# Welcome!

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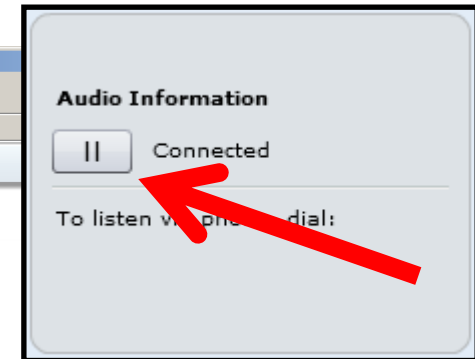
- **This event is being recorded.**

Troubleshooting Audio

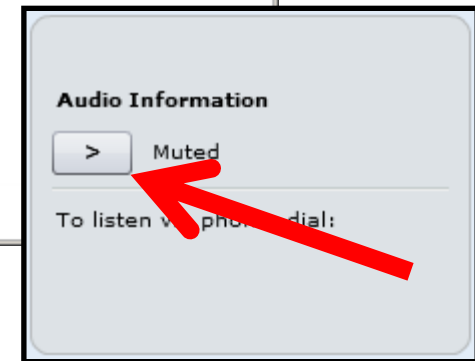**Audio from computer speakers breaking up? Audio suddenly stop?**

- **Click <u>Pause</u> button**

- **Wait 5 seconds**

- **Click <u>Play</u> button**
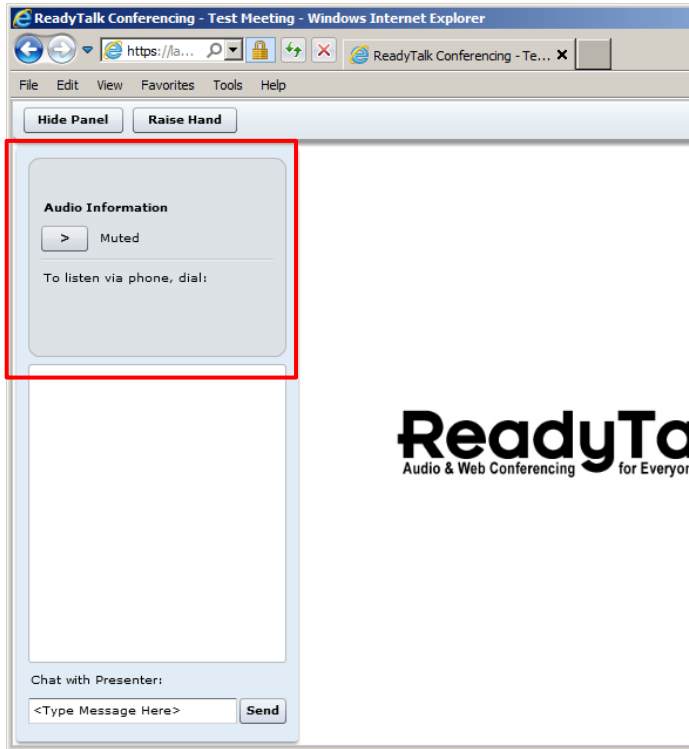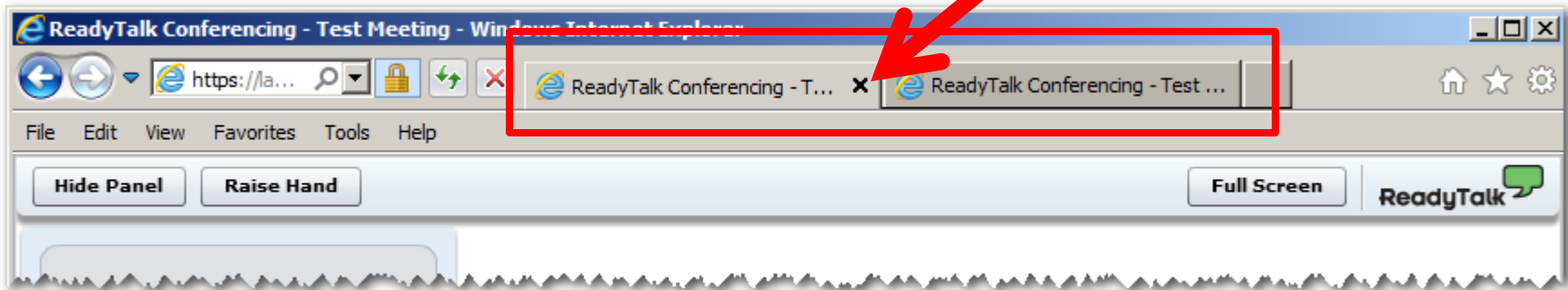
Location of Audio Controls

Step 1

Step 2

Troubleshooting Echo

- **Hear a bad echo on the call?**

- **Echo is caused by multiple browsers/tabs open to a single event – multiple audio feeds.**

- **Close all but one browser/tab and the echo will clear up.**

Example of Two Browsers Tabs open in Same Event

Submitting Questions

Type questions in the "Chat with Presenter" section, located in the bottom-left corner of your screen.

CMS

CENTERS FOR MEDICARE & MEDICAID SERVICES

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)

Alexander Tomich, DNP, RN, CIC
Marcelina Wawrzyniak, MSN, RN
Department of Infection Prevention and Control
Rush University Medical Center

Melissa A. Janes, MSN, RN-BC, IP Manager
Emma Camarena, MSN, RN, ACCNS-AG
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

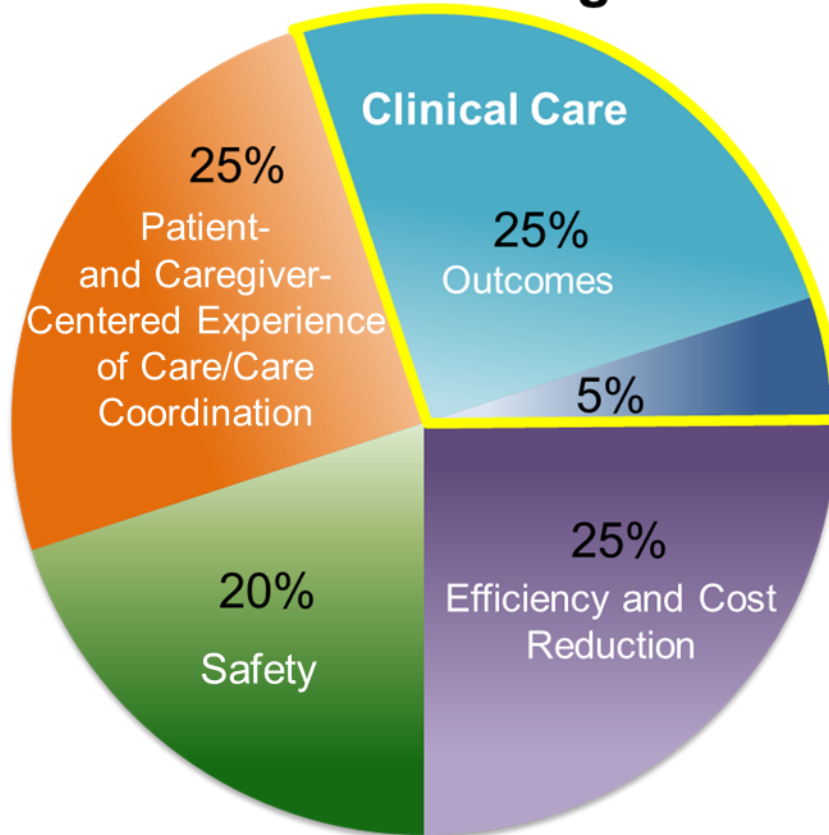- Methods to improve CAUTI/CLABSI Standardized Infection Ratios (SIRs)

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

Clinical Care
- 25% Outcomes
- 5%

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

Clinical Care

Outcomes	Process
MORT-30-AMI	AMI-7a
MORT-30-HF	IMM-2
MORT-30-PN	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

Domain Weights

- 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

NHSN Measures
Standard Population Data

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.

| Data Period	FY 2017 Program Year	FY 2018 Program Year	FY 2019 Program Year	FY 2020 Program Year
NHSN Measures **Baseline** Period	Current standard population data	Current standard population data	New standard population data	New standard population data
NHSN Measures **Performance** Period	Current standard population data	Current standard population data	New standard population data	New standard population data

CLABSI and CAUTI Locations

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.

Data Period	FY 2017 Program Year	FY 2018 Program Year	FY 2019 Program Year	FY 2020 Program Year
Hospital VBP Program **Baseline** Period	**CLABSI:** Adult, Pediatric, and Neonatal ICU locations **CAUTI:** Adult and Pediatric ICU locations	**CLABSI:** Adult, Pediatric, and Neonatal ICU locations **CAUTI:** Adult and Pediatric ICU locations	**CLABSI:** Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards **CAUTI:** Adult and Pediatric ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards	**CLABSI:** Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards **CAUTI:** Adult and Pediatric ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards
Hospital VBP Program **Performance** Period	**CLABSI:** Adult, Pediatric, and Neonatal ICU locations **CAUTI:** Adult and Pediatric ICU locations	**CLABSI:** Adult, Pediatric, and Neonatal ICU locations **CAUTI:** Adult and Pediatric ICU locations	**CLABSI:** Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards **CAUTI:** Adult and Pediatric ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards	**CLABSI:** Adult, Pediatric, and Neonatal ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards **CAUTI:** Adult and Pediatric ICUs and Adult or Pediatric Medical, Surgical, and Medical/Surgical Wards

Resources

- Quick Reference Guide for the FY 2017 and 2018 Programs are available at
http://www.qualityreportingcenter.com/

- FY 2017 Direct Link:
http://www.qualityreportingcenter.com/wp-content/uploads/2015/02/IQR-FY2017_VBP-Domain-Weighting-Infographic.pdf

- FY 2018 Direct Link:
http://www.qualityreportingcenter.com/wp-content/uploads/2015/10/FY-2018-Infographic-VBP-Domain-Weighting_FINAL_508.pdf
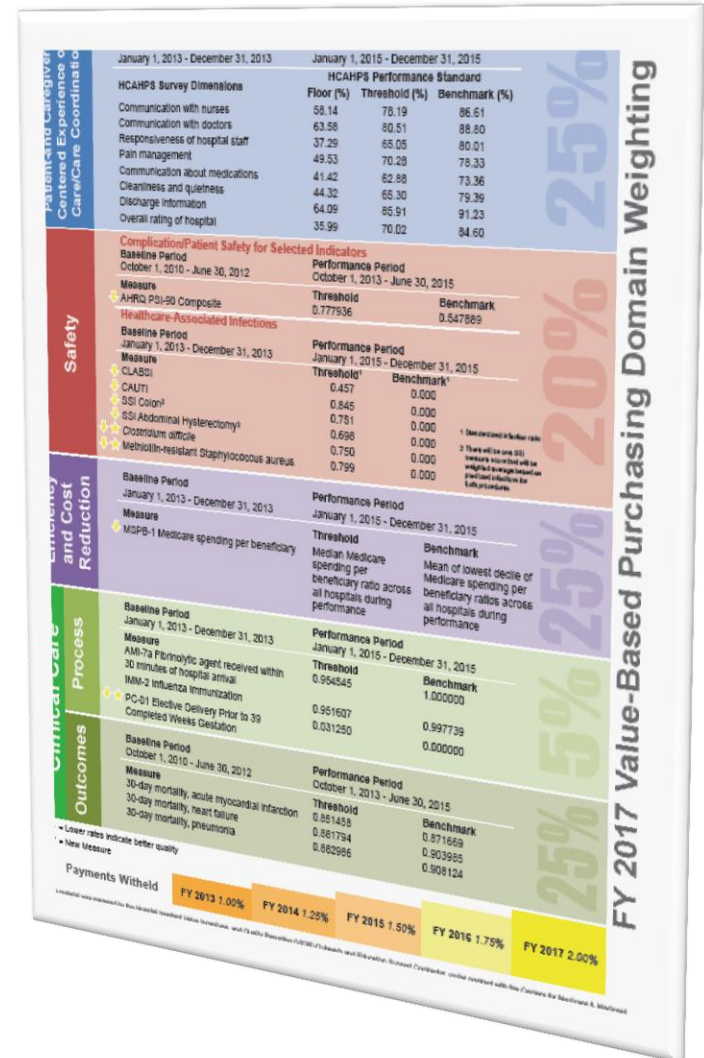
Hospital Value-Based Purchasing Patient Safety Series:
CAUTI and CLABSI

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

Hospital Value-Based Purchasing Patient Safety Series:
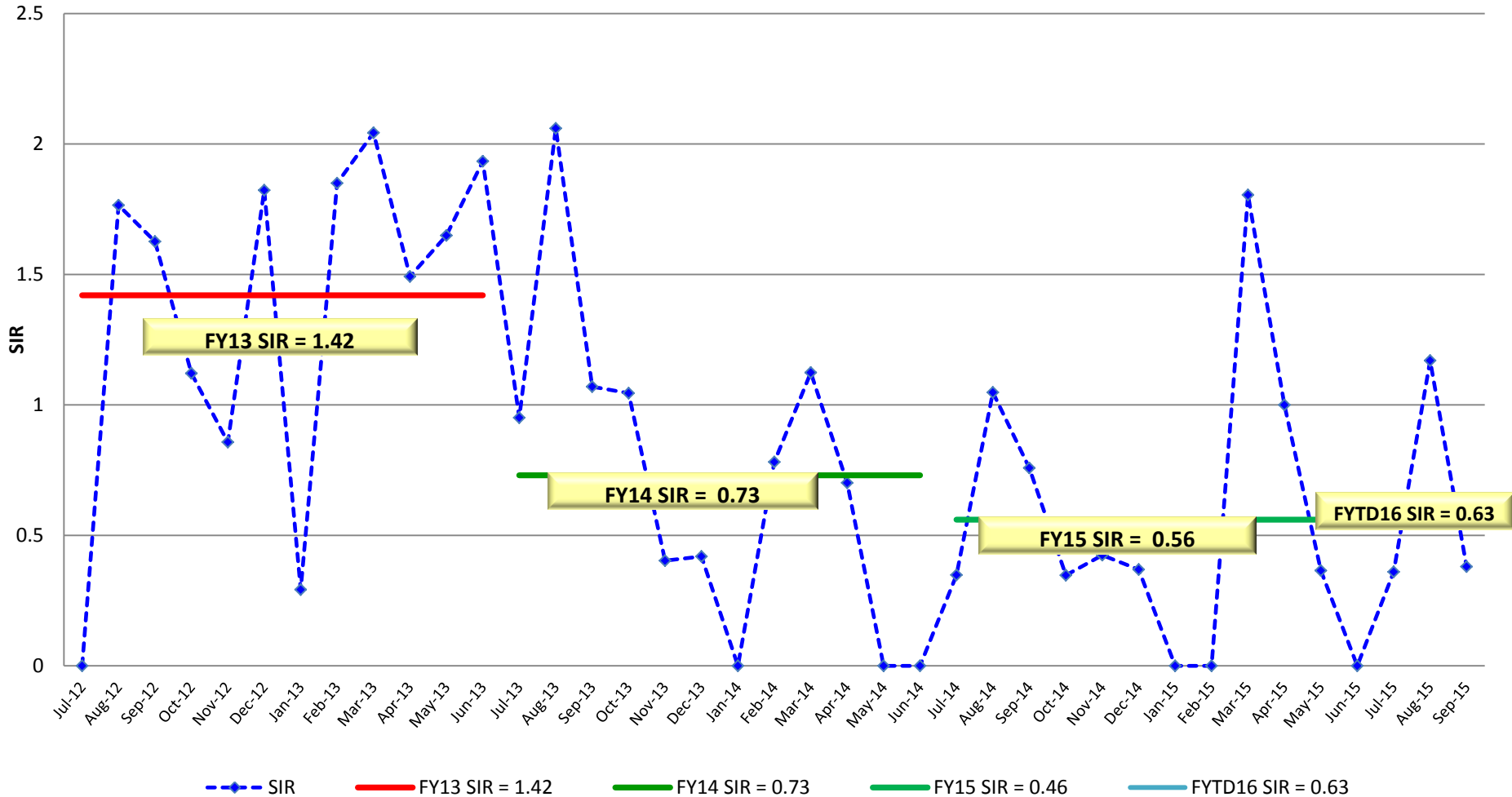CAUTI and CLABSI

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
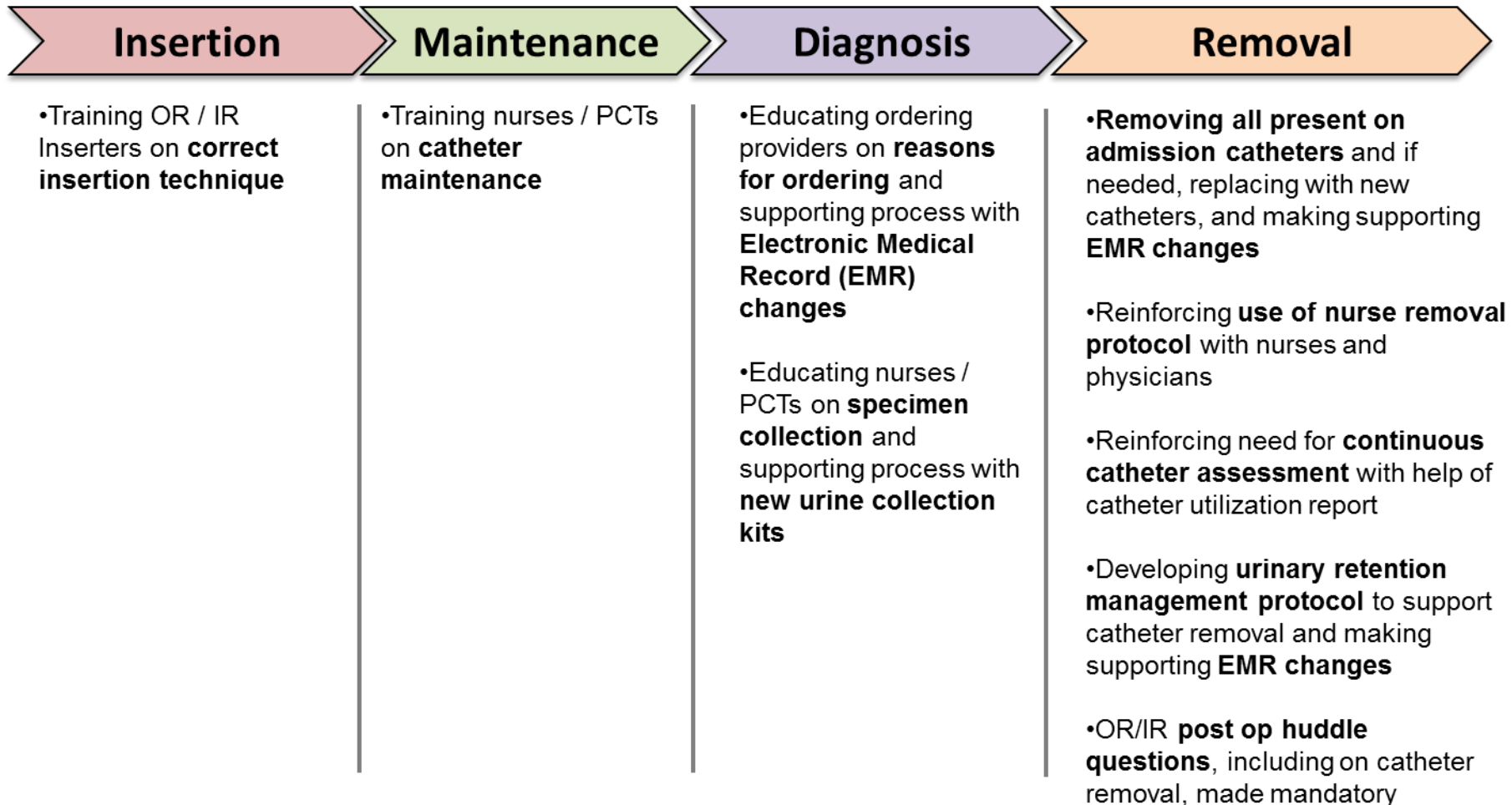 - Multidisciplinary collaboration

Rush University Medical Center CAUTI
Acute Inpatient Units Standardized Infection Ratio
FY 2013–2016 Year to Date

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	Maintenance	Diagnosis	Removal
•Training OR / IR Inserters on **correct insertion technique**	•Training nurses / PCTs on **catheter maintenance**	•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**	•**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
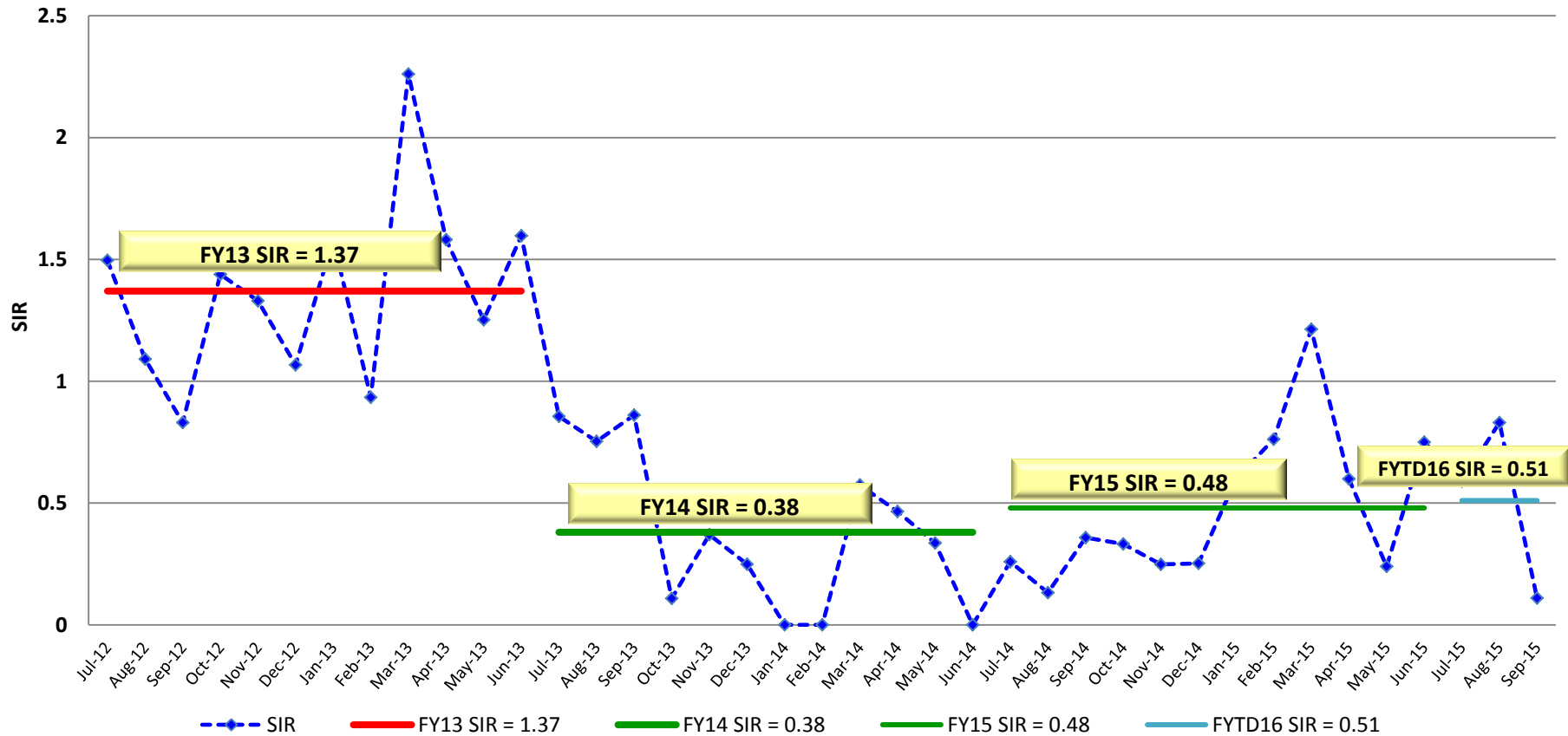
CLABSI INITIATIVE
RUSH UNIVERSITY MEDICAL CENTER FY 2013–2015

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

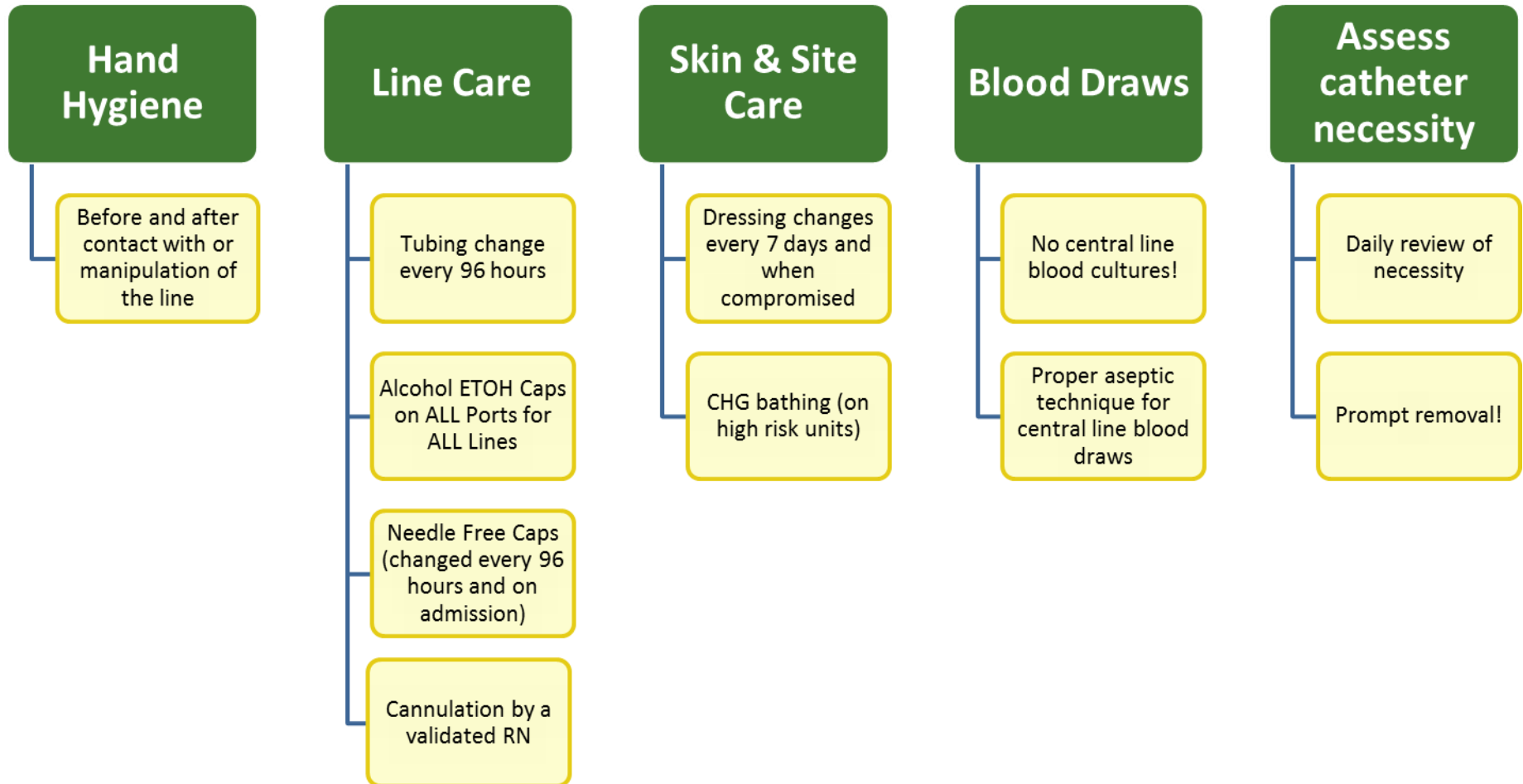# Rush University Medical Center CLABSI Acute Inpatient Units SIR FY 2013–2016 Year to Date

CLABSI Initiative Highlights
FY 2013–2015

FY 2013	FY 2014	FY 2015

• **MD and RN rapid improvement cycles on insertion and maintenance**
• **MD: Focus on conscientious insertion and removal of lines**
• **RN: Focus on maintenance**
  o **Scrub the hub**
  o **Adding lines in EMR to chart cap changes**
  o **Charge RN to inquire about lines to be removed**
• **Review of dialysis practices**
	• Maintenance
	  o CHG Bath Utilization in high risk units
	  o CLABSI Accountable Education and Peer Feedback process to pilot units
	  o ETOH Cap Pilot
	  o Neutral Access Device
	  o PICC Securement Device
	• CLABSI Diagnosis
	  o Peripheral VS Central Line Blood culture initiative
	• Prompt removal of Lines
	  o Hardwire Daily Needs Assessment
		• Maintenance
		  o CHG Bath Utilization
		  o ETOH Cap Pilot House Wide
		  o CLABSI Accountable Education and Peer Feedback process to all units
		  o 91% CLABSI in lines 7+ days after insertion
		• CLABSI Diagnosis
		  o Peripheral VS Central Line Blood Culture House wide
		  o Reason for Culture order revision
		• Prompt removal of Lines
		  o Hardwire Daily Needs Assessment tool on Internal Medicine Floors
		  o Decrease use of SlimPorts
		• RN CLABSI Re-education
		  o Education module
		  o PAC dressings and champion units

• **137 CLABSI**	• 38 CLABSI
	  • 72% Decrease
		• 48 CLABSI
		  • 64% Decrease FY13-FY15

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

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)

- 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

 # CL Blood Cultures FY2014–2015

87

11

FY14   FY15
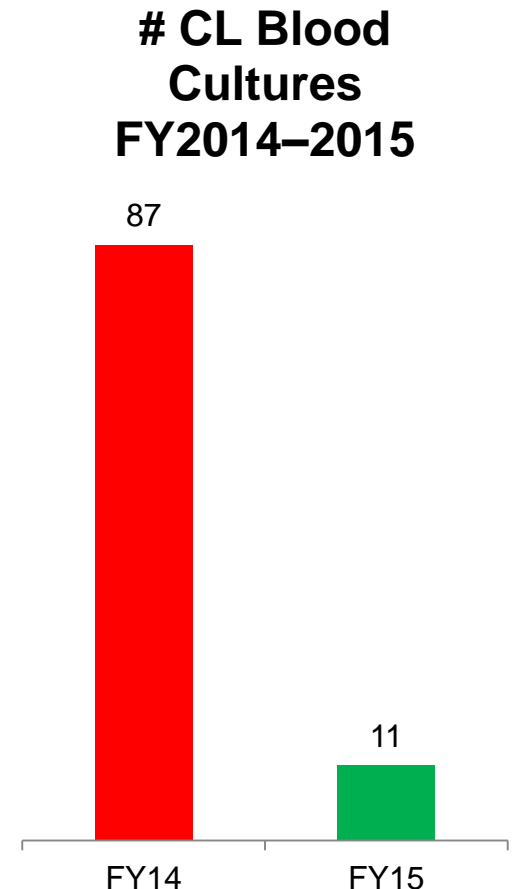
Hospital Value-Based Purchasing Patient Safety Series:
CAUTI and CLABSI

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

Hospital Value-Based Purchasing Patient Safety Series:
CAUTI and CLABSI

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)
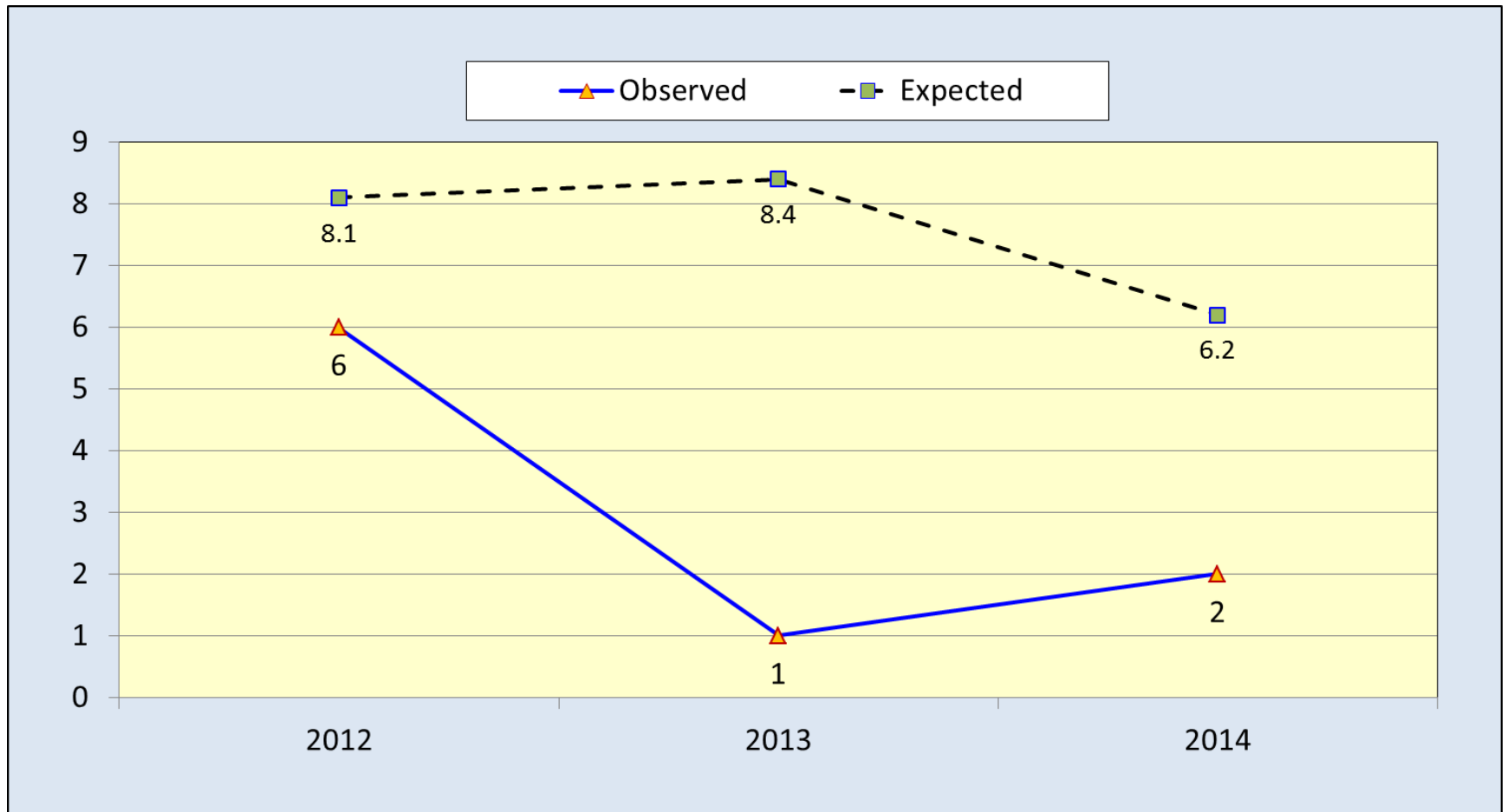 - 598,067 outpatient visits (FY 2014)
- **4,084 employees**

Analysis of the Data

KAWEAH DELTA
Infection
Prevention

KDMC CLABSI Performance
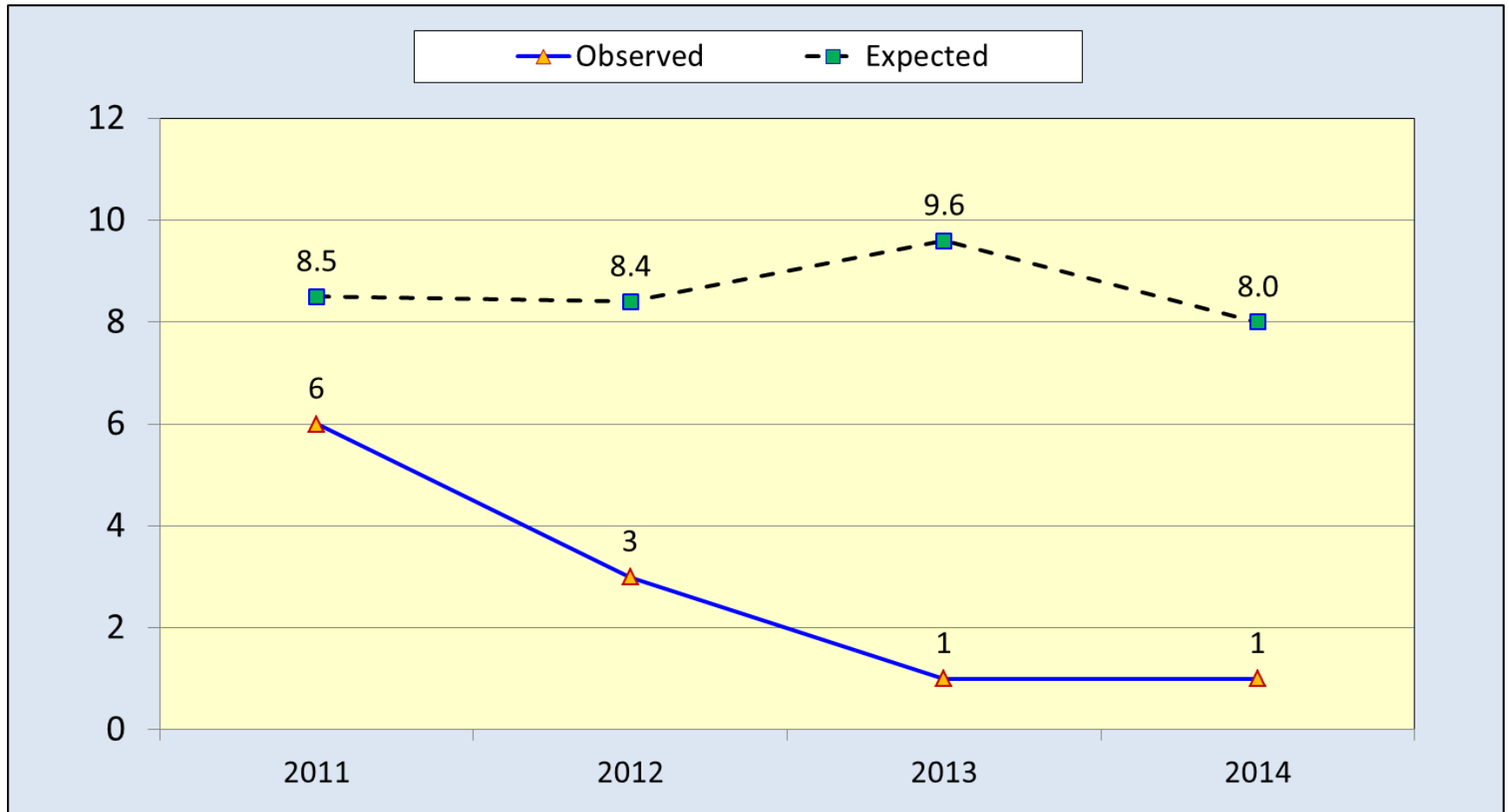
KDMC CAUTI Performance

Structure for Improvement

- **Executive Team:**
  - Appointed Healthcare-Associated Infection Prevention Steering Committee (HAIPS) (2011)
- **Purpose:**
  - Establish subcommittees for CLABSI/CAUTI (and others)
    - o 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 CLABSIs and CAUTIs

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
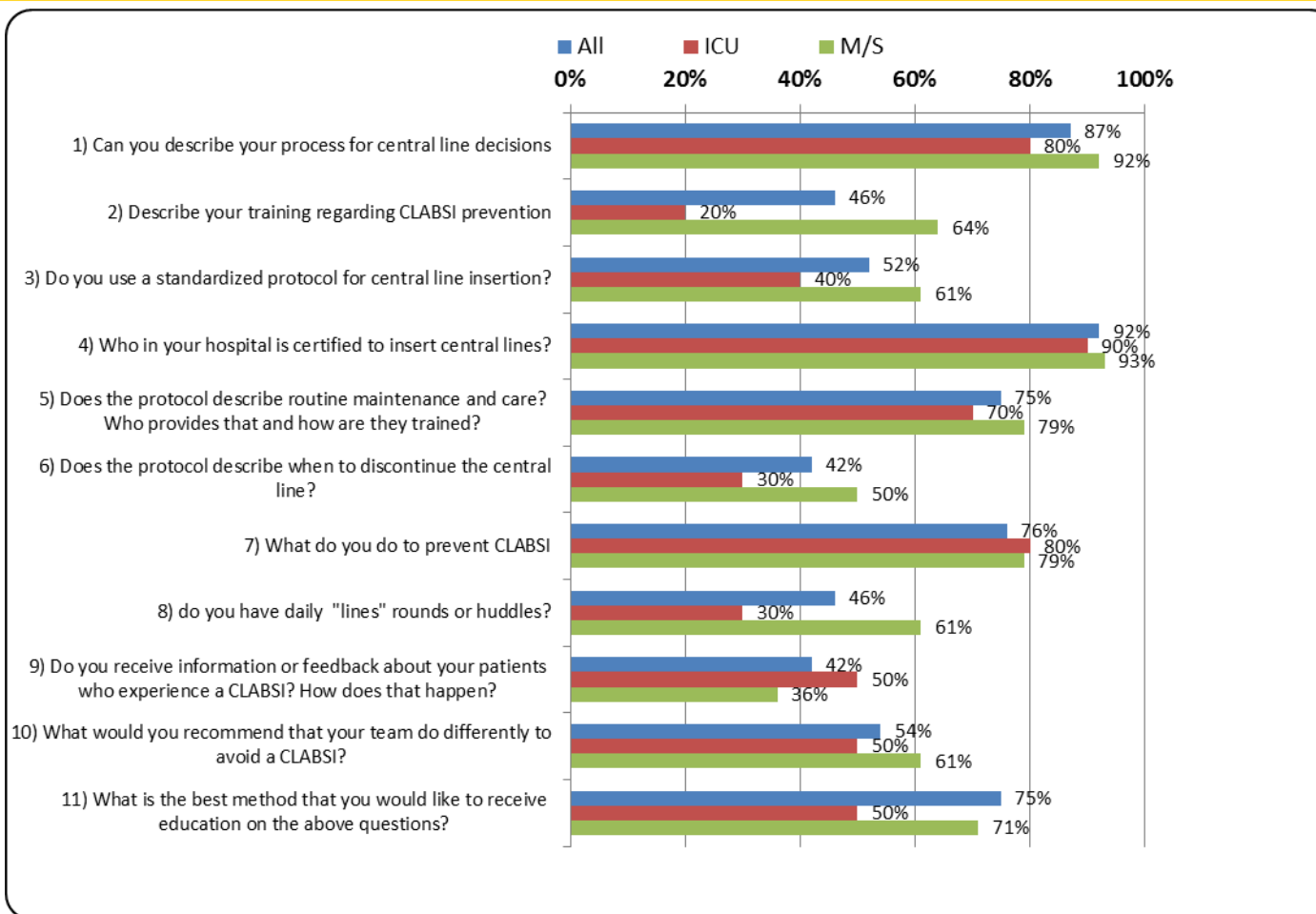 - Daily review of line necessity with physicians

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 (RNs)
- Results were much different then we thought

CLABSI Survey

Legend: All (blue), ICU (red), M/S (green)

Question	All	ICU	M/S
1) Can you describe your process for central line decisions	87%	80%	92%
2) Describe your training regarding CLABSI prevention	46%	20%	64%
3) Do you use a standardized protocol for central line insertion?	52%	40%	61%
4) Who in your hospital is certified to insert central lines?	92%	90%	93%
5) Does the protocol describe routine maintenance and care? Who provides that and how are they trained?	75%	70%	79%
6) Does the protocol describe when to discontinue the central line?	42%	30%	50%
7) What do you do to prevent CLABSI	76%	80%	79%
8) do you have daily "lines" rounds or huddles?	46%	30%	61%
9) Do you receive information or feedback about your patients who experience a CLABSI? How does that happen?	42%	50%	36%
10) What would you recommend that your team do differently to avoid a CLABSI?	54%	50%	61%
11) What is the best method that you would like to receive education on the above questions?	75%	50%	71%

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 <u>immediately</u> 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

CE Credit Process

Thank you for completing our survey!

Please click on one of the links below to obtain your certificate for your state licensure.

You must be registered with the learning management site.

New User Link:
https://lmc.hshapps.com/register/default.aspx?ID=da0a12bc-db39-408f-b429-d6f6b9ccb1ae

Existing User Link:
https://lmc.hshapps.com/test/adduser.aspx?ID=da0a12bc-db39-408f-b429-d6f6b9ccb1ae
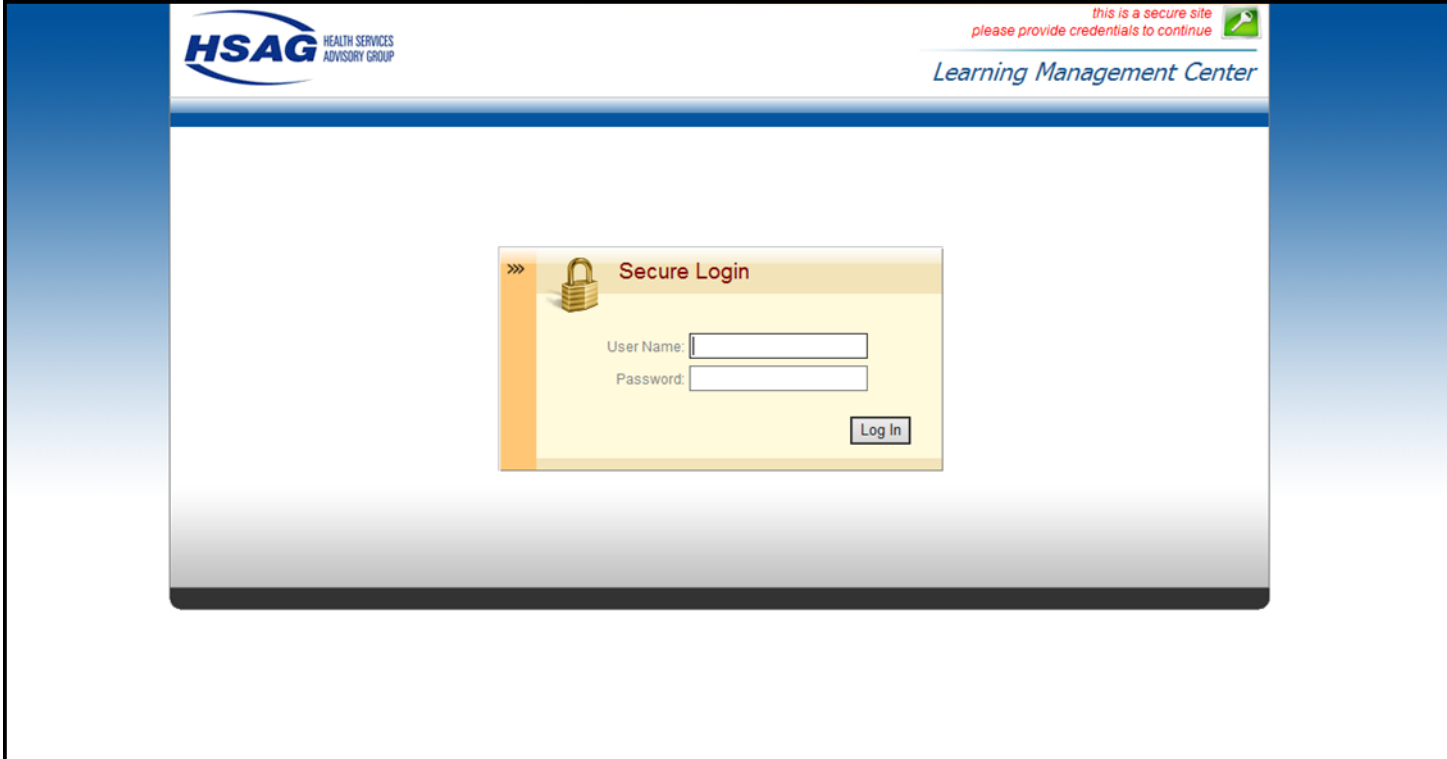
Note: If you click the 'Done' button below, you will not have the opportunity to receive your certificate without participating in a longer survey.

Done

CE Credit Process: New User

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

ListServes
Sign up on
www.QualityNet.org

Website
www.QualityReportingCenter.com