



Healthcare Quality Reporting Program

**HOSPITAL-ACQUIRED INFECTIONS AND PREVENTION ADVISORY SUBCOMMITTEE**

8:00-9:00am, May 23, 2011

Department of Health, Room 401

**Goals/Objectives**

- To discuss HAI work to date and make policy recommendations for pending and upcoming reports

**Members**

T Nicole Alexander, MD	T Maureen Marsella, RN, BS	T Janet Robinson, RN, Med, CIC
T Rosa Baier, MPH	T Linda McDonald, RN	G Melinda Thomas
G Utpala Bandy, MD	T Leonard Mermel, DO, ScM	T Georgette Uttley, MEd, BSN, RN
G Margaret Cornell, MS, RN	T Pat Mastors	T Nancy Vallande, MSM, MT, CIC
T Marlene Fishman, MPH, CIC	T Robin Neale, MT (ASCP), SM, CIC	G Cindy Vanner
T Yongwen Jiang	T Kathleen O'Connell, RN	T Samara Viner-Brown, MS
T Julie Jefferson, RN, MPH, CIC	G Lee Ann Quinn, RN, BS, CIC	

**Time**

**Topic/Notes**

8:00am **Welcome & Administrative Updates**

*Leonard Mermel, DO, ScM*

- Len opened the meeting and reviewed today's objectives, which included reviewing the 5-day preview report for Q1 2011 MRSA CLABSI data (the first report).
- Previous meeting's action items:
  - **Create mock data reports by ICU and facility** (Rosa/Rachel) – **Complete**  
Rosa and Rachel created mock data reports (with fake hospitals and data) that were distributed with the voting link.
  - **Vote on mock-up data reports** (Voting Members) – **Complete**  
Of the 21 Voting Members of the Subcommittee, 14 voted:
    - o 57.1% (n=8) voted to keep the consumer report stratified by ICU type.
    - o 42.9% (n=6) voted to calculate facility diamonds and link to the Methods report for stratified results.
  - **Provide feedback on the data submission template by 5/4** (All) – **Complete**  
Rosa and Rachel incorporated all feedback into the CLABSI, MRSA CLABSI and C. Difficile data submission links:
    - o MRSA CLABSI: <https://www.surveymonkey.com/s/HospitalCLABSI-MRSA>
    - o C. Difficile: <https://www.surveymonkey.com/s/HospitalCDifficile>
    - o CLABSI: <https://www.surveymonkey.com/s/HospitalCLABSI>

Ann will send the links with her data submission reminders, which go out four weeks and two weeks before each quarter's deadline.

8:10am **MRSA CLABSI Preview Report**

*Rachel Voss, MPH*

*Rosa Baier, MPH*

- Rosa shared the mock report voting results (see action items), which reinforced the Subcommittee's prior recommendation to provide consumers with diamonds stratified by ICU type.
- The group reviewed copies of the 5-day preview period, which Ann will distribute formally after the meeting (along with the CLABSI preview report). Once Ann's email is sent, the 5-day period begins. Hospitals can correct any errors or submit data (if they did not previously). Hospitals that submit data during the 5-day preview period will not have another opportunity to preview the report before it is published.
- Participants discussed the preview report, focusing on how to display data for ICUs without a national comparison (i.e., the expected rate). Discussion focused on:
  - o How to group these ICUs (as separate tables or at the end of the report)
  - o If/how to calculate diamonds when these ICUs have rates of 0%
  - o What is meaningful for consumers
  - o What is statistically valid
- **Votes:** The Subcommittee voted to:
  - o Group ICUs without NHSN comparison data together, after the data tables (Yes – 12, N – 0, Abstain – 1).
  - o Include language about how rates of 0% are the lowest-possible score, even if there is no comparison data for SIRs (Y – 12, N – 1, A – 1).

8:45am ***C. difficile* Pilot**

*Rosa Baier, MPH*

*Leonard Mermel, DO, ScM*

- Rosa asked for any thoughts or questions about the *C. Difficile* pilot. The report template is ready for the pilot data (due 8/11). Diamonds will be calculated based on the state average, similar to the hospital pressure ulcer methodology.
- Gina reminded the group that, although some hospitals indicated previously that they might submit pilot data via NHSN, the module is not currently available. In lieu of the ability to submit to NHSN, pilot data (Q2 2011) at:  
<https://www.surveymonkey.com/s/HospitalCDifficile>
- Ann will send reminders four weeks and two weeks before the deadline, with the CLABSI and MRSA CLABSI reminders.

8:55am **Action Items & Next Steps**

*Rosa Baier, MPH*

- During the open forum, participants raised two topics:
  - o As an FYI, Nicole and Len shared information about a grant that HEALTH is submitting, which seeks to partner with pharmacy vendors to collect data antibiotic use in an automated way. This is the first step towards assessing antibiotic pressure and furthering efforts around antibiotic stewardship, which is a topic that the HAI Collaborative has discussed.

- Georgette asked for people's thoughts about the *Partnership for Patients* videos that Maureen distributed to the HAI Collaborative distribution list. Those who had seen them expressed concern that the videos shifted responsibility from providers to visitors and provided some potentially incorrect information about the use of hand sanitizer vs. hand washing.
- **Action items:**
  - Share any recent NHSN benchmarks with Rachel or Rosa (All)
  - Provide feedback on the MRSA CLABSI preview report (Hospitals)
  - Update the MRSA CLABSI report based on today's votes (Rachel/Rosa)
  - Share the *Partnership for Patients* videos with the Subcommittee (Rosa/Maureen)
  - Perform periodic reporting scans, as directed by the Subcommittee (Rachel/Rosa)
- Next meeting: 7/25/11      (June meeting cancelled)



Healthcare Quality Reporting Program

**METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) BLOODSTREAM INFECTIONS**

Care Outcomes Report, January-March 2011

MRSA bloodstream infections are reported on the [Department of Health's \(HEALTH's\) Web site](#). Diamonds are assigned based on how different each hospital's performance is from other hospitals nationally:

- Better than expected
- About the same as expected
- Worse than expected

You can learn more about the MRSA bloodstream infections report by reading the Methods. It includes more information about the data and why this information is important. If you have questions about a hospital's performance, please contact that hospital directly by clicking on each hospital's name.

MRSA bloodstream infections may be preventable with proper care, but some hospitals may have higher rates even if they provide good care. For example:

- There may be more MRSA bloodstream infections in hospitals that care for more patients who have had antibiotics recently, come from nursing homes, or who have diabetes. Patients who are often in the hospital are also at greater risk.
- Some hospitals may have higher rates if they test more patients for infections. They may be more likely to find or diagnose infections.

MRSA bloodstream infections are caused by a kind of bacteria that can enter the body in many ways. Hospitals in Rhode Island report MRSA bloodstream infections that their intensive care patients get through their central lines (a kind of [catheter](#), or medical tube). MRSA bloodstream infections are also called MRSA central line-associated bloodstream infections, or MRSA CLABSI.

The diamonds show you how hospitals compare to one another\*

**Table 1:** MRSA Bloodstream Infections in Coronary Critical Care Units (CCUs)

Hospital ICU (Alphabetical)	Diamonds
<a href="#">Miriam Hospital</a>	——
<a href="#">Rhode Island Hospital</a>	——

**Table 2:** MRSA Bloodstream Infections in Medical Intensive Care Units (MICUs)

Hospital ICU	Diamonds
<a href="#">Rhode Island Hospital</a>	——

\*Statistical methods are described in the Methods (separate document).

The diamonds show you how hospitals compare to one another\*

**Table 3:** MRSA Bloodstream Infections in Medical/Surgical Critical Care Units (ICUs) at Major Teaching Hospitals

Hospital ICU (Alphabetical)	Diamonds
<a href="#">Kent County Hospital</a>	----
<a href="#">Memorial Hospital</a>	----
<a href="#">Miriam Hospital</a>	----
<a href="#">Providence Veteran’s Affairs Medical Center</a>	x
<a href="#">Roger Williams Medical Center</a>	----

x This hospital did not report data for this unit.

**Table 4:** MRSA Bloodstream Infections in Medical/Surgical Critical Care Units (ICUs) at All Other (Non-Teaching) Hospitals

Hospital ICU (Alphabetical)	Diamonds
<a href="#">Landmark Medical Center</a>	----
<a href="#">Newport Hospital</a>	----
<a href="#">Our Lady of Fatima Hospital</a>	----
<a href="#">South County Hospital</a>	x
<a href="#">Westerly Hospital</a>	----

x This hospital did not report data for this unit.

**Table 5:** MRSA Bloodstream Infections in [Women & Infants Hospital’s](#) Level III Neonatal Intensive Care Units (NICU), by Birthweight

Birthweight (Grams)	Diamonds
<750 grams	n/a
751-1,000 grams	n/a
1,001-1,500 grams	n/a
1,501-2,500 grams	n/a
>2,500 grams	n/a

n/a There is no national comparison for this kind of unit.

**Table 6:** Umbilical Catheter-Associated MRSA Infections at [Women & Infants Hospital’s](#) Level III NICU, by Birthweight

Birthweight (Grams)	Diamonds
<750 grams	n/a
751-1,000 grams	n/a
1,001-1,500 grams	n/a
1,501-2,500 grams	n/a
>2,500 grams	n/a

n/a There is no national comparison for this kind of unit.

\*Statistical methods are described in the Methods (separate document).

The diamonds show you how hospitals compare to one another\*

**Table 7:** MRSA Bloodstream Infections in Neurosurgical Intensive Care Units (INCs)

Hospital ICU	Diamonds
<a href="#">Rhode Island Hospital</a>	n/a

n/a There is no national comparison for this kind of unit.

**Table 8:** CLABSI Ratings among Pediatric Medical/Surgical Intensive Care Units (PICUs)

Hospital ICU	Diamonds
<a href="#">Rhode Island Hospital</a>	---

**Table 9:** MRSA Bloodstream Infections in Surgical Intensive Care Units (SICUs)

Hospital ICU	Diamonds
<a href="#">Rhode Island Hospital</a>	---

**Table 10:** MRSA Bloodstream Infections in Surgical Cardiothoracic Critical Care Units

Hospital ICU (Alphabetical)	Diamonds
<a href="#">Miriam Hospital</a> CVTS**	---
<a href="#">Rhode Island Hospital</a> CTIC <sup>HH</sup>	---

\*\* CVTS: Cardiovascular Thoracic Surgical Care Unit

<sup>HH</sup> CTIC: Cardiovascular Thoracic Intensive Care Unit

**Table 11:** MRSA Bloodstream Infections in Trauma Intensive Care Units (TICUs)

Hospital ICU	Diamonds
<a href="#">Rhode Island Hospital</a>	n/a

n/a There is no national comparison for this kind of unit.

\*Statistical methods are described in the Methods (separate document).



## Healthcare Quality Reporting Program

### **METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) BLOODSTREAM INFECTIONS**

#### Methods

MRSA bloodstream infections are reported on the [Department of Health's \(HEALTH's\) Web site](#). The information on this page provides additional details about the results presented, including the data source, how hospital diamonds are calculated, and why this information is important.

MRSA bloodstream infections are caused by a kind of bacteria that can enter the body in many ways. Hospitals in Rhode Island report MRSA bloodstream infections that their intensive care patients get through their central lines (a kind of [catheter](#), or medical tube). MRSA bloodstream infections are also called MRSA central line-associated bloodstream infections, or MRSA CLABSI.

#### **Measure Information** ([adapted from the Centers for Disease Control and Prevention](#))

Topic	Why is this information important?
Methicillin-resistant Staphylococcus aureus (MRSA)	MRSA bacteria most commonly cause skin infections. MRSA is resistant to (cannot be treated with) certain antibiotics.
MRSA central line-associated bloodstream infections (MRSA CLABSI)	MRSA CLABSI are reasonably preventable with proper care, especially good hygiene.

#### **Definitions**

Word or Phrase	What does this mean?
Bloodstream infection	An infection caused by bacteria entering a patient's blood.
Central line	A special kind of medical tube ("IV") that connects directly to a patient's heart or a major blood vessel. It can be used to draw blood or give patients medicines or nutrition.
MRSA CLABSI	A type of bloodstream infection caused by MRSA bacteria that enter the blood through a central line. These infections are not related to another infection, such as a urinary tract infection, pneumonia, or wound infection. Any <i>S.aureus</i> infection that tests oxacillin-resistant.
Intensive Care Unit (ICU)	A hospital unit that cares for critically-ill patients.
Rate	A score that reflects new (hospital-acquired) infections over a period of time. For the MRSA infection rates, this timeframe is three months. <i>Lower</i> rates are better for MRSA.

#### **Data Source**

Hospitals in Rhode Island collect information about the MRSA CLABSI that their ICU patients get and share it with the Department of Health for reporting. Hospital rates are based on MRSA CLABSI. For MRSA CLABSI rates, *lower* numbers are better.

## Measure Calculation

The information in this section is for people who want details about the data calculations. For each ICU, two numbers are calculated: (1) **MRSA CLABSI incidence**, and (2) a **Standardized Incidence Ratio (SIR)**. Incidence is needed to calculate each hospital's SIR, and the diamonds presented in the public report are based on the SIR.

1. **MRSA CLABSI incidence** is calculated as follows:

$$\text{Rate} = \frac{(\text{number of MRSA CLABSI})}{(\text{number of central line days})} \times 1,000$$

The number of patients who develop a MRSA CLABSI is the **numerator**. The number of central line days (the number of days when patients could have developed an infection in the ICU) is the **denominator**. The **incidence rate** is the numerator divided by the denominator multiplied by 1,000. Each hospital's rate is compared to the rates of other hospitals nationally using SIRs.

2. Incidence rates are used to calculate **SIRs**, which are:

$$\text{SIR} = \frac{(\text{observed cases})}{(\text{expected cases})}$$

The **observed cases** are the actual number of MRSA CLABSI (incidence rate numerator) and the **expected cases** are the number we expect to see if we applied the national average MRSA CLABSI incidence rate to each hospital's patient population (the incidence rate's denominator). *Lower* scores are better. An SIR score less than 1.0 means the incidence is better than expected.

For hospitals with SIRs calculated, each hospital's SIR is included in the public report and helps to determine its diamond category (see "Diamond Categories").

## Diamond Categories

The diamond categories help you understand how each hospital's incidence compares to its expected incidence (or "expected cases," determined based on the national average):

- Worse than expected
- About the same as expected
- Better than expected

These categories are determined mathematically to ensure that the differences are meaningful. In detailed terms, this means that hospitals with either one diamond (—) or three diamonds (—) have MRSA incidence rates that are "statistically significantly different" from their expected rates.

## Diamond Calculation

The information in this section is for people who want statistical details about the diamond calculations. The diamond categories are determined based on hospitals' SIRs (see "Measure Calculation"). An SIR less than 1.0 means the hospital's rate is lower (better) than expected; an SIR greater than 1.0 is higher (worse) than expected. The margin of error, or "90% confidence interval," determines whether each SIR is meaningfully different from 1.0. Diamonds are assigned as follows:

- One diamond (—): If the SIR falls above 1.0 (is worse than expected) AND its margin of error, or "90% confidence interval," does not include 1.0, then the hospital has one diamond.
- Two diamonds (—): If the 90% confidence interval for the SIR includes 1.0, then the hospital's score is not accurate enough to categorize it as better or worse than other hospitals (the national average). The hospital has two diamonds.

- **Three diamonds (—):** If the SIR falls below 1.0 (is better than expected) AND its margin of error, or “90% confidence interval,” does not include 1.0, then the hospital has three diamonds. **Note:** The exception is when the hospital does not have any infections (where zero is the best performance). When this occurs, a hospital is automatically given three diamonds.

**Data Table, January-March 2011**

The data table below provides additional details which are not presented in the Data Report, including:

- Number of MRSA CLABSI
- Number of central line days
- MRSA rate per 1,000 central line days
- SIR, based on the national average<sup>1</sup>
- 90% CI range

Hospital (Alphabetical by ICU Type)	Number of MRSA CLABSI Infections	Number of Central-Line Days	MRSA CLABSI Rate per 1,000 Central Line Days	SIR	90% CI		Diamonds
					Lower Limit	Upper Limit	
<b>Coronary Critical Care Units (CCUs)</b>							
<a href="#">Miriam Hospital</a>	0	165	0.00	0.00	-	-	----
<a href="#">Rhode Island Hospital</a>	0	191	0.00	0.00	-	-	----
<b>Medical Intensive Care Units (MICUs)</b>							
<a href="#">Rhode Island Hospital</a>	0	1,011	0.00	0.00	-	-	----
<b>Medical/Surgical Critical Care Units (ICUs) at Major Teaching Hospitals</b>							
<a href="#">Kent County Hospital</a>	0	797	0.00	0.00	-	-	----
<a href="#">Memorial Hospital</a>	0	468	0.00	0.00	-	-	----
<a href="#">Miriam Hospital</a>	0	852	0.00	0.00	-	-	----
<a href="#">Providence Veteran's Affairs Medical Center</a>	x	x	x	x	x	x	x
<a href="#">Roger Williams Medical Center</a>	0	380	0.00	0.00	-	-	----
<b>Medical/Surgical Critical Care Units (ICUs) at All Other (Non-Teaching) Hospitals</b>							
<a href="#">Landmark Medical Center</a>	0	654	0.00	0.00	-	-	----
<a href="#">Newport Hospital</a>	0	194	0.00	0.00	-	-	----
<a href="#">Our Lady of Fatima Hospital</a>	0	368	0.00	0.00	-	-	----
<a href="#">South County Hospital</a>	x	x	x	x	x	x	x
<a href="#">Westerly Hospital</a>	0	133	0.00	0.00	-	-	----

x This hospital did not report data for this unit.

<sup>1</sup> Burton DC, Edwards JR, Horan TC, Jernigan JA, Fridkin SK. Methicillin-resistant staphylococcus aureus central line-associated bloodstream infections in US intensive care units, 1997-2007. *JAMA*. 2009; 301(7):727-736.

Hospital (Alphabetical by ICU Type)	Number of MRSA CLABSI Infections	Number of Central-Line Days	MRSA CLABSI Rate per 1,000 Central Line Days	SIR	90% CI		Diamonds
					Lower Limit	Upper Limit	
<b>Women &amp; Infants Hospital's Level III Neonatal Intensive Care Units (NICU), by Birthweight</b>							
<750 grams	0	191	0.00		n/a		n/a
751-1,000 grams	0	168	0.00		n/a		n/a
1,001-1,500 grams	0	217	0.00		n/a		n/a
1,501-2,500 grams	0	124	0.00		n/a		n/a
>2,500 grams	0	18	0.00		n/a		n/a
<b>Umbilical Catheter-Associated Infections at Women &amp; Infants Hospital's Level III NICU, by Birthweight</b>							
<750 grams	0	105	0.00		n/a		n/a
751-1,000 grams	0	116	0.00		n/a		n/a
1,001-1,500 grams	0	152	0.00		n/a		n/a
1,501-2,500 grams	0	46	0.00		n/a		n/a
>2,500 grams	0	27	0.00		n/a		n/a
<b>Neurosurgical Intensive Care Units (INCs)</b>							
<a href="#">Rhode Island Hospital</a>	0	530	0.00		n/a		n/a
<b>Pediatric Medical/Surgical Intensive Care Units (PICUs)</b>							
<a href="#">Rhode Island Hospital</a>	0	322	0.00	0.00	-	-	----
<b>Surgical Intensive Care Units (SICUs)</b>							
<a href="#">Rhode Island Hospital</a>	0	398	0.00	0.00	-	-	----
<b>Surgical Cardiothoracic Critical Care Units</b>							
<a href="#">Miriam Hospital</a> CVTS	0	443	0.00	0.00	-	-	----
<a href="#">Rhode Island Hospital</a> CTIC	0	483	0.00	0.00	-	-	----
<b>Trauma Intensive Care Units (TICUs)</b>							
<a href="#">Rhode Island Hospital</a>	0	400	0.00		n/a		n/a

- Confidence intervals are not applicable when the SIR equals 0.000.

n/a There is no national comparison for this type of unit.

News Release

FOR IMMEDIATE RELEASE  
May 13, 2011

Contact: OASH Communications  
(202) 205-0143

## **HHS Unveils New Interactive Video to Prevent Healthcare-Associated Infections** *New Training Supports Goals of Partnership for Patients*

The U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Health today released *Partnering to Heal: Teaming Up Against Healthcare-Associated Infections*, an interactive computer-based video-simulation training program. This training program helps support the goals of the Partnership for Patients, a new public-private partnership that will help improve the quality, safety and affordability of health care for all Americans.

Healthcare-associated infections harm many patients, causing injury and raising costs. On average, 1 in 3 patients admitted to a hospital suffers a medical error or adverse event and at any given time about 1 in every 20 patients is affected by an infection related to hospital care. On average, 1 in 7 Medicare beneficiaries is harmed in the course of care, costing the government an estimated \$4.4 billion every year.

To help address this public health challenge, the HHS Office of the Assistant Secretary for Health developed *Partnering to Heal*. This training program permits viewers to "become" one of five characters who can make decisions that impact health risks, and then view the results of those decisions and learn from the outcomes. It is designed to be used by students in the health professions, early-career clinicians, and other healthcare personnel, as well as patients and families to help prevent infections acquired in hospitals and other healthcare settings. Available online at no cost, [\*Partnering to Heal\*](#) promotes a team-based approach to reducing preventable infections and deaths in the United States.

"The current data highlight the urgency to train providers in infection control practices," said Howard K. Koh, MD, MPH, assistant secretary for health. "We're hoping this video tool will help eliminate preventable infections."

The video teaches viewers how to prevent the most prevalent hospital-acquired infections by sharing knowledge of universal and isolation precautions to take in healthcare settings. The training is designed to increase knowledge, alter attitudes, and shift the behaviors of clinicians and patients by focusing on principles of teamwork, communication, hand washing, flu vaccination, and the appropriate use of antibiotics and medical devices. *Partnering to Heal* is designed to be used as a facilitated training session or by individuals as a self-paced learning tool.

*Partnering to Heal* seeks safer and better care for all patients, which is consistent with the recently launched Partnership for Patients: Better Care, Lower Costs initiative. This new national public-private partnership with hospitals, medical groups, consumer groups and employers will help save lives by preventing millions of injuries and complications in patient care over the next three years. HHS has set a goal of decreasing preventable hospital-acquired conditions by 40 percent (compared with 2010 rates) by the end of 2013. Achieving this goal should result in approximately

1.8 million fewer injuries and illnesses to patients, with more than 60,000 lives saved over the next three years. The Partnership for Patients has the potential to save up to \$35 billion in healthcare costs.

To access the *Partnering to Heal* training video, see <http://www.hhs.gov/partneringtoheal>. For more information about Partnership for Patients visit <http://www.HealthCare.gov/center/programs/partnership>.

## FACT SHEET

# ***Partnering to Heal: Teaming Up to Prevent Healthcare-Associated Infections***

An interactive, computer-based training for health professionals and students on preventing HAIs  
May 2011

## ***Partnering to Heal: Teaming Up Against Healthcare-Associated Infections***

*Partnering to Heal* is a computer-based, interactive learning tool for early-career clinicians, health professional students, and patients and visitors on preventing healthcare-associated infections.

The training highlights effective communication about infection control practices and ideas for creating a “culture of safety” in healthcare institutions to keep patients from getting sicker. *Partnering to Heal* follows five main characters who each make decisions, controlled by the user:

- **A Physician & Hospital Administrator**, Nathan Green, Director of a Hospital Post-op Unit, ready to start new prevention efforts in the unit
- **A Registered Nurse**, Dena Gray, working to learn effective communications skills for interacting with her patients
- **An Infection Preventionist**, Janice Upshaw, a new employee charged with using a team-based approach to reducing infections
- **A Patient Family Member**, Kelly McTavish, whose father was just admitted to the hospital
- A third-year **Medical Student**, Manuel Hernandez, who wants to gain confidence to make a difference for his patients.

The training is designed to engage a variety of individuals within the hospital -- including patients and visitors -- in a team-based approach to preventing healthcare-associated infections. The training seeks to address the underlying thinking and behaviors of clinicians which contribute to the occurrence of healthcare-associated infections, rather than on specific clinical interventions such as the proper way to insert a central line.

### **Background**

The U.S. Department of Health and Human Services (HHS) created *Partnering to Heal* as part of a wider effort that works closely with public and private sector partners to improve the quality, safety, and affordability of health care for all Americans. Examples include the [HHS Action Plan to Prevent Healthcare-Associated Infections](#) which outlines a goal to train the next generation of healthcare providers in infection control practices and foster a “culture of safety” in healthcare institutions. The Action Plan’s goals and activities are aligned with the newly launched [Partnership for Patients: Better Care, Lower Costs](#), a public-private partnership to reduce hospital-associated illnesses and injuries by 1.8 million by 2013. The new national partnership with hospitals, medical groups, consumer groups and employers will help save lives by preventing millions of injuries and complications in patient care over the next three years.

### **Accessing the Training Materials**

To access the training, a facilitator’s guide, and additional resources:  
<http://www.hhs.gov/ash/initiatives/hai/training/>.

## FACT SHEET

# ***Partnering to Heal: Teaming Up to Prevent Healthcare-Associated Infections***

An interactive, computer-based training for health professionals and students on preventing HAIs  
May 2011

### **Training Content**

*Partnering to Heal* targets clinical audiences (students and early-career clinicians) as well as patients and visitors to assist in the prevention of:

- Surgical site infection
- Central line-associated bloodstream infection
- Ventilator-associated pneumonia
- Catheter-associated urinary tract infection
- *Clostridium difficile* infection
- Methicillin-resistant *Staphylococcus aureus* (MRSA) infection.

In addition, basic protocols for universal precautions and isolation precautions are covered to protect patients, visitors, and practitioners from even the most common disease transmissions. *Partnering to Heal* targets knowledge, attitudes, and behaviors of healthcare practitioners, patients, and visitors. Key behaviors targeted include:

- Teamwork
- Communication
- Hand washing
- Flu vaccination
- Appropriate use of antibiotics
- Proper insertion, maintenance, and removal of devices, such as catheters and ventilators.

### **About the Technology**

In *Partnering to Heal*, users assume the identity of characters in a computer-based video simulation and make decisions as each of those characters. Based upon the decisions, the storyline branches to different pathways and outcomes. The training may be used by groups in facilitated training sessions and by individuals as a self-paced learning tool.

This type of interactive, computer-based training has been shown to enhance individual's critical thinking and decision making skills in a way that helps individuals perform better when they face similar situations and pressures in real life. Research<sup>1</sup> has shown this to be an effective tool in knowledge acquisition and behavior change.

### **Partnership for Patients**

*Partnering to Heal* seeks safer and better care for all patients, which is consistent with the recently launched [Partnership for Patients](#) initiative. As part of the initiative, HHS has set a goal of decreasing preventable hospital-acquired conditions by 40 percent (compared with 2010 rates) by the end of 2013. Achieving this goal should result in approximately 1.8 million fewer injuries and illnesses to patients, with more than 60,000 lives saved over the next three years. The Partnership for Patients has the potential to save up to \$35 billion in healthcare costs.

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<sup>1</sup> Five studies were conducted, the most notable from the Robert Wood Johnson Foundation and the Boston University School of Public Health. The study examined the effects of a training program to reduce adolescent substance abuse. It found that, relative to comparison students, students who engaged in the training met 90% of outcome measures, indicating training effectiveness.

## **What Can You Do to Help Message *Partnering to Heal*?**

On May 13, U.S. DHHS is releasing an interactive video *Partnering to Heal: Teaming Up Against Healthcare-Associated Infections*. The training is designed to engage a variety of individuals within the hospital – the physician, the nurse, the infection preventionist, the hospital administrative leader, as well as patients and visitors – in a team-based approach to preventing healthcare-associated infections.

*Partnering to Heal* seeks safer and better care for all patients, which is consistent with the recently launched Partnership for Patients: Better Care, Lower Costs initiative.

Please help us spread the news. We have some suggested tweets, Facebook content, and email blasts. Please use the Twitter hashtag: #hhspfp, Partnership for Patient: Better Care, Lower Costs initiative, when tweeting about this training since we're targeting the same stakeholders.

In the coming days, we're going to post a trailer to YouTube pointing consumers and healthcare professionals to the training and to the web site.

Thanks for your help.

### **FACEBOOK POSTS**

**After 12pm ET on Friday, May 13<sup>th</sup>**

The HHS Office of Healthcare Quality introduces *Partnering to Heal: Teaming Up Against Healthcare-Associated Infections*, an interactive learning tool for early-career clinicians, health professional students, hospital patients and visitors. Play one of five characters to learn how each can contribute to--or prevent--risk of infection: (Using the link shrink option with: <http://www.hhs.gov/ash/initiatives/hai/training/>).

### **TWITTER**

**After 12pm ET on Friday, May 13<sup>th</sup>**

**Hashtag - #hhspfp when referencing this training video.**

HHS releases *Partnering to Heal*, online patient safety training for clinicians and patient advocates—a great free resource: (Using the link shrink option with: <http://www.hhs.gov/ash/initiatives/hai/training/>).

Just-released HHS training engages hospital staff, patients, and visitors as a team to prevent infections: (Using the link shrink option with: <http://www.hhs.gov/ash/initiatives/hai/training/>).

*Partnering to Heal* training empowers the entire healthcare team, including patients, to prevent infections: (Using the link shrink option with: <http://www.hhs.gov/ash/initiatives/hai/training/>).

Help to prevent nearly 100,000 U.S. deaths each year from healthcare-associated infections. HHS presents Partnering to Heal: (Using the link shrink option with: <http://www.hhs.gov/ash/initiatives/hai/training/>).

Team up against healthcare-associated infections. Check out (Using the link shrink option with: <http://www.hhs.gov/ash/initiatives/hai/training/>) from HHS.

### **EMAIL BLAST**

**After 12pm ET on Friday, May 13<sup>th</sup>**

The U.S. Department of Health and Human Services brings you:

# Partnering to Heal

TEAMING UP AGAINST HEALTHCARE-ASSOCIATED INFECTIONS

## **HHS Office of Healthcare Quality Offers Free HAI Prevention Training**

### ***Partnering to Heal: Teaming Up Against Healthcare-Associated Infections***

*Partnering to Heal* is a computer-based, interactive learning tool for early-career clinicians, health professional students, and patients and visitors.

The training highlights effective communication about infection control practices and ideas for creating a “culture of safety” in healthcare institutions. *Partnering to Heal* follows five main characters who each make decisions, controlled by the user:



**Physician and Hospital Administrator**, Nathan Green, Director of a Hospital Post-op Unit, ready to start new prevention efforts in the unit



**Registered Nurse**, Dena Gray, working to learn effective communications skills for interacting with her patients



**Infection Preventionist**, Janice Upshaw, a new employee charged with using a team-based approach to reducing infections



**Patient Family Member**, Kelly McTavish, whose father was just admitted to the hospital



Third-year **Medical Student**, Manuel Hernandez, who wants to gain confidence to make a difference for his patients

To access the training, a facilitator's guide, and additional resources:  
<http://www.hhs.gov/ash/initiatives/hai/training/>.



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