KHC Hospital Improvement Innovation Network

August 23, 2017
10 to 11 a.m.

Kansas Healthcare Collaborative

623 SW 10th Ave. • Topeka, KS 66612 • (785) 235-0763 • www.khconline.org

Agenda

- Welcome and Announcements
- HIIN Milestone 5 & Data Update
- HIIN Readmissions Challenge
- Using the evidence:
  Readmissions Prevention Strategies
- #123 Pledge for Equity and KFMC Disparities Report
- Resources and Upcoming Events

Introductions

Presenters

Kansas Healthcare Collaborative
- Michele Clark, MBA, CPHQ, ABC, Program Director
- Rob Rutherford, Senior Health Care Data Analyst

Cynosure Health
- Pat Teske, BSN, MHA, Implementation Officer

Kansas Foundation for Medical Care
- Sarah Irsik-Good, MHA, Vice President

Hospital Sharing
HIIN READMISSIONS CHALLENGE

Lawrence Memorial Hospital
Ava Trahan, MBA, CPHQ
Director, Quality Services

Ransom Memorial Hospital
Dorothy Rice, RN, BSN, MBA
Director of Quality & Trauma

And . . . ?

August 23, 2017 Kansas Healthcare Collaborative 3

Kansas Participates in Recent HRET Events

HRET Journey Ahead Meeting

San Diego, July 25-26

Holton Community Hospital was among several that presented storyboards on becoming Highly Reliable Organizations.

August 23, 2017 Kansas Healthcare Collaborative 4

HRET Journey Ahead Meeting

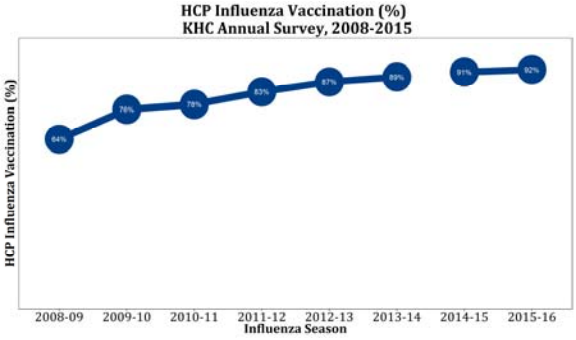
San Diego, July 25-26

Coffeyville Regional Medical Center HRO poster presentation.

More than 300 individuals from across the nation assisted HRET with generating bold ideas for the journey ahead.

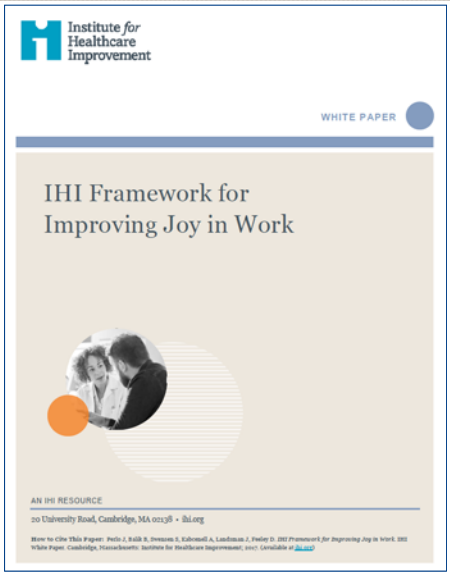
Thank you!

2016-17 Health Care Personnel Immunization Survey is almost complete



Visit online toolkit at
www.khconline.org/initiatives/health-care-personnel-influenza-immunization

New Resource



New IHI White Paper!

Joy In Work

What matters to you?

This white paper describes:

- **The WHY**: The importance of joy in work
- **The HOW**: 4 steps leaders can take to help staff find joy and meaning in their work
- **The WHAT**: 9 critical components of a system for ensuring a joyful, engaged workforce

www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx

Quarterly HIIN Activities Survey

2Q2017 HIIN Activities Survey:

What's your proudest achievement so far?

- Zero falls for the most recent month/quarter
- Successfully implemented a sepsis protocol
- PFAC up and going
- Inputting data regularly

Quarterly HIIN Activities Survey

2Q2017 HIIN Activities Survey:

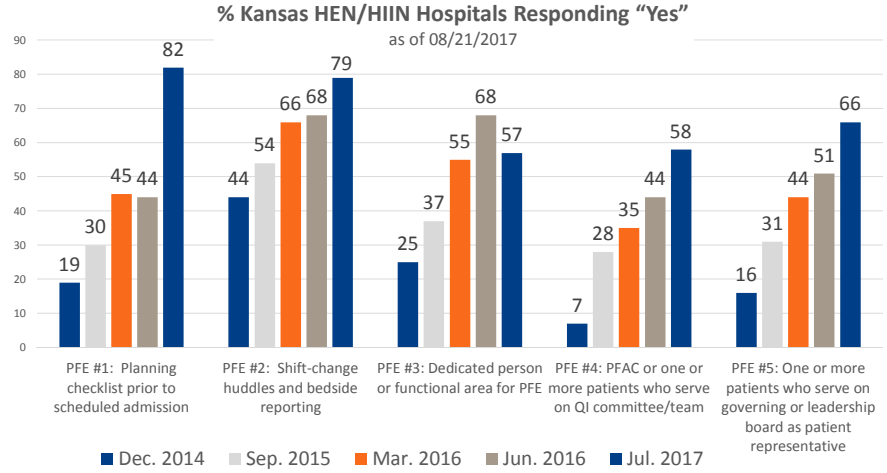
What's your highest priority for 3Q2017?

- Sepsis identification/treatment
- Readmissions
- Improve/start PFAC
- New EHR/EMR

August 23, 2017 Kansas Healthcare Collaborative 9

Preliminary Results HIIN Quarterly Metrics Survey

CMS Partnership for Patients Patient and Family Engagement Metrics



August 23, 2017 Kansas Healthcare Collaborative 10

Measures & Data Update

- Milestone 5 Progress
- Report Changes
- PFE & Operations Metrics
- Readmissions

Rob Rutherford
Senior Health Care Data Analyst
Kansas Healthcare Collaborative
RRutherford@khconline.org
(785) 235-0763 x1326

Our *Next* HIIN Milestone (#5)

- All HIIN data are current – October through May* – by September 20, 2017.
- Met reduction goals in at least 5 topics.

Please help us collectively meet this target.

**Being current through July is preferred!*

Current Progress (as of Aug. 1)

IMPROVEMENT

- **85%** of KHC HIIN Hospitals have met year 1 goals for at least 5 topics!
- **39%** of KHC HIIN Hospitals have met year 1 goals for at least 8 topics!

DATA SUBMISSION

- **69%** have submitted data through May (April for Readmissions)

Current Improvement (as of Aug. 1)

Topic	% Meeting Y1 Goals
ADE	83
CAUTI	77
CDI	63
CLABSI	58
Falls	56
MRSA	72
PrU	61
Readmissions	48
Sepsis	40
Worker Safety	77

Preliminary Results Milestone 5

Current Submission (as of Aug. 1)

Topic	% Meeting Y1 Goals
ADE	72
CAUTI	72
CDI	78
CLABSI	87
Falls	75
MRSA	-
PrU	66
Readmissions	80
Sepsis	59
Worker Safety	72

August 23, 2017 Kansas Healthcare Collaborative 15

Preliminary Results Milestone 5

Top 3 Data Submission Gaps

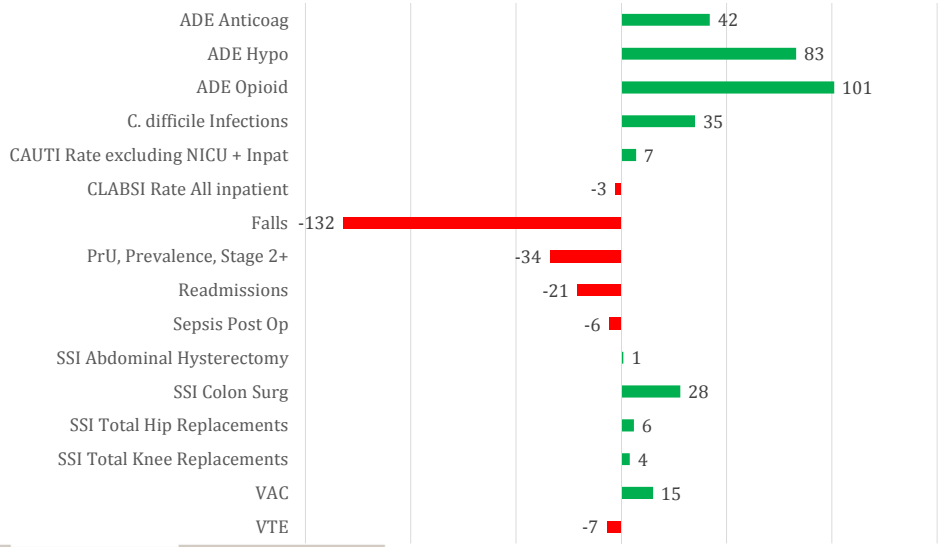
Number of Hospitals Needed to Submit Data	Measures
48	Any of the new Sepsis Measures • Overall Sepsis Mortality • Hospital-onset Sepsis Mortality
39	≥Stage 2 Pressure Ulcer/Injury Measure
32	Any Adverse Drug Event Measure • Naloxone Administration • Hypoglycemia in Inpts Receiving Insulin • Excessive Anticoagulation with Warfarin

By Sept. 20: Need monitoring data for October 2016 to May 2017.
Questions? Contact Rob at 785-231-1326

August 23, 2017 Kansas Healthcare Collaborative 16

Preliminary Results Milestone 5

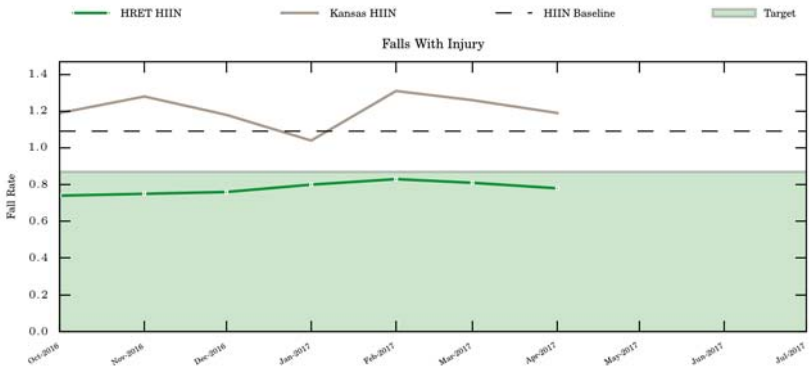
KHC HIIN Harms Prevented



August 23, 2017 Kansas Healthcare Collaborative 17

Preliminary Results Milestone 5

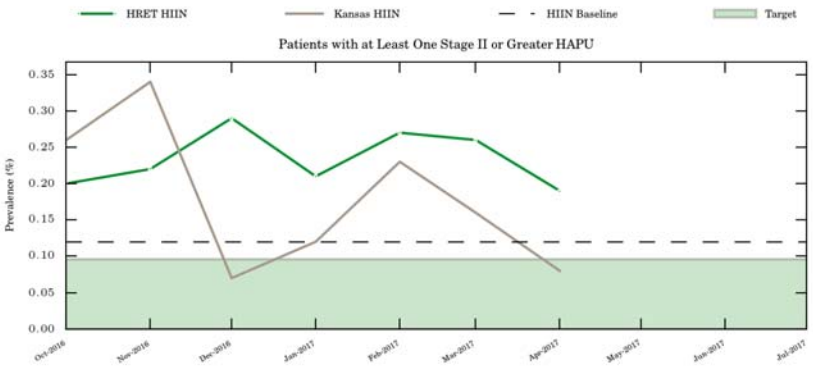
Falls with Injury



August 23, 2017 Kansas Healthcare Collaborative 18

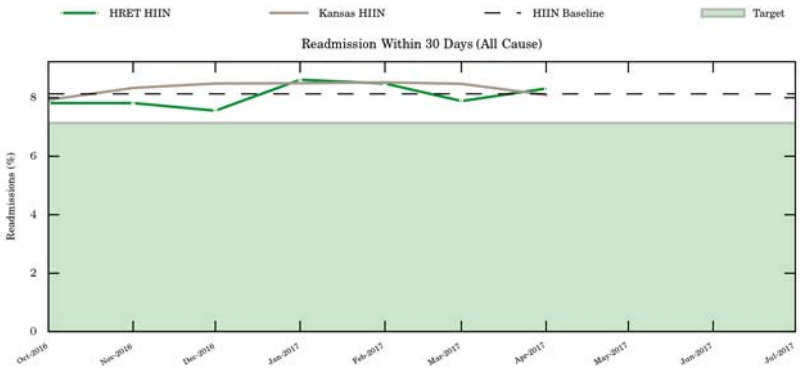
Preliminary Results Milestone 5

Pressure Ulcers Stage 2+



Preliminary Results Milestone 5

Readmissions (All Cause)



Analytic and Side-by-Side Reports

- The cut-off for old or "stale" data is now anything older than May 2017. (05/2017)

FY18 Medicare Readmissions Penalties

- In FY 2018, Medicare is penalizing 2,573 hospitals, just two dozen short of what it did last year.
- Between 2007 and 2015, the frequency of readmissions for conditions targeted by Medicare dropped from 21.5 percent to 17.8 percent.
- This year, the average penalty will be 0.73 percent of each payment Medicare makes for a patient between Oct. 1 and Sept. 30, 2018.

Kaiser Health News

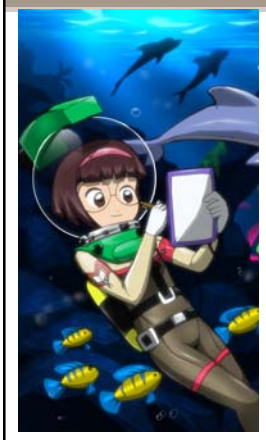
FY18 Medicare Readmissions Kansas

Rank	STATE	% PENALIZED	HOSPITALS PENALIZED	HOSPITALS NOT PENALIZED	HOSPITALS NOT EVALUATED
1	MD	0%	0	0	49
2	SD	29%	6	15	39
3	ID	36%	5	9	27
4	MT	46%	6	7	49
5	OR	47%	16	18	26
6	UT	53%	17	15	14
7	CO	58%	28	20	30
8	**KS**	**60%**	**31**	**21**	**85**
9	NE	61%	14	9	66
10	AK	63%	5	3	14

Kaiser Health News

Kansas HIIN 2016-2017 Data Submission Schedule

Outcome & Process Measures for HACs occurring in:	Readmissions for index discharges in, and SSI for procedures performed in:	Submission Due
October, 2016	September, 2016	November 30, 2016
November, 2016	October, 2016	December 31, 2016
December, 2016	November, 2016	January 31, 2017
January, 2017	December, 2016	February 28, 2017
February, 2017	January, 2017	March 31, 2017
March, 2017	February, 2017	April 30, 2017
April, 2017	March, 2017	May 31, 2017
May, 2017	April, 2017	June 30, 2017
June, 2017	May, 2017	July 31, 2017
July, 2017	June, 2017	**August 31, 2017**
August, 2017	July, 2017	September 30, 2017



HIIN Readmissions Challenge

Take A Dive, Interview Five

THROUGH SEPTEMBER 2017

- ❑ Identify 5 or more patients in the hospital that have been recently readmitted.
- ❑ Interview five patients/caregivers using the ASPIRE 2 tool.
- ❑ Aggregate interview results using the Readmission Case Review Analysis tool.
- ❑ Analyze responses for new insight regarding "why" patients soon returned to the hospital.
- ❑ Share what you learned with KHC using the hospital feedback SurveyMonkey link below.

ASPIRE 2 Tool:
www.hret-hiin.org/resources/display/aspire-tool-2-readmission-review-tool

Readmissions Case Review Analysis Tool:
www.hret-hiin.org/resources/display/readmission-case-review-and-analysis

Hospital Feedback Survey:
https://www.surveymonkey.com/r/hiin-readmissions-dive

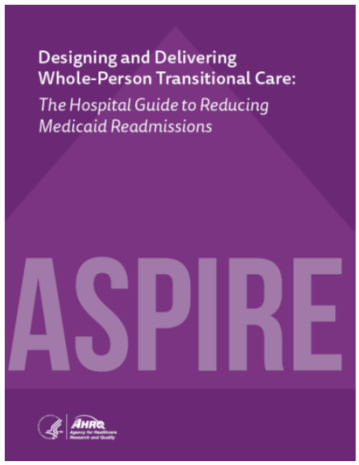
Polling Question

Describe where you are in the readmissions challenge

- First I have heard of it
- Discussing with out team
- In process of beginning interviews
- Have conducted a few interviews already
- Have completed interviews

- READMISSION REVIEW TOOL
  - Gets at the story behind the story
  - Instructions
    1. Identify patients in the hospital who have been readmitted.
    2. Ask the patients/caregivers if they are willing to have a 5- to 10-minute discussion about their recent hospitalizations.
    3. Capture patient/caregiver responses.
    4. Analyze responses for new insight regarding "why" patients returned to the hospital soon after being discharged.

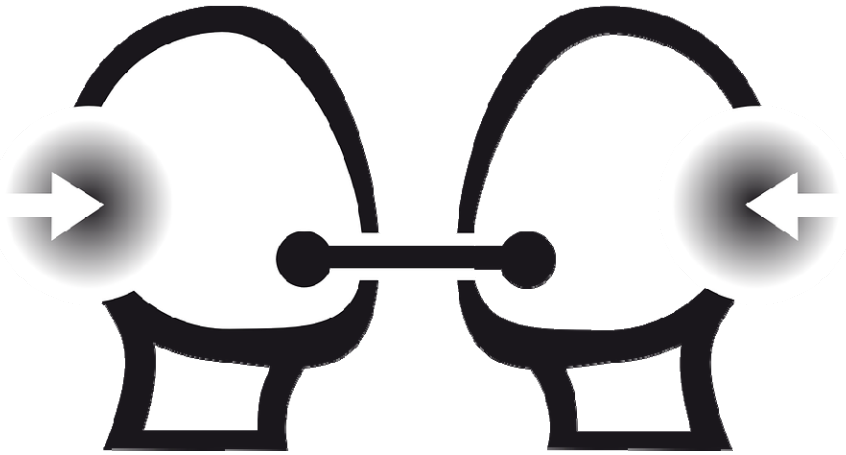
Tool #2



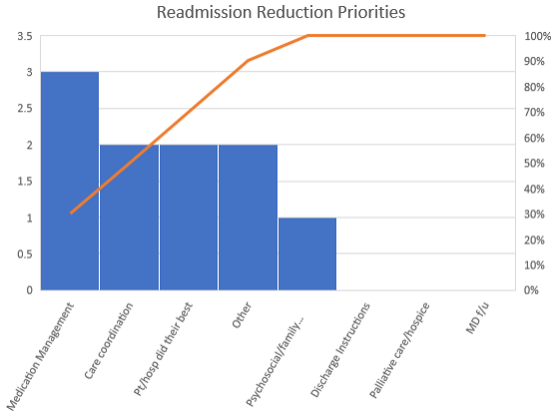
Dig deep to understand root ***causes***

- Ask "why" 5 times to elicit the "root causes" of readmissions.
  - If an interview revealed that a patient did not take her medication.
    - Why did she not take her medication? She did not take it because she did not have it.
    - Why? She did not go to pick it up from the pharmacy.
    - Why…? Continue to ask until you have identified opportunities that your hospital team can address (e.g., bedside delivery of medication, teach-back, medication reconciliation; such services may exist for some patients but not others or may be delivered as available rather than consistently).
  - Try to avoid citing disease exacerbations or noncompliance as root causes. If those are factors, ask "why" again.

What did you learn?



Lawrence Memorial Hospital HIIN Readmissions Challenge



Focusing on patients' perceptions of barriers can help focus our solutions.

~LMH

Using the evidence: Readmissions Prevention Strategies

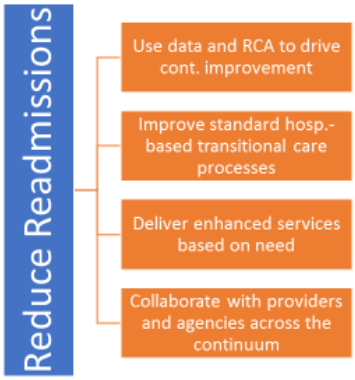
- HRET HIIN tools and resources

Pat Teske, BSN, MHA
Implementation Officer
Cynosure Health
pteske@cynosurehealth.org

HIIN AIM

Reduce all cause 30-day readmissions by 12 percent by September 27, 2018.

Readmission reduction drivers

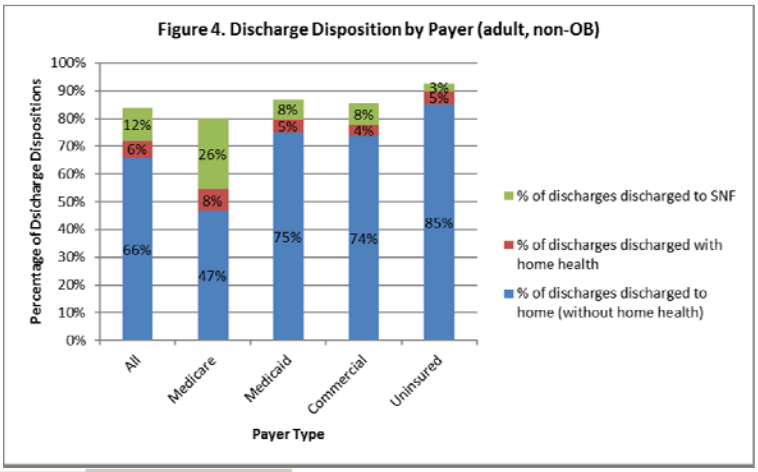


HRET HIIN Readmissions Change Package Driver Diagram
CP

The data driver

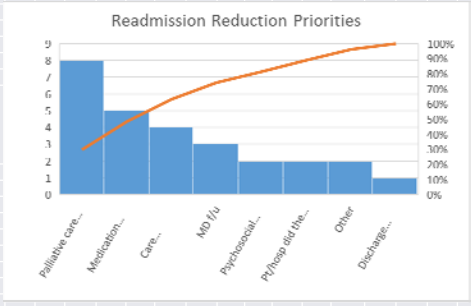
USE DATA AND ROOT CAUSE ANALYSIS TO DRIVE CONTINUOUS IMPROVEMENT	ANALYZE DATA TO INFORM YOUR TARGETING APPROACH	Change Idea
	UNDERSTAND ROOT CAUSES OF READMISSIONS; ELICIT THE PATIENT, CAREGIVER AND PROVIDER PERSPECTIVES	Change Idea
	PERIODICALLY UPDATE APPROACH BASED ON FINDINGS; ARTICULATE YOUR READMISSION REDUCTION STRATEGIES	Change Idea
	DEVELOP A PERFORMANCE MEASUREMENT DASHBOARD TO USE DATA TO DRIVE CONTINUOUS IMPROVEMENT	Change Idea

Data analysis learnings?

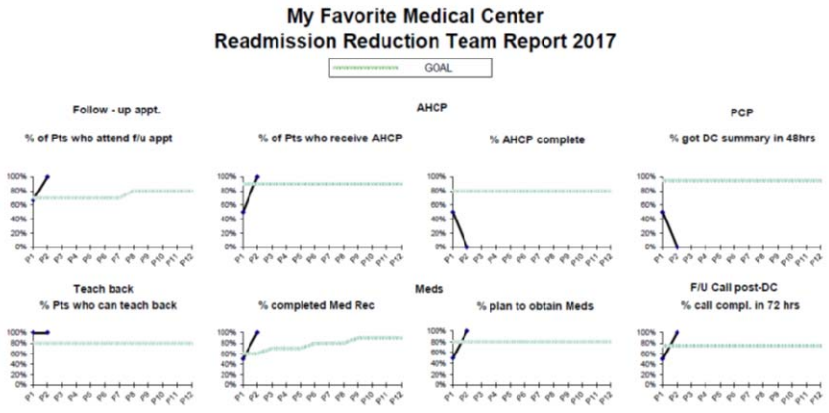


Aggregate and prioritize

Reason	Pt. A	Pt. B	Pt. C	Pt. D	Pt. E	Pt. F	Pt. G	Pt. H	Pt. I	Pt. J	Pt. K	Pt. L	Pt. M	Pt. N	Pt. O	Pt. P	Pt. Q	Pt. R	Pt. S	Pt. T	Total
Medication Management	Y		Y				Y				Y		Y								5
Discharge Instructions	Y																				1
Palliative care/hospice			Y			Y			Y		Y			Y		Y		Y	Y		8
Care coordination					Y							Y				Y				Y	4
MD f/u			Y					Y							Y						3
Psychosocial/family dynamics					Y					Y											2
Pt/hosp did their best		Y															Y				2
Other	Y													Y							2



Sample dashboard

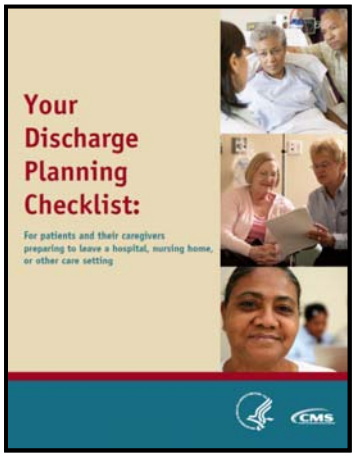


Second Primary Driver

IMPROVE STANDARD HOSPITAL-BASED TRANSITIONAL CARE PROCESSES

ENGAGE PATIENTS AND THEIR CAREGIVERS TO IDENTIFY THE "LEARNER," UNDERSTAND CARE PREFERENCES AND ASSESS READMISSION RISK FACTORS	Change Idea
FACILITATE INTERDISCIPLINARY COLLABORATION ON READMISSION RISKS AND MITIGATION STRATEGIES	Change Idea
DEVELOP A CUSTOMIZED CARE TRANSITIONS PLAN, TAKING INTO ACCOUNT PATIENT PREFERENCES AND ADDRESSING READMISSION RISK FACTORS AND POST-HOSPITAL CONTACT NAMES AND NUMBERS	Change Idea
USE TEACH BACK TO VALIDATE PATIENT UNDERSTANDING; USE LOW HEALTH LITERACY TECHNIQUES AND/OR PROFESSIONAL TRANSLATION SERVICES TO OPTIMIZE UNDERSTANDING AND TEACH BACK	Change Idea
MAKE TIMELY POST-DISCHARGE FOLLOW UP PHONE CALLS TO FOLLOW UP ON SYMPTOMS AND REVIEW THE CARE TRANSITIONS PLAN	Change Idea

How are you using it?



- Download the CMS discharge planning checklist
- If you're not already using it, make a plan to start

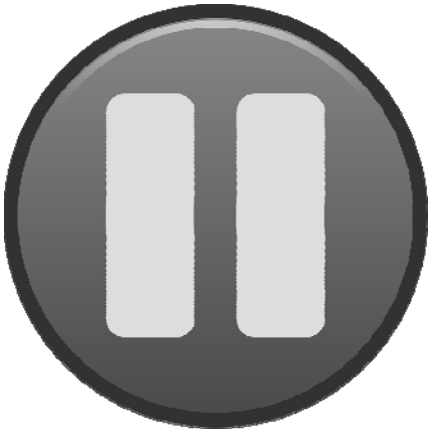
2017 Driver Diagram

DELIVER ENHANCED SERVICES BASED ON NEED

PALLIATIVE CARE	Change Idea
CONDITION SPECIFIC PROGRAMS	Change Idea
PHARMACY INTERVENTION	Change Idea
COMPLEX CARE MANAGEMENT	Change Idea
ED PAUSE	Change Idea

ED Pause

- Disrupt the ordinary process of automatic readmissions
- Know who was recently discharged
  - E.g. Flag
- Identify person & process for ED to get support to determine patient's disposition



2017 Driver Diagram

COLLABORATE WITH PROVIDERS AND AGENCIES ACROSS THE CONTINUUM	IDENTIFY THE CLINICAL, BEHAVIORAL, SOCIAL AND COMMUNITY BASED SUPPORTS THAT SHARE THE CARE OF YOUR HIGH RISK PATIENTS	Change Idea
	CONVENE A CROSS-CONTINUUM TEAM OF PROVIDERS AND AGENCIES THAT SHARE THE CARE OF YOUR HIGH RISK PATIENT POPULATIONS	Change Idea
	IMPROVE REFERRAL PROCESSES TO MAKE LINKING TO BEHAVIORAL, SOCIAL AND COMMUNITY BASED SERVICES MORE EFFECTIVE AND EFFICIENT	Change Idea

Walk a mile in my shoes

- Shadow program
- ED & SNF
- Experience a day in the life
- Stronger understanding and empathy

Download

Preventable Readmissions Top Ten Checklist

- Develop a data-informed targeting strategy to identify target populations with higher than average rates of readmissions. Deliver enhanced readmission reduction strategies to these "target population" patients.
- Identify root causes of readmissions based on interviewing patients, caregivers and providers. Prioritize your improvement strategies based on those that will address the root causes of readmissions among your patients.
- Improve care transition processes for all patients, regardless of readmission risk. Refer to the proposed practices articulated in the proposed CMS Conditions of Participation for Discharge Planning.
- Provide a customized transitional care plan for all patients.
- Effectively communicate with patients and caregivers. Use translation services, teach-back, motivational interviewing and materials written in plain language.
- Deliver enhanced readmission reduction services for your target populations based on their root causes of readmissions.
- Design a high utilizer approach for patients with four or more admissions per year. Identify their "driver of utilization," and use care plans to improve care across settings.
- Engage the emergency department as a new site of readmission reduction activities.
- Collaborate with clinical, behavioral, and social service providers to improve cross-setting care processes for shared patient populations. Ensure you are aware of the services and supports that are available from other providers and agencies in your community.
- Measure what you implement, driving to reliable delivery of improved processes.

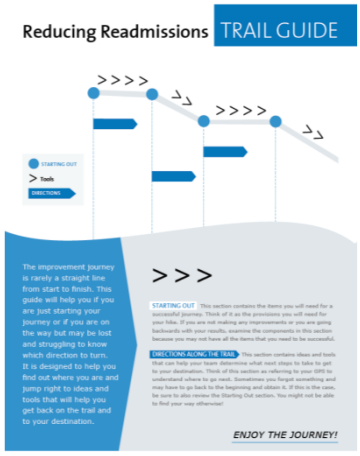
www.hret-hiin.org/resources/display/preventable-readmissions-top-ten-checklist-date-or-last-preventable-readmission

Additional resources

Readmissions Fishbowl series

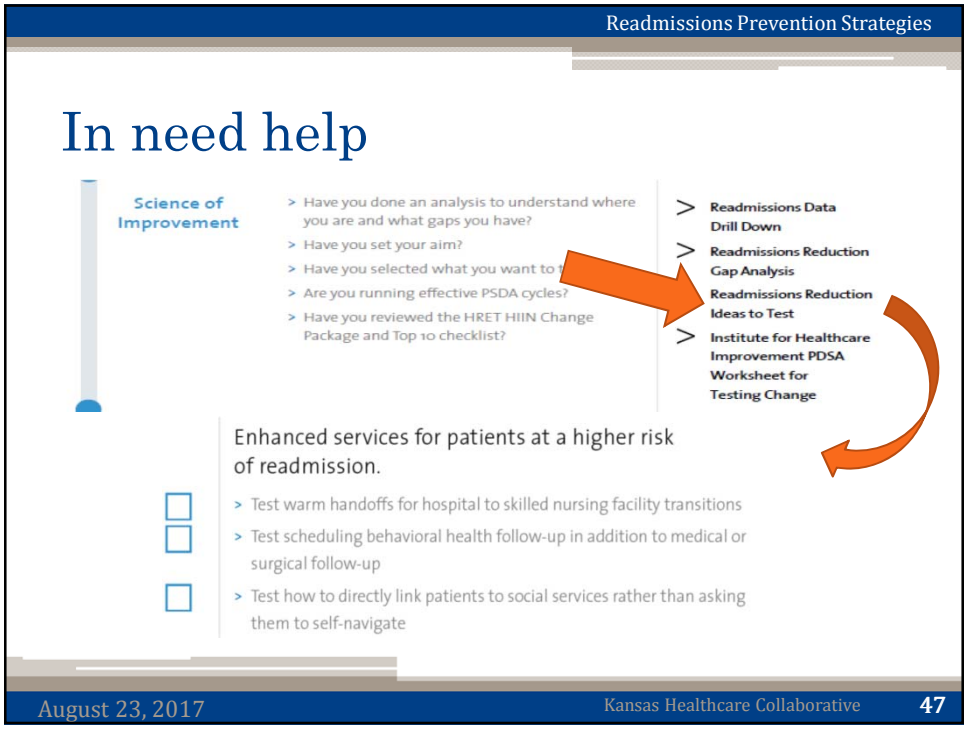
Whiteboard videos

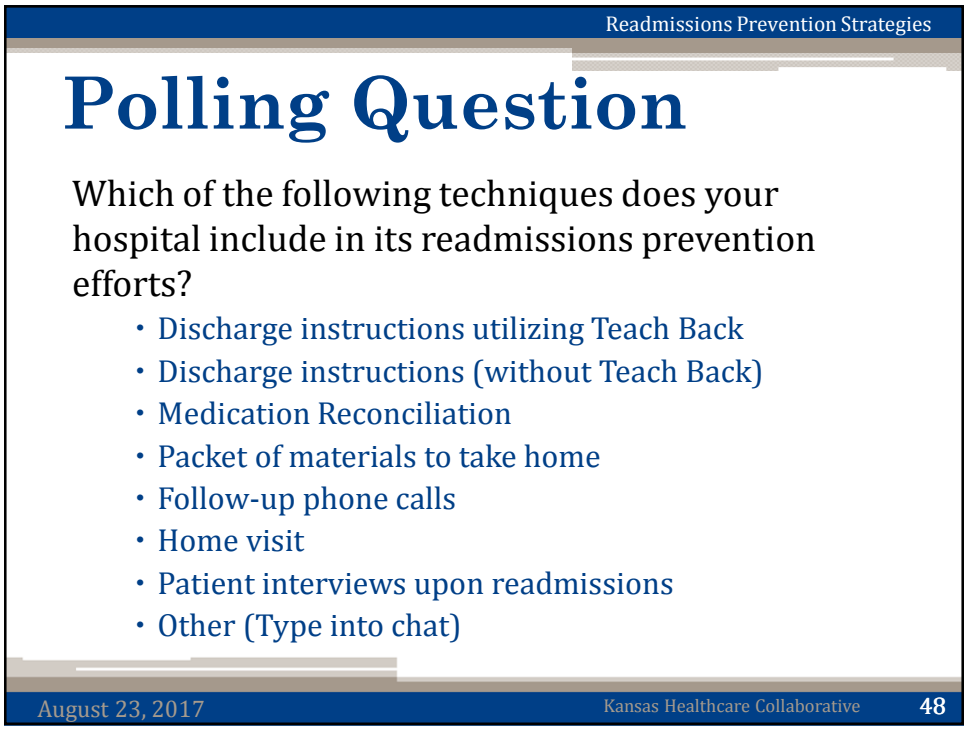
NEW! Readmissions Trail Guide



- Get your GUIDE
- Action oriented resource to:
  - Help get you started, or
  - Help you along the way
- Imbedded links to key tools and resources
- Go directly to where you need help

http://www.hret-hiin.org/resources/display/readmissions-trail-guide


Readmissions Prevention Strategies
In need help
Science of Improvement
> Have you done an analysis to understand where you are and what gaps you have?
> Have you set your aim?
> Have you selected what you want to
> Are you running effective PSDA cycles?
> Have you reviewed the HRET HIIN Change Package and Top 10 checklist?
> Readmissions Data Drill Down
> Readmissions Reduction Gap Analysis
Readmissions Reduction Ideas to Test
> Institute for Healthcare Improvement PDSA Worksheet for Testing Change
Enhanced services for patients at a higher risk of readmission.
> Test warm handoffs for hospital to skilled nursing facility transitions
> Test scheduling behavioral health follow-up in addition to medical or surgical follow-up
> Test how to directly link patients to social services rather than asking them to self-navigate
August 23, 2017
Kansas Healthcare Collaborative
47


Readmissions Prevention Strategies
Polling Question
Which of the following techniques does your hospital include in its readmissions prevention efforts?
• Discharge instructions utilizing Teach Back
• Discharge instructions (without Teach Back)
• Medication Reconciliation
• Packet of materials to take home
• Follow-up phone calls
• Home visit
• Patient interviews upon readmissions
• Other (Type into chat)
August 23, 2017
Kansas Healthcare Collaborative
48

Reach out if you need help

- Pat Teske, RN, MHA
- pteske@cynosurehealth.org

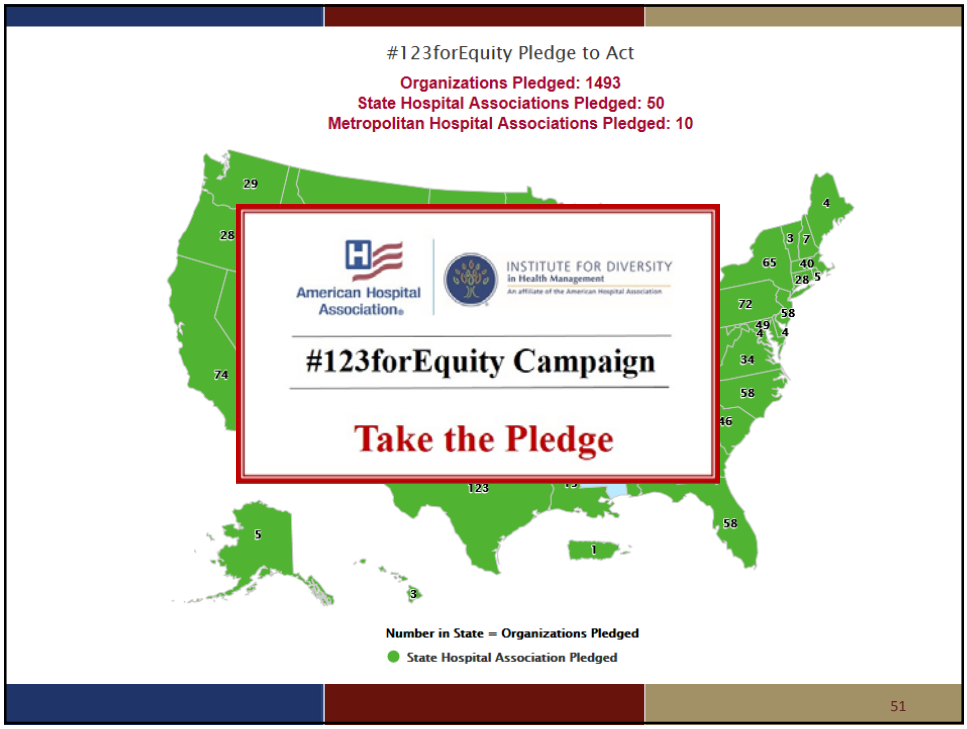
Cynosure HEALTH

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains Quality Innovation Network

Sarah Irsik-Good, MHA
Vice President
Kansas Foundation for Medical Care

State Program Director - Kansas
Great Plains Quality Innovation Network



Readmission Disparities Report

- Hospital specific report to identify gaps in care using your readmission rates
- Stratification of the 30-day readmission rate we've been providing you (developed from CMS Claims data)
  - By Age
  - By Gender
  - By Race
  - Rural Zip Codes
  - CMS Designated Socio Economic Status (SES) Zip Codes
- **Provided July 20, 2017** and then quarterly

Take the Pledge

52

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Great Plains Quality Innovation Network

Kansas Trends?

Readmission Disparities Report dated July 20, 2017

	2015Q4	2016Q1	2016Q2	2016Q3	2016Q4	*Difference*
National 30 day Readmission Rate	17.98%	17.98%	17.92%	17.91%	17.80%	
30 Day Readmission Rate	15.90%	15.91%	15.73%	15.71%	15.73%	-2.07%

Note: Shown quarters represent the last quarter of a rolling four quarter period. (Data Source: Medicare Part A Claims)

Kansas Trends?

By age….

Kansas	2015Q4	2016Q1	2016Q2	2016Q3	2016Q4	*Difference*
30 Day Readmission Rate	***15.90%***	***15.91%***	***15.73%***	***15.71%***	***15.73%***	
Patients 18-64 Years Old	20.78%	20.82%	20.82%	20.57%	20.28%	4.55%
Patients 65-84 Years Old	14.74%	14.71%	14.51%	14.59%	14.70%	-1.03%
Patients 85+ Years Old	14.45%	14.62%	14.40%	14.36%	14.24%	-1.49%

By gender….

30 Day Readmission Rate	***15.90%***	***15.91%***	***15.73%***	***15.71%***	***15.73%***	*Difference*
Female Patients	15.47%	15.54%	15.24%	15.15%	15.10%	-0.63%
Male Patients	16.44%	16.39%	16.35%	16.43%	16.52%	0.79%

54

Kansas Trends?

By race….

30 Day Readmission Rate	*15.90%*	*15.91%*	*15.73%*	*15.71%*	*15.73%*	*Difference*
Underserved	19.43%	19.55%	19.41%	18.94%	18.54%	2.81%
Asian	20.00%	18.80%	20.20%	18.70%	19.50%	3.77%
Black	20.50%	21.00%	20.80%	20.60%	20.20%	4.47%
Hispanic	16.80%	16.70%	17.80%	17.30%	16.00%	0.27%
North American Native	17.60%	16.90%	17.70%	16.50%	16.50%	0.77%
Other	17.30%	16.30%	15.60%	14.70%	16.40%	0.67%
Unknown	17.30%	16.10%	14.60%	13.10%	11.30%	-4.43%
White	15.50%	15.50%	15.30%	15.40%	15.40%	-0.33%

By socioeconomic status….

30 Day Readmission Rate	*15.90%*	*15.91%*	*15.73%*	*15.71%*	*15.73%*	*Difference*
Rural Zip	15.34%	15.28%	15.09%	15.07%	15.07%	-0.66%
SES Designated Zip	40.83%	24.69%	21.78%	20.41%	33.49%	17.76%

55

How can we help?

- Provide a data file of key claim indicators for your "DD" review.
  - Drill Down
  - Deep Dive
  - Data Dice
- Assist with identifying additional data sources
  - i.e. Kansas Health Matters Website

KansasHealthMatters

- Assist with intervention selection and project plan development
  - i.e. Self Management Education train-the-trainer programs

Take the Pledge

56

Contact Information

Amanda Bridges
Care Coordination Project Manager
800-432-0770 x 349
amanda.bridges@area-a.hcqis.org

Tisha Carlson
Hospital Quality Improvement Specialist
800-432-0770 x 335
Tisha.carlson@area-a.hcqis.org

This material was prepared by the Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for Kansas, Nebraska, North Dakota and South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-GPQIN-KS-C3-09/0817

57

Resources & Upcoming Events

- Sepsis Awareness Month
- KHC HIIN Hand Hygiene Collaborative
- Upcoming Events

Michele Clark
Program Director
Kansas Healthcare Collaborative
mclark@khconline.org
(785) 235-0763 x1321

2017 SEPTEMBER SEPSIS

SAY SEPSIS SAVE LIVES

SEPSISAWARENESSMONTH.ORG

Healthcare Toolkit

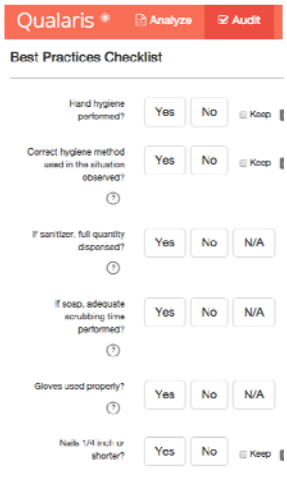
Public Toolkit

Media Tookit

Sepsis Alliance launched a brand new healthcare toolkit this year to make hospital participation in **Sepsis Awareness Month** even easier. From printable posters to social media content, a nursing education tool, patient toolkit and more, find resources and materials to spread.

www.sepsisawarenessmonth.org

KHC HIIN Hand Hygiene Collaborative



Enrollment is still open!

KHC is launching a new Hand Hygiene Collaborative to help hospitals track and improve hand hygiene within their facilities. Participation includes easy-to-use, mobile software provided at no cost to each hospital for observation-based measurement.

Next collaborative learning session will be held **Friday, October 6, at 11 a.m.** CT.

For more information, visit:
www.khconline.org/initiatives/hiin-initiatives/hand-hygiene-collaborative

QualarisAudit
Software for improving best practices

South-Central HIINergy Partners

Bi-monthly regional webinars hosted by a different partner state each month

Host State	Webinar Date	Topic
AR	Jan. 25	Getting Started in HIIN *Recording available!*
OK	March 22	UP Campaign *Recording available!*
LA	May 24	Patient and Family Engagement *Recording available!*
TX	Aug. 2	Transforming Cultures for Safety *Recording available!*
KS	**Sept. 27**	**Equity & Diversity**
MO	Nov. 15	Sepsis

Kansas • Oklahoma • Texas
Missouri • Arkansas • Louisiana

Wednesdays, 10 to 11 a.m., CT
4th Wednesdays of each month
KHC HIIN Webinars alternate months. (Same time.)

2017 KHC HIIN Meeting Schedule

HRET HIIN Roadshow is coming to Kansas!

SAVE THE DATE:
Tuesday
November 14, 2017

Marriott Hotel
Salina, KS

Audience	Webinar Date
HIINergy	August 2
Kansas	August 23
HIINergy	**September 27**
Kansas	October 25
HIINergy	November 15
Kansas	December 20

Mark your calendars.

All HIIN webinars will be held from 10 to 11 a.m. CT

All sessions will be recorded and posted to the KHC education archive.

Upcoming HIIN Webinars

HRET HIIN: Acute Skin Failure from Sepsis: Preventing Injury with Early Mobility
Thursday, August 31 ● 11:00 a.m. to 12:00 p.m.

HRET HIIN: Sepsis Virtual Event
Thursday, September 7 ● 11:00 a.m. to 12:00 p.m.

HRET HIIN: Sepsis SNAP Information Session
Monday, September 11 ● 2:00 to 3:00 p.m.

Partnership for Patients: How to Engage Patients & Families to Prevent Sepsis and Reduce Readmissions
Tuesday, September 12 ● 1:00 to 2:00 p.m.

Register at: www.hret-hiin.org/events/upcoming-events.shtml

Upcoming HIIN Webinar

Partnership for Patients Pacing Event:
Examining Efforts around Antibiotic Stewardship
Thursday, August 24 ● 12:00 to 1:00 p.m. CT

This Pacing Event will examine antibiotic stewardship work at the hospital and national levels to provide information, examples of efforts, and emerging work on this topic. This event will feature one hospital's efforts to improve stewardship through a multi-faceted approach that includes examining available data and working to identify patient risk, as well as emerging efforts around *C. diff* to examine real-time surveillance and readmissions.

In addition, we will highlight the important role of bedside nurses in antibiotic stewardship, including linking their work to the Centers for Disease Control and Prevention's (CDC) Antibiotic Stewardship Core Elements.

Pre-register at:
https://secure.confertel.net/tsRegisterD.asp?course=68601002

When registering, indicate that your organization is affiliated with the AHA/HRET HIIN.

Upcoming HIIN Webinar

HRET HIIN: Falls Virtual Event

Goodbye Bundle, Hello Care Plan

Tuesday, September 12 ● 11:00 a.m. to 12:00 p.m.

With the wide adoption of electronic documentation, individualized care planning has become a challenge especially in the area of fall prevention. Learn about an innovative tool that was developed at Bringham Young's Women Hospital that has led to a reduction in overall fall rates and fall with injury rates.

The **Fall TIPS : Tailoring Interventions for Patient Safety** tool is a laminated bedside clinical decision support tool that links risk factors to interventions , engages the patient in developing the plan and communicates the fall plan. Join this event to learn what is in the **Fall TIPS tool kit** and how your organization can gain access and implementation support.

Register at: www.hret-hiin.org/events/upcoming-events.shtml

Upcoming Fellowship Events

Non-fellows are encouraged to audit any of the virtual fellowship events

HRET HIIN: QI Fellowship Foundational Virtual Event
Wednesday, September 13 ● 11:00 a.m. to 12:00 p.m. CT

HRET HIIN: QI Fellowship Accelerated Virtual Event
Wednesday, September 13 ● 12:30 to 1:30 p.m. CT

HRET HIIN: PFE Fellowship Virtual Event #10
Wednesday, September 20 ● 11:00 a.m. to 12:00 p.m. CT

Pre-register at: www.hret-hiin.org/fellowships/qifellowship/index.shtml

HRET HIIN ADE Fishbowl

Opioid Safety

Join the HRET HIIN on August 24th for our next "Fishbowl" event where you will watch brave organizations learn by doing...in real time.

Join in as they develop aim statements and measures, organize small improvement teams, and begin rapid cycle Plan-Do-Study-Act (PDSA) learning and improvement cycles.

See how small tests of change can lead to learning from failure; failure that rapidly leads to success.

The intended audience is for hospital teams working to reduce ADEs due to opioids.

July 20, 2017 ● 11:00 – 12:00pm

August 24, 2017 ● 11:00 – 12:00pm

September 26, 2017 ● 11:00 – 12:00pm

Pre-register at www.hret-hiin.org/Resources/ade/17/ade_fishbowl_series.shtml

HRET HIIN Readmissions Fishbowl

Reduce Readmissions

Does your organization have an opportunity to gain new insights and test strategies to reduce readmissions?

Join the HRET HIIN on August 24th for the next reducing readmissions "Fishbowl" event where you will watch the process improvement journey of five HRET HIIN hospitals, *including Ransom Memorial Hospital in Ottawa, Kansas*!

Listen in as the hospitals create reduction aim statements, focus on their target population and develop their first small test of change to implement in their readmissions reduction efforts.

July 13, 2017 ● 11:00 – 12:00pm

August 10, 2017 ● 11:00 – 12:00pm

September 14, 2017 ● 11:00 – 12:00pm

Pre-register at: www.hret-hiin.org/Resources/readmissions/17/readmissions_fishbowl_series.shtml

Best Wishes for a Fabulous Day!

Questions?

Contact your KHC Team

KHC Office Phone: (785) 235-0763

Kansas Healthcare Collaborative

Kendra Tinsley
Executive Director
ktinsley@khconline.org

Michele Clark
Program Director
mclark@khconline.org

Rosanne Rutkowski
Program Director
rrutkowski@khconline.org

Toni Dixon
Communications Director
tdixon@khconline.org

Rhonda Lassiter
Executive Assistant
rlassiter@khconline.org

Eric Cook-Wiens
Data and Measurement Manager
ecook-wiens@khconline.org

Chuck Duffield
Performance Improvement Manager
cduffield@khconline.org

Alyssa Miller
Project Assistant
amiller@khconline.org

Amanda Prosser
Project Coordinator
aprosser@khconline.org

Rob Rutherford
Senior Health Care Data Analyst
r rutherford@khconline.org

Jill Daughhetee
Quality Improvement Advisor
jdaughhetee@khconline.org

Karlen Haury
Quality Improvement Advisor
khaury@khconline.org

Devin June
Quality Improvement Advisor
djune@khconline.org

Mary Monasmith
Quality Improvement Advisor
mmonasmith@khconline.org

Josh Mosier
Quality Improvement Advisor
jmosier@khconline.org

Jonathan Smith
Quality Improvement Advisor
jsmith@khconline.org