

LTACH Collaborative and vSNF Workgroup Joint Meeting on Interfacility Transfer Communication Across the Healthcare Continuum

November 9, 2022

Healthcare-Associated Infections Program
Center for Health Care Quality
California Department of Public Health



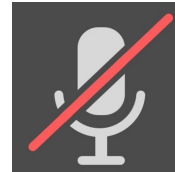
Housekeeping Reminders



This session is
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If your name does
not show up,
please “right click”
to rename



Please stay muted
if you are not
speaking



To comment, you
can unmute or
type into the Chat

Implicit Bias

- Describes how our unconscious attitudes or judgements can influence our thoughts, decisions, or actions
- Includes involuntary, unintentional perceptions made without awareness
- Occurs as our brains sort information and perceive data to understand our world
- Affects our decisions, contributing to societal disparities
 - Self awareness about implicit bias can promote healthcare diversity and equality
- Learn more about your own implicit bias at [Project Implicit](https://implicit.harvard.edu/implicit/) (implicit.harvard.edu/implicit/)



Agenda

12-12:10PM	Welcome and Project Introductions
12:10-12:20PM	Review Interfacility Transfer Communication Form <i>Becca Czerny, Antimicrobial Stewardship Project Coordinator, HAI Program, California Department of Public Health</i>
12:20-12:30PM	Interfacility Transfer Communication: The LHD Experience <i>Guest speaker: Kelli Clark, Clinical Director, San Bernardino Department of Public Health</i>
12:30-1:25PM	Breakout Groups and Discussion
1:25-1:30PM	Next Steps

vSNF Workgroup - Background

- 1.5 year-long project to support infection prevention and control programs in vSNF (subacute)
- Goal: Prevent outbreaks, contain transmission, and limit spread of MDRO to new facilities and regions.
- To achieve this, participating facilities will:
 1. **Observe a measurable improvement** to hand hygiene and environmental cleaning and disinfection practices by implementing a quality improvement (QI) project that includes an adherence monitoring program,
 2. **Increase staff awareness and knowledge of MDRO** through web-based workshops and dissemination of infection prevention and control materials, and
 3. **Build relationships** among vSNF, with local health departments, and with LTACH in their referral network.

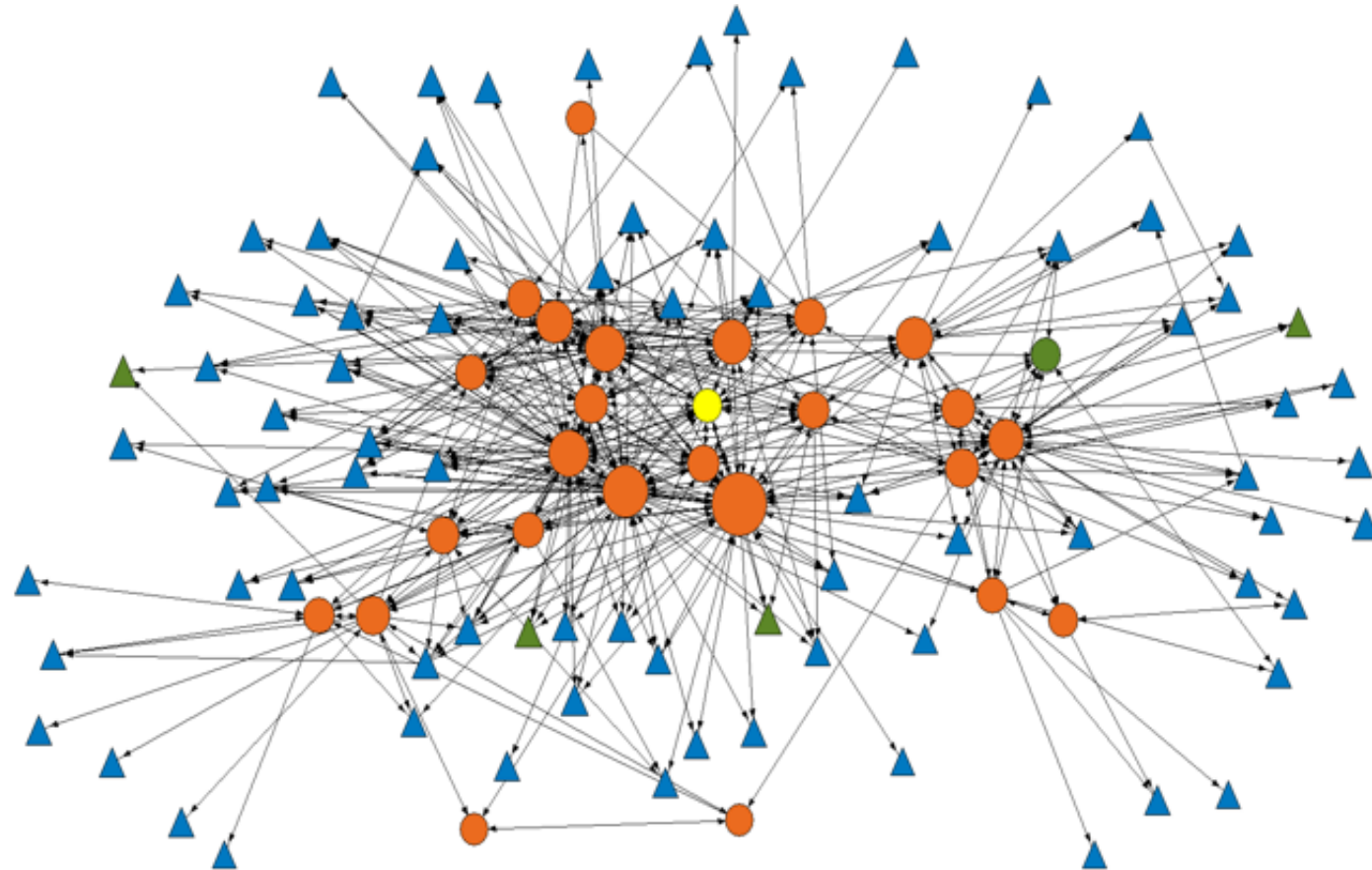
LTACH Collaborative - Background

- 1.5 year-long project to support Antimicrobial Stewardship Programs in LTACH.
- Goals: Prevent the emergence of MDRO and other collateral effects associated with overuse of antimicrobials, and to support facility application to the CDPH HAI AS Honor Roll either as a new member or upgrade their designation if an existing member to recognize their efforts.
- To achieve this, participating facilities will:
 1. **Design one AS intervention** at each facility that includes a monitoring plan.
 2. Apply to the **CDPH HAI ASP Honor Roll** as a new member or upgrade designation if applicable.
 3. **Build relationships** with LHD, other participating LTACH, and vSNF in their referral network.

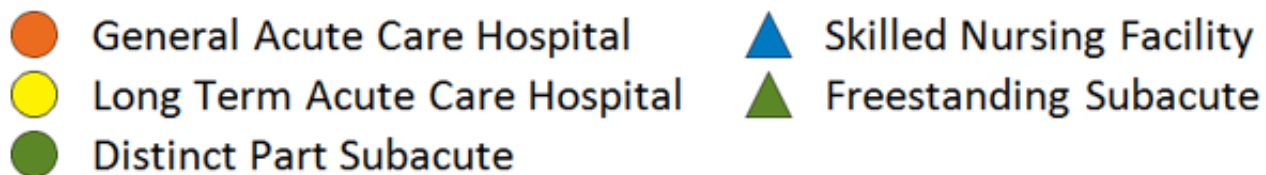
Goals of Joint Meeting

- **Build relationships** among participating vSNF and LTACH who share patient populations, along with local health departments
 - **Establish communication expectations** among and between facility types
 - **Collaboratively agree on best practices** for interfacility communication success
-
-

Patient Sharing Networks Lead to MDRO Spread

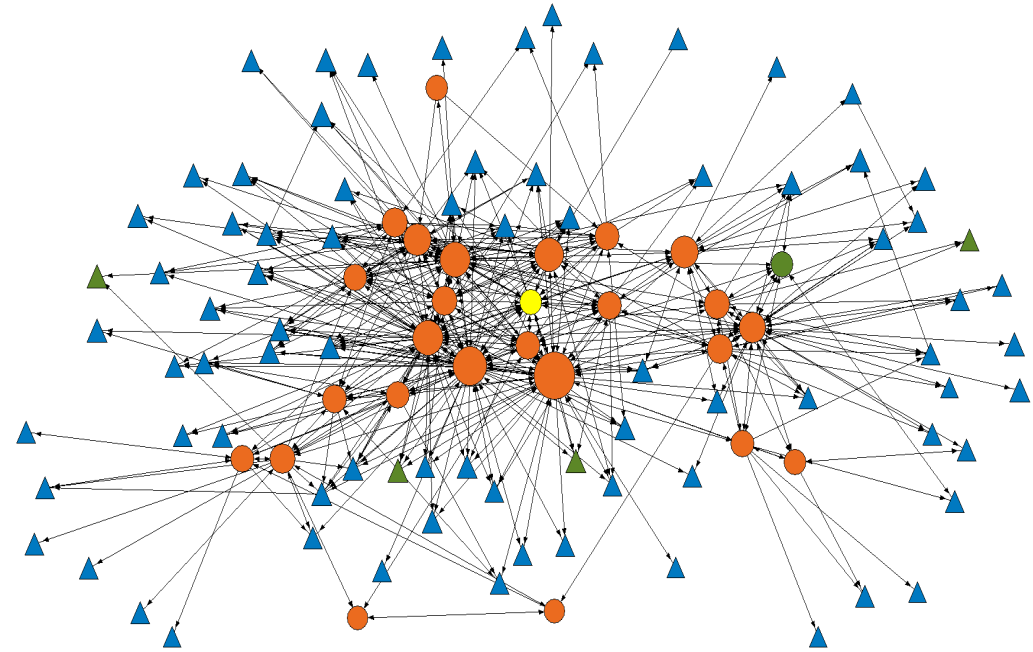


- Can spread easily **within and between** healthcare facilities





A REGIONAL APPROACH



Communication

- Key to preventing interfacility transmission!
- Actively seek MDRO status of all admissions
- Flag medical record for future admissions
- Inform receiving facility of patient MDRO status and IPC recommendations
- Educate patients and family
- Use interfacility transfer form

[Interfacility Transfer Communications Guide](http://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/InterfacilityCommunication.aspx)

(www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/InterfacilityCommunication.aspx)

Affix patient labels here.

HEALTHCARE FACILITY TRANSFER FORM

Use this form for all transfers to an admitting healthcare facility.

Patient Name (Last, First): _____

Date of Birth: _____

MRN: _____

Transfer Date: _____

Receiving Facility Name: _____

Contact Name: _____

Contact Phone: _____

Sending Facility Name: _____

Contact Name: _____

Contact Phone: _____

PRECAUTIONS

Patient currently on precautions?

Yes No

If yes, check all that apply:

Airborne Contact Droplet Enhanced Standard*

Personal protective equipment (PPE) to consider at receiving facility*:



Gloves



Gown



Mask



N95/PAPR



Eye Protection

Long-term care facilities may implement Enhanced Standard precautions for patients with MDRO or risk factors for transmission, i.e., gown and glove use for high-contact care activities (<https://www.cdph.ca.gov/Programs/CHCQ/LCP/DPH%20Document%20Library/AFL-19-22.pdf>); such patients may be on Contact precautions in acute care settings.

ORGANISMS (Include copy of lab results with organism ID and antimicrobial susceptibilities.)

Patient has multidrug-resistant organism (MDRO) or other lab results requiring precautions?

Yes (record organism(s), specimen source, collection date) No

Exposed to MDRO/other (record organism(s) and last date(s) of exposure if known)

Organism	Carbapenemase (if applicable)**	Source	Date
<input type="checkbox"/> <i>Candida auris</i> (C. auris)			
<input type="checkbox"/> <i>Clostridioides difficile</i> (C. diff)			
<input type="checkbox"/> <i>Acinetobacter</i> , multidrug-resistant (e.g., CRAB**)			
<input type="checkbox"/> Carbapenem-resistant Enterobacterales (CRE**)			
<input type="checkbox"/> <i>Pseudomonas aeruginosa</i> , multidrug-resistant (e.g., CRPA**)			
<input type="checkbox"/> Extended-spectrum beta-lactamase (ESBL)-producer			
<input type="checkbox"/> Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)			
<input type="checkbox"/> Vancomycin-resistant <i>Enterococcus</i> (VRE)			
<input type="checkbox"/> No organism identified (e.g., molecular screening test**)			
<input type="checkbox"/> Other, specify: (e.g., SARS-CoV-2 (COVID-19), lice, scabies, disseminated shingles (<i>Herpes zoster</i>), norovirus, influenza, tuberculosis)			

**Note specific carbapenemase(s) (e.g., NDM, KPC, OXA-23) if known



INTERFACILITY TRANSFER COMMUNICATION








Elements of Interfacility Transfer Communication

1. Where to record information and where to find it (how to find it)
2. What to record, what to share
3. Who to communicate with
4. When to share information
5. How to communicate (verbally, IP-to-IP, by email (to PH), in a big stack of EMR, inter-facility transfer form)

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HEALTHCARE FACILITY TRANSFER FORM			
Use this form for all transfers to an admitting healthcare facility.			Affix patient labels here.
Patient Name (Last, First): _____			
Date of Birth: _____	MRN: _____	Transfer Date: _____	
Receiving Facility Name: _____			
Contact Name: _____		Contact Phone: _____	
Sending Facility Name: _____			
Contact Name: _____		Contact Phone: _____	
PRECAUTIONS			
Patient currently on precautions?		If yes, check all that apply:	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Airborne <input type="checkbox"/> Contact <input type="checkbox"/> Droplet <input type="checkbox"/> Enhanced Standard*	
Personal protective equipment (PPE) to consider at receiving facility*:			
			
<input type="checkbox"/> Gloves	<input type="checkbox"/> Gown	<input type="checkbox"/> Mask	<input type="checkbox"/> N95/PAPR
			
			<input type="checkbox"/> Eye Protection
*Long-term care facilities may implement Enhanced Standard Precautions (PDF) (www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-19-22.pdf) for patients with MDRO or risk factors for transmission, i.e., gown and glove use for high-contact care activities; such patients may be on Contact precautions in acute care settings.			
ORGANISMS (Include copy of lab results with organism ID and antimicrobial susceptibilities.)			
Patient has multidrug-resistant organism (MDRO) or other lab results requiring precautions?			
<input type="checkbox"/> Yes (record organism(s), specimen source, collection date) <input type="checkbox"/> No			
<input type="checkbox"/> Exposed to MDRO/other (record organism(s) and last date(s) of exposure if known)			
Organism	Carbapenemase (if applicable)**	Source	Date
<input type="checkbox"/> <i>Candida auris</i> (<i>C. auris</i>)			
<input type="checkbox"/> <i>Clostridioides difficile</i> (<i>C. diff</i>)			
<input type="checkbox"/> <i>Acinetobacter</i> , multidrug-resistant (e.g., CRAB**)			
<input type="checkbox"/> Carbapenem-resistant Enterobacterales (CRE**)			
<input type="checkbox"/> <i>Pseudomonas aeruginosa</i> , multidrug-resistant (e.g., CRPA**)			
<input type="checkbox"/> Extended-spectrum beta-lactamase (ESBL)-producer			
<input type="checkbox"/> Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)			
<input type="checkbox"/> Vancomycin-resistant <i>Enterococcus</i> (VRE)			
<input type="checkbox"/> No organism identified (e.g., molecular screening test**)			
<input type="checkbox"/> Other, specify: (e.g., SARS-CoV-2 (COVID-19), lice, scabies, disseminated shingles (<i>Herpes zoster</i>), norovirus, influenza, tuberculosis)			
** Note specific carbapenemase(s) (e.g., NDM, KPC, OXA-23) if known			

HEALTHCARE FACILITY TRANSFER FORM
 Use this form for all transfers to an admitting healthcare facility.

Affix patient labels here.

Patient Name (Last, First): _____

Date of Birth: _____ MRN: _____ Transfer Date: _____

HEALTHCARE FACILITY TRANSFER FORM
 Use this form for all transfers to an admitting healthcare facility.

Affix patient labels here.

Patient Name (Last, First): _____

Date of Birth: _____ MRN: _____ Transfer Date: _____

Receiving Facility Name: _____

Contact Name: _____ Contact Phone: _____

Sending Facility Name: _____



Contact Name: _____ Contact Phone: _____

Contact Phone: _____

Contact Phone: _____

all that apply:
 Contact Droplet Enhanced Standard*

Receiving facility*:

 
 N95/PAPR Eye Protection

[Standard Precautions \(PDF\)](#)
 (www.cdph.ca.gov/Programs/AFL-19-22.pdf) for patients with
 who require use for high-contact care activities; such patients

(D and antimicrobial susceptibilities.)

Other lab results requiring precautions?
 (date) No
 (date(s) of exposure if known)

	Carbapenemase (if applicable)**	Source	Date
<input type="checkbox"/> <i>Candida auris</i> (<i>C. auris</i>)			
<input type="checkbox"/> <i>Clostridioides difficile</i> (<i>C. diff</i>)			
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HEALTHCARE FACILITY TRANSFER FORM

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Patient Name (Last, First): _____

Date of Birth: _____ MRN: _____ Transfer Date: _____

Receiving Facility Name: _____

PRECAUTIONS

Patient currently on precautions?

Yes No

If yes, check all that apply:

Airborne Contact Droplet Enhanced Standard*

Personal protective equipment (PPE) to consider at receiving facility*:



Gloves



Gown



Mask



N95/PAPR



Eye Protection

*Long-term care facilities may implement [Enhanced Standard Precautions \(PDF\)](#) (www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-19-22.pdf) for patients with MDRO or risk factors for transmission, i.e., gown and glove use for high-contact care activities; such patients may be on Contact precautions in acute care settings.

Enhanced Standard*

Eye Protection

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[Interfacility Transfer Communications Guide](#)

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HEALTHCARE FACILITY TRANSFER FORM

Use this form for all transfers to an admitting healthcare facility.

Affix patient labels here.

Patient Name (Last, First): _____

Transfer Date: _____

Phone: _____

Phone: _____

ly:

Droplet Enhanced Standard*

ly*:



95/PAPR

Eye Protection

utions (PDF)

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Source

Date

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Methicillin-resistant *Staphylococcus aureus* (**MRSA**)

Vancomycin-resistant *Enterococcus* (**VRE**)

No organism identified (e.g., molecular screening test**)

Other, specify:

(e.g., SARS-CoV-2 (COVID-19), lice, scabies, disseminated shingles (*Herpes zoster*), norovirus, influenza, tuberculosis)

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Affix patient labels here.

CLINICAL STATUS

Patient has any of the following symptoms or clinical status?

Yes No

If yes, check all that currently apply:

- | | |
|---|---|
| <input type="checkbox"/> Cough/uncontrolled respiratory secretions | <input type="checkbox"/> Total dependence for activities of daily living ⁵ |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Rash consistent with an infectious process (e.g., vesicular) |
| <input type="checkbox"/> Acute diarrhea or incontinent stool ⁵ | <input type="checkbox"/> Draining wounds ⁵ |
| <input type="checkbox"/> Incontinent of urine ⁵ | <input type="checkbox"/> Other uncontained bodily fluid / drainage |

ANTIBIOTICS/ANTIFUNGALS

Patient is currently on antibiotics/systemic antifungals?

Yes No

If yes, specify:

Antibiotic/Antifungal	Dose	Frequency	Indication	Start Date	Stop Date

DEVICES⁵

Patient currently has any of the following devices?

Yes No

If yes, check all that currently apply:

- | | |
|--|---|
| <input type="checkbox"/> Central line/PICC, Date inserted: | <input type="checkbox"/> Wound VAC |
| <input type="checkbox"/> Hemodialysis catheter | <input type="checkbox"/> Tracheostomy |
| <input type="checkbox"/> Fecal management system | <input type="checkbox"/> Urinary catheter, Date inserted: |
| <input type="checkbox"/> Percutaneous gastrostomy feeding tube | <input type="checkbox"/> Suprapubic catheter |
| | <input type="checkbox"/> Mechanical ventilation |

IMMUNIZATION STATUS

Patient received immunizations (e.g., Pneumococcal, Influenza, COVID-19) in the past 12 months? (Attach immunization record, if available.)

Yes (specify below) No

Vaccine	Date(s)

⁵ Risk factors for MDRO transmission per [Enhanced Standard Precautions](#) (PDF) (www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-19-22.pdf)

Affix patient labels here.

CLINICAL STATUS

Patient has any of the following symptoms or clinical status?
 Yes No

If yes, check all that currently apply:

<input type="checkbox"/> Cough/uncontrolled respiratory secretions	<input type="checkbox"/> Total dependence for activities of daily living [§]
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Rash consistent with an infectious process (e.g., vesicular)
<input type="checkbox"/> Acute diarrhea or incontinent stool [§]	<input type="checkbox"/> Draining wounds [§]

CLINICAL STATUS

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 Yes No

If yes, check all that currently apply:

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<input type="checkbox"/> Vomiting	<input type="checkbox"/> Rash consistent with an infectious process (e.g., vesicular)
<input type="checkbox"/> Acute diarrhea or incontinent stool [§]	<input type="checkbox"/> Draining wounds [§]
<input type="checkbox"/> Incontinent of urine [§]	<input type="checkbox"/> Other uncontained bodily fluid / drainage

Date

<input type="checkbox"/> Fecal management system	<input type="checkbox"/> Suprapubic catheter
<input type="checkbox"/> Percutaneous gastrostomy feeding tube	<input type="checkbox"/> Mechanical ventilation

IMMUNIZATION STATUS

Patient received immunizations (e.g., Pneumococcal, Influenza, COVID-19) in the past 12 months?
 (Attach immunization record, if available.)
 Yes (specify below) No

Vaccine	Date(s)

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CLINICAL STATUS

Patient has any of the following symptoms or clinical status?

Yes No

If yes, check all that currently apply:

Cough/uncontrolled respiratory secretions

Vomiting

Acute diarrhea or incontinent stool⁵

Incontinent of urine⁵

Total dependence for activities of daily living⁵

Rash consistent with an infectious process (e.g., vesicular)

Draining wounds⁵

Other uncontained bodily fluid / drainage

ANTIBIOTICS/ANTIFUNGALS

Patient is currently on antibiotics/systemic antifungals?

Yes No

If yes, specify:

Antibiotic/Antifungal	Dose	Frequency	Indication	Start Date	Stop Date

IMMUNIZATION STATUS

Patient received immunizations (e.g., Pneumococcal, Influenza, COVID-19) in the past 12 months? (Attach immunization record, if available.)

Yes (specify below) No

Vaccine	Date(s)

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CLINICAL STATUS

Patient has any of the following symptoms or clinical status?

Yes No

If yes, check all that currently apply:

- Cough/uncontrolled respiratory secretions
 Vomiting

- Total dependence for activities of daily living⁵
 Rash consistent with an infectious process (e.g., vesicular)

DEVICES⁵

Patient currently has any of the following devices?

Yes No

If yes, check all that currently apply:

Central line/PICC, Date inserted:

Hemodialysis catheter

Fecal management system

Percutaneous gastrostomy feeding tube

Wound VAC

Tracheostomy

Urinary catheter, Date inserted:

Suprapubic catheter

Mechanical ventilation

Fecal management system

Percutaneous gastrostomy feeding tube

Suprapubic catheter

Mechanical ventilation

IMMUNIZATION STATUS

Patient received immunizations (e.g., Pneumococcal, Influenza, COVID-19) in the past 12 months? (Attach immunization record, if available.)

Yes (specify below) No

Vaccine	Date(s)

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Affix patient
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CLINICAL STATUS

Patient has any of the following symptoms or clinical status?

 Yes No

IMMUNIZATION STATUS

Patient received immunizations (e.g., Pneumococcal, Influenza, COVID-19) in the past 12 months?
(Attach immunization record, if available.)

Yes (specify below) No

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IMMUNIZATION STATUS

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INTERFACILITY TRANSFER COMMUNICATION: THE LHD EXPERIENCE



LHD Discussion

- **Kelli A. Clark**, MSN, RN, PHN, Clinical Director, San Bernardino Department of Public Health
-
-

BREAKOUT GROUPS AND DISCUSSION

Introductions

- Name
- Facility/County
- Role
- How are you involved in interfacility transfer communication? (Or how would you like to be involved?)

Discussion Questions

- Do you proactively reach out to a facility to obtain MDRO status? What is your process?
- Who is responsible for collecting and sharing patient information for transfers at your facility?
- What information do you share?
- When do you share patient information?
- Do you use a built-in system in the EMR or other tool to communicate key information?
- What is the chain of communication between and among vSNF and LTACH for all transfers? (e.g., IP-to-IP, by email)
- How do you ensure the information gets to the receiving facility? Who checks on if the communication occurred?
- How can local public health support this effort?



NEXT STEPS



Next Steps

- Fill out the **course evaluation** (required for CEU)
- Join us for upcoming meetings:
 - LTACH: Developing QI Projects – Strategies and Barriers
 - Cohort 2: December 13, 2022
 - Cohort 3: January 10, 2023
 - Wednesday, February 8, 2023: vSNF meeting on **Environmental Cleaning and Disinfection Strategies for EVS Managers – Part 1**

For vSNF:

- Continue to **check in monthly** with your HAI Program IP and continue **planning and implementing your QI project**
- Access resources** on the [vSNF webpage](http://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/vSNF.aspx)
(www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/vSNF.aspx)

Questions?

LTACH Contacts

Jane.Kriengkauykiat@cdph.ca.gov

Becca.Czerny@cdph.ca.gov

vSNF Contact

Erin.Garcia@cdph.ca.gov