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Quality Improvement Fellowship

Session 6: Celebration & Sharing

March 26, 2026

- Benefis Missouri River Medical Center
- Community Hospital of Anaconda
- Fallon Medical Complex
- Frances Mahon Deaconess Hospital
- Glendive Medical Center
- Granite County Medical Center
- Intermountain Health Holy Rosary Hospital
- Logan Health - Shelby
- Sidney Health Center
- St. Luke Community Healthcare

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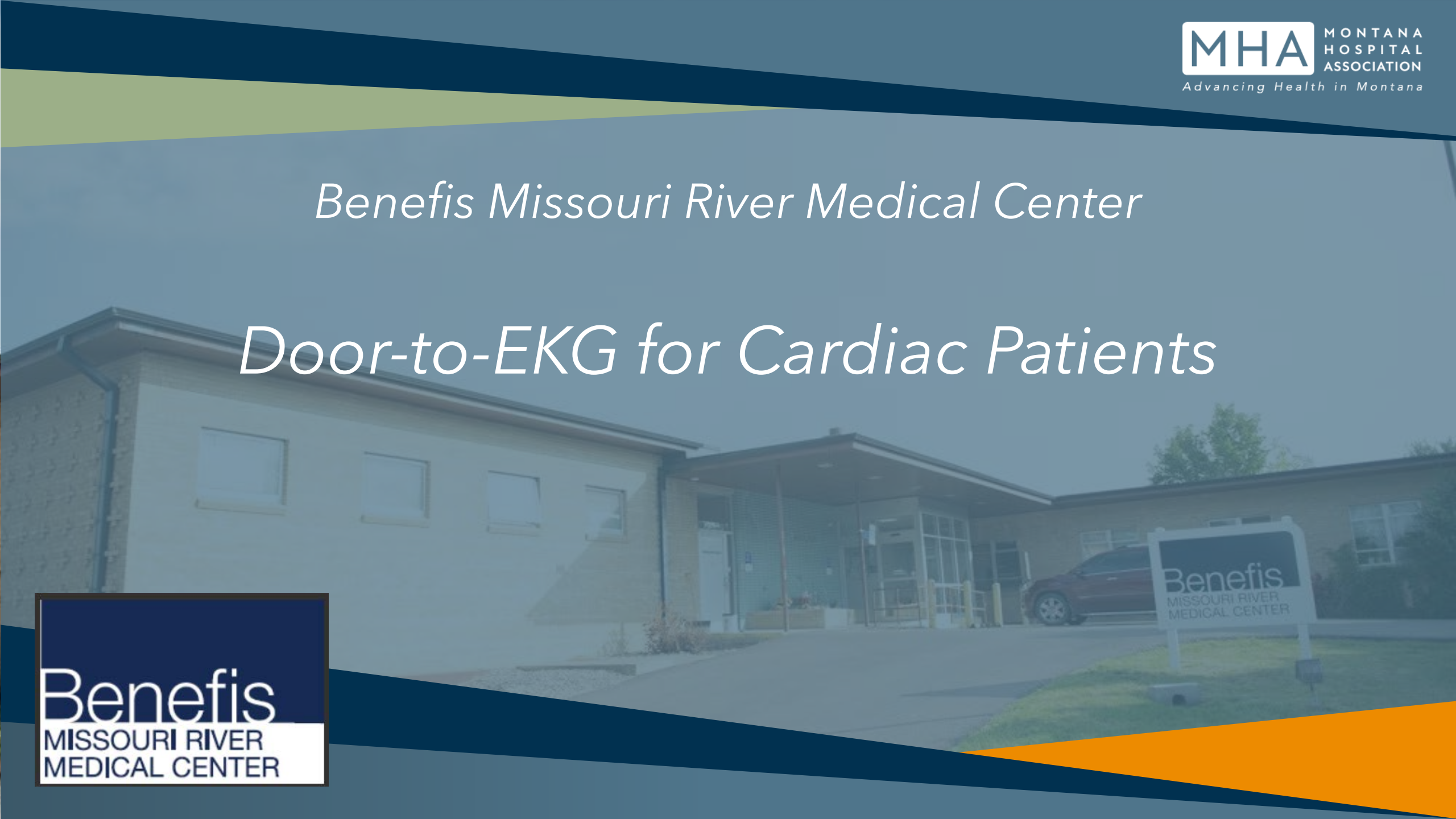
Benefis Missouri River Medical Center

Door-to-EKG for Cardiac Patients



Benefis
MISSOURI RIVER
MEDICAL CENTER

Define the Problem

Background: Why did you choose this project? Why was it important to work on?

Briefly describe the problem you aim to improve. Describe why it matters to your patients, staff, or others.

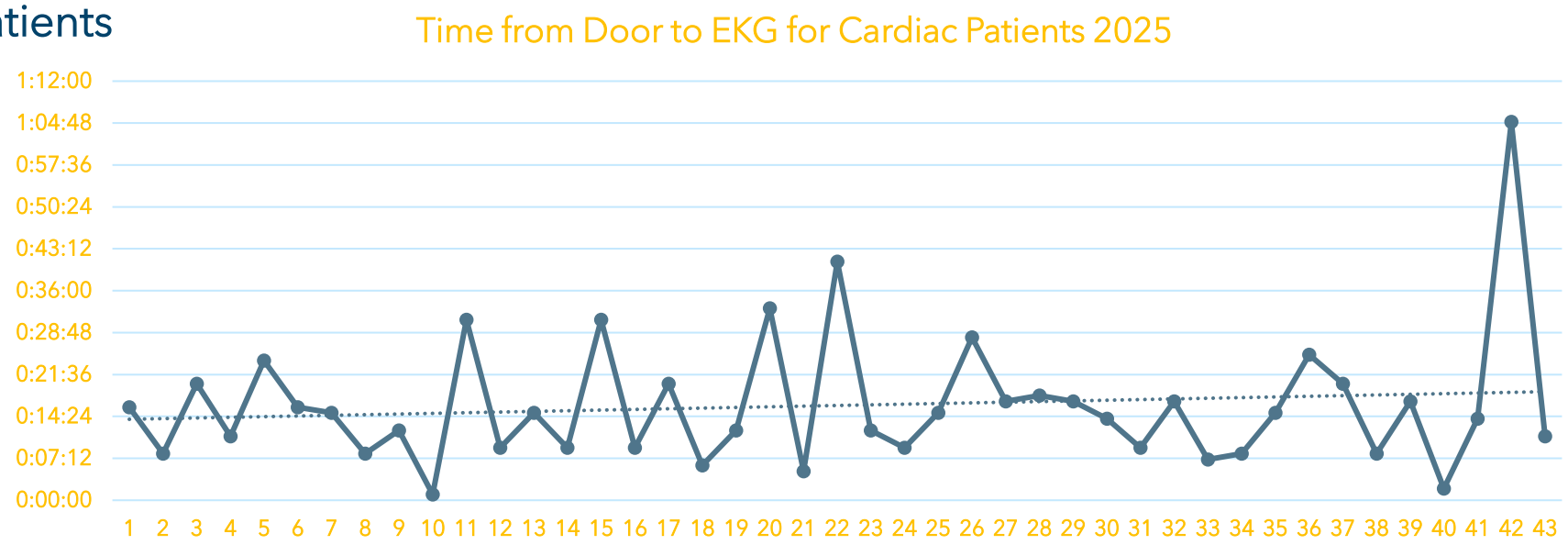
BMRMC applied for Cardiac Recognition with the State for the first time this year. During this process it was recognized that our average door-to-EKG time for cardiac patients in the ER was 15:13 in 2025. The evidence-based standard from AHA is to have the EKG in <10 min from arrival as delayed EKG results can lead to missed opportunities for timely intervention and treatment, which may result in severe complications or even death.

Baseline Data

Baseline: What is your baseline data?

Provide your baseline data or current performance.

In 2025, the average time from door-to –EKG for cardiac patients was 15 min, 13 sec.



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AIM Statement

Project Aim: What is your goal and how will it be measured?

State your improvement goal using SMART criteria: Specific, Measurable, Achievable, Relevant, Time-bound. Include who will do the work, what will improve, by when, and by how much.

BMRMC will reduce door to EKG time on suspected cardiac patients in the ER to <10 minutes by July 1, 2026.

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Anticipated/Actual Outcomes

Outcomes: How will you know a change is an improvement?

Provide your outcome and process measures. Include balancing measures, if identified. Provide input on how often you collected the data and how. Include any data to date.

- **Outcome Measure:** Average door-to-EKG time will be < 10 min on BMRMC ER cardiac patients.
- **Process Measure:** Use of the chest pain standing orders allows nurses to order and obtain an EKG on suspected cardiac patients prior to provider arrival. Will monitor if nurses are using the standing orders by tracking if the EKG is being done before or at least within 3 min. of provider arrival.
- **Balancing Measure:** Will make sure that provider notification time does not increase >10 min.
- **Data Collection Plan:** Will continue to collect all door-to-EKG times, provider notification times, and who the nurse and provider is on all suspected cardiac patients in the ER biweekly.

PDSA: Plan/Do

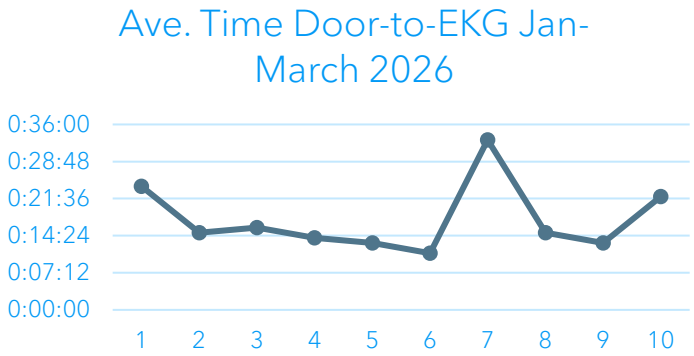
What did you do to make a change?

- After reviewing the first 2 months of 2026 data and identifying which nurses consistently achieved the lowest times, we interviewed them to understand their workflow. Because our cardiac patient volume is low, it isn't practical to run a full PDSA cycle with only one nurse with one patient. Instead, we will share the most effective steps from the fastest nurses with the entire team and apply this refined process to the next PDSA cycle with the next eligible patient.

- We will screen for potential chest pain patients twice a week. After each trial, we will follow up with the involved nurses to gather feedback and make any necessary adjustments to the process and start a new PDSA cycle.

- We are currently working with our Epic Analyst to create a quick order button within the ED narrator that will decrease ordering time.

PDSA: Study



Explain the changes seen based on the data above or experiences; knowing some benefits may not be measurable in numbers.

- Generalized education regarding our current door-to-EKG time and what the evidence-based standard currently is, <10 min, was done with the nurses and providers in January.
- The time increased since bringing attention to the process in January to 17:36 by mid March.
- The next step, where we currently are, is to review the process of those with the best times, review what they are doing differently, tweak the process, and share with the other staff after each encounter.

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PDSA: Act

What are you going to do next?	
Adopt, Adapt, or Abandon?	Currently still adapting the process after each episode identified in the ER.
Changes to be made?	Changing the process with any identified barriers or identified best practice from each review.
Lessons Learned?	
Next steps or future goals?	
Conclusion	

** This slide can be deleted if you have not reached this part of your PDSA cycle.

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Project Acknowledgements

Emily Anderson, RN - Director of Nursing, Swing Bed & Trauma Coordinator

Penny Smoot RN, BSN, CPHQ - Regional Quality and Education Specialist

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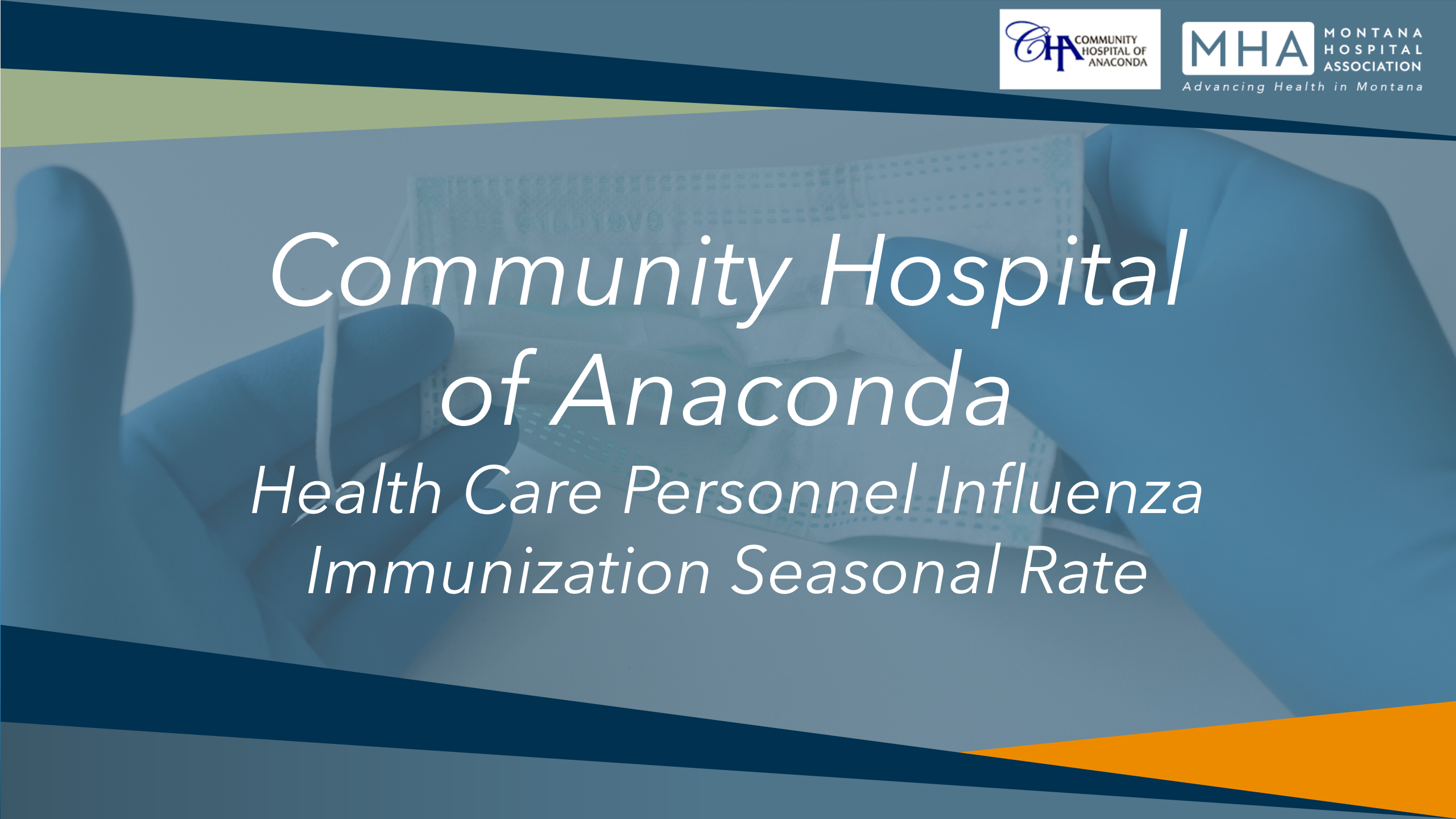

Community Hospital of Anaconda

Health Care Personnel Influenza Immunization Seasonal Rate

Define the Problem

Background: Community Hospital of Anaconda Health Care Personnel Influenza Immunization Rate has decreased from prior pre-covid epidemic numbers. Reports of local insurges and overall local, regional, and national emerging statistics of negative impacts of possibly one of the worst influenza seasons in over a decade. Public national CDC dashboards provide weekly awareness; activity mapping, season severity, estimated illness count, clinical lab positives, hospitalization, mortality rates are among the subdivisions.

Montana may have a general activity classification of low, however locally in December our clinical lab positives were 40%, that means our patients, staff, and local community were sick; showing signs of a contagious respiratory illness that can lead to severe health complications, especially for high-risk populations, however, leaving all of us vulnerable to increased hospitalization and mortality rates. Knowing the single best way to reduce everyone's risk from the seasonal flu and its potentially serious complications is (of course hygiene – thank you Florence Nightingale) to get vaccinated every year. We tasked ourselves to ensure that all our employees are aware, educated and able to obtain the vaccine this year (2025-2026 Season Oct '25- Mar '26).

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Baseline Data

Baseline: HCP Immunization Rate Season 2024: 48% 2026: Currently 57%
Oct 2025: 36% *Nov 2025: 53%* *Dec 2025: 57%* *Jan 2026: 57%* *Feb 2026: 57%* *Mar 2026: 60% & pending*

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AIM Statement

Project Goal: HCP Flu Immunization Rate will increase by 20%, (from 48% 2024-25 rate, would be 68%) by March 31st, 2026.

This project's aim will reach all CHA staff; education about the internal vaccination program specifically related to Influenza, general health impacts of the virus and the role of immunization prevention, local up to date CDC dashboard information and ensuring that all are aware of their impact and participation not only in this QI, an annual seasonal IC event and the in this communicable health status of and for our families and community.

Specific	HCP Flu immunization Rate
Measurable	20% increase from 48% (last year) (would be 68%)
Achievable	Yes (51more staff need to be immunized)
Relevant	Yes (Flu is active in the local areas and influenced by the national presence)
Time-bound	By March 31st, 2026.

Anticipated Outcomes: Data collection analysis will show % point changes weekly.	
Outcome Measure (what overall results will show success):	Staff obtaining immunizations, identifying gaps – outlier populations will provide areas to focus on. This population will shrink, weekly.
Process Measure (what steps will indicate progress toward goal):	Staff receptiveness of committee's acts and increased immunization rate. All staff will complete an annual check-in with IC/UR by end of March.
Balancing Measure check (any unintended effects- e.g.; overtime):	Do not want to cause staff to be uncomfortable – private matter for some, and no overtime or burden.
Data Collection Plan (source, frequency, who collects, simple tool- daily or weekly):	IC/UR tracks daily, weekly and monthly analysis of immunization data. Analysis will aid in gearing up on focus areas for next season.

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Anticipated/Actual Outcomes

Anticipated Outcomes: Data collection analysis will show % point changes weekly.

Outcome Measure (what overall results will show success):	Staff obtaining immunizations, identifying gaps – outlier populations will provide areas to focus on. This population will shrink, weekly. Most of the population did participate/ complete the QI requested process. The "gap" changed from those not vaccinated to those not completing an annual IC-infection control check-in with the staff health nurse.	Gaps: Persons not checked in with IC for the season	January	February	March working data
		Groups/Departments	31	25	25
		Individuals	161	115	85
		Rounded % of gap population	**36%**	**29%**	**22%**
		Staff Vaccinated	57%	57%	60%
Process Measure (what steps will indicate progress toward goal):	Staff receptiveness of committee's acts and increased immunization rate. All staff will complete an annual check-in with IC/UR by end of March. Staff participation increased after a new process event more than with the standard process.	Check-in Method	January	February	March
		Leadership Meetings	0	46	pending
		Booths		46	pending
		Department huddle visits	1		
		Scheduled/ routine process	New hires	New hires/Fit Test	New hires/
			0	0	0
Balancing Measure check (any unintended effects- e.g.; overtime):	Do not want to cause staff to be uncomfortable – private matter for some, and no overtime, or burden. Staff more open to signing a declination then being vaccinated, this opportunity was openly provided.	Identified Issues for not being vaccinated or unintended effects			
		19% Belief: Religious/Spiritual, disbelief the vaccine works or is beneficial, don't need not around patients			
		15% Health Related: Exacerbates long covid symptoms, or general side effect wax & wane & take longer to over come (up to months), autoimmune disorder, gut health, allergy, Guilian Barre Syndrome			
		13% Timing Issues: "out of season", forgot, ended up getting the flu already this season			
Data Collection Plan (source, frequency, who collects, simple tool- daily or weekly):	IC/UR tracks daily, weekly and monthly analysis of immunization data. Analysis: initially a secondary gain became a primary focus during the processes that will set strategy , and aid in gearing up on focus areas for next season.	**Losses**	Signage still up most don't "see"	Trends Negative or Positive seen within departments "out of season"	Increased signage of declinations, flat vaccination rate
		Wins	Send out Influenza kit to department heads **pre-season** with season dates, education, declination statement		
			Fun factor: boards brought to meetings; Leadership		
			Losses are wins- deeper dives	Losses are wins- focuses for next year; where/when	

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OUTCOMES

Outcomes: Analysis of weekly data collections with show change via % points.

Provide your outcome and process measures. Include balancing measures, if identified. Provide input on how often you collected the data and how. Include any data to date.

January: Outcome was department and gap analysis 31departments of 161 employees needed opportunity or confirmation for a vaccine this season. Employee and department details provided to infection control by Human Resources and Analytics. Department directors were informed of QI and goal at end of month during Leadership Meeting.

February: Awareness Booth; visible and portable, IC option to go to each department directly; Review of data collection – weekly, End of month Leadership meeting (all department heads aware all staff need to check-in with IC/UR by end of March, given updated status on influenza season statistics/ headlines).

March: Some department directors are very engaged and follow up directly with IC to ensure that their staff too have engaged one way or another during the month, Signage at time clock and staff bulletin boards have not captured staff attention. Departments have trends either they obtains the vaccine or have a coincidentally similar decline from many of that department's staff Ei. "out of season". Reviews of data and system has stimulated positive changes for next season; amping up early staff communication, easier individual access to education and forms, monthly follow ups and special events September to March 2026.

PDSA: Plan/Do

Look at data: STEP 1 (First wave of activity)

This step set the topic for improvement showing the beginning season rate of staff immunized against influenza at 36%. Goal is 68%.

Initial test design: Review data and obtain base for gap of those not vaccinated for this influenza season	
Objective of test: (What are you trying to learn?)	Look into the data: Current process Infection Control/ Utilization Nurse has open door policy on immunizations and signage posted throughout the influenza season what's the results.
Who / Where / When: (Team roles, location, dates)	Initial steps in January Human Resources, IC/UR, Analytics review employee list and vaccination status per 2025-2026 influenza log
Duration & scope: (e.g., one nurse, one shift, two days)	Current employees January through March 2026
Actions (steps): (Checklist of what will be done)	Analysis those not vaccinated by department, campus location, and shift of work.
Data plan: (What to measure during this test; collection tool; frequency; who collects)	Quanty in each gap
Prediction: (What do you expect will happen?)	Identify location, shift, department influenza immunization and or awareness gaps within the hospital structure

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PDSA: Plan/Do

Reach out to staff; Preestablished encounters and new events: STEP/Wave 2

This step changed data from initial season baseline of 36% to end of January 57% staff obtained their seasonal influenza vaccine.

2nd test design: Creatively engage staff embarking on mandatory participation	
Objective of test: (What are you trying to learn?)	Put into play new steps into an annual process that staff can not sidestep.
Who / Where / When: (Team roles, location, dates)	IC/UR to bring QI project to Leadership Meetings; inform every department head of project, goal, and level of staff participation required
Duration & scope: (e.g., one nurse, one shift, two days)	Monthly Meeting, One meeting at a time. (January, February, & March)
Actions (steps): (Checklist of what will be done)	IC/UR will be presenting QI, in each meeting if not formally at least during around the table comments
Data plan: (What to measure during this test; collection tool; frequency; who collects)	IC/UR will collect data; staff that check- in with IC as a result of the meeting announcement, education, and direction
Prediction: (What do you expect will happen?)	Department Heads will inform their staff to check in with IC/UR before end of month no later than end of March.

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PDSA: Plan/Do

Include a Fun Factor Monthly "Eye catching" Events for all staff: STEP/Wave 3

This step changed data focus from gap focus re: vaccination rate to reason for signing the refusal declination form.
Keeping the open-door approach for education related to influenza season and self choice for vaccination.
This step gave life to a routine necessity opening the door to open communication and data retrieval as to what were staff's thoughts.

3rd test design: Put into play a fun event that staff will want to partake in.	
Objective of test: (What are you trying to learn?)	Include a fun factor- Monthly **February is the KISSING BOOTH**
Who / Where / When: (Team roles, location, dates)	Booth was made by IC/UR and analytics by Feb. 14, 2026. **Presented to staff by Week of Feb. 14th Valentine's day**
Duration & scope: (e.g., one nurse, one shift, two days)	Present to staff throughout the month of February. The display has a measuring gauge toward the goal on the left, CDC and local dashboard information on the left, and center *"WE Got KISSED"* **IC brought and displayed at meetings and staff interactions**
Actions (steps): (Checklist of what will be done)	Staff that stop by the booth is checked off as "checking in" – staff will be educated on the flu and the hospital vaccination protocols – given a "kiss" – a vaccine, and a chocolate kiss in these cases *Empowers Staff*
Data plan: (What to measure during this test; collection tool; frequency; who collects)	Use current collection tools as who check-in, is vaccinated or declined
Prediction: (What do you expect will happen?)	That staff will stop by or have interaction with the IC this month. Gauge on the left moved up and participants applied their sticker of participation in the center

Community Hospital of Anaconda

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Stickers:
Vaccinated by month
Early in season:
RED Syringe
Feb:
Purple Syringe
March:
Green Syringe
Signed declination:
Heart

PDSA: Study

Acknowledged when a change in direction occurred? **STEP/Wave 4**

Staff were participating (88%) but what were they saying? Taking a step back and diving deeper into the immunization refusal declination reasons, which uncovered a loss of data between all the paper forms. Validated all were on paper logbook and in computer spreadsheet to validate calculations.

	BASELINE VALUE	REMEASURE VALUE	Did you improve?
Gap: Staff influenza immunized	36%	60%	Yes, our goal was 68%
Gap: Staff with no annual Infection Control check-in	36%	22%	Yes, **88%** of staff have participated in this QI
Gap: Staff signed refusal declination	4.9%	18%	N/A, directly affects the vaccinated count

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ACTION

What are you going to do next? Step 5 The Wave that will carry through end of 2026 "ACTION TIME"

Throughout the cycles or waves of this project Plan Do Study Act was involved at least a little in each of them. Setting up for the timing that will be largest gain to be seen which will be making the adjustments to the process for the coming season ('26-'27 Health Care Personnel Influenza Immunization Season).

Adopt, Adapt, or Abandon?	The Community Hospital of Anaconda Staff HCP Influenza Immunization program will: Adapt and Adopt.
Changes to be made?	*Extend the timing and focus of the program at least from Sept to March. *Engage the staff individually and early on. *Have easy access to the programs; education, local and national dashboards for imperative timing, forms, objectives and goals. *Preserve the importance of data analysis routinely, to engage the staff uniquely at least monthly *Spearhead early any miss guided ideas or thought of the season *Review timing and other processes for Annual Mandatories, New Hires, and obtaining and maintaining data lists
Lessons Learned?	Spontaneity- visual cues can be dismissed – routine signage Staff will communicate and participate if given the tools at their level
Next steps or future goals?	Make changes to include at least those noted above for next season
Conclusion	Having 88% of all staff participate in QI was a great win, not all things negative were losses. Insightful and set exciting changes in framework for program next year.

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Project Acknowledgements

Kelly Skocilich RN UR/IC
Krista Clark RN UR
Jamie Johnson RN CNO
Deanna Phillips HR
Kristi Danforth RN Clinical Analytics

UR – Utilization Review
IC - Infection Control
CNO – Chief Nursing Officer
HR – Human Resources

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Fallon Medical Complex

Employee Engagement

Define the Problem

Background: Why did you choose this project? Why was it important to work on?

- Employee engagement plays a crucial role in any workforce, but especially in the field of healthcare. Staff engagement directly influences job satisfaction, workforce stability, and the quality of care provided to patients and residents. Leadership at Fallon Medical Complex (FMC) recognized the need to better understand staff perceptions related to workload, leadership support, communication, and workplace culture.

- The problem: There is a limited climate of trust and teamwork at FMC. While financial incentives are not feasible at scale, there is a critical opportunity to strengthen employee engagement through improved connection, collaboration, and leadership presence. Enhancing the perception of leadership support and fostering a culture of teamwork are essential to creating an environment where staff feel valued and reconnected to the meaningful work we do each day.

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Baseline Data

Baseline: What is your baseline data?

- To establish a baseline and identify specific opportunities for improvement, an anonymous Employee Engagement Survey was distributed to all staff. The results provided valuable insight into organizational strengths as well as areas requiring attention, allowing FMC leadership to prioritize strategies targeting improved staff experience, strengthening organizational culture, and ultimately support higher-quality, safer care for our patients.

- Anonymous Feedback
- Scalable Answers
- Sections:
  - Overall Engagement
  - Role Clarity & Workload
  - Leadership & Management
  - Growth & Recognition
  - Culture & Communication
  - Wellbeing
  - Open-ended questions (4)

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Engagement Survey Results:

Results:

- 48 responses returned (62%)
- Role & Tenure collected (not everyone chose to answer)
  - 11 managers
  - 16 staff members
  - 3 senior leaders

  - 4 - <1 year
  - 9 - 1-3 years
  - 5 - 4-6 years
  - 15 - 7+ years

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Score	Question
4.5 avg (strongly agree)	Q1. I feel engaged in my day-to-day work.
4.2 avg (agree)	Q2. I am proud to work for FMC.
3.8 avg (agree)	Q3. I would recommend FMC as a great place to work.
4.2 avg (agree)	Q4. I see myself working here one year from now.
4.5 avg (strongly agree)	Q5. I understand what is expected of me in my role.
4.3 avg (agree)	Q6. I have the tools and resources I need to do my job well.
4.0 avg (agree)	Q7. My workload is manageable.
4.3 avg (agree)	Q8. My work makes good use of my skills and strengths.
4.0 avg (agree)	Q9. My manager communicates clearly and regularly.
4.0 avg (agree)	Q10. My manager cares about me as a person, not just an employee.
3.7 avg (agree)	Q11. I receive helpful feedback that supports my growth.
2.9 avg (neutral)	Q12. Leadership takes appropriate action to deal with poor performers.

Score	Question
3.5 avg (agree)	Q13. Leadership communicates a clear vision for the organization.
3.6 avg (agree)	Q14. I have opportunities to learn and grow here.
3.6 avg (agree)	Q15. I feel recognized and appreciated for my contributions.
3.8 avg (agree)	Q16. I feel respected at work.
3.8 avg (agree)	Q17. I feel comfortable sharing ideas or concerns.
4.1 avg (agree)	Q18. I feel a sense of belonging on my team.
3.6 avg (agree)	Q19. Important information is shared in a timely manner.
3.6 avg (agree)	Q20. I trust leadership to make good decisions for the organization.
3.3 avg (neutral)	Q21. FMC shows genuine care and concern for its employees.
3.2 avg (neutral)	Q22. There is a climate of trust and teamwork throughout FMC.
4.1 avg (agree)	Q23. I can maintain a healthy work-life balance.
3.9 avg (agree)	Q24. I feel supported in my role at FMC.

Q25. What is one thing we do well that we should keep doing?

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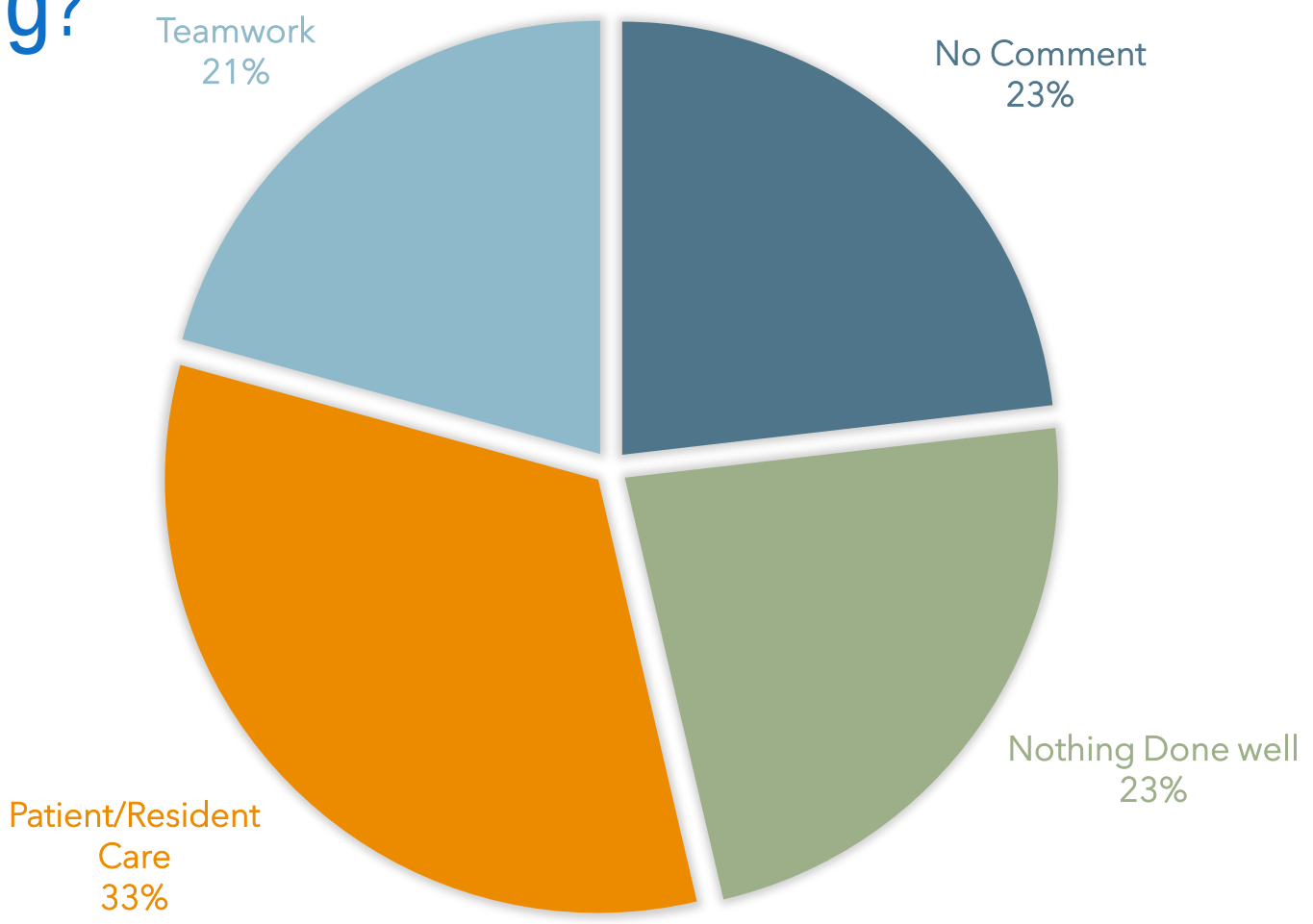
Q25. What is one thing we do well that we should keep doing?



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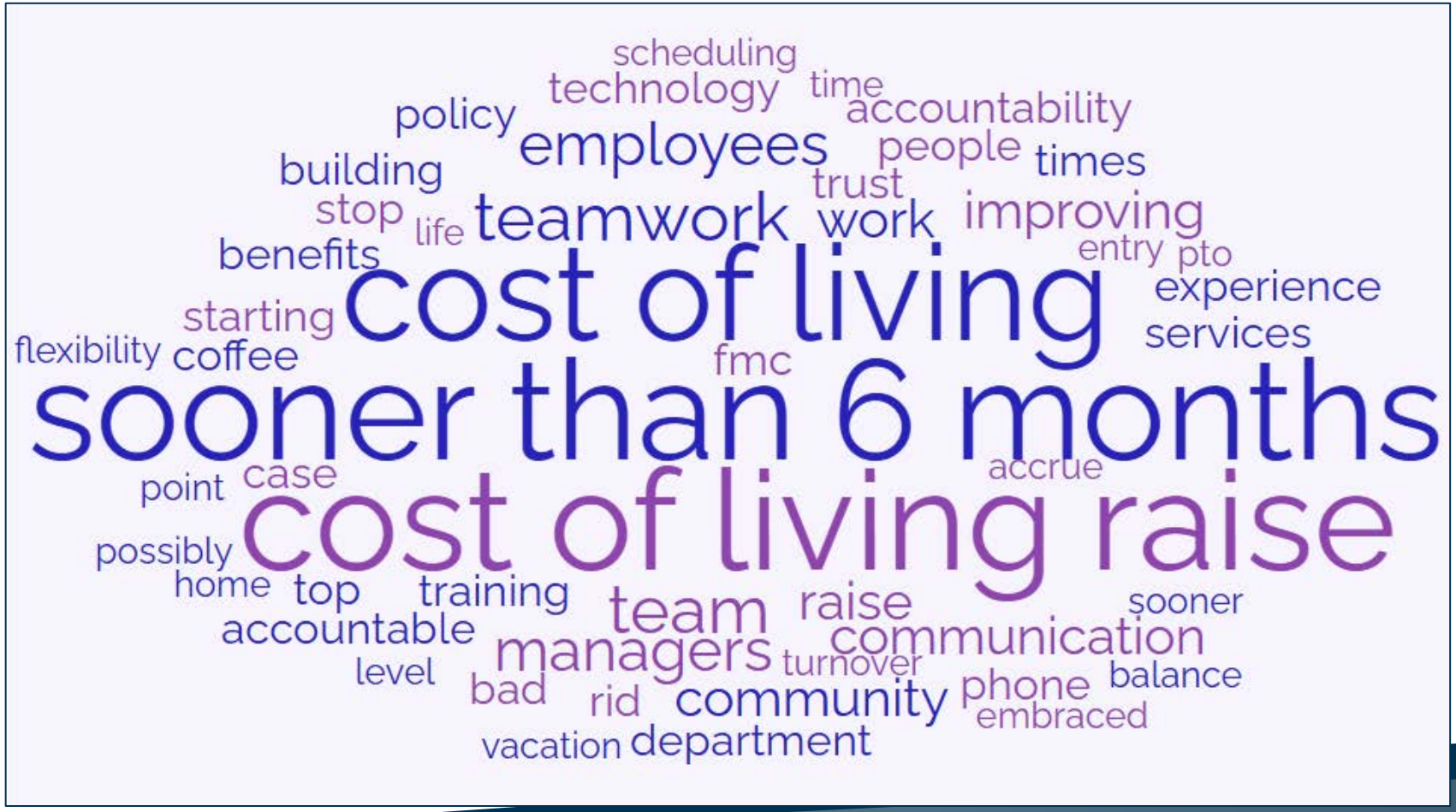
Q26. What is one thing that would most improve your experience here?



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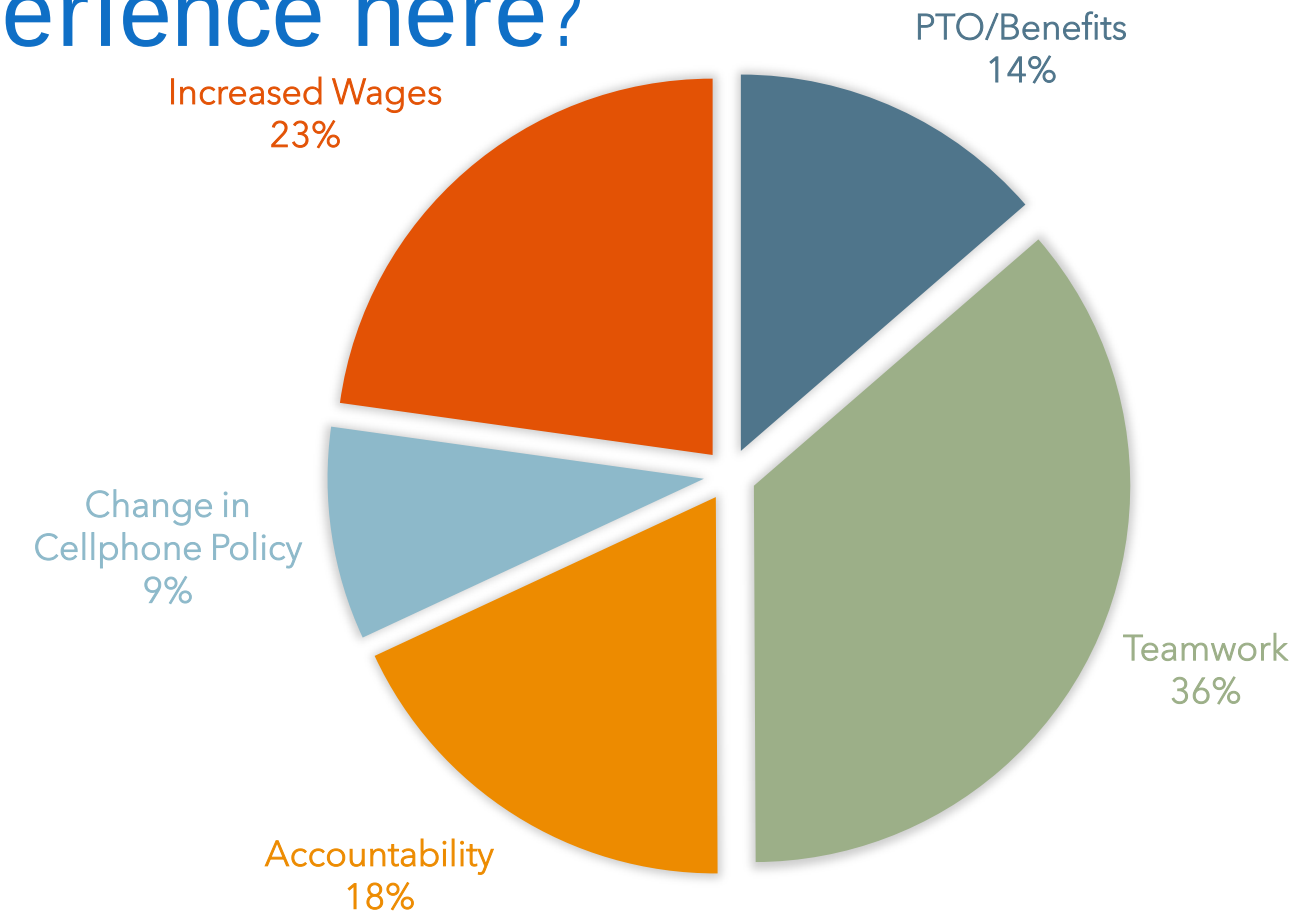
Q26. What is one thing that would most improve your experience here?



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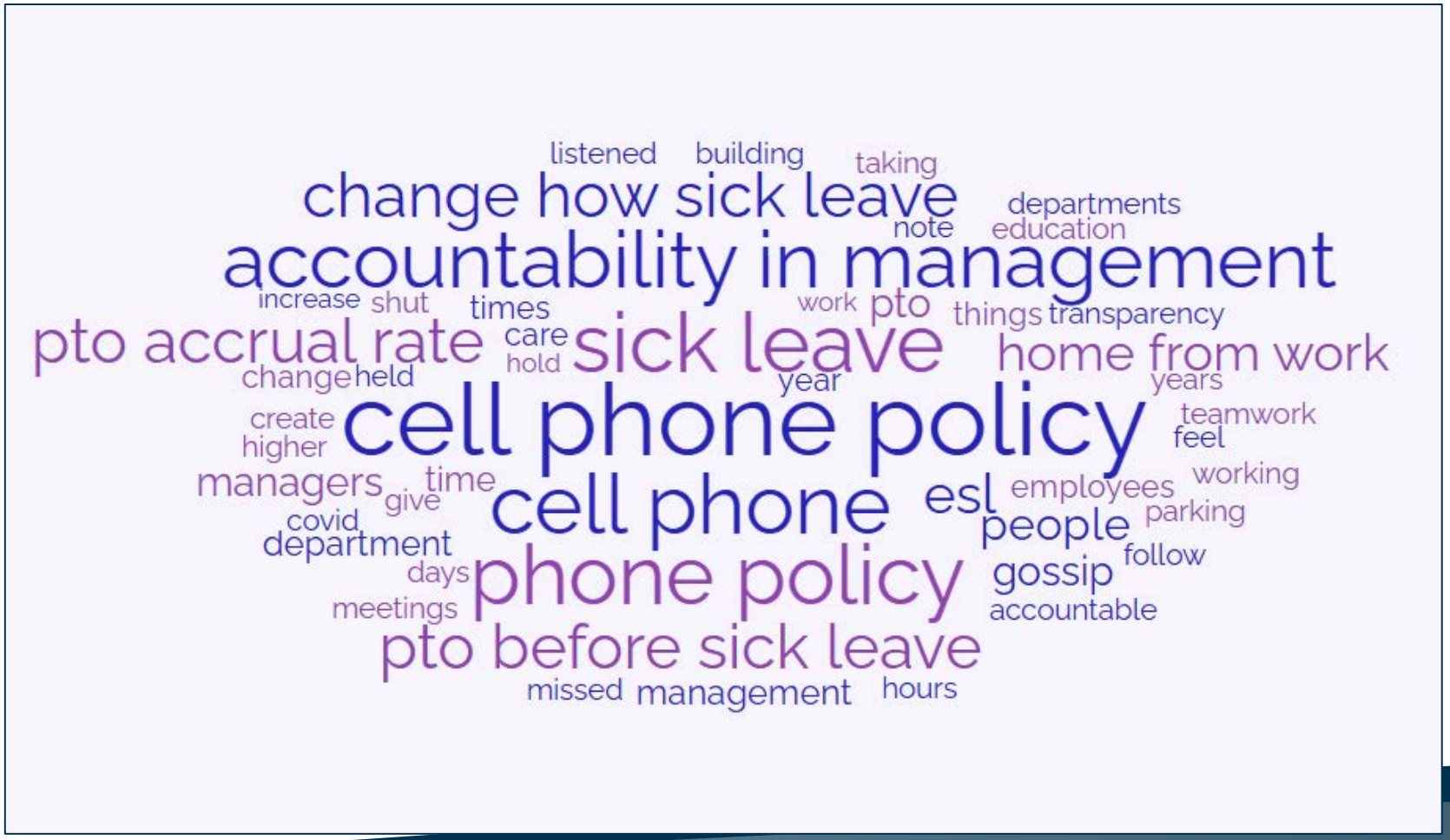
Q27. If you could change one thing about FMC, what would it be?



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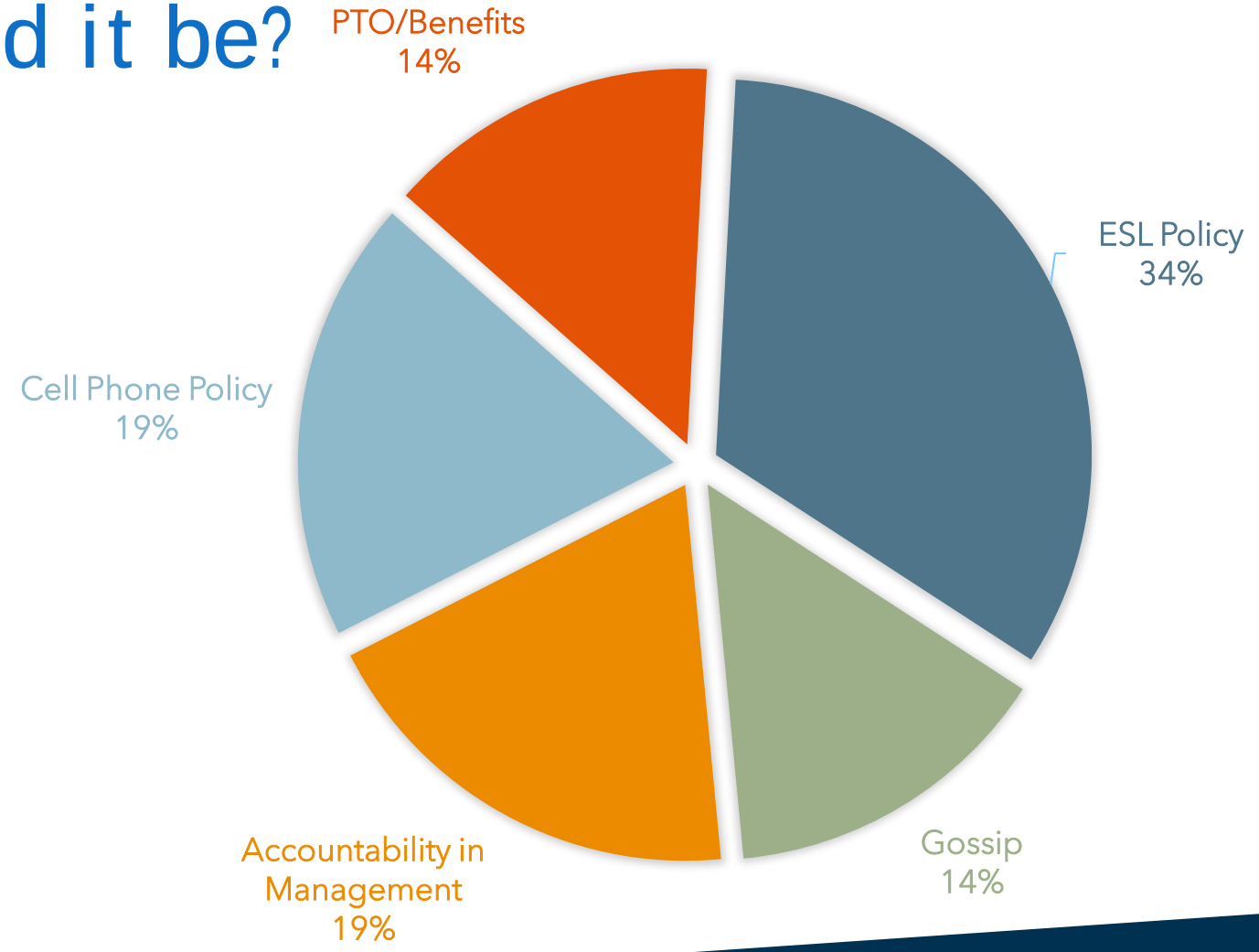
Q27. If you could change one thing about FMC, what would it be?



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Q28. Any additional comments you'd like leadership to hear?

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OVERALL results:

- 93.75% positive/mostly **positive** results, quantitatively.

- 6.25% is the area to focus on for improvement.

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Q12, 21, 22:

12. Leadership takes appropriate action to deal with poor performers.

21. FMC shows genuine care and concern for its employees.

22. There is a climate of trust and teamwork throughout FMC.

Q12, 21, 22:

~~12. Leadership takes appropriate action to deal with poor performers.~~

21. FMC shows genuine care and concern for its employees.

~~22. There is a climate of trust and teamwork throughout FMC.~~

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Q12, 21, 22:

21. FMC shows genuine care and concern for its employees.

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AIM Statement

Project Aim: What is your goal and how will it be measured?

The goal of this project is to improve employee perception of leadership support, accountability, and organizational care at FMC by increasing the Employee Engagement Survey score for Question 21: “FMC shows genuine care and concern for its employees.” within 60 days. This will be accomplished through leadership presence and the implementation of a structured staff appreciation initiative across all shifts and departments throughout the facility.

Anticipated/Actual Outcomes

Outcomes: How will you know a change is an improvement?

Process measures will track leadership visibility and recognition efforts, while outcome measures will evaluate improvements in employee perception of leadership support, trust, and organizational care.

Process Measures:

- Staff Participation in Sunshine Board (goal=at least 10-15 recognition posts per month)
- Leadership Rounding Completion (goal=100% departments rounded on each week)
- Leadership Presence Documentation (goal=at least 3 actionable themes identified within 30 days)

Outcome Measures:

- Increase Survey Scores (12,21,22) by ≥0.5
- Achieve ≥4.0 staff perception of leadership support
- Reduce "nothing" responses from 38% to ≤20%

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PDSA: Plan

What did you do to make a change?

- Improve overall employee engagement, morale, and perception of leadership support (60 days)
- Small test of change: 30-day Leadership Presence and Appreciation Initiative
  - Actions:
    - Weekly leadership rounding (10-15 minutes in each department)
      - What's going well? What's getting in your way? What can we improve? Do you feel supported?
    - "You matter" recognition board- Sunshine Board – capitalize on Sunshine Card system
  - Measures of success
    - Informal staff feedback
    - Increase in recognition board participation
    - Quick pulse survey – use initial evaluation as baseline

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PDSA: Do

What did you do to make a change?

- Begin weekly rounding schedule: INCLUDE ALL SHIFTS!!
- Leaders document themes – no names.
- Launch Sunshine board and encourage peer to peer recognition
- Provide small appreciation gesture Week 2 or 3 (Handwritten Thank You Cards)
- BE VISIBLE and CONSISTENT!

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PDSA: Study

Explain the changes seen based on the data above or experiences; knowing some benefits may not be measurable in numbers.

- After 30 days:
  - Review common themes
  - Compare pre and post survey results
  - Assess participation in recognition board
  - ID recurring themes/barriers/concerns

	BASELINE VALUE	REMEASURE VALUE	Did you improve?
Weekly Winning Email Replies	13%		
Rounding "Temp Check" Rating	7.7 out of 10		

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PDSA: Act

- If successful: adopt
  - Standardize leadership rounding and monthly recognition
- If partially successful: adapt
  - Adjust timing, frequency, or communication approach
- If impacted minimally: abandon/expand
  - Start over - Go deeper – work flow review, staffing patterns, 1:1s, listening sessions, wellness initiatives…

Project Acknowledgements

- **Questions?**

Project Team Members:

Libby Barth, Quality Improvement
Fallon Medical Complex

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Frances Mahon Deaconess Hospital

Behavioral Health Involuntary Admissions

Define the Problem

Background: The QAPI Team received a PI Request to establish a clear, legally sound, and ethically appropriate process to manage our involuntary behavioral health patients that ensures they receive appropriate evaluation and definitive care as soon as possible.

Our goal is to ensure timely evaluation and access to definitive, appropriate care while maintaining patient and staff safety. FMDH, as a critical access hospital, is not structured or staffed to safely manage prolonged involuntary behavioral health holds. Current processes frequently result in extended lengths of stay-sometimes lasting up to two weeks-while legal and placement arrangements are pursued. These extended stays require intensive staffing resources, including continuous 1:1 observation in addition to assigned nursing care, placing significant strain on the hospital's staffing model. Furthermore, prolonged confinement in a non-therapeutic environment without access to specialized behavioral health services is not in the best interest of the patient and may negatively impact care outcomes.

Baseline Data

Baseline:

Metrics for Patients fully through court placement include:

- *Average initial order to discharge to definitive care=8.6 days*
- *Average admission to emergency hold order=0.5 days*
- *Average order to initial hearing=2.5 days*
- *Average initial hearing to court order placement hearing=2.8 days*
- *Average placement hearing to discharge to definitive care=3.2 days*

**still gathering data for staff time and dollars*

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AIM Statement

Project Aim: What is your goal and how will it be measured?

Our goal is to establish and implement a standardized, legally sound process for involuntary behavioral health admissions that reduces the average length of stay (from psychiatric emergency hold order placed with patient going through the court system to discharge to definitive care) by at least 20% from 8.6 days to 6.7 days by September 30, 2026.

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Anticipated/Actual Outcomes

Outcomes: How will you know a change is an improvement?

Anticipated/Actual Outcomes

Primary Outcome

- Reduce average length of stay from psychiatric emergency hold order to discharge to definitive care by ≥ 20% (8.6 → ≤6.7 days)

Process Indicators

- Improved timeliness of psychiatric evaluation and court-ordered placement actions
- Consistent use of standardized involuntary admission workflow

Balancing Measures

- Monitor staffing impact (1:1 observation hours, overtime)
- Monitor patient and staff safety events

Data Review

- Case-based tracking with monthly QAPI review

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PDSA: Plan/Do

What did you do to make a change?

(Pre-Implementation)

Plan

- Develop a standardized workflow for involuntary behavioral health admissions
- Focus on early psychiatric evaluation, timely legal actions, and placement coordination
- Define roles across nursing, providers, discharge planning, and administration

Do (Planned)

- Conduct small-scale testing on new involuntary admissions of the standardized workflow once education and communication are completed.
- Limit initial test of change to a defined number of cases to allow rapid evaluation and adjustment prior to full implementation.

PDSA: Study

Explain the changes seen based on the data above or experiences; knowing some benefits may not be measurable in numbers.

(Planned Evaluation) Measures to Assess Improvement

	BASELINE VALUE	REMEASURE VALUE	Did you improve?
Average LOS from emergency hold order to discharge	8.6 days	___ days	
Time from court placement order to acceptance	3.2 days	___ days	
Staffing impact (1:1 observation hours, overtime)			

*baseline data have been established. Following implementation of standardized workflow, data will be re-measured and compared to baseline to determine whether changes result in measurable improvement-project is in planning phase, no remeasurement data avail

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Project Acknowledgements

Jace Ball, PA-C VP Emergency Services Project Sponsor/Clinical Advisor
Kandi Svenningson, RN IP & Quality Facilitator
Kevin Ross, MD Clinical Advisor
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Cassie Stringer, RN ER/ICU Coordinator Team Member
Alicia Odom, RN Med Surg Coordinator Team Member
Kayla Dix, RN Discharge Planner Team Member
Marcie Sannon, VP Quality Team Member

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Glendive Medical Center

Medication Reconciliation

Define the Problem

Medication reconciliation is vital to successful patient outcomes before, during, and after any health visit. An incorrect medication list can lead to medical errors and adverse events for the patient.

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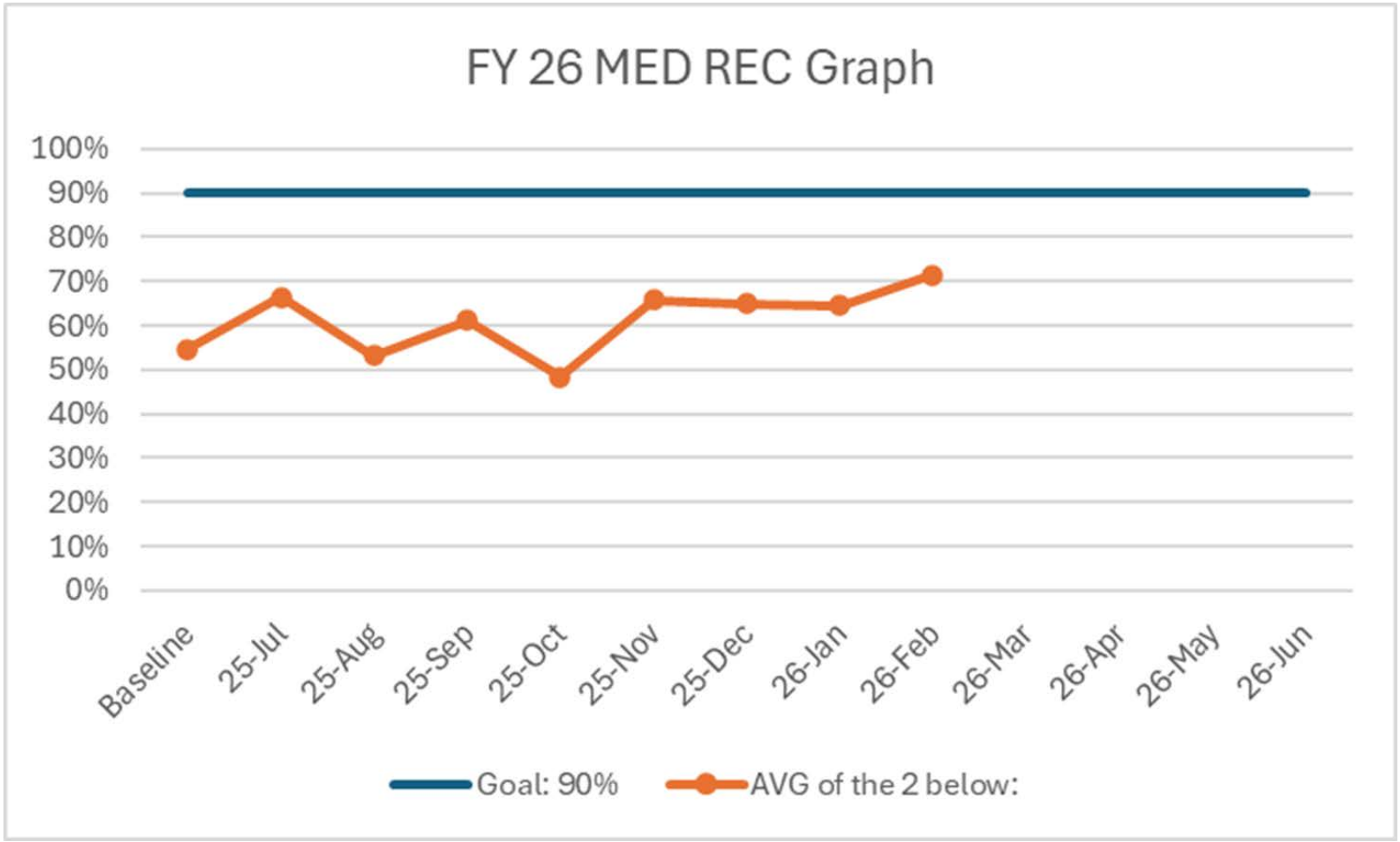
Baseline Data



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AIM Statement

Our goal is to improve provider medication reconciliation compliance from 54.6% to 90% by June 30, 2026.
As of 2/28/2026 our compliance is 71.5%.

The nurses/MA's already perform at a high rate of compliance in their area of documenting medications by history.

We focused on providers in primary care, which included our RHC primary care providers and our Wibaux clinic providers; and inpatient discharge medication reconciliation (hospitalists, inpatient Behavioral Health, Obstetrics, Nursery).

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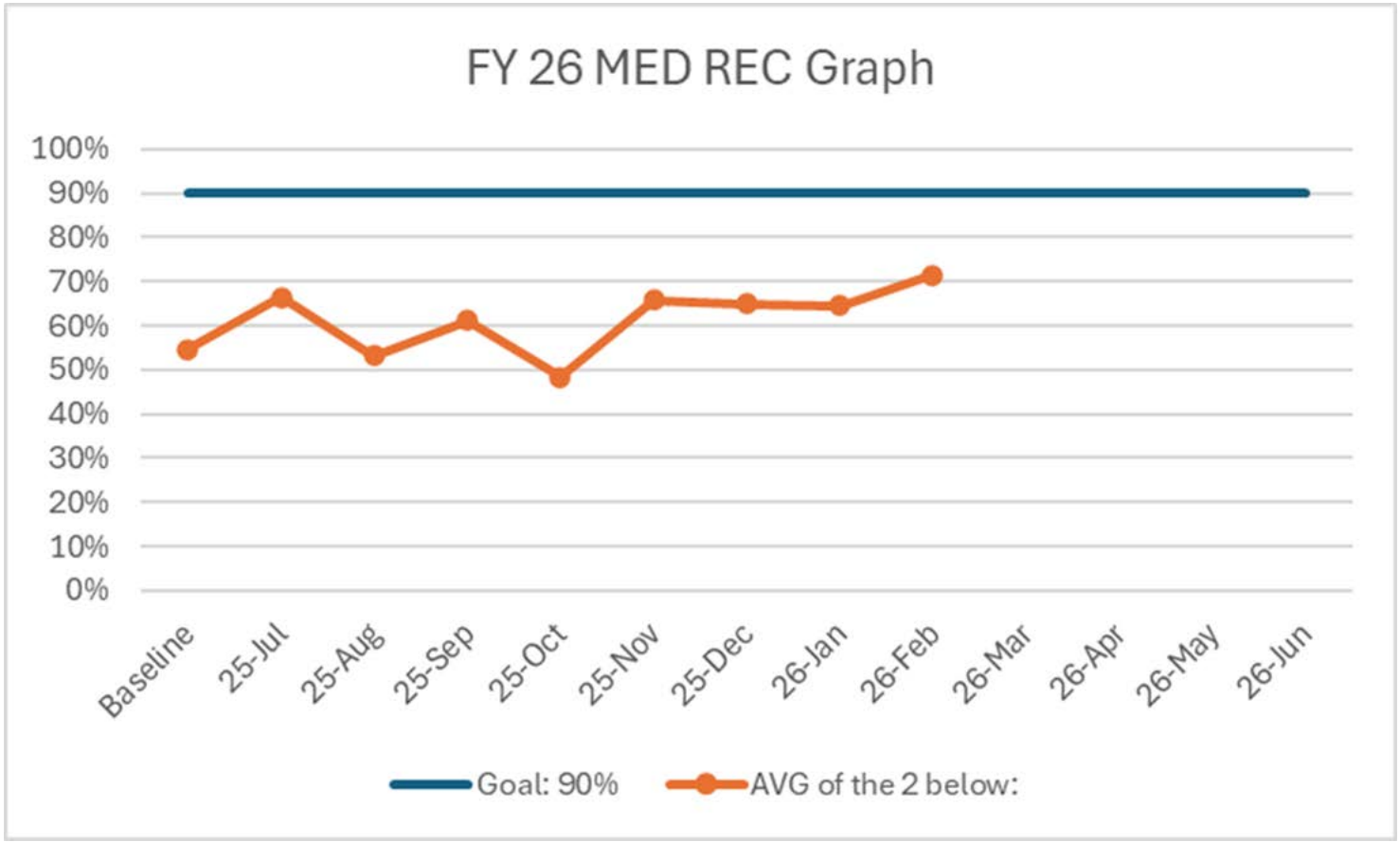
Anticipated/Actual Outcomes

Outcomes: How will you know a change is an improvement?

Medication Reconciliation data is collected Monthly from EHR Medication Reconciliation Report.



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PDSA: Plan/Do

- Informatics staff provided one-on-one education with providers.
- Director of Quality attends Medical Staff meetings to share education and feedback.
- Monitor data monthly for improvement.
- Director of Quality rounds with providers one-on-one sharing the monthly data.

PDSA: Study

- Upon sharing data: learned from hospitalist concerns regarding Inpatient Medication Reconciliation Report
  - Hospitalist feels that Med Rec is a hard stop in his work flow–why aren't his scores 100%
  - Another hospitalist felt that Med Rec numbers were off due to swing bed inclusion in report
  - Report questions sent to Information Systems
    - They sent up to Host of EHR
    - Response was work flow
    - Work flow investigated–not the issue
    - Questions sent back to Host of EHR
  - Host of EHR has sent concerns/questions to Cerner/Oracle–creator of report to investigate
    - As of 3/20/26 waiting on response

PDSA: Act

What are you going to do next?	
Adopt, Adapt, or Abandon?	Clinic workflows are stable-will continue Hospital report is being investigated, we will adapt to new changes if needed, etc.
Changes to be made?	None in the clinic; unknown in the hospital
Lessons Learned?	Providers need data, even when they don't necessarily like the data
Next steps or future goals?	Continue to share data Future for hospital is a working report that accurately shares the data
Conclusion	Clinic workflows are stable Hospital report, potential workflows may change

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Project Acknowledgements

Sam Hubbard	Vice President of Operations
MJ Marx	Director of Quality
Danielle Reynolds	Quality Nurse
James Barnick	RN, Information Specialist
Christopher Bingham	Information Specialist

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Granite County Medical Center

Michelle Kirsch, RN

Define the Problem

Background: Why did you choose this project? Why was it important to work on?

Two thirds of Granite County Medical Center Medicare patients do not take advantage of their Medicare Annual Wellness visit benefit to proactively prevent health problems.

Patients in Granite County seek medical care for chronic conditions and medical emergencies but have minimal engagement in preventative care and health literacy. Limited participation in preventable care can result in preventable hospitalizations.

Granite County Medical Center had 3 ER visits and 2 Inpatient admissions by patients that did not attend their Medicare Annual Wellness visit in 2025 resulting in healthcare costs totaling $175,000. Without these few patient outliers, the average cost of care per Medicare patient in our health system would drop from 35K per patient to 28K per patient.

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Baseline Data

Baseline: What is your baseline data?

Only 47 of the 150 Medicare patients in our community attended Medicare Annual Wellness appointments at Granite County Medical Center in 2025.

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AIM Statement

Project Aim: What is your goal and how will it be measured?

State your improvement goal using SMART criteria: Specific, Measurable, Achievable, Relevant, Time-bound. Granite County Medical Center identified 150 Medicare patients who are eligible for Annual Wellness Exams in 2026. Philipsburg clinic nurses will connect by phone with 80% of these patients to proactively assist them in wellness visit scheduling with their PCP before the end of 2026.

Anticipated/Actual Outcomes

Outcomes: How will you know a change is an improvement?

Outcome Measure: Increase Annual Wellness visits from 47 in 2025 to 75 in 2026.
Process Measure: Connect by phone with 80% of the patients.
Balancing Measure: Some patients do not answer the phone/call back and others may refuse care.

Monitor Quarterly Annual Wellness Visits to be sure we are on-track to reach our goal of completing 75 annual wellness visits in 2026.

We completed our Initial sampling and results are as follows:
Process Measure Results: 7 Voicemails Left, 5 patients reached initially when called.
Outcome Measure Results: 8 of the 12 patients in the sample, have Medicare Annual Wellness Visits scheduled.

PDSA: Plan/Do

What did you do to make a change?

What were you trying to test? If contacting patients by phone would encourage them to schedule Medicare Annual Wellness visits.

Who was involved? The nurses and providers in the Philipsburg Clinic and the Medicare patients who were due to have a wellness visit in Q1 of 2026.

What was the duration and scope? 12 patients who qualified for a Medicare Annual Wellness visit in Q1 of 2026.

What will be done? Clinic nurses will call patients and track feedback on success of calls/callbacks.

What did you expect to happen? We hoped patients would call back after leaving messages and be willing to schedule wellness visits to help them focus on preventative health.

PDSA: Act

What are you going to do next?	
Adopt, Adapt, or Abandon?	Granite County Medical Center will adopt the approach of proactively calling Medicare patients eligible for there Annual Wellness exams by phone throughout 2026.
Changes to be made?	Patients that do not call back within 2 weeks of a voicemail being left will be called a second time.
Lessons Learned?	Patients liked receiving calls from their PCP to encourage them to seek preventative care.
Next steps or future goals?	Complete this project throughout 2026 and compare total year results with our 2025 baseline data.
Conclusion	The nurses reported that patients overall, appreciated getting a phone call from the nurse, and wanted to come in if it is what their provider recommends.

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Project Acknowledgements

Candi Walden, LPN - Philipsburg Clinic

Liz Prince, LPN – Philipsburg Clinic

Jessica Martin, NP – Granite County Medical Center

David Neill, PA – Granite County Medical Center

Michelle Kirsch, RN – Granite County Medical Center

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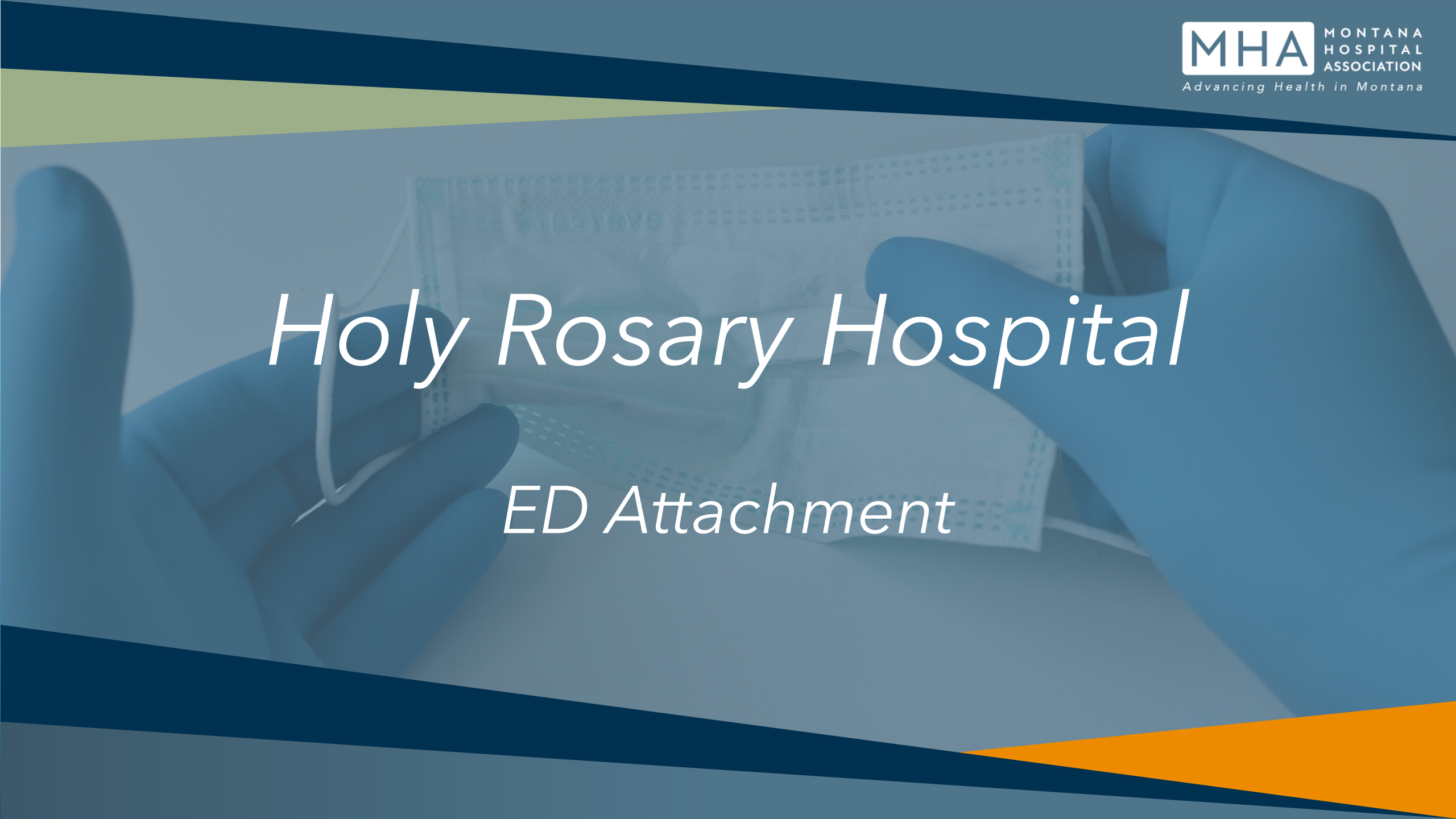

Holy Rosary Hospital

ED Attachment

Define the Problem

Background: 7-Day return visits to the Emergency Department

The 7-day return visits to the Emergency Department is a metric CMS specifically measures for patients 18-years of age and older. The measure is part of the Medicare population, which includes patients with multiple high-risk chronic conditions. Along with reducing healthcare costs, the measure aims to improve care coordination, particularly during transitions from the ED to the community, and to reduce the risk of medication errors, repeat ED visits, nursing home admissions, hospitalizations, and death.

Intermountain Health participates in Vizient Quality & Accountability Study, which is a benchmarking initiative to identify and promote best practices in healthcare. In the "Effectiveness" domain this was Holy Rosary's top opportunity.

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Baseline Data

Baseline: Vizient Q&A-Effectiveness Domain – Period 1 Ranking 65th percentile - Goal 100th percentile

Top Opportunity within Effectiveness Domain:

- 7-day return visits to ED
- Current ranking 2nd percentile – Goal 100th percentile

Follow-up appointments are not currently being scheduled prior to being discharged from Emergency Department.

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AIM Statement

Project Aim: By using an internal process to ensure patients are scheduled with their existing Primary Care Provider(PCP)—or assisted in establishing PCP—we can strengthen continuity of care, improve efficiency, and ultimately support better health outcomes.

Our goal is to improve our Vizient Q&A ranking in Effectiveness from 65 to 70 by 2026 Period 4 results, by implementing ED Providers placing Primary Care referral orders for patients needing follow-up within 7-days and the appointment being scheduled prior to ED discharge.

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Anticipated/Actual Outcomes

Outcomes: We will know a change in the outcome by our Vizient Q&A 7-day return visits to our ED measure

Weekly we will track how many ED provider referrals are made and how many of those referrals are scheduled within the same day.

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PDSA: Plan/Do

Created a reliable & trackable way to schedule follow-up appointments for our patients prior to discharge from the ED.

- With each stakeholder bringing unique insight into understanding the "why," we were able to gain buy-in to the new process quickly.
- The clinic committed to opening one "transition-of-care" appointment per day on each primary care provider's schedule.
- ED providers were excited to know that with the new process these requests would now be scheduled *reliably*.
- Patient Access caregivers stationed in the ED received a tip-sheet explaining how to locate transition-of-care appointment openings and manage the incoming referrals. If they are unable to schedule, our clinic Patient Access caregivers will complete the scheduling on the next business day.
- Informatics supported the work by ensuring that data tracking for the new process was fully functional.

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PDSA: Study

Plan to go-live March 23rd, 2026.

- *Ran a test with all stakeholders in one room to ensure the process ran smoothly between four different entities.*
- *After process was mapped out tip sheets were created.*
- *Education went out to our ED Providers, ED RN & Patient Access teams the week of 03/16 through 03/20.*
- *Education was relayed via email communication, shared during Huddles, and Staff Meetings.*
- *President, ED Manager, Patient Access Manager and Chief Medical Officer will be rounding during Go-Live week to ensure the process goes smoothly.*
- *Will collect first week of data April 3rd.*

PDSA: Act

What are you going to do next?	
Adopt, Adapt, or Abandon?	During Go-Live week manage barriers as they arise in real-time.
Next steps or future goals?	Future goals would be to create a process to schedule follow-up appointments for patients that have primary care providers at other facilities prior to ED discharge.
Conclusion	Patients often struggle within a complex medical system, which can create unnecessary stress during an already vulnerable ED visit. Using this new internal process to streamlining urgent, unexpected follow-up appointments can reduce stress not only for the patient, but ED and clinic caregivers also. Having the ability to accommodate these appointments for our patients will not only alleviate stress but expedite the patient back to functional health.

Project Acknowledgements

Jay Littlefield, MD, Chief Medical Officer
Shanelle Weeding, NP, ED Physician
L'Dene McAvoy, Primary Care Clinic Manager
Dina Kuchynka, BSN, ED Nurse Manager
Michelle Kuper, Patient Access Manager
Trish Sattler, Informaticist
Chantel Brooks, MSN, Clinical Excellence-Operations Manager

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Logan Health - Shelby

EDTC Documentation

Define the Problem

Background: Why did you choose this project? Why was it important to work on?

Briefly describe the problem you aim to improve. Describe why it matters to your patients, staff, or others.

Problem Statement:

Early on in 2025, EDTC documentation performance at Logan Health-Shelby hovered near the 90% goal but began to decline mid year. During the final four months of the year, scores dropped further as staff adjusted to documenting EDTC information within the new EMR system. By the end of 2025, the percentage of patients with adequately documented transfer information averaged 76%, well below the 90% target.

Why it Matters:

Effective communication is crucial for preventing adverse events in healthcare. Providing complete and accurate EDTC information during patient transfers supports safe, seamless transitions, helps prevent errors, reduces unnecessary testing, and lowers readmission rates.

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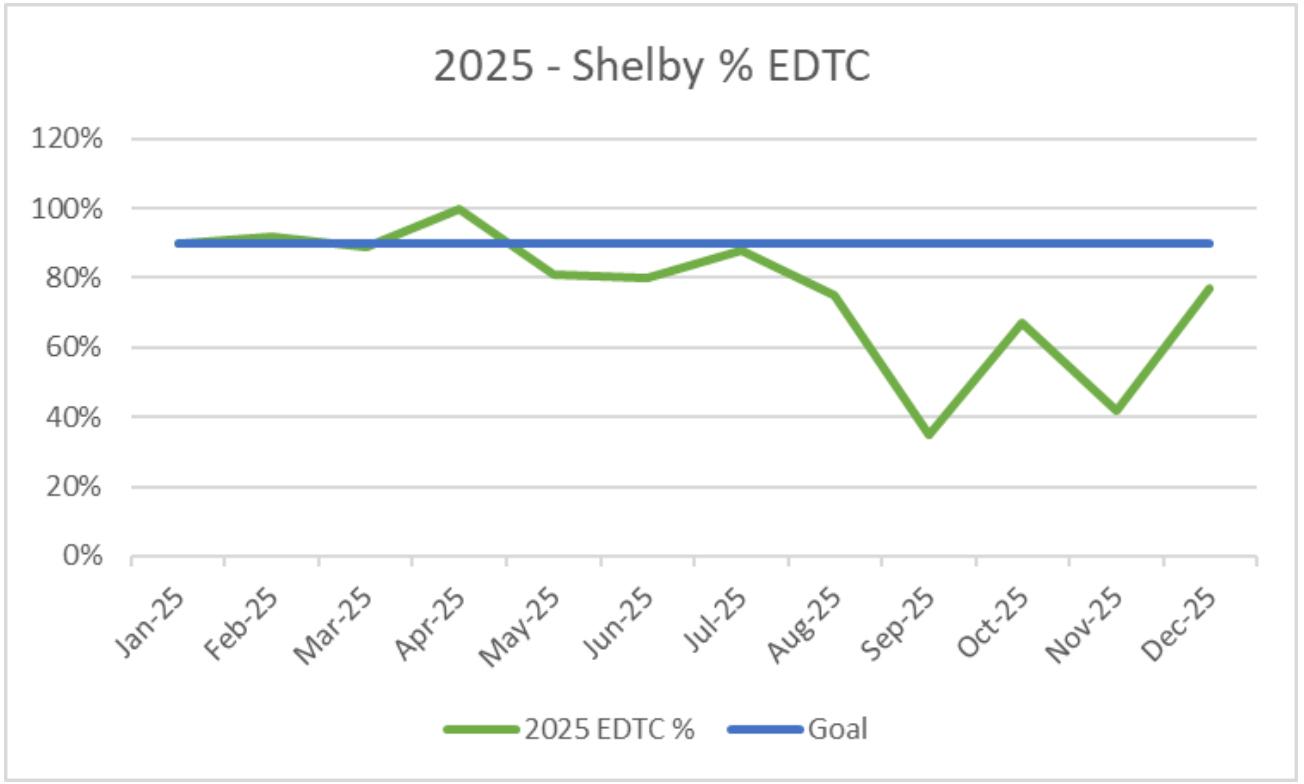
Baseline Data

Baseline: What is your baseline data?

Provide your baseline data or current performance.



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AIM Statement

Project Aim: What is your goal and how will it be measured?

State your improvement goal using SMART criteria: Specific, Measurable, Achievable, Relevant, Time-bound. Include who will do the work, what will improve, by when, and by how much.

The Emergency Department will achieve and sustain at least a 90% EDTC compliance rate throughout 2026 by implementing highlighted checkboxes as a visual cue to support consistent and accurate completion the required EDTC elements for every patient transferred to another facility.

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Anticipated/Actual Outcomes

Outcomes: How will you know a change is an improvement?

Provide your outcome and process measures. Include balancing measures, if identified. Provide input on how often you collected the data and how. Include any data to date.

Outcome Measure:

Increase the percent of required Emergency Department Transfer Documents (EDTC) elements that are verified as sent with transferred patients.

Processing Measures:

The team will assess whether highlighted checkboxes will improve the completeness of ED transfer documentation. Each month, Quality staff will audit transfer records collected from Power Bi for all eight required EDTC elements and share results with the Director of Nursing, the Emergency Department staff and Hospital leadership to promote accountability and sustain progress.

Balancing Measures:

It may be necessary to regularly educate and reemphasize the purpose of the highlighted boxes to ensure that staff does not overlook the highlighted checkboxes that indicate completion and transfer of all required EDTC elements.

PDSA: Plan/Do

What did you do to make a change?

Provide an overview of your tests of change. What were you trying to test? Who was involved? What was the duration and scope? What will be done? How did you measure? What did you expect to happen? How were team members and patients engaged?

Test of change

This test aims to determine whether highlighting checkboxes on the transfer documentation helps Emergency Department nurses and providers to accurately complete the required EDTC elements for all transferred patients.

Team Roles:

Emergency Department:

- Share current EDTC percentage and goal with staff
- Highlight required checkboxes of ED documents required for transfer
- Ensure Emergency Department staff know the required documentation that must accompany every patient transfer and how to document it in the patient chart
- Emergency Department staff will complete EDTC documentation for all transferred patients
- Inform Emergency Department staff on progress towards the goal

PDSA: Plan/Do

What did you do to make a change?

Provide an overview of your tests of change. What were you trying to test? Who was involved? What was the duration and scope? What will be done? How did you measure? What did you expect to happen? How were team members and patients engaged?

Quality personnel:

- Quality personnel will download the Emergency Department transfer report monthly from Power BI and review all related transfer documents to confirm that all eight required EDTC elements are included for every transferred patient.
- Findings will be shared with the Director of Nursing, the Emergency Department staff and Hospital leadership to support transparency, accountability, and sustained process change.
- Success will be celebrated and adjustments will be made to drive continued improvement.

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PDSA: Study

Explain the changes seen based on the data above or experiences; knowing some benefits may not be measurable in numbers.

If you have done small tests of change, outline your results, data can be included in the table below if you choose. If you are still in the "do" phase, explain how you will study the impact. Summarize your insights. Include data if available.

EDTC Documentation	2025 BASELINE VALUE	2026 REMEASURE VALUE	Did you improve?
January 2026	67%	71%	Yes
February 2026	67%	92%	Yes
March 2026	67%		

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PDSA: Act

What are you going to do next?	
Adopt, Adapt, or Abandon?	• Continue to highlight the required checkboxes of ED documents required for transfer and educate Emergency Department staff on the documents that must be transferred
Changes to be made?	• Determine who is best suited to highlight the required checkboxes on the transfer document • Evaluate whether manually highlighting the current transfer document is sustainable long-term or if producing a pre-highlighted version in-house would be a more effective solution
Lessons Learned?	• Small changes can lead to significant improvement
Next steps or future goals?	• Celebrate success and continue encouraging the process to maintain the improvement • Consider creating an in-house version of the transfer form with the required EDTC elements pre-highlighted
Conclusion	• Highlighting the required checkboxes on the ED transfer documents may be a useful reminder to ensure staff consistently and accurately document all required EDTC elements for every transfer patient

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Project Acknowledgements

- ***Courtney Hovland, RN- Director of Nursing***
- ***Katryna Racki, LPN- Shift Supervisor***
- ***Shelby Emergency Department-***

  Nursing Staff and Providers

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Sidney Health Center

Project Name

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St. Luke Community Healthcare

Pee Whiz, Make it Culturally Appropriate

Define the Problem – The Golden Backstory

Through ongoing data monitoring, the Infection Preventionist identified a 44% contamination rate among urine specimens in 2025, creating significant barriers to appropriate patient care and clinical decision-making.

Contaminated urine specimens result in:

- Misdiagnosis of UTIs
- Inappropriate ordering of antibiotics
  - Antibiotics ordered when not needed
  - Incorrect antibiotic ordered
  - Excessive days of therapy (DOT) resulting in additional expense to patient and increased risk of adverse side effects
- This contributes to the development of Multi-drug resistant organisms(MDROs)
- Expensive repeat testing due to inconclusive results

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Baseline Data

In 2025, 133 urine specimens collected on patient who were admitted to ACF were cultured.

- Of the total specimens, 59 of them (44%) were considered contaminated.
- 108 were obtained by “Clean Catch” method
  - 58 (54%) of these were considered contaminated
- 25 were obtained by intermittent catheterization (straight cath)
  - 1 (4%) of these were considered contaminated

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AIM Statement

Utilizing both broad and targeted staff education, we will reduce the overall contamination rate for urine cultures down to 30% for the period of April 2026 to December 2026.

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Anticipated/Actual Outcomes

We expect staff to engage more intentionally when a specimen collection is ordered. We expect staff to assess the patient's knowledge, educate patient's appropriately, and reassess that clean catch specimens are collected appropriately.

We expect the number of urine specimens collected via catheter will increase, as several patients will be determined to be unable to properly provide a clean sample.

We hope to see at least a 10% decrease in the contamination rate of clean catch specimens alone, but plan for much of the improvement to be realized as a result of the increased utilization of catheter specimens.

PDSA: Plan/Do

The intervention focuses on reducing urine specimen contamination through standardized education and improved collection method selection. Nursing staff were educated on evidence-based clean-catch technique and criteria for utilizing intermittent catheterization when patients are unable to perform a clean-catch reliably.

The initiative was launched at the March 10 staff meeting. Data collection was initiated post-implementation to evaluate effectiveness.

PDSA: Study

Explain the changes seen based on the data above or experiences; knowing some benefits may not be measurable in numbers.

If you have done small tests of change, outline your results, data can be included in the table below if you choose. If you are still in the "do" phase, explain how you will study the impact. Summarize your insights. Include data if available.

	BASELINE VALUE	REMEASURE VALUE	Did you improve?
Contamination Rate	44%	27%	Yes

Data from March 10th – March 18th: 3 out of 11 specimens were contaminated.

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PDSA: Act

What are you going to do next?	
Adopt, Adapt, or Abandon?	Adapt
Changes to be made?	Further, individualized training provided at Skills Day in May.
Lessons Learned?	Address negative trends with nursing staff sooner.
Next steps or future goals?	Continue tracking data and providing feedback.
Conclusion	Sustaining this improvement will require continued data monitoring, consistent staff education, and reinforcement or appropriate collection practices.

Project Acknowledgements

Project Team Members Name & Titles

John Dresen
Infection Preventionist & Contamination Crusader

Katie Harding
Quality Improvement Champion

Quincy Taylor
Med/Surg Manager and All Around Great Guy

Abigail Byers
Director of Nursing and Fearless Leader

URINE
GOOD
HANDS

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