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WRITE UP YOUR INFECTION CONTROL DEPARTMENT'S BUSINESS-STRATEGIC PLAN

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INFECTION CONTROL DEPARTMENTS

- Before 1970's Infection Control Programs didn't exist or were ignored
- Standards developed in 1960s and 1970s
 - An RN and occasionally an MD identified
 - Little structural change for 20-30 years
- In 1990's standards shift to process and outcomes
 - IC Programs grew and changed
 - Cost control became more important
 - IP responsibility grew
 - Occupational health
 - Quality improvement

FOR MORE INFO...

Soule B, Am J Infect Control 2002;30(2):107-119



VALUE DEMONSTRATION

- Changing policy, regulation and infection concerns along with growing roles of IP and hospital epidemiologists
- Need to be prepared to demonstrate value and respond to change
- Strategic planning
 - Typically put on a shelf and ignored
 - Frequent changes suggest >1yr plans lack utility
 - Perhaps new thinking is needed?



THE STRATEGIC BUSINESS PLAN

- Required component of successful Infection Control Departments
- Used to maintain existing hospital support
- Identify new requirements and opportunities to provide safe care – increase support
- Plans don't always correlate with success
 - Too fancy
 - Too many numbers (need to break even)
 - Aren't linked to needs and opportunities
 - Underestimate employee time!
 - Overly optimistic



OVERVIEW OF A STRATEGIC BUSINESS PLAN

○ Administrative

- Mission Statement and Scope
- Defining Program Goals and Objectives
- Program Assessment

○ Personnel

- Director, Assistant Director
- Infection preventionists, data analysts

○ Infection Control Plan

- Surveillance, environmental monitoring
- Outbreak investigation capacity

○ Integration into organization

- Occupational health, environmental services



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PLAN: STRATEGIC THINKING FIRST

Questions for strategic thinking

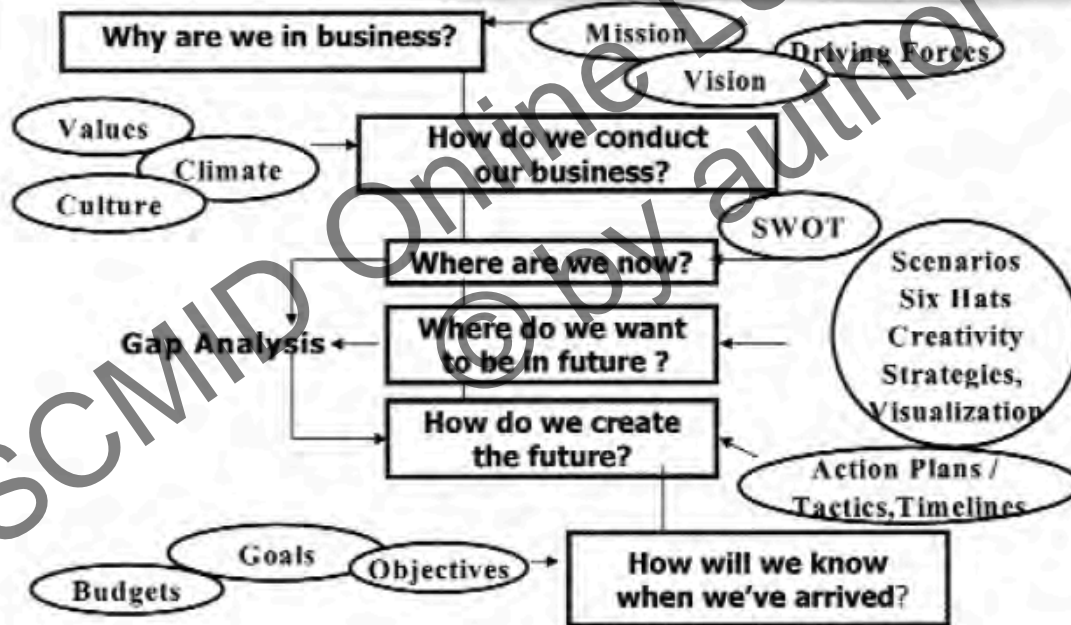


Fig 1. Questions for strategic thinking. (Adapted from Crouch CE. Strategic planning. Available at <http://www.crouchnet.com>. Used with permission.)

FOR MORE INFO...

Soule B, Am J Infect Control 2002;30(2):107-119

FIRST: MISSION STATEMENT

- Why do we exist?
- What is our role in the hospital, system
- Sets general parameters for accomplishing goals
- Begin with open-ended brainstorming
 - Include all those that will carry out plans
- Write, re-write, circulate to the group
 - Have it reviewed by non-involved staff
 - Chief Medical and Nursing Officers

FOR MORE INFO...

Soule B, Am J Infect Control 2002;30(2):107-119



IMPORTANCE OF MISSION STATEMENT

- Goals of the infection control department need to be integrated into the hospital/system's mission statement
- The mission statement should communicate why we are in the business of healthcare epidemiology and infection control



EXAMPLE: MISSION STATEMENT

- Promote the safety of patients, personnel, trainees and visitors
- Decrease the risk for healthcare associated infections (HAIs) to the irreducible minimum by limiting unprotected exposure to pathogens throughout the Health System via a primarily horizontal approach to infection prevention that cuts across all potential pathogens with multipotent interventions
- Minimize the risk of transmission of infections associated with the use of procedures, medical equipment and medical devices
- Provide education and feedback to staff on infection control issues
- Serve as a regional resource and collaborate with public health agencies on infection prevention, and create knowledge in infection control



EXAMPLE #2: MISSION STATEMENT

- “We collaborate with professionals with multiple skills and talents to improve the quality of care and reduce risk to patients, staff, and visitors from nosocomial infections and other noninfectious events”

FOR MORE INFO...

Soule B, Am J Infect Control 2002;30(2):107-119



EXAMPLE #3: MISSION STATEMENT

- To promote awareness of health care workers and coworkers, patient and visitors about the importance of infection prevention and control measures and to make it part of their daily practice to primarily prevent and secondarily contain nosocomial infections, and to ensure a safe working environment for employees and a safe environment for patients.

FOR MORE INFO...

Al Khalidi Medical Center (Jordan) - https://www.kmc.jo/infection_control.html

ANOTHER GOOD EXAMPLE

- “Hospital Epidemiology is a department with expertise in infection control and related disciplines. Our mission is to promote a healthy and safe environment by preventing transmission of infectious agents among patients, staff and visitors. This will be accomplished in an efficient and cost effective manner by a continual assessment and modification of our services based on regulations, standards, scientific studies, internal evaluations and guidelines”

FOR MORE INFO...

Hoffmann K, Infect Control Today, Dec 2000



SCOPE OF PROGRAM

- Provides focus to your plan
- Example:
- Entire Health System—all inpatient and outpatient areas, including off-campus ambulatory sites
- All patients, visitors, healthcare workers and other employees, volunteers, and trainees



PLANNING FOR TODAY

- Program Assessment
- Defining Program Goals and Objectives

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STRATEGIC PLANNING: SWOT

- Strengths
- Weaknesses
- Opportunities
- Threats
- “Situational Analysis”
- Framework
 - Organization: Strengths and Weaknesses
 - External / Internal: Opportunities and Threats



SWOT

- Organized approach to brainstorming
- “Where we are now”
- Must be explicit about what you are analyzing
 - Entire IC Program
 - Individual components (e.g. surgical infections)
- Analysis used to develop strategic and business plans



SWOT DOMAINS

- Administrative
- Clinical
 - MDRO
 - Device Infection
 - Outbreak investigation
 - Pandemic preparedness
 - Public Reporting
- Education
- Infrastructure
- Resources
- Organizational culture



ADDITIONAL CLINICAL CONSIDERATIONS

- Look at specific infections, surveillance
- Internal issues:
 - *C. difficile*, MRSA, cardiac surgery infections
 - Look at past 2-3 year data, recent data
- External threats
 - Pandemic influenza (H7N9)
 - MERS
 - Norovirus



STRENGTHS

Strengths (Internal)

- Offer advantages to the organization?
- Distinct and valuable competencies and expertise?
- What programs/staff do very well?
- Adequate financial resources and support?
- Leader in your area or in organization?
- Well-designed program and functions?
- Good reputation in organization?
- Access to and use of economies of scale?
- Clear value to organization?

FOR MORE INFO...

Soule B, Am J Infect Control 2002;30(2):107-119



WEAKNESSES

Weaknesses (Internal)

No clear strategic direction?

Decreasing or lack of adequate financial support?

Limited opportunity to participate fully in organizational decisions?

Missing any key skills or competencies?

Poor track record in realizing results?

Internal operating problems?

Vulnerable to competitive pressures?

Services too narrow?

Weak organizational image?

Competitive disadvantage in the organization?

FOR MORE INFO...

Soule B, Am J Infect Control 2002;30(2):107-119

OPPORTUNITIES

Opportunities (External)

Expand or change services to meet broader range of customer needs?

Serve additional customer groups?

Diversify into new areas?

Changes in technology?

New or changed governmental policy or guidelines related to field?

Changes in population demographics that affect work?

FOR MORE INFO...

Soule B, Am J Infect Control 2002;30(2):107-119



THREATS

Threats (External)

Competition for functions or resources?

Required skills for job, services changing?

Growing competitive pressures in health care organization or system?

Changing customer preferences, needs?

Changes in technology threatening program?

Downsizing? Re-engineering?

Lack of support for program?

Regulatory or compliance issues?

FOR MORE INFO...

Soule B, Am J Infect Control 2002;30(2):107-119



SWOT EXAMPLE, SMALL SOUTH AFRICAN HOSPITAL

Threats

- *Cholera in population – many patients tapping into resources*
- *Only hospital in 50 km radius*
- *Performance review indicates knowledge/skills gaps regarding caring for patients with cholera*
- *Small complement of staff on the establishment – no resources in the community if anyone falls ill*

Opportunities

- *Cholera in population – many clients requiring beds*
- *Only hospital in 50 km radius*
- *Developing unique unit-specific training regarding community care for cholera patients to supplement to keep patients out of hospital*
- *Education of staff and training of care workers*

Weaknesses

- *Cholera in population – staff members could succumb*
- *High levels of patients with HIV infection already occupy beds in the hospital, but could also succumb to cholera*
- *Many single-parent families among staff – sick children might keep staff members home*
- *Only hospital in 50 km radius – no facility to refer surplus patients to*

Strengths

- *Dedicated staff, specialised and specially trained to care for patients with cholera during disaster management*
- *Mentor or facilitator system, willing to provide “by-the-bedside” support for colleagues who work long hours*
- *Policies and disaster procedures are in place to supplement the normal functioning of the hospital*
- *A hospital disaster plan has been developed to allow minimum staff to care for maximum patients*
- *A supportive public health (clinic) service exists in the community*

FOR MORE INFO...

Ziady L, Professional Nursing Today, 2009



RECOMMENDATIONS FROM SWOT

- TOWS Matrix Tool
- Allows SWOT to generate action plans
- Shows relationship between internal and external factors
- First, list each strength, weakness, opportunity and threat
- Then match:
 - strengths with opportunities
 - strengths with threats
 - weaknesses with opportunities
 - weaknesses with threats



TOWS MATRIX

Table 1 The TOWS matrix model.

Strengths

Opportunities

S-O strategies

(Pursue opportunities that are good fit with strengths)

Make use of the new communication channels to explain and justify prioritization decisions.

Threats

S-T strategies

(Identify ways to use strengths to reduce vulnerability to threats)

Assign role of caring for the needs of the elderly or vulnerable to a staff member within the incident command structure.

Weaknesses

W-O strategies

(Overcome weaknesses to pursue opportunities)

Direct a portion of new government investment towards refining old technologies.

W-T strategies

(Establish defensive plan to prevent weaknesses from making policies susceptible to threats)

Legal/licensing sanctions against physicians who provide vaccine to non-priority individuals in the face of rationing crises.

S, strengths; W, weaknesses; O, opportunities; T, threats.

FOR MORE INFO...

Uscher-Pines Public Health 2008 122:183-191

PAIRING STRATEGIES

- Strength-opportunity: guide the Department towards missions that play to its strength
 - Hand hygiene in main acute care hospital at high levels – export toolkit and implementation skills to community hospital to improve hand hygiene
- Weakness-opportunity: investment here can lead to new opportunities
 - CLABSI rates high, investment in antimicrobial catheters could lead to drastic improvements in 2014



PAIRING STRATEGIES

- Strength-threat: Identify ways to use existing ability to hold off threats
 - High rates of employee vaccination against seasonal influenza through existing collaboration with employee health – well prepared for possible H7N9 or MERS vaccine distribution
- Weakness-threat: Plan to invest in highly vulnerable areas
 - Low levels of respirator (N95 mask) fit testing leave staff vulnerable to novel respiratory pandemics – invest in staffing to increase fit testing, purchase PAPRs (Powered Air Purifying Respirator)



LINKING TO STRATEGIC BUSINESS PLAN

- Each of these pairings is a potential highlight or ask in your business and strategic plan
- Highlights – what makes you look good
- Ask – maintain or increase hospital support; identify philanthropic donors



PLANNING FOR THE FUTURE

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SCENARIO PLANNING

- “Disaster planning” on paper to rehearse and avoid surprises, prepare
 - What can we do **right now**
- Identify trends
 - Surveillance – unit closure from MDRO GNRs
 - Media Reports – MERS, pandemic influenza, Ebola
- Key uncertainties
 - Availability of N95 masks or vaccine in pandemics
 - Staffing issues during pandemic
 - PPE donning/doffing training
- Timeframe: 1 year (for annual strategic plan)



STEPS FOR SCENARIO DEVELOPMENT

- Identify major stakeholders affected
 - Community, University
- Delineate future trends
 - Perform research as needed to validate trends
 - Surveillance
- Identify important future uncertainties
 - New technology, new government mandates
- Construct and use scenario themes



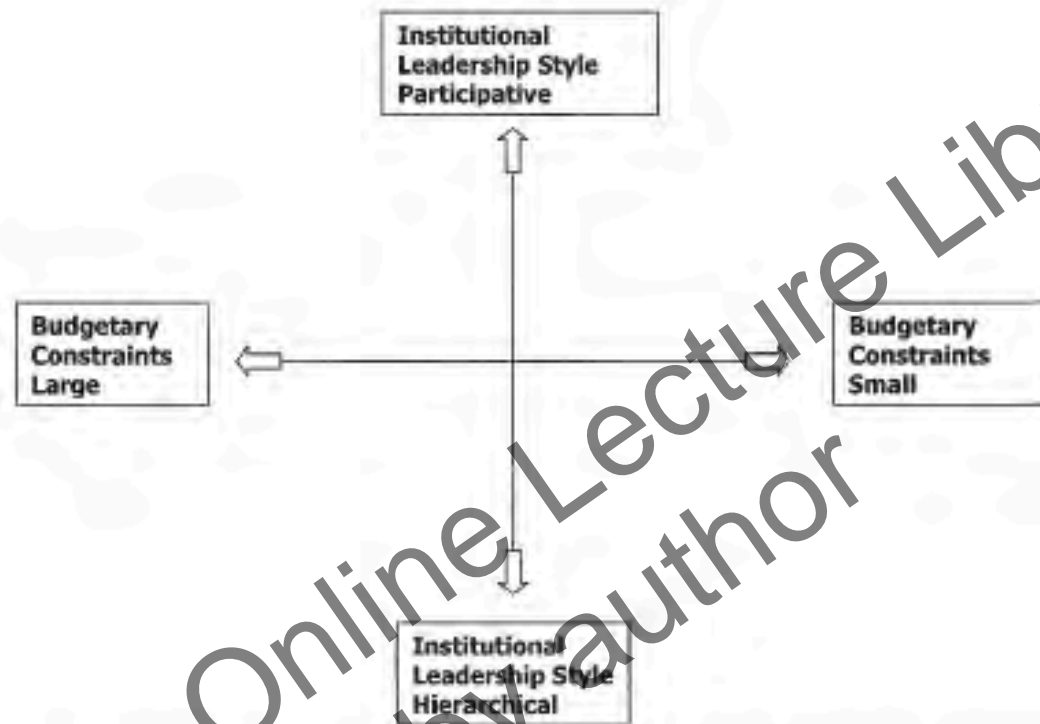


Fig 2. Model for scenario planning. Possible futures for an ISPC program with 2 future uncertainties on crossed continuums: budgetary constraints and institutional leadership style. Select 1 quadrant with 2 of the possibilities, and develop a scenario of what the future would look like if they were to become realities. Consider the scenario for planning and ISPC future as related to departmental function and structure, regulatory compliance, hiring a new epidemiologist, availability of computer and staff resources, interventional methodologies, new scientific information, and other variables.

FOR MORE INFO...

Soule B, Am J Infect Control 2002;30(2):107-119

ISSUES WITH SCENARIO PLANNING

- Can lead to worst case assessment
 - Pessimistic approach overcome through incorporating probability
- Can take significant amounts of time
 - Takes away from daily surveillance and educational responsibilities
- Staff not always willing to contribute opinions



BRIDGING SCENARIOS TO ACTION

- Gap Analysis

- 4 Steps

1. Identify an existing weakness, issue or goal
 - High CLABSI rates of 4.2/1000 catheter-days
2. Describe desired future
 - CLABSI rate less than 1.5/1000 catheter-days
3. Outline the Gap between current reality and future
 - 2.7 CLABSI per 1000 catheter-days
4. Identify steps necessary to close the Gap
 - Low bundle compliance must be increased
 - Improved bundle tracking requires IT modification
 - Purchase CHG patches for exit site



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THINGS IGNORED IN BUSINESS PLANS

- The People
 - Don't forget who you are and what your strengths are
 - You are smart and could be recruited by other facilities
- Opportunities
 - What you can do to make the hospital/system better and safer
 - How “we” can become a leader in safe hospitals
- Context
 - What is changing in the regulatory environment or society
 - “Safety Culture”
 - Public Reporting, Pay for performance



THE PERSONNEL

- CEO at University:
- “I am not investing in an infection control department, I am investing in you and your team”
- First part of your business plan should be to get your CVs in order
 - For each member of your team
 - Years of experience, education, certification
 - Local, national leaders
 - Past success = future success, mention track record



INFECTION CONTROL TEAM

- Epidemiology
- Statistics
- Patient care experience
- Occupational Health
- Disinfection, Sterilization
- Environmental Services
- Infectious Diseases
- Microbiology
- Education
- Management



SWOT LINKED TO PERSONNEL

- SWOT at University of Maryland
- Identified need for increased staffing
- In FY09 we added additional staffing into our annual strategic plan with justification section



OVERALL JUSTIFICATION OF ASKS

- The aim is to take an already strong infection control program to the next level. We have consulted with the two leading infection control quality models in the US (Duke and Washington University). We have had meetings with their hospital epidemiologists and directors of infection control. We have discussed details of their model including physician and infection control practitioner FTE per hospital bed and services provided, reporting structure and dollar amounts provided by the respective hospitals. Our requests are based upon these discussions, an internal audit of our already provided services and our experience functioning as associate hospital epidemiologist at UMMC



JUSTIFICATION FOR NEW STAFF SUPPORT

- Aim: Provide a 24 hours a day infection control program
- Based hospital size and current services provided, a physician salary of 1.5 FTE plus benefits distributed across 2-4 physicians will provide more optimal supervision, support and ability to meet goals. Each physician will directly collaborate with an assigned infection control professional. This will lead to better implementation and buy-in of infection control interventions.
- The addition of a ½ time programmer is requested so that we can better access the Central Data Repository for quality improvement and meet the additional needs of public reporting to the Department of Public Health



PERSONNEL

- Physician service contract: of \$XXX,XXX dollars including fringe benefits for faculty support (hospital epidemiologist and associate hospital epidemiologists) salary support and 24/7 coverage of infection control. This amount will have a 5% cost of living adjustment annually.
- Salary support for Director of UMMC infection control (Senior RN, CIC, MPH with 30 years experience)
- Salary support for 4 infection control professionals (2 senior infection control professionals and 2 infection control professionals) – request for 1 additional senior ICP above current staffing
- Full-time administrative assistant- request for additional 0.5 FTE above current staffing
- ½ time programmer with upper-level computer skills including SQL and PSQL programming that can directly access the Central Data Repository – new request
- ½ time data analyst



ORGANIZATIONAL STRUCTURE

- The program will be a distinct department of UMMC. The hospital epidemiologist and the Director of UMMC infection control will report directly to the Chief Medical Officer. The Director of UMMC infection control will also have dotted-line accountability as a director to the senior vice-president of patient care services and the Chief Nursing Officer
- Include Organization Chart



D. Infection control coverage chart:

Sr. ICP 1 Locations	Sr. ICP 2 Locations	ICP 3 Locations	ICP 4 Locations
<p>Women's and Children's Health – includes NICU and PICU, pediatric diagnostic testing areas, pediatric ambulatory clinics Labor and Delivery Full-term Nursery Pediatric Emergency Room Pediatric PACU EMS liaison In-patient medical units <u>units</u></p>	<p><u>Perioperative Services:</u> Operating Rooms Main PACU Same Day Surgery Prep Center Interventional Radiology Cardiac Cath EP Lab Central Sterile Processing MDC and PDC SICU NCICU CTICU In-patient surgical units</p>	<p>Shock Trauma Center: 3 ICUs and 3 <u>IMCs</u>, PACU, OR, clinic Bronchoscopy Suite</p>	<p>Medicine: includes MICU, CCU and <u>IMCs</u> Oncology inpatient and outpatient clinics Endoscopy Suite Psychiatry – inpatient and outpatient Adult ED</p>
<p>Duties: Surveillance for BSI, MRSA metrics, focused review of C-section surgical site infections JCAHO compliance: mock tracers, policy and procedure development and revision to include toy cleaning, pet therapy, dietary (mgm't of infant formulas, breastfeeding) Review Infection Control Risk Assessments for all facility projects in areas of responsibility Emergency Preparedness EOC representative Representative for Quality forums for areas of responsibility</p>	<p>Duties: Surveillance - focused review of surgical site infections for identified services JCAHO compliance: mock tracers, policy and procedure development and revision to include all sterilization processes and anesthesia practices; ensure standardization of practices in the diagnostic testing areas Review Infection Control Risk Assessments for all facility projects in areas of responsibility Value Analysis representative – <u>Peri-op</u> and Critical Care Representative for Quality forums for areas of responsibility</p>	<p>Duties: Surveillance for BSI and MRSA metrics for STC and SICU, NCICU and CTICU JCAHO compliance: mock tracers, policy and procedure development and revision to include all of STC and <u>bronchoscopy</u> Review Infection Control Risk Assessments for all facility projects in areas of responsibility Representative for Quality forums for areas of responsibility</p>	<p>Duties: Surveillance for BSI and MRSA metrics for areas of responsibility JCAHO compliance: mock tracers, policy and procedure development and revision to include psychiatry, oncology, and endoscopy Review Infection Control Risk Assessments for all facility projects in areas of responsibility Representative for Quality forums for areas of responsibility</p>



**INFECTION CONTROL STAFF
COMMITTEE PARTICIPATION**

Committee	Frequency of meetings	IC Representative (as of Nov 2007)
Executive Infection Control Committee	6-7/year	All
Value Analysis Oversight	Monthly	<u>Hebden/Standiford</u>
Medical Supply/Perioperative Services/Critical Care Value Analysis	Monthly x 3	<u>Hebden</u>
Environment of Care	Monthly	<u>Hebden</u>
Space Planning	Biweekly	<u>Hebden</u>
Employee Health Work Group	Monthly	<u>Hebden/Standiford</u>
Clinical Practice Committee	Monthly	<u>Hebden</u>
Clinical Practice Workgroup	Monthly	<u>Hebden</u>
JCAHO Oversight	Monthly	<u>Hebden</u>
Pharmacy and Therapeutics Committee	Monthly	<u>Standiford</u>
Antimicrobial Subcommittee of P&T	Monthly	<u>Standiford</u>
Performance Improvement Committee	Monthly	<u>Hebden/Standiford</u>
Emergency Preparedness Workgroup	Monthly	<u>Standiford</u>
Pediatrics Quality	Quarterly	Fuss
NICU Committee	Monthly	Fuss
PICU Committee	Monthly	Fuss
Pediatrics Operations	Ad hoc	Fuss
Transplant Operations	Quarterly	<u>Hebden/Standiford</u>
Orthopaedics Quality	Quarterly	<u>Fuss/Standiford</u>
Patient Safety Team	Twice monthly	Fuss
Medicine Quality	Quarterly	<u>Hebden</u>
Medicine Performance Improvement Team	Monthly	<u>Hebden/ Standiford</u>
MICU Committee	Monthly	<u>Hebden/Standiford</u>
Neurosurgery Quality	Quarterly	<u>Standiford</u>
NSICU Committee	Monthly	<u>Hebden</u>
Surgery Quality	Monthly	<u>Hebden</u>
Surgical Critical Care Operations	Monthly	<u>Hebden/Standiford</u>
Cardiac Surgery Quality	Quarterly	<u>Hebden/Standiford</u>
Shock Trauma Center ICU Quality	Monthly	<u>Hebden</u>
SICU Quality Committee	Monthly	<u>Hebden/Standiford</u>
Vascular Surgery Quality	Quarterly	<u>Hebden</u>
General Surgery	Quarterly	<u>Hebden</u>
Medical Executive Committee	Monthly	<u>Standiford</u>



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INFECTION CONTROL PLAN

- List and rank specific Goals/Targets
- List current year position for that goal
- List next years target for that goal
- Identify specific action items to meet the new goal including existing strengths and planned improvements identified in the SWOT and Gap analysis
- List specific metrics and outcomes that will be tracked (surveillance) to document accomplishment of the Goal/Target



○ Acknowledgement:

- Mike Edmond, VCU Medical Center, Virginia

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GOALS

- **Enhance compliance with hand hygiene**
 - Rank #1
- **Reduce central line associated bloodstream infections (CLABSI)**
 - Rank #2
- **Reduce surgical site infections**
 - Rank #3
- **Maintain environmental hygienic standards and appropriate sterilization processes**
 - Rank #4
- **Monitor for and rapidly control infectious disease outbreaks**
 - Rank #5



GOAL #1: ENHANCE COMPLIANCE WITH HAND HYGIENE

- Context:
 - Most effective means for reducing the transmission of nosocomial pathogens
 - Studies in the literature on average demonstrate suboptimal HH compliance by HCWs
- 2012 Level: 85%
- 2013 Target: 95%



GOAL #1: STRATEGIES TO MEET HH GOAL

- Educate healthcare workers through multiple venues
- Monitor HH compliance monitoring with a team of roving monitors, ICU observations by ICPs, and unit self observations
- Feedback hand hygiene compliance rates
- Empower patients to ask HCWs to wash their hands; includes a video for patients available in patient rooms
- Ensure convenient placement of alcohol-based hand rubs
- Bare Below the Elbows Campaign ongoing
- New HH signs/prompts in the clinical environment
- Explore potential implementation of new HH monitoring technologies



GOAL #1: METRICS -PROCESS OR OUTCOME

- HH compliance rates stratified by location, job category and date/time of observation
- Unit-based HAI rates

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GOAL #3: REDUCE SURGICAL SITE INFECTIONS (SSI)

- Context: Development of SSIs for some procedures can be associated with high rates of morbidity and mortality

	2013	2014 Target
CT Surgery	2.2%	1.1%
Neurosurgery	1.1%	0.9%
Hip and Knee	1.2%	0.6%



GOAL #3: STRATEGIES TO MEET GOAL

- Provide concurrent surveillance for SSIs in cardiothoracic surgery, neurosurgery, orthopedic surgery, laparoscopic cholecystectomy, colon surgery, total abdominal hysterectomy
- Provide appropriate and timely perioperative antimicrobial prophylaxis
- Practice appropriate hair removal
- Use chlorhexidine as preoperative skin prep
- Warm patients postoperatively
- Control blood glucose in cardiac surgery patients
- Decolonize cardiac surgery, neurosurgery, joint replacement patients harboring MRSA prior to surgery
- Appropriate urinary catheter discontinuation
- Feed back of process and outcomes metrics to surgeons, OR staff and anesthesiologists
- Chlorhexidine bath for all preoperative patients immediately prior to procedure



GOAL #3: METRICS

- Outcome:
 - SSI rates for selected procedures
- Process:
 - Rates of appropriate perioperative antibiotic selection, preoperative dosing within 60 minutes of incision, discontinuation within 24 hours of surgery's end (exception: cardiothoracic surgery within 48 hours), appropriate hair removal, post-operative normothermia, use of chlorhexidine as skin prep, glucose control in CT surgery patients, and appropriate foley catheter discontinuation



GOAL #5: MONITOR FOR AND RAPIDLY CONTROL INFECTIOUS DISEASE OUTBREAKS

- Context: Rapid detection of outbreaks and prompt control reduces morbidity and mortality
- Planned preparatory activities:
 - Concurrent surveillance for HAIs as well as microbiologic surveillance to quickly identify clusters of infections
 - Investigate reports from providers (sentinel surveillance)
 - Communication with local and state health department
 - Test potable water at least yearly for presence of pathogenic *Legionella* species



OTHER THINGS TO INCLUDE

- Education roles
 - New employees
 - Annual training
 - Facility and System outreach
 - List employee time spent on each activity
- Policies and procedures (Manual)
 - List all documents that infection control is responsible for
 - List date of last update
 - List which documents will be updated this year
- Regulatory Compliance
 - List mandatory reporting requirements and estimated time spent on each activity



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ANNUAL REPORT

- Follows directly from annual strategic plan
 - Mission Statement
 - Scope
 - Summary of Key Accomplishments (lower infections)
 - Since you started program
 - In last year
 - List major interventions
 - Summary of 5-10 year trends of each goal/target with focus on recent targets



KEY ACCOMPLISHMENTS

- 88% reduction in bloodstream infections over the past 9 years
- 16% reduction in joint implant infections over the past 6 years
- 67% reduction in cardiothoracic surgical site infections over the past 6 years
- Hand hygiene compliance exceeding 90% for the past 4 years



MAJOR INTERVENTIONS

- 2004 - Hand hygiene campaign
- 2006 - Central line insertion bundle
- 2007 - Chlorhexidine bathing of ICU patients
- 2009 - "Wash up, wipe down" and "bare below the elbows" campaigns
- 2011 - Implementation of urinary catheter bundle
- 2012 - Chlorhexidine bathing outside of ICUs

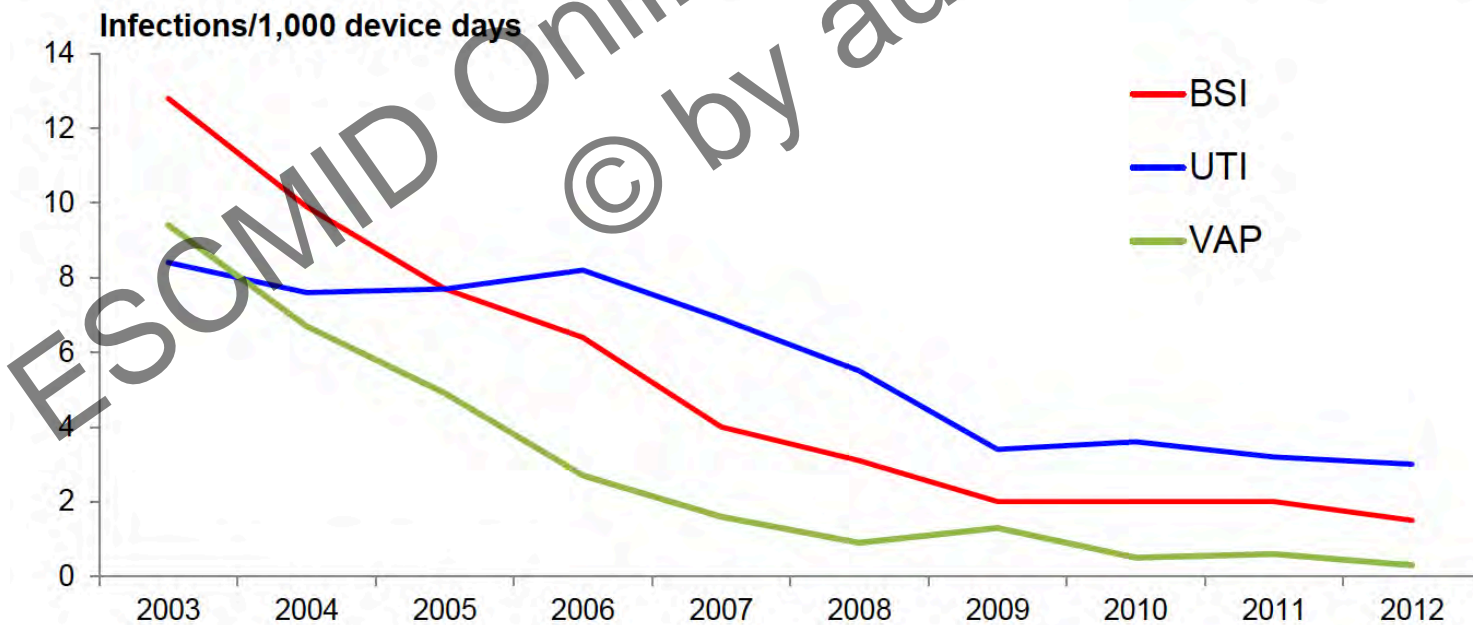


ANNUAL TRENDS

Device Associated HAIs, Adult ICUs

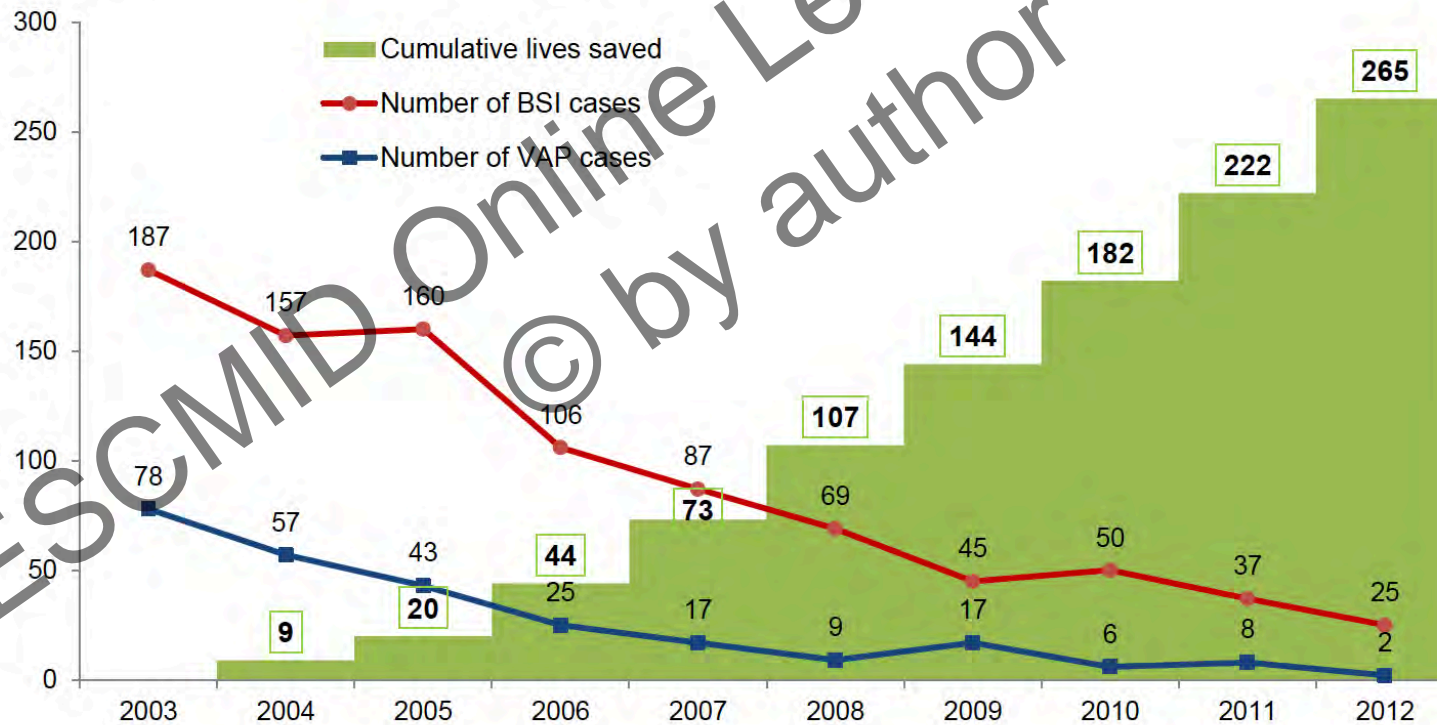
Infections/1000 device days

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Change since 2003
BSI	12.8	9.9	7.7	6.4	4.0	3.1	2.0	2.0	2.0	1.5	88% reduction
UTI	8.4	7.6	7.7	8.2	6.9	5.5	3.4	3.6	3.2	3.0	64% reduction
VAP	9.4	6.7	4.9	2.7	1.6	0.9	1.3	0.5	0.6	0.3	97% reduction



PROGRAM VALUE

Estimated Lives Saved Over 9 Years
By Preventing Device Associated Infections in Adult ICUs



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THANK YOU

- Mike Edmond, MD MPH MPA
 - University of Iowa Carver College of Medicine
- Barbara Soule, RN MPA, CIC
 - Providence St. Peter Hospital, Olympia, WA
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