10.20.10

California Senate Committee on Health

Senator Elaine Alquist , Chair

My Name is Annemarie Flood an Infection Preventionist and member of Healthcare-Associated Infection Advisory Committee and I am speaking today on behalf of the chairperson of the Healthcare-Associated Infection Advisory Committee (HAI-AC) Kim Delahanty.

The Healthcare-Associated Infection Advisory Committee (HAI-AC) is a legislatively mandated advisory committee charged with making recommendations to the California Department of Public Health (CDPH) on the prevention of healthcare-associated infections. The Committee was created by Senate Bill 739, Chapter 526, Statutes of 2006 and appointed by the department on July 1, 2007. This group of 24 dedicated individuals have worked long hours with no compensation , often paying out of their own pocket for flights to meetings, because they care so passionately about healthcare associated infections. Many have dedicated their careers to preventing these infections while other members have lost loved ones to this largely preventable scourge. The group ranges from parents to national leaders in the field in healthcare associated infections. We attempt to make all recommendations by consensus.

Our role according to the laws passed by this august body is to "...make recommendations related to methods of reporting cases of hospital acquired infections occurring in general acute care hospitals: and "... make recommendations on the use of national guidelines and the public reporting of process measures for preventing the spread of HAI that are reported to the department..."..

The committee has worked hard to bring California the best state of the art public reporting system for healthcare associated infections (HAIs) and assist the California Department of Public Health (CDPH) in developing regulations and guidelines in preventing HAIs.

In order to respect the committees time I will not recount our long string of successes working collaboratively with CDPH but will focus on three issues I feel this body should know are my concerns for the committee.

The original language on the reporting of surgical site infections was unfortunately not written in a way that allowed for interpretation by either the HAI-AC or CDPH. The result is the law is contradictory asking us to report clean or clean contaminated gastro-intestinal surgery. Without a complex explanation I will only say that there is no gastro intestinal surgery that falls into that category. Additionally, the language appears to suggest that the data from different types of surgeries that have very different risks of infection be combined. The consensus of the experts is this would yield data that would be meaningless to Californians. We are more than willing to work with the Senate to offer new language that we feel would meet the intent of the legislations.

The committee recently voted to request that CDPH stop requiring facilities to screen inborn babies transferred to that hospital's neonatal intensive care unit. This was done after the committee received testimony from Dr. Bradley, one of the foremost experts on MRSA in pediatrics. He noted in such cases babies do not have significant bacterial load to be tested effectively for colonization and that such testing can actually harm neonates. We have yet to hear back from CDPH on this recommendation.

Lastly the committee has been struggling with the issue of weighing priorities given the law. The laws that founded the committee and drive our work require that outcomes be reported to the

public be reported by January 1, 2011 and that they be risk adjusted according to our recommendations or the Centers for Disease Control and Prevention. We agree that without risk adjusting the data are meaningless, counterproductive and in some cases lead to conclusions that are the exact opposite from the reality of healthcare associated infections at some institutions. Unfortunately, CDPH gathered much data from hospitals using a form that did not allow for risk adjustment. The data combined regular medical floors with bone marrow transplant units that have the highest risk for certain types of infections because of the patient's depleted immune systems. The data gathered was frankly of limited value. CDPH has done much hard work since then to assure that all data going forward can be risk adjusted. Unfortunately CDPH feels the pressure to release this data on central line infections that are meaningless because of the deadline. Both CDPH and the HAI AC are torn between the deadline in the law and the requirement that the data be risk adjusted and therefore meaningful. We hope that CDPH moves to only release meaningful data.

As you maybe aware CDPH recently released data on hospital specific vaccination rates at facilities. The HAI-AC had advised CDPH not to release the data as our analysis was that it was horribly flawed and not verified. Unfortunately, through external events the data was released. The result was a data set in which eight hospitals claimed to have vaccinated or received vaccination declination forms on over 100% of their employees, clearly this type of information is not useful or accurate.

Lastly, the committee has struggled with the Bagley Keane act. We have no objection to public meetings and in fact invite the public to each meeting and have been happy with their high attendance. However, when we are reviewing data to determine its quality and usefulness for public reporting and what if any caveats need to be posted with the data, the fact that this information is now public defeats the purpose of this review. Other states have dealt with this issue in their public infection reporting laws by having an exception to open meetings only for the data analysis section.

We thank the committee for the opportunity to present our concerns and look forward to working with you in the future.

Respectfully,

Annemarie Flood for Kim Delahanty, CDPH HAI AC Chair