Part 1—*Clostridium difficile* Prevention:
Coming Together to Examine What Works

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Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

HealthInsight

Clostridium difficile
Your foot in the door for Antibiotic Stewardship, Interfacility Transfer Communication & Environmental Services improvement

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2

Objectives

Participants will be able to:

- Describe an initiative to assess CDI prevalence
- Describe interventions including interfacility transfer communication between hospital and SNF, and environmental hygiene

We will

- Discuss adaption to real-world funding
- Discuss opportunities for collaboration

3

Scenario

- ELC Grant Dream Team
  - CDI Collaborative with Oregon Patient Safety Commission

http://oregonpatientsafety.org/

4

Scenario

- ELC Grant Dream Team
  - CDI Collaborative with Oregon Patient Safety Commission
- Reality
  - Funding, staffing
  - Timing: Ebola

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OREGON PATIENT SAFETY COMMISSION

http://oregonpatientsafety.org/

5

Recruitment

- Built on EIP CDI Surveillance in 1 county
- Built on OPSC success with CUSP collaborative
  - NHSN CDI Lab ID Event
- Started with long-term care networks
  - Outreach two-ways: corporate and local

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6

Mixed-methods

- Baseline assessments
  - CDC Tool
  - Facility-specific report, goals
- Education
  - CDI slides, CNA education, binder
  - On-site, Grand Rounds, webinars
- Connection with hospitals and SNFs
  - Interfacility transfer communication
  - Environmental hygiene
- Website
  - All resources available

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7

Summary

- Enrolled 3 hospitals
- 8 skilled nursing facilities
- 5 main areas of work:
  - Surveillance: NHSN enrollment
  - Best practices
  - Environmental hygiene
  - Antibiotic stewardship
  - Interfacility transfer communication

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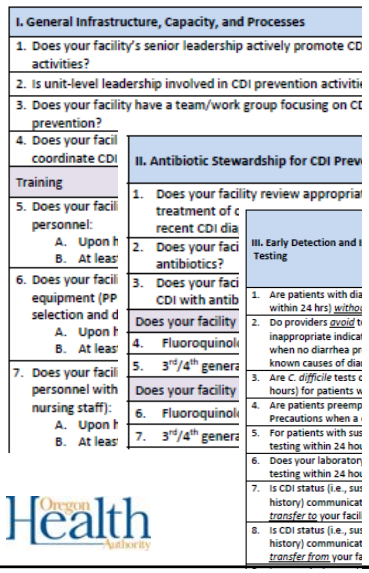
~~Assessment~~ Consultations



I. General Infrastructure, Capacity, and Processes

1. Does your facility's senior leadership actively promote CD activities?
2. Is unit-level leadership involved in CDI prevention activiti
3. Does your facility have a team/work group focusing on CD prevention?
4. Does your facil coordinate CDI

Training

5. Does your facil personnel:
   A. Upon h
   B. At leas
6. Does your facil equipment (PP selection and d
   A. Upon h
   B. At leas
7. Does your facil personnel with nursing staff):
   A. Upon h
   B. At leas

II. Antibiotic Stewardship for CDI Prev

1. Does your facility review appropria treatment of c recent CDI dia
2. Does your faci antibiotics?
3. Does your faci CDI with antib

Does your facility

4. Fluoroquinol
5. 3rd/4th genera

Does your facility

6. Fluoroquinol
7. 3rd/4th genera

III. Early Detection and Testing

1. Are patients with dia within 24 hrs) *witho*
2. Do providers *avoid* t inappropriate indica when no diarrhea pr known causes of dia
3. Are *C. difficile* tests c hours) for patients w
4. Are patients preemp Precautions when a
5. For patients with sus testing within 24 ho
6. Does your laboratory testing within 24 ho
7. Is CDI status (i.e., sus history) communicat *transfer to* your facil
8. Is CDI status (i.e., sus history) communicat *transfer from* your fa

Based on our discussion, your facility would like to work on the following areas:

1. Develop measurable goals around *C. difficile* and disease affecting antibiotic stewardship:
   a. # antibiotic starts/1,000 resident days
   b. # urinalysis and urine cultures ordered/1,000 resident days and # positive urine cultures
   c. # *C. difficile* diagnoses/10,000 resident days, etc.
2. Implement formal surveillance for *C. difficile* in order to track changes following interventions:
   a. Begin enrollment process to enter CDI cases into NHSN surveillance system.
3. Prevent the spread of infection through robust facility infection control:
   a. Develop door signage, education, and data sharing methods that reach visual learners.
   b. Trial using hand hygiene, personal protective equipment and point of care observation tools to observe and provide real-time feedback to staff (See attached).
   c. Increase access to hand hygiene ABHR in physical therapy and meals.
   d. Verify influenza vaccination in staff: **35% of eligible HCWs** were reported vaccinated during 2014–2015 season (See attached report). Share data with staff and compare.
4. Implement and strengthen interfacility transfer communication around MDRO and *C. difficile*.
   a. Reinforce where the IFT form should live, who is responsible for updating, how it will be copied and join the resident's transfer order and papers. Perform audits for forms.
   b. Genevieve to reach out to main referral hospitals to verity hospital IFT processes.
5. Strengthen the antibiotic stewardship:
   a. Share educational pamphlet on CDI for residents and families (See attached).
   b. Develop a pamphlet for families/residents about antibiotic stewardship.
   c. Discuss with medical director how to respond to a resident's change in condition without reflex to antibiotics, unless indicated: nursing assessment, infection criteria vs other (e.g., dehydration), non-antibiotic treatments (e.g., hydration), appropriate laboratory testing (e.g., urine culture before antibiotics), and indications for antibiotics.
6. Strengthen the effectiveness of environmental cleaning:
   a. Develop a regular, sustainable, and non-punitive audit program of room, medical equipment, and deep cleaning with housekeeping.
   b. Include housekeeping in infection control and response planning.

We will touch base in about 1 month by phone to see how the above goals are progressing, identified barriers, and next steps. Thank you for your valuable time.

Regards,
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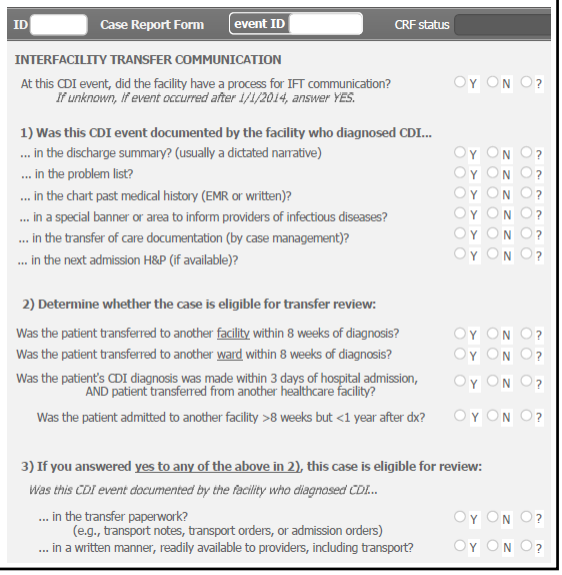
Interfacility Transfer Evaluation

- Rule Jan 2014
- New plan:
  - 27 hospitals
  - 60 SNFs
- Database
- Chart review
- Analysis



ID | Case Report Form | event ID | CRF status

INTERFACILITY TRANSFER COMMUNICATION

At this CDI event, did the facility have a process for IFT communication? Y N ?
If unknown, If event occurred after 1/1/2014, answer YES.

1) Was this CDI event documented by the facility who diagnosed CDI...

... in the discharge summary? (usually a dictated narrative) Y N ?
... in the problem list? Y N ?
... in the chart past medical history (EMR or written)? Y N ?
... in a special banner or area to inform providers of infectious diseases? Y N ?
... in the transfer of care documentation (by case management)? Y N ?
... in the next admission H&P (if available)? Y N ?

2) Determine whether the case is eligible for transfer review:

Was the patient transferred to another facility within 8 weeks of diagnosis? Y N ?
Was the patient transferred to another ward within 8 weeks of diagnosis? Y N ?
Was the patient's CDI diagnosis was made within 3 days of hospital admission, AND patient transferred from another healthcare facility? Y N ?
Was the patient admitted to another facility >8 weeks but <1 year after dx? Y N ?

3) If you answered yes to any of the above in 2), this case is eligible for review:

Was this CDI event documented by the facility who diagnosed CDI...

... in the transfer paperwork? (e.g., transport notes, transport orders, or admission orders) Y N ?
... in a written manner, readily available to providers, including transport? Y N ?

Prevalence Project

- Identify prevalence at admission for units with high rates of CDI
- Look for transmission events
  - Hospital
  - Future: LTACH? SNF?

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11

Collaboration

- Acumentra Health joined 1 visit, also used tool
- Webinars about antibiotic stewardship (AWARE)
  - Rural Health Network
  - Grand Rounds
  - Oregon Health Care Association
- Oregon Patient Safety Commission
- Office of Licensing & Regulatory Oversight

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12

Resources

- CDI Learning Session
- CDI Toolkit
- CNA Education (in progress)
- (Self) Assessment Tools
- NHSN Education

Future

- Continue facility support with Acumentra Health
- Include interfacility transfer communication of infectious diseases in “care transition”
- Dovetails with Ebola Part B grant
  - Onsite consultation and observations
  - Facility-specific plans
- Need assistant

Oregon Healthcare-Associated Infection Team

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