North Dakota Hospital Association Innovate-ND

HRET Hospital Improvement Innovation Network

December 5, 2019

Educational Events

HRET HIIN

HRET HIIN QIN-tastic Webinar
Early Identification of Sepsis: A Community Commitment
12/12/19 | 11:00 a.m.-12:00 p.m. CT
Register here.

HRET HIIN PFE | "What matters to you?" Series
Session 3, RESPECT
12/17/19 | 11:00 a.m.-12:00 p.m. CT
Register here.
Session 4, TELL THE STORY
01/07/20 | 12:00-1:00 p.m. CT
Register here.

PI Collaborative Sessions
02/10/20 | 12:00-1:00 p.m. CT
Register here.
03/09/20 | 12:00-1:00 p.m. CT
Register here.

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

NDSU's Public Health Seminar Vaccine Hesitancy, Vaccine Exemptions, and the Return of Vaccine Preventable Diseases: Policy and Research Implications
Click here to access the recording.

All HRET HIIN event recordings are/will be available on-demand

Important Dates to Remember

Remember to report your HIIN data in CDS every month!

Deadline	Reporting Period
12/31/19	Performance Data for November 2019 Discharges

Shout Outs!

ND Rocks! Thank you to all of the Innovate-ND HIIN Leads for a 97% submission of the Quarterly Operational Survey: PFE/HEOA Metrics!

HRET HIIN PI Collaborative Update
The HRET HIIN announced last week that over 400 hospitals signed up for the PI Collaborative. Nikki and Jean are proud to share that 20 are ND hospitals! We thank you for recognizing the value of ongoing PI education and taking advantage of this opportunity with nationally recognized subject matter experts!

Congratulations to **Pembina County Medical Center** on their completion of all requirements to meet the **Platinum Milestone**!

Shout out to **CHI Mercy Health Valley City**! Jean and Nikki stopped in to visit and were treated to the opportunity to observe their daily discharge huddle. This multidisciplinary team including a Case Manager, Physician, Floor Nurse, Pharmacist, Spiritual Director, Physical Therapist, Occupational Therapist and Respiratory Therapist meets Monday through Friday at 10 to 10:30 am to discuss all patients, inpatient, observation and swing bed, to plan for their discharge. It was a fast-paced meeting with input from all. It was so fun to see this best practice in action!

on the HRET HIIN website http://www.hret-hiin.org/. Select the desired topic and scroll down to "Watch a Recent Data Event."

Partner Educational Events

National Diabetes Prevention Program
Lifestyle Coach Training
12/05/19-12/06/19
To register contact Nikki Johnson at (701) 231-5165 or Nikki.a.johnson@ndsu.edu.
Registration deadline 11/27/2019.

Wound Care Education Institute/Relias
Nutrition from A to Zinc
12/11/19 | 11:00 a.m.-12:00 p.m. CT
Register here.

AHA Team Training | TeamSTEPPS
Introducing Community Conversations in Health Care
12/11/19 | 12:00-1:00 p.m. CT
Register here.

AHA Health Forum
The Impact and Prevention of False Positive CLABSIs
12/12/19 | 12:00-1:00 p.m. CT
Register here.

ND Department of Health Division of Disease Control
INFECTION WARS: Defeating Novel MDROs
12/19/19 | 12:00-1:00 p.m. CT
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.

In addition, we were very excited to hear about the innovative work their new Patient and Family Advisory Committee has recently accomplished:

- Development of a "Sleep Menu" which assists patients to get to sleep at night: a back rub, warm blanket, special drink such as hot tea or warm milk, ear plugs, eye masks, and soothing music are some of the ala carte options!
- A "Gift of Life" Wall, honoring those in the community who have donated organs has been established in the main entrance waiting area. A plaque for each donor with their photo and a description of that person's life are placed on the wall, accompanied by this poem:

  My Final Gift
  It is now time
  For me to move on
  Into the dusk,
  But also the dawn.
  I will remain
  As the morning comes
  As I've left behind
  A gift for someone.
  So another may walk,
  May talk, may see.
  Where their life was locked,
  I offered a key.
  I am a donor
  To someone in need.

- Placed water cooler in ER waiting room as it was recognized that there was no access to water at night for those waiting for their loved ones.
- Upgraded water fountains throughout the facility so that patients and families could fill their water bottles.

Quality Milestones Recognition

COPPER Milestone:	**COPPER, BRONZE & SILVER Milestone:** Cooperstown Medical Center Heart of America Medical Center – Rugby Southwest Healthcare Services – Bowman St. Luke's Hospital – Crosby 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
COPPER, BRONZE, SILVER, GOLD & PLATINUM Milestone: Carrington Health Center Cavalier County Memorial Hospital and Clinics – Langdon CHI Garrison Community Hospital	

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. 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

CHI St. Alexius – Devils Lake
First Care Health Center – Park River
Jacobson Memorial Hospital – Elgin
McKenzie County Healthcare System – Watford City
Pembina County Memorial Hospital – Cavalier
Presentation Medical Center – Rolla
Sakakawea Medical Center – Hazen
Sanford Mayville Medical Center
Sanford Hillsboro Medical Center
St. Aloisius Medical Center – Harvey
St. Andrew's Health Center – Bottineau
Wishek Community Hospital

FEATURED RESOURCE

CDC's National Influenza Vaccination Week: December 1-7

National Influenza Vaccination Week (NIVW), observed December 1–7, was established by CDC in 2005 as an awareness week to highlight the importance of continuing influenza vaccination activities throughout the holiday season and beyond. It's a great time to vaccinate people who have not yet been protected against flu and to call or send a reminder message to those who have not been vaccinated to be sure they get protected. Vaccination efforts should continue through the holiday season and beyond because peak influenza activity generally does not occur until February (with some variability year to year). Providers are encouraged to continue vaccinating patients throughout the influenza season, including into the spring months.

This year, CDC is focusing on groups at high risk of flu-related complications, hospitalizations, and death, such as children younger than 5 years, adults over 65, people with chronic conditions such as asthma, heart disease, and diabetes, and pregnant women. Click on the graphic below to access the NIVW campaign resources from CDC, including web tools, videos, communication hints, matte articles to submit to newspapers, animated images, graphics, and more.

ADES

Simple to Follow Inpatient Insulin Dosing Algorithm

HRET HIIN Hospital Wide List Serv | 11/17/19

Sliding scale insulin as the sole source of glycemic control in an inpatient is an antiquated practice that has been decried in the literature for at least 20 years. So why is it so common? It turns out there are two reasons:

1. Many doctors do not know how to order inpatient insulin, and
2. They underestimate the importance of labile glucose levels and therefore "have not seen harm."

We are here to help with Reason Number 1. Thanks to the generosity of Kristen Kulasa, MD, endocrinologist at UC San Diego and a national glycemic control expert with the Society of Hospital Medicine, we have

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

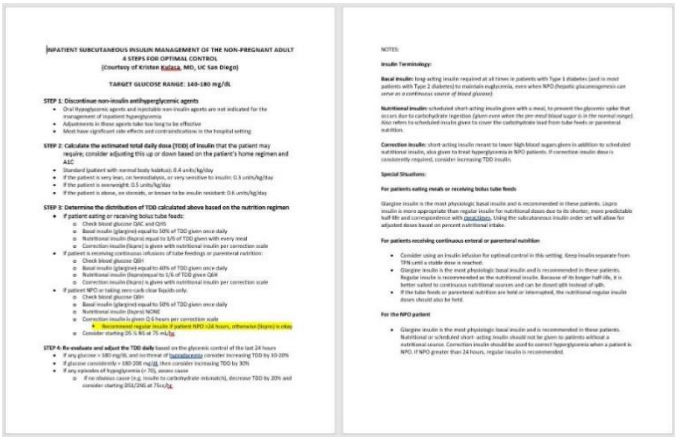
INNOVATE-ND SUPPORT TEAM

Jean Roland
jroland@qualityhealthnd.org
701/989-6227

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

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

been given permission to provide you (upon your request) with the inpatient insulin dosing algorithm that their residents are required to use. It's easy, straightforward, and successful. Help your docs move into the 21st Century. Trial it, then consider hardwiring it into the EMR CPOE.



~Please contact Jean or Nikki if you'd like a copy of this algorithm.

ANTIBIOTIC STEWARDSHIP

CDC Updates Core Elements of Antibiotic Stewardship of Hospitals

The Centers for Disease Control and Prevention recently released its updated *Core Elements of Hospital Antibiotic Stewardship Programs* to reflect experience and evidence since releasing the elements of successful stewardship programs in 2014. A summary of the updates is provided below. Included with the updated guidelines is an *Antibiotic Stewardship Program Assessment Tool* that provides examples of ways to implement the Core Elements. Read more.

Summary of Updates to the Core Elements of Hospital Antibiotic Stewardship Programs

Optimizing the use of antibiotics is critical to effectively treat infections, protect patients from harms caused by unnecessary antibiotic use, and combat antibiotic resistance. Antibiotic stewardship programs can help clinicians improve clinical outcomes and minimize harms by improving antibiotic prescribing.

In 2019, CDC updated the hospital Core Elements to reflect both lessons learned from five years of experience as well as new evidence from the field of antibiotic stewardship. Major updates to the hospital Core Elements include:

Hospital Leadership Commitment: Dedicate necessary human, financial and information technology resources.

- The 2019 update has additional examples of hospital leadership, and the examples are stratified by "priority" and "other."
- Priority examples of hospital leadership commitment emphasize the necessity of antibiotic stewardship programs leadership having dedicated time and resources to operate the program effectively, along with ensuring that program leadership has regularly scheduled opportunities to report stewardship activities, resources and outcomes to senior executives and hospital board.

Accountability: Appoint a leader or co-leaders, such as a physician and pharmacist, responsible for program management and outcomes.

- The 2019 update highlights the effectiveness of the physician and pharmacy co-leadership, which was reported by 59% of the hospitals responding to the 2019 NHSN Annual Hospital Survey.

Pharmacy Expertise (previously "Drug Expertise"): Appoint a pharmacist, ideally as the co-leader of the stewardship program, to lead implementation efforts to improve antibiotic use.

- This Core Element was renamed "Pharmacy Expertise" to reflect the importance of pharmacy engagement for leading implementation efforts to improve antibiotic use.

Action: Implement interventions, such as prospective audit and feedback or preauthorization, to improve antibiotic use.

- The 2019 update has additional examples of interventions which are stratified to "priority" and "other." The "other" interventions are categorized as infection-based, provider-based, pharmacy-based, microbiology-based, and nursing-based interventions.
- Priority interventions include prospective audit and feedback, preauthorization, and facility-specific treatment recommendations. Evidence demonstrates that prospective audit and feedback and preauthorization improve antibiotic use and are recommended in guidelines as "core components of any stewardship program." Facility-specific treatment guidelines can be important in enhancing the effectiveness of prospective audit and feedback and preauthorization.
- The 2019 update emphasizes the importance of actions focused on the most common indications for hospital antibiotic use: lower respiratory tract infection (e.g., community-acquired pneumonia), urinary tract infection, and skin and soft tissue infection.
- The antibiotic timeout has been reframed as a useful supplemental intervention, but it should not be a substitute for prospective audit and feedback.
- A new category of nursing-based actions was added to reflect the important role that nurses can play in hospital antibiotic stewardship efforts.

Tracking: Monitor antibiotic prescribing, impact of interventions, and other important outcomes like C. difficile infection and resistance patterns.

- It is important for hospitals to electronically submit antibiotic use data to the National Healthcare Safety Network (NHSN) Antimicrobial Use (AU) Option for monitoring and benchmarking inpatient antibiotic use.
- Antibiotic stewardship process measures were expanded and stratified into "priority" and "other."
- Priority process measures emphasize assessing the impact of the key interventions, including prospective audit and feedback, preauthorization, and facility-specific treatment recommendations.

Reporting: Regularly report information on antibiotic use and resistance to prescribers, pharmacists, nurses, and hospital leadership.

- The 2019 update points out the effectiveness of provider level data reporting, while acknowledging that this has not been well studied for hospital antibiotic use.

Education: Educate prescribers, pharmacists, and nurses about adverse reactions from antibiotics, antibiotic resistance and optimal prescribing.

- The 2019 update highlights that case-based education through prospective audit and feedback and preauthorization are effective methods to provide education on antibiotic use. This can be especially powerful when the case-based education is provided in person (e.g., handshake stewardship).
- The 2019 update also suggests engaging nurses in patient education efforts.

Antimicrobial Resistance in Bacteria from Livestock and Companion Animals

CDC |Emerging Infectious Diseases | Volume 25, Number 12 – December 2019

This CDC article is a valuable resource to better understand the contribution of animal-derived pathogens to antimicrobial resistance: Antimicrobial Resistance in Bacteria from Livestock and Companion Animals.

AHRQ Views Blog: Using Antibiotics Safely in Hospitals: Then, Now and Beyond

AHRQ's support of the current U.S. Antibiotic Awareness Week, which each year raises awareness about antibiotic resistance and the importance of appropriate antibiotic use, is the subject of a new blog post by Melissa A. Miller, MD, MS, a medical officer for AHRQ's Healthcare-Associated Infections Program. Each year 2.8 million people in the United States get an antibiotic-resistant infection, and at least 35,000 people die, according to the most recent statistics. AHRQ has long funded research and developed practical tools to help clinicians use antibiotics appropriately. The most recent is the new Acute Care Hospital Toolkit, developed after more than 400 hospitals participated in the AHRQ Safety Program for Improving Antibiotic Use. The toolkit helps hospitals develop or improve antibiotic stewardship programs. Access the blog post. To receive all blog posts, submit your email address and select "AHRQ Views Blog."

CDC Publishes Updated ACIP Recommendations

CDC published *Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine among Adults Aged ≥65 Years: Updated Recommendations of the Advisory Committee on Immunization Practices* in the November 22 issue of MMWR (pages 1069–1075). Two important sections are reprinted below.

New Pneumococcal Vaccine Recommendations for Adults Aged ≥65 Years Old (page 1073)

PCV13. PCV13 vaccination is no longer routinely recommended for all adults aged ≥65 years. Instead, shared clinical decision-making for PCV13 use is recommended for persons aged ≥65 years who do not

have an immunocompromising condition, CSF leak, or cochlear implant and who have not previously received PCV13.

CDC guidance for shared clinical decision-making. When patients and vaccine providers engage in shared clinical decision-making for PCV13 use to determine whether PCV13 is right for the specific individual aged ≥65 years, considerations may include the individual patient's risk for exposure to PCV13 serotypes and the risk for pneumococcal disease for that person as a result of underlying medical conditions.

If a decision to administer PCV13 is made, it should be administered before PPSV23 (5). The recommended intervals between pneumococcal vaccines remain unchanged for adults without an immunocompromising condition, CSF leak, or cochlear implant (≥1 year between pneumococcal vaccines, regardless of the order in which they were received). PCV13 and PPSV23 should not be coadministered.

ACIP continues to recommend PCV13 in series with PPSV23 for adults aged ≥19 years (including those aged ≥65 years) with immunocompromising conditions, CSF leaks, or cochlear implants.

PPSV23 for adults aged ≥65 years. ACIP continues to recommend that all adults aged ≥65 years receive 1 dose of PPSV23. A single dose of PPSV23 is recommended for routine use among all adults aged ≥65 years. PPSV23 contains 12 serotypes in common with PCV13 and an additional 11 serotypes for which there are no indirect effects from PCV13 use in children. The additional 11 serotypes account for 32%–37% of IPD among adults aged ≥65 years. Adults aged ≥65 years who received ≥1 dose of PPSV23 before age 65 years should receive 1 additional dose of PPSV23 at age ≥65 years, at least 5 years after the previous PPSV23 dose.

Considerations for shared clinical decision-making regarding use of 13-valent pneumococcal conjugate vaccine (PCV13) in adults aged ≥65 years (page 1074)

- PCV13 is a safe and effective vaccine for older adults. The risk for PCV13-type disease among adults aged ≥65 years is much lower than it was before the pediatric program was implemented, as a result of indirect PCV13 effects (by preventing carriage and, thereby, transmission of PCV13-type strains). The remaining risk is a function of each individual patient's risk for exposure to PCV13 serotypes and the influence of underlying medical conditions on the patient's risk for developing pneumococcal disease if exposure occurs.
- The following adults aged ≥65 years are potentially at increased risk for exposure to PCV13 serotypes and might attain higher than average benefit from PCV13 vaccination, and providers/practices caring for many patients in these groups may consider regularly offering PCV13 to their patients aged ≥65 years who have not previously received PCV13:
  - Persons residing in nursing homes or other long-term care facilities
  - Persons residing in settings with low pediatric PCV13 uptake
  - Persons traveling to settings with no pediatric PCV13 program
- Incidence of PCV13-type invasive pneumococcal disease and pneumonia increases with increasing age and is higher among

persons with chronic heart, lung, or liver disease, diabetes, or alcoholism, and those who smoke cigarettes or who have more than one chronic medical condition. Although indirect effects from pediatric PCV13 use were documented for these groups of adults and were comparable to those observed among healthy adults, the residual PCV13- type disease burden remains higher in these groups. Providers/practices caring for patients with these medical conditions may consider offering PCV13 to such patients who are aged ≥65 years and who have not previously received PCV13.

Click here to access the full article.

HAIs

Society of Critical Medicine | Reducing CAUTIs and CLABSIs

The following link was distributed by Society of Critical Care Medicine (SCCM). It provides a summary of a presentation that occurred at the SCCM Congress; discussing reducing CLABSI and CAUTI in ICUs with SCCM and AHRQ experts. Within the link is great information and a link to a recording of the session.
https://www.sccm.org/Blog/November-2019/Strategies-for-Reducing-and-Eliminating-CLABSI-And

ICU Infographic Keeps CAUTI Top of Mind

HRET HIIN Infections Listserv | 11/26/19

AHRQ has published an ICU CAUTI Infographic that is a perfect tool for reminding your ICU staff of the key points to CAUTI prevention in the ICU. This infographic can be posted or used as a handout to prompt discussion and keep these four areas in our focus:

1. Raise awareness and understanding of the risks of a urinary catheter.
    a. Dispel myths: not all critically ill patients need indwelling urinary catheters
    b. Indwelling urinary catheters cause more harm than just UTIs; they can also lead to Clostridiodes difficile infection, pain, urinary incontinence, immobility and increased length of stay.
2. Consider the alternatives for measuring fluid intake and output: daily weights, external catheters, male and female urinals, straight catheterization, commodes, absorbent pads to be weighed to obtain output.
3. Rethink the “Culture of Culturing” urine
    a. Do not do reflex pan culturing.
    b. Do not do automatic lab or radiological exams for a febrile patient without a clinical evaluation.
    c. Don’t assume the fever is due to a UTI, consider respiratory, gastrointestinal, bloodstream, or neurological pathology impacting thermoregulation.
4. Tackle CAUTI
    a. Pause and verify that the patient has an approved indication before inserting or re-inserting a catheter.
    b. Involve a second person during insertion to facilitate aseptic technique.
    c. Evaluate continued need daily.
    d. Empower nursing staff to discontinue catheter use as soon as possible.

Please share this tool with your CAUTI reduction team.

FALLS

Fall-Related Nursing Education

HRET HIIN Hospital Wide Listserv | 11/21/19

A 2018 article, Preventing Falls In Hospitalized Patients, outlines the key, evidence based strategies for preventing injuries from falls in hospitals. This downloadable resource can serve as a staff education tool for annual education refreshers or competency fairs. The article includes a post test and nursing CEUs are available.

This article is consistent with the HIIN's messaging around preventing injuries from falls and immobility because it stresses the importance of individualized care planning to address patient specific risk factors.

Moving forward consider:

- Incorporating nursing staff education on preventing harm from falls and immobility into nursing orientation
- Providing annual education updates on falls and immobility

Evidence Related to Video Monitoring in Fall Reduction is Growing

HRET HIIN Hospital Wide Listserv | 12/03/19

Patients at high risk for fall are typically provided a multitude of interventions including bed and chair alarms, low beds and sitters, none of which have been proven to be effective in preventing falls. Video monitoring (VM) of patients at risk for falls is a new technology that is gaining evidence on its effectiveness in reducing falls, sitter usage and cost while improving patient, family and staff satisfaction.

In a 2018, Free Full Text Article, the results of implementation of VM in a 115 bed inpatient rehabilitation facility is described. The key clinical practice points and outcomes for implementation of VM at this site include:

- VM is a nonobtrusive mechanism for preventing falls.
- VM can reduce falls in an inpatient rehabilitation setting.
- VM can reduce sitter costs in an inpatient rehabilitation setting.
- VM can be useful in reduction of falls in cognitively impaired patients.

PFE

HRET HIIN PFE Virtual Event Series

HRET HIIN kicked off the "What Matters to You" series on November 12! The first session focused on receiving information and learning to

ask, "What matters to you?" instead of, "What's the matter with you?" The recording for this event can be found here and the slides can be found here. (Please see registration links to upcoming events in the left-hand column of this newsletter.)

It's not too late to join this series! Lead by PFE subject matter experts, Tara Bristol-Rouse and Martha Hayward, this highly interactive virtual event series explores ways to implement transformative thinking to better serve patients and their families. Participants will learn how to test ways to receive, record, and respect patients' preferences and needs as well as the importance of storytelling and key strategies for telling stories that will inspire action in hospitals!

PRESSURE ULCERS

Medical Devices: Culprits in Harm

HRET HIIN Hospital Wide Listserv | 11/25/19

Medical Device Relate Pressure Ulcer/Injury (MDPRU) data was extracted from the 2016 International Pressure Ulcer Prevalence data that included nearly 100,000 adult inpatient stays in US and Canadian hospitals. Access the full article here.

The hospital acquired pressure injury prevalence rate was 3.1% (n=3113). The prevalence of MDPRU was 0.06% (n=601), with 75% of the MDPRUs being hospital acquired. By stage, 58% were Stage 1 or 2, 15% were deep tissue injuries and 22% were full thickness, stages 3-4 injuries.

Anatomical location of MDPRUs: the most common location were the ears (29%) and feet (12%). Most common device culprits: nasal O2 tubing (26%); other (19%); casts and splints (12% and CPAP/BiPAP masks (9%).

A 2018 article, Evidence-based practice: Medical device-related pressure injury prevention, provides a review of the literature regarding prevention of MDPRUs and includes a printable set of MDPRU Prevention badge cards. A 2016 article by Black and Kalowes, Medical Device-Related Pressure Ulcers, serve as a resource for device issues and preventive practices.

Black and Kaowes cite a large study by Apold and Rudrych examining the use of preventive practices and found that >74% of MDPRUs were not reported until they reached a stage 3-4 and 63% had no documentation of skin inspection, device removal or pressure relief. The authors recommend these activities take place at bedside handoffs when two nurses are present so that the skin can be thoroughly inspected and preventive measures implemented.

DIVERSITY/DISPARITIES

Poverty: Not a Lack of Money, but Rather a Lack of Resources

Typically, poverty is thought of in terms of financial resources only. However, the reality is that financial resources, while extremely important, do not explain the differences in the success with which

individuals leave poverty, nor the reasons that many stay. The ability to leave poverty is more dependent upon other resources than it is upon financial resources. Each of these resources plays a vital role in the success, and health, of an individual.

To better understand patients from poverty, a working definition of poverty is, “the extent to which an individual does without resources.” These resources include the following:

- FINANCIAL: Having the money to purchase goods and services
- EMOTIONAL: Being able to choose and control emotional responses, particularly to negative situations, without engaging in self-destructive behavior (this is an internal resource and shows itself through stamina, perseverance, and choices)
- MENTAL: Having the mental abilities and acquired skills (reading, writing, computing) to deal with daily life
- SPIRITUAL: Believing in divine purpose and guidance
- PHYSICAL: Having physical health and mobility
- SUPPORT SYSTEMS: Having friends, family, and backup resources available to access in times of need (these are external resources)
- RELATIONSHIPS/ROLE MODELS: Having frequent access to adults (peers) who are appropriate, who are nurturing to children, and who do not engage in self-destructive behavior
- KNOWLEDGE OF HIDDEN RULES: Knowing the unspoken cues and habits of a group

The more resources a patient has, the more likely they are to be compliant with a care plan, and the more likely they are able to be successful once discharged from hospital care. Does your assessment include evaluating whether or not patients possess these resources? When the patient is lacking one or more of these resources, does the discharge plan include a strategy to compensate for the missing resource? Could there be improvement in the way we communicate complex medical information for enhanced comprehension? Would we be able to move the needle on the patient’s outcomes? Could there be a reduction in patient-provider misunderstandings and conflict? How might this contribute to broaden efforts to boost community health and stability?

MISCELLANEOUS

Rural Health Day

November 21 was National Rural Health Day (NRHD)! On the third Thursday of November each year, the National Organization of State Offices of Rural Health, all 50 State Offices of Rural Health, their partners, sponsors, and community stakeholders, celebrate NRHD. This day provides an opportunity to celebrate rural hospitals and health systems and shine a light on the unique health care challenges that rural communities face and how they think creatively to address these challenges. To view activities from NRHD, please click on AHA's social media content here. For additional information on NRHD, visit the National Organization of State Offices of Rural Health's website here.

CDC Issues EVALI Guidance for Health Care Providers

On November 19, CDC issued a press release titled *CDC Updates EVALI [e-cigarette or vaping lung injury] Guidance for Health Care*

Providers as Flu Activity Increases Nationally—EVALI and Flu Symptoms Often Similar. See excerpts from the press release reprinted below.

CDC today released updated guidance for health care providers to help diagnose and treat patients with e-cigarette or vaping lung injury (EVALI). This updated guidance, published in Morbidity and Mortality Weekly Reports (MMWR), comes as the 2019–2020 influenza season approaches, when many patients may show up in outpatient clinics or hospitals with symptoms of respiratory illness.

This new guidance is an update to the clinical guidance CDC previously released in October 2019. “Clinicians serve a critical role in both identifying and treating patients with EVALI,” said CDC Principal Deputy Director, Anne Schuchat, MD (RADM, USPHS, RET).

Key Recommendations from Updated Guidance

- Health care providers should ask patients with symptoms of respiratory or gastrointestinal illness, or other symptoms such as fever, chills or weight loss, about their use of e-cigarette, or vaping, products. They should evaluate patients with suspected EVALI according to previously published CDC recommendations.
- Not all patients with a history of e-cigarette or vaping product use who present for evaluation of respiratory, gastrointestinal, or other symptoms require hospitalization. EVALI patients can be managed on an outpatient basis if they have normal levels of oxygen in their blood, no respiratory distress, no other health conditions that might compromise lung capacity, reliable access to health care should their symptoms worsen, and strong social support systems.
- Influenza testing should be strongly considered, especially during flu season. Health care providers should consider prescribing antiviral medications if clinically indicated.
- Corticosteroids can be considered for outpatients on a case-by-case basis, however, they should be used with caution in outpatients, because this treatment modality has not been well studied among outpatients, and corticosteroids could worsen respiratory infections.
- Treatment strategies such as behavioral counseling are recommended to help EVALI patients discontinue using e-cigarette or vaping products.
- Health care providers should emphasize the importance of annual flu vaccines for all patients 6 months of age or older, including patients at risk of EVALI.

Characteristics of Non-Hospitalized EVALI Patients

This clinical guidance was released along with a second report in MMWR that provides new information about both hospitalized and non-hospitalized EVALI patients. The report found that as of November 5, 2019, among the 1,977 EVALI patients with available data on hospitalization status, 94% were hospitalized. Demographic characteristics were similar between hospitalized and non-hospitalized patients with most being male and under 35 years of age.

Both reports continue to reinforce key public health recommendations to prevent EVALI, which are based on epidemiologic, laboratory, and clinical data being analyzed by CDC. Click here to review the entire press release.