Healthcare-Associated Infections (HAI)
Advisory Committee

899 N. Capitol St. NE,
Room 6002
May 2, 2018 | 10:00am – 12:00pm

Meeting Summary Report

1. Welcome and Introductions

Dr. Iyengar started the meeting by having all in-person attendees introduce themselves and their respective stakeholder group affiliations (i.e. acute care sector, skilled nursing facility (SNF) sector, outpatient primary care sector, etc.).

2. Recap on Mission, Vision and Goals of the Committee

Dr. Iyengar provided a recap on the mission and vision of the Healthcare-Associated Infection (HAI) Advisory Committee. The **mission** of the Committee is to identify HAI prevention activities, recommend evidence-based practices and sustainable interventions, establish targets, and monitor and communicate progress to stakeholders and the public. The **vision** is to help healthcare facilities to provide the best possible quality of care in the District by ultimately eliminating HAIs.

Dr. Iyengar mentioned that the Advisory Committee has been successful in addressing the current mission as it's stated and that updates to both the mission and vision of the Committee will be discussed during the Administrative Discussion agenda item.

Dr. Iyengar also reminded those in attendance that the Committee was set up to represent larger healthcare sector stakeholder groups as opposed to individual hospital/health facilities. This was done by having individual professional organizations nominate their Committee members so that there could be a more equal representation from the various sectors (such as SNF, acute care, etc.). Therefore, the expectation from Committee members would be that they represent their sector's perspective as opposed to their individual and respective institution's perspectives. This means serving as a liaison between the Committee and their sector peers (i.e. others who work in the same sector but at different facilities) in a way that facilities a bidirectional flow of information (i.e. provide updates to stakeholder peers about the Committee and voice issues/concerns/general perspectives from peers to the Committee). This bidirectional communication might come in the form of verbal updates at professional organization meetings, submitting a short blurb to an email listserv, distributing Committee Meeting Summary Reports to other Committees, etc.

3. **Administrative Discussion**

Dr. Iyengar started the discussion by mentioning that the Committee was set up to represent larger healthcare sector stakeholder groups as opposed to individual hospital/healthcare facilities. This was done by having individual professional organizations nominate their Committee members so that there could be equitable representation from the various sectors (such as SNF, acute care, etc.). Therefore, the expectation from Committee members would be that they represent their sector's perspective as opposed to their individual and respective institution's perspectives. This means serving as a liaison between the Committee and stakeholder peers (i.e. others who work in the same sector but at different facilities) in a way that facilities a bidirectional flow of information. Communication back to sector peers might come in the form of verbal meeting updates at professional organizations, submitting a short blurb to an email listserv, distributing Committee Meeting Summary Reports to other Committees, etc.

One attendee mentioned that it's difficult to send updates out on a regular basis because DC is such a small jurisdiction that it results in a lot of one-on-one interactions. A DC Hospital Association (DCHA) member mentioned that it might be helpful to have DC Health provide in-person updates at one of their regularly scheduled committee meetings. DC Health said that this is where distributing the Meeting Summary Reports would be useful because it could be done in lieu of an in person a DC Health update.

Dr. Iyengar asked the Committee members and attendees if they felt that it would be beneficial to formalize the quorum and voting process. She provided an overview of how this is conducted at the DC Health Board of Medicine (BOM) (of which she is an active member). The formal process for the BOM meetings is as follows: all attendees/members are introduced and the agenda items are opened for discussion. All procedures and discussions are recorded and members can make motions during the discussions (for example "I move we draft a letter of support for…"). Someone else would then second that motion and, once that motion has been seconded, the discussion becomes specific to that motion. Each person then says "aye" or "nay" as part of the formal voting process.

Representatives from DHCA and DC Medical Society (DCMS) agreed that a voting process would be needed if the Committee is to be tasked with making formal recommendations and would ultimately legitimize Committee moving forward. Dr. Iyengar emphasized that this means DC Health will be more assertive in their follow-up to establish a quorum for each meeting.

The discussion shifted to how attendance should be managed around voting and what would ultimately qualify as a quorum. A few Committee members thought that voting should only occur in-person because it results in more engagement and understanding of the discussion at hand. There was some concern about missing opportunities to vote as a result of last minute work emergencies that prevent someone from being able to attend a Committee meeting. Many attendees asked what would constitute a quorum. It was suggested that in order to attend a quorum, there should be a representative from each stakeholder group (i.e. DCHA, DC Healthcare Association (DCHCA), DC Primary Care Association (DCPCA), etc.). It was ultimately decided for the time being that in order to obtain a quorum, there needed to be at least 75% of the representatives from each stakeholder group. This might present some difficulties with the stakeholder groups that

have official Committee members who have been less engaged with the Committee for various reasons. DC Health will draft a manual that describes the processes for obtaining a quorum and for conducting votes.

4. Subcommittee Updates

a. *C. difficile* (CDI)

Dr. Glenn Wortmann provided an update about the most recent activities of the CDI Subcommittee. This subcommittee meets on a quarterly basis, is co-led by Dr. Glenn Worthmann (DCHA), Dr. Xiaoyan Song (DCHA), Titilayo Unegbu (DCHCA), and Ganiat Yusuf (DCHCA), and is coordinated by Jackie Reuben (DC Health HAI Program). Members of the subcommittee represent the following DC stakeholder groups: DCMS, DC Health Community Health Administration (CHA), Qlarant (formally named Delmarva Foundation), and DCHA.

Dr. Wortmann provided an overview about a successful reduction of hospital onset CDI at a healthcare facility. This subcommittee hopes to implement a similar intervention within District hospitals and skilled nursing facilities, if funding and resources permit.

b. Antimicrobial Stewardship

Jackie provided an update about the most recent activities of the Antimicrobial Stewardship Subcommittee. This subcommittee meets on the first Tuesday of every month, is co-led by Dr. Jesse Goodman (Region Organized Against Resistance (ROAR) Coalition) and Dr. Jennifer Thomas (Qlarant), and is coordinated by Jackie Reuben (DC Health HAI Program). Members of the subcommittee represent the following DC stakeholder groups: DOH Health Regulation and Licensing Administration (HRLA), Howard School of Pharmacy, DCHA, DCMS, DCHCA, and DCPCA.

This subcommittee is making headway with various educational resources such as antimicrobial stewardship educational videos that are being filmed in July 2018. These videos will include local antimicrobial stewardship subject matter experts (many of whom are subcommittee members) and will be made publically available on the DC Health website. Dr. Iyengar mentioned that these might be a good segue into eventually requiring antimicrobial stewardship training for clinicians in the District.

The subcommittee also completed a District-wide antibiogram with data from 2017 from District SNFs, short and long-term acute care facilities, veterinary hospitals, and some outpatient clinics. This antibiogram has not yet been widely distributed.

c. CAUTI

Dr. Xiaoyan Song provided an updates for the CAUTI Subcommittee. This subcommittee is by Dr. Xiaoyan Song (DCHA) and coordinated by Emily Blake (DC Health HAI Program). Members of the subcommittee include DCMS, DC Health CHA, Qlarant, DCHA, and DCHCA.

Dr. Song presented 2016 and 2017 NHSN data for DC's short-term acute care hospitals. Trending for 2017 appears to be downward when compared to 2016, with the exception of a slight increase in the 4th quarter of 2017; this slight increase is thought to be due to the intense influenza season. Setting a goal of no more than 30 CAUTI cases per facility each year would be ideal moving forward (this would be for both short-term and long-term acute care hospitals). She also presented data about the proportion of patients on a foley catheter for this same timeframe. These data showed that foley catheter utilization remained stable and consistently 20% lower than the rest of the country.

Discussion ensued about what might impact the rates and foley catheter utilization ratios at individual facilities and different facility types. For some facilities with a low census, their rates can change drastically with just one CAUTI case. This brought up the fact that data are only able to convey one part of a complicated story and that the subcommittee should probably be proactive in reaching out to individual facilities to get some additional insight. One DCHA representative expressed how useful it would be if this subcommittee could serve as a resource for CAUTI reduction support; Dr. Song confirmed that this is a route that the subcommittee intends to take and is in the process of drafting facility-specific announcement letters.

5. HAI Program Updates

DC ICAR Initiative

Jackie provided an update about the on-going Infection Control Assessment and Response (ICAR) initiative that was started in the District during the fall of 2017. This is a nationwide CDC initiative being implemented on a local level and in accordance with individual jurisdictional priorities. DC has completed assessments in all of its acute care facilities and skilled nursing facilities and will start dialysis assessments in the fall of 2018.

Thus far, the DOH HAI program has assessed 100% of DC's short-term acute care facilities and 100% of DC's long-term acute care facilities; this was done in partnership with DCHA and their STRIVE Initiative. The DC Health HAI Program has assessed 100% of DC's skilled nursing facilities in partnership with APIC. Dialysis facilities will also be assessed in partnership with APIC, however, these have not yet started.

Preliminary findings indicate that both routine auditing and routine feedback from audit data seems to be a big area for improvement across facilities and healthcare sectors. Similar trends also being seen nationwide, especially within areas such as injection safety, CDI, and sterile device reprocessing.

Next steps for the ICAR initiative include 1) the distribution of individualize facility narrative reports, 2) the creation of an aggregate report that will allow for cross facility comparisons (within the same healthcare sectors) and document common gaps in the District that can further guide resources, new initiatives, and interventions, and 3) implementation of CDC's Targeted Assessment and Prevention (TAP) strategy in select facilities.

6. Next Steps

Upcoming meetings for 2018 are scheduled for:
- August 8, 2018
- November 14, 2018

DC Health will send out a draft Advisory Committee Procedure Manual for official Committee members to review.

7. Adjournment
- Next Meeting rescheduled for August 8, 2018 (in-person)