

COHORT FIVE

Program/Education

HealthPartners

Main Line Health

Monmouth Medical Center

Ochsner Health System

Our Lady of the Lake Regional Medical Center

Aurora Health Care – GME Team

Aurora Health Care – Radiology Team

HealthPartners





NI VII Meeting Three/Storyboard

Aligning Health Professions Education and Organizational Strategy to Create a Teaming Framework for Training Health Professional Learners

Michelle Noltimier RN BSN MBA

Director for Physician Assistant and Nurse Practitioner Graduate Education

HealthPartners Institute

Office of Health Professional Education

Kelly Frisch, M.D.

Executive Director & DIO

HealthPartners Institute

Office of Health Professional Education



Background

As an organization, HealthPartners has a mission to provide the best quality and value for patients and members by designing and implementing models of care that provide convenient, effective care for patients. We have many successful models of teaming already established and have various initiatives that link teaming behaviors to desired patient care outcomes.

Our objective is to learn about existing teaming efforts across our large health system, identify essential elements of teaming and create a shared vision around teaming. With our experience responding to the COVID 19 pandemic, we will incorporate learnings from both the clinical setting and our educational structure as we plan for future training.

Objective

Create a framework from which health professional learners are trained in teaming skills that will improve patient care outcomes.



Methods: Audience, Interventions, Measures

Through the support and guidance of the AIAMC National Initiative VII, a team of educators, leaders, clinicians and learners at HealthPartners will collaborate to:

- > Curate content related to teaming as a resource for our organization.
- > Develop an inventory of HealthPartners initiatives/efforts that includes teaming as a method to achieve better patient care outcomes.
- > Identify the essential teaming skills identified across HealthPartners initiatives.
- > Collect valuable learnings from the effects of the COVID 19 pandemic as it relates to how teams were effective in caring for patients.
- > Compare learnings from the COVID pandemic with the initial list of essential teaming skills to distill the core skills that will be incorporated into new teaming framework.



Methods: Audience, Interventions, Measures

Future Work After March of 2021

- > Incorporate teaming skills into the design of a new curriculum framework,
- > Implement and measure the outcome of this curriculum on learners perceived confidence and competence related to their ability to “team on the fly” to improve patient care outcomes.
- > Share future recommendations with HealthPartners leaders, educators and clinicians.



Results (to Date)

Developed an inventory of HealthPartners initiatives/efforts that includes teaming as a method to achieve better patient care outcomes.



Inventory of System Wide Initiatives: **Teaming Skills**

- **Accountability**
- **Communication**
- **Awareness and improvement mindset: anticipation; monitoring; identify barriers**
- **Empathy**
- **Interpersonal connection**
- **Adaptive change**
- **Collaboration**
- **Innovate within restraints**
- **Ability to find/use resources/guidelines/standards-checklist**
- **Resiliency**
- **Leadership-give direction**
- **Global perspective**
- **Timely action**
- **Composure**
- **Morale**
- **Prioritization**
- **Expand abilities within team members**
- **Flexibility**
- **Commitment to team**
- **Deep listening**
- **Building trust**
- **Deal with uncertainty**
- **Awareness of team**
- **Inclusion**
- **Compassion**
- **Seek to understand**
- **Know each other's work**



Inventory of System Wide Initiatives: Goals

- Patient satisfaction-fits lifestyle
- Provider satisfaction
- Efficiency/streamline
- Communication
- Empathy for clinician
- Resiliency for clinician
- Quality of patient care (decrease infections)
- Safety/ decreased risk for patient care
- Accountability of team
- Present error
- Faster care
- Decrease length of stay
- Culture- small town
- Affordable



Inventory of System Wide Initiatives: Measurement

- **Time/throughput- length of stay**
- **Observation by outside evaluators**
- **Data-pages**
- **Application**
- **Patient quality**
- **Risk management**
- **Survey of providers- validated scale**
- **Patient experience/perception-real time feedback**
- **Direct feedback**
- **Completion of training**
- **Peer review assessments**
- **Needs assessment**
- **Total cost of care**
- **Intolerance to uncertainty (scale)**
- **Perceived stress scale**
- **Plans are successful or not**
- **HCAPS**
- **Team member stories**



Inventory of System Wide Initiatives: Training Approach

- Focus on early adaptors
- Awareness email
- Presentations
- Simulation
- 1:1 communications
- Focus on stakeholder input
- Scenarios
- Pilot activity
- Participants selected based on scenario
- Classes
- Drills
- Work off normal practices
- Course
- Voluntary
- Telling the story
- 2-day training event
- Regular meetings with leaders (30 min) and frontline workers (30 min)
- 15 min orientation all caregivers
- Huddles
- BR briefs
- Experiential learning (10 hour medical improv)
- Debrief and reflection
- UPC task force
- Peer learning



Discussion: Barriers & Next Steps

Phase three: August 2020 - October 2020

- > Identify teaming skills that emerged as essential from the COVID 19 pandemic
- > Compare COVID 19 teaming skills with larger HealthPartners teaming initiative goals and distill a core list to incorporate into a curriculum framework.

Phase four: October - December 2020

- > Create recommendations for future approach to training for HealthPartners

Phase four: December 2020 – March 2021

- > Disseminate findings through a paper and poster summary



Main Line Health



NI VII Meeting Three/Storyboard

Nurturing Collaborative Skills in the Clinical Learning Environment

Sandra Ross, LSW, Elena Umland, PharmD, FNAP, Katherine Pang, DO, Joanna Dixon, MSN, RN, CEN, Michael Danielewicz, MD, Eleanora Yeiser, DO, Sarah Hirsh, MD, Salma Mami, Chinwe Onyekere, MPH, Barry D. Mann, MD



Introduction & Aim

Training for healthcare providers is often siloed with limited opportunity for interaction with other disciplines prior to graduation. Main Line Health and Jefferson are clinical rotation sites for multiple disciplines, and recognized an opportunity to incorporate interprofessional training during clinical rotations. **Our goal is to increase appreciation for interprofessional collaboration among students from various disciplines through monthly case conferences and patient encounters.**

We strive to create a sustainable model of bringing students together to learn about, from, and with each other. The ultimate goal is for students to **value professional teaming to improve patient outcomes and incorporate a sense of confidence working with an interprofessional team to improve patient care.** We aim to determine if an interprofessional conference in the early phase of learning results in improved self-efficacy and improved ability to function in a team in the clinical setting, through assessing interventional methods impact and determine replicability of the project with our academic affiliate, Jefferson.



Methods: Audience, Interventions, Measures

- A series of 5 case conferences involving student participants from multiple disciplines were created to be delivered via zoom
- Disciplines involved: medicine, nursing, physical therapy, occupational therapy, respiratory therapy, social work, pharmacy, medical assistants
- Students are split into interprofessional teams to discuss cases with a focus on identifying the value of each member of the team in addressing various elements of the case
- Small groups respond to discussion questions in zoom breakout rooms throughout the case conference and then report out to the larger group
- The conferences are co-facilitated by family medicine residents and advanced nursing candidates

Measurement:

- IRB approval obtained at Main Line Health and Jefferson
- Interprofessional Collaborative Competency Attainment Scale (ICCAS): a 21-item self-assessment tool that evaluates participants' perception of ability to demonstrate behaviors related to collaborative care
- Jefferson Teamwork Observation Guide® (JTOG®): a 15-item survey designed to identify the level of performance in collaborative practice behavior in groups
- ICCAS is distributed at the conclusion of case conferences and JTOG is administered after interprofessional patient encounter and debrief
- JTOG outcomes will be evaluated relative to ICCAS findings



Discussion: Barriers & Next Steps

- Scheduling conferences and patient encounters at a time that is conducive to participation from all disciplines without overwhelming patients
- Knowledge gaps between different disciplines dependent upon level of training and prior clinical experience
- We have minimized barriers with consistent communication and early scheduling so disciplines have time to make adjustments to their schedules
- Interprofessional teams of students established during the monthly case conferences will assess and develop a plan for a hospitalized patient. Students will convene at a predetermined time in the afternoon to discuss their assessment and plan with members of their interprofessional team. This will be followed by a feedback and debriefing session. Students will complete the JTOG® to identify the level of collaborative practice behaviors observed in their interprofessional team.

Areas for Guidance/Input:

- How do we engage students with varying schedules in patient care/assessment without overwhelming the patient?
- Strategies to get preceptors on the same page regarding the purpose of the patient encounter activity and the guidance they provide for an interprofessional team
- How do we replicate the amount of engagement in in-person sessions over zoom



Monmouth Medical Center





Hand Hygiene Compliance Protocol

Joseph Jaeger, DrPH

Pranoy Mohapatra, MHA

Priya Fernicola, MPH, MS,

Christine Steinberger

Introduction [or Background] & Aim [or Purpose/Objectives]

- To establish a reliable and non-biased method of tracking and improving hand hygiene
- Current hand hygiene data is gathered through secret shopper manual observations
- This leads to small sample sizes and a potential “halo effect”
- We aim to establish a system that captures more thorough and accurate baseline data and subsequently improving behavior and culture as related to hand hygiene



Methods: Audience, Interventions, Measures

- Pilot study to take place on pediatric floor due to closed/easily observed environment, multiple types of members of care team, strong leadership support, and lower financial impact
- Plan to install electronic monitoring systems (GoJo, SmartLink, Vitalacy etc) to capture realtime hand hygiene data to establish accurate baseline data
- Implement interdisciplinary learning initiatives and/or automated reminders after 3 months



Results (to Date)

- Project has been paused due to Coronavirus- hope to resume work shortly



Discussion: Barriers & Next Steps



Ochsner Health System





NI VII Meeting Three/Storyboard

Teaming on Labor and Delivery – Ochsner Baptist

Rajiv B Gala, MD – Project Lead

Lauren Bergeron, MD – OB Hospitalist

Joseph Biggio, MD – Ochsner OB System Lead / MFM

Tabitha Duvernay – OB Nursing Leadership

Jessica Grote, MD – Ob/Gyn Resident (PGY3)

Roneisha McLendon, MD – OB Anesthesia

Barry Starr, MD – Pediatric Hospitalist

Anna White, MD – Ob/Gyn Residency Program Director



Introduction [or Background] & Aim [or Purpose/Objectives]

Introduction

As we reflected on our current culture in Labor and Delivery and some of the potential barriers, the two that stood out were the medical hierarchy and impact of sudden changes in acuity/plans. While we have a “stop the line” culture, it doesn’t always happen in practice because of fear or lack of situational awareness. As our unit gets busier, we need to find a way to promote and encourage psychological safety and clear communication in our environment. Questions in plans should not be limited because of fear or silo mentalities (intentional or otherwise)

Aim

Our vision is to deliver a world-class experience on Labor and Delivery that our patients recommend to their loved ones, our employees are proud to be a part of, and our learners carry with them to any future employer.

The mission of our group is to provide the highest level of maternity care in the Gulf States through our integrated, team-based approach.



Methods: Audience, Interventions, Measures

Methods

We have tried to create a three-pronged approach to improving Teaming on Labor and Delivery:

- We have re-structured the staffing coverage to provide greater continuity on the unit
- We are implementing a Safety Checklist
- We are hoping to offer educational sessions on communication and situational awareness, adapted from TEAMSTEPS

Audience:

- Obstetrics team on L&D – Generalist faculty, Hospitalists faculty, MFM faculty, Ob/Gyn residents
- Anesthesia team – OB Anesthesiologists, OB Anesthesiology fellows
- Nursing team – Day and Night nursing staff, Remote monitoring nurses (FHT Bunker)
- Pediatrics team – Pediatrics Hospitalists; NICU

Interventions:

- Self-paced TeamSTEPPS modules on Communication, Situational Monitoring, and Mutual Support
- Safe Surgery Checklist

Measures:

- Team performance observational tool after each case
- Teamwork Perceptions Questionnaire (T-TPQ)
- Teamwork Attitudes Questionnaire (T-TAQ)



Results (to Date)

Results

Pre-intervention observations

- High performance during *acute events* (107/115)

- Significantly lower performance during *“routine care”* (46/115)

Safe Surgery Checklist Template

Before Induction of Anesthesia - *Hold!*

RN verifies with Patient & Anesthesia:

- Patient identification (name and DOB)
- Planned procedure matches consent
- Surgical site / laterality confirmed / marked
- Known allergies

ANESTHESIA BRIEFING - *in OR*

Circulating Nurse & Anesthesia discuss:

- Anesthetic plan, including airway or aspiration risk
- Planned position
- DVT prophylaxis (SCDs)
- Risk of hypothermia (if operation >1 hour)
 - Warmer in place
- Blood availability
 - Adequate IV access established
- Required preop tests resulted / reported
- Planned postop destination

Before Skin Incision

TIME OUT

Circulating Nurse asks:

“Is everyone ready to perform the time out? Any unfamiliar staff in the room? Let’s all introduce ourselves by name and role.”

Entire Surgical Team confirms:

- Patient name & DOB
- Surgical procedure to be performed
 - Refers to consent
- Surgical site / marking visible (if required)
- Case requirements available (imaging/ implants/equipment/instruments/supplies)

Surgeon shares:

- Operative plan
- Expected duration
- Anticipated blood loss &/or difficulties
- Confirms implants and/or special needs

Anesthesia Professional shares:

- Any concerns
- Antibiotic prophylaxis given within the last 60 minutes
 - Redosing plan (if applicable)

Circulating Nurse and Scrub Tech share:

- Sterility confirmed
- Medications on field
- Fire risks
- Other concerns

Surgeon asks:

“Does anybody have any concerns? If you see something that concerns you during this case, please speak up.”

Before Surgeon Leaves Room

SURGEON LED TEAM DEBRIEFING (Calls for when closing)

Surgeon confirms:

- Name of the procedure(s) performed

Nurse reviews with team:

- Instrument, sponge, and needle counts
- Specimen labeling (including patient name) & classification
- Wound class
- Final anesthesia type

Anesthesia reports:

- Relevant physiological information: I & O, EBL, etc.

TEAM DEBRIEFING

Entire Surgical Team discusses:

- Postop concerns: destination, foley status, local injection, etc.
- Equipment issues
- Other opportunities for improvement – What could have been done to make this case safer or more efficient?

PATIENT LABEL

Ochsner Baptist Medical Center

LASQC Louisiana Surgical Quality Collaborative

Ni

The checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged. Based on the WHO Surgical Safety Checklist (<http://www.who.int/patientsafety/whosurgery/en/>)
© 2008 World Health Organization. All rights reserved. - SSC Master Template - Revised 7 August 2010

Discussion: Barriers & Next Steps

Discussion

It is well established that team-based health care is directly correlated with improved patient outcomes and clinician well-being. Effective teamwork hinges on the psychological safety of each member and the ability to learn and think together irrespective of one's status in the medical hierarchy. Our unit has undergone a total transition based on our experiences during COVID and our new team model is still trying to overcome historical norms.

Barriers

We have had 3 major barriers – resistance to change, increased pressures on productivity, and new leadership at all levels. While the new core leadership has brought a fresh perspective on clinician burnout and strategies to overcome it, the greater team still fears this change. Communication and constant, transparent reflection will continue to build trust among everyone.

Next Steps

We are continuing to measure the impact of the new Safe Surgery Checklist so we can expand this to all facets of care on labor and delivery. We also hope to provide more coaching on effective teaming on L&D.



Our Lady of the Lake Regional Medical Center





OUR LADY
OF THE LAKE



AiAMC
Alliance of Independent
Academic Medical Centers

NI VII Meeting Three/Storyboard

Incorporating Lessons Learned to Increase Participation and Engagement in Interdisciplinary Huddles within Surgical Units

Meridith Bergeron, EdD; Sophia Solomon, MSN, RN; Kirsti Hill, BSN;
Tiffany Huffman, BSN, CMSRN; Michelle Nelson, DNP; Emily Stevens, MA, LCSW-BACS;
Rich Vath, MAEd; Phillip Allen, MD, MBA; Brent Allain, MD, FASMBS



Introduction & Aim

- National focus on Interprofessional (IP) rounds.
 - > Institute of Medicine advocates rounding involving IP teams to support patient care and improve patient safety.¹
- Research demonstrates improved efficiencies and diminished cost and length of stay when collaborative IP practice occurs.^{2,3,4}
- Healthcare providers participating on IP teams report greater job satisfaction⁵ and there is increased workforce retention.⁶
- Overarching Aim
 - > Implement a Quality Improvement (QI) Project to advance the use of interprofessional rounds and patient safety discussions including events that need to be reported on OLOL's SUR 2 unit, which involves the LSU Surgery Residency Program and the LPG Surgeon's Group.
- Priorities and Goals
 - > Improve patient experience
 - > Decrease patient harm
 - > Decrease length of stay
 - > Increase IP participation and engagement



Methods: Audience, Interventions, Measures

- IP rounds on SUR 2 that include patient care team held Monday through Friday at 2:00 p.m.
- The rounds are thirty minutes and involve a scripted rhythm, with a role for all professionals.
- Primarily focused on discharge planning.
- Additional focus added on safety, quality, value, and equity.
- Review of unit-level data.
- Promote discussion of additional focus areas with educational components tailored to the setting and patient population.
 - > Five-minute discussion occurring at least once per week
- Measures
 - > IP attendance
 - > Harm scores
 - > Readmission rates
 - > HCAHPS
 - > Team Member Engagement Surveys



Results

- Collection of baseline data
 - > IP round attendance
 - > Harm scores
 - > Readmission rates
 - > HCAHPS
 - > Team Member Engagement Surveys



Discussion: Barriers & Next Steps

- Barriers

- > Launch postponed due to COVID-19 and hold on elective surgeries
- > Time and availability
- > Willingness to change
- > Limited resources
- > Unclear goals for discharge

- Next Steps

- > Piloting project (October 2020)
- > Launching (November 2020)
- > PDSA cycles (occurring every eight weeks)



References

1. Kohn LT, Corrigan JM, Donaldson MS (eds). *To Err is Human: Building a Safer Health System*. Washington, DC: National Academic Press. 2000.
2. Reeves S, Goldman J, Burton A, Sawatzky-Girling B. Synthesis of systematic review evidence of interprofessional education. *J Allied Health*. 2010;39:198-203.
3. Curley C, McEachern JE, Speroff T. A firm trial of interdisciplinary rounds on the inpatient medical wards: an intervention designed using continuous quality improvement. *Med Care*. 1998;36:AS4-AS12.
4. Smyrnios NA, Connolly A, Wilson MM, Curley FJ, French CT, Heard SO, Irwin RS. Effects of a multifaceted, multidisciplinary, hospital-wide quality improvement program on weaning from mechanical ventilation. *Critical Care Medicine*. 2002;30:1224–1230. doi: 10.1097/00003246.
5. Körner M. Interprofessional teamwork in medical rehabilitation: A comparison of multidisciplinary and interdisciplinary team approach. *Clin Rehabil*. 2010 Aug; 24(8):745-55.
6. Xyrichis A, Ream E. Teamwork: A concept analysis. *J Adv Nurs*. 2008;61:232–241. doi: 10.1111/j 1365-2648.2007.04496.x.



Aurora Health Care GME Project





We are  AdvocateAuroraHealth



NI VII Meeting
Three/Storyboard

Crisis Response Mock Drills

Jacob Bidwell MD, Nicole Eull PsyD, Dawn Faucett, Tricia La Fratta MBA,
Esmeralda Santana C-TAGME, Deborah Simpson PhD,
Keyonna Taylor-Coleman MD

Graduate Medical Education, Milwaukee, Wisconsin



Introduction

- Approximately 300 to 400 practicing physicians die by suicide each year ¹
- Residents are at high risk (depressive disorders, depressed mood, burnout, and suicidal ideation)²⁻⁴
- Extensive prevention interventions
 - Prepare faculty for appropriate response in a time of crisis
- Adapted ACGME endorsed toolkit:⁵
 - Conduct “Mock Drills” to assess PDs, APDs, Coordinators, and Chiefs for preparedness
 - Provide education + feedback on response

Aim

- To ensure knowledge of the Crisis Communication Plan and Mental Health Support Plan, individual responsibilities and roles, nuances and exceptions to ensure smooth use of plan in time of emergency
 - POLICY KNOWLEDGE = 25%
 - ☑ Ability to access GMEC crisis plan and Program Specific Plan (“no call, no show”) what resources are relevant to your situation, who must be informed)
 - ACTIONABLE KNOWLEDGE = 75%
 - ☑ How proceed (e.g., call resident 2-3 times, Loss prevention notification is situation specific)

1. Center C, Davis M, Detre T, et al. Confronting depression and suicide in physicians: A consensus statement. JAMA. 2003;289:31613166. Mata DA, Ramos MA, Bansal N, et al. Prevalence of depression and depressive symptoms among resident physicians: A systematic review and meta-analysis. JAMA. 2015;314:23732383.
2. Mata DA, Ramos MA, Bansal N, et al. Prevalence of depression and depressive symptoms among resident physicians: A systematic review and meta-analysis. JAMA. 2015;314:23732383.
3. Bellini LM, Baime M, Shea JA. Variation of mood and empathy during internship. JAMA. 2002;287:31433146.
4. Dyrbye LN, West CP, Satele D, et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. Acad Med. 2014;89:443451.
5. After Suicide a Suicide: A Toolkit for Physician Residency/Fellowship Programs (American Foundation for Suicide Prevention - AFSP) http://www.acgme.org/Portals/0/PDFs/13287_AFSP_After_Suicide_Clinician_Toolkit_Final_2.pdf



Methods: Audience, Interventions, Measures

- Adapted ACGME endorsed toolkit:⁵
 - Known as the “Crisis Communication Plan”
 - Approved by and is a partnership of GME, GMEC, Legal, HR, PR, EAP and Security
- Conduct “Mock Drills” to assess PDs, APDs, Coordinators, and Chiefs for preparedness
 - Conducted within each individual residency program
 - Each drill = 3 scenarios
 - 2 assessors complete assessment of competency
 - Provide education + feedback on response

MOCK DRILL RESPONSE/SCORING SHEET

- Designed by team consensus
- Approved by GME leadership and HR
- Sheet includes detailed ratings of:
 1. Awareness and use of policy
 2. Actions to be taken x when x who
 3. Confidentiality considerations
 4. Special considerations
- Each of 3 mock scenarios has a specific Mock Drill Response Sheet



Results (to Date)

Mock drills completed for all of our residency and fellowship programs

Compiled data to compare across programs

Reviewing & reconciling scoring inconsistencies

Identifying areas that need more teaching

We have used feedback and common questions during drills to guide improvements to the process



Discussion: Barriers & Next Steps

Scheduling 2 raters plus PD, APD, and Chiefs - daunting task requiring several schedule changes

Conducting mock drills with one program at a time, gave us the opportunity to debrief and provide specific feedback relevant to the nuances of each program

We will continue to reinforce the use of the plans and follow through (eg, incident cards for unexcused absences)



@AuroraGME @myskillrx @jakebidwell



Aurora Health Care Radiology Project



Radiation Exposure, Reduction Techniques, and Standardization of Swallow Study Evaluations

Mason A. Brown, MD¹, Shelly Reimer, MD¹, Leah Presper², Theresa Ackerman², and
William MacDonald, MD¹

Aurora St. Luke's Medical Center, Departments of [Radiology](#)¹ and Speech
Pathology², Milwaukee, WI

PURPOSE AND INTRODUCTION

■ Purpose

- Retrospectively establish a fluoroscopic radiation exposure baseline
- Monitor prospective reduction techniques

■ Introduction

- Swallow study evaluation: a procedure where a patient drinks contrast under real-time X-ray to evaluate laryngeal penetration or aspiration
- Long-term exposure to ionizing radiation from fluoroscopic procedures can lead to side effects



METHODS

■ Data

- Retrospective analysis of radiation exposure to the resident over the course of a 4-week rotation
- Absorbed dose: ionizing radiation absorbed per unit mass, measured in Grays (Gy)

■ Implementations

- Replaced/provided personal protective equipment per Occupational Safety and Health Administration guidelines
- Developed standardized evaluation flowchart



RESULTS

■ Patient Radiation Exposure Data

	Time (minutes)	Radiation (mGy)	Runs
Average	1.9	7.9	13.5
Median	1.8	7.2	13
Range	0.3 – 4.3	1.5 – 24.3	1 – 26

■ Resident Exposure Data prior to Implementations

	Time (minutes)	Radiation (mGy)
Estimated Exposure/Rotation	367.7	23.9

- Residents performed 100 swallow studies (3.1 hours of radiation exposure) per 4-week rotation

DISCUSSION

■ Healthcare providers are at the greatest risk of developing cataracts if radiation safety glasses are not utilized

- In the setting of COVID precautions that include wearing a face shield and N95 mask for all swallow study evaluations, fluoroscopy technologists and speech pathologists had significantly low safety glasses utilization rates
- Placing safety glasses on workstations in the room and direct encouragement did not increase utilization rates

■ Critical Next Steps

- Develop laminated sign with emphasis on radiation safety and potential consequences
- Calculate comparative exposure data following implementations

