AHRQ Safety Program for Intensive Care Units: Preventing CLABSI and CAUTI

Transcript
Senior Leadership Podcast—Why Senior Leadership Engagement Matters

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[*Opening music*]

TJ Lewis: Welcome to our podcast, which is produced by the Agency for Healthcare Research and Quality. I'm TJ Lewis, and I'm joined here by Louella Hung with HRET, the Health Research & Educational Trust of the American Hospital Association.

So, Louella, what brings us here today?

Louella Hung: What we're trying to do is talk to actual senior leaders who are out in the field and ask them what makes certain hospitals and ICUs successful in reducing healthcare-acquired infections, also known as HAIs, and how senior leaders contribute to that success.

TJ: We've asked a few of them to join us today to discuss what exactly they do that sets their program apart. First up, we have Joan Wynn. Joan is the chief quality officer at Vidant Health.

Joan, tell me a little bit about your position there at Vidant Health. What are you responsible for?

Joan Wynn: As the chief quality officer, I help to set policy and direction—the strategy of where we're headed with the quality and patient safety work—across our eight-hospital health system. We also have a pretty significant ambulatory physician office practice business line of many primary care and specialty providers in about 80 different locations in our region.

TJ: We also have Jennifer LaRosa from Newark Beth Israel Barnabas Health in Newark, New Jersey. Jennifer is a physician and the patient safety and quality officer.

Jennifer, how long have you been in that role?

Jennifer LaRosa: I've been in that role for about 2 years. I've been at Newark Beth for about eight. I wear a lot of different hats at Newark Beth Israel. I'm also the director of the ICU, the assistant director of two divisions—Pulmonary and Critical Care, and Hospice and Palliative Care. I do a lot of work with end of life, with patient experience, with readmissions, and of course with safety and quality, which means making sure that patients, when they come to the hospital, frankly, leave either in a better, or at the very least, the same state in which they came.

TJ: Finally, we have a pair from Novant Health. Michael Vaccaro, V.P. of nursing and chief nursing officer, and Susan DeCamp-Freeze, their senior director of infection prevention.

Michael, how long have you and Susan been there at Novant Health?

Michael Vaccaro: I've been with Novant for about 9 years now and been in the chief nursing officer role for 2 years and been working in that capacity with Sue for about that time period. We have a great partnership, and really it's key to the work that we do every day on trying to improve our hospital-associated infections.

TJ: Sue, tell me a little bit about the role you find yourself in at Novant and how you got there.

Susan DeCamp-Freeze: I have responsibility for infection prevention for the system, so that includes our acute care hospitals, our physician practices, ambulatory surgery centers, imaging centers, etc. When I came back into Novant, had been with another health care system, had come in in the clinical improvement role, then they needed some assistance with risk, and then the infection prevention role. Someone laughed and said I was sort of the journeyman. But infection prevention, I have to say, is my passion. I'm very excited to have that opportunity.

TJ: So, healthcare-acquired infections or hospital-associated infections, HAIs. Is it safe to say that probably everyone listening has a pretty good understanding of what those are and how they affect health care facilities?

Michael: Yeah. They certainly have an impact for all of health care and for our patients. Nobody expects to come to a hospital and get an infection that they weren't there to have treated. And so, first and foremost, the work that we're doing is important for the patients that we take care of.

TJ: Have these always been a problem?

Michael: I would say healthcare-associated infections have been a challenge for some time. And I think there was a time where it was really thought of as it was just the price of being in intensive care unit or it was the price of being in the hospital, that you were just at risk. And I think we recognized that that's not the way it is. There's opportunities for really addressing that and with best practices, really moving the needle on reducing the number of hospital-acquired infections in our facilities. We've seen a tremendous impact on ventilator-associated pneumonias. Now we've really got to work on CLABSI and CAUTI and *C. diff,* and some of these other infections.

TJ: I'm going to back up for just one second. Could you help me explain a little bit, what are we talking about when we say CLABSI and CAUTI?

Michael: CAUTI is a catheter-associated UTI. That's a urinary tract infection that someone gets as a result of a Foley catheter. And then a CLABSI is a central line-associated bloodstream infection, which would be an infection, a bloodstream infection, which they get as a result of a line that's placed, a PICC [peripherally inserted central catheter] line or a central venous catheter of some kind.

TJ: These aren't necessarily unique to ICUs, but are they more prominent?

Michael: Our patients in ICUs tend to be sicker with a higher acuity. And so, oftentimes, they have conditions that tend to lend themselves to having central lines more often or Foleys more often.

TJ: Talk about the impact to the facilities.

Michael: It impacts our patients' experience, which impacts who we are as an organization, impacts people's desire to come to our facility. But there's financial implications now. Those patients that come to our facility and develop an infection on our watch that's deemed to be hospital-associated, then that's on us to treat and manage. So, not just for the patient experience perspective, but also from a financial perspective, it is in our best interest to make sure that we eradicate these infections.

TJ: What was the impetus within your system for the escalated prevention efforts?

Susan: Certainly the attention that CMS [Centers for Medicare & Medicaid Services] put on HAIs and how that factored into their pay-for-performance programs started capturing the attention of folks who were not clinical and whose job it was to look at the bottom line and started asking questions. I think a combination that is was always important and then you had the added layer of potential financial penalties.

TJ: Jennifer, how about your facility?

Jennifer: We had one year, a good number of years back now, 6 or 7, where we

were above the benchmark with CLABSIs. I'm known as somebody who's like a dog with a bone. I'm going to keep chewing on it until it's all gone or it's fixed. The CEO said, "I'd like you to get involved in our CLABSI prevention effort," and you know what? It really didn't come down to me doing anything particularly special or inventive or new. What it came down to was making sure that every day, on every patient, every bundle element was met. It requires that level of detail to enjoy success. I think what we're seeing in a lot of communities and a

lot of medical centers is that you really can achieve zero. On July 22 at our ICU, we were 1,365 days CLABSI-free. That's only because we've been so meticulous.

TJ: So, Joan, do we have to wait until HAIs are a problem within our facilities to escalate efforts to prevent them?

Joan: No. We know by the literature and by looking at what other organizations have done over the last several years, what are the best practices that we should implement. I do think that what we know about human behavior is that humans drift and don't always do as we're supposed to do. So, it's that constant observation and feedback. That is one of the ways that senior leaders can really help in this type of quality project or safety project is being there to observe the practices and being able to give feedback and coaching.

TJ: Typically, who's considered responsible to senior leader for the ICUs?

Michael: Certainly, the ICU leadership starts with the clinical leader for that area, whether it's a nursing director or a nursing manager. Different organizations have those folks titled differently. It starts with that nursing leader, as well as the medical director for that ICU. It really rises to the level of the facility—president, the chief nursing officer in the company in that facility, as well as the vice president of medical affairs or CMO, or whatever your organization title is.

TJ: Sue, can you talk about the importance of that senior leadership engagement with the frontline staff?

Susan: I think without it, even a very engaged and passionate ICU team can only go so far. There are things that they can impact at the local level within their team, and there are things that they cannot without the engagement of senior leadership.

Michael: As a CNO, I see that as my role. It's not just a matter of the ICU clinical manager and the medical director to be focused on it. I need to know what's going on in the ICU. I need to be supporting that team, removing barriers, also being aware of the work that they're doing, supporting it, rounding in those areas. I think by doing so, you raise the level of engagement of all of the team. That is, I think, important and been a big part of how we've continued to move the needle in this area is by having that level of engagement.

TJ: How does your level of engagement affect who you report to or the board?

Michael: Much like our community is attuned to HAIs and the impact of HAIs, so is our board. We're not shy about setting the bar high. When we're not meeting the mark, our board wants to know and wants to understand what we are doing to address that. So, there's that engagement at a facility level with our team members, and our strategies are key because our board expects it as well.

Susan: Having the level of engagement from senior leaders allows for a more fulsome explanation of what does that dashboard mean versus, "Hey, I heard from my neighbor who had an infection," that we're really able to speak to what we're doing, what we're trying to accomplish. One of the, to me, major reasons to have that senior level of engagement is that they are in the best position to remove those barriers as they become identified and put the right resources in place to make it be successful.

[*Closing music*]

What resonates with me the most is when staff can be successful. Most people in health care, especially when they're at the bedside, came to work to make a difference in their patients' and their families' lives. If we can put a structure in place that allows them to do what they got into nursing or medicine for in the first place, and they can do it on a day-to-day basis, and they can see the fruits of their work and that it's being recognized, that does it for me.

Louella: Sometimes, it's hard to know what to do or where to start, but as a senior leader, you know your role is important in this journey. You've heard some very specific examples on this podcast from senior leaders who've been successful in leading change, and what they've done to inspire and promote improvement. We encourage you to access resources that are available in this program and begin your journey as a senior leader, committed to reducing CLABSI and CAUTI in your organization.

TJ: On behalf of Louella Hung, a quick thanks to Michael Vaccaro, Susan DeCamp-Freeze, Jennifer LaRosa, and Joan Wynn for joining us on this segment. Please join us for the next segment as we further discuss the importance of senior leader engagement and the teams that they support. This podcast was produced by the Agency for Healthcare Research and Quality, part of the U.S. Department of Health & Human Services.

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