Michigan Healthcare Associated Infections (HAIs) Crosswalk

MPRO, MHA Keystone Center for Patient Safety & Quality, and the Michigan Department of Community Health SHARP Unit are joining together to work collaboratively on HAIs. The following table maps the HAI initiatives currently being implemented by each of the organizations. This crosswalk provides a quick view of the various elements of each activity including similarities.

	MPRO	MHA-Keystone	MDCH-SHARP Unit
Project timeline	**8/01/2011 to 7/31/2014**		
CAUTI Catheter Associated Urinary Tract Infection			
Overall Goal	Reduce CAUTI rates	Care & Removal and Insertion Bundle: Reduce CAUTI rates through the reduction in the use of urinary catheters and through appropriate catheter insertion	Measure CAUTI rates in Michigan healthcare facilities; Support MPRO & MHA Keystone
Process Measure	Urinary catheter utilization Reduction in the number of urinary catheter days per number of patient days	Care & Removal: Prevalence of urinary catheters Insertion: Prevalence of inappropriately placed catheters in the ED	NA
▪ Data Source	NHSN	MHA Care Counts/Excel	NA
▪ Final Target	Reduction In Rate > or = to 10% number of catheter days per number of patient days	Limited evidence yet as to the "ideal rate of prevalence" we have reduced usage by 25 percent to date.	NA
▪ Baseline Period	2/1/11 – 7/31/11	Care & Removal: Variable beginning January 2007 Insertion: Variable beginning April 2012	NA
▪ Re-measurement Period	To be determined by CMS based upon availability of NHSN data	On-going	NA
Outcome Measure	1. Reduction in rate of CAUTI for a targeted facility compared to the baseline rate of CAUTI cases in that same facility	Care & Removal: • CAUTI rate per patient days • CAUTI rate per device days	CAUTI infection rates & urinary catheter utilization rates. CAUTI SIRs when available through NHSN

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	2. Performance Standardized infection rate (SIR) for each recruited facility	Insertion: • Catheter Placement Rate	
▪ Data Source	NHSN	▪ MHA Care Counts and/or NHSN import (through the DUA from MDCH Sharp)/Excel	NHSN
▪ Final Target	1.Reduction In Rate (RIR) >or = to 25% 2. SIR will be based on the national SIR average to be determined at a later date with the most current national average CAUTI SIR data from NHSN in 2012	40% reduction in overall HACs over 3 years compared to 2010 data	NA
▪ Baseline Period	1. 2/1/11 – 7/31/11 for RIR 2. Standardized infection rate (SIR), does not require a baseline	Year: 2012 – variable months	NA
▪ Re-measurement Period	To be determined by CMS based upon availability of NHSN data	On-going	NA – ongoing surveillance
Other Metrics	▪ CUSP Training ▪ Implementation of Urinary Catheter tracking protocols ▪ Hand Hygiene (HH) protocol ▪ Implement evidence based interventions	▪ Appropriateness of urinary catheters according to the HICPAC / CDC guidelines ▪ Culture of Safety through SAQ, CUSP, and HSOPS	▪ Increase the number and types of facilities providing CAUTI data to SHARP
Reporting Requirements	▪ 6 months of data reported to the NHSN by 10/31/11 for inclusion in target facility baseline data ▪ Confer CAUTI NHSN rights to	▪ Care & Removal: Reported each quarter since January 2007 ▪ Insertion: starting in 2012,	▪ No reporting requirements by SHARP, however, participating facilities must sign a Data Use Agreement (DUA) before voluntarily conferring rights to

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	MPRO and National Coordinating Center (NCC) for quality improvement and benchmarking ▪ Continuously submit CAUTI metrics to NHSN	baseline and implementation monthly, quarterly for sustainability	MDCH SHARP within NHSN ▪ NHSN requires 3 consecutive months of CAUTI reporting when using this module. ▪ CMS requires CAUTIs to be reported by adult & pediatric ICUs in acute care hospitals beginning January 2, 2012, and by long term care hospitals & inpatient rehabilitation facilities by October 2012.
Other	▪ Signed Participation Agreement – Two facility leadership signatures, with one being a member of the Board of Directors ▪ Provide technical assistance to participating facilities ▪ Develop and Implement learning and action networks (LANs) including sharing of best practices	▪ Participation through the On the CUSP: Stop CAUTI National Project, MHA Keystone and/or Health Engagement Network (HEN) ▪ Education on HICPAC Guidelines and CAUTI Surveillance ▪ Coaching calls to share successes and barriers among Michigan HAI teams	▪ Quarterly, semi-annually, and annually measure **aggregated** CAUTI infection rates and urinary catheter device utilization ratios from participating hospitals ▪ Semi-annually, and annually provide individual facility CAUTI infection rates and urinary catheter device utilization ratios to **each** participating hospital ▪ Provide technical assistance to hospitals voluntarily sharing data with SHARP ▪ Monthly conference calls with facilities using NHSN to share updates & provide training on NHSN modules ▪ Provide monthly facility-identified NHSN data reports to MHA Keystone. Reports are for

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			those facilities with have signed the DUA Addendum.
CDI-Clostridium difficile Infection			
Overall Goal	Reduce CDI	We are not actively pursuing a CDI initiative at this time.	20 to 30 acute care facilities and skilled nursing facilities (SNFs) will join the Michigan MRSA/CDI Prevention Initiative to reduce and eventually eliminate MRSA and CDI.
Process Measure	NA	NA	To be determined
▪ Data Source	NA	NA	To be determined
▪ Final Target	NA	NA	To be determined
▪ Baseline Period	NA	NA	To be determined
▪ Re-measurement Period	NA	NA	To be determined
Outcome Measure	Reduction in cases of CDI for a targeted facility as compared to the baseline number of CDI cases for the same facility	NA	Michigan MRSA/CDI Prevention Initiative participants shall use 6 months of baseline data and 18 months of follow up
▪ Data Source	NHSN	NA	Acute care facilities will use NHSN Laboratory-identified (LabID) event. SNFs to be determined
▪ Final Target	Reduction In Rate > or = to 10%	NA	To be determined
▪ Baseline Period	7/ 01/2012 through 12/31/2012	NA	To be determined
▪ Re-measurement Period	To be determined by CMS based upon availability of NHSN data	NA	To be determined
Other Metrics	▪ Develop and implement an antimicrobial stewardship program ▪ Hand Hygiene (HH) protocol ▪ Implement evidence based interventions	NA	▪ Reduced antimicrobial use in collaborative prevention initiative facilities ▪ Number of facilities engaged in MDCH MRSA/CDI collaborative prevention initiative ▪ Number of MRSA and CDI infections prevented across healthcare continuum

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			▪ Number of MRSA/CDI acute care hospitalizations avoided ▪ Assess knowledge level of healthcare personnel on MRSA/CDI
Reporting Requirements	▪ 6 months of CDI baseline data reported to NHSN by 1/31/2013 for inclusion in recruitment of target facility ▪ Targeted facility must meet threshold of facility wide incidence rate = or > than 6 Healthcare Onset (HO) –CDI cases per 10,000 patient days at baseline ▪ Confer CDI NHSN rights to MPRO and National Coordinating Center (NCC) for quality improvement and benchmarking ▪ Continuously submit CDI metrics to NHSN	NA	▪ 6 months of MRSA/CDI baseline data reported to the NHSN and MDCH ▪ Continuous reporting on a monthly base
Other	NA	NA	▪ Letter of application/needs assessment to be sent to potential facilities by mid-January 2012 ▪ Deadline for application February 3, 2012 ▪ Application review by Collaborative by February 14, 2012 ▪ Prevention Initiative kick off

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	MPRO	MHA-Keystone	MDCH-SHARP Unit
			conference in April 20, 2012 ▪ Needs assessment data from hospitals and SNFs focusing on prevention practices on MRSA/CDI will be collected and analyzed to develop training programs and tools ▪ Develop and provide a basic training workshop for acute care facilities and SNFs on reducing and preventing transmission of MRSA/CDI for participating agencies ▪ Provide MRSA/CDI consultation with Infection Prevention expert as needed ▪ Facilities will choose to make MRSA/CDI prevention a priority.
Surgical Site Infection (SSI)			
Overall Goal	To reduce SSI	40% reduction in overall HACs over 3 years compared to 2010 data	Measure SSI rates and SIRs in Michigan healthcare facilities; Support MPRO in their activities
Process Measure	NA	Pre-operative briefing/use of the WHO Surgical Checklist	NA
▪ Data Source	NA	Chart Review	NA
▪ Final Target	NA	95 percent of surgeries have a pre-operative briefing	NA
▪ Baseline Period	NA	January 2008	NA
▪ Re-measurement Period	NA	On-going	NA
Outcome Measure	NA/TBD	SSI Rates for Colorectal Surgery	SSI rates and SIRs (overall and by procedure)
▪ Data Source	NA/TBD	▪ NHSN import (through the DUA	NHSN

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		from MDCH Sharp)	
▪ Final Target	Participation in SSI reduction project or initiative	40% reduction in overall HACs over 3 years compared to 2010 data	NA
▪ Baseline Period	NA	2010 data	NA
▪ Re-measurement Period	NA	Monthly	NA – Ongoing surveillance
Other Metrics	Existing or intended SSI project Start date of the project Number of cases Process or protocol used Measure of Improvement	NA	Increase the number of facilities voluntarily providing SSI data to SHARP
Reporting Requirements	▪ Confer SSI NHSN rights to MPRO for quality improvement and benchmarking	▪ NHSN data will be sent to MHA through the DUA from MDCH Sharp	▪ No reporting requirements by SHARP, however, participating facilities must sign a Data Use Agreement before voluntarily conferring rights to MDCH SHARP within NHSN ▪ NHSN requires that numerator and denominator data on all selected procedure categories be collected for at least one month. ▪ CMS requires the reporting of abdominal hysterectomies and colon surgeries by acute care hospitals, effective January 1, 2012.
Other	NA	Culture of Safety through SAQ, SUSP, and HSOPS	▪ Quarterly, semi-annually, and annually measure **aggregated** SSI rates and SIRs from our participating hospitals ▪ Semi-annually, and annually provide individual facility SSI

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			rates and SIRs to **each** participating hospital ▪ Provide technical assistance to hospitals that voluntarily share data with SHARP ▪ Monthly conference calls with facilities using NHSN to share updates & provide training on NHSN modules
Carbapenem-Resistant *Enterobacteriaceae* (CRE)			
Overall Goal	NA	We are not actively engaged in CRE prevention at this time.	Enroll 20 Acute Care and Long Term Acute Care (LTAC) facilities in the CRE Prevention Initiative with the goal of reducing CRE prevalence
Process Measure	NA	NA	Antibiotic usage in CRE patients - # of doses of certain antibiotics in the X months prior to CRE detection
▪ Data Source	NA	NA	Pharmacy records
▪ Final Target	NA	NA	
▪ Baseline Period	NA	NA	TBD
▪ Re-measurement Period	NA	NA	TBD
Outcome Measure	NA	NA	▪ **Overall prevalence**: # of first CRE isolates per patient for each unit/facility, plus # of patients with history of CRE colonization/infection per 100 patient admissions ▪ **Prevalence density** based on clinical culture (and AST data, if applicable): # of first CRE isolates per patient for each unit/facility plus # of patients with history of CRE

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			colonization/infection per 1,000 patient days
▪ Data Source	NA	NA	TBD (likely NHSN and/or NHSN-like data collection form)
▪ Final Target	NA	NA	Statistically significant reduction in overall CRE prevalence or prevalence density rate
▪ Baseline Period	NA	NA	TBD
▪ Re-measurement Period	NA	NA	TBD
Other Metrics	NA	NA	
Reporting Requirements	NA	NA	Monthly reporting of CRE
Other	NA	NA	▪ Assemble Surveillance Working group (major healthcare systems) – precursor to CRE collaborative ▪ Identify definitions and implement best practice recommendations for CRE Prevention ▪ Assess # of CRE infections prevented across the healthcare continuum ▪ Assess # of CRE acute care hospitalizations avoided
Central Line-Associated Bloodstream Infection (CLABSI)			
Overall Goal	Opted Out: Support MHA Keystone in their activities	Prevention of ICU based CLABSI	Measure CLABSI rates in Michigan healthcare facilities; Support MHA Keystone in their activities
Process Measure	NA	NA	NA
▪ Data Source	NA	NA	NA
▪ Final Target	NA	NA	NA
▪ Baseline Period	NA	NA	NA

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▪ Re-measurement Period	NA	NA	NA
Outcome Measure	NA	CLABSI Rates	CLABSI infection rates, central line device utilization ratio, and SIRs
▪ Date Source	NA	Chart review / NHSN	NHSN
▪ Final Target	NA	0	NA
▪ Baseline Period	NA	2004	NA
▪ Re-measurement Period	NA	Monthly	NA – ongoing surveillance
Other Metrics	NA	NA	Increase the number and types of facilities providing CLABSI data to SHARP
Reporting Requirements	NA	Voluntary reporting of monthly CLABSI rates.	▪ No reporting requirements by SHARP, however, participating facilities must sign a Data Use Agreement before voluntarily conferring rights to MDCH SHARP within NHSN. ▪ NHSN requires surveillance in at least one inpatient location for at least one calendar month. ▪ CMS has required the reporting of CLABSIs in acute care adult, pediatric and neonatal ICUs since January 1, 2011. Beginning October 2012, CMS will also require CLABSI reporting from long term acute care hospitals.
Other	NA	NA	▪ Quarterly, semi-annually, and annually measure **aggregated** CLABSI infection rates and central line device utilization

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			ratios from participating hospitals ▪ Semi-annually, and annually provide individual facility CLABSI infection rates and central line device utilization ratios to **each** participating hospital ▪ Provide technical assistance to hospitals and other healthcare facilities that voluntarily share data with SHARP ▪ Monthly conference calls with facilities using NHSN to share updates & provide training on NHSN modules ▪ Provide monthly facility-identified NHSN data reports to MHA Keystone. Reports are for those facilities which have signed the DUA Addendum
Multidrug-Resistant Organisms (MDROs)			
Overall Goal	NA	Not directly engaged in this activity	Measure MDRO rates in Michigan healthcare facilities
Process Measure	NA	NA	NA
▪ Data Source	NA	NA	NA
▪ Final Target	NA	NA	NA
▪ Baseline Period	NA	NA	NA
▪ Re-measurement Period	NA	NA	NA
Outcome Measure	NA	NA	MDRO LabID and infection surveillance rates (MRSA, C.diff, VRE, CRE, Acinetobacter)
▪ Date Source	NA	NA	NHSN

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▪ Final Target	NA	NA	NA
▪ Baseline Period	NA	NA	NA
▪ Re-measurement Period	NA	NA	NA – ongoing surveillance
Other Metrics	NA	NA	Increase the number and types of facilities providing MDRO data to SHARP
Reporting Requirements	NA	NA	▪ No reporting requirements by SHARP, however, participating facilities must sign a Data Use Agreement before voluntarily conferring rights to MDCH SHARP within NHSN. ▪ NHSN requires 3 consecutive months of MDRO reporting for LabID events and any 3 months within a year for infection surveillance reporting.
Other	NA	NA	▪ Quarterly, semi-annually, and annually measure **aggregated** MDRO LabID and infection surveillance rates from participating hospitals ▪ Semi-annually, and annually provide individual facility MDRO LabID and infection surveillance rates to **each** participating hospital ▪ Provide technical assistance to facilities voluntarily sharing data with SHARP ▪ Monthly conference calls with facilities using NHSN to share updates & provide training on

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	MPRO	MHA-Keystone	MDCH-SHARP Unit
			NHSN modules
Other (Ventilator-Associated Pneumonia, Post-Procedure Pneumonia, etc)			
Overall Goal	NA	Prevent VAP in ICU patients	Measure infection rates in Michigan healthcare facilities; Support MHA Keystone in their activities
Process Measure	NA	Ventilator Bundle including elevation of head of bead >30 degrees, stress ulcer prophylaxis, DVT prophylaxis, trial of weaning and sedition management	NA
▪ Data Source	NA	Daily rounding audit	NA
▪ Final Target	NA	100 percent	NA
▪ Baseline Period	NA	2004	NA
▪ Re-measurement Period	NA	Monthly	NA
Outcome Measure	NA	VAP Rate	Infection rates, ventilator device utilization ratio
▪ Date Source	NA	Chart review	NHSN
▪ Final Target	NA	0	NA
▪ Baseline Period	NA	2004	NA
▪ Re-measurement Period	NA	Monthly	NA – ongoing surveillance
Other Metrics	NA	NA	Increase the number and types of facilities providing data to SHARP
Reporting Requirements	NA	Voluntary reporting.	▪ No reporting requirements by SHARP, however, participating facilities must sign a Data Use Agreement before voluntarily conferring rights to MDCH SHARP within NHSN. ▪ NHSN may have specific reporting requirements.
Other	NA	NA	▪ Quarterly, semi-annually, and annually measure **aggregated** infection rates from our

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			participating hospitals ▪ Semi-annually, and annually provide individual facility infection rates to **each** participating hospital ▪ Provide technical assistance to facilities voluntarily sharing data with SHARP ▪ Monthly conference calls with facilities using NHSN to share updates & provide training on NHSN modules ▪ Provide monthly facility-identified NHSN data reports to MHA Keystone. Reports are for those facilities which have signed the DUA Addendum

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