North Dakota Hospital Association Innovate-ND

HRET Hospital Improvement Innovation Network

June 6, 2017

Educational Events

HRET HIIN

ICU Care: A Team Sport
06/06/17 | 11:00 a.m.-12:00 p.m. CT

PFE Fellowship | Milestone Check: How is it Going?
06/07/17 | 11:00 a.m.-12:00 p.m. CT

QI Fellowship | Foundational Track
06/14/17 | 11:00 a.m.-12:00 p.m. CT

QI Fellowship | Accelerating Improvement Track
06/14/17 | 12:30-1:30 p.m. CT

Readmissions | Reduce Readmissions Fishbowl Series 2
06/15/17 | 11:00 a.m.-12:00 p.m. CT

PFE Fellowship Coaching Call
06/16/17 | 11:00 a.m.-12:00 p.m. CT

PFE Fundamentals | PFAs: Awe Got Them! Now What?
06/20/17 | 11:00 a.m.-12:00 p.m. CT

ADE – Opioid Safety Fishbowl Series 2
06/22/17 | 11:00 a.m.-12:00 p.m. CT

Information and registration links for **all** upcoming virtual events can be found under the "Upcoming Events" tab on www.hret-hiin.org.

All event recordings are/will be available on-demand on the HRET HIIN website www.hret-hiin.org. Select the desired topic and scroll

Important Dates to Remember

06/30/17	Performance/monitoring data for May 2017 discharges

See How One Rural Community Tackles Care Transitions

Get inspired to innovate for improved care coordination. Find out how a rural North Dakota hospital and a nearby clinic approach patient transitions and their impact on readmissions and emergency department visits in a new story at Huddle for Care. The story highlights efforts by Sakakawea Medical Center and Coal Country Community Health Center to reduce 30-day readmissions and improve their continuous care model to ensure patients consistently received warm hand-offs.

REMINDER: CMS Evaluation of Partnership for Patients (PfP) Hospital Engagement Network (HEN) Program

CEOs from randomly selected hospitals will receive an online survey tobe filled out as part of a CMS program evaluation process. For comparison purposes, the survey will collect information from hospitals that participated in the PfP and hospitals that did not participate in the PfP. The original email was sent on May 24 from pfp2_evaluation@econometricainc.com with the subject line "CMS Evaluation of the Partnership for Patients 2.0. Please complete this survey by June 14." The first reminder email to non-responders was sent on May 31.

Thank you **Jamie Nienhuis** for contributing to the EPIC discussion on the PFE LISTSERV©!

Heart of America–Rugby has enrolled their ED and **three** clinics in the Outpatient Antibiotic Stewardship initiative led by QHA! Click here to learn more about this initiative and how you can enroll your ED and other outpatient settings in this important work. This initiative will tie in very nicely with the HRET HIIN hospital antibiotic stewardship action that's coming!

down to “Watch a Recent Data Event”.

SDSMA
Provider Perspective on Patient Centered Care Webinar Series | Quality Equals Financial Success
06/06/17 | 12:15-12:45 p.m. CT
Register here.

Great Plains QIN
Quality Payment Program Office Hours
06/07/17 | 12:00-1:00 p.m. CT
Register here.

HPOE
The Impact of Community Health Workers
06/07/17 | 11:00 a.m.-12:00 p.m. CT
Register here.

SDSMA Healthstream Webinar Series: Keeping Patients Safe
Part 3: Understanding the Patient’s Perspective on Patient Safety
06/08/17 | 2:00-3:00 p.m. CT

Click here to register for either of these webinars.

AHA
Art and Science of Storytelling to Engage and Inspire Health Care Teams
06/08/17 | 1:30-2:30 p.m. CT
Register here.

Great 8+
Sleep Hygiene/Falls, Pt. II
06/08/17 | 2:00-3:00 p.m. CT
Register here.

American Hospital Assn.
Hospitals Against Violence
06/13/17 | 12:00-1:00 p.m. CT
Register here.

Partnership for Patients

Quality Milestones Recognition

COPPER Milestone:	COPPER, BRONZE & SILVER Milestone:
COPPER & BRONZE Milestone: Ashley Medical Center Carrington Health Center Cavalier County Memorial Hospital CHI Mercy Health–Valley City CHI St. A’s Mercy Hospital–Devils Lake Community Memorial Hospital Cooperstown Medical Center First Care Health Center Garrison Community Hospital Heart of America Medical Center Jacobson Memorial Hospital Care Center Kenmare Community Hospital Linton Hospital McKenzie County Healthcare System Mountrail County Medical Center Nelson County Health System Northwood Deaconess Health Center Pembina County Medical Center Presentation Medical Center Sakakawea Medical Center Sanford Hillsboro Medical Center Sanford Mayville Medical Center Southwest Healthcare Services St. Aloisius Medical Center St. Andrew’s Health Center St. Luke’s Hospital Tioga Medical Center Towner County Medical Center Unity Medical Center Wishek Community Hospital	**COPPER, BRONZE, SILVER & GOLD Milestone:**
COPPER, BRONZE, SILVER, GOLD & PLATINUM Milestone:	

ADEs

HHS Announces $70 million in Funding to Address Opioid Crisis
The Department of Health and Human Services last week announced more than $70 million in new funding opportunities to prevent and treat opioid use disorders and deaths. The grants include up to $28 million to help states increase access to medication-assisted treatment; $41.7 million to help local governments and tribal organizations train and provide resources to administer emergency treatment; and $1 million to expand access to overdose treatment. In addition, HHS recently announced up to $3.3 million for a state pilot program to treat pregnant and postpartum women with substance use disorders, and up to $2.6 million to increase recovery support for substance abuse and addiction.

How to Recruit and Maximize a Representative Patient and Family Advisory Council to Improve Patient Safety
06/13/17 | 1:00-2:00 p.m. CT
Register here.

AHRQ
2017 TeamSTEPPS National Conference
06/14/17-06/16/17 | Cleveland, OH
The mission of this conference is to bring tools, techniques and new thinking to assist health care professionals in successfully implementing TeamSTEPPS. To learn more about this conference or to register, visit their website. If you have questions, please contact AHRQTeamSTEPPS@aha.org.

APIC
2017 National Conference
06/14/17-06/16/17 | Portland, OR
Click here for details.

MMIC
Reducing Surgical Risk for the Obese Patient: A Multi-center, Multifaceted Patient Safety Program
06/14/17 | 12:00-1:00 p.m. CT
Register here.

Johns Hopkins Armstrong Institute
Taming the Opioid Epidemic: The Role of Naloxone Prescribing
06/14/17 | 1:00-2:00 p.m. CT
Register here.

AHRQ
Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families | Part 2 – Medication Management & Warm Handoff
06/16/17 | 11:00 a.m.-12:00 p.m. CT
Register here.

BCBSND
Gearing Up for Worksite Wellness
06/20/17 | Bismarck, ND
Register here.

CDC

HEALTHCARE-ASSOCIATED INFECTIONS

Your 'Culture of Culturing' is a Team Sport

The pressure to reduce CAUTIs by capturing “infections” present on admission may be leading to unintended consequences. We are hearing from some facilities that routinely collect a urinalysis (UA) and/or urine culture (UC) on patients who are admitted with a urinary catheter despite the patient being asymptomatic. The collection and testing of urine specimens in asymptomatic patients is not supported by evidence-based guidelines. It leads to false-positive results, unnecessary antibiotics, selection of multidrug resistant organisms (MDROs), C. difficile, over reporting of CAUTI, and excessive costs. In other words, “don’t perform urinalysis or urine culture unless patients have signs and symptoms of urinary tract infection.”

A recent paper by Garcia and Spitzer provides compelling evidence that will help you drive urine culture management that is designed to capture those who truly have a UTI and avoid culturing those who are likely to be simply colonized. The paper was published online May 2, 2017, in the American Journal of Infection Control (AJIC) and can be accessed here. Improving your ‘culture of culturing’ is a team sport that requires collaboration involving infection preventionists, administration, nursing, medical staff and the clinical laboratory.

How do we switch the mindset from “culture because we can so we can prove it isn’t ours” to “culture only patients with clinical signs and symptoms so we only give antibiotics to those who actually need them”?

This is a massive culture shift for some of us. We want to hear from those of you who have flipped the switch on an outdated, clinically non-supported routine of performing UAs and UCs on patients who have a urinary catheter but no signs or symptoms of a UTI.

Questions for the Field
- Where did you start? The emergency department?
- Who did you engage? Staff nurses? Hospitalists?
- What have you learned?

Additional Resources
- Morgan DJ, et al. Choosing Wisely in healthcare epidemiology and antimicrobial stewardship. *Infect Control Hosp Epidemiol* 2016;37:755-60
- Infectious Diseases Society of America Guidelines for the Diagnosis and Treatment of Asymptomatic Bacteriuria in Adults
- Lo W et al. SHEA/IDSA Practice Recommendations: Strategies to Prevent Catheter-Associated Urinary Tract Infections in Acute Care Hospitals: 2014 Update. *Infect Control Hosp Epidemiology* 2014;35(5):464-479
- Stagg A, Lutz H, Kirpalaney S, et. al. Impact of two-step urine culture ordering in the emergency department: a time series analysis. BMJ Qual Saf. Published Online First: 3 May 2017. Doi: 10.1136/bmjqs-2016-006250
- Dietz J, Lo T, Hammer K, Zegarra M. Impact of eliminating reflex urine cultures on performed urine cultures and antibiotic use. AJIC, 2016. 44:1750-1
- HRET HIIN Resources

Using the CDC's TAP Strategy to Prevent Healthcare-associated Infections: Running and Understanding TAP Reports
06/20/17 | 11:00 a.m.-12:00 p.m. CT
See joining instructions here.

New England QIN

Connecting Across the Community to Address the Needs of Patient with Complex Needs
06/22/17 | 10:00-11:00 a.m. CT
Register here.

National Patient Safety Foundation Webcasts

The National Patient Safety Foundation (NPSF) now offers complimentary access to past NPSF webcasts. Check back often to see what is available. Visit the NPSF Webcast Archive website and follow the instructions on your screen.

Save the Date

HRET Adaptive Leadership
08/02/17-08/03/17 | Chicago, IL

Adaptive Leadership in Medicine training will be held in Chicago August 2-3, 2017. This is an opportunity for a physician and administrator from the same organization to join together and gain valuable leadership tools. HRET HIIN hospitals are eligible to receive a scholarship that includes the training, hotel and airfare free of charge. Non-HIIN hospitals are also encouraged to apply, but please note that their scholarship includes only the cost of the training. Those interested in applying will be required at the time of registration to identify the individual from their organization who will be joining them.

- The newly updated HRET HIIN CAUTI change package includes tips for how to avoid culturing for asymptomatic bacteriuria (ASB)
- Review the HEN 2.0 CAUTI Antimicrobial Stewardship webinar covering ASB for more information about Asymptomatic Bacteriuria.

Sepsis—Early Recognition, Timely Treatment

New England Journal of Medicine recently released an article entitled, Time to Treatment and Mortality during Mandated Emergency Care for Sepsis. The authors, Seymour, et al, conducted a statewide evaluation in New York assessing the completion rate of the 3-hour bundle and sepsis mortality between April 2014 and June 2016. In 2013, New York (one of the first states) required their hospitals to report and follow evidence-informed protocols for the early identification and treatment of severe sepsis or septic shock. The article can be found here.

Key findings from this evaluation include:

- Median time to complete the 3-hour bundle was 1.3 hours – the time to treat varied widely across hospitals, with a variation of 1 to 2 times across hospitals
- Median time to administration of broad-spectrum antibiotics was 0.95 hours.
- Patients who received antibiotics (later) in hours 3 through 12 had 14% higher odds ratio of in-hospital death than those who received antibiotics within 3 hours
- Each hour of time to the completion of the 3-hour bundle was associated with higher mortality ("On average, the completion of the 3-hour bundle at 6 hours was associated with mortality that was approximately 3 percentage points higher than the mortality associated with completion of the bundle in the first hour")
- No association between the time to completion of the initial bolus of intravenous fluids and outcome was discovered in this analysis, but should not be interpreted as evidence in favor of abandoning early fluid resuscitation
- Adherence with 3-hour bundle ranged from 60-90% across hospitals

Overall, results showed the longer the time to completion of a 3-hour bundle of care for patients with sepsis and the longer the time to administration of broad-spectrum antibiotics, the higher risk-adjusted in-hospital mortality.

Sepsis is a time sensitive illness and demands that we recognize and treat it in a timely manner. As you move forward with sepsis reduction in your hospital, measure internal compliance with the 3-hour bundle and evaluate what you can do to improve the timeliness of treatment in your facility.

Get on Track with Antibiotic Stewardship

A link to the recording of the May 15 event, *Get on Track with Antibiotic Stewardship*, along with a link to the slides is available on the HRET-HIIN website.

Has Your Hospital Considered a Hand-Shake Free Zone as an HAI Intervention?

Read more about this concept here.

Look for application details in future issues of the Innovate-ND Newsletter. Note that this is an HRET-sponsored meeting, not an HRET HIIN-sponsored meeting.

QHA's 2017 Quality Forum
08/10/17 | Fargo, ND

HRET HIIN Road Show
10/02/17-10/03/17 | Fargo, ND

NDHA's 2017 Annual Convention & Trade Show
10/03/17-10/05/17 | Fargo, ND

RESOURCES

LISTSERV®
Sign up and help meet our goal of approximately 1,000 subscribers per LISTSERV® topic. These platforms enable peer-sharing and are used to promote virtual events and highlight innovative topic-specific strategies to reduce harm. New subscribers are added on the first day of each week.

On the Web

New CDC Course: Hand Hygiene, Glove Use and Preventing Transmission of C. difficile

As part of the Clean Hands Count Campaign, the Centers for Disease Control and Prevention (CDC) is offering a new hand hygiene education course: Hand Hygiene, Glove Use and Preventing Transmission of C. difficile. Click here to read more.

NHSN Training

NHSN 2017 training materials have been posted to the National Healthcare Safety Network (NHSN) website. Resources available on the website include:

- Presentations with case studies from the 2017 annual training
- Self-Paced Interactive Computer Based Training Modules
- NHSN Frequently Asked Questions (FAQs)

Topics covered in the training materials include presentations on NHSN definition and rule changes for 2017; CLABSI, CAUTI, MRSA and CDI, VAE, and SSI surveillance updates; new NHSN analysis tools; Reporting MRSA and CDI LabID Data; and analysis of Antimicrobial Use and Resistance. All materials can be found on the NHSN training page.

Updated 2017 interactive self-paced training courses are now available on the NHSN website. Training courses include: Introduction to Device-associated module; CLABSI, CAUTI, VAP, CLIP, MRSA Bacteremia and CDI LabID Event Reporting; Introduction to Procedure-associated module; and SSI. These online courses provide instructional slides with detailed graphics, screen shots with step-by-step examples of form completion for instructional purposes, practice questions, and case study examples. Hyperlinks to the forms, protocols and NHSN manual are available throughout the courses and available for printing if needed. All interactive trainings and NHSN web streaming are available on the NHSN website under "Self-Paced Interactive Training."

The 2017 NHSN Patient Safety Component (PSC) Frequently Asked Questions (FAQ) documents have been posted to the NHSN website and include the following: SSI Procedure Codes; SSI; BSI; UTI; CLABSI; CAUTI; CLIP; VAE; VAP; MDRO/CDI; CDIFF/MRSA; and Miscellaneous. Click here to access the documents.

FALLS

Falls Risk Screening

There is an overreliance of the assigning of a numerical risk score for falls. Basically, all patients are at risk for a fall when in the hospital and their level of risk changes from moment to moment as their physical and psychological condition changes. Fall risk tools will perform differently in different setting and with different populations. Common adult/elder fall risk screening tools that have been validated include:

- Morse
- Hendricks II
- STRATIFY

Fall risk screening should trigger a comprehensive assessment of common risk factors, with associated interventions activated to minimize the risk. These include reviewing medications that increase risk of falls

The HRET HIIN website is a one-stop-shop for all HRET HIIN information and events! Check it out at www.hret-hiin.org.

Social Media
Follow the HRET HIIN on Twitter @HRETtweets! Here they'll be promoting virtual events, highlighting recruitment numbers, state partners and hospitals! Re-tweet, reply or like their posts and share your HIIN journey using #WhyImHIIN.

You can also join the HRET-HIIN on Facebook and LinkedIn. Follow the instructions for joining by clicking on the correlating icon on the right-hand side of the page when you log onto the HRET HIIN website (www.hret-hiin.org)

INNOVATE-ND SUPPORT TEAM
Jean Roland
jroland@qualityhealthnd.org
701/989-6227

Nikki Medalen
nmedalen@qualityhealthnd.org
701/989-6236

Jon Gardner
jgardner@qualityhealthnd.org
701/989-6237

and reducing or eliminating these medications; treating or preventing gait or balance issues through activity and/or rehab services; supporting elimination and toileting needs; addressing orthostatic hypotension, etc. The use of yellow gowns, socks, and other "high risk" signage alone will not prevent falls. The United Kingdom's NICE Guideline: Falls in older people: assessing risk and prevention provides guidance on multifactorial falls risk assessment and interventions specific for older patients

Fall Definition: For the HIIN, report falls with minor injury or greater. Minor injury is defined as any intervention that is applied as a result of the fall (e.g., ice, Band-Aid, pain medication, etc.). Report assisted and unassisted falls, including those in which a patient is lowered to the floor. Fortunately, most assisted falls do not result in injury.

Fall Injury Risk: Don't forget to assess patients for risk of injury. Use the ABCS as part two of fall risk screening to identify patients who can be seriously injured if they do fall. The ABCS include:

- A – Age greater than 85
- B – Bones: osteoporosis, history of fracture, bone metastasis
- C – Coagulation: bleeding disorder or on anticoagulation therapy
- S – Surgery: post-surgical patients

Questions for the Field
What is your process for screening and communicating fall INJURY risk?
Do you have a system to link risk factors with interventions in your care plan that you can share? Do you have a falls care plan?

Reference
Aranda-Gallardo, M., Morales-Asencio, J. M., Canca-Sanchez, J. C., Barrero-Sojo, S., Perez-Jimenez, C., Morales-Fernandez, A., Mora-Banderas, A. M. (2013). Instruments for assessing the risk of falls in acute hospitalized patients: a systematic review and meta-analysis. BMC Health Services Research, 13, 122.

Teach-Back for Fall Safety: Beyond Checking the Box

HRET HIIN hosted a Falls Virtual Event on May 11 focusing on the power of supporting patient autonomy in fall safety. In this event, "*Teach-Back for Fall Safety: Beyond Checking the Box*," national subject matter expert, Patricia Quigley, PhD, APRN, FAAN, FAANP examined how nurses can change the way they speak to patients about fall prevention in a way that can engage and activate the patient, while preserving their dignity and autonomy. Dr. Quigley was followed by a teach-back case study from Summit Healthcare in AZ. Ruth Zimmerman RN, MSN, CPPS and Nanette Garvin RN, BS shared their organization's teach-back implementation story. Takeaways included:

1. The importance of addressing health literacy in patient education materials and other documents, and
2. That teach-back can be slow to adopt, and therefore engaging front line staff and leaders during the initial planning phases can expedite its adoption.

The recording and slides can be accessed here.

Is Orthostatic Hypotension Contributing to Falls in Your Hospital?

As we more actively mobilize patients, it is important that we assess for orthostatic hypotension. Orthostatic hypotension is defined as a systolic blood pressure decrease of at least 20 mm HG or a diastolic blood pressure decrease of at least 10 mm Hg within three minutes of standing up. Orthostatic hypotension has been observed in all ages but occurs more frequently with the elderly, especially those who are sick and frail. It can cause light headedness soon after standing and can contribute to falls.

The Centers for Disease Control and Prevention have developed an instructional and documentation tool for measuring orthostatic hypotension that can be accessed on the HRET HIIN website here.

Non-pharmacological treatments for orthostatic hypotension include:

- Dorsiflex feet several times before standing
- Make slow, careful position changes
- Eat small frequent meals
- Increase salt and fluid intake
- Elevate head of bed 5 to 20 degrees
- Schedule activities in the afternoon
- Wear compression stockings

PRESSURE ULCERS

Wound Ostomy and Continence Society Publishes 2017 Update

Position Statement on the Role and Scope of Practice for Wound Care Providers

The Wound Ostomy and Continence Society published a 2017 update to their position statement on the Role and Scope of Practice for Wound Care Providers. Their scope parameter recommendations are briefly summarized below. NOTE: Practice limits are defined by each state. Each nurse is accountable to practice in accordance with the specific requirements of the licensing board in the state(s) in which the nurse practices:

- WOC Advanced Practice RN (APRN)– Licensed as an Advanced Practice RN – can make medical diagnoses and may have prescriptive authority. Level of autonomy to function independently or in collaboration with a physician is dependent upon the state.
- WOC Graduate-Level Prepared Registered Nurse – Has advanced knowledge, skills, abilities and judgement to function at the level determined by their nursing position. Applies knowledge from advanced preparation to help achieve optimal outcomes for patients with wounds.
- WOC Registered Nurse – Functions under the guidance of an MD or APRN. Provides expert consultation and hands-on care, establishes comprehensive management plans. Performs sharp debridement and chemical cauterization per physician order.
- Wound Treatment Associate (WTA) – Works under the direction of a supervising APRN, WOC specialty nurse or physician. Implements treatment plans and preventative measures, provides ongoing monitoring of wounds.

The scope of practice document can be accessed here. This document supports the WOC Registered RN and above in making treatment recommendations for the prevention and treatment of wounds. Depending upon state law, the WOC APRNs may have prescriptive authority and can initiate treatment orders without a physician order.

READMISSIONS

Readmissions Whiteboard Video Series Released

The HRET HIIN has released a new resource, the readmissions whiteboard video series. This 11-part series is delivered by readmissions expert Dr. Amy Boutwell, HRET HIIN Readmissions SME and developer of the newly released AHRQ Hospital Guide to Designing and Delivering Whole-Person Transitional Care. The purpose of these whiteboard videos is to focus and align with the material in the HRET HIIN Preventable Readmissions change package and top ten checklist. The goal is to facilitate an improved understanding of best practices to test and implement, in order to support organizations' efforts in reducing all cause 30-day readmissions by 12 percent by September 2018.

The HRET HIIN encourages reviewing and utilizing all 11 videos in this series for strategies focused on the development and sustainability of readmissions reduction plans and programs. To support your team's use of the videos, HRET will host "Whiteboard Wednesdays," and post to the LISTSERV® one new whiteboard video each week. Join us in watching one whiteboard video per week and in incorporating these key concepts into your readmission reduction work!

How Does Your Hospital Team Integrate Patient and Family-Centered Care to Reduce Unnecessary Admissions?

During the Joint PfP Readmission Affinity Group and PFE Affinity Group Webinar on 5/23/2017, the Institute for Patient and Family Centered Care (IPFCC) presented their *Better Together: Partnering with Families* initiative. This IPFCC campaign supports hospital leaders with the background, information, tools, and assistance needed to change visiting policies for patients' families. IPFCC has developed a toolkit, which may be accessed here. The toolkit is designed for hospitals at the beginning stages or hospitals in need of additional resources for changing the concept of "families as visitors to families as partners."

The Conversation: A Revolutionary Plan for End-of-Life Care

“A life well-lived deserves a good ending.” What does a good ending mean for you? Your loved ones? Or your patients? Dr. Angelo Volandes is a physician, writer and patients’ rights advocate. He is Co-Founder and President of Advance Care Planning Decisions, a non-profit foundation implementing systems and technologies to improve the quality of care delivered to patients in the healthcare system. In his book, “The Conversation: A Revolutionary Plan for End of Life Care,” Dr. Volandes offers a solution that is medicine’s oldest and least technological tool: talking. Studies suggest there are numerous barriers to communication between doctors and patients. For individuals to be empowered, they must be informed. He calls for a radical re-envisioning of the patient-doctor relationship. He offers ways for patients and their families to talk about the difficult issue of end-of-life choices to ensure that patients are at the center and in charge of their medical care. Dr. Volandes has a considerable amount of experience and has

demonstrated success and clinical benefits of advance care planning, including videos as a tool for empowerment.
Click here to read the full article.

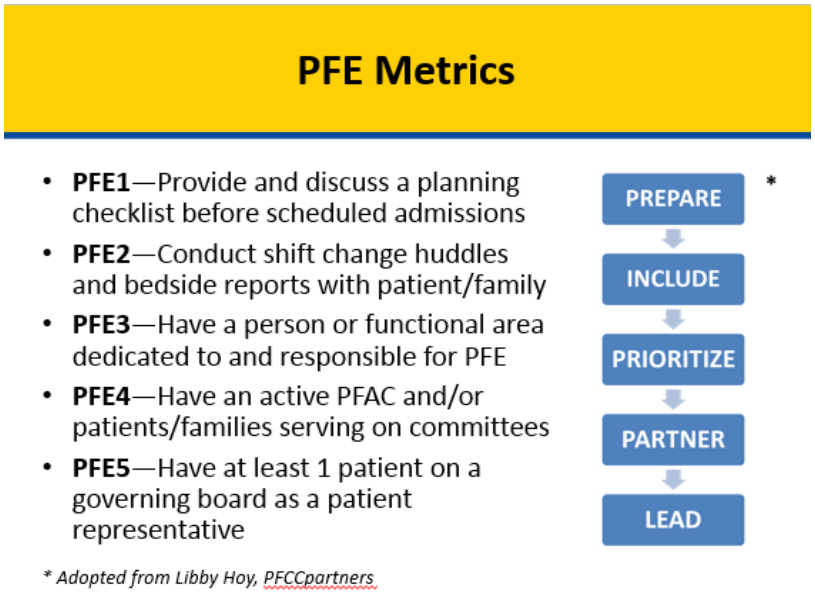
PFE

Highlights from May PFE Learning Event

How to Help Hospitals Get Started on the PFE Journey

In the May PFE Learning Event, representatives from two HIINs - Joy Benn, Minnesota Hospital Association and Boris Kalanj, Hospital Quality Institute (HQI), a partner of Health Services Advisory Group (HSAG) - shared strategies to help hospitals get started on the PFE journey. Joy acknowledged several common barriers to meeting PFE Metrics 3 and 4, including limited resources, but noted that the "willingness to change the health care landscape and make PFE a priority" is what counts. To help create this willingness, the Minnesota Hospital Association uses a multi-pronged approach to support its hospitals, including providing in-person trainings, coaching, networking, and webinars - which all help to create the sense "that we are all in this together." Joy concluded by noting that while the first step in the PFE journey is often the most difficult, but "when we include patients, we see the magic happen and our efforts pay off."

Boris shared HSAG's assessment approach which includes "deconstructing" the five PFE Metrics to get a more precise picture of what is going on, including potential issues and successes, and to get more reliable and consistent data over time. Clinical Improvement Advisors (CIAs) - who serve as HSAG's "field staff" and receive extensive PFE training - lead a facilitated interview with a hospital quality leader to complete the assessment. Boris also shared HQI's "PFE Metric Worksheet," a 1-page reference tool to help hospitals understand the intent of the metrics. Boris noted that the worksheet serves both as a measurement tool and an intervention as it creates the opportunity for in-depth discussion about each of the PFE metrics.



Christine O'Farell, the Director or Quality Management at Barton Healthcare - a small hospital in South Lake Tahoe, California and a

member of the HSAG HIIN - shared Barton's experiences and lessons learned related to launching a Patient and Family Advisory Council (PFAC) in 2014. Christine emphasized the importance of leveraging leadership buy-in and using evidence-based practices. She also emphasized that limited resources should not be a barrier, noting that the Department of Quality Improvement "started on a shoestring," and partnered with the Department of Public Relations to provide materials and snacks at the PFAC meetings. Today, Barton's annual PFAC budget of about $500.00 covers snacks and supplies for the meetings. Christine also noted that in previous years the CalHEN has covered some expenses for their PFAC members to attend a conference.

The slides and a recording of the event are available here.

Spotlight on Dominican Hospital

An important catalyst for improved patient care within the NICU of Dominican Hospital (member of Dignity Health HIIN) has been their Family Advisor Council. "We've always had a family atmosphere here but our Council has really deepened our connection to our patients and families," shares Michele Fahrner, BSN, MSN, RNC-NIC, Nurse Director of Maternal Child Health. Started in 2012, the group meets quarterly and consists of five nurses and five families with additional families supporting particular initiatives. Families have a one-year term limit so new voices can always be included. "It's important to get a new generation of families so they can offer feedback on what is currently happening," explains Fahrner.

The group has had several wins including improvements to a patient binder, which contains information about newborn care, breastfeeding, charting baby weight gain, a flyer about their Family Advisor Council among other materials. Additionally, the group took over the planning for the annual NICU reunion to great success. "They've made it amazing," says Fahrner. "We now invite families from five years back not just two. And we've taken it off-site and added a game station, a photo booth, and face painting by fairies, cowboys and pirates."

A hospital-wide initiative about car seat safety began when a parent raised her concerns at a family advisory council. "One of the nurses brought it back to me and I said, 'Go see what's out there,'" says Fahrner. "Because of that, we paid for our nurses to be trained as car seat techs and held bimonthly events to teach parents how to install their car seats correctly. From there we took it even further to where we have our foundation funding an in-house car seat tech who teaches all parents before they go home on how to install their car seat correctly. We now have this fantastic program that started from a parent's suggestion."

Although leadership support is essential, Fahrner urges units looking to start a council to empower their nursing staff to take charge.

Patient and Family Voices

"*A Terribly Wrong Turn*" | Kelly Parent, IPFCC, PFE Contractor

At any given moment, our lives can dramatically change. In 2003, my life took a "terribly wrong turn" when my husband and I were told that our daughter had cancer.

Our daughter's treatment consisted of 14 months of surgery, radiation therapy, and chemotherapy. Somewhere in that timeframe, I started realizing that I needed to do something in response to this " terribly wrong turn." In retrospect, there were many conversations with family and friends that started me on the path to becoming an advocate for patients and families living with and through illness and injury. However, one memory distinctively stands out in regard to why I chose to work toward creating a health care culture that embraces the engagement of patients and families in their care.

My daughter and I were watching a story about AIDS-orphaned children in Africa - children her age who were serving as parents for their younger siblings. She looked at me and said something along the lines of, "In America, people might die young but at least they had a good life when they were alive. But in Africa, people die young and their lives were not as good as ours in America."

The correctness of this statement was not up for debate; rather this was a perception of the world as seen through the lens of a 9-year-old little girl in the battle of and for her life. Hearing her words that were so self-reflective, so strong, and so selfless despite what I viewed as a "pretty crappy life" of surgery, chemo, and radiation, stopped me in my tracks. She opened my eyes so I may see those outside of myself and stop - or at least slow down - feeling sorry for her and our family. She gave me the strength, direction, and conviction to move into action.

I am so fortunate to be able to help patients and families navigate complex healthcare systems, engage in care planning and decision-making that reflects their goals, values, and beliefs, ask questions and correct inaccuracies, and accept nothing short of dignified and respectful care. The reward of helping others is the silver lining to our family's "terribly wrong turn."

Today more than ever, we need to help each other: people helping people. Contact your local healthcare institution to find opportunities where you may share your wisdom and advice helping others who are following in your healthcare footsteps.

6 Steps to Creating a Culture of Person and Family Engagement in Health Care

Developed by Planetree International and the Patient-Centered Primary Care Collaborative Support and Alignment Network, with assistance from the Institute for Patient- and Family-Centered Care (IPFCC), this toolkit is designed for health care practices participating in the Transforming Clinical Practice Initiative (TCPI). The toolkit may also be valuable to any practice seeking strategies to improve PFE and provides guidance on creating a culture that emphasizes and incorporates PFE in every aspect of care, to ultimately improve quality of care.

Culture of Safety

Hospitals Against Violence Hope Day of Awareness

Join AHA/HRET on June 9 to participate in the AHA's Hospitals Against Violence Hope (#HAVhope) Day of Awareness. #HAVhope will

focus national attention on ending all forms of violence through a digital media campaign – shared tweets, posted photos and other online efforts. Please participate in the following ways:

- Use #WhyImHIIN and #HAVhope on social media to highlight your work or commitment to combat violence in your community or workplace. You can use AHA's Telling the Hospital Story toolkit to help guide these efforts.
- Share a photo on June 9 using #WhyImHIIN and #HAVhope on social media of yourself holding hands with others in your community or workplace committed to combating violence. This collection of photos will provide a visual to demonstrate that we stand together to combat violence.

Senior Leadership Resources for Enhancing Safety Cultures

Two recent publications provide valuable information to facilitate the journey to develop cultures of safety and high reliability in hospitals.

- The Institute for Healthcare Improvement (IHI) and Safe & Reliable Healthcare collaborated to produce a white paper describing a framework for safe, reliable and effective care. The paper describes the two foundational domains of the culture and the learning system, and outlines the component parts of each to support organizations in defining and advancing a system of safety.
- The American College of Healthcare Executives and the National Patient Safety Foundation's Lucian Leape Institute published **Leading a Culture of Safety: A Blueprint for Success.** This guide is a resource to support health care leaders in developing a culture of safety in their organizations. The resource provides strategies, tips, and self-assessment tools to assist organizations in advancing cultural change.

New "Blueprint" Guides Leaders in Building a Culture of Safety

Patient safety experts have increasingly pointed to the roles of organizational culture and leadership in the success of patient and workforce safety initiatives. *Leading a Culture of Safety: A Blueprint for Success* is a new evidence-based resource developed by the American College of Healthcare Executives (ACHE) and the NPSF Lucian Leape Institute (LLI). ACHE and the LLI (an NPSF program that is now part of IHI) partnered with progressive health care organizations and experts in leadership, safety, and culture to identify strategies known to contribute to a culture of safety. Leaders can use the Blueprint to guide their organizations' culture transformation.

Change Package Update

The Culture of Safety change package has been released! Change packages for Malnutrition and VTE will be available by the end of next week. Change packages for Diagnostic Error and Antibiotic Stewardship are in development and scheduled to be released in July.

DIVERSITY

Take the AHA 123FOREQUITY Pledge

HRET challenges every HRET HIIN hospital leader to commit to the following:

1. **TAKE THE PLEDGE** – Pledge to begin taking action to achieve the National Call to Action goals to help ensure equitable, safe care for all persons in every community.
2. **TAKE ACTION** – Implement strategies that are reflected in your strategic plan and supported by your board and leadership. Provide updates on progress to the AHA and your board in order to gauge progress, and develop tools/resources to support your work.
3. **TELL OTHERS** – Achieve the goals, be recognized and tell your story. Share your learnings with others in conference calls and other educational venues, including social media, to accelerate progress and demonstrate to the public our collective commitment.

For more information and to take the pledge, click here.

MISCELLANEOUS

Improving Nurse Communication with a 56-second Strategy
Using nurse communication to deliver compassionate care is a high priority in the business of healthcare, especially considering the unique impact nurses have on the patient experience. Read the full story.