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

January 16, 2018

Educational Events

HRET HIIN

HRET HIIN QI Foundations for Change Fellowship Call 1
01/17/18 | 11:00 a.m.-12:00 p.m. CT

HRET HIIN QI Accelerating Improvement Fellowship Call 1
01/17/18 | 12:30-1:30 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.

SPECIAL EDUCATIONAL EVENT FOR ND HOSPITALS ONLY!!!
Wake UP: Opioid & Sedation Management w/ Dr. Steve Tremain
1/18/18 | 11:30 a.m.-12:30 p.m. CT

Access Information:
https://zoom.us/j/5951148239
Meeting ID: 595 114 8239 #
or
iPhone one-tap :
US: +16468769923,,5951148239# or +16699006833,,5951148239#
or
Dial-in:
(646) 876-9923
Meeting ID: 595 114 8239 #

SAVE THE DATE—UP Campaign Coaching Calls

Important Dates to Remember

Remember to report your HIIN data in CDS every month!

Deadline	Reporting Period
1/31/2018	Performance data for December 2017 discharges

Quality Milestones Recognition

COPPER Milestone:
Tioga Medical Center
Towner County Medical Center - Cando

COPPER, BRONZE & SILVER Milestone:
McKenzie County Healthcare System – Watford City
Sanford Hillsboro Medical Center
Northwood Deaconess Health Center

COPPER & BRONZE Milestone:
Ashley Medical Center
Carrington Health Center
Cavalier County Memorial Hospital - Langdon
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 - Rugby
Jacobson Memorial Hospital - Elgin
Kenmare Community Hospital
Linton Hospital
Mountrail County Medical Center – Stanley
Nelson County Health System - McVille
Pembina County Medical Center - Cavalier
Presentation Medical Center - Rolla
Sakakawea Medical Center - Hazen
Sanford Mayville Medical Center
Southwest Healthcare Services - Bowman
St. Aloisius Medical Center - Harvey

COPPER, BRONZE, SILVER & GOLD Milestone:

Script UP: Optimize Medications | Dr. Steven Tremain
02/22/18 |11:30 a.m. CT

Get UP: Early Progressive Mobility | Maryanne Whitney
03/29/18 | 11:30 a.m. CT

Soap UP: Hand Hygiene | Barb DeBaun
04/12/18 |11:30 a.m. CT

Partner Educational Events

The Partnership Center
Opening Your Doors: Congregational Readiness and Recovery Support
01/17/18 | 11:00 a.m.–12:00 p.m. CT
Register here.

HRSA
Play to Your Strengths: Exploring the Small and Rural Hospital Advantage
01/17/18 | 1:00–2:00 p.m. CT
Register here.

TMIT High Performer Webinar
Drug Diversion: A Drill Down Approach
01/18/18 | 12:00–1:00 p.m. CT
Register here.

Partnership for Patients NCD Pacing Event
Gaining Buy-in for Preventing Adverse Drug Events Related to Anticoagulants and Opioids
01/18/18 | 1:00–2:00 p.m. CT
Register here.

CDC NHSN Webinar
Annual Facility Survey for Critical Access Hospitals
01/23/18 | 1:00–2:00 p.m. CT
Register here.

New England QIN
Highlights from Home – Innovative Approaches to Enhance Care Transitions and Med Safety
01/25/18 | 10:00–11:00 a.m. CT
Register here.

Great Plains QIN
Delivering High-Quality Patient Care to Improve the Nation's

St. Andrew's Health Center - Bottineau St. Luke's Hospital - Crosby Wishek Community Hospital Unity Medical Center – Grafton	
COPPER, BRONZE, SILVER, GOLD & PLATINUM Milestone:	

Progress through the Innovate-ND HIIN Milestones

February 16, 2018, Quality Improvement Fellowship Deadline Approaching Quickly

With continued thanks for your ongoing support of the Hospital Improvement Innovation Network (HIIN) goals of reducing all cause inpatient harm by 20 percent and readmission by 12 percent, HRET is sharing an aligned professional development offering available to your front-line and managerial staff. *HRET covers the cost of this offering as a benefit of your participation in the HRET HIIN*. Recognizing that it is difficult to build in-house quality improvement capabilities and kick-start projects, the Health Research and Educational Trust (HRET) as partnered with the Institute for Healthcare Improvement (IHI) to offer a Quality Improvement Fellowship Program from January to July 2018 for HIIN participating hospitals. The program offers interactive webinars and online courses on key topics in quality improvement and safety, while fellows simultaneously work on a project to improve outcomes in their own department or unit. This program is valued at over $1,250 per fellow and is only available to HRET HIIN partners. Past fellows have worked on:

- Reducing Central Line Infections
- Timely reporting of CVA results to ED physicians
- Reducing Falls in Medical/Surgical Units
- Adherence to Sepsis Bundle

Share this free professional development opportunity widely within your organization. Multiple fellows may participate from your organization; they can work as a team on a project, or individually. In the past, fellows have come from nursing, quality improvement, patient safety and infection prevention departments, though all who work to improve patient care are welcome.

The fellowship program team has held informational calls which will provide a detailed overview and answer questions for those interested. Read more and access registration information by clicking on this link fellowship section.

5 New Year's Resolutions for Your Organization in 2018

(modified from Executiveaura.com)

1. CLARIFY THE VISION AND STRATEGY
Often, top leaders in the organization have a clear strategy and wonder why it's not filtering to the entire organization. It could be how it is written, how it is said, and/or how it is communicated. Everyone should be able to state it and live it.

2. INVEST IN YOUR LEADERS

Health: An Overview of AMA's Resources
01/25/18 | 12:00–1:00 p.m. CT
Register here.

Great Plains QIN Community Antibiotic Stewardship Hot Topic: Urinary Tract Infections in Post-Acute and Long-Term Care Residents
01/30/18 | 12:15–1:00 p.m. CT
Register here.

APIC 2018
45th Annual Conference
06/13/18-06/15/18 | Minneapolis, MN

Registration is now open! Registering early saves you $100 off the full conference registration rate. Save even more by taking advantage of the group discount to save an additional $200 just by registering four or more attendees from your institution. Register now!

SAVE THE DATE

The Role of Environmental Services Teams in HAI Prevention
03/27/18-03/28/18 | Bismarck, ND

Developing an Antibiogram Webinar
04/24/18 | 12:15-1:00 p.m. CT

Quality Health Associates of North Dakota 2018 Quality Forum
08/23/18 | Bismarck, ND

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.

Priorities and deliverables are always changing. Take time to update roles and responsibilities, and offer professional development to fill in the talent gaps. Strive for best-in-class trainers, high-quality content and measurable results to change behaviors, attitudes and thinking.

Foster mentoring relationships. Encourage the experienced employees to apply their wisdom and experience to spreading their knowledge and forming the new generations.

3. **CREATE A POSITIVE CULTURE**
   Human capital is your top investment. The goals are to recruit, retain and motivate your employees for high productivity. The culture exists to execute the strategy. Design culture audits, culture committees and internal ambassadors to connect senior leadership with everyone in the organization.
4. **COMMUNICATE EFFECTIVELY**
   Too much email? Silos? Clear and concise communication makes a difference. Create a communication strategy, set new goals and train people effectively.
5. **LEAD MOTIVATING MEETINGS**
   Assure that every meeting has a clear agenda, purpose and outcome. Every manager should be a top-notch meeting planner and facilitator. Learn to listen 80% of the time and speak only 20% of the time.

Teams from Cavalier County Memorial Hospital, Langdon; CHI St. Alexius Health, Garrison; and First Care Health Center, Park River, completed the PFE and/or QI Fellowships in 2017. This brings them one step closer to achieving the prestigious *Platinum* level in Innovate-ND HIIN Milestone Program.

CHI St. Alexius Health, Carrington, has moved their discharges processes beyond the four walls of their hospital! Now this is innovative thinking! Read more…

Featured Resource…Standards of Medical Care in Diabetes

HRET HIIN ADE 1b, Hypoglycemia in Patients [receiving insulin or other hypoglycemic agents] remains the most challenging of the ADE topics in North Dakota hospitals.

In January of 2017 the American Diabetes Association published the Standards of Medical Care in Diabetes – 2017. In follow-up, the ADA has now released a position statement, Standards of Medical Care in Diabetes – 2018, Abridged for Primary Care Providers

ADVERSE DRUG EVENTS

Key Strategies to Prevent Hypoglycemia

Steve Tremain | HRET HIIN ADE Listserv |1/07/2018

Two of the key strategies for prevention of hypoglycemia are (1) abandoning sliding scale insulin as the only method of glucose control in a hospitalized patient, and (2) avoiding hypoglycemia due to insulin/meal/carbohydrate intake mismatch. The following articles are great resources for attacking these issues.

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

Nau et al from the West Virginia School of Medicine published an article in 2010 titled "Glycemic Control in Hospitalized Patients Not in Intensive Care: Beyond Sliding-Scale Insulin". Arguments against sliding scale insulin are summarized, and guidelines for physiologic subcutaneous insulin are provided. The article can be found here. Kodner et al from Louisville reinforce avoiding sliding scale insulin in their 2017 article found here. Articles urging physicians to abandon the use of sliding scale insulin were written as early as 2001. It's been 17 years. How can we help these "laggards" move forward?

Marelli et al from Italy describe an elegant protocol for a nurse-managed protocol to avoid hypoglycemia. The protocol reduced hypoglycemic events by 56%. The elements are three-fold:

- "If examinations or procedures requiring prolonged fasting are scheduled, a glucose solution must be infused intravenously from the first skipped meal until oral feeding is reestablished." Prandial [bolus] insulin is stopped. Basal insulin is maintained.
- "At the end of each meal, nurses must make sure the patient has eaten the planned amount of carbohydrates. To help the nurse check the patient's carbohydrate intake, a new set of diets in which only few, easily identified foods contained carbohydrates: breakfast: milk and bread; lunch: pasta or rice, bread and fruit; dinner: soup, bread and fruit. If the patent has eaten only part or none of the carbohydrates, the nurse suggests s/he should make up for the uneaten amount, offering foods easily available in the ward containing known amounts of carbohydrates."
- "In case of lack of appetite, or repeated partial intake of the planned food, prandial [bolus] insulin must be given at the end of the meal, the dose matching the amount of carbohydrates actually eaten."

The article can be found here.

Moving forward consider

- How have you successfully moved the physicians past sliding scale insulin alone?
- Are your nurses preventing hypoglycemia with similar protocols? Are they assessing carbohydrate intake?

Review the HRET HIIN Adverse Drug Event Change Package, found here.

Pharmacist-Driven Warfarin Management Superior to Usual Practice

Downing, Mortimer, and Hiers report in the American Journal of Health-System Pharmacy that pharmacists, using literature-based warfarin management protocols for initiation of warfarin therapy, decreased time to therapeutic range by 12 hours and increased the percentage of INRs in the therapeutic range from 28% to 38%. Additionally, pharmacist-driven warfarin management decreased the number of sub-therapeutic INRs from 55% to 39%. Supra-therapeutic INRs between 3 and 5 did increase slightly. The article can be found here.

These findings support accumulating evidence that pharmacy-driven warfarin protocols decrease time to therapeutic INR, decrease sub-therapeutic INRs, and decrease INRs > 5, resulting in more patients having INRs within the therapeutic range.

the correlating icon on the right-hand side of the page when you log onto the HRET HIIN website (www.hret-hiin.org)

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As you read this consider how you can implement a pharmacist-driven warfarin management protocol in your hospital. Who should you include on your team? What barriers do you need to address?

Managing Warfarin-Antibiotic Interactions

Ha, et al, in 2016 published an article from the University of Michigan Health System studying the impact of a standardized protocol for warfarin adjustments when patients are on antibiotics known to cause Drug-Drug-Interactions (DDIs). Implementation of the guidelines resulted in greater time within the therapeutic range for inpatients (72% vs 50%), and improved time within therapeutic range (70% vs 46%) across transitions of care. Bleeding events dropped from 4 to 0 (p=.11) with this approach as well. The article can be found here. Those with full access can find the protocol by clicking the "Supplemental Material" tab to the right of the article.

HOSPITAL-ACQUIRED INFECTIONS

Antibiotic Stewardship Coaching Call and Facilitate Discussion

Antibiotic stewardship is assuring the right drug, in the right dose, for the right duration, at the right time, every time. The CDC has published Antibiotic Stewardship Core Elements for various healthcare settings (Hospital; Small and Critical Access Hospitals; Outpatient; and Nursing Homes). There is notable alignment in the guidelines that create opportunities to establish programs that complement one another. For purposes of this coaching event attention focused on the hospital and outpatient guidelines; the on-demand STRIVE Antibiotic Stewardship Learning Modules served as the platform for discussion. An expert panel addressed questions and shared their experiences in implementing their Antibiotic Stewardship Program. Access the event recording and a detailed summary here (presentations).

Reducing Unnecessary Urine Cultures

Jackie Conrad | Cynosure Improvement Advisor

The benefits of reducing unnecessary urine cultures have been demonstrated in a large-scale study published in JAMA in August 2017. The article can be accessed: here. The year-long project, based in community long term care facilities, followed the traditional CUSP CAUTI Collaborative model and achieved a **54% reduction in CAUTI rates in one year.**

Highlights from outcomes:

- Catheter utilization went up slightly
- Urine culture orders decreased 15% from 3.49 to 3.08 per 1000 catheter days
- ***CAUTI rate decreased 54%*** from 6.78 to 2.63 per 1000 catheter days

It is hard to break the habit of screening patients with urinary catheters on admission, whether to "catch" a present on admission (POA) CAUTI or to attempt to diagnose and treat foul-smelling or dark urine. If your organization is still doing this, it's time to STOP. Well-meaning clinicians who send unnecessary urine cultures are contributing to patient harm when unnecessary antibiotics are ordered. Treatment of asymptomatic

bacteriuria (ASB) may be associated with antimicrobial resistance, *C. difficile* infections, and increased costs. The practice may also lead to over-diagnosis of CAUTI.

How Can YOU Reduce Unnecessary Urine Cultures in Your Organization to Drive Down Your CAUTI Rate? The following recommendations are published in *Principles of highly reliable care: improving the culture of culturing—avoiding unnecessary urine cultures in catheterized patients*. Fakih, M. Ascension health. February 2014.

Key Points Related to Obtaining Urine Cultures:

- Make sure clinicians are aware of the appropriate indication to obtain urine cultures
- Point out the risk of indiscriminate urine cultures on patient outcomes
- Address the local "culture" or practice of clinicians at your organization to align with optimal patient care
- Avoid ordering cultures without a clinical assessment of the patient's condition

How to Reduce Unnecessary Urine Cultures:

1. Evaluate current process for obtaining urine cultures. Are urinalysis or urine cultures part of standing orders, power plans, do you do screening cultures on admission?
2. Evaluate practice patterns for certain physician groups, specialties or units. Encourage ordering cultures based upon clinical evaluation for patients for potential source of sepsis. Evaluate surgical processes and discourage routine cultures in patients not undergoing urologic surgery.
3. Provide education on when it is appropriate to obtain urine culture on a patient with an indwelling urinary catheter.
4. Conduct periodic audits on urine cultures in the ICU to look for trends, especially if your CAUTI rates are not dropping with interventions focused on improving insertion and maintenance.
5. Promote appropriate urinary catheter use to reduce risk of CAUTI. No catheter, no CAUTI.
6. Use urinary catheters only based upon indications, with prompt removal when no longer needed. The absence of the device reduces the risk of bacteriuria and the chances of obtaining a urine culture without an appropriate reason.

When to Obtain or Not Obtain a Urine Culture in a Patient with an Indwelling Catheter:

Discourage Urine Culture Use in a Catheterized Patient	**Appropriate Urine Culture Use in a Catheterized Patient**
• Urine Quality: color smell, sediments, turbidity. These do not constitute signs of infection.	• Part of an evaluation of sepsis without a clear source. CAUTI is often diagnosed by exclusion.
• Screening urine cultures on admission or before non-urologic surgeries.	• Based upon clinical findings suggestive of CAUTI, for example pelvic discomfort or flank pain.
• Standing orders for UA or UC without an appropriate indication.	• Prior to urologic surgeries where mucosal bleeding is anticipated or in transurethral resection of prostate.

• PAN culturing. Be mindful in evaluating source.	• Early pregnancy. Avoid urinary catheters if possible.
• Obtaining urine cultures based upon pyuria (white blood cells in urine) in an asymptomatic patient.	
• Asymptomatic elderly and diabetics (high prevalence of asymptomatic bacteriuria).	
• Repeat urine culture to document clearing of bacteriuria. This provides no clinical benefit to the patient.	

Articles to review to support your work:
- Article: Promoting appropriate urine culture management
- Article: Approach to a Positive Urine Culture in a Patient without Urinary Symptoms

Peer-shared Resources:
- Asymptomatic Bacteriuria Practice Treatment Guidelines
- Asymptomatic Bacteriuria Algorithm

***AJIC* review: Preventing CAUTIs in Nursing Homes**

A study published in the December issue of *AJIC*, "A national collaborative approach to reduce catheter-associated urinary tract infections in nursing homes: A qualitative assessment," was summarized by Timothy Bowers, MT(ASCP) MS, CIC, FAPIC. The Communications Committee publishes reviews of select articles appearing in *AJIC* and highlights the major points that impact the practice of infection prevention. Past article summaries can be found on the APIC website.

The Timing of Early Antibiotics and Hospital Mortality in Sepsis

A recent journal article re-examined antibiotic timing and sepsis treatment because there have been mixed results in the past. The retrospective study of 35,000 inpatients found that every hour of delay in antibiotics after recognition of sepsis was associated with increased odds of mortality.
https://www.ncbi.nlm.nih.gov/pubmed/28345952

As you read this article consider the following:
- Do you measure time from sepsis recognition to antibiotic administration?
- What is the average time in your Emergency Department? On your floors and ICU?
- What improvement ideas have been successful to decrease the time of positive sepsis identification to antibiotic administration?
- Do you have an Infectious Disease specialist on your sepsis team?

Newly Published Sepsis Resources

HRET HIIN Readmission Listserv | 1/11/2018

JAMA **Post-Sepsis Morbidity| Patient Information Page**
(January 2, 2018)
https://jamanetwork.com/journals/jama/fullarticle/2667724

JAMA Review |**Enhancing Recovery From Sepsis: A Review** (January 2, 2018)
https://jamanetwork.com/journals/jama/article-abstract/2667727?redirect=true

Survival from sepsis has improved in recent years, resulting in an increasing number of patients who have survived sepsis treatment. Current sepsis guidelines do not provide guidance on post-hospital care or recovery. This review suggests in the months after hospital discharge for sepsis, management should focus on (1) identifying new physical, mental, and cognitive problems and referring for appropriate treatment, (2) reviewing and adjusting long-term medications, and (3) evaluating for treatable conditions that commonly result in hospitalization, such as infection, heart failure, renal failure, and aspiration. For patients with poor or declining health prior to sepsis who experience further deterioration after sepsis, it may be appropriate to focus on palliation of symptoms.

FALLS

Strategies to Prevent Falls

In case you missed the HRET HIIN Falls virtual event, ***Falls Myth Busting: What to STOP doing to START improving,*** the event recording is now posted on the HRET HIIN website and can be accessed here.

It's time to face the truth if your organization is still struggling with reducing fall related injuries, the leading patient harm in many organizations. Is your program on the right track in moving toward the list of STARTS or are you in a rut, relying on practices on the STOP list? Gather your team, listen to the recording and reevaluate your current strategy.

Below is a summary of the information covered by presenters and panelists Jackie Conrad RN, MBA, RCC™ Patricia Quigley, PhD, ARNP, CRRN, FAAN, FAANP, Steve Tremain, M.D., FACPE and Beverly Meyers from Satana Hospital, KS during the thought provoking event.

Facing the Facts about Fall Injury Prevention

- All fall are NOT equal – unassisted falls are associated with injury and should be treated as a care failure. Assisted falls usually do not result in harm and may occur as a result of patient mobilization.
- Score based intervention bundles are not effective in preventing falls. Are you treating a score or a patient with individual risk factors?
- Forced immobility to prevent falls is causing functional decline and new walking dependence in elders (16-59% of elders are impacted)
- The term non-compliant is over used. Most patients believe that fall prevention is important but it does not apply to them. Evidence supports that structured education about risk and consequences can reduce falls and injuries.
- Bed alarms cause more harm than good including alarm fatigue, forced immobility and patient dissatisfaction. There is no evidence that they reduce falls

- Nursing alone cannot reduce fall related injuries. Organizations that take a whole house approach accelerate improvement.
- Medications are the most modifiable risk factor.

Stops	Starts
Relying on a Fall Risk Score for Action	Focusing on identifying risk factors and activating interventions for each risk factor
Using a high-risk bundle or score based interventions	Creating an individualized plan for care based upon risk factors
Using bed alarms and sitters to restrict mobility	Supporting the patient's highest level of mobility at least three times a day with a staff assisted/supervised mobility program
Relying only on walking	Using other methods of bed and chair mobility
Telling patients what to do, calling them noncompliant and naming family as the problem	Engaging patients as partners in safely mobilizing. Teach risks, consequences of a fall and strategies to prevent using teach back
Believing you cannot afford to resource a mobility program	Training sitters to ambulate patients Use the most appropriate level of clinician to assess and mobilize (PT Stewardship) Calculate the ROI
Targeting nursing alone to prevent fall related injuries	Adopting a whole house approach. Interdisciplinary environmental rounds Leadership attendance in post fall huddles Physician and pharmacy for medication review Rehab supports a culture of mobility
Focusing on preventing all falls	Focus on preventing injuries from falls Focus on preventing unassisted falls Focus RCAs or huddles on unassisted falls as a process of care failure

Together, we can find a new path.

- If you are an organization or unit that has already started to reap the benefits of the strategies in the START category, what did you try and what did you learn? Inspire someone!
- If you are an organization ready to find a new path, what will you STOP doing first?

READMISSIONS

Palliative Care and Advance Care Planning in Rural Communities

Last month the HRET HIIN hosted a virtual event focusing on filling gaps in the provision of palliative care and advance care planning in rural communities. Advance Care Planning is a billable service that helps patients and families with complex illnesses prepare for care at home and determine, in advance, when hospital care should be accessed in order to prevent unnecessary readmissions.

Advance Care Planning Training Resources:

- IHI Open School PFC 202: Having the Conversation: Basic Skills for Conversations about End-of-Life Care: PFC 202: Having the Conversation

- CDC Course: Advance Care Planning: An Introduction for Public Health and Aging Services Professionals: CDC Advance Care Planning Intro

Study Links Higher Patient Satisfaction to Lower Readmissions

Pat Teske |Readmissions Listserv |1/03/2018

I've never met with an organization that was not interested in improving their patient experience scores so I wanted to begin the year by sharing this recent article that links higher patient satisfaction to lower readmissions. The study included 846 patients at Massachusetts General Hospital and concluded that patients who reported high satisfaction with their overall care experience were 39% less likely to be readmitted than patients who were not as satisfied.

As you read this article consider what strategies you have implemented to improve communication with your patients. Remember, better communication = better understanding of how to self-manage following discharge.

PFE

PFE SNAP Series

The HRET HIIN team is planning a PFE SNAP program. Safety Networks to Accelerate Performance (SNAP) are voluntary learning networks that address emerging best practices related to HIIN topics. Early-adopter hospitals set bold aims and test new practices using effective measurements and experienced improvement infrastructure to develop interventions that can be disseminated to all HRET HIIN hospitals.

The PFE SNAP will take the place of the PFE Fellowship for 2018. The current plan is to target states and hospitals that need the most coaching and guidance for PFE and high priority HIIN topics. More information and registration details will be released soon.

WORKFORCE SAFETY

Disruptive Behaviors

Do **ALL** staff, patients, and families in your organization feel safe speaking up when they have a patient safety or workforce safety concern? In response to this polling question during the October 2017 virtual event *Building an Integrated Approach to Address Disruptive Behaviors*, 70% of respondents answered, "**Some** of these people, **some** of the time."

What will it take for everyone in your organization to answer, "**All** of these people, **all** of the time?"

During the event, Betsy Lee, Improvement Advisor, and Bruce Spurlock, MD, President and CEO, Cynosure Health, explored the concept of psychological safety and its impact on the whether or not people feel comfortable speaking up to express safety concerns.

Subject matter expert, Michelle Carlstrom, LCSW-C, CTM, described her experiences at Johns Hopkins University in the development and

use of an integrated spectrum of actions and reporting to address disruptive behaviors across a continuum of actions. She provided definitions and examples of behaviors, as well as actions to intervene at each level.

Ms. Carlstrom specifically noted the importance of discerning whether bullying is “accidental” or “malicious.” These are described as separate “pit stops” on the continuum, and she encourages managers and leaders to discern the underlying motivations as they seek to address these categories of behaviors.

Key event takeaways included:

- Disruptive behavior includes a wide range of behaviors from incivility to aggression. The anchor points on the continuum provide a common language for consistent reporting and action.
- Such behaviors can be an indicator of escalating risk, potential safety/quality concerns, and even potential incidents of workplace violence.
- Disruptive behaviors can impact morale, employee engagement, and turnover. They can also lead to decreased work effort and increased quality and safety concerns. Left unaddressed, they can breed a culture of silence.

Download the slides for details, and check out the HRET HIIN Culture of Safety Change Package for more tips in promoting psychological safety.

Things to consider moving forward:

- Does your hospital have clear definitions and policies related to disruptive behaviors to promote reporting and inform consistent actions?
- Does your hospital have triggers defined in your organization that are intended to provide an early warning of a potential problem or future risk of workplace violence?

MISCELLANEOUS

HRET HIIN Releases New Physician Podcasts

The topic for the first podcast is *Physician Activation and Participation in Quality Improvement Activities.* Dr. Bruce Spurlock from Cynosure Health facilitates a discussion with Dr. Gary Roth, Chief Medical Officer of Michigan Health and Hospital Association about approaches that are most effective to align physician priorities with the hospital’s quality improvement agenda. Dr. Roth highlights the importance of identifying a physician champion and optimizing data to increase involvement.

The second podcast titled *Physician Engagement Activation in Hospital Quality & Safety Programs*, provides methods to activate physicians in hospital quality and patient safety programs within rural critical access settings. Listen to Dr. Bruce Spurlock from Cynosure Health facilitate a discussion with Dr. Jason Cohen, Chief Medical Officer from North Valley Hospital in Whitefish, Montana. The discussion focuses on building a culture of participation, designating physician leaders, and creating common goals among staff.

Be sure to visit the HIIN Physicians page for additional physician related activities.