MARYLAND HEALTH CARE COMMISSION

Summary of the Healthcare-Associated Infections (HAI) Advisory Committee Meeting

January 24, 2018

Committee Members Present	**Committee Members Absent**
Veronica Black, MBA (conference call)	Sara E. Cosgrove, MD, MS
Lynne V. Karanfil, RN, MA, CIC (conference call)	Anthony Harris, MD, MPH
Stephanie Mayoryk, RN, BSN, CIC	Emily Heil, PharmD
Bryan T. Meehan, Sr. (conference call)	Andrea Hyatt, CASC
Peggy Pass, MS, BS, RN, CIC, FAPIC	Robert Imhoff
Michael Anne Preas, RN, BSN, CIC	Rajesh Shah, MD
Jack Schwartz, JD (conference call)	Kerri Thom, MD
Darlene Smith, RN, CIC (conference call)	
Geeta Sood, MD (conference call)	
Renee Webster, RS (conference call)	
Lucy Wilson, MD, ScM	

Public Attendance	**Commission Staff**
Richard Brooks, MDH	Theressa Lee
Becky Cook (MedStar SOMD)	Courtney Carta
Peggy Pass, RN	Julie Deppe
Graciela Perez (MedStar SOMD)	
Janice Pineda (MedStar SOMD)	
Clare Rock, MD	

1. Call to Order

Theressa Lee, Director, Center for Quality Measurement and Reporting, called the meeting to order at 1:00 p.m.

2. Overview of Maryland Health Care Quality Reports Website

Courtney Carta, Chief of Hospital Quality Initiatives, gave a brief update of the website, the Maryland Health Care Quality Reports. She reviewed the major features and functions of the website including how to get more detailed information from individual hospitals, as well as how to compare multiple hospitals. She also demonstrated where and how to find the most current HAI data.

3. Hospital Presentations – Clostridium Difficile Performance Improvement

Ms. Carta noted that for the first time, the Maryland standardized infection ration (SIR) for C.diff was better than the national average. However, the majority of hospitals' performance was still classified as "same" or "worse" than the national average, indicating that there is still plenty of room for facility-level improvement. Three hospitals, Doctor's Community Hospital, MedStar Southern Maryland Hospital, and Peninsula Regional Medical Center, each demonstrated significant performance improvement over the past 3 years. Two hospitals presented their interventions and best practices.

MedStar Southern Maryland Hospital Center – Journey to Reduction in Hospital Onset Clostridium difficile Occurrences
Becky Cook and Janice Pineda presented on the C. diff improvements at MedStar Southern Maryland. In 2013, the C. diff rates were very high. They developed an initiative to address these rates, beginning in 2014. After program implementation, the rates and number of infections continued to decrease. They developed a formal C. diff task force, comprised of a multidisciplinary team that meets monthly to review best practices. The team created policies and protocols to prevent, treat, and provide guidance to staff. The program also included education to nursing staff on a monthly basis to help trouble shoot and empower them to speak up if they notice signs and symptoms. The infection department and other disciplines reviews every case. Every Friday, the teams huddle to discuss different issues, including C. diff cases. The team also focused on hand hygiene for staff, patients, and visitors. The hospital placed visualization boards on all units to provide information about current status of infection rates. They report data to the C. diff task force which is reported up to the infection prevention committee and other leadership committees. The hospital is taking a systems approach to share information and get feedback via the other MedStar hospitals. They are using EMRs to drive ordering of tests or to monitor when testing might be possible. They also continue to provide ongoing education.

Do you do any antibiotic surveillance after discharge? No, we don't track them after discharge. We can look at when they were last in the hospital. Is there a connection with antibiotic use of that patient and was it appropriate? We're looking closely at that when we huddle and discuss cases.

Any intervention with environmental services? Our EDS has implemented a program where they have done extra training with certain individuals who will go in and clean the C. diff discharge rooms. We have implemented novel technology for using in the rooms in all C. diff discharge rooms. They also try to get the bathrooms every day, if possible. The hospital does not have designated C. diff rooms but we look back to see if we have a hospital-onset, if they were in the room prior to the diagnosis.

How many C. diff tests are ordered and how many are ruled out as C. diff? We don't have a ratio, but we get a page on every order and we look each one up. There are probably 8 orders a day on average. Once or twice a day, we call the physicians to see if we can look at the order. The lab also won't retest in 7 days so we can't override that if it's less than 7 days and those get

eliminated. We eliminated cases that have had colon preps where we feel it wouldn't be appropriate.

Were there any issues you ran into during program implementation? We occasionally get pushback from physicians when we say we don't think it meets the criteria for testing, but we have an escalation policy that leadership stands behind. No matter how much education we do, we have to continually do that.

Do you have a pharmacist on the antibiotic stewardship and prevention team? Who interacts with the prescriber? Our antibiotic stewardship program is pharmacist lead. She is invited to C. diff task force and pharmacy is represented. The pharmacists monitor antibiotic usage include de-escalation and pharmacy guided dosing. They help us get data to help track what's going on.

Has anyone had success educating providers and ensuring patients are not on stool softeners or ordering PCRs? When we review C. diff orders, we look at that and provide real time feedback to physicians if we don't think it's an appropriate test. Our hospitalist lead is involved in the effort and talks to his group about ordering a C. diff test and the use of laxatives. We're also trying to figure out how to use EMR to find out if patient has been on laxatives or had an elevated white count.

Do you have any plans in place for weekends and holidays? Monday-Friday we take the pages, and on weekends and holidays, the nursing supervisors take the page. We also batch the testing, so we test at 10:30am and 4:30pm. If an order goes in in the middle of the night, we have time in the morning to research the test and the lab calls us to verify if we want those tests run. The infection team gets about 8 calls a day to verify testing. MedStar also has a daily safety call and we discuss every patient with an order so that everyone in the hospital is aware of who has C. diff and who has an order.

Have you noticed a change in prescribing fluoroquinolones? It went down after order sets changed but I continue to ask for monitoring because it has leveled off. We do go back and look at the data to see if it's still being ordered appropriately or bypassing it.

Peninsula Regional Medical Center (PRMC) – C. diff Reduction
Karen Mihalik, Mike Miller, Beth Prouse and Dawn Sullivan presented on their C. diff reduction rates. In 2014, PRMC started making some changes and have remained under the national benchmark since 3Q2016. In the first round of intervention implementation (2013) they began de-escalation of antibiotics IV to PO and they added probiotics option that came across with antibiotic orders via the EMR. In January of 2014, they added bleach cleans for every C. diff room and the infection prevention team did CDI rounds to talk to different units, patients, nurses to provide education, and prevention methods. In the second round of interventions (March 2014) they did a Kaizen, which is a focused group to fully identify the problem. Non-infection prevention team members observed what was really happening in different units. Based on the observations, they did patient/family education, CDI net learning for staff, and they redesigned their isolation signs. Anyone with a positive test remained on isolation until they were discharged. Bleach wipes were put on isolation door units and they developed solutions to address stocking/restocking problems. Developed a nursing home diarrhea/suspected C. diff

protocol. EVS staff did ATP monitoring (30x/week). They look at cleanliness and they put dedicated C. diff staff to clean the patient room upon discharge. In the third round of interventions (December 2014), they created a CDI project with weekly meetings, they did CDI rounds and educated staff, particularly in areas with high case rates. They created a stool collection checklist sent down with each specimen to the lab. The specimens weren't accepted without the checklist. The ATP monitoring process was changed to 5x/day. If it was unacceptable, the room was cleaned again. The lab would not accept any inappropriate testing within 14 days of a positive test. Stool alerts popped up in McKesson [electronic health record] and it would send a note to the area printer/charge nurse and an email to clinical quality specialist saying there was a stool specimen ordered, but not obtained. We involved physician champions more often and they continued education through staff meetings, newsletters, and net learning.

When you send the stool in the first 48 hours, the nurse doesn't need an order? The presence of diarrhea in the first 48 hours, is enough for the nurse to be able to send for testing.

What was the most successful part of your intervention? Multiple aspects. When we did the huddle and drilled down on the patients, we could see where the problems were. The clinical quality specialists could take that information back to their units. And the different departments can discuss safety issues so the whole hospital will get the information as to what caused the C. diff. Our nursing CQS educated staff, the lab only accepted appropriate stools, and pharmacy looked at appropriate antibiotics. Information was shared with everybody. When you look at our data, we would start a few things but it didn't sustain, until we implemented different things as a whole.

Can you talk more about antibiotic reduction and if you've seen any associations with specific antibiotic reductions and drastic infection reductions? We took a look at the antibiotics that were causing the most. The reductions still went down, but once we had the full team approach when we saw the real reductions. Even if you reduce antibiotic use, you'll still get infections if there are still spores present. The antibiotic reduction was just a piece of the puzzle. Part of the success of the program is administration backing. Our administrators have been onboard. We have a full clinical staff that will pick up the slack when the pharmacist is off. The hospitalist group has a great relationship with clinical pharmacist. Having this level of support is key.

In terms of cost, has there been pushback for maintaining the C. diff specialists? The specialists were only there for a few weeks. We don't have them anymore. They ran their course for what we needed them for. Leadership was supportive. We also hired quality specialists focused on problems in each division in the hospital to ensure the appropriate education and activities are occurring within those units.

Is the Environmental unit part of a union? I don't have our EVS director with us, but I don't think so. We had no problems with them doing this. The director is with us at the meetings and promotes whatever we do and has been helpful with ATP monitoring.

Did you see a significant reduction in tests being sent to the lab? Yes, we saw a reduction for inpatient C. diff tests.

4. Other Business

Ms. Carta noted that the next round of public reporting is scheduled for March 2018 and will include CLABSI, C. diff, and MRSA. Ms. Carta also reminded hospitals that the NHSN administrator will have to accept an updated agreement to participate and consent. The deadline is April 14th or hospitals risk losing access to NHSN. Ms. Carta asked participants to send their feedback about the new format of the HAI Advisory Committee Meetings and any ideas/topics for the future.

5. Adjournment: Next Meeting Date- Tentative April 25, 2018

Ms. Lee ended the meeting at approximately 3:45 pm. The next meeting is tentatively scheduled for April 25, 2018.