North Dakota Hospital Association
Innovate-ND
HRET Hospital Improvement Innovation Network

November 11, 2017

Educational Events

HRET HIIN

Get UP | Early Mobility Matters: In & Out of the ICU
11/16/17 | 1:00–2:00 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.

Partner Educational Events

PfP PFE Monthly Learning Event | How to Help Hospitals Engage Physicians and Frontline Staff in PFE
11/14/17 | 1:00-2:00 a.m. CT
Click here to register.

Centers for Disease Control & Prevention | CDC TAP Strategy, Part I | Running and Interpreting NHSN TAP Reports
11/14/17 | 11:00 a.m.-12:00 p.m. CT
Click here to register.
Dial-in Number: 1-877-280-9413
Pass Code: 84754138

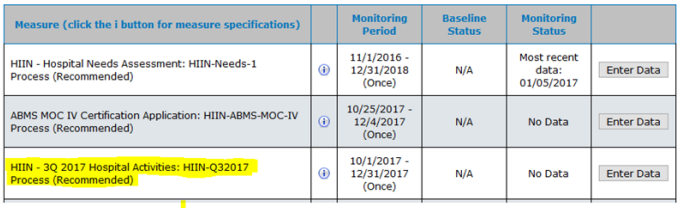
Texas Medical Foundation QIN
Outpatient Antibiotic Stewardship Across the Continuum of Care: A Community-Driven Approach
11/15/17 | 12:00-1:00 p.m. CT
Click here to register.

Great Plains QIN
The Big Picture of Diabetes Self-Management Education
11/16/17 | 12:00-1:00 p.m. CT
Click here to register.

Important Dates to Remember

Remember to report your HIIN data in CDS every month!

Deadline	Reporting Period
11/27/17 12/01/2017	Performance Data for October 2017 Discharges 3rd Quarter 2017 Hospital Activities Report in CDS. This appears as the 3rd measure in the list of measures in CDS. Please note that although the monitoring period states 10/1/17–12/31/2017, this is actually for the period 7/1/2017-10/31/2017, the 3rd Quarter of 2017. Please complete this report by December 1. It should take approximately 15-20 minutes to complete. We encourage you to include a team approach to completing this report that includes executive leadership.



Measure (click the i button for measure specifications)		Monitoring Period	Baseline Status	Monitoring Status	
HIIN - Hospital Needs Assessment: HIIN-Needs-1 Process (Recommended)		11/1/2016 - 12/31/2018 (Once)	N/A	Most recent data: 01/05/2017	Enter Data
ABMS MOC IV Certification Application: HIIN-ABMS-MOC-IV Process (Recommended)		10/25/2017 - 12/4/2017 (Once)	N/A	No Data	Enter Data
HIIN - 3Q 2017 Hospital Activities: HIIN-Q32017 Process (Recommended)		10/1/2017 - 12/31/2017 (Once)	N/A	No Data	Enter Data

Quality Milestones Recognition

COPPER Milestone:	COPPER, BRONZE & SILVER Milestone: McKenzie County Healthcare System Sanford Hillsboro Medical Center
COPPER & BRONZE Milestone: Ashley Medical Center Carrington Health Center Cavalier County Memorial Hospital CHI Mercy Health – Valley City CHI St. Alexius – Devils Lake CHI Community Memorial Hospital – Turtle Lake CHI Garrison Community Hospital Cooperstown Medical Center First Care Health Center – Park River Heart of America Medical Center	**COPPER, BRONZE, SILVER & GOLD Milestone:**

TMIT
Sepsis and Triage: Maximizing Safety of Incoming Patients
11/16/17 | 12:00-1:30 p.m. CT
Click here to register.

AHA's and the Institute of Diversity in Health Management Three-part Equity of Care Award Webinar Series
11/20/17 | 12:00-1:00 p.m. CT
Click here to register.

ND Department of Health, Disease Division | Antibiotic Stewardship in CAHs
11/21/17 | 12:00-1:00 p.m. CT
Registration and access information forthcoming.

Great Plains QIN
Prescription Drug Monitoring Programs, Part II | Best Practices and Overcoming Barriers
11/28/17 | 12:15-12:45 p.m. CT
Click here to register.

North Dakota Antibiotic Stewardship Facilitated Discussion with Subject Matter Experts
11/30/17 | 11:30 a.m.-12:30 p.m. CT
No registration is necessary!
Dial-in #(800) 251-5450
Conference ID 100-6227 #

Great Plains QIN
Dream Teams – vs – Scream Teams: The Art & Science of Building Effective Leadership Teams
12/05/17 | 12:00-1:00 p.m. CT
Click here to register.

Centers for Disease Control & Prevention
CDC TAP Strategy, Part II | Assess
12/12/17 | 11:00 a.m.-12:00 p.m. CT
Click here to register.
Dial-in Number: 1-877-280-9413
Pass Code: 54567205

Great Plains QIN
Prescription Drug Monitoring Programs Coaching Call
12/12/17 | 12:15-12:45 p.m. CT
Click here to register.

Texas Medical Foundation QIN

Jacobson Memorial Hospital Kenmare Community Hospital Linton Hospital Mountrail County Medical Center Nelson County Health System Northwood Deaconess Health Center Pembina County Medical Center Presentation Medical Center Sakakawea 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 Wishek Community Hospital Unity Medical Center	
COPPER, BRONZE, SILVER, GOLD & PLATINUM Milestone:	

Zero Harm Awards

Twenty-one Innovate-ND hospitals are on track to receive at least one Zero Harm Award, with 5 hospitals on track to achieve two!

Data is now being reviewed for accuracy. Watch for the ZERO HARM award recipients in the next newsletter!

Zero Harm Awards will be awarded on a quarterly basis: November (data through Sept); Feb (data through Dec); May (data through March); August (data through June).

McKenzie County Healthcare Systems Implements Change to Facilitate Transitional Care Coordination

Preface: In January of 2016 McKenzie County Health System (MCHS) embarked on a project to improve transitional care coordination. CEO, Dan Kelly, reports that this is an evolving process and that they are on track to seamless care transitions as evidenced by the feedback from those directly involved. Linda Irwin, who leads the TCC efforts stated, "Patients always appreciate me calling them and helping them schedule a follow up visit with their provider and always enjoy me checking up on them for the next 30 days." According to HIIN data submitted to CDS through the Innovate-ND program, MCHS has sustained zero readmissions for eight consecutive months, indicating that stable processes are in place. Thank you MCHS for sharing your story!

The Affordable Care Act of 2010 established transitional care programs with the aim of improving quality and reducing costs. Transitional Care programs assist hospitalized patients with often a most vulnerable transfer in a safe and timely manner from one level of care to another or from one type of care setting to another.

Most healthcare managers are well aware of the Institute of Medicine's reports, To Err Is Human: Building a Safer Health System and Crossing

Outpatient Antibiotic Stewardship Across the Continuum of Care: A Community-Driven Approach
12/13/17 | 12:00-1:00 p.m. CT
Click here to register.
01/21/17 | 12:00-1:00 p.m. CT
Click here to register.

Centers for Disease Control & Prevention
CDC TAP Strategy, Part III | Using TAP Feedback and Resources to Prevent HAIs and Improve Patient Safety
01/16/17 | 11:00 a.m.-12:00 p.m. CT
Click here to register.
Dial-in Number: 1-877-280-9413
Pass Code: 57426177

Texas Medical Foundation QIN
Outpatient Antibiotic Stewardship Across the Continuum of Care: A Community-Driven Approach
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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.

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the Quality Chasm: A New Health System for the 21st Century. Despite the popularity of these sentinel reports within the healthcare community, in the United States care remains suboptimal when measured against the prescripts offered in these seminal publications.

A transition from one healthcare setting to another, or in many cases home, affords potential lapses in care. If not a lapse in care then the possibility that the patient will not carry through with their prescribed aftercare program. There are numerous research articles demonstrating that patients moved from one level of care to another without adequate coordination results in unnecessary readmissions. It is against this backdrop that the McKenzie County Healthcare Systems decided to implement our transitional care management initiative.

In January, 2016 MCHS began participating in a rural Accountable Care Organization (ACO). The overarching goal was to improve patient outcomes via implementing preventative care measure. Aspects of this initiative were enhanced care coordination, wellness visit completion, decreasing Emergency Department visits, and decreasing readmissions. Recognizing the importance of the care coordinating aspect of this, we hired a care coordinator the same month. To complicate matters the healthcare system began transitioning our electronic health records at the same time as entering the ACO. In July, 2016 we went live with Epic. As such our start in the ACO was not accompanied with immediate success.

After a short adjustment period we began refocusing on the goals of the ACO. We simultaneously pursued increasing annual wellness visits, Chronic Care Management, and Transitional Care Management. Though all three of these areas within care coordinating were important, Transitional Care Management potentially had the largest immediate impact in reducing adverse patient events. Coincidentally, this is also the area we saw initial movement in. After recognizing the momentum we began focusing extensively on how to improve the TCM service.

At the start, our management team explained the programs in various meetings. Then the Care Coordinator met with individual hospital providers and explained the benefits of the program. After this we noticed some notification of discharges, but it was inconsistent and often late. Upon review we realized we were relying on someone's blind memory to prompt this order and notification. To help automate the process we were able to add an order on our discharge order set. The Care Coordinator and management then reiterated the need for the hospital providers to use the order sets, and explained how this would automate the process for TCM, but also for other types of orders upon discharge. We were then able to get the order to trigger a notification to the Care Coordinator. The thought process was to eliminate the number of algorithms the providers had to go through, capture all inpatient and swing bed discharges and then the Care Coordinator could call the patient, see what help they needed, and ultimately determine if the patient qualified for Transitional Care Management. A parallel obstacle was identifying a process for our primary care providers to provide the care for TCM patients. Through the efforts of the primary care providers and care coordinator, internal workflows were identified and implemented so the TCM service could be completed. We believe this to be our most pivotal single effort to decrease hospital readmissions.

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
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

We continue to identify ways to obtain notification from discharges outside of our facility for patients who live in the area, and how to optimize the communication between hospital provider, care coordinator, patient and primary care provider. We fully recognize the need to continue to push the envelope; at the same time we also recognize how far we have come in our efforts to improve patient outcomes through reduction of hospital readmissions.

HRET HIIN Roadshow Recap

Once again, a huge thank you to everyone who attended the HRET HIIN Roadshow in October. It was an event chocked full of valuable information around organizational high reliability and readmission reduction – an event designed to "*promote skill-building that directly applies to hospital-based improvement work with a focus on foundational, crosscutting leadership as well as improvement and change management strategies*."

HRET Roadshow organizers provided participants with a detailed recap of the event. If you weren't able to attend the Roadshow, check out HRET's "event recap" and correlating tools posted on QHA's website. It can be found under "Presentations" on the Innovate-ND web page or by using this link Roadshow Recap.

Featured Resource

ASPIRE | Designing and Delivering Whole-Person Transitional Care: The Hospital Guide to Reducing Medicaid Readmissions Toolbox

Designed with the Medicaid population in mind, the ASPIRE guide is appropriate for all readmissions. The Agency for Healthcare Research and Quality (AHRQ) commissioned this guide to identify ways evidence-based strategies to reduce readmissions can be adapted or expanded to better address the transitional care needs of the adult Medicaid population. It provides tools that can be used in the day-to-day working environment of hospital-based teams and cross-setting partnerships as well as guidance on who should use the tools and what to do with the output of the tools. Of focused interest to Innovate-ND participating hospitals is the readmission review tool - ASPIRE includes a readmissions interview guide and root cause analysis to assist quality and clinical staff in understanding the patient or caregiver's perspective about readmissions.

ADVERSE DRUG EVENTS

New Opioid and Drug Overdose Resources

The CDC recently launched Rx Awareness, a powerful communication campaign featuring real-life accounts of people recovering from opioid use disorder and people who have lost loved ones to prescription opioid overdose. The campaign is intended to increase awareness and knowledge among Americans about the risks of prescription opioids and stop inappropriate use. Rx Awareness is CDC's latest effort in the fight against the prescription opioid overdose crisis.

On October 20th, the CDC also released a new report in the *Morbidity and Mortality Weekly Report* titled, *Illicit Drug Use, Illicit Drug Use*

the HRET HIIN website (www.hret-hiin.org)

INNOVATE-ND SUPPORT TEAM

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Disorders and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas – United States. This report shows that the rates of drug overdose deaths are rising in nonmetropolitan (rural) areas and are surpassing rates in metropolitan (urban) areas. Click here to view the report.

Combat Opioid overuse in your hospital by using the AHA's *Stem the Tide: Addressing the Opioid Epidemic* toolkit.

ANTIBIOTIC STEWARDSHIP

Antibiotic Stewardship Coaching Opportunity

STRIVE Antibiotic Stewardship On-Demand Learning Modules

States **T**argeting **R**eduction in **I**nfections **v**ia **E**ngagement - STRIVE - is an infection reduction initiative rolled out by the Centers for Disease Control and Prevention (CDC) in partnership with the Health Research & Educational Trust (HRET) - the education arm of the American Hospital Association. STRIVE conveners have created a robust education curriculum that includes on-demand learning modules. They have very generously offered to make their Antibiotic Stewardship learning modules available to ND healthcare professionals engaged in antibiotic stewardship program implementation. While these learning modules were created with hospitals in mind, much of the information is pertinent to **all** healthcare settings.

Please join QHA's first Antibiotic Stewardship Coaching event! Here's our step-by-step plan to integrate the STRIVE modules into our AS coaching plan… our ask of you is…

1. By November 27, access and listen to the STRIVE antibiotic stewardship modules. There are 3 and each is 18-22 minutes in duration. Click here STRIVE Antibiotic Stewardship Learning Modules
2. As you listen jot down your questions, concerns, requests, suggestions and other feedback and email it to jean.roland@area-a.hcqis.org.
3. **Mark your calendars**…on November 30 from 11:30 a.m.-12:30 p.m., we'll convene for a facilitated discussion! A panel of ND antibiotic stewardship subject matter experts will join this virtual event to address your questions, give you an opportunity to share your AS experience so far, solicit dialogue among the participants, and create a true learning and action forum!
   Dial-in # (800) 251-5450 | Conference ID 100-6227 #

Antibiotic Stewardship in Nursing Homes

The recording for the October 19, 2017 WebEx, *Antibiotic Stewardship in Nursing Homes*, has been added to the Great Plains QIN Web site. Click here to review the recording.

FALLS

New Falls Resource Available!

The HRET HIIN Falls Team just added a new resource to support your hospital's work in reducing injurious falls. The UCLA Critical Thinking Fall Prevention Case Studies can be accessed here.

The four video case studies target the development of critical thinking skills by nursing staff. The videos can be used as a self-learning module or as part of a facilitated group discussion.

Case study and video descriptions:

Medicine Patient. 7min 30 seconds. Audience: Nursing staff.
Elderly patient with UTI and urosepsis, uses glasses, hearing aid and a cane. Deals with addressing visual and auditory deficits and importance of use of teach-back to validate patient understanding.

Bone Marrow Transplant Patient. 8 min 40 seconds. Audience: Nursing staff.
Young, independent, male patient with injury risk who is undergoing procedure and sedation. Privacy with toileting and injury risk is addressed.

Liver Transplant Patient. 9 minutes. Audience: Nursing staff.
65-year-old patient on Lasix and lactulose which cause dizziness and will require frequent toileting. Husband is at the bedside while patient is on the commode. Deals with supervision with toileting, family assistance, and injury risk issues.

Neurology Patient. 6 Minutes. Audience: Nursing staff.
Patient has communication deficits and left-sided weakness. Urinary catheter removed. Deals with addressing communication, cognitive deficits, and team communication.

HEALTHCARE-ASSOCIATED INFECTIONS

SNAP Series: Successful Sepsis Transfer Partnerships Forming in Louisiana

St. James Parish Hospital and Ochsner Medical Center in Louisiana are off to a great start in their joint effort to improve sepsis outcomes by improving transfer practices between their facilities. So far, the two facilities have hosted each other for site visits and have assembled a multidisciplinary team to participate in the project, including an ER director, a transfer center medical director, infectious disease physicians, and all other Ochsner transfer center team members, including the Ochsner flight team. The hospitals are also working together to spread community awareness about sepsis reduction by sharing information about the initiative via Facebook.

PERSON AND FAMILY ENGAGEMENT

Updated Partnership for Patient (PfP) Strategic Vision Roadmap for Person and Family Engagement

The latest edition of the PfP Strategic Vision Roadmap for Person and Family Engagement is now available here. This Roadmap replaces the first edition and the PFE metrics addendum. The second edition of the Roadmap includes information about the connection between PFE and health equity. While the Roadmap is updated, it is encouraged that you and your hospitals continue to refer to the health equity addendum for more in-depth information.

READMISSIONS

Regional CAH Quality Network Meetings | November 13-17, 2017

We look forward to next week's Regional CAH Quality Network meetings when Dr. Amy Boutwell presents **Building the Dream Team: Establishing the Conditions for Effective Multi-Stakeholder Coalitions.** Building off of her August presentation, *Developing a Motivating Vision and Calling Stakeholders to Action,* Dr. Boutwell will explain why structure matters within a team or coalition; discuss the importance of developing a real team with the right people, a shared purpose, and enabling team structures; diagnose the challenges our teams and coalitions are facing; and, establish the conditions to enable our teams and coalitions to function effectively.

MISCELLANEOUS

November | National Alzheimer's Disease Awareness & Family Caregivers month and National Hospice/Palliative Care Month

Acknowlege these important observances in your hospital!
National Alzheimer's Disease Awareness
National Hospice/Palliative Care Month