TAP Prevention Prioritization Toolkit

This toolkit has been developed for use by partners in prevention as a component of the Centers for Disease Control and Prevention's (CDC) Targeted Assessment for Prevention (TAP) Strategy. Facilities may use this compilation of templates to help prioritize their infection prevention gaps and develop strategies to implement corresponding interventions. This toolkit may be most helpful to facilities after deploying the TAP Facility Assessments and reviewing their results using the TAP Feedback Report. Within these example template tools, facilities may adapt and modify the content they select to be most relevant to their prioritization and implementation efforts. Further, partners are encouraged to explore alternative tools as needed, noting that the examples provided here are not mutually exclusive nor do they represent an exhaustive list of available tools. For more information, visit the Targeted Assessment for Prevention (TAP) Strategy website (https://www.cdc.gov/healthcare-associated-infections/php/toolkit/tap-strategy.html).

For questions and requests for technical assistance, please email CDC at HAIPrevention@cdc.gov.

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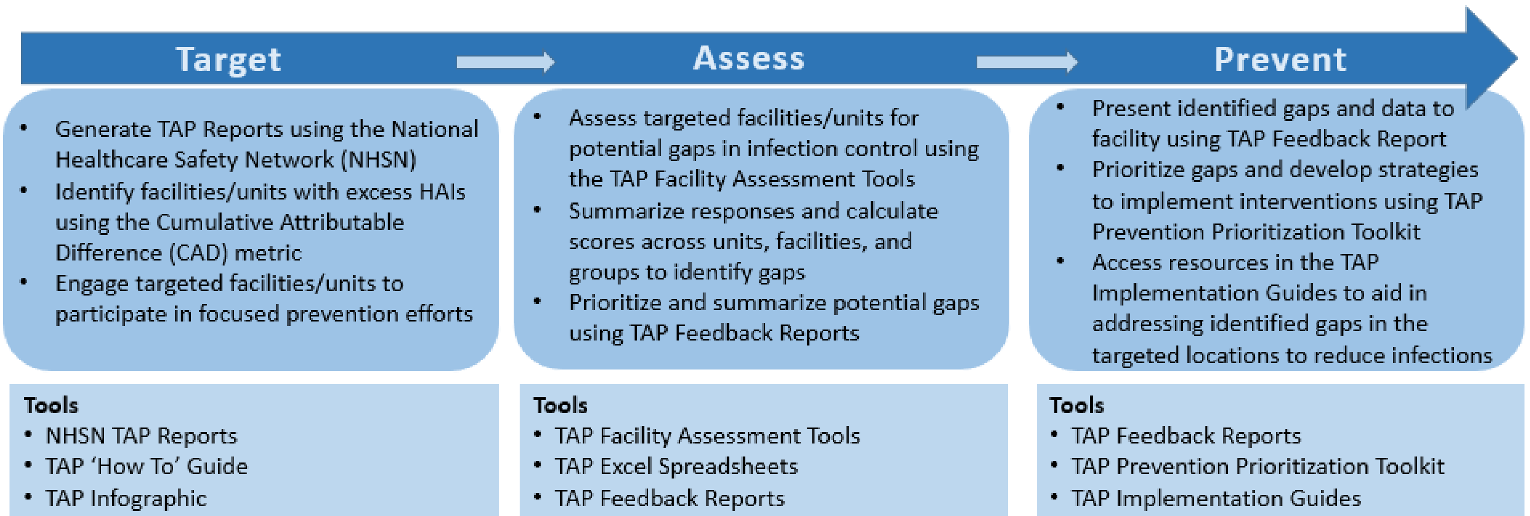
TAP Strategy Overview

The Targeted Assessment for Prevention (TAP) Strategy is a quality improvement framework that uses data for action to prevent healthcare-associated infections (HAIs). The TAP Strategy consists of three components: **1)** Running TAP Reports in the National Healthcare Safety Network (NHSN) to target healthcare facilities and specific units with an excess burden of healthcare-associated infections (HAIs), **2)** Administering TAP Facility Assessment Tools to identify gaps in infection prevention in the targeted locations, and **3)** Accessing infection prevention resources within the TAP Implementation Guides to address those gaps.



The TAP Strategy and accompanying tools can be utilized for the prevention of catheter-associated urinary tract infections (CAUTIs), *Clostridioides difficile* infections (CDIs), and central line-associated blood stream infections (CLABSIs).* Prevention partners engaged in quality improvement and collaborative work may use the TAP Strategy to identify and prioritize facilities within their jurisdictions to assist with their HAI prevention efforts. This Strategy can be tailored to specific HAI reduction goals and healthcare settings.

The TAP Strategy offers a focused and targeted approach to infection prevention. Reducing infections in facilities and/or units identified as having the highest burden of excess infections may more efficiently reduce the jurisdiction and/or facility-wide standardized infection ratio (SIR). Further, using the TAP Facility Assessment Tools to identify specific gaps within a facility allows for customization of strategies to facilitate prevention efforts. This targeted approach aims to minimize resources required while maximizing impact as partners work towards the goal of elimination.

CDC is available to assist partners with all aspects of TAP Strategy implementation. Please email HAIPrevention@cdc.gov with any questions and/or requests for technical assistance.

*NHSN TAP Reports are now available for MRSA in Acute Care Facilities; however, there is currently no TAP Facility Assessment available for MRSA. If you have any questions or would like to further discuss interventions to prevent MRSA bloodstream infections in acute care hospitals, please contact CDC at HAIPrevention@cdc.gov.

Description of Prevention Prioritization Tools

Project Charter

The Project Charter describes the performance improvement rationale, goals, barriers, and anticipated resources to which the team will commit. By engaging staff members directly involved with the improvement project, the Project Charter may facilitate success by providing a working knowledge of the project, outlining specific performance measures and targeted improvement goals, and identifying key stakeholders that may promote project success.

Practice Analysis

The Practice Analysis Tool may help in determining the "gaps" between processes currently in place in your organization and the identified best practices. When used by the improvement project team, the Practice Analysis may help a facility understand the differences between current and best practices, and assess the barriers that may need to be addressed before successful implementation of best practices.

Implementation Plan

The Implementation Plan can guide project teams in defining the tasks and actions required to implement each best practice, as well as developing a communication and training plan. This tool may also be used to set a timeframe and target dates for the completion of outlined tasks/actions and accompanying communication and training.

Small Test of Change Worksheet

The Small Test of Change Worksheet is based on the Plan-Do-Study-Act cycle, common among healthcare quality and improvement methods. This worksheet guides the team through planning the test or observation, trying out the test on a small scale, analyzing and studying the data, and refining the change based on the collected data.

PICK Chart

The PICK Chart may help facilities categorize and prioritize improvement ideas. This chart is similar to a prioritization matrix based on the "payoff" and "difficulty" of each idea. This tool may help facilities in categorizing their improvement ideas into four quadrants: Possible idea, Implement idea, Challenge idea, and Kill idea.

Strategy Grid

The Strategy Grid allows for focusing of efforts based on the needs and feasibility of improvement projects. Strategy grids may be especially useful when agencies have limited capacity and want to focus on areas with the greatest possible return on investment. These tools may also be useful in the improvement process by helping the team move from brainstorming into prioritization and implementation.

Strategy Prioritization Matrix

The Strategy Prioritization Matrix allows for the brainstorming of activities, and helps to prioritize improvement projects by assigning values to the ideas based on urgency, potential impact, feasibility, resources, community readiness, and integration. Totaling the points for each strategy may help facilities prioritize their quality improvement projects.

Project Charter

This tool has been adapted from the *Toolkit for Using the AHRQ Quality Indicators, How to Improve Hospital Quality and Safety* (https://www.ahrq.gov/professionals/systems/hospital/qitoolkit/index.html) and may be further modified as needed for infection prevention interventions.

What is the purpose of this tool? The purpose of the project charter is to describe the performance improvement rationale, goals, barriers, and anticipated resources to which the team will commit.

Who are the target audiences? Staff members directly involved in the improvement project. Consider adding representatives from the physician and nursing staff, along with quality improvement representatives.

How can the tool help you? Upon completion of the project charter, the implementation team will have the following:

- Working knowledge of the project.
- Specific performance measures and targeted improvement goals.
- Identified organizational forces that may promote or impede project success.

Instructions:

1. Describe the project scope and provide goal statement. For example, consider which organizational departments will be involved in the project. Which units will this project affect? Are certain service lines being included? What patient population(s) will be included?
2. Document the case for change; list the key reasons for initiating the project, specifically stating the problem. These may come from TAP Facility Assessment.
3. List the performance measures and baseline performance data. Set a performance goal for each measure.
4. List the project milestones that will guide your team in keeping on track. Milestones are major points in a project lifecycle. Some milestones for improvement projects could be the development of a tool or policy or completion of staff training on a new procedure.
5. Consider factors that are potential barriers to success such as resistance to change, resource limitations, or time constraints.
6. List the individuals or groups who will be affected by these strategies; include stakeholders.
7. Choose team members based on stakeholder analysis. Enter the project team members’ names. Review the estimated percentage of time the executive liaison, clinical liaison, and project liaison will dedicate to the project.
8. Document any additional resources that may be required, such as team members and administrative support.
9. Review the charter with the executive, clinical, and project liaisons and obtain signatures.

Project Charter form continued on next page

Project Charter

Institution:

Project Name:

Start Date:

Target Completion Date:

Project Liaison:

PROJECT PLAN

1. **PROJECT DESCRIPTION/SCOPE:** (*Pilot unit or housewide project? Specific patient population? Are certain service lines being included?)*

2. **CASE FOR CHANGE (Potential Return on Investment):** *(Describe the reason(s) for initiating the project, specifically stating the problem)*

3. PERFORMANCE MEASURES

	Baseline	***Goal***

4. MILESTONES

	Evaluation Date

5. POTENTIAL BARRIERS TO SUCCESS

ASSEMBLE TEAM & RESOURCES

6. STAKEHOLDERS. List the individuals or groups who may be affected by these strategies.

7. TEAM MEMBERS. Consider including representatives from stakeholder groups noted above.

Executive Liaison:	Team Member:
Clinical Liaison:	Team Member:
Project Liaison:	Team Member:
Team Member:	Team Member:
Team Member:	Team Member:

8. ADDITIONAL RESOURCES NEEDED

9. SIGNATURES	DATE
Executive Liaison:	
Clinical Liaison:	
Project Liaison:	

Practice Analysis

This tool has been adapted from the *Toolkit for Using the AHRQ Quality Indicators, How to Improve Hospital Quality and Safety* (https://www.ahrq.gov/professionals/systems/hospital/qitoolkit/index.html) and may be further modified as needed for infection prevention interventions.

What is the purpose of this tool? The purpose of the practice analysis is to provide project teams with a format in which to do the following:

- Compare the best practices with the processes currently in place in your organization.
- Determine the "gaps" between your organization's practices and the identified best practices.
- Select the best practices you will implement in your organization.

Who are the target audiences? The project liaison will be the primary individual to prepare this written practice analysis, but the entire improvement project team should be engaged in performing the practice analysis. Consider adding representatives from the physician and nursing staff, along with quality improvement representatives.

How can the tool help you? Upon completion of the gap analysis, project teams will have the following:

- An understanding of the differences between current practices and best practice.
- An assessment of the barriers that may need to be addressed before successful implementation of best practices.

Best practices include evidence-based practices, as found in guidelines for infection prevention and control. For more information, see the CDC Guidelines Library (https://www.cdc.gov/infection-control/hcp/guidance/index.html).

Instructions:

1. List the expected best practice in the header row.
2. In Column 1, list all the steps (strategies) associated with implementing the best practice process.
3. In Column 2, document your organization's current practices (may have been identified in the TAP Facility Assessment). Be specific and include information such as policies, protocols, guidelines, and staffing.
4. In Column 3, identify barriers that may hinder successful implementation of each best practice strategy. Consider systems, procedures, policies, people, equipment, etc.
5. In Column 4, indicate whether your organization will implement the best practice strategy. If not, explain why.
6. Repeat steps 2-4 for each best practice, adding rows as needed.

Practice Analysis tool continued on next page

Practice Analysis Tool

Individual Completing This Form:

Best Practice #1 **(Gap identified from TAP Facility Assessment):**

Best Practice Strategies	How Your Practices Differ From Best Practice (Those Identified through the TAP Facility Assessment)	Barriers to Best Practice Implementation	Will Implement Best Practice (Yes/No; Why not?)

Best Practice #2 **(Gap identified from TAP Facility Assessment):**

Best Practice Strategies	How Your Practices Differ From Best Practice (Those Identified through the TAP Facility Assessment)	Barriers to Best Practice Implementation	Will Implement Best Practice (Yes/No; Why not?)

Best Practice #3 **(Gap identified from TAP Facility Assessment):**

Best Practice Strategies	How Your Practices Differ From Best Practice (Those Identified through the TAP Facility Assessment)	Barriers to Best Practice Implementation	Will Implement Best Practice (Yes/No; Why not?)

Example:

Best Practice **(Gap identified from TAP Facility Assessment):** ***Training on hand hygiene at least annually***

Best Practice Strategies	How Your Practices Differ From Best Practice (Those Identified through the TAP Facility Assessment)	Barriers to Best Practice Implementation	Will Implement Best Practice (Yes/No; Why not?)
Annual training for all personnel on hand hygiene practices will be added to the annual skills fair	*Currently provide training upon hire, but do not provide annual training*	*Time, accountability, current training is computer module and not demonstration*	*Yes*

Implementation Plan

This tool has been adapted from the *Toolkit for Using the AHRQ Quality Indicators, How to Improve Hospital Quality and Safety* (https://www.ahrq.gov/professionals/systems/hospital/qitoolkit/index.html) and may be further modified as needed for infection prevention interventions.

What is the purpose of this tool? The purpose of the implementation plan is to provide a format in which to:

- Define the tasks/actions required to implement each selected best practice.
- Develop a communication/training and implementation plan.
- Set a timeframe and target dates for the completion of tasks/actions and communication/training.

Who are the target audiences? The project liaison will be the primary individual to complete this implementation plan, but the document should be used as a working document by the entire improvement project team. Consider adding representatives from the physician and nursing staff, along with quality improvement representatives.

How can the tool help you? Upon completion of the implementation plan, the project team will have a customized project plan that will guide activities through established timeline to completion of implementation.

Best practices include evidence-based practices, as found in guidelines for infection prevention and control. For more information, see the CDC Guidelines Library (https://www.cdc.gov/infection-control/hcp/guidance/index.html).

Instructions:

1. In the header row, list the best practice your organization will implement, which may have been identified in the TAP Facility Assessment.
2. In Column 1, list the detailed tasks/actions for each best practice.
3. In Column 2, assign responsibility to team members for the completion of each detailed task/action.
4. In Column 3, identify the target implementation start dates.
5. In Column 4, determine whether communication/training is required for each task. If so, include the target dates of communication/training in Column 5.
6. In Column 6, add the actual implementation start date.
7. Repeat steps 1-6 for each best practice, adding rows as needed.
8. Review the implementation plan at each team meeting. If target dates are not met, determine the cause and revise the implementation plan. Ultimately, the project's executive liaison will be responsible to ensure that the team has the adequate resources to complete tasks and that the team stays on track with task deadlines.

It is essential to consider several categories of key tasks when generating a list of detailed tasks/actions. Consider these key task categories:

- Design/Customization of Best Practice
- Policy/Protocol Development
- Tools (documentation, forms, etc.)
- Staffing/Resources
- Equipment/Materials
- Education/Training
- Performance Evaluation

Implementation Plan continued on next page

Implementation Plan

Individual completing this form:

Best Practice #1 **(Gap identified from TAP Facility Assessment):**

Detailed Tasks/Actions Associated With Implementation of Best Practice	Team Members Assigned to Each Task	Target Implementation Start Date	Communication and/or Training Required? Yes/No	Communication and/or Training Scheduled Dates	Actual Implementation Start Date

Best Practice #2 **(Gap identified from TAP Facility Assessment):**

Detailed Tasks/Actions Associated With Implementation of Best Practice	Team Members Assigned to Each Task	Target Implementation Start Date	Communication and/or Training Required? Yes/No	Communication and/or Training Scheduled Dates	Actual Implementation Start Date

<u>Best Practice #3</u> (Gap identified from TAP Facility Assessment):

Detailed Tasks/Actions Associated With Implementation of Best Practice	Team Members Assigned to Each Task	Target Implementation Start Date	Communication and/or Training Required? Yes/No	Communication and/or Training Scheduled Dates	Actual Implementation Start Date

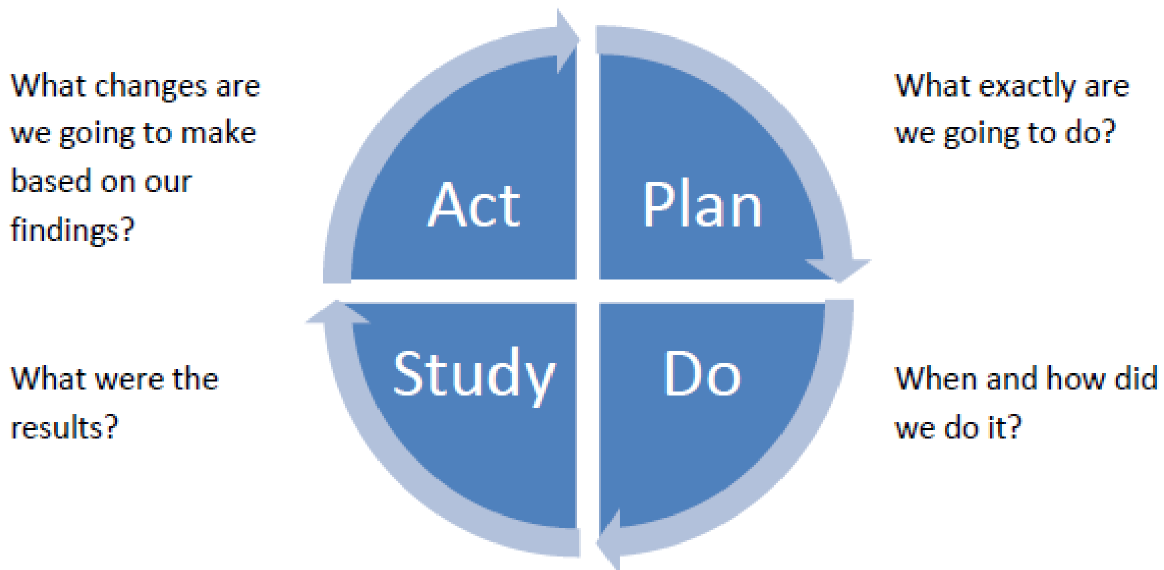
Small Tests of Change Worksheet

The Small Test of Change Worksheet (http://birthtools.org/birthtools/files/ccLibraryFiles/Filename /000000000234/Testofchangeworksheet.pdf) is adapted for use from Alliant Georgia Medical Care Foundation (GMCF) and the Georgia Learning Collaborative. The purpose of the Small Tests of Change Worksheet is to guide implementation teams through the Plan, Do, Study, Act cycle and may be used to conduct multiple small tests of change on the journey to the overall improvement goal.

During a Performance Improvement Plan you will try out some changes and then see whether or not they made a difference in the area you were trying to improve. In the PLAN stage, the team learns more about the problem, plans for how improvement would be measured, and plans for any changes that might be implemented. In the DO stage, the plan is carried out, including the measures that are selected. In the STUDY phase, the team summarizes what was learned. In the ACT phase, the team and leadership determine what should be done next. The change can be adapted (and re-studied), adopted (perhaps expanded to other areas), or abandoned. That decision determines the next steps in the cycle.

Model for Improvement: Three questions for improvement

1. **What are we trying to accomplish (aim)?**
2. **How will we know that change is an improvement (measures)?**
3. **What change can we make that will result in an improvement (ideas, hunches, theories)?**



TEAM LEADER:

GOAL: Overall goal you would like to reach.
Every goal may require multiple smaller tests of change

1. PLAN: List your action steps along with person(s) responsible and timeline.

Items to consider:

- *What is the objective of the test?*
- *What do you predict will happen, why?*
- *What change will you make?*
- *Who will it involve (e.g. one unit, one floor, one department)?*
- *How long will the change take to implement?*
- *What resources will they need?*
- *What data need to be collected*

Describe your test of change including person responsible, when to be done, and where to be done.

Test of change	Person Responsible	When to be done	Where to be done

List the tasks needed to set up this test of change

List the tasks (Enter as many as you need to for this test of change)	**Person Responsible**	**When to be done**	**Where to be done**

Predict what will happen when the test is carried out

What measures will you use to determine if the prediction is a success?

Predictions (Enter as many as you need to for this test of change)	**Measures for predictions** (Include a measure for each prediction)

2. DO: Describe what actually happened when you ran the test of change

- *Implement the change*
- *Try out the test on a small scale*
- *Document problems and unexpected observations*
- *Begin analysis of the data*

3. STUDY: Describe the measured results and how they compared to the predictions (set aside time to analyze the data and study the results and determine if the change resulted in the expected outcome)

- *Complete the analysis of the data*
- *Compare the data to your predictions*
- *Summarize and reflect on what was learned. Look for: unintended consequences, surprises, successes, failures.*

4. ACT: Describe what changes to the plan will be made for the next cycle from what you learned (If the results were not what you wanted, you try something else. Refine the change, based on what was learned from the test.)

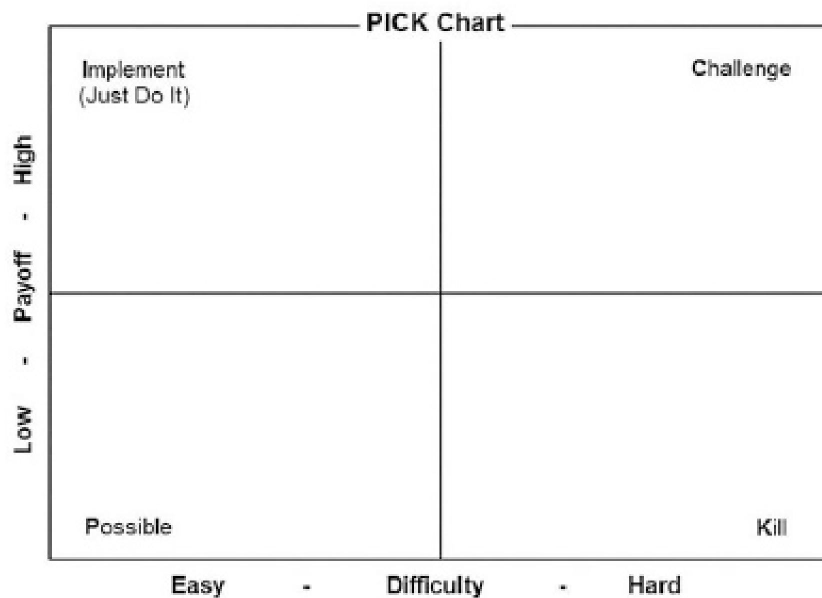
- ***Adapt*** *– Modify the changes and repeat PDSA cycle*
- ***Adopt*** *– Consider expanding the changes in your organization (to additional units, staff, disciplines)*
- ***Abandon*** *– Change your approach and repeat PDSA cycle*

PICK Chart

The PICK Chart (https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/implementation-guide/appendix-b.html) is adapted for use from the Agency for Healthcare Research and Quality (https://www.ahrq.gov/). The purpose of the PICK chart is to generate and critically examine ideas to address practice gaps and to determine whether to proceed with implementation.

A PICK chart is a Lean Six Sigma tool used to categorize and prioritize improvement ideas based on the difficulty and payoff of implementation. Sometimes called an effort/impact chart, the chart has four quadrants:

- **P**ossible idea
- **I**mplement idea
- **C**hallenge idea
- **K**ill idea



An easy way to create a PICK chart is to draw a 2 x 2 grid either on a whiteboard or a large paper flip chart. Have participants place improvement ideas (written on sticky notes) in the quadrant where they feel the idea best fits.

A PICK chart can be a helpful tool for deciding what to work on first. The ideas in the “Implement” quadrant are likely a good place to start. The team can then start looking at some of the ideas in the “Challenge” quadrant that are more difficult but have a high payoff. The ideas in the “Possible” quadrant are not a priority to pursue, and the ideas in the “Kill” quadrant should likely not be considered.

Here are some guidelines for using a PICK chart:

- Don’t let participants put their sticky notes between quadrants. They need to decide what quadrant they go in. The beauty of sticky notes is that they can always be moved as the team discusses each idea.
- Keep the PICK chart simple. Don’t subdivide each quadrant or allow participants to be strategic about the quadrant they place their sticky note in.
- If participants have trouble putting an idea in the quadrant labeled “Kill,” explain that “Kill” just means that the idea is hard to do and has a low payoff.

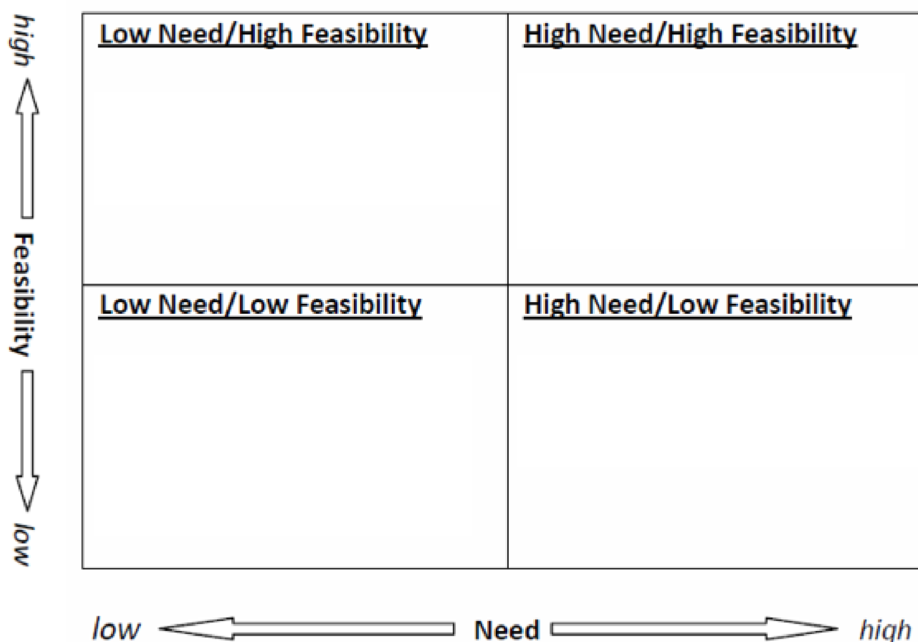
Strategy Grid

The Strategy Grid (pages 4-5, https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf) is adapted for use from the National Association of County & City Health Officials (https://www.naccho.org/). The purpose of the Strategy Grid is to facilitate focusing of efforts on the needs and feasibility of improvement projects. This tool is particularly useful when facilities are limited in capacity and want to focus on areas that provide the greatest return on investment.

Instructions:

1. **Select criteria** – Choose *two* broad criteria that are currently most relevant to the agency (e.g. 'importance/urgency,' 'cost/impact,' 'need/feasibility,' etc.). Competing activities, projects, or programs will be evaluated against how well this set of criteria is met. The example strategy grid below uses 'Need' and 'Feasibility' as the criteria.
2. **Create a grid** – Set up a grid with four quadrants and assign one broad criteria to each axis. Create arrows on the axes to indicate 'high' or 'low,' as shown below.
3. **Label quadrants** – Based on the axes, label each quadrant as either 'High Need/High Feasibility,' 'High Need/Low Feasibility,' 'Low Need/High Feasibility,' 'Low Need/Low Feasibility.'
4. **Categorize & Prioritize -** Place competing activities, projects, or programs in the appropriate quadrant based on the quadrant labels. The example below depicts 'Need' and 'Feasibility' as the criteria.

   Interventions categorized as *High Need/High Feasibility* are considered high demand and high return on investment, and may be given the highest priority with sufficient resources to maintain and continuously improve. Interventions categorized as *High Need/Low Feasibility* may be longer-term projects that have a great deal of potential but may require more investment. Focusing on too many of these items at once can overwhelm an agency, but they should be considered due to the high need categorization.



Strategy Prioritization Matrix

The Strategy Prioritization Matrix (https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=2ahUKEwj85Mfp4pzeAhXLzFMKHXFYD8EQFjABegQICBAC&url=http%3A%2F%2Fwww.healthykansans2010.org%2Ftobacco%2Fdocuments%2FMeeting2%2FStrategy%2520Prioritization%2520Matrix.doc&usg=AOvVaw18u-8rOGtYSINP_50MZNXy) is adapted for use by Healthy Kansans 2010 (http://www.healthykansans2010.org/tobacco/default.asp). The Strategy Prioritization Matrix helps teams prioritize improvement projects by assessing ease of implementation, potential impact, availability of resources, and facility readiness for change.

Strategy Prioritization Matrix Instructions

Tasks:

1. Brainstorm strategies.
2. Review list of strategies to determine relevance to disparities, reduce redundancy or duplication, and clarify meaning. Consolidate strategies, if appropriate.
3. As a team, use the Prioritization Matrix below to rank order strategies. Rank strategies for each criterion using the following scale:
   - **High = 3 points**
   - **Medium = 2 points**
   - **Low = 1 point**
4. Assign total points for each strategy.
5. Calculate the results.
6. Interpret the results and identify the top three strategies, with higher scores (total points) representing higher priority items.
7. Discuss until your team has achieved consensus on the **top three** strategies.

Criteria:

- **Urgency:** Is this a priority issue that needs to be addressed in the next 1-3 years?
- **Potential Impact:** Is it likely that addressing this critical issue will have a significant impact on one or more specific populations? Do you have reason to believe you can be successful on this issue?
- **Actionable/Feasible:** Are there opportunities for action to address the critical issue? Is there room to make meaningful improvement on the issue?
- **Resources:** Are resources (funds, staff, expertise) either readily available or likely resources can be obtained to address the critical issue? Are there resources through the state and community members to work on the issue? If not, can resources be acquired?
- **Organizational Readiness:** Is this a critical issue identified as important by the organization? Are people in the organization engaged around the issue? Is there organizational momentum to move this initiative forward?
- **Integration:** Is there opportunity for interdisciplinary collaboration? Is there opportunity to build on existing initiatives? Will this duplicate efforts?

Strategy Prioritization Matrix Example

Critical Issue: *C. difficile* tests being ordered for inappropriate indications.

Goal Example: *By June 30, 2019, demonstrate 95% appropriate testing for C. difficile, to be confirmed through auditing process.*

STRATEGIES	Urgency	Potential Impact	Actionable/ Feasible	Resources	Organizational Readiness	Integration	Total Points
Strategy Example: Create an electronic alert to appear at the time of test order, which includes the appropriate indications for C. difficile testing.	1	3	2	2	2	3	**13**
Strategy Example: Educate ordering providers on appropriate indications for C. difficile testing.	3	2	2	3	2	2	**14**
Strategy Example: Establish a system for staff collecting the test specimen to confirm appropriate indication and discuss with ordering provider if needed.	2	2	2	3	1	1	**11**
Strategy Example: Implement a CDI testing audit form for laboratory personnel to complete upon receipt of sample to confirm appropriate indications.	3	3	3	3	2	2	**16**

Strategy Prioritization Matrix Worksheet

Critical Issue: ____

Goal: ____

STRATEGIES	Urgency	Potential Impact	Actionable/ Feasible	Resources	Organizational Readiness	Integration	Total Points

Additional TAP Resources

For more information about how your facility can utilize the TAP Strategy, please visit the TAP Website (https://www.cdc.gov/healthcare-associated-infections/php/toolkit/tap-strategy.html).

For technical assistance in implementing the TAP Strategy, contact local partners in prevention including HIINs, QIN-QIOs, your State Health Department, or contact the CDC at HAIPrevention@cdc.gov

	Tools	**Location**
	TAP Reports	NHSN Patient Safety Component: https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf
Target	TAP Infographic	TAP Infographic: https://www.cdc.gov/healthcare-associated-infections/media/pdfs/TAP-Infographic-P.pdf
	NHSN Guidance	NHSN Website: https://www.cdc.gov/nhsn/
	TAP Facility Assessments	TAP Website: https://www.cdc.gov/healthcare-associated-infections/php/toolkit/tap-strategy.html
Assess	TAP Excel Spreadsheets	Email HAIPrevention@cdc.gov
	TAP Tool Guide	Email HAIPrevention@cdc.gov
	TAP Feedback Report	Component of TAP Excel Spreadsheets
Prevent	TAP Prevention Prioritization Toolkit	TAP Website: https://www.cdc.gov/healthcare-associated-infections/php/toolkit/tap-strategy.html
	TAP Implementation Guides	TAP Website: https://www.cdc.gov/healthcare-associated-infections/php/toolkit/tap-strategy.html