Save the Date! 2016 Spring Conference

According to the Institute for Health Technology Transformation, changes in the health care landscape, such as EMR implementation, health information technology, reimbursement mandates, new care delivery models and a focus on patient-centered quality care are making process improvement a top priority for hospitals and health systems. Given the onslaught of change initiatives facing the U.S. health care system, health care organizations must aggressively use process improvement tools to effectively measure the outcomes for these and related initiatives. The complexity of health care systems in comparison to other more linear industries, that have successfully utilized process improvement tools, leaves significant room for improvements in patient care, organizational efficiency and cost savings. Health care providers have realized millions of dollars in savings by utilizing process improvement tools and techniques to evaluate and optimize operations and patient care. Provider groups that embrace holistic strategies and proven process improvement tools for health care will be poised to succeed in the post-reform 21st century health system.

Mark your calendars...IAHQ is preparing for an informative 2016 IAHQ conference to address process improvement on Wednesday April 20th at the Holiday Inn & Suites at Jordan Creek. More details to follow!
Happy New Year!

Have you ever been to a Disney park? Are you or anyone you know one of those people who are gaga over some Disney character? Growing up I knew about the movies, cartoons, characters and that there was an amusement park but I never had Disney mania. We didn't have the extra cable channels so I didn't watch the Mickey Mouse Club with Britney Spears, Justin Timberlake and Christina Aguilera. I wasn't regularly exposed to the Disney empire until I had a daughter that insisted on watching one Disney movie again and again until I could recite the entire movie by heart. Then it was on to the next flavor of the month.

This all changed in early 2013 when I had the opportunity to attend a Disney Institute leadership course with a few co-workers. We had a credit with a medical equipment company which allowed for an all-expense paid experience that altered not only my opinion of the Disney phenomenon but my passion for patient and staff excellence. I am now a diehard Mickey Mouse fan and have the mouse ears hat to prove it!

Let me share a true story.

Once upon a time...

There was a group of hospital executives and other healthcare leaders in a faraway land called Kissimmee, Florida. Everyone was excited to have a break from the office but suspicious of yet another conference. As the instructor began and the sharing of the magic ensued, these (metaphorically) blind mice started to peek out at this new world at Disney. They simply had to find out more! From the classroom, to the behind the scenes tours the group decided to enter the park. “Research” must be done to understand. Rides to ride, food to eat and laughs to be had. Why this is the happiest place on earth! Not only were their unrealized dreams coming true, more dreams developed.

On the last day, as each person was presented with their Mickey Mouse graduation ear caps (adorned with a tassel nonetheless) no one thought it could get any better. From behind the curtain a guest had arrived! MICKEY!!! That wonderful mouse came to celebrate with us!

And they lived happily ever after.

I have never witnessed that many grown professional adults go so crazy over what is basically a glorified mascot. The entire room gushed “MICKEEEEEEEY!” You would have thought we were preschoolers; even each of us enjoying our individual professional photo with him! We certainly had a great time and learned some very basic and business-altering theologies in our short three days at the leadership class.

Why do I tell you this story and what does it have to do with healthcare quality in Iowa? Very simple: mission. Iowa is top in quality for a reason; hard working neighbors doing what they would want done to them. Disney focuses so pointedly on their mission that anything that doesn't align with that isn't even brought to the table to be argued. Every healthcare entity in Iowa has a mission. Physicians, staff, communities, businesses and the people they serve believe in the mission which ultimately, keeps the doors open to continue carrying out the mission.

The Iowa Association for Healthcare Quality's mission is to cultivate excellence in healthcare quality through statewide networking, professional development and the provision of resources. Walt Disney was quoted saying “expect perfection, settle on excellence”. Isn't that what Iowans want and need? A reliable local healthcare system that is always striving for perfection and delivering the best care, at the right time, the correct way each time for each individual. It seems to be an impossible job but there are those who have a passion for this charge. Healthcare quality professionals are one of the priceless pieces of every organization’s success. IAHQ mission is to support, nurture and grow healthcare quality professionals so Iowans can live their best lives.

I thank you for taking time to read this welcome letter from me and I truly hope you find an overwhelming amount of tools, resources, colleagues, education, and opportunities within not only this newsletter but also in your membership.

With Warmth,
Shawna Forst
Data governance key to health information initiatives

By Greg Gillespie

Published January 29 2016, 5:45am EST

More in Data analytics Healthcare analytics  Data governance

The need for a strong data governance structure has been talked to death in healthcare, but even for all the ink the topic has received, most healthcare organizations lack a sound plan, which could come back to haunt them as they embark on analytics and other complex data initiatives.

Without a firm foundation for assuring the overall management of the availability, usability, integrity and security of data in healthcare organizations, quality issues could limit the effectiveness of initiatives that rely on the trustworthiness of the underlying data.

John Moore, founder and managing partner at Boston-based analyst firm Chilmark Research, said the firm’s research finds that most healthcare organizations have “fairly rudimentary” governance structures. Only 15 percent to 20 percent have full-fledged data governance frameworks in place, he adds.

“You have to keep in mind that a decade ago, the industry had very few EHRs in place, so data governance structures to decide how to define and share data across systems wasn’t something people were working on,” he says. “The healthcare data value chain starts with strong governance and information management, but we don’t have a lot of good models in this industry, so you’re seeing a lot disparate point solutions instead of the integrated solutions really needed to move analytics forward.”

“A strong data governance infrastructure means that we can ensure that our data privacy and security policies are applied consistently to all our data,” says Rasu Shrestha, health systems CIO at UPMC Enterprises.

The shift to shared saving and risk-based reimbursement has revealed the cracks in data governance and information management infrastructures at many organizations that are having significant problems getting the data pieces in place to keep their heads above water. Michael Hunt, M.D., chief population health officer at St. Vincent’s Health Partners, a 275-physician medical group in Bridgeport, Conn., cites research that shows 70 percent of accountable care organizations don’t make money.

“The data set for the Medicare Shared Savings Program requires reporting for 27 different quality measures, and many of those ACOs apparently couldn’t submit the appropriate quality data,” Hunt says. “Does anyone think they didn’t make a huge effort to hit their targets and qualify for incentive payments? Right now the industry is trying just to get an infrastructure in place to capture the utilization and quality metrics, and bring some visibility to costs. It’s difficult to start thinking about advanced analytics in an environment where you have to jump through so many hoops.”

Joe Kimura, M.D., chief medical officer at the Boston-based Atrius Health, says the 750-physician medical group alliance wouldn’t be able to launch analytics if it hadn’t done the extremely hard work—politically and technologically—of defining the high-level business concepts and clinical definitions that rule its data.

At Atrius Health, those concepts and definitions are guided by medical directors, with help from financial and operations staff. Most of the organization’s revenue is under full-risk contracts with the State of Massachusetts, so Atrius, like St. Vincent’s, poured resources into designing a governance infrastructure that could handle the rigor of quality reporting.

More than 90 percent of Atrius’ ACO reporting is captured in automated reports, but it still struggles capturing certain discrete information, such as details on follow-up measures, for its reporting.

But data governance, fundamentally, is getting together and defining the information on hand. For example, who is a patient of Atrius Health? “Marketing wants to count someone we haven’t seen in four years; finance wants to say that if we haven’t seen them in 12 months, they are not on a roster and aren’t a patient; as a physician, I would say someone I’ve seen in the past three years is a patient,” Kimura says. “People have different ideas for different business purposes, but the bottom line is that you have to come together as an organization and decide. You can’t have three definitions, because if you try to go forward in that way, it takes a brutal amount of work to revise your data infrastructure.”

Another challenge is to ensure that an organization is defining data in a way that’s clinically and financially valuable to its mission. For example, the Healthcare Effectiveness Data and Information Set (HEDIS) defines a diabetic patient for reporting purposes. But Atrius has a much more detailed definition of diabetes that includes additional claims, EHR and pharmacy data.

“The HEDIS definition is fine for reporting, but we feel our definition gives us a more accurate look at our diabetic patients and is more clinically valuable,” Kimura says. “Definitions are not necessarily universal, which is why governance is an enterprise responsibility, not just one person or department.”

The University of Pittsburgh Medical Center also has invested heavily in creating a data governance infrastructure years ago when it started having multiple information system go-lives and saw a need for those data streams to converge, says Rasu Shrestha, the health systems chief innovation officer and executive vice president at UPMC Enterprises, which funds incubators and leads commercialization efforts for UPMC technology products and services.

“We bet big on interoperability years ago, but to do so meant that right from the beginning, we realized that to converge data you had to have a common set of rules and definitions,” Shrestha says. “We operate more than 20 hospitals and a health plan with more than 2.5 million covered lives. Without a framework and rules around data ownership and stewardship, we couldn’t bring those streams together in a meaningful way. And just as importantly, a strong data governance infrastructure means that we can ensure that our data privacy and security policies are applied consistently to all our data.”

Shrestha adds that UPMC is discussing ways to commercialize its data governance best practices and information management models.
Where are we now? What was learned from the last step? How can we amplify what worked? How can we muffle what did not?

Goal
- What should be happening?
- What does SOLVED look like?
- What will the process owner(s) be doing? Instead of what they are currently doing.

- Standardize & stabilize what worked OR Go through the process again.
- What is the Goal?
- What is NOW preventing us from achieving this goal?

Act
- Did it work? If so great & do it again! If not - do something else.

Plan
- What is 1 step you can take toward the goal RIGHT NOW?

Check

Do

What is the current condition?
Telligen Iowa Quality Innovation Network Stakeholder Report

About Quality Innovation Networks and Quality Improvement Organizations

The Centers for Medicare & Medicaid Services leads a national health care quality improvement program. The program is implemented locally by an independent network of QIOs in each state and territory. We convene providers, practitioners, and patients to build and share knowledge, spread best practices, and achieve rapid, wide-scale improvements in patient care, increases in population health, and decreases in health care costs for all Americans.

**CARDIAC HEALTH**
- About 2,200 people die every day from cardiovascular diseases.
- 155 eligible providers working with Telligen
- 155 eligible providers receiving technical help
- 36 home health agencies working with Telligen
- 36 home health agencies receiving technical help

**HEALTH INFORMATION TECHNOLOGY**
- Secure medical record access would merit switching doctors for 2 out of 3 people
- 252 eligible providers and eligible hospitals working with Telligen
- 219 eligible providers and eligible hospitals receiving technical help

**DIABETES CARE**
- Nearly 28% of the people in the US don’t realize they have diabetes.
- 22 eligible providers working with Telligen
- 25 active peer educators
- 199 beneficiaries registered for DSME classes

**HEALTHCARE-ASSOCIATED INFECTIONS**
- Prevention practices can lead to a 70% reduction in certain infections
- 25 hospitals working with Telligen
- 25 hospitals receiving technical help

**NURSING HOME CARE**
- 1 in 5 nursing home residents suffers preventable harm
- 246 nursing homes working with Telligen
- 148 nursing homes completing QAPI self-assessments

**COORDINATION OF CARE & MEDICATION SAFETY**
- 1 out of every 5 adults over age 65 is readmitted to the hospital after discharge
- 6 active communities working with Telligen
- 9 interventions implemented to improve coordination of care

**QUALITY REPORTING & VALUE-BASED INCENTIVES**
- 239 providers attending QIO forums

For more information, contact the support center at laqiosupport@area-d.hcqis.org or 515-440-8600.

This material was prepared by Telligen, Medicare Quality Innovation Network Quality Improvement Organization, 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. IDEOB-IA OIN 3/2015-31354
Shawna Forst is the Service Excellence Manager and Lean Healthcare Coach at Pella Regional Health Center. Shawna has been a LEAN Healthcare Facilitator since January 2007 and has two years’ experience as a technician in a cardiac unit. Shawna graduated from Simpson College in 2002 with a Bachelor of Arts in Physical Education and a Coaching Endorsement. In 2010 she became a Certified Professional in Healthcare Quality (CPHQ) and received her LEAN Green Belt certification in 2014. Shawna also holds instruction certification for Non-violent Crisis Intervention, A.L.I.C.E, and is a Certified Hospital Emergency Coordinator.

Iris Vering, BA, MS, currently serves as the Director of Quality Services at Waverly Health Center in Waverly, Iowa. In this role, Iris guides performance improvement, organizational excellence, risk management, public quality reporting, organizational insurance, accreditation efforts, medical staff coordination, and employee and patient safety. Prior to assuming this position in August 2005, Iris spent 14 years working in biotech manufacturing in all aspects of the environmental health & safety arena. Additional experience includes development & implementation of sustainability management systems in conjunction with existing quality systems.

Iris holds a Bachelor of Arts degree in Biology from Wartburg College, and Master of Science in Public Relations from Boston University.

Ellyn Cowan is the Program Lead for Data Strategies at the Iowa Healthcare Collaborative in Des Moines, Iowa. She received her Master’s Degree in Public Health from the University of Pittsburgh in 2014, specializing in Community and Behavioral Health Sciences, and her Bachelor’s Degree from the University of Northern Iowa in 2011, majoring in Psychology. Ms. Cowan has experience in both clinical, hospital and home-based care, and academic settings. She has experience with data analysis, health management and policy, program planning and evaluation, community health needs assessments, and public health communication. Ms. Cowan currently supports data reporting and analysis for the Hospital Engagement Network (HEN), Transforming Clinical Practice Initiative (TCPI), and the State Innovation Model Initiative (SIM). Ellyn is your District E Representative.

Jennifer Arp has been a Registered Nurse since 1995. Her new position is district D representative. Jennifer’s experience spans a variety of things from working on Med/Surg, ICU, ED, Cardiac Rehab, Infection Preventionist, Quality Coordinator and Clinical Instructor for nursing students.

She is currently the Performance Improvement Director at Cass County Memorial Hospital and have been there 20 years. Jennifer oversees Quality, Risk Management, Infection Prevention, Employee Health, Safety, Lean and Care Coordination/Utilization Review. I have a passion for what I do and want to improve the quality of care patients receive.
DISTRICT MEETINGS IN YOUR AREA:

District A: Michelle Dettmann– All meetings are 10:00 AM at Cherokee Regional Medical Center-Cherokee Iowa...February 3, May 4, August 3 and November 2

District B: Megan Mollenbeck

District C: Sarah Pavelka: July/Aug TBA contact Sarah for more details

District D: Jennifer Arp—TBA

District E: Ellyn Cowan—TBA

District F: Angela Freeman-March 11 (Albia) , May 13 (Pella) September 16 (Newton)

District G: Open

District A met on Wednesday November 4th, 2015 at the Cherokee Regional Medical Center. We had 26 members attending and the education for the meeting was Inpatient CMS measures for 10/1/2015 discharges and forward. The education was presented by Jennifer Kok, Avera health. Christy Mintah provided an on-line demonstration of the QualityNet.org inpatient, outpatient, structural and MBQUIP measures.

Michele Dettmann RN

District A Representative
COPING

⇒ WITH AN ACTIVE SHOOTER SITUATION

- Be aware of your environment and any possible dangers
- Take note of the two nearest exist in any facility you visit
- If you are in an office, stay there and secure the door

Contact your building management or human resources department for more information and training on active shooter response in your workplace.

PROFILE

⇒ OF AN ACTIVE SHOOTER

An active shooter is an individual actively engaged in killing or attempting to kill people in a confined and populated area, typically through the use of firearms.

CHARACTERISTICS

⇒ OF AN ACTIVE SHOOTER SITUATION

- Victims are selected at random
- The event is unpredictable and evolves quickly
- Law enforcement is usually required to end an active

CALL 911 WHEN IT IS SAFE TO DO SO

HOW TO RESPOND

⇒ WHEN AN ACTIVE SHOOTER IN IN YOUR VICINITY

1. Evacuate
   - Have an escape route and plan in mind
   - Leave your belongings behind
   - Keep your hands visible

2. Hide Out
   - Hide in an area out of the shooter’s view
   - Block entry to your hiding place and lock the doors
   - Silence your cell phone and/or pager

3. Take Action
   - As a last resort and only when your life is in imminent danger
   - Attempt to incapacitate the shooter
   - Act with physical aggression and throw items at the active shooter

HOW TO RESPOND

⇒ WHEN LAW ENFORCEMENT ARRIVES

- Remain calm and follow instructions
- Put down any items in your hands (i.e., bags, jackets)
- Raise hands and spread fingers
- Keep hands visible at all times
- Avoid quick movements toward officers such as holding on to hem for safety
- Avoid pointing, screaming or yelling
- Do not stop to ask officers for help or direction when evacuating

INFORMATION

YOU SHOULD PROVIDE TO LAW ENFORCEMENT OR OPERATOR

- Location of the active shooter
- Number of shooters
- Physical description of shooters
- Number and type of weapons held by shooters
- Number of potential victims at the location
Hospitals Need to Plan for Active-Shooter Scenarios

Neil Ostenweil

October 30, 2015

BOSTON — "Avoid, deny, defend, treat" — these are the four key principles for coping with an active shooter in a hospital, a situation that everyone must prepare for, said a disaster preparedness expert here at the American College of Emergency Physicians (ACEP) 2015 Scientific Assembly.

"Unlike shootings at a school or a mall, we still have stuff going on," said David Callaway, MD, director of operational and disaster medicine at the Carolinas Medical Center in Charlotte, North Carolina. "We still have the septic patient, we still have heart attacks, we still have grandma with her busted hip who we have to take care of."

The grim reality is that from 2000 to 2014, there has been a steady increase in hospital-based shootings in the United States. They have been increasing in frequency and complexity, they involve more weapons and more improvised explosive devices, and the shooters are targeting more victims and attacking more subtargets, Dr Callaway said.

Boston, host of the ACEP meeting, has experienced the horror of a hospital shooting. In January, Michael Davidson, MD, a 44-year old interventional cardiologist, was shot and killed at Brigham and Women's Hospital. The shooter committed suicide after killing Dr Davidson.

Sadly, Boston is far from alone. From 2000 to 2011, there were 154 hospital-related shootings in the United States; 59% took place inside the hospital and 41% occurred outside on hospital grounds, according to a recent study (Ann Emerg Med. 2012;60:790-798). Those shootings occurred in 40 states and resulted in 235 injuries or deaths.

Motivations for the shootings included grudges, revenge, suicide, ending the life of an ill spouse or relative, and escape for prisoners brought in for medical care. The case fatality rate was 55%. The victims were primarily the shooter and the intended target, and 91% of the shooters were male.

Since that study was published, another 39 hospital-based shootings have occurred, Dr Callaway reported.

**Workplace Violence**

Studies have shown that healthcare workers are increasingly at risk for workplace violence; 60% of all workplace assaults occur in a healthcare setting. And 46% of all assaults or violent acts that result in lost works days are committed against registered nurses, Dr Callaway said.

The first response to the presence of an active shooter or the sound of gunshots is generally disbelief: "Oh, that was firecracker," he explained. But it is imperative for those in the vicinity of a shooter to accept the situation and deliberate quickly on the available options — run, hide, fight — and then take decisive action, he said.

The first priority for those on scene is to avoid danger by removing potential targets from the shooter’s vicinity by running, hiding, and calling 911 when it is safe to do so.

This denies the shooter access to potential targets. More than one-third of all active shooting incidents end within 5 minutes, and police generally arrive on site quickly, so lives can be saved if the potential targets can hold out until help arrives.

Those on site can take action by hiding in secure locations, if available, locking or blockading doors with a gurney, chair, desk, or IV pole, for example, turning off lights, and silencing phones.

Those in hiding can prepare to defend themselves by strategically positioning themselves near entrances and arming themselves with ad hoc weapons, such as the metal regulator on an oxygen supply tank, a fire extinguisher, or even a hard plastic telephone handset.
According to the US Federal Bureau of Investigation, 13% of active shooting incidents that occurred from 2000 to 2013 ended with unarmed civilians subduing the shooter.

**Treating Victims**

Dr Callaway cited a 2011 report that states that it takes police an average of 60 to 90 minutes to determine whether a shooting scene is secure from any obvious perpetrator threat (*EMS World*. 2011;40:42-48).

"Are we really going to wait for the scene to be secure before we start treating?" he asked.

Waiting is usually not an option, especially when there are critically injured victims. For this reason, hospitals and other healthcare facilities need to have in place careful, detailed, site-specific plans for what to do. The plan should include steps aimed at balancing the need to immediately treat victims and other patients in urgent need with operational concerns related to timing, staffing, restricted access, and crime scene investigations.

The facility plan should also include steps for integrating first-care providers, such as bystanders, families, and other patients; nonmedical first responders, such as hospital support staff and administrators; and medical first responders, such as emergency medicine providers, trauma surgeons, and critical care unit staff.

Although there is no single right answer, emergency plans should focus on maximizing the protection of lives, Dr Callaway said.

Bryan Wexler, MD, director of the division of disaster medicine and emergency management at WellSpan York Hospital in Pennsylvania, said that his institution, like many others, is working to develop a comprehensive active-shooter response plan that incorporates the main hospital and the various affiliated offices and services.

"We have a trauma facility that has a lot of capability, but we are also responsible for and have obligations toward our smaller community hospitals, which have variable levels of responsibility for the community and variable levels of capability," he told Medscape Medical News.

"The other issue we are facing is making sure that our licensed sites — outpatient family practice units and specialty services that have multiple groups under one umbrella — also have a plan in place," he added.

Dr Wexler reported that his institution, like many others, has received bomb threats and encountered armed assailants and threats of violence, but has not yet had a shooting incident.

*Dr Callaway and Dr Wexler have disclosed no relevant financial relationships.*


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Send comments and news tips to news@medscape.net.
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Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims

As you submit electronic claims for services, remember that:

- Claims with ICD-10 diagnosis codes must use ICD-10 qualifiers; all claims for services on or after October 1, 2015, must use ICD-10
- Claims with ICD-9 diagnosis codes must use ICD-9 qualifiers; only claims for services before October 1, 2015, can use ICD-9

How to Use ICD-10 Qualifiers

Use ICD-10 qualifiers as follows (FAQ 12889):

- For ASC X12 837P 5010A1 claims, the HI01-1 field for the Code List Qualifier Code must contain the code “ABK” to indicate the principal ICD-10 diagnosis code being sent. When sending more than one diagnosis code, use the qualifier code “ABF” for the Code List Qualifier Code to indicate up to 11 additional ICD-10 diagnosis codes that are sent.
- For ASC X12 837I 5010A1 claims, the HI01-1 field for the Principal Diagnosis Code List Qualifier Code must contain the code “ABK” to indicate the principal ICD-10 diagnosis code being sent. When sending more than one diagnosis code, use the qualifier code “ABF” for each Other Diagnosis Code to indicate up to 24 additional ICD-10 diagnosis codes that are sent.
- For NCPDP D.0 claims, in the 492.WE field for the Diagnosis Code Qualifier, use the code “02” to indicate an ICD-10 diagnosis code is being sent.

Keep Up to Date on ICD-10

Visit the CMS ICD-10 website and Roadto10.org for the latest news and and official resources, including the ICD-10 Quick Start Guide and a contact list for provider Medicare and Medicaid questions. Sign up for CMS ICD-10 Email Updates and follow us on Twitter.
Why Performance and Process Improvement?

Healthcare is delivered within a living network of customers. These varied stakeholders often have competing goals that add to the complexity of how care is administered and directly impact target performance, reliability, outcomes, and reimbursement. To address critical factors impacting patient care delivery systems, HQPs use process improvement methods and tools to evaluate, measure capability, and redesign operational and clinical processes. HQPs support the work of multidisciplinary project teams determining how best to achieve consistently high-quality and efficient healthcare delivery in all settings. Collaborative work within and between organizational departments, and often beyond facility walls, is necessary to achieve consensus and commitment to innovation.

Performance and process improvement (PPI) applies specific tools to gain insight into the organization and measure the effectiveness of its programs, processes, and work force. PPI competencies are critical to an HQP’s ability to impact healthcare delivery systems and guide an organization to achieve optimal levels of performance.

HQPs in PPI excel when they have a combination of improvement science, project management, and change management competencies focused on achieving the objectives of the organization and positioning it for success. The effective application of PPI tools requires that the quality professional possesses communication, facilitation, analytical, and motivational skills consistent with successful change management and innovation deployment. As agents of change, quality professionals must be focused, results driven, and able to collaborate and lead others in the quest to achieve and sustain operational and clinical excellence.
Upcoming Events

Q Essential Information Session February 12, 12-1 pm CST

Telligen Events: 2/11/16– Webinar-1 hour Inpatient Psychiatric Facility (IPF) Quality Reporting/Improvement Update.

2016 IONL & IHE Spring Conference—May 18th: Registration is now open. This year’s conference will feature nationally recognized speakers Louise Selanders, nurse historian, Kevin O’Conner, and Bobbie Staten. For assistance with registering online, please contact Joah Hogan @ 515-283-9309.

Telligen: 2/24/16/Sharing Call/1 hour-How to Improve your Pressure Ulcer

HEN Virtual Learning Community February 16, 2016 8am-12 pm CT
- Discuss HEN 2.0 Progress and ongoing collaborative work
- Learn about Health Equity and using REAL data time

SIM Conference—March 8, 2016