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February 15, 2011

Dear Healthcare Associated Infections Advisory Committee Members,

The University of California's Healthcare Epidemiology Collaborative, a team of infection control experts, epidemiologists, and clinical nurses from the five UC Medical Centers, have led a concerted effort across the five UC medical centers to reduce blood stream infections occurring across our 140,000 annual inpatient admissions. Since 2008 this effort reduced adult, non burn ICU central line associated blood stream infections (CLABSI) by 55% with over 77,000 annual central line days. The UC Healthcare Epidemiology Collaborative has been able to facilitate this reduction through the sharing of best practices for limiting CLABSI, comparing surveillance results, and working together to change behavior at our hospitals.

Our Collaborative agrees that strict adherence to NHSN guidelines for reporting CLABSI is essential to providing the ability to track and compare improvement in these infections. Our group recently met to consider and overcome areas of ambiguity in this reporting that creates uncertainty in hospital to hospital comparison. While some variability in reporting has been documented by others and can be expected due to the challenges and complexity of laboratory and clinical analysis, our Collaborative believes that other variability can be resolved through an agreement on the definition of the NHSN guideline: "There must be no evidence that the infection was present or incubating at the time of admission to the acute care setting". Our Collaborative suggests the following definitions be adopted by hospitals to improve comparability of infection rate data:

Infections not present or incubating at the time of inpatient admission must:

- Be found beginning on calendar day 4 or later
- Count inpatient admission day to the hospital as day 1
- Not include emergency department positive blood cultures in surveillance, unless the patient has been admitted or is located in the emergency department inpatient staging area
- Not consider duration of central line after day 4
- Attribute infections found after calendar day 4 post discharge as community acquired
- Attribute location of infection to where patient was located 2 calendar days prior to date of positive culture
- Report infection date to NHSN as the date of the positive blood culture

Our collaborative agrees that these definitions are consistent with NHSN guidelines and the California Health and Safety Code. Specifically, the 4 calendar day waiting interval actualizes the generally accepted 48 hour threshold for infections to be classified as hospital acquired as modeled from the CDC

specification: "Multidrug-Resistant Organism & Clostridium difficile-Associated Disease (MDRO/CDAD) Module" (http://www.cdc.gov/nhsn/PDFs/pscManual/12pscMDRO_CDADcurrent.pdf) which states on page 12-6:

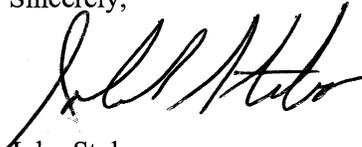
NHSN will categorize LabID Events as healthcare facility-onset vs. community-onset to ensure that all healthcare facility-onset cases have been hospitalized at least a full 48 hours.

Considering: 1) variable times of day that admissions occur and 2) the absence of clinical data to confirm if cultures represent infection incubating at the time of admission, this is operationalized by classifying positive cultures obtained on day 1 (admission date), day 2, and day 3 of admission as community-onset (CO) LabID Events and positive cultures obtained on or after day 4 as healthcare facility-onset (HO) LabID Events.

Any steps hospitals can implement to increase the comparability of their results will instill confidence in their reporting. From this launching point hospitals can then more fully trust their dialog on comparative improvement and thus leverage best practices and commitments to reduce CLABSI as well as other monitored infections such as CAUTI and VAP.

Our hospitals plan to adopt the above specified definitions for our NHSN reporting in January 2011 in order to improve the comparability of our CLABSI results. We propose other hospitals adopt this approach to improve the comparability of results throughout California.

Sincerely,

A handwritten signature in black ink, appearing to read "John Stobo". The signature is fluid and cursive, with a large initial "J" and "S".

John Stobo
Sr VP