**2014 Annual WAHQ Conference**

**Storyboards**

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<tbody>
<tr>
<td>Safety Zone</td>
<td>Colleen O’Brien MSN, MSMI, RN, CPHQ, ASQ CMQ/OE, ASQ CQA Bellin Health <a href="mailto:cmobri@bellin.org">cmobri@bellin.org</a> 920-433-7905</td>
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<tr>
<td>Incident Reporting Software: From Vendor Selection to Implementation</td>
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**Summary:** The purpose of this project was to select, install and implement a web based incident and complaint/compliment reporting software tool for Bellin Health. Incident reporting refers to safety events such as falls or medication errors.

**Core Team members:** Janelle Beckett RN, Mary Mueller RN, Kathy Wautlet RN, Diane Koepke, Katie Kosch PharmD, Colleen O’Brien RN

**Aim(s):** Move from an antiquated paper incident reporting system to a robust electronic reporting system that is flexible to accommodate all current paper event reporting processes including patient safety events, employee health events, and patient complaint and compliments. The web-based solution will be easy for staff to report events. The system will have report capabilities to identify trends for process improvement and re-design, and enhance a safety culture.

**Measures:**

1. Completed implementation of electronic reporting of patient/visitor safety events.
2. Increased incident and medication event reporting by 10% by 12 months after implementation.
3. Increase in staff response to ease of reporting a safety event.
4. Patient Care process re-designs are implemented based on an analysis of safety event data.
5. Safety event data is incorporated into the Quality Improvement Council and departmental meetings.
6. Improved safety culture survey results for non punitive response to errors and frequency of events reported.

**Results:**

1. System was selected, implemented and rolled out department by department with full implementation completed by August 2011.
2. Event reporting increased 54%.
3. Staff reported ease in reporting events, indicated by the increase in events reported.
4. Within 6 months after implementation 5 system redesigns/issues were identified and resolved.
5. Scorecard measures were created to reflect number and closure of events. Process implemented to provide summary data back to departments.
6. Nonpunitive Response to Error percent positive responses improved from 50% 2010 to 53% in 2012. Frequency of events reported dropped from 69% in 2010 to 63% in 2012 which is counterintuitive to the 54% increase in actual number of events reported.

**Lessons Learned:**

1. Involving the staff from the start with vendor selection created excitement, interest and buy in.
2. The use of project management knowledge, skills and tools contributed to a successful product selection, implementation and installation.
3. Staff appreciated the ease of going from paper to electronic reporting.
4. Changing from paper to electronic often brings to light issues not easily seen before. In this case, there was no standard practice for what constitutes closing an event, including who, does what by when.
5. Staff and Leaders struggled with giving up the paper forms and using only the electronic forms.
Medication Safety: A Medication Error Reduction Program

**Contact person:**
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**Summary:** Patient health, safety, and satisfaction are directly influenced by the timely and safe delivery of medications. Medication administration is a complex process impacted by fatigue, communication, and human factors which can contribute to medication errors. Standardization of the medication administration process can be an effective method to mitigate these factors and reduce medication errors.

**Core Team members:** Roxanne Cliff, BSN, RN, MHA; James Dembowiak, R.Ph; Mirella DeRango, PharmD, BCPS; Jan Fuchsen, BSN, RN, MA; Chasity Hill, BSN, RN; Jacklyn Justus, MSN, RN; Elizabeth Saltigerald, RN; Cecelia Lorenz, MSN, RN; Mary Regozzi, BSN, RN; Dan Rosin, BSN, RN; William Stafford, PharmD; Sherry Tennies, MSN, RN; Jessica Panfil, LPN

**Aim(s):** Examine the current medication administration process to identify non-value added activities and practice variances, and then standardize the medication administration process. The goal was to reduce medication errors to 1% or less for all medications given (per 10,000 doses), reflecting best practice.

**Measures:**
Baseline for the current medication administration process was obtained by observing the delivery process using a standardized tool. Variances in the medication administration process and non-value added activities were identified. Primary factors contributing to medication errors on the unit included lack of a standardized medication process, new patient care unit, and new nursing model. Actionable steps were identified to improve the medication administration process. A standardized medication administration process was developed, piloted, studied, and implemented on the unit with a monthly score card to reflect control measures. Staff were re-educated on the elements of safe medication administration. Medication errors were tracked using the monthly score card.

**Results:**
This project resulted in the development of a standardized medication administration process that was efficient and effective. The process used the acronym SAFE MED PASS and was included in staff education and reminders were placed on all medication carts. The standardized process reduced administration time by 5.5 minutes and had 5 fewer steps. Medication errors were reduced from 5.15% /10,000 doses (October 2012) to 0.38%/10,000 doses (September 2013).

**Lessons Learned:**
A new patient care unit and nursing model contributed to increased medication errors. It is imperative that medication administration processes be evaluated to identify factors that impede safe medication delivery. Standardizing medication administration processes can work to reduce factors that contribute to medication errors and improve safe medication practices. Quarterly medication pass audits and error tracking is imperative to avoid practice drift and sustain improvement.
### AMCO Inpatient Patient Experience

**Storyboard topic/title:**

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**Contact person:**
Shirley Schmick RN BSN  
Quality Improvement Coordinator  
Aurora Medical Center Oshkosh  
920-456-7646  
shirley.schmick@aurora.org

**Summary:** *Improvement in Inpatient Patient Experience* Aurora Medical Center Oshkosh

**Core Team members:** Shane Carter RN MSN, Chief Nursing Officer, Heather Hoeffler RN MSN, Director of Nursing, Mary Merwin, Director of Clinical Operations, Shirley Schmick RN BSN, Quality Improvement Coordinator Senior

**Aim(s):** Utilization of Best Practice Principles—Strategies were implemented in the inpatient units to improve patient satisfaction, the patient experience, and drive clinical quality. Research has proven that by implementing these key strategies, the patient experience will be enhanced.

- A.I.D.E.T.
- Purposeful Rounding on patients – 5 Ps
- Bedside report
- Purposeful Rounding on staff
- Concurrent real-time audits and coaching of staff
- Employee Recognition
- Patient Communication White Boards
- Post discharge phone calls
- Transparency of Data – Unit Metric Boards/Staff Meetings

**Measures:**

**Where we were:** AMCO Patient Experience/Service Impact in Inpatient for 2010:
- January 2012 Overall rating 45 out of 100 per results of Press Ganey patient surveys.

**Results:**

**Improvements Realized: YTD December 2013:**
AMCO Inpatient Overall rating increased 74 out of 100 per Press Ganey Survey

**Lessons Learned:**

Continued reinforcement/emphasis on best practices is essential. Take into account unique characteristics of each unit.
**Fundamental Engineering at UW Health: Partnering to Redesign Care**

**Summary:** The current era of healthcare reform demands rapid improvements and redesign efforts to improve the quality of care and decrease costs. Nationally, there is growing recognition of the value of industrial and systems engineering expertise to lead healthcare redesign efforts (Reid, 2005). Academic health centers affiliated with universities with industrial engineering (IE) departments have a unique opportunity to develop partnerships.

University of Wisconsin Health, an academic medical center employing 1,255 primary and specialty care physicians, has recognized the importance of encompassing industrial engineering concepts and tools to improve quality within the health system. UW Health leverages the skills of industrial engineers by partnering with the UW-Madison Department of Industrial and Systems Engineering (ISyE) to promote innovation and facilitate improvement in the healthcare setting. The UW-Madison ISyE department has approximately 212 undergraduate and 143 graduate students per year. As of 2012, the program is ranked seventh in the nation (US News).

**Core Team members:** UW Health Program Coordinators (full-time health systems engineers employed by UW Health), UW Health Executive Leaders (leaders from quality and operations who oversee the program), UW-Madison ISyE Department Leaders (department chair, department administrator, student services coordinator, and participating faculty)

**Aim(s):** Provide real world health care project experience to UW-Madison Industrial Engineering (IE) students, Provide quality improvement project support to UW Health.

**Measures:** Electronic surveys are provided to students, UW Health project leads, and UW-Madison faculty at the end of each semester to measure satisfaction with their experience. Student participants are asked to rate their level of satisfaction from 1 (very dissatisfied) to 5 (very satisfied) regarding their overall satisfaction with UW Health and average satisfaction with UW Health project lead support. They are also asked to estimate the average hours spent per week at project site, if completing the project was a valuable learning experience, and how likely they are to seek a position in healthcare.

**Results:** Projects have shown measurable improvements in clinical and non-clinical processes, with a range of topics from job analysis, workflow redesign, and schedule optimization. In total, **362 projects have been completed by 629 students since 2006.** Survey results show high satisfaction by students, project leads, and ISyE faculty.

**Lessons Learned:** Several critical success factors have been identified to partnering with academic industrial engineering student programs. First, a clear program structure needs to exist with identified administrative and physician leaders and a program coordinator with a relationship with the UW-Madison industrial engineering department. The implementation of UW Health engineering staff members as mentors for student project teams has also contributed to the success of the program. Additionally, the UW-Madison industrial engineering department course objectives need to be aligned with the health care system needs, and it is helpful to have faculty with a dedicated interest in health systems engineering.
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| **UW Health Improvement Network:** Advancing UW Health’s Culture of Continuous Quality Improvement | Amy Smyth  
Amy.smyth@uwmf.wisc.edu |

**Summary:** Since 2012, the UW Health Improvement Network (UWHIN) has facilitated the development and continued growth of UW Health’s culture of continuous quality improvement. Using the exact methodology (FOCUS-PDCA) being taught across the organization, the UW Health Quality, Safety, and Innovation department has redesigned the UWHIN Program to improve the effectiveness of the content, increase participation, cater to the needs of a diverse workforce, and advance organizational strategic priorities.

**Core Team members:**
All Members of UW Health Quality, Safety, and Innovation Department:
Pratik Prajapati, MHA, Program Director of Improvement and Innovation Education
Amy Smyth, MA, Improvement Coach
Julianna Spranger, Improvement Coach
Sally Kraft, MD MPH, Medical Director

**Aim(s):** Increase the number of learners participating in the UWHIN education program from 1000 to 2000 by December 31st, 2013.

**Measures:** Number of learners by course

**Results:** Number of learners completing the basic-level: 1659

**Lessons Learned:**
- Streamlining education program content to emphasize key learning objectives
- Catering to customer needs by aligning education program with focused improvement efforts
- Improving communication and marketing efforts to increase participation
- Leveraging organizational leaders to encourage participation
- Developing an evaluation tool to provide feedback to facilitators on completed improvement projects
### Storyboard topic/ title: Storyboard topic/ title:  
**Serious Reportable Event (SRE) Reporting**  
**To Serious Safety Event Rate (SSER)**

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| **Serious Reportable Event (SRE) Reporting** | Chris Lutze, RN, Patient Safety QI Specialist  
Children’s Hospital of Wisconsin  
clutze@chw.org |
| **To Serious Safety Event Rate (SSER)** | |

**Summary:**
The current serious reportable event (SRE) rate does not capture all patient harm. Successful implementation of the serious safety event rate (SSER) requires thoughtful deliberation and the development of a transition and education plan. SSER is recommended measure proposed by Solutions for Patient Safety (SPS) Collaborative to track improvement over time in reducing harm and building a high reliability organization.

**Core Team members:**
Surgical quality consultant, manager of data integrity, Clinical Risk manager, and Chief Medical officer, vice president of medical affairs, pediatrician, magnet coordinator, public relations manager, and patient safety management.

**Aim(s):** The team will develop & implement the serious safety event rate (SSER) for 2014.

**Measures:** Data about the current state: Current SRE measures include reported clinical quality events (Midas event reports, rapid response and code events), as well as those that meet the CMS, & NQF serious reportable events, and TJC defined sentinel events.

**Definitions:**
- **NCC MERP:** National Coordinating Council for Medication Error Reporting and Prevention.
- **HPI SEC:** Healthcare Performance Improvement Safety Event Classification.

**Results:** All of 2013 serious patient safety events classified using the NCC MERP severity index coding have been reclassified using the HPI SEC levels of harm, as of 02/2014 to establish a baseline, and the SSER rate will be implemented as of 02/2014.

**Lessons Learned:** As serious safety events do not occur frequently, the rate presents a clearer picture of event rate trends and it rewards sustained improvement, rather than episodic improvement in preventing serious safety events. To achieve a “zero” SSER, the hospital must provide care that results in 12 consecutive serious safety event-free months. The SSER can be used to determine baseline performance and to track effectiveness of efforts to improve reliability in patient safety performance.
### Storyboard topic/ title:

| Moving Care to the Right: Community Partnerships for Improved Outcomes |

### Contact person:

Vicki Wetenkamp  
Administrative Director, Clinical and Service Excellence  
Holy Family Memorial, Manitowoc, WI  
920-320-2730  
VWetenkamp@hfmhealth.org

### Summary:

Holy Family Memorial has partnered with area nursing homes to provide the “Right Care in the Right Setting with the Right Outcomes”. We implemented PCMH’s within 3 LTCF’s, developed protocols for care currently used in 7 LTCF’s, and improved the physician call rotation to take advantage of a smaller pool with focused expertise.

### Core Team members:

Dr. Mary Govier, Internist; Dr. Lorraine Jackson, Internist; Dr. Gary Schmidt, Family Medicine; Patti Bertsche, RN; Cheri Seifert, RN, Julie Place, RN, Director of Nursing Long Term Care Facility; Vicki Wetenkamp, Quality Management, Sally Zimmerman, Clinic Operations

### Aim(s):

Improve communication and coordination as patients transitioned from inpatient care to nursing homes, develop standardized protocols for care of nursing home patients starting with discharge from the hospital, and provide the right care in the right setting.

### Measures:

Hospital readmissions from the Nursing Home; ED transports from the Nursing Home.

### Results:

Development of protocols for CHF, COPD, and pneumonia  
Reduced Readmissions from the 3 Nursing homes with physician clinics  
Reduced ED transports from those same 3 nursing homes

### Lessons Learned:

Communication and collaboration are key to improved care for our patients during transitions of care.  
The aging population requires a different model of care delivery which must be addressed as you look at population health.  
Physician leadership is critical to improving models of care.
Reducing Unnecessary Antipsychotic Use Through Quality Assurance & Performance Improvement

Contact person:

Jody Rothe, RN, WCC
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jrothe@metastar.com

Summary: CMS leads a National Nursing Home Quality Care Collaborative, which aims to engage nursing home teams in a learning in action network to spread techniques such as: innovative leadership methods, successful practices for recruiting and retaining quality staff, ideas for celebrating the resident, skill building for enhancing teamwork and communication across the health care continuum, ways to develop a continuous learning organization, practices for providing exceptional clinical care, and foundational business practices that support quality care.

MetaStar and key stakeholders deploy local efforts to spread these methodologies through the Wisconsin Quality Coalition (WiQC)- including 193 nursing homes. One of WiQC’s priorities is the reduction of unnecessary antipsychotic use for patients with dementia in nursing homes. Unnecessary antipsychotic drug use is a significant challenge in dementia care. Data from the Centers for Medicare & Medicaid Services show that in 2010 more than 17 percent of nursing home patients had daily doses exceeding recommended levels. Too often antipsychotic medications are used in nursing homes to modify behavior without considering the risk of increased falls with fractures, hospitalizations and other complications. This results in residents with poor health and higher health care costs. By lowering the use of unnecessary antipsychotic medications, we can improve the quality of life for residents.

Core Team members: MetaStar Staff; WiQC/AE Advisory Board

Aim(s): Improving health care quality is an urgent priority that requires everyone’s efforts. The WiQC uses the QAPI model to identify problems, test solutions, and sustain positive change. As one of the aims of the coalition, WiQC supports the Partnership for Patients’ goal of reducing unnecessary antipsychotic use by 15%.

Measures: The WiQC focuses clinical, organizational, Quality Assurance & Performance Improvement measures. For antipsychotic use in particular, MetaStar looked at a quality measure that reports the percentage of long-stay residents who are receiving antipsychotic drugs in the target period (Definition per Minimum Data Set [MDS] 3.0 per v8.0 04-15-2013).

Results: Nursing homes teams contributed to successful outcomes by using QAPI processes.

- Antipsychotics have been reduced by an 8% relative improvement rate from July 2013 to December 2013
- 100% of the nursing homes have selected goals and topics for improvement
- Over 77% of the 193 nursing homes are making improvements in their topics
- 100% of nursing homes have a system in place to measure their progress
- Over 85% have completed a QAPI self-assessment

Lessons Learned: There are several national and state initiatives that focus on dementia care and quality improvement in nursing homes, which can be a barrier for nursing homes unsure where to focus their efforts. The MDS quality measure changed during the measurement period, which may have led to rework or shifts in focus. Nursing homes sometimes face challenges choosing targets and deciding which individuals should be part of the process improvement teams.
### Stoughton Emergency Department Goes Lean!!!

#### Summary:
By conducting a Kaizen activity the Stoughton Hospital Emergency Department determined appropriate supply needs and locations. All staff was encouraged to get involved in this LEAN initiative. Significant waste reduction and cost savings were realized through this activity. As the department plans for remodeling in the near future, this information will be helpful with space planning in the new facility.

#### Core Team members:
Tina Strandlie, ED Manager; Nicki Rowin, RN; Scott Blackledge, RN; Chelsey Toso, RN; Eileen Barry, RN; Carrie Swofford, ED Tech.

#### Objectives:
- Reduce waste in the Emergency Department by eliminating at least one supply exchange cart, amount of linen and expired items
- Reduce clutter in the ED Rooms to prevent hazards
- Provide easier access to supplies and standardize storage
- Realize cost savings to the department

#### Measures:
Supply cost per patient

#### Results:
Supply costs per patient declined 2.7% over 6 months after interventions. In addition, the department organized storage space, standardized supplies, removed clutter and noisy C-lockers. More space was created for a dedicated eye room as well as critical Cardio-pulmonary equipment storage in the ED.

#### Lessons Learned:
This was a team project across multiple disciplines. The ED staff worked with Material Services to decrease the amount of supplies on hand. The ED staff was highly engaged in finding solutions to the problems (how much of each item was needed, where these items would be stored conveniently, decrease wasted steps, decrease clutter etc.) Since the rooms have been de-cluttered ED has not had any trips/falls in the department by staff.
**Storyboard topic/title: Improve Surgical Outcomes using Surgical Best Practice Processes**

**Contact person:** Ray Riska  
Froedtert Hospital  
Ray.Riska@froedtert.com

**Summary:** Team set out to reduce surgical site infections; cardiac risk and VTE prevention by applying Best Practice Surgical Process/Outcomes in near real-time. Each day a report is generated that includes process measures from the previous day surgical cases. A Quality Coordinator and Anesthesia Quality Analyst review the process measures to identify opportunities for improvement. Involved Surgical staff is contacted with opportunities for improvement within a day of the case. This allows near real-time education and clarification of the opportunities. Since this process has been implemented Performance Improvement Compliance has increased from 97% to 99%. Identifying the remaining 1% failures has allowed us to identify the EHR best practice alerts and structured cuing interventions that are needed to reach 100%.

**Core Team members:** Mary Conti RN, Data Analytics Coordinator, Ray Riska RN, Quality Management Coordinator, Michael Law, Senior Reporting Analyst, Jamie Rodee, Anesthesia Quality Analyst, Kathy Lauer MD, Director of Quality, Anesthesia, Susan Huerta, PhD, VP Quality, Dr. John Weigelt, Medical Director Joint Quality Office

**Aim(s):** To improve surgical outcomes and accountability by using near real-time process information this allows interaction and teaching of responsible parties.

**Measures:** Surgical Best Practices
- Prophylactic antibiotics within 60 minutes prior to incision
- Prophylactic antibiotics selected based on guidelines
- Prophylactic antibiotics discontinued within 24 hours of incision
- Administration of Beta Blocker to Chronic Beta Blocker surgical patients
- Anticoagulation and/or mechanical compression of surgical patient at risk of VTE

**Results:**
- Increased awareness of best practice guidelines
- Increased communication among and with accountable staff
- Increased compliance with Surgical Best Practice Measures
- Improve Surgical Outcomes

**Lessons Learned:**
- Leadership buy-in imperative (Administrative and Medical)
- Identify available resources and limitations
- Energize, complement, and recognize team
- Understanding of EHR documentation is key
- Data is needed to facilitate and maintain change
### Implementation of an integrated, sustainable, performance improvement plan, in a shifting healthcare environment.

**Storyboard topic/title:**

- Performance improvement (PI) is an expectation of all stakeholders. However, sustaining an integrated plan is challenging due to competing priorities and limited resources. In Fall 2011 we implemented, and have sustained, a comprehensive performance improvement plan, utilizing the CARF framework.

**Core Team members:** Margie Amato MS, RN-Program Manager; Margaret Edelstein MSN, RN-Quality Management; Dr. Kenneth Lee-SCI Medical Director, Division Manager; Cecelia Lorenz, MS, RN—MIO Coordinator

**Aim(s):** Implement an integrated, sustainable performance improvement plan, requiring:

1. Alignment of goals, practice, and resources
2. Integration of PI processes, embedding best practice
3. Adaptability to the shifting requirements of health care

**Measures:** Clinical outcomes; patient/stakeholder satisfaction; program efficiency.

**Results:** Sustained improvement in clinical outcomes including med errors and fall rates: Increased efficiency in key programs: Improved patient/stakeholder satisfaction. Successfully maintained gains and integrated new measures. (Data available).

**Lessons Learned:**

1. Solicit input and participation from all stakeholders.
2. Clarify priorities, gain consensus.
3. Anticipate impact of major events—i.e.: Program relocation.
4. Utilize resources of larger facility/community.

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