn—We implemented this system at our hospital last year and 72% of physicians returned the attestation forms and 62% got vaccinated. So it is possible to implement it; the medical staff and administration can get this done.

Mendelsohn—Regarding definition of “employee” and “facility” where the facility is part of a larger organization; employee is defined as part of the facility actually caring for the patients; also request clarification of physicians on payroll but not onsite, i.e. telemedicine staff.

Chinn—It should be sent to every employee. This is easier to accomplish than trying to determine which subgroups get which forms.

[Further discussion regarding need to capture non-employees, onsite staff and simplification of data.]

Witt—This recommended format can be mandated to the hospitals. It is simpler than we’re making it: anyone who gives clinical care needs to be included. There will be some outliers or non-captured information, but it

will be better to collect what we can and report using the simplest method possible.

Butera—Include an amendment to include medical staff categories: doctors, DOs, dentists, podiatrists, and others.

Motion (Winston)—Move to accept Surveillance Form as presented, with amendments to first non-employee category (edit category to read “non-employee medical staff and allied health professionals”, as well as to include definitions for these including: MD, DO, dentists, podiatrists, nurse practitioners, physician assistants, and others) and to remove second and third non-employee categories from the form.

Second—Eck

Discussion:

Trivedi—Fifty percent of pilot hospitals were unable to provide non-employee data, so the numerator and denominator will vary by hospital if we include those groups for 2009 and 2010.

Labar—Did the pilot hospitals know how to pull the non-employee data? The Joint Commission (JC) already asks that contracted staff confirm vaccination/declination.

Mikles—Perhaps hospitals that are doing this successfully can model for others in the State how to improve their vaccination rates. From a patient safety perspective, this is very important.

Myers—There has been no discussion on the volunteer data. Also would like clarification that the declination form includes the phrase “does not include those vaccinated elsewhere” as friendly amendments.

Labar—Volunteers were discussed by the subcommittee when discussing the need to get declination form data from any individual who has direct patient contact, that definitely includes volunteers.

Rogers—Just as a reminder, in California, in general, physicians are often not hospital staff, so it is important to include *everyone* with patient contact.

Motion Passed by unanimous (19 yes – 0 no - 0 abstention).

[Note: Declination form and Attestation form were determined by Chair to be prescriptive to facilities and therefore not adoptable as a motion.]

Shannon Oriola introduced Dr. John Bradley, Professor of Infectious Diseases at UCSD

Bradley—Thank you for the privilege of being here to talk with you. I am a Pediatrician with an interest in infectious diseases. My role in my career has been to treat and prevent infections. I like to use the literature and evidence to base decisions on policy. You have to strike a balance. There

- HAI Program to send a Thank You letter to Dr. John Bradley for coming to speak to the HAI AC.

is no perfect policy. I am here today to suggest that screening the babies who are born to mothers who come directly to the ICU is not cost effective, and more importantly, represents a risk to the babies.

Some of these babies, especially those between 400 and 500 grams (about one pound) are so small that even putting a swab up their nasal passages for culture can cause trauma.

When we had over 400 babies with negative cultures, we said that we had 400 and asked if we could stop. We were told to continue with cultures. Then we had 800. We have had over one thousand babies admitted from delivery to the NICU all with negative cultures. I believe that practice is not appropriate. I am just as concerned about MRSA as everyone else.

One of our suggestions for our NICU was to do a quarterly point prevalence assessment to see how many babies that you didn't suspect were infected might be colonized. We worry that there are other babies who are asymptomatic but might be colonized. I don't know if quarterly surveillance of all babies in the nursery is the answer. The field is evolving, but culturing babies as they come to the NICU is not a way to diagnose babies who are colonized.

Colonization is something that occurs after someone is inoculated. So if a mother is colonized with MRSA as a baby is born, the baby will pick up the colonization. It makes sense that the baby would be inoculated, but there are no data as far as how quickly babies are culture positive when they are born to a mother with MRSA.

If a mother is colonized, it may be three, four or five days before the baby tests positive, even if the baby is inoculated. This shows that testing the baby as it comes to the unit, even if it is susceptible to become positive, it may not show as positive and we cannot relax and assume that it will not become positive.

- When checking for MRSA colonization, we are worried about USA 300 strain, but none of the studies found USA 300, but other MRSA strains.
- Of nasal cultures, only about 30% are USA 300, which is the strain we want to keep out of the nursery.
- Some of the babies may be subjected to MRSA from others such as siblings.
- And the mothers may screen negative but are colonized and breastfeeding.

Myers—Do you have any idea of how many tests you have done to date without finding any MRSA positive results?

Bradley—Over one thousand babies.

Oriola—What about the percentage for C-section babies?

Bradley—For the high risk (i.e. c-sections) the positive result rate is 20-

30%. You have to get the babies out before they are colonized, particularly before there is membrane rupture in the mother. Colonization rate is much less when the baby isn't delivered through the birth canal.

Labar—Does the number of sites tested (cultured) affect the results?

Bradley—It is likely that the more sites you test and the more sensitive the test, there will be a higher yield of positive results. But can you culture everything for every site on every baby? You can increase the cost of the program and find more positive results, but so much cost to pick up just a few more results may not be worth it.

Mendelsohn—So from your experience, when is the best time to culture?

Bradley—In the Boston study, for seven years they did weekly cultures, the first positive culture in babies was on average after six days. The earliest was three days. All babies in the nursery were tested every week. So three to five days would be the starting point.

Discussion:

Oriola— There may be a better timeframe (after likely colonization three to five+ days after admittance to NICU) to test and contain the babies that are MRSA positive.

Motion (Oriola)—Move to discontinue MRSA active surveillance testing requirement for screening inborns to an NICU.

Second—Myers

Discussion:

Chinn—The motion would be dependent on the methodology used in place of screenings on arrival to NICU. The idea, even in the guidelines, is to know your institution's rates.

Eck—Is there more value focusing the testing on high risk infants due to prenatal conditions or high risk births/mother's health? I mention this in the spirit of the law, not just to address the letter of the law. Can we address the source of the infection, the mother?

Bradley—Yes, identifying mothers is a way to document a high risk situation and a patient who is more likely to transfer MRSA to a baby. That is a wonderful idea; it goes along with the notion that there must be a better way to identify these babies than are identified in the bill as currently written. So that is one way; screening at three and five and seven days is another way.

Flood—For inborns, the main risk is if the mother is infected. The mother would be a much better surrogate for this particular population.

Witt—There is a problem in that the statute is fairly specific, but we can give guidance based on scientific data or expertise. In looking at the language, screening does not necessarily have to mean swabbing the infant. Testing the mother may be interpreted as testing the patient for MRSA.

Moss—Is the screening a rapid test or (three days for a) culture?

Bradley—Most of them are culture based, and take two to three days. A few are PCR based. Rapid tests are not DNA-based but the technology there is rapidly progressing. Culture tests are fast enough to generate results before the asymptomatic infants become significant risks to other infants.

[Chair reminded the Committee that the HAI AC does not *make* or *alter* any legislation. Committee-approved motions are *recommendations* that are made to CDPH based on scientific evidence, expert opinion, and studies.]

Motion (Oriola)—Move to discontinue MRSA screenings for inborns in the NICU.

Second—Myers

Motion Passed by majority 'aye' (14-3-2) vote.

CDPH Pilot Study:

McClendon—Options for the Declination Form:

- Option 1: Form with vaccination/declination only.
- Option 2: Form(s) with 'declination' and 'declined due to vaccination elsewhere'.

Nelson—The fewer forms the better. More forms lead to picking up or filling out the wrong forms. A dual-purpose single form would be preferred.

Winston—There are really three options. One is to leave the declination form as it is which doesn't capture the information on testing elsewhere; the second way is to put both declination and vaccine taken elsewhere information on the same form; and the third way is to do separate forms, one for declining and one for vaccines taken elsewhere.

Torriani—The information the hospitals need to provide are: total, the number vaccinated, the number vaccinated elsewhere, the number declined and the number with no information. We have to correct the data now because people were selecting declined if they got the vaccine elsewhere. This is the purpose of changing the data collection.

Flood— The law specifically says the employee has to have a signed declination form. We need to indicate that the hospital needs to incorporate some kind of process to get the correct information. We can't mandate to the hospital how they have to do that. Whatever process is chosen will go through their medical staffs.

[Chen noted that forms cannot be provided; CDPH can only provide a sample form which hospitals may or may not choose to use]

<p>McGiffert—There needs to be a process to go back to hospitals who submit the data incorrectly.</p> <p>Chair—There is a validation process that will occur.</p> <p>Chair—So we've already voted on the piece we can vote on; it will have to be up to the facilities to develop their process for collecting the information. Therefore we will not consider the other two presented [slide presentation] motions.</p>	
<p>Subcommittee Report / Antibiotic Stewardship (see detailed subcommittee report on HAI website)</p> <p>Witt—There are several areas that were proposed. The first is how to define antibiotic use. This is an approximate number of days that patients receive antibiotics. This is a measure of the number of days patients received antibiotics. We do it based on multiple coverages and maybe anti-fungoids. This was approved in this Committee. We have identified that the stratification must be part of this report; some means of stratification is something that needs to be defined in the future for this information to be useful. This was also approved unanimously.</p> <p>We discussed public reporting and supported the process measures. As far as outcome measures, at this time what will be collected has yet to be defined, the subcommittee suggests deferring reporting until the State has collected some data and reviewed this area.</p> <p>The subcommittee's next meeting will involve defining the elements of antibiotic stewardship and establishing some measure of what an antibiotic stewardship program represents. This may involve a toolbox or other information for sharing with statewide facilities or other tool.</p> <p>The subcommittee deferred all decisions on <i>C. difficile</i>.</p> <p>The subcommittee recommends that some advanced training is necessary for the management of an antibiotic stewardship program.</p> <p>Myers—Facility to facility data will be very different based on the various geographies and resistance of organisms in different localities.</p> <p>Witt—It will be more difficult because of this local ecology issue. However, any surveillance program will have some number of those included unfairly and those who don't get included (unfairly). The subcommittee recognizes that there will be outliers or exceptions but that is the nature of surveillance. Need additional details regarding inclusion and exclusion (exceptions) of data and antibiotic use.</p> <p>Eck— We need to equip the public with information to make decisions in their healthcare. Defining the critical components of antibiotic stewardship, frequency and data collection are needed. This would help define some of the early questions that can be used to standardize somewhat and start the process.</p> <p>Witt—We should be defining what are the minimum elements of what defines an antibiotic surveillance program based on what it attainable and</p>	<ul style="list-style-type: none"> • The Chair for each active HAI AC subcommittee (Antibiotic Stewardship, Metrics, and <i>C. difficile</i>) will prepare and send a report of subcommittee information presented during the August 30 meeting for HAI Program distribution to HAI AC members.

reportable. We want to insure that the correct antibiotics for your hospital are being applied to meet patient needs based on our Medical Use Evaluation (MUE). We may put together a toolkit that will help guide hospitals in tracking and applying our recommendations.

Flood—Are there other regulatory bodies that require any of this information?

Labar—JC does, but it is not mandatory.

Butera—The law is in place that requires hospitals to have an antibiotic stewardship program, but the questions to be asked about what constitutes these programs are vague and nebulous. So the task of this subcommittee is to focus on the minimum elements of such a program. The subcommittee may recommend a toolbox of elements that would perhaps be appropriate (not a one-size-fits-all) that facilities could use. Finally, the facility will have to be responsible for its antibiotic program based on its own environment and epidemiology.

Chair—To recap: Subcommittee will meet again to define what antibiotic stewardship really means; components including antibiogram and a toolkit, and perhaps consider Medical Use Evaluation (MUE).

Public Comment

McGiffert—Could we require that each facility submit to CDPH a description of their antibiotic program.

Chen—That would require legislation.

C. difficile subcommittee: (See detailed *C. diff* subcommittee report on the HAI website)

Murthy—Reviewed the NHSN LabID methodology being proposed versus the prevailing methodology. The subcommittee reviewed surveillance versus the need to translate that for the public.

The strength of the LabID module was fairly straightforward, and included standardization and consistency in reporting. The negatives found were mainly in the terminology and interpretation of the module requirements, and due to variation in hospital testing methods.

The process also does not take into account patient populations such as transfers who are at risk and may have been treated at another facility during colonization and are now being tested at a different facility.

With additions and modifications to the LabID module, the subcommittee recommends implementing the module.

The submitted report will be distributed with preliminary recommendations for CDPH review. Suggested changes recommended by subcommittee include:

- Who is doing PCR testing/how is this tested. Methods used, i.e. traditional enzyme immunoassay (EIA) may miss 20%; must note if using PCR

- Where has the patient been in the last four weeks/what is the facility type?
- Identifying classification (healthcare associated as opposed to healthcare facility onset)

These modifications would be for CDPH to discuss with CDC on changing the module.

When NHSN asks the question of “whether the patient was in your facility in the past four weeks”, it is considered facility associated, and we have an objection to that.

Chinn—There aren’t issues with the lab reporting. An issue that we do have is that NHSN asks “was the patient in your facility in the last four weeks?” If you say yes, the infection is considered facility associated, and there is objection to that.

If the patient has been in other types of facility (such as dialysis center), the case will be indeterminate (facility associated, etc).

Myers—These classifications will not be completed before the report for the first six months.

[Additional discussion led to division of proposal into two separate modules, one to accept NHSN LabID module for *C. difficile*, then a second motion modifying the module.]

Motion (Oriola) to accept using the NHSN LabID module for *C. difficile*.

Second—Torriani

No additional discussion.

Motion Passed by majority ‘aye’ (16-0-1) vote.

Motion (Oriola) that the *C. difficile* Subcommittee recommend to CDPH to request from CDC to modify the NHSN *C. difficile* LabID module with three questions:

- 1) Who is doing PCR testing/how is this tested
- 2) Where has the patient been in the last four weeks
- 3) identifying classification (healthcare associated as opposed to healthcare facility onset)

Second—Murthy

No additional discussion.

Motion Passed by majority ‘aye’ (14-1-1) vote.

Metrics Subcommittee (Metrics)—(See detailed Metrics subcommittee report on the HAI website)

Chinn—We were charged with guidance on metrics for the 2011 healthcare associated infection report. Because of the reasons I will outline for you, we agreed that this would not be a feasible thing to do. The unanimous recommendation from this subcommittee is not to report in January of 2011, but to wait until June of 2011.

Before April 2010, each hospital had its own method for submitting information to CDPH; there was no external validation of data. Comparison of outcome data is therefore impossible as each hospital had its own methodology.

Prior to April 2010 the case finding methodology was different. The determination of the denominator was also different. There was no stratification or risk adjustment for measures such as type of hospital or types of patients seen at the individual institution.

The current legislation requires that these rates be reported as adjusted rates. This is impossible as hospitals prior to 2010 were not reporting data with this stratification. It would take enormous resources to get hospitals to look back at their data and re-report the data.

Metrics also looked at whether there is an opportunity to present aggregate data. That also has difficulties because of the methodology and whether the data would provide an accurate representation of healthcare associated infections.

The Committee decided that beginning June 2011, the HAI Program begin the process for the healthcare associated infection reporting. This would include central line associated infections, MRSA, and *C. difficile*, and *staph aureus*.

Moss—Regarding the position of the subcommittee, is this a position that the reporting dates mandated by law will now be missed and an extension requested? Why does the subcommittee or this Committee feel that it can recommend against legislation? What in the world does this Committee think it is doing by going against legislation?

Myers—The question for us was whether we would violate the data format, in that it was impossible to risk adjust, or do we violate the law and extend the deadline? So the question we asked was whether the data we could present would be *of any use* to the consumer in choosing the safest hospitals and helping hospitals to improve their rates. We made the decision that extending the deadline is best for the public and the healthcare providers.

California reporting will be more comprehensive than other states. Missouri for example has only been reporting central line infections in the ICU for the past three years. It is incumbent on the HAI AC that the data that is put forth is accurate; putting out inaccurate data and then having to retract is not the way to gain public trust.

Chair—These are recommendations; it does not mean that CDPH will implement any of the recommendations.

Mikles—Even as a consumer advocate, the first responsibility to the public is for the provision of real, accurate data that the public can use. Better to do it correctly than to have to include footnotes and caveats explaining why things aren't correct.

Moss—You are saying that all the data that hospitals provided, and we can report nothing? Every hospital took the time to provide the data, so to clarify: the Committee will not recommend reporting anything based on that data? We should be able to find something that we can provide. It is unbelievable that you smart people cannot come up with something. No wonder you don't want consumers represented here.

Chinn—We greatly value the opinions of consumers; Ms. Mikles is also here representing consumers. The subcommittee did discuss providing aggregate data. There is nothing to compare that to, and in the following year, it will be reported differently. That is something that we can look into.

Torriani—There are negative consequences by using non-risk stratified and non-comparable data. As an example of doing things right, New York handled their reporting in a consecutive way, and, importantly, had significant consumer involvement. That is what we want to do, not to just put raw data on a website with a number. It takes time to develop this information.

Myers—Not only is the data provided not NHSN-compliant, but the hospitals created (individually) their own definitions of what a "case" of *C. difficile* entailed. When there is no set definition, the result is bad data, plain and simple. It would not be meaningful or productive to present it.

Oriola—We are *all* consumers of healthcare. For patient safety and validity, it makes sense to push the reporting out six months to get good and useful data.

Flood—Is there any salvageable central line infection ICU data available? Second, the MRSA or VRE bloodstream infection questions were more of a "yes" or "no" question, so is there any salvageable data there?

Chinn—Part of the problem was the definition of the denominators.

Labar—Much of that data was external to NHSN. But the facilities that did use NHSN, that data is there and valid? (Yes).

Trivedi—The NHSN data is valid only in location and conferred rights. In some cases data was reported to NHSN and by paper, so some of the data provided was double reported. There would be additional verification required.

Motion (Chinn)—**Move to delay public reporting date from January 2011 to June 2011 to verify the data, and to post the reason for the delay on the HAI website, and to post the expected date of public reporting on the website.**

Second—Eck

Motion Passed by majority aye (15-1-1) vote.

<p>Letter supporting HR 1549 / SB 619</p> <p>Eck—CDPH cannot submit the letter, but at our last meeting HAI AC decided that we can send this letter on behalf of the people of the state of California.</p> <p>Nelson—Concerns about purview of the Committee. However, it should be made clear that the letter is being sent on behalf of the people of the State of California.</p> <p>Labar—As a Committee member, it would be irresponsible to take a "yes" vote on this without understanding the consequences and impact to legislation.</p> <p>Moss—It is too risky and irresponsible to vote as a Committee on this.</p> <p>Eck—Following the last meeting, the legislation was provided to each member, and you were all asked to read and review it in preparation for this meeting. What we can do through healthcare is a small fraction of the impact; 75% of antibiotics get to us through our foods. This is the least we can do for the people of California.</p> <p>Motion (Stolp)—Move for HAI AC to accept and submit the letter supporting federal HR 1549 / SB619 to House and Senate legislators.</p> <p>Second—Eck</p> <p>[Chair recognized that no motion necessary; members may sign or not sign as individual members in support of this legislation.]</p> <p>Chair—So Todd Stolp will complete the letter and submit it to the HAI Program; the HAI Program will then distribute the letter for signature of any Committee member who would like to sign the letter.</p>	<ul style="list-style-type: none"> • Todd Stolp will send finalized version of letter supporting federal HR 1549 / SB 619 legislation; HAI Program to coordinate e-distribution to membership for signatures of those members wishing to sign.
<p>Action Items (Chair)</p> <ul style="list-style-type: none"> • HAI Program to send ‘Thank You’ letter to Sharp HealthCare for hosting. • HAI Program to report to HAI AC members on the number of California hospitals which have conferred rights for NHSN. • HAI Program to send out to all HAI AC members the link to the HAI website. • HAI Program will post a table of timelines and due dates for HAI related activities; the HAI Program will build a live document on the website with this information (this document may be a calendar, timeline, or other format). • HAI Program to send a Thank You letter to Dr. John Bradley for coming to speak to the HAI AC • Letter on Antibiotic Use in Animals will be distributed via email. • Subcommittee Chairs will provide written reports on their subcommittee activities. 	

**Next Meeting: October 7, 2010. This meeting will be in Sacramento.
Subsequent Meeting: November 18, 2010. (Sacramento).**

Chair—Thank you everyone for your time and commitment.
Meeting Adjourned

Acronyms

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