Inpatient Admission Workflow

Promoting a seamless admission process by enhancing nursing communication

1st Presentation Date: 06/28/2022, 08/23/2022, 1025/2022, 12/27/23, 02/28/2023, 04/25/2023, 06/27/2023, 08/22/2023, 10//24/23

Document Last Presented: 12/18/2023

Quality Story: (Inpatient Admission Workflow)

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

KOM Target: Implementation of a seamless workflow in which patients are safely and efficiently admitted to the Inpatient Department. This will be monitored by documentation of handoff communication between nurses at the patient bedside in the admission note. Goal = 95% face to face bedside handoff between nursing staff at the patient bedside.

Current KOM Status: October = 89%, November = 96%. Goal met in November.

Background:

The process of admitting patients to the Medical/Surgical floor has historically been challenging, whether the patient is a direct admit, coming from the ED, or coming from the OR. Communication is paramount as there are many moving parts to the admission process. Over the years, different algorithms and communication tools have been developed, but nothing has been sustained. Therefore a CI project has been developed to address this issue.

Driver:

This project is driven by Stoughton Health's focus on Quality Care and Patient Satisfaction, as well as Employee Satisfaction. This topic was mentioned several times in the recent hospital Safety Survey.

Team:

Project Leader: Heather Kleinbrook

Members: MS: Kelsey Jenny, Naomi Franklin, Beth King, Marissa Julseth, Jennifer Wagner, Ericka Adams, Jane Furgason

ED: Rachel Borchardt

OR: Sarah Corbett

Changes:

List the changes that have been made leading to improvements.

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What?	Why?	When?
Educate staff of workflow, including traveling staff and new employees. Getting in front of travelers to share project and expectations upon orientation to the floor	Ensure all staff in all departments are on the same page regarding admission workflow/process.	12/2022 and ongoing
Email to all nursing staff on MS, ICU, ED, and OR to share project and admissions to inpatient departments.	Educate all staff of expectations, purpose/why, and goal of project.	December 2022 and ongoing
Present project at All Nurse Meeting	Need staff buy-in and participation in project.	January 10, 2023
Develop admit note template and share with inpatient staff – encourage use	Consistent documentation for all staff, in the same place, addressing same needs	January,2023 and ongoing
Audit charts for compliance and share results with nursing team	Encourage staff buy in and ownership of project's success	January 2023 and ongoing
Manager providing individual feedback and addressing in annual evaluations as growth opportunity	Education, encourage buy-in, compliance with project	January 2023 and ongoing

Measures:

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

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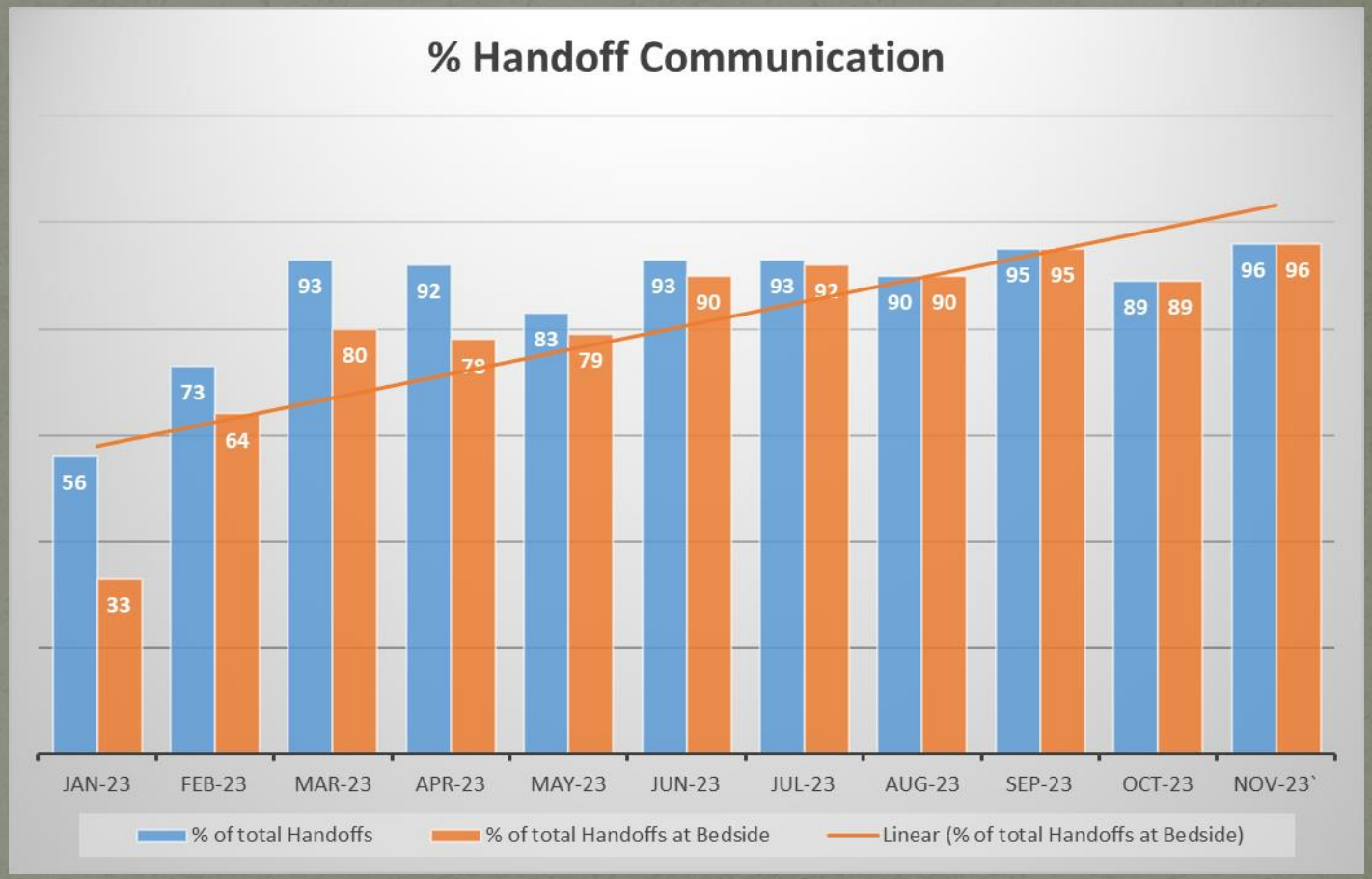

P Plan D Do A Act S Study

Findings:

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Results:

Did you accomplish your goals? Goal met for November

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

Epic creates a divide in which staff enter information in different spots in the EHR based on what is available to them – example: ED nurses view is different than IP nurses view and access to flowsheets vary between departments. Thus, need to document bedside handoff in a progress note. This note can also be used to share information needed for other projects.

Project has affected other QM Projects (Isolation, Wound) due to nature of items discussed during hand-off.

Project has improved communication and relationships between nursing departments and individual staff members.

Project will hopefully affect positive patient satisfaction as patients/families are involved in the hand-off process.

Getting in front of traveling nurses and addressing quality management projects during orientation has proven helpful to their understanding and compliance.

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 audit and promote all nurses to develop workflow addressing handoff communication at bedside.

Individual education. Growth opportunity for nursing staff during evaluations.

Project leader is recommending the following:

CI Council approval for completion of project: Yes – have made significant improvements and shown sustainability over past several months among regular staff.

Project still in progress, project will continue: No

Isolation

"Suspect It, Isolate It"

-Bill Wilson, 2/23/22 at 1135

1st Presentation Date: 04/26/2022, 06/28/2022, 08/23/2022, 10/25/2022, 12/27/2022, 02/28/2023, 04/25/2023, 06/27/2023, 08/22/2023, 10/24/2023

Document Last Presented: 12/18/2023

Quality Story: Isolation

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Goal(s): Ensure the safety of all patients, visitors, and health care providers who may have direct or indirect contact with patients requiring isolation precautions.

KOM Target: Correctly identify what microbes require implementation of isolation precautions, with precautions initiated within 60 minutes of identification, to ultimately reduce potential exposure to staff = 60% of the time. Zero SZP related to Isolation Precautions (missed banners, signage, timeliness of implementation) as identified by Infection Prevention.

Current KOM Status: 71% compliance in October and 53% compliance in November with implementing isolation precautions within 1 hour (current KOM target = 60%). Goal met in October, faltered in November. October = 0 and November = 1 SZP events entered regarding missing isolation precautions. Goal met in October, fell short of goal in November.

Background:

All visitors and staff rely on appropriate isolation signage on patient doors to protect themselves from potentially harmful microbes. Unfortunately, there has been an increase in SZP event reports regarding isolation precautions, specifically with isolation precautions not being ordered on appropriate patients or signage not being placed in a timely manner. This has a direct effect on the safety of all patients, hospital staff , and visitors to our organization.

Driver:

The mission of Stoughton Health is to provide safe, quality healthcare. This project addresses the safety of patients, visitors, and employees.

Team:

Project Leader: Heather Kleinbrook
Members: Alissa Knudson, Michelle Sondreal, Cori Heise, Jane Furgason, Shannon Montcalm, Christy Torpy, Carly Hanson
Ad Hoc Members (initial stakeholders): Bill Wilson, Jen White, Autumn Kumlien, Dan Arndt, Angie Rowin-Tippit, and Nikki Rowin

Changes:

List the changes that have been made leading to improvements.

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What?	Why?	When?
Introduction and continued discussion of project in Inpatient Staff meetings.	Promote staff buy-in and ownership of project and how to solve issues with interventions the group endorses.	12/12/23 and 12/24/23
Work on hand-off communication between ED and MS/ICU in addressing isolation needs. Expectation is to perform face to face report at bedside when admitting to the floor. Isolation status is to be part of this hand-off, as well as ensuring banners are entered in EPIC.	Identifying isolation needs prior to patients arriving to the floor will assist in placing appropriate signage prior to patients' arrival.	In Process as part of the Admission to Inpatient CI Project
Bill will continue to data collect and share findings with team and staff. In turn, shared with staff.	Allows for continued monitoring for improvement, or lack thereof, to guide project.	08//09/2022 and on-going
Emails sent to individual staff to complete employee follow-up to SZP event reports so that they can review why they missed isolation opportunity and review workflow.	Address event directly and allow staff time to self-reflect and review work process leading to event – learning opportunity – enhance communication/problem-solving with with manager to determine opportunity for improvement.	November 2022 and on-going.
Meeting with Bill Wilson	Review data and try to drill down on any trending causing recent slip in performance	June 13th, 2023
Getting in front of travelers to share project and expectations upon orientation to the floor	Promote understanding of quality projects and expectations of all staff in promoting safe, quality care	September,2023 and on-going.
Email communication to Isolation Team asking for suggestions on who to improve project.	Team approach and buy in. Bedside staff with best solutions.	12/05/2023

Measures:

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

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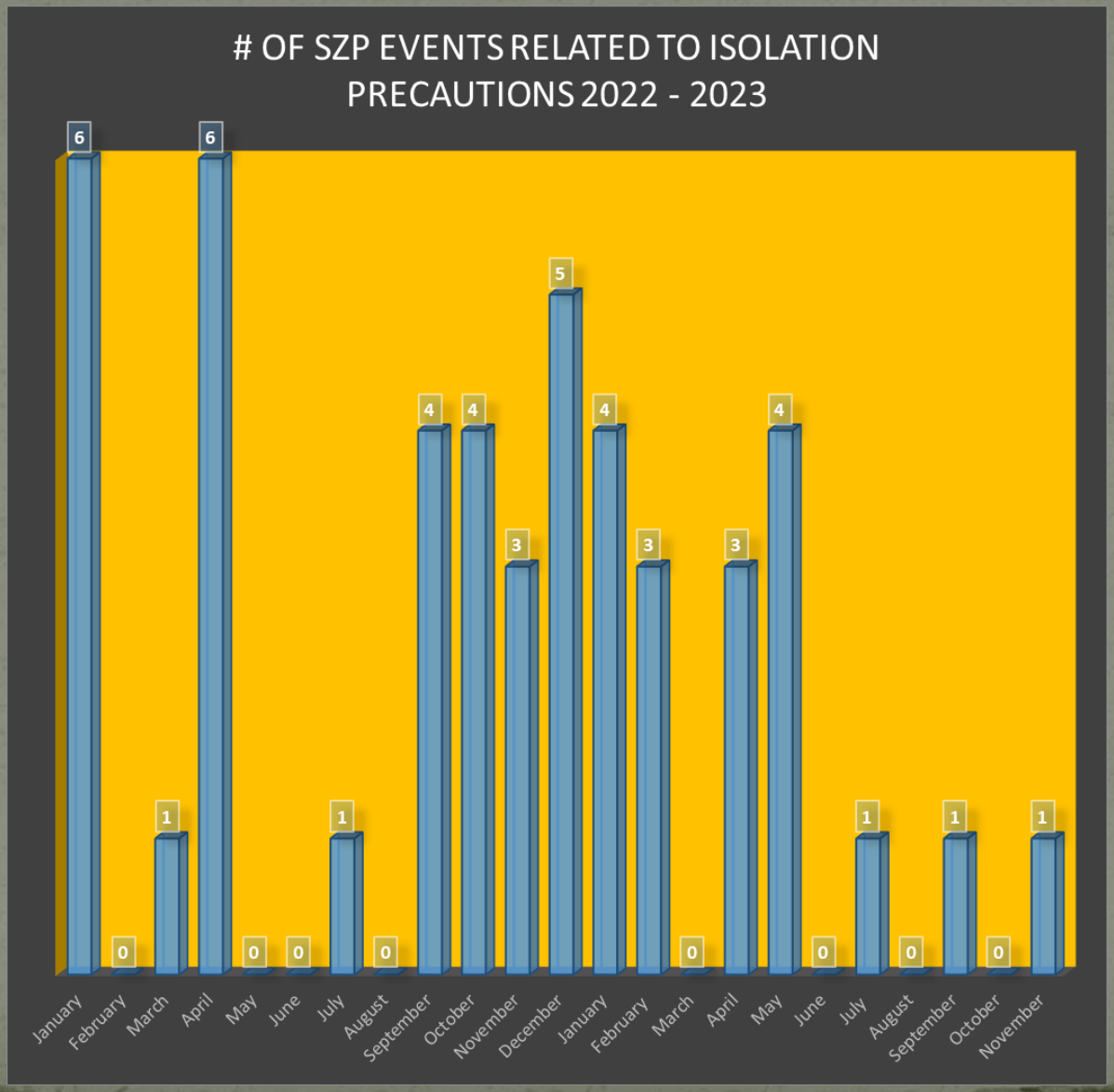

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Measures:

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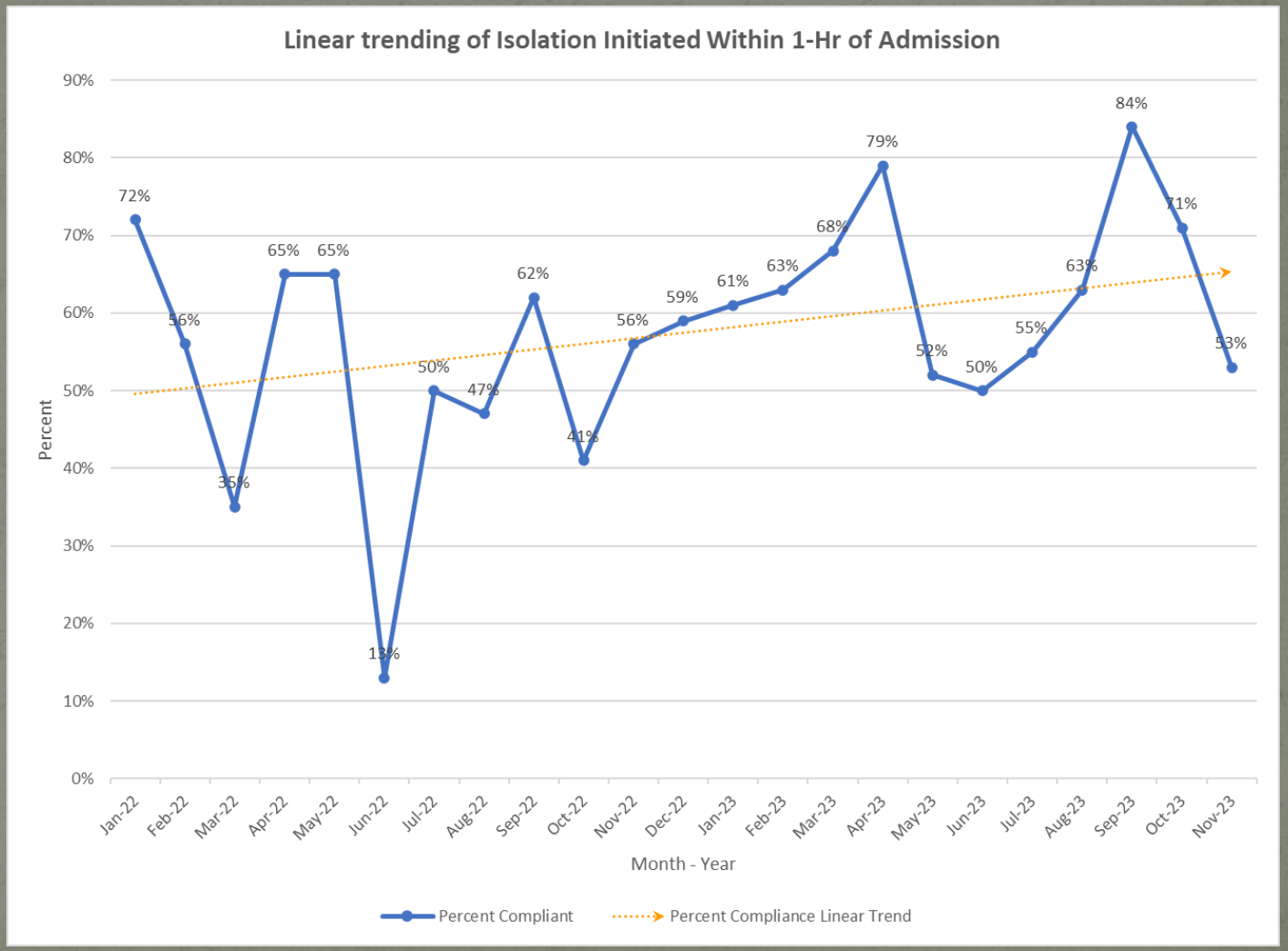

Findings:

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Results:

Did you accomplish your goals? Have shown improvement overall since project's implementation.

Lessons Learned:

Continue to encourage compliance with initiation of precautions from the ED. Address as part of handoff communication.

Staff are getting more aware and engaged in entering isolation precautions once patients are on the floor and once there is suspicion of an infectious process.

Predicting increase in respiratory cases as we head into the flu and respiratory season – anticipate increase in isolation cases.

Bill Wilson has been invaluable in rounding and addressing issues with staff in real time, which has created an increased focus on infection prevention among all 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)

Continue to support project thru the current respiratory season and maintain current interventions for sustainability.

Ask staff for additional ideas for project improvement.

Project leader is recommending the following:

CI Council approval for completion of project: No

Project still in progress, project will continue: Yes

Skin Injury and Wound Assessments

Part 2 of Wound Care and Pressure Ulcer Project

1st Presentation Date: 08/23/2022, 10/25/2022, 12/27/2022, 02/28/2023, 04/25/23, 06/27/23, 08/22/23, 10/24/2023
Document Last Presented: 12/18/2023

Quality Story: (Skin Injury and Wound Assessment)

P L A N

Goal(s): What are you trying to accomplish

KOM Target: Care Plans addressing wound/skin issues will be completed 90% of the time upon admission. This includes addressing wounds, potential for skin breakdown based on Braden Scale assessments equal or less than 18, cellulitis, and surgical incisions.

Current KOM Status: October = 66% and November = 70%.

Background:

This is Part 2 of our Skin Injury and Wound Project.

The Wound Warriors remain committed to timely wound assessments, implementation of appropriate interventions, prevention of wounds, and effective wound treatment.

This phase of the project is needed as it was noted that care plans were not consistently being developed addressing skin/wound issues. We became good at doing assessments, but not carrying that information forward to ensure appropriate follow-up. Going forward, this project will address appropriate care planning and realistic intervention implementation to ensure that patients are receiving individualized care for their skin/wound needs.

Driver:

This project is driven by the Quality and Safety Pillar and is in line with enhanced patient satisfaction and quality outcomes.

Team:

Project Leader: Heather Kleinbrook

Wound Warriors: Anne Kolasch, Alissa Knudson, Marisa Ludlum, Jess Duckwitz, Claire Jones, Danielle Ebert, Shelby Hollis, Deb Tofte, Qazee Yang

Changes:

List the changes that have been made leading to improvements.

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What?	Why?	When?
Real time chart auditing care plans addressing skin/wound deficits, cellulitis, surgical incisions, high risk for skin breakdown	Manager to capture data in real time to address needs and educate staff in the moment to promote compliance Emails being sent to staff who fail to meet goals, as well as to those who are high performing to provide positive feedback and encourage consistency	April 1st - ongoing
Monthly data collection and sharing	Hard data to show need for project, improvement or lack there of	April 1st - ongoing
Manager sending emails to staff when succeeding in creating care plans and when needing reminders	Positive feedback and real-time feedback when falling short	June and ongoing
Providing education to new staff and travelers as part of orientation	Continue to reinforce importance of care planning with new staff to build good habits	June and ongoing
Review of project in staff meetings	Maintain focus on project goals, answer questions, problem-solve	December 12th and 14th, 2023
Wound Warrior, Anne Kolasch, to present education at Annual Competency Days	Educate staff on wound care and how to address needs	October and November 2023
Development of a shift-to-shift handoff tool	Focus on QM projects between nursing staff to ensure completion of required items	October 23rd, 2023

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Creating Excellence Together

Measures:

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

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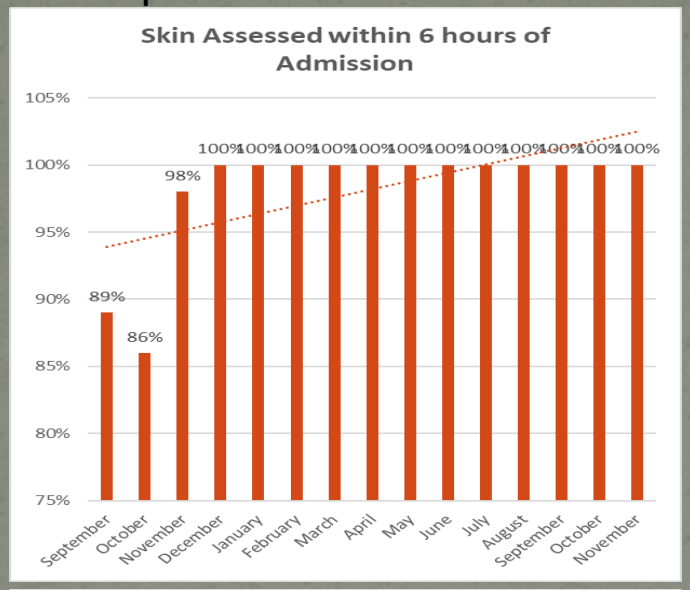

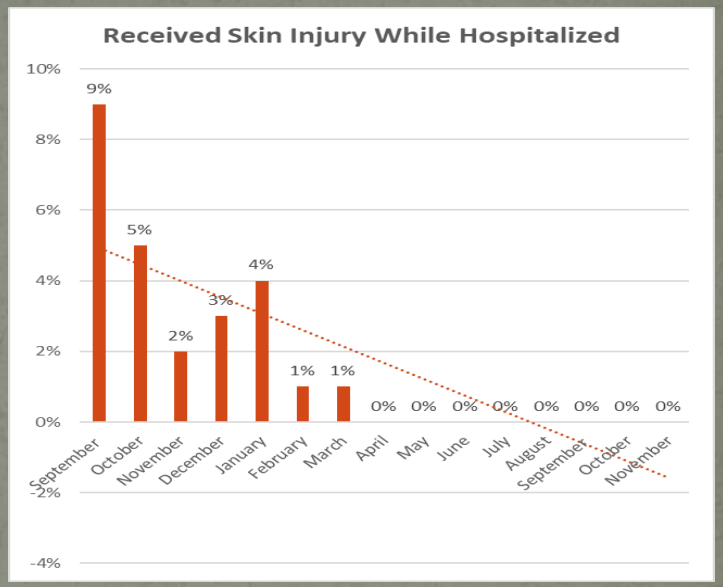

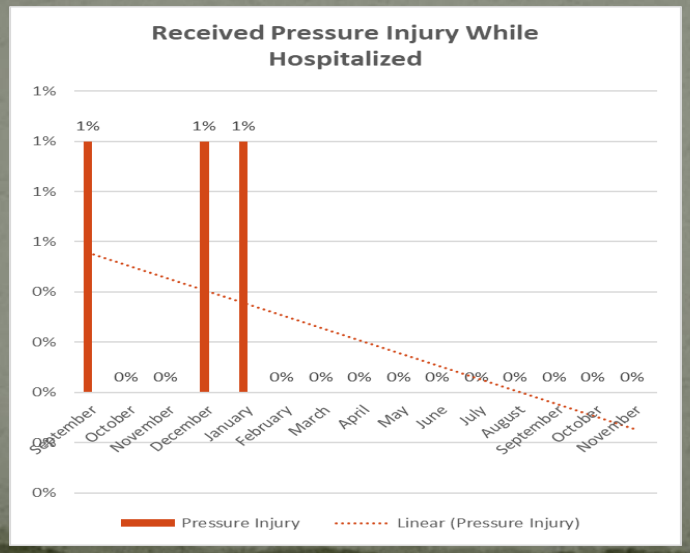

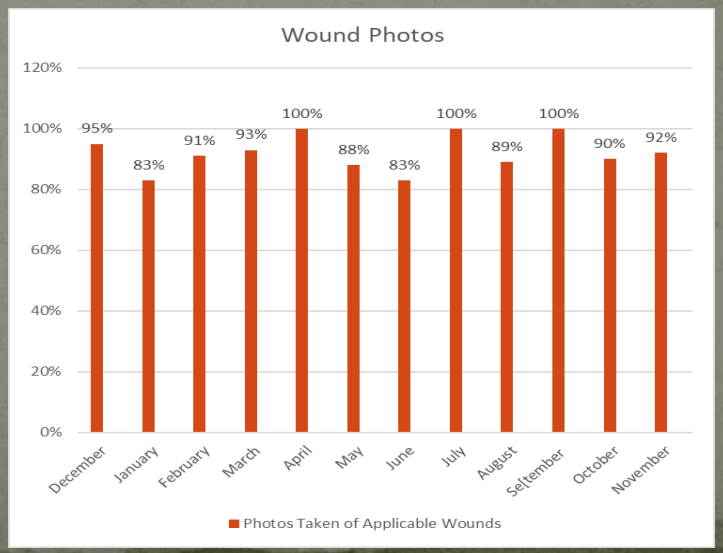

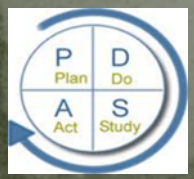

Measures:

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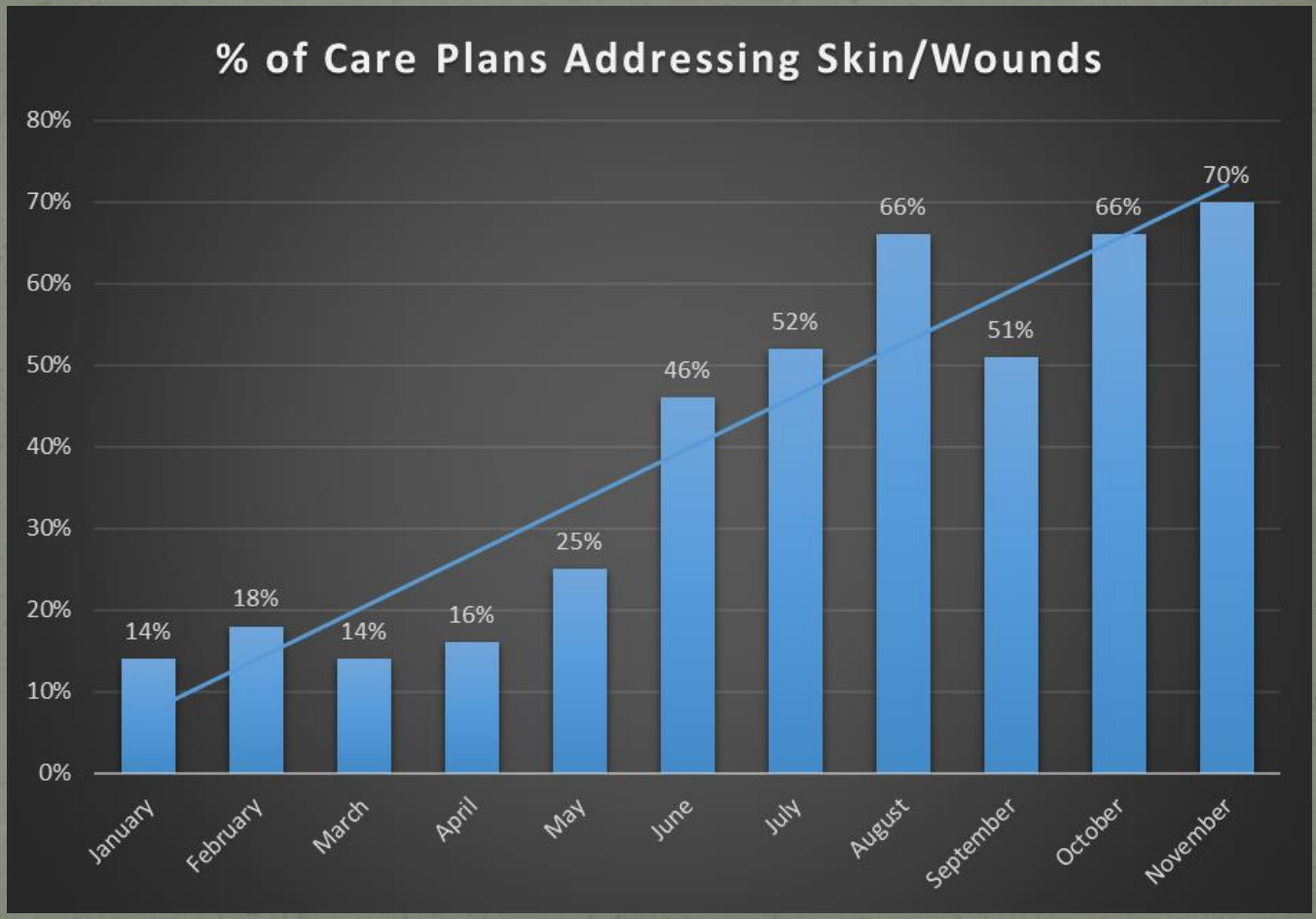

Findings:

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Results:

Did you accomplish your goals? **In progress – significant improvement noted since implementation of project.**

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

Utilizing shift-to-shift handoff tool has been helpful as a reminder to staff of QM project data to be completed, including care plans.

Care planning in general has shown improvement, not just on this project, but on other care plans as well.

Is 90% too lofty of a goal?

Overall project has been instrumental in focusing staff attention on wound and skin injury. Have not had a patient with a skin injury since April 2023. No patient has received a pressure injury since January 2023. Skin assessments taking priority and consistently being completed within 6 hours of admission. Proper documentation of skin issues, including use of photos is now commonplace.

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)

Beginning April 1st, all charts will be reviewed for care planning upon admission

Data will be reviewed on a monthly basis.

Educate staff on new work process and expectations

Share project results with individuals and nursing team

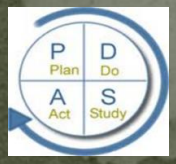
Educate and support those needing help implementing new workflow and provide positive feedback to those doing a great job

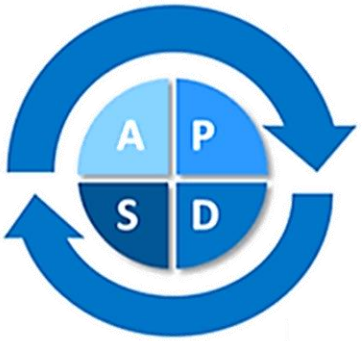
Share project in the daily dose in the future

Project leader is recommending the following:

CI Council approval for completion of project:

Project still in progress, project will continue:





Medical-Surgical Department

Increase in Swing Bed Admissions

STOUGHTON HEALTH

Document Last Presented: 12/18/2023

Quality Story:

Swing Bed

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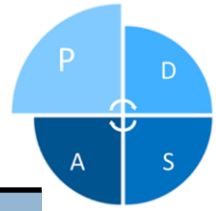


Goal(s): What are you trying to accomplish?

KOM Target: Increase Swing Bed patient admissions to >41 this year (Jan – Dec 2023) to match pre-COVID numbers
Current KOM: YTD = 23 SWB admissions, Need to admit 18 SWB admissions before the end of the year to meet pre-pandemic numbers.

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

During COVID, Swing Bed admissions declined due to the need to maintain open beds for acute care patients. Now that we are moving to our new post-COVID norm, it feels like we are in a place to open more beds to transitional care patients.

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

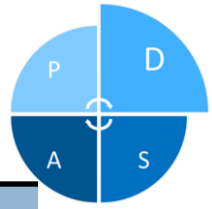
Supports several areas of the strategic plan. Most obvious, it supports the bottom line financially, but it also keeps beds filled which guarantees staff hours and boosts staff satisfaction. It also enhances relationships with other hospitals by taking their patients to open beds for more acute needs which makes us good partners.

Team:

Project Leaders: Heather Kleinbrook
Members: Case Managers, Social Workers, Inpatient Rehab Staff, Nurses, and Hospitalists

Changes:

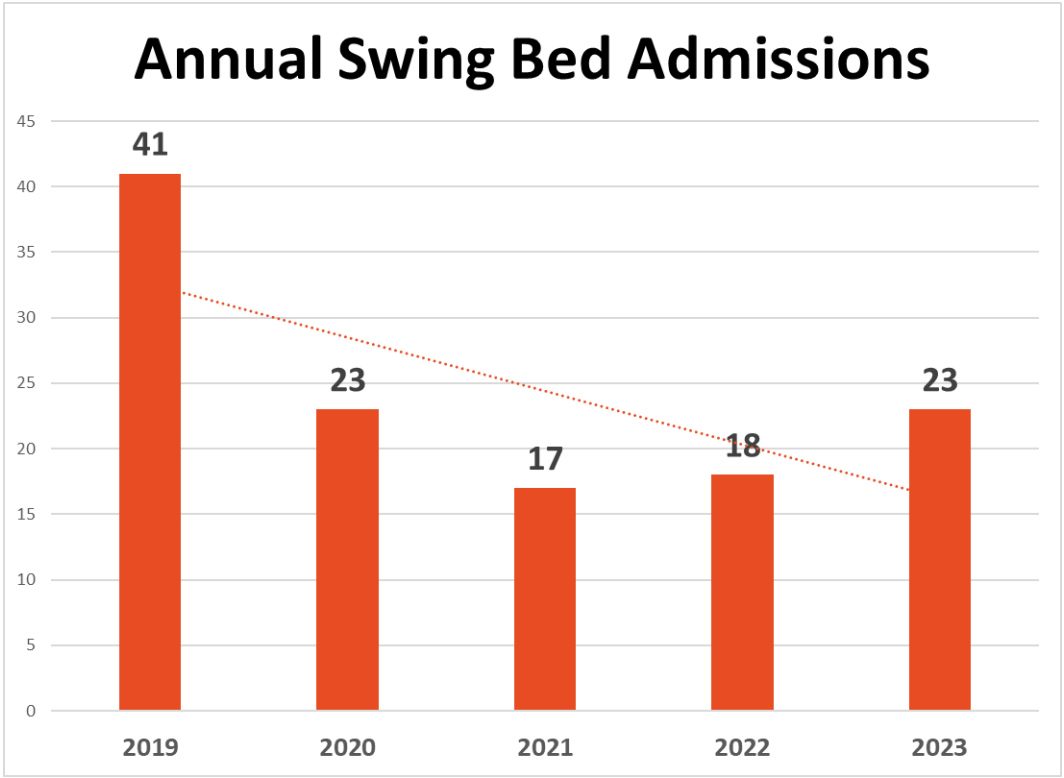
List the changes that have been made leading to improvements.



What?	Why?	When?
Manger meeting with Amy Hermes	Discuss project and goals.	April 2023
Meeting with stakeholders and follow-up discussion in daily huddle	Share goals and expectations with stakeholders – develop standard referral process – discuss data collection	04/26/2023
Meeting with Paula Knowlton, Stroudwater	Obtain education on SWB reporting and data collection for future sharing of metrics.	04/27/2023
Discussion and identification of potential Swing Bed candidates in Daily Huddle	Want to keep appropriate SWB candidates in our organization for further care. Review outside referrals for appropriateness and coverage.	04/26/23 and on-going
Meetings with UW Hospital	Discuss how we can be partners in working together to accept appropriate SWB referrals to Stoughton Health.	3/13/23 4/24/23 On-going
Introduction of project to all staff	Encourage staff buy-in and enforce positive aspects of SWB stays.	06/13/23 and 06/15/23

Measures:

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



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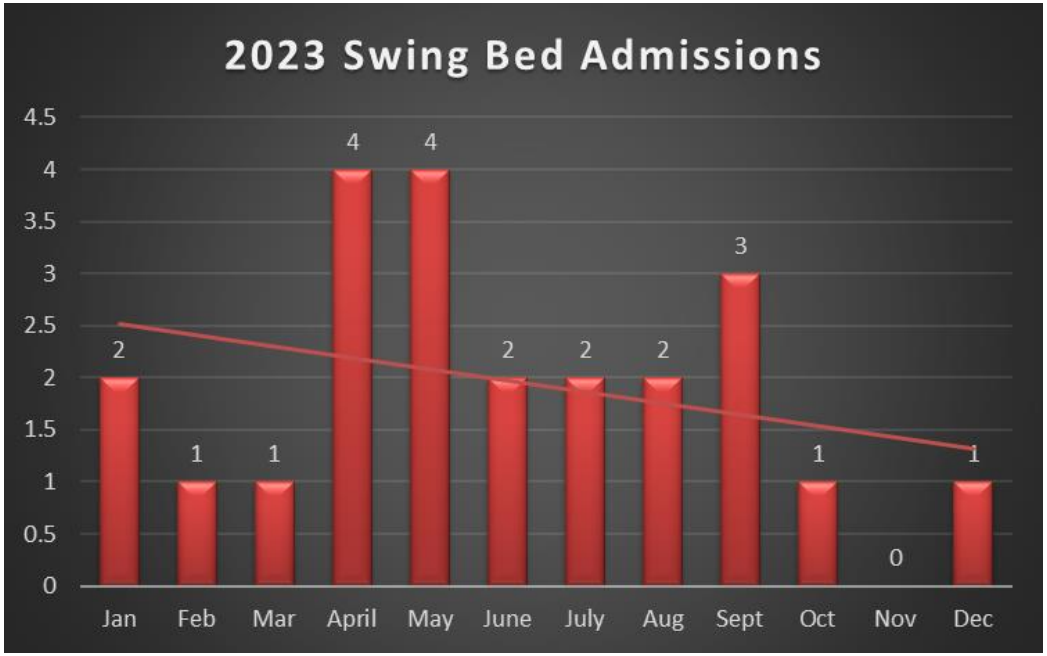

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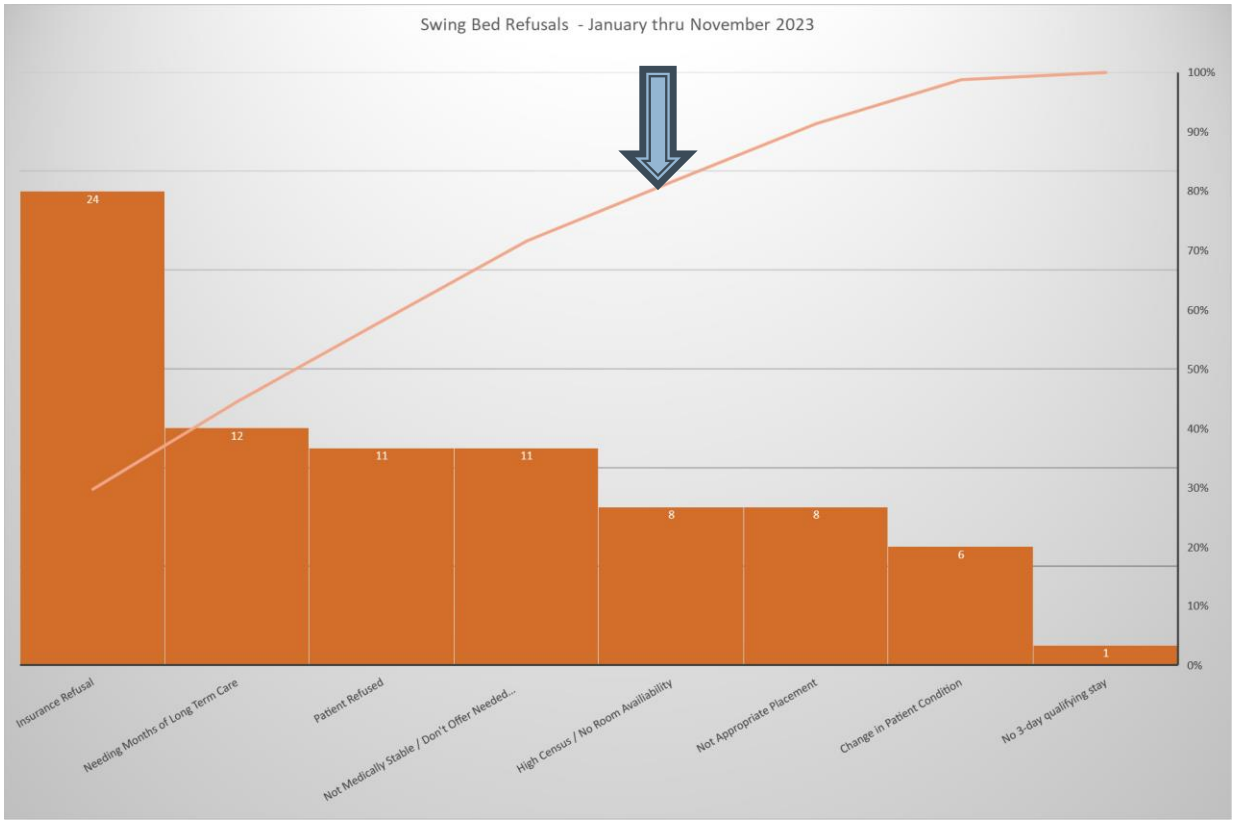

Findings:

Results: Did you accomplish your goals?
Ongoing.

Lessons Learned: What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?
Enhanced the referral review process among team members. Consistent review of potential admissions in daily huddle. Team aware of need to increase SWB referrals/patients. Providing Patient Choice, however promoting positives of SWB program and encouraging appropriate candidates to utilize Stoughton Health vs going elsewhere for rehab needs. Completed Pareto and as suspected, insurance is greatest barrier to SWB admissions.

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 encourage SWB utilization among inpatients. Case Managers keeping log of referrals and reasons for decline for manager to review.

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

Geriatric Psychiatry

Neuropsychological Testing

STOUGHTON HEALTH

06/27/2023, 08/22/23,

Document Last Presented: 12/18/2023

Quality Story:

Neuropsychological Testing

PLAN

Goal(s): What are you trying to accomplish? Implement Neuropsychological Testing (NP Testing) on the Geriatric Psychiatry Unit as Dr. Vetter has retired.
KOM Target: Implementation of NP Testing process, followed by 100% compliance with NP Testing within 4 days of order. Current KOM Status: 100% compliance.

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?
Dr. Dee Vetter had previously completed NP testing for GP patients requiring testing. She has recently retired without a plan for implementing testing going forward.	The testing (RBANs) is helpful in determining dementia in older adults, which is an important diagnostic tool for patients on the GP Unit. This affects all pillars and directly affects quality patient care.

Team:
Project Leader: Heather Kleinbrook Members: Jake Dunn – LCSW, Sarah Endicott – APNP, Dr. Amy Connell – Psychiatrist

Changes:

List the changes that have been made leading to improvements.

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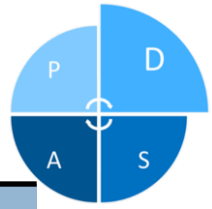
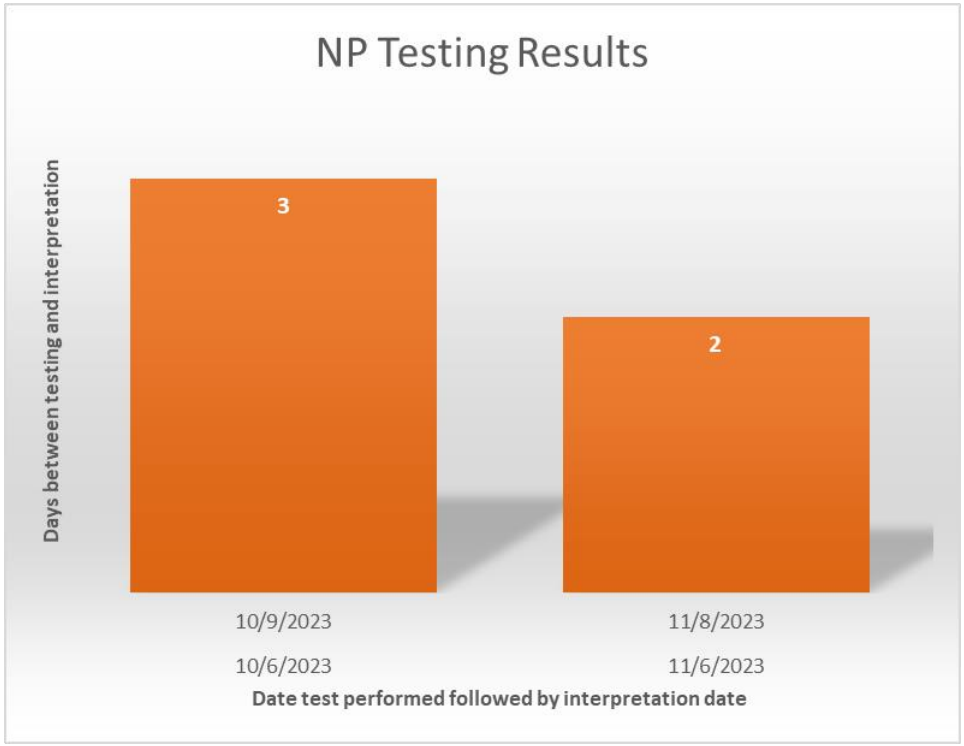


What?	Why?	When?
Meeting with stakeholders.	Determine if it is possible to administer testing with current staff.	Winter, 2022
Determine and order testing supplies.	Need RBANs testing guides and scoring sheets for implementing diagnostic assessments.	Winter, 2022
Individuals to review testing processes and scoring. Practice testing.	Ensure testing is performed and scored accurately.	Winter, 2022
Meeting with Stakeholders	Determine that all processes are in place and that staff are comfortable moving ahead with project.	2/17/2023 4/01/2023
Implement testing patients.	Implement project and ensure seamless process.	10/06/2023 and 11/06/2023

Measures:

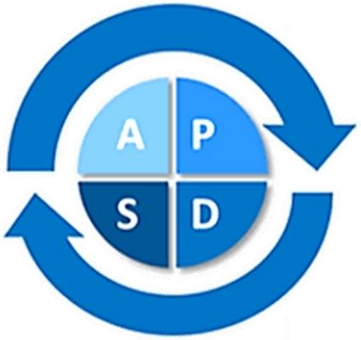
Include graphs of your measurement, results of surveys, etc. Include benchmarks or comparative data when available.



Findings:

Results: Did you accomplish your goals?
Goal met. Implemented testing with first patients on 10/06/2023 and 11/06/2023, with results interpreted on10/09/2023 and 11/08/2023 respectively, both within set goal of 4 days.
Lessons Learned: What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?
Testing went off without a hitch. Benefit to having Sarah Endicott provide testing with Dr. Amy Connell interpreting the results for a seamless process.

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 provide Neuropsychological Testing to individuals who would benefit from assessment on the GP Unit.
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



Geriatric Psychiatry

Lab Draws – Hospital Based Inpatient Psychiatric Services (HBIPS) Measure – Screening for Metabolic Disorders

STOUGHTON HEALTH

1st Presentation Date: 10/24/2023

Document Last Presented: 12/18/2024

Quality Story:

HBIPS – Screening for Metabolic Disorders

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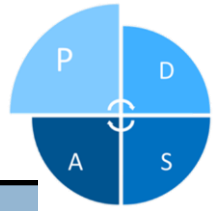


Goal(s): What are you trying to accomplish?

KOM Target: 100% compliance with metabolic screening completion. Screenings may be conducted at Stoughton Health or another facility, as long as they are conducted within 12 months prior to the patient's date of discharge. Screenings must include: blood pressure (BP), body mass index (BMI), blood glucose/hemoglobin A1C (BG/HgbA1c), and a lipid panel.

Current KOM Status: 100% compliance – 12 of 12 charts with metabolic screening note.

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

Studies show that antipsychotics increase the risk of metabolic syndrome. Metabolic syndrome is a cluster of conditions that occur together, including excess body fat around the waist, high blood sugar, high cholesterol, and high blood pressure, all of which increase the risk of coronary artery disease, stroke, and type 2 diabetes. This is a required measure for reporting and on occasion, is missed among the GP patients. More so, patients are having labs repeated or getting extra lab draws to capture this information, which is an inconvenience to the patient and lab staff, as well as a poor use of resources.
Additionally, if patients have completed labs outside of Stoughton Health prior to admission, it is challenging getting results into the active EPIC record, resulting in repeat lab draws to collect the information in the active chart.

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

This is a HBIPS measure for reporting, addressing our quality and financial pillars, as well as a patient satisfier.

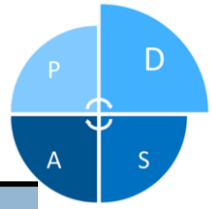
Team:

Project Leader: Heather Kleinbrook
Members: Stacy Wendt and GP Nursing Staff

Changes:

List the changes that have been made leading to improvements.

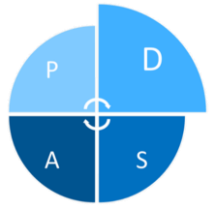
DO



What?	Why?	When?
Discuss issue in GP staff meeting.	Allow for problem-solving and staff input into issue and potential solutions. Encourage staff buy-in.	10/04/23 and 10/05/23
Meet with GP charge nurse to determine interventions. Obtain feedback from Rhonda Tesmer, Clinical Quality Specialist (reporter of HBIPS measures).	Ensure opportunities for improvement are realistic and able to be achieved.	10/11/2023
Develop Process Map.	Create best work flow to achieve results.	10/11/2023
Develop Smart Phrase for Nursing Admission Note.	Standardize documentation upon admission to ensure that information is captured in the active chart and is easy to retrieve for data collection.	10/24/23
Educate nursing on new process.	Compliance.	10/24/23
Audit Charts.	Monitor project improvement and adjust as necessary.	11/01/23 and ongoing.

Changes:

List the changes that have been made leading to improvements.



Sample Note Using Smart Phrase

Screening for Metabolic Disorders

BMI:33.36kg/m

B/P:140/67

A1C:

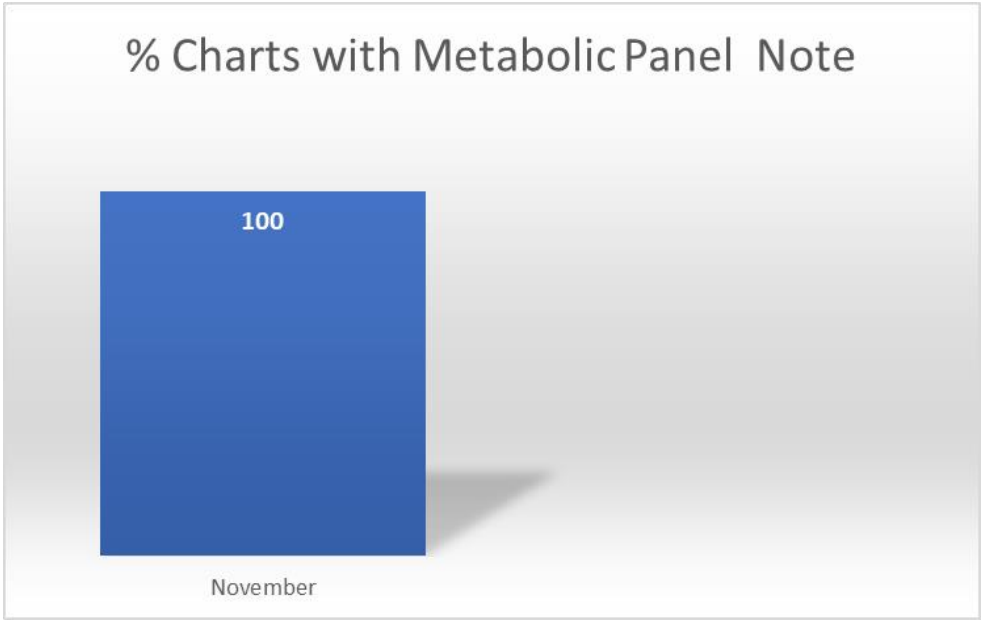
	Latest Reference Range & Units	Most Recent
Hemoglobin A1c	<=6.0 %	4.9 11/16/23 09:19

Lipid Panel:

	Latest Reference Range & Units	Most Recent
Cholesterol	<=200 mg/dL	170 11/16/23 09:20
Triglycerides	<=149 mg/dL	85 11/16/23 09:20
HDL	>=40 mg/dL	50 11/16/23 09:20
LDL Calculated	0 - 100 mg/dL	103 (H) 11/16/23 09:20
LDL	<=99 mg/dL	61 6/29/20 08:15
CHOL/HDL RATIO	%	3 11/16/23 09:20
Non HDL Cholesterol	mg/dL	120 11/16/23 09:20
Cholesterol (EXTERNAL RESULT)	25 - 200 MG/DL	169 (E) 3/30/21 11:26
Triglycerides (EXTERNAL	15 - 150	47 (E)

Measures:

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



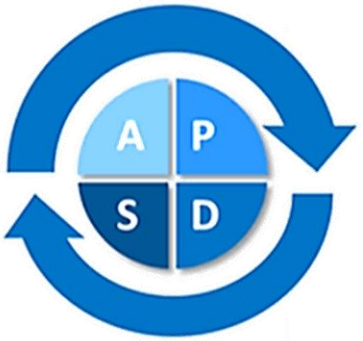
Findings:

Results: Did you accomplish your goals?
Goal met for first month of implementation.

Lessons Learned: What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?
Problem: getting information into our active EPIC chart from other organizations/facilities. Will need to enter information via smart phrase upon admission.

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?)
Work with nursing staff to determine how to get metabolic screening information into our active GP chart to show we are addressing/meeting measures. Begin auditing charts on 11/01/2023 and on-going Review project in staff meetings 12/06/23 and 12/07/23 Educated staff 1:1 as needed going forward

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



Emergency Services

Isolation Signage

STOUGHTON HEALTH

1st Presentation Date: August 22, 2023

Document Last Presented: December 18, 2023

Quality Story:

PLAN

Isolation Signage

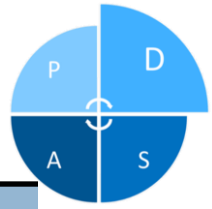
Goal(s): What are you trying to accomplish?
KOM Target: 95% of ED patients being admitted will have isolation signage indicated Current KOM Status: 65%

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?
Patients that come through the ED do not always have proper signage in place. Since COVID, staff have not been as diligent. This exposes other departments as well as not communicated when patient is admitted.	Prevent other staff from getting ill and decrease transmission to other patients.

Team:
Project Leader: Tina Strandlie, Bill Wilson Members: ED Staff

Changes:

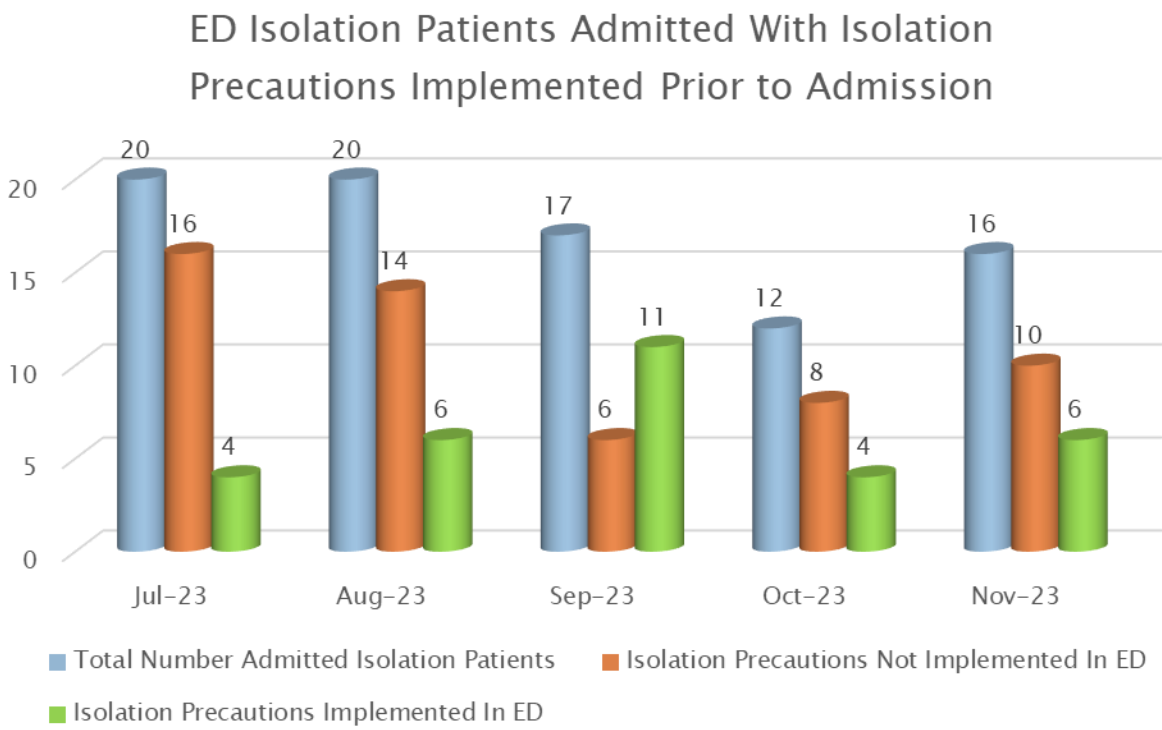
List the changes that have been made leading to improvements.

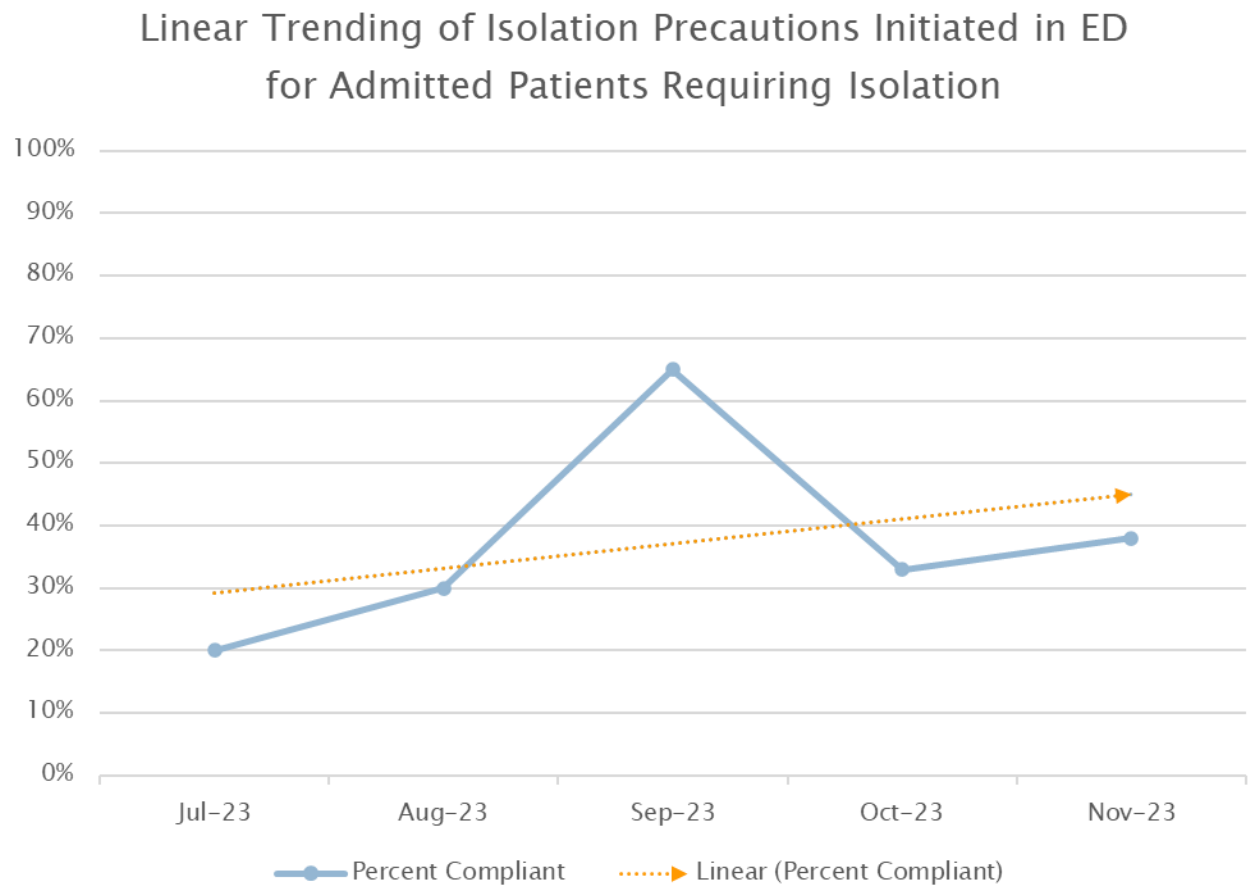


What?	Why?	When?
Monitor Isolation precaution signage in ED	Protect other staff and patients from cross contamination	August 2023
Met with Bill to discuss Isolation	I don't have an idea of how often staff are documenting isolation precautions	August 2023
Increase of COVID patients and influenza/RSV season is near	Prevent others from getting ill do to infections	August 2023
Discussed at staff meeting	Improve communication with staff and why we are doing this	September 2023
Verified we have proper door signage	We had depleted our supply during COVID	September 2023
Tina chart review during the day	Just in time training	October 2023
Share October results with staff	Staff buy in. With the increase of all respiratory infections, staff are more aware of the importance of signage	October 2023

Measures:

Bill Wilson continues to collect data for this project




Linear Trending of Isolation Precautions Initiated in ED for Admitted Patients Requiring Isolation
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Percent Compliant
Linear (Percent Compliant)

Findings:

Results: Did you accomplish your goals?

No

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

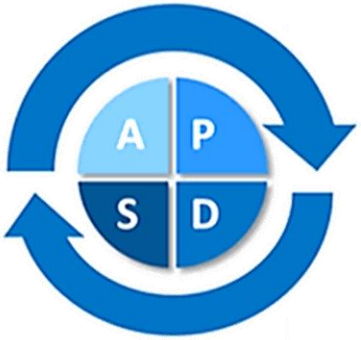
We have seen significant volume increase as well as an increase of patients presenting with respiratory infections. We have moved to a triage model and it isn't getting communicated to the primary RN that the patient is not on precautions after triage.

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?)

Stoughton Volumes: July 1763, August 1811, September 1765, October 1895 and November 2056. The majority of the patients are coming in from 10am – 9pm. Work with staff to make sure the patient is under precautions as soon as they are being tested.

Project Leader is Recommending the Following:

QM Council approval for completion of project?: Enter YES
Project still in progress, project to continue: Enter YES



Emergency Management

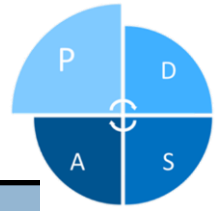
Evacuation Plan

STOUGHTON HEALTH

1st Presentation Date: June 27th, 2023

Document Last Presented: December 18th, 2023

Quality Story:



Evacuation Plan

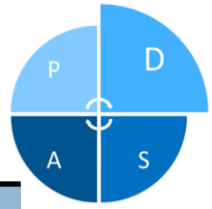
Goal(s): What are you trying to accomplish?
KOM Target: Complete Evacuation Policy/Procedure and Drill with community partners Current KOM Status: 50 % has been completed

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?
The hospital has not had an evacuation drill in 10 years. When reviewing the policies there is no policy strictly for evacuation but part of many policies.	Safety for our patients and staff in the event of an evacuation. Working with community partners.

Team:
Project Leader: Tina Strandlie Members: Emergency Management Committee

Changes:

List the changes that have been made leading to improvements.



What?	Why?	When?
Policy and Procedure	There is no P & P for evacuation.	May 2023
Community partner meeting	Discuss evacuation of the hospital with Fire and EMS captains	April 2023
Plan evacuation exercise with Forum	Forum members tabletop discussion and survey of hospital in the event of an evacuation	May 2023
Assign job duties and descriptions for Chiefs and Officers	Forum members understand their role and responsibilities	June 2023
DNV recommended all Care Coordinators received HICS 100, 200	The Admin on call is the "Incident Commander" however DNV felt the person in house opening the command center should have basic training	September 2023
Care Coordinators and charge RNS have been assigned HICS 100, 200	DNV Recommendations	November 2023, 85% complete. Those that are primary CCs are completed.
Mary Hermes and I are developing a training exercise for February with Forum	Provide training for chiefs and officers to better understand their role during an event	February 2024
Med Sled training completed	Staff requested more thorough med sled training after the last drill, this was added to competency day	October and November 2023

Measures: Areas of improvement after the evacuation drill 6/26

CORRECTIVE ACTION PLANNING (CAP)							
Based on the comments and Critique Summary, list observations/recommendations, identify corrective actions, assign areas of responsibility and completion dates as indicated below.							
Observation	Recommendation	Corrective Action Description	Individual Responsible	Start Date	Completion Date	Does this need to be retested?	Retest Date
ICC Commander didn't have enough information of the event before others started coming into room	Incident commander and whomever is reporting the situation are the only ones in the room until all details are obtained	No one enters the room until all information to ICC Commander has been received	Incident Commander	Table top drill	Fall 2023	Yes	
PIO did not have enough information for media	See above	After the initial briefing of the event, IC will communicate to all chiefs and officers	Incident commander	Table top drill	Fall 2023	Yes	
Communication was poor. Too many people in ICC, radios were not working, people standing in ICC with radios, while those on patient care areas didn't have any	Decide who is in need of a radio. Not everyone needs to have a radio.	Decide as a leadership group what makes the most sense (who is in ICC, who is across the hall etc.) to determine how to communicated. Purchase more radios and test regularly.	Chris Schmitz/Jason Schoville	Fall 2023	TBD	Yes	
Logistics officer needed more help	Review what officers/chiefs should be working together	Forum meeting in the future review HICS assignments	Most reasonable person in this role	July 2023	Fall 2023	Yes	
First time select staff have used med sleds	Med sled training during hands on competency days	Staff training	Diane Griswold	Oct 2023	Oct 2023	Next evac drill	
Chiefs/Officers didn't have resources	Make a "tool kit" for individual positions	Container made with clip board, job description, vest est.	Tina Strandlie	June 2023	July 2023	Yes at next drill	

Findings:

Results: Did you accomplish your goals?

Yes. The drill was done on June 26th. Forum members were given opportunities to send areas of improvement. After action review was completed. Fire Chiefs were invited for Forum meeting to discuss HICs.

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

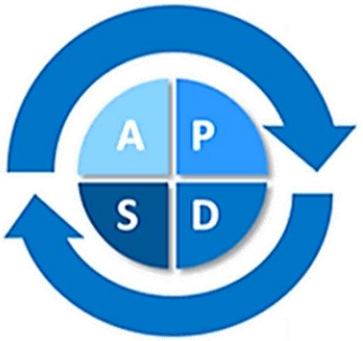
Everything that happens outside of the command center runs smoothly. Every drill/real event we find more areas we can improve on as a group. Communication is where we struggle within the Command center but those on the outside, don't see it, which is a good thing. As the Forum group continues with drills/real events we will spend more time on improving the Command Center/Chiefs and Officers.

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?)

The plan is to do a table top drill in the Fall to discuss logistics of who should be where, how to adequately use radios, what officers/chiefs need to be in the same room, how to disseminate information and making sure everyone has the tools they need. We have not been able to do a table top drill. Decision has been made to do a training session for all chiefs and directors based on their skill set (February?) after this is completed we will do a tabletop drill.

Project Leader is Recommending the Following:

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



Emergency Services

Emergency Department to Inpatient Services

STOUGHTON HEALTH

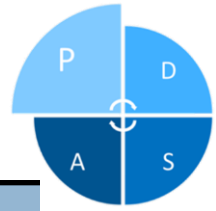
1st Presentation Date: October 23, 2023

Document Last Presented: December 18th, 2023

Quality Story:

Emergency Department to Inpatient Services

PLAN



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

KOM Target: <60 Minutes
Current KOM Status: Days averaging 79 minutes and Evening 97 minutes

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

We have seen an increase of wait times for patients from time of admission until they get to inpatient. This is a dissatisfier for patients and it disrupts workflow for staff.

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

Patient satisfaction. Improved workflow between the departments.

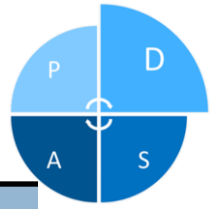
Team:

Project Leader: Tina Strandlie
Members: ER and Inpatient staff

Changes:

List the changes that have been made leading to improvements.

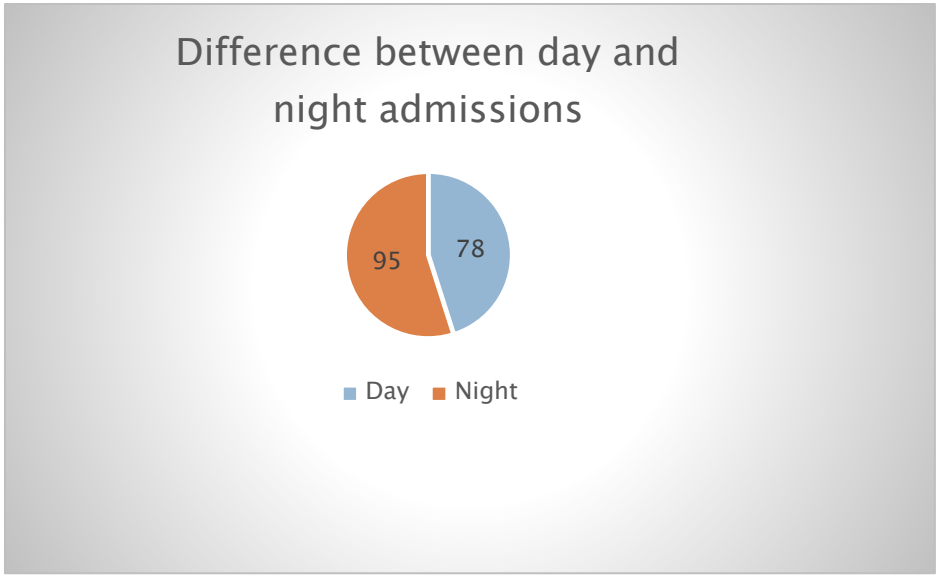
DO



What?	Why?	When?
Data collection to see where we are	Target KOM	August and September
Staff are documenting delays for admission	Is this a provider issue or a nursing issue	October 2023
Discussed at ER Committee meeting and Inpatient meeting	Providers aware of QM project and why we are doing it	November 2023

Measures:

Average time from ER Disposition to Admit to Patient arriving on Inpatient



Findings:

Results: Did you accomplish your goals?

No. Nights are getting better and days admission time is increasing.

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

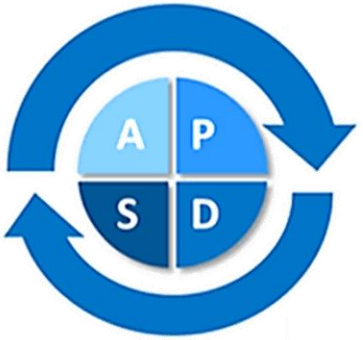
My focus will be the difference between day/evening admissions and if it is specific to one nocturnist. Once this has been determined then I will drill down to delays between ER and Inpatient.
Inpatient has been busier and it has taken more time to admit patients. Inpatient has been more respective of setting a time goal of admitting the patient. This helps the ED staff be prepared and get the patient admitted in a timely manner.

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?)

Discuss the finding regarding hospitalists with Dr. Menet and determine if there are barriers for the nocturnist to put see patient/put in orders. Discuss with staff to document any delays for admission. Continue to monitor

Project Leader is Recommending the Following:

QM Council approval for completion of project?: Yes
Project still in progress, project to continue: Yes



Laboratory and Off-Site Urgent Cares

Respiratory Virus Testing Standardization

STOUGHTON HEALTH

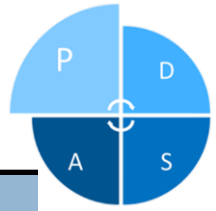
1st Presentation Date: 10.2023

Document Last Presented:10.2023

Quality Story:

Respiratory Virus Testing Standardization

PLAN



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

KOM Target:
1. Implement a Cepheid GeneXpert Xpress at each Urgent Care site by 12/1/2023
2. Eliminate resulting errors for respiratory virus testing by implementation barcode sample ID and instrument interfaces.

Current KOM Status:
1. Go Live 11/28/2023 at both Urgent Care Sites
2. 0 resulting errors in 2023 thought Oct and Nov. Interface implemented at time of go live.

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

Currently we are running different respiratory virus testing platforms between the Hospital and Urgent care sites. The Cepheid GeneXpert at the hospital and the Abbott ID Now at the urgent care sited. The Abbott contracts have expired and will need to be re-negotiated. Since the main lab is no longer using the Abbott instrument commitment volumes will drop significantly and pricing increases are expected. Having the different testing platforms requires management to 2 different sets of reagents and additional upkeep. On the Abbott platform each assay is testing individually required a different sample collection for each; while the Cepheid platform is can test multiple viruses of the same sample.

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

Transitioning the urgent care site to the Cepheid system will standardize testing throughout the system giving the same care to patients regardless of which site they visit and decrease reagent management needs. Additionally, the system will help to improve patient outcomes by offering the multiple virus testing off a single sample collection, as well as decreased cost to patients. An additional benefit will be the implementation of interfaces eliminating manually entry of results and preventing errors.

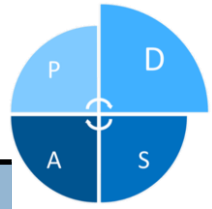
Team:

Project Leader: Kyle Sippel
Members: Kathy Skotzke, Alicia Hookstead, Tina Strandlie, Dr. Diebold, IT, SSM Beaker build team,

Changes:

List the changes that have been made leading to improvements.

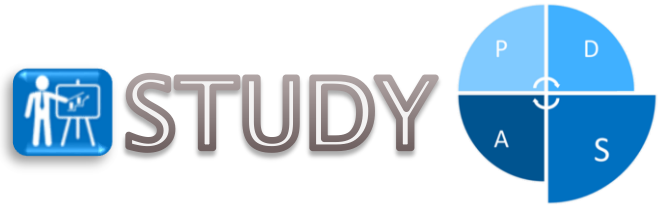
DO



What?	Why?	When?
The instruments were delivered and setup at the main lab for required verification and Validation	Lab regulations require that all equipment undergoes a verification process before it can be used for patient testing.	Oct 9th 2023
Instrument method validations were completed.	These are required by our regulatory agency and intended to ensure instrument performance and result accuracy	Oct and Nov 2023
Epic build was completed and build was validated including interface testing.		Oct and Nov 2023
Urgent Care policies and forms were updated and included in staff education.		Nov 2023
Urgent Care Nurses and Radiology tech were trained.		Nov 13th – Nov 28th.
Barcode printers were set up at each Urgent care site		Nov 21st
Instruments were setup at each site and performance and interface connectivity was verified.		Nov 27th
Instruments went live		Nov 28th 2023
Barcode printers were set up at each Urgent care site		Nov 21st

Measures:

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



Project Plan Summary:
12 of 12 steps completed

	Start Date	Complete Date
Submit Budgitary Requests	Jul-23	Sep-23
Final discussion with ER and UC Staff	Aug-23	Sep-23
Purchase Equipment	Sep-23	Sep-23
Delivery and Install	10/9/2023	10/9/2023
Instrument Validaiton	10/10/2023	11/10/2023
Epic Build including interface	10/3/2023	10/1/2023
Epic Testing / Validation including Interface	11/1/2023	11/16/2023
End User Training	Nov-23	Nov-23
Setup printers and Barcode Scanners	11/21/2023	11/21/2023
Install Instruments at each site	11/27/2023	11/28/2023
Final Validaitons	11/27/2023	11/28/2023
Go Live - Goal 12/1/2021	11/28/2023	11/28/2023

Results Entry Errors:

Oct and Nov- 0 manual entry errors related to ID Now testing

* Instrument interface implemented eliminating manual result entry.

Findings:

Results: Did you accomplish your goals?

Yes – Go Live by 11/28/2023
Instrument interface implemented.

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

- Several minor workflow issues were identified in UC staff workflows. They were quickly adjusted and no further concern.
- Additional concerns expresses regarding the increased time for results. Now that we are live staff will monitor and adjust workflow to compensate.

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?)

Monitor workflow for any issues.

Project Leader is Recommending the Following:

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

Laboratory

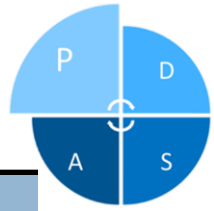
Implementation of an 8 Module Cepheid GeneXpert Increase in Respiratory Virus Testing Capacity

STOUGHTON HEALTH

1st Presentation Date: 10.2023

Document Last Presented:10.2023

Quality Story:



Respiratory Virus Testing and Capacity

PLAN

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

KOM Target:
1. Implement a Cepheid GeneXpert 8X16 module system 12/1/2023
2. Maintain >90% of respiratory virus tests resulted in <50min including during peak seasons (Dec-March)

Current KOM Status:
1. Fully implemented – Live 11/16/2023
2. 98% of tests resulted in <50min (November).

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

The hospital currently has a 4 module GeneXpert system which is utilized for all our respiratory virus testing alone with STI and other urogenital health. The system was implemented in March. This system as been able to keep up with demand to this point. As we move into the respiratory Virus season (Dec-March) we typically see significant increase in demand. Based on numbers and observations from previous years, the current 4 tests at a time could like result in frequent backups; therefore, increasing turn around time and length of stay in ER.

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

This project will double our testing capacity from 4-8 test at one time. Each test can consist of all 4 common respiratory viruses. This increase in capacity will eliminate the majority of the times in which the analyzer would be full resulting in delays. This analyzer also has the ability for further expansion up to 16 modules if volumes would ever dictate the need.

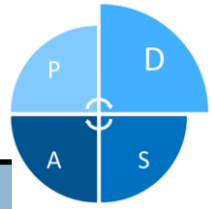
Team:

Project Leader: Kyle Sippel
Members: Alicia Hookstead, SSM Beaker Team, Lab Staff

Changes:

List the changes that have been made leading to improvements.

DO



What?	Why?	When?
A full review and of our current volumes and delays vs. our projected volumes and potential for significant delays was done	This was done to determine our potential risk and our need for expansion	July 2023
The decision was made to look to expand instrument capacity by purchasing a 2nd 4 bay instrument to doing an upgrade to an 8X16 bay system. – Budget requests submitted.		July 2023
New instruments ordered. A 8X16 capacity instrument. (8modules with capability to expand up to 16)		Sept 2023
The instruments were delivered and setup at the main lab for required verification and Validation	Lab regulations require that all equipment undergoes a verification process before it can be used for patient testing.	Oct 9th 2023 Validation began Oct 10th
Instrument and Epic validations completed.		October
Go Live		11/2/2023

Measures:

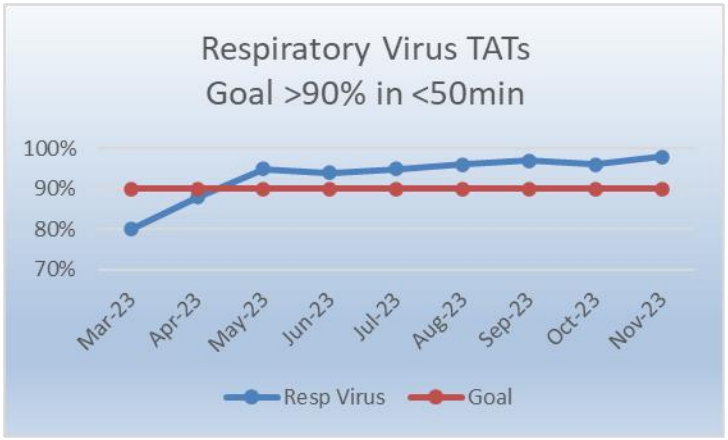
Include graphs of your measurement, results of surveys, etc. Include benchmarks or comparative data when available.

STUDY

P D A S

Project Plan Summary:
7 of 7 steps completed
Live 11/26/2023

	Start Date	Complete Date
Submit Budgitary Requests	Jul-23	Sep-23
Purchase Equipment	Sep-23	Sep-23
Delivery and Install	10/9/2023	10/9/2023
Instrument Validaiton	10/10/2023	11/10/2023
Epic Build including interface	10/3/2023	10/12/2023
Epic Testing / Validation including Interface	10/12/2023	11/2/2023
Go Live - Goal 12/1/2021		11/16/2023

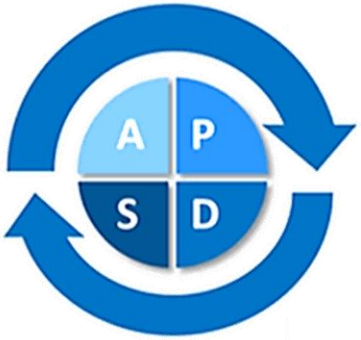


Findings:

Results: Did you accomplish your goals?
Yes – Live 11/16/2023 November – 98% of results available in <90 min
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?)
No further actions, will continue to monitor turn around times as part of our laboratory QA.

Project Leader is Recommending the Following:
QM Council approval for completion of project?: Yes Project still in progress, project to continue: Enter No



Sleep Disorders Center

Decrease the Time for Direct Referral Approval

STOUGHTON HEALTH

1st Presentation Date: 6.2023

Document Last Presented: 10.2023

Quality Story:

Decrease the Time for Direct Referral Approval

PLAN

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

KOM Target: 2-3 Days
Current KOM Status: <2 days for SSM Patients and SSM referrals.
<2 days for Non SSM patient referrals.

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

Direct referrals for sleep studies are referrals that are coming from providers outside the SSM Sleep Medicine Clinics. These orders must be approved by our Medical Director prior to scheduling. Currently the orders are kept in the Stoughton Sleep Lab office and will be picked up and delivered to Dr. Rakita every other week when he or staff hold clinic here is Stoughton. Therefore depending on timing, orders could take several weeks to a month to get approval. Once approved by Dr. Rakita, they then need to go through an insurance authorization before patients can scheduled.

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

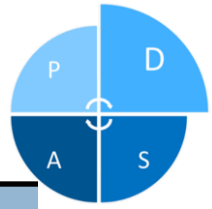
By improving the process in which Dr. Rakita approved these orders, we will be able to get the studies authorized quicker by insurance and reach out to patients sooner to schedule their studies. The quicker approval time will also potentially help us maximize our actual in lab schedule, which is scheduling out 3 months at this time.

Team:

Project Leader: Kyle Sippel
Members: Dottie Love, Star Reed, Megan Goetzman, Lindsey Oldenburg – SSM Sleep Clinic, Dr. Jason Rakita – Medical Director.

Changes:

List the changes that have been made leading to improvements.



What?	Why?	When?
SSM used a process which utilized a standard referral template that can be sent through in-basket to Dr. Rakita, He can then review, comment and approve the orders. Lindsey from SSM Clinic reached out to discuss this process and our interest	With moving us to that process it will standardized how Dr. Rakita gets direct referrals from different labs, allowing him to have a consistent process and be more efficient.	May 2023
Staff began a trial of entering the necessary information manually from the outside referral into the in-basket referral and sending it to Dr. Rakita electronically similar to our process with SSM referrals.	This would allow us to use the same process we do for our SSM patient while still providing Dr. Rakita with all the necessary information; not relying on a manual paper transfer processes, which is the cause of our delays.	Trialed 1st patient 10/3.
The process highlighted above for the Non-SSM referrals was streamlined; standardizing the information being added to the in-basket referral and creating a process for scanning the full referral packet received for the outside client into Epic.	To create a consistent standardized process for everyone to follow.	October and November
All sleep tech were trained on the new referral process.		End of October

Measures:

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

- <2days Average time for approval for all referrals.
  - We have 3 additional non SSM referral in November in which new process was utilized.
    - 10/14 sent to Rakita - approved 10/14 -External Documents scanned scanned 10/17
    - 11/15 - sent to Rakita - approved 11/17 -External Documents scanned scanned 11/18
    - 11/20 - sent to Rakita - approved 11/20 - External Documents scanned 11/20

Findings:

Results: Did you accomplish your goals?
Yes – All referrals were approved in <2 business days

Lessons Learned: What did you learn as a result of this project? Unexpected discoveries? Problems or barriers?
• We will have a new medical director that will need to be trained on the processes.

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?)
• Maintain use of the new in-basket referral processes for both SSM and Non-SSM patients • Train the new medical director (when assigned) on the review process.

Project Leader is Recommending the Following:
QM Council approval for completion of project?: Enter Yes Project still in progress, project to continue: Enter No

Sleep Disorders Center

Natus Sleep Works System Upgrade

STOUGHTON HEALTH

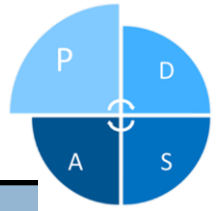
1st Presentation Date: 10.2023

Document Last Presented:10.2023

Quality Story:

Natus Sleep Works System Upgrade

PLAN



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

KOM Target:
1. Completion of the Natus Upgrade By April 1st 2024, including implementation of the Standardized SSM Sleep Study report.
2. Prevent patient cancelation due to equipment memory issues.

Current KOM Status:
1. Project is proceeding as expected.
2. Oct and Nov – 2 patients had to be rescheduled and 1 result delay due to memory storage issues with current system .

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

Natus Sleepworks is our software we use for performing and scoring in-lab sleep studies. The system was implemented in 2018. SSM is currently in he process of implementation of a standardized Sleep Study report and reached out to see if we would consider adopting that report as well. In review, it was determined SSM is on a newer version and our current software can not support the report. Additionally we are reaching capacity on our system which has resulted in patients having to be canceled last minute as the software would not work.

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

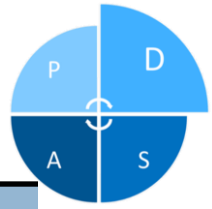
The standardized report will streamline the review of reports for shared patients improving result quality. This will also improve the ability of providers to communicate data with each other, other specialists involved in the patient's care (Otolaryngology), and insurance companies when coordinating care to optimize treatment and working on getting treatments authorized through insurance. The upgraded hardware would allow for increased storage and intern preventing down time and cancellations.

Team:

Project Leader: Kyle Sippel
Members: Dottie Love, Sto IT, Natus, SSM Sleep staff, SSM IT staff

Changes:

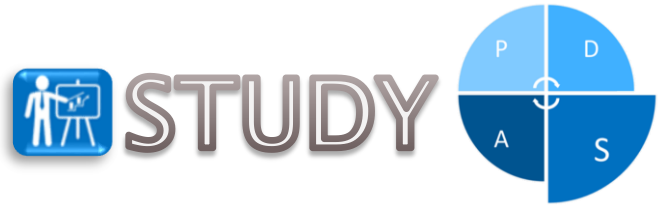
List the changes that have been made leading to improvements.



What?	Why?	When?
Initial discussion was had with Natus regarding what would be needed to increase memory and gain access to the SSM report templates. It was determined a software upgrade would be needed to run the report and a hardware upgrade would be needed to increase memory. Requested Quotes for both software and software and hardware upgrade.	We needed to determine what would be need to be able to use the SSM report template.	June 2023
We met with SSM to ensure the standardized reporting template would be made available to us as an affiliate.	At times, different systems and templates are not made available to us as SSM affiliates. It would not make sense for us to do a full upgrade if we would not be able to access the report.	Mon 10/9/2023 – SSM gave the approval and recommendation for us to be able to implement the report.
Met with Natus to further discuss our needs and obtain an updated quote. Quotes obtained.		Nov 17th
Project request will be taken to Administrative Council for approval to purchase.		Dec 7th

Measures:

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



Project 2 of 6 steps complete

Project Steps:	Start Date	Completion Date
System review with Natus and Obtain Quotes	Nov-23	Nov-23
Verify with SSM access to report template	Nov-23	Nov-23
Request funding and purchase equipment and software	12/7/2023	
Installation of upgraded computers and systems.		
Work with SSM to create STO version of the standard report template.		
Training staff on upgrades software		

Patient Cancellations:
Oct – 1 (Room 2)
Nov – 1 (Room 1) + 1 result delay

Findings:

Results: Did you accomplish your goals?

No: 2 of 6 steps completed.

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

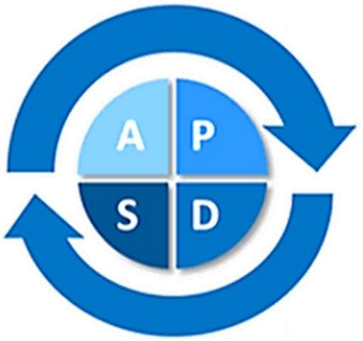
- We learned in discussion with Natus that our equipment will no longer be supported after Feb of 2025.
- They recommended we consider replacement of Cameras and amplifiers as well. They offer bundled pricing which would include the upgraded computers as well as the additional hardware that will not be supported. Bundled pricing would save about $7000 per room vs buying equipment individually.
- Replacing all hardware would increase overall project cost by approximately $18,000
- Our amplifiers have not had issues, but we are having some issues with camera and inferred in room 1 which did result in a patient having to be sent home.

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?)

- Request final admirative project approval and funding. – Dec 7th
- If approved – submit purchase documents and begin to schedule implementation with Natus.

Project Leader is Recommending the Following:

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



Plant operations

Life Safety Codes

STOUGHTON HEALTH

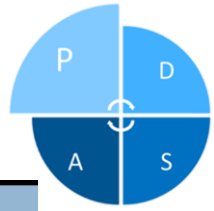
1st Presentation Date:12-18-2023

Document Last Presented:

Quality Story:

Life Safety Codes

PLAN



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

KOM Target:100%
Current KOM Status:

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

To enhance clarity and emphasize the importance of high priority work orders, we have implemented a system that highlights these orders in pink. Additionally, we have included relevant codes alongside each work order to provide a clear explanation of the compliance regulations. This addition empowers individuals with questions or concerns to easily reference the codes and gain a deeper understanding of the underlying regulatory requirements.

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

To stress the importance and value of these work orders. If we do not stay with in compliance not only will we be cited for infractions, but it could be a life safety situation.

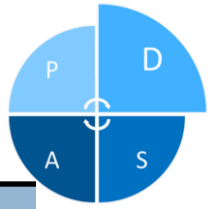
Team:

Project Leader:Rob Maurer & Jason Schoville
Members:Plant Operations Team

Changes:

List the changes that have been made leading to improvements.

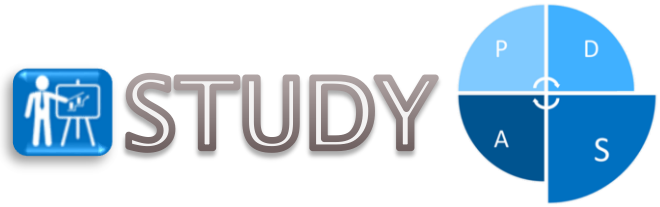
DO



What?	Why?	When?
Listing the NFPA codes along side the compliance preventative maintenance procedures.	This will help to have a better understanding and meaning of the code that is listed for the work order it pertains to.	TBD

Measures:

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



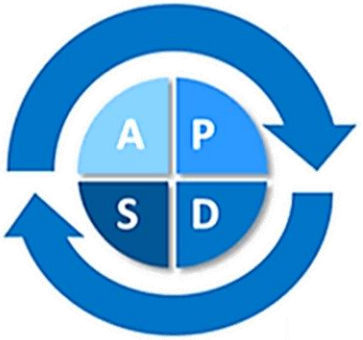
Findings:

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?)

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



HIM

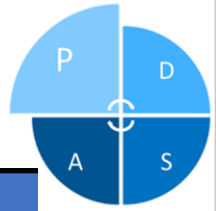
Coding Denial Review

STOUGHTON HEALTH

Document Last Presented: 12/19/23

Quality Story: Coding Denial Review

PLAN



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

KOM Target: To reduce coding denials by 30%
Current KOM Status: 27% reduction over 6 months

June: 140	September: 113
July: 100	October: 112
August: 126	November: 103

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

Denials can be for a multitude of reasons as simple as a coder missing a modifier on a procedure code to a complex payer policy on echocardiograms. Like claim edits, I am doing some spring cleaning to make workflows more efficient by education PFS on denials they can work independently and reducing time for my coding review.

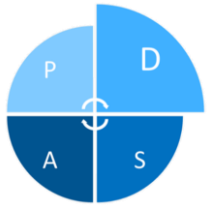
Driver: Explain why the project is critical to SH. Why does it relate to the strategic plan?

Reducing the number of denials will result in less time for both PFS and coding to rework the accounts as well as reducing AR days.

Team:

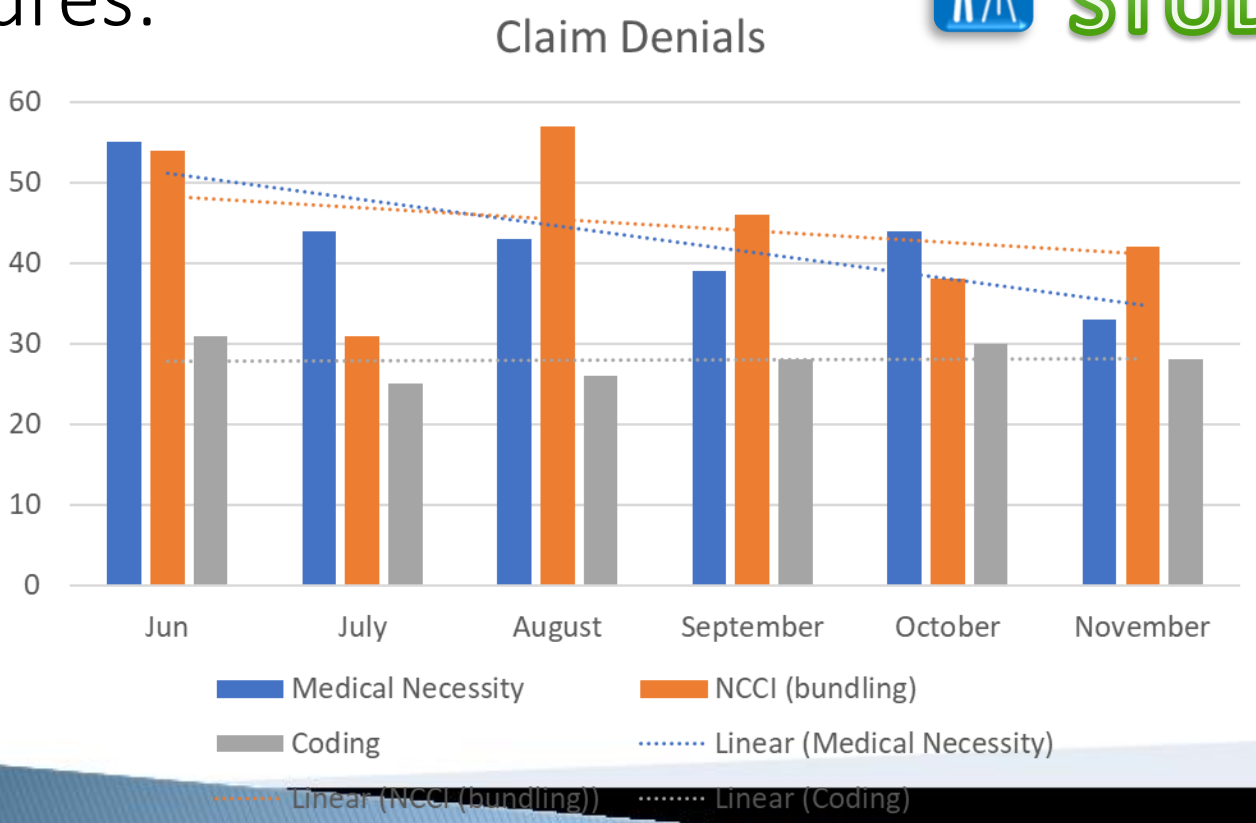
Project Leader: Victoria Valdez
Members: Priscilla Amador, Emily Goetz, Megan Kollmansberger, Sue Meseberg, Kathy Muhs, Nichole Rothenburger, Chelsie Schyvinck

Changes:



What?	Why?	When?
Coder education and feedback	Education opportunity for denials	Ongoing
Monitoring denials	To determine if denials have been appropriate	Ongoing
Analyzing data and trends	To determine where there is the most opportunity	Ongoing
Start payer rule spreadsheet	To reduce denials and keep rules straight	October
Coder Audits	Ensure coding accuracy, another form of feedback to reduce errors	November

Measures:



STUDY

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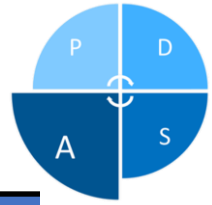
Findings:

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?

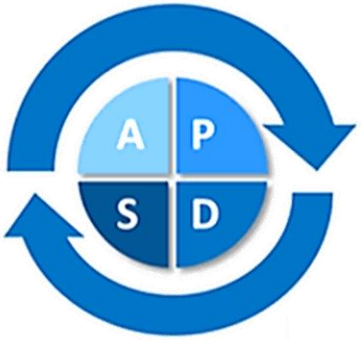
- eC is a very helpful tool, but there is a lot of information in the reports and it can be a little tricky to tease out the data I need.
- Coders like the feedback, they want to do things right and they too don't want denials/errors.

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 working/auditing denials and looking for automation opportunities
- Beginning to have coders work their denials and offer education
- 2024 Coding updates are also coming out, so it will be important to ensure the team is in front of these updates to avoid new

Project Leader is Recommending the Following:

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



HIM

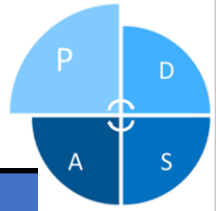
Plan of Care for Therapy

STOUGHTON HEALTH

Document Last Presented: 12/19/23

Quality Story: Plan of Care for Therapy

PLAN



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

KOM Target: 100% Verified Compliance
Current KOM Status: Non-Verified Compliance

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

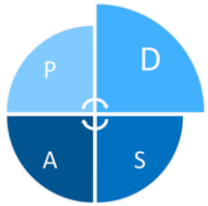
- Registration is doing this on paper for PCPs outside SSM
- Reg is writing patient info and sending to HIM (not best practice)
- Manual process without checks and balances
- Medicare requirement is vague/ambiguous
- Opportunity for consistency/standardization among location
- Epic functionality
- Compliance

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

Currently, there is not a specified number of attempts from CMS to obtain a PCP's signature on a plan of care. We think there is additional functionality in Epic. It's been on our to-do list for a while, and we're tearing off the band-aid. There is efficiency to be gained by the therapist by looking at Epic functionality.

Project Leader: Victoria Valdez
Members: Lisa Bear, Abby Campbell, Susie Wendt, Liz Touchett, Sarah Watkins

Changes:



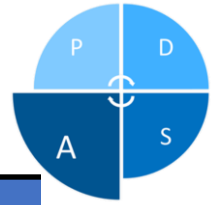
What?	Why?	When?
Plan of Care (POC) Kick off meeting	Project planning	9/11/2023
POC team meeting	Sharing back what we were able to find for best practice/guidelines	9/20/2023
Consulted PARA	To see if they can find specific documentation for the number of attempts required for POC signatures-reiterated Medicare's ambiguous language	9/28/2023
Collaboration w/ Roundtable	To see if they can find specific documentation for the number of attempts required for POC signatures-recommended 3 attempts as a reasonable number	10/2/2023
Plan of Care Tracking	To determine volumes	Ongoing

Measures:

STUDY

Sept/Oct External Oregon Plan of Care Tracking	
Patients	54
Returned signatures	51
2nd attempts made	9
POS returned after 2nd attempt	8
Needed 2nd attempt	2
Not Returned after 2nd attempt	1

Findings:



Results: Did you accomplish your goals?

No, not yet- we're just getting started.

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

- There's more to this process than what appears- multiple layers
- There's multiple hands in this process
- There may be Epic functionality we're not using
- Medicare requirements are ambiguous

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?)

- Define requirements as needed and develop a Stoughton Health process
- Review SSM/non-SSM Epic instance flow, compare with other affiliates
- Review Epic functionality opportunities
- Track volumes both in SSM and outside of SSM
- Track Reg admin time/HIM scanning time
- Create a tracking log for external requests
- Review audit SSM/Internal POC Requests for Compliance

Project Leader is Recommending the Following:

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

Epic Contract Building

A tool used to document and communicate Performance Improvement Projects

1st Presentation Date: 06/28/2022
Document Last Presented: 12/19/2023

Quality Story: Contract Building

P L A N

Goal(s):

What goal are you trying to accomplish?

To build contracts in Epic for our contracted insurance payers

KOM Target: Complete Epic Build of All Contracted Insurance Payers

Current KOM Status (12/08/23): Total of 30 Insurance Plans

- **2 in Production**
- **5 ready to move to Production**
- **6 in Testing**
- **17 in build process**

Background:

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

Previous to the Epic Instance Merge in 2018, we had a number of our contracts built in Epic to track reimbursement. We have struggled to get contracts built in the new instance and need to make this a priority.

Driver:

Explain why the project is critical to SH. How does it relate to the strategic plan?

The purpose of building contracts in Epic is two-fold. First, the contract module compares the actual reimbursement to the expected reimbursement according to that contract's terms.
Second, Epic allows us to model any changes during contract negotiations. We can estimate the effect on reimbursement and negotiate terms effectively.

Team:

Project Champion: Sarah Watkins
Project Leader: Beverly Pope
Members: Beverly Pope, Mary Erdman

Changes:

List the changes that have been made leading to improvements.

D

O

What?	Why?	When?
Weekly meetings for building	Continue forward progress on other contracts	Ongoing
Contracts moved to PSUP	Moved two additional contracts to PSUP for testing	November 2023
Questions also posted to EpicWeb for assistance	Trying to find additional help	November 2023
Requested meeting with SSM-IHT	Still unable to move completed contracts to Production	December 2023

Measures:

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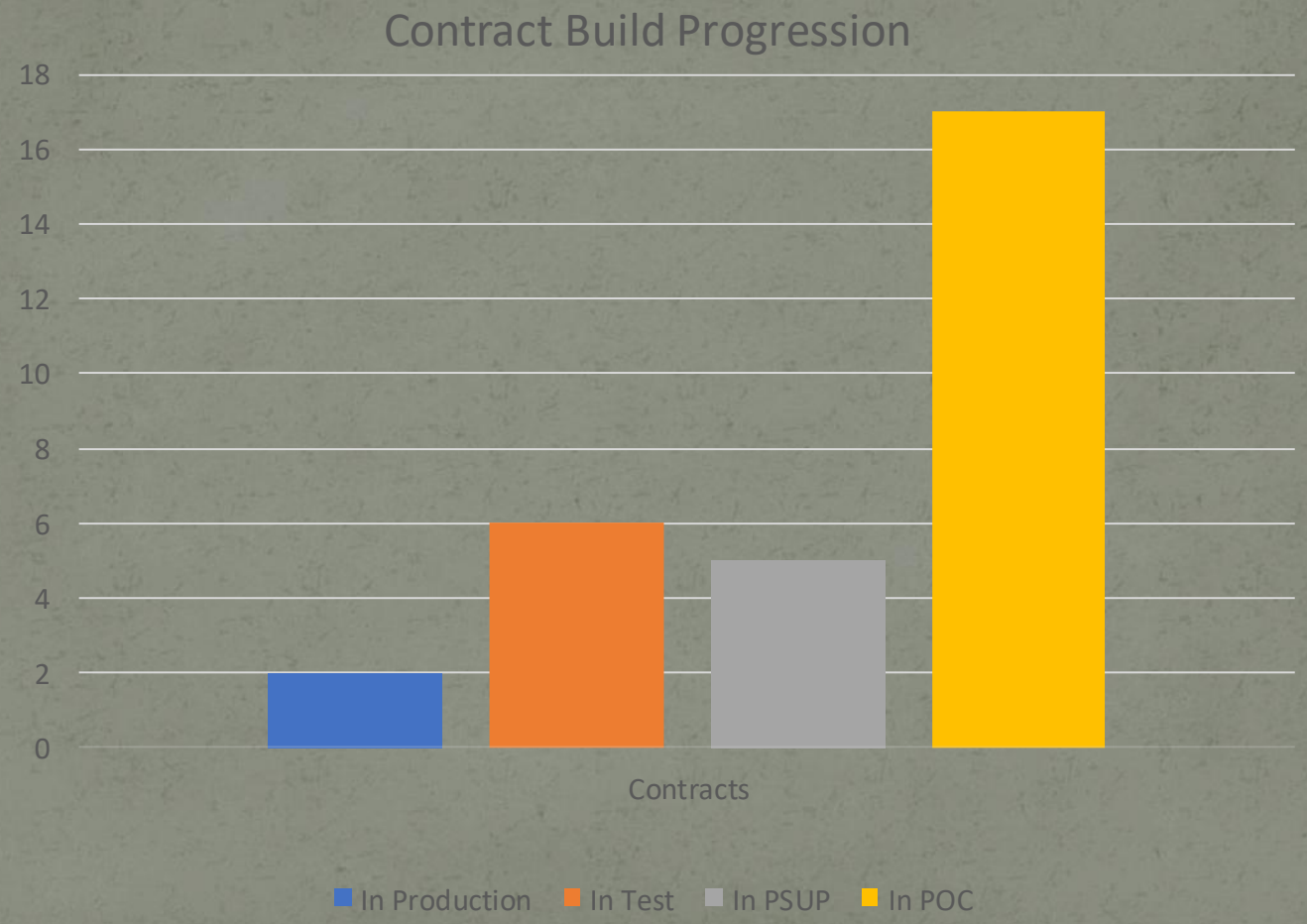


Findings:

A C T

Results:

Did you accomplish your goals?

Not yet, but we are working toward our goal.

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

- Stay the course
- Slow and steady wins the race

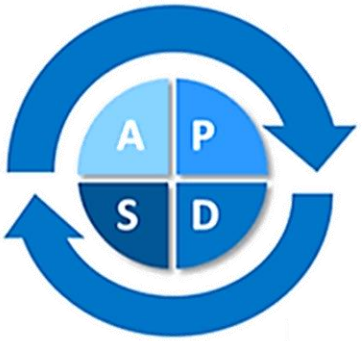
Next Steps: What actions are you going to take based on your findings? (e.g. roll out to additional units, modify and make additional improvements; abandon the effort; change course)

- Continue with build/test/move
- Continue to work with affiliates and SSM-IHT to complete more contracts
- Meet with SSM-IHT to complete move to Production
- Continue to analyze contracts in production for build accuracy
- Review Epic work queue logic flagging payment discrepancies

Project leader is recommending the following:

CI Council approval for completion of project: No

Project still in progress, project will continue: Yes



PFS

Provider Based Billing for Specialty Clinics

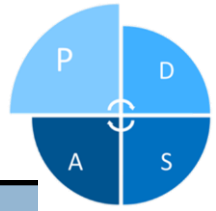
STOUGHTON HEALTH

Document Last Presented: 12/19/2023

Quality Story:

Provider Based Billing for Specialty Clinics

PLAN

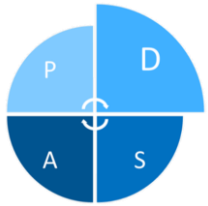


Goal(s): What are you trying to accomplish?	
KOM Target: Implementation of provider-based billing for Stoughton Health Specialty Clinics located at Stoughton Hospital. Current KOM Status: Beginning stages	
Background: Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.)	**Driver:** Explain why the project is critical to SH. Why does it relate to the strategic plan?
The Specialty Clinics visits are billed differently than other services at Stoughton Health. This different billing was done to maintain consistency with our Madison location and the SSM Dean Medical Group Clinic, both of which can't be provider based billed.	We were advised we could increase our revenue by moving to provider-based billing. This would allow us to bill both a facility fee and a professional fee for services. As the orthopedic practice has grown, we are using more drugs which we will be able to obtain at a lower cost with 340b pricing if provider based billed.
Team:	
Project Leader: Sarah Watkins Members: Beverly Pope, Victoria Valdez	

Changes:

List the changes that have been made leading to improvements.

DO



What?	Why?	When?
Emailed RWHC Patient Business Manager Roundtable	To find other facilities that have made this change	August 2023
Communicated with Natalie Thompson of Crossing Rivers	She responded to the Roundtable email	September 2023
Researching requirements for changing to provider-based billing	There are guidelines and regulations that must be followed	Ongoing
Started reviewing checklist	To keep track of process	December 2023

Measures:

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

Findings:

Results: Did you accomplish your goals?

No, we are just beginning this project.

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

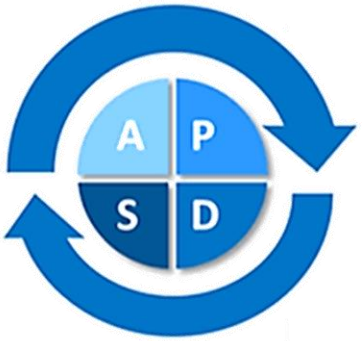
- There are many regulations to meet when making a change like this.
- Affiliate partnerships can be very helpful with projects like this.

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?)

- Project planning—use the guides and information we have found to develop a plan and start moving forward.
- Stakeholder meeting
- Evaluate patient impact and notification requirements.

Project Leader is Recommending the Following:

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



Medical Imaging

Release of Medical Imaging Records

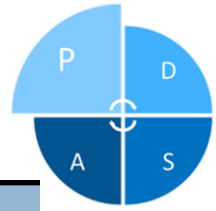
STOUGHTON HEALTH

1st Presentation Date: August 22, 2023

Document Last Presented: December 19, 2023

Quality Story:

Release of Medical Imaging Requests

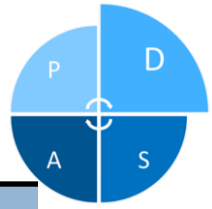


Goal(s): What are you trying to accomplish?	
KOM Target: Implement a streamline process for release of imaging requests Current KOM Status: 40% completed	
Background: Explain what the original situation was. Why was a change recommended? (e.g. variation, poor outcome, etc.)	**Driver:** Explain why the project is critical to SH. Why does it relate to the strategic plan?
Imaging workflows have rapidly changed due to new applications, increased volumes, and increase demands for image transfers between facilities. This has created inefficiencies and confusion on the process.	Providing and receiving images is an important part of the continuation of care for our patients.
Team:	
Project Leader: Sara Sturmer Members: Medical Imaging Team and HIM	

Changes:

List the changes that have been made leading to improvements.

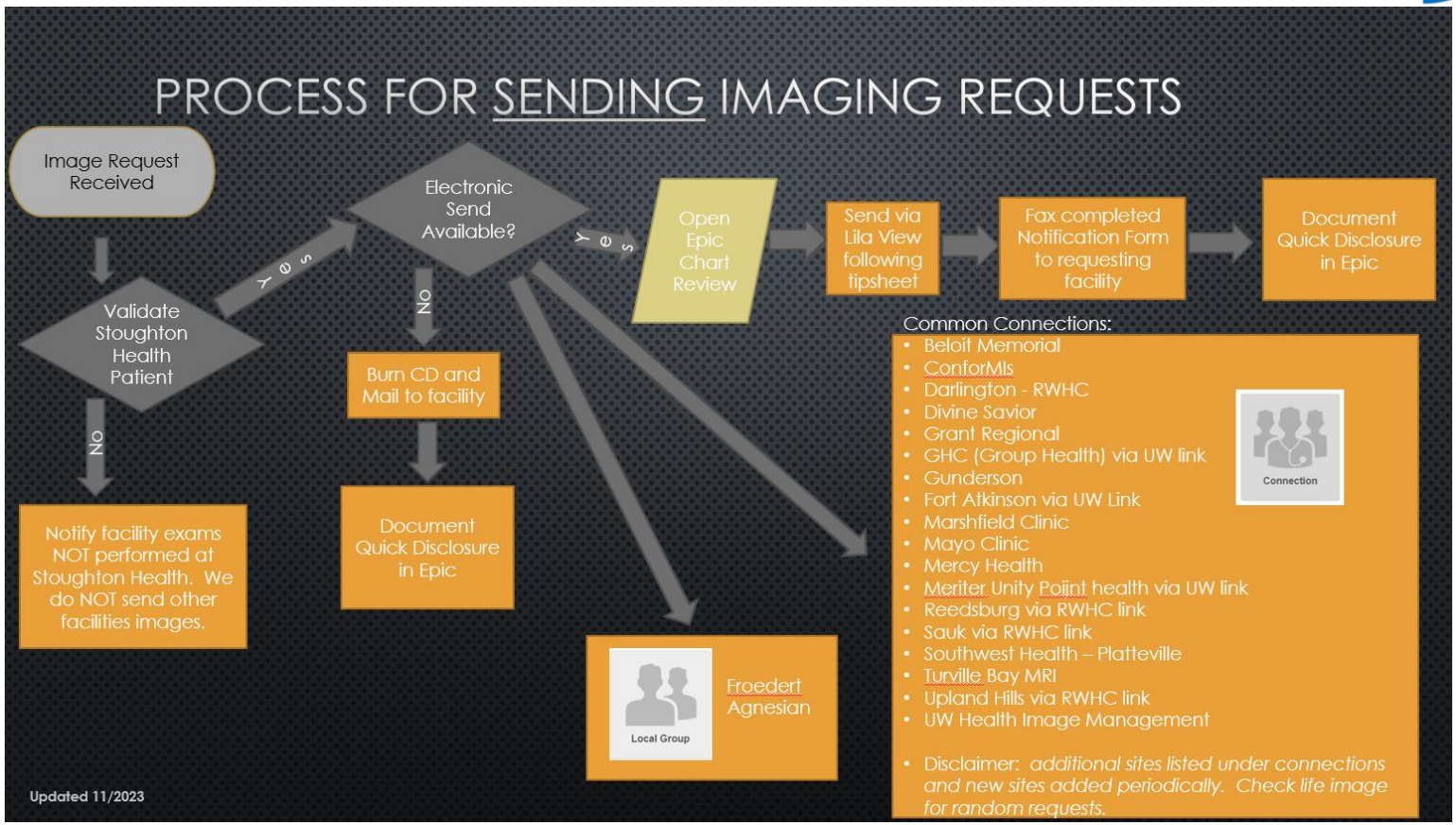
DO



What?	Why?	When?
Request access to Life Image for Lisa Bear	Give Lisa ability to send images directly through Epic Life Image when requested to support imaging.	Ticket placed 8/16/2023 **INC7430739**
Training completed with Lisa	Access received and training completed.	August 29, 2023
Created Process Map	To streamline process and provide resource to team.	October 2023
Reviewed Process Map at Technologist Meeting	*Obtain feedback, suggestions, and clarification. Updated accordingly.*	*November 6, 2023*
Updated process map and print	*Updated process map, printed for Image Transfer Reference binder, and emailed to urgent care locations*	*November 14, 2023*
Determine how staff can check Quick Disclosure when asked if images have been sent.	*If documenting quick disclosures will help inform sites if images or CD's have been sent, need access to this*	*November 2023 – ticket placed to Epic 11/14/2023* INC7565701

Measures:

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



Findings:

Results: Did you accomplish your goals?

Yes, process map developed.

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

- HIM has only had 1 request since access to life image has been granted.
- Process has been simplified with the access of life image sending within Epic and Life Image.
- Learned that when a quick disclosure is completed in Epic, it is viewable under List Disclosures but ONLY for the person that documented it. This is not helpful for any team member to check to validate something has been sent.

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?)

Follow up again with the Epic team to determine if staff can view disclosures in the chart if someone else documented it. Discuss with HIM the quick disclosure documentation requirements.

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