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Practice forum

Merging health care systems: An example of utilizing quality principles in infection prevention standardization

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When Ascension Wisconsin was formed, it merged 4 long-established health systems: Ministry Health Care, Affinity Health System, Wheaton Franciscan Healthcare, and Columbia St Mary's. One of the challenges encountered during the first year was redundancy in many policies and processes. Setting a structure, establishing goals, and evaluating progress led to success for Ascension Wisconsin's Infection Prevention Council.

When Ascension Wisconsin (AW) was formed, it merged 4 long-established health systems: Ministry Health Care, Affinity Health System, Wheaton Franciscan Healthcare, and Columbia St Mary's. The result brought together 20 hospitals, 114 primary care clinics, 24,000 associates, and more than 1000 medical group physicians to establish a single, unique health care delivery system within the state. One of the challenges encountered during the first year was redundancy in many of the policies and processes. Infection prevention, a component of the Quality Systems department, was identified as an area that could provide the opportunity to improve the high reliability of the organization to drive efficiencies, eliminate redundancy, unify policies, and collaborate to improve outcomes related to health care–associated infections (HAIs).

In October of 2016, AW quality leadership formed an Infection Prevention Council (IPC) that included representation from each hospital in the system. Membership included infection preventionists and representatives from lab, nursing, pharmacy, environmental services, product procurement, and quality. The chair of the IPC reflects the dyad leadership model set by Ascension leaders at the national level. The dyad leadership model is based on collaboration between an administrator and a medical professional,[1] so the director of Infection Prevention and an infectious diseases specialist were chosen as the leadership dyad for the IPC.

METHODS

A charter was drafted in October 2016, and it was approved at the first IPC meeting in November 2016. The initial approved charter for the IPC included the following processes:

1. Develop an overall strategy for infection prevention aligned with the health care system and relevant regulatory bodies.
2. Manage the scalability of infection prevention standardization across Wisconsin.
3. Create, refine, and implement policies and protocols that support achievement of the Quadruple Aim—affordable care, exceptional outcomes, exceptional experience for those we serve, exceptional experience for providers.
4. Coordinate resources for surveillance and education related to HAIs across Wisconsin.
5. Define metrics that provide ongoing program evaluation and guide achievement of health care–associated infection (HAI) targets in collaboration with senior leadership.
6. Coordinate response to and management of emerging communicable diseases.
7. Engage and partner with hospitalist medicine, medical, surgical, laboratory, and pharmacy services as necessary.
8. Develop an efficient strategy for communicating infection prevention initiatives and changes for AW.
9. Monitor outcome measures to identify opportunities to improve performance.

The IPC established monthly meetings and a standard agenda format. A calendar year plan was approved in February 2017. The AW

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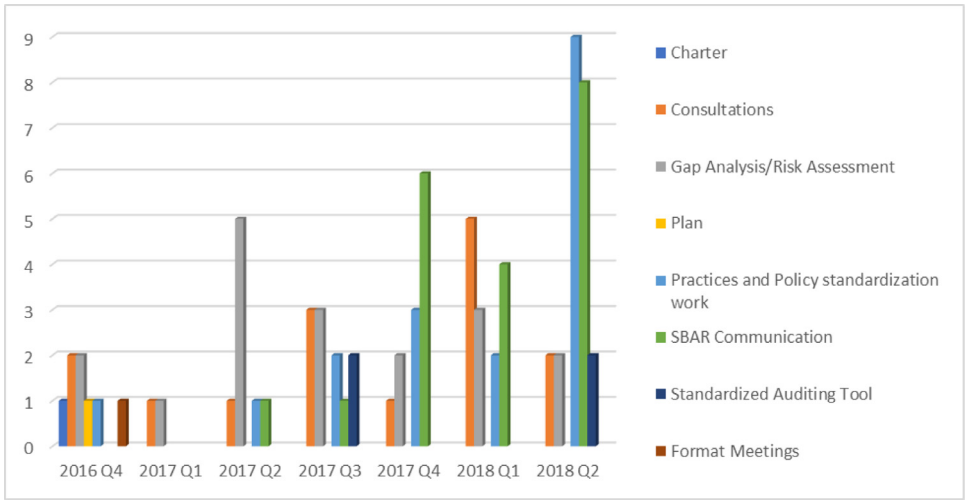

Fig 1. Timeline of deliverable work.

Quality and Safety Committee, which oversees AW IPC, began to set benchmarks in the spring of 2017. The AW IPC changed the annual plan to a fiscal year plan in July 2017 to support the quality plan.

RESULTS

The first few meetings consisted of identifying opportunities to create unified policies across the system and to begin the process of implementing changes to help drive down the rate of HAIs across the system. Members volunteered and were divided into 8 main workgroups to collaborate on the various initiatives: (1) hand hygiene, (2) central line–associated bloodstream infections, (3) catheter-associated urinary tract infections, (4) methicillin-resistant *Staphylococcus aureus* and *Clostridium difficile*, (5) surgical site infection (SSI) colon, (6) SSI abdominal hysterectomy, (7) SSI hip replacement, and (8) knee replacement. Each workgroup began with a gap analysis using a tool called the yokoten, which is a method of sharing practices across a market and is used widely in manufacturing organizations that apply lean principles.[2] The tool allowed visualization of the issues and helped the workgroup to set priorities to align practices based on the gaps identified. A large amount of the gap analysis work was completed in the second quarter of 2017 (Fig 1). Development of an efficient strategy for communicating occurred during this first phase, as well. The council utilized the SBAR (Situation-Background-Assessment-Recommendation) technique as its formal method. Nursing has used this form of communication, and the logical approach of the tool fit well with the needs of the council to communication necessary changes.[3]

From the time of the first meeting through the second quarter of 2018, the AW IPC produced 78 specific deliverables categorized in 8 different areas: (1) charter, (2) consultations, (3) gap analysis/risk assessments, (4) plan, (5) practices and policy work, (6) SBAR communication, (7) auditing tools, and (8) format meetings. As efficiency and standardization improve, the more developed the team becomes and the more deliverables are produced.

DISCUSSION

The PDSA (Plan-Do-Study-Act) cycle for testing a change is embedded in quality workflows in health care. Figure 2 displays a typical cycle and model for improvement as detailed by Langley et al.[4] Stages in development of the IPC mirrored the PDSA standard

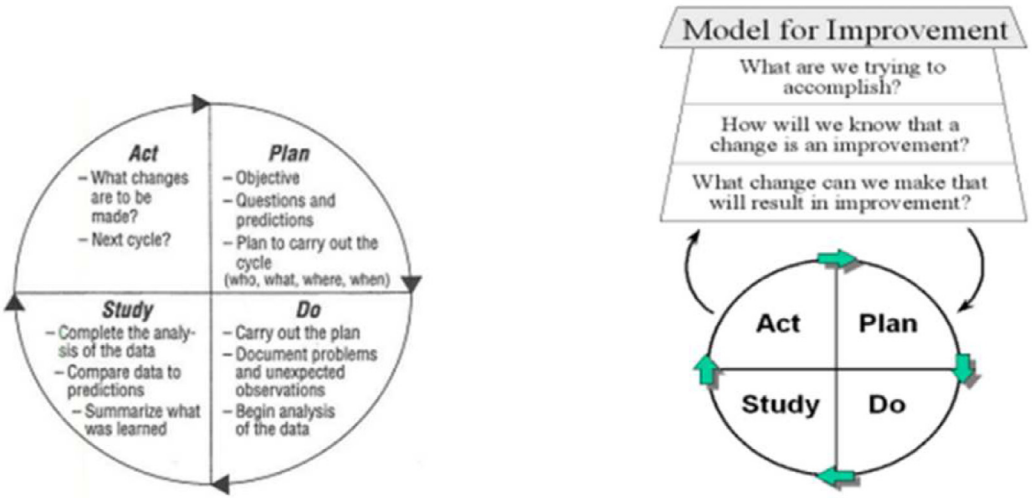

Fig 2. Quality cycle and model for improvement PDSA.

for process improvement: charter the IPC (Plan), set goals (Do), establish a plan and evaluate the plan at regular intervals (Study), and implement standardization processes (Act).

Team development takes time. The initial goals of the council were aggressive and had to be adjusted to allow for team building. In 1965, Bruce Tuckman first described the concept of "forming, storming, norming, and performing," and this council struggled in the forming stage for the first 6 months.[5] We encountered challenges such as associates leaving the organization, struggles with communication, and learning how to resolve conflict. Learning from struggles is part of process improvement, and leaders were amenable to changing the initial design of the council.

In the second quarter of 2017, leadership changed in the council, and a new evaluation and goal setting were performed. Input from all members of the council led to reducing the number of separate workgroups, as well as developing a new and formal process flow for policy approval. With the new structure, the team returned to the forming stage and produced several gap analyses in the quarter. Gap analysis is similar to the Study phase in the PDSA cycle. The results displayed in Figure 1 for the third quarter of 2017 show the productivity improvement in practices and policy standardization, SBAR communications, and consultations. As the council became more integrated into the health care organization, demand for consultations and SBAR communications grew. Beginning in the fourth quarter of 2017, more departments, services, and leaders requested consultations items, and the productivity of the team grew. Key stakeholders within AW recognized the AW IPC as an effective team, and support for standardization grew.

In late 2018, the IPC performed a survey to evaluate team effectiveness and reviewed their accomplishments. The results were indicative of a productive team atmosphere, but a few areas were found where communication could be improved. The council addressed the opportunities for improvement at the next meeting and discussed the concept of Robert's Rules of Order.

CONCLUSIONS

Our IPC moved into the performing stage of team development and remains in the performing stage while the health care system continues to align. In some team development models, there is an adjourning stage; however, our team has no intention of adjourning, as the collaborative teams are working and there is never an end to the work and attention required to reduce HAIs in AW. We learned that being patient and cycling through PDSA to make improvements are key to sustaining momentum for this collaborative process.

References

1. Springer K. Commentary: ascension combines clinicians, administrators in 'dyad' leadership teams. Mod Healthc 2016, Nov 5.
2. Demeter K, Levente S, Béla-Gergely R. The impact of subsidiaries' internal and external integration on operational performance. Int J Prod Econ 2016;182:73-85.
3. Jurns C. Using SBAR to communicate with policymakers. Online J Issues Nurs 2019;24. https://doi.org/10.3912/OJIN.Vol24No01PPT47.
4. Langley G, Nolan K, Nolan T. The foundation of improvement. Qual Prog 1994;27:81-6.
5. Tuckman B. Developmental sequence in small groups. Psychol Bull 1965;65:384-99.