Government of the District of Columbia
Department of Health

District of Columbia
Health and Medical Coalition

Healthcare-Associated Infections (HAI) Workgroup & Advisory Committee
Kickoff Meeting

Room 406 at 899 N. Capitol St. NE
November 16, 2016
10:00 AM – 12:00 PM

Meeting Summary Report

1. Welcome & 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 September Committee Meeting

Emily provided an overview of the key points discussed at the last advisory committee meeting, which took place on September 21, 2016. At this meeting there were representatives from many healthcare settings such as short-term acute care hospitals, long-term acute care hospitals, skilled nursing facilities (SNFs), outpatient primary care, academic and coalition partners. Representatives from these settings agreed that there were several priorities that span across the various healthcare sector lines and are currently very challenging. These issues included 1) communication breakdown during the patient transfer process between facilities and settings (e.g. when a patient in a SNF is sent to an acute care facility or when someone is discharged from acute care facility and needs to follow-up with their PCP), 2) ensuring that all appropriate staff are properly trained and educated about appropriate antibiotic use and how to work towards ongoing education and training, 3) a more efficient flow of health information, especially electronically and 4) the lack of antibiograms, whether it's at the facility, district or regional levels.

During the September meeting there was discussion about recruiting additional stakeholders who could represent medical directors (from SNFs) and case managers (from both SNFs and acute care facilities). The DOH HAI Program had some difficulty with how to best identify and recruit these specific stakeholders so they made this an action item on the November meeting's agenda for further discussion (please see "Additional Items" section for further details).

One of the major challenges discussed during the September meeting was the need to tackle the spread of multidrug resistant organisms (MDROA) and *Clostridium difficile* (CDI) by strengthening the interfacility patient transfer process. As a result of this discussion, the DOH HAI Program developed a short survey to get a preliminary and high-level understanding of the patient transfer practices utilized by each facility and healthcare setting, as well as how each of the facilities are impacted by outside facility transfer practices. Responses from this patient transfer questionnaire were compiled for presentation during today's meeting (please see "Patient Transfer Questionnaire " section for further details).

Another item mentioned during the September Advisory Committee meeting was the pending newly revised regulations, which were available for public comment at that time. These newly revised regulations (DCMR 22-208.1) were brought up during the meeting to give all of the healthcare facilities an additional heads up about the changes. DOH reiterated that the facilities still have the opportunity to weigh in and provide feedback about the regulations, if they felt the need to do so. The DOH HAI Program sent all committee members a link that contained the newly proposed regulations and how feedback could be formally submitted for the DC Council review (please see "Additional Items" section further details).

Victoria provided a brief overview of the Health and Medical Coalition (HMC) for those attendees who were not at the initial Advisory Committee kick-off meeting in September. The HMC was established by an Executive Order signed by Dr. LaQuandra Nesbitt in March 2015. The HMC is a multi-agency coordination entity that creates synergy between public health, healthcare, and emergency management (planning, exercises and response). The mission is to strengthen the resilience of the healthcare system to disasters through strategic planning, stakeholder engagement, and training and exercises. Three workgroups were developed through the HMC, including the HMC-HAI Workgroup, which houses the DC HAI Advisory Committee. The purpose of the HAI Workgroup is to advance infectious disease preparedness planning across public health and healthcare systems through facilitation of cross-discipline coordination/communication.

3. Patient Transfer Questionnaire

One of the major challenges discussed during the September meeting was the need to tackle the spread of MDRO's and CDI by strengthening the interfacility patient transfer process. As a result of this discussion, the DOH HAI Program developed a short survey where they asked each individual facility to outline the current process for transferring and receiving patients as well as identify the major challenges their facility faces when taking-in or sending-out a patient for continued care. Responses were collected in both quantitative and qualitative formats, depending on the question being asked. Emily presented the results of the patient transfer questionnaire, which included responses submitted by staff working within skilled nursing, long-term acute care and short-term acute care facilities. The HAI Program received responses from 8 of the 10 DC acute care facilities and 7 of the 19 DC SNFs at the time of the November meeting.

<u>Transferring/Discharging Patients to another Healthcare Facility for Additional Care</u>

When asked the question "Is MDRO infection status **specifically communicated** to the receiving facility?" over one-third of responding facilities said they do not specifically communicate infection status to the receiving facility (Figure 1). This question gets at one of the major concerns expressed by many representatives during the September meeting discussion, which is difficultly with determining the MDRO infection status of a patient either prior to or shortly after his or her arrival (for example, the patient arrives without any lab results or a clinical staff member has to take a lot of time to sift through entire medical record to find out whether or not the patient needs to be on contact precautions, etc.).

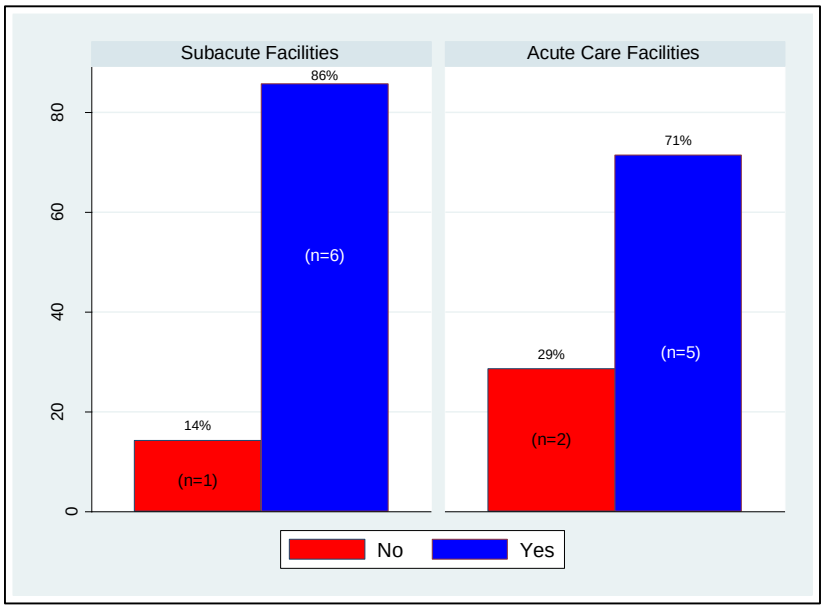

Figure 1: Responses to the question: "Is MDRO infection status specifically communicated to the receiving facility?" from the Patient Transfer Questionnaire.

When asked the question "Does your facility **require** the completion of a transfer form to accompany the patient?" over three-fourths of responding facilities said they do not specifically require a transfer form to accompany an outgoing patient (i.e. a patient being sent to another healthcare facility for the purpose of continuing their care) (Figure 2).

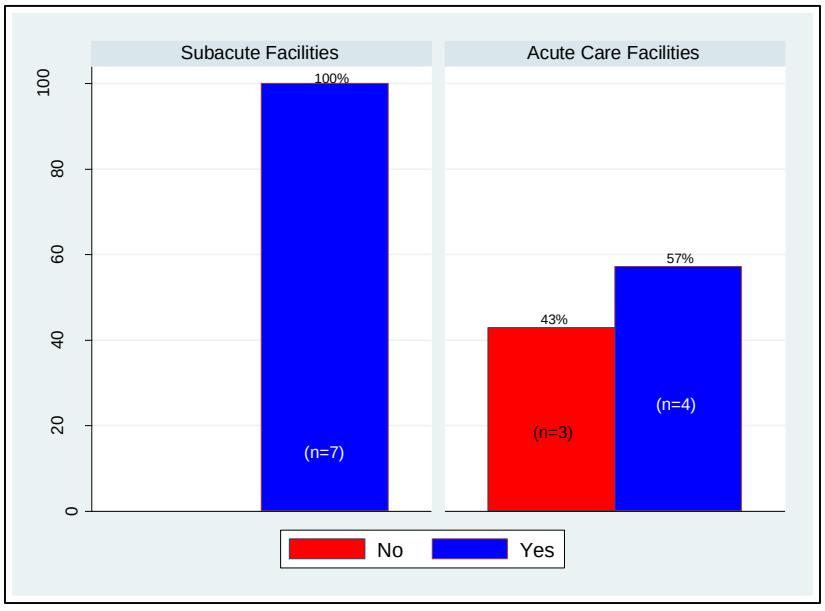

Figure 2: Responses to the question: "Does your facility require the completion of a transfer form to accompany the patient?" from the Patient Transfer Questionnaire.

Facilities that reported requiring the completion of a transfer form provided DOH with the information included on their forms. All of these facilities required the following information: 1) patient name 2) patient date of birth, 3) name address of sending facility and 4) address of sending facility. Over 90% of the facilities required "reason for transfer" and "sending facility point of contact" be included on their

forms. Over 80% of the facilities required the "condition of patient on transfer," "patient diagnosis" and "culture reports/labs" be included on their forms. Over one-third of transferring facilities did not require that information about a point of contact at the receiving location be included on their patient transfer forms (Figure 3).

	No	Yes
Name/address of sending facility	***0***	***14 (100%)***
Sending facility point of contact	1 (7%)	13 (93%)
Receiving facility point of contact	6 (43%)	8 (57%)
Reason for transfer	1 (7%)	13 (93%)
Mode of transportation	4 (29%)	10 (71%)
Condition of patient on transfer	2 (14%)	12 (86%)
Patient name/initials DOB	***0***	***14 (100%)***
Patient isolation status	3 (21%)	11 (79%)
Patient antibiotic status	4 (29%)	10 (71%)
Patient diagnosis	2 (14%)	12 (86%)
MDRO infection status	5 (36%)	9 (64%)
Culture reports/labs	2 (14%)	12 (86%)
Discharge summary	5 (36%)	9 (64%)
Complete medical record	7 (50%)	7 (50%)

Figure 3: Reponses to the question: "What information is provided to the receiving facility?" from the Patient Transfer Questionnaire.

The most commonly reported method of communication used to share patient discharge and transfer information is paper records that accompany the patient, which was reported by 86% of the responding facilities. The second most commonly utilized form of communication under these circumstances is verbal communication, which was reported by 57% of the responding facilities. Forty-three percent of facilities reported using an electronic form of communication during the patient discharge and transfer process. Most facilities used a combination of paper and verbal communication, with the SNFs more commonly reporting verbal or paper (i.e. not electronic). In the comments section of this question, it was often noted that verbal reports were not consistently given or documented when received.

Communication during the transfer process was highlighted in the qualitative results, which lead to many additional questions for discussion such as 1) should there be a District-wide patient transfer form required? 2) What specific form elements are a "must" to be completed? 3) How does the issue with staff turn-over play into being able to identify a point of contact? The quantitative and qualitative portions of the question also made it apparent that while providing a complete medical record technically means all of the wanted and required information is being given or received, however, in practice this is not exactly the most helpful and efficient way of doing so.

When asked "How is the patient physical transported from your facility?" 86% of respondents reported using a non-emergency medical transportation provider, 43% reported that the patients themselves or their families transported them to the next facility and 36% of respondents reported that they used facility-managed transportation.

Receiving Patients from another Healthcare Facility for Additional Care

When asked the question "Does the admitting staff ask if the patient has been treated or resided in another healthcare facility in the recent past (e.g., last 30 days)?" Over one-third of responding facilities responded "no" (Figure 4) and some went further to comment that sometimes a healthcare worker will

informally ask this question but not always document the obtained information in the patient's medical record.

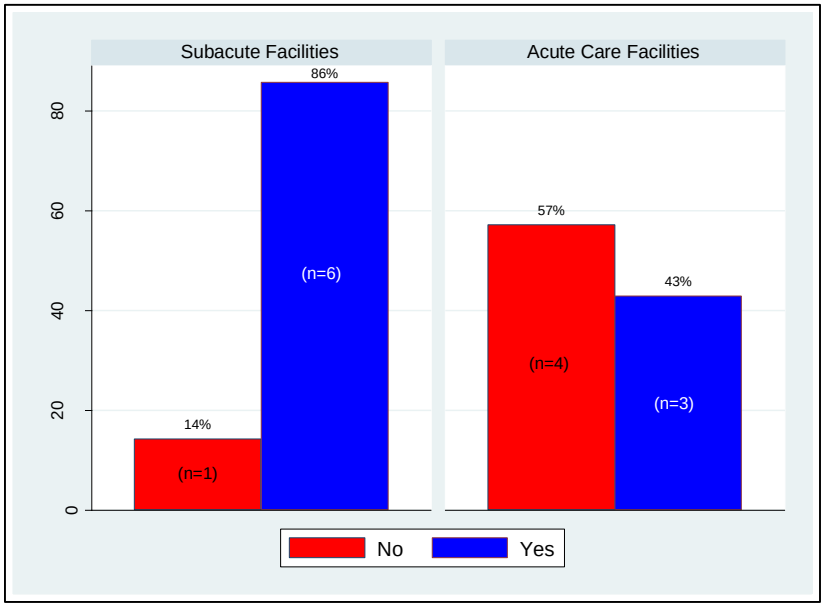

Figure 4: Responses to the question: "Does the admitting staff ask if the patient has been treated or resided in another healthcare facility in the recent past (e.g., last 30 days)?" from the Patient Transfer Questionnaire.

In analyzing the challenges reported by acute care facilities with transferring/discharging patients, two general themes emerged: 1) the authorization/approval process, and 2) patient transport. The most common authorization/approval challenges with regards to sending/discharging a patient were: insurance coverage (patient's insurance status; insurance issues across states may delay the transfer process), capacity of the receiving facility (in size/available beds), types of beds (e.g. long-term care beds for Medicaid patients), and the level of care required for the patient (vent patients, patients with co-occurring psych or substance abuse disorders). The two main issues that emerged with regards to transportation were timeliness and lack of clear communication between sending and receiving facilities. Similar to challenges faced by acute care, sub-acute facilities reported issues with the timeliness of transportation vehicles, as well as the capacity of vehicles to transport patients with specific needs. Communication was also identified as a theme, with the main challenge surrounding the communication of patient clinical information.

In receiving patients, acute care facilities commonly face challenges with patient insurance coverage (huge) or with receiving correct information. Poor communication of clinical information was also reported as being a hindrance to patient care at times. Major concerns for the sub-ac facilities in receiving patients was the inability to accept patients during certain hours or days when all staff disciplines are not onsite and assess the patient upon arrival. In addition to this, communication of clinical information that pertains to MDRO status was reported as being especially challenging for sub-acute care facilities, such as the ability to obtain lab reports confirm diagnosis of MDRO status or a timely change in patient medication.

4. Advisory Committee Discussion in Response to Patient Transfer Questionnaire

Emily started the discussion by asking the Committee what their initial thoughts were after seeing the results of the patient transfer questionnaire. An acute care representative stated that one major

challenge with communicating MDRO status to secondary facilities is that often times a lab result will come back after the patient has been transferred to an outside facility. This makes it difficult and sometime impossible to track down the appropriate person to communicate the lab results. There is also sometimes a challenge with admission staff remembering to ask about a patient's MDRO status if the information is not immediately available. While infection control staff are mindful about flagging newly admitted patients who have MDROs, this is something that the admission staff don't always catch. A SNF representative stated that each time a new patient is admitted to her facility, the discharge summary is reviewed, and however, this doesn't always contain a patient's antibiotic or MDRO status. It would be nice if all of the important and pertinent information could be available in one place. There was continued discussion from the SNF representatives about the challenges with managing a patient who is admitted late at night when there are less staff on hand to sift through all of the paperwork. This is especially challenging for some SNFs because they don't have the same level of round-the-clock staffing that acute care facilities have. In addition, if a patient's MDRO status is unknown upon admission, the SNF is stuck balancing whether or not they should immediately isolate the patient because if they don't and later on have to move the patient then they're in violation of other patient safety regulations (such as not restricting the number of times a patient is moved from room-to-room).

A representative from the acute care community mentioned that there's a lot of work going on with the coordinated care model and that a lot of other states, such as Massachusetts, are making great strides. While the main goal of this model is to prevent readmissions, it might also serve as an opportunity to positively impact the spread of the HAIs. It would be a good idea to better understand the status of coordinated care within DC and what groups are actively working on this. There are often non-clinical staff involved in the discharge process, however, their non-clinical roles make it a bit challenging to efficiently tackle the poor communication issues that result in the spread of MDROs. Additional acute care representatives thought it would be a good idea to look further into how non-clinical staff could be better assisted with addressing clinical challenges (such as the spread of MDROs) using pre-existing systems.

A HRLA representative stated that it is disconcerting that there sometimes only exist verbal communication about MDRO status and that this verbal communication is not always documented. This makes it difficult to audit facility practices and can compromise patient safety. Another acute care representative stated that many of the existing patient transfer forms are clearly very old and outdated, as indicated by the fact that the only communicable disease shown on one of the example forms is Tuberculosis and nothing else (such as MRSA). It would be more productive to have an up-to-date form that highlights today's current clinical priorities. Further discussion looped back to looking into other exiting models that utilize a common approach to tackling priority HAIs, such as MDROs. Examples of this would be flagging patients with MDROs in various EMRs. However, a SNF representative states that the problem still lies with the issue of poor communication when a patient moves between acute care and SNF facilities. Most of the SNFs do not have sophisticated EMRs the way acute care facilities do, which means flagged patients aren't necessarily known to the SNFs upon arrival. This also happens when patients are sent from SNFs back to the acute care facilities.

Dr. Iyengar asked if Committee members thought that having a standardized city-wide form or system would be of interest to all healthcare facilities and settings. This would also include standardize guidance on communication procedures. An acute care representative stated that not all acute care patient populations are relevant to the SNF setting so it would be important to have well-defined priorities and risk stratification incorporated into any standardize forms. Another acute care representative mentioned that looking into what other states are currently doing to address this issue would be a good next step. The Committee should also consider looking into the possibility of incorporating CRISP to automatically generate the desired HAI discharge information for easy presentation to discharge planners. Dr. Iyengar

stated that to DOH HAI Program could do some further research into other states' activities and interventions around this complicated issue and then further survey DC's healthcare facilities about patient transfer form priorities moving forward. She also stated that CRISP is unfortunately not yet available to DC's SNFs or the DOH due to cost and user agreement issues. She and her HAI team will need to look into possible ways of getting around these issues but it could take longer than what is practical for the committee. An acute care representative stated that this challenge of figuring out how to efficiently communicate HAI/MDRO information across healthcare settings during times of admission and discharge is a good opportunity to build strong and lasting partnerships between the acute care and post-acute care settings. Perhaps DOH could look into a platform that would serve as a neutral and low-cost starting point for this communication, such as RedCap.

5. Additional Items

Identifying Medical Directors and Prescribers

During the September meeting there was discussion about recruiting additional stakeholders who could represent medical directors (from the SNFs) and case managers (from both SNFs and acute care facilities). The DOH HAI Program had some difficulty with how to best identify and recruit these stakeholders, specifically medical directors who oversee prescribing practices at the sub-acute care facilities. Other states and jurisdictions have associations that represent sub-acute care medical directors, however, that does not exist for DC. Therefore, the HAI Program requested some additional assistance from the advisory committee in identifying and recruiting individual medical directors who would be appropriate for membership.

Representatives from the SNFs clarified the prescribing hierarchy within a few of the SNFs. However, they also mentioned that there can be a lot of variation in Medical Director presence and practice from facility to facility. At some facilities the prescribing is done over the phone and doctors will only visit the facility on occasion (e.g. once a week). There are some facilities where the Directors of Nursing (DON) and other nurses have a good rapport with the Medical Directors and other facilities where that is not the case. There is also the challenge of varying education levels where the LPNs are not as aware of what to look out for when checking in with the Medical Director about a patient's antibiotic status (i.e. whether or not continuing on the current regiment seems appropriate).

Many Committee members stated the importance of bringing the SNF Medical Director stakeholder group to the table because they are more likely to implement Committee recommendations if they were part of the discussion beforehand. The DOH HAI Team will continue to seek out individuals for recruitment to the Committee.

Legislation Update

Revisions to DCMR 22-208, which regulates the reporting of healthcare-associated infections, was approved by the DC Council in October 2016. No comments were submitted to the Council for consideration during the review and approval process. Written guidance from the DOH HAI Program will be forthcoming. Until then, facilities are not expected to change any of their current practices with regards to HAI reporting.

Examples of NHSN Data Uses

The DOH HAI Program put together a few data displays using NHSN data for the District. These graphs were put together upon request by a committee member during the September kick-off meeting. The figures below are meant to demonstrate the capability and usefulness of NHSN data (Figure 5, Figure 6).

These data are currently available in DC for acute care facilities, however, there are plans to start working with the SNFs to start inputting their individually collected surveillance data into NHSN so they can also benefit from this standardized national surveillance system.

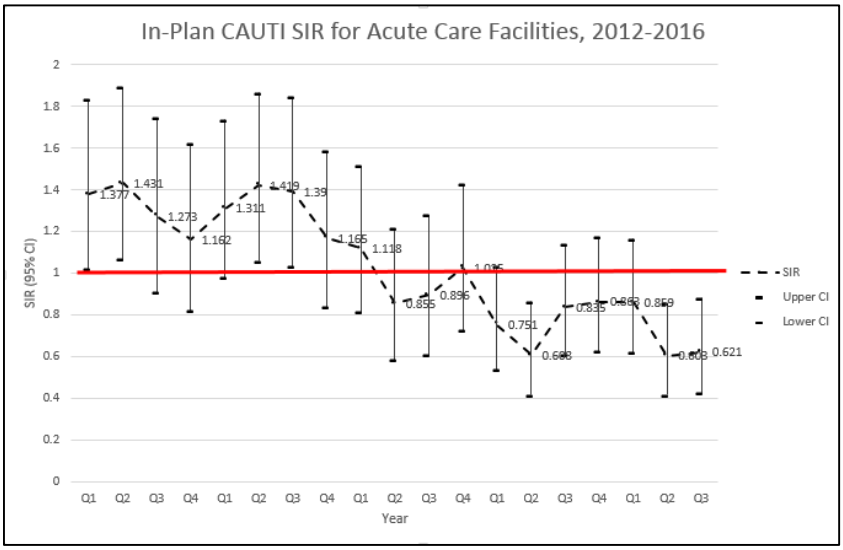

Figure 5: District-wide NHSN CAUTI data, broken down by year. DOH currently only has access to NHSN data for acute care facilities and no other type of healthcare facility.

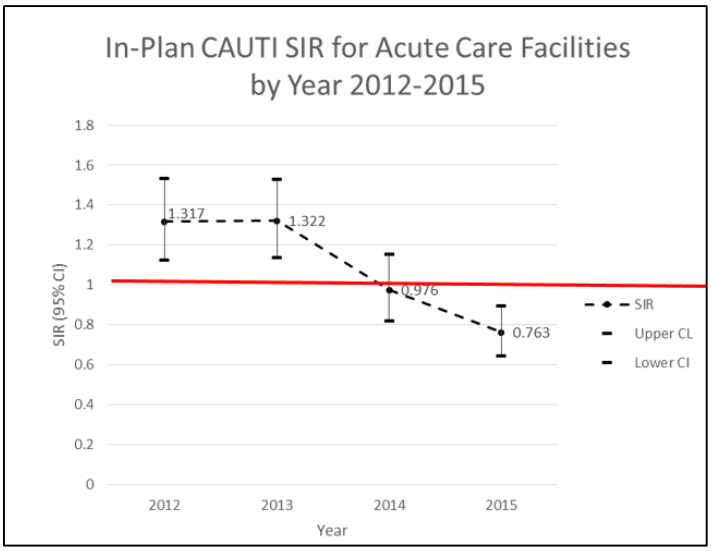

Figure 6: District-wide NHSN CAUTI data, broken down by quarters. DOH currently only has access to NHSN data for acute care facilities and no other type of healthcare facility.

<u>Funding Opportunity</u>

Dr. Song approached the DOH HAI Program about applying for a grant that could potentially provide some funding to implement and evaluate an intervention that might improve the patient transfer process here in DC. There currently exists a funding opportunity for taking a two-pronged approach to addressing MDROs: The first prong being antibiotic use (AU) and the second prong being preventing the spread of MDROs. Dr. Song and the DOH HAI Program are particularly interested in applying for funding to implement and assess potential interventions in preventing the spread of MDROs during the patient transfer process. Both parties would be open to working with other interested parties on also applying for funding for AU initiatives. The grant application is due in January or in June 2017 (rolling application).

HMC-HAI Workshop: In an effort to be as inclusive as possible, the HMC HAI Workgroup will be hosting a DC-wide workshop for the purpose of giving all individual healthcare staff and 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. The objective of this workshop will be to Discuss and identify potential HAI prevention priorities for the HMC-HAI Workgroup Advisory Committee and a few of the main goals of this meeting will be to introduce the Committee, provide point of contact information to facilities and get feedback from healthcare community to inform committee priorities. A tentative date has been set for March 22, 2017 and additional planning for this meeting will take place at the next Advisory Committee meeting on January 25, 2017.

Health Alert Action Network: Aisha Williams, HMC Supervisor, provided an overview of DC's Health Alert Action Network (HAN). The HAN is a secure communication system that exchanges information within and between agencies and different disciplines throughout the District. This system utilized multiple communication formats (such as text, email, phone, fax and pager messaging) to deliver blast communications. There are 4 tiers of alert messaging categories that can be utilized, depending on the urgency of each specific message. It's important that all of DC's healthcare stakeholders are signed up to receive HAN alerts. Additional information, including how to sign-up to receive HAN messages, can be found at www.dohhan.com or by contacting Arlene Thomas at Arlene.Thomas@dc.gov or 202-671-4222.

6. Overarching Discussion Themes and Priorities

- Need a short-term solution to addressing MDRO/HAIs during patient transfer process (i.e. interfacility transport, movement and previous exposures)
- Need a long-term solution to addressing communication around interfaciltiy discharge and transfer processes
- Need to frame and refine Advisory Committee goals with regards to specific HAIs of focus

7. Next Steps

Distribute details about AHRQ grant funding opportunity: Those who are interested in learning more about the details of the AHRQ grant opportunity, which focuses on antibiotic use and preventing the spread of MDROs, should reach out to Dr. Song at XSong@childrensnational.org.

Seek out and recruit Medical Officers/Directors from SNFs for Advisory Committee: DCHA will recruit representation from the acute care Medical Directors community and the DOH HAI Program will continue working on recruiting sub-acute care Medical Directors, specifically those that would represent the SNF community.

Reach out to other states about controlling MDROs during patient transfer process: The DOH HAI Team will do some further research into other states' activities and interventions surrounding patient transfer and HAIs/MDROs.

Identify current and best practices with discharge process: The DOH HAI Team will do some further research into other states' activities and interventions surrounding patient transfer and HAIs/MDROs.

8. Adjournment: Next Meeting Date – January 25, 2016 (in-person)