| IHC Patient Safety Award Poster Abstracts

CHI Health Mercy Council Bluffs | *Working to END Clots: A Quality Improvement Project to Prevent VTE*

The purpose of the CHI Health Mercy Council Bluffs Quality Improvement Project was to decrease the incidence of healthcare-associated venous thromboembolism (VTE) at a small midwestern hospital using the FOCUS-Plan Do Study Act (PDSA) methodology. Interventions included education for nurses and providers, engagement with therapy staff, relocating Sequential Compression Devices (SCDs), pumps and tubing into patient rooms, and creating interactive patient education materials. Process measures included appropriate provider prophylaxis orders, frequency of patient refusal to wear SCDs, provider notification of patient refusal and case analysis. Data was collected between November 2022 and June 2023 and demonstrated a patient refusal rate of less than 30% on a medical-surgical (Med/Surg) Unit and a drop from 67% to as low as 10% on a Post Critical Care Unit. Providers ordered appropriate mechanical and pharmacological prophylaxis 94% and 92% of the time respectively. VTE events decreased from 16 events during the same time period the previous year to 6 events during the 8-month project period. Provider notification of a patient's refusal to wear SCDs remains an opportunity, occurring 71% of the time on the Med/Surg Unit and 49% of the time on Post Critical Care. Next steps may include development of an interprofessional concurrent case review process and a protocol for reassessment of patient risk when transferred to a higher level of care.

Clarke County Hospital | *Falls Improvements: Hospital Wide Goals*

Clarke County Hospital's goal is to keep patients safe. Their team plans to meet this goal by reducing the number of falls in the hospital. To reduce falls on all inpatients, it was Clarke County Hospital's goal to increase awareness in all departments. Each department focused on a specific area and created a measurable audit. Clarke County Hospital staff conducted a theory that if each audit showed improvement, fall rates would decrease.

Drake University | *Leveraging Telehealth Partnership, Remote Patient Monitoring, and Medication Reviews to Improve Chronic Disease Outcomes in Rural Iowa*

Access to care in rural Iowa is a challenge for many patients. Access to care limitations compromise patient safety and results in poor chronic disease outcomes with increased hospitalizations and emergency department visits. Telehealth (TH) using health coaches and remote patient monitoring (RPM) positively impacts patient outcomes. Enhanced medication therapy management using medication safety reviews (MSR), decrease medication misadventures. By joining these modalities and providing them to rural Iowa clinics, Drake University staff developed a unique approach to the delivery of TH to rural Iowans. Partner clinics in rural northern Iowa refer patients for TH with RPM. Patients are contacted by phone to have an explanation of the program and receive enrollment assistance. Once enrolled, appropriate RPM equipment is sent to the patient and monitoring of blood pressure, glucose, or weight is initiated. Patients taking a high-risk medication or less than 10 medications are contacted for a complete MSR with recommended medication changes sent to the patient's healthcare provider and the patient. Initial analysis of results demonstrates clear improvements in blood pressure control and other outcome parameters. For blood pressure, nearly 60% of patients were at target following enrollment in the program. Following a completed MSR, the medication risk scores are reduced by at least 10% which is associated with improved medication safety. Patient feedback on the program has been overwhelmingly positive with patients stating it has raised their awareness monitoring health outcomes and adhering to medication regimens.

Genesis Medical Center | *Using the Code A Process to Mitigate Workplace Violence*

Genesis Medical Center's objective was to provide staff with information pertaining to the growing prevalence of workplace violence in America. This included the Joint Commission response to the crisis and the actions taken to drive safety through the prevention of workplace violence. By utilizing a multidisciplinary team approach and A3 methodology, Genesis developed a workplace violence task force to mitigate workplace violence.

Great River Health | *Tiered Huddle Structure*

The purpose of Great River Health's Tiered Huddle Structure was to provide a clear, consistent, efficient method to support caregivers with daily challenges and to recap the last 24 hours. Tiers 1 and 2 equip leaders to identify issues, support resolution and escalate challenges. The benefits of Tier 1 include better time resolution, organization safety and process improvement. Tier 3 of the structure is led by an Executive Team Member and its task is to continuously reinforce the purpose of huddles. During the implementation of this tier, staff identified that "no problems" is a problem and that huddles are an improvement activity and a benefit when it comes to reporting and problem solving.

Hansen Family Hospital | *Demolition to a Safe Zone*

Hansen Family Hospital's Emergency Services Department is fully dedicated to every patient's experience. The 24/7 emergency room is committed to providing prompt care without interruption or delay while maintaining the safety of patients, visitors, and colleagues at all times. With an overall rise of patient traffic in recent years, came a small increase in unpredictable behavior. This resulted in occasional violent and destructive behavior towards staff and equipment. Through the hospital's responsibility to patient care and overall safety within the organization, it was evident that changes were necessary to increase security measures and eliminate safety gaps. A committee was formed of staff from each patient touchpoint to address safety concerns and determine what steps were necessary to positively impact patient care. Emergency visit metrics from the previous three years were analyzed and factored into discussions on how best to proceed with increasing security measures and positively impacting patient care. It was determined that with the correlation of increased emergency visits and uptick in violent behavior, a department renovation and redesign was the best way to proceed to improve safety gaps and continue providing efficient patient care.

Happy at Home Consulting | *Utilizing a Falls Prevention Program to Improve Chronic Disease Management in Community Dwelling Older Adults*

This presentation explores how falls prevention and management of chronic disease are connected for older adults in the community. Combining falls prevention with strategies for chronic disease management offers a well-rounded way to improve overall well-being. By focusing on physical activity, building strength and improving balance, results show falls prevention programs naturally help with managing chronic conditions. Using insights from the CAPABLE program (April 2022 - July 2023) in Polk and Dallas Counties, a collaboration between Happy at Home Consulting, the Iowa Department on Aging and Greater Des Moines Habitat for Humanity, was formed to show how falls prevention can significantly impact the overall health of older adults.

Jefferson County Health Center (JCHC) | *CareLink: Bridging the Gap for Optimal Recovery and Wellness*

JCHC is dedicated to serving over 15,000 residents with compassion and pride and faced the challenge of navigating patient transitions during COVID-19. Collaborating with the University of Iowa Hospital and Clinics, a transformative grant-driven initiative emerged in 2020. The culmination of the grant initiative gave rise to the Transitional Care Program. Later, this expanded to include a Chronic Care Program, aimed at supporting patients' return to the community and improving healthcare compliance. JCHC identifies program candidates through referrals from JCHC hospitalists, the Emergency Department, and clinic providers, targeting those with complex health needs or social obstacles to adherence. The programs continuously evolve through meticulous analysis, seeking to identify and rectify barriers within the system integrating involvement from diverse disciplines. Evidence attests to the program's communal value, with the Transitional Care Nurse Team's guidance proving instrumental for optimal health and well-being. Looking forward, JCHC envisions a future where systemic hindrances are dismantled, and collaborative efforts thrive. The trajectory set by JCHC fosters resilience, guiding patients towards recovery and lasting wellness.

Knoxville Hospital and Clinics | *Reducing Healthcare Acquired Pneumonia Through Improved Oral Care*

Knoxville Hospital and Clinics identified an increase in the rate of patients with healthcare acquired pneumonia in 2020. Based on research, a med surg nurse suggested improved oral care for hospitalized patients. Oral care kits with antiseptic rinse, suction connector, and a self-contained spittoon were implemented. As one of several tactics to reduce healthcare acquired conditions, improved oral care contributed to a significant decrease in healthcare acquired pneumonia that has been maintained since 2021.

Mary Greeley Medical Center (MGMC)

| *Breaking Down Barriers and Reducing Restraints in the Intensive Care Unit*

In 2019, MGMC used 2,745.9 hours of soft wrist restraints in their Intensive Care Unit (ICU) with patients on a ventilator. In 2020, they saw a drastic increase in soft wrist restraint use to 7,742.8 hours. In 2021, another increase to 8,584.3 hours. In addition to the drastic increase in the number of hours patients were spending in soft wrist restraints, MGMC staff were consistently falling below their goal of 90% compliance with their documentation. The standard of care, prior to August 2021, was to place soft wrist restraints on all patients on a ventilator upon arrival to the ICU, or when intubation occurred. MGMC staff did this for airway protection and to keep these patients safe. MGMC knew that they had opportunities for improvement and, utilizing the continuous quality improvement model, they formed a team composed of key stakeholders. After reviewing the literature, MGMC found a reference from the American Hospital Association and reached out to them in June 2021. MGMC then brought them onsite to complete a mock survey and the results yielded several opportunities for improvement. MGMC took their suggestions, and along with the recommendations in the literature, worked with staff and providers to develop a new standard of care. Once MGMC had determined what their new standard would be, they revised their restraint policy and removed mitts, as they determined these were not a physical restraint. Once the policy updates were complete, they educated all staff and providers and began the trial with five patients on a ventilator. These patients all had unsecured mitts instead of the soft wrist restraints, and MGMC had no unplanned extubations with any of the trial patients. In September 2021, the revised policy was fully implemented along with a strict "no restraint use" standard of care. Historically, MGMC has audited charts with patients that have been restrained for more than 72 hours. However, MGMC recognized that they were unable to prevent prolonged restraint use because they had already been restrained greater than 72 hours when the audit occurred. MGMC was also unable to meet the goal of 90% compliance in their documentation. MGMC made the decision to add to the MGMC audit tool, and audit charts of patients that have been restrained more than 24 and 48 hours. This provides MGMC with an opportunity to prevent prolonged restraint use and continue to improve patient outcomes. Since implementation, MGMC has reduced physical restraint use in their ICU by over 99%. They went from 32 patients restrained in 2022 to only one patient restrained in 2023. The drastic reduction in restraints solidifies their continued vigilance around restraint use.

| *C the DIFFerence: Cross-Functional Collaboration to Reduce Hospital-Acquired C. difficile Infections*

In 2020 and 2021, MGMC hospital-onset Clostridioides difficile (C. diff) infections were unfavorably higher than expected. With the collaboration of the Iowa Department of Health and Human Services (Iowa HHS) and McFarland Clinic Infectious Disease physicians, a careful case review was conducted and revealed some colonized C. diff cases were misidentified as active infection cases due to the testing practices. Misidentification of such cases can not only falsely increase reportable infection rates but more importantly lead to unnecessary time, costs and antibiotic usage for treatment. Improved results were obtained through provider support for best testing practices using education, adjusting automatic testing cascades and automatic cancellation of unnecessary tests.

| *Efficacy and Safety of Pharmacist-Driven AUC-Based Vancomycin Dosing: Using Metrics to Monitor Success*

To improve clinical outcomes and minimize harm, MGMC provides a pharmacist-driven vancomycin dosing consult service. The service transitioned from a trough-based to Bayesian area under the curve (AUC) dosing in June of 2019 using InsightRx software. In April 2021, the interdisciplinary antimicrobial stewardship (AMS) team identified, through physician feedback, that an opportunity to improve patient outcomes by reducing time to therapeutic vancomycin levels existed. Immediate planning followed by implementation to establish framework for each pharmacist dosing vancomycin included optimizing goal AUC targets, establishing a 24-hour time-to-achieve-target and creating a standardized smart phrase to guide the pharmacist through each dosing decision to provide a consistent process. The pharmacists who provide vancomycin dosing were then educated. To monitor dosing services and adverse drug reactions, quarterly tracking of the percent of vancomycin levels at goal within 24 hours and percent patients with an acute kidney injury after 48 hours into therapy was established. To establish goals for the MGMC Dosing Service Program, the MGMC chose to benchmark their institution vs other institutions using the same InsightRx software. The outcomes are sustained by including these metrics as a standard agenda item for review at quarterly MGMC AMS meetings. If quarterly data is not reaching MGMC goals, a plan for action is established. Through 2023 consistent results have shown MGMC's vancomycin dosing service is achieving their desired outcomes and is outperforming other institutions using the InsightRx software. To help improve vancomycin dosing outside of MGMC, MGMC has shared their strategies with the software vendor.

| *Facilitating of a PGY1 Pharmacy Residency Program at a Rural Community Hospital*

With increasing demands for pharmacist postgraduate residency training and few programs with a rural healthcare focus, MGMC collaborated with Drake University College of Pharmacy and Boone County Hospital to develop a one-year pharmacy residency program. This program focuses on rural and critical access hospital pharmacy practice. One of the goals of this program is to complete patient safety- and quality improvement-focused research projects that benefit the organization and ultimately, drive practice change.

| *Making an Impact with a Nursing Impact Dashboard*

Accurate documentation on behavioral health (BH) patients helps minimize risks associated with errors, enhances patient safety and ensures organizations are meeting regulatory requirements. To meet regulatory requirements, MGMC adopted a policy requiring audits on every BH patient, every day. These audits took 15-20 hours every week and more for those patients missing documentation. In 2017, the MGMC BH unit partnered with a BH team member. Processes were discussed, improvement opportunities were identified. Weekly meetings focused on improving processes and making a nursing impact dashboard (NIDs) that could track each patient's medical record for required documentation. Although the MGMC BH team was spending an inordinate amount of time each day on audits, the goal of the NID was to help the nurses be accountable to their documentation. The nurses were given access to the NID and were able to see how they compared to their peers. The NID improved almost all documentation to 98-100% within 6 months of its release.

MercyOne Newton

| *Improving Medication Safety Through Emergency Drug Administration Preparedness*

According to some sources, medication errors are one of the highest leading causes of death in the United States. Medication Administration errors occur at an increased rate during high stress situations, such as during care of a critically ill patient. It is the responsibility of all hospitals to be as proactive as possible in preventing medication errors. This is especially difficult in the emergency room when staff may lack knowledge of the patient, or may lack time to implement and utilize technology, such as during a cardiac arrest. The MercyOne Newton team has leveraged a relatively low-tech method of assisting nursing with delivering correct medication doses quickly and effectively, in the form of a printed book on top of each crash cart in their facility. This book features color coding to help draw attention to the most pressing information (dosing and administration), is specific to the medication concentration or strength that staff stocks and lists the specific rate to set the IV pump (when applicable). MercyOne Newton staff also separated pediatric information from adult information, to make the pediatric information more readily available in the case of a pediatric emergency. It is important to note that while MercyOne Newton staff is aware that there are ways to leverage technology to help prevent medication dosing errors, they also have some system limitations impacting their ability to immediately implement some of these safety measures.

| *Our Journey to Zero Harm: Medical Errors Should Not be the Third Leading Cause of Death in This Country*

MercyOne Newton is excited to share about the culture of safety that is permeating every discipline of their facility! MercyOne Newton has improved safety outcomes for patients and the momentum is increasing with colleagues who realize the impact they can have. MercyOne Newton has also improved significantly in the number of near-miss incidents reported. The entire facility, backed by a fearless administrative team, is embracing the culture of proactive risk reduction by looking for the near-miss before it finds the patient. By looking at the systems process behind each near miss, MercyOne Newton makes it easier for staff to do the right thing, and harder for the wrong thing to occur. They have incentivized finding these areas of "Swiss Cheese" through multiple campaigns and make it their mission to fix any reported holes. Staff actively embraced the Safety-First Culture when it was first introduced in 2018 and have added the tools from Trinity's Together Safe Program. The MercyOne Newton Staff Culture Survey has increased the number of staff who do not fear reporting due to negative consequences. They also keep the safety behaviors and communication tools front of mind on huddle boards, have leaders round and question staff on which tool they are focusing in that month, have staff give examples of how those tools were used. These safety tools are scientifically proven to work if used consistently. MercyOne Newton created some of their own tools to highlight great catches, near-misses,

and news articles on what has gone wrong in other facilities, so they do not become complacent. MercyOne Newton patients and families are being brought along on this journey toward zero harm.

Montgomery County Memorial Hospital (MCMH) | *Sepsis Mortality*

In March of 2022 MCMH was made aware their sepsis mortality rates were much higher than that of their peers in the Compass HQIC program. T**his** triggered the formation of the Quality Improvement Team to do further analysis. There had indeed been 10 sepsis related deaths since January 2021 according to claims data. A team of individuals carefully analyzed those 10 patient records. Conclusions were drawn following this deep dive into those records. The MCMH team found that the patients were admitted with two or more Systemic Inflammatory Response Syndrome (SIRS) criteria being triggered, which caused the advanced registered nurse practitioner (ARNP) hospitalists to list sepsis as an admitting diagnosis. In all cases, the patient received the appropriate treatment with serial lactate levels, blood cultures and antibiotics. MCMH utilized Cerner Community Works for their electronic medical records (EMRs), which provides a sepsis advisor that leads the practitioner through the appropriate interventions for evidence-based care. In nearly all of these cases, the patients failed treatment or had other chronic diseases that caused the patient/family to transition to comfort measures only. The patients died but a number of them did not in fact actually die from sepsis, but from another chronic condition. MCMH's inpatient medical director became involved in the process and began educating the ARNP hospitalists about resolving diagnoses at the time of death so appropriate coding would occur. In none of the cases reviewed did they find significant deviance from the 3-Hour Sepsis Bundle. Staff may have missed an occasional lactate measurement, but antibiotics were always given promptly. Since this education has occurred, MCMH has reduced sepsis mortality by 80% and their compliance with the sepsis bundle remains >95%. MCMH has had 2 Sepsis deaths recently, but those were analyzed carefully. One was in a 97-year-old woman with many comorbidities who went to comfort care. The other was a 75-year-old who came in with sepsis-induced pancytopenia, which carries an extremely high mortality rate. She was offered a higher level of care but refused to be transferred and succumbed to her illness. Those have been the only two sepsis deaths since MCMH began their education process over a year ago. MCMH will continue to educate and review all deaths, specifically all sepsis-related, for improvement. MCMH care has never deviated from the evidence-based sepsis bundle, but great lessons were learned in proper documentation and coding practices.

Orange City Area Health System | *For Score and 7 Percent Ago: Using Readmission Risk Scoring to Prevent Hospital Readmissions*

As part of providing care for the whole patient, Orange City Area Health System has strived to reduce 30-day readmissions after a hospital stay. In the past 2 years, they have been able to utilize multiple tools built into their EMR to aid in planning appropriate follow-up care for patients, one of them being a Readmission Risk Score. The EMR gives each patient a score based on multiple factors such as medical history, medications, age, test results and number of recent admissions. It also categorizes each patient as high, moderate, or low risk. One of the biggest changes their team has made is setting a goal for all high-risk patients that are discharged to follow-up with a provider (primary care physician, specialist, or home health nurse) within 3-5 days after discharge. With this and other changes made over the past 2 years, the Orange City Area Health System has seen their hospital readmission rate drop by over 7%.

Pella Regional Health Center (PRHC)

| *Falling for Our Patients*

The PRHC Fall Prevention Project is an ongoing effort by a multi-disciplinary team to improve patient safety by utilizing standard practice tools to reduce patient falls on their Med/Surg and ICU floors. Their core team for this project is comprised of an infection control nurse, organizational excellence team members, the chief and associate chief nursing officers, physical therapy, environmental services, case management, pharmacy, nurse educators, med/surg leaders and staff members. In 2021, PRHC had a fall rate of 4.7%, which was higher than their peer group average and their falls with injury rate was 1.7%. Over the past two years, med/surg staff have worked diligently to increase their rounding compliance rate, which has had a positive impact on falls. The overall fall rate for 2022 dropped to 2.5% and the falls with injury rate dropped to 1.05%. The goal was to further improve the rounding compliance rate from a goal of 70% in 2022 to 80% in 2023 in order to keep patients safe from falls. Through observations and examining current processes, an opportunity was discovered to identify inpatients more easily with a high fall risk. Patients at high risk for falls that were aware of their limitations were identified by one small identifier on their patient ID band. This made it difficult for staff to easily identify patients who need additional support to prevent falls. New door magnets have been implemented for a program called "Walk with Me," which was created for this patient population. Additionally, yellow patient gowns were implemented to help staff easily identify all high fall-risk patients on the unit. The goal of both changes was to increase visibility and identification of patients with high fall risk so that all staff in Med/Surg/ICU could quickly identify a patient that needs additional care and support to prevent falls. Using best practice guidelines provided by their Compass HQIC Advisor from Iowa Healthcare Collaborative, the committee continues to evaluate all falls to look for additional opportunities for improvement. The PRHC Fall Committee has also updated the Fall Prevention Policy and drafted new standard work to help ensure that staff are taking all potential factors into consideration when completing the Morse Fall Scale Assessment. They are also working to create a more robust post-fall assessment so that further opportunities for improvement can be identified.

| *Destination: Reducing Specimen Labeling Errors*

The reduction of specimen labeling errors project at PRHC was a collective effort between the Organizational Excellence, Emergency, Infusion, Lab, Clinics, Information Technology and Nursing departments. By developing a subcommittee for this project, PRHC was able to utilize input from multiple department leaders and front-line staff while making use of layers of process improvement strategies to collect and

analyze the data within project parameters to arrive at the root causes of their specimen labeling errors. To improve patient safety and to comply with The Joint Commission National Patient Safety goals, a goal was set to reduce the number of mislabeled or unlabeled specimens that arrive at the PRHC Main Lab Department for testing by reducing the error rate by 50% from 2022. No more than 35 in 2023, or no more than 2-3 per month. Dividing the data into 4 distinct areas assisted PRHC in determining how to best enhance the opportunities for improvement separately. Opportunities within the EMR were identified to provide staff with tools to make the process more efficient, and staff suggestions were used to aid in reminders of best practices. Reinforcing current policy with increased surveillance and education by leaders and reviewing each of the labeling errors with front-line staff aided PRHC in improving awareness and the prevention of specimen labeling errors. By using these steps, PRHC has reduced specimen labeling errors by approximately 50% from this time last year in clinic sites and by approximately 35% from the highest identified areas in the hospital.

| *Improving Care Transitions: Addressing Social Stressors Prior to Discharge*

As a way to help patients reduce barriers and achieve better health, PRHC screens their inpatient population for social drivers of health (SDoH) needs upon admission. Screening upon admission allows the PRHC Case Management Team time to provide community resource information based on each patient's county of residence and connect to resources during their stay if needed. To begin this process, a multi-disciplinary team met and chose the questions that would be asked after a significant amount of research was conducted. The PRHC IT Department built the SDoH questions into the EMR and set up a notification for the Case Management team if patients have SDoH needs and want assistance. Early in the screening process, PRHC realized that their question on housing instability was not set up the same as the others and was potentially providing the Case Management Team with false positive results. Reports showed that 53% of patients identified housing insecurity as a concern. This result is significantly higher than any other SDoH need. This allowed PRHC to conduct a second PDSA cycle around changing the format of their housing question. After changing the housing question to the same format as the other SDoH questions, the answers on the housing question (6%) more closely aligned with the answers of the other SDoH questions. This result was reassuring and gave PRHC confidence in their screening process. Now that PRHC accurately record and notify the Case Management Team of patients' social stressors, Case Managers can focus on providing resource information to the patients who state they want assistance.

Regional Medical Center (RMC) | *Blending Our Purpose: Patient Family Advisory Council and Fundraising Committee Unite*

To bring outside perspective, RMC implemented a Patient Family Advisory Council (PFAC) in the fall of 2019 to engage patients and/or caretakers on how to make RMC the chosen place for healthcare in rural Iowa. This group is interested in seeking ways to make the patient's experience better, such as displaying more directional signage to the elevator and offering food vouchers to caretakers with patients. Since the PFAC group has sincere interest in the betterment of RMC and is involved with the services RMC provides, it was decided blending PFAC, and the Fundraising Committee would be a benefit to RMC. The combination occurred in spring 2023 and has been fruitful in making fundraising decisions for the next fiscal year.

Sanford Sheldon Medical Center | *Spinning Down the Rates: Safe Reduction of Primary Cesareans*

Maternal morbidity and mortality rates in the United States are greater than other developed countries and continue to be on the rise. Using this information as a driver, Sanford Sheldon Medical Center accepted an invitation to be a part of the Iowa Maternal Quality Care Collaborative to safely reduce primary cesarean rates. Over an 18-month period, with the use of education and practice changes they were able to meet their goal of Nulliparous, Term, Singleton, Vertex/NTSV rates less than 20%.

Shenandoah Medical Center (SMC)

| *Addressing Diversity, Equity, and Inclusion in Rural Health*

Millions of Americans live in rural areas and depend on the nearest hospital for their healthcare needs. Rural hospitals face many struggles when it comes to health diversity, equity, and inclusion (DEI), but strive to provide high quality patient care. Addressing challenges daily, rural healthcare systems, like SMC, require innovative strategies to meet the needs of all patients. The development of a DEI council allows SMC to improve care and attitudes for all staff and patients through an inclusive culture which increases staff and patient satisfaction. SMC's DEI Blueprint is a road map providing directions on how to do just that with over 80% of staff trained on unconscious bias and 10 council members, they are working toward improving their health equity needs daily.

| *A Collaborative Approach to Sepsis Identification and Care in a Critical Access Hospital*

SMC nursing leadership recognized an opportunity for improving care related to sepsis. An interdisciplinary team was created to improve early identification of SIRS criteria, sepsis diagnosis and patient outcomes. A process was developed, and a three-hour bundle was implemented. Auditing, ongoing education and data collection will continue to improve outcomes for patients diagnosed with sepsis.

Spencer Municipal Hospital | *Community Partnerships: Improving Care Transitions*

Spencer Municipal Hospital and the Elderbridge Agency on Aging formed a partnership in 2019 to initiate the Iowa Return to Community (IRTC) Program. The program is a collaborative effort with a variety of partners including hospitals, long-term care facilities, Area Agencies on Aging, home and community-based service providers that assists non-Medicaid individuals ages 60 and older, return to their community following a hospital or long-term care facility stay. The PDSA Methodology was used for implementation of the program. Spencer Municipal Hospital discharge planners assess patients during their hospital stay for discharge needs and make referrals to the program. The 4-year partnership has provided to be a successful tool for discharge planning and a valuable service for keeping individuals in their homes. To date,

the program has provided services for 346 clients. Spencer Hospital and Elderbridge have developed a strong community partnership and will continue work together for discharge needs from the hospital and offer applicable services to individuals in the community.

State of Iowa HHS | *Implementing an Evidence-based Falls Prevention Program for Community Dwelling Older Adults*
The Iowa HHS Division of Aging and Disability Services, formerly the Iowa Department on Aging, received the 2020 Empowering Iowa Communities to Reduce Falls and Fall Risk Grant to implement Community Aging in Place, Advancing Better Living for Elders (CAPABLE), an evidence-based falls prevention program, in Iowa. CAPABLE is a person-directed, home-based program that improves independence, safety, and health by improving medication management, problem-solving ability, strength, balance, mobility, and home safety. Research has shown that CAPABLE has provided more than six times the return on investment. Roughly $3,000 in program costs per participant yielded more than $30,000 in savings in medical costs driven by reductions in both inpatient and outpatient expenditures. Through partnerships with Happy at Home Consulting, Connections Area Agency on Aging and Dallas County Hospital, eighty-seven consumers were served with CAPABLE since August 2020 in targeted Iowa counties. Thirty-nine consumers completed the program to fidelity which required six occupational therapist visits and two to four registered nurse visits. More than a decade of research shows that CAPABLE reduces the impact of functional impairment and disability, enhances motivation and self-efficacy, reduces health disparities, improves emotional health and reduces hospitalizations and nursing home days. All these outcomes support older adults remaining independent in their homes.

Stewart Memorial Community Hospital (SMCH) | *Increasing Medicare Wellness Visits*
With the Transition Case Manager Team, SMCH identified that their rural health clinic providers were falling far short in scheduling of annual wellness visits. When patients are not seen at a minimum annually, it sets them up for various pitfalls. Furthermore, the facility benefits financially when Accountable Care Organization (ACO) patients meet the standards set by Medicare. Medicare set a goal for 52% of all ACO patients to have an annual wellness exam completed. SMCH set a goal for >60% of all Medicare patients to have an annual wellness exam. SMCH's first data was reported in October of 2022 and at that time the cumulative total of wellness exams among all Medicare patients was only 44%. SMCH provided education to both clinic providers and front-line clinic staff to highlight the importance of scheduling these exams. Both from a patient centered perspective and from a financial standpoint. At the outset SMCH only had one clinic provider who was meeting the 52% goal (current state). SMCH has 8/10 providers >52% goal and 5/10 meeting the facility goal. SMCH continues to update clinic providers and staff monthly with the data. Providers that are falling out of compliance are sent a list of patients who need a wellness exam scheduled.

Van Buren County Hospital (VBCH) | *Opioid Safety Project*
Iowa HHS 2022 data shows that the number of patients with opioid prescriptions in Van Buren County is above the average in comparison to other counties in Iowa. This means safety practices and processes are vital for VBCH and within the community. The Opioid Workgroup was developed after the completion of the VBCH Annual Compliance Risk Assessment. The organization noted a need for better opioid prescription monitoring on an outpatient basis and further optimization on tools within the EMR to help the clinicians continue safe practices. The workgroup is a multidisciplinary team that includes a provider champion, pharmacy, quality, clinical informatics and clinic leadership. The workgroup determined that providing patients who have an opioid prescription with a guided plan would ensure that prescriptions would be utilized in a safe and effective manner. With the help of the VBCH EMR functionality, and process improvements that were implemented in the outpatient setting, the VBCH noted a 40% increase in up-to-date pain agreements that were collected. Also, due to the engagement from the multidisciplinary work group other processes and projects developed organically from conversation, and ideas presented during this workgroup, clinic huddles and medical staff meetings. The opioid workgroup is still active and plans to continue improving processes and working together on safety surrounding opioid prescriptions at VBCH and within the community.

Van Diest Medical Center (VDMC) | *Collaborating to Reduce Unnecessary ADC Overrides*
Automated Dispensing Cabinets (ADCs) are a staple tool in the arsenal of many medical facilities aimed at promoting safety in medication administration. ADCs offer a variety of features and functions that complement and strengthen nursing practice standards by creating barriers to common medication administration errors. Pharmacist verification of all medication orders prior to administration is a critical first step in supporting the ADC's human factors engineering functions. Monitoring of cabinet overrides by the Department of Pharmacy is a best practice common to many facilities that use them. VDMC is a county facility including a 25-bed Critical Access Hospital (CAH) offering a variety of inpatient and outpatient services, as well as four certified Rural Health Clinics (RHCs) located in Webster City, Iowa. VDMC serves patients residing primarily in Hamilton and contiguous counties. The VDMC Department of Pharmacy employs five full-time staff, including two pharmacists. After hours pharmacy services are provided by a contract telepharmacy. Pyxis ADCs are utilized in all areas of the VDMC main campus that administer medications and/or vaccines to patients. Pyxis ADCs allow override access to unordered and unverified medications, which is common and serves to allow medication access in an emergency. Verification by pharmacists is accomplished via the EMR system. VDMC uses Cerner CommunityWorks as its primary EMR. Facility policy dictates all verification processes must occur within an hour of order entry. Verification of most orders occurs in thirty minutes or less. The Department of Pharmacy monitors overrides of all ADCs as part of its regular surveillance. In the spring of 2019, the pharmacists observed anecdotal evidence that indicated pervasive and progressive use of override functions in situations that could be avoided. This concern was brought to the Department of Quality Management for discussion and support of ongoing assessment and improvement activities.