APIC GREAT LAKES

2025 EDUCATIONAL WEBINAR SERIES

Preventing Resistance and Infections by Integrating Systems in Michigan (PRIISM)

a collaborative to improve infection prevention in nursing homes and enhance communication with hospitals

July 8, 2025

Housekeeping

- Please mute your line
- Have questions for our speaker? Drop it in the chat to be asked!

Continuing Education (CE)

- There are no CEs available for today's session

Welcome

Karen Jones, MPH, RN, CIC,
LTC-CIP, FAPIC
University of Michigan

Preventing Resistance & Infections by Integrating Systems in Michigan

A collaborative to improve infection prevention, 2018 – 2022

IMPACT OF A COLLABORATION-FOCUSED INTERVENTION TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS BEFORE AND DURING COVID-19

KM Jones*, MT Greene*, J Meddings, J Mantey, SL Krein, M Harrod, A Montoya, JP Mills, L Mody | *Clinical Infectious Diseases - 2025*

OBJECTIVE

To test a collaborative model aimed at reducing infection rates in nursing home (NH) residents.

METHODS

Analytic Sample: 63 NHs and their affiliated 18 hospitals, grouped into four 12-month cohorts (2018–2022), with 40 NHs pre-COVID and 23 NHs during COVID.

Intervention Components:

- 2 cohort-wide and 4 regional meetings
- Infection prevention education and training
- Bi-directional knowledge sharing, with input from state health department
- Surveillance and monthly feedback reports

Analysis: Negative binomial regression to assess infection rate changes.

RESULTS

Implementation Year 2018 to 2020 (Pre-COVID)

32% ↓ Total infection rates in NHs decreased (IRR 0.68, p = 0.03)

63% ↓ Urine culture order rates in NHs decreased (IRR 0.37, p < 0.001)

Implementation Year 2020 to 2022 (During-COVID)

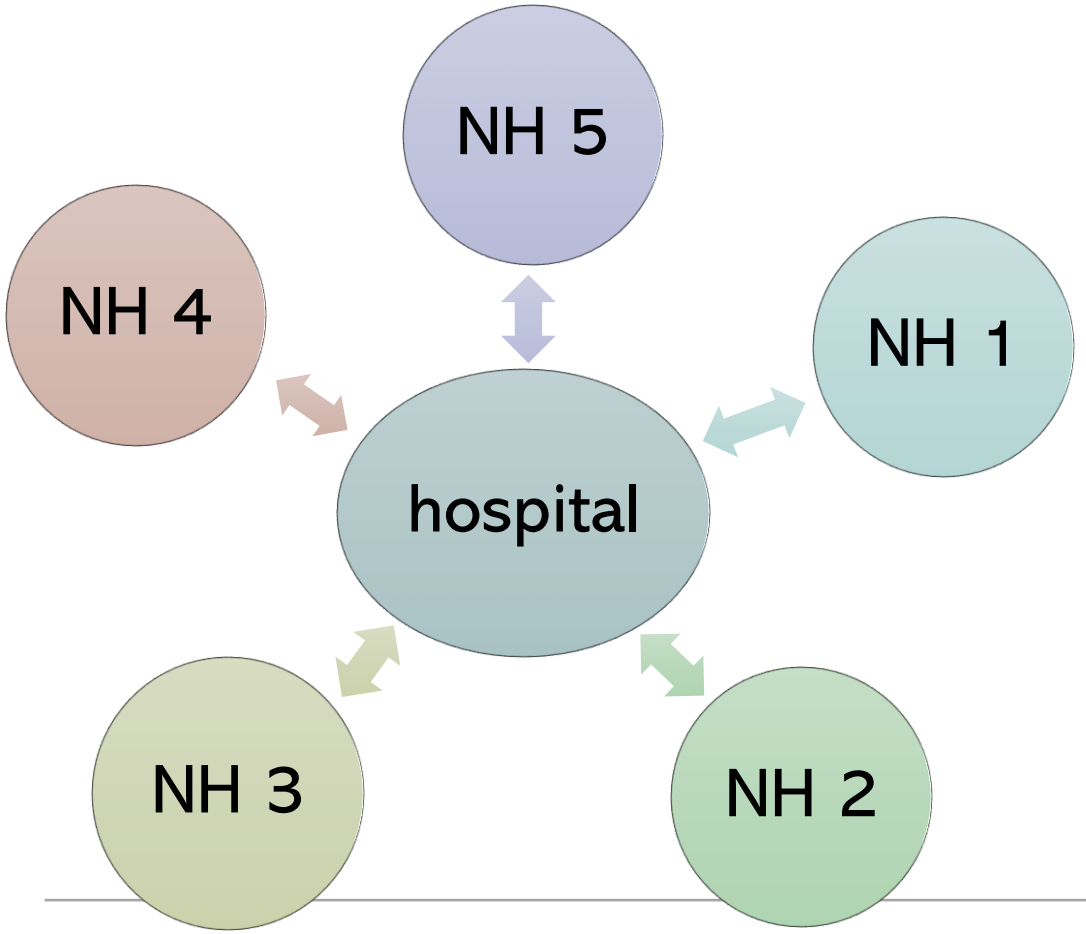
These improvements were not sustained.

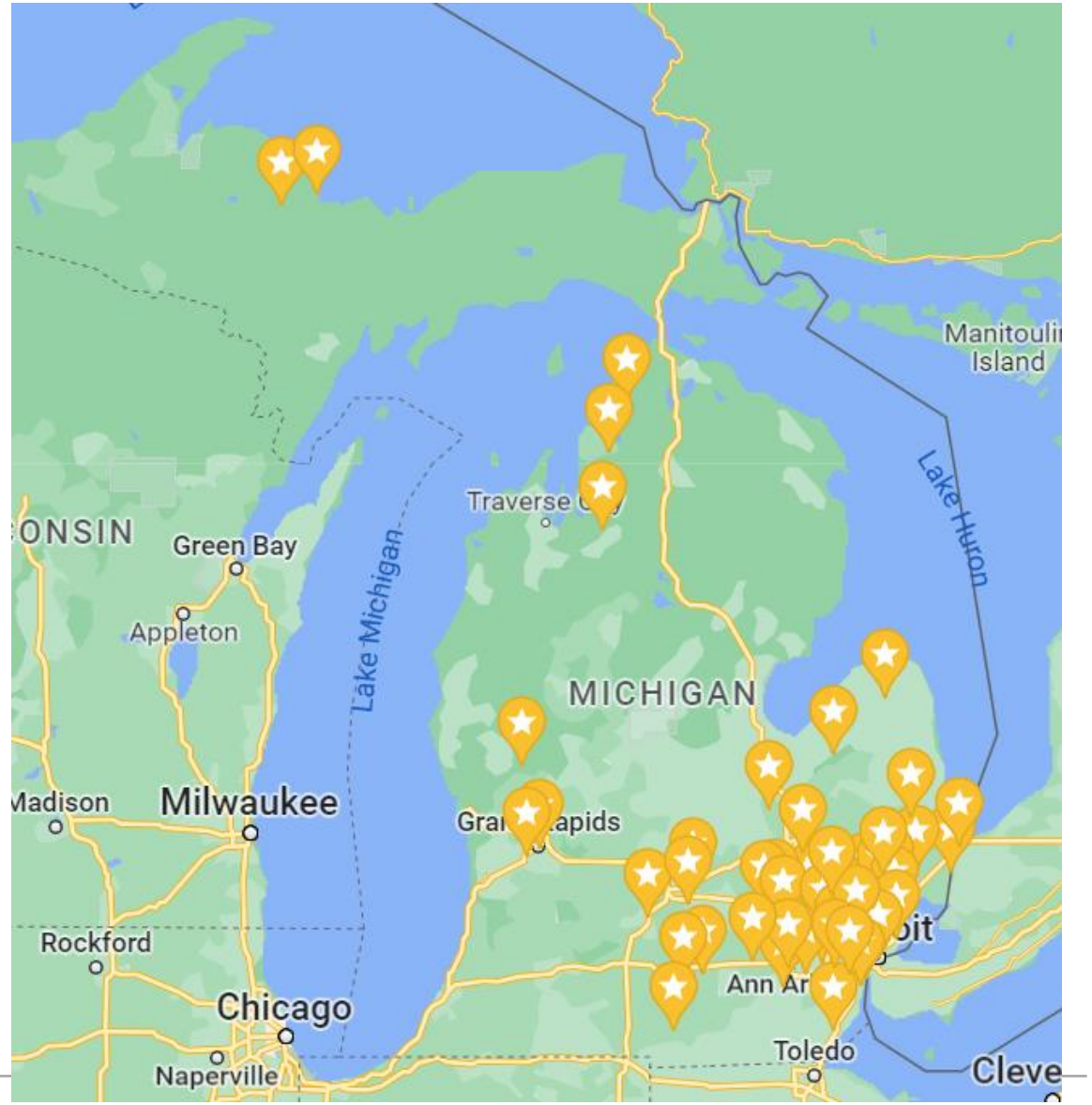
NHs faced resource limitations, affecting infection control efforts.

CONCLUSION

Our collaborative regional model was helpful in reducing NH infections and urine culture order rates. However, these reductions were not sustained during the COVID-19 pandemic due to competing priorities.

PRIISM hospital & nursing home cluster





Today's speakers

Karen Jones, MPH, RN, CIC, LTC-CIP, FAPIC
Project Coordinator/Infection Preventionist
Division of Geriatrics and Palliative Care
The University of Michigan
Ann Arbor, Michigan

Julie Scott, RN, BSN
Infection Preventionist
D.J. Jacobetti Home for Veterans,
Marquette, Michigan

Randy Holland, MHA, BSN, CIC
Director of Infection Control
and Ancillary Services
Hillsdale Hospital,
Hillsdale, Michigan

Conflict of Interest

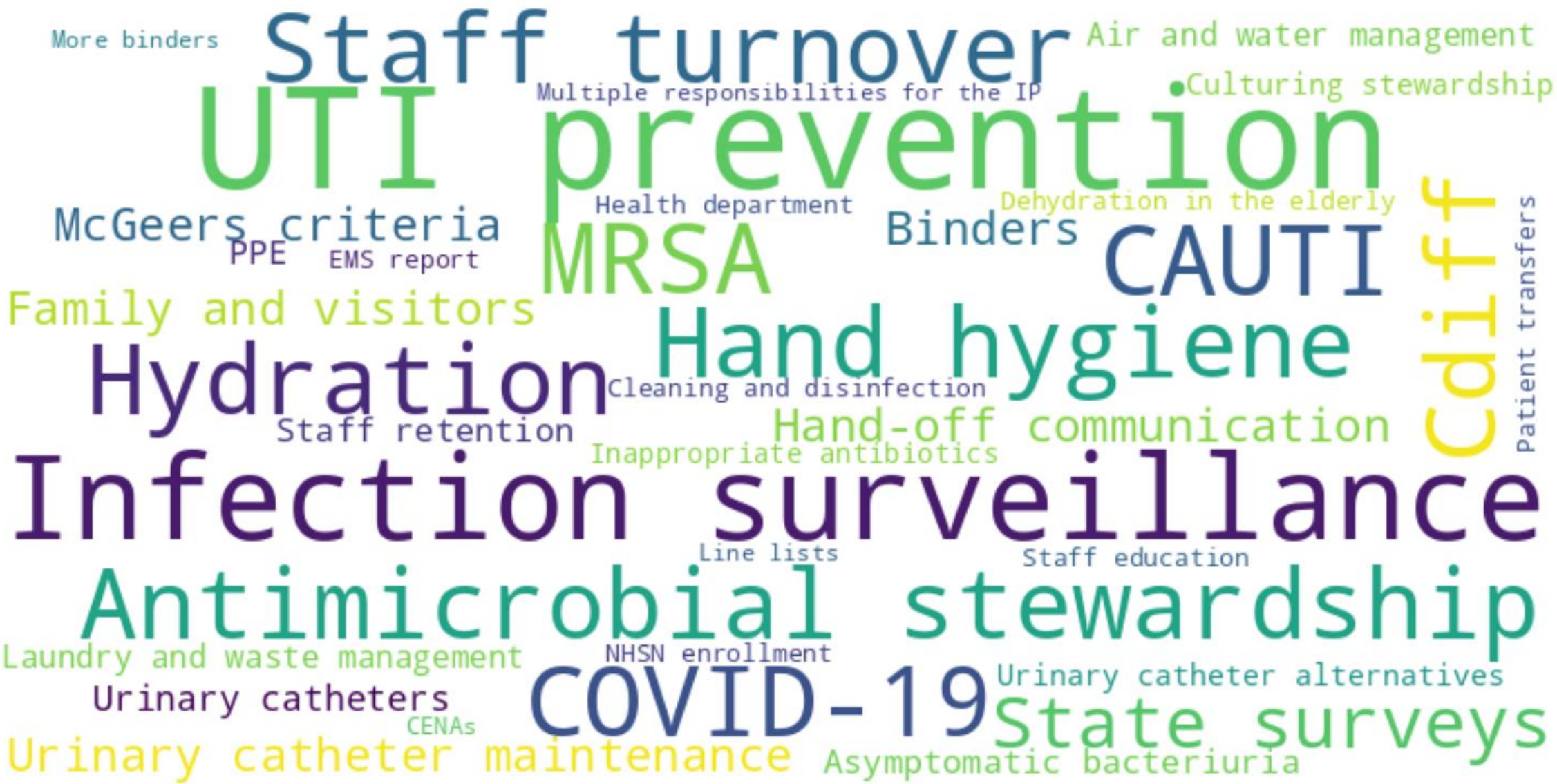
- Karen Jones receives a salary from Wolters Kluwer. No products relevant to this relationship will be discussed.
- Julie and Randy report no conflicts of interest.

Objectives

Describe	The 4-year infection and control (IPC) partnership between hospitals and their referral nursing homes.
Define	The recruitment, interventions, results, and lessons learned before and during the COVID-19 pandemic.
Illustrate & Discuss	Two nursing facility infection preventionists' experiences from PRIISM participation.

From acute care IP to . . . .

- An academic setting
- Plenty of resources and personnel
- Nursing home IPC (can't be that much different, can it?)

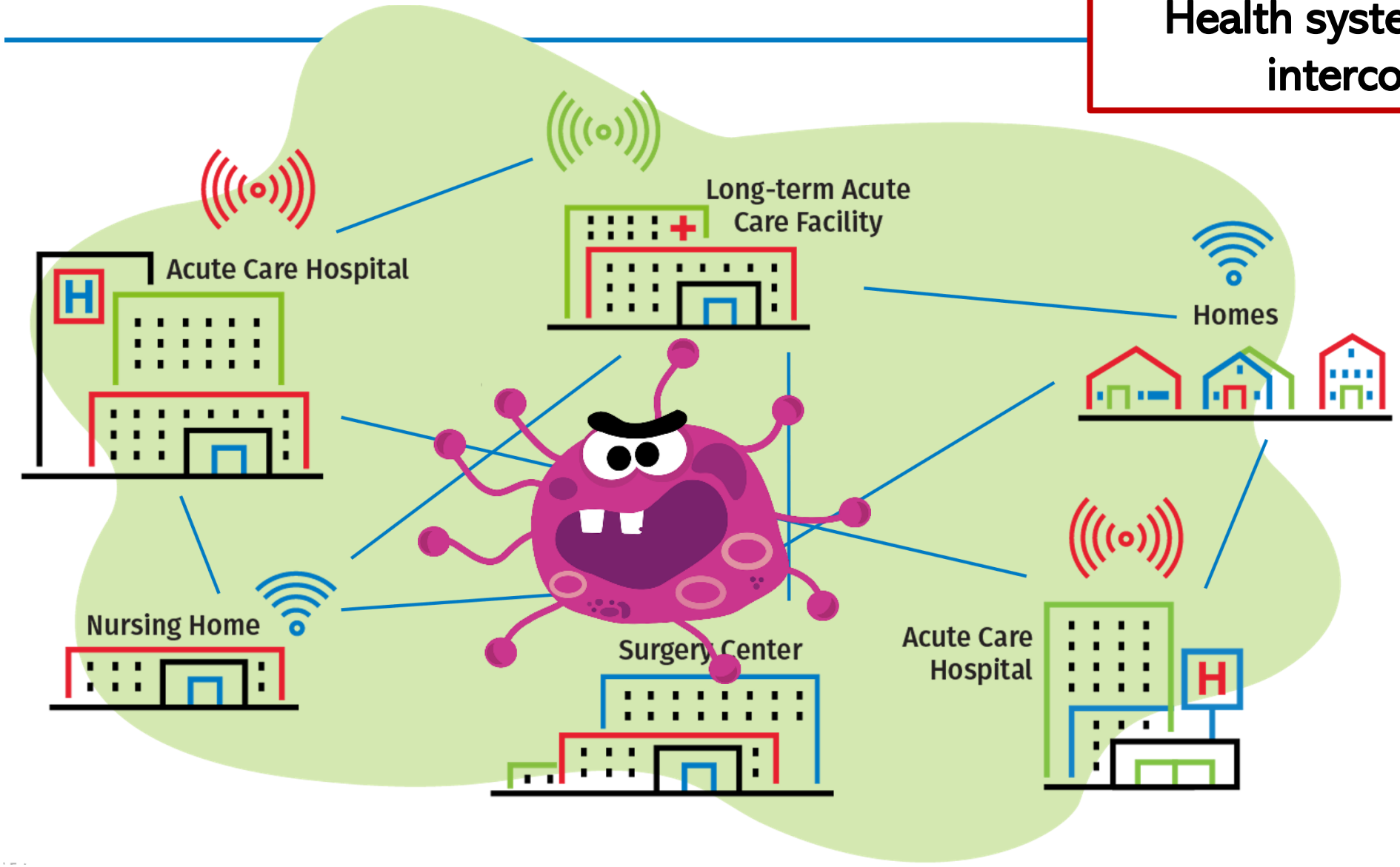

More binders
Staff turnover
Air and water management
Multiple responsibilities for the IP
Culturing stewardship
UTI prevention
Health department
Dehydration in the elderly
McGeers criteria
PPE
EMS report
MRSA
Binders
CAUTI
Cdiff
Patient transfers
Family and visitors
Hand hygiene
Hydration
Cleaning and disinfection
Staff retention
Hand-off communication
Inappropriate antibiotics
Infection surveillance
Line lists
Staff education
Antimicrobial stewardship
Laundry and waste management
NHSN enrollment
Urinary catheter alternatives
Urinary catheters
COVID-19
State surveys
CENAs
Urinary catheter maintenance
Asymptomatic bacteriuria

IPC in nursing homes

- Short-stay (av LOS = 28d) vs. long-term care (av LOS =835d) residents
- Home-like environment, congregate setting
- Services offered vary
- On-call providers vs. on-site
- Revised McGeer and Loeb criteria
- Despite differences, overarching goals of preventing infection, resident safety

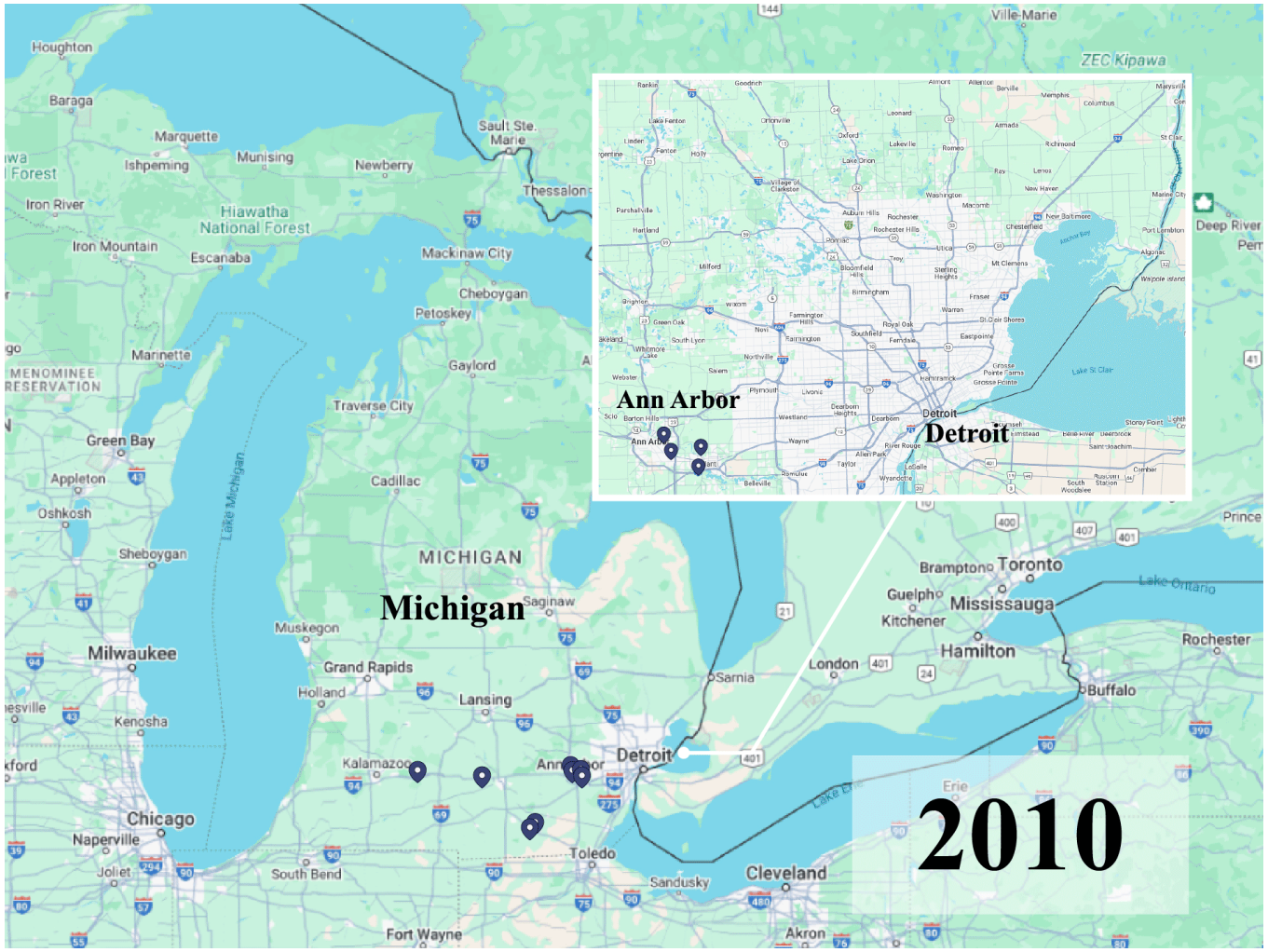
Sengupta, 2022.
Werner, *JAMA*, 2018.

Health systems are highly interconnected.



Partnerships make good things happen

- Since 2010, Dr. Lona Mody has supported IP efforts in nursing homes and across the continuum of care.



History of research and partnerships in nursing homes

- 2010-2013 Targeted Infection Prevention (TIP) Study
  - Multi-component intervention, residents w/indwelling devices, active surveillance, structured staff education
- 2012 Gown and Glove Use
  - Examined bacterial transfer during care in nursing homes
- Pathway from Functional Disability to Antibiotic Resistance in Nursing Home Residents
  - Increased functional disability = greater risk of resistant organism acquisition
- CAUTI CUSP in LTC
  - *On the CUSP: Stop CAUTI*
- 2020-2021 AHRQ ECHO National Nursing Home COVID-19 Action Network (M-ECHO)

https://criisp-mody.lab.medicine.umich.edu/home

VIEWPOINT

Can Infection Prevention Programs in Hospitals and Nursing Facilities Be Integrated?

From Silos to Partners

Lona Mody, MD, MSc
Division of Geriatric and Palliative Medicine, Department of Internal Medicine, University of Michigan Medical School, Ann Arbor; Institute for Healthcare Policy and Innovation, University of Michigan, Ann Arbor; and VA Ann Arbor Healthcare System, Ann Arbor, Michigan.

Lanina Washer, MD
Division of Infectious Diseases, Department of Internal Medicine, University of Michigan Medical School, Ann Arbor; and Department of Infection Prevention and Epidemiology, Michigan Medicine, Ann Arbor.

Scott Flanders, MD
Institute for Healthcare Policy and Innovation, University of Michigan, Ann Arbor; and Division of Hospital Medicine, Department of Internal Medicine, University of Michigan Medical School, Ann Arbor.

Dissemination and implementation of evidence-based interventions have successfully reduced central line–associated bloodstream infections, surgical site infections, and *Clostridium difficile* in many acute care hospitals partly as a result of resourceful, diverse, and proficient hospital infection prevention teams. However, infection prevention programs in nursing facilities are less well developed.

Contemporary nursing facilities are composed of 2 distinct populations: patients who require skilled nursing and rehabilitation care after a hospital stay (postacute care) and long-term care residents who permanently reside at these facilities. Nursing facilities encounter many challenges in effectively implementing and maintaining infection prevention programs. First, both patients receiving postacute care and long-term residents frequently visit common areas including dining rooms, rehabilitation areas, and family visitation rooms, increasing the risk of pathogen transmission. Second, nursing facilities lack in-house diagnostic testing and rely on offsite physicians, leading to delays in the evaluation and management of individuals with acute infections. Third, the postacute care population has inherently more active medical problems, with more devices, wounds, recurrent hospital stays, and high antibiotic use compared with long-term care residents. Most important, nursing facilities lack adequate resources to support the increasingly complicated infection prevention mandates such as infection surveillance, staff education, and implementation of antimicrobial stewardship programs. However, we believe the transition toward integrated health care systems provides a unique oppor-

tients returned to the hospital, resulting in additional costs, functional decline, and delayed recovery, contributing to a vicious spiral of morbidity and mortality. To deliver quality health care across the continuum of care for this rapidly growing population, an effective, well-funded, and adaptive infection prevention program is critical.

Evolution of Infection Prevention Programs

Hospital infection prevention programs developed in the 1960s and were subsequently shaped by the 1974 Study on the Efficacy of Nosocomial Infection Control. The study found a site-specific reduction in nosocomial infection ranging from 7% to 48% in hospitals with effective infection prevention programs that included 1 infection control nurse, 1 trained hospital epidemiologist, and data audits with feedback to surgeons.[4] In 1976, the Joint Commission on Accreditation of Healthcare Organizations began requiring infection control programs for hospitals. The emergence of drug-resistant organisms and evidence-based standards spurred maturation of these programs. Contemporary hospital infection prevention teams now include epidemiologists, infection control practitioners, and quality improvement specialists that shape policy, conduct surveillance, and ensure compliance.

Mandates to create similar programs in nursing facilities soon followed. Recognition of major deficiencies in care led to the Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987 (OBRA), and required individualized infection control programs. The US Centers for Medicare & Medicaid Services (CMS) pay facilities for their services only if those facilities are certified to be in compliance with the OBRA

Mody, JAMA Viewpoint, 2018.

Project Aims

Develop integrated model of hospital and nursing home infection prevention in nursing homes (NHs) and their referring hospitals.

Disseminate this intervention across 3 additional 12-month cohorts for at least 60 NHs & 15 hospitals.

Evaluate impact of this model on outcome measures (MRSA, *Cdiff*, urinary catheter use, urine testing).

Determine participant satisfaction by using qualitative methods.

VIEWPOINT

Opinion

Can Infection Prevention Programs in Hospitals and Nursing Facilities Be Integrated?
From Silos to Partners

Lona Mody, MD, MSc
Division of Geriatric and Palliative Medicine, Department of Internal Medicine, University of Michigan Medical School, Ann Arbor; Institute for Healthcare Policy and Innovation, University of Michigan, Ann Arbor; and VA Ann Arbor Healthcare System, Ann Arbor, Michigan.

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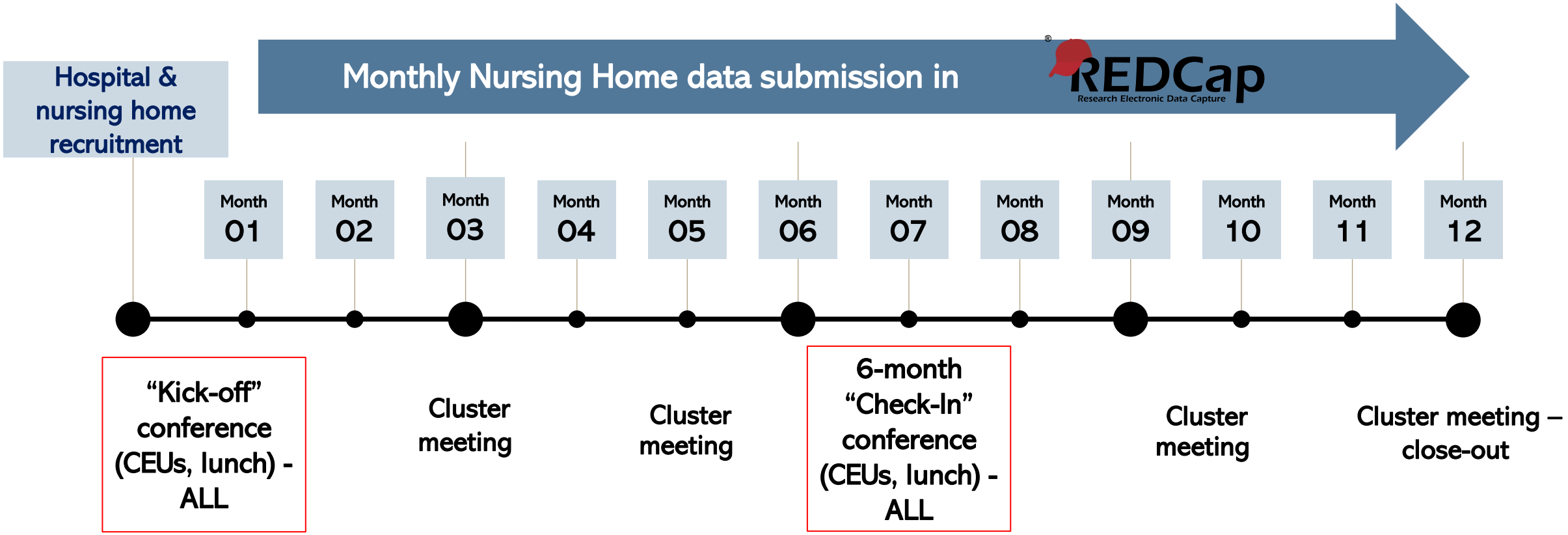
Mody, *JAMA Viewpoint,* 2018.

12-month Project Timeline

Prior to Kickoff:

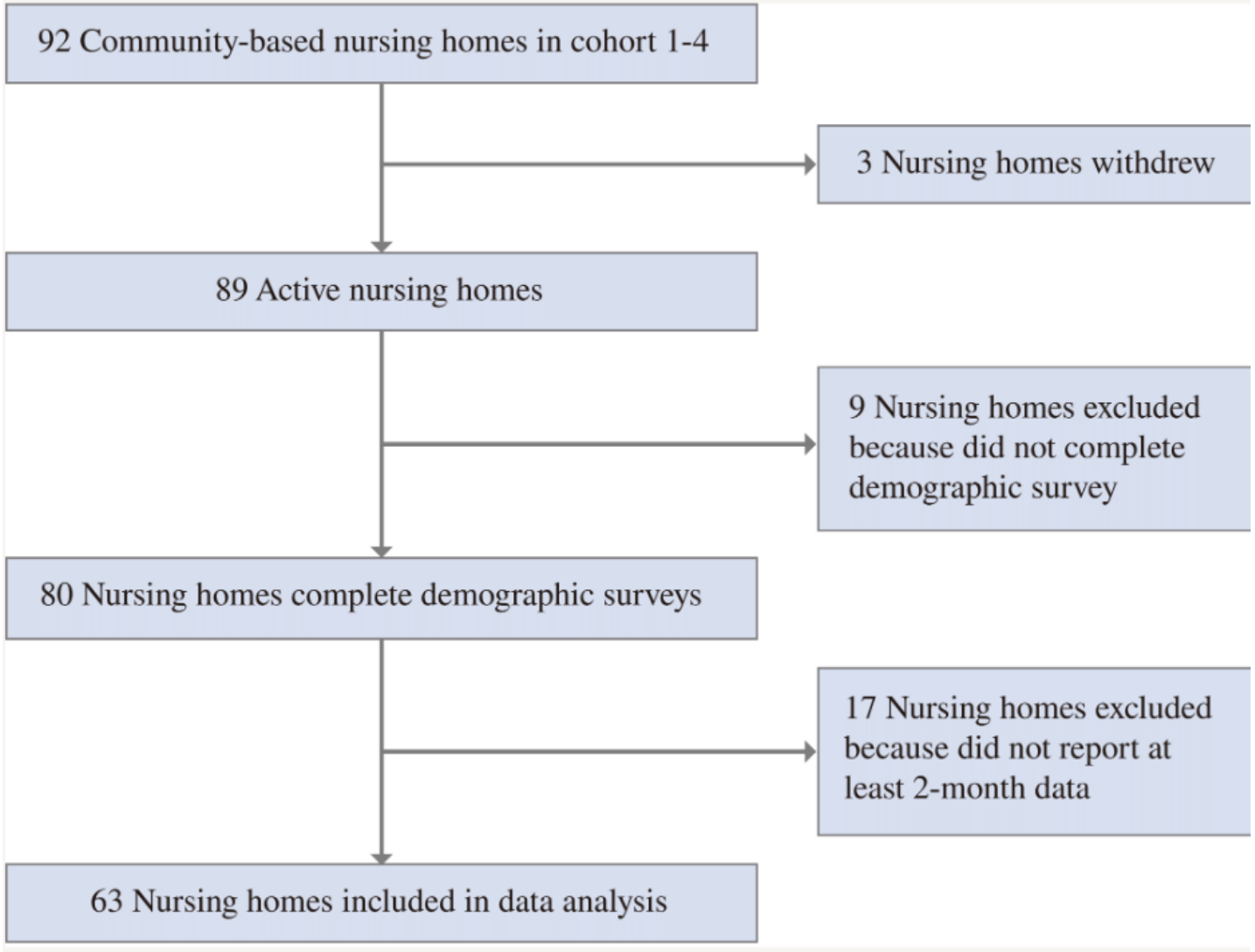
- ✓36-question demographics/practice survey (NH)
- ✓Previous year's infection data (NH)
- ✓Identify roles & responsibilities (NH and hospitals)



Recruitment and responsibilities

- Recruitment
- Roles and responsibilities
  - Infection preventionists, directors of nursing, administrators, corporate leadership (nursing home)
  - Directors/medical directors of IP, directors of case management/post-acute care (hospital)
- 12-month participation commitment
  - Attendance and participation in meetings
  - Monthly data submission (NHs only)

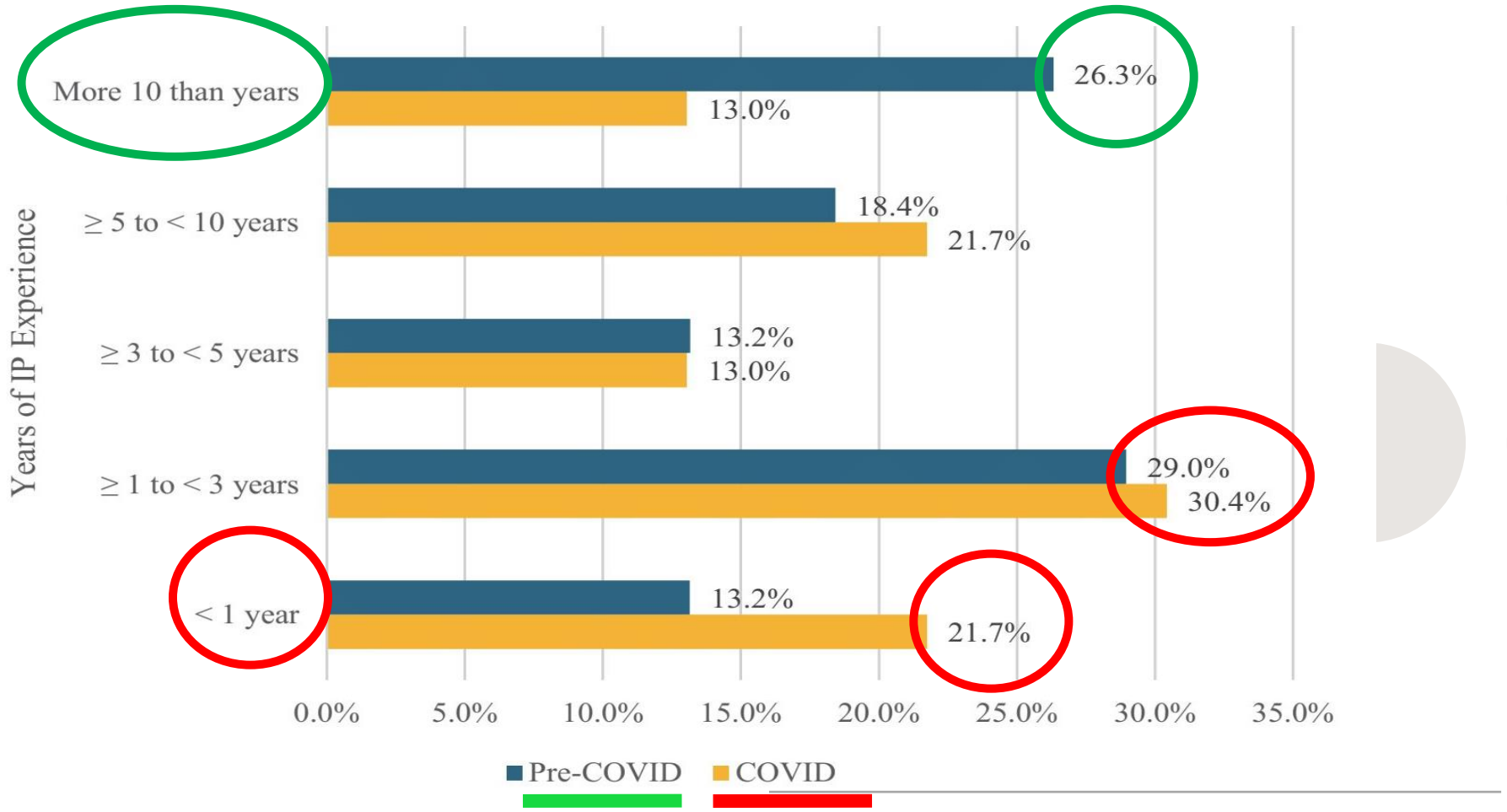
Michigan nursing home participation



PRIISM nursing home details

	Pre-pandemic (n=40)	During pandemic (n=23)	P-value
Mean bed size	121	121	.95
For-profit	83% (33)	43% (10)	.001
CMS Five-star Quality rating (average)	3.9	4.4	.04
Full-time employee for IP	1.08	0.86	.0067
“Highly engaged” in project	45% (18)	65% (15)	.12

NH IP experience in years

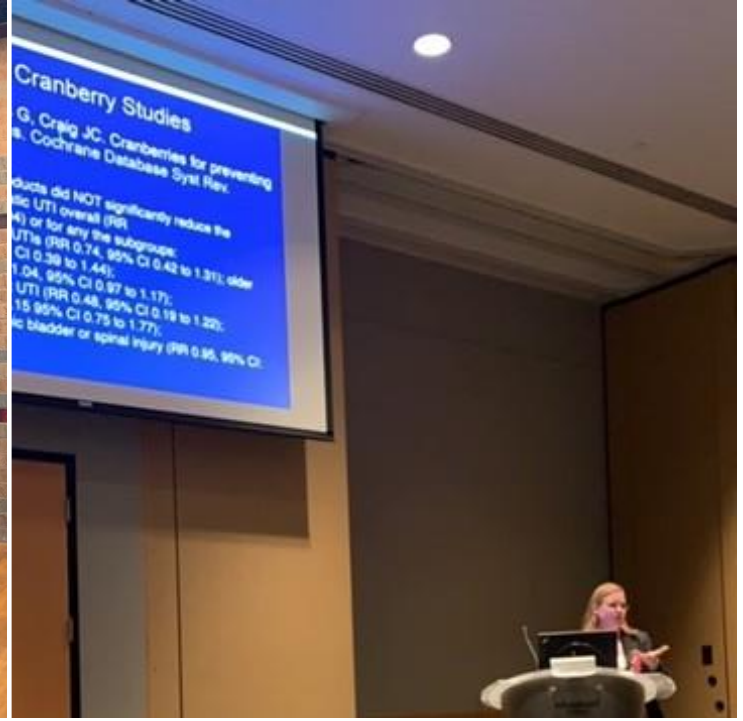


Top IP challenges in nursing homes

	#1 Challenge	#2 Challenge	#3 Challenge
C1 2018 (11)		Employee hand hygiene compliance	Communication w/referral hospitals
C2 2019 (27)		Resident and family engagement	Communication w/referral hospitals
C3 2020 (9)		Employee hand hygiene compliance	Influenza vaccine to staff
C4 2021(14)		Employee hand hygiene compliance	(tied) Standard Precautions; Transmission-based Precautions

Top IP challenges in nursing homes

Project Year (*n*)	#1 Challenge	#2 Challenge	#3 Challenge
C1 2018 (11)	Staff turnover = 54.5%	Employee hand hygiene compliance	Communication w/referral hospitals
C2 2019 (27)	Staff turnover = 70.4%	Resident and family engagement	Communication w/referral hospitals
C3 2020 (9)	Staff turnover = 100%	Employee hand hygiene compliance	Influenza vaccine to staff
C4 2021(14)	Staff turnover = 71.4%	Employee hand hygiene compliance	(tied) Standard Precautions; Transmission-based Precautions



In-person conferences & “Cluster Meetings”

- Kick-off conference brought all participants together, shared goals
- 6-Month Check-In reconvened all participants, presented results, areas of focus
- Quarterly “Cluster Meetings” held at/near the hospital

IP staff education: fun & interactive

- Examples presented at each in-person meeting
- Materials provided to take back to facility
- Family Feud, Jeopardy dupes; “Wheel of Infection”

PRIISM Basics

Convenient locations

SME speakers

Focus on UTI/CAUTI prevention but all IPC topics covered

Site visits & staff education

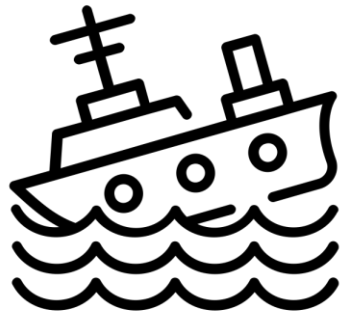
PRIISM Project website

On-demand videos

Monthly Feedback Reports, PRIISM team recs

Support the development and execution of “Small Test of Change”

Keeping an IP project afloat during a pandemic



Created by Smashing Stocks from Noun Project

Adjusted recruitment	Expanded meeting options	Support from health department
• Delayed start of Cohort 4 by 9 months (Mar - Nov 2021)	• Year 3: After kick-off, remainder virtual • Year 4: Conferences in person or virtual, cluster meetings all virtual	• MDHHS partners attended every meeting, presented recs and answered questions

Nursing home data totals

	Pre-COVID (Mar 2018 - Feb 2020) N= 40 NHs	COVID (Mar 2020 - Oct 2022) N=23 NHs
UTIs	1,291	548
CAUTIs	241	104
CDI	114	23
MRSA	44	26
Total infections	1,721	701
Urine cultures ordered	3,009	1,144
Device-days	56,258	29,568
Resident-days	1,364,492	566,142

[1]Pre-COVID months of data = 412; [2]COVID months of data = 234.

Nursing home data

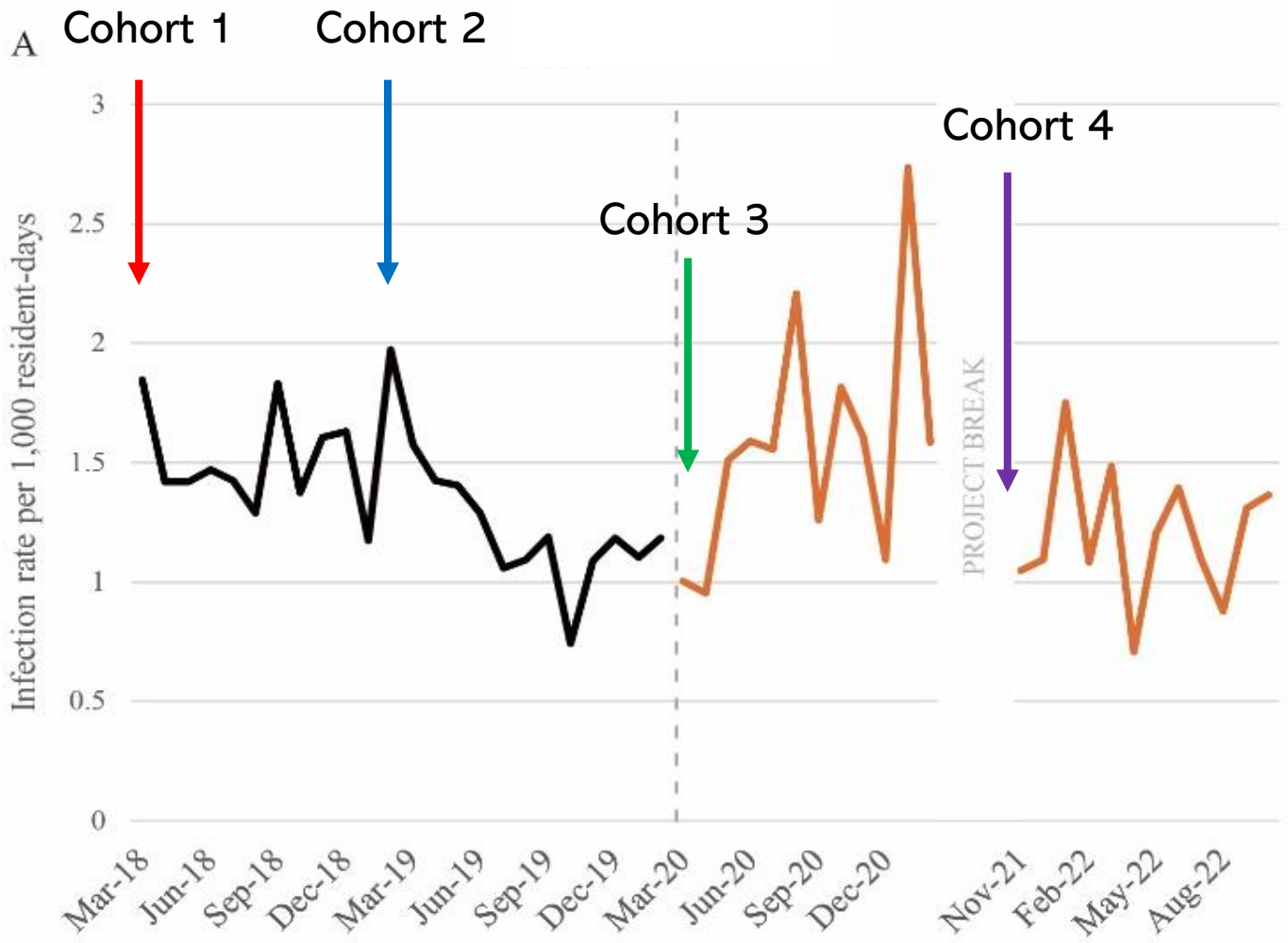
	Pre-COVID[1] (2018-20) N= 40 NHs	COVID[2] (2020-22) N=23 NHs	p-value
UTI*	0.99	1.02	0.64
CAUTI**	9.19	3.41	<0.001
CDI*	0.09	0.04	0.01
MRSA*	0.03	0.04	0.29
Total infections*	1.13	1.29	0.79
Urine cultures ordered*	2.59	2.08	0.003
Device utilization	4.24	5.42	<0.001

[1]Pre-COVID months of data = 412; [2]COVID months of data = 234.

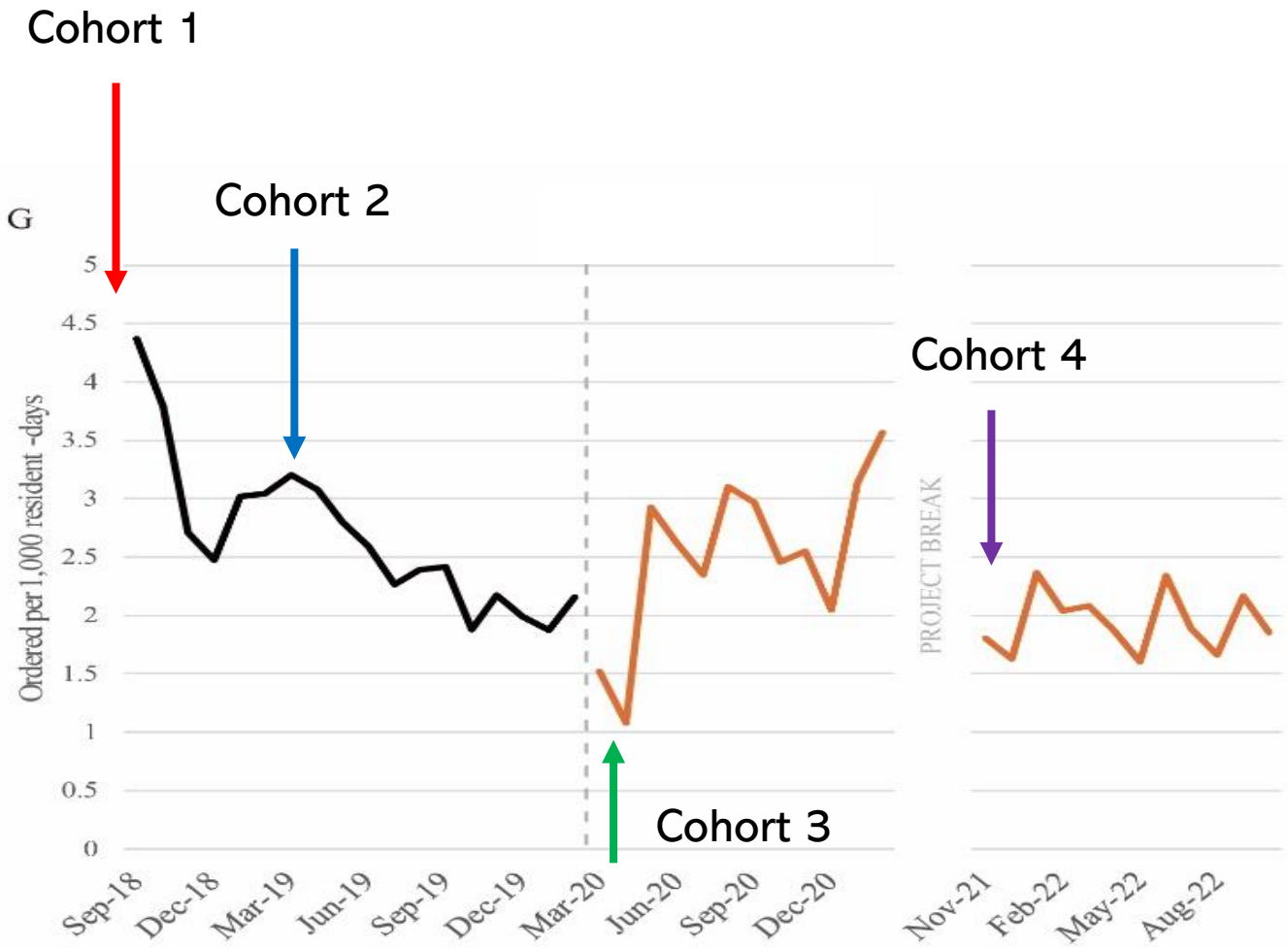
*Per 1000 resident days; **per 1000 device days

Total infections, all project years

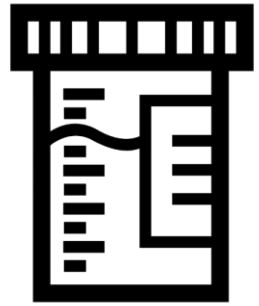
- 32% decrease in total infections (C1 & C2)
- No change during pandemic



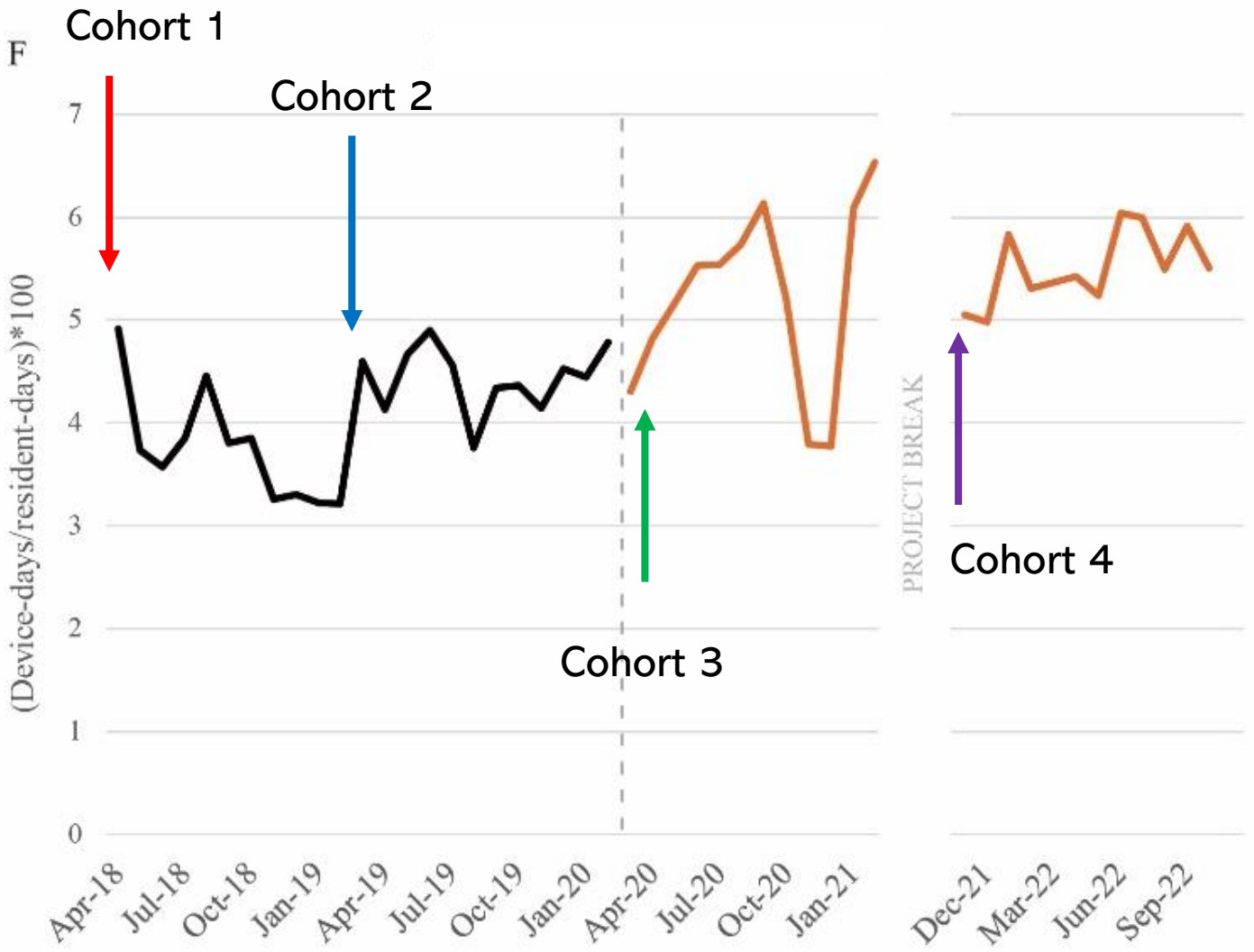
Urine cultures



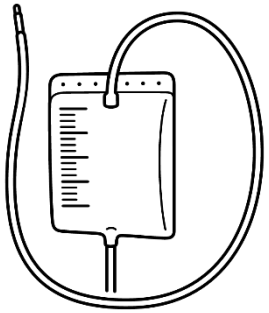
- 63% decrease in urine culturing pre-pandemic (C1 & 2)
- Cohorts 3 & 4 had lower numbers at start of project



Urinary catheter use



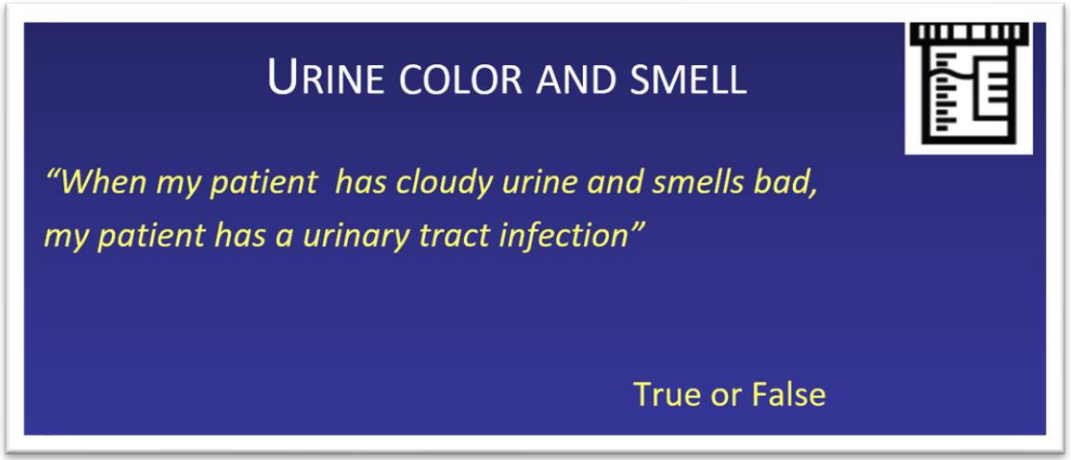
- Decrease during Cohort 1
- Increased use during pandemic
- However, no corresponding increase in urine culturing

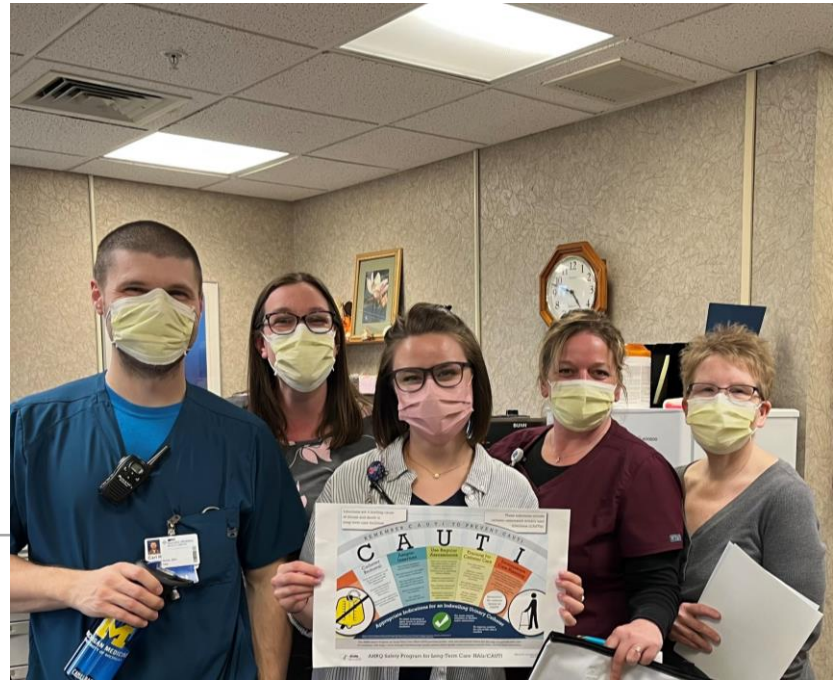


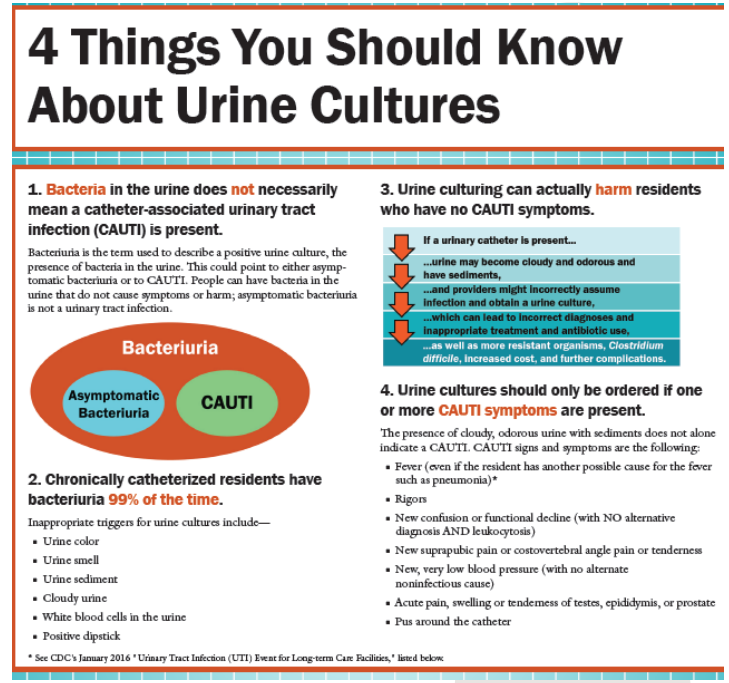
Small Test Change

- 27 NHs participated in PRIISM's Small Test of Change
- Aligned w/PRIISM goals, measurable, targeted, adjustable, scalable
- Ex: hand hygiene education. environmental cleaning and disinfection, antimicrobial stewardship, resident and family education

On-Site Education







Does resident have symptoms of a UTI?

NO → Watchful waiting

YES → Collect urine culture by clean-catch or straight cath. Begin antibiotics if indicated.

dysuria, new frequency or incontinence, suprapubic/testes pain or tenderness, costovertebral pain, gross hematuria

cloudy or foul-smelling urine, fever w/another other cause

Loeb's Minimum Criteria: guide clinical treatment
Revised McGeers: surveillance criteria

Review culture results when available. **Reassess resident.** Determine diagnosis.

Urine culture negative → **Notify provider ASAP & plan to d/c abx if already started**

Urine culture positive → **Perform antibiotic timeout.** Correct: Antibiotic – Dose – Route - Length of time

Always reassess resident before initiating antibiotics!

Behunin, 2022

Conclusions

- A proactive engagement approach impacts HAI prevention in nursing homes.
- Qualitative data indicate benefit of these relationships.
- Additional data indicates more IP support needed (++ responsibilities with high turnover, less experienced IPs).
- Frameworks like PRIISM can withstand with backing of dedicated participants.

Thanks to those who have participated – nursing home leaders, hospital partners, and staff at MDHHS.

Featured speaker

Julie Scott, RN, BSN
Infection Preventionist
D.J. Jacobetti Home for Veterans,
Marquette, Michigan

MICHIGAN VETERAN HOMES

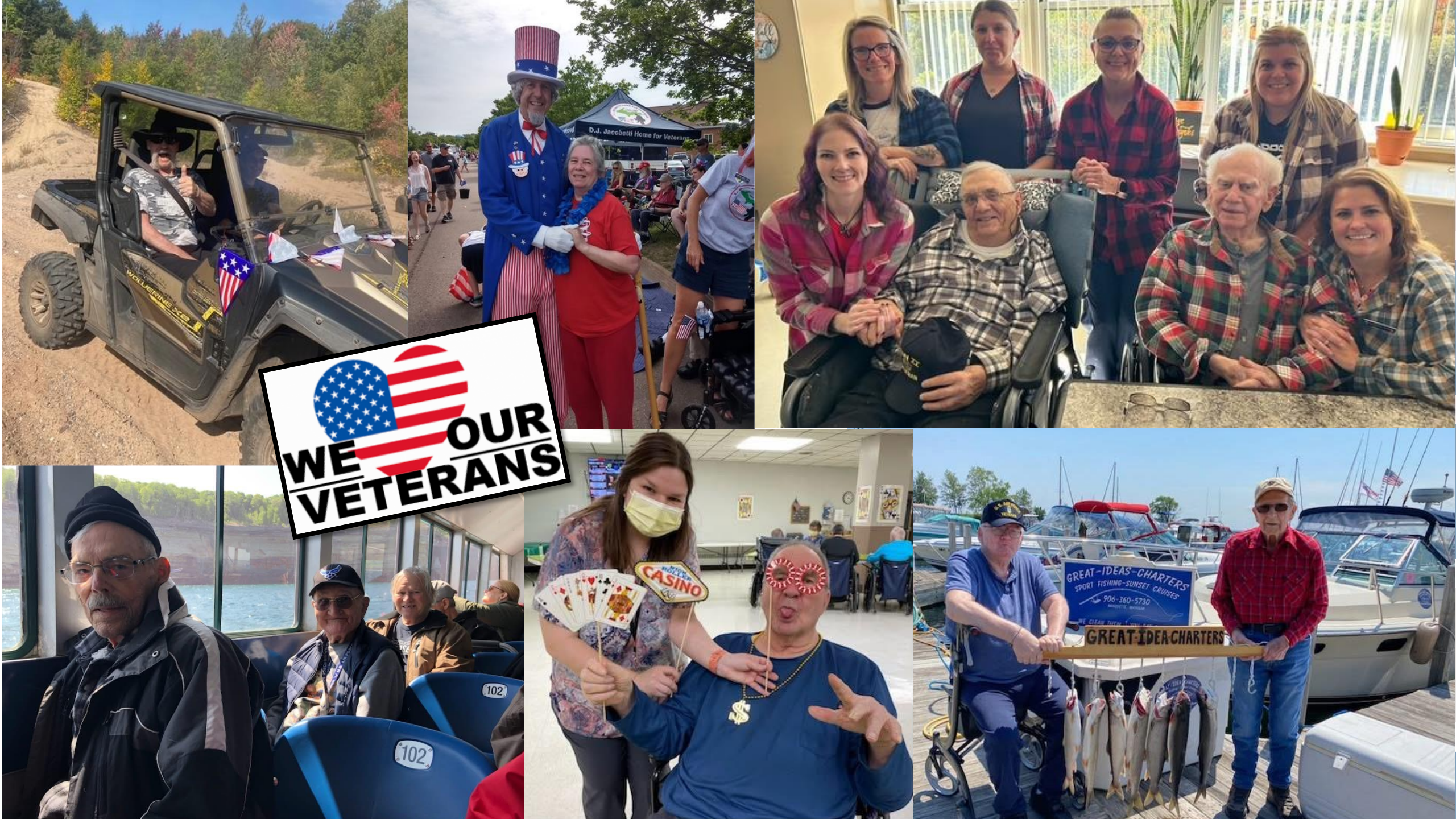
D.J. Jacobetti

- 126 bed facility in the Upper Peninsula of Michigan
- Veterans and their spouses
  - 95% male
  - 98% veterans
- Established in 1981 in the former St. Mary's Hospital
- 5 units
- 1 FTE IP

IP Challenges

- Building is dated
- Only 5 single rooms
- Our South units are suites
  - 2 rooms share a bathroom – 4 members
- Population
  - 95% male veterans
- Only 3 of 5 units are certified

- New Home Coming Summer 2028


WE OUR
VETERANS
D.J. Jacobetti Home for Veterans
CASINO
GREAT-IDEAS-CHARTERS
SPORT FISHING-SUNSET CRUISES
906-360-5730
GREAT-IDEA-CHARTERS

St. Mary's Hospital – built in 1955

Why we joined & what we did…

Participated in CDC- ECHO project in 2020-2021 and developed a relationship with UM.

The ECHO project was beneficial. PRIISM was a natural continuation. PRIISM focused on UTIs/CAUTIs which was an issue at our facility.

Virtual meetings, monthly data submission, PRIISM project website, materials and resources, access to subject matter experts and other IPs to connect with.

Attended by IP and Administrator.

Onsite visit

- Requested assistance with staff education on urine culturing stewardship. Instead of immediately ordering a UA C&S, what can we do? Together, we developed a plan for the education.
- Included all healthcare staff including providers, RNs, LPNs, and care aides. I promoted the education via emails, posters, personal invitations. We offered food, treats & prizes.
- We had great feedback from staff. The education was well attended, and staff were very complimentary. They appreciated the in-person education and felt Karen was very knowledgeable and friendly.
- During the education, multiple staff brought up our hydration stations, which we removed during COVID d/t concerns for spread of infection. As hydration status is essential for residents and impacts urine culture ordering, I did a STOC project on this topic, which complimented the urine culture stewardship education.

Hydration Station

Objective: Increase fluid intake in our members by re-introducing Hydration Stations.

Hydration Stations: An area with multiple water dispensers, filled with juice or infused water, that is easily accessible to all members. This allows members to have access to water at anytime to help themselves to. They do not have to solely depend on staff to get them fluids.

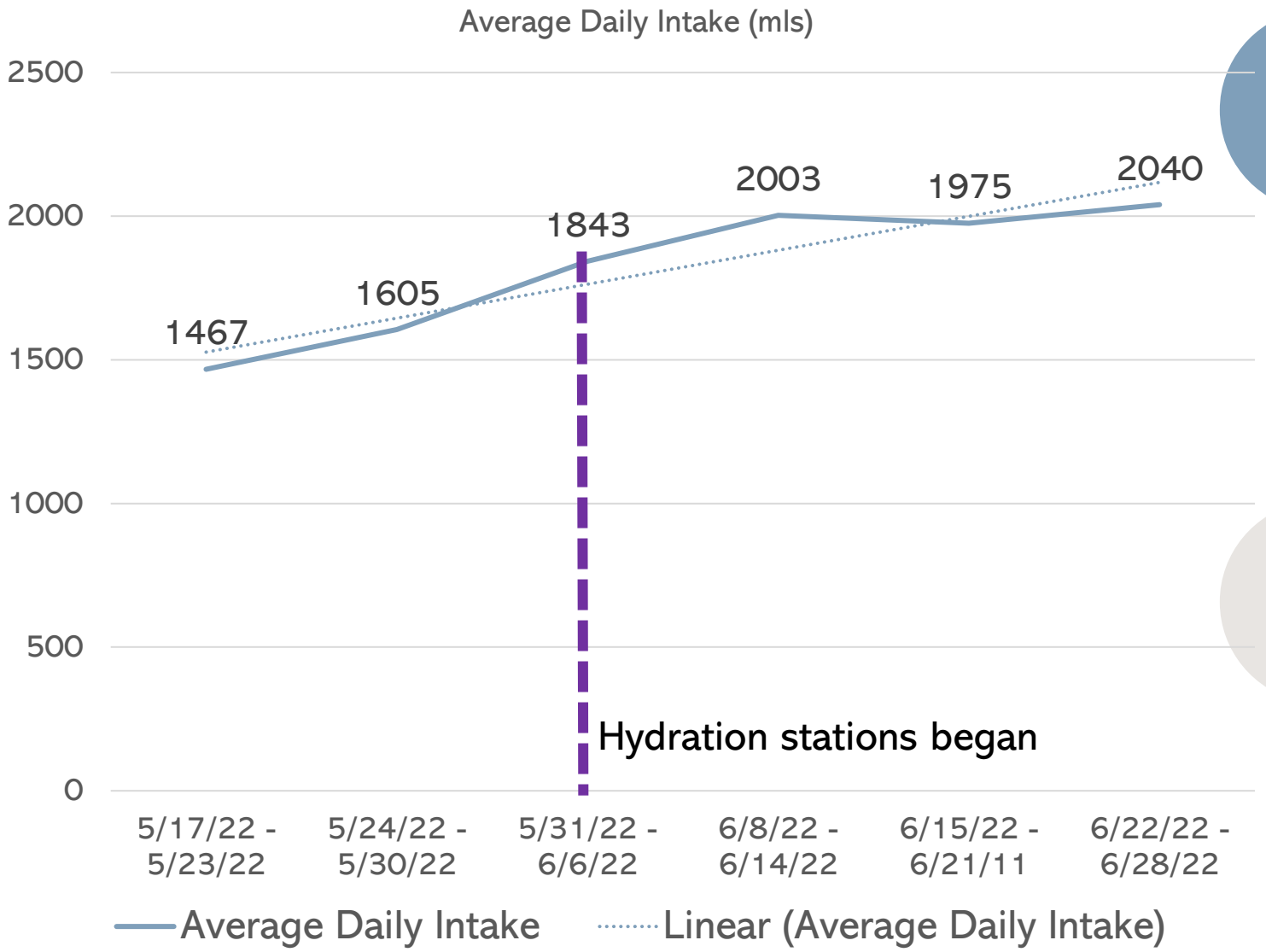
By providing water/juice that is easily accessible and looks appealing to our members, we can increase their fluid intake and independence.

Why is this an issue at our facility?

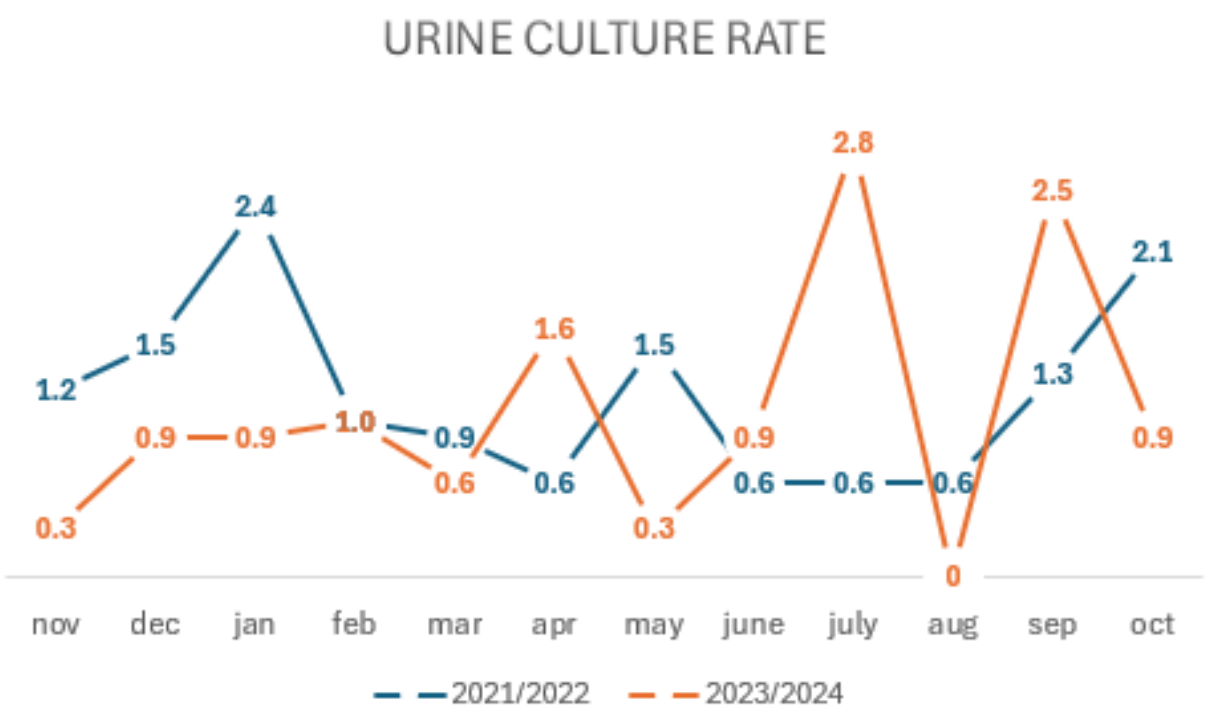
Hydration Stations were removed during COVID to prevent spread of infection. This resulted in members having no self serve options to obtain fluids for themselves.

Outcomes – oral hydration

- This graph compares average daily fluid intake 3 weeks prior to implementing Hydration Station and 3 weeks while in use.
- Positive feedback from members and staff.



Results

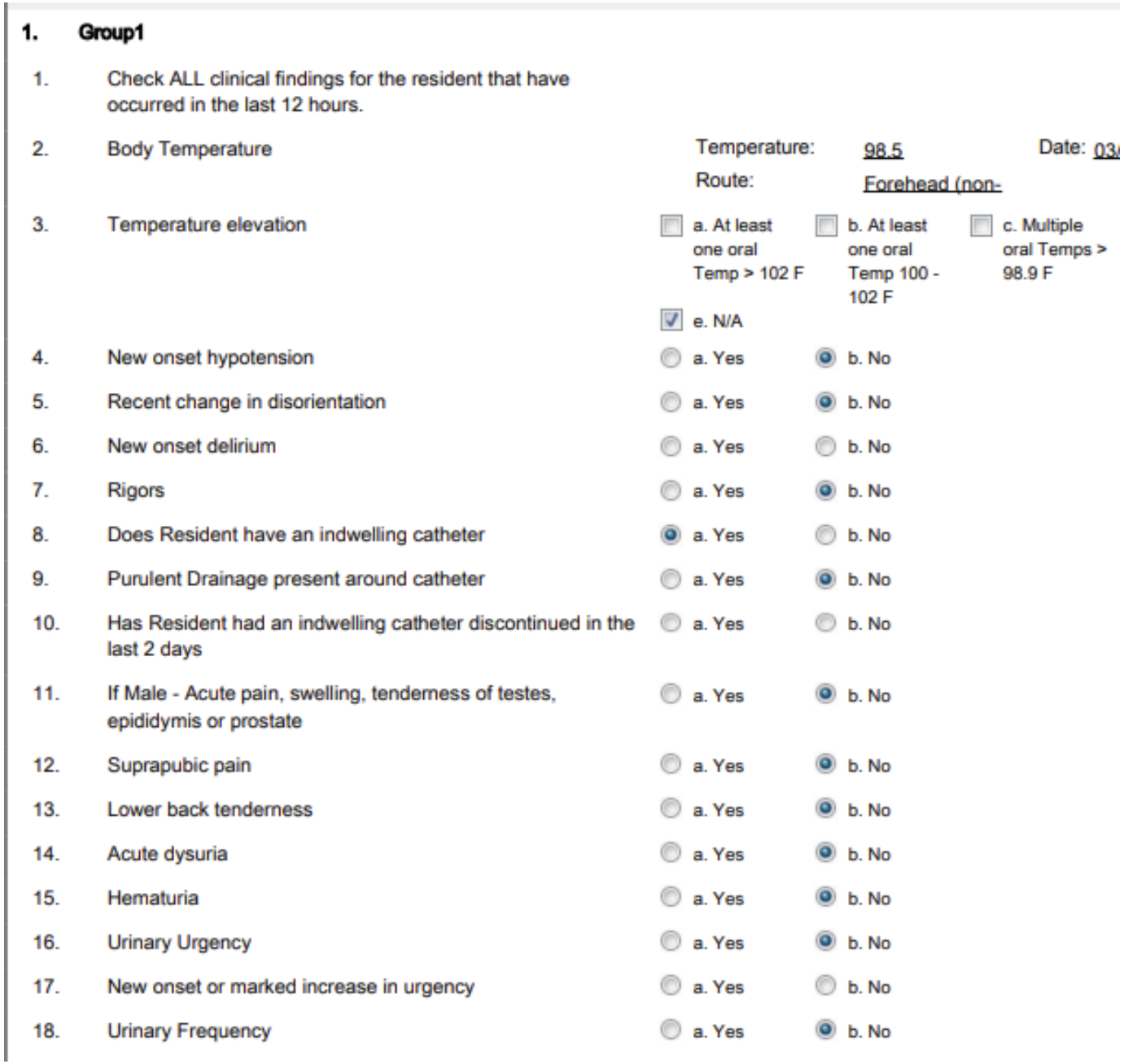


Average Urine Culture Rate	
2021/2022	1.19
2023/2024	1.06

- Urine culture rate comparison
  - 2021/2022 – data collected during PRIISM
  - 2023/2024 – facility data collection

What we took away from PRIISM

- Implemented the use of a UTI screener when symptoms do not meet criteria
- Utilize handouts/educational material from PRIISM to re-educate staff
- Introduced the hydration stations to all units after successful STOC on our 2N unit



1.	Group1	
1.	Check ALL clinical findings for the resident that have occurred in the last 12 hours.	
2.	Body Temperature	Temperature: 98.5 Date: 03/ Route: Forehead (non-
3.	Temperature elevation	☐ a. At least one oral Temp > 102 F ☐ b. At least one oral Temp 100 - 102 F ☐ c. Multiple oral Temps > 98.9 F ☑ e. N/A
4.	New onset hypotension	○ a. Yes ◉ b. No
5.	Recent change in disorientation	○ a. Yes ◉ b. No
6.	New onset delirium	○ a. Yes ○ b. No
7.	Rigors	○ a. Yes ◉ b. No
8.	Does Resident have an indwelling catheter	◉ a. Yes ○ b. No
9.	Purulent Drainage present around catheter	○ a. Yes ◉ b. No
10.	Has Resident had an indwelling catheter discontinued in the last 2 days	○ a. Yes ○ b. No
11.	If Male - Acute pain, swelling, tenderness of testes, epididymis or prostate	○ a. Yes ◉ b. No
12.	Suprapubic pain	○ a. Yes ◉ b. No
13.	Lower back tenderness	○ a. Yes ◉ b. No
14.	Acute dysuria	○ a. Yes ◉ b. No
15.	Hematuria	○ a. Yes ◉ b. No
16.	Urinary Urgency	○ a. Yes ◉ b. No
17.	New onset or marked increase in urgency	○ a. Yes ○ b. No
18.	Urinary Frequency	○ a. Yes ◉ b. No

Featured speaker

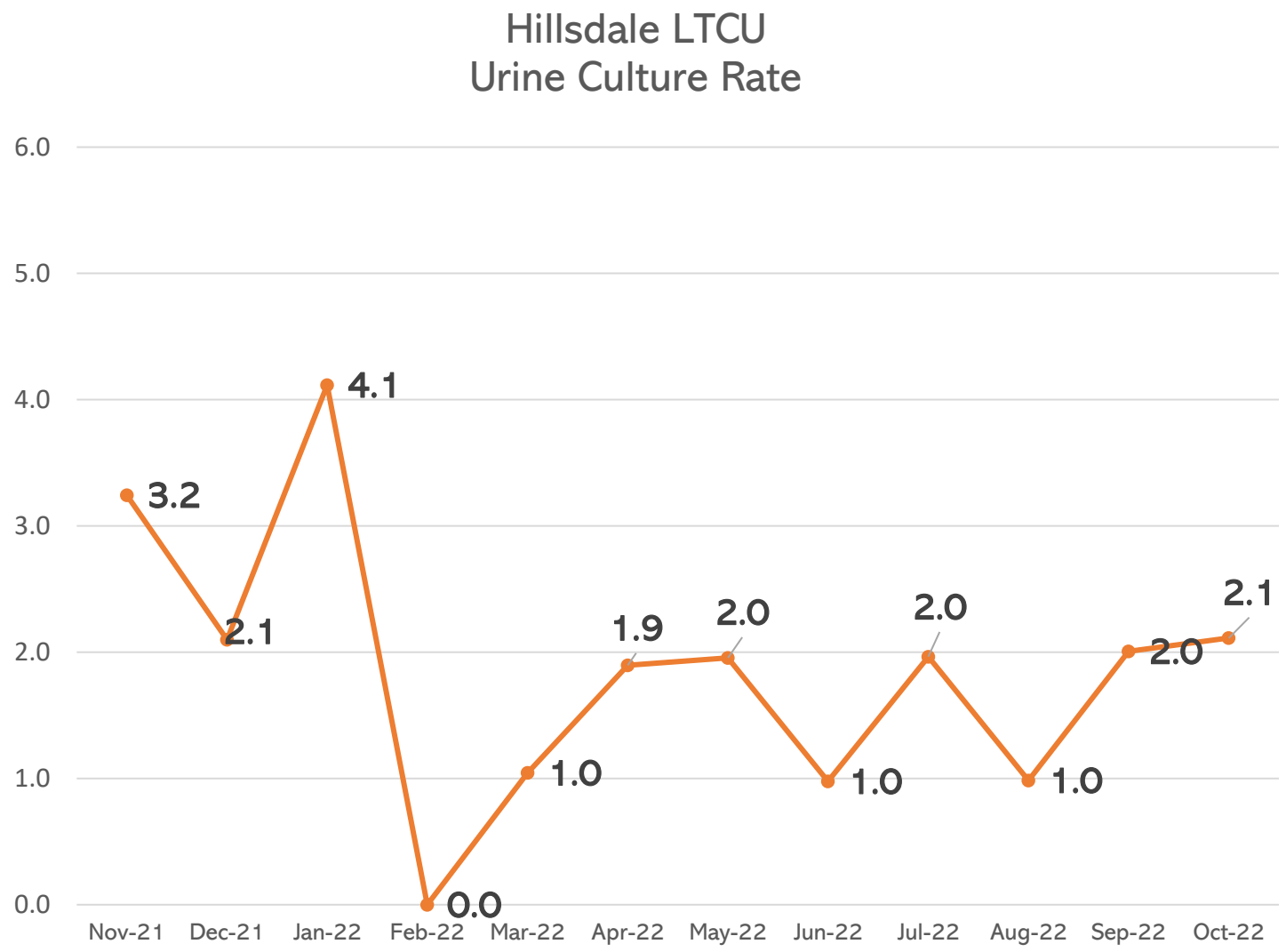
Randy Holland, MHA, BSN, CIC
Director of Infection Control
and Ancillary Services
Hillsdale Hospital,
Hillsdale, Michigan

Hillsdale Hospital - LTCU

- 38 beds, split evenly between long-stay and short stay
- Facility is housed within Hillsdale Hospital
- IP FTE = .5 (just me)
- Participated with University of Michigan in ECHO, subsequently PRIISM

Focus on UTI prevention and correct prescribing

- Urine cultures
- Antibiotic use
- PRIISM's Small Test of Change – kicked off antibiotic stewardship initiatives



How things are going

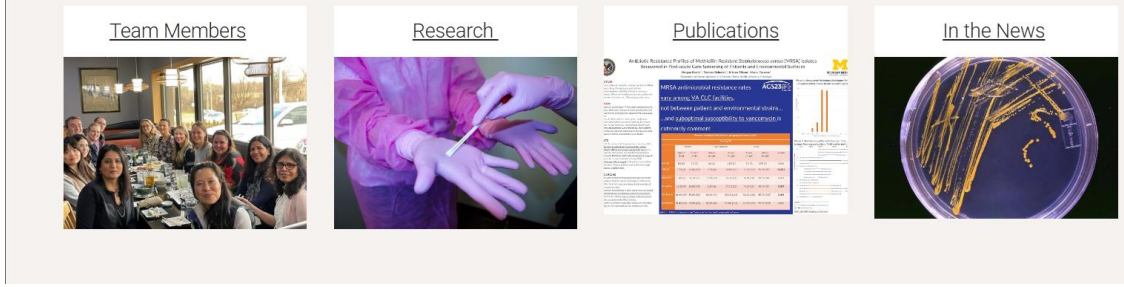
- Ongoing partnerships
  - With University of Michigan and Michigan State University
  - Encouraged us to seek continued grant funding to support patient safety
- Innovative strategies
  - Electronic hand hygiene monitoring (only LTCF in Michigan!)
  - UV room disinfection
  - Alternative to room curtains

Alternative to room curtains

UV light room disinfection

CRIISP

Center for Research and Innovations In Special Populations



The Center for Research and Innovations In Special Populations (CRIISP), led by Dr. Lona Mody, **applies translational epidemiologic research methods to enhance disease outcomes in vulnerable populations**. Our projects utilize a variety of research methods from observational and molecular epidemiology, clinical trials to implementation science with an explicit attention to mentoring junior investigators in research leadership.

https://criisp-mody.lab.medicine.umich.edu/home

Questions?

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- Bonner A. Hope springs eternal: Can Project ECHO transform nursing homes? J Am Med Dir Assoc, 2021 ;22:225-227

- Jones KM, Krein SL, Mantey J, et al. Characterizing infection prevention programs and urinary tract infection prevention practices in nursing homes: A mixed-methods study. Infect Control Hosp Epidemiol. 2024 ; 45: 40-47.

Housekeeping

- Please mute your line
- Have questions for our speaker? Drop it in the chat to be asked!

Continuing Education (CE)

- There are no CEs available for today's session

Welcome

Karen Jones, MPH, RN, CIC,
LTC-CIP, FAPIC
University of Michigan

Q+A

Upcoming APIC-GL Webinars

- **Aug 12** – Member Presentations
- **Oct 9** – APIC-GL Fall Conference
- **Nov 4** – NHSN Rebaseline

Please note this schedule is subject to change.
All changes and additional event details will be communicated via email, once confirmed.

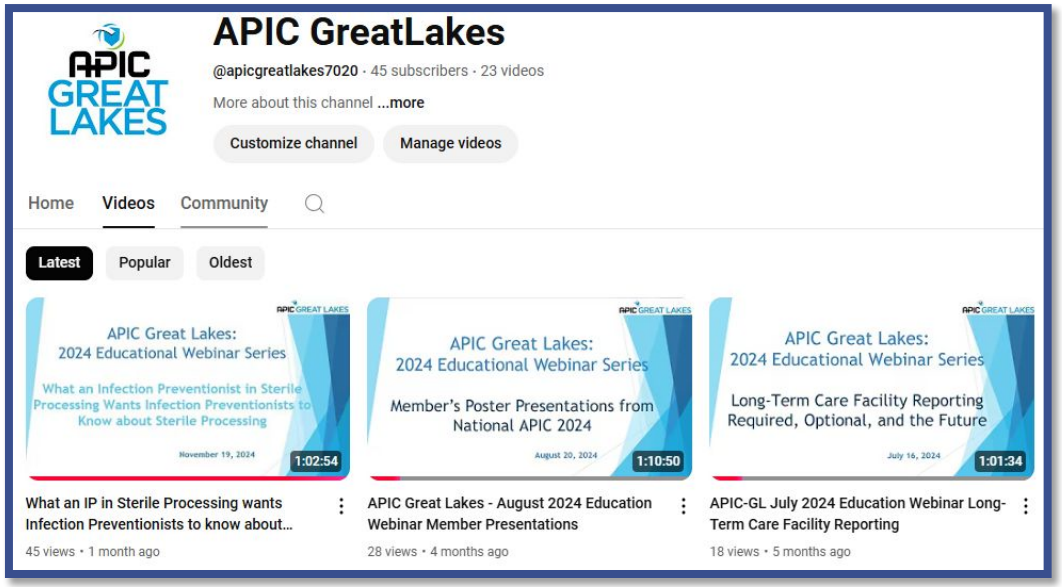
Please direct questions to
Kelsey Ostergren – kostergren@mha.org,
Chau Nguyen - chau.nguyen@corewellhealth.org, or
Denise Parr – parrd1@michigan.gov

2025 APIC Great Lakes Fall Conference

- Oct 9
- Eagle Eye Golf Club & Banquet Center
- Registration deadline - Sept 23

Missed a webinar? No worries!

- Check out the APIC- GL YouTube Channel, where you can find recordings of all prior meetings!



- Presentation slides & any supplemental materials can be found on the APIC-GL website

Job Postings

- If you have an open position you would like to post to the APIC-GL webpage, please email us at apicgreatlakes@gmail.com

- Link to job board

APIC GREAT LAKES

PEER MENTORSHIP ROUNDTABLE

Thank you for joining us today!