**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, 5th Floor HECC**
**June 14, 2017 | 10:00am – 12:00pm**

## Meeting Summary Report

### 1. Welcome and Introductions

Dr. Iyengar welcomed and thanked everyone for attending the Health and Medical Coalition (HMC) Healthcare-Associated Infections (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. 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 meeting include continuing 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 Committee Roles and Responsibilities

Emily provided the Committee with an overview on the expectations surrounding serving as a member. One of the main reminders was that the Committee was formed to have representation from diverse healthcare stakeholder groups as opposed to having representation from individual healthcare facilities. The purpose of this was to make the Committee more inclusive while remaining small enough to facilitate substantive discussion. Therefore, professional associations, which tend to represent various healthcare sectors, were invited to join the Committee by nominating 1-3 representatives.

In order for the Committee to serve its dual purpose of facilitating productive conversation while remaining inclusive to larger groups, DOH is expecting Committee members to serve as liaisons between the Committee and their larger stakeholder groups. This means bringing information to the Committee from their respective colleagues in their fields/associations as well as disseminating information from the Committee back to their colleagues in their respective fields/associations. In addition, regular Committee member attendance is tantamount to the success of the Committee's mission and vision.

Overall the DC HAI Advisory Committee is charged with making recommendations to DC DOH when it comes to planning, implementing and evaluating HAI prevention activities within the District. The HAI Program is acutely aware of the need for diverse expertise and diverse sector consensus when it comes to addressing HAI related issues in the District.

## 4. Discussion about Short and Long Term Committee Priorities

**Quick Review of Acute Care District Level NHSN Data**

Jackie provided the Committee with an overview of DC's NHSN data for the past two years. Data were presented for the short-term and long-term acute care facilities and for each type of reportable HAI in DC (with the exception of SSIs and CRE) between January 1, 2015 and June 9, 2017; all 2017 data were considered incomplete for April through June. She also presented the CLABSI and CAUTI data in a way that contrasted different facility locations, such as critical care, wards, and stepdown units.

For CLABSI and CAUTIs, there has been no significant difference between the District and the national baseline for each quarter in 2015 and 2017. In general, MRSA has not had any significant differences from the nation baseline in this timeframe, with the exception of the first quarter of 2016 where there was an outbreak within a single facility. CDI has been significantly different from the national baseline (with each quarter having more and more subsequent numbers of infections) since quarter 3 of 2016, which also aligns with the feedback provided by the larger HAI stakeholder group during the HAI Spring Workshop in March 2017.

A few of DC's acute care facilities have had some data quality issues, some of which have been reported to the HAI Program and are being actively addressed by the facilities. The HAI Program is also in the process increasing support for conducting or improving internal NHSN validation activities within individual facilities. The HAI Program applied for additional funding to conduct external NHSN validation activities, however, the current political and funding climate (at the congressional level) does not give DOH programmatic staff high hopes for receiving these extra funds.

**Active Committee Discussion: CDI**

Several acute care representatives started a discussion about the need to take a deeper dive into the District's CDI data. Facilities that have identified CDI issues are actively working towards addressing them. However, these facilities expressed feeling a bit overwhelmed due to a lack of guidance and evidence-based understanding surrounding this particular pathogen. One acute care representative speculated that the CDI issue at their facility is likely due to a combination of things: 1) CDI is induced by improper use of antibiotics, 2) some patients are already extremely vulnerable to CDI as a result of being on chemotherapy, 3) many cases are likely missed opportunities for properly identifying the causal pathogen in a timely manner (i.e. norovirus versus CDI), and 4) a lack of defined roles with regards to who should take the lead in identifying CDI in the facility (infection controls staff, ED staff, etc.). There's also the challenge of distinguishing between colonized versus infected. Unfortunately many facilities feel they are

being penalized for having to report community onset cases as hospital onset cases into NHSN due to a lag time between testing and admission and due to a lack of clear testing protocols within their facilities. A SNF representative also mentioned that over testing for CDI is a common occurrence within the non-acute long-term care setting, as well.

General consensus among today's meeting attendees was a CDI subcommittee should simply focus on figuring out what the next best steps for addressing CDI in the district would be, as opposed to trying to eliminate CDI in the District. For example, there's still a lot of research that needs to be done to gain an understanding about the burden on CDI in the District. While all acute care facilities in the District have been reporting CDI data to DOH via NHSN for many years, there are still gaps within these data and unanswered questions. In general, it would probably be best for this subcommittee to get a clearer picture about CDI in the District and then figure out the best way to approach it at a local level.

**Active Committee Discussion: Antimicrobial Stewardship (AS) and Antimicrobial Use (AU) Data**

The Committee and meeting attendees agreed that it's important to focus on utilizing data resources that are already available from DOH, individual healthcare facilities, and other government partners as opposed to focusing on collecting new data. Right now a few acute care facilities are working towards reporting AU and antibiotic resistance (AR) data into the NHSN Antimicrobial Use and Resistance (AUR) module. However, this is a costly, time consuming, and difficult endeavor and will not be a reliable source of AU and AR data anytime within the near future. The only NHSN antimicrobial stewardship data that is available from all District healthcare facilities is through the annual NHSN facility survey.

During the April Committee meeting there was discussion about obtaining and analyzing claims data for antibiotic prescribing practices. The challenges with this, however, is that private and Medicaid/Medicare claims data are segregated into different datasets, which would then have to be requested from separate District stakeholder groups (e.g. DC Healthcare Finance, Delmarva Foundation, etc.). A SNF representative said that, in light of the new CMS AS mandate, the SNFs are collecting everything related to AS. However, there's little direction or guidance surrounding this data collection. An acute care representative mentioned that obtaining AS outcomes data is very easy to collect, however, that is not the case with AS process data. A Delmarva representative mentioned that AS and AR initiatives are in the process of starting within the DC SNFs, which could serve as a preexisting resource that might be leveraged or used to bolster other related initiatives.

A Delmarva representative brought up the fact that many (if not most) acute care facilities are already collecting their own AU data, however, these data are not shared with other facilities in the District. This is something that the HAI Advisory Committee might consider requesting the facilities to share with DOH and the Committee so individual facilities' efforts could be maximized and ultimately benefited by more stakeholders. This would of course be done with the caveat that pharmacy data is extremely complex and difficult to measure and that any District-wide AU database would simply be a best estimate even after it's cleaned and validated. A ROAR representative brought up the fact that ROAR has created a regional antibiogram for the past few years, which enables facilities to get an idea about other facilities' AR data and use it for their own AS purposes. Unfortunately, significantly more effort is required by the facilities to collect and share AU data in the same way they share AR data with ROAR.

A few Committee members asked if it would be possible for the regional antibiogram to be shared made publically available, either at a facility level or aggregate level. ROAR's response was they are not comfortable with making the antibiogram publically available (e.g. on the DC HAI Advisory Committee

website) because it is still possible to determine which facility is which even though the antibiogram is technically de-identified. Another caveat with the antibiogram is that it was a side activity for all facilities involved. Some of these facilities have had some turnover with the staff who originally worked on it, so this may result in lags or resistance with future versions. An acute care representative said that regardless of these caveats, a regional antibiogram made publically available would send a message that DOH and the Committee are engaged on the issue of AR.

In general, the consensus that addressing AS through a subcommittee would be a lot of work and it would be important to remain cognizant of collaboration fatigue. AS is a topic that encompasses a lot of different fields and addressing any one issue might get complicated very quickly. This AS subcommittee discussion also re-highlighted the major gap the Committee has with SNF prescribers. A ROAR representative mentioned that the upcoming DOH SNF infection control assessments might serve as a good opportunity for identifying and engaging some of these folks.

**Active Committee Discussion: CAUTIs**

An acute care representative noted during Jackie's NHSN data presentation that, while CAUTIs in DC are under the national baseline and have not had any significant changes from the baseline during the past two years, the CAUTI SIR for the District could still be much lower. Addressing CAUTIs could be a relatively simple endeavor (as compared to addressing CDI and issues surrounding AS) that would yield high rewards within the realm of patient safety and hospital reimbursements; in other words, addressing CAUTIs would be considered low hanging fruit for the Committee. A ROAR representative said that activities used to address CAUTIs (i.e. initiatives that focus on improved protocols and efforts that instill behavior change) would also likely cascade down into other activities areas of focus for the Committee, such as AS.

The general consensus among those in attendance was that many facilities don't currently have strong checks and balances when it comes to routinely assessing the need for a Foley catheter. Anecdotally, it is not uncommon for a patient to be transferred from one unit or facility to another unit or facility with a Foley catheter and nobody checks upon discharge whether or not it is still appropriate for the patient to have it in place. Therefore, focusing on evidence-based protocols that lead to system-wide behavioral changes might be a good area of focus for a subcommittee.

## 5. Discussion about Subcommittee Formation

Preliminary consensus among attending Committee members was to form the following three subcommittees:

1) CDI
2) CAUTI
3) Antimicrobial Stewardship

However, due to this meeting's low attendance, subcommittees will not be finalized without input from the larger HAI Committee group. Therefore, there are still opportunities for Committee members to propose new ideas for subcommittees if they feel there are additional areas that warrant immediate attention. Non-Committee members (i.e. those who are part of the larger stakeholder groups being represented) would also be welcomed to join the subcommittees.

Dr. Iyengar suggested that the subcommittees would be used to take practical and tangible action towards an HAI issue in the District and that the subcommittees would be in charge of figuring out what this action would entail. The subcommittees would come up with a proposal that would then be approved by the

larger Committee. The subcommittee would formulate their own approaches (e.g. meeting frequencies, etc.) and adapt these approaches as needed.

Committee attendees at this meeting also thought it would be best to have subcommittee meetings take place monthly until they are fully up and running and that a larger proportion of the Committee meetings could start taking place via conference calls (instead of always occurring in-person).

## 6. Next Steps

The HAI Program will send out a brief survey to inform immediate next steps about:

- Committee members' interest and approval of proposed subcommittee formation
- Identifying subcommittee leads and co-leads

## 7. Adjournment: Next Meeting Date – August 9, 2017 (in-person)