
Date:March 16, 2017
Time: 3:30pm-5:00pm
Bridging the
GAP
A WEBINAR ADRESSING THE GAP BETWEEN ACUTE AND NON-ACUTE CARE SETTINGS
NV ASP
Nevada Antimicrobial Stewardship Program


RENO
THE BIGGEST LITTLE CITY IN THE WORLD

The Island of Reno, Sparks and Carson City


The Island of Las Vegas
& Henderson

The Island of Las Vegas & Henderson


WORLD'S BRIGHTEST SPOT
THE LAS VEGAS STRIP
Nevada is a Small Part of Our World
LAS VEG
STRIP

Think Globally - Act Locally

"Bridge the Gap" Between Health Care Providers

Presented by:

Norman Wright, RN, BSN, MS

Kindred Hospital, Sahara

and

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Mountainview Hospital

NV ASP

Nevada Antimicrobial Stewardship Program

http://dpbh.nv.gov/Programs/Office_of_Public_Health_Informatics_and_Epidemiology_(OPHIE)/

https://twitter.com/nv_ophie

With the support of:

Kimisha Causey & Adrian Forero

APIC

Spreading knowledge.
Preventing infection.®

HealthInsight

a partnership for the future of health care

Learning Objectives

Develop a collaborative between Nevada APIC chapters, Health Care Providers and OPHIE to reduce transfer of pathogens.

Develop goals to improve communication between all Nevada Health Care Providers.

Promote safe transfer of patients between the varied Health Care levels from Acute Care Hospitals, LTAC, LTC to Home Health Care.

Promote the use of Inter-facility transfer form between varied systems and levels of health care.


Las Vegas, Reno and Nevada
is a very small part of our World


New York

Think Globally
Act Locally

First we must define the problem.

Defining the problem

According to the CDC

Antibiotic-resistant germs cause more than 2 million illnesses and at least 23,000 deaths each year in the US.

Up to 70% fewer patients will get CRE over 5 years if facilities coordinate to protect patients.

Preventing infections and improving antibiotic prescribing could save 37,000 lives from drug-resistant infections over 5 years.

https://www.cdc.gov/vitalsigns/stop-spread/index.html

According to CDC the Problems are:

- **Germs spread between patients and across facilities.**
- **Antibiotic resistance is a threat.**
- ***Nightmare germs called CRE (carbapenem-resistant Enterobacteriaceae)* can cause deadly infections and have become resistant to all or nearly all antibiotics we have.**
- **CRE spread between health care facilities like hospitals and nursing homes when appropriate actions are not taken.**
- **MRSA infections commonly cause deadly pneumonia & sepsis.**
- **Pseudomonas aeruginosa can cause HAIs, including bloodstream infections. Strains resistant to almost all antibiotics are in hospitalized patients.**
- **These nightmare germs are some of the most deadly resistant germs identified as "urgent" and "serious" threats.**

https://www.cdc.gov/vitalsigns/stop-spread/index.html

Infection Control &
Hospital Epidemiology

NV ASP

SHEA
Education & Research Foundation
HELP SUPPORT
EDUCATION & RESEARCH

Hospital Transfer Network Structure as a Risk Factor for *Clostridium difficile* Infection

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"Results suggest infection control is not under the exclusive control of a given hospital but is also influenced by the connections and number of connections that hospitals have with other hospitals."

Infect. Control Hosp. Epidemiol. 2015;36(9):1031–1037

https://www.ncbi.nlm.nih.gov/pubmed?linkname=pubmed_pubmed&from_uid=26047207

http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/OPHIE/dta/Publications/C.%20diff%20-%20Washoe%20(v%202014%20i%2030%20e%202.0)%20(002)(1).pdf

https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/div-classtitlehospital-transfer-network-structure-as-a-risk-factor-for-span-classitalicclostridium-difficilespan-infection-div/5EF752664DEEDA0AD32879 3148704 CD9

"This elderly appearing man, with repeated multiple admissions across multiple facilities throughout the Las Vegas Valley, presented to the hospital on a transfer from a local post-acute facility."

"This epidemic strain of Clostridium Difficile (NAP 027-NAPI-BI) is known to produce a significantly higher number of C-diff spores"

The epidemic BI/NAP1/027 strain of C. difficile is more lethal, causes more extensive brain hemorrhage, and is antigenically variable from previously studied strains.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3731247/

RGJ Reno Gazette-Journal
PART OF THE USA TODAY NETWORK

CDC reports Nevada's first 'nightmare bacteria'

Marcella Corona, mcorona@rgj.com Published 6:04 a.m. PT Jan. 13, 2017 |

“Public health officials reported a Reno woman who died last year from an incurable superbug – a problem that is spreading in the U.S.

The bug was resistant to 26 different antibiotics, according to the Morbidity and Mortality Weekly Report.

So the CDC basically reported that there was nothing in our medicine cabinet to treat this lady,”
said Dr. Randall Todd, division director of epidemiology & public health preparedness for Washoe County Health Dist.

Inter-facility Infection Control Transfer Form

This form must be filled out for transfer to accepting facility with information communicated prior to or with transfer

Please attach copies of latest culture reports with susceptibilities if available

Sending Healthcare Facility:

Patient/Resident Last Name	First Name	Date of Birth	Medical Record Number
		___/___/_____	

Name/Address of Sending Facility	Sending Unit	Sending Facility phone

Sending Facility Contacts	NAME	PHONE	E-mail
Case Manager/Admin/SW			
Infection Prevention			

Is the patient currently in isolation? ☐ **NO** ☐ **YES**

Type of Isolation (check all that apply) ☐ **Contact** ☐ **Droplet** ☐ **Airborne** ☐ **Other:** _____

Does patient currently have an infection, colonization OR a history of positive culture of a multidrug-resistant organism (MDRO) or other organism of epidemiological significance?	**Colonization or history** *Check if YES*	**Active infection on Treatment** *Check if YES*
Methicillin-resistant Staphylococcus aureus (MRSA)		
Vancomycin-resistant Enterococcus (VRE)		
Clostridium difficile		
Acinetobacter, multidrug-resistant*		
E coli, Klebsiella, Proteus etc. w/Extended Spectrum B-Lactamase (ESBL)*		
Carbapenemase resistant Enterobacteriaceae (CRE)*		
Other:		

Does the patient/resident currently have any of the following?

☐ Cough or requires suctioning
☐ Diarrhea
☐ Vomiting
☐ Incontinent of urine or stool
☐ Open wounds or wounds requiring dressing change
☐ Drainage (source)_____
☐ Central line/PICC (Approx. date inserted ___/___/_____)
☐ Hemodialysis catheter
☐ Urinary catheter (Approx. date inserted ___/___/_____)
☐ Suprapubic catheter
☐ Percutaneous gastrostomy tube
☐ Tracheostomy

Is the patient/resident currently on antibiotics? ☐ **NO** ☐ **YES:**

Antibiotic and dose	**Treatment for:**	**Start date**	**Anticipated stop date**

Vaccine	**Date administered (If known)**	**Lot and Brand (If known)**	**Year administered (If exact date not known)**	**Does Patient self report receiving vaccine?**	
Influenza (seasonal)				○ yes	○ no

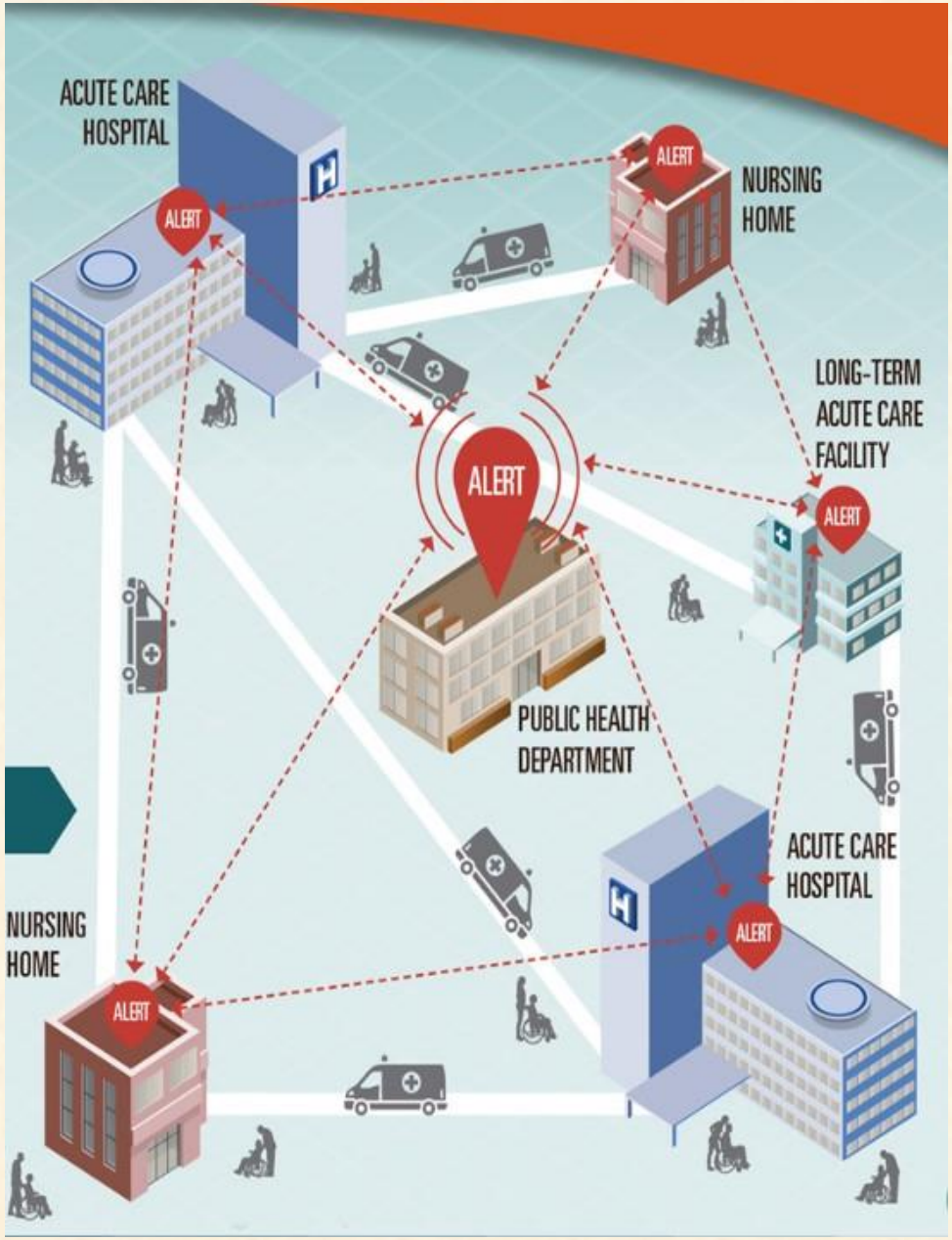
The Journey of the IFICTF

- **September 2015- The need for a better communication tool was identified**
- **Give our community partners the same information that we want them to give us**
- **October 2015- Brought the idea to each of our committee meetings for "buy in"**
- **Identified the "Top 10" places our patients go to and come from**
- **November 2015- Invited the "Top 10" to Mountainview Hospital to review our communication tool**
- **December 2015- Updated the transfer papers to eliminate "double documentation"**
- **January 2016- Shared and received approval with various medical committees at Mountainview.**
- **Shared with NV ASP, local APIC chapter**
- **February /March 2016- Housewide Education Campaign**
- **April 2016- Official kick off**
- **May-September 2016- Feedback, reinforcement, shared communication from other facilities**
- **October 2016- Back to Basics**
- **November 2016- Present- Continue to educate (Nursing Orientation, GME, Staff Meetings)**

Feedback…teaching moments

- **Incomplete forms are sent to me from receiving facilities**
- **Copies are reviewed with involved staff**
- **Sharing the POSITIVES has been very important, it's really helped get the staff on board**
- **Received this email on May 3, 2016 …..our process kick off was April 19, 2016. This email was shared on our hospital intranet**
- **We transferred in a patient a couple of nights ago. When I came in the following morning to look over the admission I saw the patient was coming from an acute hospital stay r/t SIRS and was here to finish out the antibiotics. They had been pan cultured while in the hospital which showed multiple systems affected with multiple MDROs. EVERY culture including date, origin of specimen and result with organism was there. I was able to review the meds and clinical status, get out onto the floor and work with the nurses and CNAs on things to be watching for and what to report right way. I then called our ID provider and by the time I was done, felt like we had a great handle on the patient and his care.**

Facilities need to work together



As members of the healthcare community all of us are responsible for preventing the transmission of organisms

Communication between facilities is just as important as communication within each of our individual facilities

When we don't work together, we have the potential to cause harm to our patients

Let's not forget about involving transport companies and EMS so that they can take proper precautions

Common Approach *(Not enough)*

- Patients can be transferred back and forth from facilities for treatment without all the communication and necessary infection control actions in place.

Independent Efforts *(Still not enough)*

- Some facilities work independently to enhance infection control but are not often alerted to antibiotic-resistant or *C. difficile* germs coming from other facilities or outbreaks in the area.

- Lack of shared information from other facilities means that necessary infection control actions are not always taken and germs are spread to other patients.

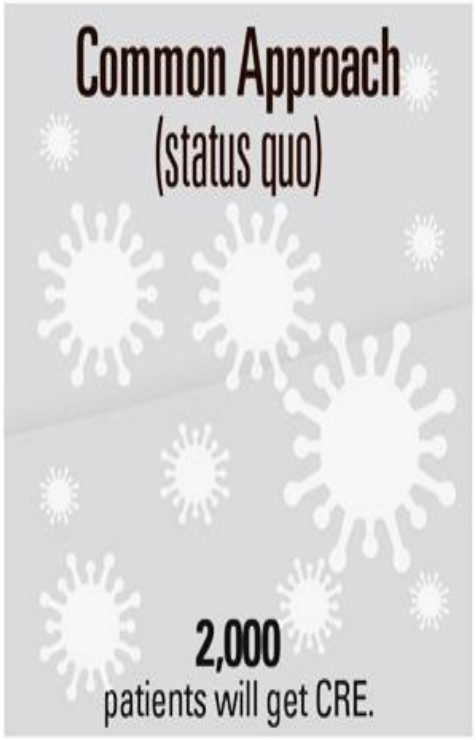
Coordinated Approach *(Needed)*

- Public health departments track and **alert** health care facilities to antibiotic-resistant or *C. difficile* germs coming from other facilities and outbreaks in the area.

- Facilities and public health authorities share information and implement shared infection control actions to stop spread of germs from facility to facility.

More patients get infections when facilities do not work together.

(Example: 5 years after CRE enters 10 facilities in an area sharing patients)



CRE will impact 12% of patients.

CRE will impact 8% of patients.

CRE will impact 2% of patients.

SOURCE: CDC Vital Signs, August 2015.

Take Steps Now! Public health departments should lead coordination.

- Identify the health care facilities in the area and how they are connected.
- Dedicate staff to improve connections and coordination with health care facilities in the area.
- Work with CDC to use data for action to better prevent infections and improve antibiotic use in health care settings.
- Know the antibiotic resistance threats in the area and state.

SOURCE: CDC Vital Signs, August 2015.

Facilities work together to protect patients.

Common Approach *(Not enough)*

- Patients can be transferred back and forth from facilities for treatment with[out] all the communication and neces[sary] infection control actions in pl[ace]

Independent [Ef]

- Some [pa]
- [in]formation from other fa[cilities] that necessary infection co[ntrol] actions are not always taken and germs are spread to other patients.

Build Bridges

Coordinated Approach *(Needed)*

- Public health departments track and **alert** health care facilities to antibiotic-resistant or *C. difficile* germs coming from other facilities and outbreaks in the area.
- Facilities and public health authorities share information and implement shared infection control actions to stop spread of germs from facility to facility.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www.nvasp.net

Stereo

CBS

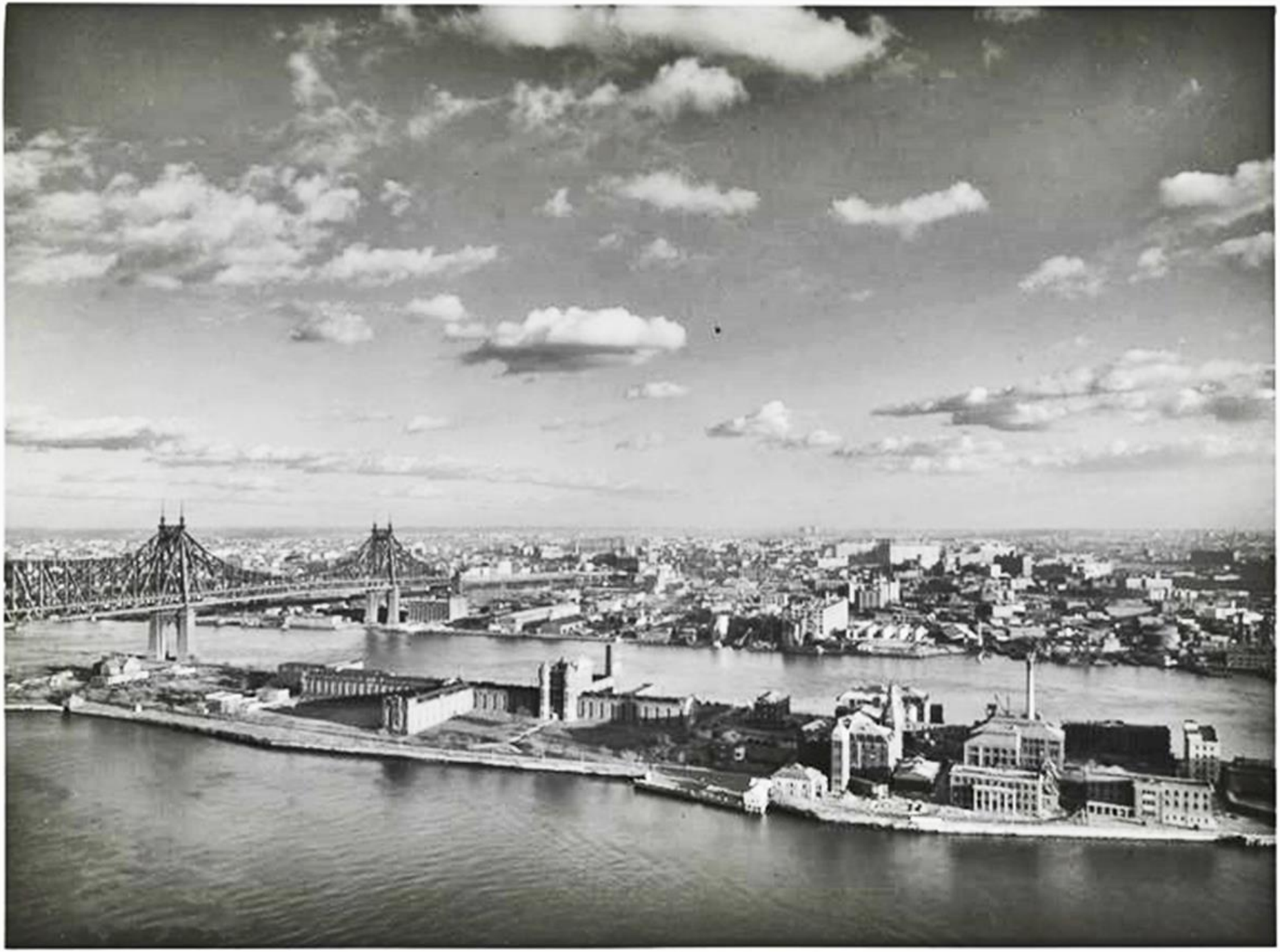
CBS 7169

SIMON & GARFUNKEL

THE 59th STREET BRIDGE SONG (FEELIN' GROOVY)

I AM A ROCK


New York



“Superbug”

Infection Preventionists Raise Your Hand

I’m an Infection Monitor

Duck and Cover

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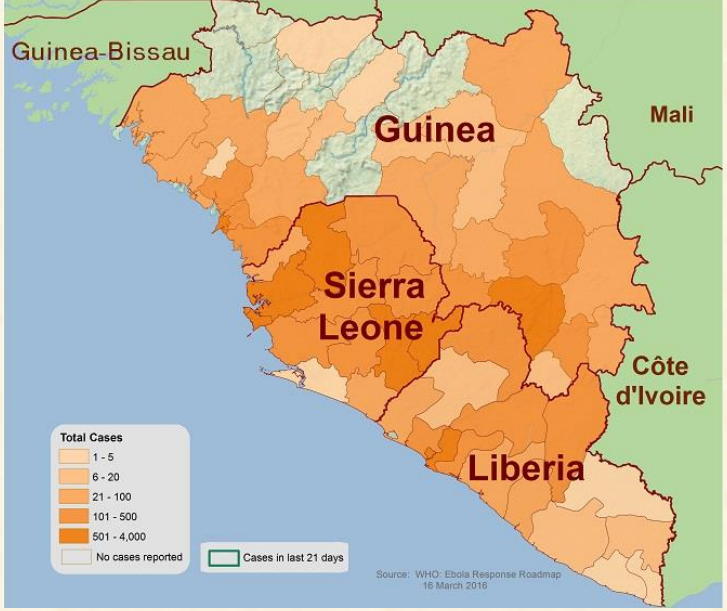
EBOLA



Countries with Former Widespread Transmission and Current, Established Control Measures[1]

Country	Total Cases (Suspected, Probable, and Confirmed)	- Laboratory-Confirmed Cases	Total Deaths
Guinea [2]	3814	3358	2544
Sierra Leone [3]	14124	8706	3956
Liberia[4]	10678	3163	4810
Total	**28616**	**15227**	**11310**

http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html

Ebola deaths outside of Africa

Country	Total Cases (Suspected, Probable, and Confirmed)	Laboratory-Confirmed Cases	Total Deaths
Nigeria	20	19	8
Senegal	1	1	0
Spain	1	1	0
United States	**4**	**4**	**1**
Mali	8	7	6
United Kingdom	1	1	0
Italy	1	1	0
Total	**36**	**34**	**15**

http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html

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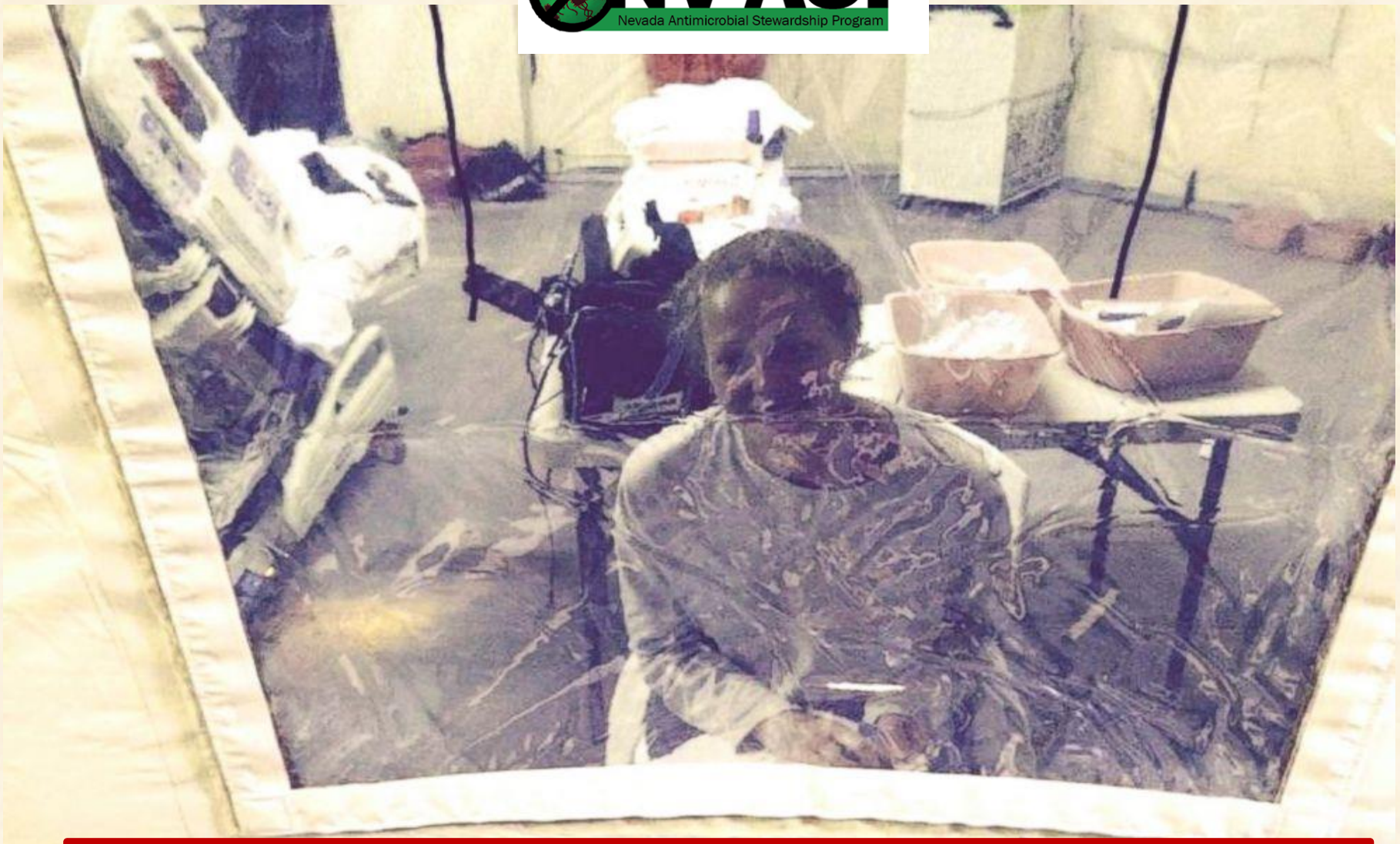

A “Nevada nurse” in “isolation” in New Jersey after working with Ebola patients.

Defining the problem

Nursing Homes and Assisted Living (Long-term Care Facilities [LTCFs])

In "Nursing homes, skilled nursing facilities, and assisted living facilities, LTCFs) . . . Infections are a major cause of hospitalization and death; as many as 380,000 people die of infections in LTCFs every year."

https://www.cdc.gov/longtermcare/prevention/
https://www.cdc.gov/hai/pdfs/toolkits/InfectionControlTransferFormExample1.pdf

“The LTCF is functionally the home for the resident, who is usually elderly and in declining health and will often stay for years, hence comfort, dignity, and rights are paramount. It is a low-technology setting. Residents are often transferred between the acute care and the LTC setting, adding an additional dynamic to transmission and acquisition of HAIs.”

https://www.cdc.gov/longtermcare/prevention/

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“An atmosphere of community is fostered (in the LTCF), and residents share common eating and living areas and participate in various activities. **Thus, the psychosocial consequences of isolation measures must be carefully balanced against the infection control benefits.”**

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3319407/

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"The presence of MDROs in the LTCF has implications beyond the individual facility. Because residents of LTCFs are hospitalized frequently, they can transfer pathogens between LTCFs and receiving hospitals; transfer of patients colonized with MDROs between hospitals and LTCFs has been well documented.[192,193] On the other hand, **LTCF residents remain in the facility for extended periods of time, and the LTCF is functionally their home.** **An atmosphere of community is fostered, and residents share common eating and living areas and participate in various activities. Thus, the psychosocial consequences of isolation measures must be carefully balanced against the infection control benefits. "**

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Implementation of isolation procedures identical to those found in a hospital may result in undesirable social and psychological consequences & functional decline for residents.[207]

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3319407/

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"Transmission-based precautions" (a.k.a. "Isolation") refers to the actions (precautions) implemented, in addition to standard precautions, that are based upon the means of transmission (airborne, contact, and droplet) in order to prevent or control infections."

Transmission-based precautions

are maintained for as long as necessary to prevent the transmission of infection. It is appropriate to use the least restrictive approach possible that adequately protects the resident and others. **Maintaining isolation longer than necessary may adversely affect psychosocial well-being. The facility should document in the medical record the rationale for the selected *transmission-based precautions.***

https://www.cms.gov/Regulations Guidance/Guidance/Transmittals/downloads/r55soma.pdf

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"The use of appropriate transmission-based precautions when an LTCF resident develops symptoms or signs of a transmissible infection ..reduces transmission opportunities."

However, once it is confirmed that the resident is no longer a risk for transmitting the infection, removing transmission-based precautions avoids unnecessary *social isolation*.

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https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r55soma.pdf

Journal of the American Geriatrics SocietyVolume 61, Issue 7, Version of Record online: 3 JUN 2013

The Consequences of Poor Communication During Transitions from Hospital to Skilled Nursing Facility: A Qualitative Study

SNF Nurses described feeling overwhelmed by the constant need to gather and reconcile information received from hospitals. (because of) *inadequate discharge communication.*

Missing or incomplete, conflicting, and inaccurate information produced significant care delays because of the time-consuming process of gathering and reconciling the information required to implement a safe plan of care.

Conclusion: Nurses noted multiple deficiencies in hospital-to-SNF transitions, with poor-quality discharge communication being identified as the major barrier to safe and effective transitions. This information should be used to refine and support the dissemination of evidence-based interventions that support transitions of care

http://onlinelibrary.wiley.com/doi/10.1111/jgs.12328/pdf

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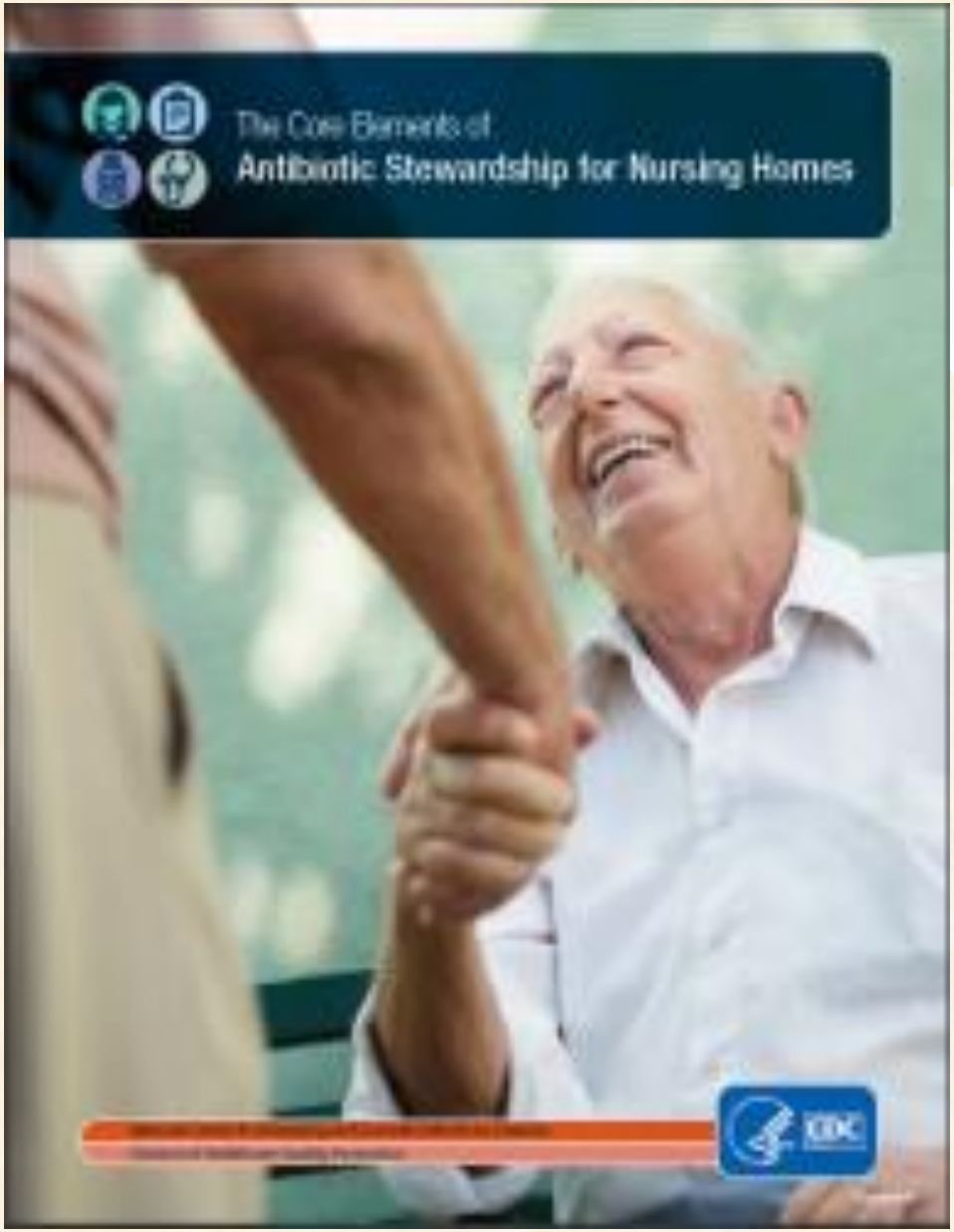

https://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html

Defining the Problem

According to the CDC, "Each year in the United States, at least 2 million people become infected with bacteria that are resistant to antibiotics and

at least 23,000 people die each year as a direct result of these infections."

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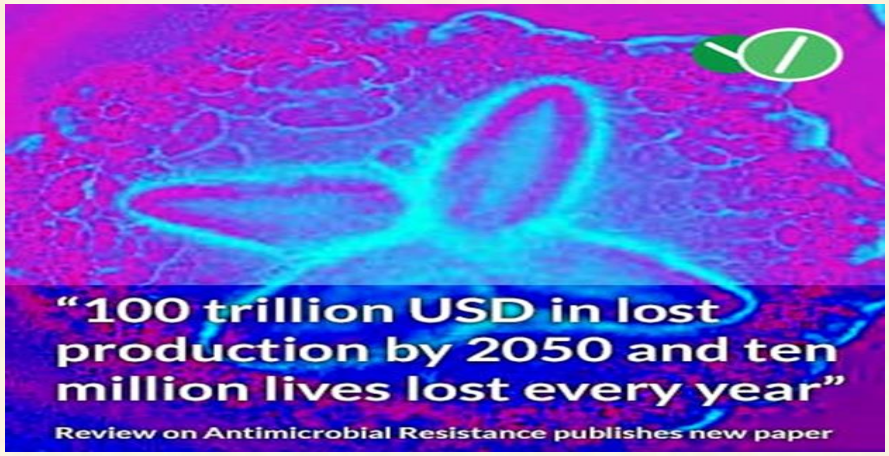

"The damaging effects of antimicrobial resistance (AMR) are already manifesting themselves across the world. Antimicrobial-resistant infections currently claim at least 50,000 lives each year across Europe and the US alone, with many hundreds of thousands more dying in other areas of the world. But reliable estimates of the true burden are scarce."

http://amr-review.org/

"Based on scenarios of rising drug resistance for six pathogens to 2050, we estimated that unless action is taken, the burden of deaths from AMR could balloon to 10 million lives each year by 2050, at a cumulative cost to global economic output of 100 trillion USD. On this basis, by 2050, the death toll could be a staggering one person every three seconds and each person in the world today will be more than 10,000 USD worse off."

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Based on United Nations report World Population Prospects: The 2015 Revision, 2015, which cites current world population of 7.3 billion and projected world population in 2050 of 9.7 billion.

http://amr-review.org/sites/default/files/160525_Final%20paper_with%20cover.pdf

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Think Globally
Act Locally

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We must be partners and communicate with each other if we are to solve the problem of antibiotic resistance

Inter-Facility Infection Control Transfer Form

- Communication tool
- Clear, concise information
- Facility to facility, as well as within a facility
- Improves patient care
- Decreased potential for patient harm
- Three main viewpoints:
  - Sepsis
  - Antimicrobial Stewardship
  - Infection Prevention

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https://www.cdc.gov/hai/pdfs/toolkits/InfectionControlTransferFormExample1.pdf

NV ASP
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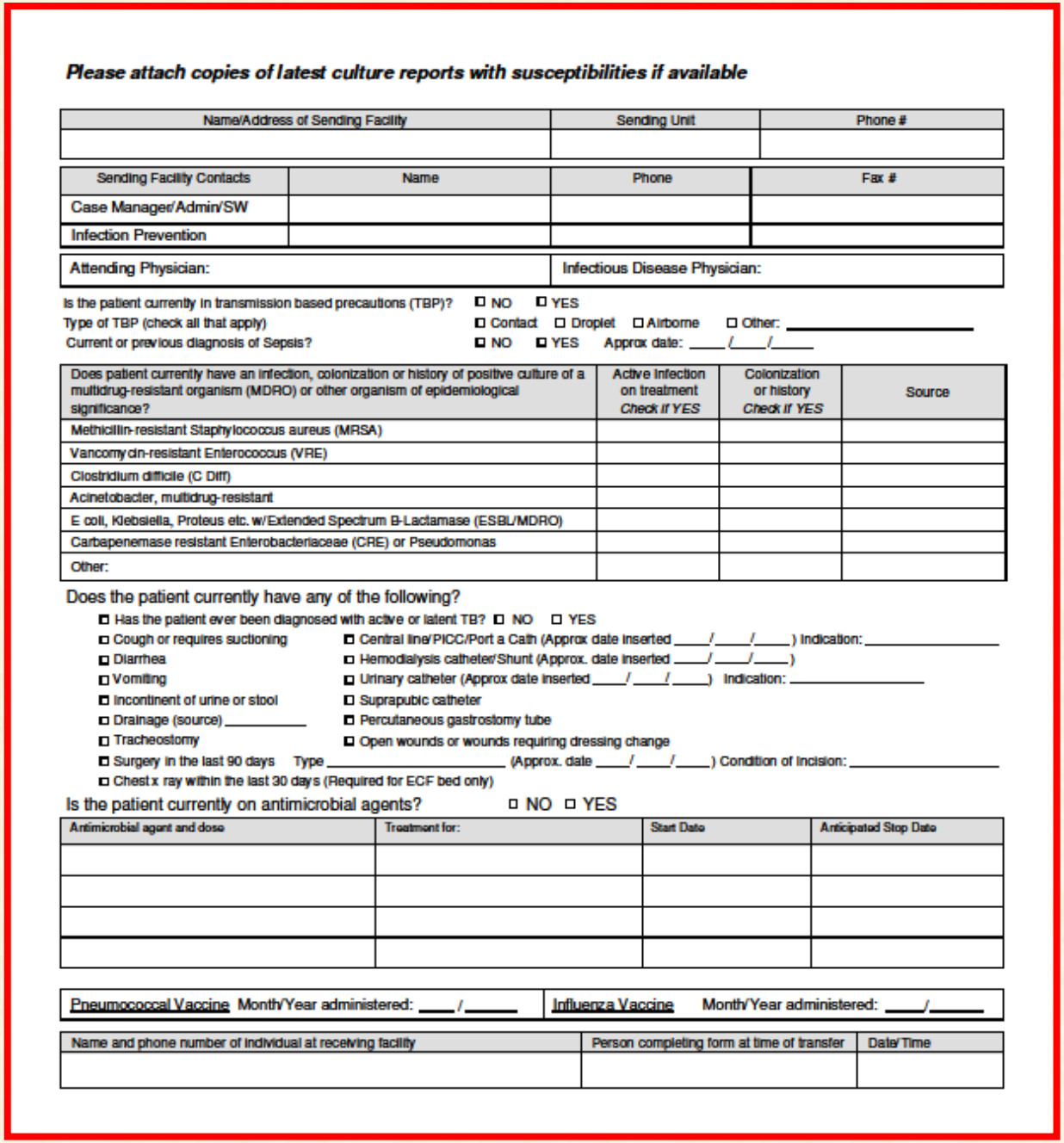
Inter-facility Transfer Form

This is available on the NVASP.net webpage under

FORMS



Please attach copies of latest culture reports with susceptibilities if available

Name/Address of Sending Facility	Sending Unit	Phone #

Sending Facility Contacts	Name	Phone	Fax #
Case Manager/Admin/SW			
Infection Prevention			

Attending Physician:	Infectious Disease Physician:

Is the patient currently in transmission based precautions (TBP)? ☐ NO ☐ YES
Type of TBP (check all that apply) ☐ Contact ☐ Droplet ☐ Airborne ☐ Other: _____
Current or previous diagnosis of Sepsis? ☐ NO ☐ YES Approx date: ____/____/____

Does patient currently have an infection, colonization or history of positive culture of a multidrug-resistant organism (MDRO) or other organism of epidemiological significance?	Active Infection on treatment *Check if YES*	Colonization or history *Check if YES*	Source
Methicillin-resistant Staphylococcus aureus (MRSA)			
Vancomycin-resistant Enterococcus (VRE)			
Clostridium difficile (C Diff)			
Acinetobacter, multidrug-resistant			
E coli, Klebsiella, Proteus etc. w/Extended Spectrum B-Lactamase (ESBL/MDRO)			
Carbapenemase resistant Enterobacteriaceae (CRE) or Pseudomonas			
Other:			

Does the patient currently have any of the following?

- ☐ Has the patient ever been diagnosed with active or latent TB? ☐ NO ☐ YES
- ☐ Cough or requires suctioning
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Incontinent of urine or stool
- ☐ Drainage (source) _____
- ☐ Tracheostomy
- ☐ Surgery in the last 90 days Type _____ (Approx. date ____/____/____) Condition of incision: _____
- ☐ Chest x ray within the last 30 days (Required for ECF bed only)
- ☐ Central line/PICC/Port a Cath (Approx date inserted ____/____/____) Indication: _____
- ☐ Hemodialysis catheter/Shunt (Approx. date inserted ____/____/____)
- ☐ Urinary catheter (Approx date inserted ____/____/____) Indication: _____
- ☐ Suprapubic catheter
- ☐ Percutaneous gastrostomy tube
- ☐ Open wounds or wounds requiring dressing change

Is the patient currently on antimicrobial agents? ☐ NO ☐ YES

Antimicrobial agent and dose	Treatment for:	Start Date	Anticipated Stop Date

Pneumococcal Vaccine Month/Year administered: ____/____	Influenza Vaccine Month/Year administered: ____/____

Name and phone number of individual at receiving facility	Person completing form at time of transfer	Date/Time

South Dakota Inter-facility Infection Control Transfer Form

Please use this form when transferring a patient with Carbapenem-resistant Enterobacteriaceae (CRE)

This form must be filled out for transfer to accepting facility with information communicated prior to or with transfer.

Please attach copies of latest culture reports with susceptibilities if available.

Sending Healthcare Facility:

Patient/Resident Last Name	First Name	Date of Birth	Medical Record No.

Name/Address of Sending Facility	Sending Unit	Sending Facility Phone

Sending Facility Contacts	Name	Phone	E-mail
Case Manager/Admin/SW			
Infection Prevention			

Is the patient currently in isolation? ☐ **No** ☐ **Yes**

Type of isolation (check all that apply) ☐ **Contact** ☐ **Droplet** ☐ **Airborne** ☐ **Other:**_____

Does patient currently have an infection, colonization OR a history of positive culture of a multidrug-resistant organism (MDRO) or other organism of epidemiological significance?	Include Colonization or history *Check if YES*
Carbapenem-resistant Enterobacteriaceae (CRE)	
Clostridium difficile (Cdiff)	
Methicillin-resistant Staphylococcus aureus (MRSA)	
Vancomycin-resistant Entrococci (VRE)	
Acinetobacter (Multi-drug resistant)	
E coli, Klebsiella, Proteus etc. w/Extended Spectrum B-Lactamase (ESBL)	
Pseudomonas aeruginosa (CRE ESBL)	

Does the patient/resident currently have any of the following?

- ☐ Cough or requires suctioning
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Incontinent of urine or stool
- ☐ Open wounds or wounds requiring dressing change
- ☐ Drainage (source)_____
- ☐ Central line/PICC (Approx. date inserted___/____/
- ☐ Hemodialysis catheter
- ☐ Urinary catheter (Approx. date inserted___/____/
- ☐ Suprapubic catheter
- ☐ Percutaneous gastrostomy tube
- ☐ Tracheostomy

Printed Name of Person completing form	Signature	Date	If information communicated prior to transfer: Name & phone of individual at receiving facility

LOS ANGELES COUNTY
HEALTHCARE FACILITY TRANSFER FORM

Please use this form for ALL transfers to admitting facility.
This form is NOT meant to be used as criteria for admission.

Place patient label here.

Patient Name *(Last, First):*		
Date of Birth:	**MRN:**	**Transfer Date:**
Receiving Facility Name:		

⚠ **Currently in Isolation Precautions?** ☐ **Yes**

If Yes, check:

☐ Contact ☐ Droplet ☐ Airborne

Check all PPE (personal protective equipment) to be considered:

☐ **No** isolation precautions

Organisms			
	Does the patient have any MDROs (multi-drug resistant organisms) or other lab results for which the patient should be in isolation? Please include any infection, colonization, history, or "rule-out" communicable diseases.	Check **Yes** for MDRO or communicable disease & include **date** of specimen, if known.	☐ **No** known MDRO or communicable diseases
	C. difficile	☐ Date:	
	CRE (Carbapenem- resistant *Enterobacteriaceae* such as: *Klebsiella*, *Enterobacter* or *E. coli*)	☐ Date:	
	MDR gram negatives *(such as: Acinetobacter, Pseudomonas, etc.)*	☐ Date:	
	ESBL (extended-spectrum beta lactam resistant such as: *E. coli, Klebsiella*)	☐ Date:	
	VRE (vancomycin-resistant *Enterococcus*)	☐ Date:	
	MRSA (methicillin-resistant *Staphylococcus aureus*)	☐ Date:	
	Other: _____ Such as: lice, scabies, disseminated shingles, norovirus, flu, TB, etc.	☐ Date:	

Please include **lab results** with antimicrobial susceptibilities, **medication documentation** with antibiotic therapy end dates, and any additional info.

CONTACT INFORMATION

Sending Facility Name:

UTAH INFECTION CONTROL TRANSFER FORM

(Discharging Facility to complete form and communicate information to Receiving Facility)

Demographics

Patient/Resident *Last Name*	*First Name*	Date of Birth:	MRN:	Discharge Date:
Sending Facility Name:		**Contact Name:**		**Contact Phone:**
Receiving Facility Name:				

Precautions

Currently in Isolation Precautions? ☐ **Yes**

If Yes check: ☐Contact ☐Droplet ☐Airborne ☐ Other:_____

☐ **No** Isolation Precautions

Organisms

Did or does have *(send documentation)*:	**Current Infection, History, or Ruling Out***
Multiple Drug Resistant Organism (MDRO):	☐ **Yes**
MRSA	☐
VRE	☐
Acinetobacter not susceptible to carbapenems	☐
E. coli or Klebsiella not susceptible to carbapenems	☐
Significant communicable disease:	☐ **Yes**
C. diff	☐
Other±: _____ ±*e.g.; lice, scabies, disseminated shingles, norovirus, flu, TB, etc.*	☐ **(current or ruling out)**
***Additional info if known:**	

☐ **No** Known MDRO or Communicable Diseases

Symptoms

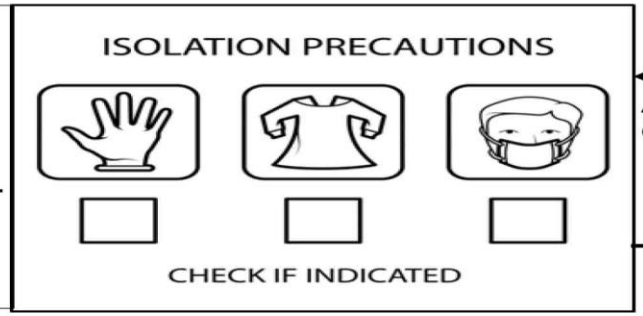
Check yes to any that <u>currently</u> apply*):

- ☐ Cough/uncontrolled respiratory secretions
- ☐ Incontinent of urine
- ☐ Vomiting
- ☐ Acute diarrhea or incontinent of stool
- ☐ Draining wounds
- ☐ Other uncontained body fluid/drainage
- ☐ Concerning rash (e.g.; vesicular)

***NOTE: Appropriate PPE required ONLY if incontinent/drainage/rash NOT contained**

☐ **No** Symptoms or PPE **not required** as "contained"

Required PPE



Answers to sections above

ANY YES: Check Required PPE

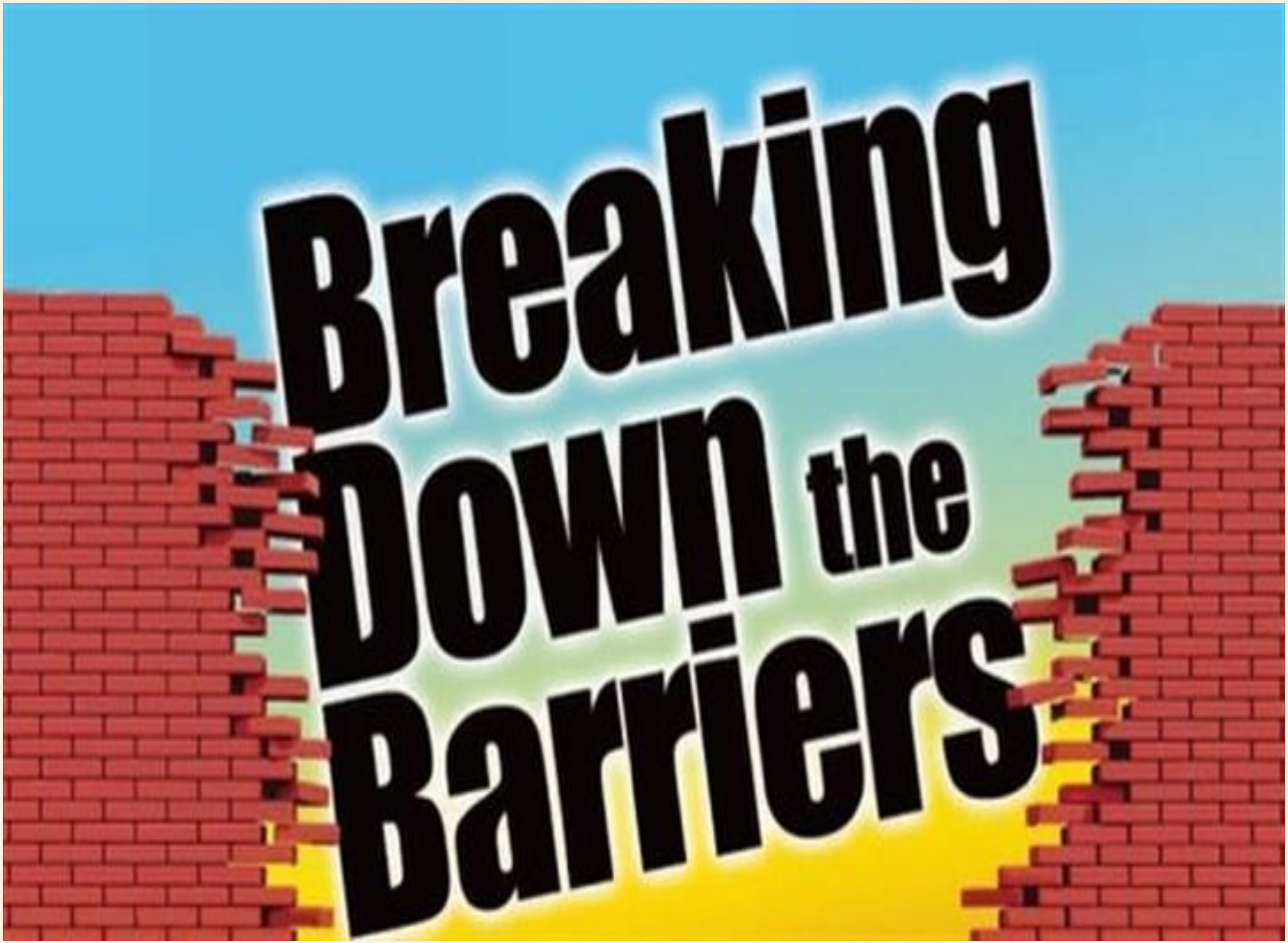
ALL NO: Just sign form

Person completing form: _____

Role: _____ Date_____/_____/_____

Version 1.6 4/23/2014 – e.version

Los Angeles
and
South Dakota


Breaking
Down the
Barriers

J Am Med Dir Assoc. 2010 May;11(4):239-45. doi: 10.1016/j.jamda.2009.08.006. Epub 2010 Mar 12.

What are your Organizational Barriers to Communication?

(1) hospital-nursing home affiliations, pharmacy or laboratory agreements, cross-site staff visits, and cross-site physician care;

(2) hospital size, teaching status, and frequency of geriatrics specialty care;

(3) nursing home size, location, type, staffing, and Medicare quality indicators; and

(4) hospital-to-nursing home communication, consistency of hospital care with health care goals, and communication quality improvement efforts.

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J Am Med Dir Assoc. 2010 May;11(4):239-45. doi: 10.1016/j.jamda.2009.08.006. Epub 2010 Mar 12.

The most frequently reported perceived barriers to communication were

1) sudden or unplanned transfers (44.4%),
2) transfers that occur at night or on the weekend (41.4%),
3) hospital providers' lack of effort (51.0%), lack of familiarity with patients (45.0%), and lack of time (43.5%). Increased hospital size, teaching hospitals, and urban nursing home location were associated with greater perceived importance of these barriers, and
4) cross-site staff visits and hospital provision of laboratory and pharmacy services to the nursing home were associated with lower perceived importance of these barriers.

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Format: Abstract J Gerontol Nurs. 2004 Jun;30(6):10-5; quiz 52-3.

The transition of elderly patients between hospitals and nursing homes. Improving nurse-to-nurse communication.

Cortes TA[1], Wexler S, Fitzpatrick JJ.

Lack of patient information is a particular problem when a patient is transferred from one health care facility to another. The lack of information needed to develop a timely and effective plan of care for an older adult transferred to the nursing home facility may exacerbate disruptions in the older adult's care. Also, adjustment or readjustment to the nursing home or hospital environment may be prolonged. **Persistence of problems or difficulty in adjustment may then lead to exacerbation of the disease processes and, ultimately, hospital readmissions.** Evidence suggests that elderly patients discharged from the hospital have high readmission rates**. Although the patient is most affected by a breakdown in communication, everyone in the nursing home involved in the resident's care is also affected.** All staff who provide care to the resident, including nursing, medicine, nutrition, pharmacy, social work, and physical therapy staff members, must be cognizant of issues related to communication for patients being transferred. In this article, the authors discuss the development, implementation, and results of a model designed to increase the communication surrounding the transition of elderly patients from an inpatient unit to and from nursing homes.

J Am Geriatr Soc. 2010 May;58(5):901-7. doi: 10.1111/j.1532-5415.2010.02804.x. Epub 2010 Apr 6.

Factors associated with potentially preventable hospitalization in nursing home residents in New York State: a survey of directors of nursing.

CONCLUSION:

Efficient and effective care depends on continuity of communication between nurses and physicians and adequate access to patients' medical history, laboratory results, and ECGs.

https://www.ncbi.nlm.nih.gov/pubmed/20406315

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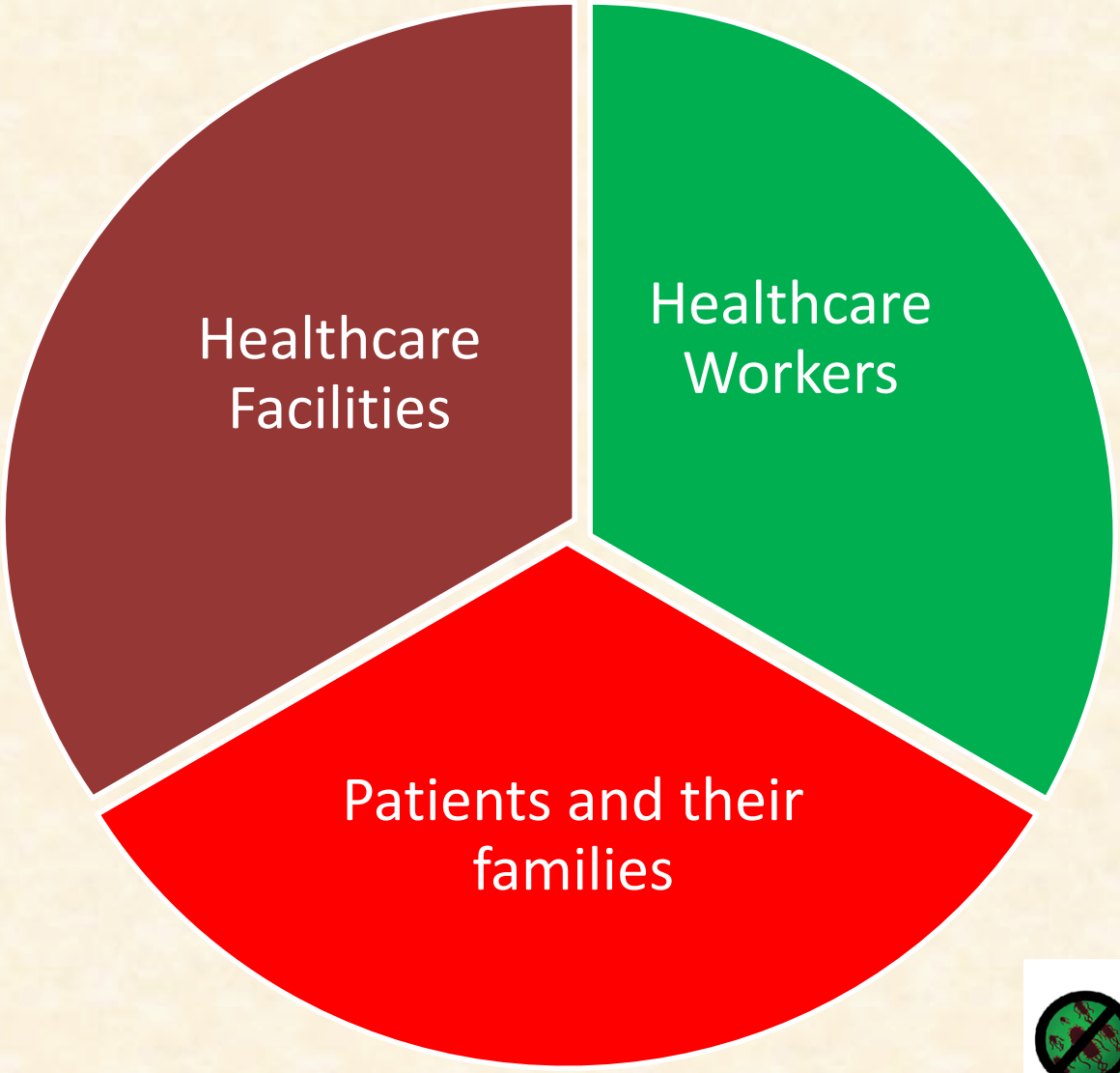
The Three Legged Stool



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J Aging Res. 2014;2014:873043. doi: 10.1155/2014/873043. Epub 2014 Feb 9. Following up on clinical recommendations in transitions from hospital to nursing home. Caruso LB1, Thwin SS2, Brandeis GH1. Abstract

Following up on recommendations made at the time of a hospital discharge is important to patient safety. While data is lacking, specifically around the transition of patient to nursing home, it has been postulated that missed items such as laboratory tests may result in adverse patient outcomes. To determine the extent of this problem, a retrospective cohort study of subjects discharged from an academic medical center and admitted to nursing homes (NH) was followed to determine the type of discharge recommendations and the rate of completion. **In addition, for the purpose of generalizability, the 30-day hospital readmission rate was calculated. Recommendations were made on 51 subjects. Almost a quarter of the recommendations made by the hospital discharging team were not acted upon.** Furthermore, for the majority of those recommendations that were not acted upon, a reason could not be determined. **In concert with national data, 20% of the subjects returned to the hospital within 30 days. Further investigation is warranted to determine if an association exists between missed recommendations and hospital readmission from the nursing home setting.**

In concert with national data, 20% returned to the hospital within 30 days.

https://www.ncbi.nlm.nih.gov/pubmed/24678422

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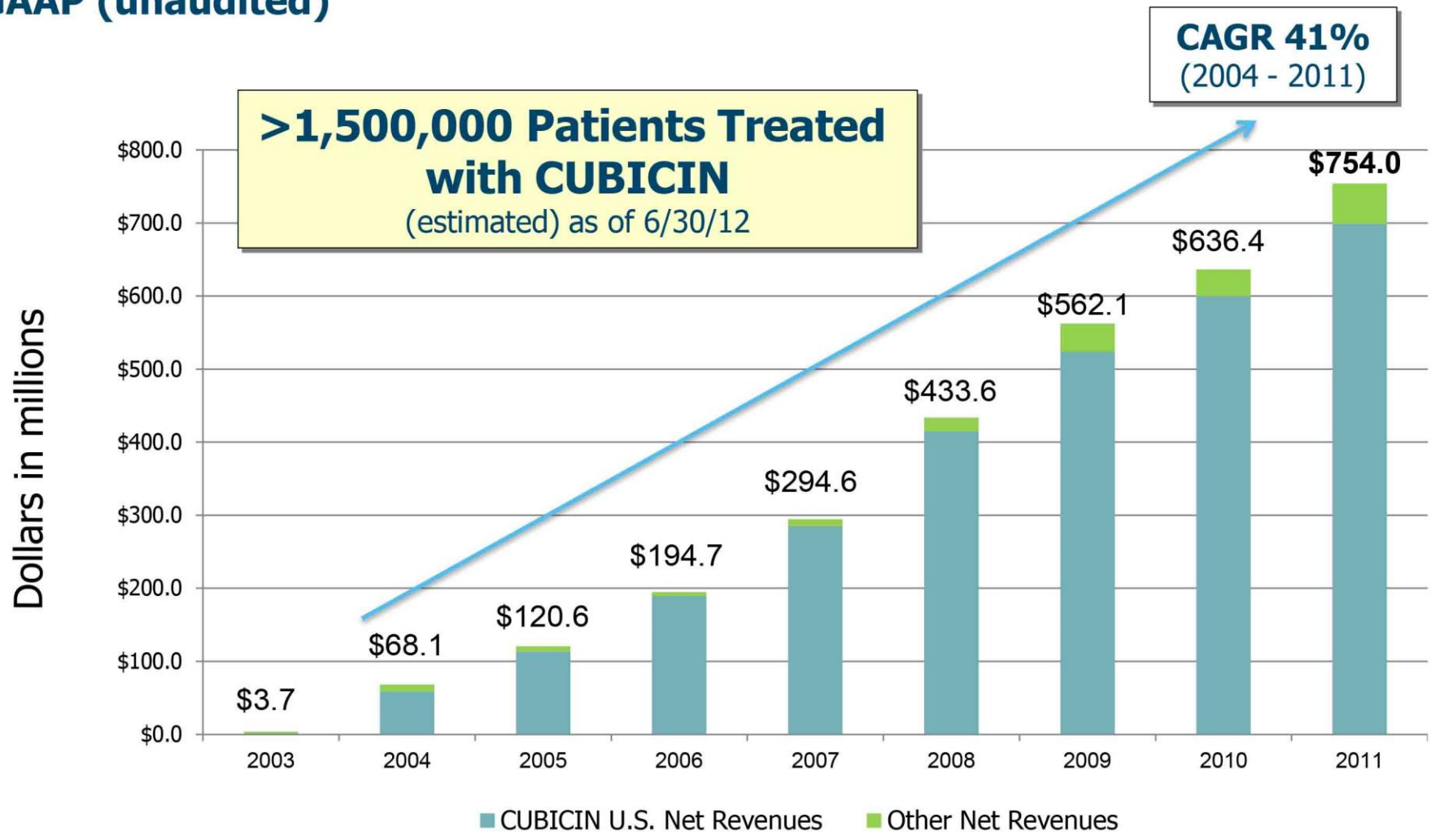
Cubist Annual Total Net Revenues

We Estimate Peak Year Sales of CUBICIN will surpass $1B in the U.S

CUBIST PHARMACEUTICALS

GAAP (unaudited)



CUBICIN: On Historic Path to Blockbuster Status

CUBIST PHARMACEUTICALS

Cumulative Sales of U.S. I.V. Antibiotics Post Launch

We estimate peak year sales for CUBICIN **will surpass $1 Billion** in the U.S.

$3,604 M CUBICIN Gross Sales in First 104 Months (through 2Q12)

ROCEPHIN®

TYGACIL®

ZYVOX I.V.®

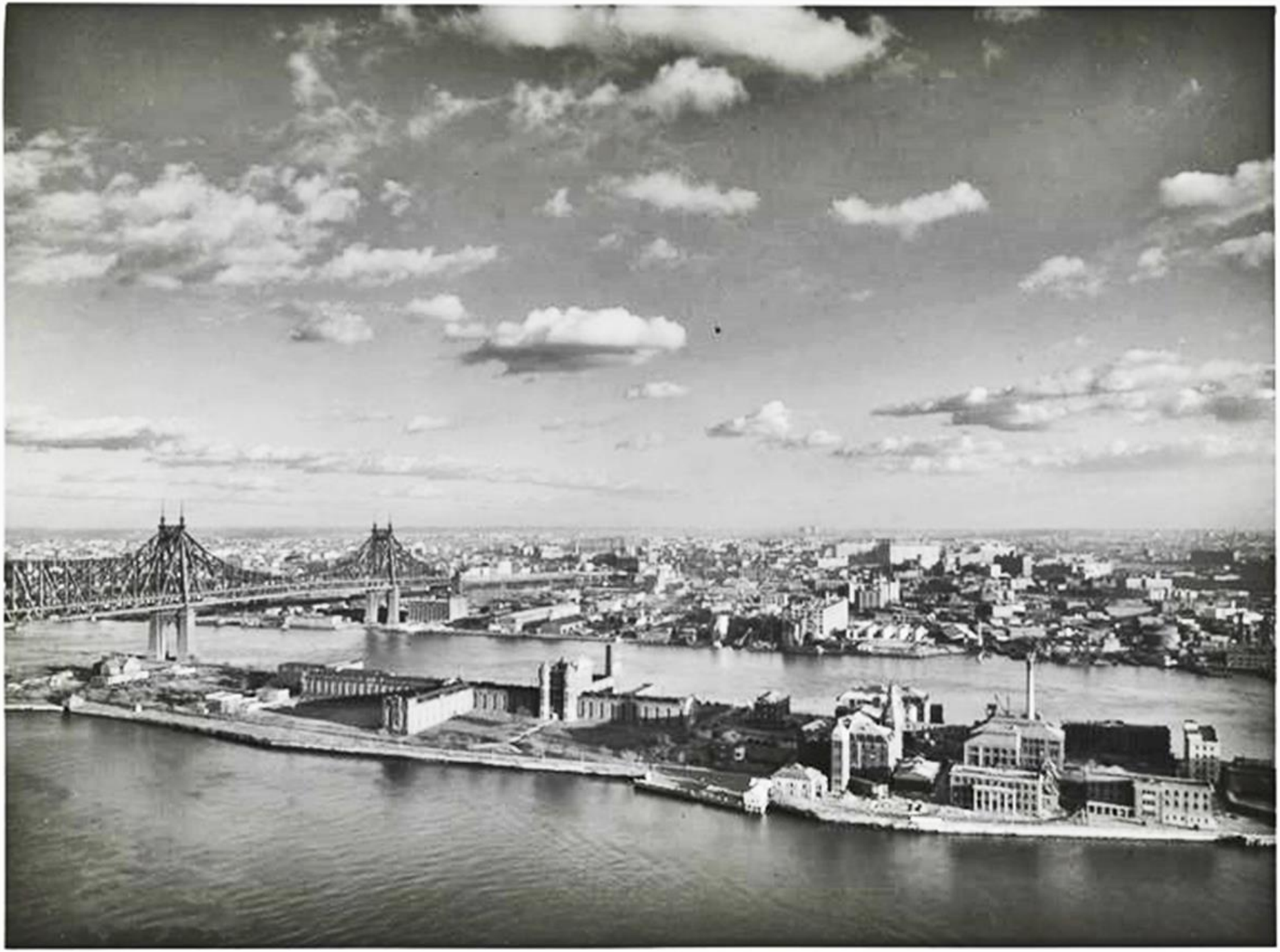
ZOSYN®

$4,000,000
$3,500,000
$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0

1st mo, 8th mo, 15th mo, 22nd mo, 29th mo, 36th mo, 43rd mo, 50th mo, 57th mo, 64th mo, 71st mo, 78th mo, 85th mo, 92nd mo, 99th mo

CUBICIN® ZOSYN® ROCEPHIN® ZYVOX I.V.® TYGACIL®

Source: ICS Gross orders for CUBICIN, IMS Gross Sales for other products




WELFARE ISLAND
QUEENS PLAZA
605


RIDE

Nevada Antimicrobial Stewardship Program

www.NVASP.NET

Our Goal

To reduce inappropriate use and overuse of antibiotics in hospitals, long term and home health care

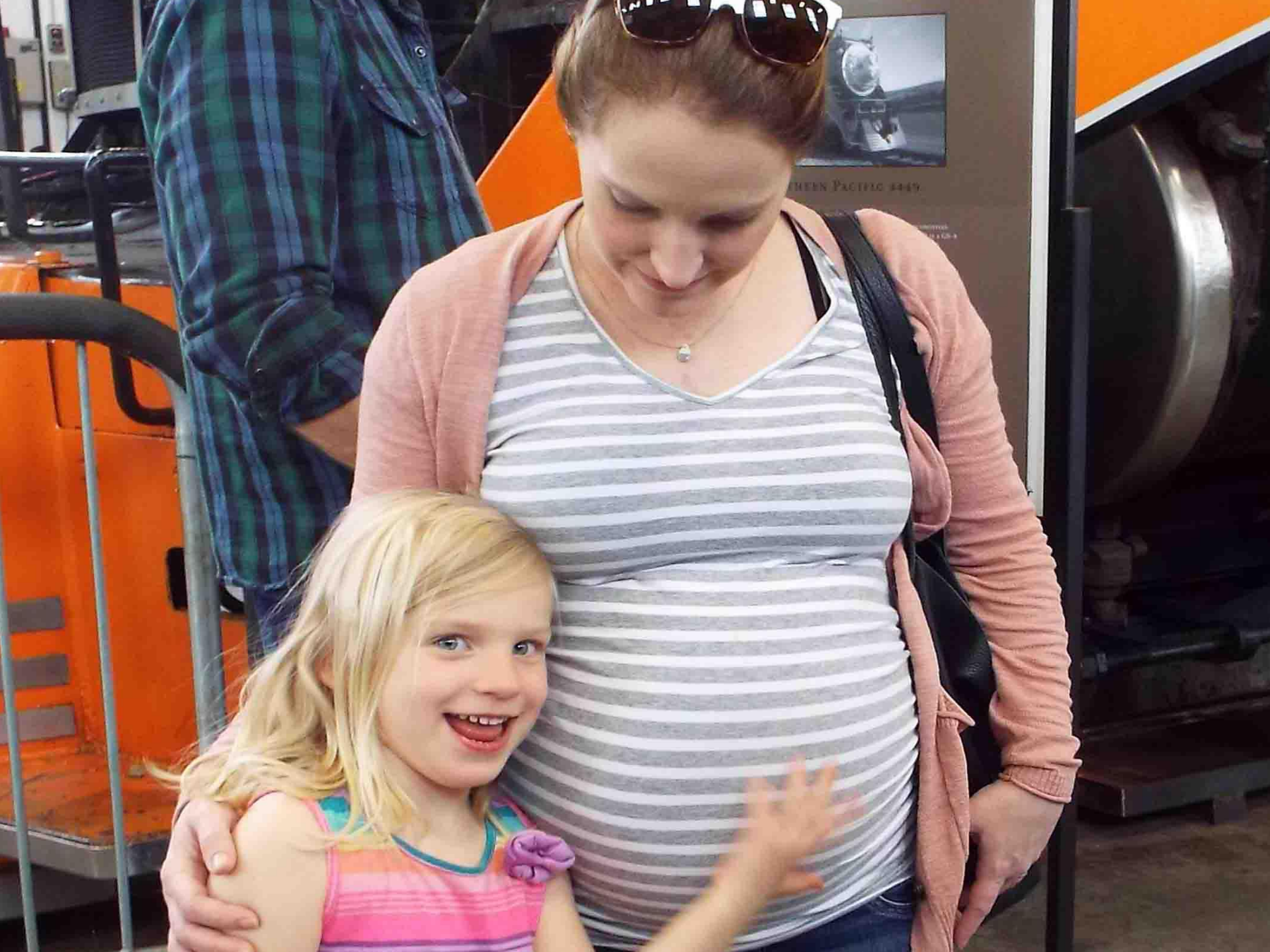
NV ASP Nevada Antimicrobial Stewardship

EVOLUTION OF ANTIBIOTICS

Misuse Yesterday + Resistance Today

= No Choices Tomorrow

“This program is designed to cover a variety of topics related to the evolution of antibiotics and how we can change the future with responsible distribution.”



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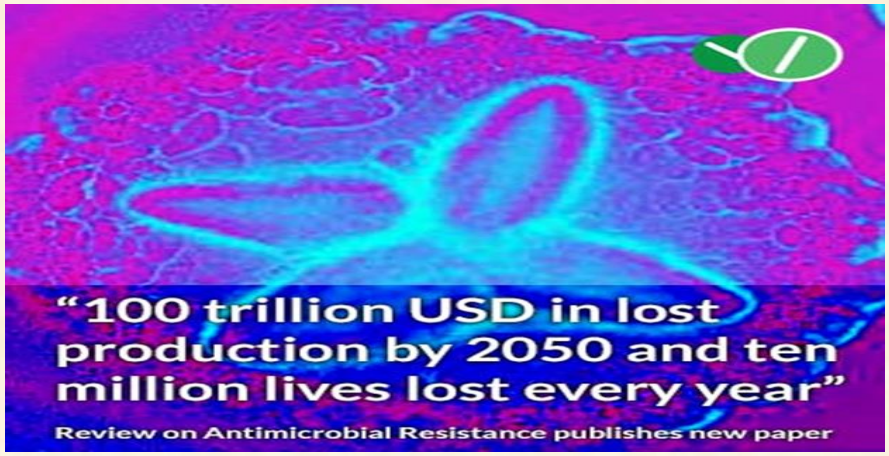

"The damaging effects of antimicrobial resistance (AMR) are already manifesting themselves across the world. Antimicrobial-resistant infections currently claim at least 50,000 lives each year across Europe and the US alone, with many hundreds of thousands more dying in other areas of the world. But reliable estimates of the true burden are scarce."

http://amr-review.org/

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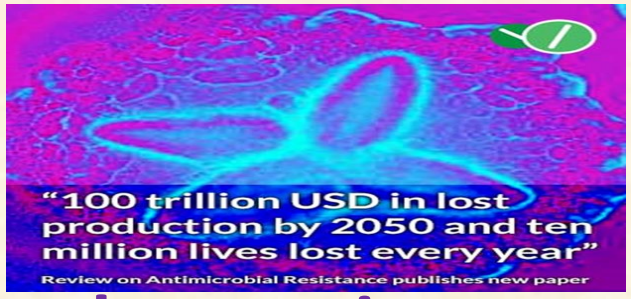

"Based on scenarios of rising drug resistance for six pathogens to 2050, we estimated that unless action is taken, the burden of deaths from AMR could balloon to 10 million lives each year by 2050, at a cumulative cost to global economic output of 100 trillion USD. **On this basis, by 2050, the death toll could be a staggering one person every three seconds and each person in the world today will be more than 10,000 USD worse off."**

Based on United Nations report World Population Prospects: The 2015 Revision, 2015, which cites current world population of 7.3 billion and projected world population in 2050 of 9.7 billion.

http://amr-review.org/sites/default/files/160525_Final%20paper_with%20cover.pdf

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Inter-facility Transfer Form

Please attach copies of latest culture reports with susceptibilities if available

Name/Address of Sending Facility	Sending Unit	Phone #

Sending Facility Contacts	Name	Phone	Fax #
Case Manager/Admin/SW			
Infection Prevention			

Attending Physician:	Infectious Disease Physician:

Is the patient currently in transmission based precautions (TBP)? ☐ NO ☐ YES
Type of TBP (check all that apply) ☐ Contact ☐ Droplet ☐ Airborne ☐ Other: _____
Current or previous diagnosis of Sepsis? ☐ NO ☐ YES Approx date: ____/____/____

Does patient currently have an infection, colonization or history of positive culture of a multidrug-resistant organism (MDRO) or other organism of epidemiological significance?	Active infection on treatment *Check if YES*	Colonization or history *Check if YES*	Source
Methicillin-resistant Staphylococcus aureus (MRSA)			
Vancomycin-resistant Enterococcus (VRE)			
Clostridium difficile (C Diff)			
Acinetobacter, multidrug-resistant			
E coli, Klebsiella, Proteus etc. w/Extended Spectrum B-Lactamase (ESBL/MDRO)			
Carbapenemase resistant Enterobacteriaceae (CRE) or Pseudomonas			
Other:			

Does the patient currently have any of the following?

- ☐ Has the patient ever been diagnosed with active or latent TB? ☐ NO ☐ YES
- ☐ Cough or requires suctioning
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Incontinent of urine or stool
- ☐ Drainage (source) _____
- ☐ Tracheostomy
- ☐ Surgery in the last 90 days Type _____ (Approx. date ____/____/____) Condition of incision: _____
- ☐ Chest x ray within the last 30 days (Required for ECF bed only)
- ☐ Central line/PICC/Port a Cath (Approx date inserted ____/____/____) Indication: _____
- ☐ Hemodialysis catheter/Shunt (Approx. date inserted ____/____/____)
- ☐ Urinary catheter (Approx date inserted ____/____/____) Indication: _____
- ☐ Suprapubic catheter
- ☐ Percutaneous gastrostomy tube
- ☐ Open wounds or wounds requiring dressing change

Is the patient currently on antimicrobial agents? ☐ NO ☐ YES

Antimicrobial agent and dose	Treatment for:	Start Date	Anticipated Stop Date

Pneumococcal Vaccine Month/Year administered: ____/____	Influenza Vaccine Month/Year administered: ____/____

Name and phone number of individual at receiving facility	Person completing form at time of transfer	Date/Time

University of Nevada, Reno School of Medicine

PROJECT ECHO

CONNECTING NEVADA'S COMMUNITIES TO SPECIALTY CARE

SNHD

Southern Nevada Health District

NHA

Nevada Hospital Association

NNA

NEVADA NURSES ASSOCIATION