WISCONSIN HOSPITAL ASSOCIATION

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2022 QUALITY REPORT

2022

Challenge Met:

Health Care Quality Remains Top-of-Mind Amidst Unpredictable Pandemic

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2021: A YEAR OF RESILIENCE

A Message From Eric Borgerding, WHA President and CEO

The period covered in this Wisconsin Hospital Association (WHA) annual Quality Report was one in which hospitals and the people working in them were tested like never before. Deservedly so, health care providers here and around the world have drawn praise and gratitude for their resilience in the face of COVID-19. Undoubtedly, the commitment of Wisconsin's hospitals and health systems to their patients and their communities over the past year saved countless lives and prevented even greater virus spread throughout the state.

Wisconsin's hospitals served as both the front line and the last line of defense in fighting the COVID-19 pandemic, adapting their operations quickly to maximize the safety of their patients, staff and the community while adding workers where needed and appropriating available space and resources to attend to increasing numbers of infected patients. Health care providers throughout the state also stepped up to perform hundreds of thousands of COVID tests within their facilities and in drive-through sites. And hospitals are helping us all return to the lives we miss by administering millions of doses of COVID-19 vaccines.

All the while, hospitals continued to deliver babies, attend to accident victims and treat chronic diseases. When federal restrictions on non-emergent care were lifted in April of 2020, hospitals and health systems welcomed patients back to receive care that may have been delayed. Meanwhile, hospitals throughout the state actively participate in and fund community development activities that enhance the quality of life of their neighbors.

And true to the state's long-standing commitment to patient safety and health care quality, standards of practice in Wisconsin's hospital remained high throughout this challenging time, as the data in this report show.

Across the Centers for Medicare & Medicaid Services' (CMS's) various health care quality programs, Wisconsin hospitals demonstrate leadership. 2021 saw a continued trend of increasing numbers of hospitals in the state qualifying for the higher-level payment bonuses for the agency's Hospital Value-Based Purchasing Program. Wisconsin hospitals also register fewer unplanned readmissions than the national average, according to CMS data.

Wisconsin hospitals and health systems have been pioneers in quality measurement and have long shared safety and quality data with the public. WHA's CheckPoint is one of the nation's leading statewide, voluntary hospital quality reporting initiatives, meeting the demands of clinicians and consumers for information on the quality of care Wisconsin hospitals provide to their patients and communities. CheckPoint also helps foster a culture of collaboration in Wisconsin that fuels continuous improvement among hospitals, supported by the initiatives detailed in the following report, with the understanding that improving care is a journey with no end.

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Introduction

Health care quality always remains a top priority in Wisconsin hospitals, even during a prolonged COVID-19 pandemic. Hospital staff throughout Wisconsin experienced a second year like no other in their lifetimes in 2021, and yet, they met the challenge with patient safety at the forefront of everything they did. The Wisconsin Hospital Association quality team is grateful for the passion, compassion, adaptability and resilience of the health care professionals throughout the state so devoted to their patients and their communities. Coordinating the evolving components of a public health emergency warrants both acknowledgment and praise, especially given the complex and sustained response the pandemic called for, including:

- Care coordination and collaboration;
- Merging virtual and in-person care, balancing telehealth;
- Clinical trials and life-saving vaccines;
- Consumer and clinician-facing digital health tools that reduce clinician burnout;
- Building a responsive and reliable supply chain;
- Staffing shortages, as detailed in the WHA workforce report; and
- Advancing health equity and reducing disparities.

This report chronicles the initiatives and outcomes associated with quality improvement and patient safety efforts in Wisconsin hospitals and health systems from Jan. 1, 2021, to Dec. 31, 2021, a period in which the state's health care system was under extreme stress due to the ongoing public health crisis.

The COVID-19 Pandemic: A Career Defining Moment for Quality Leaders

By Bobby Redwood, M.D., WHA Physician Quality Improvement Advisor

Bobby Redwood, MD

In health care, we are all reeling from successive COVID waves and the general disruption that the pandemic has wrought on our professional lives; quality leaders are no exception. Pre-pandemic, the rhythm of the hospital quality curriculum felt quite routine: regulatory readiness, benchmarking, PDSA…CLABSI, CAUTI, hand hygiene…lather, rinse, repeat. Any pattern that we had established in our respective leadership roles was certainly disrupted in March 2020 and will likely remain disrupted for some time.

Early on, we all experienced a crash course in disaster preparedness and crisis operations. Did your hospital have an incident command structure? If so, when was the last time it was actually operationalized? We may have retained our doffing and donning motor memory from the Ebola preparedness work in 2014, but could we have imagined the mile-long testing lines, the shortages of disposable gowns or the re-use of N95s that we saw in 2020?

After the first COVID wave, the crisis morphed into a different beast—a pandemic plus a budget crisis. Health systems appropriately spent massive sums to deliver needed care during the first wave, but the limited capacity and truncated lines of service have had ripple effects on quality improvement work that are still being felt. Some health systems downsized administrative staff to shunt necessary resources to frontline care workers. Many of the tools that we use to influence physician quality such as symposiums or hands-on workshops were scaled back for infection control and budgetary reasons. We all needed to prioritize immediate patient care to handle the barrage of COVID-related work that seemed to be hitting our hospitals like waves on the beach. When we do have a quality meeting, it often starts with, "While we're all here, I have a quick COVID update to share…"

Things have to normalize at some point, right? Well, briefly in October 2021, it seemed like we were getting there. Strategic priorities were looking beyond the pandemic, but hospital crowding and emergency department boarding were showing up front and center as serious issues. Sepsis and stroke quality improvement seemed to be getting back on track. We even (cautiously) began rolling out a few new initiatives in 2022. Procedural sedation checklist audits anyone? And then…Omicron. Just like that, we had testing bottlenecks, postponements of elective procedures and national guard troops filling tech and nursing assistant roles.

The first (and probably most important) lesson that we have recently learned is that we must take care of the caretakers. COVID is not going away anytime soon. Our systems are strained. Burnout is real. As a physician quality leader in my hospital, I am doing wellness rounds with our staff now more than ever. "How are you doing? Really doing?" "What support do you need to do your job?" "This is hard. What would make it a little bit easier?" Later in the day, when the volume picks up, my tone typically pivots to gratitude rounds. "Thank you for showing up today." "You are propping up your community during an historic hardship." "You are a health care soldier." "What you do matters."

As a new physician quality improvement advisor at WHA in 2016, I remember designing the curriculum for the first WHA Physician Quality Academy. It was an elegant curriculum, crammed into three thick binders, based on the triple aim: improving the experience of care, improving the health of populations and reducing per capita costs of health care. Two years into the pandemic, the triple aim remains 100% relevant, but I think we are all aware there's a need for a fourth binder: maintaining the wellness of the care team. As quality leaders, we are trained to embrace change and to thrive on progress. We are able to see what tomorrow's needs are, so we can start working on them today. If no one has told you yet today, thank you for what you do, and thank you for taking care of our health care workforce. Risking hyperbole, I think it is fair to say that the need for leadership in health care quality improvement has never been as essential as it is right now, and the stakes have never been higher.

Quality Data Tracking and Reporting

WHA's quality improvement practices are led by a measures team, whose members represent more than 80 hospitals and health systems in Wisconsin. The measures team comprised the following members in 2021:

- Carrie Nelson, Advocate Aurora
- Sue Raduenz, Bellin Health
- Kris Melaas Merkel, Marshfield Medical Center
- Kayla Mobley, Tomah Health
- Tom Rampulla, Ascension
- Lisa Sheldon, Gundersen Health System
- Holly Francis, Mercyhealth
- Linda Drummond, UW Health
- Christine Klement, Aspirus
- Sue Peiffer, HSHS Wisconsin
- Dr. Mbonu Ikezuagu, ThedaCare

In 2004, the Wisconsin Hospital Association (WHA) launched its voluntary hospital quality reporting program, CheckPoint. CheckPoint was the first statewide, voluntary hospital quality reporting initiative in the country. It is designed to meet the demand for information on the quality of care provided by community hospitals.

Improving health and patient care is essential to Wisconsin's hospitals, health systems and clinicians. Each day, health care professionals and hospital executives work tirelessly to provide clinical expertise and leadership to reduce or prevent costly chronic diseases, maximize patient outcomes and improve health across the continuum of care.

Performance data on 45 metrics tracked by acute care and critical access hospitals across Wisconsin summarize the progress and trends on specific quality measures related to births, hospital acquired infections, mortality, patient experience, patient safety and readmissions. By sharing information, Wisconsin hospitals can benchmark their progress against other hospitals in the state. In addition, the CheckPoint initiative has been a catalyst for Wisconsin hospitals to contact peers that are doing well in a clinical area to identify best practices that can be implemented in their own organizations. This sharing of best practices facilitates rapid improvement.

Following are a few Wisconsin success stories as featured in CheckPoint for this past year, during an extremely tumultuous time.

Birth Measures:

- Term Newborn Complications reduced 31.75%.
- Newborn Screening Transit Time improved 1.49%, up to a 99.46% on-time rate.

Infection Measures:

- Clostridioides Difficile Infections (CDI) reduced by 6.06% since the 2019 baseline data.
- Surgical Site Infections (SSIs) for Abdominal Surgeries reduced by 44.14% (surgical cases were down, but infections were as well).
- Zero-infection notables:
  - » Wisconsin hospitals performed extremely well during the pandemic with regards to the following infections tracked in CheckPoint, with 26 hospitals having zero infections in all six categories (or zero infections in all categories that applied to them): Central Line Associated Blood Stream Infection (CLABSI), Catheter Associated Urinary Tract Infection (CAUTI), Clostridioides Difficile Infection (CDI), Methicillin-Resistant Staphylococcus Aureus (MRSA), Surgical Site Infection–Colon Surgery (SSI-C) and Surgical Site Infection–Abdominal Hysterectomy (SSI-H). Additionally, 17 hospitals had zero infections in five of the six categories.
  - » Tracking Standardized Infection Ratio (SIR) changes for acute care hospitals (applicable to larger volume hospitals), showed 22 hospitals with a reduction in CAUTIs, 15 reduced CLABSIs, 30 reduced CDIs, 18 reduced MRSAs, 19 reduced SSI-Cs and 10 reduced SSI-Hs. (The Standardized Infection Ratio (SIR) is the primary summary measure used by the National Healthcare Safety Network (NHSN) to track health care-associated infections (HAIs). In HAI data analysis, the SIR compares the actual number of HAIs reported to the number that would be predicted, given the standard population (i.e., NHSN baseline),

adjusting for several risk factors that have been found to be significantly associated with differences in infection incidence. A SIR greater than 1.0 indicates that more HAIs were observed than predicted; conversely, a SIR less than 1.0 indicates that fewer HAIs were observed than predicted.)

Patient Experience:

- While Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) measures for Wisconsin remained above the national average (higher is better) through the first 11 months of the pandemic (through March 31, 2021), the state and national averages have both slightly declined since 2019. HCAHPS assessments include the following experiential feedback:
  - Always Quiet at Night
  - Definitely Recommend Hospital
  - Doctors Always Communicated Well
  - Nurses Always Communicated Well
  - Patient Rated Hospital High
  - Patients Always Received Requested Help
  - Patients Understood Their Care When They Left
  - Room Always Clean
  - Staff Always Explained Medications
  - Staff Provided Discharge Instructions

Patient Safety:

Patient safety outcome highlights for the period covered in this report include the following:

- Falls with Major Injury declined during the pandemic by 33.33%.
- Pressure Injuries/Ulcers showed no significant change, but considering the average length of stay at hospitals was longer during the COVID-19 pandemic, this is notable.

Wisconsin Hospital Performance with Federal Medicare Measures

The driving force behind hospital quality improvement initiatives and the metrics associated with health care efficacy and patient safety is the desire by health care providers to maximize the health outcomes of their patient populations. Through its Hospital Value-Based Purchasing Program, Hospital-Acquired Conditions Reduction Program and Hospital Readmissions Reduction Program, the Centers for Medicare & Medicaid Services (CMS) aims to improve the care provided by the nation's hospitals and link Medicare payments to health care quality in the inpatient setting. In all three programs, Wisconsin hospitals improve year over year and routinely outperform other health care providers. Optimal health care in Wisconsin remains a top priority.

An additional full year of living and working through the COVID-19 pandemic resulted in many changes regarding CMS data requirements. After a data reporting waiver in the first two quarters of 2020, 2021 brought extraordinary circumstance exemptions and program measure suppressions. A blanket measure suppression policy was also put into effect stating that CMS would not use certain measures from the last two quarters of the 2020 reporting period, significantly impacting CMS's Value-Based Purchasing Program, Hospital-Acquired Conditions Reductions Program and Hospital Readmissions Reduction Program.

Hospital Value-Based Purchasing

According to CMS, the Hospital Value-Based Purchasing (VBP) Program is designed to improve the quality, efficiency and safety of care that Medicare beneficiaries receive during acute care inpatient stays as well as improve their experience.

In the fiscal year (FY) 2022 Inpatient Prospective Payment System (IPPS) Final Rule issued on August 13, 2021, CMS determined that circumstances caused by the COVID-19 public health emergency significantly affected National Healthcare Safety Network (NHSN) Healthcare Associated-Infection (HAI), Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and the Medicare Spending per Beneficiary (MSPB) measures in the FY 2022 Hospital VBP Program. As a result, in the final rule, CMS suppressed those measures from the FY 2022 Hospital VBP Program. Because CMS is suppressing many measures, CMS believes there will not be enough data to award a Total Performance Score to any hospital in FY 2022. As a result, no hospital will have a Total Performance Score calculated, and no hospital will have payments adjusted due to the Hospital VBP Program in FY 2022.

The goals of CMS's Hospital Value Based Purchasing Program include:

- Eliminating or reducing the occurrence of adverse events (e.g., health care errors resulting in patient harm);
- Adopting evidence-based care standards and protocols that result in better outcomes for Medicare patients;
- Re-engineering hospital processes that improve patient experience of care;
- Increasing the transparency of care quality for consumers, clinicians and others; and
- Recognizing hospitals that are involved in the provision of high-quality care at lower cost to Medicare.

Bonuses are paid from a 2% withhold from all participants to top performing hospitals that score higher than average when comparing a hospital's "achievement" and "improvement" for each measure in the program. Scores are calculated based on measures within four domains, each weighted equally at 25%:

- Efficiency and cost reduction: Medicare spending per beneficiary
- Safety: hospital acquired infections
- Clinical outcomes: mortality and complications
- Person and community engagement: patient satisfaction/HCAHPS (hospital consumer assessment of health care providers and systems) scores

A summary of the Hospital Value-Based Purchasing Program for fiscal year 2021 is available at https://qualitynet.cms.gov/inpatient/hvbp/resources#tab3.

Hospital-Acquired Conditions

Through the Hospital-Acquired Conditions (HAC) Reduction Program, CMS reduces payments to hospitals based on their performance on measures of hospital-acquired conditions. CMS evaluates overall hospital performance using total HAC scores. Hospitals with total HAC scores in the worst-performing quartile receive a 1% payment reduction on their overall Medicare fee-for-service payments for fiscal year 2022 discharges.

CMS includes the following measures in its HAC Reduction assessment:

Claims-based composite measure of patient safety:

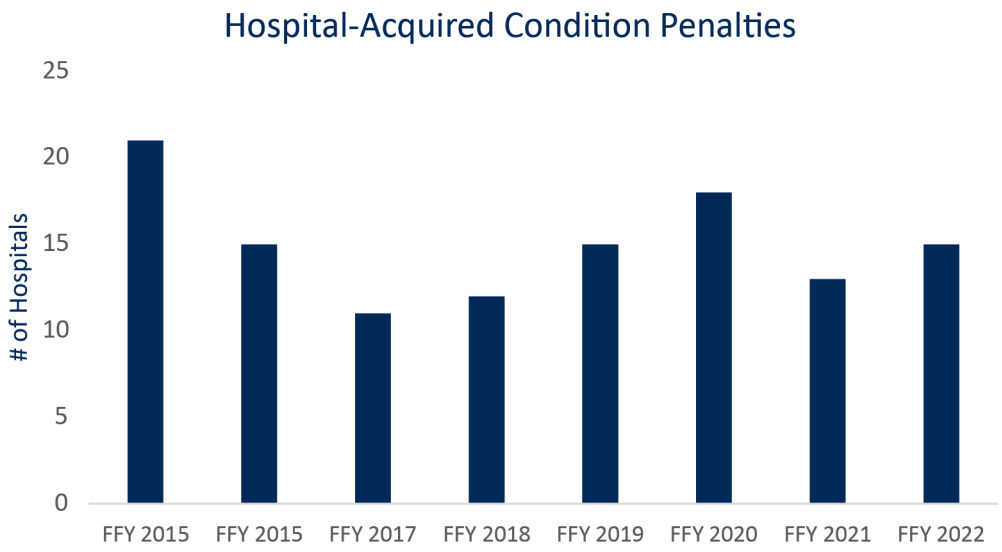
- MS PSI 90 (patient safety and adverse events composite)

CDC NHSN (Centers for Disease Control and Prevention National Healthcare Safety Network) health care-associated infection measures:

- CLABSI (central line-associated bloodstream infection)
- CAUTI (catheter-associated urinary tract infection)
- SSI (surgical site infection for abdominal hysterectomy and colon procedures)
- MRSA (methicillin-resistant Staphylococcus aureus)
- CDI (Clostridioides difficile infection)

A fact sheet related to the Hospital-Acquired Condition Reduction Program is available at https://qualitynet.cms.gov/inpatient/hac.

As with the Value-Based Purchasing Program, infection measure outcomes for the Hospital-Acquired Conditions Reduction Program contribute to a hospital's overall performance score. With this program, the lowest performing quartile of hospitals across the nation incur a financial penalty. For fiscal year 2022, this equates to 15 Wisconsin hospitals that received a penalty.



Hospital Readmissions Reduction Program

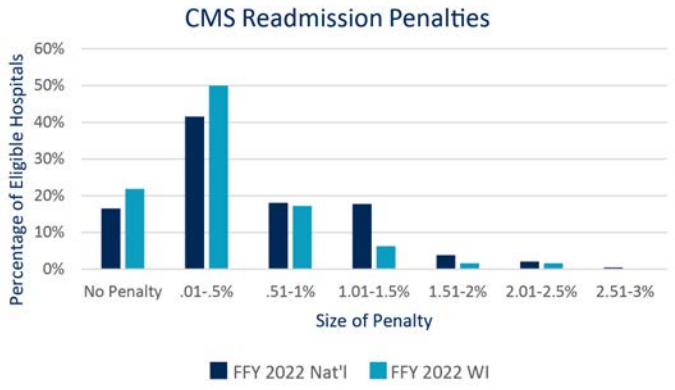
The Hospital Readmissions Reduction Program (HRRP) reduces payments from the Centers for Medicare & Medicaid Services (CMS) to hospitals with excess readmissions. According to CMS, the program is designed to improve communication and coordination to better engage patients and caregivers in post discharge planning. Unplanned readmissions to hospitals are both costly to health care providers and disruptive to patients and their families. Payments within this program may be reduced by up to 3%, depending on the performance outcomes for each of the six identified measures. Fourteen Wisconsin (22% of eligible hospitals) will receive no penalty this year. Nationally, this remains an area of focus, and Wisconsin performs higher than the national average (16% will have no penalty nationally).

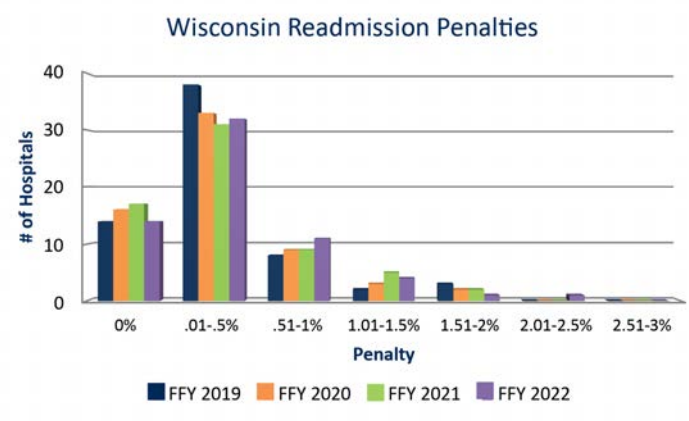
CMS includes the following measures in its Hospital Readmissions Reduction Program assessment:

- Acute myocardial infarction
- Heart failure
- Pneumonia
- Chronic obstructive pulmonary disease
- Total hip and/or total knee arthroplasty
- Coronary artery bypass graft surgery

CMS calculates a payment reduction for all HRRP-eligible hospitals. CMS applies the payment reduction to all Medicare fee-for-service base operating diagnosis-related group payments regardless of condition or procedure.

A fact sheet related to the HRRP is available at https://qualitynet.cms.gov/inpatient/hrrp.





CMS Star Ratings

Hospitals have long been pioneers in quality measurement and have long shared safety and quality data with the public. The large volume of information on Care Compare on Medicare.gov, and the specialized focus of many of the measures publicly reported, could overwhelm patients and consumers. The Overall Star Rating summarizes the information on Care Compare on Medicare.gov in a simple and familiar way. The intent of the Overall Star Rating is to summarize a wide range of publicly reported measures in a single metric. The Overall Star Rating reflects more than 50 measures across five aspects of quality: Mortality, Safety of Care, Readmissions, Patient Experience, and Timely & Effective Care. The Overall Star Rating supplements, rather than replaces, the information on Care Compare.

As part of the April 2021 refresh of Care Compare, CMS updated its hospital Overall Star Ratings. Star Ratings, in addition to the Medicare programs listed earlier, represent several sources of data and ways to rank hospital performance.

According to CMS, the key enhancements made to Overall Star Ratings include the following:

- Replaces the deeply flawed latent variable modeling approach with a simple average.
- Collapses measure groups from seven to five.
- Only assigns rating to hospitals reporting minimum number of measures in certain groups.
- Assigns hospitals to peer groups based on the number of measure groups reported.
- Allows critical access hospitals to withhold public reporting of star ratings.
- Will include Veterans hospitals in the program beginning in calendar year 2023.

The following national statistics representing the stratification of Star Ratings across all U.S. hospitals comes from the American Hospital Association:

U.S. Hospitals 4/1/21 N = 3355		
Star Rating	**Number of Hospitals**	**Percentage of Total**
5 stars	455	13.6%
4 stars	988	29.4%
3 stars	1018	30.3%
2 stars	690	20.6
1 star	204	6.1%

Comparing hospitals' rankings from January 2020 to April 2021 is difficult given the number of methodology changes. The following table shows how Wisconsin hospitals performed compared to the national data above:

Wisconsin Hospitals 4/1/21 N = 87		
Star Rating	**Number of Hospitals**	**Percentage of Total**
5 stars	25	28.7%
4 stars	31	35.6%
3 stars	24	27.6%
2 stars	7	8.0%
1 star	0	0.0%

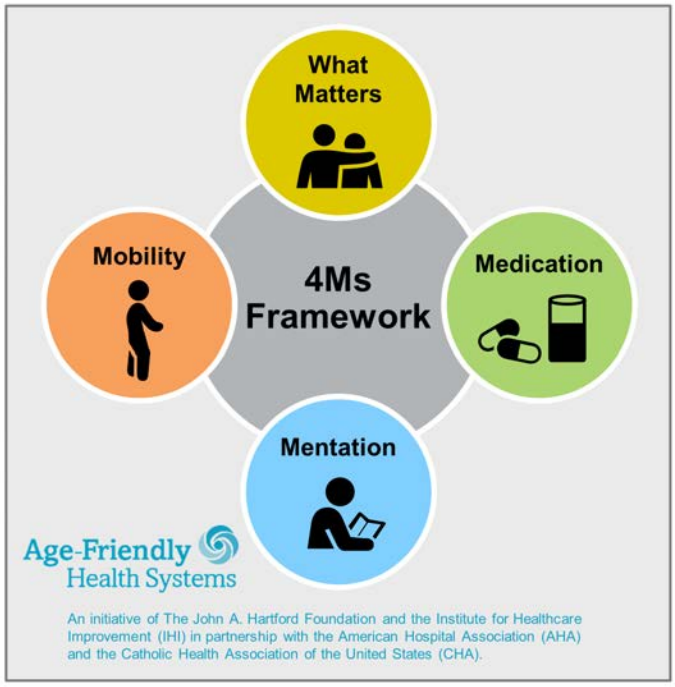
The number of four- and five-star hospitals exceed the national average. Also notable is the fact that no Wisconsin hospitals received a one-star rating. The next data refresh from CMS is expected in spring 2022.

Wisconsin Quality Initiatives

Age-Friendly Health Systems Seek to Improve Care for Older Adults

The population of the United States is not as young as it used to be. The year 2035 represents a projected major demographic turning point in the U.S. The legendary baby boomer generation will all be over the age of 65 that year. Also, one-in-five Americans will be of retirement age, and for the first time in history, persons over the age of 65 will outnumber those under 18.

Addressing the health care needs of a large and diverse older adult population will require new and innovative solutions. To prepare to meet these ensuing challenges, WHA encourages its members to join the Age Friendly Health System movement. Two of WHA's member systems (and multiple hospitals) have already committed. This movement was founded by The John A. Hartford Foundation and the Institute for Healthcare Improvement, in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States.



What Matters
Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication
If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation
Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility
Ensure that older adults move safely every day in order to maintain function and do What Matters.

Falls

Dr. Patricia Quigley, the "nurse who won't give up on falls," presented *Safe Patient Handling–Falls and Falls with Injury* webinar series from July – October 2021. The four-part series offered 60-minute webinars designed to meet the needs of hospitals interested in advancing safe patient handling (Falls) programs to reduce the risk and occurrence of falls. They were held monthly followed with a coach call two weeks after each webinar for hospital participants to engage in discussion and networking and to receive additional support. Webinar topics included Safe Mobility is Fall Prevention, Best Practices to Reduce Falls Associated with Toileting, Redesigning Post Fall Management and Program Evaluation: Reengineering Fall and Fall Injury Programs (Infrastructure, Capacity and Sustainability).


Dr. Patricia Quigley

Dr. Quigley shared, "All organizations share commitment to value-based, mission-driven, competent, safe, and quality care to those in need of their care. Acknowledging that excellence is a journey, so too is the quest toward protecting patients from preventable falls and fall-related injuries. The WHA dedicated programs and resources in partnership with its member health care systems to enhance patient safety programs' infrastructure, capacity and

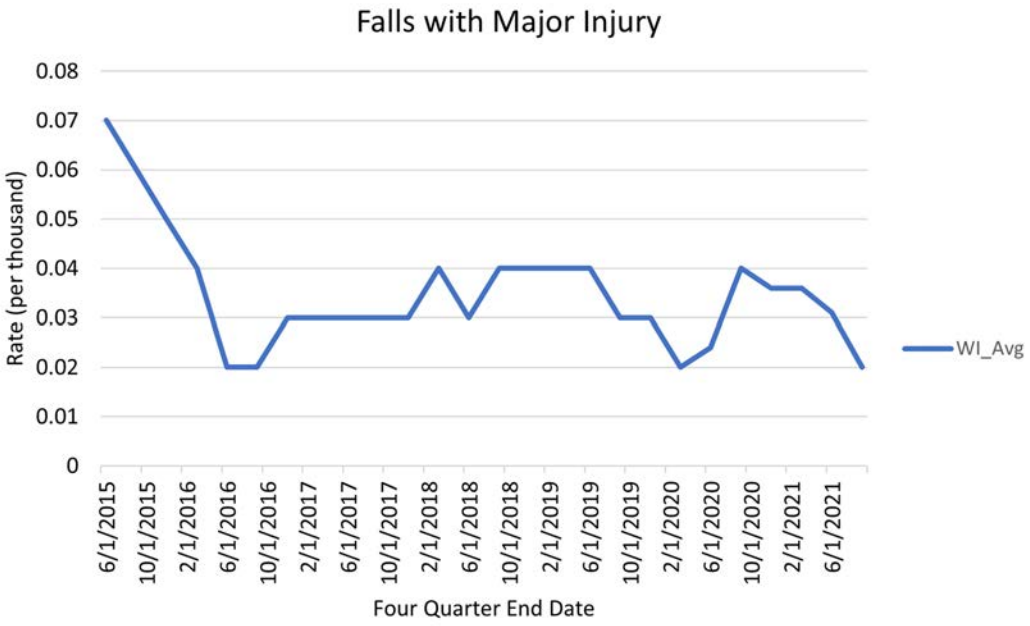
outcomes. I am honored and delighted to collaborate with WHA and the hospital members, knowing that our shared journey is rich with opportunities and successes."

More than 70 individuals representing over 60 hospitals and health care systems participated in one or more of the webinars and coach calls.

Key takeaways:

- It is not enough to look only at the patient's fall risk; it is important, too, to look at the patient's interaction with his or her environment, a major contributor to falls.
- Look at the age distribution of a hospital's population over the last year, noting that data shows people older than 75 frequently sustain injury with a fall, while those 85 and older sustain significant injuries that lead to death.
- Roughly 10-20% of falls occur in bathrooms and are related to toileting.
- Post-fall huddles are an essential core intervention which should take place within 15 minutes of a fall and should include the patient/resident whenever possible.
- A root cause analysis study can help determine the reason for the fall and the events leading up to it and can help identify actions to prevent reoccurrence. Modify the plan of care as necessary.

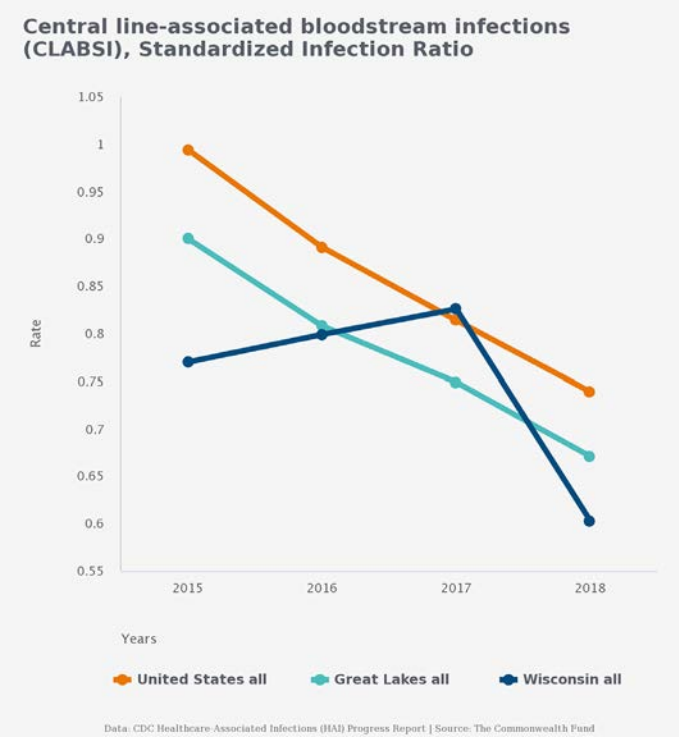
The number of falls had increased slightly at the beginning of the pandemic, but then declined since mid-2020. Given the large number of participants, a focus on reducing falls as one of the top priorities in patient safety is clear across the state.

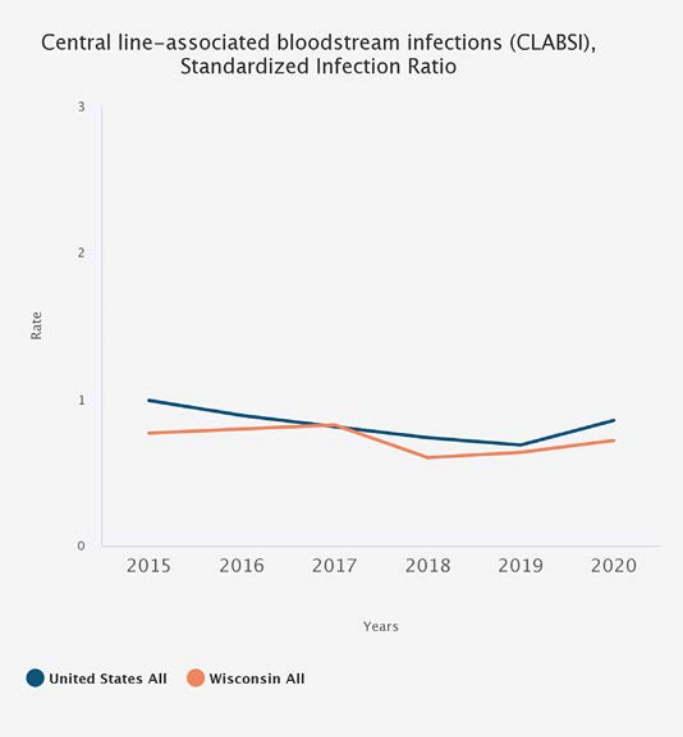


Hospital-Acquired Infections

Wisconsin hospitals have long been engaged in developing a comprehensive infection prevention program. In October 2019, WHA, MetaStar and the Wisconsin Department of Health Services partnered to bring an Infection Prevention Boot Camp to Wisconsin. The bootcamp provided all-day training and a manual packed full of resources to help guide new and veteran infection preventionists (IPs) working in both hospitals and nursing homes. An online resource now exists that keeps those ideas and resources fresh and at IPs' fingertips.

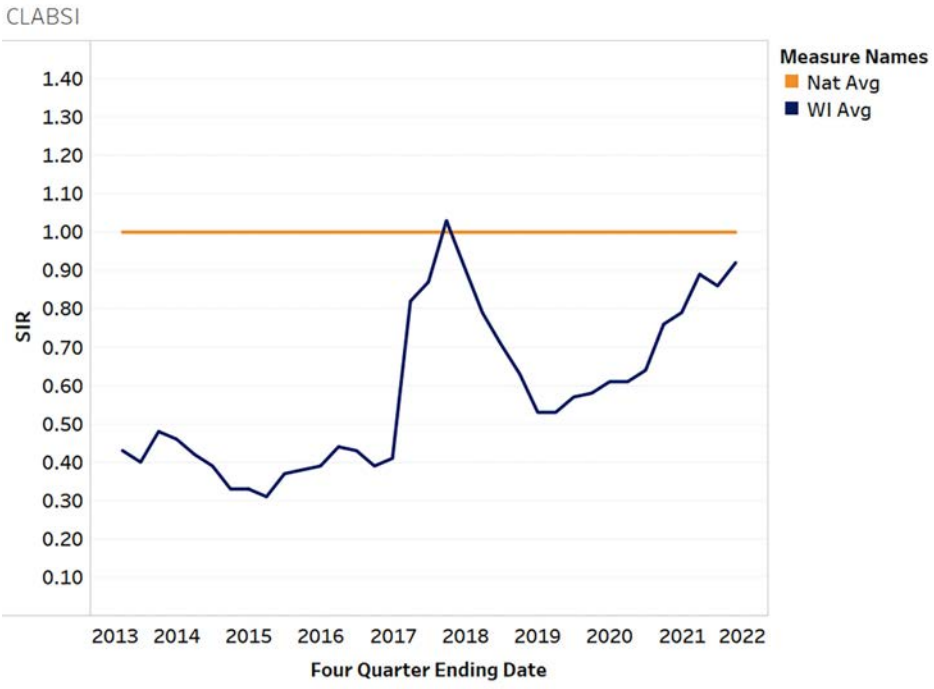
Data represented from the CDC Healthcare-Associated Infections (HAI) Progress Report listed from the Commonwealth Fund shows how Wisconsin compares to the Great Lakes Region as well as across the U.S. This data is pre-pandemic but is a good representation of where Wisconsin hospitals perform for some of the HAI categories.





Post-pandemic, the data shows Wisconsin lower than the national average (SIR=.86) through 2020, with a SIR of .72, placing Wisconsin in the "Top Performing State" category.

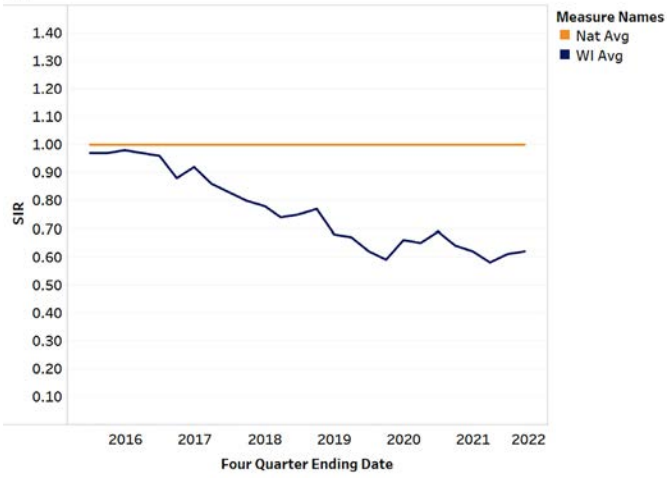
Local data from CheckPoint through the third quarter of 2021 shows CLABSI infections have increased during the pandemic, but still remain under the SIR goal of 1.0



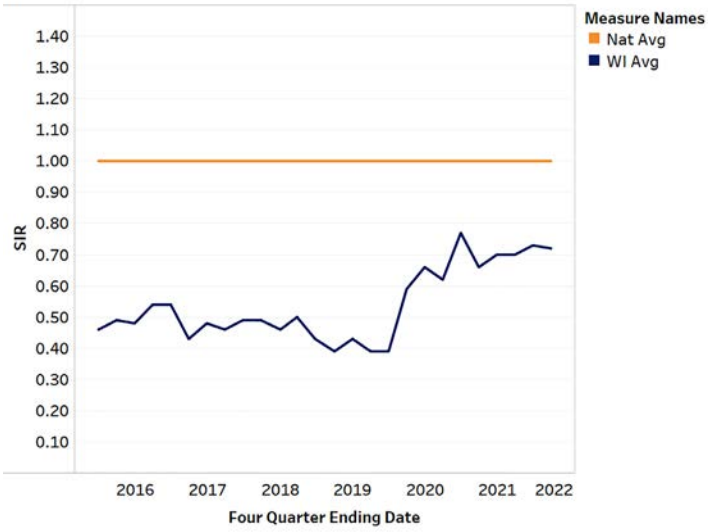
Other HAI performance data can be found here (SIR<1.0 is better):

CAUTI

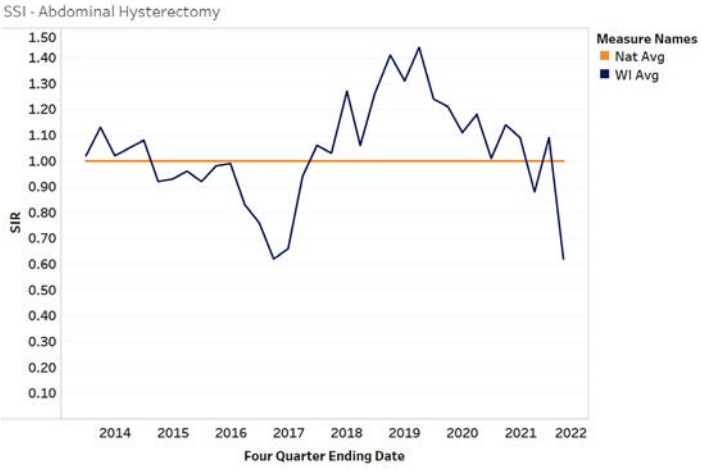
CDI



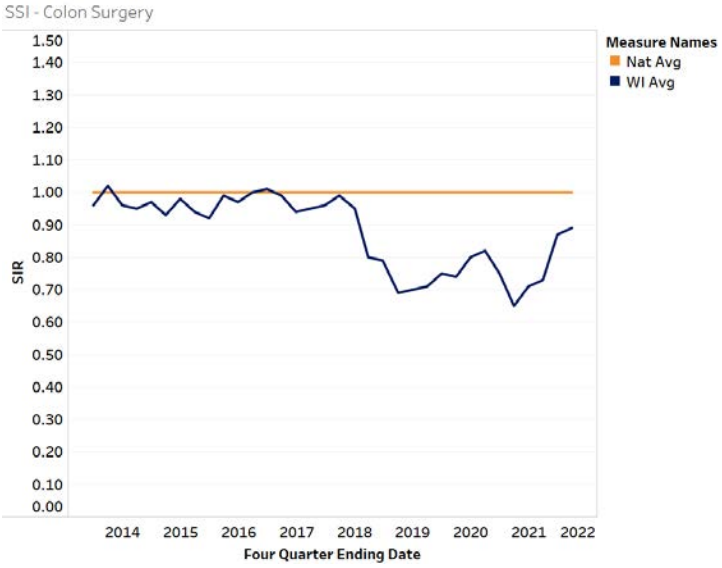
MRSA



SSI - Abdominal Hysterectomy

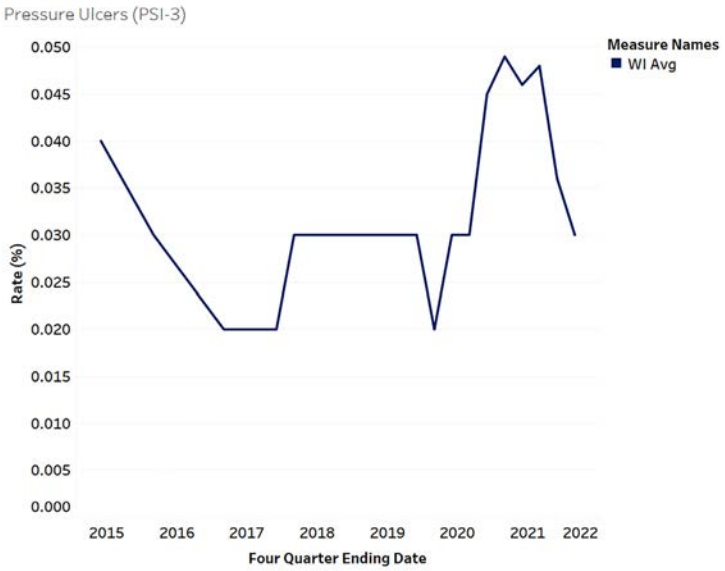


SSI - Colon Surgery



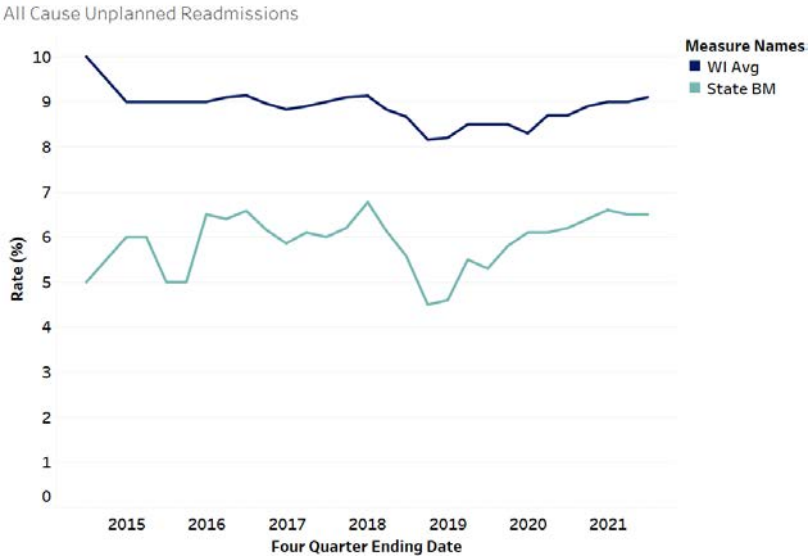
Pressure Ulcers/Pressure Injuries

Seeing such a decline during the pandemic is a success, especially considering increased lengths of stay and the number of vented patients with high acuity levels.



Readmissions

Readmission levels remained fairly steady, with slight increase during the pandemic. Wisconsin's top 10% of hospitals (represented as the state benchmark) for readmissions register readmission rates below 7%.



Health Equity and Social Determinants of Health

WHA's Quality team and the WHA Information Center (WHAIC) have joined together to develop tools to support members in identifying and eliminating barriers to the delivery of equitable health care.

In Fall 2021, member hospitals received and had the opportunity to complete a Health Equity Organizational Assessment (HEOA). The HEOA responses identified current efforts around a hospital's health equity journey and evaluated the ability to identify and address health disparities in several evidence-based areas, including:

- Consistent collection of accurate demographic data;
- Use of demographic data to identify and resolve disparities; and
- Implementation of organizational and cultural structures required to sustain the delivery of equitable care.

A HEOA dashboard will be published to members in 2022 to offer a summary of HEOA results and allow hospitals to review areas of opportunity and resources available to address disparities in care. A health equity collaborative four-part webinar series *Journey to a Healthier Wisconsin* is also planned for 2022.

Opioids

WHA's Physician Improvement Advisor Bobby Redwood, M.D., presented a webinar, *Reducing the Risk of Opioid Use Disorder, Overdose and Death*, focused on combatting the opioid epidemic in coordination with sponsorship by the Wisconsin Office of Rural Health. According to DHS, Wisconsin is experiencing its third wave of the opioid epidemic, with the first starting in 1999 when opioid prescriptions rose to control pain. From there, the epidemic evolved to include the use of heroin (cheaper than opioids) and later synthetic opioids (such as Fentanyl). Sixty-seven participants from 40 hospital/health systems and organizations engaged in this webinar.

Topics addressed included decreased opioid prescribing, alternatives to opioids, harm reduction (use of naloxone) and medication assisted treatment. The content stems from U.S. Centers for Disease Control and Prevention guidelines addressing person-centered practices and reducing the risk of opioid use disorder, overdose and death.

Collaboration Opportunities and Resources

Coverdell Stroke Systems of Care

The WHA quality team hosted a stroke systems of care (SSoC) collaborative in early 2021, through a partnership with Dot Bluma, the stroke project specialist at MetaStar and John Bowser, Wisconsin Coverdell program director at the Wisconsin Department of Health Services. Funding for the stroke program is made possible by the Paul Coverdell National Acute Stroke Prevention Program at the Centers for Disease Control and Prevention.

The aim for this collaborative was to help rural and critical access hospitals across Wisconsin develop stroke systems of care that meet standards for achieving Acute Stroke Ready Hospital criteria and achieve better outcomes for stroke care. The collaborative was led by subject matter experts actively working in the field with proven success implementing innovative processes, and networking sessions were offered for participants to partner with SSoC experts and peers.

Participants represented 59 Wisconsin hospitals. One participant in the collaborative reflected, "I highly appreciate the EMS interface! I was able to use this information to provide education to our local EMS agencies." Another noted, "...helped to increase my overall understanding of the transferring hospital's emergent care and transfer protocols." Feedback from the session also included the following note: "...loved being able to connect, discuss, and brainstorm with other stroke coordinators on how to effectively and efficiently take care of stroke patients. It's great to get ideas from others on areas that are working because it's given me areas to implement those ideas."

Session recordings, presentations and resources shared during the meetings are accessible from the WHA Quality & Patient Safety Resources Stroke Systems of Care Collaborative webpage. Below is a brief description of each webinar hosted.

1. ***Community Awareness and Pre-Hospital Care***
   Presenter: Carrie Rupert, director of clinical services, Bellin Health Oconto Hospital and Clinics
   Focus: Establishing a comprehensive public awareness and stroke program in the rural communities

   Presenter: Dr. Kerry Ahrens, emergency medicine physician, Aurora BayCare in Green Bay, and medical director for Oshkosh Fire Department
   Focus: EMS stroke management best practices for optimal stroke care in the pre-hospital setting

2. ***Pursuing Acute Stroke Readiness Hospital (ASRH) Certification***
   Presenter: Dot Bluma, stroke project specialist, MetaStar, Inc.
   Focus: Criteria for achieving Acute Stroke Readiness Hospital (ASRH) Certification

   Presenter: Cathy Connor, MSN RN CEN, director of emergency services and stroke program coordinator, Aspirus Langlade Hospital
   Focus: The journey to achieve ASRH certification

3. ***ED/Emergent Care Perspective: Transferring Hospital – Advocate Aurora Health***
   Presenters: Amber Koplitz, manager of emergency services, respiratory therapy and house supervision, and Jessica Baerwald, stroke coordinator, Aurora Medical Center, Washington County
   Focus: Critical components of stroke care for the acute stroke patient in the ED and transfer protocols for fast turnaround times

4. ***ED/Emergent Care Perspective: Transferring Hospital – Advocate Aurora Health St. Luke's Medical Center***
   Presenter: Suzy Lesser, ASLMC stroke program manager, Aurora St. Luke's Medical Center
   Focus: Critical components of stroke care in the ED – from an Acute Stroke Ready Hospital (ASRH) to Comprehensive Stroke Care (CSC) hospital's perspective, including efficient and effective transfer communication strategies and engaging with the needed consulting services

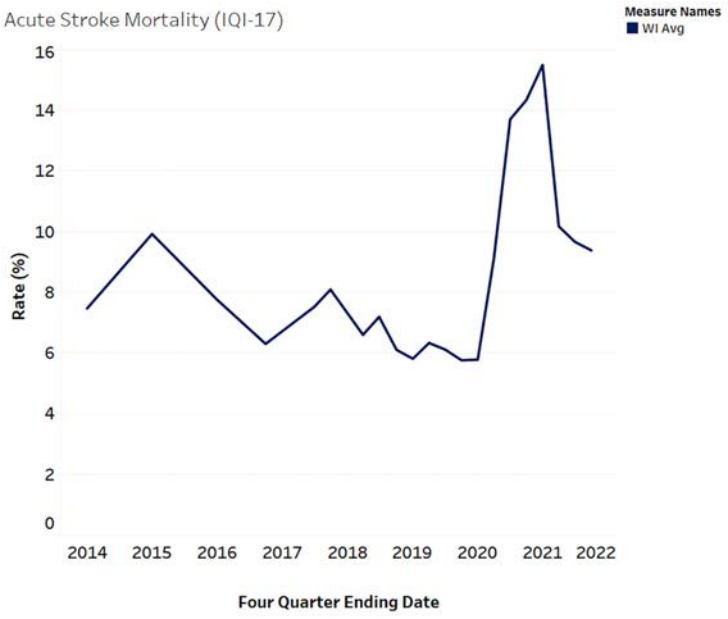
5. ***Post-Acute Care – UW Health, Transitions of Care***
   Presenter: Niki Bennett, comprehensive stroke program coordinator, UW Health
   Focus: Transitions of care for the stroke patient for efficient and effective patient transport from acute care to post-acute care

   Presenters: Kristin Randall, stroke program coordinator, and Amy Shadick, manager of inpatient rehabilitation, ThedaCare
   Focus: Acute inpatient rehabilitation – supporting stroke victims as they recover in inpatient rehabilitation

   Presenter: Lauren Davis, clinical advisor, LeadingChoice Network
   Focus: Organizing information to support stroke victims as they recover – skilled nursing facility perspective

6. ***Get with the Guidelines Stroke Overview***
   Presenter: Heidi Erl, emergency department/stroke coordinator, Aspirus Medford Hospital and Clinics, and Susan Abelt, MS, quality improvement manager and quality, outcomes research and analytics, American Heart Association
   Focus: Get with the guidelines overview

The graph below shows a spike in stroke mortality during the early months of the COVID-19 pandemic. Reasons are uncertain but may include patients themselves delaying care due to fear of going to the hospital or being put at risk for added exposure to COVID-19 during this uncertain time. The American Heart Association and National Center for Biotechnology Information, which advances science and health by providing access to biomedical and genomic information, also report evidence that suggests COVID-19 could increase the chance of a stroke, with increased hypercoagulability associated with the virus.



Superior Health Quality Alliance

The Superior Health Quality Alliance (Superior Health) is comprised of eight member organizations – all with long track records of success driving achievement of Medicare quality improvement goals as a Quality Innovation Network – Quality Improvement Organization (QIN-QIO), Hospital Improvement Innovation Network (HIIN), and/or End-Stage Renal Disease Network (ESRD). Member organizations include:

- Illinois Health and Hospital Association
- MetaStar
- Michigan Health & Hospital Association
- Midwest Kidney Network
- Minnesota Hospital Association
- MPRO
- Stratis Health
- Wisconsin Hospital Association

Superior Health's diverse capabilities and commitment to excellence form a comprehensive quality improvement organization dedicated to collaborative approaches to improve the health of the communities it serves.

Superior Health became a prime awardee of the Network of Quality Improvement and Innovation Contractor (NQIIC) in 2019, which allows Superior Health to partner with other Quality Improvement contractors under the new CMS Indefinite Delivery/Indefinite Quantity (IDIQ) contract mechanism to support quality improvement efforts. As a NQIIC awardee, Superior Health has demonstrated health care quality improvement expertise, serving as:

- Quality improvement experts;
- Facilitators/change agents for health care transformation by achieving bold aims at a high value; and
- Innovators of quality improvement.

The mission of the Superior Health is to improve the quality of health and health care through innovation, effectiveness and efficiency in designing and implementing CMS NQIIC initiatives that are person-centered and integrated across the continuum of care and services.

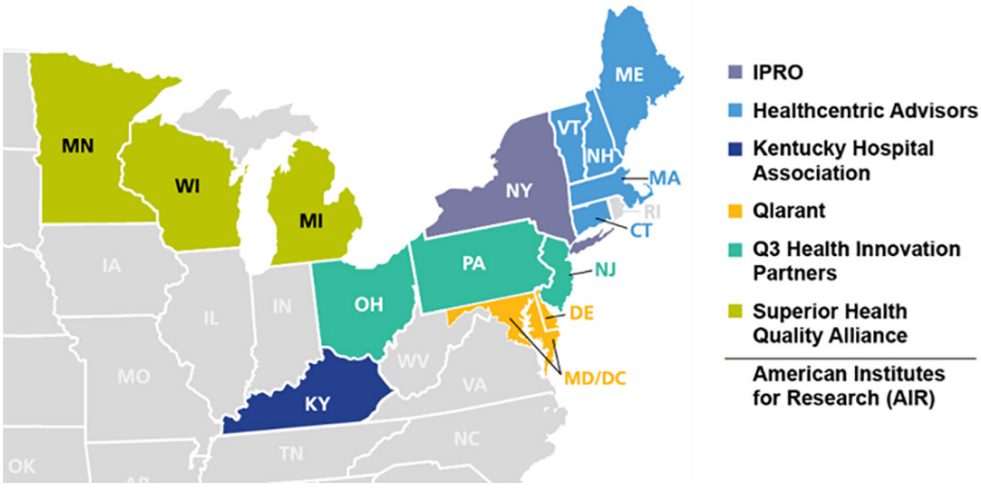
Hospital Quality Improvement Contract

The Hospital Quality Improvement Contract (HQIC) four-year contract from CMS launched in March 2021. Superior Health is one of many organizations working together to provide quality improvement support to 271 hospitals across the 12-state IPRO HQIC. The IPRO HQIC supports participating hospitals by strengthening existing patient safety processes and facilitating quality improvement strategies to improve patient safety and reduce all-cause harm, working with government agencies, providers and patients to implement innovative programs that bring policy ideas to life. Superior Health has enrolled 125 small rural and critical access hospitals, with 30 participating from Wisconsin.

Designed to build upon the quality improvement work under the CMS's national Partnership for Patients Hospital Engagement Network (HEN) 1.0 and 2.0 and Hospital Improvement Innovation Network (HIIN) contracts that ran from 2011-2020, the HQIC efforts provide focused support and technical assistance to small, rural and critical access hospitals across Michigan, Minnesota, Wisconsin (Superior Health) and nine eastern states.

WHA's technical assistance with the hospitals began in late 2021 and focused on implementing person and family engagement, identifying health equity practices, engaging hospital leadership, and addressing patient safety priority areas. Webinars offered in 2021 included:

- Improving opioid stewardship across the surgical continuum;
- Disruption as an opportunity to improve care;
- Readmission reduction: transforming into a care partner hospital;
- Reducing readmissions – successful rural hospital strategies; and
- Creating a hospital community's social needs profile.



Participating hospitals receive monthly newsletter updates filled with offerings, opportunities and available resources on priority "all-cause harm" topic areas (see graphic)—all at no cost. Hospital quality leaders also meet with a dedicated quality improvement advisor on a reoccurring basis, as well as when needed, to discuss quality priorities, connect with local and national subject matter experts and more. Hospitals have access to the American Institute for Research, which offers expertise and support on person and family engagement best practices exclusively to hospitals in the IPRO HQIC network. Participation also includes access to an online community Listserv, connecting hospitals across the IPRO HQIC network of 12 states the ability to collaborate, ask questions, share tools and resources and discuss challenges with hospital patient safety and quality leaders from the entire IPRO HQIC region. Additionally, the IPRO HQIC makes hundreds of resources easily accessible via the HQIC resource library.

Fourteen learning and networking webinar events were held in 2021. Topics included opioid stewardship, pressure injury, pain management, sepsis, adverse drug events, antibiotic stewardship, health equity and social determinants of health. Multiple events on a variety of patient and family engagement topics were also held. Wisconsin hospitals showed great engagement in these learning opportunities. Every event was attended by at least one Wisconsin hospital. Additionally, more than 73% of Wisconsin hospitals participated in at least one event, and 63% participated in two or more events.

Shine a Light on Stigma Campaign

Superior Health has launched the Shine a Light on Stigma Campaign to reduce stigma for people with substance use disorder. An important intervention strategy in substance use disorder is meeting the patient where he or she is. WHA Physician Improvement Advisor Dr. Bobby Redwood has developed a video series on the seven stages of change for opioid use disorder. While the brief videos are directed to physicians, all health care professionals can benefit from the person-first language they espouse when talking to someone about substance use disorder:

- Shine a Light on Stigma Stages of Change Series - Introduction
- Shine a Light on Stigma Stages of Change Series - Stage 1: Precontemplation
- Shine a Light on Stigma Stages of Change Series – Stage 2: Contemplation
- Shine a Light on Stigma Stages of Change Series - Stage 3: Preparation
- Shine a Light on Stigma Stages of Change Series – Stage 4: Action
- Shine a Light on Stigma Stages of Change Series - Stage 5: Maintenance
- Shine a Light on Stigma Stages of Change Series - Stage 6: Recurrence

Front Line Forces

As a Superior Health partner organization, WHA works on many aspects of health care quality across the continuum of care. One example is the development of Front Line Forces training modules and resources.

Front Line Forces is a collection of educational training modules and resources developed for nursing assistants working in nursing homes and long-term care facilities which is applicable to caregivers in other health care settings, too. The program aims to empower front line staff by increasing their confidence in making the right decisions. Its resources are designed to build a foundation of knowledge to further learning and improve the application of clinical skills in real-life situations.

Front Line Forces' growing library of videos, e-learning modules and more is available on the Superior Health Front Line website.

- Pressure Injury and Prevention
- Caregiver Wellbeing
- Hand Hygiene
- Substance Use Disorder
- Preventing Falls and Falls with Injury
- Vaccinations

WHA Awarded Wisconsin Partnership Program Community Impact Grant

WHA was one of four recipients of a Wisconsin Partnership Program Community Impact Grant. The $1 million grant will fund a five-year initiative to support community-academic partnerships and their initiatives to improve health and advance health equity by addressing the social determinants that influence health and wellbeing.

The initiative, Wisconsin Rural Health & Substance Use Clinical Support (RHeSUS), conducted in collaboration with the University of Wisconsin School of Medicine and Public Health, will work to improve access to treatment and care for people struggling with substance use disorders in rural Wisconsin.

The partners will focus to increase the number of health care providers who prescribe pharmacotherapies for use disorders, improve access to medical care and peer recovery support for rural residents and decrease opioid overdose rates.

Additional details and participation opportunities will be made known in 2022.

Wisconsin Quality Residency Program

There are many things to learn when starting a new position as a health care quality leader. Regulatory and accreditation requirements, basic risk management skills, quality data reporting methods, and useful quality improvement methods and tools are just a few.

The Wisconsin Quality Residency Program, created through a partnership between WHA and the Rural Wisconsin Health Cooperative (RWHC), was launched in 2014 and provides a comprehensive curriculum of core quality improvement concepts and leadership essentials instructed by experts in the field, bringing participants together for learning and networking. The quality improvement staff of WHA and RWHC partnered again in the fall of 2021, offering monthly learning modules, adult learning strategies, engaging discussion and applied practice exercises. Learning is supported by virtual networking and coaching calls, resource and document sharing and supplementary support via direct email and a private Listserv for communication, all of which is included in the program. This program is open to all Wisconsin hospitals and health care systems and is specifically designed for novice health care quality leaders with limited experience conducting quality improvement and patient safety initiatives in the hospital setting. Modules are facilitated by a team of expert and veteran quality professionals. Learning module topics included:

- The evolution of health care quality - how it fits in the “big picture”
- Accreditation and survey readiness
- Hospital compliance and state and federal oversight
- Quality measures requirements
- Quality improvement methods
- Using data to make decisions
- Project facilitation and implementation
- Culture of safety and just culture
- Care coordination, infection prevention, social determinants of health
- Risk Management
- Medical staff functions and engaging clinicians in quality
- Patient and family engagement - quality and putting it all together

The 2021-2022 Wisconsin Quality Residency Program participants represent the following hospitals:

- Bellin Health Oconto Hospital
- Fort HealthCare
- Gundersen Boscobel Hospital and Clinics
- Gundersen Moundview Hospital
- Gundersen St. Joseph's
- HSHS Wisconsin Hospitals – Sacred Heart, St. Joseph's, St. Vincent's, St. Mary's, St. Nicholas and St. Clare's

- Memorial Medical Center of Ashland
- Reedsburg Area Medical Center
- Stoughton Health
- ThedaCare Regional Medical Center – Appleton
- ThedaCare Medical Center – New London
- ThedaCare Medical Center – Shawano
- Vernon Memorial Healthcare
- Watertown Regional Medical Center

2021-2022 Quality Residency Program presenters included the following organizations and representatives:

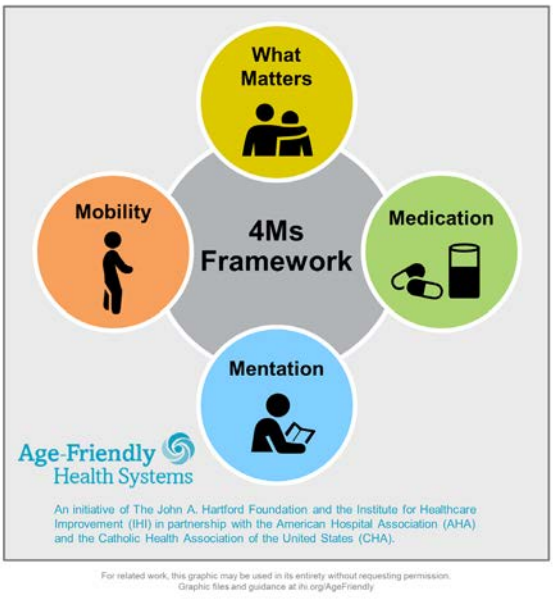
- Hospital Sisters Health System (HSHS)
- Marshfield Medical Center
- Mayo Clinic Health System
- Mile Bluff
- Rural Wisconsin Health Cooperative
- Sarah Pavelka
- Sauk Prairie Healthcare
- UnityPoint – Meriter
- Wisconsin Department of Health Services
- Wisconsin Office of Rural Health

2021-22 Quality Residency Participants

Hospital Quality Improvement Showcase

Advocate Aurora Health

As the older adult population continues to age, communities are tasked with supporting the physical and mental health needs of older adults, at times, leaving health systems unprepared to provide the necessary care to meet their complex needs. Recognizing this, Advocate Aurora Health (AAH) set out to become an Age-Friendly Health System, defined as one in which every older adult gets the best care possible, experiences no health care-related harms and is satisfied with the health care they receive. The Age-Friendly Health System provides a framework of four evidence-based elements of high-quality care, the "4Ms"—What Matters, Medication, Mentation and Mobility—to improve patient outcomes.



What Matters
Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication
If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation
Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility
Ensure that older adults move safely every day in order to maintain function and do What Matters.

Aging increases the risk of chronic diseases and comorbidities. Over 50% of hospitalized patients in AAH are older adults; therefore, it is AAH's commitment to provide excellent clinical care for older adults.

AAH's age-friendly implementation began with a small test of change in the clinic setting with senior resource nurses. Leadership support in the clinic helped with the ability to pull the nurses from the frontline so they could attend to the work in the Action Communities, while IT resources were offered to standardize the nurses' patient assessment. The team also included a patient to account for the voice of patients and families, as reality checks. The team used the Plan, Do, Study, Act (PDSA) model for improvement to ensure consistent implementation of the 4Ms was assessed weekly.

Advocate Aurora's health at home also implemented the age-friendly 4Ms in their "perfect patient visit" and standardized documentation with the visit template. Orientation for new team members included age-friendly 4Ms, and quality PDSAs were performed through review of the patient electronic medical record.

With the successes of the clinic and home care pilot program, AAH identified additional pilot sites at five hospitals that will be the first to go through the Institute for Healthcare Improvement's Action Community and implement the 4Ms at their sites. These sites will set the standards for age-friendly implementation for the entire AAH system across Wisconsin and Illinois. The goal is to have all sites designated as age-friendly by the end of 2024. A system data dashboard is in the works that will include process documentation of the 4Ms.

AAH had to pause its age-friendly implementation during the recent surges of COVD-19, which has halted full implementation efforts and data collection. Even with this pause, the sites have continued to educate staff how to assess and act on the 4Ms in real time. Even though full-scale implementation is still on the horizon, the culture change happening in the units that are educating on the 4Ms is demonstrating decreases in sitter usage, Beers medications administered, delirium rates and falls.

Moving forward, AAH will identify age-friendly champions/teams at each site of care. These champions will lead the age-friendly efforts at the site, and they will become the "expert" to guide all units/clinics on the implementation of 4Ms care across the care continuum. As system co-leads to provide ongoing support to teams, they will hold collaborative meetings monthly to support teams throughout the system. One collaborative will be with units/sites that have already implemented and achieved age-friendly designation that will work on quality improvement and maintenance efforts. The second collaborative will be for sites that are going through the IHI Action Community and working on implementation efforts.

AAH is also creating an AAH age-friendly guide to assist teams in their implementation efforts and is creating education models specific to implementation of each of the 4Ms to be used systemwide. Quality improvement efforts utilizing the 4Ms will help AAH improve its older adult patient experience scores and expand upon its diversity, equity and inclusion efforts.

AAH Lessons Learned:

- Just as in any journey, you need a compass to guide your way. AAH engaged executive and system leaders to set the direction and support the efforts.
- "What matters" should be asked of our patients, team members and leaders—this will allow you to gain perspective and to stay true to the focus of the effort.
- Work smarter, not harder. Partner with the experts, engage in the IHI Action Communities and utilize all the tools that have been created.
- This is an interdisciplinary effort, and it is important to have the right people at the table, including patients, front line staff and leaders of various roles and settings. This allows you to leverage vast expertise and insight to each of the 4Ms.
- Leads at system level are vital, and they will drive the efforts. Having champion leaders at the site is essential, and they are the fuel needed to implement the effort. Engaging innovators and early adaptors will lead culture change.
- These efforts should be done in the spirit of learning and improvement. Complete PDSA cycles to learn, adjust and make improvements along the way.
- Align this work with programs/processes that are already in place. Stress to teams that this is not adding anything to their plate; rather, it is improving on and getting credit for work that is already done. Demonstrate how Age-Friendly Health System program aligns with current efforts and shared goals.

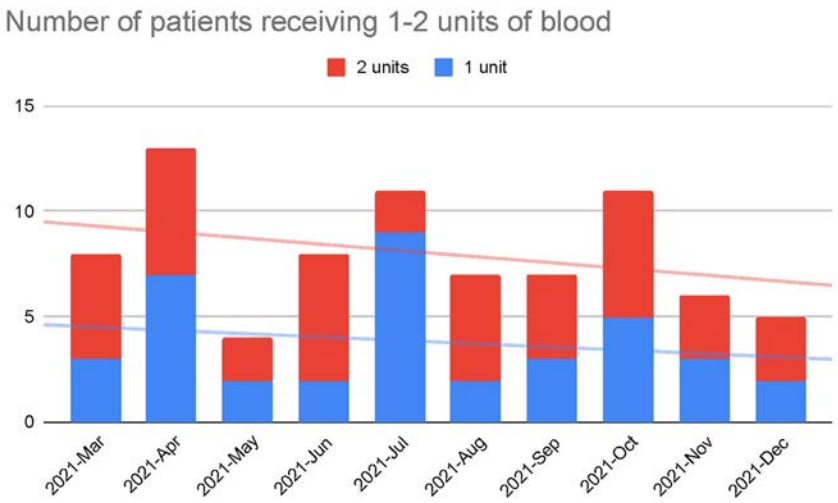
Ascension Wisconsin

Anemia of Pregnancy

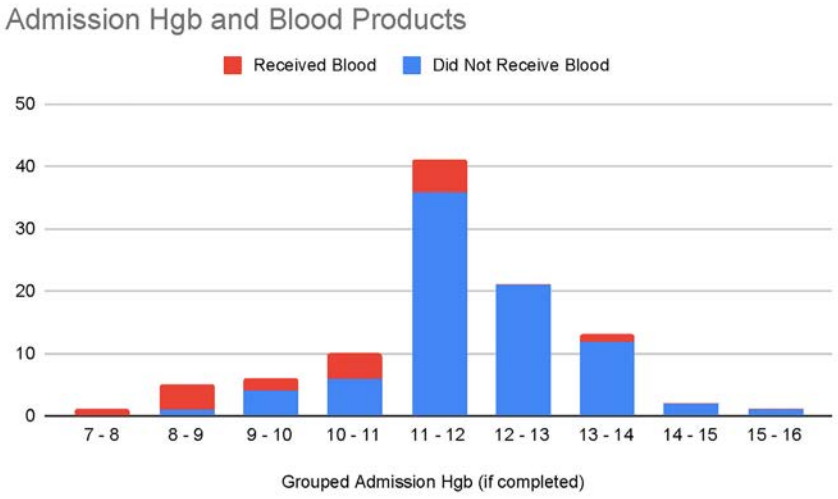
Reduction of severe maternal morbidity was identified as a priority project for the perinatal service line for Ascension Wisconsin. Analysis showed that blood transfusion was the most common morbidity encountered. Approximately 70% of the patients with a blood transfusion required only 1-2 units of blood and had minor blood loss during their delivery hospitalization. Further analysis revealed that many of these patients were anemic at the time of admission, which prompted a closer look at the diagnosis and treatment of iron deficiency anemia during pregnancy.

The primary goal of this work was to ensure that women were treated adequately for iron deficiency anemia during pregnancy so they would have normal hemoglobin levels at the time of delivery. A normal hemoglobin level will both allow the patient to tolerate a normal blood loss as well as have the energy to interact with and care for her newborn.

We defined success as an increase in the number of women with a hemoglobin greater than 11 g/dL on admission and a reduction in 1- and 2-unit blood transfusions. Additionally, we monitored the number of patients who required a 1- or 2-unit blood transfusion each month across Ascension Wisconsin.



While also monitoring the admission hemoglobin levels for patients experiencing a hemorrhage event, a clear link between anemia on admission and the need for blood transfusion after a hemorrhage was determined. This graph shows the admission hemoglobin values and the need for a blood transfusion of any number of products after the hemorrhage event. All of the patients with normal hemoglobin values on admission had significant total blood loss before transfusions were needed.

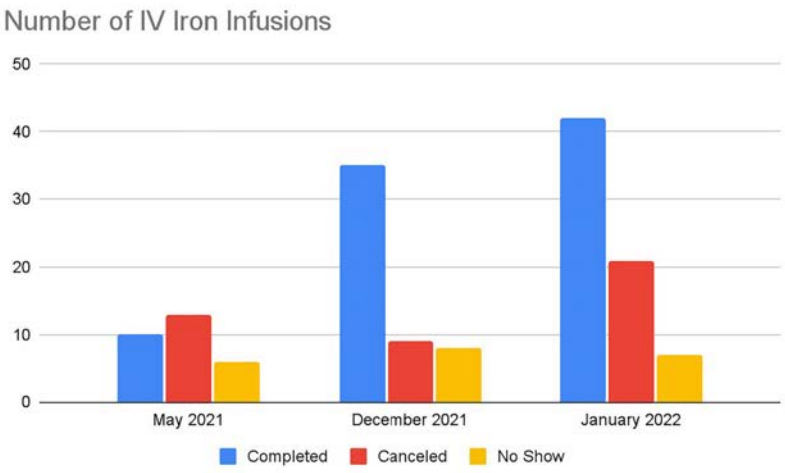


Severe maternal morbidity review teams analyzed individual patient cases. It was identified that many patients who received a blood transfusion were not coded for the procedure. By March 2021, all transfusion procedures were coded to accurately reflect care regardless of insurance type, which allowed for accurate monitoring of process improvement. The review teams counted the number of blood products used for each case and identified the need for improved treatment of iron deficiency anemia during pregnancy. An algorithm was created that includes close monitoring of lab values and progression to IV iron infusions when oral supplementation is determined to be inadequate.

Ambulatory leaders were engaged to disseminate the anemia algorithm. After several months, further strategies were developed to verify that the algorithm was being followed. The clinics developed anemia of pregnancy tracking tools to monitor the treatment provided during the pregnancy and identify ongoing opportunities to enhance the care provided. An anemia of pregnancy treatment protocol was agreed upon by obstetric providers, and ambulatory nursing staff were empowered to enact the protocol orders when needed.

The work is ongoing, but there have been many successes throughout utilizing iterative rapid cycle process improvement. Patients are being closely monitored for anemia throughout their pregnancies. There has been a substantial increase in the number of patients who receive IV iron. More obstetric providers are now ordering IV iron therapy instead of referring patients to hematology, which increases timely infusion. Additionally, through engagement of the Ascension Maternal Health Social System Initiative, patients have received navigation assistance to help break down barriers in access to care.

The graph below shows IV iron infusion data from one ambulatory setting:



Throughout this project so far, there are several key lessons learned:

- A small team that meets frequently is crucial for keeping momentum towards reaching goals.
- Partnership is needed between the ambulatory and inpatient settings to maximize best outcomes for patients.
- Leverage technology by using shared tools to organize, collaborate and share results.
- Consistent procedure coding is necessary to accurately document the patient care provided.
- Providing real case feedback to providers demonstrates how their work impacts patient outcomes.

Ascension Wisconsin

Recovery Coach

In 2018, Ascension Wisconsin implemented a recovery coach program to provide peer support to patients presenting to the emergency department with substance use disorders (SUDs). Recovery coaches are trained professionals that have lived experience with substance abuse who have found their path to recovery.

Since October 2018, recovery coaches have provided over 1,600 consultations in four Ascension Milwaukee area hospitals. The program's need has grown with the emergence of the COVID-19 pandemic; overdose deaths, particularly opioid-related deaths, have sharply increased over the past two years. To meet this continued need, Ascension Wisconsin is expanding the recovery coach program to all 10 hospitals covering the Fox Valley, Milwaukee and Racine communities beginning March 2022. This is one component of the system-wide opioid strategic plan to increase access to treatment and recovery services.

Program expansion is possible because of multiple grant-funding sources, including the state opioid response grant, funded through the Substance Abuse and Mental Health Services Administration and the ED2 Recovery grant, funded through Wisconsin Voices to recovery. These grants provide recovery coach services to patients with opioid and stimulant use disorders. To ensure all patients have access to these services, the Ascension Wisconsin Foundations cover referral costs for those patients who don't qualify under the grant terms.

The recovery coach program is a collaborative effort among many disciplines, services and community partnerships. Emergency medicine physicians and nurses are the frontlines to recognize persons in crisis and initiate a recovery coach referral. Behavioral health collaborates with case management to create awareness of outpatient treatment programs, both internal or community-based, and facilitates referrals when needed. The recovery coach organization assists the patient to overcome barriers to recovery and help make connections to community resources to support recovery.

Complementary to the recovery coach program are specific strategies aimed at treatment and recovery for persons with opioid use disorder (OUD). At Ascension St. Joseph Hospital, a multidisciplinary team of emergency department, chemical dependency, and family medicine specialists provide patients the opportunity to start treatment with buprenorphine while in the hospital. Since the start of this team, known as the buprenorphine or "B team," in March 2021, 46 patients started treatment who may not otherwise sought treatment for OUD. Another strategy used at Ascension St. Joseph emergency department is giving naloxone kits free to patients at increased risk of opioid overdose. In 2021, 79 patients received free naloxone, while another 260 patients received a prescription for naloxone. The success of the free naloxone program has led to expansion to all Ascension Wisconsin hospitals beginning March 2022.

Success is more than the number of patients treated; it is found in the compassionate care provided to persons who often feel stigmatized by their SUD. Success is also the life-changing stories of those we serve. The following story was shared by one of our emergency medicine providers.

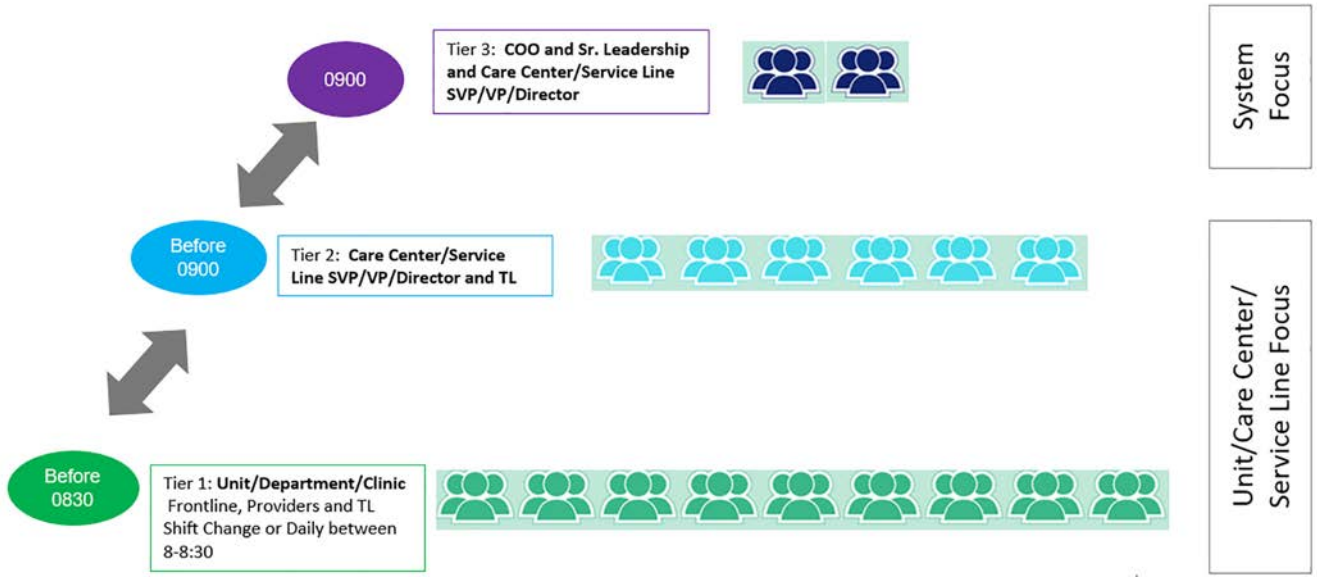
> There is a patient the staff knows pretty well and is a "regular" in the emergency department. He was without a stable home and addicted to heroin. He would come to the ED often, especially on cold nights. He was extremely averse to talking about his health and usually left soon after eating a sandwich and warming up. A few months ago, he presented with back pain and a fever. He had an epidural abscess, a known complication of IV drug abuse. This is a life-threatening infection that needs emergent neurosurgery. He refused surgery and was going to leave the hospital. The need to use heroin during withdrawal is so strong that all he could think of was to get out of the hospital to use. Our recovery coach was able to talk to him; we talked about options for pain management, and he agreed to surgery. A few months later, I walked into a room to meet a patient that had cut himself while doing dishes. He said, "You know me. You took care of me a few months ago." It was the same patient. He was transformed. He was happy, proud, looking me in the eye. He had been successful in avoiding opiates since the surgery. He had reunited with his family and was living with them. He was even caring for his sisters' kids while she went to work. I don't think my feet touched the ground for the rest of the shift.

Bellin Health System, Green Bay

Tiered Huddles Drive Improved Communication, Real-Time Problem-Solving

The COVID-19 pandemic made it more important than ever for Bellin Health to fully understand daily operations, prioritize what was most important and open daily lines of communication between senior leaders, employees and providers across a broad geographic range. Situational awareness, prioritization and communication were key—as was celebrating wins during what continued to be a difficult time for individuals across the organization. And it all had to happen quickly, given the incredible demands on time for everyone from frontline staff to behind-the-scenes support and senior leaders.

Enter tiered huddles, a mechanism that provides daily insight into performance across the organization and within each facility, service line and support department while empowering teams at all levels to identify and solve problems daily. These standing 10- to 15-minute Monday-Friday meetings focus on positivity and wins, as well as any imminent risks to Bellin's core business that need to be addressed. The three tiers of Bellin's tiered huddle structure allow for effective and efficient cascading of information that facilitates fast problem-solving and an improved overall communication structure.



"We knew we had to be extremely strategic, efficient and focused if we were going to add daily standing meetings to our teams' incredibly busy schedules," said Bellin Health Chief Quality Officer Lisa Harton, who led this work with Chief Medical Officer Dr. Cynthia Lasecki and Chief Operating Officer Sharla Baenen. "What we have found is that these sessions have a host of benefits for our leaders and teams and have actually saved time through improved communication and a proactive focus on our core business and how we can help each other achieve the best outcomes."

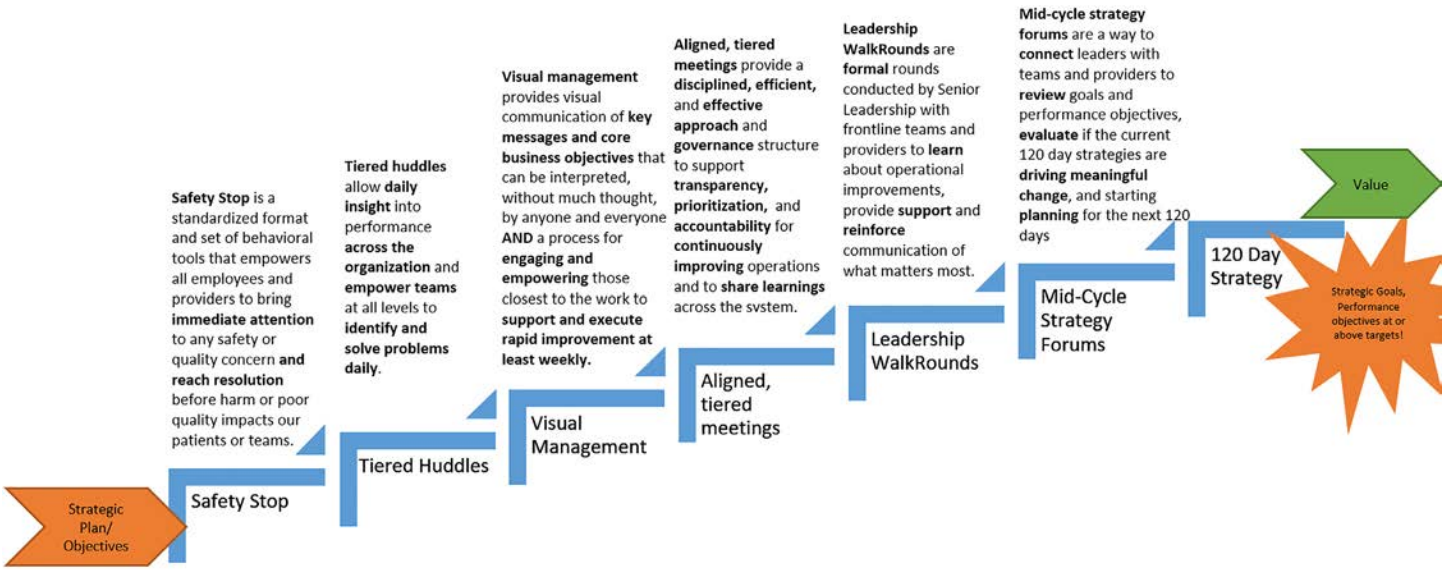
Quantitative and qualitative analysis have shown the tiered huddle system is working for Bellin Health. This structure resulted in the following after studying and adjusting tiered huddles daily for 60 days during a pilot, weekly during the next 90 days, and then monthly:

	Goal	Trend Up or Down	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Efficient- Tier 3 conducted in 30 minutes	100%	Up					100%	100%	100%	100%	100%	100%
Leadership Engagement- % daily participation in Tier 3 huddle	100%	Up					100%	100%	100%	100%	99%	99.80%
Learning: #Shared System Learnings per month (2 shared learnings and 1 good catch)	6/month	Up					8	8	9	10	10	9 avg
Effective: Tier 3 follow-up items updated or closed within 2 business days	90%	Up					65%	55%	68%	89%	90%	UP
Number of "good catches" reported in the event management reporting system	Increase from baseline 2nd Quarter Avg: 63	Up	60	60	69	57	80	81	81	86	70	71/qrtr

A six-month post-implementation improvement review identified numerous benefits, including leaders feeling more connected with their own teams and other teams within the organization, including those in Bellin's northern region. Leaders also cited improved communication, a proactive approach that focuses on core business, quick follow-up to concerns and a positive—not blame-based—approach to problem-solving. It's all part of Bellin Health's "we go together" philosophy, with tiered huddles facilitating the rapid deployment of resources when different areas of the organization are in need of help.

Tiered huddles are the first phase of the Bellin Operating System, which is a system-wide disciplined approach to service delivery and improvement that will support Bellin's strategic goals and performance objectives. The Bellin Operating System is grounded in a culture in which everyone is capable, empowered and expected to make improvements every day. The tiered huddle team will continue to learn, study and adjust while linking the improvements to the 2023 safety culture and psychologic safety surveys.

"Tiered huddles are making a tremendous difference for our organization, but we know they are just the beginning of a future of continued quality improvement for Bellin Health," said Baenen, the system's COO. "We look forward to using this experience to leverage future improvements for the benefit of our teams—and ultimately for the patients, families and communities we serve."



Bellin Health System, Green Bay

Communication Orders after Discharge

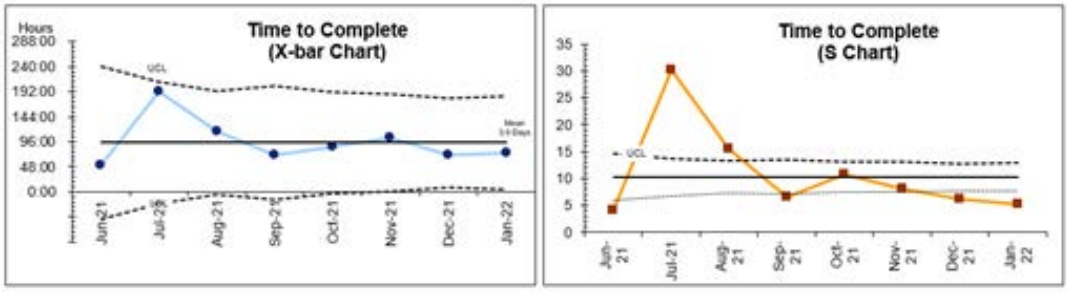
In 2019 and 2020, Bellin Health documented four serious patient safety events that were attributable to gaps at discharge. A review of two years of data on patient safety events demonstrated that the highest frequency of errors was attributable to diagnostic tests not being ordered or performed. Inpatient and/or discharging providers are not the correct resource for follow-up because they could be out of rotation and not be back for an extended period and, therefore, would not see the patient's test results. This project was picked as a quality improvement priority as there exists a process gap to communicate recommended labs or imaging at discharge (in a standard fashion) to the appropriate managing provider performing follow-up with the patient, leaving the opportunity for delays in patient care. Patients with delays in care or treatment are more likely to have readmissions and preventable adverse events.

AIM: By September 2021, develop a system-wide process to communicate diagnostic test follow-up orders needed post-discharge, targeting zero harm in related post-discharge diagnostic test safety events and closure of communication order within three days. Metrics and associated targets for the project included the following:

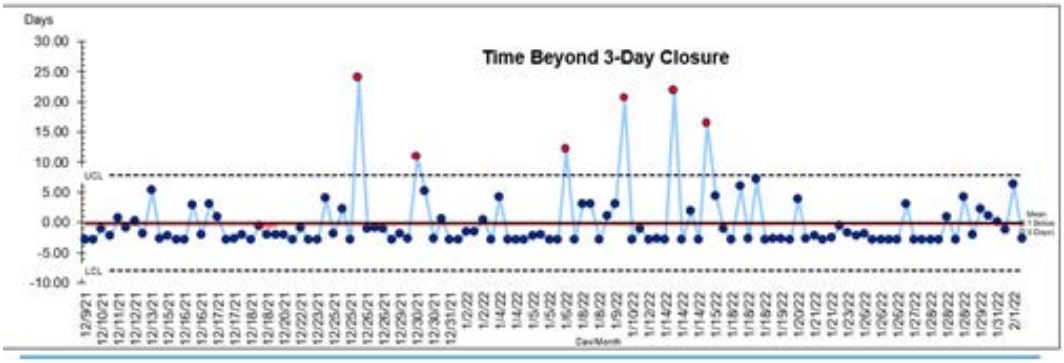
- Time Between Recommended Orders and Closure (target three days or less)
- Closure of Recommended Labs/Imaging Beyond Three Days (target < one day above)
- Patient Harm Events Related to Discharge Diagnostics (target = 0)
- Recommended Lab and Imaging Communication Order in Discharge Summary (target 98%)
- Volume of Hospitalist-Placed Outpatient Lab/Imaging Orders (target = 0).

We set out to develop a process with our hospitalist group with the end goal of spreading the process system-wide.

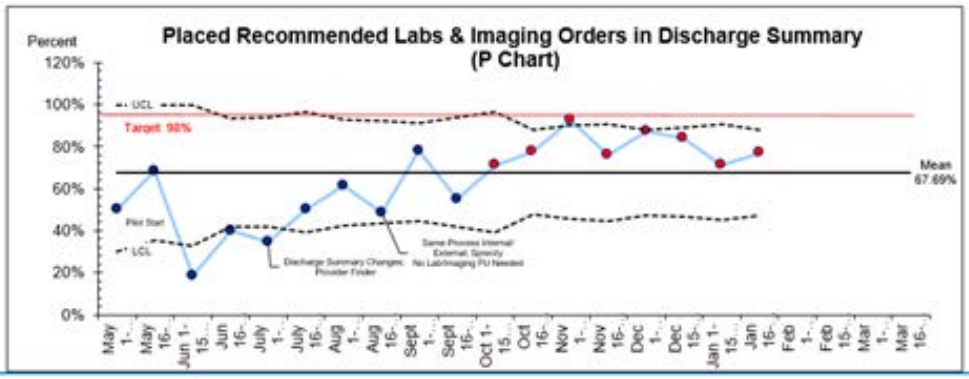
- **Days Between Test Recommendations and Closure**
  - Average 3.9 Days to Complete



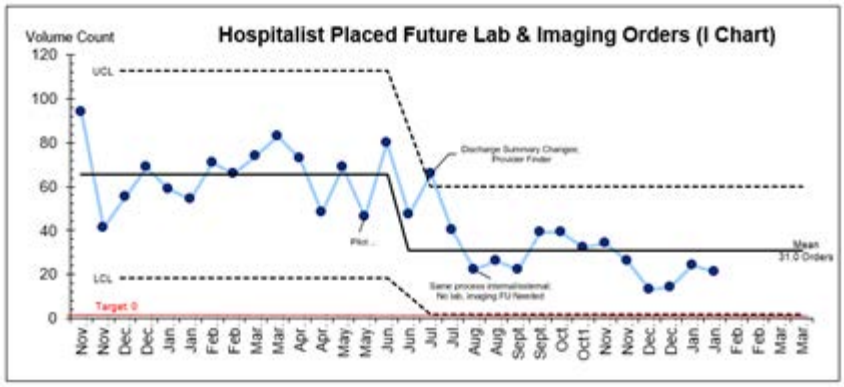
- **Days Beyond 3-Day Closure**
  - Average -0.1 Days Below (2.9) Days for December 2021/January 2022
  - Improved from 1.9 Days Above – Average through October 2021



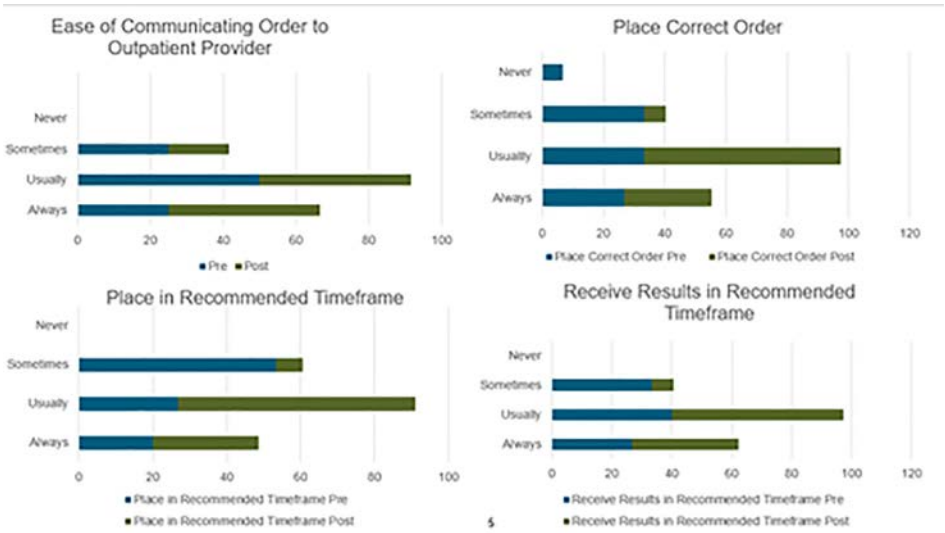
- **Placed Recommended Labs & Imaging in Discharge Summary**
  - Working toward target
  - Overall average 67.69%
  - End Jan 2022 average of 77.08%



- **Hospitalist Placed Outpatient Lab/Imaging Orders**
  - Seeing gains toward target
  - 115 orders placed at pilot start in May 2021 → January 2022 - 31



We implemented this process, borrowed from UW Health, making adjustments with Plan-Do-Study-Act (PDSA) findings. The general concept is that we started a pilot with our hospitalist group where providers are able to document recommended lab and imaging post-discharge in a communication order. When utilizing the discharge order set, the hospitalists must choose the recommended labs/imaging order and complete details or select that no labs or imaging are needed post-discharge. This communication order goes to the selected provider in-basket for Bellin-internal providers. Non-Bellin providers will also see the recommended labs/imaging post-discharge in the discharge summary (as long as all orders are pulled into the discharge summary). Upon receiving the order in a specific "order requests" in-basket, Bellin-internal providers review the recommendations and place orders or adjust the plan of care per their medical expertise. Non-Bellin internal providers receive recommendations in the discharge summary and follow their established process to complete needed follow-up. See high-level change pre- and post-implementation.



We have had zero patient harm events related to discharge diagnostic needs since prior to the pilot start. This project's spread and process control were impacted by the pandemic. While averages show improvement, we do see data points above the upper control limit and will need to continue investigations on those outlier data points and determine what actions are needed to sustain work closer to targets. Our next goal remains to spread into the emergency department, which was delayed due to surge volume.

Bellin Health System, Green Bay

In-Home Hospitalization Option Provides Host of Benefits for Patients and Care Teams Alike

When Steve Wilson was diagnosed with COVID-19 in October 2021, he faced a 10-day hospital stay and plenty of uncertainty. His wife of 47 years, Judy, was stuck at home, missing him and feeling disconnected from the care he was receiving in the hospital.

That all changed when Steve became the first patient in Bellin's Hospital to You program, an in-home hospitalization option for eligible Medicare patients within a 5-mile radius of Bellin Memorial Hospital in Green Bay. The first offering of its kind in northeast Wisconsin, Hospital to You offers everything the patient would receive during a traditional hospital stay, but with the privacy, familiar surroundings, support system and comforts of home.

Steve and Judy Wilson at home with their dog. Steve was Bellin Health's first Hospital to You patient in fall 2021.

"It's definitely better at home, with your family—and I've got a dog, too," Steve said, reflecting on the experience during an interview after his recovery. "So, to me, it helps in the healing process. The staff that did come out, they were just awesome. I just couldn't ask for more."

Hospital to You services include daily provider visits (in-person or video), in-home vital sign monitoring and lab draws; medical equipment and transportation; mobile imaging, medications and meals. Patients receive care from a robust team including nurses, nursing assistants, social workers and physical, occupational, speech and respiratory therapy services. Care team access is 24/7 with the ability to respond on-site within 30 minutes.

Bellin took on the challenge of providing an in-home hospitalization option after Medicare rules changed to allow for reimbursement for this type of care. Health system officials knew it could assist with hospital volumes that had been continuously high before COVID-19 and had only increased as the pandemic wore on.

"This is a true game-changer for the way we are able to care for our patients, and early feedback has been overwhelmingly positive," said Bellin Health Care Beyond Walls Director Maggie Koch. "The future of population health lies in programs like this, which allow us to better meet our patients' needs where they are, while lowering the cost of care and offering an optimal experience for those we serve."

Programs like Hospital to You have been shown to have numerous benefits, including increased patient satisfaction and decreased hospital length of stay, readmissions, emergency department visits and nursing home admissions. Clinical outcomes are comparable or better, patients typically heal faster at home and risks for higher-risk patients (infections, communicable diseases, delirium, falls) are decreased.

"During our weekly quality review huddles, we were able to determine that we were providing the same safe, high-quality care expected for any Bellin patient," said Melissa Patnode, team leader for Hospital to You. "It is inspiring to see the difference this program is making, and we look forward to continued learning as we grow the program and maximize its effectiveness for our patients and teams."

As for the Wilsons, they would recommend the program to anyone, Judy said.

"I just can't say enough about it," she said. "Why wouldn't you want to come home and heal?"

Click here to watch a video with more of Steve and Judy's Hospital to You story.

Bellin Health Oconto

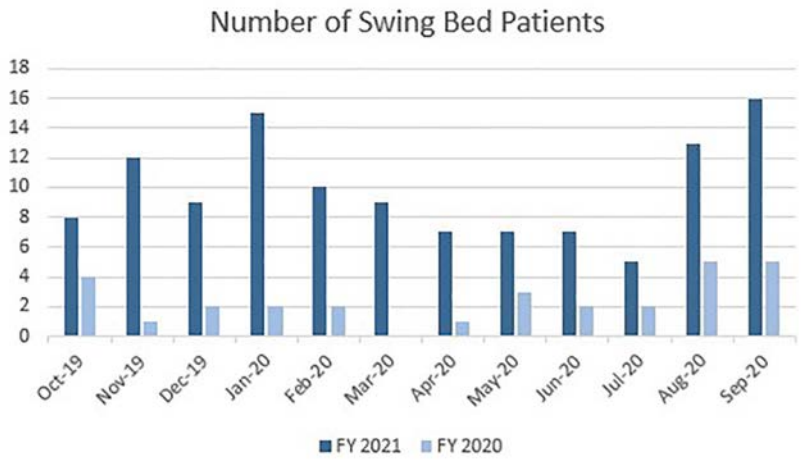
Swing Bed Program

2021 was a year of innovation, born out of the desire to do as much good for as many people as possible, despite the challenging environment. Bellin Health Oconto's hospital poured energy and effort into the development and expansion of their swing bed program. It was a pandemic project born out of statewide bed crunch, a desire to combat social isolation and a need for more complex care to be delivered in rural settings. Many skilled nursing facilities were closed to admissions or were at capacity, causing a bottle-neck back-up of inpatients who weren't well enough to go home but needed another place to go. Even when there were skilled nursing facility beds available, the inability to see a family member caused patients such anxiety that they could not agree to the move out of acute care. This was the impetus of the project. Acute COVID-19 patients did not remain at Oconto, so it was a way to help the region and to help keep beds open in the larger hospitals for acute patients. Services were expanded and partnerships were built across the Bellin system to deliver the care these individuals needed.

Although licensed for 10 beds, six rooms were set up for inpatients and then several multi-purpose rooms in other areas of the hospital that could be used for inpatients. At first, the goal was set to fill six rooms, and then to fill 10 beds and keep the census relatively stable at those numbers.

The team began looking outside what was originally thought to be the definition of a swing bed patient in the past. It was important to determine what other things were feasible to do at a critical access hospital with limited resources. For example, a patient was admitted on peritoneal dialysis. The patient brought his home cycler; the hospital ordered supplies to be sent to the unit from our larger hospital in Green Bay that typically stocks those supplies. The patient was able to direct the peritoneal dialysis cares since he did his dialysis independently at home, but he was physically limited to do them himself. There were also referrals for patients who needed total parenteral nutrition. Our pharmacy department created a process to manage patients with that need. Another area of growth was providing specialized wound vac care. The hospital does not historically keep wound vacs in house, so the referring hospital sent the wound vac with the patient, which is a great exercise in trust building and teamwork. The wound care team expanded services to assist in the specialty care needed by these patients. A small team of clinicians received training to ensure exceptional care could be provided even when wound specialists were not present. Patients came to us in a sicker and weaker state than ever before.

The swing bed team worked with each patient individually on goals that were meaningful and attainable to them. Patients who came in had resigned themselves to the fact that they would likely spend the rest of their days in a nursing facility; however, they achieved a goal they never believed possible and were able to be safely discharge to their homes. In past years, patients who came to swing beds were typically local. With nursing homes in the region full or closed, beds became scarce, and referrals continued to come in from all over. Several patients were admitted from Sturgeon Bay, Algoma, Appleton and regional locations who were unable to find a bed closer to home. The hospital fulfilled the mission to do the most good for as many as possible.



Although the peak of the pandemic has (hopefully) passed, the hospital continues to push the boundaries. The hope is to use the rehab beds for local folks needing rehabilitation and are willing to learn new skills or get new equipment to make that happen—for example, individuals needing tube feeding and those with mental health challenges with limited discharge options. The hospital

team collaborated with specialty providers to provide more and more telemedicine visits. Some providers stopped by Oconto to see patients instead of having them sent to Marinette for a clinic visit. The project born out of necessity has brought a new sense of imagining what is possible and making it a reality through coordination across a health care system motivated to keep its patients at the center of its care.

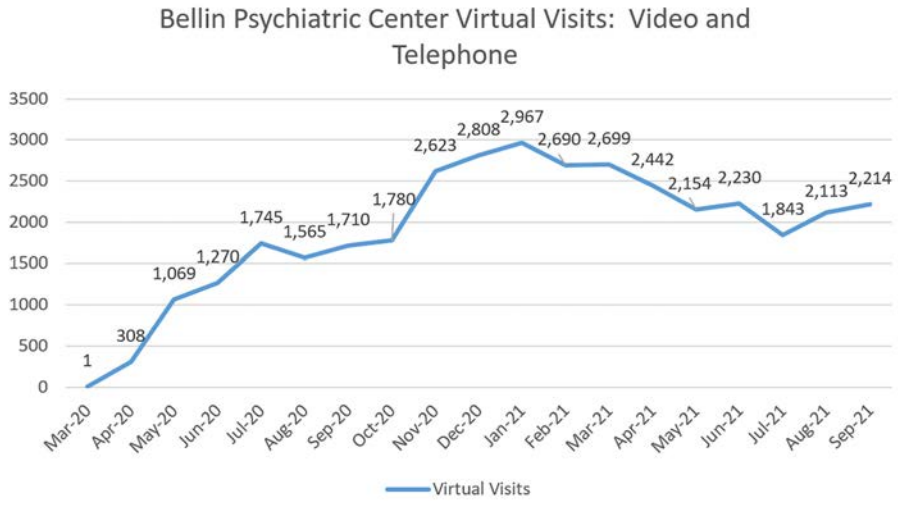
This journey has taught many lessons. First and foremost, never underestimate the human spirit. The amazing hospital team, backed by solid processes, built hope for the patients, proving there was no such thing as an unattainable goal. Other lessons were more practical. Transportation is a big problem in rural areas. Many patients were unable to set up a ride with friends or family and do not have reliable transportation to get to follow-up appointments. Telemedicine has been so great for the patient to save the hardship of getting a friend or family member to drive to the appointment or simply just enduring a road trip when a patient is ill or having pain. The hospital developed a more robust wound care team to accommodate all the complex wounds and wound vacs, a much-needed specialty in this region. Last but not least, the huge increase in volumes caused the team to run low or even out of supplies that had always been plentiful (snacks, gauze, personal hygiene items, etc.). Orders that used to last a week were now lasting only one to two days, which meant someone had to go on a road trip to get those supplies until the periodic automatic replenishment levels could be increased. 2021 will be a year not easily forgotten. Amidst all the challenge, there was triumph.

Bellin Psychiatric Center, Bellin Health

Improving Access to Behavioral Health Care: A Focus on Equity

The COVID-19 pandemic has had an enormous impact on the psychological wellbeing of the communities Bellin Health serves, at once increasing the need for mental health services and presenting a new opportunity to provide those services in a safe and effective manner.

To address well-documented transportation challenges, ease the way for the patients it serves and provide an alternative to traditional in-person mental health services, Bellin Psychiatric Center (BPC) began providing virtual visits in March 2020. The center quickly grew from a volume of a single visit that month to an average of 2,454 virtual visits per month during fiscal year 2021.



"At Bellin Health, we live our vision that the people in our region will be their healthiest during every stage of their lives, and our communities will thrive," said BPC Department Chair Dr. Emily Rademacher, a psychiatrist who was part of the multi-specialty improvement team that spearheaded the change. "Mental health is a key aspect of this commitment, and we knew we had to do things differently to truly meet the increasing needs of our communities."

Dr. Rademacher worked with BPC Hospital Operations Director Debbie Patz and Ambulatory Clinical Services Director Marilou Counard to launch the improvement team, which included clinical experts as well as representatives from the legal, information technology, billing, coding and scheduling areas. The team worked together to address and overcome challenges, including scheduling process changes, obtaining appropriate authorizations and consents and working with variations in patients' technical access and ability.

The benefits of this ongoing improvement work have been many, including removing transportation-related time, cost, work and childcare barriers for patients. The improvement team successfully assisted in the recruitment of four telemedicine providers into historically challenging-to-recruit roles, and the virtual offering improved efficiency and allowed the expansion of therapy and group therapy services. Many patients felt safer and more comfortable staying at home due to the pandemic, and clinical observation of the patient in his or her home environment assisted provider diagnosis and treatment plans. What's more, the technology improved the ability to see patients' facial expressions and presentation without the barrier of a mask.

The improvement team continues to work on ongoing gaps in rural access and for elderly patients. At the same time, they are celebrating the launch and rapid expansion of this service and all it means for the patients and communities they serve.

"This improvement journey allowed us to eliminate a transportation gap that was influencing equity challenges to receiving care," Patz said. "Now we can easily see patients when they are sick, homebound or constrained by geography, allowing us to provide the care they need to address this critical aspect of overall health. We will continue our work to improve this service for all who need it."

Froedtert & the Medical College of Wisconsin

Remote Patient Monitoring for COVID-19 Provides Comprehensive Care and Support 24/7

Innovative technology gives those who test positive for COVID-19 24/7 access to an expert care team virtually, keeping patients out of hospitals.

COVID-19 is a disease with symptoms that can span weeks or even months. Having 24/7 access to a care team can provide support and guidance and even save a trip to the hospital. Through remote patient monitoring, those who test positive for COVID-19 who need medical attention but do not need to be hospitalized are supported by providers who can triage and facilitate in-person care, if needed.

"Many people who test positive for COVID-19 do not require inpatient care but can benefit significantly from on-demand access to their care team," said Erin Green, RN, executive director of clinical operations at Inception Health, the innovation arm for the Froedtert & the Medical College of Wisconsin health network. "With remote patient monitoring and associated tools, we are further able to extend support beyond the acute phase of a patient's COVID-19 journey—recognizing that recovery is more often a marathon, not a sprint."

What is remote patient monitoring?

Remote patient monitoring is a way for health care providers to deliver comprehensive care to patients outside of the traditional hospital. Communicating through a secure app or platform on a computer, tablet or smartphone, patients can share their symptoms and other important information about their health status with providers who make recommendations for care.

Within the Froedtert & MCW health network, remote patient monitoring is managed virtually by a team of expert nurses who specialize in this unique way to deliver care. The nurses communicate with patients through the GetWell Loop app. Before the COVID-19 pandemic, GetWell Loop was in place to monitor patients with chronic conditions, such as hypertension or diabetes. However, in early 2020, the health network started using the platform for COVID-19 patient care.

"Through daily screenings, symptom checks and a direct line to our team, we are able to monitor patient progress, detect early signs of decline and intervene proactively to avoid hospital admissions," Green said.

The platform has two care plans to support people who are receiving care for COVID-19 on an outpatient basis: the COVID-19 Acute Symptoms or Exposure plan and the COVID-19 Pediatric plan. There is a third care plan, COVID-19 Recovery, for people who were previously admitted to the hospital for COVID-19 and have since been discharged. This remote patient monitoring service is available to patients at no additional cost.

Benefits of Remote Patient Monitoring Throughout the COVID-19 Pandemic

1. Access to 24/7 phone support from a critical care nurse with access to health records and care team

All Froedtert & MCW COVID-19 patients receive information about how to use the remote monitoring service and a phone number to the helpline virtual care nurse on call.

"Unlike some digital monitoring tools, this is not an outsourced solution," Brad Crotty, MD, Froedtert & MCW internal medicine physician, chief digital engagement officer for the health network and the chief medical officer for Inception Health. "These are Froedtert & MCW nurses who understand what you're going through, have the context of your health record and can be in touch with your care teams as needed."

Caring for Patients with COVID-19

Last year, more than 13,000 COVID Care Kits were distributed to patients with COVID-19. Each kit contains bilingual education materials, a pulse oximeter, hand sanitizer, face coverings and a bottle of water.

- **4,611** patients were monitored remotely throughout their COVID-19 diagnosis and **336** patients were monitored remotely after hospitalization for COVID-19
- **1,616** triage episodes were triggered by remote monitoring
- **56,132** COVID-19 testing e-visits
- **839** monoclonal antibody infustions to help prevent hospitalizations

Biometric values such as oxygen saturation level, temperature and heart rate are important vital signs to monitor for COVID-19 patients. Using their own pulse oximeter, thermometer and heart rate monitor, patients enrolled in the remote patient monitoring service can input these values into the app daily, as well as any symptoms, such as shortness of breath or nausea. They can also direct message the virtual care team nurses with questions or concerns. Alerts are triggered in the platform for any concerning changes, which will may result in a virtual care team nurse reaching out to the patient with a phone call.

"While designed as an asynchronous support tool, our remote patient monitoring service allows for the virtual care team to quickly identify new or worsening symptoms. We are then able to provide specific guidance using the patient's electronic health record," Green said. "We have a purposeful triage, intervention and escalation plan, as well as a robust relationship with our access center team. This means that if we are directing a patient to seek a higher level of care, we can provide a warm hand-off to the receiving team. This allows for fluid streamlined care and a seamless transition for the patient."

The self-isolation and stress associated with a COVID-19 diagnosis can affect mental health. Virtual care nurses can connect patients who may benefit from mental health support resources to SilverCloud, another digital health tool available through the Froedtert & MCW health network.

2. Reduced odds of being hospitalized with COVID-19

Research is underway to quantify the benefits of remote patient monitoring for COVID-19. Several studies that have already been published show that COVID-19 patients in a remote monitoring program have a lower hospitalization rate. This is also the case for Froedtert & MCW patients—according to Inception Health's preliminary data, a Froedtert & MCW patient's odds of being hospitalized with COVID-19 are 30% lower if they are undergoing remote monitoring. The lower hospitalization rate is not associated with a higher mortality rate.

"We believe therapies available for COVID-19, such as monoclonal antibody therapy, are only a small factor reflected in our data," Dr. Crotty said. "A large part of our success is due to our nurses being able to provide good and helpful information around self-care at home, including proning, or laying on your stomach, to allow for more air in the lungs, which was one of the more effective ways identified early on of treating hypoxia (lack of oxygen) in COVID-19 patients."

3. The right care at the right time

The COVID-19 pandemic has led to an unprecedented strain on hospitals across the United States. In January 2022, Wisconsin recorded a record-breaking number of new COVID-19 cases. More than half of hospitals in Wisconsin were at overall peak capacity, with more than 90% of the state's hospital beds in use and nearly 95% of the state's ICU beds in use, according to the Wisconsin Department of Health Services. Remote patient monitoring gives people who do not need a hospital bed the convenience and comforts of hospital-level care at home, while providing the most critical patients with all of the resources in a hospital setting.

"If we can prevent people from becoming so sick that they would need to be admitted, we consider this a win," said Dr. Crotty. "Remote patient monitoring allows us to right-size care and treat people in the most effective setting possible through a simple and personalized digital experience."

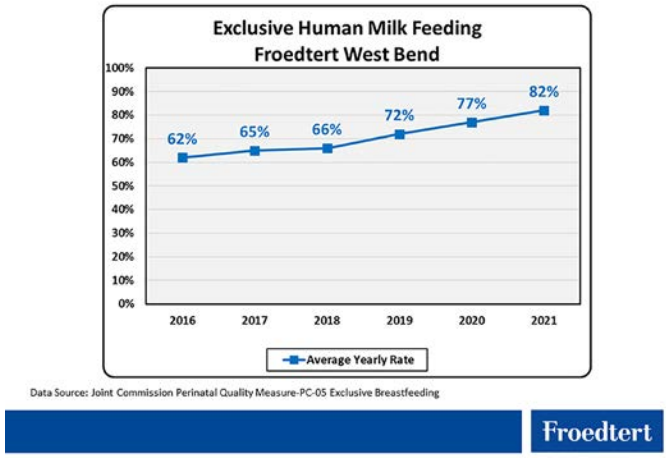
Triggered by alerts within the remote patient monitoring platform, Froedtert & MCW virtual care nurses have reached out to patients more than 2,000 times, according to October 2021 data from Inception Health.

"Without the opportunity to speak with one of our nurses, consider that these patients might have unnecessarily gone to the Emergency Department," Green said. "Remote patient monitoring is a critical tool. We can meet patients where they are at in their journey, provide the type of care they need in their recovery and help them manage their COVID-19 diagnosis at home."

Froedtert & MCW Froedtert West Bend Hospital

Exclusive Human Milk Feeding QI Initiative

Froedtert West Bend Hospital Birth Center's breastfeeding initiative began in May 2019 with a commitment to promoting and supporting breastfeeding practices. Froedtert West Bend set a goal to increase their exclusive breastfeeding rate to 70% for 2020; an increase over their 2018 rate of 66% (exceeding The Joint Commission goal of 52.9% or above).



Several measures were implemented as defined by a multidisciplinary team of lactation consultants, OB providers, the neonatology director, pediatric providers, and birth center staff. To help increase the expertise on the unit, Froedtert West Bend added two Certified Lactation Consultants (CLC) who also worked as labor nurses, to the three International Board-Certified Lactation Consultants (IBCLC) already on staff. All nurses on the unit were trained and educated on hand expression of milk and shown how easily hand expression can be taught to mothers. These methods were reviewed with mothers before formula was given.

Additionally, an antenatal hand expression study (expression of early milk and colostrum in the final few weeks of pregnancy) was started with diabetic patients, which included hand expression during labor to collect breastmilk to be given after delivery to babies with low blood sugar, instead of formula. To further promote exclusive human milk feeding, whether it is mother's milk or donor human milk, Froedtert West Bend worked with Mother's Milk Bank of the Great Lakes in implementing pasteurized human donor milk (PHDM). This process took months to implement, including working with the multidisciplinary team to gain approval from hospital administration and hospital infection prevention, and required writing policies and procedures, educating staff, setting up monitored refrigerators and freezers, using proper warming protocol, producing educational material and consent forms for patients, and analyzing algorithms for decision making on when to use donor milk. Froedtert West Bend wanted patients to understand and be reassured that PHDM is screened, pooled, tested, and pasteurized to eliminate harmful bacteria or other potential infecting organisms. The first PHDM was used September 11, 2019. Also, during this time, the perinatal coordinator joined a collaborative

through the Wisconsin Perinatal Quality Collaborative (WisPQC) comprised of other hospitals working to increase exclusive human milk feeding, sharing lessons learned.

Froedtert West Bend's focus on patient education continued throughout 2020, and included lactation consultants:

- Seeing all patients daily
- Reformatting the facility's lactation sheets to color-coded sheets and providing these to all breastfeeding patients in an informational packet
- Continuation of a monthly lactation support group
- Sending My Chart messages as a follow up to patients

The donor milk freezer which is located in the newborn nursery.

In conjunction, the perinatal coordinator added information about the importance of breastfeeding into prenatal education into Baby Scripts, the prenatal education app that Froedtert uses with patients. The lactation consultants and perinatal coordinator reviewed the feeding trends monthly (see table 1). While no specific trends were identified over time, chart reviews found additional ways to advocate breastfeeding. Prenatal education was held virtually and through the app. Lactation support continued to be offered as an outpatient service for patients needing more intensive support on a 1:1 basis.

Table 1

Monthly breakdown of feedings
Exclusive mom's milk
Mom's milk and donor
Mom's milk and formula
All formula
Breast milk, donor and formula

Used for discussion with staff for QI

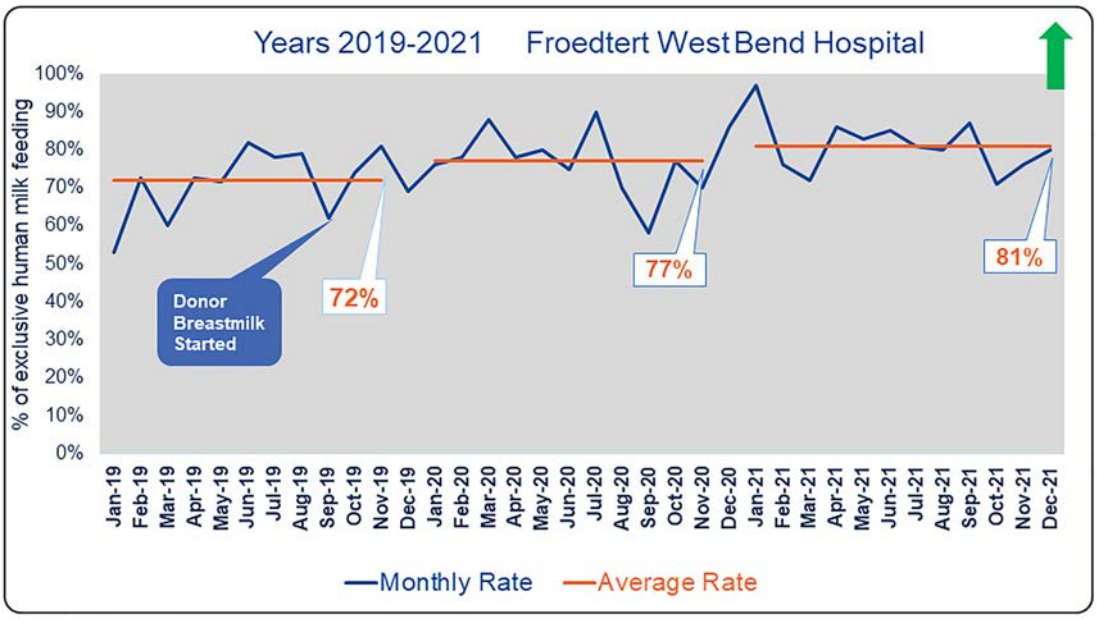
In 2021, the focus continued with education. Staff had annual breastfeeding education "back to basics," including feeding patterns in the first 24 hours, review of hand expression, troubleshooting problems with feeds at change of shift, and trying to put baby skin-to-skin before giving report (so the next RN could help with the baby's latch). This addressed trends seen in previous months of infants going too long between feeds due to needing assistance with feeding at change of shift.

The perinatal coordinator and lactation coordinator continued to focus on chart review. When goals were not met, opportunities for improvement were discussed and shared with staff. For example, if a baby was breastfeeding and was given formula as well they found a progress note was missed explaining the offer of donor milk being an option. This led to an opportunity for quality improvement where the perinatal coordinator and the lactation consultant would meet with RNs and discuss the any missed opportunity to document nursing education. This education continued with focus on discharge teaching for breastfeeding, allowing staff nurses to be involved in discharge discussions with the patient. This allowed the lactation consultant to have more time to work on feedings with families.

Staff education board where different breastfeeding information was posted with breastfeeding graphs.

Goals identified for 2022 include education for providers and staff regarding management of plugged ducts and mastitis reflecting new emerging guidelines. In light of PHMD shortage nationwide, staff was encouraged to continually re-evaluate the need for use of PHDM, watching for indications that improved breastfeeding may allow discontinuation of additional supplementation.

Each month the perinatal coordinator, with the quality department, share the exclusive human milk feeding rate with the birth center staff compared to our goal to date. The interdisciplinary team reviews the data during their bi-monthly meetings as well. This helped to visualize, with graphs, how our interventions were working. Froedtert West Bend has exceeded their goal of exclusive breastfeeding and has seen a steady rise for the last two calendar years and into 2022.



Data Source: Joint Commission Perinatal Quality Measure-PC-05 Exclusive Breastfeeding

Marshfield Clinic Health System

Early Adopter of COVID-19 Vaccine Requirements for Employees

Since the start of the COVID-19 pandemic, Marshfield Clinic Health System (MCHS) has put the safety, health and wellbeing of patients, employees and communities at the forefront. Safety, along with guidance from the Centers of Disease Control and Prevention, has influenced every decision made during the COVID-19 pandemic.

With widespread availability of the COVID-19 vaccine, and after considering the risks and benefits of requiring the vaccine, MCHS announced in early August 2021 that all employees and providers were required to meet MCHS COVID-19 vaccine requirements by Nov. 15, 2021. This decision was made for the following reasons:

- To support the organization in living out its mission and core values of excellence, trust and being patient-centered;
- With COVID-19 positive cases rising across the country, the trend not slowing down, and most of the COVID-19 hospitalizations and deaths attributed to unvaccinated individuals, requiring the vaccine is the best way to protect the health and safety of MCHS employees and patients; and
- To assure the community and our patients, families, visitors and employees that we are providing them with the safest possible environment.

Leaders in employee health, human resources, infection prevention and other departments collaborated together to identify policies and processes to support vaccine administration as well as medical and religious exemptions. Knowing that staff had different viewpoints toward the new MCHS vaccine requirement, leadership communicated that they hoped all staff would choose to remain with MCHS and get their vaccine or secure an appropriate exemption and follow the associated mitigation strategy. Many resources were also developed to support employees having the information they needed on the COVID-19 vaccine and the MCHS vaccine requirements.

Despite this support, some employees chose to not comply with the MCHS vaccine requirements given their strong opposition to the COVID-19 vaccine and ultimately left the organization.

Since the Centers for Medicare & Medicaid Services announced in December 2021 that eligible health care providers must have a COVID-19 vaccine policy in place, health care systems have adopted policies to comply with the federal rules requiring staff to receive the vaccine. MCHS is proud to be an early adopter of the COVID-19 vaccine requirements and will continue to live out its mission and values by requiring and enforcing safety measures to protect the lives and health of patients, employees and the communities it serves.

Marshfield Medical Center – Ladysmith

Recovery Coach Program at Marshfield Clinic Health System

Marshfield Clinic Health System (MCHS) implemented a pilot recovery coach program at MMC-Ladysmith in September 2021. The addition of an on-site recovery coach adds another support option for those concerned about their own or someone else's substance use.

This program is the result of the innovative use of a federal service program (AmeriCorps) to develop peer recovery support services. In 2017, MCHS Center for Community Health Advancement launched AmeriCorps Recovery Corps, the AmeriCorps program that recruits and trains individuals with lived experience to serve as recovery coaches. Members undergo training in the Connecticut Community for Addiction Recovery (CCAR) model of recovery coaching. Recovery coaches support someone who is concerned about their own or someone else's substance use.

The need was brought forth to the center from a local recovery task force, which identified recovery support services as a service gap in the community. The health system acknowledged the need and felt it was important to meet people where they are. Therefore, they agreed to integrate these services within the hospital setting by use of referral from primary care, emergency department, behavioral health, self-referral, etc. This service can be utilized by both patients and community members and is free of charge.

The integration of recovery coach services within the health system has been successful with an expansion plan to other clinic locations soon.

Marshfield Medical Center – Weston

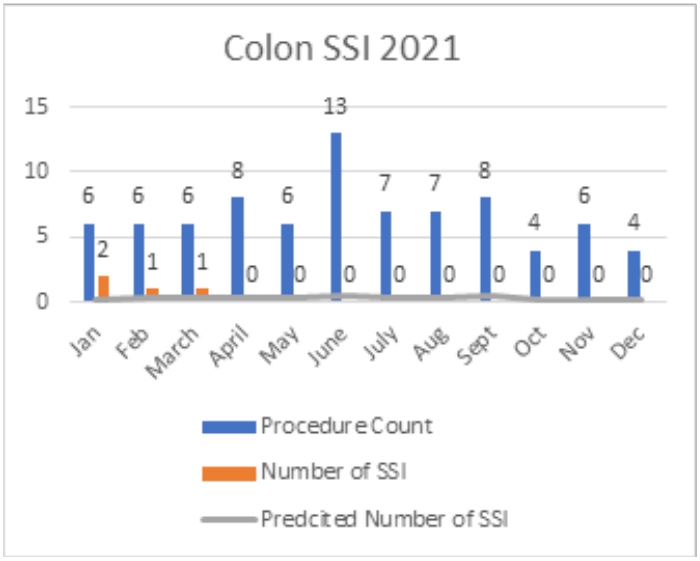
Surgical Site Infection Reduction in Colorectal Surgery

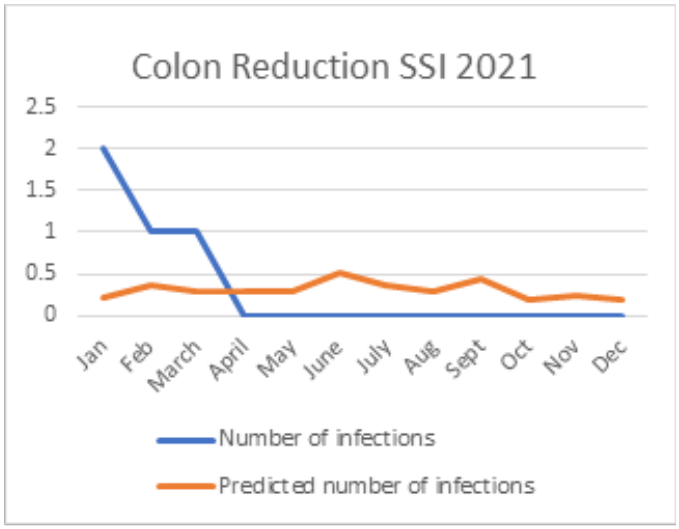
Surgical site infections (SSIs) are the most common hospital-acquired infection and often result in prolonged hospital stays, increased cost and a higher risk of postoperative mortality. It is estimated that 60% of all SSIs can be prevented with implementation of evidence-based guidelines. The National Health and Safety Network (NHSN) requires all acute care hospitals to complete surveillance and report all incidents of SSI in colorectal surgeries as part of its patient safety monthly reporting plan.

In early 2021, infection prevention identified a sharp increase in surgical site infections involving colorectal surgeries. There were zero colon surgical site infections reported for 2020 until two cases were identified in December. This was followed by an additional four cases identified in the first quarter of 2021. Infection prevention immediately began thorough investigations into each of the cases, collaborating with the surgical services team at MMC-Weston. Additionally, infection prevention conducted direct operating room observations and made SSI the focus of the infection prevention committee meetings for the next several months.

At the time, there was no formal colon SSI prevention bundle in place. Marshfield Clinic Health System has a robust quality and safety team. A system initiative named the Colon Premier Care Project had been initiated in 2019; however, full implementation of the project was put on hold due to the COVID-19 pandemic. Infection prevention (IP) reached out to quality team members and gathered information on the elements involved in the Colon Premier Care Project and presented the information to the infection prevention committee. A small work group met to compare elements of the bundle to current practice. Several areas were identified as opportunities to improve upon, including adherence to a closing protocol, consistent nasal decolonization, consistent use of chlorhexidine gluconate bathing prior to surgery and re-dosing of preoperative antibiotics. After implementation, these measures were tracked during routine IP active surveillance for compliance.

After March 2021, there are zero SSI colon infection cases. IP continues to conduct active surveillance on all colon cases performed at MMC-Weston and present outcomes to the infection prevention committee on a regular basis.





Southwest Health, Platteville

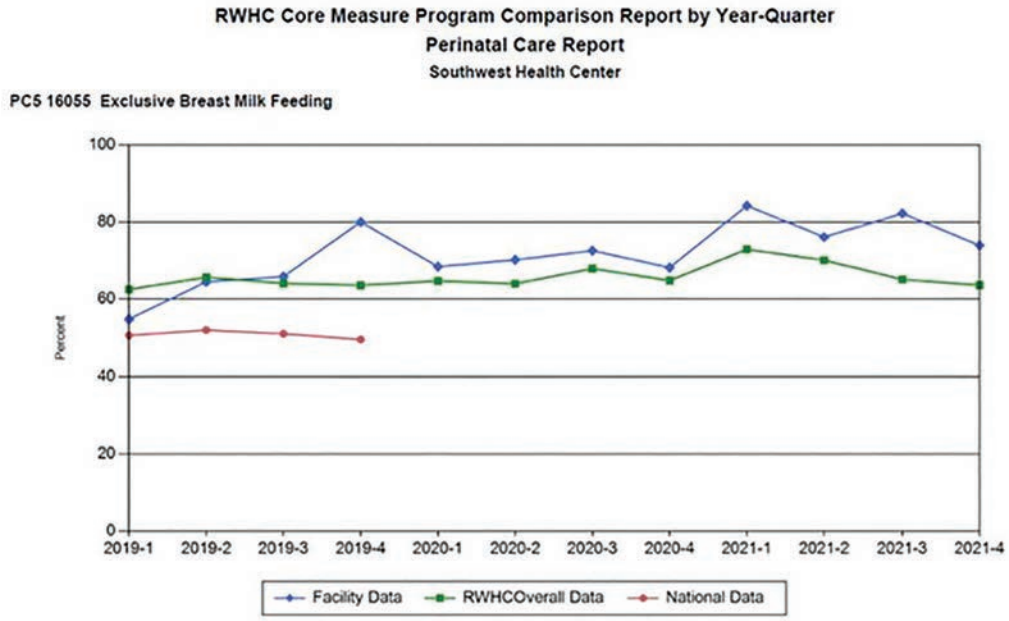
Southwest Health applied for and received a Population Health Improvement Grant from the Wisconsin Office of Rural Health, designated for the obstetric (OB) department to combat the rising obesity epidemic in Grant County, Wisconsin. This grant was used to help the Southwest Wisconsin community and Southwest Health's patients understand the importance of exclusive breastfeeding, including a decrease in the likelihood of obesity and additional health benefits for both baby and mother. Receiving this grant allowed the OB department to upgrade its equipment, provide additional training for the staff, and educate the community on financial and developmental benefits. Southwest Health's OB department decided to focus on exclusive breastfeeding for quality improvement after scoring a low benchmark of 58% in the exclusive breastfeeding rate in the second quarter of 2019. The Office of Rural Health’s funding is provided through the federal Medicare Rural Hospital Flexibility Program.

While the OB at Southwest Health is enthusiastic about the care it provides, a disconnect existed between nurse education and breastfeeding training to the patients. A portion of the resources for the quality improvement initiative were spent on a universal, 16-hour Institute for the Advancement of Breastfeeding & Lactation Education (IABLE) training for staff. The IABLE training, created by a Wisconsin physician, helps bridge the gap between all educational institutions. The training educates staff about the benefits of exclusive breastfeeding, provides tangible educational materials and creates consistency in policy when encouraging mothers to breastfeed. To make this a sustainable change, Southwest Health hired an international board-certified lactation consultant (IBCLC) and a certified lactation consultant (CLC) as breastfeeding advocates at the hospital. After implementing changes from the quality improvement initiative, Southwest Health found additional aspects that help mothers, like encouraging skin-to-skin contact, having the first feeding in the operating room post-C-section, rooming-in with the baby 24/7, close follow-up and connection with the CLC.

“My goal as a CLC is to help new moms feel confident when feeding their child. Whatever proactive measures we can take like educating about different breastfeeding positions or hand expressing techniques, all help give moms peace of mind that they are providing for their child,” says Southwest Health’s CLC.

After a baby is born, OB staff encourage breastfeeding within the first hour of delivery. With trained staff present, breastfeeding may come a little easier. As the new moms go home, they may not have the same support or resources available, and breastfeeding may become a challenge. New equipment can help bridge the gap between hospital and home to help the transition. Equipment purchased through the collaborative for new moms included a pre- and post-feed baby scale, breastfeeding covers, loaned breast pumps (until moms receive their own from insurance), additional pump parts, halo cribs and donor milk. All this equipment is used to help ease moms into transitioning back to home life with a baby. This equipment can be the difference between a new mom having the comfort and accessibility to breastfeed and establishing a good supply or relying on formula.

After implementation, Southwest Health can proudly share that the exclusive breastfeeding rate as of September 2021 was 77%, well above Wisconsin's state average of 62%, as represented in the graph below. This outcome means mothers feel more comfortable breastfeeding their children while using the education and resources provided by the nurses and hospital post-birth.



Tomah Health, Tomah

Tomah Health Rolls Out New Patient Feedback Program

Tomah Health has collaborated with Real-time Feedback by NRC Health to enhance patient experience and help drive service recovery. Patients who received care in the hospital’s urgent care, Warrens clinic, specialty clinic and same-day surgery departments will be contacted within three days of their visit for a two-minute call or email.

Tomah’s Shelly Egstad said, “Real-time feedback results demonstrate a statistically significant impact to enhancing a patients’ experience and perception of care. The program enables our rapid resolution of any issues identified where we can coordinate additional needs with our patients and staff.” The survey program is already paying dividends. The partnership is an example of Tomah’s continued dedication toward ensuring patients have an excellent care experience and using best practices established within the health care industry. Hospital staff also appreciate receiving the feedback, which allows them to enhance care further.

Patients interested in sharing additional feedback can do so by visiting the hospital’s website at www.tomahhealth.org.

Upland Hills Health, Dodgeville

Transitional Care Management: An Evidence Based Approach to Eliminating Care Gaps

In recent years, Upland Hills Health (UHH) restructured to a hospitalist model, expanded its service area to include seven primary care clinics and converted all patient care areas to a shared electronic medical record (EMR) solution. Despite significant growth and improvements over a short amount of time, continuity of care remained challenging, especially for patients hospitalized with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and diabetes. There was an innate need for a more collaborative approach to coordinating care and an even greater need to increase communication with primary providers after a hospital stay. To improve the patient experience and quality outcomes and to reduce readmission rates, UHH saw the implementation of transitional care management (TCM) as a prime opportunity to bridge the gap between the inpatient and outpatient worlds.

TCM provides care coordination for 30 days following hospitalization and is designed to eliminate gaps in care and reduce readmission rates. It ensures a comprehensive discharge plan, prompt follow-up communication to patients and/or caregivers, complete medication reconciliation, timely follow-up with a primary provider and referrals to community resources. TCM has been recognized since 2013 by the Centers for Medicare & Medicaid Services and many insurers as a reimbursable, preventative wellness program. UHH applied for and was awarded grant funding from the Federal Office of Rural Health Policy to incorporate this best practice to its everyday workflows. With financial support totaling $538,987 over a three-year period, UHH was set to begin development of a TCM program in the fall 2019. Looking back, some may think that taking on a sizable quality improvement (QI) project at the onset of a pandemic was just plain crazy, but there was no greater time to ensure care coordination.

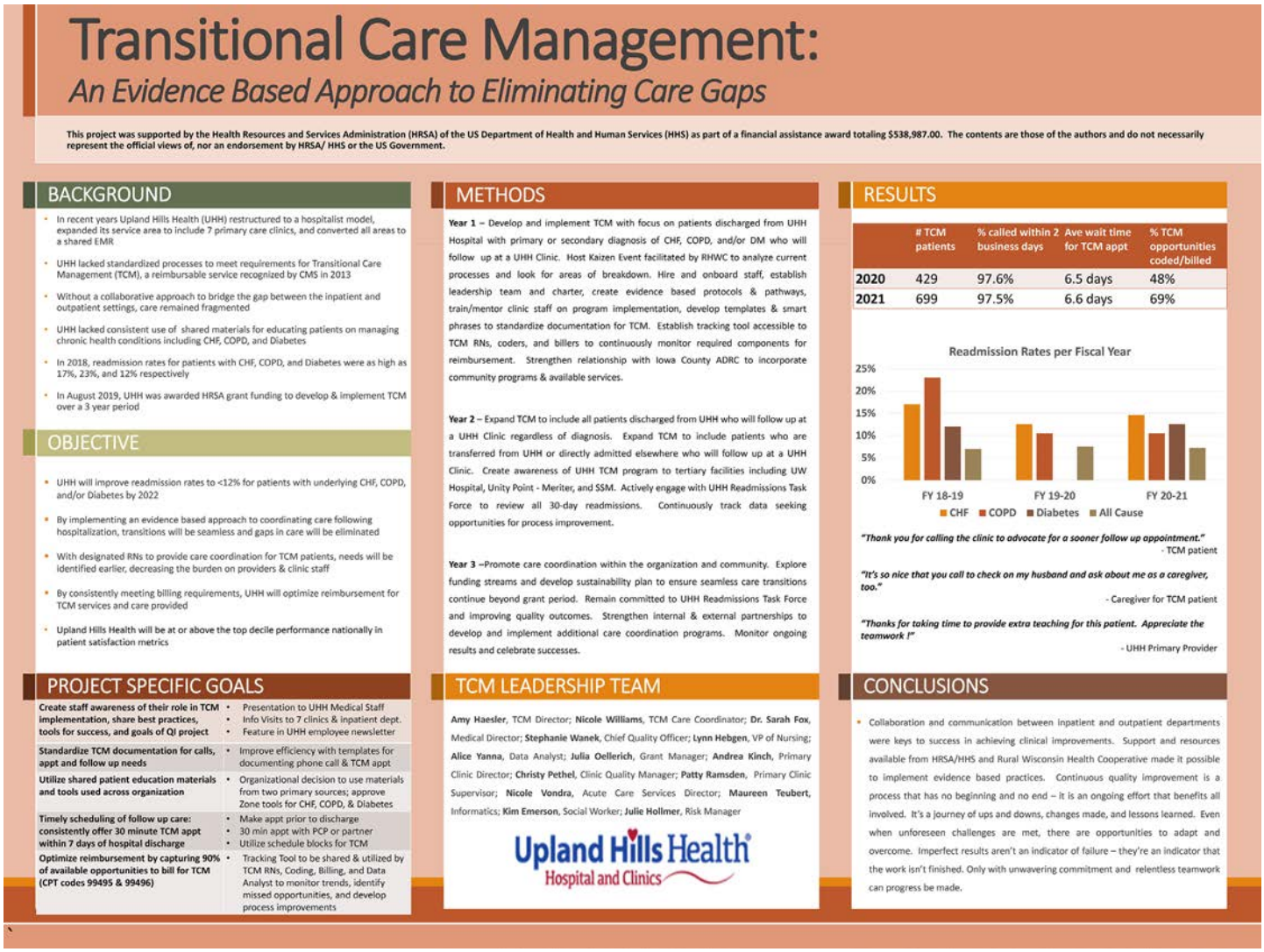
Year one of the project emphasized the development of a strong foundation. Hiring qualified staff, establishing measurable goals and creating action plans were initial priorities. A day-long Kaizen event in December 2019 proved to be a crucial element. More than 25 UHH staff members and two facilitators from the Rural Wisconsin Health Cooperative focused on continuous improvement cycles, analyzed current processes, identified areas of breakdown and developed new workflows to optimize communication and standardize work. A plan-do-study-act model was used to implement plans for small tests of change, and a TCM leadership team began meeting regularly to oversee project progress and meet grant deliverables.

An initial target population consisted of adult patients with a diagnosis of CHF, COPD or diabetes who were hospitalized at UHH and would receive follow-up care at a UHH primary care clinic. These chronic conditions paired with other co-morbidities, problem-prone medications and increased social isolation during a pandemic set up the perfect storm to put patients at an increased risk of complications and readmission. TCM nurses based in the hospital prioritized attending interdisciplinary rounds to anticipate discharge plans and potential needs of patients returning home. Standardized processes guaranteed that patients were called within two business days of discharge. Use of templates and message routing within a shared EMR provided complete, real-time updates to primary providers. Appointment blocks in clinic schedules helped to consistently provide a focused follow up visit within a specific timeframe. A comprehensive spreadsheet shared by TCM nurses, coders, billers and data analysts was used to track the necessary components for reimbursement during the 30 days after the hospitalization.

Patient education and engagement were identified as vital components of the QI project. TCM nurses partnered with patients to provide the tools and information they needed. Organizationally, a decision was made to use materials from two approved sources. Additionally, zone tools for CHF, COPD and diabetes were utilized. These visual references, resembling a stop light, helped patients to more easily recognize warning signs and manage symptoms. To increase patient engagement, grant funds were used to provide patients in need with scales, medication planners, blood pressure monitors and pulse oximeters. The cost of transportation to medical appointments was also covered for those in need to ensure access to follow up with providers and specialists. For patients at high risk of readmission, TCM nurses provided additional follow-up phone calls over the course of 30 days following the hospitalization to educate on self-management and increase patient engagement.

By year-two of the project, TCM was extended to all patients hospitalized at UHH who would receive follow-up at a UHH primary care clinic, regardless of age or diagnosis. Despite the increased patient volumes, it seemed there was still a significant number of patients being missed—those following up in a UHH primary care clinic after being hospitalized elsewhere. This included patients transferred

from UHH to a higher level of care as well as those admitted directly to other hospitals. With the development of reports within our EMR and collaboration with health information technology staff at other area hospitals, automatic notification processes were established. This allowed continuity of care for UHH patients even when they hospitalized elsewhere. This outreach alone nearly doubled the number of patients served by TCM within two years of implementation.



Upland Hills Health's quality improvement dashboard 2022

Now in its third and final year of grant funding, UHH is focused on sustainability. Implementing a QI initiative during a pandemic had its challenges, but it has certainly been beneficial for patients as well as providers. Through follow-up phone calls alone, TCM nurses have made numerous good catches related to medications being taken incorrectly, referrals that had gone amiss or a need for increased services in the home. Standardized processes and streamlined documentation have resulted in increased reimbursement for TCM. Missed opportunities are tracked and reviewed on a monthly basis for continued improvement. Consistently, more than 97% of all discharged patients receive a follow up call within two business days, and on average, patients are seen within seven days for a TCM appointment. Primary providers have expressed appreciation for the increased coordination and patient education being completed.

Optimization strategies to reduce 30-day readmission rates continue at full strength. Despite efforts made during the period of grant funding for this project, these rates remain higher than desirable, especially for patients with CHF, COPD and diabetes. When reflecting on the impact of recent challenges, we are soon reminded of the abrupt shut down of services and limited availability of community resources in 2020-2021. This included cancelled outpatient services, routine well-visits in our clinics, transportation

agencies and supportive home care programs. The overall risk of readmission for anyone with chronic conditions quickly increased; yet, outlets for assistance seemed more limited than ever. TCM nurses were able to provide weekly calls to those at highest risk to help manage symptoms at home. A multidisciplinary readmission taskforce was established to review all unplanned 30-day readmissions. This group continues to meet bi-weekly to identify root causes and opportunities for improvement.

In conclusion, collaboration and communication between inpatient and outpatient departments is the key to success in achieving clinical improvements. Patient-centered care isn't a singlehanded effort; rather, it is a continual effort by all members of our organization. It requires a culture of quality and a mutual understanding of best practices and evidence-based care. Continuous improvement is a process that has no beginning and no end—it is an ongoing effort that benefits all involved. It's a journey of ups and downs, changes made and lessons learned. Imperfect results aren't an indication of failure—they're an indicator that the work isn't finished. Even when unforeseen challenges are met, there are opportunities to adapt and overcome. Only with unwavering commitment and relentless teamwork can progress be made.

(This project was supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) as part of a financial assistance award totaling $538,987.00. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by HRSA/HHS or the U.S. government.)

UW Health, Madison

Nurse-Led Research: Improving Pressure Injury Care for Patients with Dark Skin Tones

Understanding skin tone and how it relates to assessment in preventing and identifying pressure injuries and/or tissue damage can be difficult. Research conducted by Health Research & Educational Trust shows us hospital-acquired pressure injuries affect more than 2.5 million Americans annually. Pressure injuries often lead to poor patient outcomes and increased hospital length of stay, negatively impact hospital quality measures and are costly for the hospital system due to reimbursement challenges.

Traditionally, nurses assessing patients' skin for pressure injury are taught to look for redness to detect the first signs of damage, but this proves challenging when assessing patients with darker-pigmented skin, who require tactile and sensory assessments as well. At UW Health, adult inpatients with dark skin tones had under-recognized and/or misdiagnosed pressure injuries, specifically deep-tissue pressure injuries that result in more severe stages and complications.

That's why Courtney Maurer, DNP, RN, chose to conduct her final Doctor of Nursing practice quality improvement project on improving nurse assessment and documentation of pressure injuries specific to dark skin tones. For Courtney, this work was important as racial inequity was sweeping the nation.

"As nurses, we are educated in health care disparities with a focus on racial injustice, public health and chronic diseases, but education and resources on the acute care needs of patients with dark skin are limited," says Courtney. "I was not confident in my skin assessment skills of patients with dark skin tones, and I recognized a need for organizational resources and further education for inpatient nurses that was inclusive of diverse patient populations."

She began the improvement project by completing a needs assessment and comparing current documentation and resources with international assessment. In addition, she shared visual examples of different-stage pressure injuries to help nurses better identify pressure wounds on dark skin tones. This work led to engaging UW Health's diversity, equity and inclusion team, nursing documentation committee and Center for Clinical Knowledge guidelines. She collaborated with UW Health's Burn and Wound Center team and a clinical nurse specialist to create a translating-research-into-practice-resource sheet and a five-minute video modeling a skin management, nursing informatics and the nursing practice council—all working together to implement recommended terms in the skin and wound nursing documentation flowsheets in our electronic medical record. Courtney worked closely with intensive care unit (ICU) clinical nurse specialists, skin care nurses, the wound team and staff in four adult ICUs at University Hospital, providing pre- and post-surveys to gain understanding of nurse perceptions, attitudes, previous education and resource availability.

Courtney's resources can now be found on UW Health's intranet and are part of the University of Wisconsin School of Nursing curriculum. "I'm finding materials being laminated at nursing stations and on bulletin boards. The feedback from nurses has been positive, and the adoption of documentation changes and resources from other facilities, such as Agrace, the American Family Children's Hospital and UW Health SwedishAmerican Hospital, has shown the profound need nurses had for these resources."

Courtney says she hopes this work empowers other nurses to look for ways to improve processes and continue to educate and work together to eliminate disparities in health care outcomes. "I know I can speak for other nurses when I say we feel proud when we know the work we are doing to better ourselves is what's right for our patients and will ultimately improve the quality of our care."

For additional information, see the paper detailing this project here: http://www.wha.org/Home/Common-PDFs/UW-Health-supporting-Doc-Maurer-DNP-Scholarly-Proj.pdf.

Clement J. Zablocki VA Medical Center, Milwaukee

Ground-breaking Partnership Aids Veterans

An innovative partnership between the Milwaukee VA Medical Center and a neighboring municipal fire department reaped big dividends in 2021—and likely saved the life of a Veteran.

The Mobile Integrated Healthcare (MIH) program was established in 2020, involving the emergency department at the Milwaukee VA and the West Allis Fire Department.

"This is a first-in-the-nation relationship between VA and fire departments," said Ben Thelen, nurse manager for the Milwaukee VA emergency department (ED). The program seeks to find out why some Veterans make numerous trips to the ED and then figure out ways for the Veterans to better manage their health to decrease visits to the ED.

Members of the Mobile Integrated Healthcare program with the West Allis Fire Department stand ready to help Veterans.

It starts with a team of specially trained paramedics who make house calls to Veterans known to make frequent visits to the ED. These aren't emergency lights-and-sirens calls; instead, the paramedics are working proactively. They talk with the Veterans about their medications, check out their surroundings and make sure they are in contact with the right resources.

"We get eyes on them in their house, in their environment, to see what issues they have that can be mitigated," said Capt. Armando Suarez Del Real, MIH program coordinator for the West Allis Fire Department. "If they are utilizing the ED a lot, chances are they are not complying with some area of their care plan."

"They find things that we can't see here in the ED," said Ann Baggett, social worker for the Milwaukee VA Emergency Department. "It helps us a lot."

West Allis is the first fire department in the state to have an MIH program, said Suarez Del Real. "It's not the norm, but in our opinion, this is the future of EMS. It's a very proactive approach to EMS. We're trying to reduce the inherent risks that are involved in most people's lives."

Veteran rescued

That became evident in April of 2021 when the program saved an elderly Veteran who was living in squalor and being preyed upon by neighbors and crooks. Baggett asked the West Allis crew to check on the Veteran—referred to in this article as Mr. H to protect his confidentiality as a VA patient—after his actions and visits to the hospital raised some red flags.

Milwaukee VA social worker Ann Baggett, left, talks with Lt. A.J. Ottow of the Mobile Integrated Healthcare program with the West Allis Fire Department. Their collaboration helped save a Veteran who was living in squalor and being preyed upon by neighbors and crooks.

Baggett discovered that Mr. H—who was a frequent visitor to the Emergency Department—had not been seen by his primary care team in four years—despite Mr. H continually telling VA staff he was seeing his doctor and that everything was fine. And he seemed to be in good health.

But during visits in early 2021, Mr. H showed signs of physical decline and cognitive impairment, Baggett said: His shoes were ragged; he was complaining of foot pain, and his Parkinson's disease appeared to be getting worse.

"He seemed more disheveled — not all the way confused, but you knew something was going on," she said.

Mr. H had lived in the same rooming house for decades — a building he owned until recently, when he lost it due to financial hardship. He then became a tenant in the house, and it wasn't long until unsavory neighbors and others started taking advantage of him.

Milwaukee VA social worker Ann Baggett, left, talks with Lt. A.J. Ottow of the Mobile Integrated Healthcare program with the West Allis Fire Department. Their collaboration helped save a Veteran who was living in squalor and being preyed upon by neighbors and crooks.

It got so bad at one point that Mr. H spent a week sleeping under the porch.

When Baggett heard that, she alerted the county's Adult Protective Services as well as the MIH team in West Allis.

And when Lt. A.J. Ottow, a lieutenant with the West Allis Fire Department's MIH team, arrived at Mr. H's home, he was shocked and appalled.

'Absolutely atrocious'

"His room was absolutely atrocious," he said, saying it was the worst situation he had ever seen. "The bedsheets were threadbare, and the mattress — I wouldn't have my worst enemy sleep on that mattress. And he had no clothes, no food."

There was no kitchen, no refrigerator or even a microwave oven. Mr. H had been subsisting on sweet rolls given to him by a neighbor.

Ottow learned that Mr. H's Meals on Wheels deliveries were being stolen routinely, along with clothes he would receive via the county. He had been robbed at gunpoint just weeks prior, and a 22-year-old woman he referred to as his "fiancée" was continually scamming him out of cash.

Mr. H would go to his bank regularly to withdraw cash — often large sums of it — and when his neighbors caught on, the scamming, bilking and thefts escalated.

"This was by far the worst because it was on so many levels: It was on a health-care level. It was on a mental level. It was on a living situation. It was a safety consideration. It was neglect and malnutrition. And you had criminal aspects," Ottow said.

Ottow took immediate action, contacting the Milwaukee VA and county authorities.

Ottow personally cleaned up Mr. H's room, hauling out multiple bags of garbage, repairing furniture and putting away his new clothes.

But more significantly, Ottow was able to convince Mr. H he needed to see a VA doctor, and an appointment was set for one week later.

Mr. H was admitted to the hospital, which triggered a chain of events that led to a room in the Community Living Center. Family members were contacted, and plans were put in motion to get Mr. H into an assisted living facility.

Reinforcing the mission

The outcome reinforces the mission of the Mobile Integrated Healthcare program. Such programs — sometimes referred to as "community paramedics" — are relatively new but gaining traction throughout the country, Ottow said.

"I really enjoy the program. It allows the Vets to realize they are not out here on their own," Ottow said. "We're there to help them with their needs and wants. The goal is to keep people as healthy and as happy as they can be."

Since the Milwaukee VA cemented its relationship with the West Allis MIH, and the partnership has shown big dividends: Thelen said unnecessary Emergency Department visits have been reduced by 50%.

"It's been really great," Thelen said. "The Vets love it, and the staff likes knowing they have that option."

WHA Member Hospitals

AdventHealth, Durand
Amery Hospital & Clinic, Amery
Ascension All Saints Hospital, Racine
Ascension Calumet Hospital, Chilton
Ascension Columbia St. Mary's Hospital, Milwaukee
Ascension Columbia St. Mary's Hospital Ozaukee, Mequon
Ascension NE Wisconsin - Mercy Campus, Oshkosh
Ascension NE Wisconsin - St. Elizabeth Campus, Appleton
Ascension Sacred Heart Rehabilitation Hospital, Milwaukee
Ascension SE Wisconsin Hospital - Elmbrook Campus, Brookfield
Ascension SE Wisconsin Hospital - Franklin Campus, Franklin
Ascension SE Wisconsin Hospital - St. Joseph Campus, Milwaukee
Ascension St. Francis Hospital, Milwaukee
Ascension Wisconsin Hospital, Greenfield
Ascension Wisconsin Hospital, Menomonee Falls
Ascension Wisconsin Hospital, Waukesha
Aspirus Divine Savior Hospital & Clinics, Portage
Aspirus Eagle River Hospital, Eagle River
Aspirus Langlade Hospital, Antigo
Aspirus Medford Hospital & Clinics, Inc., Medford
Aspirus Merrill Hospital, Merrill
Aspirus Plover Hospital, Stevens Point
Aspirus Rhinelander Hospital, Rhinelander
Aspirus Riverview Hospital & Clinics, Inc., Wisconsin Rapids
Aspirus Stanley Hospital, Stanley
Aspirus Stevens Point Hospital, Stevens Point
Aspirus Tomahawk Hospital, Tomahawk
Aspirus Wausau Hospital, Wausau
Aurora BayCare Medical Center, Green Bay
Aurora Lakeland Medical Center, Elkhorn
Aurora Medical Center - Bay Area, Marinette
Aurora Medical Center - Manitowoc County, Two Rivers
Aurora Medical Center - Washington County, Hartford
Aurora Medical Center, Burlington
Aurora Medical Center, Grafton
Aurora Medical Center, Kenosha
Aurora Medical Center, Oshkosh
Aurora Medical Center, Summit
Aurora Psychiatric Hospital, Wauwatosa
Aurora Sheboygan Memorial Medical Center, Sheboygan
Aurora Sinai Medical Center, Milwaukee
Aurora St. Luke's Medical Center, Milwaukee
Aurora St. Luke's South Shore, Cudahy
Aurora West Allis Medical Center, West Allis
Bellin Health Oconto Hospital, Oconto
Bellin Hospital, Green Bay
Bellin Psychiatric Center, Green Bay
Beloit Health System, Beloit
Black River Memorial Hospital, Inc., Black River Falls
Burnett Medical Center, Grantsburg
Children's Wisconsin - Fox Valley Hospital, Neenah
Children's Wisconsin - Milwaukee Hospital, Milwaukee
Clement J. Zablocki VA Medical Center, Milwaukee
Crossing Rivers Health Medical Center, Prairie du Chien
Cumberland Healthcare, Cumberland
Door County Medical Center, Sturgeon Bay
Edgerton Hospital and Health Services, Edgerton
Essentia Health St. Mary's Hospital, Superior
Fort HealthCare, Fort Atkinson
Froedtert & the Medical College of Wisconsin - Froedtert Community Hospital – Mequon, Mequon
Froedtert & the Medical College of Wisconsin - Froedtert Community Hospital – New Berlin, New Berlin
Froedtert & the Medical College of Wisconsin - Froedtert Community Hospital – Oak Creek, Oak Creek
Froedtert & the Medical College of Wisconsin - Froedtert Community Hospital – Pewaukee, Pewaukee
Froedtert & the Medical College of Wisconsin - Froedtert Hospital, Milwaukee
Froedtert & the Medical College of Wisconsin - Froedtert Menomonee Falls Hospital, Menomonee Falls
Froedtert & the Medical College of Wisconsin - Froedtert West Bend Hospital, West Bend
Granite Hills Hospital, West Allis
Grant Regional Health Center, Lancaster
Gundersen Boscobel Area Hospital and Clinics, Boscobel
Gundersen Lutheran Medical Center, La Crosse
Gundersen Moundview Hospital and Clinics, Friendship
Gundersen St. Joseph's Hospital and Clinics, Hillsboro
Gundersen Tri County Hospital & Clinics, Whitehall
Hayward Area Memorial Hospital & Water's Edge, Hayward
Holy Family Memorial, Inc., Manitowoc
Howard Young Medical Center, Woodruff
HSHS Sacred Heart Hospital, Eau Claire
HSHS St. Clare Memorial Hospital, Oconto Falls
HSHS St. Joseph's Hospital, Chippewa Falls
HSHS St. Mary's Hospital Medical Center, Green Bay
HSHS St. Nicholas Hospital, Sheboygan
HSHS St. Vincent Hospital, Green Bay
Hudson Hospital & Clinic, Hudson

(continued on next page)

WHA Member Hospitals (continued)

Indianhead Medical Center, Shell Lake
Lakeview Specialty Hospital & Rehab, Waterford
Marshfield Medical Center, Marshfield
Marshfield Medical Center, Beaver Dam
Marshfield Medical Center, Eau Claire
Marshfield Medical Center, Ladysmith
Marshfield Medical Center, Minocqua
Marshfield Medical Center, Neillsville
Marshfield Medical Center, Park Falls
Marshfield Medical Center, Rice Lake
Marshfield Medical Center, Weston
Marshfield Medical Center - River Region, Stevens Point
Mayo Clinic Health System - Chippewa Valley, Bloomer
Mayo Clinic Health System, Eau Claire
Mayo Clinic Health System, La Crosse
Mayo Clinic Health System - Northland, Barron
Mayo Clinic Health System - Oakridge, Osseo
Mayo Clinic Health System - Red Cedar, Menomonie
Mayo Clinic Health System, Sparta
Memorial Hospital of Lafayette Co., Darlington
Memorial Medical Center of Ashland
Mercyhealth Hospital and Medical Center - Walworth, Lake Geneva
Mercyhealth Hospital and Trauma Center - Janesville
Midwest Orthopedic Specialty Hospital, Franklin
Mile Bluff Medical Center, Mauston
Milwaukee Rehabilitation Hospital, Greenfield
Miramont Behavioral Health, Middleton
North Central Health Care, Wausau
Orthopaedic Hospital of Wisconsin, Glendale
Osceola Medical Center, Osceola
Prairie Ridge Health, Columbus
ProHealth Oconomowoc Memorial Hospital, Oconomowoc
ProHealth Rehabilitation Hospital of Wisconsin, Waukesha
ProHealth Waukesha Memorial Hospital, Waukesha
ProHealth Waukesha Memorial Hospital, Mukwonago
Reedsburg Area Medical Center, Reedsburg
River Falls Area Hospital, River Falls
Rogers Behavioral Health, Oconomowoc
Sauk Prairie Healthcare, Prairie du Sac
Select Specialty Hospital - Milwaukee - St. Francis, Milwaukee
Select Specialty Hospital - Milwaukee, West Allis
Select Specialty Hospital, Madison
Southwest Health, Platteville
Spooner Health, Spooner
SSM Health Monroe Hospital, Monroe
SSM Health Ripon Community Hospital, Ripon
SSM Health St. Agnes Hospital, Fond du Lac
SSM Health St. Clare Hospital, Baraboo
SSM Health St. Mary's Hospital, Madison
SSM Health St. Mary's Hospital, Janesville
SSM Health Waupun Memorial Hospital, Waupun
St. Croix Regional Medical Center, St. Croix Falls
Stoughton Health, Stoughton
The Richland Hospital, Inc., Richland Center
ThedaCare Medical Center, Berlin
ThedaCare Medical Center, New London
ThedaCare Medical Center, Shawano
ThedaCare Medical Center, Waupaca
ThedaCare Medical Center, Wild Rose
ThedaCare Regional Medical Center, Appleton
ThedaCare Regional Medical Center, Neenah
Tomah Health, Tomah
Tomah VA Medical Center, Tomah
UnityPoint Health - Meriter, Madison
University Hospital, Madison
Upland Hills Health, Inc., Dodgeville
UW Health Rehabilitation Hospital, Madison
Vernon Memorial Healthcare, Viroqua
Watertown Regional Medical Center, Watertown
Western Wisconsin Health, Baldwin
Westfields Hospital & Clinic, New Richmond
William S. Middleton Memorial Veterans Hospital, Madison
Willow Creek Behavioral Health, Green Bay

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