Infection Prevention Collaboration: Hospitals and SNFs
Objectives

• The participant will be able to: Identify opportunities for collaboration between hospitals and nursing homes in addressing shared problems within a region

• The participant will be able to: Describe population health principles applied to infection prevention, detection and control of *C. difficile* infection within a region

• The participant will be able to: Describe the emerging public health role in improving population health within a region
• **AGENDA**

• **Case Example:** Hospital Infection Preventionist and twelve years of collaboration within a region
  – The beginning: Solving a shared problem: MRSA and the patient transfer
  – Evolving collaboration model: New partners (public health; home health; physician practices)
  – The UTI project and the Watchful Waiting protocol

• **Case Example:** QIO coach and *Clostridium difficile* prevention in a region
  – Identifying common problems: Early identification to managing antibiotics
  – Using regional data

• New roles for public health in a region
  – Building regional collaboratives throughout the state
  – The public health detailing process: Using new methods to work with regional partners
Case Example #1

• Hospital Infection Preventionist and twelve years of collaboration within a region
New Hampshire Acute Care Hospitals, Critical Access Hospitals and Population Distribution

New Hampshire Hospitals
- Acute Care Hospitals
- Critical Access Hospitals

Population Distribution*
- 0 - 999
- 1000 - 2999
- 3000 - 8999
- 9000 - 29999
- 30000 - 59999
- 60000 - 110000

Upper CT Valley
Littleton
Weeks
Androscoggin
Dartmouth Hitchcock
Alice Peck Day
New London
Valley Regional
Lakes Regional
Franklin
Concord
Cheshire
Monadnock
Portsmouth
Elliot
Catholic Medical
St Joe's
Southern NH
Parkland

*Taken from 2010 US Census data. Not actual population. This map is intended to only show distribution.
It began with a logjam…

- CMC Case managers were concerned that long term care facilities would not allow residents to return to nursing facilities until MRSA cultures were negative.

- Long term care facilities voiced frustration regarding not being able to maintain contact precautions for their residents.

- Discharge delays were > 7 days.
Provided Resources

• Advisors
  • CMC Infection Preventionist
  • NH DHHS Public Health Nurse-Keene District Office

• Reference materials
How we worked with LTC facilities

• CMC reached out to individual LTC IPs

• Encouraged LTC IP to call the public health nurse for verification of information
  – Ensured consistent messaging

• Provided copies of N.H. DHHS MDRO Guidelines
  – Challenges
    • Turnover of staff
    • “Corporate Policies”
Established Annual Long Term Care Networking Group (now called IP Networking Group)

- First annual meeting November 1998
- Bi-annual meetings began in 1999
- Now bi-monthly meetings
Who has been Involved

- Cheshire Medical Center
- Maplewood
- Cedarcrest
- Applewood
- Langdon Place
- Westwood
- Genesis
- The Woodward
- N.H. DHHS
- Prospect Place
- Pheasantwood
- Home Health Care
- Keene State College
- Monadnock Dialysis
- QIO
Sustaining our Networking Group

• Surveyed group approximately 3 years ago

• Consensus: The Networking Group adds value and we should continue
Collaboration

- When new IPs begin at LTC facility, public health nurse calls them followed by CMC IP
  - Provide introduction/orientation
  - Invite to Networking Group

- IP and public health nurse provide in-service education/references prn at LTC facilities
What we share…

• **CDC Guidelines for Infection Control in Healthcare Personnel**
  (Includes: Healthcare worker vaccinations; Post exposure protocols; Work restrictions due to illness)

• McGeer’s *Definitions of Infection for Surveillance in Long-term Care Facilities*

• New Hampshire DHHS: HANs and Guidelines

• Invitation to join New Hampshire Infection Control and Epidemiology Professionals statewide group
What we share…

• Infection Control Surveillance Documents
  – Infection Report Forms
  – Antibiotic Line List
  – Infection Line List
  – Surveillance grid for outbreak tracking

• Infection Control Week Program
  – Ideas for games and activities
SB 438
Flu and Pneumococcal Vaccinations

• Share resident/patient flu and pneumococcal vaccine status between facilities

• Share employee flu vaccine rates and strategies for successful programs
State updates

• TB
  – Skin testing in LTC Facilities
  – Statewide annual TB infection rates
  – TB risk assessments
  – Recommendations for low-risk facilities

• Flu updates, MDRO FAQs, outbreak updates (e.g. West Nile Virus/EEE)
Hand Hygiene

• Articles

• Compliance trackers

• *High Five for Healthy New Hampshire* materials
Influenza

• Worked together during 2004 Influenza vaccine shortage

• Worked together during 2009 H1N1 outbreak
Contact Information

• Names, phone numbers, emails of all area IPs,
  – updated frequently

• Coming next: website for sharing
Outcomes

• Eliminated transfer delay days due to C-diff, MDRO colonization and infection

• Eliminated “test for cure”

• Share vaccine information
  – decrease re-vaccination
  – increase communication

• Offer timely information related to clusters/outbreaks in our community (e.g. influenza and norovirus)

• Excellent communication during influenza vaccine shortage and H1N1 outbreak

• Sharing of vaccine
Outcomes

• Know our partners and colleagues

• Network

• Established Trust
Nursing Home Resident Flu Vaccination Rates

Goal: 90%

Goal Healthy People 2020: 62%

% Immunized

Facility A  Facility B  Facility C  Facility D  Facility E  Facility F  Facility G

2012-2013  2013-2014
Nursing Home Resident Pneumococcal Vaccination Rates 2013

GOAL: 90%

CMS 2005-2006 Rate: 66%

Facility A
Facility B
Facility C
Facility D
Facility E
Facility F
Facility G
Working to Reduce Treatment of Asymptomatic bacteriuria

• Developed **SBAR Watchful Waiting** tool
We’ve only just begun…

• Share with other partners
  – establish networks throughout the state via DHHS Public Health nursing network

• Bring **Watchful Waiting** to EDs
Case Example #2

- QIO coach and *Clostridium difficile* prevention in a region
Revisiting the Epidemiology

- *Clostridium difficile* caused nearly half a million infections and was associated with about 29,000 deaths in 2011 (CDC, *NEJM*, 2/2015)

- Onset *OUTSIDE* the hospital more common than previously thought
FIGURE 1. Percentage of *Clostridium difficile* infection (CDI) cases (N = 10,342), by inpatient or outpatient status at time of stool collection and type/location of exposures* — United States, Emerging Infections Program, 2010
Measurement: Outcome
Categorize Cases by location and time of onset

Admission

Discharge

2 d

< 4 weeks

4-12 weeks

> 12 weeks

HO

CO-HCFA

Indeterminate

CA-CDI

Day 1

Day 4

Time

HO: Hospital (Healthcare)-Onset
CO-HCFA: Community-Onset, Healthcare Facility-Associated
CA: Community-Associated
* Depending upon whether patient was discharged within previous 4 weeks, CO-HCFA vs. CA
† Onset defined in NHSN LabID Event by specimen collection date
Figure 1. Estimated U.S. Burden of *Clostridium difficile* Infection (CDI), According to the Location of Stool Collection and Inpatient Health Care Exposure, 2011.

Of the estimated cases of community-associated CDI, 82% were estimated to be associated with outpatient health care exposure. CO-HCA denotes community onset health care–associated infection, HO hospital onset, and NHO nursing home onset.

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Estimated Number of Annual CDI Cases

<table>
<thead>
<tr>
<th></th>
<th>CA CDI</th>
<th>HCA CDI</th>
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<tbody>
<tr>
<td>Cases</td>
<td>150,000</td>
<td>300,000</td>
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</table>

Lessa et al NEJM 2015; 372(9):825-34
Increasing Needs for Public Health Approach Across the Continuum of Care
How *C. difficile* Spreads

George, a 68-year-old man, goes to the doctor’s office and is diagnosed with pneumonia. He is prescribed antibiotics, drugs that put him at risk for *C. difficile* infection for several months.

One Month Later

George breaks his leg and goes to a hospital. A healthcare worker spreads *C. difficile* to him after forgetting to wear gloves when treating a *C. difficile* infected patient in the next room.

Hospital

Wears gloves

Two Days Later

George transfers to a rehabilitation facility for his leg and gets diarrhea. He is not tested for *C. difficile*. The healthcare worker doesn’t wear gloves and infects other patients.

Rehab Facility

Does not wear gloves

Three Days Later

George goes back to the hospital for treatment of diarrhea and tests positive for *C. difficile*. He is started on specific antibiotics to treat it. Healthcare workers wear gloves and do not spread *C. difficile*. George recovers.
Do Healthcare Workers (HCWs) have *C. difficile* Knowledge?
Healthcare Workers Knowledge re: *C. difficile*

**Results:** Eleven studies were included. Four were specific to *C. difficile* and 7 to MRSA. All studies found that technical understanding of *C. difficile* was poor and that staff were concerned about risks to patients and themselves. Technical understanding for MRSA, however, was good, and staff were less concerned about their own health.

Information provision was perceived to be inadequate and untrustworthy, which included the media. Practice in most studies was poor.

Understanding factors that impact on health care professionals’ risk perceptions and responses toward *Clostridium difficile* and meticillin-resistant *Staphylococcus aureus*: A structured literature review
All infections are local...

• What keeps us mindful? Local data has meaning to folks in the situation
• Comparative data has meaning to folks taking a big picture view
HO - Sx at day 4 or through stay
CO - Sx on admission or to day 4
CO-HCFA - DC within last 4 weeks

<table>
<thead>
<tr>
<th></th>
<th>HO #</th>
<th>Exp</th>
<th>SIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>10</td>
<td>9</td>
<td>1.11</td>
</tr>
<tr>
<td>2013</td>
<td>6</td>
<td>8.1</td>
<td>0.74</td>
</tr>
</tbody>
</table>
Background: Epidemiology

Risk Factors

- Antimicrobial exposure
- Acquisition of *C. difficile*
- Advanced age
- Underlying illness
- Immunosuppression
- Tube feeds
- ? Gastric acid suppression

Main modifiable risk factors
Prevention Strategies: Core

• Implement an antimicrobial stewardship program
• Contact Precautions for duration of diarrhea
• Hand hygiene in compliance with CDC/WHO
• Cleaning and disinfection of equipment and environment
• Laboratory-based alert system for immediate notification of positive test results
• Educate about CDI: HCP, housekeeping, administration, patients, families

http://www.cdc.gov/ncidod/dhqp/id_CdiffFAQ_HCP.html
Focus: Process 1st, then Outcome

• Are the parts/steps in the system performing as planned? Are we on track in our efforts to improve the system?

• Allows approach to be one of Horizontal vs Vertical integration

• To successfully use data to improve quality and cost, health systems must get more granular with their data. They can’t just look at outcome measures. They must also track the evidence-based process measures that drive better outcomes. (Dan Burton, Health Catalyst, 2015)
Focus of Interventions re: Exposure and Acquisition

- **Education**: Early assessment of risk, immediate contact precautions with diarrhea ID; placement; review of defects
- **Education**: Lab tests in use; appropriate ordering
- **Hand hygiene**: Program improvement/enhancements (e.g. managing supplies; placement of devices; training of observers)
- **Contact Precautions**: “Hands on” training; Development of specific work processes and flow (e.g. transporting patients)
- **Environmental cleaning**: Deploying systems for assessment of cleaning adequacy (e.g. marking of high touch areas) with staff feedback and training
Early Detection and Testing

- Awareness of risk factors
- Understanding of testing methods
- Protocol for careful testing [Key: Identification and rx of symptomatic patients]
## Staff Survey: Assessment and Testing for *C. difficile*

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which patients, upon admission to the facility, would be considered “at risk” for <em>C. difficile</em>?</td>
<td></td>
</tr>
<tr>
<td>What signs and symptoms would cause you to suspect <em>C. difficile</em> infection?</td>
<td></td>
</tr>
<tr>
<td>What is the facility protocol regarding testing? (patient assessment including number of diarrheal stools; obtaining an order; type of specimen appropriate for testing; type of test to order; frequency of testing)</td>
<td></td>
</tr>
<tr>
<td>What constitutes a positive <em>C. difficile</em> lab test?</td>
<td></td>
</tr>
<tr>
<td>What constitutes a negative <em>C. difficile</em> lab test?</td>
<td></td>
</tr>
<tr>
<td>When should re-testing be performed and what is the protocol for this?</td>
<td></td>
</tr>
</tbody>
</table>
Empiric Precautions

- Diarrhea: acute diarrhea with a likely infectious cause in an incontinent or diapered patient
Exercise

• Walter Snow, 82, was treated for a UTI with Levaquin two weeks ago. He began to have diarrhea, abdominal pain, and Temp elevation. A liquid stool specimen was positive for *C. difficile* Toxin B.

Walter has been sharing a room for the past 2 years with his good buddy, Ralph Ward.

What is your plan for infection control? What are you major considerations?
Exercise (Con’td)

• Walter’s condition continues to deteriorate and he is transferred to the hospital directly into the ICU.

• How will Walter’s infection control plan change (if at all) given this setting?
Hand Hygiene

• Systems Assessment: Hand Hygiene

• Assessment via observation: “Every system is perfectly designed to get the results it gets”.

• Changing the culture

“Quit barking, I’ll be out when I’m ready.”
With washed paws of course
Hand hygiene: Changes that will result in improvement

- **Demonstrate knowledge**: Clinical staff understand key elements of hand hygiene practice

- **Demonstrate competence**: Clinical staff use appropriate technique when cleansing their hands

- **Enable staff**: Alcohol-based hand rub and gloves are available at point of care

- **Verify competency, monitor compliance, and provide feedback**: Hand hygiene performed at the right time, in the right way; gloves used appropriately
Systems Assessment Of Environment of Care: Hand Hygiene

• Dealing with “hidden issues”: # of dispensers allowed on units d/t fire/safety code

• Responsibilities “off shift” for supply and refill

• Whose budget is it? The paper towel problem
Hand Hygiene: Observation

“I think we’re doing pretty well with hand hygiene.”  *IP in LTCF*

“What do the numbers show?”  *QIO Coach*

“I’m observing all the time as I walk through the units.  *IP in LTCF*
“You can’t manage what you don’t measure”  

Demming

In God we trust. Everyone else… bring data.
The Environment

• Cleaning the patient environment: Collaborating with local housekeeping team; Standardizing ; Measurement

• Cleaning equipment: Who? What? When?
SNHMC Approved Surface Disinfectants

- Wear gloves when using any of the products.
- Wear eye protection if you anticipate splashing.
- Write contact time on wipe container lid when put into use.

<table>
<thead>
<tr>
<th>Product</th>
<th>Active Ingredient</th>
<th>Contact Time</th>
<th>Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sanicloth AF3</td>
<td>Quaternary ammonium compound (alcohol free)</td>
<td>3 minutes</td>
<td>General purpose hard surface disinfectant</td>
</tr>
<tr>
<td>Sanicloth Bleach</td>
<td>Sodium hypochlorite (bleach)</td>
<td>4 minutes</td>
<td>Hard surface disinfectant for bleach resistant surfaces and specialty equipment</td>
</tr>
<tr>
<td>Cavicide</td>
<td>Benzyl ammonium chloride</td>
<td>1 minutes</td>
<td>Hard surface disinfectant for specialty equipment (isolettes)</td>
</tr>
<tr>
<td></td>
<td>Quaternary ammonium compound</td>
<td>3 minutes</td>
<td>General purpose hard surface disinfectant</td>
</tr>
</tbody>
</table>

- Environmental Services may use additional hard surface disinfectants for large surface area cleaning/disinfection.
- Additional products may be used in limited clinical areas as dictated by patient care equipment manufacturer.

November 2012
Laundry

- The OSHA Bloodborne Pathogen Standard and the CDC Guideline on Environmental Infection Control in Health-Care Facilities both state: *Handle contaminated textiles and fabrics with minimum agitation to avoid contamination of air, surfaces, and persons...Bag or otherwise contain contaminated textiles and fabrics at the point of use...Do not sort or pre-rinse contaminated textiles or fabrics in patient-care areas.*

Further, the CDC Guideline notes: *Maintain the receiving area for contaminated textiles at negative pressure compared with the clean areas of the laundry...*
“Knowing the difference between adaptive and technical challenges is one of the key tasks of leadership.”

Ronald A. Heifetz

**Technical work:** activities with known solutions and science

**Adaptive work:** culture change; requires a change of values, attitudes, or beliefs

The Improvement Team must do both well.
EMS Transport – Hospital to SNF

- Many EMS providers are non-hospital based. Some are from large corporations (like AMR) and some are volunteers in rural hospitals.

- EMS typically responsible for cleaning and maintaining own equipment.

- Compliance with cleaning and disinfection as well as training for PPE use not always clear.
EMS Transport

• Ensure infected or colonized areas of the patient’s body are covered and contained.

• Don clean PPE and perform hand hygiene PRIOR to transporting patient and again when handling the patient UPON ARRIVAL to destination.
A Few Thoughts on the Coach Role

- Midwife
- Mirror
- Motivator
- Mother Confessor
- Moderator
Antibiotic Use in LTC

There is intense antimicrobial use in long term-care facilities (LTCFs), and studies repeatedly document that much of this use is inappropriate.

Antimicrobial Stewardship

• **Long Term Care:** Focus on management of UTI
  – Use of rx algorithms with model policy development
  – Creation of facility level antibiograms
  – Plan for f/u with LTCF patients rx in the E.D.
Findings: Association between *C. difficile* infection and prior PPI use.
Proton Pump Inhibitor Drugs (PPI)

- Marketed under various brand and generic drug names as prescription and over-the-counter (OTC) products
- Work by reducing amount of acid in the stomach
- Prescription PPEs: to rx conditions such as gastroesophageal reflux disease (GERD); stomach and small intestine ulcers, and inflammation of the esophagus
- Over-the-counter PPIs are used to treat frequent heartburn
Proton Pump Inhibitors

• “antibiotic surrogates” Dale Gerding (IHI, 2015)
• Removed from order sets at Kaiser Permanente
• Decrease use in nursing homes (Scotland)

From: IHI
When your people ask you,
When are we going to be through this?
Tell them, we’re not.
The world wants to make things a movie.
It is more like a soap opera.
Hospital Acquired *C. difficile* Trends
References

• State of New Hampshire Recommendations for the Prevention and Control of Multidrug-Resistant Organisms (MDROs) and Clostridium difficile Infection (CDI) for Healthcare Agencies and Community Settings. February, 2014.


• WIHI, All Hands on Deck to Reduce C.difficile, 4/9/2015. Dale Gerding et. al (www.IHI.org)
References


• [http://www valeoflevenhospitalinquiry org/report aspx](http://www.valeoflevenhospitalinquiry.org/report.aspx)

References

New Roles for Public Health in a Region
Evolving Role of Public Health Nursing in New Hampshire
NH Department of Health and Human Services Mission Statement

The Department of Health and Human Services mission is to join communities and families in providing opportunities for citizens to achieve health and independence.
NH DPHS Vision Statement

- Collaboration with many public health system partners
- Awareness of evolving public health environment to best inform policy makers
- History of community partnerships that are unique to our State
- Crafting a solid foundation toward the goal of a regional public health system
Yesterday

A look back at the roots of public health nursing
Yesterday

The idea of cultivating the health of individuals by changing the culture of a community has been alive for more than a century
Yesterday

• **Lillian Wald** (1867-1940):
  – Coined the term “Public Health Nurse”
  – Founded the Visiting Nurse Service in 1893
  – By 1913, she employed 92 nurses
  – Educated low-income NYC families on
    • Infection Control
    • Disease Transmission
    • Preventative Care
Yesterday

• Lillian Wald
  – PHN’s must treat social and economic problems
  – Expansion of role beyond caring for the sick
  – PHN must address health of the entire neighborhood
  – Cooperation with social agencies to improve living conditions
  – Early advocate for nursing in schools
Yesterday

• 1980’s-1990’s

  – Emergence of the local federally qualified health centers
  – Two local Health Departments in NH
  – Regional offices throughout the State
Yesterday

- Disease prevention and control activities
- Outbreak investigations
- TB Control
- Immunization services
- “Silo” model of service delivery
- Started 24/7 on-call public health nurse
Yesterday

- Follow-up on all new refugees
- Training and consultation for partners
- Responding to new and emerging public health threats
- PHN in most cases was the only State public health presence in communities
Today

The evolution of integration
Today

- Rising health care costs
- Increasing awareness of the importance of primary prevention and the social/environmental determinants of health
- The Affordable Care Act
- Primary care and public health have a shared goal of improving population health
Today

• Partnerships between primary care and public health may improve:
  – Efficiencies
  – Workforce outcomes
  – Population health
  – Ability to achieve the Healthy People 2020 Goals
Public Health Nurse Liaison

Establish an interpersonal relationship with a community, a system, family or individual intended to increase or enhance their capacity for improving health outcomes.

Promote and develop alliances among organizations or constituencies for a common purpose. Build linkages, solve problems, and/or enhance local leadership to address health concerns.
Today

- Integrated services
- Efficient and shifting use of resources
- Core public health functions maintained
- Instituting local infection prevention networks
- Community Advisory Boards
- CHIP based on SHIP
- Increased awareness of behavioral health needs
Today

• Improvement of population health indicators
• Integrating public health with primary care
What is Population Health?

• Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups.
Today

Characteristics of Population-based practice:

The broad determinants of health are considered, not just the causes of disease.

The practice is directed at all levels of intervention: communities, the individuals, and families living with in them and the systems within a community that also impact on health.
Today

As public health nurses, our work in achieving health equity must follow this same path, building upon the assets within a community, building new relationships, strengthening existing relationships, rebuilding weakened relationships, strengthening the capacity of people within the community to care for their own health and the health of each other.
A core competency of public health nursing is the ability to establish **partnerships**. Public health nurses partner within groups and populations in planning interventions and resolve health issues, enabling them to learn from the community and formulate appropriate solutions. The public health nurse develops plans that reflect best practices, identifies strategies, action plans and alternatives to attain expected outcomes, and implements the identified plans through partnerships within the community.
Today

The public health nurse **collaborates** with and provides **consultation** to representatives of the population, various community groups, organizations, health and human services professionals and elected officials to facilitate the implementation of programs and services and to provide for and promote the health of the population.
Today

Communities and community organizations can be vital contributors to the resources and capacity of a public health system.
What is Public Health Detailing?

• Based on Academic Detailing Models
  – Promotes evidence-based care through educational outreach to clinicians
  – Promotes evidence-based recommendations and data while utilizing the face-to-face communication approach of industry detailers
  – Provides relevant clinical information in an objective and engaging format
  – Provides the opportunity to influence physician practices to improve public health indicators
Public Health Detailing in the State of New Hampshire

- Improve prevention, screening and management of infectious diseases
- Expand the scope and reach of infectious disease prevention services within existing health care programs
- Build partnerships which will improve population health indicators
Public Health Detailing: The Goals

- Promote efficient and timely reporting of notifiable diseases
- Provide screening recommendations
- Conduct and organize workshop and training on various communicable disease topics
- Provide infection control guidance, support and resources
- Identifying pilot projects and opportunities for collaboration
Public Health Detailing: The Goals

• Build partnerships
  – Hospitals
  – Long-term care
  – Primary care physicians
  – FQHC’s
  – Contracted Agencies
Assessment

• **Reportable Diseases**
  – Accessibility of the NH Reportable Disease List/Guidelines
  – Reporting practices
  – Barriers
Assessment

• TB Screening and Treatment
  – Availability of TB skin testing/IGRA testing
  – Proficiency in administering/interpreting skin tests
  – Need for technical assistance
  – Challenges with treatment recommendations
Assessment

• Adult Vaccines
  – Availability of adult vaccines
  – Enrollment in the NH Adult Immunization Program
  – Assessment of vaccine status
  – Vaccine administration and documentation
  – Referral mechanisms
Assessment

• Do they receive DPHS Health Alerts and data reports? Are they helpful?
• What additional information is needed?
• Thoughts for future conferences/trainings?
• How can DPHS be more helpful to the practice?
• Opportunities for partnerships?
Education

- Hepatitis C Screening Recommendations
- Standards for Adult Immunization Practice
- NH Reportable Disease List
- NH Communicable Disease Report Form
- Links to websites and other resources
Next Steps

• Implement evaluation tool
• Evaluation results will guide the next phase of Public Health Detailing
Evaluation

• Feedback Tool
  – One month post-visit
    • Will practices change in the future as a result of the visit?
  – Six months post-visit
    • What changes have been made in practices as a result of the visit?
Evaluation

Feedback Tool

– Were providers satisfied with the detailing visit?
– Was the length of the visit appropriate?
– Were the materials shared with other staff?
– Has knowledge increased?
– How could the visits be improved?
– If no changes will be made, what are the reasons?
– What other assistance can DPHS provide?
Lessons Learned

• Detailing can be conceptualized to virtually any topic
• Scheduled visits prove to be more fruitful
• Regional efforts work well, but not always realistic
• Patience and persistence
• Be flexible when arriving at the facility
• Highlight partnerships and collaboration
Tomorrow

Partnering to improve population health
Tomorrow

- The integrated health care system of the future requires shared objectives that guide empowered individuals and communities on their quest to be active participants in their own health.
References


• National Resource Center for Academic Detailing, 2015.

• New Hampshire Department of Health and Human Services, Bureau of Infectious Disease Control, 2015.