Hospital Value-Based Purchasing (VBP) Program Patient Safety Series: SSI Colon and SSI Hysterectomy

Presentation Transcript

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Matt McDonough: Good afternoon everybody and thank you for joining us for this afternoon's webinar. My name is Matt McDonough. I'm going to be your virtual host for today's event and before we turn things over to our first

presenter of the day, we like to cover some housekeeping items with you so that you understand how today's event will work and how you can send your questions to be answered by our panelists today. As you can see in this slide, we are streaming our audio feed over ReadyTalk®'s Internet streaming feature. What that means to you is it there is no telephone line required but you do have to have those computer speakers or headphones connected and turned on, of course, to listen to today's streaming audio feed. Now, if for whatever reason, you encounter some difficulty with our streaming audio or you don't have computer speakers that are working or are reliable, we do have a limited of dial-in lines that are available. If you do need that dial-in number, please send us a chat massage. We do have subject matter experts manning that chat window today and they will be happy to get that dial in number out to you as soon as possible. Also, as always, we are recording this event to be archived for playback at a future date.

Now, if you are streaming audio over your speakers today, there are a couple of common issues that you may encounter such as your audio from your speakers becoming choppy or breaking up, or it may stop completely. Before dialing in, there is something you can try to do on your end to resolve that situation, and that is to either click the refresh icon which is illustrated in the graphic at the bottom of this slide, or you can click the F5 key. Either of those will refresh your browser window. And what that will do, it will temporarily disconnect you from the event and reconnect you within a matter of seconds. It will also restart your audio feed at the current slide. So if you are experiencing those types of audio issues, that may be a very simple solution to help you resolve those. Again, if this solution doesn't work for you. We do those have those limited number of dial-in lines available and you'll simply need to just send a Chat message in to obtain one of those numbers.

Now, also you may hear an echo on the call in a certain circumstance and that circumstance is actually if you're connected more than once to an event. You can see on this slide what it may appear like if you're connected to our event today in more than one browser or tab. When that

happens, you'll hear multiple audio feeds and it sounds like an echo on your speakers. This is a very easy situation to resolve. You'll simply close all but one of those browsers or tabs. What that will do is get you down to a single audio feed and that will clear the echoing situation up. So again, if you hear an echo, close all but one of your browser tabs connected to this event and you should hear that echo clear up.

Now, although we are in a listen-only mode today, that does not mean that you can't send in your questions to our speakers today. We do have a Chat with Presenter feature on our screen here. It's located in the bottom left corner in your screen, illustrated here by that yellow arrow. At any time you can send in a question to our panelists by simply typing your question in that box and then clicking *Send*. When you do that, your question will be seen by all of our panelists today, and as time and as resources and of course, the availability of answers allows us, we'll answer as many questions as we can in the Chat box today. However, please do keep in mind that your questions are being archived to be addressed in a future Q and A document.

And that's going to do it for my brief introduction. So without further ado, I'd like to hand things over to Bethany to get us started.

Bethany Wheeler: Thank you, Matt. Hello and welcome to our Hospital Value Based Purchasing, first, or excuse me, the second session in this Patient Safety Series covering the surgical site infection or SSI measures. My name is Bethany Wheeler and I will be your host for today's event. Before we begin, I'd like to make a few announcements. This program is being recorded. A transcript of the presentation, along with the question and answers, will be posted to the Inpatient website, www.qualityreportingcenter.com; again, that's www.qualityreportingcenter.com within ten business days, and will be posted to *QualityNet* at a later date. If you are registered for this event, a reminder email, as well as the slides, were sent out to your email about two hours ago. If you didn't receive that email, you can download the slides at the Inpatient website. Again, that's www.qualityreportingcenter.com. And now I'd like to welcome our guest

hospitals, Carolinas HealthCare System in Pineville and Robert Packer Hospital. Thank you for joining us today and agreeing to present your story on how your hospital improved in the SSI measures. If you have a question for either Carolinas Healthcare System Pineville, Robert Packer Hospital, or myself as we move to the webinar, please type either Carolina, Robert Packer, or Bethany at the beginning of your question so we can direct the question to the appropriate party. Any questions that are not answered during our question and answer session at the end of the webinar will be posted to the qualityreportingcenter.com website within ten business days, although we do hope to get as many questions in the last half hour of the call.

In today's presentation, I will be providing a short overview on the usage of the SSI measures within the Hospital Value-Based Purchasing program. The majority of today's webinar will be the presentation of the best practices and stories of our two guest hospitals, who worked to improve their SSI volumes and scores.

Participants will be able to identify how colon surgery and abdominal hysterectomy SSIs are utilized in the Hospital VBP Program, discuss improvement plans and best practices with other hospital providers, and identify interventions to improve SSI infection rates.

So the SSI measure was first included in the Hospital Value-Based Purchasing program during the Fiscal Year 2015 program year. CMS has continued to adopt and retain the SSI measure through each of the subsequent Fiscal Years but have been proposed through the IPPS Proposed and Final Rule. The latest year the SSI measure has been proposed is Fiscal Year 2018. It is anticipated that CMS will propose measures for the Fiscal Year 2019 program year and the Fiscal Year 2017 IPPS Proposed Rule to be released this spring. In the Fiscal Year 2017 program year, the CLABSI/CAUTI measures, in addition to the MRSA, CDI (inaudible), SSI, are in survey as part of the Safety Domain, which is weighted at 20 percent of the total performance. The performance period for SSI in Fiscal Year 2017 is calendar 2015, which is January 1, 2015 to December 31, 2015.

In Fiscal Year 2018, the SSI measure was still included in the Safety Domain which increased the domain weight to 25 percent from the 20 percent seen in Fiscal Year 2017. The performance period for SSIs in Fiscal Year 2018 is Calendar Year 2016. I also have a few updates to provide regarding SSI submissions to NHSN. ICD-10 PCS codes will replace ICD-9 CM code on October 1, 2015. However, NHSN will not have the ability to receive these codes until the January 2016 NHSN release. Beginning October 1, 2015 and continuing until the January 2016 NHSN release, when entering surgical procedure denominator data, until an NHSN first exercises surveillance, facilities should infer to NHSN procedure code. Example, (inaudible), as identified in the new map being provided, but the applications cannot accept ICD-10, PCS, or CPT codes associated with the procedure until the release of the 2016 application in January. This includes data that is entered manually, electronically downloaded, or imported via a common separated value or CSV file. The NHSN application can accept ICD-9 PCS codes for all of 2015 if the facility has access to them. Once the NHSN release takes place in 2016, facilities will once again be able to choose to enter the NHSN operative procedure code category, or instead, enter one of the ICD-10, PCS, or CPT code and have NHSN auto-populate the NHSN operative procedure code category. Also we would like to note, the ICD-10, PCS, and CPT code fields will remain as optional fields in 2016. ICD-10, PCS and CPT code do not differentiate between final fusion and repeat final fusions. Therefore, the NHSN procedure group fusion will include both fusion and re-fusion procedures, and the re-fusion category should not be used for procedures performed on or after October 1, 2015. Requirements to not infer NHSN operative procedure code category, “Other,” to ICD-10, PCS, and CPT codes are available in NHSN resources. “Other” is a default category for NHSN operative procedures which do not fall into one of the 39 NHSN operative procedure code categories, and for which NHSN does not provide any benchmarking data. For these reasons, NHSN category of “Other” will not be mapped to ICD-10, PCS, and CPT code and will not be available for use in 2016. Any infections associated with procedures in that group will not be considered as an NHSN surgical site infection beginning with October 1, 2015 procedures. There is no other turnover,

quite a few updates there, so for a full recap of the updates I just listed, you may reference the presentation transcript when it comes available on the qualityreportingcenter.com website, and that should be up within ten business days.

The NHSN measures are calculated by CDC and currently include the CLAUTI, CLABSI, MRSA, CDI and colon and abdominal hysterectomy SSI measures in the Fiscal Year '17 program year and subsequent program years. They measure the occurrence of these HAIs in hospitals participating in the Hospital Value-Based Purchasing program. In order to calculate the NHSN measures for use in both the hospital IQR Program and the Hospital Value-Based Purchasing Program, CDC must go through several steps. First, CDC determines each NHSN measure's number of predicted infections. CDC determines the number of predicted infections using both specific patient care location characteristics, for example, number of days in which a patient in an ICU has a central line and infection rates that occurred among a standard population, sometimes referred to by CDC as the national baseline but referred to on the slide as standard population data. Finally, for each NHSN measure, CDC calculates the standardized infection ratio, also known as the SIR, by comparing a hospital's observed number of HAIs with the number of HAIs predicted for the hospital, adjusting for several risk factors. As part of routine measure maintenance, CDC is updating the standard population data to ensure the NHSN measures' number predicted infections reflect the current state of HAIs in the United States. Currently, CDC calculates the standard population data for the HAI measures based on data it collected previously. CDC calculates the standard population data for the SSI measures based on data collected in 2006 through 2008. Beginning in 2015, CDC will collect data in order to update the standard population data for all of these NHSN measures. The Calendar Year 2015 standard population data for HAI measures will hereafter be referred to as *New* Standard Population data because the Hospital VBP program populates improvement plans using comparison between data collected from hospitals in a baseline period and data collected in a performance period. The Hospital VBP program must treat CDC standard population data

differently from other quality programs. CMS has determined that working (inaudible) CDC's *New* Standard Population Data to the current standard population data in order to calculate improvement points. If CMS does not address CDC's measure update, they will be unable to prepare the baseline and performance periods for NHSN measures in the fiscal year, starting in the Fiscal Year '17 and Fiscal Year '18 program years. To address the problem, CMS intends to use the current standard population data to calculate performance standards and calculate and publicly report measure scores in public Fiscal Year '18 program year as you can see in the table on the slide. For the Fiscal Year 2019 program year and subsequent years, the Hospital VBP program will use the *New* Standard Population Data to calculate the performance standards and calculate and publicly report measure scores.

And I know you're all tired of listening to me and want to listen to your guest hospital guest speakers, so I'll wrap it up. I thank you all for listening to my short overview and updates to the SSI measure. Remember, for the questions that you submit to the Chat box, please state who the question is intended for, either Carolinas, Robert Packer, or myself, Bethany. Carolinas HealthCare System Pineville, we welcome you, and the floor is now yours.

Tammie Stahl: Hello, everyone. Thank you for joining us today. My name is Tammie Stahl. I'm the Clinical Coordinator for Anesthesia at Carolinas HealthCare System Pineville. I have been involved in performance improvement since 2011 with a particular attention paid to decreasing surgical site infections. It is my pleasure to speak with you today about the team approach to reducing surgical site infections with the focus on how together, as a team, at Carolinas HealthCare System, we were able to provide a safer environment for our patient.

As you can see from this slide, decreasing surgical site infections requires engagement from the entire team. From the first interaction with the patient in pre-anesthesia testing until the patient is discharged, the team includes members from anesthesia, nursing, infection prevention, quality

assessment and our surgeon. A few members of our team will give you their perspective today.

On this slide, you can see that our process includes the goal, the methodology and the framework. The goal of decreasing surgical site infections in hysterectomy and colon surgeries evolved from the Carolinas HealthCare System Hospital Engagement Network which was abbreviated, HEN, which was a two-year project involving 29 system hospitals. Its focus was to reduce patient harm by 40 percent and preventable readmissions by 20 percent by the end of 2014. Surgical site infection was one of ten focus areas of HEN. The methodology used was a PDSA or Plan, Do, Study, Act. Many changes were made along the way to allow us to overcome our challenges. The Surgical Care Improvement Project, SCIP, provided us with the framework we needed to begin our focus. Some of the core measures we followed were patient temperature management, correct antibiotic timing, correct antibiotic selection, and antibiotic discontinuation within 24 hours. All of these core measures were audited daily by our quality assessment RN for every patient and random monthly audits were completed by the anesthesia PI team. Any deviation from standard was followed-up on immediately. Correct antibiotic selection and timing began in the pre-operative area.

Laura Schuetz: My name is Laura Schuetz. I am the Nurse Manager of Pre-Anesthesia Testing, Day Surgery and PACU. Our Pre-Anesthesia Testing department contacts each patient prior to surgery and conducts a thorough medical and surgical history which is then communicated to the pre-operative, operating room, and anesthesia teams. We partner with our patient by providing an educational handout on how to prevent surgical site infections. We give this handout to them when they come in for their pre-operative lab appointment with hopes to start the infection prevention process before they ever come into the hospital. This education handout includes information about preventing infections, as well as information about symptoms and treatment of infections. Our colon and hysterectomy patients spend at least one night in the hospital. These patients get a bright

orange form placed on the front of their chart which helps prompt antibiotic timing.

Ellen Crabtree: My name is Ellen Crabtree. I am the Clinical Supervisor for the Day Surgery Unit at the Carolinas HealthCare System Pineville. On the morning of surgery, every colon and hysterectomy patient is given a chlorhexidine bath from head to toe. Each packet of bath wipes has six wipes that correspond to color zones of the body. The patient is instructed to perform the bath, wiping in a downward fashion to clean away from the body. When the patient is ready for the antibiotic, the nurse goes into the approved antimicrobial prophylaxis protocol to select the appropriate antibiotic. This antibiotic protocol has an alternative, approved antibiotic if the patient is allergic to the primary selection. If the physician wants additional antibiotics or a different antibiotic, that is communicated the morning of surgery.

Tammi Stahl: On this slide you can see that communication is the key to meeting our goals. Anesthesia worked closely with the Surgeon and the Pre-operative RN to ensure that the patient received the correct antibiotic. Antibiotic timing was our biggest challenge especially with "to follow" cases or cases that started later in the day. With a case requiring Vancomycin due to surgeon preference or patient allergy, had to be started soon enough to be effective but not before the two-hour "prior to incision" window. Another challenge that we faced was that the pre-operative antibiotics historically were given on the floor, on call to the OR for our in-house patients. These patients often fell out of the SCIP protocol for antibiotic timing. We changed our practice so that now we never give antibiotics on the floor, on call to the OR. Anesthesia manages all pre-operative antibiotic timing to ensure it is delivered according to protocol. If our Pre-operative RN notices that the patient has an allergy or the patient requires Vancomycin, they call the CRNA. The CRNA communicates with the Surgeon in the room to decide the best start time for the medication. With this communication, we were able to meet our two-hour goal for antibiotic timing with Vancomycin. Prevention of hypothermia has a clear benefit for the patient in terms of reduced mortality and morbidity. Our goal was

to have the patient's temperature will be equal or greater than 96.8 degrees Fahrenheit, documented within 15 minutes immediately after anesthesia end time. We actively warmed all of our patients undergoing general or spinal anesthesia that may last longer than 60 minutes.

On this slide, we will discuss how the Surgical Safety Checklist is a system-wide tool used to improve patient care. The Surgical Safety Checklist was developed by the Carolinas HealthCare System Surgical Quality and Safety Operations Council. This is abbreviated QSOC. Carolinas HealthCare System QSOC provides an organized approach to identifying and implementing best practices that drive quality and safety across the system. 22 QSOC teams cover functional areas such as infection prevention, readmission, and surgery. The Surgical Safety Checklist followed World Health Organization guidelines. It was adjusted to meet the unique needs of our operating rooms at Carolinas HealthCare System Pineville. It is consistently used as a standard of practice to verbalize key safety checks in the operating room before the induction of anesthesia, prior to skin incision, and before the leaving the operating room with every surgical patient. At least 30 cases are audited monthly for the correct use of the Surgical Safety Checklist.

Heather Gore: My name is Heather Gore and I'm one of the clinical supervisors in the OR. This is our Surgical Safety Checklist that we use at Pineville. We use this for every patient. The first column is completed in Pre-Op and addresses antibiotic prophylaxis and also addresses the risk of hypothermia. The middle column is a template used to standardize our surgeon-led timeout. This column addresses final antibiotic administration, surgical prep used, and appropriate drying time. The third column is a debriefing section in which the OR team has the opportunity to discuss anything the team could have done more efficiently for the patient. The staff use this tool to report any concerns they feel that need to be addressed with the leadership team.

Some of our successes. We were the first hospital within (CHS) to go live with the surgeon-led time out. We have excellent buy-in from the staff and from our surgeons. The timeout process gives the team the

opportunity to speak up in real time and the Surgical Safety Checklist gives the team the opportunity to write comments, concerns, or suggestions to the leadership team. We then compile the written comments and email them out and discuss with staff at daily huddles and staff meetings. Some of our challenges were staff education. Anytime you have a process change, you have to have staff buy-in. We educated the staff at daily huddles and meetings on the importance of the surgeon-led time out and the Surgical Safety Checklist. We also, as a leadership team, supported the staff to speak up and bring any issues or concerns to us immediately. We also engage our staff with helping to adjust the Checklist to meet the needs of our operating room.

Allison Paysour: I'm Allison Paysour, Clinical Supervisor for the OR. One of the changes implemented during the performance period was the use of a standardized prepping solution. Chlorhexidine gluconate became the skin prep of choice for both hysterectomies and colon surgeries. In addition to the standardized prep, we implemented a firm three-minute dry time for the prep. We supplied each operating room with a timer, and staff were instructed to wait the full three minutes. Once the prep is complete, the circulator starts the three-minute timer. The circulator also looks at the clock and announces the time that it is acceptable to begin the draping process. In the beginning, we faced some challenges. Surgeons often tried to rush the three-minute drying time but our staff were encouraged to speak up for patient safety. We provided team Steps training to empower staff to speak up if they have concerns and to reinforce that the three-minute drying time must be followed. The patient cannot be draped until the prep is dry, ensuring the scalpel is not passed for incision until the three minutes have passed. Our team eventually standardized the practice and everyone is aware that the three minutes will be observed every time.

Amanda Ianello: Hello, my name is Amanda Ianello. I'm a Clinical Supervisor on the surgical unit at CHS Pineville. I'm going to talk about briefly about the post-operative care that has been implemented to reduce surgical site infection. As mentioned earlier in the presentation, the implementation of the orange SCIP forms has greatly helped our staff to alert them that their

patients have time sensitive care needs. Best practice shows that the full course of antibiotics after surgery should be administered within the first 24 of hours of anesthesia end time and our goal with a hundred percent compliance. Until this awareness in proactive patient care management was hardwired, teammates had a great deal of assistance from the facility quality assessment nurse with timing antibiotic administration. In the quality assessment, role post-operative patients were monitored in real time and communication was maintained to make sure that antibiotics were administered within 24 hours. Because the quality assessment nurse was not on site 24 hours a day, the charge nurse on (inaudible) also performed real time audits for these patients. Obtaining this goal did not come without obstacles. A combination of standard medication administration time, inconsistent order entry, and varied anesthesia end times made this goal challenging. Bedside nurses in both PACU and surgical units work closely with pharmacy staff to ensure that patient's orders met this initiative and that medications were administered promptly to patients. PACU implemented the practice of faxing the SCIP sheet to pharmacists so that they could schedule antibiotic administration times to coordinate with SCIP parameters. Another significant change in post-operative care of this patient population is the surgical dressing used. There is a transition from gauze and tape dressing that require daily or twice daily dressing changes to AQUACEL® AG surgical dressings. AQUACEL® dressings have been proven to reduce surgical site infection by up to 76 percent. These dressings, unless their condition has been compromised, remain intact for seven to ten days after surgery which greatly reduces the risk of contamination in open wounds. The implementation of this dressing reduced the workload of bedside nursing staff. The only challenge to this type of dressing is patient compliance, especially in the post-operative population presenting with acute confusion. In this patient population, close monitoring is essential to maintain a non-compromised sterile dressing. When the dressing has been compromised, bedside nurses recover the wound with another AQUACEL® AG dressing.

Tammi Stahl: This slide details our results. As you can see in the table, we improved both the SSI colon and SSI hysterectomy SIRs from the baseline period in 2012 to the performance period in 2014 by a substantial amount. But physically we went from 7.288 predicted and nine observed SSI colon infections in the baseline period with a SIR of 1.235 to 6.317 predicted and only two observed infections with a SIR of 0.317 in the performance period. For the SSI hysterectomy measure, we went from 3.181 predicted and one observed SSI hysterectomy in the baseline period with an SIR 0.314 to 2.5 predicted and zero observed infections in all, in the performance period with an SIR of zero.

In conclusion, we have learned that decreasing surgical site infections requires multiple departments across the hospital system, collaborating as one to improve patient outcomes. We are delighted to see that all of our efforts from the patient to the surgeon has resulted in decreased surgical site infections at Carolinas HealthCare System Pineville. As you can see, together as a team, we can make the surgical process safer for all patients, one patient at a time.

Bethany Wheeler: Thank you for your presentation. As a reminder, please submit either Carolinas or Robert Packer as the beginning of your question so we can direct them to the correct party at the end of the webinar. We should have approximately the last 30 minutes of the call to address the questions that were entered during the presentation. At this time though, I would like to welcome the team from Robert Packers. The floor is now yours.

Andrew Klee: First, a little background on Robert Packer Hospital. We are a two hundred and fifty-eight bed tertiary medical center and teaching hospital in the north central part of Pennsylvania, right on the Pennsylvania/New York border. We have residency programs in Internal Medicine, General Surgery and family Medicine, as well as a Cardiovascular Fellowship program. This year we entered into an affiliation with a local medical college for third and fourth year students to round with Guthrie positions as part of their education. Despite being a rural area, we still average more than 15,000 admissions each year along with 5,000 inpatient surgical

procedures and 10,000 out-patient ones. So we definitely manage to keep busy.

One of the most critical aspects for quality improvement is a solid infrastructure that allows for the proper generation, reporting and utilization of data. For SSIs, the two most significant sources are, of course, the National Healthcare Safety Network, NHSN, and the American College of Surgeons National Surgical Quality Improvement Program, NSQIP. Having those data sources available is great, but the presence of a dedicated data manager is really what makes this engine run. Equally important are the groups that receive and study the reports that are generated from this data. This includes myself, as well as Dr. Tom VanderMeer, our Vice Chair of Quality, Education and Research, Dr. Brian Fillipo, our CMO, and a whole host of committees all the way up to our Board of Directors. The intent here is to get data into the hands of physician leaders, administrative leaders, and department managers who can help implement the initiatives upon which the data is based. These initiatives include the development of projects and implement Lean and Six-Sigma principles, and most recently, the Surgical Unit-based safety program, SUFT, that originated out of Johns Hopkins. Finally, an electronic medical record is quite literally a requirement in this day and age of Meaningful Use, and at Guthrie we utilize Epic, which includes the uptime program for our ORs.

Getting back to NSQIP, the utilization here at Robert Packer Hospital has centered around not just general and vascular surgery cases, but also a number of sub-specialties, and certain targeted procedures. One of the most significant benefits of NSQIP is really its reliance on clinically-based data. This isn't data that has been pulled from a finance spreadsheet or some other document that relies on administrative information. Data entered into NSQIP and the reports generated from that data become standardized and validated via the criteria that build into NSQIP. Our certified data collector, Nicole, can rely on that data, on that criteria, excuse me, when extracting this data, confident in knowing the correct measures, the right factors are all being included. Every quarter, the data

is risk adjusted and benchmarked against the other participating NSQIP facilities so we know where we stand against the rest of the crowd by means of an odds ratio. We re-tune this data collection, as well, to ensure that the right information is being collected and entered. The end result assists, allows our physicians and other leaders to be equipped with the tools needed for clinical decision making.

On this graph, here, you can see our general surgery surgical site infection odds ratio for the past several quarters, from the end of 2011 right up to the end of 2014. As you can see for 2012 and about half of 2013, our SSI rates were higher than the other NSQIP facilities, about 40 percent to be a little bit more precise – obviously, not the place for any respectable healthcare provider would want to be, which is what compelled us to really look in the mirror and see what had to change.

If the previous graph did not get your attention, then I guarantee this one will. This is the odds ratio for our colorectal SSIs which climb to just over 2.00. There really wasn't a particular reason as to why this happened. We didn't have an outbreak of a particular organism, for example. It's more of a cumulative factor of a number of different processes that we simply had to evaluate and improve.

Here you see data from that same period of time, only from the NHSN perspective. All the other infection prevention sitting in the audience will be probably recognize this is as one of the many data tables that can be generated from that system. The number of procedures along with the observed and expected number of infections is used to calculate the standard infection ratio or SIR. Again, from the NSQIP data, we already knew there was an issue with our colorectal procedures but this has helped to reinforce and confirm that there was indeed a problem.

Incision site infection reduction is nothing new to Robert Packer. It started in earnest over eight years with the combined efforts of Dr. Tom VanderMeer and our Senior Vice President of Surgical Services, Barb Pennypacker. Over the years, these two individuals have really tirelessly introduced and then championed a number of best practices proven in the

literature to reduce surgical site infections, and I'll get into the specifics of those practices in the next couple of slides. The primary focus of these efforts will find colorectal procedures, as you saw for good reason, but we were also mindful to implement processes that were likely that have an impact on other patient populations, as well. So over the next several slides, I'm going to divide the discussion into the four categories that you see here: the pre-operative phase; the management of the patient intra-operatively; I'll touch on changing our culture related to development infections; and then I'll close with the mention of some of our ongoing efforts.

Starting with the pre-operative phase, our goal was getting the patient to the optimal state, or at least as close as possible, through a variety of proven measures. Glycemic management is perhaps the most significant of these measures and one of the first changes we attempted. It was important to make getting that HBa1c test a routine step for all inpatient procedures. The benefits of adequate measurement have been well established, of course, but the tricky part was making that a rote part of the pre-operative phase. We implemented an alert system: the surgeon was notified whenever the HBa1c exceeded eight percent, and it's left up to the surgeon, at that point, to make the call whether that elevated rate warranted canceling procedure. We're currently considering lowering that threshold down to 6.5 percent in the face of continuing developments in the literature. We have also incorporated the use of chlorhexidine body wash, which is given to patients to shower with the night before and morning of their procedure. Education is provided through our Pre-Admissions Services Department, as well, so patients are given not only the information on what is expected of them and also what they can do to minimize the chance of infection. Finally, normothermia is a well-established measure, and that is accomplished via these Bearhuggers in our prep area. Moving on to the antibiotic section, we built order sets in Epic that were based on our own institution's antibiogram, so we were able to select antimicrobials that made sense according to the resistance patterns of organisms seen in our community. One of our standard selections is, of course, Ancef, and we went with a standardized dose of

two grams, as many other facilities have as well, especially in the light of an increasingly morbidly obese population. We leveraged both our Epic system and provider education to actively discourage the use of Vancomycin, to try and prevent inappropriate use of one of the last big guns in our antibiotics holster. The timing of antibiotics has been a struggle for many facilities for years, and Robert Packer has been no exception, but we were able to take a Lean-centered approach to where and when the antibiotic was administered to get it as close to that one-hour timeframe as possible. Our anesthesiologists played a critical role in that process and are now the champions of antibiotic administration. And of course, the use of oral antibiotics as part of the bowel prep has been proven time and again in the literature, very strong evidence of its effectiveness, so that is also a no-brainer addition to our process.

Moving onto the Intraoperative Management – and I apologize here, the re-dosing times of these antibiotics are somehow switched – I'm blaming the Christmas elves here. That should be four hours for the Ancef and two hours for the Zosyn according to the ASHP therapeutic guidelines. The use of a wound protector to maintain moisture at the incision site and thus prevent the potential for infection has been an effective tool. But the next two items that you see here, the implementation of a separate closing table and re-gloving at the time of fascial closure were processes that have significantly reduced the potential for contamination during these types of procedures. Finally, there has been a lot of work, a lot of collaboration within our surgical department to not just improve basic operative technique, but also to increase our utilization of the technology available to us, particularly the laparoscopic and robotic methods.

I just wanted to include this graph to illustrate the importance of timely feedback. We all keep track of SCIP measures, but how effective is it to get a report back a month or so later telling us how well or poorly we adhere to a measure? Not so much. Daily data collection by our abstractors allows that information to fed back to our physicians at a regular basis, weekly, I believe, so that they know to refocus their attention should a measure get too far out of range.

Changing the culture of any healthcare facility is of course much easier said than done. Many facilities are staffed by individuals who have grown accustomed to doing things a certain way regardless of whether that approach is still considered best practice or is even all that effective. Again, I wanted to give another shout out to Dr. Tom VanderMeer and Barb Pennypacker, they really taught this institution the basics of change, Change Management 101, if you will. This approach has been as strategic as you can get, implementing change. Such change will likely yield a bunch of failed projects, so it's important to carefully prioritize the initiatives that you want to see implemented. It's also about actively engaging your frontline workers to get the inputs and insight of those down in the trenches, who know what works, what might not, and very often they can make suggestions someone higher up may not have even considered. Along those same lines, keeping the lines of communication, that feedback loop open, helps to keep those frontline workers invested in the process. Soliciting ideas and then never communicating back to people will only serve to push them away and likely actively disengage them from future initiatives. In other words, people want to feel that they are active partners in a process, not a focus group that is abandoned after the information is gleaned from them. I have here "Make it easy to do the right thing," but a phrase I've been hearing with increasing frequency, especially in our Lean projects, is to "Make it difficult to do the wrong thing." So if there's a certain behavior or outcome you want people to accomplish, the more you connect, you steer people actively away from doing what you do not want them to do, the more roadblocks you can put in their way, in other words, you will find it is easier to get them to do that desired behavior. Now when there is a desire to implement change, you know the old saying "In God we trust, all others bring data." Making an objective case for change based on, not just the literature but your own data, to provide a tremendous amount of ammunition to get that initiative off the ground. That's why it is vital to establish and utilize data sources that provide the rock-solid information you need so that when a physician or whomever may be your target audience looks at that data, they know it's an accurate representation of reality. Finally, new processes have to be monitored. You can't just assume it's like a baby bird ready to leave the

nest. Keeping tabs on that process that's illustrated in the Plan, Do, Study, Act Model or the Plan, Do, Check, Act Model, lets you know what's working and what needs to be fixed.

This picture here is an illustration of making it easy to do the right thing. When our anesthesiologists go into Epic to do their documentation, they can select that big "Antibiotic Administered" tab to quickly and easily document the administration of those meds. There's no hunting around the database trying to find the correct field to enter the data – it's right there, literally starting them in the face.

I mentioned earlier about the importance of communication in keeping that feedback loop open. We do that, at Robert Packer, through a variety of forums. The Quarterly Surgical Services meeting gathers together all surgeons, anesthesiologists, OR staff, and others in one big auditorium. Every surgical infection from the previous six months is discussed inside and out – what happened (what were the results), where were the opportunities to prevent that infection that we missed, and what can be done to prevent that infection from happening again (or at least mitigating as much as possible, the odds of it happening). We also leverage our own physicians and other leaders to develop effective teaching opportunities and training tools. For example, our residents, they eagerly and actively serve as resources to disseminate that education to the rest of our staff. You can see some of the other forms we utilize, section meetings for specialties for example, where again, the use data to actively engage others is critical.

As I mentioned early in the presentation, the Surgical Unit-Based Safety Program has been one of our more recent initiatives, and here we started the program by literally asking staff how they envisioned the next infection to their patients would happen. What would be the cause of that infection, what factors would come into play? We then asked them to come up with potential opportunities for improvement. And from that initial meeting, we identified five areas, centered around the OR environment itself, most significantly how that environment is cleaned in between cases and at the end of the day, the turmoil cleaning. Another

one of our Lean projects, you noticed I've mentioned Lean a number of times today, is centered around optimizing tissue levels of antibiotics at the time of the incision, while another project is looking at ways to improve the preoperative process that includes the use of enhanced recovery pathways. One of my personal projects has been the implementation of an automated hand hygiene surveillance system throughout inpatient units of our facility, which uses RFID technology to monitor entry and exit hand hygiene right down to the individual person. No more one group of healthcare workers blaming another! In both the OR and inpatient units, we will be expanding our use of ultraviolet disinfection as an adjunct to our manual cleaning process, which itself is audited (through the use of a bioluminescent gel and a black light) to determine how well the high-touch areas in a room are cleaned.

In summary, the reduction in our surgical site infections has come as a result of focusing on the implementation of evidence-based practices; heavy reliance on high quality, validated data; [and] open, honest, and respectful communication between peers and our leaders. We've essentially established a dyad that allows for the dissemination of data and ideas. Engaging frontline workers and making them an active participant in change has been critical, and above else, no matter the target audience for our initiative, making it easy to do the right thing. Thank you very much for your time today, and I hope you were able to take a few, good ideas away from this presentation to implement at your own facilities.

Deb Price: Well, thank you, Andrew. My name is Deb Price, and now I'd like to go over the CE certificate slide. Today's webinar has been approved for 1.5 continuing education credited by the boards listed on this slide. You'll note that the first bullet indicates 1.0 continuing education credited, we have enlarged it to one and a half because we intend to answer questions for the next 30 minutes or so. These are the boards. We have the Florida Board of Social Work, Marriage, Family, Therapy and Mental Health, Board of Nursing Home Administrators, Dietetics and the Board of Pharmacy. We are now a national registered Nursing provider, and as

such, if you are any type of nurse, you can use that provider number 16578 and you will be covered under our licensure.

We now have an online CE certificate process. You can receive your CE certificate two separate ways. If you registered for the webinar through ReadyTalk®, a survey will automatically pop-up when the webinar closes. This survey will allow you to get your certificate. However, some of you are in a room where just one person registered, so only that one person will be able to get the certificate from this webinar. In about 48 hours, we will be sending out another link and we are asking that everyone passes that link to the other people in your room so they will be able to get a certificate also. After completing, after the completion of the survey, you will click "Done," the word done at the end of the survey and another page will pop up that will ask you to register on our HSAG learning management center. This is a completely separate registration from the ReadyTalk® registration that you are listening to right now. Please use your personal e-mail like Yahoo or Gmail or AT&T, and that is because we have found that a lot of hospitals have firewalls that are continuingly changing so it's easier if you put your personal email in. We don't have any firewalls that block our links from personal emails.

If you can't or if you can't get your certificate or if you experience some kind of problems, what are you going to do next? Well, first of all, if you do not immediately receive a response to your email that you signed up with, you know that there's some kind of firewall that's blocking the link. So then we ask you to go back to the survey where you see a new user link and register your personal email. If you can't get back to that link, the previous link, don't worry because again we will be passing out another survey in 48 hours.

This is what the bottom of the survey looks like. You see in the bottom right hand corner, there's a little, gray box, rectangular box that says "Done." So when you're done with the survey, you click the word "Done." And then another page pops up like this and has two green links in the center. The first green link is the New User link and the second one is the Existing User link. So if this is the first webinar that you need to get

a certificate with, or if you've been having problems with getting certificates, click on the New User link and register your personal email. That should work for you. If, however, you've been getting your certificates all along, use the Existing User link.

This is what pop ups if you click on the New User link. You note that you put your first name, your last name, your entire personal email there and then some phone number for us to call you back or for us to be able to locate you.

This is what the Existing User link page looks like. You put your user name and that's the complete email address, including what's after the at sign. So it would be the complete, whatever at HSAG.com or gmail.com or yahoo.com, all of that goes into the user name.

And now, I'd like to pass the webinar to Kristen Woodruff to go over questions that came in today. Kristen, take it away.

Kristen Woodruff: Thank you Deb. The first question I'd like to ask is for Robert Packer Hospital regarding BearHugger warming devices. "Some centers, which perform total joint and spine surgery, have recommended against their use in these cases, as air turbulence from these machines may disrupt laminar flow and may be associated with higher SSI rates. What are your thoughts on that?"

Andrew Klee: That's an interesting question. I saw it pop up a couple of times during the course of the presentation. This is Andrew Klee, by the way. We have not seen any subsequent infections in those patient populations here at our facility. However, I would like to take a look at that literature, if the questioner could forward the link that they saw that literature in, and I'd like to take an additional look at that if I could.

Kristen Woodruff: Thank you, Andrew, and a question for the Carolinas. "Have you seen evidence that one CHG chin-to-toe bath has been effective, and what evidence did you use to implement this?"

Female: I don't have the answer to that.

Female: Could you repeat the question? I think it's a great question.

Kristen Woodruff: I'll repeat the question. "Have you seen evidence that one CHG chin to toe bath has been effective, and what evidence did you use to implement this?"

Female: That's a great question. We haven't … I don't really know how to answer it right off the bat. We have followed suit with other facilities, and I will need to research that to go back to you.

Kristen Woodruff: Okay, thank you. Also, we have several questions come in that showed that they, that other providers would be interested in getting a copy of the sheet you used for the decreasing of SSIs in your patients. Would you be willing to share that?

Female: Yes, we certainly would.

Kristen Woodruff: Wonderful, thank you. The next question is for Robert Packer Hospital. "We have evolved with paying great attention to the SCIP measure of starting antibiotic on time and wonder about the importance of validating the antibiotic completion time. Is there any correlation in your study?"

Andrew Klee: A correlation between?

Kristen Woodruff: They expand by saying, "We would like to get completion, time validated, documented and incorporated into our checklist to determine any SSI correlation for higher BMI surgicals that have a higher tissue perfusion."

Andrew Klee: Not that we've noticed to this point, although with EPIC and Uptime we're certainly able to drill down to that level. That's something to be keeping an eye on, especially with the morbidly obese population, which we see a significant portion of within our population, as well.

Kristen Woodruff: Thank you, Andrew. Also for you, Andrew, "Do you use oral antibiotics for all patients undergoing colon surgery?"

Andrew Klee: To my knowledge, for the vast majority, yes, we do use those.

Kristine Woodruff: Thank you, and a question for Pineville, "Are your documents and checklists imbedded in your electronic medical record?"

Female: Some of them are and some of them are not.

Kristen Woodruff: Okay.

Female: The Surgical Safety Checklist is a tool we use from pre-op to the end of the operating process, and that tool is used by the operating room staff to evaluate the case and follow-up with any issues that we may have had. The yellow SCIP sheet follows from pre-op and goes all the way to the floor, so our RN can follow to make sure that all of the measures are being followed. And, that's what we did through 2014 to help follow the best practices.

Kristen Woodruff: Great, thank you. Now for Robert Packer, "Can you elaborate on what you mean by a 'wound protector and a separate closing table?'"

Andrew Klee: The wound protector, from what I understand, is an elastic product that fits around the circumference of the working area and allows for an essentially better exposure of the sites and the visualization of the site.

Kristen Woodruff: Thank you. This is for Amanda at Carolinas, "You stated you used orange SCIP forms. What are those forms and what is their content? Also, who completes them and are they documented in EMR?"

Amanda Ianello: The orange SCIP forms are just a tool that the nurses use starting in pre-op going through the OR to PACU, and up on the floor we finish them, and just like I said, a tool to help us track time-sensitive material and to make sure that all SCIP measures are met. It's not a part of the permanent medical record, and the nurses are the teammates who complete the tool.

Kristen Woodruff: Thank you. Now a question for both facilities, if you would both like to speak to this, it states, "Can either of you share any measures that you took in cases of unplanned or emergent colon or hysterectomy cases that assisted in the decrease of your SSIs?" Robert Packer?

Andrew Klee: I'm sorry, I was waiting for the other facility to go first. Not to my knowledge, no.

Kristen Woodruff: Carolinas, any input?

Amanda Ianello: Yes, for our patients that are like traumatic or urgent cases, these patients obviously don't get a bath, but as far as the OR, as far as prepping and prep dry time and timeout and following the Surgical Safety Checklist, we do all of that. Same thing for SCIP. SCIP is followed, as well, for those patients.

Kristen Woodruff: Thank you. Now, Andrew, for Robert Packer, "Are you continuing to monitor SCIP measures even though they are no longer required?"

Andrew Klee: Yes, it still serves as a helpful internal benchmark even though we're not, you know, recording anything externally.

Kristen Woodruff: Thank you. For Carolinas, "What is the brand of the wipes that are color-coded for parts of the body?"

Amanda Ianello: They are *Sage* brand, and the wipes are not color-coded; the tool for the patient is color-coded."

Kristen Woodruff: Okay, thank you for clarifying. And for Amanda, "Has the improvement in SIR for colonoscopy and hysterectomy been maintained during the past calendar year?"

Amanda Ianello: Those results won't be available until first quarter of 2016.

Kristen Woodruff: Okay, and also for Pineville, "What is the surgical skin prep that was used for hysterectomy and colon cases?"

Amanda Ianello: We use chloroprep.

Kristen Woodruff: Thank you. When – I'm sorry, this question is for Robert Packer. "When re-gloving at the time of fasciaclosure, are the MDs using instant surgical scrub after removing gloves, before re-gloving?"

Andrew Klee: Yes.

Kristen Woodruff: Thank you. Also at Robert Packer, "How many concurrent quality abstractors do you have?"

Andrew Klee: The total number of current abstractors we have – actually, I don't have the number right here in front of me, but I can check on that and get back.

Kristen Woodruff: Thank you. Another question for the Carolinas, "How did you get buy-in from the staff and physicians for your team?"

Amanda Ianello: So, for the timeout portion, that was physician-led. We had multiple meetings with the OR team and our physician, Dr. Thies, who you saw on our presenter page. Well, you didn't see him, but his name was on there. Anyways, he was our physician that led that, and so he would discuss that at all of the physician meetings and that kind of stuff. So, he encouraged the other physicians. Well, he has a team who also did team steps. We sent all of our teammates through the team steps programs and really just encouraged them. And also, the leadership team, if they had issues or concerns, you know, we took them very seriously and addressed them right then.

Kristen Woodruff: Thank you. Also for Carolinas, "Do you have guidance to providers for re-dosing antibiotics intra-operative for longer duration procedures?"

Amanda Ianello: Yes, we do. I don't have it in front of me, so I can't give you the details, but in every OR, we have a list that has all the antibiotics and the timing for re-dosing. When the CRNA or anesthesia provider believes it's time to re-dose, they discuss it with the surgeon; and, at that time, we will re-dose or not, depending on the surgeon's suggestions.

Kristen Woodruff: Thank you. Also, we had several questions regarding the specialized dressing used post-op. What was the name of it?

Amanda Ianello: The dressing post-operatively is the AQUACEL® Ag dressing.

Kristen Woodruff: Great, thank you. "In the statistics that you showed at Carolinas, were trauma colon surgeries included in the statistics?"

Amanda Ianello: Yes.

Kristen Woodruff: Thank you. And Carolinas, "Have you initiated a determination of using different sterile instruments to close the incision than were used during the colon surgery itself?"

Amanda Ianello: So, once these instruments have been contaminated, they're removed from the field, like they may be put on the basin or covered or put somewhere else, but then they're not re-used again. And so, if they need a clean instrument or to do something else, they'll get it.

Kristen Woodruff: Thank you. For Robert Packer, "HbA1c pre-op – is the patient billed for this test or is the cost part of the cost of the surgical procedure itself?"

Andrew Klee: That's something I would have to look into, although I know we haven't had any issues in the past associated with it. I know it's covered with most healthcare plans, so it hasn't become an issue for most of the cases that we've had to deal with.

Kristen Woodruff: Thank you. Carolinas, "How were pre-op antibiotics selected? Did you use the ASHP guidelines?"

Amanda Ianello: We have a protocol that's in place throughout the hospital system that was approved by pharmacy and therapeutics.

Kristen Woodruff: Thank you. Also, this one is for Amanda, "The QA nurse that assisted with compliance, what was the nurse's function out on the unit?"

Amanda Ianello: She came up as just – almost like a consulting role. She would kind of look at SCIPs and remind nurses, kind of proactively intervene to re-time antibiotics and make sure that Lovenox or beta-blockers are given at appropriate timeframes. So, she's just an extra set of eyes.

Kristen Woodruff: Okay. "Did she also answer patient questions?"

Amanda Ianello: No, she did not have interaction with the patients.

Kristen Woodruff: Okay, thank you. Okay, and now we have a couple questions for Bethany. "I'd like to use the individual SSI strata to calculate my hospital's SSI Measure Score. Where can I find that formula?"

Bethany Wheeler: Thanks, Kristen. You can find that formula in – I believe it was the FY 2014 IPPS Final Rule. It's in the Hospital Value-Based Purchasing Program section or we have also listed out, step by step, on how to calculate all the Hospital Value-Based Purchasing scores, first in the FY 2016 presentation that we did that's out on QualityNet.org. It was done on July of 2015, if you would all like to reference that.

Kristen Woodruff: Thank you, Bethany. And another question for Andrew, "Did you use UV for disinfection or UV for monitoring the effectiveness of cleaning?"

Andrew Klee: We used UV as a measure for an adjunct to the manual cleaning process. So, for out of the discharge of the inpatient units there, we had someone come in with the UV lights and we reassess for our patients primarily here to come in and use that in multiple positions throughout the room. So, add in about an additional 10 to 15 minutes to a turn-around time for a room.

Kristen Woodruff: Thank you, Andrew. Additionally, for Robert Packer Hospital, "Who in your facility does the DAZO auditing in the OR?"

Andrew Klee: In the OR, well, on the inpatient units, it had been our housekeeping manager to go and do it after one of our technicians was done cleaning a room. In the OR, it's one of our managers in that environment there. So, after a case was done and the cleaning has been done, and in between each case there, the manager would duck in there real quick and dust some of the multiple high-touch areas off the room, about 17 of them, actually, and then go back in with the black light to determine where exactly where they missed.

Kristen Woodruff: Thank you for that. Additionally for you, Andrew, for Robert Packer Hospital, some of our providers would like to hear more information about the hand hygiene check that you've referred to.

Andrew Klee: You mean for the nGage™ system?

Kristen Woodruff: I believe so.

Andrew Klee: Yeah, absolutely. We're one of the few facilities across the country that is utilizing an automated surveillance system. So, I would imagine there'd be quite a bit of interest in learning more about it. And, we're definitely willing to share what we have so far.

Kristen Woodruff: Thank you so much, Andrew. Another question for Bethany, "My hospital does not perform abdominal hysterectomies, but we do perform colon surgeries. How is the SSI measure score calculated when only one of the SSI strata has data?"

Bethany Wheeler: Thanks, Kristen. So, when only one of the SSI stratum has data, you weight the total measure score for SSI to 100 percent of the strata that does have the data. So, for example, if the abdominal hysterectomy, you met the one predicted infection threshold to have the SIR calculated, and you did not in the colon stratum, you would receive the measure score that you received for the abdominal hysterectomy. Vice versa would be true if you receive the measure score in colon, but not the abdomen. You would only receive the score for the colon. Normally, how you calculate this measure is you weight the two individual measure scores for the stratum by the predicted number of infections during the performance period. So, when only one is available, 100 percent of the weight goes to that stratum.

Kristen Woodruff: Thank you. Now, for Carolinas, "Do you mostly open" – I'm sorry, "Do you do mostly open colectomies or laparoscopic colectomy? What type of dressing did you mention you are using?"

Amanda Ianello: The majority of our cases are laparoscopic, and the dressing is AQUACEL® Ag.

Kristen Woodruff: Thank you for clarifying. And one more for Robert Packer, "Can you please clarify the surgeon's re-gloving? You said that surgeons are using instant hand sanitizing prior to re-gloving to the fascia closure. Are the surgeons leaving the sterile field to Avagard™ and then re-gloving?"

Andrew Klee: What they're exactly doing, I'll have to double check to see. I don't believe they're leaving the sterile field, but I will need to double check to verify that.

Kristen Woodruff: Thanks, Andrew. "What cleaning product do you use in cleaning between cases?" And this question can be for both.

Andrew Klee: For Robert Packer, I know we recently started looking at a new product that I believe is from Ecolab called Oxivir, and supposedly it's less harsh than using a bleach solution, a little bit more effective than using something that would be like a quaternary based component there. So, we're just starting to take a look at that, so I can't really speak to how effective it is compared to what we've been using in the past, but I know that's a product we're looking at currently.

Kristen Woodruff: Thank you, and Carolinas?

Amanda Ianello: We use – it's called Sanimaster. It's what we use for our floors and then we use – we call them Purple Top White because they're purple, but hold on one second. Let me get you the exact name.

Kristen Woodruff: Great.

Amanda Ianello: They're called – PDI is the company and they're called Super Sani-Cloth. They're germicidal and that's what we use to clean all of our surfaces and our beds. And then, we also do – every 24 hours, they have a terminal clean.

Kristen Woodruff: Great, thank you so much. A follow-up question for Carolinas Pineville, "Did I understand you say that you've left Aquagel on for 10 days?"

Amanda Ianello: Yes, the dressing stands for seven to 10 days, and if they're compromised at all, they're changed before that.

Kristen Woodruff: Thank you. A follow-up question for Bethany, "Are there a minimum number of surgical cases needed to obtain a score for the SSI measure and Value-Based Purchasing, and when will the Hospital Value-Based Purchasing Program start using the sepsis measure, if you know?"

Bethany Wheeler: Thank you, Kristen, again. There is not a minimum case or surgical case count that is the minimum case amount for the measure. It's actually predicted number of infections, and that's similar to all the other HAI

measures in the Value-Based Purchasing Program. So, all of the HAI measures have a minimum predicted number of infections of 1.000. If you meet that threshold in any given measure, a SIR or Standardized Infection Ratio, would then be calculated. In terms of sepsis, it has not – CMS has not proposed sepsis be included in the Hospital Value-Based Purchasing Program. For any measure that could be included in future physical years, I would recommend referencing the newest, upcoming Proposed Rule that should be released this spring. Also, you have an opportunity to comment on any proposal in the Proposed Rule. So if you see a measure coming in and you would like your opinions to be heard, go ahead and submit a comment. CMS reads and listens to all of them.

Kristen Woodruff: Thank you, Bethany. Andrew, for Robert Packer Hospital, "With your nGage™ hand washing monitoring system, did you have trouble with the system registering staff scanning, and was the scanning based on badge identity or sensing hand at hand cleaning product station?"

Andrew Klee: The way the system runs here is, we have what's called communication units that are wired into the soap and sanitizer dispensers, both inside patient rooms and in hallways on our in-patient units. And, staff that work on those units each carry a RFID badge that's unique to their own person. So, when they enter and exit a particular patient room, their activation of any of the dispensers in that immediate area gets an indication of their overall compliance.

Kristen Woodruff: Thank you. Additionally, "Have you noticed any change in OR turnover time? Does the time between cases increase?"

Andrew Klee: That's a thing we're just starting to take a look at. And, with the addition of UV disinfection, we are anticipating that to go up slightly. Based on our experience on the inpatient sides, we know that it takes about five minutes per position when you're using UV disinfection there, and for most rooms that you're going to have to move the beds around about two or three times. So, it's added about 15 minutes to our inpatient side, and depending on the size of your operating room, you're going to probably have to move

that around the same number of times, as well. So, you would anticipate adding that additional time to your turn around time.

Kristen Woodruff: Okay. "Is AQUACEL® dressing originally placed in [the] OR or post-op units?" And, I do believe this one is for Carolinas.

Amanda Ianello: The dressing is placed in the OR.

Kristen Woodruff: Okay, thank you. Also for Robert Packer, "Is it correct that they request to re-dose Ancef intra-operatively if the procedure is longer than two hours?

Andrew Klee: Yes, if the procedure exceeds three hours, yes.

Kristen Woodruff: Thank you. One more question for Bethany, "How can we confirm if the correct data has been uploaded, or given, or sent, to CMS from NHSN?"

Bethany Wheeler: Sure. So, when a hospital submits data into NHSN at that submission deadline, on that date, for example May 15th, for submission deadline, CDC freezes that data and then provides it to CMS for uses in hospitalized QR for the preview reports that you receive and also for *Hospital Compare*, in addition to the Hospital Value-Based Purchasing Program. You can use NHSN to cross-check to make sure the reports for CMS are also correct. However, I would like to caution you that if you modify any of the data that you previously submitted after the submission deadline, that data will not be reflected in the CMS report; because, like I said before, CDC freezes that data and then provides it to CMS. So, it may be a best practice to print off or use screen shots of the data at the submission deadline, so you can go back later and then cross-check.

Kristen Woodruff: Thank you, Bethany. And, this is our final question, and it goes to Robert Packer. "For nGage™ systems, staff have to wear two badges, correct, one for ID and one for data collection? Is this true?"

Andrew Klee: That's correct. They wear their normal employee ID badge and the nGage™ badge. Most of them can wear it on the same clip, so it doesn't add any additional space taking up on their uniform there.

Kristen Woodruff: Thank you so much, and, thank you all for participating, and all the providers that were able to join us today. Thank you so much for attending today's webinar event. We hope it was helpful and we hope that you all have a wonderful day.

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