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Volume 2 Issue 1



WHY SHOULD ICPs CARE ABOUT THE LITTLE HOOVER COMMISSION?

The Little Hoover Commission (LHC) was created in 1962 by legislation drafted by Milton Mark. The goal of the LHC is to promote efficiency and effectiveness in government programs. The group consists of five people appointed by the governor, two appointed by the Speaker of the Assembly, two appointed by the Senate Rules Committee, two sitting Senate members and two sitting Assembly members. This independent, non-partisan oversight commission has looked at multiple issues since its inception, including public health, education, human services and housing.

On June 23, 2005, the LHC sent a letter to the governor and state legislature detailing recommendations for emergency preparedness and public health. Number four of the seven recommendations reads:

“Develop an aggressive response to hospital-acquired infections. By December, the administration should propose a plan – endorsed by such independent experts as the dean of California’s medical schools – that will reduce the illness and death resulting from these infections.”

The LHC reasons that if the healthcare industry is following infection control principles necessary to prevent hospital-acquired infections that fewer fatalities will occur in the event of bioterrorism or an outbreak of a new disease. The recommendation of this powerful group of people is another example of how all levels of government are starting to take hospital-acquired infections and infection prevention and control seriously.

To learn more about the Little Hoover Commission, visit:

<http://www.lhc.ca.gov/lhc.html>

DHS RESPONSE TO “LITTLE HOOVER”

In response to the Little Hoover Commission’s recommendation regarding healthcare-associated infections, the California Department of Health Services convened the “Healthcare-Associated Infections Advisory Working Group” (HAI AWG). This multidisciplinary group included representatives from infection control, public health departments, physicians, OSHPOD, OSHA, SEIU, CNA, Consumers Union, CMA and CHA. Using a consensus-based process, the HAI AWG developed evidence-based recommendations to reduce the morbidity and mortality from HAIs in the state of California. There are seven different focus areas for the recommendations:

1. California Department of Health Services
2. Healthcare Facility Infection Surveillance and Prevention Program Infrastructure
3. Public and Internal Reporting of Outcome and Process Measures
4. Prevention of Influenza Transmission in Healthcare Facilities
5. Prevention of Central Venous Catheter Related Blood Stream Infections
6. Prevention of Antimicrobial Resistance
7. Prevention of Surgical Site Infections
8. Prevention of Ventilator-Associated Pneumonia

This 45 page document is very thorough and contains an amazing amount of information and references. This paper is meant to be a tool for public and private entities to reduce HAIs in California. All of the recommendations are based on the latest research, best practices and expert information. The following excerpts convey the depth of the document:

- DHS should appoint a multidisciplinary advisory committee to direct and monitor the implementation of public reporting of quality measures.
- DHS will educate all their nurse surveyors on how to properly evaluate facilities for compliance with infection prevention and control standards.
- Healthcare facility senior leadership (with IC assistance) should evaluate and demonstrate adequacy of resources directed to infection surveillance and prevention.
- Infection prevention policies should be evidence based and enforced by staff physicians, administrators, managers and supervisors.
- Persons working or consulting in the organization including, but not limited to, administrators, department managers and supervisors, medical and nursing staff, students and volunteers should be trained in current infection prevention

strategies and be able to translate didactic principles into practice.

- Department administrators, managers and supervisors should frequently observe healthcare worker-patient interactions for compliance with hand hygiene, use of PPE and isolation procedures and take corrective action as necessary.
- The ICP responsible for the program should be at least the level of a manager and report directly to a senior administrator.
- The duties of ICPs should be directed at HAI prevention. If duties unrelated to that goal are assigned, adequate resources should be provided.
- There should be requirements or strong incentives for public reporting of process measures that are standardized across facilities.
- Offer influenza vaccination to healthcare workers at the work site, at no cost and to all shifts.
- Require influenza vaccination or written declination by direct patient care workers.
- Healthcare facilities should form a multidisciplinary committee to evaluate compliance with policies to prevent surgical site infection.
- Healthcare facilities should form a multidisciplinary committee that includes frontline staff to develop, implement and periodically evaluate compliance with policies and procedures to prevent ventilator associated pneumonia.

The chairs of the HAI AWG presented the recommendations to DHS leadership at the end of December. The group will reconvene on February 28th to review the response from DHS.



STATE LEGISLATIVE UPDATES

SB 739

This bill which would mandate public reporting of infection data currently sits in the suspension file. Senator Speier is considering rewriting the bill to reflect the recommendations set forth in the paper that was submitted to DHS by the Healthcare-Associated Infections Advisory Working Group. Keep your eyes and ears open for information regarding this bill, when it starts to move, it will go very quickly.

SB 162

This bill creates a separate Department of Public Health within California DHS which currently does not exist. It will also provide the Department with its own budget to help strengthen public health programs throughout the state. CACC recently voted to support this piece of legislation.



To identify your California State legislators, visit the following website and enter your zip code in the box specified.

<http://www.leginfo.ca.gov/yourleg.html>

Cal/OSHA Aerosol Transmissible Disease Standard

Below is the link to the **draft** document that may replace the current TB standard. Please note that aerosol transmissible disease is defined as "a disease identified by the CDC (ref HICPAC) or the CDHS as requiring airborne infection isolation or droplet precautions."

<http://www.dir.ca.gov/dosh/doshreg/atddraft.pdf>

The period for public comment will be in mid to late April. Be alert for information from APIC Sierra and Cal/OSHA.

Let me tell you the secret that has led me to my goal. My strength lies solely in my tenacity.
-Louis Pasteur

To provide information for inclusion in the newsletter or ask questions, please contact:

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