Collaborating with Area Organizations to Promote Communitywide Antimicrobial Stewardship

According to the CDC, at least 30% of antibiotics are prescribed unnecessarily, representing 47 million excess prescriptions. These needless prescriptions can lead to increasing antibiotic resistance, which can cause dangerous infections to become untreatable. While many hospitals and healthcare organizations have instituted programs to improve antibiotic use within their facilities, inappropriate antibiotic usage outside of the hospital remains a challenge for many. As a result, this has led some healthcare organizations to begin community-based antimicrobial stewardship programs that aim to promote proper antibiotic use in a collaborative setting.

To learn more about community-based antimicrobial stewardship programs, HBI’s Cost & Quality Academy spoke to Dr. Kenny Cole, Chief Clinical Transformation Officer and practicing Internist at Baton Rouge General Medical Center—a 588-bed community hospital in Louisiana. Baton Rouge General has recently joined a new collaborative organization known as the Baton Rouge Health District, in which local hospitals and health systems have banded together to raise both the overall quality of care provided and the health of their community members, starting with antimicrobial stewardship.

**Q: Can you provide background information on the Baton Rouge Health District and why it has decided to focus on antimicrobial stewardship?**

**Dr. Cole:** The Baton Rouge Area Foundation, which is a group that focuses on economic development and overall improvements in our community, spearheaded and funded the formation of the Baton Rouge Health District. It is composed of area hospitals, including Baton Rouge General, Our Lady of the Lake Regional Medical Center, Ochsner Medical Center, and Blue Cross Blue Shield of Louisiana—a major payer in the market. The goal of the District is to work together by looking past traditional competitive instincts and leverage commonalities and the economies of scale across these systems to deliver great healthcare and improve outcomes for the community.

There have been some challenges in that, of course, because how do you get people who are competing with one another to work together? Part of the answer is to come up with ideas that allow for everyone to rightfully compete and allow for non-competition activities that can cause everyone to work together to do what is right for the community. I put forth the idea of antimicrobial stewardship, which has to occur at the community level. These are bacteria that are prevalent within our region, and we are all fighting the same battles. So rather than having our own separate efforts, we decided to work together.

**Q: When did this collaboration begin and what has been its initial focus?**

**Dr. Cole:** We began in early 2017 by convening an antimicrobial stewardship task force comprised of various representatives including physicians, microbiology departments, and pharmacy departments from each of the institutions in the Health District. We asked ourselves, “How do we do this? How do we tackle this as an entity on behalf of the Baton Rouge Health District?” And so one of the big efforts that is coming out of that question is the idea of a communitywide antibiogram.

Each hospital has an antibiogram, which is basically composed of microbiological data that looks at susceptibility, resistance, and prevalence patterns of different bacteria as it relates to causes of infection. We asked ourselves, “What if we combine all of them and share that data with each other?” We want to create one antibiogram that then can be used across the community in order to drive improvement in our patterns of antimicrobial usage across the entire community.

**Key Takeaways**

**Profile**
- **Baton Rouge General Medical Center**
  - Baton Rouge, Louisiana
  - 588 Beds
  - 3,500 Hospital Staff Members

**Baton Rouge Health District**
- Multiorganization collaborative
- Works together to improve communitywide health

**Challenges**
- An abundance of unnecessary antibiotic prescriptions leads to antimicrobial resistance in the community
- It is often difficult for one organization alone to promote proper regional antibiotic usage

**Solutions**
- Multiple area hospitals joined together to raise awareness about antimicrobial stewardship
- A communitywide antibiogram comprised of shared data from Baton Rouge area hospitals
- Physicians utilized literature and the antibiogram to create evidence-based guidelines to better treat infections

**Results**
- The communitywide antibiogram helps improve antimicrobial usage patterns across the region
- The fewer amount of unnecessary prescriptions written can improve the efficacy of antibiotics
Q: How do you plan on pushing this to frontline staff to ensure that everyone’s care is aligned according to the communitywide antibiogram?

Dr. Cole: People are very happy to work alongside you if it is for the common good. Instead of taking the antibiogram data and saying to the physicians, “Here’s what we did and here’s the right way to prescribe these infections,” we want to approach this with a parallel effort. We want to convene a multidisciplinary workgroup that will be devoted to building out the evidence-based guidelines for the treatment of these certain infections. That group will have representatives of providers from each system who are scouring the medical literature to come up with agreed upon evidence-based guidelines for treatment and then really try to share and get the buy-in from the staff. Then, we’ll tweak and tailor those guidelines specifically according to the resistance patterns in the community.

Q: Do you have any plans to teach proper antibiotic use outside of the hospital? What might be the best way to go about that?

Dr. Cole: That is going to be the next phase. I am hoping that, if this collaboration goes well with the hospitals, we are going to be able to invite key ambulatory staff to the table and do something similar to what we have done at the hospital level, because the goal is to get rid of the injudicious antimicrobial use that is taking place at the community level.

Q: Do you plan on partnering with any local authorities or media outlets to assist in antimicrobial stewardship?

Dr. Cole: Maybe, but the problem is that I see how that comes across sometimes. I am really trying to build this in terms of generating success stories caused by physicians, microbiologists, and pharmacists all working together for the common good and the best interest of the patient. This is not anybody telling us how to practice medicine or what to do; this is us. This is us physicians and us providers trying to capture the stage of what needs to happen in healthcare by leading the change ourselves instead of it being forced upon us.

Q: For any other healthcare organization looking to focus on antimicrobial stewardship within the community, what advice would you give to them?

Dr. Cole: Persistence and perseverance. Any change is intrinsically hard, and I have a saying that I used when I first came to Baton Rouge General: “Change is hard in the beginning, messy in the middle, but beautiful in the end.” The beginning requires persistence and perseverance to maintain focus on what is right and to keep the patient and outcomes at the center. I think that everybody who goes into healthcare is generally very motivated by serving others, helping others, and doing what is in the best interest of patients, and so using that attribute among different providers to engage them in having focused debates and discussions about antimicrobial misuse is key to be able to achieve the belief that we can make a difference.

What does this mean for you?

<table>
<thead>
<tr>
<th>C-Suite</th>
<th>Industry</th>
<th>Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Partnering with local organizations can open the door to additional endorsements and partnership opportunities in the future</td>
<td>• Putting aside self-interests and collaborating to promote communitywide antimicrobial stewardship advances a shared objective of responsible antibiotic usage</td>
<td>• Healthcare organizations are realizing the importance of banding together to enhance the care quality for their communities</td>
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With one in every three prescriptions for antibiotics deemed unnecessary by the CDC, healthcare organizations—such as Baton Rouge General—are aiming to decrease improper antibiotic usage with antimicrobial stewardship programs.
Tailoring Interventions to Prevent Falls and Fall-related Injuries in Inpatient Psychiatry

Though many hospitals and health systems utilize established interventions to prevent falls and fall-related injuries in the inpatient setting, many struggle to prevent falls in patients with altered mental status, as these patients often do not have the capacity to respond to standard interventions such as bedside alarms. As such, some organizations are implementing fall prevention programs that tailor standard fall prevention tactics to this patient population and employ a combination of various interventions that focus on environmental adaptations and staff engagement.

Veterans Integrated Service Network 8 Patient Safety Center of Inquiry—which is located at James A. Haley Veterans’ Hospital—led a multifactorial fall and fall-related injury prevention program in multiple inpatient psychiatry units in VISN 8. This program employed a number of interventions that improve the safety of the inpatient psychiatry environment and increase staff fall prevention knowledge and engagement. To learn more about this program, HBI’s Cost & Quality Academy spoke with Dr. Tatjana Bulat, Director of the VISN 8 PSCI and Associate Chief of Staff for Geriatrics and Extended Care at JAHVH.

“I think the long-term solution to preventing falls in this patient population is to make the environment safer, because these patients cannot necessarily engage in their own care,” Dr. Bulat says. “Eliminating hazards like high beds and having interventions like shock-absorbent flooring is where the future is in preventing falls and injuries from falls for these patients.”

Identifying Key Program Elements

In 2009, research from VISN 8 showed that fall rates in inpatient psychiatry units were second only to nursing home fall rates. To address these high rates, the organization gathered a team of clinical experts and researchers in fall and fall injury prevention from the VISN 8 PSCI to conduct a literature review of interventions and implement effective solutions throughout VISN 8. This initial literature review revealed that interventions specific to inpatient psychiatry were scarce, so the team decided they would modify existing tactics. As prior analyses had revealed that most falls in inpatient psychiatry occur when patients attempt to get out of bed, walk to the bathroom, or change from a sitting to a standing position, the team decided to focus their efforts on modifications that would enable patients to move safely in their environment.

In 2010, before implementing modified interventions, the team invited seven inpatient psychiatry units in VISN 8 to join the program and then established peer leaders and identified participating staff in all seven units. In order to identify the areas where tailored interventions were most needed, the team modified an organizational falls assessment tool from the Institute for Healthcare Improvement Falls Collaborative to fit the inpatient psychiatric patient population.

Implementing Tailored Interventions

The program created a number of tailored interventions to prevent falls in the seven inpatient units throughout VISN 8, particularly in the elderly population. Beyond assigning a unit peer leader for fall prevention on every unit, the program helped improve handoffs and documentation from shift to shift in order to enhance the monitoring of at-risk patients. Additionally, the VISN 8 PSCI team modified the organization’s patient education to include information on how medications can increase fall risk.

Stemming from earlier analyses, the program also included a number of interventions that made the environment safer for patients. While some interventions like grab bars could not be used due to suicide risk, the organization was able to implement a variety of other adaptations. For example, toilets were elevated to reduce the fall risk associated

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**Key Takeaways**

**Profile**
- James A. Haley Veterans’ Hospital
- Tampa, Florida
- Teaching Hospital
- 504 Beds
- 12,046 FY 2015 Admissions

**Population**
- Inpatient psychiatric patients at risk for falling

**Interventions**
- A team was assembled to examine existing fall prevention tactics and modify them to be psychiatry-specific
- Interventions to enable ease of movement for patients were implemented, as listed in the table on the following page
- Unit peer leaders and regular education sessions support ongoing engagement

**Outcomes**
- Fall rates decreased from 8.5 per 100 occupied bed days of care to 4.8 following program implementation
- Staff compliance related to fall and fall-injury prevention techniques increased

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Fall and Fall-Related Injury Prevention Interventions Throughout VISN 8

Overall Intervention
- An IHI Falls Collaborative organizational assessment tool was modified for inpatient psychiatry and was used to identify areas for improvement.

Fall-Related Injury Prevention Interventions
- Hip protectors were customized to decrease instances of hip fracture.
- Bedside mats were modified to reduce trauma from bed-related falls.
- Patient education included information on how to protect oneself from fall-related injuries.
- Shock-absorbent flooring that can lessen fall impact will soon be applied.

Staff and Patient-Focused Fall Prevention Interventions
- A unit-based fall prevention peer leader was identified for each unit.
- Patient assessment was expanded to include injury risk upon admission.
- Handoffs and documentation was improved between shifts to better monitor patients at risk for falls.
- Patient education included information on how medications increase fall risk.

Environment-Focused Prevention Interventions
- Toilets were elevated to decrease fall risk.
- Patient beds were lowered.
- A portable lift was implemented that helped improve patient mobility.
- Tripping hazards were cleared daily.

with changing from a sitting to a standing position. Furthermore, tripping hazards were removed from patient rooms and a portable lift was acquired to help patients get in and out of bed.

“If the patient is in bed, you want it to be at the lowest position because it is harder for them to get out of bed unassisted, and if they do fall, there is less risk of injury,” Dr. Bulat says. “However, in psychiatry, they all have these platform beds, which are static, and you cannot put anything around them. We had a small project looking at how those platform beds could be redesigned so that a portable lift could be utilized to help patients with their mobility, which is especially helpful for the geriatric population.”

Improving Staff Education and Engagement

A key component of ensuring that these interventions would be effective and improve patient safety was increasing staff engagement, and as such, a major component of JAHVH and VISN 8 PSCI’s program was the establishment of the unit peer leader program. In addition to decreasing practice variation, this unit peer leader program sought to provide coaching and mentoring and develop a toolkit about fall and fall-related injury prevention that could be used at each of the seven units. This toolkit was modified by each unit leader to include fall policies and procedures unique to their unit.

The program also made staff education an integral part of the initial implementation process. Each program component was accompanied by an expert lecture and mentoring, with follow-up plans from unit leaders in five- to eight-week intervals. In the first six months of the program, staff were given monthly lectures based on strategic need, as well as biweekly conference calls. Additional web-based educational sessions were offered and stored on the organization’s intranet to be used whenever needed.

“To prevent mentally ill patients from falling, staff need to be more vigilant with their care,” Dr. Bulat says. “They need to do rounds more often to check on these patients in order to anticipate and address their needs and thus decrease the chance of falls that are due to patients mobilizing on their own.”

The program ultimately resulted in reduced fall rates, starting from 8.5 per 100 occupied bed days of care in 2009 to 4.8 when the program officially ended in 2011. The program also improved staff compliance with fall and injury prevention techniques, including a 1.7% increase in the use of fall injury risk assessments, a 3.0% increase in discharge education, and an 8.6% increase in the use of environmental safety measures to reduce severity of injury. Though the program is officially over, a majority of the interventions implemented remain in units throughout VISN 8. For hospitals and health systems wishing to improve fall and fall-related injury prevention in patients with altered mental status, JAHVH and VISN 8 PSCI’s multifactorial fall prevention program can serve as a blueprint from which to begin.

What does this mean for you?

C-Suite
- Prevention efforts, including environment modifications, may have up-front costs, but they can also lead to increased cost savings due to a reduction in patient harm

Peers
- Identifying unit champions can ensure staff members are educated on appropriate interventions
- Some fall prevention interventions may need to be modified to fit the inpatient psychiatric environment

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It is widely known that proper hand hygiene by healthcare workers aids in the prevention of healthcare-associated infections. Despite this, many hospitals and health systems find themselves engaging in hand hygiene campaigns in order to improve their institutional compliance rates. When postcampaign outcomes are not as successful as anticipated, introducing an initiative with a more unique approach—one that aims to change the organizational culture—may be needed. Hennepin County Medical Center—an academic Level I Trauma Center with over 450 beds in Minneapolis—found itself in that position after one hand hygiene initiative still left opportunity for improvement. To learn more about this ongoing journey to improve hand hygiene compliance, HBI’s Cost & Quality Academy spoke with Dr. Meghan Walsh, the Chief Academic Officer at HCMC.

Analyzing Initial Efforts and Culture Dynamics

The initial effort to improve compliance at HCMC began in 2011 when the hospital realized that it was not meeting The Joint Commission’s national patient safety goal for hand hygiene and averaged around 75% compliance in all patient care areas. This undertaking included a push to have alcohol-based hand sanitizer in all clinical areas, as well as hand hygiene compliance auditing, which had not routinely been done prior. In addition, educational posters and other reminders—including skits and manager huddles—served to inform staff about the importance of the initiative. However, once the audit data was analyzed, it became clear that some clinical areas still were not meeting expectations and that adherence was lowest among physicians, leading HCMC to examine the gap between the campaign and continued noncompliance.

The first step in assessing this gap included surveying hospital employees to ask what obstacles were preventing hand hygiene compliance. In addition to the expected barriers, like sanitizer availability and location throughout the hospital, the survey found that many people were influenced by the actions of others and that power dynamics sometimes made it difficult to speak up when proper hand hygiene did not take place. “Some comments were arising about culture,” says Dr. Walsh. “We had interns saying that it is difficult to tell people to wash their hands when you are rounding with a neurosurgeon, for example, or a whole team where nobody does it. It becomes an unspoken comment that nobody should worry about foaming in and foaming out.”

Upon initial evaluation of how to foster hand hygiene culture changes, some stakeholders pushed for increased audits to monitor compliance. In addition to the expected barriers, like sanitizer availability and location throughout the hospital, the survey found that many people were influenced by the actions of others and that power dynamics sometimes made it difficult to speak up when proper hand hygiene did not take place. “Some comments were arising about culture,” says Dr. Walsh. “We had interns saying that it is difficult to tell people to wash their hands when you are rounding with a neurosurgeon, for example, or a whole team where nobody does it. It becomes an unspoken comment that nobody should worry about foaming in and foaming out.”

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Ultimately, the organization realized that its 250 residents in 84 unique clinical areas could be a powerful resource for monitoring. Requiring each resident to perform 10 audits over a one-month period would generate 2,500 audits encompassing the entirety of the hospital. Support from the performance improvement leader within infection prevention, program directors, and department chiefs was not difficult to come by, given the importance of improving hand hygiene.

Incorporating Audits, Seeing Results, and Fostering Success

Residents’ auditing first occurred during the month of February in 2014. An electronic version of a previously used paper audit tool was created and accessible from residents’ cellphones via HCMC’s intranet, making it easy to perform audits regardless of their
location in the hospital. The audit tool contained the following five questions: The area where the audit was taking place, the role of the person being audited (e.g., physician, interpreter, therapist, etc.), if proper hand hygiene was used, and—if not—what was missing, and the name of the individual being audited (this line was later replaced with a free-text comment space). Typically, all 10 audits took residents no longer than 30 minutes, and some were able to complete more than the required amount, providing an even larger snapshot.

Traditionally, administrative and nonclinical personnel had been charged with being auditors, but HCMC found that using residents offered a new perspective that further identified the root cause of the problem. Residents themselves appreciated the fact that they could remain unseen while performing this quality improvement project and gaining insight on hand hygiene culture.

“We got a lot of great comments from the residents,” says Dr. Walsh. “Things like, ‘I realized that the attending sets the tone for the whole team’ or ‘When one person does it, others follow suit, and I see the power of leadership on a clinical team.’ This was very powerful in realizing just what was happening within their own culture.”

By requiring residents to complete audits, getting to the root of hospital culture surrounding hand hygiene at HCMC proved to be successful, with 242 residents completing a total of 2,468 audits during this pilot quality improvement initiative. Preimplementation audits found that overall compliance in patient areas was 94% in 2013, increasing postimplementation to 96% in 2014. Likewise, in the ambulatory setting, compliance increased from 92% to 97%. Further, HCMC tracked compliance by job type and found that physician compliance during this same time period increased from 92% to 96%. Institutionwide, HCMC has remained at 97–98% compliance from 2014 through the midpoint of 2017.

HCMC has continued to utilize residents to audit hand hygiene and now incorporates it into resident orientation. The roughly 100 residents that begin each June are required to complete 10 hand hygiene audits in different areas throughout institution—an introduction to culture through the power of observation. The permanent implementation of this program has also evolved to better align with a culture of recognizing those who perform well.

“The residents get to be the benefactors, which they love,” says Dr. Walsh, “and other employees, many of whom are not physicians, are happy with this intervention. They are touched by new interns who say congratulations on something they did right. It was a new way to engage not only the interns but also the other employees working in the hospital.”

Ultimately, HCMC’s initiative and success have been recognized outside of the organization as well. Since implementation in 2014, the institution has had one CMS and two Joint Commission site visits, all of which have specifically highlighted the hand hygiene program for residents as a best practice not commonly seen elsewhere.

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**What does this mean for you?**

**C-Suite**
- Improving hand hygiene compliance can decrease HAIs, limiting the risk of potential reimbursement penalties

**Industry**
- Instilling a culture that emphasizes hand hygiene is typically more impactful than one-time educational initiatives

**Peers**
- Training residents to complete hand hygiene audits—in lieu of other providers—gives physicians more time to see patients
Empowering Residents to Develop an Evidence-based Care Bundle to Prevent Colorectal Surgical Site Infections

Key Takeaways

Profile
Thomas Jefferson University Hospitals
- Philadelphia-Based
- Five Primary Locations
- 937 Licensed Beds
- 41,368 FY 2017 Admissions

Challenges
- Colorectal SSIs emerged as an outlier quality measure at Thomas Jefferson University Hospital
- New SSI prevention tactics were initially met with resistance and hesitation from hospital staff

Solutions
- Residents performed a comprehensive literature review to identify colorectal SSI prevention strategies
- An evidence-based care bundle was created to reduce colorectal SSIs
- Existing SSI prevention practices were reorganized and standardized within the care bundle for increased effectiveness
- Positive outcomes of the new tactics were posted and a checklist was created to gain staff buy-in and adherence

Results
- The colorectal SSI rate decreased from 13.9% to 4.7% over a three-year period
- Maintained a low colorectal SSI rate in years following bundle implementation

In order for healthcare organizations to provide optimal care to patients, clinical and administrative staff frequently engage in quality improvement initiatives to improve processes and outcomes. Typically, this work includes well-established providers and leaders specific to a service that is in need of positive change. Since these improvement efforts can be challenging endeavors and the changes often impact a number of staff, many organizations have found success in leveraging various roles in the development of multistage and multidisciplinary care approaches.

Thomas Jefferson University Hospital—one of five primary locations of Jefferson Health and located in Center City Philadelphia—used surgical residents to generate an evidence-based care bundle to reduce colorectal surgical site infections and standardize care for this patient population. To learn more about how Thomas Jefferson University Hospital engaged its residents in quality improvement to achieve better outcomes, HBI’s Cost & Quality Academy spoke with Dr. Benjamin Phillips, Assistant Professor of Surgery.

“Our current practices were driven by our resident team,” Dr. Phillips says. “They focused on potential areas of improvement to put together a bundle that would not only improve outcomes but also be achievable.”

Including Residents in Quality Improvement

In 2013, the Accreditation Council for Graduate Medical Education revised its “Program Requirements for Graduate Medical Education in General Surgery” to include the requirement that residents must be able to prove they can examine, assess, and continually enhance the care they deliver to patients by regularly evaluating and incorporating evidence-based research. One specific goal of this requirement is for residents to “systematically analyze practice using quality improvement methods and implement changes with the goal of practice improvement.”

Compelled by this mandate, Thomas Jefferson University Hospital supported resident-driven quality improvement projects across all departments. In the surgery department, residents were separated into six groups, each with a goal to improve one specific quality outcome measure. To better examine its surgical outcomes, the department reviewed the 2012 American College of Surgeons National Surgical Quality Improvement Program semi-annual report, to compare its surgical outcomes to other participating hospitals.

The report contains site-specific quality measures and 30-day postsurgical outcomes and revealed that colorectal SSIs were a high outlier within the organization’s SSI data. Upon discovering the outlier, residents approached the hospital’s colorectal surgeons to present the issue along with the idea to craft a colorectal surgical bundle guided by evidence-based practices. With the colorectal surgeons’ support, residents shared their plan with the hospital’s administration to obtain buy-in as well as ensure bundle protocols were standardized and aligned with organizational policies.

Establishing Components of the Bundle

In order to develop the bundle’s prevention tactics, surgical residents—with oversight from the hospital’s colorectal surgeons and surgical staff—performed a comprehensive literature review of different existing colorectal care bundles and discussed potential areas of improvement. Many of the practices already in place were still strongly recommended by best practice literature, so they were added to the new bundle, including referring patients to a smoking cessation counselor prior to surgery, instructing patients to take preoperative oral antibiotics and ingest only clear liquids the day before surgery, using chlorhexidine gluconate wipes on the skin twice before surgery, and dosing intraoperative IV antibiotics based on the patient’s weight.
In addition to these infection prevention tactics, interventions—such as using wound barriers for open and laparoscopic surgery, irrigating the abdomen before closing with antibiotic irrigation, and having all surgical staff change their gowns and gloves before shifting to a separate untouched surgical instrument tray for incision closure—were integrated into the hospital’s bundle.

“Many of the elements that ended up in the bundle were infection prevention tactics that most of us surgeons were already doing—just not necessarily as ordered and planned as it is now,” Dr. Phillips says. “Strategically organizing these practices, however, helped us increase the bundle’s effectiveness.”

Garnering Staff Buy-in and Compliance

Once the multistage bundle was formalized to include previously used tactics, reformed practices, and new interventions, residents implemented and shared the bundle by conversing with OR teams and holding town hall meetings to address any concerns.

Despite initial resistance from staff on some new tactics, bundle developers and advocates were able to drive compliance by illustrating the prevalence of colorectal SSI rates at the hospital and how the bundle can help improve patients’ outcomes. As a way to ensure medical staff recall and adhere to each step in the colorectal surgical care bundle, Thomas Jefferson University Hospital created a checklist that follows each patient throughout the perioperative steps of their colorectal procedure. The form is filled out by nurses, medical students, and surgical residents as a way to determine outcomes of the bundle and to confirm compliance.

“The first step that us bundle advocates took was to explain and show that there was a problem occurring within our department’s colorectal surgical cases,” Dr. Phillips says. “Then, we had to explain the nature of the bundle. Complying with only one aspect of the care bundle won’t be enough to drive down the SSI rate; it’s when we put all of these aspects together in an ordered checklist that we can then achieve success and even determine unessential steps.”

As a result of its colorectal surgical care bundle, the colorectal SSI rate at Thomas Jefferson University Hospital decreased from 13.9% in 2012 to 4.7% in 2015, with these rates continuing to stay low since. Additionally, components of the bundle remain the same to encourage consistent practices and teaching methods as the organization works to share the bundle across all of Jefferson Health’s campuses and surgeons.

By developing a standardized care bundle for colorectal surgeries, Thomas Jefferson University Hospital was able to greatly minimize colorectal SSI rates in a matter of a few years. For other hospitals and health systems looking to improve health outcomes among this particular patient population, Thomas Jefferson University Hospital’s resident-driven quality improvement project can serve as a novel precedent.

What does this mean for you?

**C-Suite**
- Of the postoperative infections that can occur, colorectal SSIs are one of the most frequent
- Reducing SSI rates can significantly decrease mortality and readmission rates, care costs, and length of stay

**Industry**
- Implementing standardized care bundles based on successful tactics can aid in establishing consistent high quality care

**Peers**
- Involving residents in the creation of quality improvement initiatives may drive involvement and enhance efficiency
- Obtaining buy-in from organization administration for improvement initiatives assists in expediting implementation

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**SSIs That Hospitals and Health Systems Report Are Most Challenging to Prevent**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Colorectal</td>
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</tr>
<tr>
<td>Abdominal</td>
<td>40%</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>30%</td>
</tr>
<tr>
<td>Knee Replacement</td>
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<tr>
<td>Spinal</td>
<td>17%</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>15%</td>
</tr>
<tr>
<td>Cesarean Section</td>
<td>10%</td>
</tr>
</tbody>
</table>

*Source: HBI’s Cost & Quality Academy (2017)*

As reported in a recent HBI survey, colorectal SSIs pose a great challenge for many HBI members, highlighting the need for successful tactics and strategies to reduce these prevalent infections.

**Colorectal SSI Rate Following Bundle Implementation at Thomas Jefferson University Hospital**

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>13.9%</td>
</tr>
<tr>
<td>2015</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

*Thomas Jefferson University Hospital saw its colorectal SSI rate decrease by over half after the adoption of a resident-driven care bundle and has maintained a low infection rate since the initial implementation.*

In addition to these infection prevention tactics, interventions—such as using wound barriers for open and laparoscopic surgery, irrigating the abdomen before closing with antibiotic irrigation, and having all surgical staff change their gowns and gloves before shifting to a separate untouched surgical instrument tray for incision closure—were integrated into the hospital’s bundle.

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“The first step that us bundle advocates took was to explain and show that there was a problem occurring within our department’s colorectal surgical cases,” Dr. Phillips says. “Then, we had to explain the nature of the bundle. Complying with only one aspect of the care bundle won’t be enough to drive down the SSI rate; it’s when we put all of these aspects together in an ordered checklist that we can then achieve success and even determine unessential steps.”

As a result of its colorectal surgical care bundle, the colorectal SSI rate at Thomas Jefferson University Hospital decreased from 13.9% in 2012 to 4.7% in 2015, with these rates continuing to stay low since. Additionally, components of the bundle remain the same to encourage consistent practices and teaching methods as the organization works to share the bundle across all of Jefferson Health’s campuses and surgeons.

By developing a standardized care bundle for colorectal surgeries, Thomas Jefferson University Hospital was able to greatly minimize colorectal SSI rates in a matter of a few years. For other hospitals and health systems looking to improve health outcomes among this particular patient population, Thomas Jefferson University Hospital’s resident-driven quality improvement project can serve as a novel precedent.

What does this mean for you?

**C-Suite**
- Of the postoperative infections that can occur, colorectal SSIs are one of the most frequent
- Reducing SSI rates can significantly decrease mortality and readmission rates, care costs, and length of stay

**Industry**
- Implementing standardized care bundles based on successful tactics can aid in establishing consistent high quality care

**Peers**
- Involving residents in the creation of quality improvement initiatives may drive involvement and enhance efficiency
- Obtaining buy-in from organization administration for improvement initiatives assists in expediting implementation
Establishing a Systemwide Interdisciplinary Committee to Oversee the Implementation of Opioid Safety Strategies

While the number of opioids prescribed in the United States has decreased over the years, it still remains staggeringly high and tends to vary significantly from state to state. Misuse of prescription opioids can often lead to illicit drug use and severe dependency—a trend that is partly responsible for the increasing overdose deaths from heroin, synthetic fentanyl, and cocaine in recent years. In response, many organizations are assembling interdisciplinary teams to curb the opioid epidemic, decrease the number of opioid prescriptions dispensed, and improve opioid safety.

Duke Health, an academic medical institution providing a full spectrum of clinical services across North Carolina, has created an Opioid Safety Committee designed to oversee the implementation of strategies related to opioid medication management, education, and safety. To learn more about this committee and its projects, HBI’s Cost & Quality Academy spoke with Dr. Larry Greenblatt, leader of the Opioid Safety Committee, Internal Medicine Physician, and Medical Director for Northern Piedmont Community Care—a care management program for Medicaid recipients administered by Duke Health’s Population Health Management Office.

“In 2013, we went to the medication safety committee with concerns about the developing opioid epidemic, which wasn’t really in people’s consciousness yet,” Dr. Greenblatt says. “It’s hard to believe that at the time, providers didn’t worry about this as they do today. As concerns mounted across our health system, we decided that as an organization, we needed to establish policies and procedures to address this public health problem.”

Committee Makeup

In 2013, much of Duke Health’s work around opioids began under the Opioid Safety Task Force, which was comprised of physicians, nurses, physician assistants, pharmacists, and other clinicians from across the health system. Initially, this group set out to develop guidelines, create patient education and provider reference materials, and enroll individuals in North Carolina’s Prescription Drug Monitoring Program.

In its present day iteration, a similar but smaller group of individuals make up the Opioid Safety Committee. In addition to individuals from the health system, one of the committee members serves a leadership role with the North Carolina Hospital Association sponsored by the CDC. Another member affiliated with Duke University Sanford School of Public Policy supports the committee in the development of opioid-related policies and procedures working with public officials.

“We routinely collaborate with other organizations, such as the NCHA and FDA, but also with legislators around passing and revising existing laws around opioid safety,” Dr. Greenblatt says. “A number of us are active members of a statewide group that falls under the umbrella of the Department of Health and Human Services, called the Opioid and Prescription Drug Abuse Advisory Committee, which implements statewide strategies guided by the state’s action plan.”

Barriers to Implementation

One of the primary goals of this committee is to ensure compliance with the state’s opioid prescribing guidelines, which are identical to the CDC Guideline for Prescribing Opioids for Chronic Pain though broadened to include specialty providers and primary care. Furthermore, care provided at the end of life and to patients with cancer is excluded.

In strategizing how to ensure compliance with the state guideline, the committee found that while prescribers were concerned about their patients and potential misuse of opioids, they lacked the time and resources to follow the standards. The multitude of elements—risk assessments, patient education, urine drug screens, pain management agreements—are time consuming to primary and specialty care providers tasked with treating dozens of patients daily within the constraints of a 15-minute visit.
“These barriers are universal, and what we usually find is that providers often end up skipping key steps, such as the urine drug screen or risk assessment,” Dr. Greenblatt says. “Frontline providers are slammed, and they work really hard just to end the day somewhat on schedule. We want to help integrate these tools such that we remove or reduce the roadblocks that hinder utilization.”

To address these barriers, the committee is collaborating with PDMP leadership to integrate the substance reporting system into Duke Health's EHR, as providers must currently open a web browser to enter their PDMP credentials and search the database by the patient's name and birthdate. While this may not seem like a great hindrance, delays of even a couple of minutes take away from the short window providers have with patients. Other EHR improvements the committee hopes to accomplish are driven by North Carolina's Strengthen Opioid Misuse Prevention (STOP) Act that regulates the supply of pain medications prescribed.

“As of January 1, 2018, there will be a limit of five days of medication for acute pain and seven days for postoperative pain,” Dr. Greenblatt says. “We want to make sure our EHR makes it easy to do the right thing and doesn’t default to a 10- or 14-day prescription. We want to make sure our providers are aware of this and following the law.”

### Other Key Projects

Beyond PDMP-EHR integration and medication defaults, the committee is working on distributing routine electronic communications from hospital leadership, as well as an opioid safety newsletter that covers a range of topics from regulatory issues to how-to guides for interpreting a urine drug screen and locating patient education resources. The intent of these communications is to increase awareness of the tools available to providers and improve adherence to opioid prescribing guidelines.

External to Duke Health, the committee is working with NCHA to increase naloxone prescribing, especially for patients receiving high-dose prescriptions or a combination of opioids and benzodiazepines. Among the state's roughly two million Medicaid patients, the opioid to naloxone prescription ratio is 300-to-1, which the committee views as an opportunity for improvement. In order to increase naloxone prescriptions, pharmacists will identify which patients to target based on their prescription orders, discuss the state's standing order for naloxone, educate patients on its use, and dispense the medication.

For organizations looking to assemble a team dedicated to opioid safety initiatives, the experience of Duke Health and its Opioid Safety Committee will undoubtedly shed light on the barriers and successes to come.

“Behavior change is challenging, and I think we really underestimated what it would take to get people on board with this,” Dr. Greenblatt says. “Having a diverse, interdisciplinary team that is leading the effort is key to obtaining buy-in, and it is absolutely necessary to have the support of leadership. Address opioid safety with a broad array of strategies, such as patient education, community partnerships, provider education, and EHR improvements to make the right thing the easy thing to do.”

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**What does this mean for you?**

**Peers**
- Dedicated interdisciplinary teams can help to identify and overcome barriers to procedural compliance
- Forming partnerships with regulatory groups supports the development of effective guidelines

**Industry**
- Optimizing EHR usage gives providers more time to follow dedicated guidelines with patients
- Obtaining provider buy-in is vital to sustained execution of organizational, state, or national opioid prescribing guidelines

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While the rates of opioid prescriptions dispensed has decreased in states across the country from 2014 to 2016, further strides must be taken to continue this trend and diminish the widespread impact of opioid misuse.

**Rates of Opioid Prescriptions Dispensed per 100 Persons**

Source: CDC (2017)

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<thead>
<tr>
<th>State</th>
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<tr>
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<td>West Virginia</td>
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2017 Opioid Prescriptions per 100 Persons: While the rates of opioid prescriptions dispensed has decreased in states across the country from 2014 to 2016, further strides must be taken to continue this trend and diminish the widespread impact of opioid misuse.
Coordinated Communication and Timely Result Reporting at a Sleep Center

For those who wish to improve their nighttime hours of rest, a sleep study is often the appropriate way to diagnose a specific disorder and the best method to inform treatment recommendations. However, sleep studies are complex, often do not yield quick results, and may cause confusion throughout the referral process and during the study itself, especially if the patient had little knowledge of sleep disorders prior to their experience. To help keep patients informed and their care expectations realistic, The Center for Sleep Medicine at Tufts Medical Center—a six-bed, academically affiliated sleep center in Boston—utilizes a variety of communication tools to maintain patient satisfaction and engagement.

“Sleep medicine is unique and very technical,” explains Dr. Khalid Ismail, Director of the Center for Sleep Medicine. “Our diagnoses stem from many pages of electroencephalogram and other tests, and a lot of information is analyzed. Patients don’t always know what to expect, and a considerable amount of communication is needed to set those expectations.”

Initiating Contact Upon Referral

Communication with patients begins as soon as they are referred to the sleep center for a study—oftentimes by their primary care physician—when the patient’s appointment is scheduled over the phone. Once the study is scheduled, a packet of information is mailed to the patient outlining details of the sleep center itself, as well as the steps and processes of a sleep study and what patients should bring along with them on the night of the study. The packet is meant to provide an overview of the sleep study in a level of detail that the patient may not have previously heard or read. Insurance companies also play an important role throughout the process, and communication regarding prior authorization is especially key to ensuring prompt care.

“Insurance companies ask for many pieces of information in order to obtain a prior authorization for a sleep study and not having that information upon referral can cause delays,” Dr. Ismail says. “We decided it was our responsibility to obtain this prior authorization, instead of the PCP, because we are better equipped to do so. We knew it was something that would improve the quality of service we provided.”

To ensure that all of the necessary prior authorization information is obtained, the sleep center created a form for referring PCPs that includes specific symptoms and comorbidities that insurance companies look for when processing authorization information. Made as a result of patient feedback, this has improved communication not only between the sleep center and insurance companies but also with referring PCPs, which has led to improved care for patients because the authorization for appropriate studies is processed quickly.

The Perceived Gap Between Testing and Results

Communication continues to be important as patients complete their study and wait for results and treatment recommendations. To gain perspective about patient experience during the sleep study, patients are given a survey in the morning immediately following the study. This survey asks questions about general impressions of their experience, a rating of the staff who took care of them, and a space for free-text comments. Completed surveys are given to the sleep lab supervisor and director of the center for review and have often been the mechanism that propels process improvement changes.

For example, due to the feedback from these surveys, the sleep center sought to improve the way in which it communicates results to patients. Specifically, the lag time between test completion and patient receipt of results was often a top point of criticism, so staff developed methods to educate patients on appropriate care expectations.

Key Takeaways

**Profile**

Tufts Medical Center
- Boston, Massachusetts
- Academic Medical Center
- 415 Beds
- Over 500 Faculty Physicians

**Challenges**
- Sleep study referral processes are often complex and require preauthorization from insurance companies
- Receiving results from these studies often takes longer than typical patient expectations
- Patients are frequently unfamiliar with what to expect or who can answer their questions about sleep studies

**Solutions**
- Tufts Center for Sleep Medicine developed a form to ensure PCPs address all required preauthorization items
- The results reporting process was redesigned to balance analysis with timeliness
- Sleep center administrative staff were trained on directing patients to appropriate people to answer technical questions

**Results**
- By managing patient expectations, complaints about delayed sleep study results have decreased
- Patients are now more informed and aware of the appropriate avenues to take to have their questions answered
“Patients often think it is similar to getting an X-ray or lab test—the test is done and they have results in 24 hours,” Dr. Ismail says. “These tests, of course, are not like that, as they include data from eight hours of recording that is scored and then reviewed and interpreted by a sleep medicine physician.”

To balance the complexity of sleep study interpretation with timely results reporting, the sleep center developed a form to be completed by a sleep physician immediately after the sleep study is scored and interpreted. The form details whether or not an individual has a sleep disorder and its severity or mildness, as well as information about follow-up care. For those with a mild disorder, a letter is sent to them summarizing the information on this form and explaining they will need to make a clinic appointment. The full results are sent to the PCP so that they can discuss in greater detail with the patient at their follow-up appointment.

On the other hand, if a technician identifies a patient as having a severe disorder, they will flag their recording to be immediately scored. A sleep medicine physician will provide final interpretation, and the patient will be called within 24–48 hours of study completion to go into further detail about their results and discuss treatment options. Due to this change in reporting results to patients with either mild or severe disorders, complaints on how long result reporting takes have decreased.

Setting Expectations to Achieve Better Outcomes

Additionally, The Center for Sleep Medicine at Tufts Medical Center recognizes the importance of supporting effective communication by educating staff to accommodate patients’ questions. Stemming from patients’ unfamiliarity with sleep medicine, administrative and scheduling personnel at the sleep center are often asked technical questions about sleep disorders, sleep study testing, and subsequent follow-up care. As such, administrative staff are trained to triage patient concerns to the correct contact for issues surrounding durable medical equipment replacement, the type of equipment they should use, and how to use it correctly, as well as questions about their diagnostic test and treatment options for their sleep disorder. This can help patients feel confident that their concerns are being addressed, regardless of who they talk to at the sleep center.

Finally, the center’s staff work to set appropriate patient expectations as soon as possible. To assist with this, the sleep center sends new patients a letter that outlines the general timeline of completing a sleep study, highlighting the amount of time to expect between the steps of the process. This can help set the tone for ensuring patient understanding when contacting the sleep center for more information and when to expect a longer latency period.

Communication between providers and patients is important in any healthcare setting and is especially vital to reassure patients about care they are receiving for unfamiliar diseases and disorders. For examples of good communication and enhanced continuity of care for patients in a sleep center, the Center for Sleep Medicine at Tufts Medical Center can be a prime example.

What does this mean for you?

**Industry**
- Patient expectations regarding timeliness and operations extend to all care environments
- Communication remains an effective means to improve satisfaction and care experience

**Peers**
- Establishing clear understanding and expectations with patients about sleep study processes can help to avoid negative survey responses
- Guiding PCPs to include all required information in their referrals can improve the preauthorization process
Rethinking the Patient Experience and Accounting for Patients’ Preferences to Obtain Feedback

Because of their enhanced familiarity with organizational processes, individuals working in healthcare are uniquely positioned to provide insights into their experience as patients when utilizing healthcare services—a potentially valuable resource to any organization seeking to enhance the patient experience. Therefore, hospitals may want to approach patient experience initiatives in a way that captures this specific cohort within the larger patient population. Gathering insights from healthcare employees is typically one part of what healthcare providers do to capture and amplify the voices of their patients.

Indiana University Health—a nationally-recognized academic medical center—sought to evolve the manner in which it approached patient experience by obtaining feedback on pointed issues within a shorter time period. To learn more about the evolution of its projects, HBI’s Cost & Quality Academy spoke with Nick McCallum, Senior Consultant on IU Health’s Experience Design team.

“If you come from a background in hospitality or retail, the idea of capturing consumer experience is not a novel idea,” McCallum explains. “However, patient experience has started to evolve more rapidly in just the last five years in healthcare, which is an inherently conservative sector due to its complexity and sensitivity to making changes gradually when they impact patient care.”

Patient Experience Beginnings

To that end, IU Health founded the Experience Design department in 2012 to create projects and launch initiatives that capture and improve patients’ experience as they navigate the health system. The department’s work focuses on the delivery of IU Health’s core commitments across its hospitals, clinics, and specialty care centers in order to tackle the organization’s strategic goals related to patient experience.

As the Experience Design team began working on various projects, they had to collaborate on ways to gauge feedback, understand the varied patient demographic, and—among other logistical details—create customized survey methods to spearhead their initiatives. Through this team’s support, the organization hoped to be more responsive to the issues that matter most to patients and deliver on the preferences of its patient population.

“Our goal was to get rich results without getting too specific in requesting patient feedback,” McCallum explains. “We want to allow people to tell us what their primary priorities are so that we can design changes to address broader themes rather than asking them to outline every detail. The best service or care for each person’s needs will vary widely, and our objective is to design programs and processes that can give them options.”

First Large-scale Project

One of the ways the team solicited patient feedback early in its inception was an initiative called Insider Insights, which sought to gather feedback specifically from IU Health staff members utilizing their employer’s healthcare services. Due to their familiarity with the organization’s core mission and values, these individuals were able to provide a singular lens into the patient experience at IU Health’s facilities.

“A lot of our staff carry IU Health’s insurance and have a vested interest as both staff member and patient in the success of the organization and in the delivery of its promise to provide quality care,” McCallum says. “This was a nonincentivized secret shopper program whereby team members shared what they observed in their experience during a doctor’s visit or hospital stay.”

Not only did Insider Insights provide unique feedback, it also allowed for more timely responses. Because HCAHPS surveys are administered to discharged patients anywhere

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### Key Takeaways

<table>
<thead>
<tr>
<th>Profile</th>
<th>Indiana University Health</th>
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<td></td>
<td>• Indianapolis-based</td>
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<tr>
<td></td>
<td>• Over 117,000 Annual Admissions</td>
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<td></td>
<td>• Over 2.6 Million Annual Outpatient Visits</td>
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<td></td>
<td>• Nearly 26,000 Staff Members</td>
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</table>

| Population | Hospital staff seeking methods to obtain and analyze patient feedback to determine how to enhance patient experience |
| Patient experience or quality department personnel tasked with improving patient satisfaction |

| Interventions | IU Health created a dedicated department to create projects to improve patient experience |
| IU Health staff members provided unique patient feedback in a nonincentivized secret shopper program electronic survey |
| Partnered with a cloud-based informatics company to extract data from brief electronic patient opinion surveys |

| Outcomes | Sending custom, electronic surveys during care quickened response turnaround times compared to HCAHPS |
| Incorporating patient feedback from hospital staff delivered a unique perspective with existing organizational knowledge |
| Collecting patient demographic data allowed hospital leaders to focus on the needs of certain patient populations |

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PATIENT EXPERIENCE

“We want to allow people to tell us what their primary priorities are … the best service or care for each person’s needs will vary widely, and our objective is to design programs and processes that can give them options.”

– Nick McCallum
Experience Design Team Senior Consultant at IU Health

from 48 hours to six weeks following discharge, the turnaround time for these results can take upwards of three months to receive. To gauge patient feedback sooner during this waiting period, Insider Insights utilized a customized survey to collect feedback from all staff members acting as patients at any point of service.

A New Direction

The Experience Design team has since pivoted from this initiative to other projects that align with the organization’s needs. Building upon the duality of capturing feedback from IU Health’s staff acting as patients, the team was interested in incorporating all patients’ voices through a single channel.

In 2016, IU Health began working with Vision Critical—a technology provider that offers a cloud-based intelligence platform to companies in healthcare and other industries—to extract the data it obtains from a new initiative called IU Health Insiders. A departure from its previous iteration, IU Health Insiders utilizes brief electronic surveys on topics of strategic importance to the organization in hopes of gaining patients’ perspectives on these topics. Past survey topics of interest to the organization have included patient preferences on sharing feedback about care and preferences on billing options.

The surveys are sent to an invitation-based community, and there is no incentive or cost for individuals to sign up. The community of contributing patients consists of those who are interested in sharing their voice—25% of which are IU Health staff—and having a direct impact on the decisions made among senior leadership. In addition, the organization is interested in how respondents answer by gender and age group; it currently divides the age group distribution into seven distinct categories.

“We collect basic demographic information, dissect the characteristics of our community, and figure out a way to better meet the needs of the segment of our patient population that participates in this initiative.” McCallum explains. “In doing so, we have a stratified perspective of the patients’ voices that helps us improve on the feedback we receive.”

Beyond these initiatives, the organization continues to strategize and look for new ways to incorporate the patient voice in the decisions it makes. For other organizations looking to amplify and capture the voice of their patients, IU Health’s journey from the inception of Experience Design to its current state can provide guidance on rethinking and retooling ongoing initiatives to better suit an evolving healthcare landscape.

What does this mean for you?

C-Suite
• Placing an importance on patient experience can raise public perception, potentially persuading more people to choose an organization for their health services
• Maintaining high satisfaction scores can also improve reimbursement

Industry
• Collecting patient feedback is vital to understanding their perception of the quality of care received

Sample of an IU Health Insiders’ Past Survey Results

Q: What method(s) would you prefer to use to leave feedback?

75% Survey via Email
34% Survey via Text
19% Survey Using Kiosk/iPad Onsite
7% Mailed Paper Survey
2% Other

As seen in these past survey results, the majority of respondents reported they preferred to give feedback via email, allowing the Experience Design team to act accordingly and provide email surveys more frequently.

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Designation under the American Nurses Credentialing Center’s Magnet Recognition Program® continues to be one of the highest honors a hospital or healthcare organization can achieve. Attaining this accreditation, however, can be a daunting endeavor, and a very small percent of organizations across the country have earned this designation due to the extensive data collection and staff involvement required. Although sometimes a difficult venture, the journey to Magnet recognition can be more accessible if fundamental components of preparation are made clear. The following explores key considerations for beginning your organization’s Magnet journey.

Why Pursue Recognition?
While the prestige of Magnet recognition is widespread, as is its ability to attract talented nurses to the organization, internal benefits from this designation can be seen as well. Magnet-designated organizations have improved RN satisfaction and retention rates, as well as reductions in nursing turnover and vacancy rates. Additionally, embracing the Magnet framework and its evidence-based practices can aid in further building a culture of nursing excellence and accomplishment within your organization.

How Long Will It Take?
The journey to Magnet recognition is a multiyear endeavor. For organizations that have already been designated previously, the timeline for redesignation is four years of preparation and data collection—a timeline that may lengthen for organizations readying for first recognition.

What Will You Need?
While a major commitment, many begin their journey by familiarizing and integrating the ANCC Magnet Model. This five-component framework for nursing practice and research acts as an outline for the Magnet journey ahead, and can serve as a valuable resource even if Magnet recognition is not an immediate goal for your organization.

Obtaining Magnet designation also requires the cooperation and coordination of the entire staff, as well as an organizational infrastructure capable of supporting a Magnet environment. To build this infrastructure, consider incorporating the following roles:

- **Magnet Program Director:** An individual whose main responsibilities encompass the body of work related to the entire Magnet submission process. This includes overseeing data collection and preparing the organization for the site visit by appraisers from the ANCC.

- **Magnet Steering Committee:** A high-level committee overseeing the Magnet journey and driving progress within the organization. Those involved in the committee, such as chief nursing officers or nurse managers, and hospital supervisors, are in charge of ensuring the Magnet framework and standards are constantly and consistently being met.

- **Magnet Champions:** Staff at the unit level who ignite passion and confidence for meeting goals throughout the Magnet journey. This includes developing staff education related to the Magnet model, or creating initiatives to prepare for the site visit.

- **Nursing Statisticians/Data Analysts:** As a large component of the Magnet application comprises data collection on quality indicators, it is necessary to have personnel who are able to efficiently analyze and interpret evidence-based data. For these roles, prioritize individuals who have been formally educated as statisticians to ensure accuracy and proficiency in the event that critical decisions regarding your application need to be made.