North Dakota Hospital Association Innovate-ND

HRET Hospital Improvement Innovation Network

October 9, 2019

Educational Events

HRET HIIN

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.

Event Recordings

Sepsis Alliance | The Blind Spot of Antibiotic Stewardship
Click here for the recording and here for webinar materials.

Sepsis Alliance| GE Sponsored Webinar
Can We Help 'Solve' Sepsis Together? Biomarkers: We Just Need To Be Better Listeners

- Encourage your colleagues to watch the recorded webinar at SepsisWebinar.org.
- Download the webinar slides here.
- Download the questions and answers from the webinar session here.

Partner Educational Events

AHA | Adding Value by Embedding Mental Health Care in Every Patient Visit
10/10/19 | 1:00-2:00 p.m. CT
Register here.

PFCC Partners
Core Competencies of Effective Advisors | Part of a 2-Part Series
10/15/19 | 4:00-5:30 p.m. CT
Register here.

Important Dates to Remember

Remember to report your HIIN data in CDS every month!

Deadline	Reporting Period
10/21/19	PFE/HEOA Survey (Bimonthly)
10/31/19	Performance Data for September 2019 Discharges

Quality Milestones Recognition

COPPER Milestone:

COPPER, BRONZE & SILVER Milestone:
Cooperstown Medical Center
Heart of America Medical Center – Rugby
Southwest Healthcare Services – Bowman
Unity Medical Center – Grafton

COPPER & BRONZE Milestone:
Ashley Medical Center
Kenmare Community Hospital
Mountrail County Medical Center – Stanley
Nelson County Health System – McVille
St. Luke's Hospital – Crosby
Tioga Medical Center
Towner County Medical Center – Cando

COPPER, BRONZE, SILVER & GOLD Milestone:
CHI Community Memorial Hospital – Turtle Lake
CHI Mercy Health – Valley City
Linton Hospital
Northwood Deaconess Health Center
Pembina County Memorial Hospital – Cavalier
Presentation Medical Center – Rolla
Wishek Community Hospital

COPPER, BRONZE, SILVER, GOLD & PLATINUM Milestone:
Carrington Health Center
Cavalier County Memorial Hospital and Clinics – Langdon
CHI Garrison Community Hospital
CHI St. Alexius – Devils Lake
First Care Health Center – Park River
Jacobson Memorial Hospital – Elgin
McKenzie County Healthcare System – Watford City
Sakakawea Medical Center – Hazen
Sanford Mayville Medical Center
Sanford Hillsboro Medical Center
St. Aloisius Medical Center – Harvey
St. Andrew's Health Center – Bottineau

TMIT High Performer Webinar
A Perfect Storm: The Midcourse Correction for Patient Safety
10/17/19 | 12:00-1:30 p.m. CT
Register here.

2019 APIC Applied Learning Conference
10/26/19-10/27/19 | St. Louis, MO
Register here.

Alzheimer's Association – ND Chapter
If you, your staff, your residents or their families ARE STRUGGLING WITH THE IMPACTS OF DEMENTIA, PLEASE CHECK OUT CARE CONSULTATION, provided FREE ONLY in North Dakota by funding through the ND Department of Human Services, Aging Services Division.

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

Performance Improvement Collaborative Overview

HRET HIIN will host a 6-month Performance Improvement Collaborative starting this October (recruitment is open through Friday, October 11). This exciting collaborative will support hospitals in reducing hospital acquired conditions by improving patient safety and the quality of care. Hospitals participating in the collaborative will have an opportunity to work exclusively with national subject matter experts and AHA Performance Improvement Coaches who will provide coaching and guidance on how to implement successful tests of change to address challenges and opportunities for improvement. Hospitals will also have an opportunity to network and participate in peer-to-peer sharing on common challenges and successes in reducing hospital acquired conditions.

To learn more, please take a look at the and complete this survey to receive more information. Please reach out to Jean or Nikki with any additional questions.

AHA Age-Friendly Initiative Recruitment and Resources

AHA Age-Friendly Action Community held the second "Getting Started" virtual event last week. During this event, the Age-Friendly team reviewed action community goals, participant responsibilities, and tools and resources that will be utilized during the action community.

Hospitals are still able to enroll in the Action Community by clicking here. This seven-month collaborative is designed for hospital-based teams (e.g., emergency departments, ICUs, medical-surgical units) and ambulatory care teams to test and implement the 4M Framework (Mobility, Mentation, Medication, and What Matters) and share learnings with their peers. The Age-Friendly Initiative has the ability to impact several HIIN harm measures including: falls with injury, pressure injuries, patient and family engagement, delirium, and adverse drug events.

For more on Age-Friendly Health Systems, an initiative of the John A. Hartford Foundation and Institute for Healthcare Improvement in partnership with the AHA and Catholic Health Association of the United States, click here or email ahaactioncommunity@aha.org.

FEATURED RESOURCE

Cardinal Principles for Tapering Patients Off Chronic Opioid Therapy

Patients on high dose, long term opioid therapy (LTOT) are at an increased risk for serious morbidities and death due to overdose. Despite the risks, patients understandably may be reluctant to agree to taper opioid doses for fear of withdrawal and increased pain, even when quality of life may be adversely affected. For patients that are willing to consider it, though, several types of interventions may be effective to reduce or discontinue LTOT.

Patients on high dose opioids, with moderate to severe chronic pain and co-existing behavioral health conditions, present a challenging clinical scenario for discontinuing opioids. The speed with which opioids are tapered in this population should be tailored to the individual needs of the patient. The BRAVO protocol developed by Dr. Anna Lembke of

reduce harm. New subscribers are added on the first day of each week. Send your questions on your work with hospital-acquired conditions through the LISTSERV.

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)

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Stanford University outlines a strategy for tapering patients in this population off chronic opioid therapy.

The BRAVO acronym outlines the cardinal principles for tapering patients off chronic opioid therapy. BRAVO stands for:
- Broaching the subject
- Risk Benefit calculator
- Addiction happens
- Velocity matters – and so does validation
- Other strategies for coping with pain

Resources and more information about the BRAVO protocol can be found here:
Oregon Pain Guidance Tapering Guidance
BRAVO Tapering Protocol

ADEs

Why Are Your Patients Becoming Hypoglycemic Under Your Care?

HRET HIIN Hospital Wide Listserv | 10/08/19

Treatment of hyperglycemia in hospitalized patients carries a significant risk for iatrogenic hypoglycemia and the development of hypoglycemia has been linked to mortality and morbidity. An article from 2012 investigated the causes of iatrogenic severe hypoglycemia in 172 patients and discovered some trends.

Variables related to patients having a BG less than 60mg/dl were:
- Basal insulin
- Sliding scale insulin
- Creatinine clearance
- Nutritional insulin
- Continued oral sulfonylurea use
- Weight (<60 kg)

Variables related to patients having a BG less than 40mg/dl were:
- Basal insulin
- Sliding scale insulin
- Creatinine clearance

Most of these variables are physician and nurse driven so what do we need to change to prevent iatrogenic hypoglycemia in our hospitals?
1. Modify insulin regimens upon patient admission to accommodate change in diet and exercise while hospitalized.
2. Change our target glucoses to 140-180mg/dl.
3. Coordinate nutrition with insulin administration.
4. Modify insulin dosing if glucose drops below 100mg/dl to avoid additional/ more severe hypoglycemia.
5. Do not manage patients on sliding scale alone, include basal dosing.

To read the article Prediction and Prevention of Treatment Related Inpatient Hypoglycemia click here.

To better understand why YOUR patients are becoming hypoglycemic complete this hypoglycemic discovery tool found here. This can assist in focusing your efforts to decrease hypoglycemia in your facility.

September Was Pain Awareness Month

Prescription opioids can be an effective form of pain management, but they are not always the only option. It is important to understand the potential benefits and risks before taking medications.

The Centers for Medicare & Medicaid Services (CMS) is committed to reducing opioid misuse by promoting person-centered care that encourages safe and effective pain management, including opioid and non-opioid pain treatments. Medicare Part B helps pay for the following services that may help individuals manage their pain:

- Physical therapy
- Occupational therapy
- Manual manipulation of the spine (when medically necessary)
- Behavioral health services, like depression screening

Prescription opioids, including hydrocodone, oxycodone, morphine, codeine and fentanyl, can be used to help relieve moderate-to-severe pain.

For More Information:

- Medicare Coverable Services for Integrative and Non-pharmacological Chronic Pain Management
- Pain Awareness Article for Medicare Patients
- Medicare.Gov Pain Management Webpage
- HHS Pain Management Information
- Centers for Disease Control and Prevention Treatment Options
- Taking Care of My Pain Management
- Know Your Rights, Risks and Responsibility

ANTIBIOTIC STEWARDSHIP

HHS Celebrates Commitment to Reduce Antibiotic Resistance

AHA Today | 09/24/19

The Department of Health and Human Services and Centers for Disease Control and Prevention recently celebrated nearly 350 organizations, including the AHA, during the UN General Assembly in New York for their commitment to combat antimicrobial resistance as part of The AMR Challenge. They asked partners to continue their commitments to reduce antibiotic resistance. "The success of the Challenge over the past year demonstrates what is possible, in the relatively short term, when we have real commitment to the fight against this pressing public health threat," said HHS Secretary Alex Azar. AHA helped members reduce antimicrobial resistance through targeted assessments used in a CDC action collaborative to prevent infections. The AHA Physician Alliance also hosted a collaborative to drive appropriate antibiotic use and other high-value care initiatives. In addition, the association helps hospitals improve antibiotic use and share best practices through the AHA-Health Research and Educational Trust Hospital Improvement Innovation Network; Agency for Healthcare Research and Quality Safety Program for Intensive Care Units; the *C. Difficile* Infection Prevention Collaborative; and CDC/STRIVE Infection

Control Training. Jay Bhatt, D.O., AHA senior vice president and chief medical officer, represented AHA at the event.

AHRQ Recruiting Ambulatory Clinics for Antibiotic Stewardship Program

Improving antibiotic prescribing and use is critical to effectively treat infections, protect patients from harms caused by unnecessary antibiotic use, and combat antibiotic resistance.

The Agency for Healthcare Research and Quality (AHRQ) Safety Program for Improving Antibiotic Use is recruiting pediatric and adult ambulatory clinics to participate in a free, 12-month program that seeks to improve antibiotic prescribing.

This program, which is scheduled to begin in December, will combine evidence-based guidance with strategies to address the attitudes, beliefs, and culture that often pose challenges to improving antibiotic prescribing. This program will help clinicians protect patients from exposure to unneeded antibiotics and associated side effects, including rashes and *Clostridioides difficile* infections.

Participation Benefits

AHRQ has announced that participation in this program will help clinics meet the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) requirements and can demonstrate compliance with the new Joint Commission Ambulatory Antimicrobial Stewardship Standard. Continuing education credits including Maintenance of Certification (MOC) for ABIM, ABP, and ABFM will be offered at no charge for participants.

Benefits of participating include:

- Reduce unnecessary antibiotic use and increase appropriate antibiotic use
- Improve patient safety and safety culture
- Enhance teamwork and communication around diagnosis and treatment of infections and antibiotic prescribing in your practice
- Maintain and improve patient and family satisfaction
- Improve workflow, especially during the busy cold and flu season

What data will be requested?

- Monthly data on number of patient visits, antibiotic prescriptions administered by antibiotic type, patients with respiratory infections, patients diagnosed with a respiratory condition and prescribed antibiotics (certain ICD-10 codes)
- Completion of a survey regarding practice infrastructure, antibiotic stewardship activities, and patient safety issues

Eligible Clinics

Clinics that care for children and/or adults and are:

- Primary care clinics
- Urgent care clinics
- Student health clinics
- Community-based health clinics (e.g., Federally Qualified Health Centers or FQHCs)
- Outpatient specialty clinics that provide primary care (e.g., OB/GYN)

Informational Webinars Available
Attend one of the following webinars to learn more about the program:
October 15, 10 a.m. CT | Click here to register.
October 30, 12 noon CT | Click here to register.
November 5, 1:00 p.m. CT | Click here to register.
November 14, 1:00 p.m. CT | Click here to register.

For more information, visit https://safetyprogram4antibioticstewardship.org/ or email antibioticsafety@norc.org.

Study Compares Antibiograms from Hospitals and Nursing Homes

MN Antibiotic Stewardship Collaborative Update Bulletin | 09/27/19

Veterans Administration (VA) researchers compared 2017 antibiograms for VA nursing homes with those of the affiliated VA medical centers.

Lack of agreement between nursing home and medical center antibiograms suggests that acute care antibiograms often do not accurately approximate resistance profiles in nursing homes.

If used at all, acute care antibiograms should be interpreted cautiously to guide empiric antibiotic selection in nursing homes.

Read the abstract at NCBI, Antibiograms Cannot Be Used Interchangeably Between Acute Care Medical Centers and Affiliated Nursing Homes.

HAIs

Kicking CAUTI with a Fast and Frugal Algorithm

HRET HIIN Infections Listserv | 09/26/19

The VA Health System is spreading their "Kicking CAUTI: The No Knee-Jerk Antibiotics Campaign" that led to a 71% reduction in screening for Asymptomatic Bacteriuria (ASB) and a 75% reduction in treatment of ASB. Read the full story and the details of their plan for spread of phase two, the "Less is More Campaign" here.

They developed a Fast and Frugal Algorithm that distilled 51 pages of guidelines into a two-step algorithm that helps correct cognitive biases and empowers the provider to withhold urine testing treatment. You can access the algorithm in the original article here. The tool specifically calls out pyuria as NOT a sign of a CAUTI, nor as an indication for antimicrobial treatment.

The team used real time audit and feedback to teach providers how to use the tool within a clinical context. Pharmacists consult with providers by phone if antibiotics are ordered and results of the urine culture appear to be ASB. Weekly case studies are prepared from facility audits

and shared in power point case studies, in resident rounds, and hospitalist meetings.

They used internal facilitators and subject matter experts from regional facilities and attribute their success in large part to the energy and involvement of a trusted local leader that served as a physician champion.

Consider testing this algorithm with a few staff nurses to get feedback and suggestions for potential adoption of something similar in your hospital.

Midline Catheters: Are You Seeing Any Trends?

HRET HIIN Infections List Serv | 09/27/19

A while back, we had a lively discussion about how some facilities were moving toward non-central line options (e.g., longer dwell peripheral lines or midlines). Some wondered if this was potentially going to reduce CLABSI but possibly increase peripheral line or midline infections. The concern raised by some was that avoidance of central lines might make us 'look better' (i.e., if the patient doesn't have a central line, it doesn't count as a CLABSI) yet we might miss capturing blood stream infections that were associated with lines that were not technically 'central lines.'

This recent review by DeVries and colleagues demonstrated two full years of 'zero infections' in patients who had a midline catheter. Of note is that this program was led by vascular access nurses. The article (open access, therefore available to all) may be retrieved here.

SEPSIS

CDC Highlights Sepsis Educational Resources

AHA Today | 09/24/19

The Centers for Disease Control and Prevention is encouraging patients and health care professionals to share educational materials from its Get Ahead of Sepsis campaign, which emphasizes the importance of early recognition, timely treatment, reassessment of antibiotic needs, and prevention of infections that can lead to sepsis. The materials include a new quiz that allows patients to test their sepsis knowledge.

The Sepsis Institute: Preparing Healthcare Providers for Excellence in Sepsis Care

Coming 10/11/19

On October 11, 2019, Sepsis Alliance will launch The Sepsis Institute (TSI), an online learning platform to prepare healthcare providers across the continuum of care for sepsis. It will offer healthcare providers high quality, evidence-based sepsis education, and training. Providers will have easy access to high-value sepsis training modules, webinars, and resources. Healthcare providers can earn continuing education credits for many of the courses offered on TSI. Click here to learn more.

FALLS

Falls a Major Contributor to Readmissions

HRET HIIN Hospital Wide Listserv | 09/24/19

Do you know how many older adults are admitted to your organization for a fall related injury? How about the number of older adults originally admitted for a fall related injury, and then readmitted for any reason within 30 days? Why is this important?

A recent study of over 8 million U.S. index admissions in the Hospital Cost and Utilization Project's (HCUP) Nationwide Readmissions Database of Medicare beneficiaries found that patients originally admitted with a fall-related injury have a significant risk for readmission to the hospital. Among the readmissions:

- Fall-related injuries are the third highest reason for readmission for Medicare patients in this cohort, regardless of prior fall status.
- For those patients originally admitted after a fall, though, another fall related injury is the second leading reason for readmission.
- Patients discharged to home or home health are at higher risk for readmission than those discharged to skilled nursing facilities.

What can hospitals do to keep vulnerable elders free from falls once they are transitioned home and prevent readmissions?

A multifactorial approach to assess and manage modifiable risk factors is recommended for older adults with a history of falls. The degree to which this approach has been adopted in primary care settings is unclear. A large, single health system of primary care practices sought to explore their performance with older adults post fall injury and they provide sound recommendations for practice based upon their findings. Access the full article here.

The criteria used for assessing completeness of assessment and the application of interventions can be accessed in table 1 from the article and included a medication list in table 2.

Primary Care Practice Recommendations:

- Create a structured visit note template to address fall risk factor assessments and interventions – build into the Medicare annual wellness visit
- Recommend home safety evaluations – get creative, see the EMS one step ahead program cited in the article
- Increase attention to high-risk medications – Use BEERS, STOPP START criteria
- Use the CDC's STEADI tools that provide a foundation for clinical practice, assessment, interventions and patient education materials for fall prevention.

Annual Deaths from Falls Have Tripled Since 2000

HRET HIIN Hospital Wide Listserv | 09/27/19

On June 4, JAMA published Mortality from Falls Among US Adults Aged 75 years or older, 2000-2016 with the following key findings:

- Deaths from falls increased from 8,613 a year in 2000 to 25,184 a year in 2016
- Danger rose with age
  - 75–79 year old death rate was 42 per 100,000

    - 95 and > death rate rose to 591 per 100,000
- Traumatic brain injury and hip fractures were among the causes of death
- Contributing factors to the increase:
    - Older people are living longer, independently, with chronic conditions
    - Medications that affect balance or cause drowsiness, especially psychiatric meds
    - Vision Problems

What to do about this dramatic increase in mortality with elders related to falls? In the same issue, JAMA also published a randomized clinical trial that shows the benefit of a home based, strength and balance re-training exercise program in preventing subsequent falls in older adults who experienced a fall. Many communities have these programs.

- Are you referring a patient who is admitted with injuries from a fall to strength and balance training after discharge?
- If these resources exist in your community, can you refer patients who experience a fall in your organization to community strength and balance classes?

The National Council on Aging has Evidence Based Fall Prevention Programs designed for community dwelling seniors, including various activity levels:

- "A Matter of Balance" an eight-week structured group intervention that emphasizes strategies to prevent falls and increasing
- Otago Exercise Program a set of 17 strength or balance exercises delivered by a physical therapist or physical therapy assistant, in the home
- Tai Ji Quan: Moving for Better Balance a twice a week, 24-week program focusing of warm up, core, therapeutic movements and cool down
- YMCA Moving for Better Balance 12 week, instructor-led group program is based upon the principles of Tai chi, teaching eight movements modified for fall prevention

Check out what is available in your community and share with your ED physicians, case managers, care coordinators, home care team members.

Tracking and Communicating Mobility

HRET HIIN Hospital Wide Listserv | 08/20/19

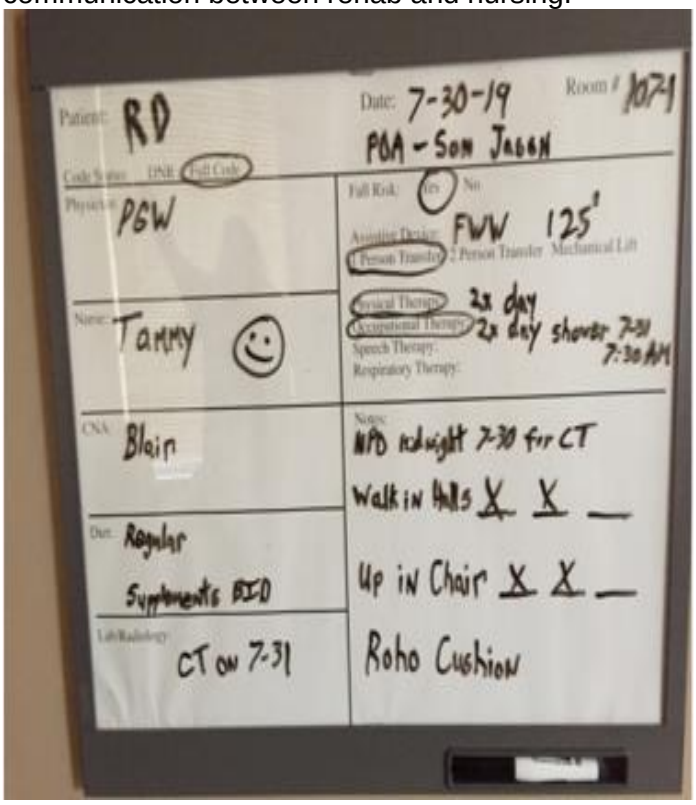
Early, progressive mobility is spreading as a strategy to reduce harm, length of stay and readmissions.

Communication of each patient's mobility plan is a key piece to the mobility puzzle. Peer hospitals have shared various methods of communicating the mobility plan utilizing white boards and the electronic record. The whiteboard is a simple method to keep all caregivers, the patient and the family up to date on the mobility plan and progress on completion of daily mobilizations.

How are you communicating and tracking patient mobilizations? Send us your pictures and creative ways you are marking or tracking distances.

To get the sharing started, below are two examples of mobility communication using whiteboards.

Cozad Community Hospital utilizes the patient whiteboard to facilitate communication between rehab and nursing.



The below hallway mobility tracker is used to track each patient's ambulation and distances. Patients and staff place magnets next to the patient room number indicate their mobilization distances. Staff add post it notes of encouragement to help keep patients and staff motivated. Read more implementation details here.

READMISSIONS

CMS Issues Final Rule on Burden Reduction, Discharge Planning

AHA Today | 09/25/19

The Centers for Medicare & Medicaid Services issued final rules reducing some regulatory burdens for providers participating in the Medicare and Medicaid programs, and revising discharge planning requirements for hospitals, critical access hospitals and home health agencies.

The burden reduction rule, proposed last year, allows health systems to use a unified/central staff across multiple hospitals for Quality Assessment and Performance Improvement and Infection Control Programs, rather than have individual staff for each separately certified hospital; lends assistance to Medicare re-approval procedures for transplant centers; allows hospitals to review their emergency preparedness plans every two years rather than annually; and removes certain other requirements for CAHs, hospitals with swing beds, home health agencies and ambulatory surgical centers.

The discharge planning rule, proposed in 2015, finalizes provisions requiring hospitals and CAHs to create discharge planning evaluations for patients who are likely to suffer adverse health consequences in the absence of adequate discharge planning, and when a patient, their representative or physician requests such a plan. The rule also requires hospitals, CAHs and home health agencies to provide certain medical information to the receiving facility when transferring patients. CMS did not finalize its proposal to require hospitals and CAHs to establish a post-discharge follow-up process for at least some patients discharged to home. Recognizing that hospitals already are doing this according to specific situations and patient needs, the agency encouraged providers to continue following evidence-based best practices to establish an appropriate process.

Community Advocates Program

HRET HIIN Newsletter | 09/27/19

Approximately 4.8 million Texans are uninsured and burdened with lack of resources, unaffordable care and increasing avoidable emergency department (ED) visits and hospital readmissions rates. Baylor Scott & White Health, one of the largest health systems in Texas, has utilized an innovative model called the Community Advocates Program as an opportunity to connect with community members, learn about their health needs – medical and social – and link them to existing resources in the community. This volunteer program trains undergraduate students to become Community Advocates and conduct social needs screenings. Community Advocates screen patients for social resource needs and connect them with appropriate services related to food, housing, health insurance, childcare, adult education, job training and other services.

Community Advocates undergo intensive learning and training before screening patients, including a one day boot camp, role playing exercises, and shadowing a clinical team at nine different clinical sites.

Additionally, Baylor Scott & White's "Community Advocates Pathways" for trained advocates provides strategic, yet sensitive considerations for navigating patient interactions. The pathways include guidelines and questions around the overall health of the individual, their education and employment status, and the need for basic commodities.

To date, 1,621 patients have been screened, and overall, 80 percent identified having a social need. The top three health needs identified by the patients were access and affordability of health care, access to food, and lack of commodities. As a result of this program, 56 percent of positively-screened patients at one of the sites accepted assistance via referrals, while 30-day readmission rates of enrolled patients dropped by 87.5 percent.

Lessons Learned:

- Being available, flexible and understanding is a must for the volunteers in the Community Advocates program.
- Continuous collaboration is required between external partners, internal stakeholders and the population served.
- Intensive training provides community advocates with the skills necessary to direct conversations with patients in a nonjudgmental and respectful manner.

To learn more about Baylor Scott & White Health's Community Advocates program please read the Members in Action case study from The AHA Value Initiative here.

PFE

Family Engagement: What Does It Look Like in YOUR ICU?
HRET HIIN Hospital Wide Listserv | 09/26/19

Family engagement in the ICU is one of the pillars of the ABCDEF bundle:
A = assess, prevent, and manage pain
B = both spontaneous awakening and spontaneous breathing trials
C = choice of analgesic and sedation
D = delirium: assess, prevent, and manage
E = early mobility and exercise
F = family engagement and empowerment

Adherence to the bundle in its entirety adherence was found to positively impact patient outcomes. Family engagement was the final bundle element to be introduced.

The abstract for a recent publication in the Critical Care Medicine Journal describes a National Collaborative's experience implementing "F = Family Engagement" can be found here.

The 63 ICU's involved in the National Collaborative initiated:

- Open visitation
- Integration of families on rounds
- Establishment of a patient and family advisory committee
- Utilization of patient and family diaries

Overall, they found a collaborative to be an effective way to guide the family engagement efforts to learn and share with peers.

DIVERSITY/DISPARITIES

Cleveland Health System Tackles Social Determinants of Health

AHA Today | 09/25/19

Cleveland-based MetroHealth opened the Institute for H.O.P.E. (Health, Opportunity, Partnership and Empowerment) to serve the local neighborhood and patients with resources such as computer and financial literacy training, a food pantry, legal counseling, a workforce development center and community kitchen. Read more.

MISCELLANEOUS

Cough Drops and Flu Shots Signal New Season

The swimming pool has been traded for the football field and the cooler temperatures signal the start of the next season: cold and flu season. When stocking up on cough drops and decongestant at the local food or drug store, individuals also have the opportunity to get an influenza vaccination. There are, in fact, nine different types of influenza vaccinations recommended for different age groups and health conditions. Read more.

Prepare Your Practices for Flu Season

As a healthcare professional, your strong recommendation is a critical factor that affects whether your patients get an influenza vaccine. Most adults believe vaccines are important, but they need a reminder from you to get vaccinated. Read more.

JAMA American Society of Hematology Guidelines for Prevention of VTE in Hospitalized Medical Patients

HRET HIIN Hospital Wide Listserv | 09/25/19

A recent article from JAMA Network details a meta-analysis convened by the American Society for Hematology (ASH) of the literature related to the prevention and management of venous thromboembolism in medical patients. The review utilized the GRADE approach to assess the evidence and make recommendations for preventative treatment of VTE. Two key recommendations emerge from the review that are applicable to hospitalized medical patients:

1. All hospitalized acutely ill medical patients are at risk for VTE and should have either chemo- or mechanical-prophylaxis
   - The recommendation for VTE prophylaxis is stronger for critically ill patients than non-critically ill patients.
   - Prophylaxis should not be continued after discharge.

2. The evidence is much stronger for the use of low molecular weight heparin (LMWH) than unfractionated heparin (UFH), and direct-acting oral anticoagulants (DOACs) are not recommended.

Over the years there has been controversy regarding the risk of medical patients for VTE. While some have stated that the risk is overstated, others, such as the Society of Hospital Medicine (SHM), have long pushed for near universal prophylaxis for medical patients. This new ASH guideline supports the view of SHM.

It is of note that these recommendations are based on a review of evidence for medical patients do not apply to surgical patients.

Reducing the Risk for VTE Through Mobility

HRET HIIN Hospital Wide Listserv | 08/13/19

Hospitalized patients are at higher risk for the development of venous thromboembolism (VTE – includes DVT and PE) just by virtue of being placed in a bed. Without a purposeful focus on encouraging mobility in hospitalized patients, many remain inactive and in bed. Without regular activity, the risk goes up.

Do you have a standardized mobility program for patients in your organization? A focus on mobility early in a patient's stay in the hospital can have far-reaching positive effects toward reducing many forms of hospital acquired harm, not just VTE. A study from a large urban teaching hospital revealed an 85% reduction in post-operative DVT rates following the implementation of a program to encourage early postoperative mobilization, coupled with a standardized approach to risk assessment and prophylaxis.

85% reduction – wow!

The findings from this study reinforce what we have been discussing about VTE prevention on the LISTSERV, and during the VTE Sprint and webinar series. A reliable, standardized approach to mobility, risk assessment and decision support for prophylaxis can improve outcomes for patients at risk for VTE.

How has your organization incorporated mobility strategies into VTE prevention?

For more information about VTE prevention strategies, take a look at the VTE Change Package on the HRET HIIN webpage.