



Healthcare Quality Reporting Program

HOSPITAL-ACQUIRED INFECTIONS SUBCOMMITTEE

8-9am, April 18, 2016

Healthcentric Advisors, 235 Promenade Street, Suite 500

1. Welcome & today's meeting objectives (8am)

- Meeting chairs: L. Mermel, S. Viner-Brown
- Program staff: E. Cooper, V. Carroll
- Voting members in attendance (8/17): U. Bandy, M. Fishman, M. Marsella, R. Neale, K. O'Connell, S. Turner, J. Robinson, N. Vallande
- Other attendees: D. Lewis (via phone), L. Martino, M. Mimnaugh S.Parente (via phone), J. Rocha, P. Winderman

2. Review of the previous meeting's action items (8:05am)

- **Request hospital flu data from State Epidemiologist (Emily) – Complete**
We are received the requested data and it will be discussed at the ad hoc meeting in May.
- **Draft recommendations for Immunization Program (Emily) – Complete**
The recommendations have been drafted and will be discussed at our ad hoc meeting in May.
- **Review Infection Prevention Assessment request letter (all) – Complete**
This letter was completed and sent to the hospitals. Emily noted that the deadline for completing the survey has been extended to Friday, April 22nd. The Miriam Hospital has agreed to be one of the onsite assessment locations. We are looking for two more hospitals and 15 nursing homes to participate in the onsite assessment. Emily also noted that once the data collection process is complete, the aggregate data will be available to stakeholders.

3. Recommendation for CME requirements (8:10am)

- *Review regulation*
Emily introduced the topic by explaining that 2016 is a re-licensing year for RI physicians, and as noted in the Rules and Regulations for the Licensure and Discipline of Physicians part 1, section 6.2, the requirement for continuing medical education requires that a minimum of two hours be related to current public health needs as identified by the Director of the Department of Health.
Currently there are no infection prevention/antimicrobial stewardship education requirements in the licensing regulations; however this requirement is an opportunity to include these topics in the requirements.
- *Review draft recommendations*
The committee discussed making a formal recommendation to the Director and to licensure regarding the CME requirements and public health topics. Emily provided a draft letter outlining the proposed recommendations. These include:



- The number of hours required that are related to current public health needs should be increased from two to four
- The list of approved topics should include Antimicrobial Stewardship
- The list of approved topics should include Infection Prevention
- The regulations should specify that two of the public health credit hours must be related to either Antimicrobial Stewardship OR Infection Prevention

The committee felt that the recommendations were good, noting that the fourth bullet should be changed to “of the four public health credit hours at least one must be related to Infection Prevention AND at least one must be related to Antimicrobial Stewardship”.

The committee then discussed the possibility of adding infection prevention/antimicrobial stewardship education requirements to the licensing regulations for other provider types (e.g. nurses, physician assistants and pharmacists). It was alternatively suggested that a new regulation be put in place outlining infection prevention/antimicrobial stewardship education requirements that would apply to multiple license types. The expansion of the requirement, through either method, will be included in this letter.

Other opportunities for future discussion included exploring the regulations for facility licensing and the regulations for healthcare worker immunization.

Emily invited further review and comment, noting that she needed all commentary by close of business on Wednesday, April 20th. A revised draft will be shared with the group before the letter is submitted.

4. Meeting with Senator Whitehouse (8:20am)

- *Initial thoughts*

Emily explained that Senator Whitehouse held a meeting on March 29, 2016 to discuss Rhode Island’s HAC reductions. Rhode Island is ranked 50 out of 51 for percent of hospitals receiving the HAC penalty, with 7 out of 11 of our hospitals receiving HAC penalties. Senator Whitehouse has requested additional information to help him understand why we rank so low compared to other states. He would also like to know if there are unique disadvantages faced by Rhode Island and, if so, how he can help level the playing field.

- *Discussion*

The committee discussed the factors that are potentially impacting our rating, which include:

- A proportionally high elderly population, which impacts HAI rates, specifically CDiff
- As a result of Rhode Island’s lower than average profit margins and Medicare margins and of the OHIC reimbursement cap, there is limited funding available for infection prevention activities, including competency-based education
- Almost all of our hospitals are using higher sensitivity testing methods for HAIs and many made this change before hospitals were able to update their testing methods quarterly (e.g. if a hospital switched their testing method, but was not able to update their testing procedure information in NHSN until the next annual survey, then the wrong adjustment factor would have been applied to their data. This could have impacted up to a year of data.)



- The variances between the existing payment adjustment programs (e.g. Value-Based Purchasing and the HAC Reduction program) make it difficult to develop a targeted, priority-based improvement plan

The committee discussed the following ways that Senator Whitehouse could help to reduce HAIs in Rhode Island and to improve our future performance within the HAC program:

- Ensure that CMS is planning to include the correction factors for testing sensitivity and community risk in the HAC calculations once we reach the period where CDI and MRSA are included in the HAC score
 - Ask CDC to include questions about resources available (e.g. IT support, FTE, overall budget, etc.) to infection prevention programs on the annual NHSN survey and publicly report this information alongside the HAI scores
 - Ask hospital leadership for information about the proportion of funding allocated to infection prevention and encourage them to work with their staff to identify and meet resource needs
 - Work with CMS to better align the payment adjustment programs so that hospitals can develop targeted, priority-based improvement plans
- *Develop formal response*
Emily has begun a draft response for Senator Whitehouse, and will be updating it with today's discussion items. She invited further commentary via email over the next few days.

5. Open forum & next steps (8:55am)

Emily asked for input on a CDC grant she is currently writing. She is planning to ask for funds for the development of HAI and Antimicrobial Stewardship education/training modules and asked the group whether this would be helpful. She explained that she modules being presented at hospitals and nursing homes in the state. The group responded that this would be more helpful if the modules could be tailored to each hospital's practices. They added that they would also want access to the training materials so that their training staff could use them. Emily also asked about training dummies would be helpful, and asked what types would be most useful. The group discussed the use of dummies for urinary catheter and central line training.

6. Action Items

- Send additional comments on the proposed CME recommendations by 4/20/16 (All)
- Update CME letter, share draft before sending (Emily)
- Send additional comments on the proposed letter to Senator Whitehouse by 4/20/16 (All)
- Update letter to Senator Whitehouse, share draft before sending (Emily)

Next Meeting: May 16, 2016 from 9-10am (ad hoc) at Healthcentric Advisors

**RULES AND REGULATIONS
FOR THE LICENSURE AND DISCIPLINE OF PHYSICIANS**

[R5-37-MD/DO]



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

DEPARTMENT OF HEALTH

1967

AS AMENDED:

December 1967	December 2002
February 1975	April 2004
February 1976	October 2004
March 1977	January 2007 (re-filing in accordance with the provisions of § 42-35-4.1 of the Rhode Island General Laws, as amended)
December 1978	October 2007
May 1982	August 2008
July 1986	August 2009
October 1988 (E)	January 2012 (re-filing in accordance with the provisions of § 42-35-4.1 of the Rhode Island General Laws, as amended)
September 1990(E)	January 2012
January 1991 (E)	May 2012
August 1991	September 2012
September 1991	April 2014
November 1992	September 2014
June 1997	October 2015
September 1998	
January 2000	
January 2002 (re-filing in accordance with the provisions of § 42-35-4.1 of the Rhode Island General Laws, as amended)	

INTRODUCTION

These amended *Rules and Regulations for the Licensure and Discipline of Physicians (R5-37-MD/DO)* are promulgated pursuant to the authority conferred under Chapter 5-37 of the General Laws of Rhode Island, as amended, and are established for the purpose of updating prevailing standards governing the licensure and discipline of physicians in Rhode Island. These specific amendments update standards and criteria for issuance of limited medical registrations¹, fees for medical records, closing of a medical practice, as well as general updating of regulatory requirements for consistency with accepted medical practice.

The healing art of medicine has changed over the years and is a collaborative endeavor involving many other health care professionals.

The Board of Medical Licensure and Discipline recognizes there are several other disciplines that participate in the healing arts. The practice of medicine is not a provincial exercise that is unique to physicians; rather there are many other licensed health care professionals who participate in these healing arts. These Regulations are intended for the physician community and to set clear boundaries for unlicensed persons or those similarly who lack qualifications.

Pursuant to the provisions of § 42-35-3(a)(3) and § 42-35.1-4 of the General Laws of Rhode Island, as amended, the following were given consideration was given in arriving at the amended regulations as to:

- (1) Alternative approaches to the regulations;
- (2) Duplication or overlap with other state regulations; and
- (3) Significant economic impact on small business.

Based on the available information, no known alternative approach, duplication or overlap was identified.

Upon promulgation of these amendments, these amended regulations shall supersede all previous *Rules and Regulations for the Licensure and Discipline of Physicians* and *Rules and Regulations for Limited Medical Registration [R-5-37REG]* promulgated by the Rhode Island Department of Health and filed with the Secretary of State.

¹ Prior to the September 2015 edition, these requirements were contained in the *Rules and Regulations for Limited Medical Registration [R-5-37REG]*, which have been repealed concurrent with the promulgation of these amendments.

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- 5.1.1 For written examinations, the Board requires applicants to successfully pass the following:
- (1) The National Board of Allopathic or Osteopathic Medical Examination (NBME) or (NBOME); or
 - (2) The United States Medical Licensing Examination (USMLE);
 - (3) The Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA)
 - (4) The Licentiate Medical Council of Canada (LMCC);
 - (5) Or any combination of examinations acceptable to the Board and as recommended by the United States Medical Licensing Examination;
 - (6) The passing score for each section of the above examinations must be 75 or more (The Board does not accept averaging of the separate components.)
 - (7) Applicants for licensure in Rhode Island must pass each section of the required examination by the third (3rd) attempt. In the event of a third (3rd) failure, opportunity for re-examination(s) shall be subject to the applicant's completion of additional requirements as recommended by the Board on a case by case basis.

Section 6.0 *Continuing Education*

- 6.1 Every physician licensed to practice allopathic or osteopathic medicine in Rhode Island under the provisions of the Act and these Regulations, shall on or before the first (1st) day of June of every even-numbered year, on a biennial basis, earn a minimum of forty (40) hours of AMA PRA Category 1 Credit™/AOA Category 1a continuing medical education credits and shall document this to the Board.
- 6.1.1 A physician's participation in an American Board of Medical Specialty's (ABMS) Maintenance of Certification program will be considered equivalent to meeting CME requirement.
- 6.1.2 A physician's participation in the AOA's Osteopathic Continuous Certification (OCC) program will be considered equivalent to meeting CME requirement.
- 6.2 The application shall include evidence satisfactory to the Board of completion of a prescribed program of continuing medical education established by the appropriate medical or osteopathic society. Participation by duly appointed members of the Board in regular Board meetings and investigating committee meetings shall be considered acceptable on an hours served basis in lieu of AMA PRA Category 1 Credit™/AOA Category 1a continuing medical education hours.
- 6.2.1 Said continuing medical education shall include a minimum of two (2) hours from a list of topics related to current public health needs, which list shall be developed by the Director in consultation with and as approved by the appropriate medical or osteopathic society. The list shall be available to physicians as of 1 July of each even-numbered year.

- 6.3 The Board, may extend for only one (1) six (6) month period such educational requirements pursuant to the provisions of § 5-37-2.1 of the Act.
- 6.4 It shall be the sole responsibility of the individual physician to obtain documentation from the approved sponsoring or co-sponsoring organizations, agencies or other, of his or her participation in a learning experience and the number of dated credits earned.
- 6.4.1 Those documents must be safeguarded, for a period of three (3) years, by the physician for review by the Board if required. Only a summary list of those documents, not the documents themselves, shall be submitted with the application for renewal of the certification.
- 6.5 Licensure renewal shall be denied to any applicant who fails to provide satisfactory evidence of continuing medical education as required by these Regulations.

Section 7.0 *Issuance and Renewal of License and Fee*

- 7.1 Upon completion of the aforementioned requirements and upon submission of the initial licensure fee as set forth in the *Rules and Regulations Pertaining to the Fee Structure for Licensing, Laboratory and Administrative Services Provided by the Department of Health*, the Director may issue a license to those applicants found to have satisfactorily met all the requirements of these Regulations. Said license unless sooner suspended or revoked shall expire biennially on the first (1st) day of July of the next even-numbered year.
- 7.2 (a) Every physician licensed during the current year who intends to practice allopathic or osteopathic medicine during the ensuing two (2) years shall file with the Board, before the first (1st) day of July of each even-numbered year, a renewal application, on such forms as the Chief Administrative Officer deems appropriate, and duly executed together with the renewal fee as set forth in the *Rules and Regulations Pertaining to the Fee Structure for Licensing, Laboratory and Administrative Services Provided by the Department of Health* on or before the first (1st) day of July in each even-numbered year. Payment shall be postmarked on or before July 1.
- (b) Notwithstanding the provisions of § 7.2(a) of these Regulations, a physician shall be eligible for a reduced renewal fee, as set forth in the *Rules and Regulations Pertaining to the Fee Structure for Licensing, Laboratory and Administrative Services Provided by the Department of Health*, if the physician complies with the following requirements:
- (1) Successful completion of the *Physician Professional Education Program* for the current renewal cycle, as established by the Director; and
 - (2) (i) For the renewal period ending 30 June 2014, documentation of successful completion of the *Physician Professional Education Program* for the current renewal cycle is filed with the Board before 1 May 2014;
 - (ii) For renewal periods ending 30 June 2016 and later, documentation of successful completion of the *Physician Professional Education Program* for



Department of Health

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April xx, 2016

Dear Dr. Alexander-Scott and Dr. McDonald,

Healthcare-Acquired Infections (HAIs) constitute a significant threat to our Nation's health. The presence of this threat is felt acutely in Rhode Island, where there are comparably higher rates of HAIs than in other states. **The impact of HAIs on the health and well-being of Rhode Islanders cannot be overstated.** HAIs negatively impact patient morbidity, mortality and quality of life.

There is also a considerable cost to our state's healthcare system, most recently in the form of Medicare reimbursement penalties under the Centers for Medicare and Medicaid Services (CMS) Healthcare-Associated Condition (HAC) Reduction Program. **In Fiscal Year 2016, 7 out of 11 acute-care hospitals in the state will receive a HAC penalty, reducing their Medicare reimbursement rate. Rhode Island has the second highest percentage of penalized hospitals in the country.**

The HAI Subcommittee, which operates within the Rhode Island Department of Health's (RIDOH's) Healthcare Quality Reporting Program, has **identified training and education related infection prevention and antimicrobial stewardship, as a high-priority task for reducing HAI rates in Rhode Island.** Although all hospitals in the state provide training and education in these areas for their providers, they are not able to fully meet this need.

Hospital Infection Prevention Programs do not have enough education funds to provide competency-based training to all of their staff and hospitals do not always have the authority to require non-employed providers (Licensed Independent Practitioners) to undergo hospital education and training programs.

We would like to present the following recommendations related to the regulation that requires physicians licensed by the state of Rhode Island to complete 40 CME hours and that those 40 CME hours "shall include a minimum of two (2) hours from a list of topics related to current public health needs" [R5-37-MD/DO, Section 6.2.1].

- The number of hours required that are related to current public health needs should be increased from two (2) to four (4)
- The list of approved topics should include Antimicrobial Stewardship
- The list of approved topics should include Infection Prevention
- The regulations should specify that two (2) of the public health credit hours must be related to either Antimicrobial Stewardship OR Infection Prevention

Following these recommendations will help to ensure that our physician workforce is adequately trained to protect Rhode Islanders from HAIs.

We thank you for your dedication to improving the quality of healthcare in Rhode Island.

Sincerely,

Samara Viner-Brown, MS
Chief, Center for Health Data and Analysis

Leonard Mermel, DO, ScM, AM (Hon)
HAI Subcommittee Co-Chair

CC: *HAI Subcommittee*
Hospital Infection Preventionists

Infection Preventionists Thoughts, Recommendations and Suggestions on the Situation of HAI's in Rhode Island

1. Suggestions for the CDC/NHSN to assure a “level playing field” among the states:

- a. Since all Rhode Island hospitals utilize the more highly sensitive PCR testing for CDI, as a state Rhode Island may be more likely to show a higher CDI rate than states that permit hospitals to use less sensitive CDI testing methods, which then are reported to NHSAN. All hospitals, regardless of their home state, should be reporting HAIs based on a consistent laboratory test.
- b. Patients with positive tests may have been performed by an unaffiliated facility; the NHSN definition does not allow us to submit this information. So a patient with known *C.difficile* can be admitted and perhaps later have a loose stool. If we are unable to obtain an appropriate specimen prior to the third midnight after admission, then a later positive test will be classified as HO even if we know it was present on admission. NHSN will count the same patient as HO three times! We are not the only hospital to document that CMS misclassifies at least 25% of the positive *C.difficile* test results as HO. This certainly misleads the public, and artificially raises the HAC score.
 - i. The same is true for a patient admitted with known MRSA. Sometimes the patient cannot clear his MRSA. We need to check blood cultures repeatedly for patients with endocarditis. This practice is the required standard of care to ensure patient safety and proper treatment.

2. Issues suggested as possibly contributing to or negatively influencing the State's HAI rates:

- a. Patients don't receive a bed bath any longer with soap and water they receive a bath in a bag which includes Chlorhexidine treated wash towels. These wash towels leave a residual amount of Chlorhexidine on the patient's skin which has proven very helpful in reducing MSRA in ICU patients but unsure how this impacts CDI patients.
- b. Patient's beds are not changed as frequently as before. Fitted sheets are used so the bed doesn't get messy and if the bed is not wet or visibly soiled the sheets aren't changed unless patient requests it. Since patients can shed CDI spores for quite some time after symptoms stop could this be a contributing factor.

- c. MRSA screening on admission may be happening at all RI hospitals per our MRSA standardization policy/guideline published in the early 2000's where this MRSA mandatory admission screening may not be required in other states.

3. Issues identified or suggested for further research or investigation to determine if they negatively impact HAI rates in Rhode Island versus other states:

- a. Study the following to evaluate how Rhode Island is different from Massachusetts:
 - Profit margin and reimbursement rates for the different New England States for care provided. Do RI hospitals get reimbursed at the same rates as MA, CT, etc.?
 - *C. difficile* testing methods in RI vs. other New England States (PCR)
 - NHSN reporting validation rates
 - Results from CDC Infection Control Assessment Tool
- b. Rhode Island has 11 acute-care hospitals (ACH) all paid under IPPS therefore required to participate in APU, HAC and HVBP reduction programs. All 11 ACH are submitting data therefore RI's total population is included in this data submission. Do other states have as many infections but they are not submitted into NHSN since their hospitals are non-IPPS or critical access hospitals that are not required to submit HAI data into NHSN?
- c. Are RI hospitals staffed with the same proportion of infection preventionists per hospital beds versus Massachusetts hospitals?
- d. Study the relationship between acute and long-term care in terms of antibiotic stewardship and how that impacts hospital HAI rates.

4. Suggestions made for "system" improvements that may positively impact Rhode Island's HAI rates:

- a. Repeated and frequent changes and complexity of the NHSN definitions and reporting require increased demands on the time of the infection preventionists and increase the risk of reporting errors.
- b. As budgets get tighter, staffing/budgets for training and education get smaller. Our nursing professional development program has all it can do to offer new nursing orientation never mind ongoing and annual education on infection control for all nursing staff. Physician education is a challenge as they are not employees of the

hospital. In New York, infection control education is mandatory for all licensed healthcare professionals every four years. There is nothing like that in RI.

- c. Improve Antibiotic stewardship.
- d. Nursing school curriculums need to be improved as they do not include/require any hands-on education regarding insertion of devices or maintaining devices... students are told they will get that training when they get to their first employer. Medical students from Brown used to have a course on Infection Control but it was dropped from the curriculum. The burden has been moved from the schools to the hospitals that have much fewer resources to oversee this training.

5. Miscellaneous comments:

- a. The work of the ICU collaborative... personally, when the focus stopped, rates increased. I am not certain that there truly was a sustained culture change (at least at RIH). A similar program, the Zero Harm Program, which was instituted at Hasbro to reduce HAIs and other hospital acquired conditions, has been successful but it has required an intensive focus and continuing resources to sustain it. This does not exist on our adult side.
- b. The CLABSI data from the ICU Collaborative was not data entered into NHSN but rather the Keystone project into a Michigan data base. NHSN definitions were used but there is question as to whether the timeframes for reporting were used as well. This change in data base might reflect the bump up from the SIR 0.49 to 0.60.
- c. Every time the patient is transferred to a new location, for example from ICU to a medical unit, another positive test gets classified as HO. Or if a blood culture is repeated in the same floor location after two weeks, another positive test gets classified as HO. NHSN will count the same patient as HO three times! Then CMS penalizes the hospital, when in fact, the patient came to the hospital with MRSA present prior to admission.
- d. The data generated by current LabID Event definitions can be extremely misleading because poor quality of care is implied, when in fact, it is just the opposite.



Department of Health

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April xx, 2016

Dear Senator Whitehouse,

As part of the Rhode Island Department of Health's (RIDOH's) ongoing efforts to protect and improve the health of all Rhode Islanders, this subcommittee aims to use data to identify opportunities for improvement and to promote transparency and consumer awareness. Our meetings are a collaborative effort combining the infection prevention expertise of the hospitals, other RIDOH programs and other Rhode Island stakeholders.

In response to your request for more information related to Rhode Island's recently released HAC Reduction Scores, and our ranking against other states and territories, we would like to share the following thoughts with you:

Opportunities to "level the playing field" for Rhode Island:

Identified needs to improve HAI prevention in Rhode Island:

We thank you for your dedication to improving the quality of healthcare in Rhode Island and we look forward to continuing our collaborative work to improve the health of all Rhode Islanders.

Sincerely,

Samara Viner-Brown, MS
Chief, Center for Health Data and Analysis

Leonard Mermel, DO, ScM, AM (Hon)
HAI Subcommittee Co-Chair

CC: *HAI Subcommittee*
Hospital Infection Preventionists

Hospital-Acquired Condition Reduction Program Fiscal Year 2016

Row Labels	# Hospitals with HAC Score > 6.75	# Hospitals	% Hospitals with HAC Score > 6.75
DC	5	7	71%
RI	7	11	64%
CT	18	30	60%
NV	13	24	54%
ME	8	18	44%
MT	5	13	38%
ID	5	14	36%
NE	9	26	35%
MN	17	50	34%
AK	3	9	33%
UT	11	33	33%
VT	2	6	33%
NJ	21	64	33%
WA	16	49	33%
NY	46	156	29%
GA	30	103	29%
CA	87	299	29%
SC	16	56	29%
OR	9	34	26%
PA	39	152	26%
MI	24	95	25%
AZ	16	64	25%
HI	3	12	25%
IN	20	87	23%
WI	15	66	23%
MO	17	75	23%
MA	12	57	21%
LA	20	96	21%
KS	11	54	20%
AR	9	45	20%
WY	2	10	20%
TN	18	94	19%
NM	6	32	19%
VA	14	75	19%
IL	23	126	18%
FL	30	170	18%
IA	6	34	18%
NC	15	86	17%
TX	55	319	17%
DE	1	6	17%
NH	2	13	15%
OK	14	91	15%
CO	7	47	15%
KY	9	65	14%
MS	9	65	14%
WV	4	29	14%
OH	17	131	13%
ND	1	8	13%
SD	2	22	9%
AL	7	83	8%
MD	0	47	0%
Grand Total	756	3358	23%

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