North Dakota Hospital Association

Innovate·ND

HRET Hospital Improvement Innovation Network

August 15, 2017

EDUCATIONAL EVENTS

HRET HIIN

HRET HIIN Readmissions | Community Partnerships: What Are Your Peers Doing?
08/17/17 | 11:00 a.m.-12:00 p.m. CT

HRET HIIN | PFE Fundamentals | Session #5: Using Stories to Impact Change
08/22/17 | 11:00 a.m.–12:00 p.m. CT

HRET HIIN | Opioid Safety Fishbowl Series 4
08/24/17 | 11:00 a.m.–12:00 p.m. CT

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

TMIT High Performer Webinars

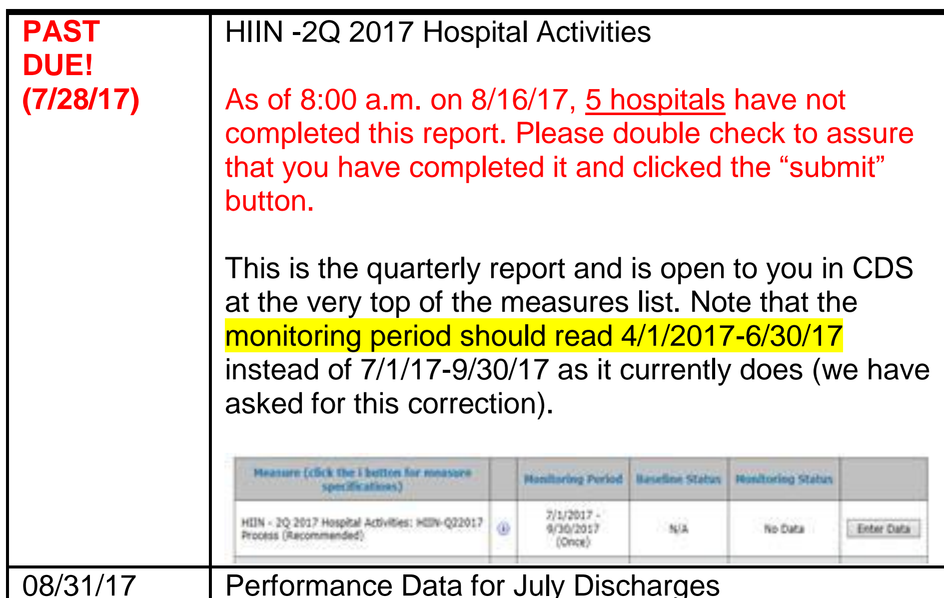
Sepsis: Bringing it All Together Part 3
08/17/17 | 12:00–1:30 p.m. CT
Register here.

New England Quality Innovation Network

Promising Practices – Incorporating Pharmacists into the Care Continuum
08/22/17 | 11:00 a.m.–12:00 p.m. CT Register **here**.

IMPORTANT DATES TO REMEMBER

Remember to report your HIIN data in CDS every month!



PAST DUE! (7/28/17)	HIIN -2Q 2017 Hospital Activities As of 8:00 a.m. on 8/16/17, 5 hospitals have not completed this report. Please double check to assure that you have completed it and clicked the "submit" button. This is the quarterly report and is open to you in CDS at the very top of the measures list. Note that the monitoring period should read 4/1/2017-6/30/17 instead of 7/1/17-9/30/17 as it currently does (we have asked for this correction).
08/31/17	Performance Data for July Discharges

Measure (click the i button for measure specifications)		Monitoring Period	Baseline Status	Monitoring Status	
HIIN - 2Q 2017 Hospital Activities: HIIN-Q22017 Process (Recommended)	i	7/1/2017 - 9/30/2017 (Once)	N/A	No Data	Enter Data

QUALITY MILESTONES RECOGNITION

COPPER Milestone:	**COPPER, BRONZE & SILVER Milestone:**
Jacobson Memorial Hospital Trinity-Kenmare Community Hospital Mountrail County Medical Center Nelson County Health System Unity Medical Center	
COPPER & BRONZE Milestone:	**COPPER, BRONZE, SILVER & GOLD Milestone:**
Ashley Medical Center Carrington Health Center Cavalier County Medical Center Cooperstown Medical Center First Care Health Center Heart of America Medical Center Linton Hospital McKenzie County Memorial CHI Mercy Health-Valley City Northwood Deaconess Pembina County Medical Center	

Great Plains QIN/Quality Health Associates

Bismarck Care Coordination Community Collaborative Quarterly Meeting
08/23/17 | 11:30 a.m.–1:00 p.m. CT
Baptist Health Care Center, Bismarck
RSVP jayme.steig@area-a.hcqis.org

Great Plains QIN

Give "Just" the Vaccine
08/23/17 | 12:00-1:00 p.m. CT
Register here.

National Learning and Action Network

Understanding Physician-to-Patient Communication Strategies to Avoid Unnecessary Antibiotic Prescribing
08/30/17 | 2:00–3:30 p.m. CT
Register here.

Great Plains QIN/Quality Health Associates

Fargo/NW MN Community Quarterly Meeting
09/13/17 | 3:00-4:30 p.m.
Dakota Medical Foundation, Fargo
Register here.

Honoring Choices ND

Improving the Quality of Life: It starts with Competent Caring Conversations
09/18/17 | 9:00 a.m.-2:45 p.m. CT
Dakota Medical Foundation | Fargo

Advance Care Planning | Facilitator Training
10/05/17 (Registration deadline Sept. 10)
Dickinson, ND
11/02/17 (Registration deadline Oct. 19)
Grand Forks, ND

If you are interested in registering or would like additional information, please contact Sally May via email at sally.may@honoringchoicesnd.org or call her at 701.989.6228.

NATIONAL PATIENT SAFETY FOUNDATION WEBCASTS

Presentation Medical Center Sakakawea Medical Center Sanford-Hillsboro Sanford-Mayville SW Healthcare Services St. Aloisius Medical Center St. Andrew's Hospital St. Luke's Hospital Tioga Medical Center Towner County Medical Center Wishek Community Hospital CHI Mercy Health – DL CHI St. Alexius Health – Garrison CHI St. Alexius Health Community Memorial Hospital – Turtle Lake	
COPPER, BRONZE, SILVER, GOLD & PLATINUM Milestone:	

Thank you to everyone who quickly responded to my emails regarding outliers and data questions in an effort to assure that our data is as clean and accurate as possible! *Nikki*

Welcome to the HRET HIIN participating hospitals who most recently agreed to participate in the new outpatient antibiotic stewardship initiative! They are: **Towner County Medical Center,** Cando (ED and clinic); **First Care Health Center,** Park River (ED); **Tioga Medical Center** (ED and clinic); **CHI Mercy Health,** Valley City (ED); **Nelson County Health System,** McVille (ED and clinic); **Mountrail County Medical Center**, Stanley (ED and clinic); and, **Jacobson Memorial Hospital and Care Center,** Elgin (ED and clinics).

Recruitment for this initiative ended July 31. The QHA team is looking forward to the work that lies ahead and the privilege of expanding the scope of their work with all of these hospitals!

Advance Care Planning

Sally May | ***Senior Quality Improvement Specialist*** **| Great Plains QIN/Quality Health Associates**

Did you know:

- **90% of people say that talking with their loved ones about end-of-life care is important but only 27% have.**
- **82% of people say it's important to put their wishes in writing but only 23% have actually done it.**

Maybe it is the time to say, "The time to change this is now." Having trained First Steps® Advance Care Planning Facilitators at your facility or within your organization demonstrates your commitment to providing the care or service that reflects the values, goals, and preferences of the individuals and families you serve.

Respecting Choices® First Steps® ACP Facilitator Certification is designed for social workers, nurses, clergy, physicians and others who

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

ND Department of Human Services Behavioral Health Conference
09/27/17-09/29/17 | Bismarck, ND
More details coming soon.

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®

want to assist adults age 18 and older identify the importance of advance care planning (ACP), reflect on their personal values and beliefs, and communicate their care preferences for when they are unable to do so for themselves. This training is designed to help participants develop the skills needed to facilitate advance care planning discussions with any adult. It is not designed for individuals to become advance care planning facilitator instructors. There are 6.75 continuing education units/hours for nurses and social workers available for the face-to-face training. Contact hours are also available for the online modules and continuing education units.

See upcoming training dates in your area in the left column. For more information or to request a training brochure, please contact Sally May via email at sally.may@honoringchoicesnd.org or call her at 701.989.6228. Please contact her to register as early as possible. A minimum of 12 registrants is required to hold the training events.

ADEs

Agency for Health Research Quality (AHRQ) Posts Opioid Data

AHRQ has published an interactive map of trends in opioid-related hospitalizations. The map which includes state by state data between 2004-2014 can be found [here](#).

How is Learning Creating Action?

On July 20, the HRET HIIN held Opioid Safety Fishbowl Event #3, "How is Learning Creating Action?," as we followed the efforts of four hospitals to reduce naloxone use:

- In Alabama, Medical West is working to reduce over-sedation in patients with Obstructive Sleep Apnea.
- In Texas, Baylor Denton is working to reduce oral and IV layering of post-op CABG patients.
- In Louisiana, Slidell Memorial is testing how to better assess pain management and sedation on the medical-surgical floors.
- In Massachusetts, Newton-Wellesley is working with the GI department to reduce the use of naloxone in the endoscopy unit and to reduce or eliminate the use of meperidine.

The recording and slides can be accessed [here](#). The table below lists the collective learnings from this event and some suggested resources.

Learnings and Opportunities for Improvement	Suggested Action Items and Resources
▪ Change is messy. You can't know everything you need to know before you start! ▪ Engage leaders and keep them engaged ▪ Show the data! ▪ Work with the willing ○ Get buy in, "enroll" ▪ Go to the "gemba" to enhance your understanding of what *actually* happens	Resources: ▪ Grab a copy of [The Improvement Guide: A Practical Approach to Enhancing Organizational Performance](#), by Langley et al. It is the basis of the Model for Improvement. Action Items: ▪ Find your champions

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

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

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○ Go watch the current process ○ Interview participants ▪ Segment: start small and test the easier scenarios ○ Get it right before you take on tougher challenges ▪ Successful change takes multiple PDSA testing and learning cycles ○ You will likely need to change your process each time ○ You may need to change your data collection tools and methods along the way ▪ Take advantage of existing structures, such as huddles, to collect feedback and get input ▪ Make data collection easy ▪ Tap into existing tools and processes and add effective tools into the workflow ▪ Appreciate the pace and continuum of change ▪ When engagement is not forthcoming, change the message and the messenger ▪ Slow and steady wins the race! ▪ *Education is necessary but never alone sufficient!*	▪ Start small and start easy ▪ Embrace small failures ▪ Have fun!
Tips on Preventing Over-sedation	**Suggested Action Items and Resources**
▪ Use balancing measures ○ In your zeal to reduce naloxone use, make sure you are not under-sedating patients and causing avoidable pain ▪ Incorporate the Pasero Opioid-Induced Sedation Scale (POSS) into the EMR workflow ▪ Hardwire the patient's use of CPAP into pre-op assessment ○ A "yes" answer triggers other specific actions ▪ Hardwire the STOP BANG questionnaire into the pre-op assessment ○ Moderate or High Risk then triggers specific actions	▪ HRET HIIN ADE Change Package available here ▪ POSS available here ▪ STOP BANG available here

HEALTHCARE-ASSOCIATED INFECTIONS

Updated NHSN Resource Available

The "NHSN Guide to the SIR" has been updated to incorporate the corrected CAUTI Models that were implemented and announced on Friday, July 21. Click here to download the guide.

Indwelling Urinary Catheters | When Are They Indicated?

An Ann Arbor article by Dr. Jennifer Meddings is **THE** resource on appropriate indications for urinary catheters. Click here to access the article.

Indwelling urinary catheter not indicated? Consider alternatives. Click here to link to a CAUTI virtual event focusing on alternatives to urinary catheters.

Strategies to test to create buy in and ownership:

- Ask the ICU physicians and nurses which types of patients they agree do NOT require an indwelling urinary catheter to create a shared mental model.
  - Patients admitted to ICU for a technology or nursing service not available on non-ICU unit, but without an illness for which hourly urine output guides care, such as: BiPAP, frequent neuro checks, insulin drips, chronic trach/vent.
  - Patient has stabilized – no longer tenuous status (example: patient with sepsis, who is no longer requiring aggressive fluids or pressors).
  - "Floor status" patient – located in ICU but awaiting availability of non-ICU bed
  - Patient with very little urine output for days – none to measure
- Appoint physician and nursing CAUTI Champions
- Ask staff for feedback on current alternatives. Is the quality of your under pads adequate, do you have female urinals available? What else do staff need?
- Coach nurses to ask physicians to describe HOW hourly output is being used to adjust in care when "accurate measurement of hourly output in critically ill patients" is listed as the indication (examples include: management of hemodynamic instability, hourly titration of fluids, drips (e.g., vasopressors), or life-supportive therapy

Other suggestions shared on other venues:

- Daily utilization rounds on every patient with a catheter
- Inclusion of catheter utilization in interdisciplinary clinical rounds at bedside.
- Track Catheter day # and include that information on the whiteboard and in handoffs
- Limit access to indwelling catheter kits – keep in medication dispensing cabinets
- Post utilization numbers by unit in a timely basis
- Determine where they are being inserted – ED, OR and target ED avoidance tactic and OR prompt removal in the PACU

Recommendations to Optimize Antibiotic Use Among Nurses

Nurses are a cornerstone of quality patient care. Because they work around the clock in a variety of healthcare settings, they're able to significantly impact patient safety through improved antibiotic use.

The American Nurses Association (ANA) recently released a white paper outlining how nurses can optimize antibiotic use and provide safer, better patient care. The white paper focuses on nurses' role in antibiotic stewardship efforts in four key areas:

- How bedside nurses can improve antibiotic use
- How to improve nurses' participation in antibiotic use activities – at both national and hospital levels
- Education and training for nurses
- How to engage nursing leaders in antibiotic stewardship efforts

To learn more about appropriate antibiotic use, click here.

FALLS

Falls Webinar Posted

The 7/11/17 Falls Event: ***Hit the Wall on Falls? Time to Recalibrate!*** is now available: HRET HIIN Resource Library. In this back-to-basics event, National Subject Matter Expert, Amy Hester, PhD, RN, BC, reviewed fall risk screening and targeted care planning as the cornerstone of any fall prevention improvement effort. Below is a summary of the key points from the event and suggested action items and resources to support your work.

What we learned from Subject Matter expert, Amy Hester, about optimal fall risk screening and care planning processes.	Suggested Action Items / Resources
Fall Risk Screening ▪ Assess the predictive value of your fall risk screening tool ▪ Understand that a falls risk tool only assesses for anticipated physiological falls. Accidental falls from tripping and slipping hazards are addressed with "universal fall precautions" ▪ Review alternative tool if your current tool is under- or over-predicting fall risk ▪ Determine when reassessment should occur	▪ Review RAND Review of the Evidence on Falls Prevention in Hospitals 2012 for a comprehensive review of falls screening tools and associated evidence. RAND Review ▪ Understand which clinical conditions are correlated with your organization's "faller" profile. ▪ Ensure your post-fall huddle tool includes information on types of falls – anticipated physiological, unanticipated physiological, accidental, behavioral or developmental. See CAPTURE Falls post fall huddle form as an example.

Falls Care Planning
▪ Do not plan care based upon a score alone. Align interventions to address individual risk factors, including risk for injury.
    ○ Elimination issues
    ○ Altered mobility
    ○ Altered cognition
	Team up with non-clinical departments to manage environmental risk:
	▪ "Clutter rounds," cord management
	▪ Assess for sharp edges in bathrooms and remove/replace

◦ Polypharmacy ◦ Orthostatic BP ◦ Risk for injury ▪ Universal Fall Precautions target accidental falls. All patients are at risk for accidental falls. ▪ Engage patients and families as partners in fall safety. Use teach-back to review fall and injury risks, safety precautions and the consequences of a fall. ▪ Material resources for Falls Care planning should include injury prevention equipment such as floor mats and low beds as well as gait belts, non-skid footwear, signage, lap belts and chair wedges, bedside commodes, enclosure beds and video surveillance.	▪ Assess door thresholds for trip hazard ▪ Assess toilet height and grab bars ▪ Safe Environment Guidelines for Toileting Sample Universal Fall Precautions: ▪ Maintain clutter-free environment ▪ Orient patient to surroundings ▪ Keep bed in low positon when patient is in bed ▪ Raise bed for transfers and care ▪ Keep top 2 side rails up ▪ Call light and personal possessions within reach ▪ Adequate lighting ▪ Patient/Family education with teach-back ▪ Use proper fitting non-skid footwear ▪ Address any equipment that tethers the patient. Sample Risk Factor based falls care plan: NICE Fall Risk Assessment and Management Tool Injury Prevention Interventions: ▪ Low beds, floor mats, hip protectors, helmets ▪ Injury Prevention Toolkit ▪ Read Amy Hester's Article: Preventing Injuries from Patient Falls Teach-Back Resources: • Teach Back Event Recording • HRET Teach Back Tool • HRET Fall Prevention Tips for Patients
Key Elements of an Effective Falls Program ▪ Screen for fall risk **AND** injury risk ▪ Plan care based upon individual risk factors ▪ Include injury prevention in plan of care for high injury risk patients ▪ Engage patients and families using teach-back	Monitor these key elements on an ongoing basis. Collect process measure data: ▪ % of patients screened for injury risk ▪ % of patients with an individualized fall care plan to address risk factors, including injury risk ▪ % of patients with documented teach-back for fall safety
What we heard/learned from the audience:	**Summary of Action Items / Resources**
Participant responses about which falls screening tool they are using: ▪ Morse – 41% ▪ Hendrich II – 10% ▪ John Hopkins – 8% ▪ Developed in house – 20% ▪ Other – 17% STRATIFY and Schmidt	▪ Choose a method to start screening for risk of injury. Integrate the screening into the fall risk documentation and include injury risk in handoffs and in signage. Two tools: ◦ Safe from Falls Gap Analysis

Participant-responses about how a fall plan is established at their facility: ▪ High or low risk bundle – 43% ▪ Individual Interventions automatically activated based upon risk – 30% ▪ Individual interventions are manually selected 24% **Participants stated that injury risk is assessed by:** ▪ ABCS – 24% ▪ Patients on blood thinners flagged – 6% ▪ Not screening for injury risk – 53% **Participants were polled on most frequently used interventions. Top 4:** ▪ Signage, wristbands - 10 ▪ Bed alarms - 10 ▪ Hourly Rounding - 9 ▪ Medication Review - 8	o ABCS Injury Risk Assessment ▪ If your fall risk screening tool is over- or under-predicting fall risk, assess the specificity and sensitivity of your Risk Screening Tool using the Fall Tool Predictive Value Worksheet ▪ Reevaluate your bed alarm utilization. Review the Falls Webinar Recording: Fall Prevention Myth Busters to learn about the lack of evidence related to popular fall interventions. ▪ Read the JAMA article: False Bed Alarms, A teachable moment

Teach-Back Tool for Falls Prevention

The HRET team recently released a new resource, the HRET HIIN Teach-Back Tool for Falls Prevention. The purpose of this tool is to guide nurses in key components of teaching fall prevention to patients and families and provide teach-back questions that can be used to evaluate the patient's understanding.

This tool was developed based on Health Literacy, the National Patient Safety Foundation's Ask Me 3 (www.npsf.org/askme3) educational program designed to encourage patients to ask their healthcare providers three good questions: What is my main problem? What do I need to do? Why is it important for me to do this?

During the May 14, 2017, HRET HINN Falls Webinar "Teaching for Fall Safety," Pat Quigley presented the background, context and use of this Fall and Fall Injury Prevention Teach Back Tool. This webinar can be viewed by clicking here.

If anyone would like to chat about using this tool, designing program evaluation to determine your teaching effectiveness, and/or redesigning this tool based on your specialty patient population's fall and fall injury prevention, contact Pat Quigley (pquigley1@tampabay.rr.com). She will be happy to assist you. This may be an exciting opportunity for your Fall and Fall Injury Prevention Committee as you plan for National Fall Prevention Awareness Day, September 22!

Pressure Ulcers

Pressure Ulcer Prevention | Insights from the Expert

Jackie Conrad RN, BS, MBA, RCC™| *Improvement Advisor* | Cynosure Health

Hemodynamic instability in the ICU and the use of vasopressors may increase the risk of pressure injury. Patients in the ICU setting may also have multiple tubes and devices, including a ventilator, sequential

compression devices, and multiple catheters and lines. They may also be required to have the head of the bed elevated for clinical reasons. These clinical conditions may potentially contribute to a patient's inability to be turned regularly to relieve pressure over bony prominences.

Hemodynamic instability is often cited by nurses in the ICU setting as a reason not to turn a patient. This condition is characterized by BP lability, brady or tachycardia, systemic hypotension, hypoxameia and/or hypo-perfusion. It can also be affected by decreased and systemic vascular resistance from sepsis.

In a study published in Wound Care and Ostomy Management in April/July 2017, the frequency of "Do Not Turn" (DNT) as a precaution was explored. A total of 4,075 ICU patients were included from four hospitals. Only **six** of 4,075 patients included were considered a DNT patient. All six of the patients that could not be turned had a diagnosis of cancer, three of which whom expired during their admissions. The results were surprising in that ICU patients can and are being turned. When a patient was unable to be turned completely, nurses could reposition using slow, small, gradual turns allowing time for stabilization of hemodynamic and oxygenation status and some reperfusion of skin tissue.

Despite hemodynamic instability, skin-saving measures can safely be implemented in critically ill, sepsis patients. See the new HRET HIIN Sepsis/HAPI Top 10 Checklist for targeted, evidence-based interventions that address the cascade of symptoms of sepsis with ten practical interventions.

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The sacral region is the most frequent anatomical location for pressure injuries due to the following factors:

- Pressure from supine positioning
- Friction and shear during repositioning and from sliding down in bed
- Moisture from incontinence and perspiration

See the Sacral Injury Prevention Top 10 checklist for practical, evidence-based interventions that will prevent injuries to this vulnerable location.

Sacral prevention Tip # 6 reads: "Apply a **multilayered soft silicone bordered dressing over the sacrum** of critically ill patients. Apply the dressing in the **Emergency Department** for patients likely to be admitted for surgery or to critical care."

Application **in the ED** is important as an early skin-saving measure to prevent friction and shear while awaiting admission.

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As safe patient handling has become a priority, the use of lifting equipment and slings is becoming more prevalent. Removal of the sling after each use is recommended, but may be impractical. The National

Pressure Ulcer Advisor Panel published a NPUAP White Paper on this topic with the following findings:

1. Results of a literature review reveals a lack of high level evidence to guide clinical practice.
2. One citation reports that leaving slings in place under patients has not increased skin damage or pressure ulcers.
3. In a study with 180 healthy adults on a standard support surface, there was no statistically significant difference in pressure, sacral temperature and sacral pH in patients with and without slings.

The 2014 International Pressure Ulcer Guidelines support the use of manual lifting aids to reduce friction and shear, and state “Lift - don’t drag – the individual while repositioning.” Successful implementation of safe patient handling equipment may be facilitated by leaving slings in place so that staff can use them immediately whenever necessary to facilitate turning and repositioning.

Here is the conundrum: mechanical lifting device slings add a barrier layer over a support surface that could reduce the efficacy of the surface, yet the clinical impact is not fully researched. The impact of timely repositioning and mobilization without dragging also has merit. The risk and benefit of slings left in place must be carefully considered for each individual patient. Nurses must consider the sling materials, the support surface, and the patient’s weight and moisture status when determining the best course of action.

READMISSIONS

Readmissions Fishbowl Series #3 | Coaching Tips/Lessons Learned

During the virtual learning event, the following coaching tips and lessons learned were offered:

- Establish expectations, such as post discharge visits, while the patient is still hospitalized.
- Think beyond the doctor for timely post discharge visits. Can you increase access using nurse practitioners or other providers?
- Keep at it! Making changes, particularly in information systems, can require several conversations. Think about what you can do to test while you are waiting for IT changes.
- Some tips for success doing post discharge calls: make sure you have the right number and inform the patient that they will be getting the call. Think about pulling in other providers such as respiratory therapy. Also, it seems helpful to say upfront that you are not calling about billing.
- Use your Patient and Family Advisors to interview readmitted patients.
- Join the CMS challenge! Interview 5 readmitted patients using the ASPIRE Tool 2: Readmission Review Tool. Report your findings and learnings to your state hospital association contact.
- Drill down on medication issues to determine the root causes. Be proactive about medication affordability. Some solutions are: Walgreen's kiosk, discounted medication programs and website resources such as www.needymeds.com and www.amion.com
- Develop strategies to communicate with your physicians using systems such as TigerText.

Additional reducing readmissions resources

- Updated 2017 Preventable Readmissions Change Package
- Updated 2017 Preventable Readmissions Top Ten Checklist
- HRET HIIN Readmissions Whiteboard Video Series
- AHRQ Hospital Guide to Designing and Delivering Whole-Person Transitional Care

You can view the virtual event and download the presentation slides here.

PATIENT AND FAMILY ENGAGEMENT

Sitting While Communicating…A Successful Strategy! Will You Commit To Sit?

Nurses and healthcare providers that sit down during patient communications raised patient satisfaction from the 9th to the 43rd percentile. In addition to this study, there are benefits to sitting when communicating with those with dementia.

When residents are seated, it may seem to them as if staff who are standing are looming over them. Experts suggest staff sit down when talking to residents. This mini-poster gives the point of view of the resident. Download here. *Tip: Post in your center where caregivers congregate to promote use of this simple but effective communication approach.*

DIVERSITY

Playbook Offers Strategies for Effective Hospital-Community Partnerships

The AHA's Health Research & Educational Trust affiliate has released a new resource to help hospitals partner with their communities to achieve a culture of health. Developed with support from the Robert Wood Johnson Foundation, the "playbook" outlines strategies and lessons learned from 10 strong hospital-community partnerships. Stay tuned for a coming compendium of case studies.