Discovery and Direction Series: Horizontal Practices

November 15, 2018
1:00PM – 2:00PM CT
AGENDA

- Welcome
- What are Horizontal and Vertical Approaches?
- Peer Sharing and Expert Coaching
- HRET Tools and Resources
- Q & A
- What’s Next?

AHA CENTER FOR HEALTH INNOVATION

American Hospital Association
Advancing Health in America
JOIN NOW!

HRET HIIN uses the LISTSERV® platform to encourage peer-to-peer networking, share HRET HIIN events and resources, and highlight innovative approaches to reduce harm.

HRET HIIN LISTSERV ®
Upcoming Sessions:

- **11/29** Special Approaches and Essential Questions (NEXT)
- **12/18** What’s Next…

Share your improvement journey with your peers! #WHYIHIIIN

**ALL CALLS ARE FROM 1:00 - 2:00 PM CT.**

**THURSDAY, OCT. 18**
ASK AN EXPERT
REGISTER

**THURSDAY, NOV. 1**
ORGANIZATIONAL RISK ASSESSMENT
REGISTER

**THURSDAY, NOV. 15**
HORIZONTAL PRACTICES
REGISTER

**THURSDAY, NOV. 29**
SPECIAL APPROACHES AND ESSENTIAL QUESTIONS
REGISTER

**TUESDAY, DEC. 18**
WHAT’S NEXT...
REGISTER

AUDIENCE: Infection preventionists, nursing leaders, front-line nurses, quality and safety professionals, infectious disease MDs or other physician leaders
Speakers

Lydie Marc, MPH, CHES
Program Manager
AHA/HRET HIIN

Betsy Lee, MSPH, RN
Improvement Advisor
Cynosure Health

Tom Talbot, MD, MPH
Chief Hospital Epidemiologist
Vanderbilt University Medical Center

Barb DeBaun, RN, MSN, CIC
Improvement Advisor
Cynosure Health

American Hospital Association
Advancing Health in America
Learning Objectives

- Discuss horizontal and vertical approaches for preventing MRSA bacteremia transmission
- Evaluate evidence and expert opinion regarding frequently asked questions about horizontal approaches
- Share tools and ideas and gather tips from peers
- Plan next steps to ensure reliability of your organization’s horizontal approaches
Samples of Organizational Risk Assessments

<table>
<thead>
<tr>
<th>Category</th>
<th>Probability</th>
<th>Risk</th>
<th>Preparedness</th>
<th>Risk Level Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geography &amp; Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential for Multi Drug Resistant Organisms (MDRO)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>16</td>
</tr>
<tr>
<td>Influenza in NE Georgia Health District 10</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>12</td>
</tr>
<tr>
<td>Community outbreaks (All and respiratory)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>9</td>
</tr>
<tr>
<td>Potential for Tuberculosis</td>
<td></td>
<td>X</td>
<td>X</td>
<td>4</td>
</tr>
<tr>
<td>Potential for Identification of State Reportable Diseases</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>4</td>
</tr>
<tr>
<td>Potential for Healthcare Associated Infections (HAI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Site Infections</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>16</td>
</tr>
<tr>
<td>Targeted Surgical Procedures</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>4</td>
</tr>
<tr>
<td>Surgical Site Infections - OpIC</td>
<td></td>
<td>X</td>
<td>X</td>
<td>4</td>
</tr>
<tr>
<td>Ventilator Associated Events - VAC/PAC/PAP</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>8</td>
</tr>
<tr>
<td>CLABSI All Nursing Units</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>30</td>
</tr>
<tr>
<td>CAUTI All Nursing Units</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>36</td>
</tr>
<tr>
<td>Neonatal Infections (NICU)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
<tr>
<td>Lab ID MDRO - MRSA, VRE, ESBL, CR, &amp; C. diff.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>32</td>
</tr>
<tr>
<td>CLABSI - HHC/ Hospice</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>5</td>
</tr>
<tr>
<td>CAUTI - HHC/ Hospice</td>
<td></td>
<td>X</td>
<td>X</td>
<td>8</td>
</tr>
</tbody>
</table>

Courtesy of St. Mary’s Health Care System
(Athens, GA)
## Samples of Organizational Risk Assessments

### 2015 Infection Control Risk Assessment Goals, Strategies & Implementation Plan

This plan has been developed by Infection Control with input and collaboration from the following:

- Infection Control Oversight Committee
- Leadership, including department managers
- Chief of Medical Staff
- Environmental Control Committee
- Chief Nursing Officer

A risk assessment is a component of this plan. The plan is formally reviewed at least annually and whenever significant changes occur in the elements that affect risk.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Goals</th>
<th>Strategies To Decrease Risk</th>
<th>Implementation</th>
<th>Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geography and Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Potential for Multi-Drug Resistant Organisms (MDRO) | Early identification of patients with a history of MDRO  
Prompt implementation of Infection Control Preventions | Assess for history of MDRO  
Review microbiology reports and flag electronic medical record of patients with positive cultures | All staff  
Infection Control | Ongoing  
Maintain isolation log for inpatients |
| Influences in NE Georgia Health District 10 | Early identification of patients with influenza symptoms | Assess for signs and symptoms  
Review microbiology reports | All staff  
Infection Control | Ongoing  
Monitor isolation log for inpatients  
Monitor microbiology cultures |
| Community outbreaks (GI and respiratory) | Early identification of outbreaks | Assess for signs and symptoms  
Review microbiology reports | All staff  
Infection Control | Ongoing  
Monitor microbiology cultures |
What are Horizontal and Vertical Approaches?

Betsy Lee, MSPH, RN
Improvement Advisor, Cynosure

Tom Talbot, MD, MPH
Chief Hospital Epidemiologist, Vanderbilt University Medical Center
What are Horizontal and Vertical Approaches?

- Horizontal
  - Broad programs that attempt to reduce all infections due to all pathogens (hand hygiene)

- Vertical
  - More marrow programs that focus on a single pathogen or anatomic site (screening and decolonization)

Wenzel RP et al Intern Journ Infect Dis 2010;14S4:S3+
MRSA Bacteremia: Prevention

- **Reduced transmission**
  - Hand hygiene, isolation precautions, aseptic technique
  - Prevention bundles
  - Environmental cleaning

- **Reduced colonization**
  - Decolonization with CHG bathing ± mupirocin
  - Screening for MRSA carriers with later isolation vs. universal decolonization

- **Reduced ecologic pressure to develop resistance**
  - Antimicrobial stewardship interventions
SHEA/IDSA PRACTICE RECOMMENDATION

Strategies to Prevent Methicillin-Resistant Staphylococcus aureus Transmission and Infection in Acute Care Hospitals: 2014 Update

David P. Calfee, MD, MS;1,a Cassandra D. Salgado, MD, MS;2,a Aaron M. Milstone, MD;3
Anthony D. Harris, MD, MPH;4 David T. Kuhar, MD;5 Julia Moody, MS;6 Kathy Aureden, MS, MT, CIC;7
Susan S. Huang, MD, MPH;8 Lisa L. Maragakis, MD, MPH;3 Deborah S. Yokoe, MD, MPH9
Strategies to Prevent Transmission of Methicillin-Resistant *Staphylococcus aureus* in Acute Care Hospitals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>System to identify patients with MRSA colonization or infection</td>
<td>Y (IB)</td>
<td>ND</td>
<td>Y (IB)</td>
<td>Y (IB)</td>
</tr>
<tr>
<td>Feedback of information to clinicians</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>Y (IB)</td>
</tr>
<tr>
<td>Education</td>
<td>Y (IB)</td>
<td>ND</td>
<td>ND</td>
<td>Y (IB)</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>Y (IA)</td>
<td>Y</td>
<td>Y (IB)</td>
<td>Y (IB)</td>
</tr>
<tr>
<td>Environmental decontamination</td>
<td>Y (IB)</td>
<td>Y</td>
<td>Y (IB)</td>
<td>Y (IB)</td>
</tr>
<tr>
<td>Dedicated equipment</td>
<td>Y (IB)</td>
<td>Y</td>
<td>Y (IB)</td>
<td>Y (IB)</td>
</tr>
<tr>
<td>Contact precautions</td>
<td>Y (IA)</td>
<td>Y</td>
<td>Y (IB)</td>
<td>Y (IB)</td>
</tr>
<tr>
<td>Masks</td>
<td>Y (II)</td>
<td>Y</td>
<td>ND</td>
<td>N</td>
</tr>
<tr>
<td>Cohorting</td>
<td>Y (II)</td>
<td>ND</td>
<td>S (IB)</td>
<td>S (IB)</td>
</tr>
<tr>
<td>Antimicrobial stewardship</td>
<td>Y (IB)</td>
<td>Y</td>
<td>Y (IA-IB)</td>
<td>Y (IB)</td>
</tr>
<tr>
<td>Active surveillance testing</td>
<td>Y (IA-IB)</td>
<td>Y</td>
<td>Y (II)</td>
<td>S (IB)</td>
</tr>
<tr>
<td>Decolonization therapy</td>
<td>S (IB)</td>
<td>S</td>
<td>S (IB-III)</td>
<td>S (IB)</td>
</tr>
<tr>
<td>Compliance with hand hygiene</td>
<td>Y (IB)</td>
<td>ND</td>
<td>ND</td>
<td>Y (IB)</td>
</tr>
<tr>
<td>Compliance with cleaning protocols</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>S (IB)</td>
</tr>
<tr>
<td>Compliance with contact precautions</td>
<td>ND</td>
<td>ND</td>
<td>ND</td>
<td>Y (IB)</td>
</tr>
<tr>
<td>MRSA prevalence or incidence</td>
<td>ND</td>
<td>Y</td>
<td>ND</td>
<td>Y (IA)</td>
</tr>
</tbody>
</table>

**NOTE:** The Society for Healthcare Epidemiology of America (SHEA) guideline and the US Centers for Disease Control and Prevention (CDC) recommendations use the CDC/Healthcare Infection Control Practices Advisory Committee system for categorizing recommendations as follows: IA, strongly recommended for implementation and strongly supported by well-designed experimental, clinical, or epidemiologic studies; IB, strongly recommended for implementation and supported by some experimental, clinical, or epidemiologic studies and a strong theoretical rationale; and II, suggested for implementation and supported by suggestive clinical or epidemiologic studies or a theoretical rationale. N, no (approach not recommended); ND, not discussed; S, approach recommended for use in certain subpopulations or specific circumstances; WIP, Dutch Working Party on Infection Prevention. Y, yes (approach recommended).
I. Basic practices for preventing MRSA transmission and infection: recommended for all acute care hospitals

3. Promote compliance with CDC or World Health Organization (WHO) hand hygiene recommendations (Quality of evidence=II)

4. Use contact precautions for MRSA-colonized and MRSA-infected patients (Quality of evidence=II)

5. Ensure cleaning and disinfection of equipment and the environment (Quality of evidence=II)

6. Educate healthcare personnel (HCP) about MRSA (Quality of evidence=III)

7. Implement a laboratory-based alert system that notifies healthcare personnel of new MRSA-colonized or -infected patients in a timely manner (Quality of evidence=III)

8. Implement an alert system that identifies readmitted or transferred MRSA-colonized or -infected patients (Quality of evidence=III)

9. Provide MRSA data and outcome measures to key stakeholders including senior leadership, physicians, nursing staff, and others (Quality of evidence=III)

10. Educate patients and their families about MRSA (Quality of evidence=III)
Questions from Chat

- Electronic Hand Hygiene monitoring - how that is going for you?
- Patient scorecards for HH compliance?
- Best way to do competency/observation when IPs are so busy?
- At what point can you feel comfortable backing away from isolation of colonized patients?
- How to incorporate Patient and Family Engagement?
- What is the best way to prevent the patient's own MRSA normal flora from causing HAI's and MRSA bacteremia?
FAQ 1 – Hand Hygiene: Should We be Using Automated Measurement Systems?

- e.g. RFID in name badge
- Active/passive sensors

- **PRO:** Prolific amount of data; provider-specific data
- **CON:** Lose real-time correction; bulky ± expensive

Without a process to address low compliance in a professional, accountable manner, you’ll just have more data but no improvement.
FAQ 2 – Hand Hygiene: How Do We Get Physicians Engaged in Hand Hygiene Improvement?

- Engage in planning (e.g. how measure, accountability)
- Rounding
- Partner with nursing leadership
- Identify early champions and highlight wins
FAQ 3 – PPE Compliance: Is There a Better Way to Measure this Besides Direct Observation?

- In short, probably not
- Need to identify not only if used but if used correctly
- Need to track compliance, feedback to end-users/leadership
- Any partners with alternative models of auditing??
FAQ 4 – PPE Compliance: *What’s Competency-Based Training?*

What are your strategies for assessing staff competencies in proper utilization of personal protective equipment (PPE)?

- Direct observation?
- Annual assessment?
- On-line knowledge assessment?
- Mixed approach?
- Other?

Please type into the chat your strategies to ensure staff and physician competencies in the proper use of PPE.
FAQ 5 - How to incorporate Patient and Family Engagement?

- Develop or customize available patient and family education materials and FAQ sheets for use in hospital and community ambulatory care sites.
- Include patients and families on infection prevention improvement committees.
- Process Measure - Percentage of patients infected with MDRO with documented education about infection prevention measures.
FAQ 6 – Isolation: *Do We Need to Isolate for MRSA Anymore?*
Reconsidering Contact Precautions for Endemic Methicillin-Resistant
*Staphylococcus aureus* and Vancomycin-Resistant *Enterococcus*

Daniel J. Morgan, MD, MS;² Rekha Murthy, MD;³ L. Silvia Munoz-Price, MD, PhD;³ Marsha Barnden, RNC, MSN, CIC;³
Bernard C. Camins, MD, MSc;⁴ B. Lynn Johnston, MD, MSc;⁵ Zachary Rubin, MD;⁶ Kaede V. Sullivan, MD;⁷
Andi L. Shane, MD, MPH, MSc² E. Patchen Dellinger, MD;⁸ Mark E. Rupp, MD;⁹ Gonzalo Bearman, MD, MPH¹⁰

**Results.** No high quality data support or reject use of CP for endemic MRSA or VRE. Our survey found more than 90% of responding hospitals currently use CP for MRSA and VRE, but approximately 60% are interested in using CP in a different manner. More than 30 US hospitals do not use CP for control of endemic MRSA or VRE.
Reconsidering Contact Precautions for Endemic Methicillin-Resistant *Staphylococcus aureus* and Vancomycin-Resistant *Enterococcus*

<table>
<thead>
<tr>
<th>Institution (number of hospitals)</th>
<th>MRSA</th>
<th>VRE</th>
<th>C. difficile</th>
<th>MDR-GNR</th>
<th>Year foregoing CP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virginia Commonwealth University MC</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>2013</td>
</tr>
<tr>
<td>University of Massachusetts (2 hospital campuses)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>2010</td>
</tr>
<tr>
<td>Detroit MC (7 hospitals)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Prior to 2003</td>
</tr>
<tr>
<td>Tufts-New England MC</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>2010</td>
</tr>
<tr>
<td>St. Johns MC, Santa Monica, CA</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>2002</td>
</tr>
<tr>
<td>University of Rochester MC</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>2014</td>
</tr>
<tr>
<td>Baylor St. Luke’s MC</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>2005</td>
</tr>
<tr>
<td>UCLA (2 hospitals)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>2013</td>
</tr>
<tr>
<td>University of Nebraska MC</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>2015</td>
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<tr>
<td>San Francisco General Hospital</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Prior to 2002</td>
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<tr>
<td>University of San Francisco MC</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Prior to 2002</td>
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<tr>
<td>Alta Bates MC, Oakland, CA</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>2014</td>
</tr>
<tr>
<td>University of Cincinnati MC</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Prior to 2002</td>
</tr>
<tr>
<td>Oakwood Hospital System, MI (4 hospitals)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Prior to 2013</td>
</tr>
</tbody>
</table>

Hospitals that use gowns and gloves for syndromic indications only (diarrhea, draining wounds)

<table>
<thead>
<tr>
<th>Institution (number of hospitals)</th>
<th>MRSA</th>
<th>VRE</th>
<th>C. difficile</th>
<th>MDR-GNR</th>
<th>Year foregoing CP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baystate Hospitals (multiple hospitals)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>2003</td>
</tr>
<tr>
<td>Dartmouth MC</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Prior to 2003</td>
</tr>
<tr>
<td>Hospitals that use decolonization of patients identified to have <em>S. aureus</em> (including MRSA)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Prior to 2003</td>
</tr>
<tr>
<td>Cleveland Clinic (10 hospitals)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Prior to 2003</td>
</tr>
</tbody>
</table>
Many studies limited by no sole focus on CP (often bundled with other interventions/other changes)

- Before-after study design
- Short LOS misses accurate assessment of acquisition of MDRO
- Short study duration/scoped (ward focused)
- Small sample size/under-powered
- Incorrect measurement of use

Rubin MA et al JAMA 2018;319:863+
The Effect of Contact Precautions on Frequency of Hospital Adverse Events

**Table 3.** Adjusted Rates of Noninfectious Adverse Events Among Patients on Contact Precautions vs Patients Not on Contact Precautions

<table>
<thead>
<tr>
<th>Type of Adverse Event</th>
<th>RR (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noninfectious adverse events*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients on contact precautions vs. not on contact precautions</td>
<td>0.70 (0.51–0.95)</td>
<td>.02</td>
</tr>
<tr>
<td>Prior hospitalization in previous 30 days</td>
<td>1.22 (0.87–1.70)</td>
<td>.25</td>
</tr>
<tr>
<td>Charlson comorbidity score ≥ 2</td>
<td>1.04 (0.75–1.45)</td>
<td>.80</td>
</tr>
<tr>
<td>Male gender</td>
<td>0.73 (0.54–0.99)</td>
<td>.05</td>
</tr>
<tr>
<td>Preventable noninfectious adverse events*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients on contact precautions vs not on contact precautions</td>
<td>0.85 (0.59–1.24)</td>
<td>.41</td>
</tr>
<tr>
<td>Male gender</td>
<td>0.67 (0.46–0.98)</td>
<td>.04</td>
</tr>
<tr>
<td>Charlson comorbidity score ≥ 2</td>
<td>0.89 (0.60–1.33)</td>
<td>.57</td>
</tr>
</tbody>
</table>

*Adjusted for matching by unit of enrollment (surgery/transplant; oncology; general medicine).
Impact of Discontinuing Contact Precautions for Methicillin-Resistant *Staphylococcus aureus* and Vancomycin-Resistant *Enterococcus*: An Interrupted Time Series Analysis

- Quasi-experimental (2011-2016)
- Outcomes: MRSA ands VRE HAI rates
- Interrupted time series analysis (better than pre vs post)
- Contact precautions changes April 2013

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA device associated infection rate per 100,000 patient days</td>
<td>5.19</td>
<td>2.88</td>
<td>.026</td>
</tr>
<tr>
<td>VRE device associated infection rate per 100,000 patient days</td>
<td>9.82</td>
<td>5.62</td>
<td>.003</td>
</tr>
<tr>
<td>Cumulative MRSA and VRE device associated infection rate per 100,000 patient days</td>
<td>15.01</td>
<td>8.50</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>All pathogen device associated infection rate per 1,000 patient days</td>
<td>1.20</td>
<td>0.89</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Note. CP, contact precautions; MRSA, methicillin-resistant *Staphylococcus aureus*; VRE, vancomycin-resistant *Enterococcus*. 

Bearman G et al ICHE 2018;39:676+
Impact of Discontinuing Contact Precautions for Methicillin-Resistant *Staphylococcus aureus* and Vancomycin-Resistant *Enterococcus*: An Interrupted Time Series Analysis

![Graph showing infection rate over time](image-url)
Impact of Discontinuing Contact Precautions for Methicillin-Resistant *Staphylococcus aureus* and Vancomycin-Resistant *Enterococcus*: An Interrupted Time Series Analysis

Bearman G et al ICHE 2018;39:676+
The CDC Weighs In . . .

- "In the past five years, more than a dozen studies, review articles, and editorials have sought to address whether CP should continue to be recommended for endemic MDROs like MRSA. The impact of discontinuing CP for MRSA-colonized or infected patients has been assessed primarily in single-center studies using lower quality quasi-experimental designs that have not identified changes in MRSA infection or acquisition rates. These studies likely underestimate the impact of discontinuing CP, including the effect on downstream adverse events (e.g., post-discharge infections)."

https://www.cdc.gov/mrsa/healthcare/clinicians/index.html
Based on the current evidence **CDC continues to recommend the use of CP for MRSA-colonized or infected patients. CDC will continue to evaluate the evidence on CP as it becomes available. In addition, CDC continues to work with partners to identify and evaluate other measures to decrease transmission of MDROs in healthcare settings.**

https://www.cdc.gov/mrsa/healthcare/clinicians/index.html
Peer Sharing and Expert Coaching

Barb DeBaun, RN, MSN, CIC
Improvement Advisor, Cynosure

Tom Talbot, MD, MPH
Chief Hospital Epidemiologist, Vanderbilt University Medical Center
Peer Sharing and Expert Coaching
Tools and Resources

Lydie Marc, MPH, CHES
Program Manager, HRET
HRET Tools and Resources

- **HRET HIIN website**
  - Change packages
  - Toolkits
  - Webinars
  - Case studies
  - Infographics
  - Guideline
  - Storyboard
  - Reports
  - UP Campaign
MDRO Change Package

- Driver Diagrams
  - Antimicrobial Stewardship
  - Horizontal Precaution to Prevent MDRO transmission
  - Assess need for universal decolonization of ICU patients
  - Patient and Family Engagement
Top Ten Checklist

- Tasks for the:
  - Health care system
  - Health care team
  - PFAC