The Sepsis Continuum: Overcome Barriers and Create Momentum

September 7, 2017
11:00 am. – 12:15 p.m. CT
WELCOME AND INTRODUCTIONS
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
<th>Presenter(s)</th>
</tr>
</thead>
</table>
| 11:00-11:05 am | Welcome and Introductions                         | Emily Koebnick  
Program Manager, HRET   |
| 11:05-11:10 am | Data Updates                                      | Mariana Lesher  
Data Analyst, HRET   |
| 11:10-11:25 am | Fluid Resuscitation: Overcoming Physician Resistance | Dr. Sean Townsend M.D.  
Dr. Steve Tremain M.D.  
Improvement Advisor, Cynosure   |
|               | Understand the science behind the recommended fluid resuscitation in Septic Shock. Learn ways to best influence physicians who may be resistance to this recommendation. |                                                                 |
| 11:25-11:35 am | Nursing Empowerment to Accelerate Sepsis Care      | Deborah Campbell, RN  
Infection Prevention Improvement Advisor, Kentucky Hospital Association   |
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:35-11:45 am</td>
<td>Family and Patient Engagement and Education</td>
<td>Brett Hartkopp BSN, RN, CPPS&lt;br&gt;Market Director Quality and Infection Prevention, Wesley Medical Center</td>
</tr>
<tr>
<td></td>
<td>Discover creative ways of engaging families in sepsis awareness and educational opportunities for patients discharged with sepsis.</td>
<td></td>
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<tr>
<td>11:45-11:55 am</td>
<td>Sepsis in Your Neighborhood</td>
<td>Patricia Stahura&lt;br&gt;ECRI Institute</td>
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<tr>
<td></td>
<td>Community awareness around sepsis is a necessary component for a sepsis program that spans the continuum, review ideas to improve this vital need.</td>
<td></td>
</tr>
<tr>
<td>11:55-12:10 pm</td>
<td>Let’s hear from YOU!</td>
<td>Maryanne Whitney&lt;br&gt;Dr. Steve Tremain&lt;br&gt;Improvement Advisors, Cynosure</td>
</tr>
<tr>
<td></td>
<td>Facilitated discussion to gather updates on your sepsis month activities.</td>
<td></td>
</tr>
<tr>
<td>12:10-12:15 pm</td>
<td>Bring it Home</td>
<td>Emily Koebnick&lt;br&gt;Program Manager, HRET</td>
</tr>
</tbody>
</table>
WEBINAR PLATFORM QUICK REFERENCE

- Mute computer audio
- Today’s presentation
- Chat with participants
- Download slides/resources
- Register for upcoming events
How Did You Hear About This Event?

A) HRET HIIN flyer
B) HRET HIIN website
C) HRET LISTSERV
D) State hospital association
E) QIN-QIO
F) Your organization/colleague
G) Other, please specify.
Sepsis Measurement

• HIIN Measures
  – Post-operative sepsis (AHRQ PSI-13)
    • 2013\(^1\): 4.19 per 1,000

• Sepsis Impact\(^2\)
  - Most expensive reason for hospitalization
  - Patients stay in the hospital 75% longer

Post-operative sepsis (AHRQ PSI 13)
Fluid Resuscitation in Sepsis

Why 30ml/kg Crystalloid is Reasonable

Sean R. Townsend, MD
Vice President Quality & Safety
California Pacific Medical Center
September 6, 2017
Why Do All Severe Sepsis Patients Need Volume?

1. Vascular volume is lost into interstitial space due to diffuse capillary leaking from cytokine release.

2. Both venous and arteriolar tone is reduced & blood volume occupies a larger intravascular space than normal.

3. Many patients also have GI and Skin losses.
Does Early Aggressive Therapy Make a Difference?
<table>
<thead>
<tr>
<th></th>
<th>CLASS I</th>
<th>CLASS II</th>
<th>CLASS III</th>
<th>CLASS IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood loss (mL)</td>
<td>Up to 750</td>
<td>750–1500</td>
<td>1500–2000</td>
<td>&gt;2000</td>
</tr>
<tr>
<td>Blood loss (% blood</td>
<td>Up to 15%</td>
<td>15%–30%</td>
<td>30%–40%</td>
<td>&gt;40%</td>
</tr>
<tr>
<td>volume)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse rate</td>
<td>&lt;100</td>
<td>&gt;100</td>
<td>&gt;120</td>
<td>&gt;140</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Normal</td>
<td>Normal</td>
<td>Decreased</td>
<td>Decreased</td>
</tr>
<tr>
<td>Pulse pressure (mm Hg)</td>
<td>Normal or</td>
<td>Decreased</td>
<td>Decreased</td>
<td>Decreased</td>
</tr>
<tr>
<td></td>
<td>increased</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory rate</td>
<td>14–20</td>
<td>20–30</td>
<td>30–40</td>
<td>&gt;35</td>
</tr>
<tr>
<td>Urine output (mL/hr)</td>
<td>&gt;30</td>
<td>20–30</td>
<td>5–15</td>
<td>Negligible</td>
</tr>
<tr>
<td>CNS/Mental status</td>
<td>Slightly anxious</td>
<td>Mildly anxious</td>
<td>Anxious,</td>
<td>Confused,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>confused</td>
<td>lethargic</td>
</tr>
<tr>
<td>Fluid replacement (3:1</td>
<td>Crystalloid</td>
<td>Crystalloid</td>
<td>Crystalloid and</td>
<td>Crystalloid and</td>
</tr>
<tr>
<td>rule)</td>
<td></td>
<td></td>
<td>blood</td>
<td>blood</td>
</tr>
</tbody>
</table>

1For a 70-kg man.

From Am. College of Surgeons ATLS Manuel
Fluids Prevent Intubation

- From Rivers: % Ventilated patients

<table>
<thead>
<tr>
<th>Hours after start of Therapy</th>
<th>0-6</th>
<th>7-72</th>
<th>0-72</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Therapy</td>
<td>53.8%</td>
<td>16.8%</td>
<td>70.6%</td>
</tr>
<tr>
<td>Early Goal Directed Therapy</td>
<td>53%</td>
<td>2.6%</td>
<td>55.6%</td>
</tr>
</tbody>
</table>

P Value: <.001 0.02

Chronic coexisting conditions--CHF:
- Control: 30.2%
- EGDT: 36.7%

FACT:

- One liter of normal saline adds **275 ml** to the patient’s plasma volume
A Randomized Trial of Protocol-Based Care for Early Septic Shock

The ProCESS Investigators*
Goal-Directed Resuscitation for Patients with Early Septic Shock

The ARISE Investigators and the ANZICS Clinical Trials Group*


Table 2. Outcomes.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>EGDT (N=1857)</th>
<th>Usual Care (N=1880)</th>
<th>Incremental Effect (95% CI)</th>
<th>P Value</th>
<th>Overall Comparison</th>
<th>Comparison among Trials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary outcome: death at 90 days — no./total no. (%)</td>
<td>462/1852 (24.9)</td>
<td>475/1871 (25.4)</td>
<td>0.97 (0.82 to 1.14)↑↑</td>
<td>0.68</td>
<td>0.68</td>
<td>0.73</td>
</tr>
<tr>
<td>Secondary outcomes: mortality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death at hospital discharge — no./total no. (%)</td>
<td>370/1857 (19.9)</td>
<td>365/1878 (19.4)</td>
<td>1.02 (0.85 to 1.21)↑</td>
<td>0.86</td>
<td>0.86</td>
<td>0.42</td>
</tr>
<tr>
<td>Death at 28 days — no./total no. (%)</td>
<td>375/1854 (20.2)</td>
<td>385/1873 (20.6)</td>
<td>0.96 (0.81 to 1.15)↑</td>
<td>0.68</td>
<td>0.68</td>
<td>0.57</td>
</tr>
</tbody>
</table>

- Subgroup analyses showed no benefit from EGDT for patients with “worse” shock (higher lactate, hypotension, predicted risk of death).

- EGDT did not result in better outcomes than usual care and was associated with higher hospitalization costs across a broad range of patient and hospital characteristics.
### Differences between treatment and control groups in the ProCESS, ARISE, and ProMISE Trials:

<table>
<thead>
<tr>
<th>Clinical Trial</th>
<th>Cohort</th>
<th>Intravenous Fluids (milliliters)</th>
<th>Central Line Placement</th>
<th>Vasopressor Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ProCESS</strong></td>
<td>EGDT</td>
<td>2805 +/- 1957</td>
<td>411/439 (93.6%)</td>
<td>241/439 (54.9%)</td>
</tr>
<tr>
<td>May 2014</td>
<td>Usual Care</td>
<td>2279 +/- 1881</td>
<td>264/456 (57.9%)</td>
<td>201/456 (44.1%)</td>
</tr>
<tr>
<td></td>
<td>Δ</td>
<td>526ml</td>
<td>35.7%</td>
<td>10.8%</td>
</tr>
<tr>
<td><strong>ARISE</strong></td>
<td>EGDT</td>
<td>1964+/-1415</td>
<td>714/793 (90%)</td>
<td>528/793 (66.6%)</td>
</tr>
<tr>
<td>October 2014</td>
<td>Usual Care</td>
<td>1713+/-1401</td>
<td>494/798 (61.9%)</td>
<td>461/798 (57.8%)</td>
</tr>
<tr>
<td></td>
<td>Δ</td>
<td>251ml</td>
<td>28.1%</td>
<td>8.8%</td>
</tr>
<tr>
<td><strong>ProMISE</strong></td>
<td>EGDT</td>
<td>2000 (1150-3000)</td>
<td>575/624 (92%)</td>
<td>332/623 (53.3%)</td>
</tr>
<tr>
<td>May 2015</td>
<td>Usual Care</td>
<td>1784 (1075-2775)</td>
<td>318/625 (50.9%)</td>
<td>291/625 (46.6%)</td>
</tr>
<tr>
<td></td>
<td>Δ</td>
<td>216ml</td>
<td>41.1%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>


## MD Ability to Predict Hemodynamics

A survey was administered pre-PA catheterization to assess the ability of physicians to predict various hemodynamic variables. The table below summarizes the results:

<table>
<thead>
<tr>
<th>Variable</th>
<th>N measured</th>
<th>% correct prediction of range of actual value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wedge Pressure</td>
<td>102</td>
<td>30%</td>
</tr>
<tr>
<td>Cardiac Output</td>
<td>97</td>
<td>51%</td>
</tr>
<tr>
<td>SVR</td>
<td>88</td>
<td>44%</td>
</tr>
<tr>
<td>R Atrial Pressure</td>
<td>98</td>
<td>55%</td>
</tr>
</tbody>
</table>

Survey administered pre-PA catheterization

CCM 1984 Vol 12, No. 7 pp549-553
Can We Predict Mortality in Infected Patients?

Systolic BP ≥ 90 still have ↑ lactate and mortality

Lowest ED reading
Fig. 1. The fluid balance between the two groups was significantly less in the stroke volume (SV) group at 24 h, 48 h, and at the end of the ICU stay compared with the usual care (UC) group. Dashed lines represent the difference in length of stay (LOS) between the two groups.

Table 2
Comparison of SV vs UC for patient outcomes in univariate analyses.

<table>
<thead>
<tr>
<th>Patient outcomes</th>
<th>SV</th>
<th>UC</th>
<th>p-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net-fluid balance – 4 h</td>
<td>808 ± 118 mL</td>
<td>926 ± 153 mL</td>
<td>0.54</td>
</tr>
<tr>
<td>Net-fluid balance – 24 h</td>
<td>1.68 ± 0.27 L</td>
<td>3.00 ± 0.36 L</td>
<td>0.004</td>
</tr>
<tr>
<td>Net-fluid balance – 48 h</td>
<td>2.14 ± 0.39 L</td>
<td>4.16 ± 0.50 L</td>
<td>0.002</td>
</tr>
<tr>
<td>Net-fluid balance – ICU LOS</td>
<td>1.77 ± 0.60 L</td>
<td>5.36 ± 1.01 L</td>
<td>0.002</td>
</tr>
<tr>
<td>In-hospital mortality</td>
<td>21/100 (21)</td>
<td>18/91 (20)</td>
<td>0.86</td>
</tr>
<tr>
<td>ICU LOS – all patients (days)</td>
<td>6.22 ± 0.58</td>
<td>8.91 ± 0.96</td>
<td>0.015</td>
</tr>
<tr>
<td>ICU LOS – survivors (days)</td>
<td>5.98 ± 0.68</td>
<td>8.87 ± 1.18</td>
<td>0.03</td>
</tr>
<tr>
<td>Mechanically ventilated</td>
<td>29/100 (29)</td>
<td>52/91 (57)</td>
<td>0.0001</td>
</tr>
<tr>
<td>Ventilator days</td>
<td>6.28 ± 1.40</td>
<td>6.71 ± 0.67</td>
<td>0.76</td>
</tr>
<tr>
<td>Vasopressor initiated</td>
<td>48/100 (48)</td>
<td>52/91 (57)</td>
<td>0.25</td>
</tr>
<tr>
<td>Vasopressor duration (hours)</td>
<td>32.08 ± 5.22</td>
<td>64.86 ± 8.39</td>
<td>0.001</td>
</tr>
<tr>
<td>Acute dialysis initiated&lt;sup&gt;a&lt;/sup&gt;</td>
<td>6/96 (6.25)</td>
<td>16/82 (19.5)</td>
<td>0.01</td>
</tr>
</tbody>
</table>

ICU = Intensive Care Unit, LOS = Length of Stay.

<sup>a</sup> Excludes patients that required chronic hemodialysis prior to admission.
Seymour CW, Gesten F, Prescott H et al. Time to Treatment and Mortality during Mandated Emergency Care for Sepsis.

Seymour CW, Gesten F, Prescott H et al. *Time to Treatment and Mortality during Mandated Emergency Care for Sepsis.*


| Table 4. Hospital Mortality in Heart Failure and Chronic Kidney Disease Subgroups |
|-------------------------------------------------|-----------------|-----------------|-----------------|----------|
| | Mortality (%) | | | | |
| All patients | 18,122 | 8.8 | 9.3 | 7.9 | 0.02 |
| Hospital 30 d | 13.7 | 14.1 | 12.6 | 0.03 |
| History of heart failure | 4,144 | 13.0 | 14.8 | 11.6 | 0.03 |
| Hospital 30 d | 18.8 | 20.7 | 17.8 | 0.13 |
| History of kidney disease | 6,285 | 9.7 | 11.5 | 7.5 | <0.01 |
| Hospital 30 d | 15.9 | 17.7 | 13.3 | <0.01 |
| Heart failure or kidney disease | 8,322 | 10.7 | 12.5 | 8.7 | <0.01 |
| Hospital 30 d | 16.8 | 18.3 | 14.5 | <0.01 |
| No heart failure or kidney disease | 9,800 | 7.4 | 6.5 | 7.2 | 0.40 |
| Hospital 30 d | 11.3 | 10.5 | 10.8 | 0.60 |

Influencing Physician Practice
Nurse Empowerment in Sepsis Improvement

Deborah R. Campbell, RN-BC, MSN, CPHQ
Infection Prevention Improvement Advisor
Kentucky Hospital Improvement Innovation Network
Role of nurses in sepsis

- Is it only assessment/recognition?
  - Current literature search - Yes, BUT....
• Nurses are often the first healthcare providers to interact with and assess the patient who presents with sepsis.
Why?

- Nursing is often a more stable, consistent group than physicians, e.g., residents and fellows rotations.
WHY?

• Nurses are almost always employees as opposed to medical providers who may be contract staff, locum tenens, etc.
Where are you?

- Do your nurses have a sepsis screen?
- Can the triage nurse (or first on the scene) call a “code sepsis” if that is appropriate?
- Can the nurse instigate a sepsis huddle?
- Can the nurse initiate an order set/protocol?
  - Draw blood cultures, lactates, etc.
  - Start an IV, fluid bolus
- Can the nurse mix antibiotics in urgent situations?
Nurse Protocol for Antibiotics

• If patient is assessed for sepsis and is deemed high risk requiring early antibiotic intervention, a nurse will access the “Peds Sepsis Kit” as follows:
  • Select patient in pyxis machine*
  • Remove med → OVERRIDE → “Peds Sepsis Kit”
  • Administer medications selected by provider according to guidance
  • Complete the documentation at the bottom of this form.
  • Place unused antibiotics and Peds Sepsis sheet in return bin to pharmacy for charging and restocking.
  • Obtain EPIC medication orders from provider to document the administration of the antibiotics used via the sepsis kit. EPIC Pediatric Sepsis Order set can be used for this.

*Courtesy of Golisano Children’s Hospital
Nursing Pathway

- At any time
- If YES to Question 1 AND
- Hypotensive (SBP < 90 or MAP < 65)
  OR
- Lactate ≥4
- Activate a CODE SEPSIS
- Then notify a provider immediately
- Start pathway to right
• There were great examples of nursing empowered protocols described on the ListServe.

• Limitations:
  – EDs and ICUs tend to allow more interventions initially by nurses than less high acuity areas
  – Continue to see limits on what nurses can do based on criteria v. having to wait for a physician to arrive, assess and order interventions
Summary

- Processes which allow nurses to perform to the limit of their scope of practice is optimal for early recognition and timely treatment.

• Questions?
• Deb Campbell, RN-BC, MSN, CPHQ, CCRN alumna
• dcampbell@kyha.com
• 502-992-4383
Patient & Family Engagement in Sepsis

Brett Hartkopp BSN, RN, CPPS
Market Director Quality & Infection Prevention
Wesley Medical Center
• 859 Bed Hospital
• Level 1 Trauma
• Only PEDs Trauma in Kansas
Discharge Opportunities

• Education to patient and families during alert process
• Questions encouraged
• Follow-up by sepsis coordinator when inpatient
• Education from sepsis coordinator during discharge planning phase of hospitalization
• Coordination with case management
Community Awareness

- Community Health Fairs
- Patient stories
- Survivor Videos
Sepsis in Your Neighborhood

Patricia Stahura RN, MSN
Senior Analyst and Consultant
ECRI Institute
About ECRI Institute

- Independent & Research Driven International Non-Profit with strict conflict of interest rules
- Evidence Based Practice Center - Agency for Healthcare Research and Quality
- Federally Certified Patient Safety Organization (PSO)
- Clinical risk management provider to all HRSA federally funded health clinics
- Patient safety and clinical quality resources to 1,000s of healthcare organizations for nearly 50 years
- ACCME accredited CME provider
- Nursing CEU provider in patient safety
- 400+ multidisciplinary staff
Sepsis in the United States

- 80% sepsis cases start outside the hospital
- 70% patients with sepsis were seen or had chronic diseases requiring frequent medical care
- One million discharges/year include sepsis diagnosis
- 62% sepsis patients are readmitted within 30 days

Source: CDC
Why Community Outreach?

• 1 billion ambulatory visits occur annually
• More Hospitalists, less Attending Physicians
• Less than half of US adults have heard of sepsis
• September is Sepsis awareness month

Source: NCHS; CDC
Community Outreach Plan

- What’s in it for me?
- Community needs
- Make contact
- Schedule a meeting
- Mobilize resources
- Community Collaborative
- Follow Up

A swift, organized response

Feedback to clinicians
Healthcare Provider Awareness

- Primary Care Centers
- Urgent Care Centers
- Dialysis Centers
- Geriatricians
- Pediatricians
- Obstetricians
- Birthing Centers
- Home Health Agencies
- Pharmacy
- Community Flu shot programs
Public Awareness

- Schools
- Churches
- Group Homes
- Clubs and community organizations
- Athletic and fitness centers
- Support Groups
- Senior Centers
- City Council

Community outreach and patient education
Topics for Community Education

• Prevent infections
• Get immunizations
• Keep scrapes and wounds clean
• Manage chronic conditions
• Recognize signs of worsening condition
• Seek medical care if not better or worse
• Say “I am concerned about sepsis”
Informational Resources

- Press and Radio Release
- Surviving Sepsis App
- Fact sheets
- Brochures
- Articles
- Infographics
- Screening tools
- Pocket cards
- Algorithms

Guidelines and tools

Know the risks. Spot the signs. Act fast.
References and Resources

CDC Sepsis
https://www.cdc.gov/sepsis/basic/index.html

http://www.cdc.gov/nchs/fastats

Sepsis Alliance
https://www.sepsis.org

Surviving Sepsis
http://www.survivingsepsis.org/Bundles/Pages/default.aspx

HRET HIIN
http://www.hret-hiin.org/topics/sepsis.shtml

ECRI Institute
https://www.ecri.org/components/hrc/pages/RMRep1215_Focus.aspx
Open the Lines

• Let’s hear from you!
Emily Koebnick, Program Manager, HRET

BRING IT HOME
Sepsis Resources

on the HRET HIIN website

Hospital Improvement Innovation Network

Engage
- Join Our HIIN
- UP Campaign
- Fellowships
- SNAP
- LISTSERV®

Sepsis

Importance: Sepsis is diagnosed in over one million patients each year in the United States (Hall et al., 2011). Furthermore, septicemia treatment resulted in an estimated $20.3 billion or 5.2 percent of the total cost for all hospitalizations and was the most expensive condition treated in the year 2011 (Hall et al., 2011). Not only is sepsis expensive and prevalent, patients diagnosed with sepsis are estimated to have a mortality rate of 28 to 50 percent (Angus, 2001). Learn more from Carl Flatley who founded the Sepsis Alliance after the death of his daughter, Erin.

The risk of mortality and urgency when treating all stages of sepsis, from sepsis to septic shock, drove the development of the three and six-hour bundles, which are approved by the National Quality Forum as the first scientifically sound, valid and reliable elements for the care of the septic patient (Dellinger, 2013). These bundles prompt the completion of the indicated tasks within the first three to six hours after the identification of septic symptoms – 100 percent of the time.

PIP Goal: By the end of year one, each participating HIIN hospital reduces sepsis by 7%, and by end of year 2, each participating HIIN hospital reduces sepsis by 20%.

Download the Sepsis Change Package
Download the Sepsis Checklist
Watch Past Sepsis Events
Access Additional Sepsis Resources
Sepsis Resources – LISTSERV®

• Join the LISTSERV®
  – Ask questions
  – Share best practices, tools and resources
  – Learn from subject matter experts
  – Receive follow up from this event and notice of future events
Sepsis Awareness Month

• Please continue to send us your inspirational stories and photos!
• You can tweet with the hashtags #sepsisawareness or #whyimhiin and/or email us your information at hiin@aha.org!
Join the HRET HIIN SNAP! **Register** for the information call on Monday, September 11 to learn more.

**WHO SHOULD APPLY**

The Sepsis Transfer SNAP will consist of up to 15 hospital pairs (one referring hospital and one receiving hospital) from across the HIIN who are deeply interested in implementing an ideal transfer process. Implementation will be focused on patients with or suspected to have sepsis. The group will develop an implementacon guide to be used by HIIN hospitals to support them in their implementation of an ideal transfer.

*The guide will include suggested practices for:*
- Early identification of sepsis in rural/CAH settings
- Early treatment of sepsis in rural/CAH settings – Treat before you transfer
- Establish and ideal transfer process from rural/CAH to receiving facility with feedback
- Operationalizing practices in EHRs

**ANTICIPATED WORKLOAD**

- Monthly internal team meeting to precede SNAP meeting 45-50 minutes
- Monthly SNAP call 60 minutes
- Monthly TA/SME call with team leader and other members as needed 30 minutes
- Testing in between calls 4-8 hours/month
- Team leader additional 4-8 hours/month to prepare for and follow up after calls to keep team on track and moving forward with action plans and data collection and submission
- Champions and those with key individual responsibilities 2-4 hours/month communicating with constituents

**INFORMATIONAL CALL**

HRET will be hosting an informational call on Monday, September 11 at 2:00 PM CST to discuss the project’s scope and answer questions.

To register [Click Here.](#)

**APPLICATIONS ARE DUE FRIDAY, SEPTEMBER 22ND.**

Applications will be available after the September 11 informational call at www.hret-hiin.org
Thank You!

Find more information on our website: www.hret-hiin.org

Questions or Comments: HIIN@aha.org