

16-ID-09**Committee:** Infectious Disease**Title:** Interfacility Communication to Prevent and Control Healthcare-Associated Infections and Antimicrobial Resistant Pathogens across Healthcare Settings**I. Statement of the Problem:**

In recent years, the average length of stay in acute care hospitals has been reduced, and extensive, complex care is provided in long term acute care hospitals (LTACs), rehabilitation centers, nursing homes, and freestanding dialysis centers (1,2). Surgeries and other invasive procedures are increasingly performed in ambulatory settings (3), and patients undergoing more complex procedures have shorter stays in acute care hospitals and are then transferred to rehabilitation centers, skilled nursing facilities, or discharged home with advanced levels of home health care (4). The frequent movement of complex patients within the healthcare system creates new challenges for care transitions.

Failures to communicate, both before and after transitions of care, are common and cause significant patient harm (5-7). In addition to harming individual patients, poor coordination between facilities contributes to the spread of antibiotic resistant infections across all healthcare facilities (8-9). Furthermore, lack of feedback when a healthcare associated infection (HAI) is identified in a different setting than the one the patient likely acquired the HAI has the potential to hinder communicable disease surveillance, prevention, and control activities.

- Deficiencies in interfacility notification and implementation of infection prevention precautions have been linked to disease transmission including outbreaks and the spread of multidrug-resistant organisms (MDROs) (8-14).
- Infection preventionists in all healthcare settings need to be aware of HAIs associated with care in their facilities so that appropriate investigative and preventive measures can be instituted, even when the patient receives follow-up care elsewhere.
- Without interfacility communication, surveillance data may be incomplete and result in inaccurate rates for public reporting and reimbursement under Centers for Medicare and Medicaid Services (CMS) Quality Reporting Programs.
- Lack of information about previous antimicrobial therapies, or indication for current antimicrobial therapies, contributes to inappropriate use of antibiotics.

Barriers to interfacility communication may include:

- Lack of accountability and communication protocols that specify when interfacility notification is indicated, who is responsible for interfacility communication (both sending and receiving information), what information should be communicated (e.g., standardized list of minimum communication elements), how to communicate effectively (e.g., electronically or via a paper form), how to confirm and document that the communication was sent and received, and how to appropriately respond to a notification in various settings
- Resource limitations for communication including staff time and information technology tools
- Attitudes and beliefs by healthcare personnel that “MDROs are everywhere” that create a lack of urgency to spur action

Barriers that primarily hinder communication from a facility sending a patient to another facility may include:

- Inadequate discharge planning and coordination on the part of the sending facility due to:
 - Breakdowns in communication within the sending facility that delay or inhibit the exchange of information outside of the facility. For example, the person communicating the information from the sending facility to the receiving facility may not have all of the information necessary for a safe

- handoff. Transporters may also not receive adequate information needed to prevent the spread of a communicable disease.
- Financial incentives not to extend patients' length of stay while searching for alternative facilities for patient transfer
 - Real or perceived hesitation on the part of the receiving facility to admit patients who are colonized or infected with *C. difficile*, an MDRO, or other organism for which transmission-based precautions may be indicated
 - Lack of protocols on how to follow up on microbiology or other relevant test results that are pending at the time of discharge
- Receiving facilities may refuse to admit patients who are colonized or infected with *C. difficile*, an MDRO, or other organism for which transmission-based precautions may be indicated due to:
 - Lack of guidance and competency-based training on appropriate infection prevention and control measures for non-acute care settings. For example, ambiguity in infection control guidelines for long term care has led to concerns about prolonged confinement to an isolation room for patients as undue restraint that infringes on patients' civil liberties.
 - Lack of reimbursement for additional costs associated with implementing transmission-based precautions including personal protective equipment (PPE), cleaning supplies, private rooms, and additional staff time needed for donning and doffing of PPE and cleaning of shared patient equipment.

Barriers that primarily hinder communication from a facility that received a patient to a previous facility that provided care for that patient may include:

- Incomplete understanding of the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA) can lead to misinformed reluctance to share protected health information under circumstances in which it is appropriate and permissible to do so (i.e., communicating information back to a facility or provider where the patient is no longer a patient) (15).
- Inadequate history or contact information from previous healthcare encounters.

Several efforts to support improved interfacility communication have been introduced, including interfacility communication standards for hospitals accredited under The Joint Commission¹⁶ (Appendix 1), the CMS proposed rules for Reform of Requirements for Long-Term Care Facilities¹⁷ (Appendix 2), and Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies¹⁸ (Appendix 3); legal requirements for interfacility communication by the State of New York (Appendix 4) and the State of Oregon (Appendix 5); and the State of Illinois' extensively drug resistant organism (XDRO) registry, which is a reporting and surveillance platform that also has the capability for facilities to manually query or establish automatic notifications to identify whether an admitted patient has a history of infection or colonization of specific organisms (Appendix 6). In addition, we seek to provide contextual understanding of HIPAA to increase interfacility communication, where it is appropriate and permissible to do so (Appendix 7). We propose to extend these efforts by recommending additional actions that focus attention and resources on improving interfacility communication to prevent the spread of communicable diseases and other HAIs in a wide range of healthcare settings.

II. Statement of the desired action(s) to be taken:

1. CSTE recommends that CDC, in collaboration with professional organizations such as the Society for Healthcare Epidemiology of America (SHEA), the Association for Professionals in Infection Control and Epidemiology (APIC) and CSTE, develop guidance by January 2018 for clear, standardized interfacility communication to prevent the spread of MDROs and other communicable diseases across

- multiple healthcare settings, and include recommended actions in relevant infection control guidance documents for healthcare facilities and transporters, CMS and state surveys, and other accreditation or certification processes.
2. CSTE recommends that CDC collaborate with CMS and other stakeholders to use available incentives to assure that the HL7 standards that support continuity of care (including but not limited to the Continuity of Care Document (CCD) and discharge summary) are updated as needed. This will facilitate enhanced surveillance and actionable data in a standardized format, which can be enabled in many jurisdictions by partnerships between HIEs and public health agencies, to prevent the spread of MDROs and other communicable diseases across multiple healthcare settings.
 3. CSTE recommends that CDC, CMS, accreditation agencies, state, tribal, local and territorial (STLT) health departments, and other stakeholders examine barriers to interfacility communication, including the root causes for why facilities may be reluctant to admit patients due to their infection or colonization status, and develop solutions through guidelines, policies, or payment structures based on these findings.
 4. CSTE recommends that CDC and professional organizations such as SHEA and APIC, develop clear guidance by January 2018 on transmission-based precautions for long term care facilities that address considerations for how to balance the need to contain the spread of microorganisms while respecting resident and patient rights to not be unduly confined to their rooms. This guidance should be included in CMS and state survey and other accreditation or certification processes.
 5. CSTE recommends that CDC integrate expectations for interfacility communication in National Healthcare Safety Network (NHSN) surveillance definitions, manuals, validation protocols, and trainings in order to promote complete and valid reporting of HAIs identified post-discharge.
 6. CSTE encourages states and other regulating bodies to consider policy options to promote or mandate interfacility communication. Examples are provided in Appendices 4, 5, and 6.

Additional detail on desired actions:

1. CSTE recommends that guidance for interfacility communication explicitly address the following:
 - a) Essential and recommended data elements to be routinely communicated between facilities to prevent infections, including organism, infection or colonization status, recent and current antibiotic therapies, and risk factors like medical devices, as appropriate
 - b) The responsible parties for sending and receiving interfacility communication to prevent infections
 - c) Inclusion of transport personnel in the communication process to ensure they are properly alerted if there is a need for transmission-based precautions or special cleaning procedures
 - d) The appropriate mode of communication (e.g., verbal, electronic, written format)
 - e) Documentation standards to ensure that information was communicated and received
 - f) Timing of communication (e.g., providing sufficient time for receiving facilities to determine appropriate room assignment or set up dedicated equipment for patients who may need transmission-based precautions)
 - g) Post-discharge communication of microbiology laboratory results that were pending at the time of transfer
 - h) Circumstances that warrant contacting a facility where a patient previously received care for the purposes of

- (1) Preventing transmission of a communicable disease in a facility where the patient was cared for previously, and where the patient’s infection status may have been unknown at the time of care.

For example, if a patient is found to have recently developed an infection with carbapenem-resistant Enterobacteriaceae (CRE), the previous facility may want to screen close contacts and implement transmission-based precautions as appropriate. If a patient is found to have *C. difficile*, the previous facility may need to be notified that they should disinfect the patients’ environment with an EPA-approved sporicidal. (See Table 1)

- (2) Providing more complete surveillance information to inform quality improvement efforts.

For example, communicating device and procedure related HAIs (e.g., surgical site infections (SSIs), central line associated blood stream infections (CLABSIs), catheter associated urinary tract infections (CAUTIs), blood stream infections associated with dialysis etc.) to the healthcare facility that is deemed to be the likely source of exposure allows for appropriate investigative and preventive measures to be instituted. STLT health departments conducting HAI surveillance also require this information to accurately inform surveillance and infection control efforts. For example, SSIs frequently develop some time after discharge and are frequently diagnosed at another healthcare facility, leading to underreporting and decreased validity of SSI data. This contributes to inadequate understanding of the burden and root causes of SSIs, preventing their remediation at the source facility.

Table 1: Examples of Priorities for Inter-facility Notification of Possible Healthcare-Associated Infections, Following Patient Transfer or Procedure

Condition	Inter-facility Notification to Previous Care Setting	Notification to Public Health Agency:
<ul style="list-style-type: none"> ● Identification of site-specific post-procedure infections, such as: <ul style="list-style-type: none"> ○ Surgical site infections (SSIs) ○ Post-injection infections including septic arthritis, abscess, or contiguous organ/space infection ○ Central line associated blood stream infections (CLABSIs) ○ Bloodstream infections in hemodialysis patients 	<ul style="list-style-type: none"> ● Report any occurrence to facility or operator that performed procedure 	<ul style="list-style-type: none"> ● Evidence of a cluster* ● Where required by law or regulation ● Unusual manifestation or outcome
<ul style="list-style-type: none"> ● Laboratory and clinical identification of specific pathogens known to cause outbreaks with significant morbidity and mortality in group residential settings, such as: <ul style="list-style-type: none"> ○ Novel MDROs ○ Carbapenem-resistant Enterobacteriaceae (CRE) ○ Invasive group A streptococcus infection ○ Norovirus ○ Influenza 	<ul style="list-style-type: none"> ● Report any occurrence immediately to previous care setting following recent transfer 	<ul style="list-style-type: none"> ● Evidence of a cluster* ● Where required by law or regulation

<ul style="list-style-type: none"> ○ Varicella ○ Hepatitis 		
<ul style="list-style-type: none"> ● Identification of organisms capable of causing outbreaks in group residential settings, with lesser morbidity, such as scabies 	<ul style="list-style-type: none"> ● Report any occurrence to previous residential care setting following recent transfer 	<ul style="list-style-type: none"> ● Evidence of a cluster* ● Where required by law or regulation

*In some situations, a single case may warrant public health notification.

III. Public Health Impact:

Guidance and expectations for interfacility communication improves patient safety by improving the ability for healthcare facilities and public health agencies to prevent the transmission of communicable diseases and the proliferation of antibiotic resistant organisms. Standardized interfacility communication will promote timely identification and investigation of disease clusters as well as provide for more complete surveillance information to inform quality improvement efforts. Additionally, enhancing the completeness and validity of surveillance data allows for more accurate inter-facility comparisons and public reporting.

IV. Revision History

13-ID-09 Communication of Possible Healthcare-Associated Infections across Healthcare Settings
 This position statement has been updated with greater detail and specificity of the public health impact of interfacility communication on efforts to prevent and control healthcare associated infections, including factors affecting sending facilities, receiving facilities, and delineating the impact on immediate needs to contain the spread of organisms within facilities as well as the need for information about HAIs to inform quality improvement efforts.

V. References

1. Bernstein A, Hing E, Moss A, Allen K, Tiggler R. Health care in America: Trends in utilization. Hyattsville, MD: National Center for Health Statistics. 2003.
2. Medicare Payment Advisory Committee. Report to the Congress: Medicare and the health care delivery system. Chapter 5: Ambulatory surgical center services. March 2012. Accessed at http://www.medpac.gov/chapters/Mar12_Ch05.pdf.
3. Deverick JA, Podgorny K, Berrios-Torres SI et al. Strategies to Prevent Surgical Site Infections in Acute Care Hospitals: 2014 Update. *Infect Control Hosp Epidemiol*. 2014 June ; 35(6): 605–627. doi:10.1086/676022.
4. Bini SA et al. Does Discharge Disposition After Primary Total Joint Arthroplast Affect Readmission Rates. *The Journal of Arthroplasty*. 2009 0 (0): 1 – 4.
5. Flabouris, A., Runciman, W. B., & Levings, B. (2006). Incidents during out-of-hospital patient transportation. *Anaesthesia and intensive care*, 34(2), 228. Accessed at <http://www.ncbi.nlm.nih.gov/pubmed/16617646>
6. Ong, M. S., & Coiera, E. (2011). A systematic review of failures in handoff communication during intrahospital transfers. *The Joint Commission Journal on Quality and Patient Safety*, 37(6), 274-274. Accessed at <http://www.ncbi.nlm.nih.gov/pubmed/21706987>

7. Segall, N., Bonifacio, A. S., Schroeder, R. A., Barbeito, A., Rogers, D., Thornlow, D. K., ... & Wright, M. C. (2012). Mark JBDurham VA Patient Safety Center of Inquiry. Durham VA Patient Safety Center of Inquiry.. Can we make postoperative patient handovers safer? A systematic review of the literature. *Anesth Analg*, 115, 102-15. Accessed at <http://www.ncbi.nlm.nih.gov.ezproxy.bu.edu/pubmed/22543067>
8. Slayton, R. B., Toth, D., Lee, B. Y., Tanner, W., Bartsch, S. M., Khader, K., ... & Miller, L. G. (2015). Vital signs: estimated effects of a coordinated approach for action to reduce antibiotic-resistant infections in health care facilities—United States. *MMWR. Morbidity and mortality weekly report*, 64(30), 826. Accessed at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6430a4.htm?s_cid=mmmm6430a4_w
9. Weiner, L. M., Fridkin, S. K., Aponte-Torres, A., Avery, L., Coffin, N., Dudeck, M. A., ... & McDonald, L. C. (2016). Vital signs: preventing antibiotic-resistant infections in hospitals – United States, 2014. *MMWR. Morbidity and mortality weekly report*, 65(9), 235-241. Accessed at <http://origin.glb.cdc.gov/mmwr/volumes/65/wr/mm6509e1.htm>
10. Chow KY, Lee CE, Ling ML, Heng DM, Yap SG. Outbreak of severe acute respiratory syndrome in a tertiary hospital in Singapore, linked to an index patient with atypical presentation: epidemiological study. *BMJ* 2004;328:195.
11. Carbonne A, Thiolet JM, Fournier S, et al. Control of a multi-hospital outbreak of KPC-producing *Klebsiella pneumoniae* type 2 in France, September to October 2009. *Euro surveillance: European communicable disease bulletin*. 2010;15.
12. Trick WE, Kuehnert MJ, Quirk SB, et al. Regional dissemination of vancomycin-resistant enterococci resulting from interfacility transfer of colonized patients. *Journal of Infectious Diseases* 1999;180:391-6.
13. Black SR, Weaver KN, Jones RC, et al. *Clostridium difficile* outbreak strain BI is highly endemic in Chicago area hospitals. *Infection control and hospital epidemiology : the official journal of the Society of Hospital Epidemiologists of America* 2011;32:897-902.
14. CDC. Multiple Outbreaks of Hepatitis B Virus Infection Related to Assisted Monitoring of Blood Glucose Among Residents of Assisted Living Facilities — Virginia, 2009–2011. *MMWR Morbidity and mortality weekly report*;61:339-43.
15. American Medical Directors Association. *Transitions of Care in the Long-Term Care Continuum Clinical Practice Guideline*. Columbia, MD: AMDA; 2010. Accessed at <http://www.amda.com/tools/clinical/toccp/index.html>.
16. The Joint Commission. 2013 Comprehensive Accreditation Manual for Hospitals: Infection Prevention and Control Standard IC.02.01.01. Oak Brook (IL): Joint Commission Resources; 2013:IC-8—IC-9.
17. CMS. 2015. Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities (CMS-3260-P) (proposed): <https://www.federalregister.gov/articles/2015/07/16/2015-17207/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>
18. CMS. 2015. Medicare and Medicaid Programs: Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies (proposed): <https://www.federalregister.gov/articles/2015/11/03/2015-27840/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals>

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Appendix 1: Standards for inter-facility communication under The Joint Commission¹⁶

IC.02.01.01 EOP 10: When the hospital becomes aware that it transferred a patient who has an infection requiring monitoring, treatment, and/or isolation, it informs the receiving organization.

IC.02.01.01 EOP 11: When the hospital becomes aware that it received a patient from another organization who has an infection requiring action, and the infection was not communicated by the referring organization, it informs the referring organization.

Appendix 2: Centers for Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities (A [Proposed Rule](#) by the Centers for Medicare & Medicaid Services on 07/16/2015)¹⁷

Transitions of Care (483.15) “Transfers or Discharge: We propose to require not only that a transfer or discharge be documented in the clinical record, but also that specific information, such as history of present illness, reason for transfer and past medical/surgical history, be exchanged with the receiving provider or facility when a resident is transferred. We are not proposing to require a specific form, format, or methodology for this communication.”

Appendix 3: Medicare and Medicaid Programs: Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies (A [Proposed Rule](#) by the Centers for Medicare & Medicaid Services on 11/03/2015)¹⁸**A(5): Hospitals: Transfer of Patients to Another Health Care Facility (482.43)**

We propose to re-designate and revise the standard currently set out at § 482.43(d) as § 482.43(e), “Transfer of patients to another health care facility,” by clarifying our expectations of the discharge and transfer of patients. We would continue to require that all hospitals communicate necessary information of patients who are discharged with transfer to another facility.

We do not propose to mandate a specific transfer form. However, we do propose to clarify our expectations regarding what constitutes the necessary medical information that must be communicated to a receiving facility to meet the patient's post-hospitalization health care goals, support continuity in the patient's care, and reduce the likelihood of hospital readmission.

Moreover, we intend to align these data elements with the common clinical data set published in the “2015 Edition of Health Information Technology (Health IT) Certification Criteria, Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications” final rule ([80 FR 62601](#), October 16, 2015). By aligning the data elements proposed in this proposed rule with the common clinical data set specified for the 2015 edition, we are seeking to ensure that hospitals can meet these requirements using certified health IT systems and existing standards.

Therefore, we propose, at the minimum, the following information to be provided to a receiving facility:

- Demographic information, including but not limited to name, sex, date of birth, race, ethnicity, and preferred language;
- Contact information for the practitioner responsible for the care of the patient and the patient's caregiver/support person(s);
- Advance directive, if applicable;
- Course of illness/treatment;
- Procedures;
- Diagnoses;

- Laboratory tests and the results of pertinent laboratory and other diagnostic testing;
- Consultation results;
- Functional status assessment;
- Psychosocial assessment, including cognitive status;
- Social supports;
- Behavioral health issues;
- Reconciliation of all discharge medications with the patient's pre-hospital admission/registration medications (both prescribed and over-the-counter);
- All known allergies, including medication allergies;
- Immunizations;
- Smoking status;
- Vital signs;
- Unique device identifier(s) for a patient's implantable device(s), if any;
- All special instructions or precautions for ongoing care, as appropriate;
- Patient's goals and treatment preferences; and
- All other necessary information to ensure a safe and effective transition of care that supports the post-discharge goals for the patient.

While we are not proposing a specific form, format, or methodology for the communication of this information for all facilities, we strongly believe that those facilities that are electronically capturing information should be doing so using certified health IT that will enable real time electronic exchange with the receiving provider.

We believe that the use of this technology can effectively and efficiently help facilities and other providers improve internal care delivery practices, support the exchange of important information across care team members (including patients and caregivers) during transitions of care, and enable reporting of electronically specified clinical quality measures (eCQMs).

We propose that the requirement and the timeframe for communicating necessary information for patients being transferred to another healthcare facility remain the same as in the current requirement. That is, hospitals would continue to be required to provide this information at the time of the patient's discharge and transfer to the receiving facility.

Appendix 4: Requirement for inter-facility communication under New York State Public Health Law Section 2819 (as amended January 1, 2008):

2 (e) "For hospital acquired infections for which the department requires tracking and reporting as permitted in this section, hospitals shall be required to report a suspected or confirmed hospital-acquired infection associated with another hospital to the originating hospital. Documentation of reporting should be maintained for a minimum of six years."

(Accessed 12/3/2012, http://www.health.ny.gov/regulations/public_health_law/section/2819/)

Appendix 5: Communication during Patient Transfer of Multidrug-Resistant Organisms

Effective January 1, 2014: When a referring health care facility transfers or discharges a patient who is infected or colonized with a multidrug-resistant organism (MDRO) or pathogen which warrants transmission-based Precautions, it must include written notification of the infection or colonization to the receiving facility in transfer documents. The referring facility must ensure that the documentation is readily accessible to all parties involved in patient transfer (for example, referring facility, medical transport, emergency department, receiving facility).

(<http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/HAI/Documents/NewOAR.333-019.pdf>)

Appendix 6: Extensively Drug Resistant Organism (XDRO) Registry:

In response to clusters of carbapenem-resistant *Enterobacteriaceae* (CRE) in Illinois, the Illinois Department of Public Health mandated reporting of CRE in 2013 and, in partnership with the Centers for Disease Control and Prevention Chicago Prevention Epicenter, launched a statewide web-based registry designed for bidirectional data exchange among health care facilities. CRE occurrences are entered and searchable in the system, enabling interfacility communication of patient information. At some facilities, admission feeds are used to automate searching the registry for patients, and the system sends alerts to the facility to check the secure XDRO registry when matches are identified.

(For more information on the XDRO registry, see www.xdro.org or http://wwwnc.cdc.gov/eid/article/21/10/15-0538_article)

Appendix 7: Facility/Provider to Facility/Provider Communications under HIPAA: Questions and Answers

Note: The following document was developed by CDC scientists and lawyers in collaboration with HHS Office of Civil Rights (OCR) program and legal staff, who oversee administration of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information may not be modified without express permission of OCR.

Health care providers [i.e., individual clinicians and facilities (including hospitals and other health care facilities such as nursing homes and rehabilitation facilities)] are increasingly active in addressing concerns about patient safety and minimizing patients' risks of adverse healthcare events. In an era when the public, policymakers, and many health care providers seek greater transparency and accountability in healthcare, these efforts include but are not limited to new or renewed emphasis on information sharing among providers themselves about adverse events that are a consequence of care processes, care process omission, or some other risk exposure during a health care episode, such as exposure to an infectious agent.

Health care providers have raised questions as to whether the HIPAA Privacy Rule permits information sharing between individual providers and/or facilities for patient safety-related purposes. This guidance assumes that the provider seeking to share such patient information is a HIPAA covered entity. While any health care provider may be faced with these questions, they tend to arise more frequently at the facility level. The term "patient" is also used here to encompass persons residing in nursing homes or other facilities, where they are often referred to as "residents." "Source facility" or "source provider" refers to the health care facility or individual provider that first cared for the patient. Protected health information ("PHI") is individually identifiable health information, such as information that identifies (or can be used to identify) a patient.

Question One

Does HIPAA permit a health care facility to share PHI with the source facility where a patient was previously treated or where a patient previously resided, without the patient's authorization, for purposes of providing notification of an infection with potential infection control implications at the source facility?

In these scenarios a resident of a nursing home is admitted into a hospital, certain medical conditions are diagnosed, and the hospital wants to disclose this health information back to the nursing home.

- A practitioner at the hospital diagnoses a patient's tuberculosis and wants to inform the nursing home so that the staff there can quarantine the coughing roommate of the index case.
- The patient is admitted with sepsis and later dies in the hospital. Blood cultures drawn at admission grow group A streptococcus. The hospital seeks to disclose that this patient was diagnosed with invasive group A streptococcal infection (which causes serious outbreaks in nursing homes) to the nursing home for infection control purposes, even though the patient will not be returning.
- The hospital diagnoses the patient with influenza early in the flu season, and wants to disclose this diagnosis to the nursing home for infection control purposes.

In each scenario the hospital will want to disclose the name of the patient so the nursing home can verify that this patient had been a resident in their home and the date and location of service.

Answer One

The HIPAA Privacy Rule permits a covered health care provider to use or disclose PHI for treatment purposes without the authorization of the patient. (Generally, disclosures of psychotherapy notes require written patient authorization, but these notes do not appear relevant here.) 45 CFR 164.506(c) and 164.508(a)(2). "Treatment" is defined to include the provision, coordination, or management of "health care" and related services. 45 CFR 164.501. "Health care" is defined to include preventive care. 45 CFR 160.103. Treatment refers to activities undertaken on behalf of individual patients. While in most cases, the information regarding an individual is needed for the treatment of that individual, the HIPAA Privacy Rule also allows the information regarding one individual (e.g., a patient) to be used or disclosed for the treatment or preventive care (e.g., vaccinations or quarantine) of other persons (e.g., patients at risk).

In these scenarios, the patient (and former nursing home resident) has or had a medical condition while at the nursing home that may directly impact the health of certain or all residents at that facility. In some cases, the nursing home did not know of this condition, or the condition had not manifested itself at the time the patient was at the nursing home. The hospital may disclose PHI of the patient (and former nursing home resident) to the nursing home for treatment purposes involving other residents.

A distinction is made between use and disclosure of PHI for treatment purposes with regard to the "minimum necessary" requirement. The "minimum necessary" requirement does not apply to disclosures of PHI for treatment purposes, and the disclosures discussed above are treatment disclosures that are permitted under the HIPAA Privacy Rule.

After PHI is disclosed to the nursing home, the information may be used for the provision of treatment to the nursing home residents. For example, preventive measures, such as cohorting, isolation, or prophylaxis of specific patients who may be at risk at the nursing home, are considered treatment under the Privacy Rule. The uses of PHI by the nursing home for treatment purposes in the above scenarios are subject to the Privacy Rule's "minimum necessary" requirement, and the nursing home's minimum necessary policies. A nursing home, as a covered entity, must identify those persons or classes of persons in its workforce who need access to PHI, and for each such person or classes of person, the category or categories of PHI to which access is needed, and any conditions appropriate to such access. 45 CFR 164.514(d)(2). For more information on the "minimum necessary" requirement, see: http://www.hhs.gov/ocr/privacy/hipaa/faq/minimum_necessary/207.html.

Question Two

Under HIPAA, is a health care facility permitted to share PHI with another health care facility that previously treated or housed a patient, without that patient's authorization, for purposes of notifying this source facility of a potential complication of care related to the health care provided at the source facility so as to monitor and improve care and prevent future complications?

- A hospital identifies a surgical site infection (SSI) that is probably attributable to an ambulatory surgical care facility and/or surgeon that performed the surgery within the past 12 months. The hospital seeks to notify the ambulatory surgical care facility about the SSI, or in a given situation, notify the surgeon directly.
- A patient is admitted to Hospital B with a surgical site infection (SSI) after an operation at another hospital (Hospital A), where the patient had been operated on and then discharged without signs or symptoms of infection. Because of federal requirements (e.g., the Centers for Medicare and Medicaid Services' Inpatient Quality Reporting program requirements) or state law or policy, both hospitals are committed to reporting all SSIs following the type of operation performed on the patient. Hospital B seeks to report the SSI to Hospital A, where the SSI is presumed to have originated, so that Hospital A can fully account for SSIs attributable to its care.

Answer Two

The HIPAA Privacy Rule permits a covered entity to use or disclose PHI for certain "health care operations" purposes without the authorization of the patient. 45 CFR 164.506(c). This includes a covered entity disclosing PHI to another covered entity for certain purposes if each entity either has or had a relationship with the individual who is the subject of the information, and the PHI being disclosed pertains to the relationship. 45 CFR 164.506(c)(4). Of relevance here, disclosures are permitted for the purpose of the covered entity receiving the information "conducting quality assessment and improvement activities; . . . population-based activities relating to improving health [and] protocol development." 45 CFR 164.501 (definition of "health care operations"). Only the minimum amount of PHI necessary for the particular health care operations purpose may be disclosed.

The disclosures discussed above are health care operations disclosures that are permitted under the HIPAA Privacy Rule. In these scenarios we assume that the hospitals sharing the PHI, the ambulatory surgical care facility, and the surgeon are all HIPAA covered entities. The hospitals disclosing the PHI would be sharing information regarding a patient who the surgical facilities (either the ambulatory care facility or the hospital) and/or surgeon had treated, and the communication is in regard to the treatment that had been provided. The disclosures are so that the surgical facilities and/or surgeon can monitor and improve the quality of care provided. This falls under "conducting quality assessment and improvement activities," and perhaps "population-based activities relating to improving health," and/or "protocol development." In these scenarios, information regarding the patient with an SSI can be shared with the surgical facilities and/or surgeon. While only the minimum amount of information regarding the patient may be disclosed, in these scenarios the identity of the patient may be shared because it is needed to investigate the cause of the infections (e.g., the dates and locations of care, and the staff involved.) There is likely to be no need to share health information regarding these patients that is unrelated to investigating the SSI.

For additional information regarding disclosures for treatment and healthcare operations purposes, see: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html>.

Appendix 8: Additional Agencies for Information

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