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Location of Audio Controls
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Hospital Value-Based Purchasing (VBP) Program Patient Safety Series: CLABSI & CAUTI

Bethany Wheeler, BS
Team Lead, Hospital VBP Program
Inpatient Hospital Value, Incentives, and Quality Reporting (VIQR) Support Contractor (SC)

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Rush University Medical Center

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Sabrina Orique, MSN, RN, AOCNS
Kaweah Delta Medical Center

November 20, 2015
Purpose

Provide Hospitals with an understanding of Catheter-Associate Urinary Tract Infection (CAUTI) and Central Line-Associated Blood Stream Infection (CLABSI) infection rates within the HVBP Program, including:

- Healthcare-Associated Infection (HAI) standard population updates from the Centers for Disease control and Prevention (CDC)
- Impact of National Health Safety Network (NHSN) determined locations for CAUTI/CLABSI baseline and performance periods
- Methods to improve CAUTI/CLABSI Standardized Infection Ratios (SIRs)
Objectives

Participants will be able to:

• Identify how CLABSI and CAUTI are utilized in the Hospital VBP Program
• Discuss improvement plans and best practices with other hospital providers
• Identify interventions to improve CAUTI and CLABSI infection rates
Hospital VBP Program
Fiscal Year (FY) 2017
Domains and Measures

Domain Weights

25% Clinical Care

25% Patient- and Caregiver-Centered Experience of Care/Care Coordination

20% Safety

25% Efficiency and Cost Reduction

Patient- and Caregiver-Centered Experience of Care/Care Coordination

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey

Outcomes
- MORT-30-AMI
- MORT-30-HF
- MORT-30-PN

Clinical Care

Process
- AMI-7a
- IMM-2
- PC-01*

Efficiency and Cost Reduction

MSPB-1

Safety

CLABSI
CAUTI

SSI: Colon & Abdominal Hysterectomy
MRSA Infections*
C-difficile Infections*
AHRQ PSI-90

An asterisk (*) indicates a newly adopted measure for the Hospital VBP Program.
Hospital VBP Program
FY 2018 Domains and Measures

- **Clinical Care**: 25%
- **Safety**: 25%
- **Patient- and Caregiver-Centered Experience of Care/Care Coordination**: 25%
- **Efficiency and Cost Reduction**: 25%

**Patient- and Caregiver-Centered Experience of Care/Care Coordination (PCCEC/CC)**
- HCAHPS Survey
- Clinical Care
  - MORT-30-AMI
  - MORT-30-HF
  - MORT-30-PN

**Safety**
- Central Line-Associated Bloodstream Infections (CLABSI)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Surgical Site Infections (SSI) (Colon & Abdominal Hysterectomy)
- Methicillin-resistant *Staphylococcus aureus* (MRSA) Infections
- *C. difficile* Infections (CDI)
- AHRQ PSI-90
- PC-01

**Efficiency and Cost Reduction**
- MSPB-1
Routine Maintenance

- CDC is updating the “standard population data” (also known as “national baseline”) to ensure the NHSN measures’ number of predicted infections reflect the current state of HAIs in the United States.
  - CAUTI standard population data is Calendar year (CY) 2009.
  - CLABSI and Surgical Site Infection (SSI) standard population data is CY 2006–2008.
  - CDI and MRSA standard population data is CY 2010–2011.
- Beginning in 2015, CDC will collect data in order to update the standard population for all measures listed above.

<table>
<thead>
<tr>
<th>Data Period</th>
<th>FY 2017 Program Year</th>
<th>FY 2018 Program Year</th>
<th>FY 2019 Program Year</th>
<th>FY 2020 Program Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSN Measures</td>
<td>Current standard</td>
<td>Current standard</td>
<td>New standard</td>
<td>New standard</td>
</tr>
<tr>
<td>Baseline Period</td>
<td>population data</td>
<td>population data</td>
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<tr>
<td>Performance Period</td>
<td>population data</td>
<td>population data</td>
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<td>population data</td>
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11/20/2015
There is an intent to propose, in future rulemaking, inclusion of selected ward (non-Intensive Care Unit [ICU]) locations in certain NHSN Measures beginning with the FY 2019 program year.

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Resources


JOURNEY TO REDUCTION: CLABSI AND CAUTI AT RUSH UNIVERSITY MEDICAL CENTER

Department of Infection Prevention and Control
Alexander Tomich, DNP, RN, CIC
Marcelina Wawrzyniak, MSN, RN
Objectives

• Detail facility ownership of HAIs
• Describe CAUTI reduction successes from FY 2013–2015
• Describe the CLABSI reduction process from FY 2013–2015
• Address plans for the future of each initiative
About Rush University Medical Center

- 1,015 Staffed Beds
- 10,005 Total full time employees (FTEs)
- 49,804 Admissions
- 410,162 Outpatient Visits
HAI Process

• Infection Prevention and Control Department staffed with 8.0 FTEs

• Once HAI identified:
  ▪ Real-time feedback provided to the unit
  ▪ Unit stakeholders meet to discuss the event with team members and Infection Prevention

• Unit presents case to HAI Committee
  ▪ Discussion of interventions and opportunities continued
HAI Committee

- Multidisciplinary committee composed of:
  - Infection Prevention Team
  - Nursing Leadership
  - Quality Leadership
  - Physician Leadership

- Meets weekly to review data, discuss events, approve interventions and HAI focus
Unit-Based Interventions

- Running tally of days since last infection on units
- Many units have Infection Prevention Committees
- Nursing Audit process of device-associated infection (DAI) prevention practices
- Attending involvement in HAI discussions
CAUTI INITIATIVE
RUSH UNIVERSITY MEDICAL CENTER FY 2013–2015
CAUTI Initiative

• FY 2013–2015
  ▪ FY 2013 Standardized Infection Ratio (SIR) was 1.29
  ▪ FY 2015 SIR was 0.56
    • 68% decrease in CAUTI

• Organization-wide, multidisciplinary performance improvement effort aimed at:
  ▪ Practice standardization
  ▪ Early discontinuation of urinary catheters
  ▪ Multidisciplinary collaboration
Rush University Medical Center CAUTI
Acute Inpatient Units Standardized Infection Ratio
FY 2013–2016 Year to Date

FY13 SIR = 1.42
FY14 SIR = 0.73
FY15 SIR = 0.56
FYTD16 SIR = 0.63
Model for Reduction

- Increase data availability across organization
- Develop a leadership and accountability structure for performance improvement activities
- Perform event reviews on each CAUTI
- Pilot process improvement on Ortho unit and spread interventions house-wide that demonstrate measureable results
Hospital-Wide CAUTI Solutions

**Insertion**
- Training OR / IR Inserters on correct insertion technique

**Maintenance**
- Training nurses / PCTs on catheter maintenance

**Diagnosis**
- Educating ordering providers on reasons for ordering and supporting process with Electronic Medical Record (EMR) changes
  - Educating nurses / PCTs on specimen collection and supporting process with new urine collection kits

**Removal**
- Removing all present on admission catheters and if needed, replacing with new catheters, and making supporting EMR changes
  - Reinforcing use of nurse removal protocol with nurses and physicians
  - Reinforcing need for continuous catheter assessment with help of catheter utilization report
  - Developing urinary retention management protocol to support catheter removal and making supporting EMR changes
  - OR/IR post op huddle questions, including on catheter removal, made mandatory
Hospital Value-Based Purchasing Patient Safety Series: CAUTI and CLABSI

CLABSI INITIATIVE
RUSH UNIVERSITY MEDICAL CENTER FY 2013–2015
CLABSI Initiative

• FY 2013–2015
  - FY 2013 SIR 1.37
  - FY 2015 SIR 0.48
    • 64% decrease in CLABSI

• Organization-wide, multidisciplinary performance improvement effort aimed at:
  - Bundle compliance
  - Practice standardization
  - Product optimization
  - Multidisciplinary collaboration
Rush University Medical Center CLABSI Acute Inpatient Units SIR FY 2013–2016 Year to Date

- FY13 SIR = 1.37
- FY14 SIR = 0.38
- FY15 SIR = 0.48
- FYTD16 SIR = 0.51

SIR

- FY13 SIR = 1.37
- FY14 SIR = 0.38
- FY15 SIR = 0.48
- FYTD16 SIR = 0.51
## CLABSI Initiative Highlights
### FY 2013–2015

<table>
<thead>
<tr>
<th>FY 2013</th>
<th>FY 2014</th>
<th>FY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD and RN rapid improvement cycles on insertion and maintenance</td>
<td>Maintenance</td>
<td>Maintenance</td>
</tr>
<tr>
<td>MD: Focus on conscientious insertion and removal of lines</td>
<td>o CHG Bath Utilization in high risk units</td>
<td>o CHG Bath Utilization</td>
</tr>
<tr>
<td>RN: Focus on maintenance</td>
<td>o CLABSI Accountable Education and Peer Feedback process to pilot units</td>
<td>o ETOH Cap Pilot House Wide</td>
</tr>
<tr>
<td>o Scrub the hub</td>
<td>o Neutral Access Device</td>
<td>o CLABSI Accountable Education and Peer Feedback process to all units</td>
</tr>
<tr>
<td>o Adding lines in EMR to chart cap changes</td>
<td>o PICC Securement Device</td>
<td>o 91% CLABSI in lines 7+ days after insertion</td>
</tr>
<tr>
<td>o Charge RN to inquire about lines to be removed</td>
<td>CLABSI Diagnosis</td>
<td>CLABSI Diagnosis</td>
</tr>
<tr>
<td>Review of dialysis practices</td>
<td>o Peripheral VS Central Line Blood culture initiative</td>
<td>o Peripheral VS Central Line Blood Culture House wide</td>
</tr>
<tr>
<td></td>
<td>Prompt removal of Lines</td>
<td>o Reason for Culture order revision</td>
</tr>
<tr>
<td></td>
<td>o Hardwire Daily Needs Assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prompt removal of Lines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Hardwire Daily Needs Assessment tool on Internal Medicine Floors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Decrease use of SlimPorts</td>
</tr>
<tr>
<td>137 CLABSI</td>
<td>38 CLABSI</td>
<td>48 CLABSI</td>
</tr>
<tr>
<td></td>
<td>• 72% Decrease</td>
<td>• 64% Decrease FY13-FY15</td>
</tr>
</tbody>
</table>

11/3/2015
Central Line Bundle

Hand Hygiene
- Before and after contact with or manipulation of the line

Line Care
- Tubing change every 96 hours
- Alcohol ETOH Caps on ALL Ports for ALL Lines
- Needle Free Caps (changed every 96 hours and on admission)
- Cannulation by a validated RN

Skin & Site Care
- Dressing changes every 7 days and when compromised
- CHG bathing (on high risk units)

Blood Draws
- No central line blood cultures!
- Proper aseptic technique for central line blood draws

Assess catheter necessity
- Daily review of necessity
- Prompt removal!
Line Maintenance

- Nursing education regarding CLABSI Prevention
  - Practice standardization regarding product use
  - Dressing changes
  - Line manipulation
- Nurse Driven CLABSI Accountable Education and Peer Feedback process
  - Patients with central lines are audited to assess compliance with documentation, dressing changes, ETOH cap compliance and CHG baths. Each unit collects data monthly
Obtaining Blood Cultures

• Peripheral only blood cultures
  ▪ August 2013
  ▪ Central Blood culture eliminated as an option in EMR
  ▪ Reason for culture required

• FY 2014–2015
  ▪ 87% decrease in central blood cultures
  ▪ 73% decrease in CLABSI

• Outliers
  • Direct intervention regarding ordering
NEXT STEPS IN SUSTAINABILITY
Next Steps

• Increase reliability and root education/interventions into consistent practice
• Continue to champion improvements in central line and urinary catheter maintenance
• Highlight successes on units with consistent high performance
Thank You

- alexander_tomich@rush.edu
- marcelina_wawrzyniak@rush.edu
KAWEAH DELTA MEDICAL CENTER (KDMC) VISALIA, CALIFORNIA

Melissa A. Janes, MSN, RN-BC, IP MANAGER
Emma Camarena, MSN, RN, ACCNS-AG
Sabrina Orique, MSN, RN, AOCNS
About Us

• **581-licensed beds:**
  - 448 general acute care
  - 54 skilled nursing
  - 16 skilled nursing
  - 63 psychiatric
  - 26,364 inpatient visits (FY 2014)
  - 598,067 outpatient visits (FY 2014)

• **4,084 employees**
Analysis of the Data
KDMC CLABSI Performance

The chart shows the observed and expected rates of CLABSI (Central Line Associated Bloodstream Infection) from 2011 to 2014.

- **Observed Rates:**
  - 2011: 6
  - 2012: 3
  - 2013: 1
  - 2014: 1

- **Expected Rates:**
  - 2011: 8.5
  - 2012: 8.4
  - 2013: 9.6
  - 2014: 8.0

The observed rates steadily decrease from 2011 to 2014, while the expected rates show a peak in 2013 followed by a decline.
KDMC CAUTI Performance

![Graph showing observed and expected values for CAUTI performance over years 2012 to 2014. The graph indicates a decline in observed values from 6 in 2012 to 2 in 2014, while the expected values remain relatively stable.](image-url)
Structure for Improvement

- **Executive Team:**
  - Appointed Healthcare-Associated Infection Prevention Steering Committee (HAIPS) (2011)

- **Purpose:**
  - Establish subcommittees for CLABSI/CAUTI (and others)
    - Select Committee Chairs
  - Establish standardized strategies
    - Decrease device associated infections (DVIs)
  - Coordinate efforts, share strategies, and establish a reporting structure for each subcommittee
  - Decrease and prevent HAIs related to CLABSI and CAUTI
CLABSIs
2012 Action Items

- Scrub the Hub Education
- Mandatory charting
- New Tegaderm dressing
- Nursing bundle:
  - Scrupulous hand hygiene
  - Scrubbing the hub
  - Dedicated dressing/cap change days
  - Use of aseptic technique with changes
  - Daily review of line necessity with physicians
Additional Interventions

- Peripherally-inserted central catheters (PICC) audits
- Utilization rates
- Education blasts
  - PROCESS CHANGE NEW KNOWLEDGE
    Communication Bundle for December
- Home Health and neonatal intensive-care unit (NICU) joined the party
Interventions

• Hospital Engagement Network (HEN)
  ▪ Provided a series of questions that the Joint commission (TJC) could ask re: devices (central lines, Foleys and vents)

• Survey developed using the HEN questions

• Surveyed about 24 Registered Nurses (RNes)

• Results were much different then we thought
CLABSI Survey

1. Can you describe your process for central line decisions?
2. Describe your training regarding CLABSI prevention?
3. Do you use a standardized protocol for central line insertion?
4. Who in your hospital is certified to insert central lines?
5. Does the protocol describe routine maintenance and care? Who provides that and how are they trained?
6. Does the protocol describe when to discontinue the central line?
7. What do you do to prevent CLABSI?
8. Do you have daily "lines" rounds or huddles?
9. Do you receive information or feedback about your patients who experience a CLABSI? How does that happen?
10. What would you recommend that your team do differently to avoid a CLABSI?
11. What is the best method that you would like to receive education on the above questions?

Sample Size: 24 RNS
- ICU RNs: 10
- MS RNs: 14
Interventions

• Provide education for:
  ▪ Anyone who will listen!
  ▪ Patients: *Let’s talk out loud!*
  ▪ Each other!

• Continue to re-evaluate processes to:
  ▪ Make changes that make sense

• Make suggestions to:
  ▪ The committee
  ▪ The executive team
  ▪ PICC RNs
  ▪ Inpatient (IP) RNs
CAUTIs
Interventions

• Implementation of CDC Toolkit
  ▪ Bundle
  ▪ Standardized Procedure
  ▪ Bladder scanners

• Quarterly Prevalence studies
Interventions

• Daily reports
  ▪ Charge nurses review with staff nurses

• Rounds with advanced practice nurses (APNs)
  ▪ “Show on the roads”

• Utilization rates
Interventions

• Standardization of supplies
• Education:
  ▪ Annual competency review
  ▪ Communication bundles
  ▪ Surveys
• Physician education
What are we doing now?

- Continuing to make process changes
- Ongoing education
  - Interdisciplinary education
  - Physician residents
  - New nurse residency program
Questions?
Continuing Education Approval

This program has been approved for 1.0 continuing education (CE) unit for the following professional boards:

- Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
- Florida Board of Nursing Home Administrators
- Florida Council of Dietetics
- Florida Board of Pharmacy
- Board of Registered Nursing (Provider #16578)
  - It is your responsibility to submit this form to your accrediting body for credit.
CE Credit Process

- Complete the ReadyTalk® survey that will pop up after the webinar, or wait for the survey that will be sent to all registrants within the next 48 hours.
- After completion of the survey, click “done” at the bottom of the screen.
- Another page will open that asks you to register in HSAG’s Learning Management Center.
  - This is a separate registration from ReadyTalk
  - Please use your PERSONAL email so you can receive your certificate
  - Healthcare facilities have firewalls up that block our certificates
CE Certificate Problems?

• If you do not immediately receive a response to the email that you signed up with in the Learning Management Center, you have a firewall up that is blocking the link that is sent out

• Please go back to the **New User** link and register your personal email account
  - Personal emails do not have firewalls
CE Credit Process: Survey

10. What is your overall level of satisfaction with this presentation?
   - Very satisfied
   - Somewhat satisfied
   - Neutral
   - Somewhat dissatisfied
   - Very dissatisfied

If you answered “very dissatisfied”, please explain:

11. What topics would be of interest to you for future presentations?

12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.

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**Existing User Link:**
https://lmc.hshapps.com/test/adduser.aspx?ID=da0a12bc-db39-408f-b429-d6f6b9cbb1ae

**Note:** If you click the 'Done' button below, you will not have the opportunity to receive your certificate without participating in a longer survey.

Done
CE Credit Process: New User

![Learning Center Registration: OQR: 2015 Specifications Manual Update - 1-21-2015](image-url)
CE Credit Process: Existing User
QUESTIONS?
Resources
Contact Us

Q & A Tool
https://cms-ip.custhelp.com

Email Support
InpatientSupport@viqrc1.HCQIS.org

Phone Support
844.472.4477 or 866.800.8765

Inpatient Live Chat
www.qualityreportingcenter.com/inpatient

Monthly Web Conferences
www.QualityReportingCenter.com

Secure Fax
877.789.4443

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