IP/Stakeholder Series: The C-Suite

By Kelly M. Pyrek

Sue Barnes, RN, CIC, FAPIC

In this new series for 2017, we highlight insights from professionals in the healthcare community regarding how to foster communication and collaboration between infection preventionists (IPs) and key stakeholders. In this issue, Sue Barnes, RN, CIC, FAPIC, an independent clinical consultant and former national program leader for Infection Prevention and Control at Kaiser Permanente, provides her perspective on how IPs can best champion their programs to the C-suite at their healthcare institutions.

In her position at Kaiser, Barnes led infection prevention efforts for the system's eight regions, 38 hospitals and 630 medical offices, and interacted frequently with members of her healthcare system's leadership. She emphasizes that communicating to a facility's administrators is one of the most important responsibilities an IP has, noting that while this task may come easily to some, many of them may have a learning curve to navigate.

Barnes provides five tips to help infection preventionists prepare an elevator speech or a more formal presentation to their institution's C-suite (e.g., chief operating officer, chief executive officer):

1. Speak their language.
2. Demonstrate a return on investment (ROI).
3. Clearly state risk.
4. Engage them with a patient story.
5. End with a clear and achievable "ask"

Regarding the first tenet, Barnes says it is critical for IPs to understand and become fluent in the pay-for-performance programs to which the healthcare industry is subject, including re-admission reduction programs, value-based purchasing and reduction of hospital-acquired conditions. "IPs must understand what the real cost to your particular hospital or hospital system is, and you can get to that very easily online," Barnes says. "There is an Advisory Board interactive map (https://www.advisory.com/research/health-care-advisory-board/resources/2013/pay-for-performance-map) which provides the impact of pay-for-performance programs by medical center. You click on the location first and scroll to your particular hospital and it breaks down what the financial impact of those three programs is. As an example, for one average hospital in the Bay Area for FY 2016, according to this map, the estimated total penalty for the three programs will be greater than $3 million. That reflects many outcomes including healthcare-associated infections (HAIs)."

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"IPs must be well-versed in how infection prevention affects those programs, including via efficiency, patient experiences, compliance with clinical process of care and ultimately outcomes." Barnes adds. "It's important to understand which infection rates are publicly reported. We started in FY 2014 with CLABSI and CAUTI as required by Centers for Medicare and Medicaid (CMS) Inpatient Quality Reporting Program, and this been expanded to include SSI for colon and abdominal hysterectomy, MRSA and C. difficile. One component that can be difficult to understand is the standardized infection ratio (SIR). That's not new, but it is becoming standard language, and is the metric that we use for reporting and discussing HAIs. IPs should have a good working knowledge of SIR and maybe even prepare an elevator speech to help members of the C-suite understand what it means."

A second key tenet is return on investment (ROI) from the institution's infection prevention program, which is absolutely critical for the C-suite to understand. "To me, ROI is icing on the cake, above and beyond what is mandated," Barnes says. "We have mandates for infection prevention programs and also for the resourcing and funding of infection prevention programs by a number of regulatory bodies including CMS and the Joint Commission. So it's important to understand all of that as well as state-based legislation and recommendations from our professional expert bodies like CDC, SHEA and APIC. ROI from infection prevention programs can be demonstrated in several ways, one being costs avoided by preventing infections, which is easy to show with a simple graph. What I have done for my administrators is to use red and green arrows that indicate increase or decrease for total numbers of infections, with the previous 12 months compared to the current 12 months for each of category of infection. Then they can easily see, for instance, the number of CAUTIs we had for the past 12 months contrasted with the current 12 months, the costs associated with those and whether we are trending up or down. Those red and green arrows seem really simplistic but feedback indicates it has been helpful to clearly demonstrate costs avoided and incurred relative to HAI (healthcare associated infections). I think it's also helpful to estimate the number of patient lives saved. Since each type of infection is tied to a certain risk of mortality, you can generate an estimated number of lives saved over the course of 12 months for each type of infection. Of course, C. difficile infection has the highest mortality rate of all of the categories of HAI, so it's important to underscore that."

Barnes continues, "Another way to demonstrate IP Program ROI is patient satisfaction. One way this is measured is with HCAHPS

Advisory Board interactive map, https://www.advisory.com/research/health-care-advisory-board/resources/2013/pay-for-performance-map

scores (hospital consumer assessment of healthcare providers and systems). This is a patient survey, and two questions are reflective of infection prevention programs: patient perception of healthcare worker hand hygiene and patient perception of cleanliness of the hospital environment.

Accreditation survey preparation is also another method of measuring ROI because a really successful CMS and/or Joint Commission survey is critical. "Additionally a patient who has an infection and is subjected to suffering because of that infection is not going to be a satisfied customer. This would contribute to the less easily measured benefit of organizational reputation."

The third tenet when speaking to hospital administrators is being clear about the patient risks and the gaps relative to infection prevention and control. "The Delphi Study from 2002 recommended one infection prevention full-time equivalent (FTE) per 100 beds; of course we know that's not sufficient," Barnes says. "Many hospitals have staffed up and are improving IP resourcing throughout the country. But overall, we are not staffed well enough. It's a rare facility where the hospital is not associated with any number of ambulatory care clinics and services. So I think it is important to ask the question, is our current resourcing in the Infection Prevention department sufficient to cover our hospital and ambulatory areas, because there more than two dozen categories of tasks and functions that must be performed according to Joint Commission and CMS standards for inpatient areas alone. And the expansion of infection prevention-specific quality indicators over the past decade has been phenomenal, so the question I ask administrators is, where do you want your FTEs for infection prevention dedicated? Do you want these clinical experts sitting at a desk tracking metrics and reporting data? In some facilities, infection prevention programs have added analysts or clerical staff and a lot of this surveillance work is shifted over to them. There is also a move in some organizations to centralize the infection surveillance function. In Kaiser's Northern California region, they have instituted centralized surveillance and reporting of infections, using one specialized team to perform this function for the 20-plus hospitals in that region. In my opinion this approach is far more efficient, giving this task to an individual or a group of individuals that are trained well and understand the definitions and how to report. And then the majority of infection preventionists' time can be focused on prevention and control of infections."

Barnes continues, "Then we get to the question about how do we ensure appropriate oversight of ambulatory services? Regulatory bodies are not yet requiring specific resourcing for oversight of the continuum of care beyond the hospital. For ambulatory areas, infection prevention is considered by regulators to be a function rather than a profession. So I always bring up the issue of oversight for ambulatory services and ask questions to underscore how clinically expert IPs are needed in order to ensure that good care is being provided. It can't just be a function, it's a dynamic profession that is always changing. So I ask members of the C-suite, for example, do you know what a Mohs procedure is? Most C-suite folks may or may not know what that is; it is a dermatology surgical procedure typically performed in an ASC in a non-OR setting. So what types of infection prevention and control measures should be applied during those procedures? That's not something that the average nurse is going to know or is prepared to know by training. And there are medication-safety issues which is huge in ambulatory care. Do your orthopedic surgeons use single-dose vials for more than one patient? Do you know about the outbreaks that have been reported throughout the country as a result of inappropriate use of single-dose vials? I also bring up the issue of flexible scope reprocessing and the great risk of infection transmission from these scopes that are so complicated and difficult to clean. And ask if they know what an elevator wire channel is and why that is important in terms of reprocessing duodenoscopes to prevent transmission of infection. Those are just a few of the many examples that can be used to underscore the clinical expertise of IP professionals, required for hands on oversight in ambulatory areas."

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The fourth recommendation that Barnes makes is engaging members of the C-suite as champions for the institution's infection prevention program. "One way to do that is by telling them a patient story," Barnes says. "Patient story-telling has become a more prevalent tool over the past decade and there are many sources of patient stories if an IP does not have a particular story from his or her own facility. A good source is https://safepatientproject.org/, and you can Google the search term of 'HAI and patient stories.'

Finally, Barnes emphasizes the importance of IPs ending their presentation or their elevator speech with a clear and achievable "ask." "One very simple thing they can easily provide is public recognition of the success of the infection prevention program and staff," Barnes says. "That might be accomplished in a newsletter, at a staff meeting, in a huddle and with monetary merit awards. This is not difficult, and it's really easy for a hospital executive to build that into existing processes, if they are not already doing it. I think it's also critical to ensure that there is dedicated resourcing for the physician partner of any infection prevention program. It's something that is often overlooked, and I cannot underscore enough the importance of having a strong physician partner who is trained, informed and enthusiastic to help lead the Infection Prevention and Control Program."

Barnes says it is up to the IP to keep his or her program visible to the C-suite, as numerous interests compete daily for hospital leadership's attention. "The pay-for-performance programs encompass so many things, that the institution's infection prevention program may get lost," Barnes warns. "It's critical to frequently reiterate to hospital leaders the value of the infection prevention program. It seems sometimes that infection prevention is still considered to be somewhat of a necessary evil. One thing pay-for-performance programs have helped to do is create visibility for the C suite about the importance of infection prevention and control, but there is still room for improvement."

Barnes encourages IPs to work through any fear or hesitancy they may have about approaching their C-suite leaders. "Really look at the big picture and see if you have enough resources to do the job well enough to protect patients," she says. "You need to share with the C-suite what's really going on in your program, where the gaps are, and engage them as champions to help support your program, get technical support, get clerical support, get a software program, get whatever it is that you need to make your patients safer. Recognize when you need help and go after it; or if you are doing a super job, then go after the recognition. If you are not regularly on the agenda for the executive committee, or if you do not know your C-suite leadership team by name, then that needs to go on your to-do list. Understanding the importance of having those conversations is key. And then be prepared, know your material, know what you are going to say in advance and keep it simple and easy to deliver. That will help build confidence to have the conversation(s)."