CORHA Member Conference Call
2:00 p.m. – 3:00 p.m. ET | Friday, November 2, 2018
Conference Line: 866-740-1260 - Passcode: 5273136

Roll Call and Welcome Remarks – 10 minutes

Governance Committee Co-Chairs

Workgroup Product Presentations – 40 minutes

Workgroup Co-Chairs and/or Subject-Matter Experts

- Detection and Reporting Workgroup – CRE Definitions
  Feedback and Comments *(all members)*
- Investigation and Control Workgroup – CDI Investigation Guidance
  Feedback and Comments *(all members)*

November In-Person Meeting Overview – 5 minutes

Governance Committee Co-Chairs

Closing Remarks – 5 minutes

Governance Committee Co-Chairs

CORHA Member Roster

Wendy Bamberg, MD Council of State and Territorial Epidemiologists *Workgroup A Co-Chair*	**Julia Marders, RN, MS** Food and Drug Administration
Gerd Clabaugh, MPA Association of State and Territorial Health Officials *Governance Committee Co-Chair*	**Patricia Meier, MD** Centers for Medicare & Medicaid Services
Kristen Ehresmann, RN, MPH Association of State and Territorial Health Officials	**Joseph Miner, MD** Association of State and Territorial Health Officials
Erin Epson, MD Council of State and Territorial Epidemiologists	**Elizabeth Mothershed, MS** Centers for Disease Control and Prevention
Linda Greene, RN, MPS Association for Professionals in Infection Control and Epidemiology *Workgroup A Co-Chair*	**Joseph Perz, DrPH, MA** Centers for Disease Control and Prevention *Governance Committee Member*
Hillary Hanson, MPH National Association of County and City Health Officials	**Jafer Razeq, PhD** Association of Public Health Laboratories
Waleed Javaid, MD Society for Healthcare Epidemiology of America *Workgroup B Co-Chair*	**Dawn Terashita, MD, MPH** National Association of County and City Health Officials *Governance Committee Member*
Marion Kainer, MD, MPH Council of State and Territorial Epidemiologists *Governance Committee Co-Chair*	

Workgroup A: Proposed Investigation/Reporting Thresholds and Outbreak Definition for Carbapenem Resistant Enterobacteriaceae (CRE)
August 16, 2018

The thresholds and definitions below are intended to be a guideline and are based on expert opinion except as noted otherwise. States and local jurisdictions may have their own requirements for reporting and outbreak definitions. Healthcare facilities should consult public health if they have questions about the definition or its application.

- CRE numbers include both colonized and infected patients.
- Prevalence definitions are intended as examples based on the average facility in a region. The CRE prevalence may vary among facilities in a region due to facility bed size, patient population, whether a facility conducts admission screening or active surveillance, and other factors. Some facilities might fall into one prevalence group for CP-CRE and a different prevalence group for CRE. Please see points for consideration for further discussion of this issue.

<table>
<tr><th></th><th>Acute Care Hospitals</th><th>Long-Term Acute Care Hospitals and Long-Term Care Facilities with Ventilated Patients</th><th>Long-Term Care Facilities (LTCF)</th><th>Critical Access Hospitals</th><th>Dialysis Facilities</th><th>Outpatient</th></tr>
<tr><td>Threshold for facility to start investigation</td><td colspan="2"><u>In regions with high prevalence CRE and/or endemic KPC</u>[1]<u>:</u>
• 1 non-KPC CP-CRE (NDM, VIM, IMP, OXA-48 type)
• 2 KPC-CRE, 2 CP-CRE (unknown mechanism*), or 2 CRE (non-CP or mechanism testing not performed)
of same organism in a 4-week period in patients on the same unit who were not previously known to be infected or colonized**. Some facilities in high prevalence areas might wish to use their facility and regional data in collaboration with public health to define a threshold for additional investigation, as 2 CRE might be too sensitive.

<u>In a region with lower prevalence CRE</u>[2]<u>:</u>
• 1 CP-CRE (KPC, NDM, VIM, IMP, OXA-48 type, or positive by phenotypic test)
• 2 CRE (non-CP or mechanism testing not performed*) of same organism in a 4-week period in patients on the same unit**

<u>In regions with very low CRE prevalence</u>[3]<u>:</u>
• 1 CRE (CP, non-CP, or unknown CP)</td><td colspan="4">1 CRE (CP, non-CP, or unknown CP in patient not previously known to be infected or colonized)</td></tr>
</table>

Threshold for reporting to PH	*In regions with high prevalence CRE and/or endemic KPC*[1]*:* • 1 non-KPC CP-CRE (NDM, VIM, IMP, OXA-48 type) • 2 KPC-CRE, 2 CP-CRE (unknown mechanism*), or 2 CRE (non-CP or mechanism testing not performed) of same organism in a 4-week period in patients that are epidemiologically-linked[#] and were not previously known to be infected or colonized. *In regions with lower prevalence CRE*[2]*:* • 1 CP-CRE (KPC, NDM, VIM, IMP, OXA-48 type, or positive by phenotypic test) • 2 CRE (non-CP or mechanism testing not performed*) of same organism in a 4-week period in patients that are epidemiologically-linked[#] with confirmatory laboratory testing *In regions with very low CRE prevalence*[3]*:* 1 CRE (CP, non-CP, or unknown CP*)	1 CRE (CP, non-CP, or unknown CP in patient not previously known to be infected or colonized)
Outbreak definition	≥ 2 CRE of same organism (or mechanism, if mechanism testing performed) in a 4-week period in patients that are epidemiologically-linked[#] or determined to be genetically related by laboratory testing.[$] Facilities in high prevalence or endemic areas whose baseline exceeds this level should work with public health to select a threshold based on historic CRE rates.	

CP=carbapenemase-producing; non-CP = non carbapenemase-producing; KPC=*Klebsiella pneumoniae* carbapenemase; NDM = New Delhi Metallo-β-Lactamase; OXA-48-type = oxacillinase; VIM = Verona-Integron encoded carbapenemase; IMP = active-on-Imipenem Metallo- β-lactamase

[1]Regions with high prevalence or endemic CRE are defined as areas where CRE are routinely identified (e.g., on average, acute care facilities and high acuity skilled nursing facilities in high prevalence regions would have more than one CRE case per month and those in endemic regions would have one or more CRE cases per week).

[2]Regions with lower prevalence CRE are defined as areas where CRE are identified with some regularity (e.g., on average, acute care facilities in these regions would have more than a few cases per year to one case per month).

[3]Regions with very low prevalence CRE are defined as areas where CRE are seldom identified (e.g., on average, acute care facilities in these regions have one or a few CRE cases per year).

*When CP mechanism is unknown, facilities should consider testing via the public health laboratory in their state or the Antibiotic Resistance Laboratory Network.

**At minimum, patients admitted to a common unit should be investigated, but additional factors that might indicate a common exposure, such as invasive procedures, could also be used. Patients do not need to have overlapping stays to meet the threshold for additional investigation.

[#]Epidemiologically-linked = Including but not limited to the following examples: residing on same unit (or within same facility if facility is small, transferred from same outside facility, assigned to same primary or consultative service, facility staff in common, had same procedure, seen at same facility, etc.
[$]Laboratory testing methods commonly used for assessing genetic relatedness include pulsed field gel electrophoresis (PFGE) and whole genome sequencing (WGS).

Points for consideration:

- CRE prevalence is highly heterogeneous in the United States. For this reason,
    - In high prevalence or endemic areas, the threshold for investigation of 2 CRE on the same unit was selected for greatest sensitivity. For some facilities in KPC endemic settings, this threshold might prove too burdensome. In this case, facilities should know their baseline CRE prevalence and choose a threshold for investigation that represents a rise above the baseline and that carefully balances sensitivity with specificity. Facilities in these regions might have a lower threshold for investigating non-*K. pneumoniae* CRE, which could carry less common carbapenemases, compared to carbapenem-resistant *K. pneumoniae.*
    - Some facilities may have a prevalence that differs from other facilities in the region. For example, for an ACH in a lower prevalence region that receives patients from facilities in higher prevalence regions, the higher prevalence thresholds might be more appropriate than those for the lower prevalence region.

Facilities should consult with public health for guidance about which prevalence threshold they should use. If the prevalence threshold is unknown, a facility should start with the thresholds for low CRE prevalence and modify as more information becomes available.

- Mechanism testing for CRE is available at 50 state public health laboratories and 7 local health departments. Facilities that do not regularly send isolates for mechanism testing should request mechanism testing for CRE that meet the following criteria 1) isolated from patients with a history of hospitalization outside the U.S. in the 6 months prior to culture collection, 2) resistant to all antibiotics tested at the clinical laboratory, 3) part of a suspected outbreak (i.e., 2 isolates that meet the criteria for further investigation by a facility).
- Non-KPC CRE remain rare throughout the U.S. Identification of any non-KPC CP-CRE, or KPC CRE in non-endemic areas, should result in a public health investigation as described in the CDC Interim Guidance for a Public Health Response to Contain Novel or Targeted Multidrug-resistant Organisms.
- Screening tests to identify asymptomatic carriers are available at no cost to facilities through the Antimicrobial Resistance Laboratory Network.
- This definition does not replace reporting of CP-CRE as part of the Nationally Notifiable Disease Surveillance System. The definition adds additional guidance for thresholds for facilities to investigate and report to public health to ensure possible outbreaks are detected early.

Workgroup B: Proposed Outbreak Investigation and Control Guidance for *Clostridium difficile*

1. Background [WG-A+B]

Clostridium difficile is a spore-forming, gram-positive anaerobic bacillus (APIC). CDC estimated that in 2011 there were nearly 500,000 *C. difficile* infections (CDI) in the United States and approximately 29,000 people died within 30 days of a CDI diagnosis (www.cdc.gov/hai/organisms/cdiff/cdiff_infect.html). CDI is a frequent cause of healthcare-associated infections (HAI) and is associated with increased length of hospital stay, costs, morbidity, and mortality (Dubberke). CDI is related to antibiotic exposure and most commonly manifests as a gastrointestinal infection ranging from uncomplicated diarrhea to severe and life-threatening pseudomembranous colitis (Cohen).

CDI can be spread from patient to patient via environmental surfaces or on the hands of healthcare workers. *C. difficile* spores can persist on environmental surfaces for extended periods of time. Both the skin and the environment of colonized patients become contaminated; healthcare personnel hands may become contaminated by touching the environment or the patient (www.cdc.gov/hai/organisms/cdiff/cdiff-patient.html). As CDI is strongly associated with previous antibiotic use, prudent use of antibiotics has a significant role in the prevention and control of CDI (www.cdc.gov/hai/organisms/cdiff/cdiff_clinicians.html).

The epidemiology of CDI has changed since the early 2000s largely due to the emergence of a new epidemic strain of *C. difficile*. The epidemic strain of *C. difficile*, BI/NAP1/027 is associated with more severe disease, higher mortality, and increased outbreaks. Outbreaks of CDI occur in healthcare settings such as acute care hospitals and long-term care facilities where there is potential for a large number of susceptible hosts to be exposed to infectious spores (www.cdc.gov/hai/organisms/cdiff/cdiff_faqs_hcp.html).

The ongoing challenge of CDI highlights the need for better use of diagnostics (appropriate test for the right patient), meticulous attention to infection prevention (including environmental disinfection), and improved antibiotic stewardship.

2. Key Points for a Successful Investigation

The following sections outline important actions and considerations in conducting an investigation of a potential outbreak of CDI in a healthcare facility. Some of these actions can be conducted by the facility, while others may require assistance from the health department. Collaboration between the facility and public health helps ensure a successful investigation. Public health should support the facility by providing guidance and resources. The health department may be able to provide assistance with infection control assessment, medical record review, laboratory testing, data analysis, and other activities as appropriate for the investigation. This will depend on the circumstances of the potential outbreak as well as the resources of the facility and the health department. The need for an on-site visit to the facility should be determined based on the number of the cases, patient population, severity of illness, and level of assistance required.

A. Initial Investigation

- Ensure the timeliness and appropriateness of testing practices. Patients should have ≥3 loose stools within 24 hours; testing stewardship prevents testing of patients with solid stool samples or other explanations for diarrhea (e.g. patients receiving laxatives or tube feeds). Note that nucleic acid amplification tests (NAAT) are very sensitive but do not distinguish CDI from asymptomatic carriage. If the cluster of cases is due to inappropriate testing, consider halting the investigation and taking steps to improve CDI testing practices.
- Construct a line list that includes admission date, admission source, location in the facility, movement of the patient within the facility, environmental cleaning, symptom onset date, date of positive test, testing method, previous history of CDI, prior antibiotic exposure, discharge date. (**Reducing *C. difficile* Infections Toolkit:** Best practices from the GNYHA/UHF *Clostridium difficile* Collaborative, page 24) [vi]
- Perform additional case finding through review of laboratory records and if indicated, medical chart review of epidemiologically linked patients.
- Utilize the list to identify commonalities among patients and determine if cases are epidemiologically linked and whether there is evidence of transmission.
- Establish a case definition including patient population, location, timeframe, as well as laboratory and clinical criteria. Consider using case classifications such as Suspect, Probable, and Confirmed.
- Capture information on infection control practices, environmental cleaning, and other relevant information.

B. Infection Control Assessment and Enhanced Precautions

- Perform an assessment of infection control practices such as hand hygiene, donning and doffing of PPE, and environmental cleaning on units affected by the outbreak (refer to the Hand Hygiene and Environmental Cleaning sections below).
- When investigating larger outbreaks consider utilizing the CDC Target, Assess, Prevent (www.cdc.gov/hai/prevent/tap.html) strategy to review awareness and perceptions of policies and practices related to CDI prevention in the affected facility or unit.
- Patients with CDI (including patients suspected of having CDI while awaiting testing) should be put in a private room and placed on contact precautions. [iv]
    - If single rooms are not available, cohort patients, providing a dedicated commode for each patient. [iv]
    - If there is a limited number of private single rooms, CDI patients with stool incontinence should be prioritized for private room placement. [viii]
- Maintain contact precautions for 48 hours after diarrhea has ceased: [viii]
    - Considerations should be made during an outbreak in a hospital to continue contact precautions for the duration of the hospitalization. [viii]
    - Clinical suspicion of CDI should outweigh negative enzyme immunoassay test results in patients with a high suspicion of having CDI, and the patient should remain on contact precautions. [iv] In such instances, supplementary testing with NAAT or a

glutamate dehydrogenase (GDH) test will be helpful if available. If the test result from either NAAT or GDH is negative, this excludes the infection control risk.

- Provide training on PPE donning and doffing practices with follow up audit and feedback provided to ensure adherence to best practices.
- Visitors should be instructed on the use of gowns and gloves. [iii]

C. Hand Hygiene
- Perform hand hygiene audit on affected unit and feedback data. [iii]
- Education on hand hygiene should be conducted followed by further observations of hand hygiene.
- Visitors should be instructed on performing hand hygiene. [iii]
- Strict hand hygiene should be performed with soap and water during an outbreak to physically remove spores. [iv]

D. Environmental Cleaning
- Audit cleaning procedures on affected units; provide feedback to environmental services staff. [xiii]
- Perform terminal cleaning after CDI patient transfer/discharge with a C. difficile sporicidal agent (EPA List K agent). Additional disinfection with no-touch technologies can be considered (e.g. UV light). [viii] (https://www.epa.gov/pesticide-registration/list-k-epas-registered-antimicrobial-products-effective-against-clostridium) [v]

E. Antimicrobial Stewardship
- Review CDI cases to optimize management by discontinuing unnecessary antibiotics and modifying antibiotic regimens to avoid antibiotics that create the greatest risk for CDI such as clindamycin, fluoroquinolones, and cephalosporins if possible. [xiii]
- If an outbreak is confirmed, conduct additional review of antibiotic prescribing practices to identify opportunities to improve overall stewardship to optimize the frequency and duration of antimicrobial therapy and the number and types of antimicrobial agents prescribed. [viii]
- A strong antimicrobial stewardship program is a key to preventing outbreaks of CDI. [iv]

F. Additional Surveillance
- Continue enhanced surveillance for additional cases while implementing control measures and assessing infection control practices.
- Utilize surveillance data to determine if control measures have interrupted transmission.
- Testing for cure is not recommended.
- Screening of asymptomatic patients is not recommended. [iv]
- Public health should follow up with the facility on a weekly basis (e.g., telephone or email contact) to monitor for additional cases and assess implementation of mitigation measures.

- If after 4 weeks there are no further cases, consider concluding the investigation.

3. Investigation and Control Resources

[See Scabies table for examples of specific investigation resources (e.g. line lists)]

4. Other Recommended Resources/Key References [WG-A+B]

[i] Association of Practitioners in Infection Control. *Guide to Preventing C. difficile Infections*. http://apic.org/Resource_/EliminationGuideForm/59397fc6-3f90-43d1-9325-e8be75d86888/File/2013CDiffFinal.pdf.

[ii] Banach D, Bearman G, et al. (2018). Duration of Contact Precautions for Acute-Care Settings. Infection Control & Hospital Epidemiology, 39(2), 127-144. https://doi:10.1017/ice.2017.245.

[iii] Cohen, Stuart H., et al. "Clinical Practice Guidelines for *Clostridium difficile* Infection in Adults: 2010 Update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA)." *Infection Control and Hospital Epidemiology*, vol. 31, no. 5, 2010, pp. 431–455. *JSTOR*, JSTOR, www.jstor.org/stable/10.1086/651706.

[iv] Dubberke E, Carling P, et. al. (2014). Strategies to Prevent *Clostridium difficile* Infections in Acute Care Hospitals: 2014 Update. *Infection Control & Hospital Epidemiology, 35*(S2), S48-S65. https://doi:10.1017/S0899823X00193857.

[v] Duberke E, Gerding D. Rationale for Hand Hygiene Recommendations after Caring for a Patient with *Clostridium difficile* infection. A Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals. Fall 2011 Update. https://www.shea-online.org/images/patients/CDI-hand-hygiene-Update.pdf.

[vi] United States Environmental Protection Agency (2018). *LIST K: EPA's Registered Antimicrobial Products Effective against Clostridium difficile Spores*.

[vii] Greater New York Hospital Association/United Hospital Fund (2011). *Reducing C. difficile Infections Toolkit: Best practices from the GNYHA/UHF Clostridium difficile Collaborative*. https://apic.org/Resource_/TinyMceFileManager/Practice_Guidance/cdiff/C.Diff_Digital_Toolkit_GNYHA.pdf

[viii] Gould C, McDonald C. *Clostridium difficile* (CDI) Infections Toolkit Activity C: ELC Prevention Collaboratives. Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention.

[ix] McDonald C, Gerding D, et. al. Clinical Practice Guidelines for Clostridium difficile Infection in Adults and Children: 2017 Update by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA), Clinical Infectious Diseases, Volume 66, Issue 7, 19 March 2018, Pages e1–e48, https://doi.org/10.1093/cid/cix1085.

[x] Massachusetts Department of Health. Infection Prevention in Long Term Care *Clostridium difficile* (*C. difficile*).

[xi] www.cdc.gov/hai/prevent/tap.html (CDC Target, Assess, and Prevent Strategy)

[xii] www.cdc.gov/antibiotic-use/healthcare/index.html (Antibiotic Prescribing and Use in Hospitals and Long-Term care)

[xiii] www.cdc.gov/hai/organisms/cdiff/cdiff_infect.html (*Clostridium difficilie* Infection)

[xiv] www.cdc.gov/hai/organisms/cdiff/cdiff-patient.html (*Clostridium difficilie* Resources for Patients)

[xv] www.cdc.gov/hai/organisms/cdiff/cdiff_clinicians.html (*Clostridium difficilie* Resources for Clinicians)

[xvi] www.cdc.gov/hai/organisms/cdiff/cdiff_faqs_hcp.html (*Clostridium difficilie* Frequently Asked Questions for Healthcare Providers)

[xiii] Subject Matter Expert Advice (opinion?)

CORHA *Workgroup to Website* Process Guidance

Approved by the CORHA Governance Committee on August 1, 2018

Background

This guidance describes the process by which CORHA-developed products advance from the workgroups to the CORHA website. This process aims to: standardize the workflow process for CORHA staff; establish Governance Committee (GC) and Council review priorities; prepare workgroup leads and SMEs for product presentations and; and allow for cohesive product branding. Of note, CORHA products are not co-branded with our member organizations. As such, we expect member organizations will assist their representatives in applying an appropriate level of product vetting, as described in Appendix A.

Workgroup to Website Processes

The workgroup to website process consists of three phases:

PHASE I (Workgroup Packet Preparation)

Upon the completion of the workgroup product, Michael and Steven will:

a. Finalize the workgroup content and copy. For the roles and expectations of CORHA workgroup members during product review periods, please refer to Appendix A.
b. Compile all accompanying and supplemental materials/resources into one packet (refer to Appendix B for CORHA workgroup packet requirements).
c. Send the product packet to Martha, copying Kate, Bonnie, and the workgroup Co-Chairs.

PHASE II (CDC and Governance Committee Review)

Upon receipt of the workgroup packet, Martha will:

a. Send the packet to the Governance Committee for review and discussion via conference call or email
    - *The purpose of this GC review is for leadership awareness. In the event that GC members have pertinent comments that need to be addressed, Martha will submit those comments to the workgroup Co-Chairs and coordinators to address.*
b. During this review period, CDC Governance Committee representative (Joe) will pursue informal scientific review from CDC.

PHASE III (CORHA Voting Member Review and Vote)

Upon Governance Committee review of the workgroup packet, Martha, will:

a. Send the packet to CORHA voting members for review.
b. If an All-CORHA call is scheduled within the next four weeks, the workgroup Co-Chairs will be expected to present the product on that call (refer to Appendix C for a guide on CORHA Council presentations).
c. Following the call, the final packet, including voting instructions, will be sent to CORHA voting members, officially marking the beginning of the open review period. For the roles and expectations of CORHA voting members during open review periods, please refer to Appendix A.
d. If there is <u>not</u> an all-CORHA call on the calendar within the next four weeks, CORHA voting members will be expected to send their comments or feedback via email during the open review period, which will be specified in the email. Please refer to Appendix D for more information on open and review periods.

e. Upon the closing of the review period, voting results will be generated via a Qualtrics report. A product is considered approved by a simple majority vote.
f. Approved products will be branded and posted to the CORHA website.
Use of Disclaimers: Because CORHA products are not co-branded by its member organizations, product pages will feature a disclaimer indicating that the positions and views expressed in this guidance do not necessarily represent the official positions of CORHA's member organizations.

APPENDIX A

Roles and expectations of CORHA workgroup and voting members during workgroup review periods:

CORHA workgroup members are encouraged to review and provide feedback on workgroup products during the development process. Comments are expected to build on the contributions of the workgroup, advance the work developed and aim to achieve consensus. Ultimately, the aim of product reviews is to ensure that recommendations align with CORHA's mission and are consistent with current science. A workgroup consensus is achieved when a majority of workgroup members agree on the final product, or when the workgroup Co-Chairs and CDC SMEs determine the product draft is final and ready for advancement.

Per the CORHA bylaws, voting members representing CORHA membership organizations listed below are expected to review CORHA products during the open review period and submit their votes. Voting members are considered representatives of their respective organizations and are responsible for reviewing products to help the Council avoid discordance with their organizations' official guidance and policies. During the open review period, voting members may consult with their organizations or subject-matter experts within their networks to help guide their feedback and vote as a CORHA member. Partner organizational representatives or organizational staff involved in CORHA will be expected to support their organizations' voting members in updating their organizations on CORHA products, obtaining the appropriate internal approvals, tracking the status of their voting members' reviews, and communicating updates to CORHA staff.

Voting Members

ASTHO:	Gerd Clabaugh, Kris Ehresmann, Joe Miner
CSTE:	Wendy Bamberg, Erin Epson, Marion Kainer
CDC:	Joe Perz, Elizabeth Mothershed
NACCHO:	Dawn Terashita, Hillary Hanson
APIC:	Linda Greene
APHL:	Jafar Razeq
SHEA:	Waleed Javaid

APPENDIX B

All CORHA product packets should include the following:

1. A Microsoft Word copy of the final watermarked draft, exclusive of markups or comments, and formatted in 14-point headings in Calibri font, and 11-point body text in Calibri font.
2. The official title of the document.
3. All current/active links to supplemental resources and materials.
4. A current roster of all active workgroup members and subject-matter experts that participated in the product development process.

APPENDIX C

CORHA product presentations by CORHA workgroup Co-Chairs or SMEs should include the following:

1. A brief overview of the product (purpose, content, etc).
2. The rationale behind the product development process (justifications, frameworks used, important research referenced, conclusions reached, etc).
3. References cited in the product and supplemental resources that will be linked to the product at the bottom of the CORHA product webpage.
4. Acknowledgement of workgroup Co-Chairs, members, and SMEs.
5. Time for questions and discussion.

Appendix D

Open and Closed Product Review Periods

Open review periods are designated timeframes during which CORHA voting members can review and submit comments on CORHA products before casting their votes. Open review time periods will be specified by CORHA staff during communication with CORHA voting members.

Review periods are considered closed when the product voting link is deactivated and the product progresses to the next step in the approval process. Comments or feedback submitted after the review period is closed will be accepted for future consideration.

Appendix E

Posted Products: Feedback and Refinement

All posted CORHA-developed products will feature a feedback mechanism whereby users will have the option of submitting feedback and suggestions through the website (e.g., an email link appearing on the page that hosts the product).

CORHA will strive to review comments on a regular basis (e.g., quarterly). In general, products will be reviewed at least bi-annually. If it is deemed necessary to revise the product in response to comments, feedback, or new information, workgroup co-chairs will consult with the CORHA Governance Committee to determine the approval process, which may be expedited (i.e., not requiring full council vote) for minor updates.

If a CORHA product addresses an issue or topic that is particularly novel or for which evidence and expert opinion are evolving, the product may be designated as “Interim Guidance” or an equivalent term. The decision to introduce this qualifier will typically be made by workgroup chairs in consultation with the CORHA Governance Committee.