The CDI Sprint was created to assist hospitals and health systems implement quality improvement techniques to reduce root causes of healthcare-onset *C. difficile* and the impact of culturing practices. Led by the HRET HIIN CDI Team and peer advisors, the Fall 2018 CDI Sprint cohort included hospitals and health systems across 29 states who were targeted for high or rising CDI rates.

The Sprint intervention consisted of using a process improvement discovery tool to address barriers that may associate with hospital onset CDI, challenges, and gaps in practices. Participants had access to one-on-one coaching, peer to peer sharing, subject matter experts and peer advisors and virtual events. Below is a summary of participants, interventions and lessons learned.
### BARRIERS THAT MAY ASSOCIATE WITH HOSPITAL ONSET CDI

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENT SAFETY</strong></td>
<td>Lack of understanding about the potentially serious effects of a true CDI infection</td>
<td>Hospital in AZ</td>
</tr>
<tr>
<td><strong>DIAGNOSTIC STEWARDSHIP</strong></td>
<td>Providers use the GI panel to test. Not clear if patient has 3 or more liquid stools before sample sent. Test previously positive c-diff patients. Some staff do not abide by contact precaution rules. Think if they do not touch the patient they do not need to gown and glove</td>
<td>Hospital in MO</td>
</tr>
<tr>
<td><strong>LABORATORY STEWARDSHIP</strong></td>
<td>Lab does not have an alternate process in place to confirm presence of toxin other than a molecular test (such as PCR)</td>
<td>Hospital in CO</td>
</tr>
<tr>
<td><strong>HEALTHCARE SYSTEM CULTURE</strong></td>
<td>Limited resources and tools for analytics, difficult to provide real-time feedback, develop scorecards, improve transparency for various stakeholders.</td>
<td>Hospital in DE</td>
</tr>
</tbody>
</table>

### WHAT WAS LEARNED?

Learnings from the CDI Process Improvement Discovery Tool assisted the acceleration of improvement efforts to enhance patient safety. Participants consistently discovered potential gaps and opportunities associated with their laboratory stewardship processes. Some of the gaps were:

- “Routine” testing (e.g. during GI procedures)
- Not using tools (e.g. algorithms)
- Failure to discontinue orders that no longer make sense
- Documentation challenges
- Treating the test, not the patient (e.g. no symptoms other than diarrhea)

As a result, hospitals worked with their state hospital association to create an action plan to address barriers and areas of opportunity. This included fostering relationships across teams/departments, implementing guidelines for appropriate testing, revamping antibiotic stewardship programs, and continue using the discovery tool to assess laboratory stewardship.

---

**We will be implementing the 2-step test utilizing GDH with NAAT. These changes will improve patient outcomes and differentiate colonization vs infection. This will also contribute to antibiotic/diagnostic testing stewardship.** — Hospital in CO

**We’re looking to implement a testing algorithm and further expand our ASP work. CDI testing is also under review to see if we should consider changing the way we approach CDI testing.** — Hospital in ME

**We are currently implementing all aspects of the decision tree. We were not following it initially, but, after this activity, education and explanation was sent out to all providers. We still struggle for full implementation, but have made alot of progress. This has been helpful.** — Hospital in LA

**Utilized "Fine Wine" demonstration in wine glass during skills lab for all nursing staff and laboratory staff on C. diff appropriate stool sample. Presented hospitals C. diff checklist to both the Antimicrobial Stewardship committee and the Infection Prevention Committee.** — Hospital in OK

---

For more information, contact HIIN@aha.org or visit our website and, under Topics, click on CDI to learn about the CDI Sprint and view recordings: www.hret-hiin.org