Government of the District of Columbia
Department of Health

District of Columbia
Health and Medical Coalition (HMC)
Healthcare-Associated Infections (HAI) Workgroup

HAI Advisory Committee
899 N. Capitol St. NE, Rm. 582
January 25, 2017 | 10:00am – 12:00pm

Meeting Summary Report

1. Welcome and Introductions

Dr. Iyengar welcomed and thanked everyone for participating in the second HMC-HAI Workgroup and Advisory Committee meeting. She then asked everyone in attendance to give their name and affiliation. She reiterated the importance of the committee and stated that the overall goal is to ultimately eliminate healthcare-associated infections.

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

Dr. Iyengar provided a recap on the purpose, mission and vision of the HAI Advisory Committee since there were some attendees who were not present at the initial September meeting. The purpose of the HMC-HAI Workgroup and the HAI Advisory Committee is to focus on HAI prevention and to give voice to a wide range of healthcare stakeholders both within and between various healthcare settings and among healthcare professionals. The Committee is also charged with making high-level recommendations to DC Government. 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. Goals of this initial kick-off meeting include starting the conversation about potential committee priorities, creating a plan of action for moving forward with identified priorities, and developing a big-picture timeline with tangible outcomes.

3. Recap on Previous Committee Meeting

Emily Blake provided an overview of the key points discussed at the last Committee meeting, which took place on November 16, 2016. This meeting was used to discuss ways of overcoming the patient transfer challenges that were documented in Jackie Reuben's Patient Transfer Questionnaire, which was distributed to short-term acute care, long-term acute care and skilled nursing facilities in October 2016. This discussion identified the need to learn from other states' successes in overcoming similar issues related to the spread of MDRO's during the patient transfer process and identify best practices that are currently being implemented elsewhere. There's also the continued challenge of being unable to identify

and recruit those in the role of medical directors and prescribers at the skilled nursing facilities (please see "Next Steps" section for further details).

Emily presented the top priorities that were identified during the previous two meetings so the Committee could remain aware of the areas in which they want to hone in on for both the short-term and long-term. Challenges related to the patient transfer process and how this plays a role in the spread of MRDOs has been one of the biggest overarching priorities, with specific activities related to antimicrobial stewardship being the second biggest overarching theme. Committee members have mentioned the importance of taking the time to frame and refine the Committee's goals with regards to specific HAIs of focus since HAIs exist as a broad category (e.g. different devices, different pathogens, different settings, etc.).

4. Research about Other States' Attempts at Mitigating Interfacility Spread of MDROs

One of the action items from the November meeting was to conduct research into how other states had overcome, or were working to overcome, the challenge of MDRO's spreading between healthcare facilities during the patient transfer process. Jackie Reuben reached out to Oregon, Illinois and Utah to learn more about their various strategies for addressing this challenge and presented the findings at this January Committee meeting. There was much discussion during the previous Committee meetings around the possibility of creating a more current standardized patient transfer form that could be utilized by all healthcare sectors. However, the main challenge with this is that different healthcare facilities have different needs for their patients, have access to different technological resources, have varying levels of personnel availability and have varying levels of personnel expertise. Therefore, the big challenge for DC is finding a systematic solution that is both effective and realistic.

State Example: Oregon

Jackie provided an overview of activities that have been implemented by the state of Oregon various to address the issue of MDROs spreading between healthcare facilities. Oregon has a CRE working group called the Drug Resistant Organism Prevention and Coordinated Regional Epidemiology (DROP-CRE) network and this working group is composed of representatives from Oregon Health and Science University, Portland VA Medical Center, Oregon State University, Oregon Public Health Division, and the Oregon Patient Safety Commission. Other collaborators include representatives from Centers for Disease Control and Prevention (CDC), regional laboratories, regional hospitals, and the Oregon Association for Professionals in Infection Control (APIC). The network has conducted surveys of laboratories, infection preventionists, and long term care facilities and has provided education through presentations, webinars, and the Oregon CRE Toolkit (pdf). The Oregon State Public Health Laboratory has increased capacity for rapid detection through testing for carbapenemases by polymerase chain reaction (PCR), Modified Hodge Test, and Carba-NP. The network provides assistance with response to individual CRE cases and outbreaks. The Public Health Division has made CRE reportable by state law to institute ongoing surveillance.

Oregon's rule 333-019-0052 mandates that when a referring health care facility transfers or discharges a patient who is infected or colonized with a multidrug-resistant organism (MDRO) or pathogen which warrants Transmission-based Precautions, it must include written notification of the infection or colonization to the receiving facility in transfer documents. The referring facility must ensure that the

documentation is readily accessible to all parties involved in patient transfer (for example, referring facility, medical transport, emergency department, receiving facility). One thing to add to this is Oregon considers the following to be health care facilities: hospitals, ambulatory surgery centers, nursing homes, residential care facilities, assisted living facilities, and adult foster homes. The rule goes on to require that when a facility becomes aware that it received a transfer or that it transferred or discharged one or more patients with an MDRO then that facility must notify the referring or receiving facility.

This rule requires that a transferring facility provide a written notification to a receiving facility if a patient has a known MDRO. However, the rule does not prescribe an exact method or a specific form of the written notification, but does provide examples of forms that facilities might use. Thus there is no standardized form that all facilities use and can expect to receive. In addition, written notification is not required to be a stand-alone form, and can therefore be might "buried" with other documents in the chart. DOH discussed the rule and its implementation with the Oregon HAI Team in November 2016. Feedback from Oregon's facilities highlighted the importance of documenting when a patient has any pending cultures to alert the receiving facility of a suspected infection and that follow-up is necessary. They also stressed the importance of asking about "MDROs or any other pathogen". The rule states "MDRO or pathogen that warrants Transmission-based Precautions," and facilities tend to focus only on MDROs. In conducting their ICAR assessments, the Oregon's DOH found that verbal communication was the most common, but that different staff roles were responsible for the communication of this information at different facilities. The Oregon DOH also found it difficult to track and enforce this regulation, as it would require intensive chart review given the frequency of transfers in the state. The DOH is currently conducting projects to validate the notification process; they are attempting to clarify who is responsible for communications at each facility so as to target and better educate these personnel. In addition, the DROP-CRE network is working to more actively involve EMS as a facilitator of communication during the transfer process. This is especially important for transfer from SNF to hospitals, Oregon's facilities noted that the most common methods of transport is ambulance.

State Example: Utah

Jackie provided an overview of activities that have been implemented by the state of Utah to address the issue of MDROs spreading between healthcare facilities in their state. Utah's original form was adopted by the CDC and Utah's HAI working group adapted the form based on feedback from their healthcare facilities, healthcare providers and medical transporters. The form is not required but is highly recommended by UTAH's DOH. After implementation, facilities stated that they liked the content and the increased communication between one another.

During Utah's ICAR assessments, the Utah DOH found that the paper copy patient transfer form was not getting much use (most times the form was only used electronically). However, one major health system is uploading the form to their electronic system. The Utah DOH also found that LTC facilities were actually using the form more than anticipated. Those LTC facilities with an electronic system could grant the acute care access to view the form's information and case management staff within the hospitals could also have access to the information.

Similar to Oregon, a major barrier for Utah was identifying who at the healthcare facilities completes the various fields and oversees the completion of the form (e.g. Discharge nurse? Discharge planner? Where is the form placed in the chart?). Their next step will be to work on a process evaluation as they have identified that reporting isn't as complete as it should be and currently needs to be improved. This

improved reporting will be necessary to populate an electronic MDRO registry, which they are hoping to have up and running 5-10 years down the line.

State Example: Illinois

Jackie provided an overview of activities that have been implemented the state of Illinoise to address the issue of MDROs spreading between healthcare facilities in their state. Illinois has a voluntary MDRO surveillance network of hospitals called the REALM project. REALM initially included acute care hospitals in Chicago with 10 or more ICU beds (24 of 25 of which were eligible), and LTACHs in Cook County (7 of 7 of which were eligible). They conducted a series of point prevalence surveys every 6 months, with KPC surveillance beginning in 2010 and results from these surveys indicated that CRE was relatively common in some Chicago HCFs (particularly LTACHs). The Illinois DOH was concerned that CRE had the potential to spread further, and prevalence data from non-ICU hospital wards, nursing homes, and outside of Chicago was limited. This led to the creation of the Illinois XDRO registry, which as two primary functions: 1) when a facility identifies a CRE-carrying patient, that patient is reported to the XDRO registry and 2) when a patient with unknown CRE status is admitted, HCF can query XDRO registry to determine whether or not isolation precautions are needed.

This XDRO registry has an automated alert system that sends a text or an email to the appropriate provider(s) alerting them that a recent facility admit has been matched in the registry and login to for more information. Patients end up in the registry via manual data entry at the Illinois DOH. The registry is HIPAA compliant and housed on a web-based portal in the same place as the Nationally Electronic Disease Surveillance System (NEDSS). This enables those who have access to NEDSS to also automatically have access to the XDRO registry.

State Example: Maryland's Chesapeake Regional Information System (CRISP)

Jackie provided an overview of Maryland's Health Information Exchange (HIE), the Chesapeake Regional Information System (CRISP), which was created in 2006 for a small number of hospitals. CRISP now includes data that is inputted from a range of stakeholders including clinicians, hospital, patients, privacy advocates, payers and regulators lawmakers. CRISP utilizes a hybrid technology approach and consists of three general HIE models: 1) A centralized model stipulates that all participants' medical records will be kept in a central repository (database), under the control of the HIE and out of the direct control of participating entities; 2) A federated or distributed model that keeps the data at its source facilities or with providers and uses the HIE as the conduit for sharing; and 3) a Personal Health Record under the control of the patient, and does away with HIE services such as master person index (MPI) and registry. The overall system uses a secure and trusted conduit rather than a centralized repository and maintains confidential healthcare data at the participating facilities, with an option for the consumer/patient to ask for his or her information to be held in a health record bank account that he or she controls. Consumers also have the ability to opt-out of participation.

Secondary uses of CRISP offer clear public health benefit. For example, databases of anonymized health information can be used to create quality improvement initiatives aimed at identifying best practices and defining evidence-based practices and care management plans. The clinical query portal is a free tool available to clinical staff, regardless of the type of healthcare facility and regardless of whether or not clinical information is being contributed to the system. Therefore it's a free tool that can be utilized by ambulatory practices and skilled nursing facilities. As clinical information is created and shared with CRISP, it is made accessible in real-time to participating health care providers through the portal. This

allows providers to securely look up patient information through the internet and provides access to real-time clinical information.

All of DC's acute care hospitals currently use CRISP. One of DC's SNFs joined CRISP in 2015 and is currently utilizing two of the system's main functions: 1) EMS notification of admit to ED or hospital in order to facilitate the coordination of care and 2) the query portal for the purpose of monitoring statuses of patients in the hospital. This SNF is currently piloting the reporting function and encountered few technological challenges when first implementing this system into their facility's day-to-day practices. The biggest issue encountered was staff remembering their user IDs and passwords. The biggest overall challenge this SNF faced with implementing CRISP was with education and change management. This is because they mainly relied on paper records beforehand (as is the case with most SNFs in DC).

5. Follow-up Discussion Mitigating Interfacility Spread of MDROs

Acute care representatives asked about the challenges Utah encountered with their patient transfer form. Jackie reiterated that the main difficulty was enforcing the use of the form and making sure it was being used properly. There was also a question about how the Oregon healthcare systems dealt with pending lab results and how these results were communicated to the next facility; this was brought up because many of DC's healthcare facilities are dealing with this particular challenge (i.e. knowing to whom at the new healthcare facilities finalized results should be communicated). The Oregon legislation did not go in to detail about the communication processes at the facility level.

An outpatient representative mentioned that many of DC's outpatient primary care facilities are already using CRISP but that many of the SNFs are not yet on board with using it in any capacity. Jackie thought that CRISP would serve as a potential short and long term solutions to mitigating the spread of MDROs when patients move between different healthcare facilities and between different healthcare settings. A SNF representative suggested having an overview of CRISP presented at an upcoming DCHCA meeting. It was also suggested that a representative from the one DC SNF that is currently using CRISP give a presentation about their experience at an upcoming DCHCA meeting; other attendees agreed with this suggestion. Other SNF representatives also stated that using a hard-copy patient transfer form would be too much additional work and not practical in emergency situations, which further bolstered the idea of pursuing CRISP as a potential solution.

Jackie mentioned that DOH is working on getting additional input from DC Fire and EMS (DC FEMS) because they have communication systems that might be able to incorporate a way to flag patients based on MDRO status. A SNF representative mentioned that this is a good idea, however, it won't capture the majority of patients who are being sent to an acute care facility. This is because SNFs often do not use EMS to send a patient to an Emergency Department (ED). Dr. Iyengar mentioned that there appears to be very clear processes honed out for sending a patient from an acute care facility to a skilled nursing facility. However, a lot of the communication process breakdown appears to occur when a patient leaves a SNF to go back to an acute care facility or elsewhere. Dr. Iyengar also reiterated the importance of distinguishing between "history of MDRO" versus being colonized or having an active MDRO infection. This is because the infection control implications are difference for each of these categories and the infection control implications vary depending on the specific healthcare setting. It was also mentioned that MDRO related guidance should be available for other situations, such as when information regarding MDRO status is completely missing from a patient's chart.

The discussion shifted towards the capacity differences experienced by SNFs versus acute care facilities when dealing with patients who are either actively infected or colonized with an MDRO. Right now SNFs only have the capability to isolate patients with an active infection whereas acute care facilities could isolate those who fall within both categories. In addition to this, isolated SNFs patients cannot leave their rooms (for the most part), which cases significant challenges with external activities such as physical therapy, socializing, etc.

6. Next Steps for Establishing the Committee

Emily Blake took a few minutes to discuss minor administrative items related to moving the committee towards a more established and formalized group. There's still the issue of getting more representation from doctors who oversee prescribing practices on the committee, especially those who work in the skilled nursing facilities. This stakeholder group plays a key role in the prescribing and HAI prevention practices at the skilled nursing facilities and therefore needs to be at the table in order for future changes to be effectively implemented. Emily also mentioned the need for the HAI Advisory Committee to have its own webpage where meeting summary reports, Committee members and other relevant items could be readily available to external Committee stakeholders and members of the public. Partnership agreement forms were passed out to Committee members to acknowledge their role and responsibility of being a Committee member. Meeting attendees were all in agreement that the meeting summary reports that should remain in the 3rd person, with the exception of DOH staff who assist with running the committee or those presenting agenda items. Meeting summaries will be sent out for review by the Advisory Committee prior to being posted on the DOH-hosted HAI Advisory Committee website.

7. HMC-HAI Spring Workshop

Shannon Davis provided an update on the Spring HAI workshop planning efforts. The main purpose of this workshop is to provide all stakeholders (individual healthcare staff and individual facilities) an opportunity to voice their thoughts and concerns about the current state of HAIs in the district and how they should be addressed and prioritized. This workshop has been tentatively scheduled for March 22, 2017 from 9am – 12pm. Goals of this workshop include 1) introducing the DOH HMC and the HMC HAI workgroup & present Committee members, 2) facilitating discussion on HAI priorities in the District and region, 3) fostering interdisciplinary stakeholder relationships and 4) highlighting District best practices. The meeting will be structured to include a keynote speakers, panel discussion, and interactive facilitated discussions among the attendees. The HMC is in the process of recruiting speakers and those who are interested in helping with planning the event; interested parties should reach out to Victoria Alabi at Victoria.Alabi@dc.gov.

8. Overarching Discussion Theme and Priorities

Look into developing practical guidance about the various MDRO statuses: Different healthcare sectors have different capabilities and different circumstances to consider when dealing with patients who have

active MDRO infection, are colonized with an MDRO or have a history of an MDRO (colonized or active infection).

9. Next Steps

Obtain priorities from external Committee stakeholders at HMC-HAI Spring Workshop: This workshop will be held on March 22, 2017 and will be open to all of DC's various healthcare stakeholders who play a role in HAI prevention. This workshop will contain a structured brainstorming session that will collect information from this wider stakeholder group. The feedback will be brought back to the HAI Advisory Committee to help determine which priorities to focus on first.

Keep working on a big-picture timeline for the HAI Advisory Committee: The HMC HAI Spring Workshop will help the HAI Advisory Committee hone out a timeline for addressing specific priorities.

Identify and recruit medical directors and physician prescribers who work in skilled nursing facilities: DOH will continue to reach out to the SNF committee to identify additional committee members to represent this stakeholder group.

Introduce CRISP to the larger SNF community: Janice Johnson will work with DCHCA to schedule a CRISP presentation at an upcoming DCHCA meeting.

10. Adjournment: Next Meeting Date – April 12, 2017 (in-person)