North Dakota Hospital Association Innovate-ND

HRET Hospital Improvement Innovation Network

February 28, 2019

Educational Events

HRET HIIN

Readmissions MVP Webinar #6
3/01/19 | 11:00 a.m.–12:00 p.m. CT

CAUTI Fishbowl #4
03/12/19 | 11:00 a.m.-12:00 p.m. CT

Readmissions MVP Webinar #7
3/22/19 | 11:00 a.m.–12:00 p.m. CT

Antibiotic Stewardship: Conquering Measurement
03/22/19 | 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.

Partner Educational Events

Quality Health Associates/NDHIN | Regional Optimization of Electronic Health Information Exchange
03/05/19 | 2:00-5:00 p.m. CT
Williston, ND
Register here.
03/12/19 | 2:00-5:00 p.m. CT
Bismarck, ND
Register here.
03/19/19 | 2:00-5:00 p.m. CT
Fargo, ND
Register here.

National Partnership to Improve Dementia Care and Quality Assurance Performance Improvement
Dementia Care & Psychotropic Medication Tracking Tool

Important Dates to Remember

Remember to report your HIIN data in CDS every month!

Deadline	Reporting Period
02/28/19	Performance Data for January 2019 Discharges
03/22/19	Operational Items – PFE/HEOA Survey, REQUIRED

Ramping-up Hospital Disparities and Equity / Patient and Family Engagement Efforts

CMS is placing an increased focus on hospitals addressing Health Disparities and Equity and Patient and Family Engagement (PFE). NDHA along with the Innovate-ND | HRET HIIN team wants to ensure your hospital is getting credit for your efforts. To accomplish this, the Innovate-ND | HRET HIIN team will host a coaching event for hospital HRET HIIN leads/teams that addresses Health Disparities and Equity as well as PFE. The coaching event is designed to assure the Health Equity Organizational Assessment (HEOA) survey, HEOA categories and the PFE metrics are interpreted correctly and answered consistently. We hope that HRET HIIN leads from each participating hospital will be able to attend one of the three sessions. If a hospital cannot attend one of the 3 sessions, one-on-one coaching calls to provide the training will be offered.

Calls have been scheduled on the following days/time; details and access information were sent to hospital HRET HIIN leads earlier this week.

- Wednesday, March 6, 2019 | 7:30 a.m. CT
- Monday, March 11, 2019 | 4:00 p.m. CT
- Thursday, March 14, 2019 | 12:00 noon CT

Participation in one of these coaching calls will count toward education participation in the Milestone program.

Quality Milestones Recognition

COPPER Milestone:	COPPER, BRONZE & SILVER Milestone:
	CHI Mercy Health – Valley City Heart of America Medical Center – Rugby Unity Medical Center – Grafton

03/12/19 | 12:30-2:00 p.m. CT
Register here.

Great Plains QIN
Digging into the Data: A Webinar Series for North Dakota Healthcare Professionals and Staff at all Levels
Quality improvement is a driving force in healthcare, but unless we measure what we are doing, it's difficult to know exactly what to improve and whether we have in fact achieved improvement. Efforts to improve systems or processes must be driven by reliable data which can help accurately identify problems and assist in prioritizing quality improvement initiatives. The **GOOD NEWS** is that you don't have to be a statistician to be successful. This webinar data series will help healthcare professionals at all levels understand data in a way that will aid in achieving and sustaining progress with the goal of gaining data independence.

A Broad View of Data
03/13/19 | 12:00-12:45 p.m. CT
Register here.

Data Readiness
03/27/19 | 12:00-12:45 p.m. CT
Register here.

Data and Clinicians
04/10/19 | 12:00-12:45 p.m. CT
Register here.

Quality Improvement and How Data Can Help Drive Change
04/24/19 | 12:00-12:45 p.m. CT
Register here.

Special Topics in Data and Peer-to-Peer Sharing
05/08/19 | 12:00-12:45 p.m. CT
Register here.

National Disparities Learning and Action Network (LAN) Event Investing in Health Equity: Funding, Cost Savings and Return on Investment (ROI)
03/13/19 | 2:00-3:30 p.m. CT
Register here.

North Dakota Infection Prevention Conference
03/20/19-03/21/19 | Bismarck, ND
Register here.

2019 ACHI National Conference
03/19/19-03/21/19 | Chicago, IL
Register here.

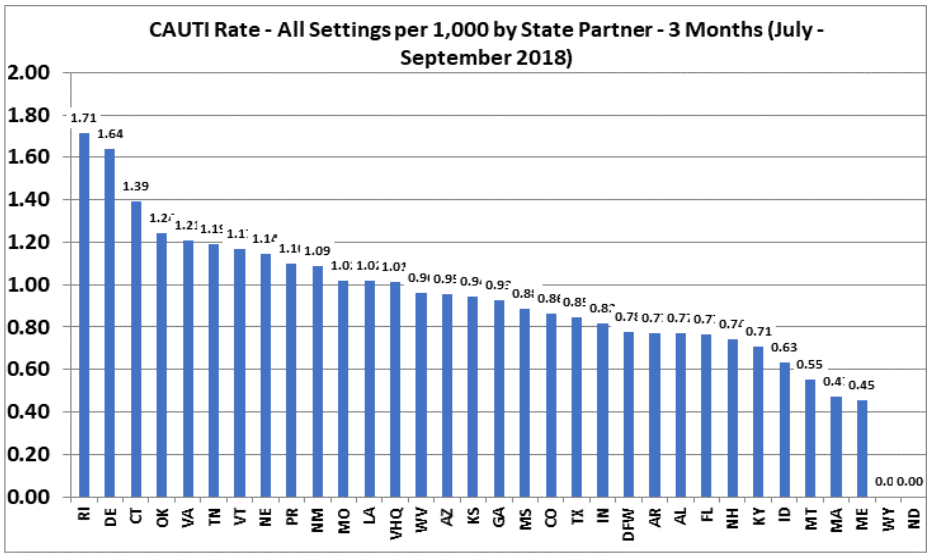
COPPER & BRONZE Milestone:
Ashley Medical Center
Cooperstown Medical Center
Kenmare Community Hospital
Linton Hospital
Mountrail County Medical Center – Stanley
Nelson County Health System – McVille
Southwest Healthcare Services – Bowman
St. Luke's Hospital – Crosby
Tioga Medical Center
Towner County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

COPPER, BRONZE, SILVER & GOLD Milestone:
CHI Community Memorial Hospital – Turtle Lake
Jacobson Memorial Hospital – Elgin
Northwood Deaconess Health Center
Pembina County Memorial Hospital – Cavalier
Presentation Medical Center – Rolla
Sanford Hillsboro Medical Center
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
McKenzie County Healthcare System – Watford City
Sakakawea Medical Center – Hazen
Sanford Mayville Medical Center
St. Aloisius Medical Center – Harvey
St. Andrew's Health Center – Bottineau

Congratulations to the **Wishek Community Hospital** on achieving the **Gold Milestone**! Make sure to read their success story, Simple Changes Reduce Readmissions, in this newsletter!

Congratulations to all ND HIIN Hospitals on your diligent work to reduce CAUTI! Recall that CAUTI was identified as one of the top 3 challenges for our ND hospitals and was therefore included in the Zero Harm Award program, along with Falls and Readmissions. Collectively, for the quarter July-September of 2018, ND hospitals reported zero CAUTI events and are among only two states in the HRET HIIN to accomplish this.



Wound Care Education Institute | Skin & Wound Management Certification Courses
February 11-15, 2019 Kansas City, MO
March 11-15, 2019 Akron, OH
March 11-15, 2019 Grand Rapids, MI
March 18-22, 2019 Indianapolis, IN
March 25-29, 2019 Lake Geneva, WI
April 8-12, 2019 Bloomington, MN
April 15-19, 2019 Des Plaines, IL
June 10-14, 2019 Kansas City, MO
June 24-28, 2019 Manitowac, WI
Prefer to stay home? Take the course online

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.

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.

Hospital Progress Reports

Innovate ND | HRET HIIN Hospital Progress Reports have been prepared and were sent via email to hospital CEOs and HIIN Leads on February 26. These reports include a summary of the improvement status for each measure that a hospital is reporting, including a last-6-month rate and a project-to-date rate, along with an estimate of costs avoided (or assumed) by the hospital based on their improvement. A run chart depicting the hospitals' harms per 1000 discharges across the HIIN project and trendline are also included. This document may be utilized to fulfill the Silver Milestone requirement of sharing HIIN performance with the Board. We also encourage you to share this report with all staff as a tool to keep them engaged in this important work.

North Dakota Infection Prevention Conference

February 27 is the last day to register for the North Dakota Infection Prevention Conference at the early bird rate of $25. The fee goes up to $50 afterwards, so don't waste time and register today! The conference will be held March 20-21, 2019 in Bismarck. Register here.

Featured Resources

Check Out the HRET HIIN Diagnostic Error Change Package

Every nine minutes, someone in a U.S. hospital dies due to a medical diagnosis that was wrong or delayed. Getting the right diagnosis is important, yet not always easy to do. HRET, in partnership with the Society to Improve Diagnosis in Medicine (SIDM), created the Improving Diagnosis in Medicine (Diagnostic Error) Change Package to help hospitals reduce patient safety incidents caused by action during the diagnostic process. It includes case studies that will guide the user in adapting tested interventions and building the infrastructure and support necessary to develop a learning organization capable of responding to adverse events related to diagnosis. For more information, please visit the HRET HIIN Diagnostic Error page here.

Trustees as Partners in Improving Community Health

Hospital board members choose to serve because they want to advance the health of their neighbors and communities. These invaluable trustees are relying more and more on population health strategies to move care and wellness initiatives beyond the four walls of the hospitals they support.

But what exactly does that mean?

The shift toward population health strategies is detailed in a new AHA-produced six-part video teaching module: "A Trustee's Guide to Population Health: Building New Foundations Linking Care with Community." The videos and accompanying discussion guide provide insights on care redesign and the importance of building partnerships with community stakeholders.

Each video offers succinct takeaways grounded in front-line experience, including:

- Improving outcomes for entire communities requires ongoing development of core capabilities and multi-disciplinary teams, including physicians, community organizations and payers.

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

- An understanding of the health of any given population requires integrated information from many sources, including electronic health records, claims data, and patient and family histories.
- Care providers cannot address all of a community's health needs without partners who can help address social determinants of health, better coordinate services and overcome barriers as patients transition home.
- Data is essential to judging success in improving outcomes and reducing costs and can also help uncover gaps in care and unmet needs.
- Community Health Needs Assessments, conducted by nonprofit hospitals every three years, are an excellent way to identify, analyze and prioritize your community's needs.

Trustee engagement on these fronts can help set the vision for community health improvement for your entire organization.

Get the ball rolling today by starting a conversation with your board about your vision, role and purpose in the community. Watch the video series together and encourage each trustee to work closely with you to enhance the well-being of their neighbors and build healthier communities.

Executive Safety Rounding

HRET HIIN Infections Listserv | 02/25/19

A cross-sectional survey study by Sexton, et al., and an editorial by Singer, both in the April 2018 issue of BMJ Quality and Safety, shed light on successful feedback strategies related to leadership safety rounds. These articles are available as free text through the BMJ.

Sexton, et al., demonstrated that Leadership WalkRounds (WR) with feedback to those involved were associated with "better assessments of safety culture, higher workforce engagement, and lower burnout." The work settings with the highest rates of WR with feedback had the highest scores in participation with decision making and growth opportunities, suggesting that rounds with feedback are involving healthcare workers in a way that helps them feel "connected to quality improvement."

In her editorial, Singer emphasizes that leader attitudes and actions are keys to success in realizing the benefits of executive safety rounds. She emphasizes 3 key points for leaders:

- Demonstrate commitment to patient safety objectives by "really showing up" for rounds, not just going through the motions. This means "being present when there and actively listening to the front-line workers with genuine curiosity about their concerns and suggestions, not just 'listening and leaving'."
- Institutionalize leader attitudes and actions through strong systems for project management and a problem-solving infrastructure. This includes closing the feedback loop and creating support structures or processes to conduct the rounds consistently. For example, it is important to create a backup system or rules regarding cancelling a scheduled round.

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

- Leverage social and contextual factors, especially through engaging middle managers as "hosts, guides, and navigators" and involving the informal, natural social networks to enhance positive messaging.

New Rural Communities Opioid Response Program Initiative

The Health Resources and Services Administration's (HRSA) Federal Office of Rural Health Policy (FORHP) will be releasing a Notice of Funding Opportunity (NOFO) for a new Rural Communities Opioid Response Program (RCORP) initiative called RCORP-Implementation (HRSA-19-082). HRSA plans to award approximately 75 grants to rural communities as part of this funding opportunity. Successful RCORP-Implementation award recipients will receive up to $1 million for a three-year period of performance to enhance and expand substance use disorder (SUD), including opioid use disorder (OUD), service delivery in high-risk rural communities. Award recipients will implement a set of core SUD/OUD prevention, treatment, and recovery activities that align with the U.S. Department of Health and Human Services' (HHS) Five-Point Strategy to Combat the Opioid Crisis. To learn more click here.

PEER-TO-PEER SHARING | READMISSION REDUCTION

Simple Changes Reduce Readmissions

Submitted by Shelly Glaesman, RN, Wishek Community Hospital

We realized there was a problem with our readmission rates when our facility was notified by Innovate-ND personnel that our readmission rates compared to other like facilities were 2-3 times the ND average. We couldn't believe it! We knew we needed to make a change. With the help of Jean and Nikki, our team, which included the Director of Nursing, Social Worker, Director of Outpatient Services, and me, derived a plan to make some changes. The following strategies were implemented, and we have been noticing some great results.

One strategy we implemented was decreasing the number of days between day of discharge and hospital follow up appointments with the patient's PCP. Our typical follow-up timeframe was anywhere from 7-14 days minimum. We have since changed it to between 5-7 days. By doing this, we were able to catch issues sooner, address any problems the patient was having, and provide recommendations that would benefit the patient and potentially keep them from being readmitted. We worked with our local nursing homes as well to decrease the length of time between a resident's discharge and follow up on nursing home rounds with our provider.

Another strategy we improved on was our call-back system. We typically do a call back to our patients post discharge to see how they are doing, if they are taking their medications as prescribed, etc. We found that the form we were using was somewhat vague and it was very easy for the patient to answer yes or no even if that was not a true answer. We have since updated our form to ask open-ended questions, ensuring the patient truly understands their medications, understands their results, are not having any problems at home, and if they are, we can take action to remedy the situation.

Our geographical location in south central North Dakota limits us to resources such as home health and hospice services. We struggle daily

with finding the right services for patients that would benefit from some type of in-home care after discharge from the hospital. Within the past 1½ years, we have started a visiting nurse program and have rolled this out to our local service area. This offers certain in-home nursing care to patients after they have been discharged home from the hospital if they meet certain criteria similar to home health. These services are not as broad as what a Home Health service could offer, however, it gets a medical person into their home to assess if more services need to be provided, if there are problems going on with the patient's vital signs, wounds, medications, etc. and if we can need to address something further. If you would like to know more about our visiting nurse program or how it works, contact Stacy Wiest, Director of Outpatient Services, at stacyw@wishekhospital.com

After implementation of the above strategies, we saw great reduction in the number of readmissions we were having. From January-June 2018, we had 16 readmissions, and July-December 2018, we were down to 3! We have had great success just by making small tweaks to services we were already offering, just delivering them in a different format or timeframe.

ADEs

The Balancing Act: Pain vs Opioid Tolerance

HRET HIIN ICU Listserv | 2/26/2019

While opioids have been the mainstay for pain control and sedation in our ICUs where complex care and urgency to treat are prevalent, long-term use can lead to tolerance.

"A" in the ABCDEF bundle refers to "assess and treat pain first" prior to sedation. This practice results in improved outcomes, including fewer vent days when compared to pain and sedation combined regimens. However, most ICU staff lack understanding of acute opioid tolerance.

A recent article in the New England Journal of Medicine Opioid Tolerance in Critical Illness provides information and strategies to balance unrelieved pain and acute opioid tolerance with indications for opioid use in the critically ill. The table below is a tool to assist in mitigating acute opioid tolerance.

Table 1. Strategies for Mitigating Opioid Tolerance or Opioid-Induced Hyperalgesia.*

Appropriate use of opioids
Use of valid assessment scales of pain before and during administration of the analgesic drug
Use of intermittent opioid therapy (oral or intravenous) rather than continuous infusions, when possible
Opioid rotation
Use of remifentanil for short-term analgesia (because of potent induction of opioid-induced hyperalgesia), except when rapid offset of effect is required, as in evaluation of head injury
Minimal use of benzodiazepines (because of delirium and potential opioid-induced hyperalgesia associated with long-term use)
Avoidance of excessive dose escalation; supplementation of opioid with nonopioid analgesics
Addition of methadone to attenuate or delay opioid tolerance
Coadministration of nonopioid analgesics as rescue therapy during procedures or to potentiate the effects of opioids
N-methyl-D-aspartate receptor antagonists (ketamine)
α_2-Adrenergic receptor agonists (clonidine or dexmedetomidine)
Gabapentinoids (gabapentin or pregabalin)
Continuous administration of nerve blocks by means of a catheter
Neuraxial: thoracic or lumber epidural blocks for thoracic, abdominal, or bilateral leg analgesia
Regional: brachial plexus block for arm analgesia; femoral or obturator block or both, with or without sciatic nerve block for lower-limb analgesia
Local: paravertebral block for rib fractures or chest-tube–associated pain; transversus abdominis block for lower abdominal surgery
Prevention or reversal of opioid-induced hyperalgesia and opioid-withdrawal symptoms
Tapering of opioid dose when pain score goal is achieved (10–20% dose reduction every 1–4 days)
Use of valid withdrawal assessment scales
Use of adjuncts to opioids (ketamine, dexmedetomidine, or gabapentinoids [gabapentin or pregabalin])
Use of methadone
Reduction of inflammation
Scheduled acetaminophen therapy
Short-term use of ketorolac†

* The nonopioid strategies that are listed are usually used in combination with opioids; dosing regimens and routes of drug administration are provided in Tables S2 and S3 in the Supplementary Appendix.
† Other nonsteroidal antiinflammatory drugs (e.g., ibuprofen) have limited use in the intensive care unit because of cardiovascular, nephrotoxic, and gastrointestinal side effects.

HAIs

NEW EVIDENCE: Decolonization Reduces Post-discharge Infection Risk for MRSA Carriers

HRET HIIN Infections Listserv | 02/21/19

In a study published last week in the New England Journal of Medicine, Susan Huang, MD, MPH and colleagues found that for hospitalized patients colonized with MRSA, patient education paired with post-discharge MRSA decolonization using chlorhexidine (CHG) and mupirocin led to a 30% lower risk of MRSA infection after discharge compared to patient education alone.

In this multicenter, randomized, controlled trial (Project CLEAR), the investigators evaluated post-discharge hygiene education, as compared with education plus decolonization with chlorhexidine mouthwash, baths or showers with CHG, and nasal mupirocin for 5 days twice per month for 6 months. Participants were followed for 12 months after discharge.

In examining the primary outcome in the analysis, 98 participants (9.2%) in the education group had a MRSA infection, as compared to 67 (6.3%) in the decolonization group. Bacteremia occurred in 28.5% of all MRSA infections. The hazard of MRSA infection was significantly lower in the decolonization group than in the education only group. The decolonization group also had a 29% lower risk of hospitalization due to MRSA infection and 17% lower likelihood of clinically judged infection from any cause.

Of particular note, there was no significant difference in resistance to chlorhexidine and mupirocin between the two groups.

Time to Make a "Diff"erence in C. Diff.

Great Plains Health in North Platte, Nebraska made CDI a priority in their facility and initiated CDI process improvement strategies using a Lean approach by developing a multidisciplinary antibiotic stewardship team based on CDC recommendations led by an internal Infectious Disease physician. The team members included the infectious disease clinic, all local primary care provider clinics, external and internal laboratories, local pharmacies and the GPH hospital staff. The team utilized HRET HIIN CDI webinars and evidenced-based tools for resources and collaborated with HRET HIIN leadership for guidance and best practices including: disinfection/room cleaning processes; daily reviews of antibiotics/correlation with labs; appropriate testing protocols and putting hard stops in place; partnering/collaboration for review of orders. Using these strategies, Great Plains Health decreased their CDI (SIR) rate from a high of 2.555 in 2015 to a rate of 0 in 2018.

Lessons Learned:

- Hospital acquired CDI is preventable with an intensive antibiotic stewardship team and leadership commitment.
- CDI process improvement can be difficult due to number of departments and external customers involved. It's necessary to overcome the barrier of "what can we really do to make a difference?"
- Taking a deep dive into internal processes can reveal what hospitals need to do to reduce harms due to CDI.

Great Plains Health was winner of the rural conference scholarship and had the opportunity to present their storyboard at the conference in January. To learn more about Great Plains Health CDI strategies, contact Nebraska state lead Renee Towne.

Urine Culture Stewardship Practices: Survey Results are In!

HRET HIIN Infections Listerv | 02/26/19

ICHE just published hospital survey results on strategies being utilized to reduce the detection of asymptomatic bacteriuria. The majority of the 52 hospitals were based in US or Canada and roughly 50% considered themselves academic medical centers. The abstract can be accessed here.

Here are the highlights of the survey results:

- 44% (23) of the hospitals have written indications or criteria for urine culture (UC) ordering.

    - 17% (4) require mandatory entry of UC indications when ordering
- 50% (26) of the labs offer reflex UC's based upon pre-defined criteria.
- Criteria for a positive UA consistently included WBCs per high powered field with a variety of cut-offs from > 5 to > 20 with the majority set at >10. Inclusion of nitrites and leukocyte esterase was found in 76% of the criteria.
- Only 35% of the hospitals reported encouraging the use of a preservative in the transport container and only 40% of the hospitals reported rejecting a specimen with a transport time > 2 hours.
- When 3 or more uropathogens are reported, 88% (46) report the culture as "mixed" with no further workup.
- With positive UCs 44% (23) cascade antibiotic susceptibility reporting and 44% (23) report selectively suppressing reports of certain antibiotics and 29% (15) report all antibiotics tested.

Attention CAUTI champions:
This data reflects the findings that our CAUTI fish hospitals discovered about their urine culture practices and shines a light on additional practices that can prevent the treatment of asymptomatic bacteriuria:

- Remember, pre-ordering practices are more important than the behind the scenes reflex and specimen processing practices.
    - Do you have written criteria for ordering a UC?
    - Is the ordering clinician required to document the indications for a UC in a mandatory field? If yes, PLEASE share your screen shots, processes, etc.
- Post- specimen collection, have you looked at these processes?
    - Does your lab have a protocol for handling specimens that exceed the transport time frame, i.e., if > 2 hours from collection without a preservative, if the specimen is rejected?
    - Are specimens with multiple uropathogens worked up differently for suspected contamination?
    - Do providers see all antibiotic sensitivity or do you suppress high risk antibiotics?

SSIs

AHRQ Stats: Deaths After Colorectal Surgery

AHRQ News Now | 02/19/19, Issue #652

The rate of adults who died within 30 days after colorectal surgery decreased from 4.3 percent in 2008 to 2.9 percent in 2017. (Source: AHRQ, 2017 National Healthcare Quality and Disparities Report Chartbook on Patient Safety.)

Surgical Site Infection Prevention Podcast Series

HRET HIIN is pleased to release three newly recorded Surgical Site Infection (SSI) Prevention Podcasts! These podcasts focus on the important role that patient and family engagement has in reducing SSI harms and on providing practical tips for how to promote practices designed to prevent Surgical Site Infections. These podcasts are ideal for Perioperative Practitioners, Infection Preventionists, Quality Leaders and other staff who are interested in engaging patients and families in efforts to prevent surgical site infections in patients.

SSI Prevention: We Can't Do It Without the Patient and Family
This podcast features **Tammy Fugate** who is the Orthopedic Navigator at St. Joseph East in Lexington, KY. Tammy shares guidance on how to customize patient education and how to best identify and minimize modifiable patient risk factors. Tammy describes how patient and family engagement are key components and have resulted in more positive clinical outcomes.

SSI Prevention: A Simple Way to Measure Process
This podcast features **Karen Shannon**, Interim OR Manager, also from St. Joseph East, who describes how a Total Joint Arthroscopy tool was designed, tweaked, and ultimately utilized to engage perioperative staff when assessing adherence to evidence-based practices. The one-page tool was designed to reliably evaluate practices and identify gaps or opportunities for improvement.

SSI Prevention: Making the Right Thing the Easy Thing To Do
This podcast features **Janet Chance**, Director of Quality, Infection Prevention & Accreditation at Cullman Regional Medical Center in Cullman, AL. Janet focuses on the value of partnering with patients and family and how to empower patients by educating them to do the right thing so they can have the best opportunity for a positive outcome. She discusses how to build a strong business plan to make the right thing the easy thing to do and to create a reliable and sustainable process that will deeply minimize the risk of Surgical Site Infections.

The podcasts are now available on SoundCloud and the HRET HIIN website here!

SEPSIS

Great Plains QIN | Free Sepsis Training for EMS

Sepsis is a life-threatening complication of an infectious process that without rapid diagnosis and treatment can quickly progress to tissue damage, organ failure and death—270,000 Americans die each year from sepsis. Alarmingly, mortality increases 8 percent with each hour an individual does not receive treatment for sepsis.

Because nearly 80% of sepsis cases begin in the community, awareness of the signs and symptoms of sepsis is critical knowledge for Emergency Medical Services (EMS). EMS professionals are critical partners as they can help prevent sepsis infection or death by knowing the risk factors, identifying the symptoms and initiating life-saving treatment.

Computerized sepsis training modules have been developed to educate EMS providers across the region of the significance of early recognition and treatment of sepsis and that sepsis is a medical emergency.

Module 1: Reducing Sepsis Harm and Death
In this module, participants will learn about the symptoms and conditions where sepsis should be suspected and why sepsis is considered an emergency event.

Module 2: Sepsis Screening Tool – Early and Reliable Identification

Participants will learn the sepsis risk factors, analyze the components of sepsis screening tools and evaluate the need for a sepsis screening tool for their local EMS unit. A sepsis screening tool is provided.

Module 3: Sepsis Alert! Support Prompt Escalation & Timely Interventions for At-risk Patients
This module focuses on utilizing the sepsis screening tool to alert receiving healthcare providers that sepsis is suspected and appropriate action can be taken. Understanding the roles and expectations of all members of the healthcare team and using a standardized communication hand-off tool are discussed.

Module 4: Utilizing Quality Improvement Techniques for EMS
Participants will learn the importance of quality improvement and basic quality improvement strategies to improve EMS processes and systems.

Click here to access the training modules. A certificate will be provided upon completion of each module.

Hour 1 Bundle: A Performance Improvement Strategy

Last year the "Hour 1 Bundle" for sepsis treatment was introduced by the Society of Critical Care Medicine (SCCM) and the Surviving Sepsis Campaign (SSC). Late in 2018 both groups asked for hospitals to pause in their implementation of the Hour 1 Bundle while additional investigation was completed. Mid-January of 2019 the "Hour 1 Bundle" has been vetted by both SCCM and SSC as a tool for quality improvement.

Strive for the Hour 1 Bundle elements of:

- Measure lactate level—Remeasure lactate if initial lactate is elevated (> 2 mmol/L)
- Obtain blood cultures before administering antibiotics.
- Administer broad-spectrum antibiotics.
- Begin rapid administration of 30mL/kg crystalloid for hypotension or lactate level ≥ 4 mmol/L.
- Apply vasopressors if hypotensive during or after fluid resuscitation to maintain MAP ≥ 65 mm Hg.

Adding this goal to your current sepsis work can help create the sense of urgency necessary when treating sepsis and septic shock. Encouraging your health care team to act as quickly as possible to initiate these elements within one hour of sepsis identification.

These recommendations and supporting literature can be found here.

FALLS

Helping Older Adults Stay Mobile

Did You Know?

- About 7,400 older adults died and more than 290,000 were treated in emergency departments in 2016 as a result of motor vehicle crash injuries.
- Changes in health that might come with age can reduce mobility and increase older adults' risks for falls and motor vehicle crash injuries.

- Health professionals can encourage older adults to use CDC's MyMobility Plan to take action now to stay safe and independent longer.

Bundling Safe Patient Handling, Mobility, Falls and HAPI

HRET HIIN Listserv | 02/26/19

Our HRET HIIN work has spent considerable time focusing on avoiding friction and shear to prevent pressure injuries and promoting early progressive mobility to prevent falls and patient harm from immobility. In a new article authored by HRET HIIN Subject Matter's experts, Kathleen Vollman and Joyce Black, Changing Perceptions of a Culture of Safety for the Patient and the Caregiver, the authors urge us to shift our paradigm to bundle patient and worker safety to create a culture of safety that protect both caregivers and patients. Access the abstract here.

The call to action is for leadership to move from a silo approach to safe patient handling (SPH), early mobility, pressure injury prevention, and fall prevention that uses separate teams and disciplines to an integrated, interprofessional approach. This involves learning to work together differently across disciplines and teams to achieve improved safety outcomes. In order to accomplish this, what needs to change?

- Improvement initiatives will transcend departmental walls
- Measurement will integrate patient and worker safety
- Organizational processes and infrastructures will be redesigned to support a cross cutting approach

To tie this back to our current focus, how can you use what you know about worker injuries related to lateral transfers and bed positioning with the data on the impact of friction and shear on skin integrity to create better ways to move patients safely?

Some big ideas from the article to achieve safe mobility for patients and staff:

- In-bed mobility aids such as friction-reducing slide sheets
- Out-of-bed assistance with ceiling or floor-based lifts, power assisted standing devices
- SPH Peer Coaches who receive additional training on equipment and act as superusers and peer coaches

The authors also stress that leadership must support this dual focus of integrating worker safety through safe patient handling by establishing the following:

- Administrative controls: leadership support, budget, policy
- Engineering controls: equipment, maintenance, and storage
- Behavioral controls: education, peer coaching, feedback to teams, and fostering a culture of safety

DIVERSITY/DISPARITIES

HRET HIIN Health Equity Organizational Assessment - Assessment Category Five

HRET HIIN Health Disparities Listserv | 02/22/19

To eliminate health disparities and increase quality of care, it is important that hospitals and health systems communicate identified gaps in disparities to create organization-and community-wide awareness of potential differences in patient outcomes. This can help promote understanding of patient population needs throughout the organization, and at the community level.

We have reviewed HEOA categories one through four: these categories have focused on data collection, staff training, ensuring data validity and reliability, and stratifying patient safety, quality and/or outcome measures using patient demographic data. It's time to take a look at how we can effectively communicate our findings.

HEOA Category Five: Hospital uses a reporting mechanism (e.g., equity dashboard) to communicate outcomes for various patient populations.

An important step toward making this assessment category a priority, is to consider joining AHA by endorsing the pledge to take action on the AHA's National Call to Action to Eliminate Health Care Disparities' goals to ensure that quality and equitable health care is delivered to all persons. We encourage hospitals and hospital systems to sign the #123forEquity Pledge to Act to Eliminate Health Care Disparities.

MISCELLANEOUS

Funding Opportunity

HRSA Small Health Care Provider Quality Improvement Grant Program–April 22.
The Health Resources and Services Administration (HRSA) expects approximately $6.4 million available to fund up to 32 rural public or nonprofit private health care organizations to improve patient care and chronic disease outcomes through implementation of evidence-based approaches to quality improvement and delivery of coordinated care in rural primary care settings. The program also encourages care that measures value by outcomes, patient-centered medical homes, and activities that integrate behavioral health into the primary care setting. Previously funded organizations under this program included projects focused on care coordination, chronic disease management, integrated care delivery systems and reduction in preventable emergency department and hospital admissions, among other topics.