North Dakota Hospital Association Innovate-ND

HRET Hospital Improvement Innovation Network

May 3, 2019

Educational Events

HRET HIIN

Falls-Delirium Sprint
05/09/19 | 11:00 a.m.–12:00 p.m. CT

Opioid Safety: Alternatives to Opioids Webinar Series #1
05/14/19 | 10:00-11:00 a.m. CT

Opioid Safety: Alternatives to Opioids Webinar Series #2
06/21/19 | 10:00-11:00 a.m. CT

Opioid Safety: Alternatives to Opioids Webinar Series #3
07/09/19 | 10:00-11:00 a.m. CT

Opioid Safety: Alternatives to Opioids Webinar Series #4
08/13/19 | 10:00-11:00 a.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

The Joint Commission | Best Practices in Anticoagulant Therapy Webinar Part 2: Preparing for new Joint Commission EPs effective July 1
05/17/19 | 11:00 a.m.–12:00 p.m. CT
Register here.

Patient Safety Movement Foundation | Webinar: Patient Safety Curriculum for All Health Professionals

Important Dates to Remember

Remember to report your HIIN data in CDS every month!

Deadline	Reporting Period
05/31/19	Performance Data for April 2019 Discharges

A huge thank you to Jennifer Lauckner and Molly Palm, St. Andrew's Medical Center, and Liz Hanson, Linton Hospital, for sharing their readmission reduction strategies at the April 18 CAH Quality Network Meeting in Bismarck.

Two thumbs up to Megan Thompson and Emily Koenig, First Care Health Center, and Jamie Nienhuis, Cavalier County Memorial Hospital and Clinics, Langdon, for sharing their experience in developing a PFAC and many facets of their PFE efforts during the PFE Bootcamp, April 23 and 24, in Minot.

Quality Milestones Recognition

COPPER Milestone:

COPPER, BRONZE & SILVER Milestone:
Heart of America Medical Center – Rugby
Unity Medical Center – Grafton

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
CHI Mercy Health – Valley City
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

05/08/19 | 11:00 a.m.–12:00 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
Special Topics in Data and Peer-to-Peer Sharing
05/08/19 | 12:00-12:45 p.m. CT
Register here.

QIN National Coordinating Center
Antibiotic Stewardship: National Updates, Progress, and Next Steps
05/08/19 | 2:00–3:30 p.m. CT
Registration required!
Register here.

2019 Minnesota Antibiotic Stewardship Conference
05/13/19 | St. Paul, MN
More information to come!

PFE Learning Event | PFEA Metrics 3, 4 and 5: The Importance of Hospital Leadership in Fostering a Culture of PFE from the Bedside to the Boardroom
05/16/19 | 12:00 p.m.–1:00 p.m. CT Register here.

Balancing Surface Disinfecting & Compatibility In Healthcare Today
05/21/19 | 1:00-2:00 p.m. CT
Register here.

Wound Care Education Institute | Skin & Wound Management Certification Courses
June 10-14, 2019 Kansas City, MO
June 24-28, 2019 Manitowac, WI
Prefer to stay home? Take the course online

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.

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
St. Aloisius Medical Center – Harvey
St. Andrew's Health Center – Bottineau

FEATURED RESOURCES

Lifespan Emergency Respite Care Grant Service

PURPOSE: *The purpose of the Lifespan Emergency Respite Care Grant Service is to offer the funding and resources to support caregivers of children with special needs or of adults who have an urgent need for respite care in the absence of any other funding sources.*

Emergency respite care may result from but is not limited to the following circumstances:
- Caregiver illness (physical, mental, emotional)
- Caregiver death or hospitalization
- Illness of a loved one
- Funeral/wake

Eligibility Criteria
The individual receiving emergency respite care services will meet the following criteria:
- Meet the definition of caregiver
- Be experiencing an emergency and does not have access to other funding sources or is on a waiting list for available services
- Lives with the care recipient, or if the primary caregiver does not live with the care recipient, the caregiver must be providing frequent on-site visits throughout the day, which are essential to assure the client's health and safety. For example, the care recipient would be unable to get out of bed, prepare a meal, etc., in the absence of the caregiver

Respite Provider
- An individual, facility, organization which provides respite care services; the provider may be a family member who does not reside with the care recipient, a friend, a neighbor as chosen by the caregiver/care recipient/legal representative

Emergency Respite Referrals/Application
- Request for services will ONLY be accepted from agencies working with caregivers and care recipients
- Aging Services cannot accept referrals directly from individuals, including caregivers, care recipients, family members, etc.

Information and Forms for Referring Agencies
- FLOWCHART: How to secure emergency respite grant funding for caregivers (March 2019)
- FORMS
  - Application (SFN 548)
  - Respite Provider Agreement *(SFN 559)*
  - IRS Substitute W-9 Form *(SFN 53656)*

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

    - Provider Service Log (Billing Form) (SFN 546)
    - (NOTE: *If you have problems accessing the forms, it may be your Web browser. Please see guidance on the State Forms Page.)*
- Lifespan Emergency Respite Care Service Standards (March 14, 2019)
- Sample: Journal/Worksheet (March 14, 2019)
- PRESENTATION: ND Lifespan Respite Care Grant: Emergency Respite Care Services

Contact:
Aging Services Division
1237 W. Divide Ave., Suite 6
Bismarck, ND 58501
ND Aging & Disability Resource-LINK toll-free 1-855-GO2LINK (**1-855-462-5465**)
711 (TTY) or Relay ND TTY: (800) 366-6888
Fax: (701) 328-8744
Email: carechoice@nd.gov

ADEs

Avoiding Inpatient Over-Sedation and Death: The Hero is an RN

HRET HIIN Hospital Wide Listserv | 04/12/19

While we are all working hard to do what we can to reduce outpatient opioid overdoses and deaths (limiting prescribing, dispensing naloxone, etc.), we cannot forget our responsibility to prevent iatrogenic inpatient opioid harm and death.

CMS data shows that about 300 inpatients die annually from iatrogenic over-sedation and under-monitoring. These are preventable and, unlike the outpatient deaths, we have the power to make these "never events."

For 20 years the Pasero-Opioid Induced Sedation Scale (POSS) has been available. This simple tool asks that the nurse assess the patient with a simple scale before administering sedation agents or opioids, reassess 15 minutes after administration, and then hourly thereafter as long as necessary. Hospitals that have implemented this have found naloxone use drop to near zero.

The POSS has been appropriately vetted and challenged in the literature and remains the best tool to assess patients outside of the ICU (use the Richmond Agitation Sedation Scale in the ICU). The POSS has high inter-rater reliability, instructs the nurse as to the acceptable actions at each level, and has become a useful communication tool.

Two new studies, found here and here illustrate its value.

You can find the POSS here.

New Podcast Series and Webinar Replay

The AHA has released three new podcasts on the Prescribe Safe Initiative, a successful community-based project bringing together hospitals, law enforcement and physicians to reduce prescription

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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medication misuse. The podcasts explore various aspects of Prescribe Safe, including how to: secure funding and support; work collaboratively with a wide variety of partners; and leverage complementary and alternative medicine to reduce the use of opioids in the management of pain. Listen to the series **here.** A replay of a recent AHA webinar on Prescribe Safe also is available. Visit the AHA webpage for more resources.

NAM Meeting on Combatting Opioids

The National Academy of Medicine Action Collaborative on Countering the U.S. Opioid Epidemic, of which the AHA is a sponsor, held a two-day meeting this week to discuss priority issues and strategies to combat the opioid crisis. Former AHA Board Chair Jonathan Perlin, MD, president, clinical services and chief medical officer of HCA Healthcare, is a co-chair of the collaborative and helped lead the meeting. AHA Senior Vice President and Chief Medical Officer Jay Bhatt, DO, who serves on the steering committee for the collaborative, participated in the meeting and helped lead a session focused on prevention, treatment and recovery services as co-chair of that collaborative working group. Read more.

Drug Overdose Deaths Among Women Aged 30–64 Years — United States, 1999–2017

New FREE Continuing Education from *MMWR* and Medscape

CDC's MMWR and Medscape are proud to introduce a new FREE continuing education (CE) activity. The goal is to inform clinicians of overdose death rates among U.S. women aged 30–64 years during 1999–2017, overall and by drug subcategories, and clinical implications for members of the health care team. CDC surveillance is the basis for this activity.

This activity is intended for internists, emergency medicine practitioners, family medicine practitioners, obstetricians, gynecologists, psychiatrists, public health officials, nurses, pharmacists, and other members of the health care team who care for women who might be at risk for drug overdose.

Upon completion of this activity, participants will be able to:

- Describe overall rates of overdose death among U.S. women aged 30–64 years during 1999–2017;
- Determine rates of overdose death by drug subcategories among U.S. women aged 30–64 years during 1999–2017; and
- Describe clinical implications of overdose death rates among U.S. women aged 30–64 years during 1999–2017.

To access this free *MMWR*/Medscape CE activity, visit http://bit.ly/2Xpqv3Q. If you are not a registered user on Medscape, register for free or login without a password and get unlimited access to all CE activities and other Medscape features.

Older Americans Awash in Antibiotics

The Pew Charitable Trusts | 04/24/19

Patients over 65 have the highest rate of outpatient prescribing of any age group. And their prescriptions come with risks to both patient safety and public health. Read more here.

Antibiotics Ties to Longer Hospital Stays for Asthma

Medscape IN FOCUS | 04/22/19

Use of antibiotics among patients hospitalized for asthma exacerbations is associated with longer hospital stays, increased cost, and no reduction in the risk for treatment failure, new data show. Read more here.

ANTIBIOTIC STEWARDSHIP

The Antibiotic Market is Broken – and Won't Fix Itself

The Pew Charitable Trusts | 04/17/19

Although patients increasingly face infections that don't respond to existing antibiotics, research to develop new antibiotics is shrinking in size and scope. Read more here.

HAIS

WHO Hand Hygiene Day is May 5!

The World Health Organization's "SAVE LIVES: Clean Your Hands" campaign aims to bring people together in support of hand hygiene and IPC improvement globally. Learn more and support the calls to action.

Low Risk Braden Score Associated with High CAUTI Risk

HRET HIIN Infections Listserv | 04/16/19

In a 2019 single site, retrospective cohort analysis from data abstracted from CAUTI root cause analysis tools, a correlation was found between high Braden scores (low risk) and early onset CAUTI (within the first seven days). This is counterintuitive! Read on.

The authors hypothesize that the patients with a higher Braden score are more likely to be active while they have a catheter in place, leading to local trauma and introduction of bacteria in the urethra. In addition, with mobilization it is more likely that problems may occur with the drainage bag positioning or kinking of tubing. This small study is food for thought. Can we use mobility as a reason for catheter removal instead of using it as a one-point restraint that limits mobility?

Implications for our improvement work:

- Include mobility in your conversations around catheter necessity and removal. Removal of catheters for ambulatory patients must be a priority.
- Ask patients about their comfort with mobility with a catheter and educate them about alternatives.
- Ask about precautions being taken for ambulatory patients with catheters.
- Evaluate your securement devices. Are they effective?

Assessing for Adequate Bladder Emptying Post Catheter Removal

HRET HIIN Infections Listserv | 12/04/18

The American Nurses Association (ANA) has published a streamlined, evidence-based RN tool for preventing CAUTI. The two page tool addressed appropriateness criteria and includes an algorithm for assessing continuation or removal of a urinary catheter, a protocol for assessing bladder emptying post catheter removal, and a checklist for insertion technique and maintenance standards. The tool can be accessed here: ANA Evidence-Based CAUTI Tool.

The protocol for assessing bladder emptying includes measuring output volume and obtaining a post-void residual by bladder scanner or straight catheterization. The protocol indicates that adequate voiding volume to assess emptying should be at least 180 ml.

Questions to consider about barriers to the immediate actions post catheter removal:

- How are you supporting your staff in assessing bladder emptying with incontinent patients? Do you weigh pads or use external catheters to assess the presence of an adequate void?
- If you have a bladder scanner, how to you ensure staff are competent in using this equipment, and that the equipment is available when the staff need it?

HRET HIIN Sprinting Away from CDI

HRET HIIN State Partners Listserv | 04/25/19

In Fall 2018, HRET held a CDI Sprint with hospitals and health systems across the nation. The 8-week quality improvement collaborative led by HRET subject matter experts and HIIN hospital peer advisors assisted participants in implementing techniques to reduce root causes of healthcare-onset *C. difficile*. The focus on laboratory stewardship helped participants identify the impact of culturing practices using the HRET HIIN CDI Process Improvement Discovery Tool. Lessons learned from the tool assisted the acceleration of improvement efforts to enhance patient safety. To learn more, click here.

The HRET HIIN CDI Sprint resulted in a rapid rate reduction for participating hospitals. HRET is assessing reduction achievements three months post sprint conclusion to assess sustainability. In addition, hospitals and health system participants reported statistically significant perceived improvement in reducing CDI through Sprint participation. Based on these results, we encourage Allied Associations to promote HRET HIIN Sprints through the option period to increase achievement of 20/12 goals.

Expiring Soon: CME from CDC: What You Need to Know About Infection Control

In 2017, the Centers for Disease Control and Prevention and Medscape launched a series of six CME/CE activities addressing the key issues surrounding infection prevention in healthcare facilities for physicians, nurses, and pharmacists. These activities are valid for credit for 2 years. Take the courses now before they expire!

The series includes:

- Risk Recognition in Healthcare Settings
- Environmental Services and Infection Prevention
- Recognizing Infection Risks in Medical Equipment
- Infection Transmission Risks Associated with Nonsterile Glove Use

- Infection Prevention: A Hierarchy of Controls Approach
- Injection Safety: A System Approach

These CME/CE certified activities are available on Medscape. You must be a registered Medscape member to access these CME/CE activities, and registration is free.

SEPSIS

Finding Sepsis Before the ED

HRET HIIN Hospital Wide Listserv | 04/25/19

An article from 2018 published in Critical Care Medicine Journal entitled Healthcare Utilization and Infection in the Week Prior to Sepsis Hospitalization took a retrospective look at over 45,000 patients admitted for sepsis in two large integrated health systems in the United States. This investigation found, “Over 45% of sepsis patients had clinician-based encounters in the week prior to hospitalization with an increasing frequency of diagnoses for acute infection and antibiotic use in the outpatient setting.” The researchers wanted to identify new opportunities for sepsis recognition and treatment prior to admission.

Given these findings we have multiple opportunities to improve early recognition and treatment of sepsis prior to admission. The abstract can be found here.

Moving forward consider what you can do to encourage sepsis recognition prior to admission. Perhaps

- Working with primary care providers in the community to identify/screen for sepsis;
- Actively identifying sepsis in your community settings; and
- Collaborate with Emergency Medical Responders to encourage screening for sepsis.

FALLS

Training Family Members for Fewer Falls and Better Outcomes

HRET HIIN Hospital Wide Listserv | 04/17/19

Memorial Rehabilitation Institute in Hollywood, Florida won a Sherman Award last year for patient/family engagement. In this improvement effort not only were family related falls decreased, but discharge to skilled nursing facility also decreased.

The approach this hospital used was to invite family members to participate in care. They focused on five essential elements of safe mobilization that families or caregivers should be trained on:

- Bed to chair transfers
- Walking
- Wheelchair management
- Toilet transfers
- Toileting

The therapist determines when the patient is ready for family to assist with mobility. Once the family can comfortably manage all five elements, they receive the orange band. Family members build confidence with training and are proud to achieve the band. Read more here.

Editor's Note: The Memorial Rehabilitation Institute received a 2018 Sherman Award for Excellence in Patient Engagement for its fall prevention program. The Sherman Award is co-sponsored by Taylor Healthcare and the IHI/NPSF Lucian Leape Institute and was awarded at the IHI/NPSF Patient Safety Congress held recently in Boston, Massachusetts.

Moving forward, consider a structured way to "invite" family members to participate in mobility and/or a mechanism to identify "family in training". This December 2018 AJN article may be a useful resource, Teaching Family and Caregivers to Assist with Mobility.

READMISSIONS

Reduction in Readmissions through Care Transitions Program

Gila Regional Medical Center (GRMC) in Silver City, NM, noted that their readmission rate was significantly higher than the national average. After reviewing, analyzing, and discussing the readmission data, the medical center decided to reevaluate and institute a Care Transitions program with a more comprehensive scope of interventions by partnering with physician's practices, community based health care programs, and community social support services. Case Management had initiated a care transitions pilot in 2016, with inpatients screened face to face by the care transitions nurse with moderate success. In 2017, a senior baccalaureate nursing student conducted a capstone focused on care transitions. The at-risk population was identified using an analytical approach and a new program was designed with expansion of the scope of interventions.

By 2016 Q1, GRMC saw day 1-7 readmission counts return to the comparative median. Analysis of the readmitted patients showed a need for better support through the discharge transition, therefore the Care Transitions Pilot Program was initiated. The program helped stabilize readmissions and ran through 2016 Q4. By 2016 Q4, the day 1-7 readmission count had decreased to 36% below the median.

Lessons Learned:

- Care Transitions must be an organization-wide endeavor rather than conducted by a single department or individual.
- Clear understanding of medication management is essential at the time of discharge to prevent the need to return to the hospital.
- No patient is discharged without having a PCP assigned and a follow-up appointment scheduled.
- This Care Transitions program model can easily be replicated by any hospital or facility without having to purchase expensive software, using current staff, and establishing collaborative working relationships with outpatient clinics and community programs.

To learn more about Gila Regional Medical Center's Care Transitions Program click here to read their case study and contact New Mexico state lead, Dan Lanari.

Reducing Readmissions through an Interdisciplinary Team Approach

Mount Desert Island Hospital in Bar Harbor, Maine's mission has been to provide compassionate care and strengthen the health of their community. The hospital's current focus has been on tackling readmissions to improve care through the following strategies: formation of an interdisciplinary team made of nurses, providers, pharmacists, a social worker, and a respiratory therapist to address all of the patient's needs; COPD and CHF Rescue Kits for patients with chronic COPD or CHF that they can obtain from a pharmacy at any time and used when certain criteria are met; providing a Better Breathing, Better Living (BBBL) comprehensive program for patients that incorporates exercise training in the home, education and behavior change; providing a Weekend Care Clinic for patients with common acute care needs; documenting verbal and written care transitions when completing the patient's final orders electronically; and having pharmacists participate in morning huddles and rounding to provide pharmaceutical education to patients when new medications are prescribed.

In 2017, the hospital averaged a readmissions rate of 6.85% and selected a readmission goal of 5% in 2018. In the first 3 quarters of 2018 the hospital averaged a readmission rate of 3.83%.

Lessons Learned and Next Steps:

- It is important to promote evidence-based community interventions to prevent and treat chronic diseases. An example being Diabetes self-Management classes.
- The Rescue kits and the BBBL program were successful strategies that will continue to be implemented.
- The Care Management team will continue to track patients who are admitted, in addition to other facilities.
- The Weekend Care Clinic was very helpful in improving access to care in the community.

To learn more about Mount Desert Island Hospital's readmissions reduction strategies, please contact Maine state lead, Sandra Parker.

MRSA/MSSA Bacteremia and Readmissions - Are You Tracking This?

The following study and associated information that was recently shared on the HRET HIIN Infections Listserv has implications for Readmissions work as well. When analyzing data for readmitted patients, are you finding higher readmission rates for patients with MSSA or MRSA infections identified during index admissions? This study gives some food for thought:

In an accepted manuscript in *Clinical Infectious Diseases*, Inagaki, et. al, examined national United States outcomes associated with invasive methicillin-resistant and methicillin-susceptible *Staphylococcus aureus* bacteremia, particularly focusing on readmissions.

The researchers conducted a retrospective analysis using the 2014 Nationwide Readmissions Database (NRD), compiled by the Healthcare Costs and Utilization Project (HCUP) of the Agency for Healthcare Research and Quality. This database captures 49.3% of all U.S. hospitalizations. They identified MSSA and MRSA bacteremia among patients 18 and older and included the results in the analysis.

Of the 92,089 patients with *S. aureus* bacteremia, 48.5% had MRSA bacteremia. The 30-day readmission rate was **22% overall** for those patients surviving the initial hospitalization. Although the 30-day readmission rates did not differ significantly between MRSA and MSSA bacteremia, MRSA bacteremia patients had a higher chance of readmission with recurrent bacteremia, higher in-hospital mortality, and longer hospitalization.

Consistent with the new findings from the CDC linking MRSA bacteremia with opioid drug use, readmission with bacteremia recurrence in this study was particularly more common among patients with endocarditis, immunocompromising comorbidities, and drug abuse.

The authors report the cost of readmission for these patients as $12,432/case overall, and $19,186 in those patients with bacteremia.

Moving forward consider

- Evaluating 30-day readmission rate for patients diagnosed with MSSA or MRSA bacteremia.
- Implementing strategies to enhance care transitions for this population of patients at risk for readmissions.

PFE

ND Patient and Family Engagement Boot Camp

Patient and Family Engagement Bootcamp, April 23-24, 2019

Nine Innovate-ND hospitals, including two mentor hospitals, First Care Health Center, Park River, and Cavalier County Memorial Hospital and Clinics, Langdon, participated in a two-day “Boot Camp” last month. Martha Hayward, HRET PFE subject matter expert, led this riveting event using her personal patient experience and subsequent PFE career track to set the stage for learning and sharing.

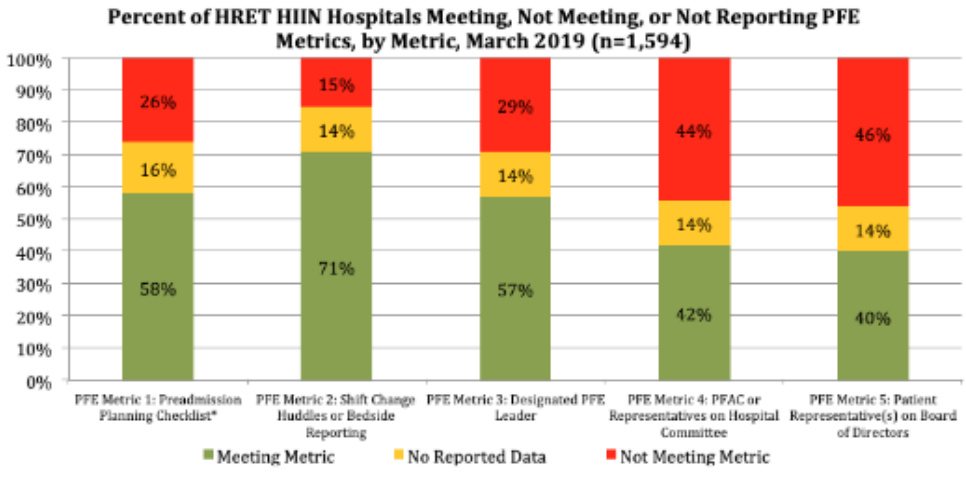
Highlights from the Bootcamp:

- The participants!
    - Angie Mahlum, Jessica Brekhus and Danielle Alsadon, Trinity – Kenmare Community Hospital
    - Jenna Hove and Ann Nelson – Tioga Medical Center
    - Amber Umbriet – Southwest Healthcare Services, Bowman
    - Molly Palm and Jenifer Lauckner – St. Andrew’s Health Center, Bottineau
    - Cindy Oien – Nelson County Health System
    - Megan Thompson and Emily Koenig – First Care Health Center, Park River

    - Marie Reimer and Alison Frueh – Sanford-Hillsboro
    - Heather Narloch – Unity Medical Center, Grafton
    - Jamie Nienhuis – Cavalier County Memorial Hospital and Clinics, Langdon
- Separating patient satisfaction (one dimensional) from patient experience (multi-dimensional); and advisors (offers suggestions about the best course of action) from advocate (supports a particular cause or action often stemming from conflict).
- Creating a culture of patient centered care: "In the hospital, the work that you do, and the connectivity you have with every individual patient is impacted by the burden or the gift of every other person in your facility."
    - Consider the difference between an initiative that is publicized to one that is internalized.
- Promote knowledge of the whole patient – aside from their illness, what do you know about the patient? (Likes/dislikes, languages, hobbies, goals)
- Move efforts away from addressing "what is the matter" to "what matters the most." Patients should feel that we are preparing and prepared for them….*we are preparing in abundance for you*.
- Review your mission/vision. Does it reflect your work? Do you reflect your mission?
- If you aren't centered on the patient, what are you centered on?
- "I find the relationship between nurses and patients mind-blowing. Nurses can do all kinds of guts and gory things, but remain so gentle and kind and treat me with such dignity. I want to die in the hospital with that kind of competence around me. Not at home…home is where I cook and entertain and live…I want my family there enjoying the casserole I have in the freezer, but I want to die in the hospital." Martha Hayward
- Regarding the picture she drew of herself for the wrap-up: "This is how I look when I feel proud…" Molly Palm

Patient and Family Engagement Performance

Thanks to all who provided timely submission of PFE data for March 2019! The figure below shows the percent of HRET HIIN hospitals meeting, not meeting, or not reporting each PFE metric for the most recent submission period.



* 229 Hospitals have no scheduled admissions (exempt) and are thus excluded from the PFE1 denominator

DIVERSITY/DISPARITIES

Actively Addressing Social Determinants of Health will Help Us Achieve Health Equity

Each April marks National Minority Health Month, providing the opportunity to acknowledge the progress made in reducing disparities, as well as a chance to reflect on what more needs to be done to achieve health equity. Discussions about health equity frequently focus on the important roles that preventive services and care quality have in determining health outcomes. While the care we receive plays an important role, health outcomes may often be driven by the conditions in which we live, learn, work, and play. Individuals with inadequate access to food or stable housing are at greater risk of developing chronic conditions and managing these conditions. They also face increases to health care costs and services that might otherwise be avoidable. These conditions are known as social determinants of health and minority populations tend to be disproportionately affected by them.

Social determinants of health can include housing, transportation, education, social isolation, and more. These factors affect access to care and health care utilization as well as outcomes. As we seek to foster innovation, rethink rural health, find solutions to the opioid epidemic, and continue to put patients first, we need to take into account social determinants of health and recognize their importance.

Addressing the social determinants of health begins with identifying a patient's needs and measuring their impact. Organizations may measure these factors using a number of existing tools that can help in the identification process, including:

- Z codes from in the International Classification of Diseases (ICD-10-CM), which are a group of codes within the ICD-10 (diagnostic) codes that help clinicians capture a patient's socioeconomic and/or psychosocial needs (Examples of Z-codes in table below),
- Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool, which is used by clinicians participating in the CMS AHC model to identify needs related to social determinants,
- PRAPARE tool (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences), developed by the National Association of Community Health Centers for providers to collect the data needed to better understand and act on their patients' social determinants of health, and
- Health Leads Screening Toolkit, which is intended to be used by clinicians as a comprehensive way to assess patients for adverse social determinants. Data collection will help us strengthen our understanding of the relationship between social determinants of health and health care use across diverse populations, allowing us to develop solutions and better connect patients to much needed services. We are beginning this effort in several post-acute care provider settings this year by proposing that some data elements be collected on standardized patient assessment instruments. Some of the data elements are derived from questions from the Accountable Health Communities and PRAPARE tools mentioned above.

Examples of Z codes	
Z55: Problems related to education and literacy	Z59: Problems related to housing and economic circumstances

Z56: Problems related to employment and unemployment	Z60: Problems related to social environment
Z57: Occupational exposure to risk factors	Z64 Problems related to certain psychosocial circumstances
Z58: Problems related to physical environment	

In an effort to reduce expenditures and improve health outcomes, CMS is testing the Accountable Health Communities Model, which is the first model to include social determinants of health. The model is based on emerging evidence that shows addressing health-related social needs through enhanced clinical-community links can improve health outcomes and reduce costs. The model also helps to foster innovation to support connections between care, food, and housing for patients in need.

Adequately and appropriately addressing social determinants of health will require the efforts of all stakeholders including beneficiaries, community groups, and health care providers. The CMS Office of Minority Health collaborated with the Health Resources and Services Administration Office of Health Equity on an event focused on social determinants of health. Participants heard from renowned speakers on how social determinants influence health outcomes, such as physical and mental health, and major chronic conditions that are more common among racial and ethnic minority groups.

For more information, please visit: go.cms.gov/omh.

MISCELLANEOUS

AHA Innovation Challenge

What if we used technology, such as artificial intelligence or virtual reality, to help all people — no matter their race, geography or income — achieve health and wellness? The 2019 AHA Innovation Challenge invites you to compete and showcase creativity in technology to address the social determinants of health and enable healthier communities. AHA is looking for early-stage breakthrough ideas in the conception, design and development phase for addressing the social determinants of health through technology. The Challenge is open to AHA member hospitals and health systems and their partners. Top 10 finalists will be evaluated by a panel of AHA-member judges and sponsors.

The top three proposals receive funding to help bring their ideas to life!
Prizes: $100,000 | $25,000 | $15,000

To view and share the AHA Innovation Challenge click on the brochure here and the video here, and to learn more, visit the website here.

Did You Know? | Screening for Cancer Is Key

CDC Did You Know? | 04/19/19

- Every year, about 140,000 Americans get colorectal cancer, and more than 50,000 die from it.

- Cancer prevention programs can help boost screening rates, reduce costs and improve quality of care in healthcare systems using proven interventions.
- Through ScreenOutCancer, healthcare and public health leaders can access strategies, tools, and technical assistance to help increase partnerships with state and local cancer programs.

Legendary Nurse Award Nominations

The North Dakota Center for Nursing is accepting nominations for the 2019 North Dakota Legendary Nurse Awards! Recipients of the awards are honored at the annual conference which will be held Friday, October 11 in Mandan. If you know of a nurse who you think should win this prestigious award that celebrates nurses across North Dakota, visit the nomination form at the link below and nominate them today. Nominations will close on May 30.
https://www.surveymonkey.com/r/CTDDML9

5 Tips for Guiding Improvement with Visual Data

By IHI Multimedia Team | 04/23/19

Health care teams need current data to guide their work. Visual management boards provide at-a-glance summary information, including unit-level measures that align with system-wide strategic goals. For help using a visual management board to sustain your team's improvement, here are five tips.