

Welcome and Instructions

- For audio, join by telephone at **877-594-8353**, **participant code 56350822#**
- Your line is OPEN. Please do not use the hold feature on your phone but do ***mute your line by dialing *6.***
- If you are having technical difficulties, email mmoch@kyha.com
- Please ask questions through the chat box or wait to the end of each section to ask the presenter





Welcome to the
Kentucky Hospital Improvement
Innovation Network -
February Update



Kentucky
Hospital
Association

Agenda

1. Site Visits Update
2. Fellowships – QI and PFE
3. 1-2-3 for Equity Pledge
4. SNAP – Safety Network to Accelerate Performance Update
5. Fishbowl?!
6. Data and Ky. Quality Counts Update
7. Topic-Based Info-Nuggets
8. Hospital Highlight – Baptist Health LaGrange and Oldham County EMS
9. K-HIIN Delirium/Care of the Aging Patient Series
10. Upcoming HRET and K-HIIN Events
11. Timeline and Next Steps



Site Visits

The K-HIIN team is STILL on the road!
So far - 53 Visits completed, thank you!



Preparation –

- Invite key team members – Senior Leadership, clinical leaders, data collectors and analysts, physician leaders, risk managers, IP, etc.
- Let us know location of meeting, media and Internet capabilities
- Be thinking about your WHY 😊 and your areas of focus

We are learning lots of great things that our hospitals are up to – you may be the next Hospital Highlight!



Fellowships

Back by popular demand!

1. QI Fellowships – KY enrollment:

Foundations for Change – 17 enrollees

Accelerating Improvement – 4 enrollees

2. Patient and Family Engagement –

7 enrollees

Thank you for participating - there's still time to sign up for PFE (Sorry, QI is now closed) – remember, our goal is to have at least one Fellow from each hospital!



#123forEquity

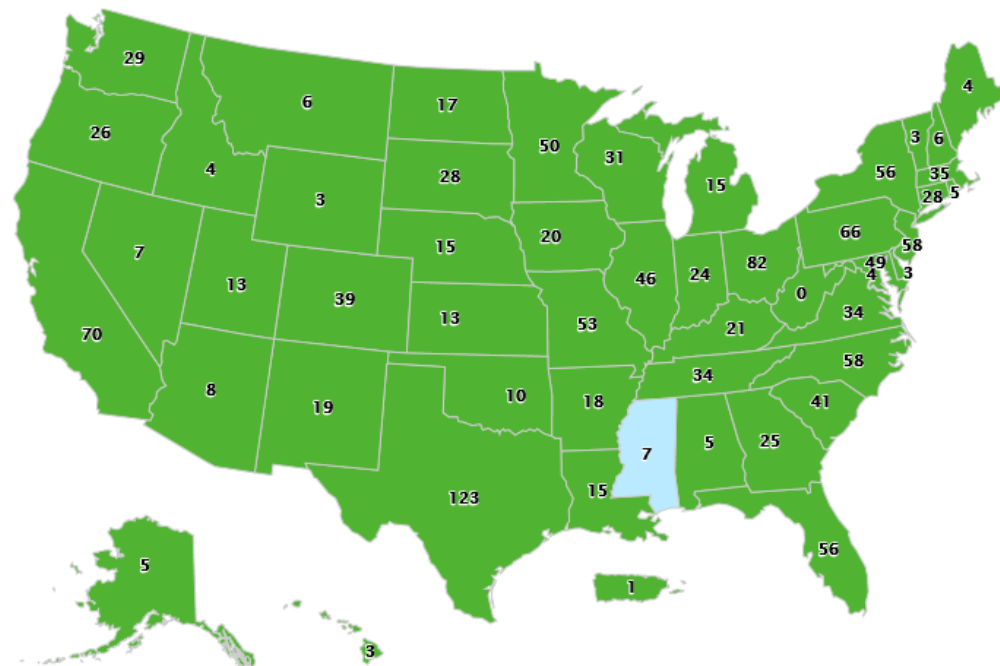
Disparities impact statement

#123forEquity Pledge to Act

Organizations Pledged: 1391

State Hospital Associations Pledged: 50

Metropolitan Hospital Associations Pledged: 10



Number in State = Organizations Pledged

● State Hospital Association Pledged



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#123ForEquity

#123forEquity Pledge

- National Call to Action
- Pledge to address the following areas in the next 12 months-
 - By end of month one, choose a quality measure to stratify by race, ethnicity, or language preference (or other socio-demographic variable such as income, veteran status, sexual orientation or gender, or other)
 - By end of month three, determine if a health care disparity exists in this measure – if yes, design a plan to address the gap
 - By end of month six, provide cultural competency training for all staff or develop a plan to ensure your staff receives cult. comp. training
 - By end of month nine, have a dialogue with board and leadership team on how you reflect the community you serve, and what actions can be taken to address any gaps if the board and leadership do not reflect the community you serve



SNAP Update

Safety Network to Accelerate Performance

- The first SNAP topic is **enhanced recovery after surgery with a focus on colorectal surgery.**
- SNAP applications are closed for this round – 2 Kentucky Hospitals applied - and were accepted! ***Baptist Health LaGrange and King's Daughter's Medical Center*** - we look forward to hearing about your progress!



Fishbowl?

- HRET is piloting a new idea – a “fishbowl” is an opportunity for a hospital to bring the HRET and Cynosure leads into their quality team meetings for consultation, tips, etc. via SKYPE or other interactive methods.
- First topic is ADE, next Readmissions
- Would you like to be in a fishbowl? Contact K-HIIN by Feb.27 for more information!





THE RACE CONTINUES

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DATA UPDATE

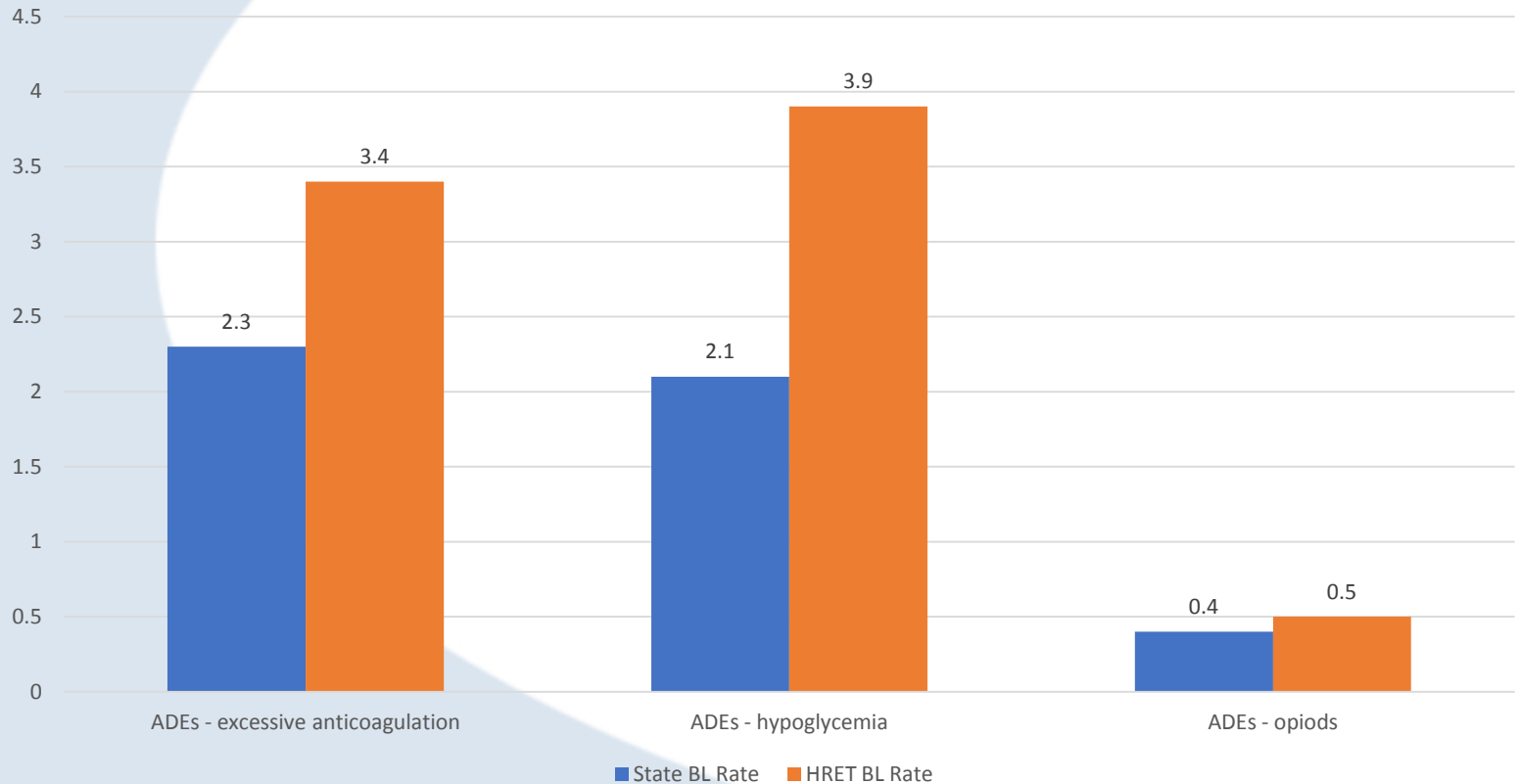


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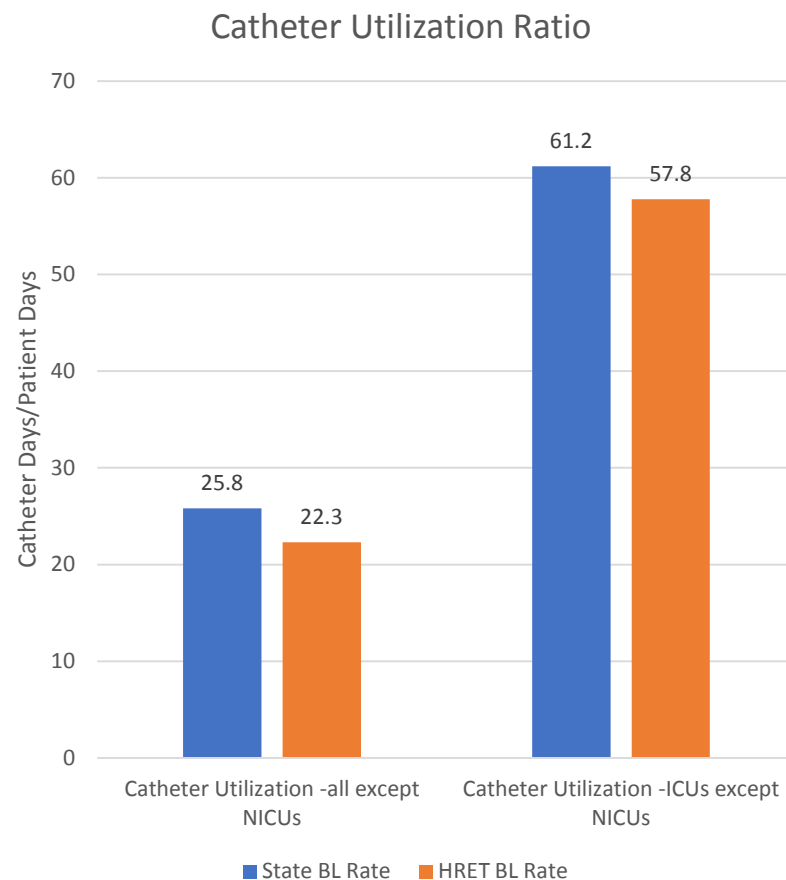
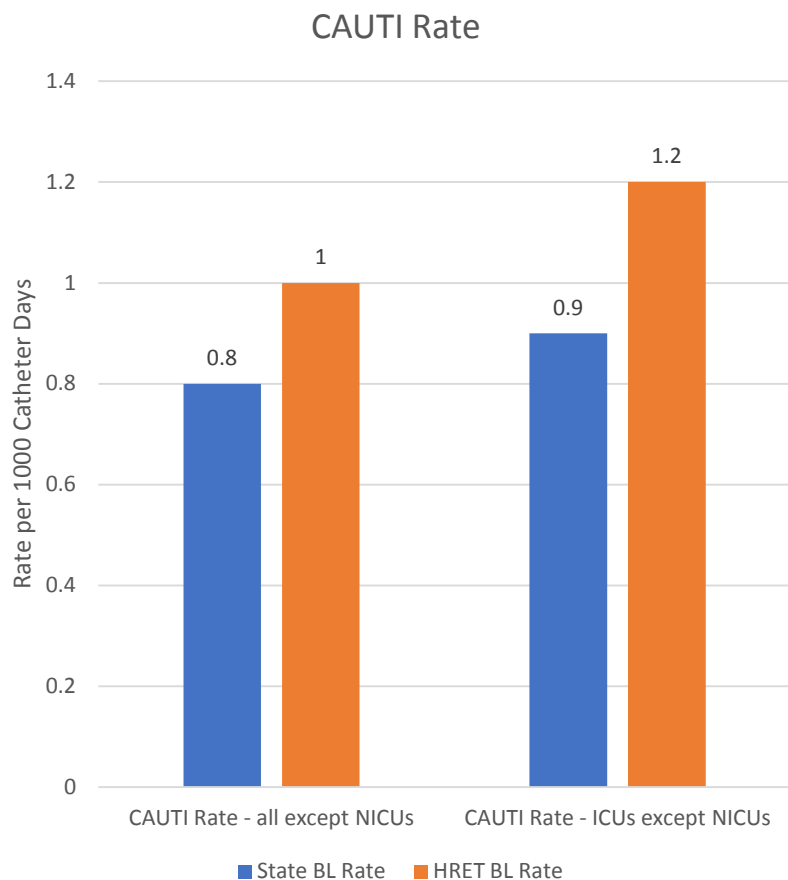


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Adverse Drug Events

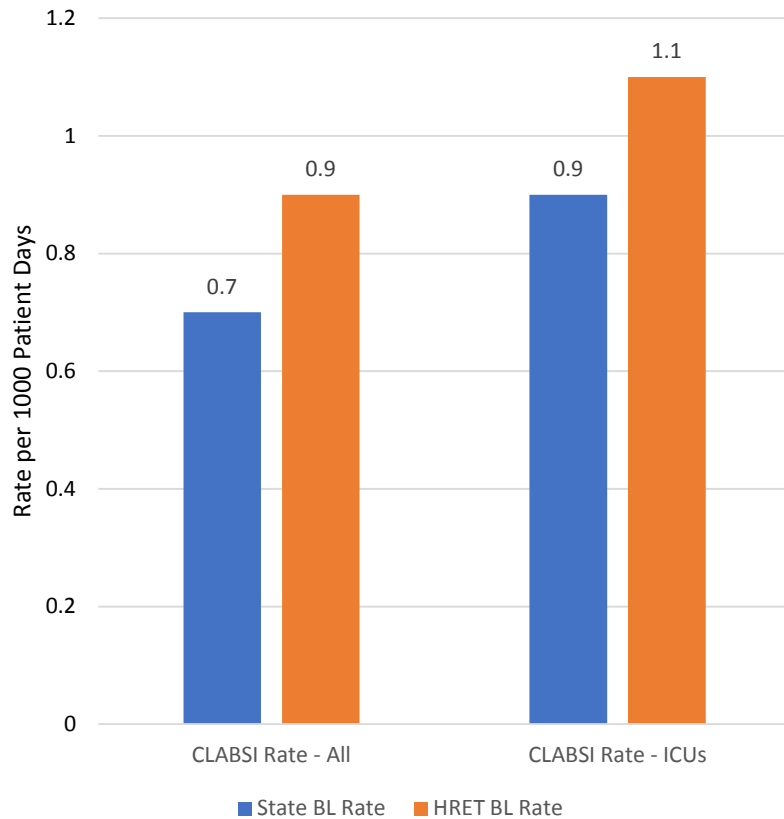


Baseline Period: 2015

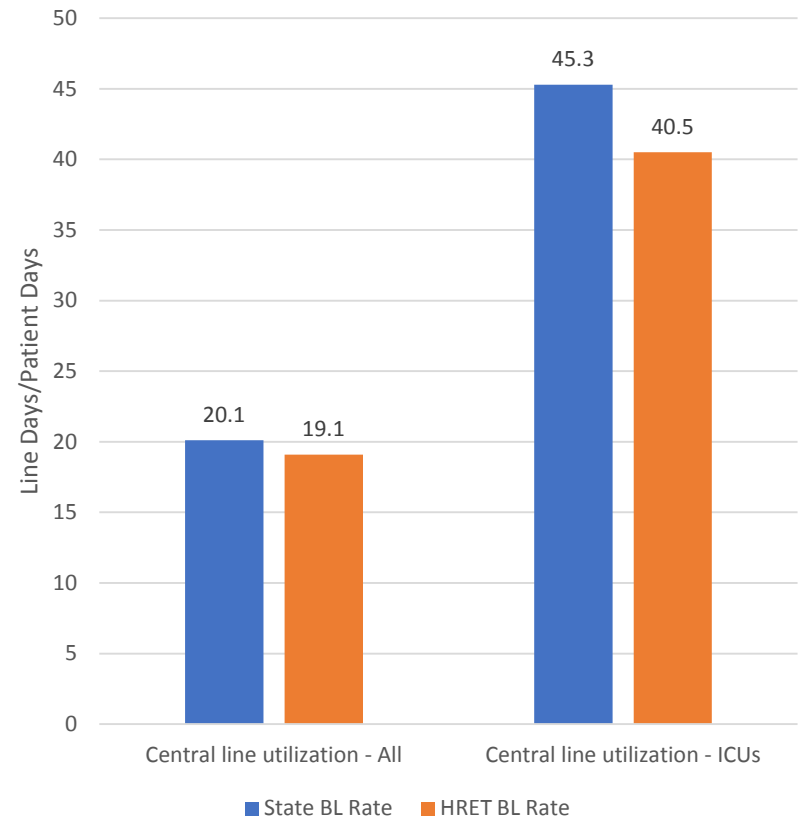


Baseline Period: 2015

CLABSI Rate

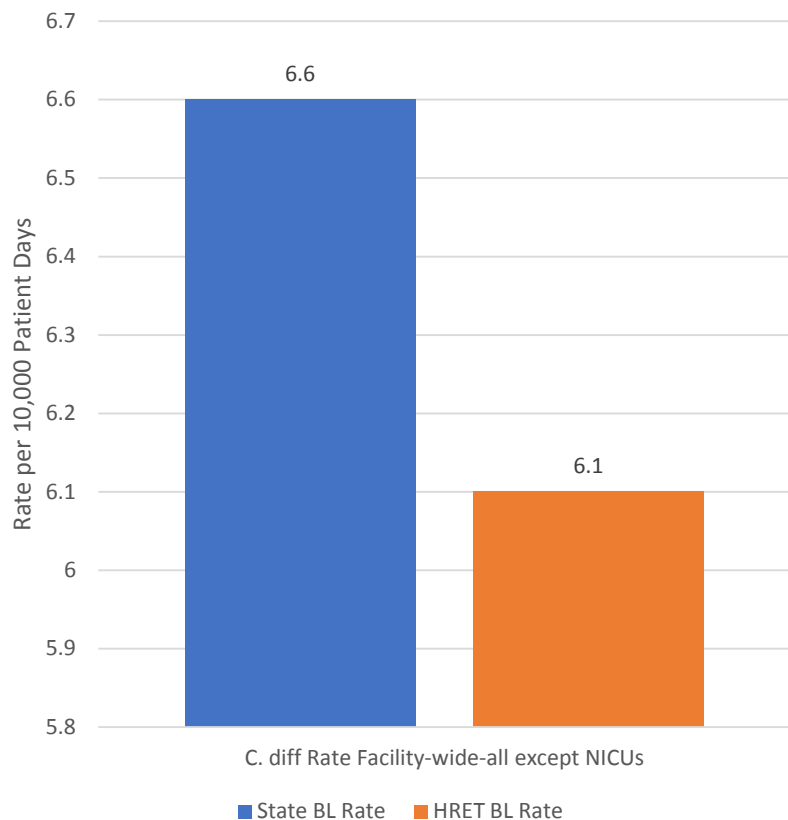


Central Line Utilization

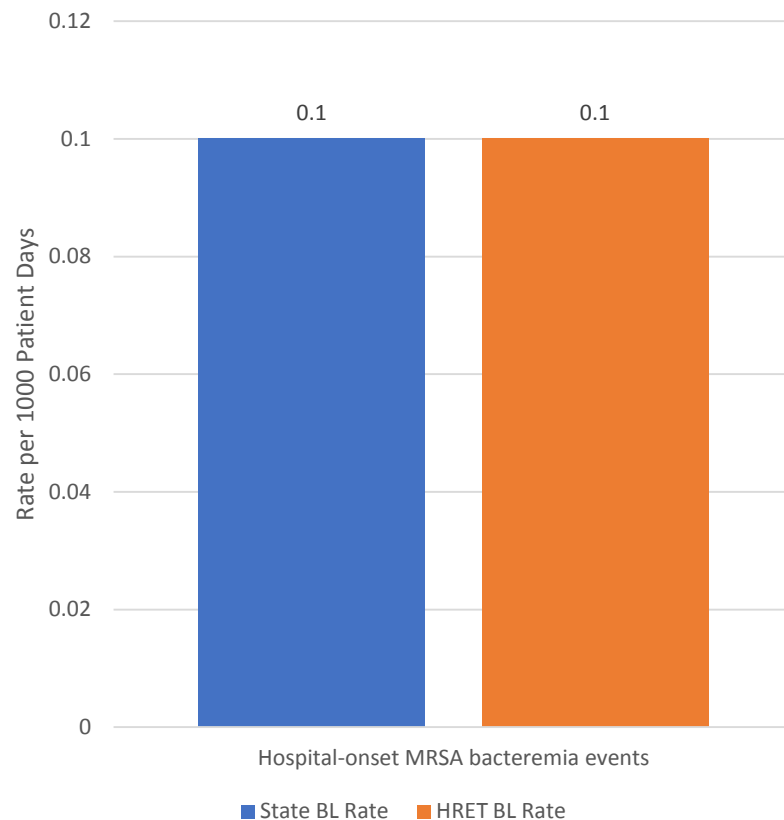


Baseline Period: 2014

C. Diff

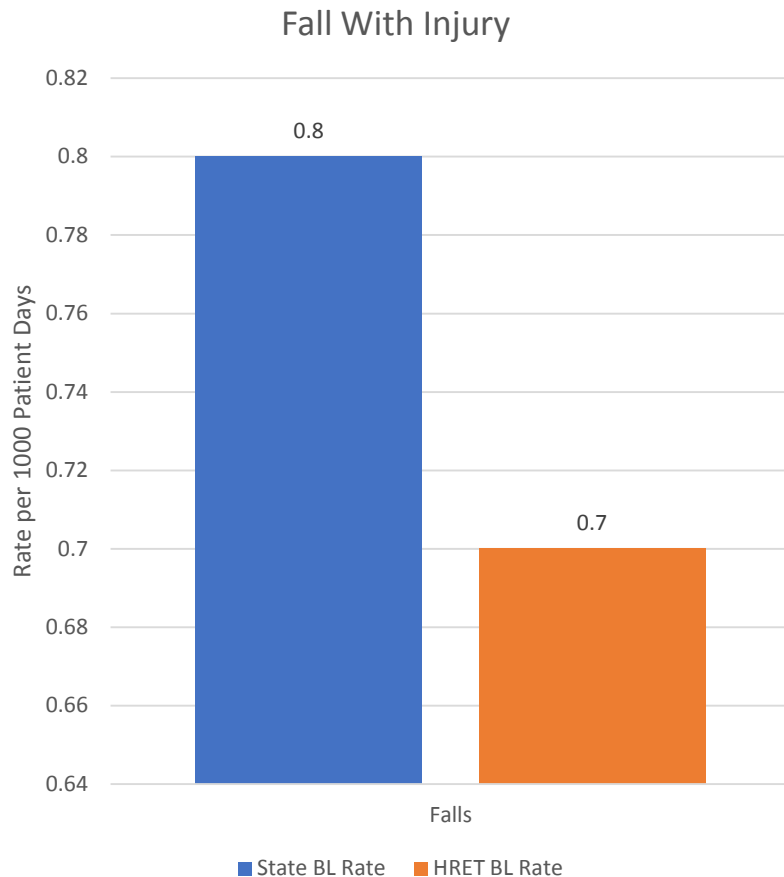


MRSA Bacteremia

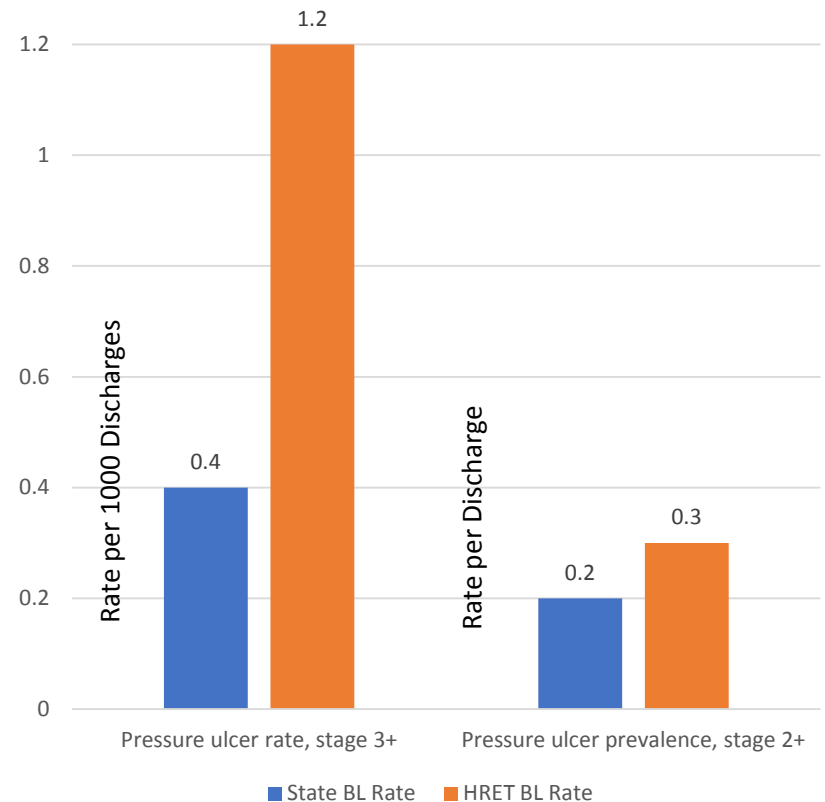


Falls With Injury Pressure Ulcer/Injury

Baseline Period Varies



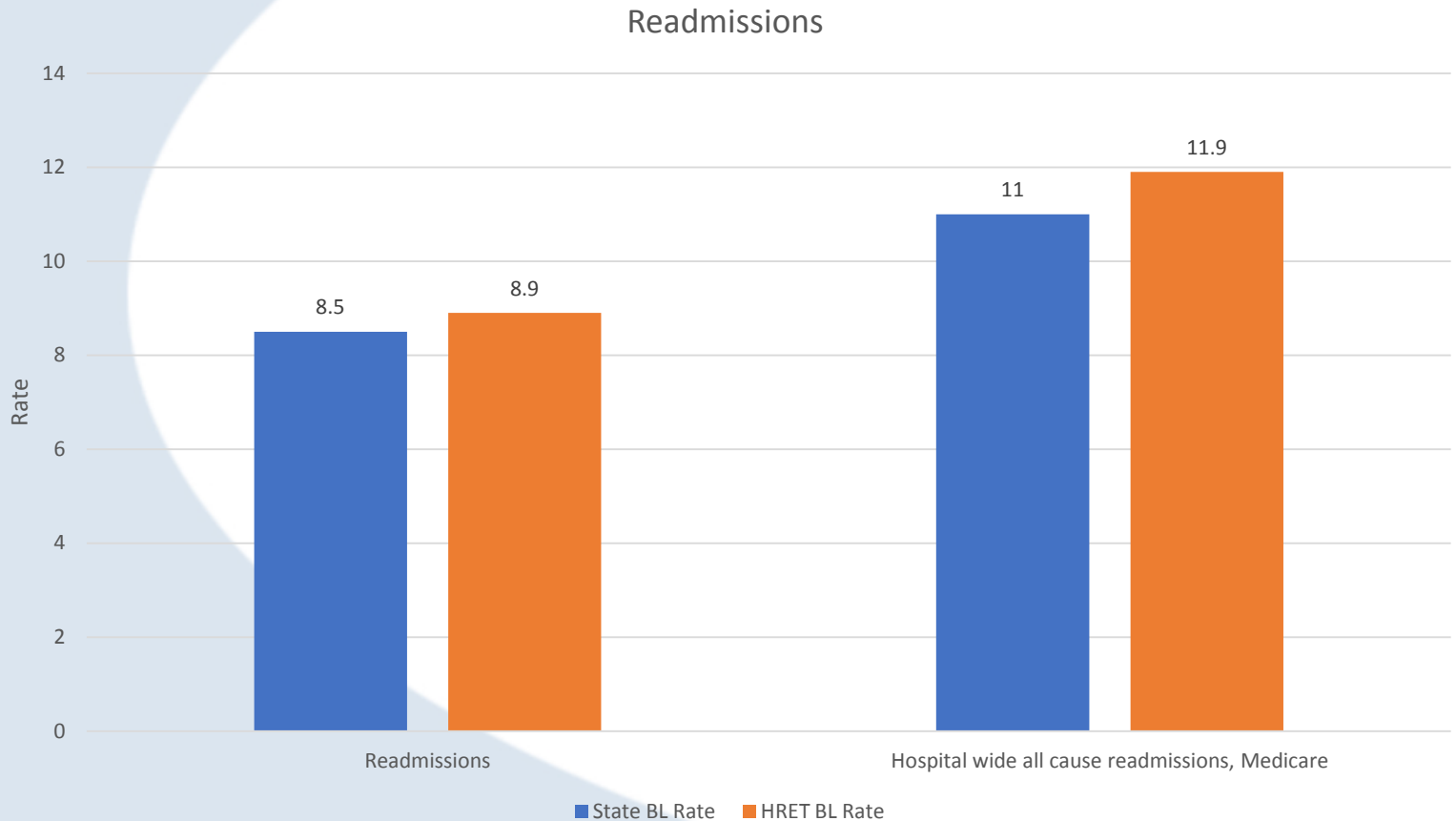
Baseline Period: Stage III or Greater – 2014 Stage II and Greater Prevalence - Varies





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Baseline Period Varies



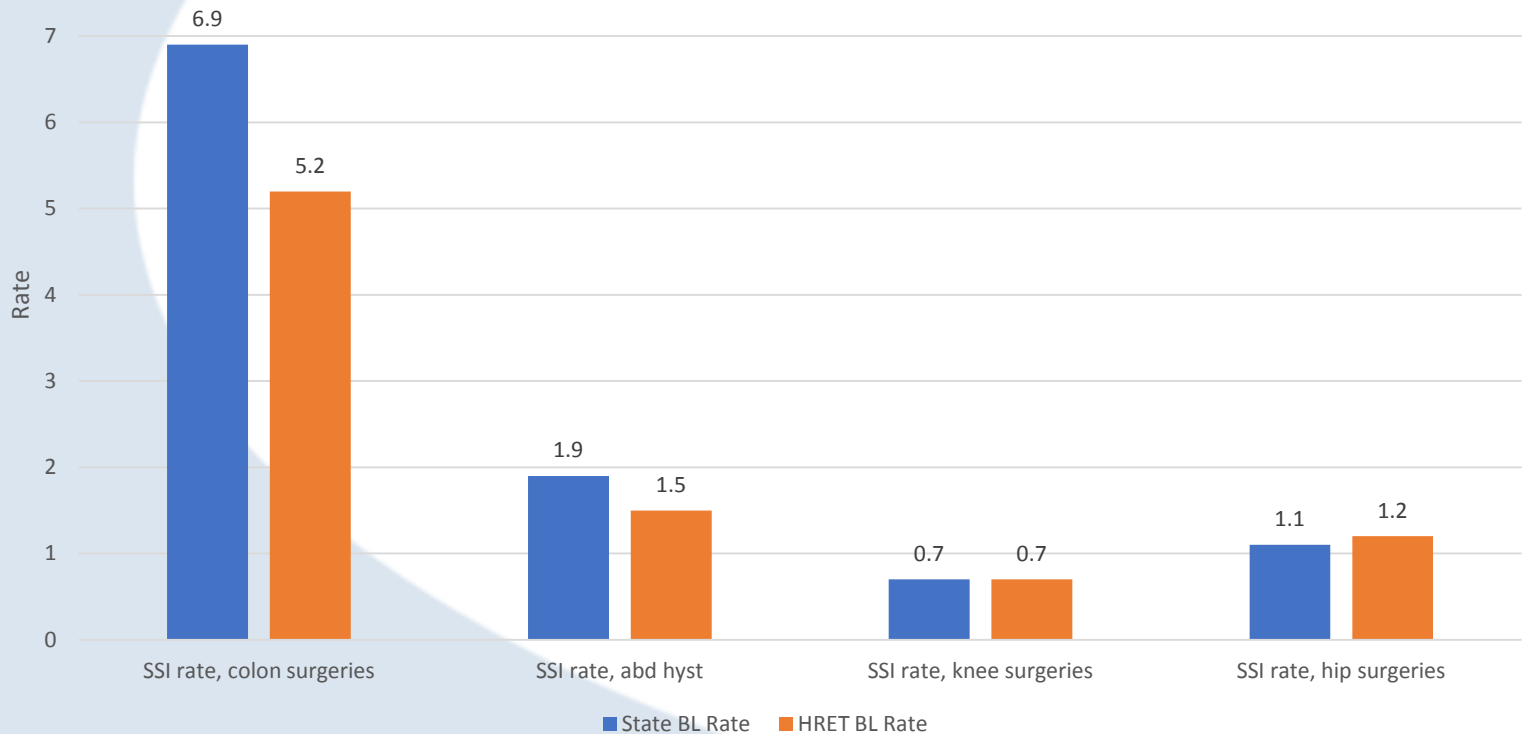


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Baseline Period: Colon and Abd Hyst - 2014

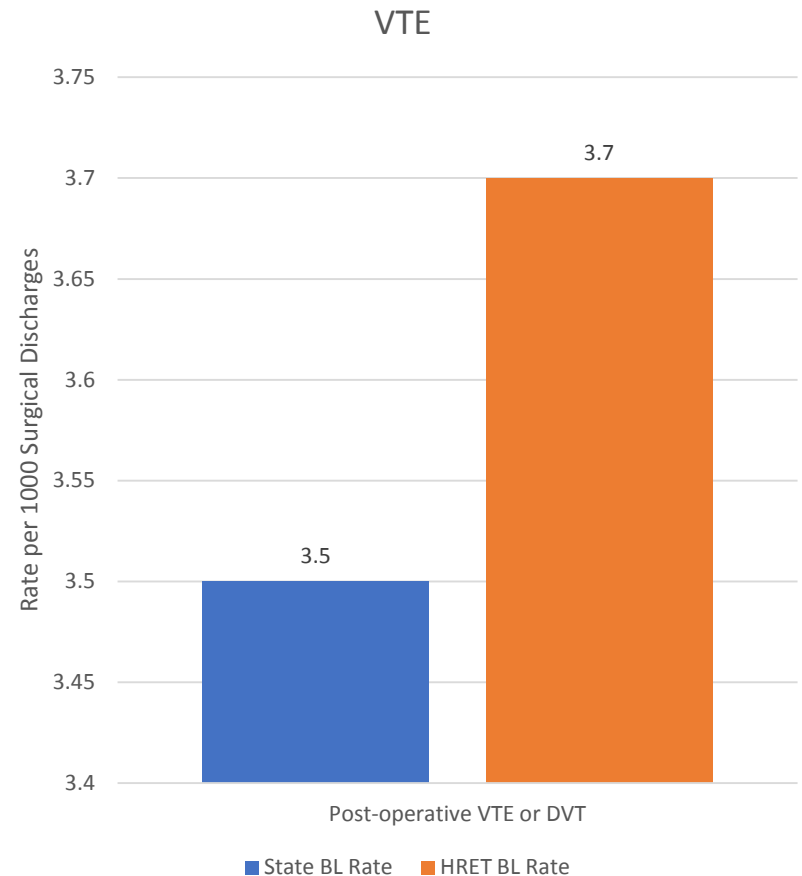
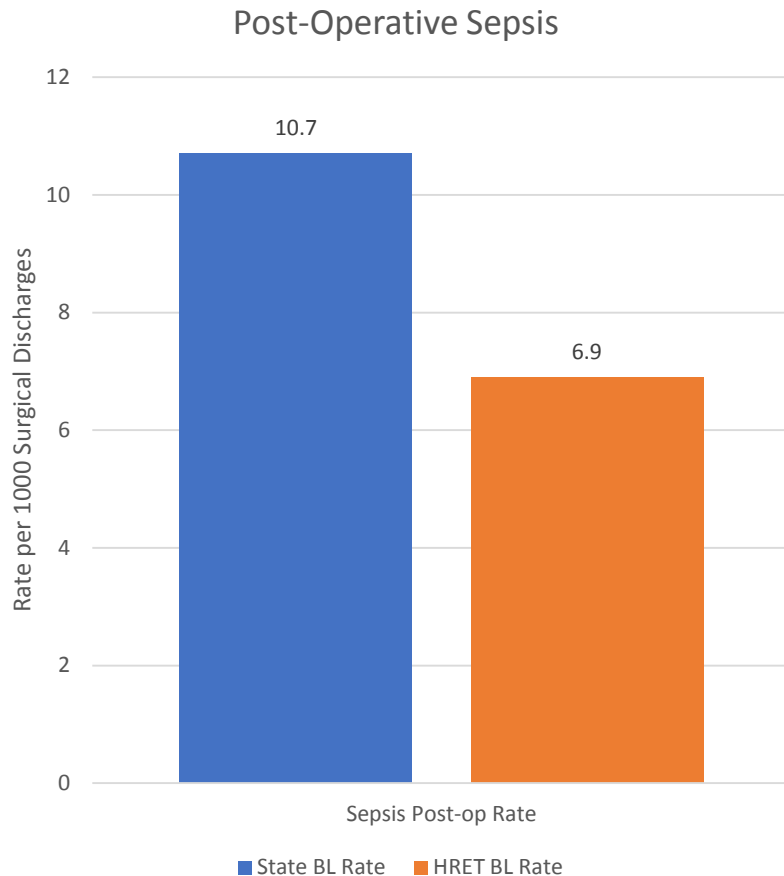
SSI Rate

Baseline Period: Hip or Knee Surgery - Varies



Post-Op Sepsis Post-Op VTE

Baseline Period: 2014



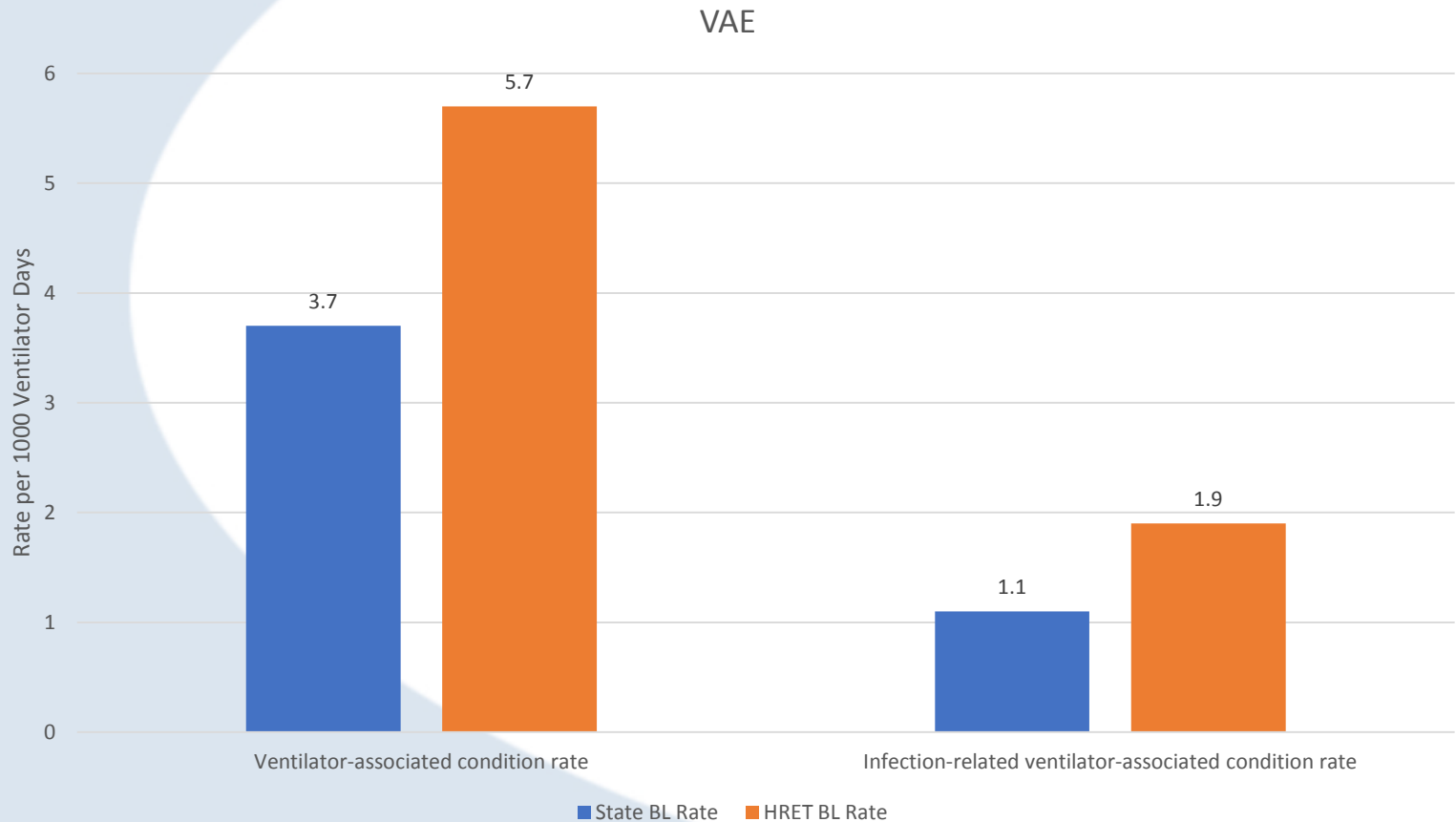


THE RACE CONTINUES

Ventilator Associated Events

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Baseline Period: 2015



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Baseline Varies





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Monthly Monitoring Data

- Beginning with October 2016 data

Monitoring Data (October 2016 – December 2016) will be due to KY Quality Counts by March 1, 2017





KY Quality Counts Data Collection System

Kentucky Hospital Improvement Innovation Network



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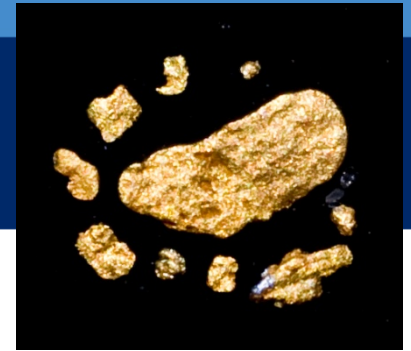
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<https://khaqualitydata.org>

And a Few Info-Nuggets



Adverse Drug Events – from recent ADE listserv activity...

Authors Barnett, Olenski and Jena published a fascinating article in NEJM analyzing “Opioid-Prescribing Patterns of Emergency Physicians and Risk of Long-Term Use”. You can find the article here <http://www.nejm.org/doi/full/10.1056/NEJMsa1610524?query=TOC>.

Here’s what they found:

- Within individual hospital emergency departments, rates of opioid prescribing varied widely between low-intensity and high-intensity prescribers
- **Long-term opioid use was significantly higher among patients treated by high-intensity prescribers than among patients treated by low- intensity prescribers (adjusted odds ratio, 1.30; 95% confidence interval, 1.23 to 1.37; P<0.001)**



- In addition, they found that within 12 months after being seen by high-intensity prescribers, patients were more likely to be seen in a hospital for:

FALLS

- **Relative Risk = 6.5 % increase**
- Absolute Risk = 2.8 excess falls per 1000 patients
- Number Needed to Injure (NNI) = 1 out of every 357 patients and

OPIOID POISONING

- **Relative Risk = 42% increase**
- Absolute Risk = 0.3 excess opioid poisonings per 1000 patients
- Number Needed to Injure (NNI) = 1 out of approximately every 3300 patients



In summary:

- There is wide variation within individual hospital Emergency Physicians regarding their opioid prescribing practices.
- *Patients treated by high-intensity prescribers (more scripts, higher doses; longer durations) were:*
 - *30% more likely to become long-term opioid users,*
 - *6.5% more likely to be treated for a fall, and*
 - *42% more likely to be treated for opioid poisoning.*



- Here are some ***suggested actions and measures to consider:***
- Share this article
- Identify the opioid prescribing practices of your ED physicians
 - % of patients who leave with an opioid prescription
 - Numerator = patients who leave with an opioid R_x from Physician A
 - Denominator = all patients discharged by Physician A
 - Morphine equivalence
 - Numerator = total morphine equivalence prescribed (dose x frequency x duration x number of scripts) by Physician A
 - Denominator = all patients discharged by Physician A



- % of patients who leave the ED with a script for more than X days (7, 10 or 14 days; no standard, choose one) supply of opioids
 - Numerator = patients who leave with an opioid R_x from Physician A if taken as prescribed would last X days or more
 - Denominator = all patients discharged by Physician A
- NOTE: Each denominator is “all patients discharged by the physician”, not just the patients discharged on an opioid

- How much variance is there?
- Share the results with your physicians to create “light” not “heat”
- Engage your PFAC team to work with ED staff and patients to create awareness of short term and long term opioid adverse events



- Engage your PFAC team and nursing staff to begin to manage pain expectations as soon as the patient comes through triage
- Check out your staff's current state of knowledge about opioid safety:
 - Take the Pennsylvania Opioid Knowledge Self-Assessment Test <http://patientsafetyauthority.org/EducationalTools/PatientSafetyTools/opioids/Documents/assessment.pdf>
 - Do your physicians know who's low risk for opioids? Who's high risk?
 - Do your physicians know that opioid naïve patients should get very low doses of short acting opioids (if their pain cannot be managed by other non-opioid alternatives such as acetaminophen or ibuprofen)?
 - Does your staff know the definition of opioid tolerant? This term means that the patient must have received at least 60 mg of morphine equivalence DAILY for the last 7 days.
- What else might you do?

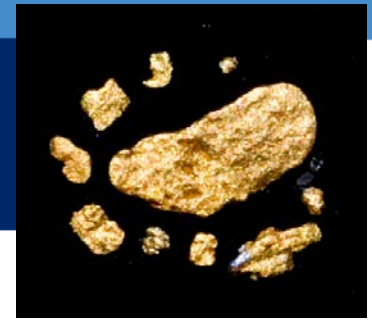


Antibiotic Stewardship Program

- Checklist for Core Elements of Hospital Antibiotic Stewardship Program:
 - Leadership Support
 - Accountability
 - Drug Expertise
 - Actions to Support Optimal Antibiotic Use
 - Tracking: Monitoring Antibiotic Prescribing, Use and Resistance
 - Reporting Information to Staff on Improving Antibiotic Use and Resistance
 - Education



And a Few Info-Nuggets

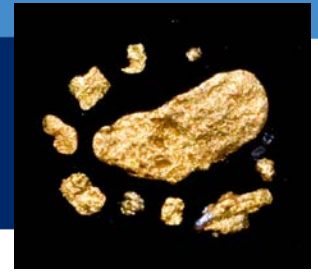


Readmission Views From the Road

- **Strategies for reducing readmissions are numerous!**
- Today in *Hospital Highlight* you will hear from Baptist Health LaGrange and Oldham County EMS about an innovative solution for keeping patients at home and healthy.
- **Be sure to register for the Quality Symposium March 14-15, in Louisville** Pat Teske, national HINN resource on readmissions, will speak on defining the readmissions population and developing strategies to drive down readmission rates.
- At that Symposium we will also hear from two hospitals in Kentucky who have had success in implementing strategies to keep potential readmission in the community.
- All these examples were learned during our recent site visits and we're eager to share them.



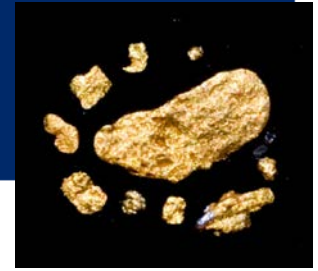
Info Nuggets- C. difficile



- Perspectives from recent studies courtesy of Dr. Eric Dubberke at Washington University in St. Louis
- C. difficile is truly ubiquitous!!
 - People are normally colonized with C. diff (We all get it, clear it and get it again all our lives.
 - We have constant exposure through our food, water, dust.....It's on our shoes and in bathrooms.
 - It is when our microbiome is changed that we become ill.
 - Exposure to antibiotics- proven
 - Gastric acid suppression?
 - Exposure to infants?



Info Nuggets- C. difficile



- Why are we seeing more positives?
 - Increased surveillance
 - Increased testing
 - Increasingly difficult to treat infections and inappropriate use of antibiotics
- Conclusions:
 - C. difficile is a clinical diagnosis- our patient is ill and has appropriate symptoms to be suspicious for C. diff → test!
 - If at least 15% of all patients are colonized at time of admission, must be very careful about screening policies and testing protocols



Hospital Highlight – Baptist Health LaGrange and Oldham County EMS



Upcoming Events

K-HIIN Delirium/Care of the Aging Patient Series
begins February 23, 1:00 p.m. – 2:00 p.m. ET

HRET HIIN CAUTI Virtual Event – February 23
from 12:00 p.m. – 12:50 p.m. ET

HRET HIIN Falls Virtual Event – March 7
from 12:00 p.m. – 12:50 p.m. ET

HRET HIIN CDI Virtual Event – March 9
from 12:00 p.m. – 12:50 p.m. ET

KHA Quality Symposium March 14 & 15, Crowne
Plaza Hotel, Louisville

<http://www.hret-hiin.org>



Timeline and Next Steps

- **Site Visits** - Schedule yours now if not already scheduled
- **Join the PFE Fellowship!**
- **Continue entering Monitoring Data into KQC**

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Questions?

