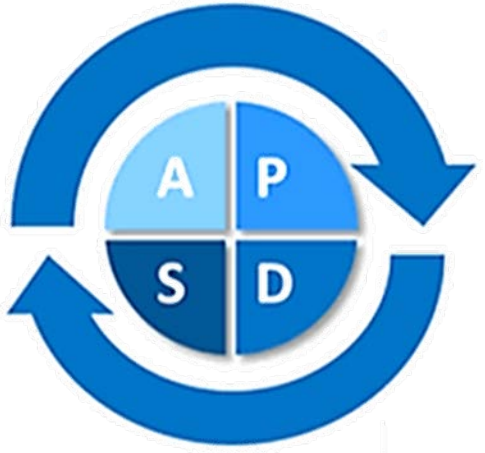



# Community Health and Wellness Center

## Health Risk Assessment (HRA) and Screening

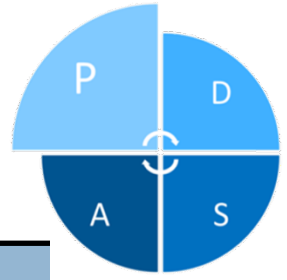
STOUGHTON HEALTH

1st Presentation Date: Jan. 24th, 2023

Document Last Presented: September 26th, 2023

# Quality Story: Health Risk Assessment (HRA) and Screening

PLAN




**Goal(s):** What are you trying to accomplish? Our objective is to find modifiable risk behaviors and help individuals sustain a positive change while adding value to a business.

KOM Target:
1 community screening and 1 business per Quarter: Community goal met. Business goal met.
Focus has been on business partnerships and getting contracts in place.

| **Background:** Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.) | **Driver:** Explain why the project is critical to SH. Why does it relate to the strategic plan? |
|---|---|
| • Increase usage of the CHWC<br>• Establish community presence<br>• Perform quarterly community screenings<br>• Book businesses for screenings, repeat annually<br>• Improve screening process | • Reduce risk for chronic disease<br>• Social determinants of health – increase access<br>• Increase employee engagement and retention<br>• Reduce absenteeism and presenteeism<br>• Increase probability of sustained change |

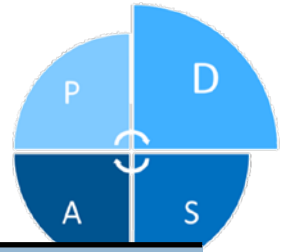
**Team:**

Project Leader: Andy Saul and Liz Touchett
Members: Jen Mora, Screening Team, Well-Being Team, PR/Marketing team

# Changes:

List the changes that have been made leading to improvements.

DO

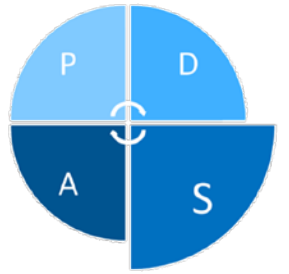


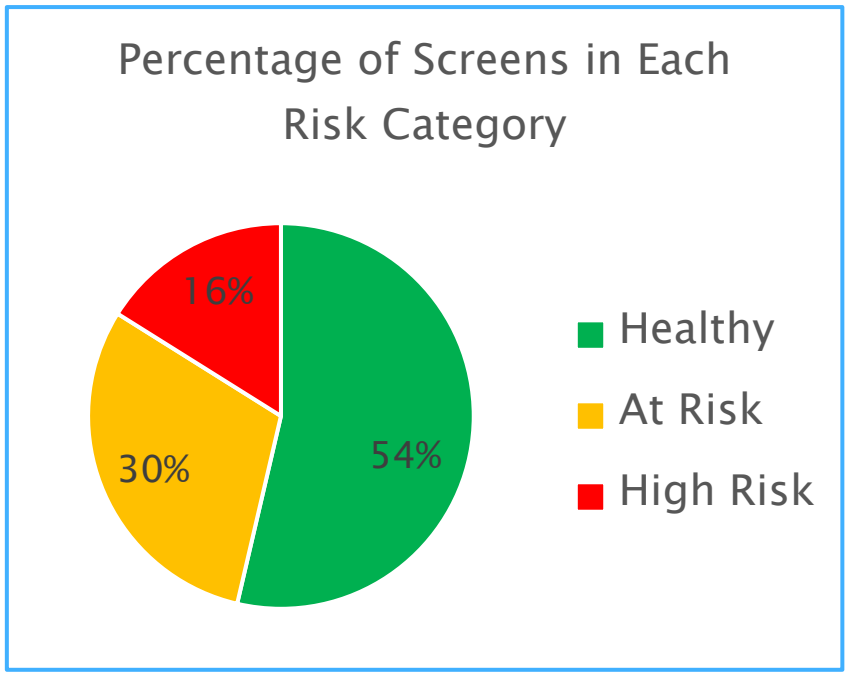

| What? | Why? | When? |
|---|---|---|
| Develop Business Plan | Aligns with our strategy | Ongoing |
| Well-Being Coaching | Behavior change and accountability | Ongoing |
| 1:1 business meetings | Partnership with SH Well-Being Program | Ongoing |
| Door to door | Prospecting | Started in September |
| Business Screening: Edward Jones and Zelm Chiropractic | Relates to our goal | October 5th<br>October 14th |
| Community Screenings | Provide a service to community members and produce revenue | October 11th<br>October 14th<br>3 times per year, 2 screening days (6 per year instead of 4) |
| Stoughton Health Benefits Fair Screenings | Measure our own statistics, benefit to employees and compare to past screenings | November 15th<br>November 16th<br>As needed |

# Measures:

Include graphs of your measurement, results of surveys, etc. Include benchmarks or comparative data when available.

STUDY




Total Screens: 932

Healthy: 500

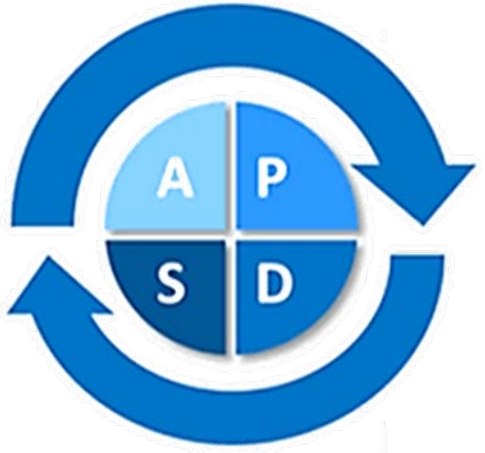
At Risk: 282

High Risk: 150

| | |
|---|---|
| Screening Dates | 6 |
| Stoughton Health Screenings | 2 |
| Business Partnerships | 2 |
| Community Screenings | 3 |
| Screening at Community Events | 3 |
| Individual Screenings | 8 |
| Coaching Sessions | 95 |
| *Data measured 11/7/23* | |

# Findings:


| **Results**: Did you accomplish your goals? |
| --- |
| **Both Goals are met.** |
| **Lessons Learned**: What did you learn as a result of this project? Unexpected discoveries? Problems or barriers? |
| Changes to screening sign-ups, flow, and reminders to improve patient experience.<br>Need to find the key decision makers in order to speed up process of signing a business contract.<br>Learning when some businesses work on their budget, we need to time our outreach. Some have let us know to reach back out in January.<br>**Purchased second CardioChek Plus device to increase efficiency.**<br>**Businesses continue to see the value of the service but don't want to take next steps to partner.** |
| **Next Steps**: What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?) |
| Pitch our plan, benefits, and process to businesses.<br>**Plan community screenings for 3 times per year. Likely February, May, and November every year.**<br>**Schedule business screenings as new partnerships are formed.**<br>**Screen current business partners annually.** |
| **Project Leader is Recommending the Following:** |
| QM Council approval for completion of project?: **YES**<br>Project still in progress, project to continue: **NO** |




# Cardiac Rehabilitation

## Electronic Phase 3 exercise referral

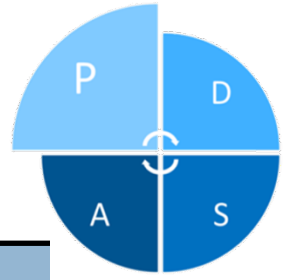
STOUGHTON HEALTH

1st Presentation Date: 11/28/23

Document Last Presented:

# Quality Story: Electronic Phase 3 exercise referral

PLAN




| Goal(s): What are you trying to accomplish? |
| --- |
| KOM Target: 80% of Phase 3 exercise referrals to be placed electronically vs a paper referral<br>Current KOM Status: |

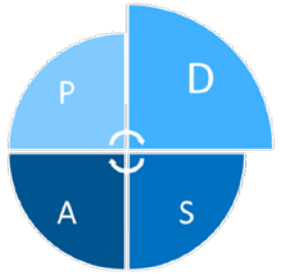
| Background: Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.) | Driver: Explain why the project is critical to SH. Why does it relate to the strategic plan? |
| --- | --- |
| All phase II referrals are placed electronically and currently phase 3 exercise referrals are paper only. We want to be consistent with all referrals from SSM providers being placed electronically. | Eliminate paper referral to be scanned into EPIC<br>Decrease wait times for a patient to start the phase 3 exercise program.<br>Prevent paper referral from getting misplaced or lost “in transit” via fax<br>Make it easier for our SSM providers to place a referral for exercise for their patients. |

| Team: Cardiac Rehab staff |
| --- |
| Project Leader:Cardiac Rehab team<br>Members: Melissa Trumm, Melanie Pavolonis, Madie Mehlhoff and Cathy Grabowski |

# Changes:

List the changes that have been made leading to improvements.

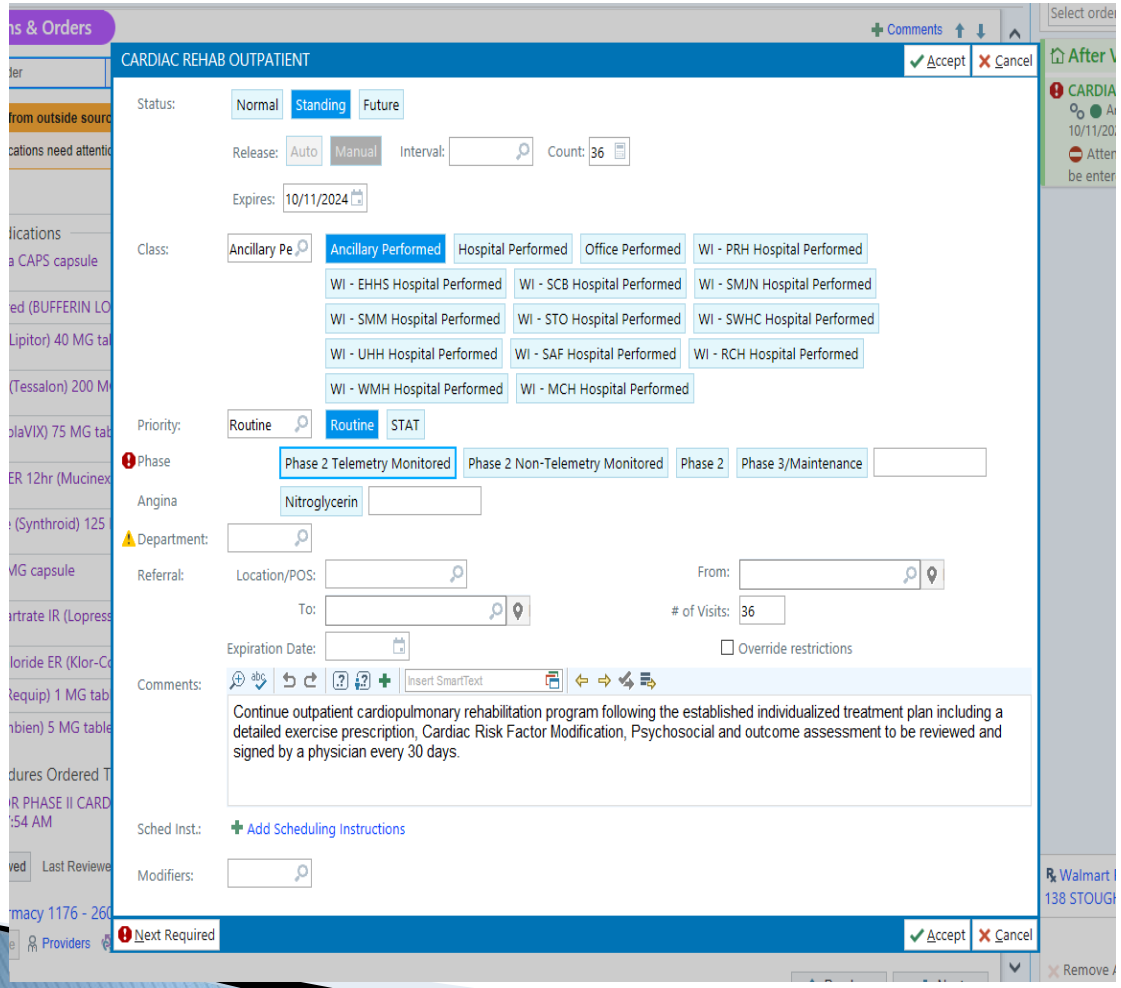
DO




| What? | Why? | When? |
|---|---|---|
| Figure out if we session numbers vs unlimited, expiration date/needing a new referral yearly or can it be ongoing and change comment ; if not, place ticket to create a new phase 3 referral order | To better represent the purpose of the phase 3 exercise program | Jan 1, 2024 |
| Create smartphrase in EPIC to send to SSM providers to ask for phase 3 referral | To make it easy for our SSM providers to place Phase 3 referral | Jan 1, 2024 |
| Test the current EPIC Phase 3 referral on a incoming phase 3 patient of Dr. Lively's | To see if Dr. Lively can place referral easily and if she can change expiration date and # of sessions if need; also, will this referral drop into our workque | Jan 1, 2024 |

# Measures:

Include graphs of your measurement, results of surveys, etc. Include benchmarks or comparative data when available.




STOUGHTON HEALTH

Patient's MRN_____

Date: _____

Regarding: _____

Dear Dr. _____,

Your patient, _____ DOB: _____, has been discharged from our Phase II Telemetry Monitored program and would like to enroll in our Phase III Maintenance Program at Stoughton Health. He/she will participate in **supervised cardiovascular exercise** in our Cardiac Rehab Department. The patient will perform exercise without telemetry monitoring.

Dr. _____

Please select the appropriate risk stratification:

☐ **LOW**
No reg LVD (EF ≥ 50%)
No ischemia, angina, ST ↓
No complex arrhythmia, rest or ex
Uncomplicated MI, CABG, proc.
Functional cap ≥ 6 METS p 3 wks

☐ **INTERMEDIATE**
Mild to moderate LVD (EF 31-49%)
Func. Cap < 5-6 METS p 3 wks
Failure to comply with intensity rx
Ischemia (1-2 mm ↓, revers. def.)

☐ **HIGH**
Severe LVD (EF ≤ 30%)
Complex arrhyth @ rest, ↑ w/ex
↓ SBP 15 mmHg or fail to ↑ w/ex
Survivor of sudden cardiac arrhyth.
Severe CAD, ischemia (>2mm ↓)

**Please check one of the following statements:**

☐ I concur with my patient's participation with no restrictions.

☐ I concur with my patient's participation in an exercise program if he/she restricts activities to _____

☐ I do not concur with my patient's participation in an exercise program. (If checked, this patient will not be able to join Stoughton Health's Fitness Program.)

☐ I would like to see my patient for further evaluation prior to his or her beginning an exercise program.

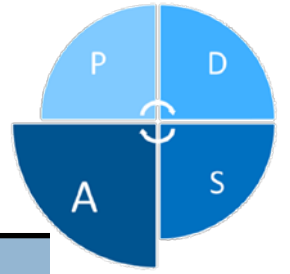
Physician's Signature:_____ Date:_____

**Please return to:**
Stoughton Health
Cardiac Rehabilitation & Wellness Center
900 Ridge St.
Stoughton WI 53589
608/873-2314 • Fax: 608/877-3489

Form No. 7046 – 6.2021

# Findings:

ACT

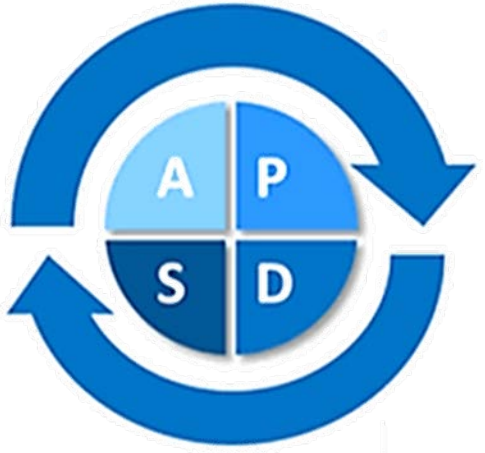



| **Results:** Did you accomplish your goals? |
| --- |
| |

| **Lessons Learned:** What did you learn as a result of this project? Unexpected discoveries? Problems or barriers? |
| --- |
| |

| **Next Steps:** What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?) |
| --- |
| 1) Review and modify workflow on how to go about requesting a Phase 3 exercise referral (Create a new smartphrase in EPIC requesting Phase 3 referral from PCP, Review/modify the current CRR5 order for Phase 3 exercise (Ie. #of sessions vs unlimited, service date, modify comments)<br>2) Test the current phase 3 exercise referral with one of Dr. Lively's patients<br>3) If all this fails, put in an EPIC ticket to have a new CRR order created for Phase 3 exercise |

| **Project Leader is Recommending the Following:** |
| --- |
| QM Council approval for completion of project?: NO<br>Project still in progress, project to continue: YES |




# Rehab Services

## Suicide Screening Tool

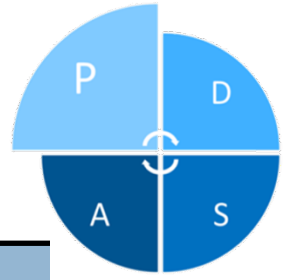
STOUGHTON HEALTH

1st Presentation Date: July 25, 2023

Document Last Presented: November 28th, 2023

# Quality Story: Insert Project Title Here

## PLAN




**Goal(s):** What are you trying to accomplish?

KOM Target: 80% of charts reviewed having added in the suicide screening to their evaluations.
Current KOM Status: Met (84.2% compliance rate)

**Background:** Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.)

Therapists have encountered situations where they felt like a patient may have been suicidal and they didn't know the steps to take or what options were available.

**Driver:** Explain why the project is critical to SH. Why does it relate to the strategic plan?

To increase patient safety.

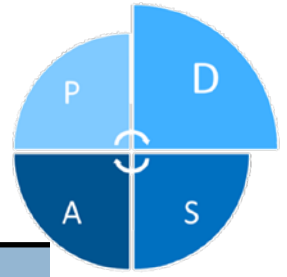
**Team:**

Project Leader: Melissa Monte
Members: Emily Devine, Michelle Hahn, Taylor Krull, Rachel Wojta

# Changes:

List the changes that have been made leading to improvements.

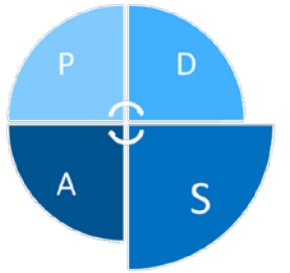
DO




| What? | Why? | When? |
|---|---|---|
| QM group looked into using the contracted behavioral health organization that the hospital uses. | To ty a keep organization process streamlined. Outcome: Need to have an MD order, so it's not appropriate for our outpatient setting. | n/a |
| Looked into what to do if patient reports being suicidal, but refuses to stay at call the 988 number | This situation happened at the hospital, so we needed to have a process for this: call 911 | Presented to staff at August meeting. |
| Staff asked about what information can be shared during a 911 call-Jen White and Legal team clarified for us. | To ensure patient confidentiality and HIPAA compliance | E-mail sent to staff 9/13 and will be reviewed during staff meeting in September |
| Met with legal team to provide guidance | Decrease hospital and staff liability if patient were to commit suicide. | E-mail sent to staff 9/13 and will be reviewed during staff meeting in September |
| Updated smartphrases and workflow implemented with staff with guidance from legal and Quality RN | To ensure patient confidentiality and HIPAA compliance and appropriate next steps when patient answers "yes" to a screening question. | Sept. staff meetings |

# Measures:

Include graphs of your measurement, results of surveys, etc. Include benchmarks or comparative data when available.


38 chart audit completed (OT, PT and per diem staff were included in the chart audits)

- 6 evaluations did not have the suicide screening tool added into their evaluation
- 32 evaluations had the suicide screening tool added into their evaluation
- 84.2% compliance rate

# Findings:


**Results:** Did you accomplish your goals?

Yes, 84.2% of evaluation chart audits completed included the suicide screening tool.

**Lessons Learned:** What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?

Did not initially take into consideration the risks associated with asking this question.

**Next Steps:** What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?)

Add this to our annual chart audit practice.

**Project Leader is Recommending the Following:**

QM Council approval for completion of project?: YES
Project still in progress, project to continue: NO


# Occupational Health and Rehab Services

## Health Promotion and Injury Prevention in the Workplace

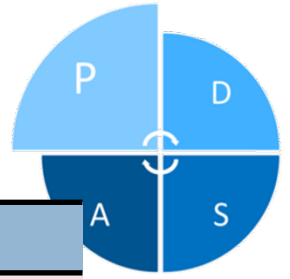
STOUGHTON HEALTH

1st Presentation Date: November 28th, 2023

Document Last Presented: New

# Quality Story: Health Promotion and Injury Prevention

PLAN




## Goal(s): What are you trying to accomplish?

KOM Target: < 10% Worker's Compensation Loss Ratio
Phase, timeline and specific KOM:
Phase 1: Worker's comp reporting and screening process, 1/01/2024, 80% SZP involving musculoskeletal injury is screened
Phase 2: Injury Prevention in the Workplace, 3/31/2024, Relias training completed by all current employees, New NEO
Phase 3: Updating job descriptions, pre-employment and return to work assessments/competency, 6/01/2024, 90% of new employees complete pre-employment assessment based on job description weight.
Current KOM Status: Phase 1: 64% completed screenings (9/14 overall, last quarter: 2/2 – 100%)
Phase 2: New project to begin in Dec., Phase 3: New project to begin in March.

## Background: Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.)

The workforce is our most valuable asset within our organization and when injuries happen, we need to respond quickly to support our workforce and reduced lost days of work. When this doesn't happen, we see higher costs through our Worker's Comp loss ratio and decreased employee engagement. From a conference, we learned about a program that another healthcare facility was implementing to improve their scorecards around injuries. A decrease in work injuries, reduced burden of worker comp costs, and early return to work support employee well-being and retention.

## Driver: Explain why the project is critical to SH. Why does it relate to the strategic plan?

We provide safe, quality care to the community and to our employee community as well. This project is intended to support our workforce and focuses on reducing workplace injuries through early intervention during the acute phase, prevention through education, exercise and screenings, and ensuring that we hire competent employees able to perform the duties they are assigned for the position in which they are being hired. Also, assuring that with longevity, employees remain competent to each job role they are involved with.

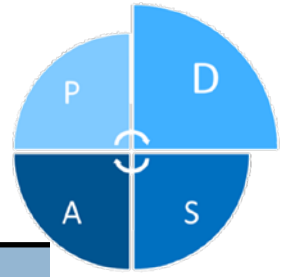
## Team:

Project Leader: Liz Touchett, Jen Mora, Melissa Monte
Members: Rachel Wojta, Kristin Klein, Emily Devine and our QM team

# Changes:

List the changes that have been made leading to improvements.

DO

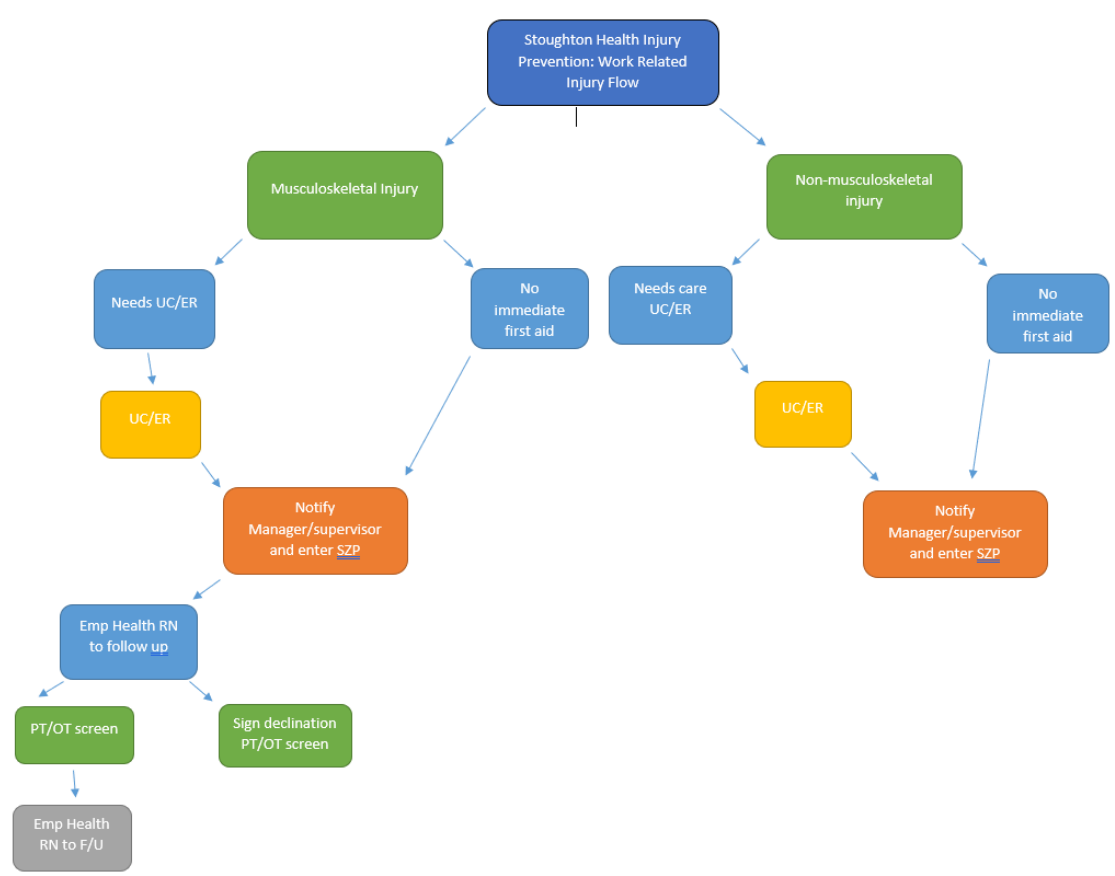


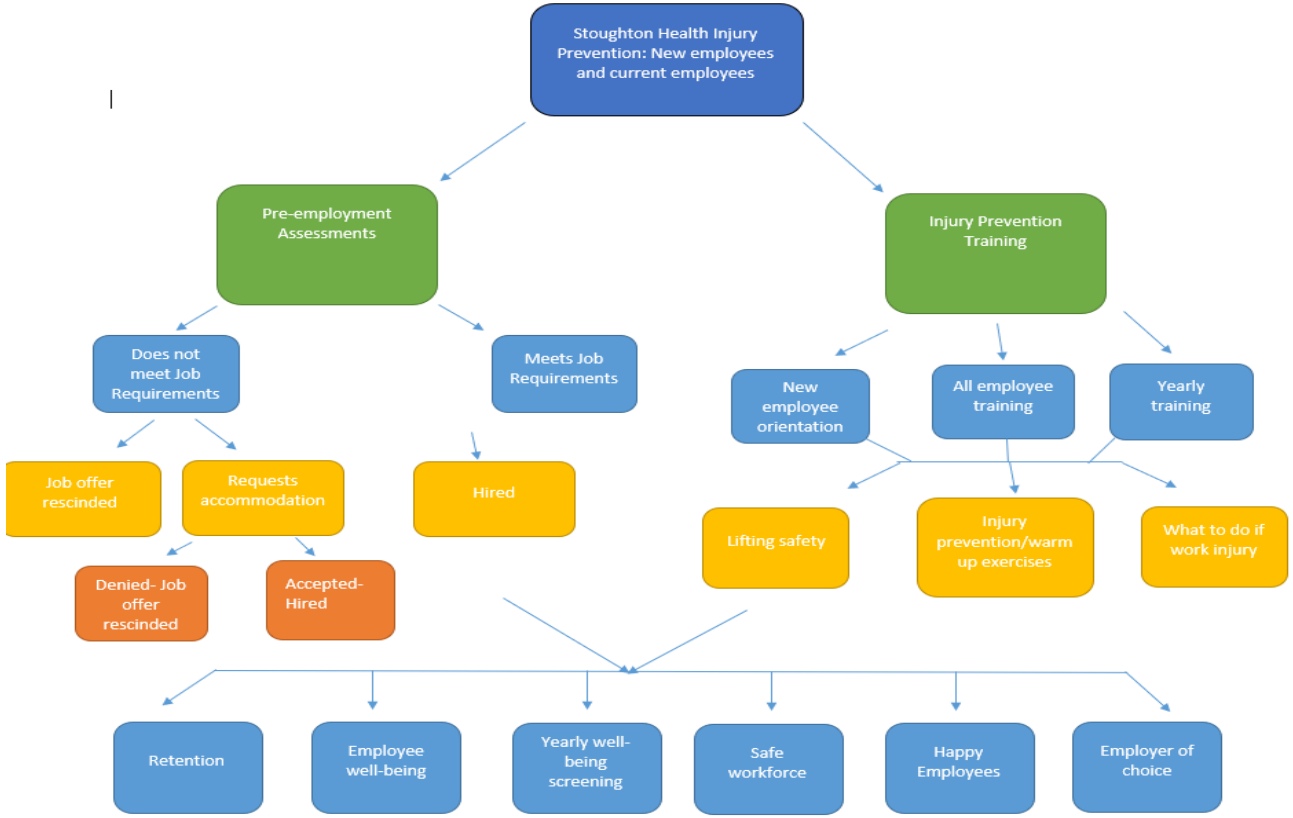

| What? | Why? | When? |
|---|---|---|
| Phase 1: Safety Zone Portal (SZP) screenings for acute musculoskeletal injuries. | Addressing an injury during the initial/acute phase reduces lost days of work and supports return to work or continuing work with restrictions. | Started workflows in Jan 2023 |
| Phase 2: Injury Prevention in the Workplace. | Observe each department and identify opportunities for improvement working with the team to drive the change. Implement dynamic warm-up specific to the area each employee works. | Observations began June 2022 and remains ongoing Completed: Med/Surg/ED, FNS |
| Phase 2a: Relias training and NEO | Updating our New Employee Orientation for injury prevention and health promotion will hardwire this program at the start of each new hires' employment and Relias training will be utilized for all current employees. | Jan. 2024 |
| Phase 3: Update job descriptions and implement pre-employment assessment tool and annual competency tool | Utilizing the US Labor Bureau data to categorize all job positions into one of four areas and be able to quantify an employee's ability to perform tasks appropriately. (New hire, return to work, competency) | June 2024 |

# Measures:

Include graphs of your measurement, results of surveys, etc. Include benchmarks or comparative data when available.

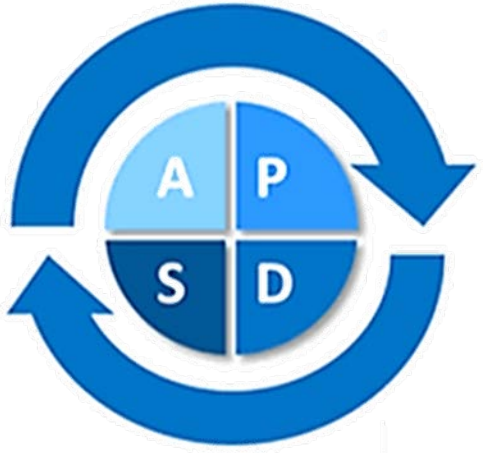
STUDY



# Findings:


| **Results**: Did you accomplish your goals? |
| --- |
| We have performed research on each of these areas and have done some preliminary work and have determined that we would like to move these projects forward with the understanding of the global impact and will work with each department as we work to achieve our goals. |
| **Lessons Learned**: What did you learn as a result of this project? Unexpected discoveries? Problems or barriers? |
| Challenges with staffing shortages in departments make it hard to observe and communicating hospital wide new processes. We were able to utilize summer town hall for phase 1 and noticed improved responses.<br>Working with HR on merging job descriptions into UKG and timing around annual evaluations. |
| **Next Steps**: What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?) |
| Finalize phase 1 process, workflow and reporting/communication. Move into phase 2 with relias training and updated NEO for 2024. Phase 3 will occur spring of 2024 with key department involvement. |
| **Project Leader is Recommending the Following:** |
| QM Council approval for completion of project?: NO<br>Project still in progress, project to continue: YES |




# Pharmacy

## Formulary Management

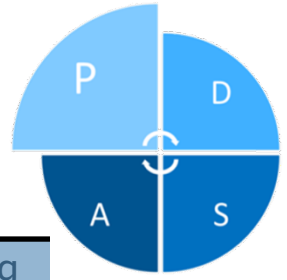
STOUGHTON HEALTH

1st Presentation Date: November 22, 2022

Document Last Presented: November 28, 2023

# Quality Story: Formulary Management

PLAN




**Goal(s):** What are you trying to accomplish? Reduce medication cost and waste by developing and managing a working hospital formulary

KOM Target:

1. By 5/31/2023, have a working formulary housed within Lexicomp and UpToDate, accessed via the Intranet.
2. By 12/30/2023, decrease the number of therapeutic duplications on formulary by 25%.
3. By 12/30/2024, decrease medication outdate value.

Current KOM Status:

Development of Working formulary: 100% completed 7/17/2023

Number of therapeutic duplications: To be determined

Raw value of medication outdates: October 2022-August 2023 Average: $5,169.54

**Background:** Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.)

Duplicate medication therapies and medication waste can have a high impact on the pharmacy budget, as well as detrimental effects on the environment.

To help achieve a sustainable supply of medication while also practicing fiscal responsibility, a working formulary needs to be developed and managed. We currently add medications to our inventory when they are requested for patients, even when they are non-formulary. The current medication list in EPIC does not distinguish between formulary and non-formulary medications.

Our hospital pharmacy currently contains several medications with the same therapeutic use, increasing medication cost as well as the amount of outdated medication.

**Driver:** Explain why the project is critical to SH. Why does it relate to the strategic plan?

This project supports the Finance Pillar as decreasing the number of medication outdates and therapeutic duplicates would allow pharmacy to save money that could be used to enhance future patient services. Additionally, decreasing the number of medications in each drug class could support the Quality and Safety Pillar, having providers look at documented evidence for the therapies provided to ensure they are the safest for our patients.

**Team:**

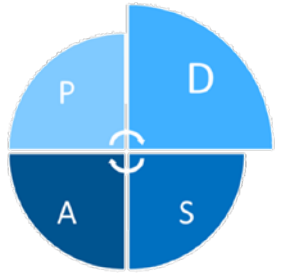
Project Leader: Pauline Cass

Members: Brianna Jacques, Tom Kostecki, Elizabeth Jacobson, Barbara Womack

# Changes:

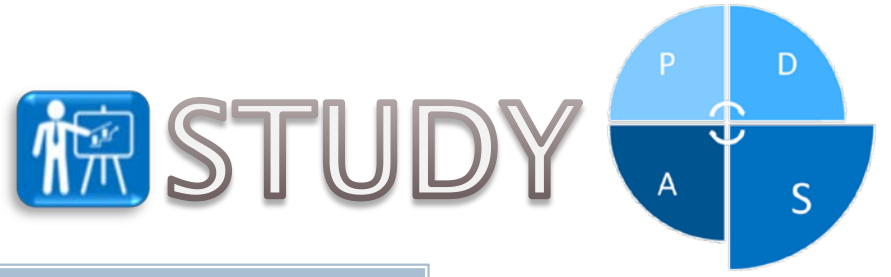
List the changes that have been made leading to improvements.

DO




| What? | Why? | When? |
|---|---|---|
| Reached out to Epic Willow for a list of all medications currently on our central pharmacy medication database | This list will serve as a basis to create a working formulary. The formulary will include all medications, including strengths and dosage forms carried, sorted by therapeutic class | October 2022 |
| Manually tracking outdated medication value/return value | To determine the value of medication we are currently outdating, for use in future analytics | October 2022-September 2023 |
| Completion of Stoughton Health Formulary | To have an accessible, maintainable formulary | July 2023 |
| Begin internal management of formulary | To determine therapeutic duplications | July 2023 |
| Create a formulary information tip sheet | To ensure proper utilization of formulary | September 2023 |
| Add formulary link to Intranet | To ensure accessibility to formulary | November 2023 |
| Build spreadsheet of therapeutic duplications for potential removal | To take to P&T committee for removal from formulary | October-December 2023 |
| | | |
| | | |
| | | |

# Measures:




## Preliminary Formulary Management

- Formulink database integration into Lexicomp and UpToDate
- Determination of current value of outdated medications

## Determining Where Savings Can Be Found

- Identification and consolidation of Therapeutic Duplications on Formulary
- Development of Updated Therapeutic Duplication Policy

Currently building spreadsheet of formulary, sortable by therapeutic class

## Maintenance of Formulary

- Identify procedure and develop policy for updating and maintaining formulary
- Create spreadsheet to track medication outdate values to determine trend over time

# Measures:

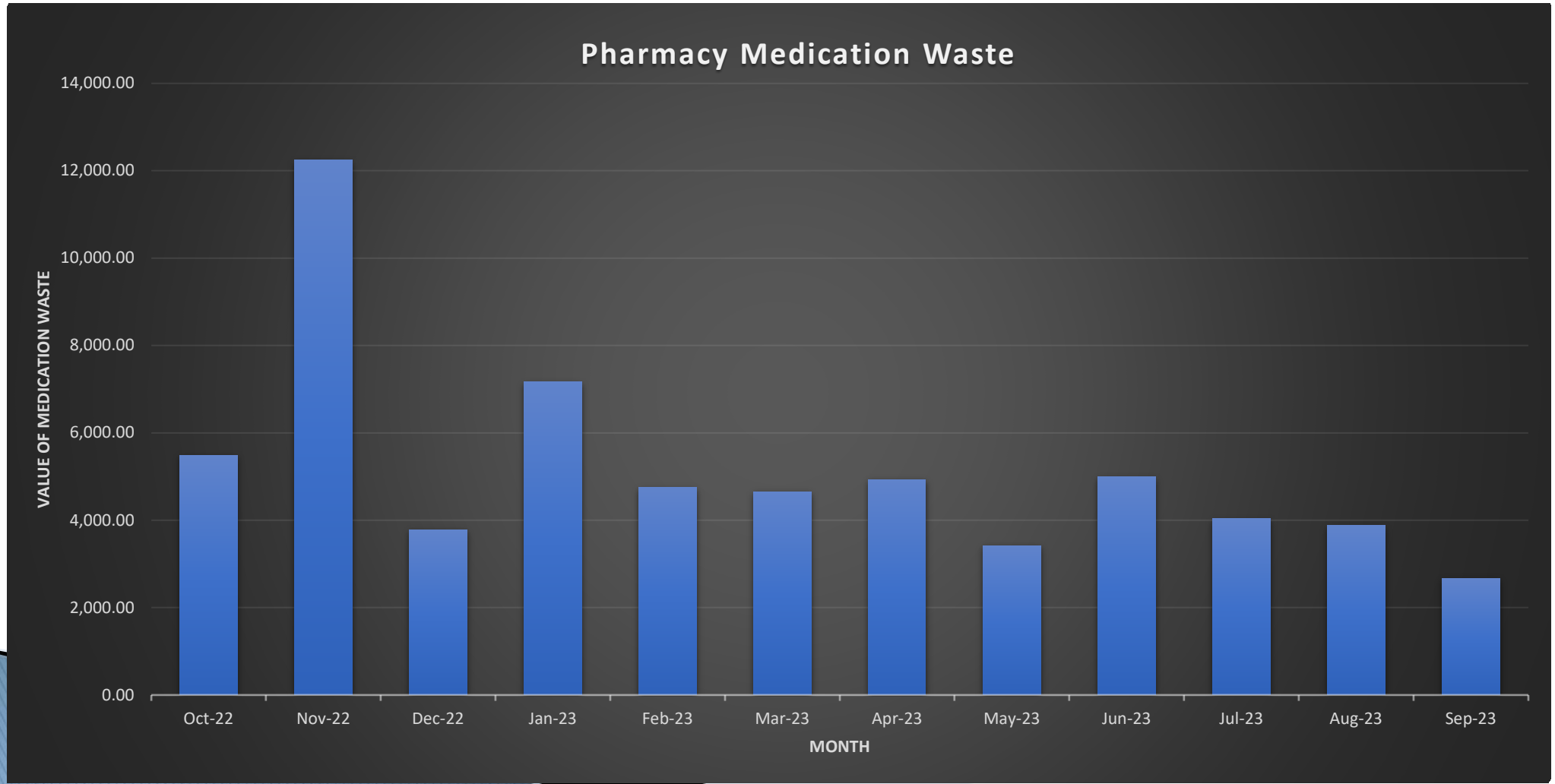

- 8 formulary deletions since July
- Deletions so far have been for seldom used dosage forms or strengths
- Example deletions:
  - Glimepiride 4 mg tablets
  - Fenofibrate (Lipofen) 150 mg tablets
  - Digoxin 0.25 mg tablet
  - Lidocaine/Tetracaine (Synera) patch
  - Hyoscamine, atropine, scopolamine, phenobarbital (Donnatol) suspension
  - Clotrimazole troches/lozenges 10 mg

# Measures:

STUDY

P D A S

*We collected 12 months worth of data to use as a comparison after duplications removed



# Findings:


**Results:** Did you accomplish your goals?

Goal 1 accomplished—maintainable formulary created. Starting process of identifying duplicate therapies

**Lessons Learned:** What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?

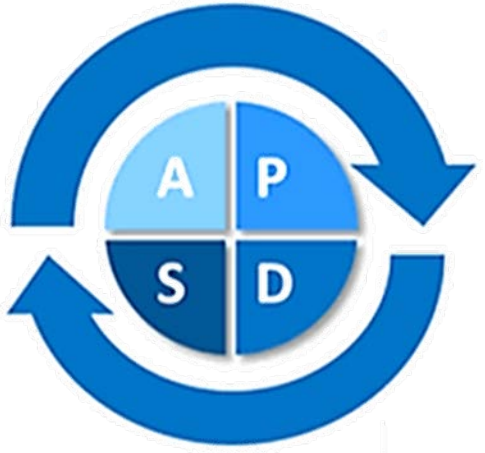
- There is not currently a formulary report built to include the therapeutic classes. Until Lexicomp can build this report we will need to manually mine data from the formulary online—with over 100 therapeutic classes this is taking significant time

**Next Steps:** What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?)

- Develop a report of therapeutic duplications to look for potential opportunities for consolidation-received 11/15 from Lexicomp

**Project Leader is Recommending the Following:**

QM Council approval for completion of project?: **NO**
**Project still in progress, project to continue:** YES




# Pharmacy

## Infliximab Dose Rounding

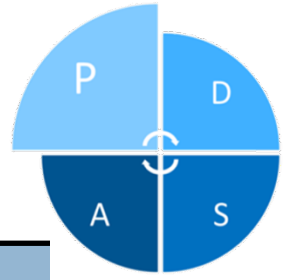
STOUGHTON HEALTH

1st Presentation Date: May 23, 2023

Document Last Presented: November 28, 2023

# Quality Story: Infliximab Dose Rounding

PLAN




## Goal(s): What are you trying to accomplish?

KOM Target:
1. Decrease infliximab (Remicade)/infliximab-abda (Renflexis) vial waste by 10%.
2. Decrease pharmacy spend on infliximab/infliximab-abda.

Current KOM Status:
1. 384 vials infliximab/infliximab-abda used in the past 12 months (October 2022-September 2023)
2. Cost of infliximab/infliximab-abda for past 12 months: ~$208,500 (October 2022-September 11, 2023)

## Background: Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.)

Remicade (Infliximab) is a monoclonal antibody used to treat autoimmune diseases. Dosing is weight-based for all indications, meaning there is no standardized dose. Dose rounding is a common practice used to avoid wasting partially used vials, ensure accurate measurement, and maximize cost avoidance. While we are utilizing the less expensive biosimilar product Renflexis for most patients, our cost for both Remicade and Renflexis over the past 12 months was $208,500 for 15 patients.

## Driver: Explain why the project is critical to SH. Why does it relate to the strategic plan?

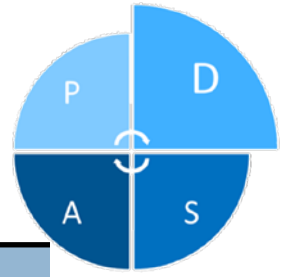
Decreasing medication waste is becoming more important to payers, with some insurance companies asking for ways to decrease waste. This project aims to satisfy this, while also supporting the SH Finance Pillar by decreasing some pharmacy spend on medication. Additionally, rounding infliximab doses to the nearest vial size would support the Quality and Safety Pillar, decreasing the potential for medication preparation errors.

## Team:

Project Leader: Pauline Cass
Members: Tom Kostecki, Brianna Jacques

# Changes:

DO




| What? | Why? | When? |
|---|---|---|
| Calculated cost spent on Remicade/Renflexis over past 12 months | To have a comparison for savings calculation | April 2023 |
| Identify Remicade/Renflexis providers | Obtain buy in from key stakeholders | May 2023 |
| Worked with PFS to identify patients receiving Remicade/Renflexis over past 12 months | Identify opportunities that could have existed for savings | May 2023 |
| Provide communication to providers regarding dose rounding process | Obtain buy in from key stakeholders | July 7, 2023 |
| Create dose rounding policy | Have a standardized process to follow for dosing Remicade/Renflexis | August 2023 |
| Dose rounding policy to P&T, MCE, MEC | Hospital policy approval process | September-December 2023 (Approved by P&T, MCE) |
| Assess current patients for appropriateness of dose rounding—contact providers | Inform providers of changes in treatment plans and ensure shared decision-making | January 2024 |
| | | |
| | | |
| | | |
| | | |

# Changes:

POLICY AND PROCEDURE

| STOUGHTON HEALTH | Effective Date: January 2024 | Title: PH- Dose Rounding of Monoclonal Antibodies and Biologic Agents | |
|---|---|---|---|
| | Original – | Page 1 of 2 | Pharmacy Manual |

**I. PURPOSE:**

The rounding of prescribed doses of monoclonal antibodies and other biologic agents up or down to the nearest vial size or a safe measurable unit has been found to be associated with fewer calculation and measure errors, therefore improving the safety of injectable prescribing, preparation, dispensing, and administration. The rounding of doses has also been found to lead to a reduction in drug waste by preventing the disposal of partially used vials during preparation. Reduced waste is associated with decreased drug costs, both environmental and monetary.

This clinical practice guideline is intended to guide the rounding of certain parenteral doses of high-cost medications up or down to the nearest vial size to enhance the safety of injectable medication preparation and dispensing administration. It is also intended to promote optimal cost effective patient care and decrease the amount of wasted medication.

**II. POLICY:**

Clinical pharmacists who enter treatment plan orders will have the ability to round doses in the electronic medical record for monoclonal antibodies and other biologic agents currently available. These medications will be rounded up or down, to the nearest vial size of 100 mg or safe measurable unit if the nearest vial size is not within 10% of dose. Drugs included for this protocol include infliximab and all its associated biosimilar products and rituximab.

**III. DEFINITIONS:**

A. **Biologic therapy**: treatment of disease by use of living organisms, substances derived from living organisms, or synthetics that take advantage of the immune system's natural ability to detect and kill cells. Examples include monoclonal antibodies, cytokines, gene therapy.

B. **Safe measurable unit**: the smallest calibration on a syringe used to prepare a dose

**IV. PROCEDURE:**

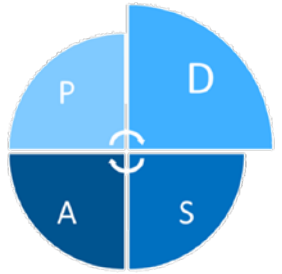
A. When pharmacy receives an order for a qualifying biologic therapy, the pharmacist will round the dose up or down to the nearest 100 mg vial size. The pharmacist will round up for any dose that is more than or equal to half of the smallest vial size OR down if the dose is less than half of the smallest vial size. (i.e. a dose of infliximab 550 mg should be rounded up to 600 mg, but a dose of 549 mg should be rounded down to 500 mg).

B. The prescribing provider will be notified of potential rounding of doses greater than 10% and must approve the new dose prior to entry of the treatment plan.

C. Providers may opt out of having the dose rounded at any time by indicating "do not modify per protocol" or other equivalent wording on the medication order.

D. For orders where dose rounding has been applied, the pharmacist shall either document on the scanned medication order or enter a progress note into the electronic medical record. The documentation shall state "Dose changed from ___ mg to ___ mg per dose-rounding policy by _____ (name of pharmacist) on _____ (date of change)."

E. Requests to add, change, or delete a medication from the dose rounding list may be made to the Pharmacy and Therapeutics Committee.

# Measures:

STUDY

P D A S

Estimated Vial and Cost Savings if Dose Rounding was Used
October 2022-September 2023

| Date Range | Number of Patients* | Number of vials Used | Cost of actual vials used** | Number of vials used with dose rounding (theoretical) | Cost of vials used with dose rounding |
|---|---|---|---|---|---|
| October 2022-December 2022 | 12 | 93 | $50,504.58 | 88 | $47,789.28 |
| January 2023-March 2023 | 12 | 100 | $54,306.00 | 89 | $48,332.34 |
| April 2023-June 2023 | 14 | 102 | $55,392.12 | 95 | $51,590.07 |
| July 2023-September 2023 | 9 | 89 | $48,332.34 | 80 | $43,444.80 |
| Potential Cost savings if rounding used | $17,378.55 | | | | |

*This data only includes patients receiving Renflexis. We had 1 patient receiving Remicade, but they are no longer receiving the medication at Stoughton. Our cost for 1 vial of Remicade is $1087.40

**The cost used for this report is our GPO price of $543.06 per vial; some of our Renflexis is eligible for 340B pricing, which is currently $203.99 per vial. There are many individual patient factors that go into whether we receive that pricing so we used GPO pricing for the theoretical savings. Actual cost data will be used once dose rounding takes place, along with individual patient data.

# Findings:


**Results:** Did you accomplish your goals?

After approval by MEC, we should begin dose rounding in January 2024

**Lessons Learned:** What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?

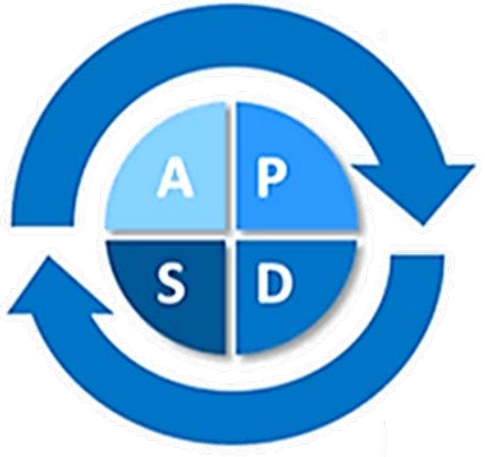
- Getting reports on usage of Renflexis/Remicade required some assistance from PFS

**Next Steps:** What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?)

- Dose Rounding Policy Approval by MEC

**Project Leader is Recommending the Following:**

QM Council approval for completion of project?: NO
Project still in progress, project to continue: YES


# Specialty Clinics

Quality improvement project to ensure provider notification of patient's abnormal vital signs(Blood Pressure & Pulse) during clinic visit

STOUGHTON HEALTH

2nd Presentation Date:

Document Last Presented:9/27/2023

# Quality Story:

PLAN

Quality improvement project to ensure provider notification of patient's abnormal vital signs(Blood Pressure & Pulse) during clinic visit

**Goal(s):** What are you trying to accomplish? This project was designed and implemented to address the identified deficiencies contributing to poor communication and follow-up of patients with elevated BP.

KOM Target: 100%
Current KOM Status: Blood Pressure 14% 7 of patients needed a recheck for blood pressure. Of those 7 patients, only 1patinet blood pressure was rechecked

Pulse 63%

**Background:** Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.)

This project was designed and implemented to address the identified deficiencies contributing to poor communication between clinical staff and provider. Clinical staff failed to communicate with provider of abnormal vital signs.

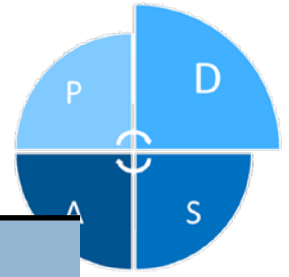
**Driver:** Explain why the project is critical to SH. Why does it relate to the strategic plan?

The implementation of a quality improvement project in the clinic setting can lead to significant improvements in staff awareness and enhance communication within staff and provider.

Project Leader: Kristin Brickl, RN
Members: Ghadeer Alafifi, Desiree Polodna, RN, Bonnie Dyson, MA

# Changes: List the changes that have been made leading to improvements.

DO



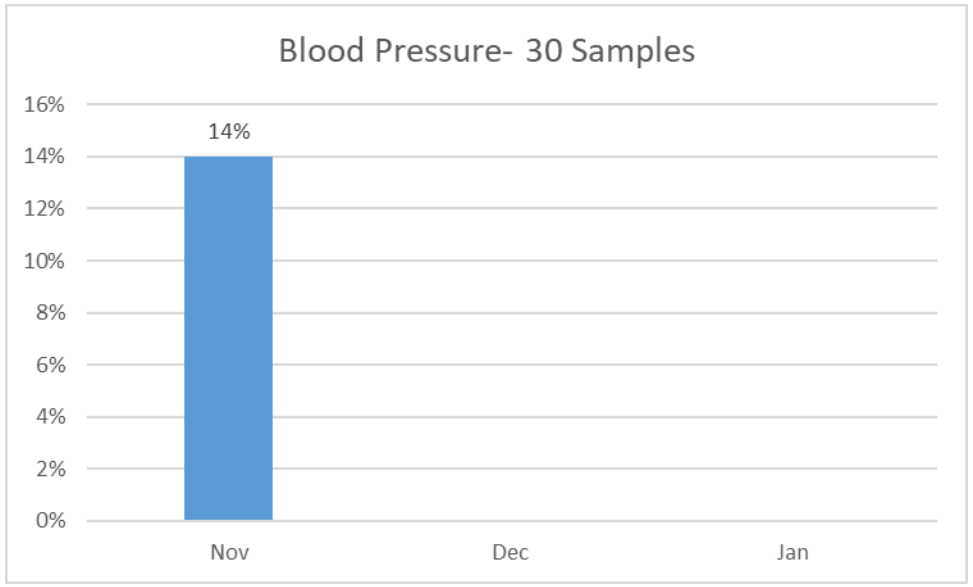

| What? | Why? | When? |
|---|---|---|
| Train clinical staff in the identification of patients with elevated BP 130/80. | Improve consistency within clinical staff and recognize potential areas of concern | 10/1/2023<br>11/7/2023- Blood pressure & pulse training and competency check |
| Recheck patients BP after 15min rest or at the end of visit | Standard of care | 10/1/2023<br>11/7/2023 Reviewed at training |
| Place recheck sign on provider's desk or computer in exam room | To improve communication with provider and remind patient to stay in room for recheck | 10/1/2023<br>11/7/2023-noticed signs in some rooms had BP of 140/80 instead of 130/80 |
| Abnormal Heart Rate(HR) | Best Practice for complete assessment | 10/1/2023<br>11/7/2023 Reviewed apical and radial pulse skills |
| Epic documentation | | |
| Communicate plan of care at the time of visit to PCP or ED | Avoid delaying patient care | Developed a dot phrase for documentation |
| Staff competency | Improve skills | Yearly |
| Audit | 30 samples<br>10 patients from Clark<br>10 patients from Dr. Rawal<br>10 patients from Renee | 11/1/2023<br>**BP** 7 out of 30 of patients needed a recheck for blood pressure. Of those 7 patients, only 1patinet blood pressure was rechecked.<br>**Pulse** 19 documented<br>11 not documented |
| Coaching & Performance evaluation | Set up expectation & accountability | |
| Manual BP taken | Accuracy | 11/7/2023-Skills check off all staff |
| | | |

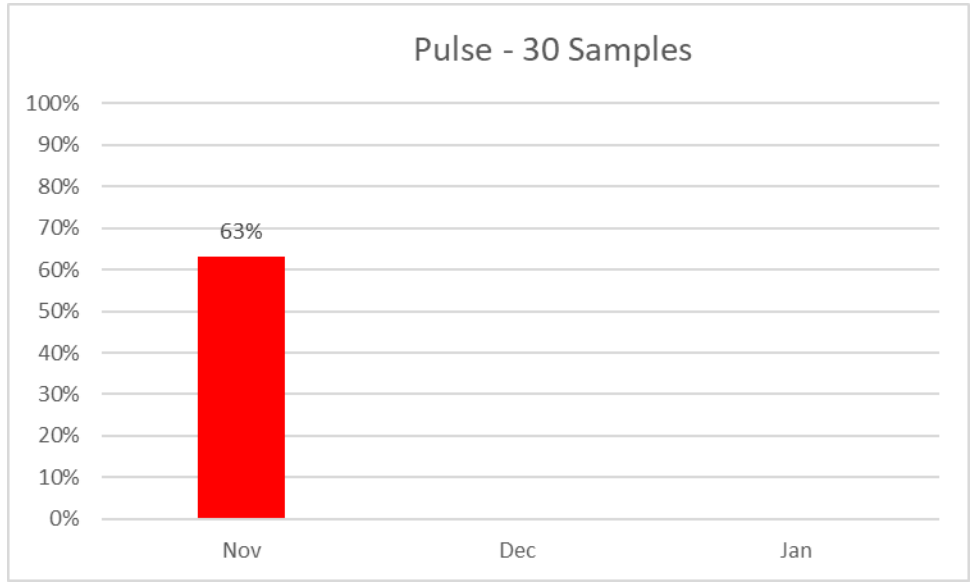
# Measures:

Include graphs of your measurement, results of surveys, etc. Include benchmarks or comparative data when available.

STUDY

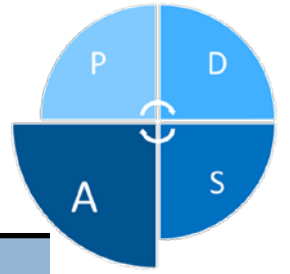
P D A S



# Findings:

ACT




**Results:** Did you accomplish your goals? No

**Lessons Learned:** What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?

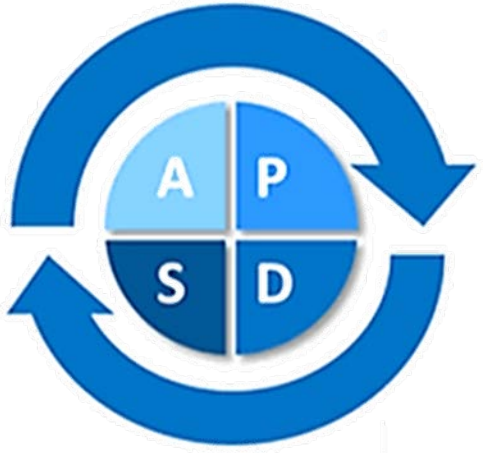
1. Noticed our sheet is listed 140/80 instead of 130/80- Corrected on 11/7/2023
2. No formal documentation to providers- created a smart phrase for epic documentation and to notify provider
3. New staff needed additional training as well as current staff requiring a review of skills
4. Provider noticed abnormal vital signs after the patient left clinic leading to additional phone calls and follow up as well as delay in intervention if needed.

**Next Steps:** What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?)

1. Improve workflow, communication, and patient care. Set up training and accountability for all clinical staff.
2. Additional observation and one on one training with new staff, along with real time follow up to ensure vitals are being taken after each patient.
3. Continue weekly audits per provider

**Project Leader is Recommending the Following: Approval to start project**

QM Council approval for completion of project?: NO
Project still in progress, project to continue: Enter YES




# Multi Specialty Clinics

## “No Stress” for Cardiology Diagnostic

STOUGHTON HEALTH

1st Presentation Date: 1/24/2023

Document Last Presented: 09/26/2023

# Quality Story: "No Stress" for Cardiology Diagnostic

PLAN

**Goal(s):** What are you trying to accomplish? **Increase** Cardiology diagnostic tests

KOM Target: an average of 30-35 patient a month
Current KOM Status: An average of 25 patients a month

Sept: 47

**Background:** Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.)

To Improve ordering and communication for Cardiology Diagnostic testing
Several departments owning pieces of this project have made this more challenging

**Team:**

Project Leader: Ghadeer Alafifi
Members: Sarah Watkins, Teresa Lindfors, Tina Degroot, Jen Mora, Alison Rece

**Driver:** Explain why the project is critical to SH. Why does it relate to the strategic plan?

- Cardiac stress testing is an important diagnostic tools in the evaluation and management of patients with known or suspected heart disease.
- Access.
  - Providing care close to home
  - Patient satisfaction:
  - Providing better access than any other hospital in Dane county
- Quality:
  - Safety (stress test that are not high risk)
  - Qualified Cardiologist, APRN & RT
  - Open time to spend with each patient
  - Getting diagnosis faster than other organization in Dane county .

# Changes:

List the changes that have been made leading to improvements.


| What? | Why? | When? |
|---|---|---|
| Cardiology Diagnostic | • ETT Reg Stress Test EKG<br>• Stress Echo LETT Stress Test<br>• CETT Cardio stress test Holter/event monitor | 11/1/2022 |
| Scheduling | • Patients are calling 3-4 different Phone numbers (RT, Cardiology, Hospital Main Number, etc.) and transferred all around.<br>• Limited Nuclear Medicine hours to only (Tue, Wed, Thu from 10:30-2:00<br>• Limited RT staff to Tuesday-Thursday<br>• ECHO scheduled by the Radiology team<br>• Lack of education | One phone number:<br>Cardiology Department<br>608-873-2349 (Internal changed 1/2/2023) External (website 1/9/2023)<br>Email sent to All staff & posted in the Daily dose,<br>Created Puzzle game<br>Communicated with Dean Providers to update their record |
| Work Qs | Communication on who is working the Work Qs<br>Two many cooks in the Work Qs Training Specialty Staff | Meeting with the RT manager & staff<br><br>Training with Spec staff started on 1/5/2023 & will continue as need it. |
| Prior Auth | Unknown Prior Auth. workflow<br>We are not getting outside referral | Manager to Communicate with Sarah W.<br>Tina & Ghadeer will have a road trip to the surrounding clinics<br>We are working on identifying who is ordering stress tests. We will start a graph by referring - providers by month to know who to thank when we go on tour and who to target if they have not. |
| Patient education | Skills & comfortable answering patients' questions.<br>Identify the top 10 questions | Started 1/5/2023<br>Having APRN support to cover these questions Working with RT & APRN on the checklist |
| Staffing | Provide staff with the support need it to be able to do their job. | After a detailed evaluation of our current staffing and operations, it has become evident that our scheduling structure has allowed for just one patient appointment per day. However, upon further analysis and discussions with the management, it's clear that our team has the capacity and capability to accommodate at least three patient appointments daily. This adjustment promises not only an increase in efficiency but also a substantial enhancement in our ability to cater to our patients' needs, potentially improving our service delivery and patient satisfaction.<br><br>Due to the complexity with scheduling and short staffing. We reached to Sarah and her team to assign staff to schedule these test - Completed<br>Tina provided staff with Training material - Completed |
| Supplies | Limited supplies to holter & event monitors | • RT was able to meet with Dr. Kaji, - Completed<br>• Mobile Cardiac Telemetry (MCT). Completed<br>• 14 Day event monitor instead of the 30 days. No additional cost. It is real time data. Completed<br>• RT staff needs HAIKU access to upload to EPIC - Tina S- Completed |
| Epic | Too many depart to schedule with one patient; for example, to schedule a Lexi stress test, you need to schedule the same patient in 411254, 411264, 411263, and 575034 & provider schedule.<br><br>Need to log out of EPIC and go to change context and pick AFF Sto NueClear Med to schedule patient. | Pilot: Two work station - Using Provider Laptop<br>If possible to have one department - Nikki |
| Fax | We lost many referral opportunities due to receiving faxes in a different department or knowing the right person to direct these faxes. Some faxes got shredded without scheduling their appointment. Patients are not getting scheduled in a timely manner or are going elsewhere if they are not contacted | New fax machine installed in Tina's office<br>Email sent to All staff and posted in the Daily Dose. |

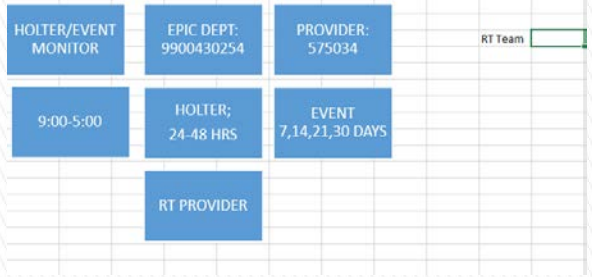
# Measures:


ETT Test

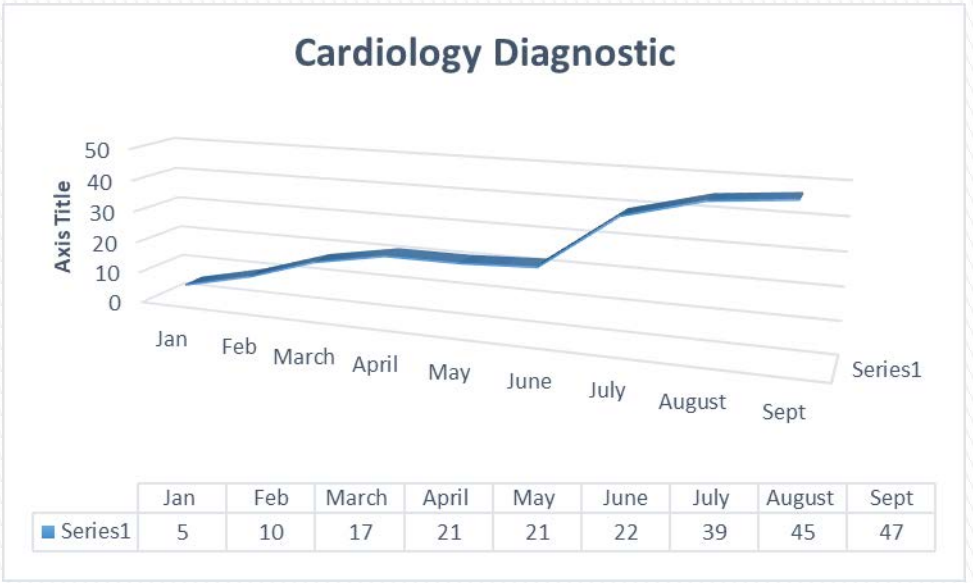

LETT Test


CETT Test

Holter Monitor




Stress ECHO scheduled by RT Team


| | Jan | Feb | March | April | May | June | July | August | Sept |
|---|---|---|---|---|---|---|---|---|---|
| Series1 | 5 | 10 | 17 | 21 | 21 | 22 | 39 | 45 | 47 |

# Findings:


**Results:** Did you accomplish your goals? Yes

**Lessons Learned:** What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?

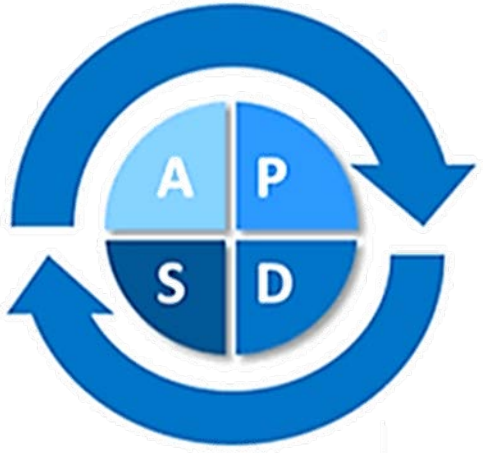
1. We have the capacity to schedule more than one patient a day
2. Several departments owning pieces of this project have made this more challenging than first realized.
3. Google review has Geriatric Psych phone number for Cardiology
4. Assigning one staff member to schedule an appointment with help with work Q and less interruption to the specialty clinics receptionist staff.

**Next Steps:** What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?)

- Working with Marketing on sending fliers to UW and SSM Primary Care once we get the new fax number.
- Continue cross-training with the front desk staff
- Schedule Road trip with APNP

**Project Leader is Recommending the Following:**

QM Council approval for completion of project?: Yes
Project still in progress, project to continue: NO




# Environmental Services

## Efficient Multiview Ordering

STOUGHTON HEALTH

November 28, 2023

Document Last Presented:

# Quality Story: Efficient Multiview Ordering

PLAN

**Goal(s):** What are you trying to accomplish?

KOM Target: 1. Reduce the time from 6 to 8 hours to order supplies in Multiview, bi-weekly to 45 minutes or less by November 1, 2023.
2. Complete 4 steps in the process to help create efficiencies.

Current KOM Status: 1. Average 80 minutes
2. Completed 3 of 4 steps (35 of 57 products have been updated on the spread sheet and Multiview).

**Background:** Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.)

- When Multiview was implemented, the old outdated SAP system definitions were transferred without a crosswalk.
- The process was time consuming and challenging to new users taking up to 6 to 8 hours every other week. Additionally, outcome totals resulted in errors ordering wrong products and quantities.
- Previously only one person knew how to manage the past and present system.

**Driver:** Explain why the project is critical to SH. Why does it relate to the strategic plan?

The opportunity for improvement is critical to:

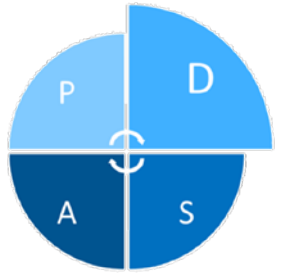
- Reduce labor
- Manage efficient inventory levels.
- Streamlining the order process to prevent incorrect orders.

Project Leader: Emily Syring
Members: Mike Harvey and Angie Rowin

# Changes:

List the changes that have been made leading to improvements.

DO

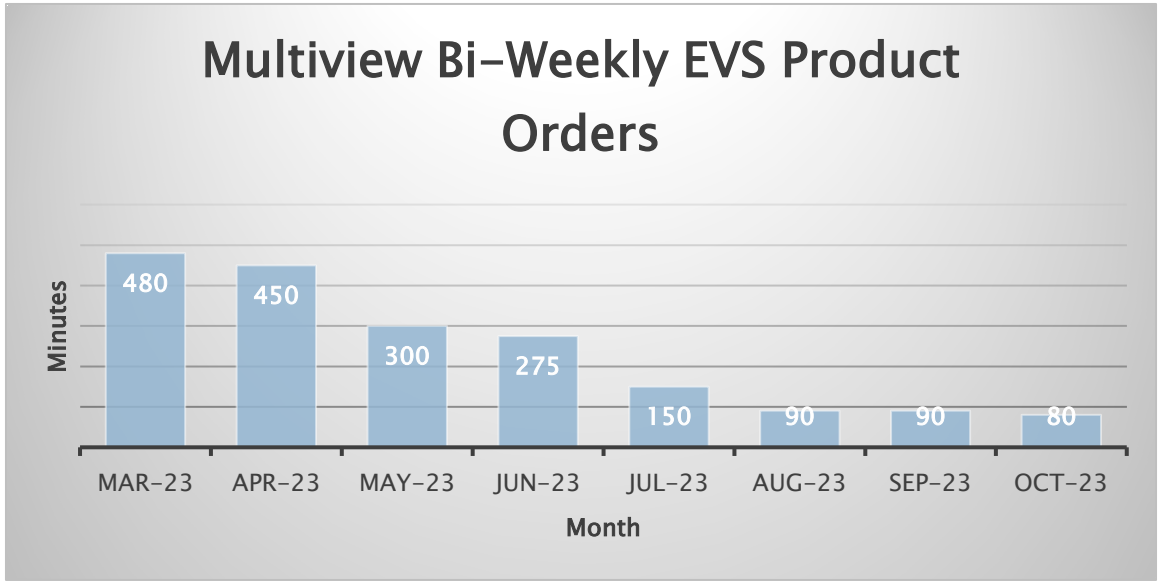



| What? | Why? | When? |
|---|---|---|
| Store all inventory products together vs itemized by business unit ID. | As we can charge products using Business Unit ID's through Multiview. This will be easier for products to be located, inventory and reduce cardboard creating more storage space. | Completed by June 23rd. |
| Train 3 team members vs 1 to provide efficient coverage going forward. | Only one staff person had the knowledge which created a risk for the department. | Welcome to Multiview training began June 23rd and completed by July 13th. |
| Research and identify accurate descriptions of products to ensure product ID matches description. | There is not a crosswalk between the old system to the new system to identify correct product and quantity when ordering. | Completed 35 of 57 products July 13th. |
| Develop an improved user friendly Multiview ordering spreadsheet. Continue to define UOM as we encounter new ones. (There are 57 products) | Streamlining the ordering process with updated knowledge of description to match the product ID#. The final step tying the information to understand Units of Measure EA/BX/CA/PK/SL | To be completed by January 15th. |

# Measures:

Include graphs of your measurement, results of surveys, etc. Include benchmarks or comparative data when available.

STUDY




Develop an improved user friendly Multiview ordering spreadsheet. Define UOM. (There are 57 products)

35 of 57 products have been updated on the spread sheet and Multiview.

| UOM (Unit of Measure) | Product ID Number | Description |
|---|---|---|
| **CA** (Case - 24 paper towels per case) | 362893 | Kleenex Multifold (slimfold) |
| **CA** (Case - 25 paper towels per case) | 265236/3645013254 | Large Paper Towel 12.4x9.4In |
| **CA** (Case - 36 toilet paper rolls per case) | 245851/3645048280 | Tissue Bthrm 8.3x4.5in |

# Findings:


**Results:** Did you accomplish your goals?

One step left to complete the project.

**Lessons Learned:** What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?

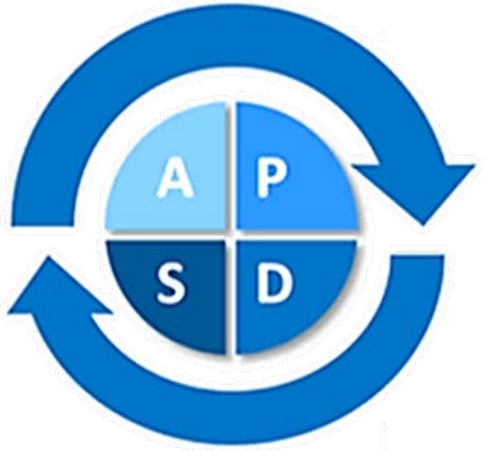
- Risk of having only one user managing supplies.
- Transferring old system ID descriptions to new was not user friendly.
- What is UOM the meaning and to define what is a CA/PK/BX/EA/SL. We learned for example: CA=case could be 6, 8 or 12 etc. which is important to know how much to order. It's about finding the correct volume to order.

**Next Steps:** What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?)

- Finish Spread Sheet adding newly identified Unit of Measure (UMO) to the spread sheet and keep changes current with Materials Services. Have completed by January 15th.

**Project Leader is Recommending the Following:**

QM Council approval for completion of project?: Enter YES or **NO**
Project still in progress, project to continue: Enter YES or NO one more cycle.




# Food and Nutrition Services

## Hot Meals for Patients for Dinner

STOUGHTON HEALTH

1st Presentation Date: 3/28/23

Document Revised on: 11/10/23

# Quality Story: Hot Meals for Patients for Dinner

PLAN

| **Goal(s):** What are you trying to accomplish? |
|---|
| KOM Target: Trial providing one hot entrée with sides by June 2023. Intent is to maintain steady Press Ganey food satisfaction scores by offering hot dinner options. Current trending reports great variability of overall food satisfaction ranging from 6th – 90th percentile. Target Percentile: 90 th or greater.<br>Current KOM Status: Med Surg: 76th percentile for quality of meals this past quarter, 67th percentile for last quarter. Geri-Psych 97th percentile for Quality of meals for two quarters, 99th for this past quarter. |

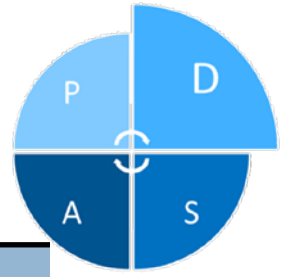
| **Background:** Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.) | **Driver:** Explain why the project is critical to SH. Why does it relate to the strategic plan? |
|---|---|
| We originally orchestrated a thoughtful menu with a diverse number of menu items. Since COVID and the staffing shortage we have had to pair down our offerings. Those patients with a history of receiving hot menu options perpetuate score quality low, based on expectations or previous experiences. | Research on providing a great employee experience tells us that patients judge us by 3 things Floor, Food and Service. If one of these is out of place or not up to the patient's standards, then our Press Ganey scores will reflect negative patient satisfaction. |

| **Team:** |
|---|
| Project Leader: Dan Arndt & Autumn Kumlien<br>Members: Katrina Rogers, Ricky Quesada, Roxanne Lehman and Melanie Jess |

# Changes:

List the changes that have been made leading to improvements.

DO




| What? | Why? | When? |
|---|---|---|
| Eliminating hot food offerings as a dinner choice implemented to accommodate for lack of staff so needed to shorten the menu and make trays disposable. | COVID-19 and lack food service workers in the greater Dane county area. | June 2021. |
| Patients commented on food selection using Press Ganey Scores. | We have a regular base of patients that remember what we used to offer. | Pre-COVID. |
| Meat Lasagna or Vegetarian Lasagna with Green Beans and a Dinner roll was trialed. | To accommodate the need and or request for hot meals from patients within our staffing capabilities. | April 2023 |
| Hot Bar is now being offered for lunch and or dinner Monday-Friday. | To offer a hot food option for patients for the dinner hour. | June 2023-Present |
| Presented a Prep Cook requisition to Administrative Council. | Utilize Prep cook to help prepare diet friendly options for specialized diets. | October 2023-Present |
| Started offering Grilled Cheese/Grilled Ham and Cheese during the dinner hour as a hot sandwich option. | Patients were requesting hot sandwich option. | October 2023-Present |

# Measures:

Press Ganey (Med-Surg.)

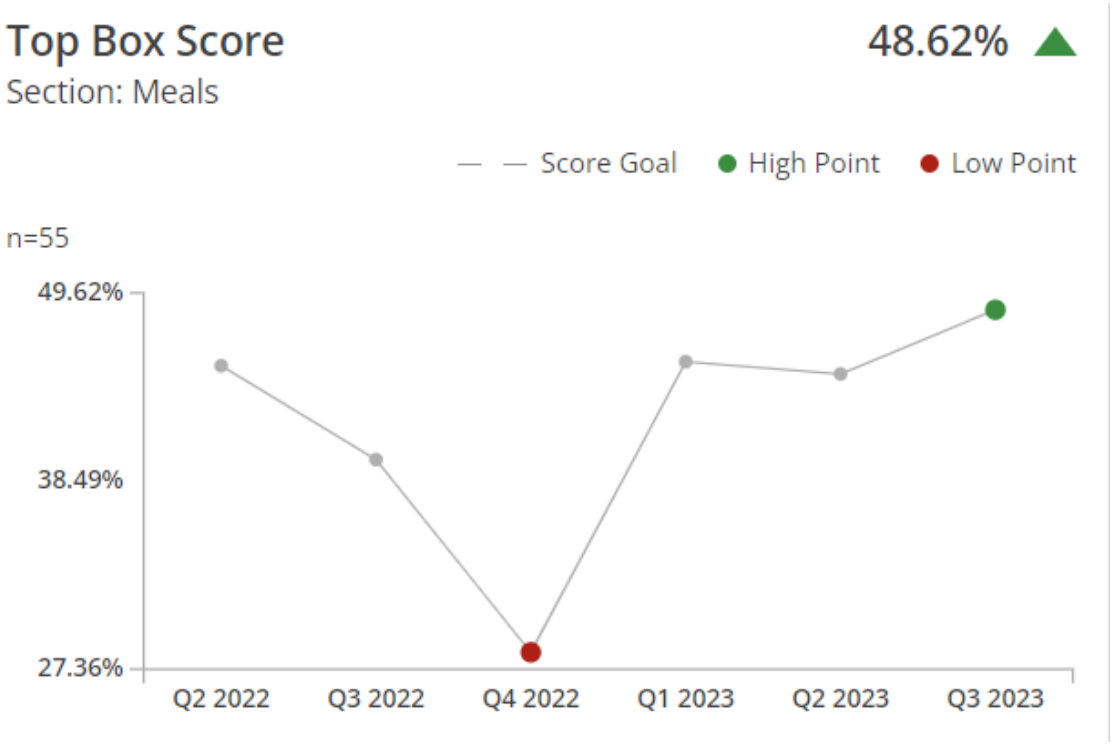

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 5187412376 | 07/06/2023 | Stoughton Hospital | Meals | Meals | | Surgical | Positive | This is the first hospital that I could CHOOSE what I want to eat. |
| 5176580613 | 07/11/2023 | Stoughton Hospital | Meals | Meals | | Surgical | Positive | Very good - fast service. |
| 5207974709 | 07/11/2023 | Stoughton Hospital | Meals | Meals | | Surgical | Negative | I wouldn't know how to make a full liquid diet taste good. |
| 5205520820 | 07/13/2023 | Stoughton Hospital | Meals | Meals | | Surgical | Positive | Better than most hospital food. |
| 5289926589 | 07/28/2023 | Stoughton Hospital | Meals | Meals | | Surgical | Negative | I would say the food could be better, fresh fruit and softer meat. Fresh salad my lettuce on more than once was wilted. |
| 5440678459 | 08/25/2023 | Stoughton Hospital | Meals | Meals | | Surgical | Negative | Most of the food I had was terrible - undercooked - inedible. |
| 5475334345 | 09/06/2023 | Stoughton Hospital | Meals | Meals | | Surgical | Negative | Just not enough to eat. |
| 5436994791 | 09/20/2023 | Stoughton Hospital | Meals | Meals | | Surgical | Positive | Excellent food. |
| 5521108595 | 09/26/2023 | Stoughton Hospital | Meals | Meals | | Surgical | Positive | Always asked if there was anything else I needed. |
| 5187412376 | 07/06/2023 | Stoughton Hospital | Nurses | Nurses | | Surgical | Positive | I had no complaints I was always well informed. |
| 5118857838 | 07/06/2023 | Stoughton Hospital | Nurses | Nurses | | Surgical | Positive | All nurses were exceptional. |

# Measures:

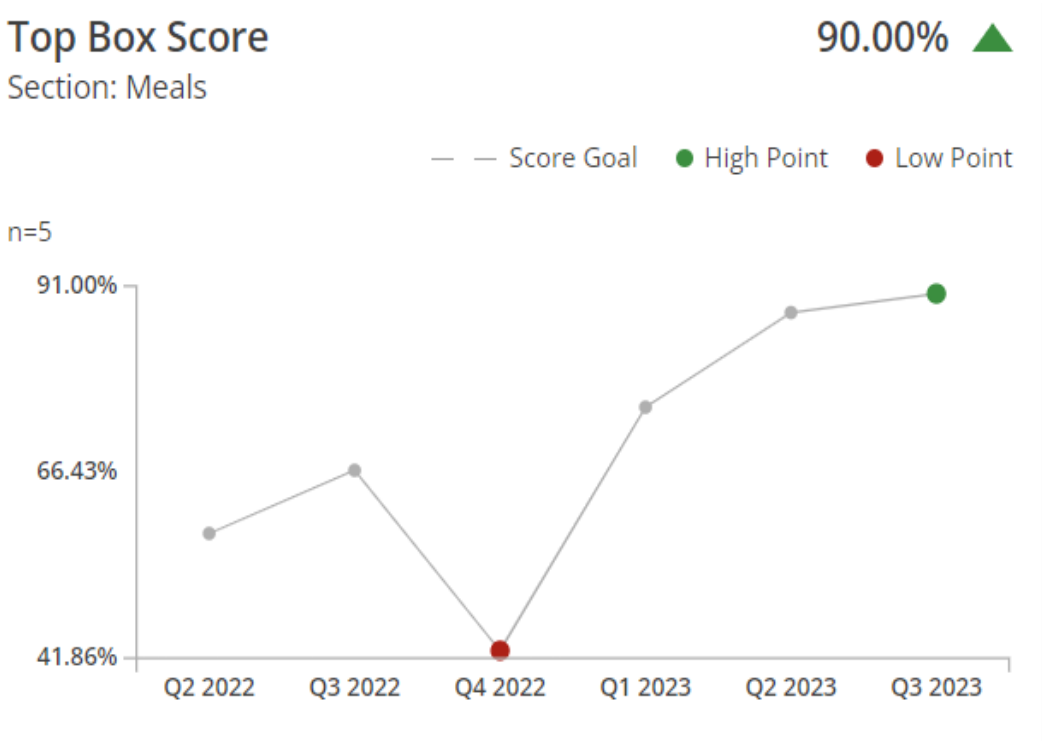
Press Ganey
Geri-Psych


| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 07/25/2023 | Stoughton Hospital | Meals | Meals | | Older Adult Psychiatric | Positive | After they did labs on me, I ate like I was starving, I gained weight. |
| 07/28/2023 | Stoughton Hospital | Meals | Meals | | Older Adult Psychiatric | Positive | I wasn't very hungry, but there was always plenty of food. |
| 09/22/2023 | Stoughton Hospital | Meals | Meals | | Older Adult Psychiatric | Positive | Lots of food - all good. |
| 09/27/2023 | Stoughton Hospital | Meals | Meals | | Older Adult Psychiatric | Neutral | I had a diabetic diet, but I never went hungry. |

# Med-Surg.

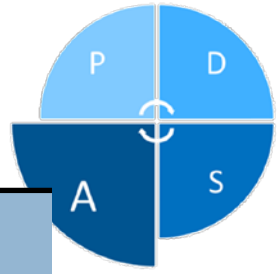



# Geri-Psych.



# Findings:

ACT




**Results**: Did you accomplish your goals?

1. Med Surg is continuously improving as shown in previous slides. Geri-Psych remains above the 90th percentile for the third quarter in a row.

**Lessons Learned**: What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?

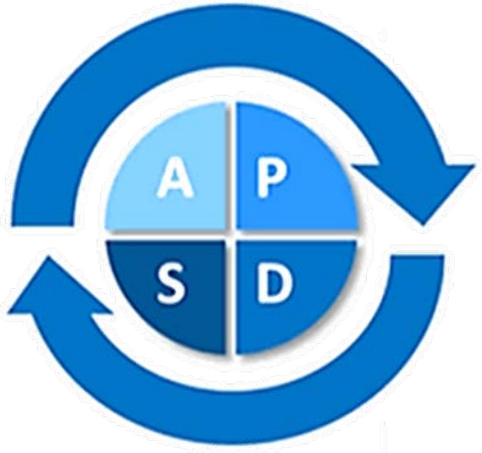
So far, we have discovered that there are a few patients who like this offering, but many still get sandwiches. We did also discover that this offering caused anxiety over the need for increased cooking skills by P.M FNS staff. When making one hot entrée special for dinner it is very hard to accommodate our top three restrictive diets ordered (cardiac, diabetic, low sodium). After researching this more, we discovered that our Food Service distributors do not make diet friendly options that are of our quality. We have found the need for a prep cook, to help create diet friendly menu options.

**Next Steps**: What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?)

1. Propose hiring of a prep cook.
2. Lower food costs by 10% by raising café prices of our Hot Bar, Sandwich Bar and Salad Bar ($.10 Increase). This will then off set some of the costs of this position.

**Project Leader is Recommending the Following:**

QM Council approval for completion of project?: NO
Project still in progress, project to continue: YES




# Material Services

## Nurse Server Cabinet Design and Restocking Process

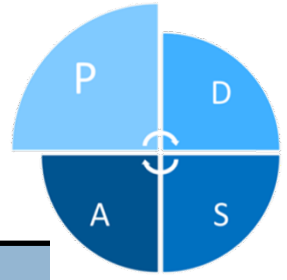
STOUGHTON HEALTH

1st Presentation Date: 5/23/2023

Document Last Presented: 11/28/2023

# Quality Story: Nurse Server Cabinet Design and Restocking Process

PLAN




**Goal(s):** What are you trying to accomplish?

KOM Target:
- Reduce the time it takes to restock nurse servers and check for expired supplies by __%
- Reduce the quantity of supplies in the nurse servers by __%

Current KOM Status:
- Not available. Have not installed new nurse server cabinets yet.

**Background:** Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.)

The current process for storing and restocking supplies in the nurse server cabinets is inefficient and unorganized. It takes a long time to determine what needs to be restocked. Supplies do not have their own compartments in the drawers which makes it difficult to count and check for expiration dates. It has been a long time since the par levels have been determined so quantities may need to be updated.

**Driver:** Explain why the project is critical to SH. Why does it relate to the strategic plan?

This project supports the Finance pillar. Having a more efficient process will save the Material Services team time and will allow them to work on other duties.

Reduce the potential for supplies expiring in the nurse servers to keep patients safe and to avoid waste.

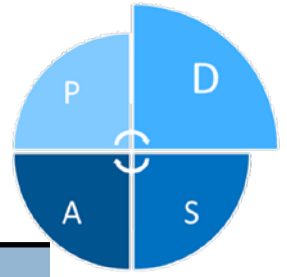
**Team:**

Project Leader: Roberta Sarow
Members: Material Services Department

# Changes:

List the changes that have been made leading to improvements.

DO

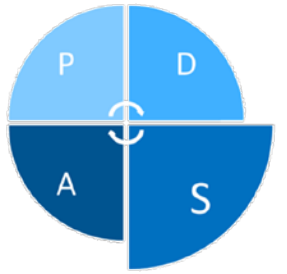



| What? | Why? | When? |
|---|---|---|
| Nursing decided on a new design for nurse server cabinets. | Needed cabinets to be more organized and for them to have separate compartments for supplies. | April 2023 |
| Install new cabinets | See above | TBD – need to coordinate with plant ops and med/surg |
| Change par levels | To reduce the quantity of supplies which will make stocking and checking expiration dates more efficient | After nurse servers are installed and usage has been analyzed |
| Identified and made a list of nurse server supplies. | For easier tracking. | June 2023 |
| Analyze usage of supplies in nurse servers. | To determine if we can reduce the par level | July-Oct 2023 |
| Analyzing usage of nurse server supplies completed. | We're able to reduce 26 par levels of 62 nurse server items | November 11/23 |

# Measures:

Total time to restock all nurse servers and replenish the nurse server cart (hours : minutes)

| Initial Measure | |
|---|---|
| Date | Time to Restock |
| 4/26/2023 | 0:50 |
| 4/28/2023 | 1:10 |
| 5/1/2023 | 1:14 |
| 5/3/2023 | 1:13 |
| 5/5/2023 | 1:05 |
| 5/8/2023 | 1:05 |
| 5/10/2023 | 1:25 |
| | |
| Average | 1:08 |


Par Level Analysis: We have analyzed all of the products in the nurse server.

| Product Id | Product | Product UOM to EA | Sum of Qty | Annual Usage | Annual + Buffer (1.65) | Daily Ave Including Buffer | x 3 Days in Between Stocking | Calculated Required Par Level (Rounded Up) | Decision on Par Level Considering Other Factors |
|---|---|---|---|---|---|---|---|---|---|
| 100574 | Cath Iv 18Ga 1.16In Shld Ntch Ndl Pshbtn | 50 | -1 | 50 | 82.50 | 0.23 | 0.68 | 1.00 | |
| 100575 | Cath Iv 22Ga 1In Shld Ntch Ndl Pshbtn | 50 | -11 | 550 | 907.50 | 2.49 | 7.46 | 8.00 | |
| 102200 | Cath Iv 20Ga 1.16In Shld Ntch Ndl Pshbtn | 50 | -8 | 400 | 660.00 | 1.81 | 5.42 | 6.00 | |
| 117419 | Ointment Hydraguard Silicone Cream 2oz | | -536 | 536 | 884.40 | 2.42 | 7.27 | 8.00 | |
| 192192 | Set Adm 105In 10 Gtt/Ml Iv Clrlnk Cnt-Fl | | -1,319 | 1,319 | 2,176.35 | 5.96 | 17.89 | 18.00 | |
| 192195 | Set Adm 37In 10 Gtt/Ml Iv Duo-Vnt 2Nd | | -1,319 | 1,319 | 2,176.35 | 5.96 | 17.89 | 18.00 | |
| 194920 | Syr .5In 28Ga .5Cc Insn Hpo Ndl Ndlpro | | -115 | 115 | 189.75 | 0.52 | 1.56 | 2.00 | |
| 270083 | Syr 3Ml Lf Grad N-Pyrg Dehp-Fr Pvc Fr Ll | | -490 | 490 | 808.50 | 2.22 | 6.65 | 7.00 | |
| 343066 | Set Xtn 325 Psi .59Ml 9.3X12.25X21.88In | | -640 | 640 | 1,056.00 | 2.89 | 8.68 | 9.00 | |
| 362646 | Syr 5Ml Ll Med | | -346 | 346 | 570.90 | 1.56 | 4.69 | 5.00 | |
| 380284 | Syr 10Ml Lf Ll Med Strl Disp | | -680 | 680 | 1,122.00 | 3.07 | 9.22 | 10.00 | |

# Findings:


**Results:** Did you accomplish your goals?

TBD – we are still analyzing usage.

**Lessons Learned:** What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?

- We never measured exactly how long it takes to stock the nurse servers. Based on our 7 day sample, we know it takes approximately 68 minutes.
- We haven't analyzed nurse servers par levels in quite a while.
- We're able to reduce par levels based on usage. This should save time with restocking. It will also save time checking expiration dates.

**Next Steps:** What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?)

- Install new nurse server cabinets
- Measure usage of supplies over time to calculate new par levels
- Determine if new par levels make sense by looking through nurse servers and talking to nurses
- Adjust par levels
- Measure how long it takes to stock nurse servers after changes have been made
- Waiting for nurse server cabinets to be installed.
- Get approval for proposed par levels from nursing.

**Project Leader is Recommending the Following:**

QM Council approval for completion of project?: NO
Project still in progress, project to continue: YES


# Off Contract Purchases Reduction

To Review and Reduce off Contract Purchases

**1st Presentation Date: 11/30/2021**
**Document Last Presented: 11/27/2023**

# Quality Story: Off Contract Purchase Reduction

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## Goal(s):

Reduce off contract purchases in order to obtain better pricing and improve financial results.

**KOM Target:**
Achieve a price index score of 50 over the most recent three-month period.

**Current KOM Status:**
Our current price index score is 51.69. If we lower that to 50, we have potential to save $110k quarterly ($491K annually) on the items we purchase.

## Background:

We switched our Group Purchasing Organization (GPO) from Premier to Vizient on 10/1/2021. Due to this change there is potential that some of our supplies fell off of a GPO contract. This means we would pay full price when better pricing is available. We need to review our purchases to ensure we are receiving pricing from a GPO contract when they are available.

## Driver:

Ensure we are obtaining the best possible pricing to improve financial results.


## Team:

**Project Leaders:** Nancee Linnerud
**Members:** Roberta Sarow and Brian Swain

# Changes:

D

O

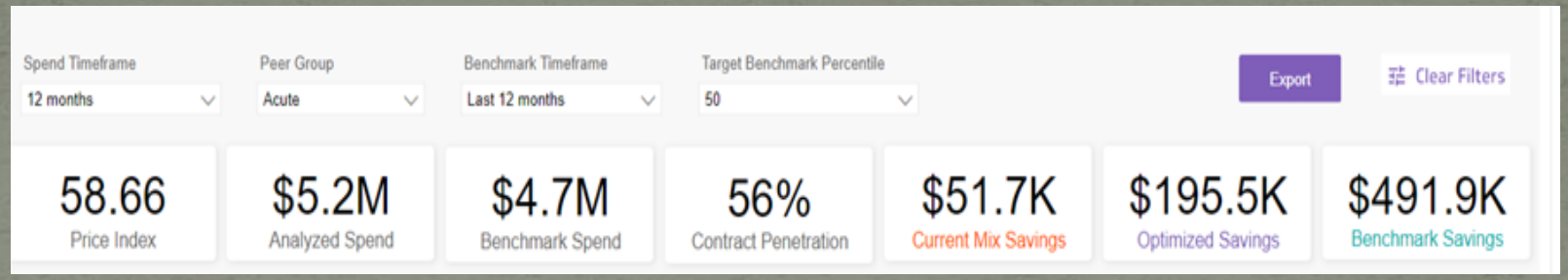
| What? | Why? | When? |
|---|---|---|
| Supply Analytics Dashboard is live | We can now access our information in the dashboard. | June 2023 |
| Activate available contracts for supplies we are purchasing but not on contract | These contracts are available, we were just unaware the contract wasn't activated | Starting June 2023 |
| Convert items with no available contract to items with Vizient contract when feasible | To obtain better pricing by converting items to contracts | Starting July 2023 |
| Receiving weekly updates from Vizient with pricing changes and opportunities to convert to on contract products. | To help identify products that are already on contract and need to be updated in Multiview. Also, to identify products with savings opportunities so we can convert or present to end users for potential conversion. | Starting Sept. 2023 |
| Considering re-establishing a product review committee. | To facilitate reviewing potential conversions to new products. | Committee formation in progress. |
| Organized and removed fields on the weekly updates from Vizient. | To make it easier to work on the conversions. | Starting October 2023 |

# Measures:

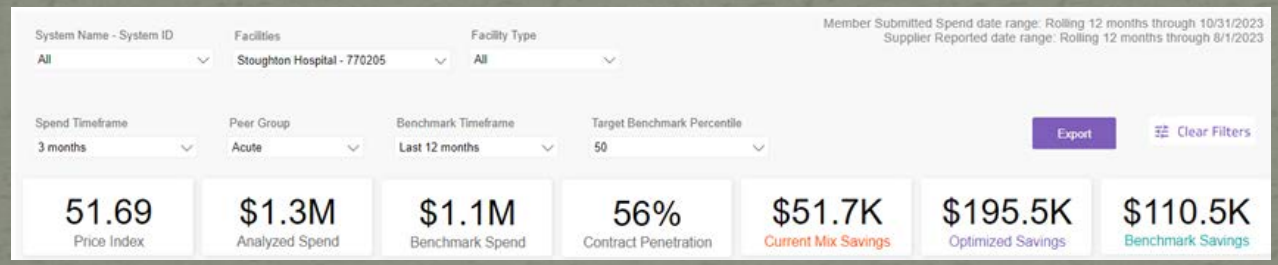
Price Index Goal: 50

S T U D Y

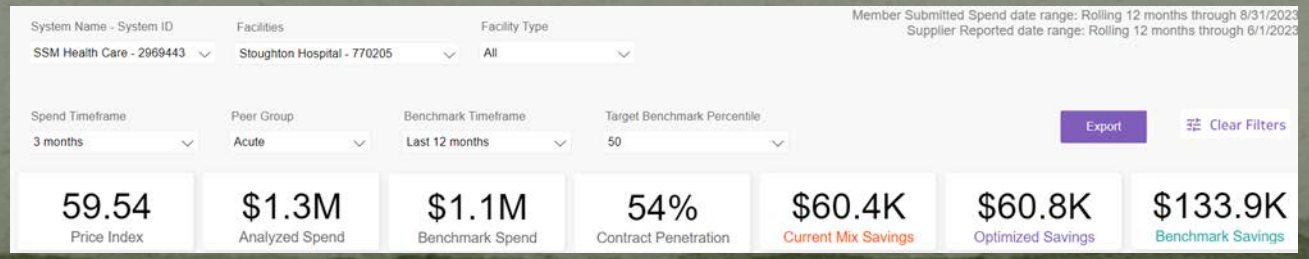
Rolling 12 Months:




Rolling 3 Months (through 10/31/2023):




Rolling 3 Months (through 8/31/2023):




# Findings:

A

C

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## Results:

Our most recent three month score dropped 8 points since our last presentation, so we are moving in the right direction.

## Lessons Learned:

- We have opportunities to obtain better pricing by activating contracts that are already available or by purchasing different items that are on contract.
- We determined we need to start up the product review committee again.
- Organized the spreadsheet, which Vizient sends, to be able to work on conversions with only the information that we need.

## Next Steps:

- Continue to research contracts and our pricing.
- Work with Vizient (Amber) to identify savings opportunities.
- Form a product review committee.
- Continue to review opportunities to convert products to on contract options.


**Project leader is recommending the following:**

**CI Council approval for completion of project: No**

**Project still in progress, project will continue: Yes**


# Lease Accounting

Implementation of Accounting Standards Codification (ASC)
Topic 842 – Lease Accounting

**1st Presentation Date: 11/22/2022**
**Document Last Presented: 11/28/2023**

# Quality Story:

P

L

A

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## Goal(s):

**KOM Target:** Fully implement the new lease accounting standard, ASC topic 842, for our year-end 9/30/2023 financial statements so we can provide accurate information and be in compliance with Generally Accepted Accounting Principals (GAAP).

**Current KOM Status:** We are 100% completed with our KOM target. We have recorded all of the required leases, provided all relevant information to the auditors and have worked with them to prepare the audited financial statements and footnotes.

## Background:

- The Financial Accounting Standards Board (FASB) issued Accounting Standards Codification Topic 842 (ASC 842) which will change how we account for our leases.
- Accounting for our leases requires very minimal effort under the old lease accounting standard.
- The new accounting standard will require us to identify traditional leases and embedded leases, track them and prepare the appropriate financial entries to record them in our accounting records according to GAAP.

## Driver:

We are required to prepare accurate financial statements according to Generally Accepted Accounting Principals.

## Team:

**Project Leader:** Brian Swain
**Members:** Accounting Department

# Changes:

D

O

| What? | Why? | When? |
|---|---|---|
| Create a tag in ContractSafe to track leases. | So we have a way to easily filter the contracts to only show leases | January / February 2023 |
| Locate leases and load them into ContractSafe | So we have all of our leases stored and managed in a central location | November 2022 – September 2023 |
| Create a template for analyzing leases. We ended up using excel for this. | To determine and document the proper accounting for each lease. | December 2022 / January 2023 |
| Make changes to the general ledger to allow for proper accounting for new lease standard (create new accounts) | So we can make the proper journal entries | January 2023 |
| Make accounting entries for new lease standard | So we can prepare the financial statements with accurate general ledger information | January 2023 – October 2023 |
| Make changes to the financial statements for the new lease accounting standard | So we can send accurate GAAP financial statements to our Board, management and creditors. | January 2023 |
| Continue to record new and renewing leases throughout the year according to the lease standard. | We will continue to find more leases that need to be recorded as they are renewed or as new leases are signed. | January 2023 – October 2023 |
| Work with our audit firm to implement the required footnote disclosures related to leases for our audited financial statements. | So we can present financial statements according to Generally Accepted Accounting Principals. | September – Nov 2023 |

# Measures:

S T U D Y

| Other Assets | | |
|---|---|---|
| Long-term investments | 3,121,110 | 2,992,282 |
| Right-of-use assets - operating lease | 1,427,178 | - |
| Interest in net assets of the Stoughton Hospital Foundation | 2,704,201 | 1,178,577 |
| Investment in Stoughton Hospital Imaging, LLC | 1,329,607 | 1,191,232 |
| Other assets | 23,945 | 11,845 |
| Total other assets | 8,606,041 | 5,373,936 |
| Total assets | $ 103,798,808 | $ 89,602,628 |

| Liabilities and Net Assets | 2023 | 2022 |
|---|---|---|
| Current Liabilities | | |
| Current maturities of long-term debt | $ 1,137,397 | $ 1,174,073 |
| Current maturities of operating lease liabilities | 390,267 | - |
| Accounts payable | 1,939,959 | 1,474,730 |
| Construction payable | 231,716 | - |
| Estimated third-party payor settlements | 27,492 | 1,875,000 |
| Accrued salaries and related withholdings | 522,914 | 476,282 |
| Accrued vacation | 1,274,127 | 1,214,812 |
| Accrued interest | 25,770 | 29,479 |
| Other current liabilities | 112,905 | 104,527 |
| Total current liabilities | 5,662,547 | 6,348,903 |
| Long-Term Liabilities | | |
| Deferred compensation | 453,620 | 379,269 |
| Long-term debt, less current maturities and unamortized debt issuance costs of $81,524 in 2023 and $107,907 in 2022 | 7,501,066 | 8,638,464 |
| Operating lease liabilities, less current maturities | 964,460 | - |
| Total liabilities | 14,581,693 | 15,366,636 |

Stoughton Health
Notes to Financial Statements
September 30, 2023 and 2022

Total right-of-use assets and lease liabilities at September 30, 2023 were as follows:

| Lease Assets | Classification on Balance Sheet | |
|---|---|---|
| Right-of-use assets - operating leases | Other assets | $ 1,427,178 |
| **Lease Liabilities** | | |
| Current | | |
| Operating lease liabilities | Current maturities of operating lease liabilities | $ 390,267 |
| Noncurrent | | |
| Operating lease liabilities | Operating lease liabilities | 964,460 |
| Total lease liabilities | | $ 1,354,727 |

Total lease costs for the year ended September 30, 2023 were as follows:

| | |
|---|---|
| Operating Lease Cost | $ 480,519 |
| Short-term Lease Cost | 284,552 |

Total lease expense under noncancelable leases was $759,232 for the year ended September 30, 2022.

The following summarizes the supplemental cash flow information for the year ended September 30, 2023.

| | |
|---|---|
| Cash Paid for Amounts Included in the Measurement of Lease Liabilities | |
| Operating cash flows for operating leases | $ 480,519 |
| Right-of-Use Assets Obtained in Exchange for Lease Liabilities | |
| Operating leases | $604,015 |

The following summarizes the weighted-average remaining lease term and weight-average discount rate.

| | |
|---|---|
| Weighted-Average Remaining Lease Term | |
| Operating leases | 3.68 Years |
| Weighted-Average Discount Rate | |
| Operating leases | 2.22% |

# Findings:

A

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T

## Results:

We have fully implemented the lease standard. The auditors didn't identify any additional leases to record and had no adjustments to our accounting for the leases.

## Lessons Learned:

- Through the multiple trainings and conversations with others we have learned that implementing this lease standard will be a challenge and require a lot of time and resources.
- We know that we have a lot of leases that we will have to analyze to determine the proper accounting treatment.

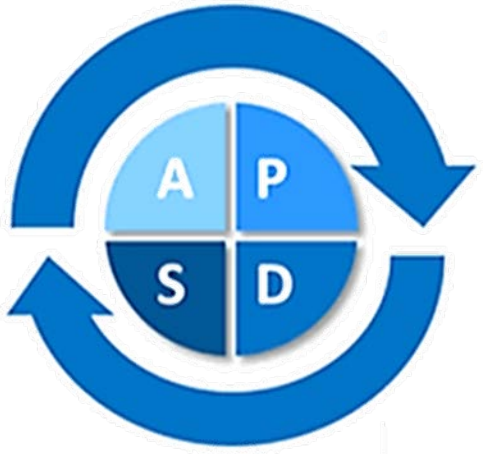
## Next Steps:

- Continue to analyze and record new and renewing leases going forward.

**Project leader is recommending the following:**

**CI Council approval for completion of project: Yes**

**Project still in progress, project will continue: No**




# Accounting

## Accounting 101

STOUGHTON HEALTH

1st Presentation Date: 11/28/2023

Document Last Presented: 11/28/2023

# Quality Story: Accounting 101

PLAN

| Goal(s): What are you trying to accomplish? |
| --- |
| KOM Target: Meet with 80% of managers before April<br>Current KOM Status: 0% – Project just starting |

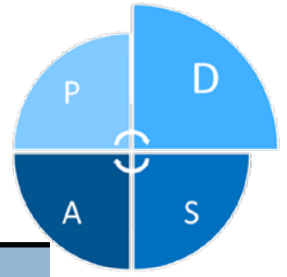
| Background: Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.) | Driver: Explain why the project is critical to SH. Why does it relate to the strategic plan? |
| --- | --- |
| Repeated errors with payroll and accounts payable can be tracked back to an overall lack of understanding of general accounting concepts. This project aims to create a curriculum and avenue for continued, scheduled education for managers and others who may need an understating of our various accounting processes. | Lack of overall accounting knowledge is making it difficult to communicate concepts efficiently throughout the organization. This impacts the finance pillar by influencing the accuracy of financial transactions and budgets as well as the timeliness of employee reimbursements, among other things. |

| Team: |
| --- |
| Project Leader: Danielle Kapanke<br>Members: Accounting Team |

# Changes:

List the changes that have been made leading to improvements.

DO




| What? | Why? | When? |
|---|---|---|
| Poll/ask managers what they might find helpful. What tools they might need. | Determine what people already know and what other things might be useful. | Before January |
| Brainstorm with Accounting team to see what repeat errors are presenting. | Define specific problems and what tools might minimize those errors. | Before January |
| | | |
| | | |

# Measures:

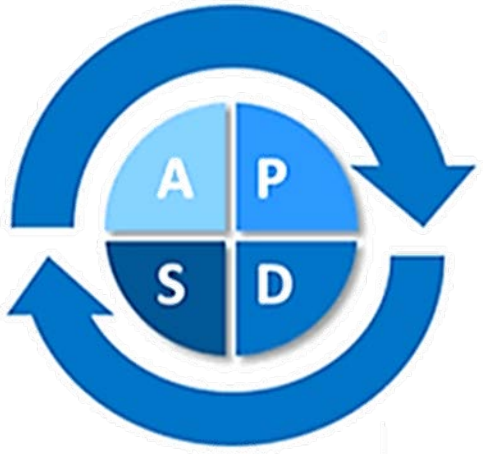
# Findings:


| **Results:** Did you accomplish your goals? |
| --- |
| No – Just starting project. |

| **Lessons Learned:** What did you learn as a result of this project? Unexpected discoveries? Problems or barriers? |
| --- |
| Started brainstorming ideas of things to communicate with managers |

| **Next Steps:** What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?) |
| --- |
| Start to explore and document what folks know and what needs are. |

| **Project Leader is Recommending the Following:** |
| --- |
| QM Council approval for completion of project?: NO<br>Project still in progress, project to continue: YES |




# Admin Support Departments

## New Intranet

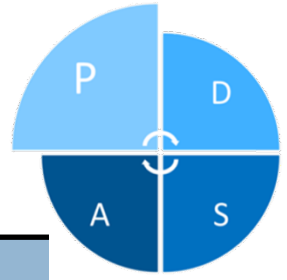
STOUGHTON HEALTH

1st Presentation Date: 9/27/22

Document Last Presented: 11/28/23

# Quality Story: New Intranet

PLAN




## Goal(s): What are you trying to accomplish?

KOM Target #1: Step 5 of 9 - Beta release of new intranet to Board of Directors.
KOM Target #2: Addition of Step 8, events board.
KOM Target #3: Step 9 of 9 - Full release of new intranet to all employees. Setback discovered in recent work requiring a redesign of the basic platform.

Current KOM Status Target #1: 100% completed to reach completion of Step 5
Current KOM Status Target #2: 100% completed to reach completion of Step 5, plus step 8
Current KOM Status Target #3: 100% completion requires last step to connect old Intranet content to new Office 365 cloud services for project to completion. Training provided 11/9/23 at leadership day.

## Background: Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.)

Current intranet platform resold as a baseline tool serviced by SSMHC. Plus, little customization available.

## Driver: Explain why the project is critical to SH. Why does it relate to the strategic plan?

Percentage of current content not relevant to SH employees as it relates more to SSMHC.

## Team:

**Project Leader:** Chris Schmitz
**Members:** Jessica Bauer, Sonja Goldbeck, Mary Hermes, Melissa Kitelinger, Laura Mays, Angie Polster, Linda Schaefer, Tonya Stenback, Jen White.

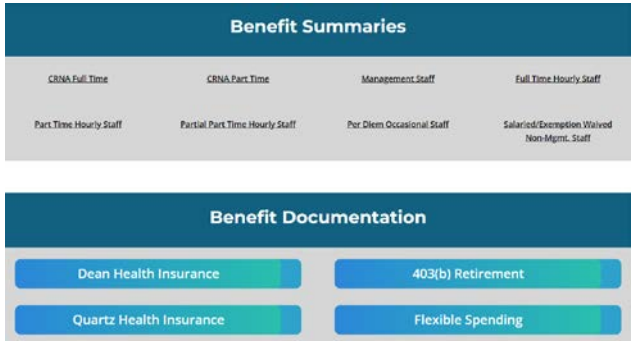
# Changes:

List the changes that have been made leading to improvements.

DO

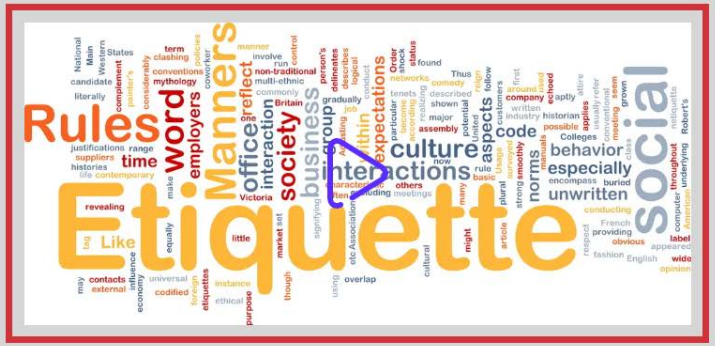
| What? | Why? | When? |
|---|---|---|
| Benefit Fair info added | Provides a portal for legal compliance and centralized communication to employees. | Added early November |
| Etiquette video added | Sets standards for employee expectations with video calls | Added November 9th |




## Etiquette

Click media to the right to view "Etiquette", a video production brought to you by the Communications and Standards Teams!



# Measures:

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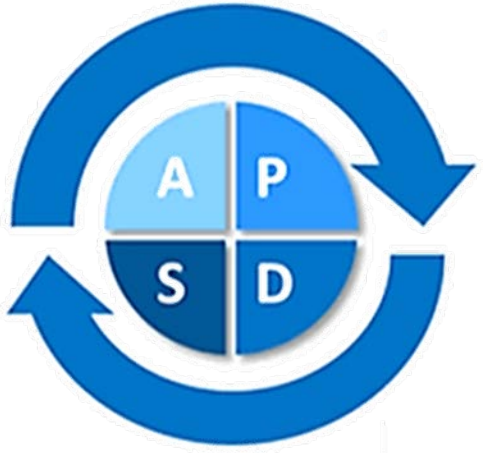
| Lead | Need | Status |
|---|---|---|
| Chris | Project completion | Step 9 Key Milestone! |
| Marketing | Events | Step 8 |
| Jessica | PnP's* | Pending O 365 |
| HR | Handbook, PnP's* | Pending O 365 |
| Angie | Rollout to BOD | Step 5 Key Milestone! |
| Mary | ET | Step 4 |
| Angie | Board Portal | Step 3 |
| Rebecca | Added Design support | Step 2 |
| Chris | Oversight of Project and formatted design | Step 1 |


*Pending connection to Office 365

# Findings:


| **Results:** Did you accomplish your goals? |
| --- |
| Phase 1 was delivered to Board on 1/19. Completed Phase 2, employee use, rolled out in February. Phase 3 includes attaching remaining content from old intranet to new O365 file. |
| **Lessons Learned:** What did you learn as a result of this project? Unexpected discoveries? Problems or barriers? |
| Conversion to O365 share drive pending. |
| **Next Steps:** What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?) |
| Migrate all remaining content to new website, then sunset old intranet service. Once completed, set goals to measure and increase traffic to new intranet website. |
| **Project Leader is Recommending the Following:** |
| QM Council approval for completion of project?: NO<br>Project still in progress, project to continue: Enter YES, ideally just one more cycle. |




# Human Resources

## Performance Reviews

STOUGHTON HEALTH

November 28th, 2023:

November 28th, 2023:

# Quality Story: Performance Reviews

PLAN

| Goal(s): What are you trying to accomplish? |
| --- |
| KOM Target: 100% of Annual Performance Evaluations completed using UKG platform.<br>Current KOM Status: No electronic tool currently |

| Background: Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.) | Driver: Explain why the project is critical to SH. Why does it relate to the strategic plan? |
| --- | --- |
| Stoughton Health has made great progress hardwiring department goals to strategic quality management initiatives. Missing is how employee goal setting drives the hospital strategic plan. | Linking employee performance to department initiatives fueling the mastery of strategic goals |

| Team: |
| --- |
| Project Leader: Chris Schmitz<br>Members: Tonya Stenback, Melissa Kitelinger and Jenifer Kenrick |

# Changes:

List the changes that have been made leading to improvements.

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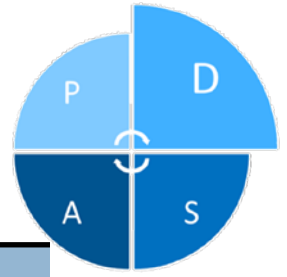


| What? | Why? | When? |
|---|---|---|
| 90-day Evaluation Built | Test business process created and tested | October 2023 |
| Annual Evaluation Built | Test business process created | October 2023 |
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# Measures:


CRITERIA
ANALYSIS
PERFORMANCE
APPROACH
100 %
EVALUATION
IMPROVEMENT
RESULTS
FEEDBACK
ASSESSMENT

# Findings:


| **Results:** Did you accomplish your goals? |
| --- |
| Test business processes unveiled a need for attestation functionality. |

| **Lessons Learned:** What did you learn as a result of this project? Unexpected discoveries? Problems or barriers? |
| --- |
| Test business processes unveiled a need for attestation functionality.<br><br>Suggestion of best practice offered by Amy Hermes. Attempting to bridge this concept with existing compliance needs. |

| **Next Steps:** What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?) |
| --- |
| There is a need to build, then test attestation functionality. |

| **Project Leader is Recommending the Following:** |
| --- |
| QM Council approval for completion of project?: NO<br>Project still in progress, project to continue: YES |


# PDSA

A tool used to document and communicate
Performance Improvement Projects

**1st Presentation Date: July 26, 2022**
**Document Last Presented: September 26, 2023**

# Quality Story: (Project Title)

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## Goal(s): What are you trying to accomplish?

**KOM Target: 50 Google reviews for Aaron Schwaab, M.D. by March 2024.**
**Current KOM Status: 1 Google review**

## Background:

Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.)
Stoughton Health and Dr. Aaron Schwaab receive very few Google reviews, we are looking to put a system in place to generate more positive reviews. (There is a system in place for the OrthoTeam and we are not looking to change it at this time.)

## Driver:

Explain why the project is critical to SH. How does it relate to the strategic plan?
Google reviews are used widely by consumers and an increase in positive reviews will help drive business.

## Team:

**Project Leader:** **Laura Mays**
**Members:** **Linda Schaefer, Mary Hermes and Ghadeer Alafifi**

# Changes:

List the changes that have been made leading to improvements.

D

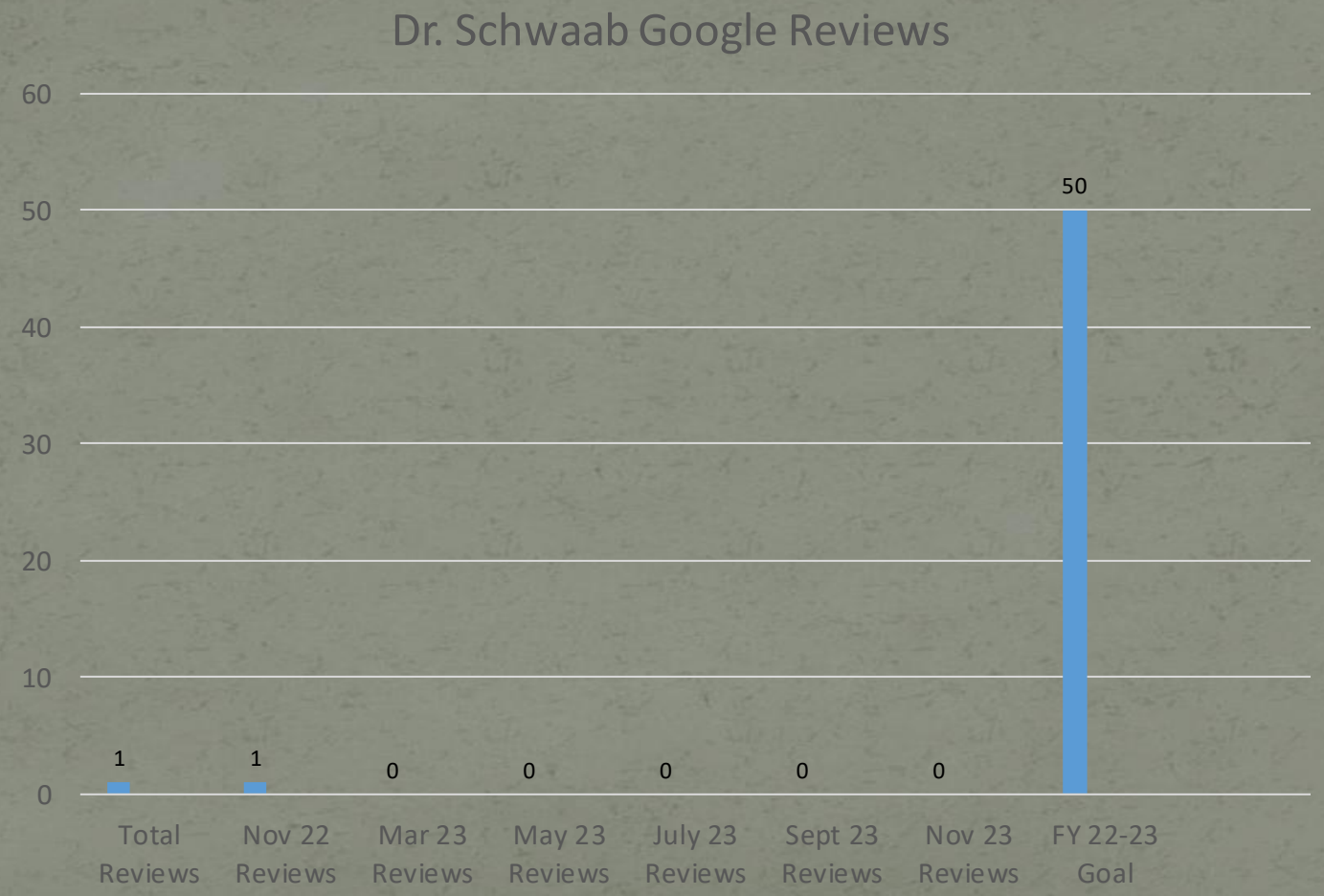
O

| What? | Why? | When? |
|---|---|---|
| Kick-off call | Explain implementation process | August 3, 2023 |
| Sent Location data | Press Ganey will use to populate dashboard | August 2023 |
| Sent Provider data | Press Ganey will use to populate dashboard | September 2023 |
| Data review calls | Review process and answer questions | August and September 2023 |
| Provided Ownership to Google business locations | Press Ganey needs to own to manage – first needed to get ownership from Amplified | September 2023 |
| Continued implementation process | Reputation and listings have to be online before the implementation of campaigns (Google reviews). | September and October 2023 |

# Measures:

Include graphs of your measurement, results of surveys, etc. Include benchmarks or comparative data when available.

S T U D Y




# Findings:

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## Results:

Did you accomplish your goals?

In progress, goal not met.

## Lessons Learned: What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?

- There are many companies that provide this service and integration with the EHR is key to an automated process.
- In June we put in a project request to SSM to integrate our EPIC with rater8 and are still waiting for a response.
- After meeting with Yext, the Yext rep contacted SSM and at this time we are not able to leverage their contract and would need to build our own interface. Working with the Yext vendor, Redox would cost $20,000.
- As a Community Connect Partner we are not allowed any more EPIC interfaces. The reporting team is about 9 months behind for any requests for reports which is what would have to happen and a flat file sent to the vendor. We will need to pursue another option.
- Press Ganey may be the vendor to meet our needs.

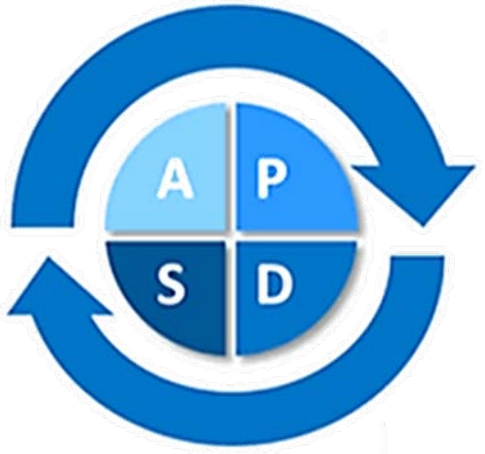
## Next Steps: What actions are you going to take based on your findings? (e.g. roll out to additional units, modify and make additional improvements; abandon the effort; change course)

- Continue to follow up with Nikki regarding SSM and our ability to integrate with EPIC.
- Ghadeer is checking to see if we have patient permission to send Google review requests.
- Ghadeer is looking at who will generate the reports and upload them to rater8 dashboard – Laura to connect with Ghadeer about the timeline and feasibility before a Clinic Coordinator is hired.
- Michelle Abey will continue the conversation with the affiliate director.
- Linda Schaefer will follow up on the request for a formal quote, review and make a recommendation.
- Linda Schaefer meeting with Press Ganey to learn more about bundled services.
- Press Ganey to schedule kick-off call.
- Review dashboard at next call on September 20th.
- Finalize implementation of listings and begin campaigns.

**Project leader is recommending the following: Continue Project**

**CI Council approval for completion of project: No**

**Project still in progress, project will continue: Yes**




# Public Relations/Marketing

## Community Benefit Reporting

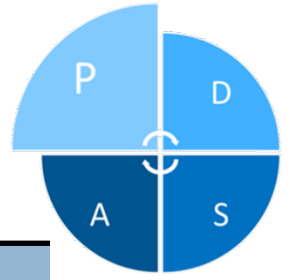
STOUGHTON HEALTH

1st Presentation Date: September 21, 2023

Document Last Presented: September 21, 2023

# Quality Story: Community Benefit Reporting

PLAN




| **Goal(s):** What are you trying to accomplish? |
|---|
| KOM Target:<br>1) 50% increase of managers (25) and staff will submit community benefit hours via the intranet during FY24 (17 managers/staff submitted in FY23)<br>2) 80% of FY24 community benefit submissions will be within 30 days of the event<br>3) 100% of the Administration will submit all FY24 community benefit hours by November 1, 2024.<br><br>Current KOM Status:<br>1) 8 managers/staff have submitted to date for FY24 2)75% submitted within 30 days of event 3) In progress |

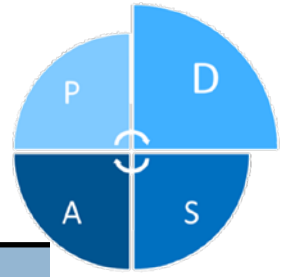
| **Background**: Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.) | **Driver**: Explain why the project is critical to SH. Why does it relate to the strategic plan? |
|---|---|
| Enter background here.<br>It has been challenging to have up-to-date reporting of Stoughton Health community benefit status as submissions may be late and/or data entry is delayed. When delayed, community benefit contributions may be missed or inaccurate. Also, at the end of the year, adds extra pressure and stress to get the annual report submitted on time. | The IRS requires accurate and timely reporting for Stoughton Health to maintain tax exempt status.<br>Internally, Stoughton Health public relations uses this information for community benefit stories, grant writing, annual report, and positive public relations for Stoughton Health's contributions to the community. |

| **Team:** |
|---|
| Project Leader: Kelly Perna<br>Members: Laura Mays, Autumn Kumlien & Kate Stanard |

# Changes:

List the changes that have been made leading to improvements.

DO




| What? | Why? | When? |
|---|---|---|
| PR Director and Community Education Coordinator will meet to review sponsorships, events, budget. | Still fresh within peoples minds for numbers served, time spent, etc...if done within 30 days of event. | Once a month<br>Nov 1 and November 13, 2023 |
| After committee review of sponsorship forms, email reminder to those that may not have submitted event with a link to submission page | Improved accuracy | Once a month<br>Oct 16: Contacted a social worker on to submit participation in a prior senior event. |
| Community Education Coordinator will have inputted all received submissions timely. | Increase accuracy of community benefit | Once a month<br>Nov 10: Set aside 3 hours for strictly data entry |
| Educate one department a month on SH community benefit forms, what qualifies, what to enter and how | Clarity for staff will ensure all allowable community benefits are submitted. | Begin by Nov. 1, 2023<br>Meeting with PR Department newer staff by November 30<br>Meeting with Forum in March or April. |

# Measures:

Include graphs of your measurement, results of surveys, etc. Include benchmarks or comparative data when available.

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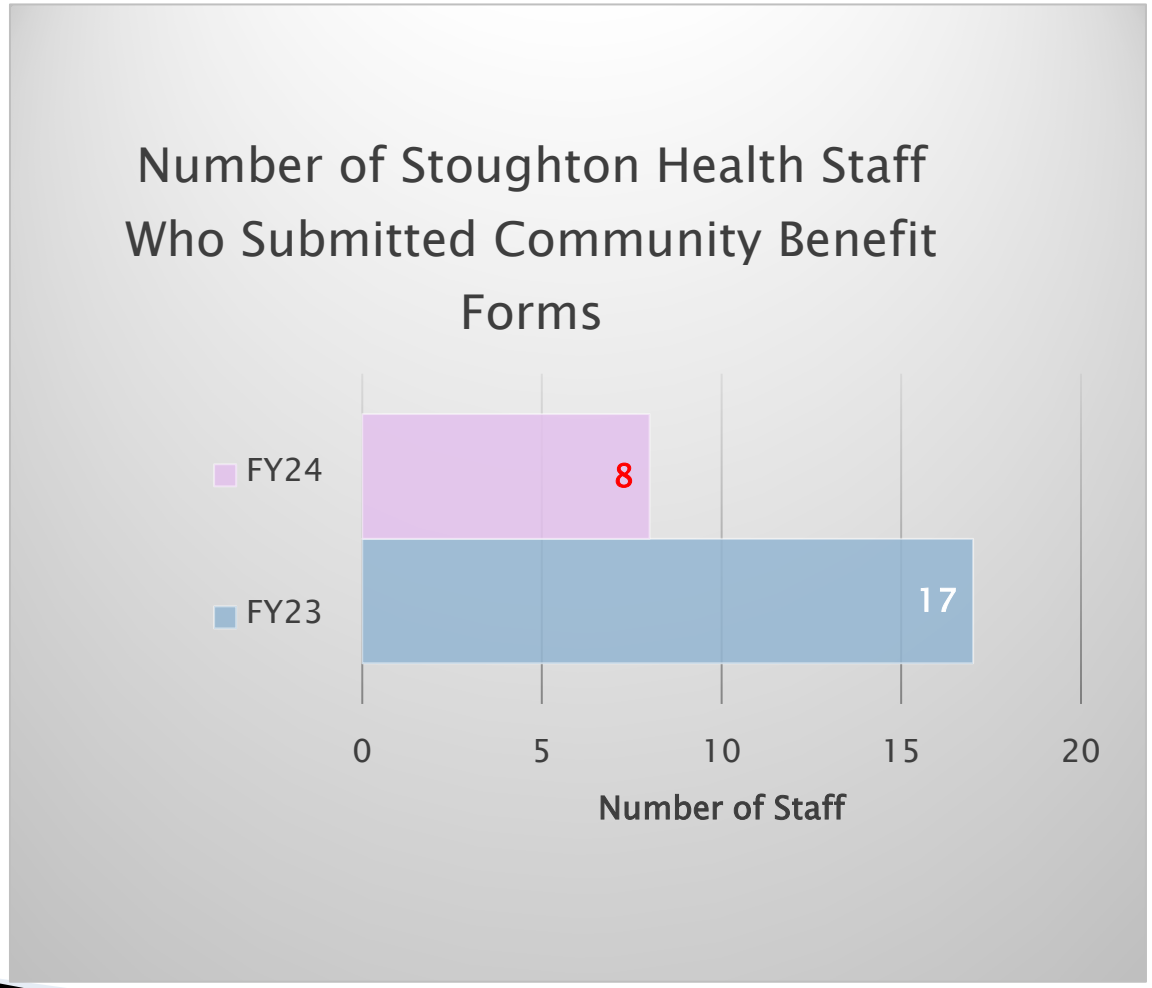
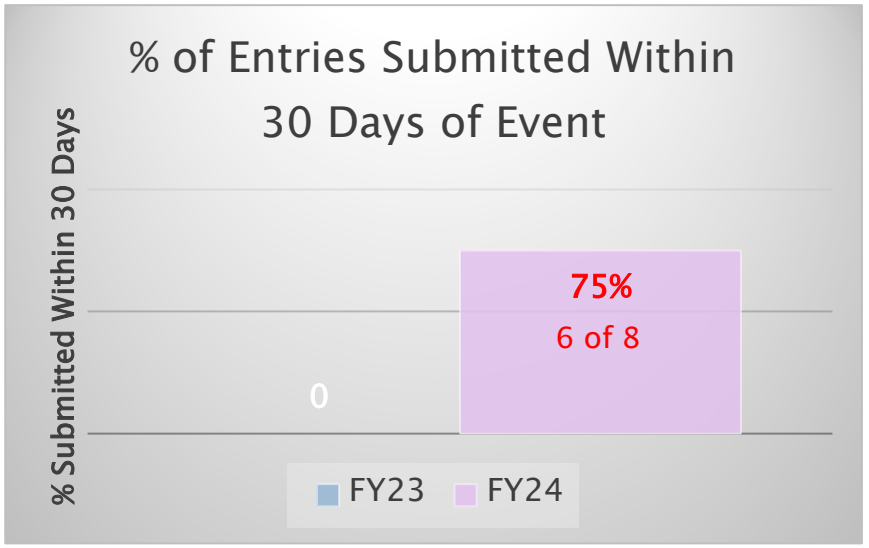
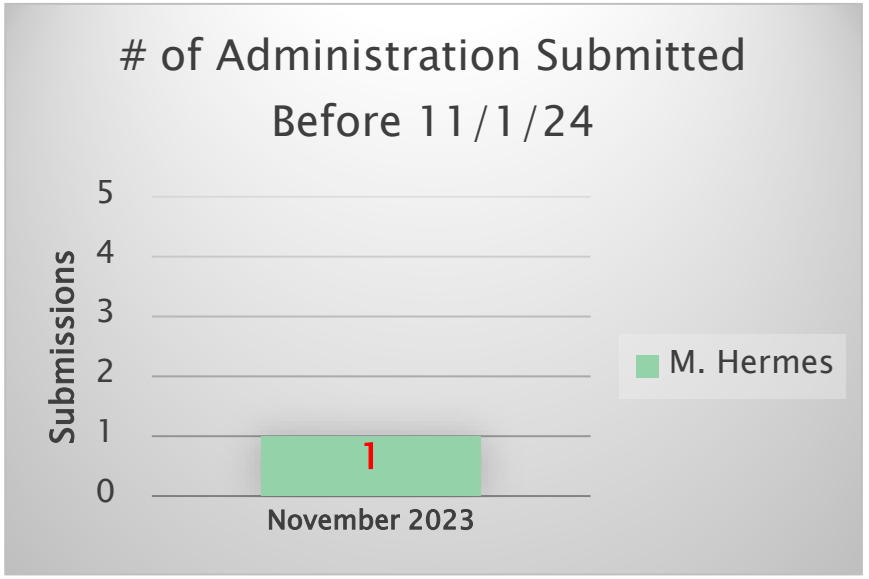
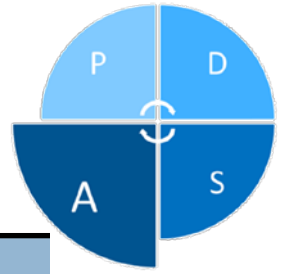


# Findings:

ACT




**Results:** Did you accomplish your goals?

**Lessons Learned:** What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?

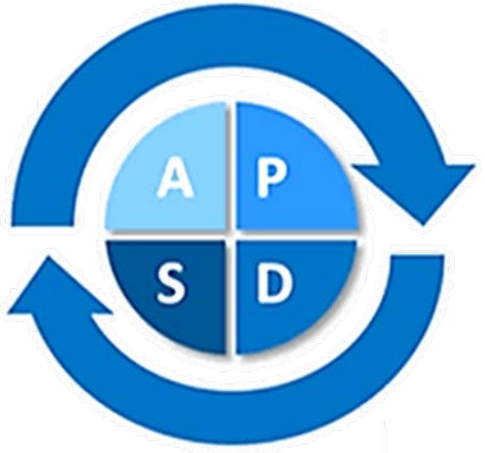
Barrier to inputting all received submissions for the current month is having the backlog of FY23.

**Next Steps:** What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?)

Moving forward will keep up with FY24 each month and catch up on FY23 as time allows.

**Project Leader is Recommending the Following:**

QM Council approval for completion of project?: NO
Project still in progress, project to continue: YES




# Hospital Leadership

## Purchasing Workflow Process

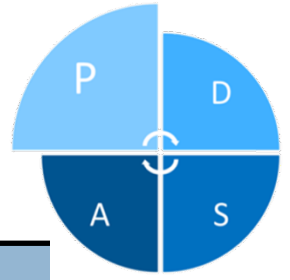
STOUGHTON HEALTH

1st Presentation Date: November 28, 2023

Document Last Presented:

# Quality Story: Purchasing Workflow Process

PLAN




| **Goal(s):** What are you trying to accomplish? |
|---|
| KOM Target:<br>1. Development of a workflow process and policy for purchasing new equipment by February 2024.<br>2. Role out to all SH Leaders by March 2024<br>Current KOM Status: New project, kick off meeting was held 10/01/2023 with project team. |

| **Background:** Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.) | **Driver:** Explain why the project is critical to SH. Why does it relate to the strategic plan? |
|---|---|
| Clinical leaders have expressed concerns with the current purchase of new equipment. There have been situations when new equipment has not been inspected by Bio Med, Plant Ops or both prior to being put into use for patients. There are also concerns regarding knowing when items are end of life so they can be planned for accordingly. The current process does not seem to identify this proactive causing equipment purchases ending up using unbudgeted dollars. Additionally, CNO has questioned if clinical leaders should be the ones negotiating with vendors for pricing and contracts. | Key drivers for this project are patient safety and financial. A streamlined process will ensure that equipment is planned and budgeted for accordingly, best contract/pricing will be secured, and patient safety will be assured by prompt inspections from Bio Med and/or Plant Ops. |

| **Team:** |
|---|
| Project Leader: Amy Hermes<br>Members: Brian Swain, Roberta Sarow, Tina Strandlie, Heather Kleinbrook, Sandra Bryan-Armstrong, Jason Schoville, Bio Med Rep, and Tim Purin |

# Changes:

List the changes that have been made leading to improvements.

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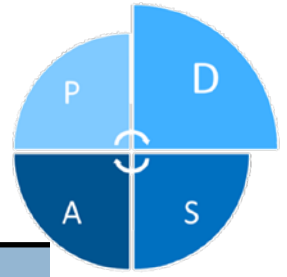


| What? | Why? | When? |
|---|---|---|
| First Meeting held 10/1 with project team | Brainstorming meeting to identify current workflow and next steps. | |
| Bio Med indicated workflow is in place at Prairie Ridge HealthCare | | CNO reached out to counterpart for current workflow and policy |
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# Measures:

Include graphs of your measurement, results of surveys, etc. Include benchmarks or comparative data when available.

STUDY

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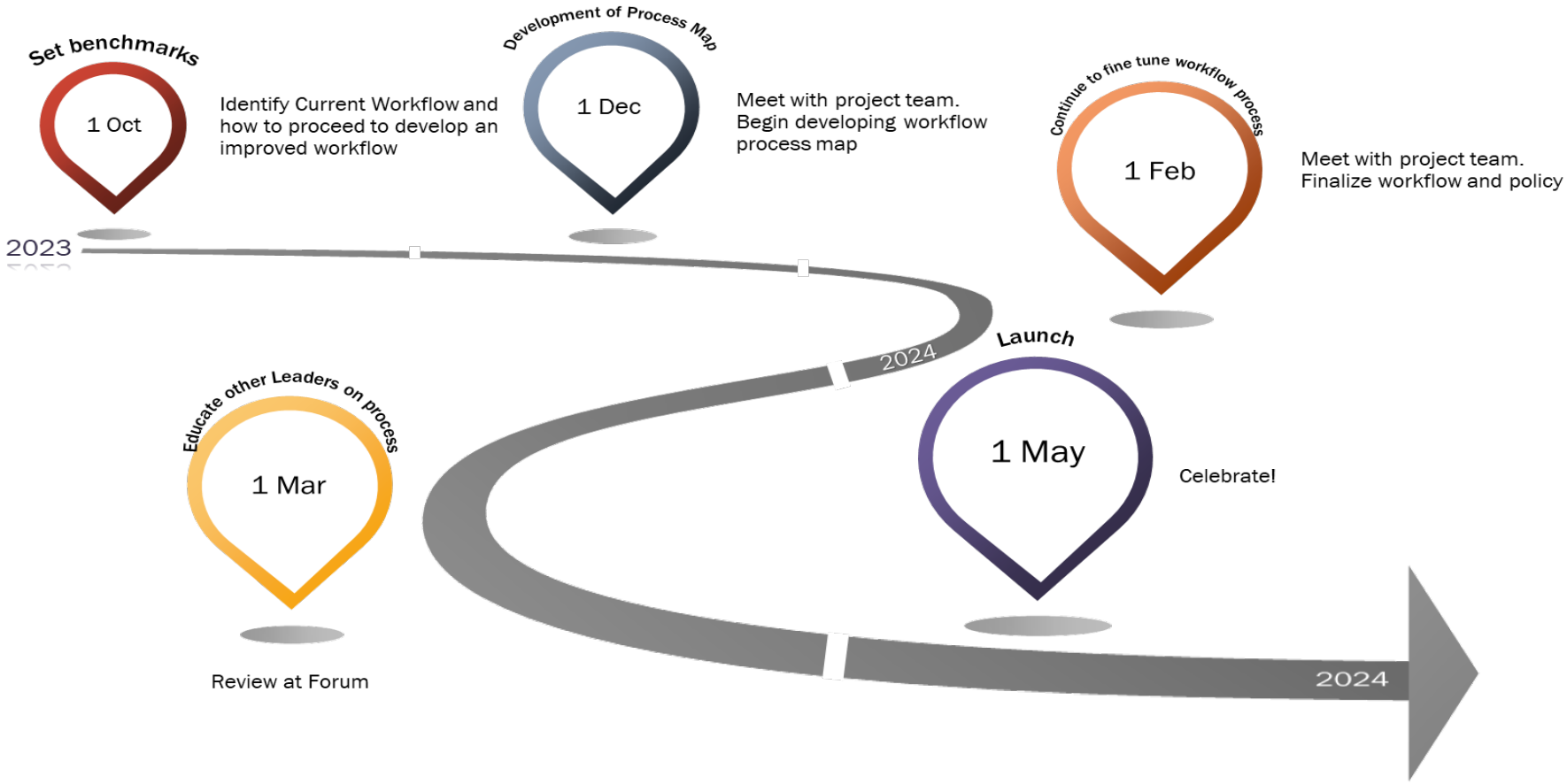
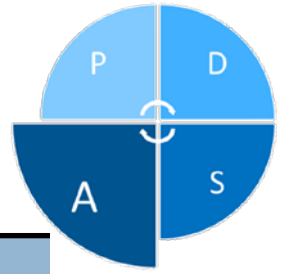


# Findings:

ACT




| **Results:** Did you accomplish your goals? |
| --- |
| No, we do have a policy in place but project team identified needs for improve and the need for a visual process map. |
| **Lessons Learned:** What did you learn as a result of this project? Unexpected discoveries? Problems or barriers? |
| There are a variety of missteps related to communication that can happen when working on ordering new equipment. Clinical leaders are not always comfortable negotiating contracts/prices, would like to know when PMs on their units are done what equipment is coming to end of service life/end of life so to plan accordingly. |
| **Next Steps:** What actions are you going to take based on your findings? (e.g. roll out to additional units; modify and make additional improvements; abandon the effort; change course?) |
| Create process map to identify areas were break down can happen and then begin to build workflow into policy. |

| **Project Leader is Recommending the Following:** |
| --- |
| QM Council approval for completion of project?: NO<br>Project still in progress, project to continue: YES |