KHC Hospital Improvement Innovation Network

August 28, 2019
10 to 11 a.m. CT

HIIN Goal:
By March 2020, hospitals in the KHC HIIN will achieve 20% reduction in all-cause harm and 12% reduction in readmissions.

Introductions

Special Guest

Kim Werkmeister, BA, RN, CPHQ, CPPS
Improvement Advisor
Cynosure Health
kwerkmeister@cynosurehealth.org

Kansas Healthcare Collaborative

Michele Clark
Program Director
mclark@khconline.org

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

Chuck Duffield
Performance Improvement Mgr.
cduffield@khconline.org
Agenda

Welcome and Announcements
HIIN Data and Measures Update
Four Strategies for Reducing Avoidable Readmissions
HIIN Resources and Upcoming Events

August Flower Lore - Gladiolus

KHC Announcements and Updates

- Kansas Sprint Leaders
- HIIN Updates
- Milestone 13 Update

Michele Clark
MBA, CPHQ, CPPS, ABC
Program Director
Kansas Healthcare Collaborative
mclark@khconline.org
(785) 235-0763 x1321
HRET HIIN Spring Sprints

Congratulations to These 7 Kansas Hospitals!

**Falls/Delirium Sprint**
- Labette Health, Parsons
- LMH Health, Lawrence
- Memorial Health System, Abilene
- Southwest Medical Center, Liberal

**Pressure Ulcers Sprint**
- Southwest Medical Center, Liberal

**Ventilator-Associated Events**
- Ascension Via Christi Hospital, Pittsburg
- Southwest Medical Center, Liberal

**Venous Thromboembolism**
- Allen County Regional Hospital, Iola
- Olathe Health, Olathe

Recordings now available

**HIIN July “Hot Topic” Events**

Discussions with subject matter experts and peers of key challenges for each topic, strategic ways to overcome them.

- **Falls**

- **Pressure Ulcers/Injuries (HAPI)**

- **Venous Thromboembolism (VTE)**

- **Ventilator-Associated Events (VAE)**
Announcements and Updates

The Health Research and Educational Trust has released a new sepsis podcast series in preparation for Sepsis Awareness Month.

Podcast topics:
• Pre-Hospital Sepsis Recognition and Treatment
• Fluid Management for Sepsis
• Post-op Sepsis SNAP Learnings
• Post-Op Sepsis Syndrome
• Future of Sepsis

Click here to access the Sepsis Podcast Series:
http://www.hret-hiin.org/resources/display/sepsis-podcasts

To access tools referenced during this podcast series, visit the HRET HIIN Sepsis web page and view the HRET HIIN Sepsis Change Package for information on the sepsis bundles.
HIIN Milestone 13
January 2017 through May 2019

Data Completeness
≥80% of applicable measures
No missing months

and

Improvement
Achievement of HIIN “20/12” Goals
≥70% of all applicable measures meeting improvement goals

Announcements and Updates

Kansas Hospitals
HIIN Milestone 13 Results
as of August 2019

DATA COMPLETE in ≥80% of Eligible Topics
71.3%

IMPROVEMENT in ≥70% of Eligible Topics
57.4%

BOTH!
49.6%
Hospitals with 100% data submission

- Anderson County Hospital
- Clay County Medical Center
- Coffey County Hospital
- Coffeyville Regional Medical Center
- Community Memorial Healthcare, Inc.
- Decatur Health Systems, Inc.
- Fredonia Regional Hospital
- Gove County Medical Center
- Greenwood County Hospital
- Hays Medical Center
- Hillsboro Community Hospital
- Hospital District No. 1 of Rice County
- Jewell County Hospital
- Kingman Community Hospital
- Kiowa District Hospital
- Labette Health
- Lincoln County Hospital
- Medicine Lodge Memorial Hospital
- Mercy Hospital Columbus
- Mercy Hospital, Inc.
- Minneola District Hospital
- Mitchell County Hospital Health Systems
- Morris County Hospital
- Osborne County Memorial Hospital
- Rawlins County Health Center
- Rooks County Health Center
- Sabetha Community Hospital, Inc.
- Saint Luke Hospital and Living Center
- Sheridan County Health Complex
- Smith County Memorial Hospital
- St. Catherine Hospital
- Stanton County Hospital
- Trego County Lemke Memorial Hospital
- Wamego Health Center
- Wichita County Health Center
- Wilson Medical Center

Hospitals with 80-99% data submission

- Bob Wilson Memorial Grant County Hospital
- Cheyenne County Hospital
- Citizens Medical Center, Inc.
- Clara Barton Hospital
- Comanche County Hospital
- Community Healthcare System, Inc.
- Edwards Co. Hosp. and Healthcare Ctr
- Ellinwood District Hospital
- Ellsworth County Medical Center
- E.W. Huston Medical Center
- Greeley County Health Services
- Grissell Memorial Hospital
- Hanover Hospital
- Hodgeman County Health Center
- Holton Community Hospital
- Hutchinson Regional Medical Center
- Kearny County Hospital
- Kiowa County Memorial Hospital
- Lane County Hospital
- Linwood Community Hospital
- LIM Health
- Logan County Hospital
- Meade District Hospital/Artesian Valley Health System
- Memorial Health System
- Miami County Medical Center, Inc.
- Nemaha Valley Community Hospital
- Neosho Memorial Regional Medical Center
- Newton Medical Center
- Norton County Hospital
- Olathe Medical Center, Inc.
- Ottawa County Health Center
- Phillips County Hospital
- Russell Regional Hospital
- Saint John Hospital
- Saint Luke Cushing Hospital
- Saint Lukes South Hospital
- Salina Regional Health Center
- Satanta District Hospital
- Scott County Hospital
- Southwest Medical Center
- Stevens County Hospital
- Sumner County Hospital District No. 1
- Susan B. Allen Memorial Hospital
- University of Kansas Healthcare System - Pawnee Valley
- Washington County Hospital
- William Newton Hospital
National and State Progress

Patient and Family Engagement Metrics

Percent of Hospitals Meeting PFE Metrics
All HIINs, HRET HIIN, and KHC HIIN: Milestone 13

<table>
<thead>
<tr>
<th>Metric Description</th>
<th>All HIIN hospitals (n=4,025)</th>
<th>HRET HIIN (n=1,592)</th>
<th>Kansas (n=112)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PFE #1: Planning checklist prior to scheduled admission</td>
<td>67%</td>
<td>95%</td>
<td>92%</td>
</tr>
<tr>
<td>PFE #2: Shift-change huddles and bedside reporting</td>
<td>63%</td>
<td>95%</td>
<td>91%</td>
</tr>
<tr>
<td>PFE #3: Dedicated person or functional area for PFE</td>
<td>89%</td>
<td>73%</td>
<td>74%</td>
</tr>
<tr>
<td>PFE #4: PFAC or one or more patients who serve on QI committee/team</td>
<td>58%</td>
<td>56%</td>
<td>79%</td>
</tr>
<tr>
<td>PFE #5: One or more patients who serve on governing or leadership board as patient representative</td>
<td>12%</td>
<td>54%</td>
<td>78%</td>
</tr>
</tbody>
</table>

CMS HIIN Phases

Core HIIN Period (2 years)
October 2016 to September 2018

HIIN Extension (6 months)
October 2018 to March 2019

Option Year ("Periods")
- Period 1 (3 months): April-May-June 2019
- Period 2 (1 month): July 2019
- Period 3 (1 month): August 2019
- Period 4 (7 months): September 2019 to March 2020*

*anticipated
Next Steps for HIIN

- Focus on “successes.” What is your biggest success story?
- Focus on “opportunities.” Finish strong over the next seven months.
- Take advantage of HIIN resources.
- Updating QHi permission form and commitment to continue HIIN participation through March 2020. (Watch your email.)
- Anticipate and prepare for next round of CMS Partnership for Patients program priorities to begin in 2020.

KHC HIIN
Measures and Data Update

- Current status
- August data reports
- Focus on readmissions
- Data submission schedule

Eric Cook-Wiens
MPH, CPHQ
Data and Measurement Director
Kansas Healthcare Collaborative
ecook-wiens@khconline.org
(785) 235-0763 x1324
Improvement on selected KHC HIIN measures

Source: HRET Improvement Calculator v7.0

New Reports
Page 1: Dashboard

- **Snapshot Date:**
  The date data files were pulled from NHSN and QHi

- **Green border:**
  - Meeting Milestone target

- **Should match your 2-page milestone report**
### New Reports

**Page 2: Summary / TOC**

- Serves as a table of contents (TOC)
  - Hyperlinks work
  - Only Milestone relevant measures included
- Green shading indicates meeting data submission targets or improvement targets
- Checkmark if any improvement statistics are meeting target
  - Baseline vs. project
  - Baseline vs. recent 6 months
  - Six or more months with a rate of zero.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Page</th>
<th>Data Submission</th>
<th>Baseline vs. Project</th>
<th>Improvement Status</th>
<th>Milestones Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADE: Malign</td>
<td>4</td>
<td>100.0%</td>
<td></td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>ADE: Infl</td>
<td>5</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>ADE: Heart</td>
<td>6</td>
<td>100.0%</td>
<td>75.4%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>ADE: ICU</td>
<td>7</td>
<td>100.0%</td>
<td>64.0%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>ADE: NUR</td>
<td>8</td>
<td>100.0%</td>
<td>73.6%</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>ADE: Respir</td>
<td>9</td>
<td>100.0%</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>ADE: Resp</td>
<td>10</td>
<td>100.0%</td>
<td>245.9%</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>ADE: Fatality</td>
<td>11</td>
<td>100.0%</td>
<td>71.1%</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>ADE: Pneum</td>
<td>12</td>
<td>100.0%</td>
<td>63.8%</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>ADE: MI</td>
<td>13</td>
<td>100.0%</td>
<td>63.8%</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>ADE: Stroke</td>
<td>14</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>ADE: CVA</td>
<td>15</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>ADE: Seps</td>
<td>16</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>ADE: COPD</td>
<td>17</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
<td>20</td>
</tr>
</tbody>
</table>

### New Reports

**Page 3: Summary / TOC**

- Optional and Kansas-only measures are provided on page 3 (with links to detail pages)
- No checkmarks because these measures do not apply to the milestone
New Reports
Detail pages

4 Sections
1. Run Chart and project statistics
2. Measure summary
3. Comparison scatter plot
4. Numerators and denominators

New Reports
Detail Pages: Run Chart and Progress Statistics

- Run chart
- If median=0, no median line is plotted
- NOTE: if the data is sparse, the plot shows a "Quarterly rate" rather than monthly.
- Should be "smoother" than monthly run charts

Progress Statistics match what is provided on the summary slide. These progress statistics "roll up" into the counts and percentages on your dashboard (page 1).
New Reports
Detail Pages: Measure Summary & Scatter Plot

- Brief measure description,
- Measure type
- Desired trend (reduction or increase)

Your facility’s “+” symbol location is determined by:
Baseline rate (horizontal axis)
Recent six month rate (vertical axis)

New Chart Format

- Each point is one Kansas HIIN hospital.
- In the report, your facility will be the blue “Plus” symbol.
- Horizontal axis is the facility-level baseline rate
- Vertical axis is the facility-level recent 6-month rate.
- Green shaded area indicates an improvement from baseline.
New Reports
Detail Pages: Numerators and Denominators

- For every month during the project period:
  - Numerator
  - Denominator
  - Data Source
- Milestone period is highlighted in blue
- Missing data is highlighted in yellow

Focus on Readmissions

**Readmission Within 30 Days (All Cause) Rate**

**Median (10/2016 – 5/2019)**
- Kansas HIIN: 6.8%
- HRET HIIN: 8.1%

Kansas has slightly lower readmissions rates than the overall HRET HIIN.

However, only modest improvement.
Focus on Readmissions

Hospital-Wide All-Cause Unplanned Readmissions - Medicare

Median (10/2016 – 5/2019)

- Kansas HIIN: 8.4%
- HRET HIIN: 10.7%

Focus on Readmissions

Scatterplot: Baseline vs. Recent 6-Month Rate

Median (10/2016 – 5/2019)

- Kansas HIIN: 6.8%
- HRET HIIN: 8.1%
Scatterplot: Baseline vs. Recent 6-Month Rate

**Impact of Outliers**

Outlier with high recent-six-month rate removed in this plot.

About half of hospitals improving.

---

Scatterplot: Baseline vs. Recent 6-Month Rate

**Segmented by Hospital Type**

The distribution of baseline and recent-six-month rates is similar for PPS and CAH hospitals.
Focus on Readmissions

- Overall, we about half of hospitals are improving

- As a state, we are improving on readmissions
  - But not meeting the reduction target (12%)

- Similar rates for PPS and CAH hospitals

<table>
<thead>
<tr>
<th>Outcome &amp; Process Measures for HACs occurring in:</th>
<th>Readmissions for index discharges in, and SSI for procedures performed in:</th>
<th>Data Submission Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2019</td>
<td>December 2018</td>
<td>28-Feb-2019</td>
</tr>
<tr>
<td>February 2019</td>
<td>January 2019</td>
<td>31-Mar-2019</td>
</tr>
<tr>
<td>March 2019</td>
<td>February 2018</td>
<td>30-Apr-2019</td>
</tr>
<tr>
<td>April 2019</td>
<td>March 2019</td>
<td>31-May-2019</td>
</tr>
<tr>
<td>May 2019</td>
<td>April 2019</td>
<td>30-Jun-2019</td>
</tr>
<tr>
<td>June 2019</td>
<td>May 2019</td>
<td>31-Jul-2019</td>
</tr>
<tr>
<td>July 2019</td>
<td>June 2019</td>
<td>31-Aug-2019</td>
</tr>
<tr>
<td>August 2019</td>
<td>July 2019</td>
<td>30-Sept-2019</td>
</tr>
<tr>
<td>September 2019</td>
<td>August 2019</td>
<td>31-Oct-2019</td>
</tr>
<tr>
<td>October 2019</td>
<td>September 2019</td>
<td>30-Nov-2019</td>
</tr>
<tr>
<td>November 2019</td>
<td>October 2019</td>
<td>31-Dec-2019</td>
</tr>
</tbody>
</table>
Strategies for Reducing Avoidable Readmissions

Kim Werkmeister, BA, RN, CPHQ, CPPS
Cynosure Health

How Do We Connect With Our Partners: Both Upstream and Downstream?
What Drives Improvement in Readmissions?

Many Resources Available to Guide Improvement
ASPIRE Guide: What Drives Improvement?

Reduce Medicaid Readmissions

Analysis

- Analyze Your Data
- Survey Your Current Readmission Reduction Efforts
- Plan a Multifaceted, Data-Informed Portfolio of Strategies
- Implement Whole-Person Transitional Care for All
- Reach Out and Collaborate With Cross-Continuum Providers
- Enhance Services for High-Risk Patients

Action

Drivers for Improvement in Readmissions

Use data to inform improvement activities

Improve standard hospital transitions of care

Deliver enhanced services based on need

Collaborate with providers and services across the continuum
Driver #1: Use Data to Inform Improvement Activities

- Analyze data to inform your targeting approach
- Understand root causes of readmissions; elicit the patient, caregiver and provider perspectives
- Periodically update your approach based on findings; articulate your readmission reduction strategies
- Develop a performance measurement dashboard to use data to drive improvement

Big Data, Little Data

**BIG DATA...**
- Lots of people
- Lots of voices
- Lots of information

**LITTLE DATA...**
- One unique person
- One small voice
- One individual customer

**BIG DATA SPOTS A TREND, WHILE LITTLE DATA SPOTS AN OPPORTUNITY.**
Big Data – What Coded Data Tells Us

Data Drill Down Tool

| Hospitalwide All-Condition, All-Payer, and Payer-Specific Readmission Analysis (adult, non-OB) |
|---|---|---|---|---|
| # discharges | Medicare | Medicaid | Commercial | Uninsured |
| # readmissions | &nbsp; | &nbsp; | &nbsp; | &nbsp; |
| Readmission rate | &nbsp; | &nbsp; | &nbsp; | &nbsp; |

| Table 2. Percentage of Discharges and Readmissions |
|---|---|---|---|---|
| % of total discharges by payer | Medicare | Medicaid | Commercial | Uninsured |
| % of total readmissions by payer | &nbsp; | &nbsp; | &nbsp; | &nbsp; |

| Table 3. Days Between Discharge and Readmission |
|---|---|---|---|
| # of readmissions within 0-4 days of discharge | &nbsp; | &nbsp; | &nbsp; | &nbsp; |
| # of readmissions within 5-9 days of discharge | &nbsp; | &nbsp; | &nbsp; | &nbsp; |
| # of readmissions between days 10-19 of discharge | &nbsp; | &nbsp; | &nbsp; | &nbsp; |
| % of readmissions in 0-4 days | &nbsp; | &nbsp; | &nbsp; | &nbsp; |
| % of readmissions in 5-9 days | &nbsp; | &nbsp; | &nbsp; | &nbsp; |
| % of readmissions in 10-19 days | &nbsp; | &nbsp; | &nbsp; | &nbsp; |

Talking to our patients

"THE KEY TO GOOD DECISION MAKING IS NOT KNOWLEDGE. IT IS UNDERSTANDING."

—Malcolm Gladwell

BLINK
Little Data – What Our Patients Tell Us (The REAL Story)

Driver #2: Improve Hospital Care Transitions Processes

- Engage patients and their families to identify the learner, understand care preferences and assess risk for readmission
- Facilitate interdisciplinary collaboration on readmission risks and mitigation strategies
- Develop a customized care transitions plan that includes patient preferences, risk factors and post discharge contact info
- Use teachback and other health literacy tactics to optimize patient/caregiver understanding
- Timely post-discharge follow up with patient and/or caregiver
Match needs with resources

- Which patients will probably do well with “normal discharge”?
- Which patients need something more?
- Which patients need far more?
- How do you know?
- What do you do?

Driver #3: Deliver Enhanced Services Based on Needs

Deliver enhanced services based on assessed needs of the patient
- Palliative care
- Condition specific programs
- Pharmacy interventions
- Complex care management
- Emergency Department pause
What are Enhanced Services?

- Additional services and supports in the time following care in your organization.
- Services not provided to all patients as part of routine care.
- Offered to subgroups identified as "high risk" of readmission.
- Delivered prior to and after discharge, often for 30 days.
- Deployed at provider expense to reduce readmissions.
- Delivered by hospital staff or by contracted staff from other entities.

Which Patients Need Enhanced Services?

- There may be several target populations at high risk of readmission identified by your data analyses.
- Consider the following high-risk target populations:
  - Patients with chronic illness
  - Patients with co-existing behavioral health diagnoses
  - Patients discharged to short term skilled nursing facilities
  - High utilizer patients
- One "standard" transitional care model would not likely meet the needs and address the root causes of readmissions for all these populations.
- Design "enhanced services" to meet the needs of each target population.
What are Enhanced Services?

- Navigating.
- Hand-holding.
- Arranging for....
- Providing with....
- Harm reduction.
- Meet "where they are."
- Patient priorities first.
- Relationship-based.

Highest Utilizer Strategies

- Identify highest utilizers
  - How many of your patients are admitted to the hospital 4 or greater times in any calendar year?
- Learn what drives their utilization
  - More than chart audits
- Meet the needs of those patients
  - These changes will have far reaching effects for other patients

What are you doing for your highest utilizers?
Many of These Patients Have, in Combination

Acute clinical:
• Sepsis, UTI
Chronic clinical:
• HF, COPD
Behavioral health
• Mood disorders
• Substance use disorder
Social issues

Little Data – What Our Patients Tell Us (The REAL Story)

Readmission Discovery Tool

Driver of Utilization Tool
Key Strategies for High Utilizer Patients

▪ Identify the patient in real-time.
▪ Engage the patient while they are on-site.
▪ View utilization as a symptom of unmet needs.
▪ Prioritize engagement.
▪ Deploy an interdisciplinary team.
▪ Be proactive in post-hospital follow up.
▪ Be patient and persistent.
▪ Have resources to deploy to meet short term needs.
▪ Use care plans to improve care across settings and over time.

Emergency Department Efforts

▪ Process to inform ED staff that this person had a prior admission
▪ Pause to interact in-person or on the phone with a care transitions team member
▪ Decision
  ▪ Admit
  ▪ Observation
  ▪ Home with follow up

What are you doing in your ED?
ED Strategies for High Utilizers

- Create a 30-day return flag on the ED Tracker Board:
  - Be sure to communicate what their desired response to the flag is.
- Use the 30-day return flag to notify the high-risk care team:
  - Real-time notification to allow team to work with ED on safe discharge.
- Use care plans and care teams’ involvement in the ED:
  - Communicate baseline clinical status, recurrent utilization, next steps.
- Consider developing "treat and return" pathways:
  - Inventory the capabilities of post acute providers and post in ED.
- Engage hospitalists in decision to admit:
  - Create a collaborative culture to reduce avoidable decisions to admit.

Driver #4: Collaborate with Providers and Agencies Across the Continuum

- Collaborate with providers and agencies across the continuum
- Convene a cross continuum of providers and agencies that share the care of your high risk patients
- Identify clinical, behavioral, social and community based support organizations that share the care of your high risk patients
- Improve referral processes to make linking to social, behavioral and community-based services more effective and efficient
Finding Agencies for Collaboration

- Highest utilization for your population
- Referral sources
- Community agencies

Working With Partners

- Hospitals, Pharmacies
- Patients and Caregivers
- Skilled Nursing Facilities, Long Term Care
- Medical Home
- Home Care Agencies, Palliative Care
- Board and Care Organizations
What Services Exist That I Am Not Aware Of?

- Community based elder care services:
  - Area Agency on Aging
  - Senior Centers
- Behavioral Health Services
  - Clinics, Drop in Centers
  - Referral Lines, NAMI
- Social Services
  - YMCA
  - Shelters
  - Food, Transportation, Utilities Assistance, 2-1-1

There Just Aren't Resources to Alleviate this Need
There Just Aren’t Resources to Alleviate this Need

ASPIRE Guide Inventory Tools
Bright Spots

- Use of data to select target populations and priorities
- Interdisciplinary collaboration / Improved educational practices
- Condition specific programs / Complex care management
- Pharmacy involvement in care transitions
- Stronger collaborations with SNF & HH
Opportunities

- Learning from and engaging with patients
- Learning what matters most to patients
- Improved health literacy / validating understanding through effective teachback
- Use of an ED pause / mechanism to discuss complex patients prior to admit
- Discussion about/referrals to Palliative Care
- Collaboration with Behavioral Health, Social/Community Resources
What Are YOUR Bright Spots and Opportunities?

Get Started

- Identify YOUR Readmission reduction goal
- Identify YOUR target population
- Apply population-specific strategies
- Choose one new idea to test
Readmissions Resources

- Readmissions Change Package
- ASPIRE Guide
- Trail Guide
- Readmissions Top Ten Checklist
- Readmissions Whiteboard Video Series
- HRET-HIIN Hospital Wide Topics LISTSERV
- Huddle for Care Discussion Forum
- Discovery Tool, Driver of Utilization Tool, Data Drill Down Tool, ASPIRE Interview Guide

Thank You!

Kim Werkmeister, BA, RN, CPHQ, CPPS
Cynosure Health
kwerkmeister@cynosurehealth.org
KHA
Three-part De-escalation Webinar Series

The Kansas Hospital Association has announced a three-part webinar series to address current challenges that many — health care employees, volunteers, and others who interact with aggressive individuals — face in the health care setting. Each webinar begins at 12:00 p.m.

- **Oct. 22** – *Sticks and Stones and Getting Along: Controlling Conflict with Communication*
- **Nov. 12** – *All Patients are Unique (Just Some more than Others): De-escalation Techniques in Atypical Health Care Settings*
- **Dec. 10** – *SECURITY: Who is Responsible? (Hint: It’s someone you know.)*

[Webinar series brochure](#)
[Online registration link](#)
Gaining Access to Shared PFA/PFAC Resources at www.khconline.org

Click on PFE icon

Then, click on the link to access the password-protected page for KHC HIIN PFA/PFAC Resources

Login information
For login information please download the PFAC-resources-and-passwords file in the webinar Downloadable File pod or contact Treva Borcher TBorcher@khconline.org

Resources

PFA/PFAC Resource Toolkit
INSTRUCTIONAL VIDEOS
Steps #1 - #7

Note: You must be logged into the PFAC Members-Only page to access the videos.

Login information
For details for accessing KHC HIIN resources, download the PFAC-resources-and-passwords file in the webinar Downloadable File pod or contact Treva Borcher TBorcher@khconline.org
This 11-month collaborative, conducted by KHC features many supports to help your hospital increase hand hygiene adherence. We welcome Cynosure Health improvement advisor Barb DeBaun as our subject matter expert and faculty.

Contact Chuck Duffield at cduffield@khconline.org for additional information

HH Cohort 2 Timeline
KHC HIIN Hand Hygiene Collaborative Cohort 2 - 79 hospitals

- Allen County Regional Hospital
- Anderson County Hospital
- Atchison Hospital
- Citizens Medical Center
- Clara Barton Hospital
- Clay County Medical Center
- Cloud County Health Center
- Coffey County Hospital
- Coffeyville Regional Medical Center
- Comanche County Hospital
- Community HealthCare System, Inc.
- Community Memorial Healthcare, Inc.
- Decatur Health Systems, Inc.
- Ellsworth County Medical Center
- F.W. Huston Medical Center
- Fredonia Regional Hospital
- Geary Community Hospital
- Girard Medical Center
- Goodland Regional Medical Center
- Gove County Medical Center
- Greenwood County Hospital
- Hanover Hospital
- Hays Medical Center
- Hiawatha Community Hospital
- Hillsboro Hospital
- Hodgeman County Health Center
- Holton Community Hospital
- Hospital District 6 Anthony Campus
- Hutchinson Regional Medical Center
- Jewell county Hospital
- Kansas Medical Center
- Kearny County Hospital
- Kingman Community Hospital
- Kiowa District Hospital
- Labette Health
- Lindsborg Community Hospital
- LMH Health
- Logan County Hospital
- McPherson Hospital Inc.
- Meade District Hospital/Artesian Valley Health System
- Memorial Health System
- Mercy Hospital Columbus
- Mercy Hospital Inc.
- Miami County Medical Center, Inc.
- Minneola District Hospital
- Mitchell County Hospital Health Systems
- Morton County Health System
- Nemaha Valley Community Hospital
- Ness County Hospital District No. 2
- Newman Regional Health
- Newton Medical Center
- Norton County Hospital
- Olathe Medical Center, Inc.
- Osborne County Memorial Hospital
- Ottawa County Health Center
- Phillips County Hospital
- Pratt Regional Medical Center
- Rawlins County Health Center
- Republic County Hospital
- Rush County Memorial Hospital
- Saberha Community Hospital
- Saint John Hospital
- Saint Luke Cushing Hospital
- Saint Luke's South Hospital
- Salina Regional Health Center
- Sheridan County Health Complex
- Smith County Memorial Hospital
- South Central Kansas Medical Center
- Stafford County Hospital
- Sumner Community Hospital
- Sumner County Hospital District No. 1
- Susan B. Allen Memorial Hospital
- Trego County Lemke Memorial Hospital
- University of Kansas - Great Bend Campus
- University of Kansas Health System
- Williams Plains Medical Complex
- William Newton Memorial Hospital
- Wilson Medical Center

Enrolled Hospitals

Upcoming Events

Upcoming KHC HIIN Webinars

KHC HIIN Webinar
Sept 29, 2019 • 10:00 to 11:00 am
Register Here: https://khconline.adobeconnect.com/khc-huin-09-25-19/event/registration.html

KHC HIIN Webinar
Oct 23, 2019 • 10:00 to 11:00 am
Register Here: https://khconline.adobeconnect.com/khc-huin-10-23-19/event/registration.html

KHC Hand Hygiene Collaborative Quarterly Virtual Session
Nov 1, 2019 | 11:00 a.m. – 12:00 p.m.
Kansas hospitals participating in Cohort 2 of the KHC Hand Hygiene Collaborative are invited to participate in each quarterly session. Contact Chuck Duffield (cduffield@khconline.org) for webinar registration link.
AHA | Patients with Opioid Use Disorder in the Outpatient and Emergency Settings

- September 24, 2019 | 12:00 p.m. - 1:00 p.m. CT | Register here.

All times listed are Central Time.

QHi Back-to-Basics Training Session
Review basics of selecting measures, entering data and running/scheduling reports
- October 3, 2019 | 1:00 p.m. – 2:00 p.m. | Register here

All times listed are Central Time.
Please provide feedback to this webinar.
Let us know your next steps.

https://www.surveymonkey.com/r/HIIN-Webinar-08282019
Executive Leadership

- Tom Bell (Co-Executive Director)
- Jerry Slaughter (Co-Executive Director)
- Allison Petersen DeGraff (Managing Senior Director)
- Karen Braman (Senior Director)
- Michele Clark (Program Director)
- Rosanne Rutkowski (Program Director)
- Jill Daughettee (Quality Improvement Advisor)
- Jana Farmer (Quality Improvement Advisor)
- Malea Hartvickson (Quality Improvement Advisor)
- Eric Cook-Wiens (Data & Measurement Director)
- Chuck Duffield (Performance Improvement Manager)
- Rhonda Lassiter (Executive Assistant/Office Manager)
- Rhonda Lassiter (Executive Assistant/Office Manager)
- Treva Barcher (Project Specialist)
- Phil Caithem (Communications Director)

Hospital-led initiatives
- Chuck Duffield
- Eric Cook-Wiens
- Michele Clark

Physician-led initiatives
- Tom Bell
- Jerry Slaughter
- Allison Petersen DeGraff
- Karen Braman
- Michele Clark
- Rosanne Rutkowski
- Jill Daughettee
- Jana Farmer
- Malea Hartvickson
- Chuck Duffield
- Rhonda Lassiter
- Treva Barcher
- Malea Hartvickson

Medical Improvement Collaborative

→ Find contact info, bios, and more at: KHConline.org/staff