Dartmouth-Hitchcock Health

CONNECTIONS

Fall 2019

A Message from Joanne M. Conroy, MD

There is no shortage of important initiatives happening throughout Dartmouth-Hitchcock Health, and I want to take a moment to thank each and every employee for your constant commitment to doing great work and for caring for the people of our region. I recognize that many of these larger initiatives—such as eD-H go live preparations at New London Hospital, the TAPP (Throughput, Access for Patients Project at D-H), the clinical services expansion at D-H Manchester and the D-HH/GraniteOne Health combination, are a tremendous amount of work on top of your day-to-day work. While it may seem overwhelming to balance these competing priorities, I want to encourage everyone to take a deep breath in those moments of frustration, take a walk, take some time for yourself, ask your colleagues and/or manager for help and guidance, and just remember that the work we are doing now paves the way for a stronger future for the D-HH system.

I also hope you will take a few minutes to read the variety of interesting stories we have in this issue of our quarterly Connections newsletter including updates about projects happening throughout the system and also stories which highlight what you and your colleagues are doing to move our system strategy forward and to uphold our system promise: Together, we bring the full power of our collective expertise to provide the best possible care to our patients, our people and our communities.

Here are a few highlights in this issue:

- Update on the Jack Byrne Center for Palliative & Hospice Care, which highlights the collaboration between VNH and D-H.
- A celebration of Alice Peck Day's eD-H transition.
- An "Inside Scoop" that profiles Jessica Lussier, Director of Emergency Services, at Cheshire Medical Center and how she and her team handled the patient evacuation this spring.
- A farewell to Bruce King, CEO and President of New London Hospital, as he retires this year.
- How New London Hospital embraced the national Stop the Bleed program.
- D-H and D-HH Telehealth program expands health care in rural areas.

As always, we welcome your feedback. If you have story ideas, questions or suggestions, please send them to: Connections@hitchcock.org.

Dartmouth-Hitchcock Health System Abbreviation Guide

- **APD** – Alice Peck Day Memorial Hospital
- **CGP** – Community Group Practice (Bedford, Concord, Hudson, Manchester, Merrimack, Milford, Nashua)
- **Cheshire** – Cheshire Medical Center
- **D-H** – Dartmouth-Hitchcock
- **D-HH** – Dartmouth-Hitchcock Health
- **DHMC** – Dartmouth-Hitchcock Medical Center
- **Mt. Ascutney** – Mt. Ascutney Hospital and Health Center

- **New London** – New London Hospital
- **VNH** – Visiting Nurse and Hospice for Vermont and New Hampshire

Employee Applause

Here are some of the accomplishments, awards and recognition from employees and volunteers across the D-HH System.

New London CEO Bruce King Plans to Retire

New London Hospital's President and CEO Bruce King has announced his intention to retire at the end of 2019, after more than 16 years in the position and 40-plus years in his health care career.

King moved to New Hampshire to work at D-H in 1987, initially as a vice president of Finance, responsible for budgeting, reimbursement and patient accounts. In 1996, he became vice president of Contracting and Network Development for D-H and the D-H Alliance organizations in New Hampshire and Vermont. In April 2003, King became president and CEO of New London, functioning in this capacity under a management contract between D-H and New London.

"On behalf of New London, I thank Bruce for his dedication and commitment to the patients and community throughout his long career," says Doug Lyon, chair of the New London Board of Trustees. "He has led New London through 16 years of constant improvement. During his tenure, badly needed new construction and renovation projects were completed at New London and the Newport Health Center, we achieved greater financial stability and finished two successful capital campaigns. Most importantly, higher quality care was delivered at New London. Staff was added in all care areas of the hospital and medical personnel from D-H now provide a wide range of specialty services formally available only in Lebanon. The integration into the D-HH System, which he championed, will provide our communities with even greater access to high-quality care. Bruce has been the widely recognized face of New London in our community and will leave very big shoes to fill."

A search committee was formed in the summer with fellow trustees and in concert with D-HH, with a goal of naming a successor in the late fall. To ensure a smooth transition, King is planning to continue serving until his successor is selected.

APD Lifecare's Jim Ewald: A Legacy of Caring

Earlier this summer, residents, staff and friends of Alice Peck Day Memorial Hospital's two senior living communities, Harvest Hill and The Woodlands, gathered to celebrate Facilities Director Jim Ewald's 23 years of service. Ewald began his tenure during the construction of Harvest Hill in 1996. He helped to shepherd the project and oversaw the move-in of its first residents. From the day Harvest Hill's doors opened on the campus of APD, he made sure every detail was attended to by himself personally or by a member of his hand-picked crew.

Ewald was also closely involved with the construction of The Woodlands in 2010. He expanded his team to make sure the community would grow into the beautiful addition to APD that it is today.

"Jim is a treasure. His co-workers and the residents loved him and he loved them back," says Cindy Jerome, executive director of APD Lifecare. "Jim felt ownership of these buildings and knew every inch of them."

Ewald knew each APD Lifecare resident by name, listened to their suggestions and made sure their needs were fully addressed. He took great pride in his work, ensuring the Harvest Hill and Woodlands communities were carefully maintained. He saw to it that every apartment became a home for its residents.

Ewald also oversaw the driver service that enabled residents to shop, go to medical visits or conduct errands. Despite an unending list of projects to complete, he always put the needs of residents first.

APD Lifecare is The Woodlands, a 63-apartment independent living community for seniors, and Harvest Hill, with 77 apartments offering assisted living, independent living and memory care. Learn more at www.apdlifecare.org or by calling Peggy Cooper at (603) 443-9575.

Breastfeeding Suite Ribbon-Cutting at Mt. Ascutney

In August, a dedication ceremony was held in the Primary Care Clinic off the main lobby of Mt. Ascutney Hospital and Health Center for a newly-installed private nursing suite, which is designed for breastfeeding or pumping by nursing mothers. The brightly-decorated nursing suite provides a comfortable, friendly, private space for mothers and babies. The suite contains occupancy-activated lighting, two benches, a fold-down table, power outlet and USB port, plus ceiling vents and an exhaust fan for comfort. The nursing suite was made possible with help from the Mt. Ascutney Hospital Auxiliary and Medical Staff, and will be available for use by patients, visitors and staff.

Mamava Lactation Stations are also at D-H in the:

- Dartmouth-Hitchcock Medical Center
    - Level 1: North Entrance Waiting Area
    - Level 3: Across from the East Mall Café and near the Spiral Staircase and Moose
    - Level 5: Outside the Matthew-Fuller Library

- Dartmouth-Hitchcock Heater Road
    - Level 2: Primary Care

New London's Catherine Bardier Elected Chair of the Governor's Council on Physical Activity & Health

New London Hospital's Director of Wellness and Population Health Catherine Bardier has been elected chair of the Governor's Council on Physical Activity & Health. The council was formed in 1991 by Executive Order of Governor Judd Gregg, and has been continued by his successors in the Governor's office. The council is charged with promoting a healthy, active lifestyle for all citizens of New Hampshire. Bardier has been serving as vice-chair since the beginning of 2018 and was first appointed in 2017 by Governor Sununu. She will assume her new role in September.

"I'm proud of the statewide activity challenges, events and achievement awards we are able to promote as a council," says Bardier. "I look forward to providing my service as chair and to continuing the passionate work of a dedicated team."

As Director, Bardier oversees community health initiatives, including the Wellness Connection Coalition and the New London Hospital Employee Wellness Program. She also serves as the chair of the Greater Sullivan County Public Health Advisory Council, and is on the Executive Committee for Dartmouth-Hitchcock Partners for Community Wellness.

The Governor's Council on Physical Activity & Health promotes several programs throughout the year, including this summer's Granite State 90-Day Challenge, a challenge to exercise every day for 20 minutes from June 1 to August 21. The council is not funded by the State of New Hampshire, but relies on contributions and grants from the business community and various state and national organizations and agencies.

For more information about the Governor's Council on Physical Activity & Health and the programs offered, visit www.nh.gov/gcpah.

Cheshire Employee Recognition Awards

Cheshire Medical Center's employee recognition awards were established to recognize employees - who are nominated by their peers - for organizational and professional excellence and for extraordinary service characterized by compassion,

responsiveness to the needs of others and a positive team-oriented attitude. This quarter, the following individuals were acknowledged:

Confirming Care for Safety's Sake at Cheshire

The Joint Commission's number one national patient safety goal is correct patient identification. Cheshire Medical Center's Patient Safety Committee recently decided to address the goal by looking at their policies and procedures with renewed focus and perspective.

"This project felt so personal," says Angela Lefebvre, RN, BSN, CEN, Accreditation and Regulatory Compliance leader, who took on the project along with Kaitlyn Wade, project management specialist. "I am a patient here. My daughter and husband are patients here. This affects our care, too."

With full support from leadership, the pair assembled an interdisciplinary team of front line staff, educators and communicators. The team soon discovered Cheshire had many policies about patient identification. "We crafted one standardized procedure that will work for all departments and services, and then launched new staff education and public awareness messaging. The buy-in has been amazing!" says Lefebvre.

"The relationships I make with my patients and their families are some of the most rewarding parts of my job. Cheshire exists within a tight-knit community," says Christine Driscoll-Carignan, RN, clinical leader, Progressive Care Unit. "My familiarity with my patients doesn't replace double-checking the details, it makes it even more important to stop and confirm each treatment plan is for the person in our care, every time. Safety is our priority."

"We chose the concept of *CareConfirm* because it speaks to some of the myths we discovered about patient identification checks," says Kristen Bernier, Cheshire's former marketing director. "Many of our staff were concerned that asking a patient their name and birth date multiple times can feel impersonal or frustrating to them. It is important to stress it is their care plan—what's on the paperwork or computer screen—that we are confirming. We check it is exactly the care meant for that individual."

The team rolled out *CareConfirm* hospital-wide in February with great success—ultimately winning the Cheshire Chairman's Award for its innovative approach to improving patient-centered care.

DHMC Named New Hampshire's Best Hospital by U.S. News & World Report

DHMC has been recognized by *U.S. News & World Report* as New Hampshire's Best Hospital in this year's annual Best Hospitals rankings.

D-H was also recognized as "high performing" in 13 clinical specialties and procedures. These high-performing areas are:

- abdominal aortic aneurysm repair
- aortic valve surgery
- cancer
- chronic obstructive pulmonary disease
- colon cancer surgery
- gastroenterology and gastrointestinal surgery
- geriatrics
- heart bypass surgery
- heart failure
- hip replacement
- lung cancer surgery
- neurology and neurosurgery
- urology

Congratulations to all of the teams that work in these specialty care and procedural areas. Their commitment to our patients is the reason why DHMC has received these important distinctions.

U.S. News & World Report's Best Hospitals list evaluates 25 specialties, procedures and conditions in more than 4,500 medical centers nationwide. In rankings by state and metro area, U.S. News recognized hospitals as high performing across multiple areas of care. The methodologies (click on the link to view the U.S. News explanation) in most areas of care are based largely (or entirely) on objective measures, such as risk-adjusted survival and readmission rates, volume, patient experience, patient safety and quality of nursing, among other care-related indicators.

Because many patients value rankings such as these as part of their decision-making process in choosing providers and hospitals, we are proud of this distinction and launched an advertising campaign to share this good news with the communities we serve.

D-HH CEO and President Joanne M. Conroy, MD Named to American Hospital Association Board of Trustees

D-HH CEO and President Joanne M. Conroy, MD, is one of seven people who have been named to the American Hospital Association (AHA) Board of Trustees. The new members were announced recently by AHA for three-year terms beginning January 1, 2020. The Board of Trustees is the highest policymaking body of the AHA and has ultimate authority for the governance and management of its direction and finances.

Conroy leads D-HH, a nonprofit academic health system and New Hampshire's largest private employer, that includes DHMC, the system's 396-bed flagship teaching hospital; the D-H Clinic, a multi-specialty group practice employing more than 1,800 providers; the D-H NCCC, one of 51 National Cancer Institute-designated comprehensive cancer centers; CHaD; four affiliated member hospitals; VNH; and 24 ambulatory care clinics around the state.

"AHA's advocacy on behalf of our nation's hospitals, and the millions of patients cared for by them, is critically important in today's shifting health care landscape," noted Conroy. "I'm proud and honored to be selected for the AHA board, and I look forward to fully engaging on the issues that are critically important to all of us who provide, and receive, care at hospitals."

Earlier in her career, Conroy served as CEO of Massachusetts-based Lahey Hospital and Medical Center (formerly Lahey Clinic). She also served as chief health care officer for the Association of American Medical Colleges (AAMC) in Washington, DC, for more than five years. In this role, she advanced AAMC's strategic imperative of leading change to improve the nation's health care system. By working with member medical schools and teaching hospitals, Conroy helped establish national health priorities and developed best practices to improve health by focusing on medical education, care delivery, research, diversity and inclusion.

Conroy is board certified by the American Board of Anesthesiologists. She received her undergraduate degree in chemistry from Dartmouth College and a medical degree from the Medical University of South Carolina, where she completed her residency in anesthesiology and served as chief resident for one year.

The AHA is a not-for-profit association of health care provider organizations and individuals that are committed to the health improvement of their communities. The AHA is the national advocate for its members, which include nearly 5,000 hospitals, health care systems, networks, other providers of care and 43,000 individual members. Founded in 1898, the AHA provides education for health care leaders and is a source of information on health care issues and trends.

"We couldn't be more pleased with Dr. Conroy's appointment to the AHA Board of Trustees," said Steve Ahnen, president of the New Hampshire Hospital Association. "Her leadership and commitment to patients and health care transformation will serve as an excellent addition to the AHA Board, and its commitment to shaping the future of the health care landscape in communities large and small all across the country."

Will Torrey, MD, Presented with the Exemplary Psychiatrist Award by the National Alliance on Mental Illness

Will Torrey, MD, D-H Department of Psychiatry's vice chair for clinical services, was presented with the Exemplary Psychiatrist Award by the National Alliance on Mental Illness (NAMI) on June 13. Torrey, who is also a professor of Psychiatry at the Geisel School of Medicine, was given the award at NAMI New Hampshire's Party with a Purpose in New Castle, NH.

The Exemplary Psychiatrist Awards program allows NAMI members, state organizations and affiliates throughout the country, "to honor the exceptional contributions that many psychiatrists make to improve the lives of people living with mental health conditions," according to the NAMI website. Torrey was nominated for the award by Ken Norton, executive director of NAMI NH.

"Will has a national reputation for his innovative and person-centered approaches to psychiatry," says Norton. "He is very careful to be inclusive about the voice of people with lived experience in the work he does, and strongly believes in the importance of educating and empowering family members and people with mental illness. He has made a lasting impact on the individuals and families he has worked with, on the medical students he has taught and supervised and on his colleagues." Norton adds that Torrey's position enables him to educate the public about the discrimination and prejudice persons with mental illness often face, and to train medical students and teach them about the family perspective in mental health care.

Torrey, who served as the medical director for West Central Behavioral Health for 14 years before coming over to lead the psychiatry department's clinical service, has been involved with NAMI since he came to Dartmouth as a resident in 1985. "The award means a tremendous amount to me, especially since I was nominated by Ken Norton, the NAMI NH director," Torrey says. "NAMI does amazing work supporting families and individuals with psychiatric illnesses, and they've done more than any other organization to combat stigma. And NAMI has also been very helpful to me in teaching residents and Geisel medical students about psychiatric illness."

Torrey has focused much of his recent work on expanding access to high-quality psychiatric care. This summer, he and D-H psychologist Kelly Aschbrenner, PhD, are teaming up with NAMI NH on a project to help the state of New Hampshire develop a well-organized, evidenced-based care approach for people when they first develop a psychosis. Based on their proposal, "First Episode Psychosis/Early Serious Mental Illness Program Planning," the NH Department of Health and Human Services recently awarded D-H the contract. "Engaging people in timely effective care when they first develop psychosis can improve the trajectory of the rest of their lives," says Torrey. "These are common illnesses and access to high-quality care really matters."

Members in Action

Jack Byrne Center Hospice Collaboration

Since opening in December 2017, D-H's Jack Byrne Center for Palliative & Hospice Care has worked closely with D-HH System member, Visiting Nurse and Hospice for Vermont and New Hampshire (VNH) to care for hospice patients from throughout northern New England. While this partnership is driven by Medicare hospice regulations—when Medicare patients are admitted for inpatient care to the Jack Byrne Center, VNH is required to oversee the care plan—the two organizations say the relationship works well.

"It's been really positive," says Ruth M. Thomson, DO, MBA, medical director, Jack Byrne Center. "VNH has a great team and we've developed a wonderful, collaborative relationship."

"We have a fabulous working relationship," says Cristine Maloney, MD, VNH's Hospice medical director. "Frequent communication is a hallmark of our partnership. We are both really committed to making sure our patients have great care and that there's a smooth transition when they are admitted and when they go home."

Thomson says there is still some confusion about the care offered at the Jack Byrne Center and VNH's involvement with that care. "Even though the Jack Byrne Center looks like a hospice facility and hospice is in the name, it is licensed as an inpatient unit of the hospital," Thomson says. "We provide inpatient care for people with serious and terminal illnesses. But we are not a licensed hospice, so we provide hospice care through partnerships with VNH and other hospices. While we at the Jack Byrne Center are doing most of the 24-hour inpatient care, VNH owns the plan of care. So there has to be a really strong collaboration."

For Medicare hospice patients to receive general inpatient care (GIP), which is the term Medicare uses for inpatient hospice care, regulations require that the care be overseen by the VNH. So, even when a patient comes into the DHMC Emergency Department and is identified as a candidate for the Jack Byrne Center, VNH needs to be the first phone call, says Thomson. "VNH helps the patient and family decide the best plan of care. If the decision is to come here, then we transfer the patient directly from the Emergency Department to the Jack Byrne Center and work on the care together. A VNH social worker will also meet with the family if they have psychosocial needs. We provide whatever help a patient and family needs, but we're very mindful they are VNH's patients."

Maloney says VNH staffers are available to speak with D-HH System providers or to do hospice informational visits with families to discuss whether hospice care makes sense for a patient. "And since the VNH is a D-HH System member, I have full access to patients' electronic medical records," Maloney says. "So, if a provider wants to talk things over, I am happy to do that."

VNH also has a liaison at DHMC, Erin McMahon, RN, who is available to answer questions from case managers, nurses, physicians, patients and families, and who meets regularly with patients and families at DHMC and the Jack Byrne Center. Maloney notes that the ideal hospice candidate has changed in recent years, so a conversation with her or McMahon may help determine if hospice care is the best choice. "People traditionally think of cancer patients in connection with hospice, but we are seeing more patients with dementia, CHF or COPD as a primary driver for their hospice stay. People with multiple medical problems are chronically ill and have recurrent hospital admissions are potential hospice patients too!"

While VNH focuses largely on providing care for home-based patients, Maloney says the Jack Byrne Center has helped VNH by providing intensive symptom management for patients and respite care. "Sometimes caregivers just need a break, and before the Jack Byrne Center opened, it was difficult to find facilities that would take a hospice patient for a few days. This enables caregivers to go out of town to family weddings, take a vacation or simply get some rest."

Maloney adds that VNH has received excellent feedback from patients who have received inpatient care at the Jack Byrne Center. "The families have really loved being there. It's hard to describe the home-like atmosphere at the Jack Byrne Center, but our patients have had a really positive health care experience there. The nursing is excellent and patients feel very well taken care of in a personalized way."

"For us, VNH is really a joy to work with," says Thomson. "They have a strong clinical team; they're very professional; and they are really open to partnering and collaborating, with the focus being on the patient and family."

Mt. Ascutney Takes Lean Six Sigma Approach to Ensure Quality and Safety

When it comes to ensuring quality in a health care setting of any size, maintaining a high standard demands continuous improvement. Securing that improvement requires a common language and methodology. The Quality, Patient Safety, and Compliance Team at Mt. Ascutney Hospital and Health Center is ensuring high quality care in a safe environment for patients by embracing the Lean Six Sigma method. Lean Six Sigma is used across numerous industries to improve performance by identifying and reducing waste.

Otelah Perry, director of Quality, Patient Safety, and Compliance at Mt. Ascutney, has extensive experience with the method, having successfully implemented Lean Six Sigma at the DHMC laboratory in 2012. When she arrived at Mt. Ascutney, she was excited to learn that Lean Six Sigma had been introduced at the hospital by her predecessor, Johanna Beliveau, who is now CEO of D-HH System member VNH.

Perry says that the Lean Six Sigma approach allows all members of the team to have an understanding of the tools and processes they will utilize to achieve improvements when they are planning projects and interventions. She explains, "By using standard terms and processes, we can brainstorm potential solutions and evaluate their effectiveness without any misunderstandings that can waste time. This makes workflows more efficient and easier to understand, which boosts staff satisfaction. Patient care gets streamlined and improved—positively affecting their satisfaction. Wasted time, money, and other resources are recaptured, helping to strengthen Mt. Ascutney toward the mission of improving the lives of those we serve."

Perry says that for any quality or safety issue at Mt. Ascutney, the core approach is defined by a five-step methodology known as DMAIC. "We define the problem," she says, "measure current performance, analyze it to determine root causes of the problem, improve by eliminating the root cause, then control by monitoring the situation, taking additional action if the root cause reappears."

Perry says that Lean Six Sigma principles can be applied to every hospital activity, from strategic planning, to integrating compliance protocols. "Excellence in patient safety and quality is the culmination of individual actions and process steps," she says. "There isn't a magic wand to quality improvement—it's a lifestyle change. It takes commitment, time, attention and sometimes perseverance, along with data, tools, structure and support."

Mt. Ascutney has committed to Lean Six Sigma by investing in extensive training for the entire Quality team and beyond, including classes hosted by D-H. "We are able to multiply continuous improvement efforts at Mt. Ascutney as more people are trained and involved," says Perry. Lean Six Sigma signifies proficiency in the method by a four-tier system of white, yellow, green and black belts, as in martial arts.

At the expert level, Perry is a certified Lean Sigma Six Black Belt, prioritizing coaching and teaching, while acting as an improvement project leader and leading the daily safety huddle. Associate Director A.J. Tapley, RN, the Hospital's Risk and Compliance Manager, also recently completed his Black Belt training. Quality Specialist Margaret Worth, RN, who leads Mt. Ascutney infection control and antibiotic stewardship committees, earned her Green Belt and led a project focused on preventing employee injuries. Certified Yellow Belts include Brenna Heighes, quality data analyst; Rosalind Klezos, quality and compliance coordinator; and Colleen George, Mt. Ascutney medical staff coordinator. Overall, the hospital has now reached nearly 40 Yellow Belts across multiple departments and all employees are now required to complete a White Belt training module.

"Together," says Perry, "we are moving forward efficiently to solve problems, not only as they arise, but before they emerge. As we work with our colleagues across the hospital, this approach is having a positive impact on the entire culture. And it's all thanks to the commitment that Mt. Ascutney has made at every level to improve patient safety and better patient care."

APD's Technology Journey: Building Bonds Across the System

Alice Peck Day Memorial Hospital's transition to system software was more than a technological transformation. Relationships and friendships formed over months of preparation, signaling the start of an era in which once-separate members now work together.

APD began its integration journey in 2018 by bringing Human Resources, Finance and Supply Chain together in one enterprise resource planning system. Next came deployment of new hardware campus-wide. Finally, APD began to implement eD-H, the unified electronic health record system that allows seamless integration with other system members, and gives patients the benefits of coordinated care across the system. A team of APD and D-HH colleagues embarked on a five-month journey of learning and training in practice environments to bring hospital employees up to speed on eD-H.

As "go-live" approached, APD began holding a daily "huddle" to allow department representatives to ask questions and get help troubleshooting issues. D-HH colleagues joined in person or by phone. Issues were tracked over time, and people expressed concerns and let off a bit of steam.

"It was a great partnership with D-HH, from top to bottom," says Dale Vidal, MD, MS, executive director, Multi-Specialty Clinic at APD. "Everyone knew it would be hard, but we were dedicated to adapting and learning. Lines of communication were a key reason behind our success, keeping everyone on the same page and able to solve problems in the moment."

After months of preparation, APD went live with eD-H in May. "Cross-functional teams from D-HH and APD worked together tirelessly to make this happen," says Kristen Kneisel-Leaning, associate vice president for Information Services, Laboratory and Radiology at APD. "Working closely with the D-HH leaders and project managers, we carefully laid the groundwork to ensure a successful transformation to D-HH systems."

Following go-live, 134 D-HH colleagues wearing bright yellow vests for easy identification arrived on campus to provide "at-elbow" support for two weeks. D-HH leaders and managers attended APD's daily huddles, listening, responding to issues, and sharing tips, tricks and information.

"The best thing about go-live was having D-HH doctors from other sites right there with us to help with the transition," says Erin McNeely, MD. "People who do the same job as you really understand how to use the tool in the way you need to use it. Without physicians and other staff at-elbow for our go-live, our patient care visits might have come to a grinding stop."

"The at-the-elbow support people were easy to work with," said Michele Moore, clinical support representative. "We were all trying to achieve the same goal of creating a seamless system for patients." Moore says the at-elbow support allayed any anxieties.

What surprised APD most about the transition? Because it was so well planned and closely monitored, Vidal says, the go-live was essentially "uneventful." "After at-elbow support ended, we knew that if we had issues with eD-H, there were trusted colleagues we could always call," she added. "That was the best surprise—the lasting relationships we formed."

Inside Scoop: Jessica Lussier, MSN, director of Emergency Services, Cheshire

In our staff profile series highlighting the roles of individuals and their departments across the D-HH system, *D-HH Connections* visits with Jessica Lussier, MSN, director of Emergency Services at Cheshire Medical Center. She joined Cheshire, a member of the D-HH System, in February 2013 as a part-time nurse and eventually became a clinical leader—a nurse managerial role. She was named director of Emergency Services in November 2018.

The Hancock, New Hampshire resident is a Connecticut native, and holds a Master of Science in Nursing (MSN) degree from Chicago's St. Xavier University. She earned her undergraduate degree from Russell Sage College in Troy, NY, in 1998. Prior to her work at Cheshire, Jessica was an emergency department nurse from 2002 to 2013 at St. Francis Hospital in Hartford, CT. She served as a nurse in the U.S. Army from 1998 to 2002, and was stationed in Germany at the 67 Combat Support Hospital. Her service included a deployment.

What does your role as director of Emergency Services entail?

I oversee the Emergency Department (ED), the contracts related to the ED, the nursing staff, Emergency Medical Services (EMS) coordination for trauma services, the behavioral health team for the acute care side of the organization and the emergency management coordination.

How many patients does the ED serve?

Our average daily ED census is 60 to 65 patients. We treat approximately 24,500 patients per year. The ED has 20 beds and two triage rooms.

Shortly after taking the reins as director of Emergency Services, you were faced with a significant challenge—managing the complete evacuation of Cheshire Medical Center. What happened?

At 10:24 am on Thursday, April 25, 2019, I was working in the ED and everyone heard a loud bang. The boiler malfunctioned, which damaged the stack so the boiler could not vent. The Engineering Team called the Fire Department, and we heard it over the police scanner. I told my staff not to panic, and went down to the boiler area to see how I could help. Fire Chief Mark Howard and his team arrived within minutes. It was discovered the hospital had no heat or hot water. We had to consider evacuating the hospital, but needed more information first.

What factors did you consider?

We weren't sure if we could get heat back, but could handle operations without hot water. But we knew the weather forecast was poor—it was rainy and the temperature was going to drop into the low 40s overnight. Another piece of information we needed was the lowest threshold temperature for the lab, CT scan and other areas. If the temperature dropped below 65 degrees, it could cause issues in those areas.

What happened next?

Around 1 pm, the administrator on call transitioned Incident Command duties to me. I felt pretty confident we would have to evacuate. Our focus was always on our patients' best interests. We gathered as much information as possible, because we didn't want to rush and make mistakes. The fire chief contacted state agencies to alert them to the possibility of evacuation. The New Hampshire Office of Emergency Management and Department of Health and Human Services were instrumental in securing resources. The New Hampshire Knowledge Center sent an urgent message to emergency management teams throughout the state to ask for all available resources for a possible evacuation.

At 3 pm, we held another Incident Command meeting and agreed to evacuate. We had 69 patients to process, of which 47 had to be transferred and focused on accurate patient placement. We expedited those patients ready for discharge, and arranged for the most critical patients to be moved first. We then determined placements for those with special needs, and started notifying family members about the transfer plans.

Were patients worried?

The inpatient team communicated with them, and they were thankful. The patients knew it would be too cold to stay at Cheshire. The team facilitated all of the patient movements and gathered their belongings and paperwork. They did a great job.

How did the evacuation work?

No one panicked because we were in control and had a plan. Fire Chief Howard coordinated the volunteer ambulances from New Hampshire and Vermont. At 5:25 pm, more than 20 ambulances arrived to transport patients to: Brattleboro Memorial Hospital, Catholic Medical Center, Concord Hospital, DHMC, Elliot Hospital, Monadnock Community Hospital, Mt. Ascutney and New London.

The ambulances lined up at the door, waiting patiently as we verified patient information—where they were going, their belongings, etc.—before releasing them for transport. We needed to control the patient flow and stay organized. It was really amazing to see all of these people show up after the call was put out that we needed help. The EMS personnel came voluntarily on their own time.

The last transfer was at 11 pm, so we evacuated 47 patients in five hours and 25 minutes! Everyone was great. They just asked, "What do you need me to do?" It didn't matter what their role was, they just pitched in. I had a vice president getting dinner for people, and a front-desk employee who had come in at 8 am but didn't leave until midnight when everything was over.

In the meantime, what was happening with the boiler?

The Engineering team did an amazing job locating a temporary boiler in Massachusetts after much research. The state helped expedite the permit process, and the team worked with Vermont Mechanical and Cheshire Engineering throughout Thursday night and all day Friday to fabricate 120 feet of welded pipe, install the boiler and get it operating without causing damage to the system. It needed to be inspected and certified by the state, and heat was fully restored at 8:30 pm on Friday, April 26.

When did you start seeing patients again?

We started admitting patients on Friday evening when we determined the HVAC system was properly regulated.

Did any of the discharged patients return?

The Incident Command Team met again Saturday morning and began coordinating patient returns. Some were discharged after their transfers and others were too sick to be transferred again. We had 25 patients return to Cheshire, with the last one returning Monday morning. I closed Incident Command on Saturday, as every patient had a transition plan or were remaining at the transferred hospital.

What was the feedback after the event?

We debriefed and the team was very positive. Everyone worked well together, no one was hurt and there was amazing inpatient leadership. Communication can always improve, so that was one area we identified to work on.

Has the evacuation helped other hospitals prepare for emergencies?

Many of my emergency management partners have reached out to learn more about the evacuation. It was the only complete evacuation of a hospital in New Hampshire, so it was a great way to test the emergency management plan we had in place. It also helped our partners think about ways to improve their own plans.

What were your thoughts post-evacuation?

I was so thankful no one got hurt during this process. It was the right decision to evacuate. Parts of the hospital were 50 degrees – it was just unsafe for us to stay. Our state partners were fantastic. Everyone did their jobs without question. I'm so grateful it went so well.

Congratulations on an impressive job well done! Now for some semi-personal questions. What's your favorite non-work activity?

Cooking. I have lots of cookbooks and enjoy creating new and different meals with my daughter.

What about you would surprise most people?

When I was growing up, I was a competitive tap dancer!

Patient Experience Moments

Surviving Battles and Blockages – Cheshire Patient Norman VanCor

A veteran of the Vietnam War, Norman VanCor is writing a book about his experiences and ultimate survival. Last year, he had reason to pause and reflect on another triumph over death—one that crept up on him in such a way that he needed to be convinced he was in real danger.

Like many of us, VanCor has dealt with a number of health issues throughout his lifetime. Last fall, he visited his primary care provider Rachel Croteau, MD, at Cheshire Medical Center, with what he thought were fairly familiar pulmonary symptoms. Croteau ordered some routine tests to explore his symptoms and ultimately recommended a nuclear stress test, which measures whether the blood flow to your heart muscle is normal or abnormal. VanCor resisted this path for some

time as it can be an unpleasant experience-especially for someone who already struggles with pulmonary function. However, Croteau persisted in her recommendation for VanCor to have the test.

Within days of receiving the results, his care team sent him up to DHMC for a heart catheterization, a procedure used to diagnose and treat certain cardiovascular conditions. As a result of that procedure, he was immediately referred to a cardiac surgeon and was told he had three very serious blockages in his aortas, necessitating a triple bypass because three coronary arteries were blocked and needed normal blood flow restored. VanCor shared that his D-H surgeon told him that without the bypass, it was very likely he would have suffered a massive heart attack by Christmas that could have been fatal.

The day after Christmas, VanCor was feeling so grateful for Croteau's wisdom, professionalism and persistence, he made a financial donation in her honor to Cheshire's Circle of Gratitude program for ultimately saving his life. The Circle of Gratitude program lets patients make a donation in honor of a specific staff member who made a difference in their care. In VanCor's words, "Dr. Croteau is an outstanding member of the medical team at Cheshire, and a caring and compassionate human being."

He also conveyed his gratitude for the swift and effective series of tests and procedures performed both at Cheshire and DHMC. While they may not have been pleasant ordeals, VanCor says he is glad he was convinced they were necessary. Everyone involved took care of him well, and he is extremely thankful to be alive to share this experience and those in his upcoming book about the Vietnam War.

D-HH in the World

New London's Stop the Bleed Program

Stop the Bleed is a national awareness campaign and a call to action launched in 2015 by the American College of Surgeons. The program trains community members how to help in a bleeding emergency prior to the arrival of professional help. A person who is bleeding can die from blood loss within five minutes. Stopping the bleeding is critical for chances of survival.

Often when people think about serious injuries resulting in critical bleeding, mass shootings are the first events that come to mind.

"While mass shootings certainly raise awareness for the need to train citizens, critical bleeding injuries are much more common than people are aware," says Pamela Drewniak, EMS and emergency preparedness coordinator at New London Hospital. "From traffic accidents, such as the motorcycle accident we saw in Randolph, NH, recently, to yard injuries involving various equipment, being prepared if such an incident happens can save a life."

In May 2018, New London joined several other organizations nationwide providing training sessions in their communities on Stop the Bleed Day. In 2019, New London EMS hosted six Stop the Bleed training sessions in the month of May in the Lake Sunapee Region, which included the towns of Danbury, Wilmot, New London and Sunapee.

Stop the Bleed is now one of the nation's largest public health campaigns. Jason Warn, paramedic at New London, is the New Hampshire State Coordinator for National Stop the Bleed Month. "One of the leading causes of preventable death in traumatic injury is unmitigated bleeding. Every individual trained becomes educated and empowered to act in someone else's time of need when precious seconds count," says Warn. "The feedback from class participants has been incredibly positive. The common theme is the sense of self-confidence in mindset and skill set among students when they complete class. Another sentiment echoed many times is that this education and training should be held in every school, in every town, to every citizen. And that Public Access Bleeding Control Kits should be placed in every public space next to any AED station. I hope to see these ideas become a reality in the near future."

For more information about Stop the Bleed, visit www.bleedingcontrol.org or contact Pamela Drewniak, EMS and emergency preparedness coordinator at New London, at (603) 526-5501 or Pamela.Drewniak@newlondonhospital.org.

Pride at New London and Beyond

At the beginning of 2019, New London Hospital launched a new committee called the Inclusive Care Environment-Team (ICE-T). The focus of ICE-T is to improve the patient, family, staff and community experience as it pertains to gender variance and sexual diversity.

"The mission of ICE-T is to provide safe, quality care that assures a valuable patient experience for every patient, every time, in partnership with patients, families and health care providers. The way we have chosen to start is by increasing knowledge and education to our staff. Our future goal is to make improvements where we can with documents and technology systems, and to keep us aware of improvements that are still needed," says Nicole Alves, manager of Service Excellence at New London. "We want to make sure we continue to improve and address as many concerns or issues when it comes to inclusive care."

In June, New London celebrated their own day of PRIDE, supporting their LGBTQ (lesbian, gay, bisexual, transgender and queer) families, staff and community. ICE-T staffed a table outside Breezes Café in the hospital with LGBTQ brochures and supportive collectibles. Group photos were taken throughout the day and posted to social media.

"I always feel tremendous pride to be an employee here at New London," said Marcia Goulart, New London recruiter. "I am passionate about being part of our ICE-T and taking positive steps in showing support for our community and staff."

CGP Collaboration Produces Camaraderie, Organizational Efficiencies

Bring together the senior practice managers, practice managers, directors of division operations and project managers from each of the D-H Community Group Practices in Concord, Manchester and Nashua. Add some special guests from Pharmacy, the Accountable Care Organization (ACO) or the Patient Service Center. Sprinkle in some idea sharing, brainstorming and a little bit of candy for good measure. The result? A highly successful model for collaboration called the D-H Regional Primary Care Operations Team.

Impactful value

Megan Todd, director of Operations, manages the monthly team meetings held at Bedford Farms. She sets the agenda with topics relevant to primary care practices, and invites guests to share information relative to the CGP that may be disseminated through team members at their respective practices.

"The team provides the opportunity to discover what everyone is working on, share successful organizational metrics, strategically solve challenges and bring uniformity to operations when possible," Todd explains. "This forum is also a safe place for people to get to know each other, making it easier to pick up the phone more readily with questions between meetings."

Mary Beth Fauteux is the senior practice manager at D-H Nashua Primary Care. She highly values the team meetings for the exchange of ideas and best practices. "We collaborate to standardize policies, procedures and workflows so Patient Service Center (the Primary Care Call Center in the CGP) operations are more seamless," she says. "We also support each other with advice to improve efficiencies across the CGP."

She notes the example of when the CGP divisions were considering changing provider schedules, and some were already experienced offering 25-minute patient visits versus 15-or 30-minute ones. Team members shared their expertise and discussed the pros and cons of alternative scheduling ideas.

Effecting positive change

Navigating challenges is a regular team accomplishment. For instance, the team tackled a significant staffing need related to Coumadin (an anticoagulation medication) management at one of the divisions. The other divisions loaned training assistance and staff coverage to alleviate the issue until permanent staffing was secured.

At one time, the Emmi automated patient outreach system (provides patient engagement programs and outreach tools) was underutilized. Team members with experience using the tool shared its benefits, and strategized how to improve consistent adoption at each division—resulting in the initiation of flu shot reminder phone calls to patients CGP-wide, along with reminder calls for cancer screenings and diabetes management.

Members of the Patient Service Center visit the team meetings regularly to ensure the call center receives clear direction regarding scheduling, messages and prescription requests across the CGP. Pharmacy team members attend every other month, as do ACO staff.

"The meetings provide a forum for us to provide updates on each of our key areas: Hierarchical Condition Categories (HCC) coding, quality (improving quality scores), patient data coordination and transitional care management," reports Nikki Crean, Manager, ACO Ambulatory Care Coordination. "A lot of standardization begins at these meetings, where we can discuss changes with the leadership team, and they can provide feedback. The work of the ACO is centralized across the organization, but our success is dependent on regular engagement with the primary care divisions."

To learn more about the D-H Regional Primary Care Operations Team, contact Megan Todd at megan.o.todd@hitchcock.org.

Telehealth Expands Health Care in Rural Areas

Providing patients access to care in rural or understaffed areas of New Hampshire and Vermont can be challenging, but D-HH's commitment to telehealth services is helping to address that challenge. Telehealth services are improving patient access and outcomes, while keeping patient care local. Mary Oseid, vice president of Regional and System Integration, and Kevin Curtis, MD, MS, medical director of Connected Care, are working in partnership to lead D-HH's telehealth services. *D-HH Connections* spoke with them about telehealth and the impact it is having on the future of health care.

What is telehealth?

Oseid: Telehealth is a group of services where a clinician is providing clinical care to a patient in a remote location, either through video, text, voice or email. This can be very simple or very complex, from iPads on a stand, to computer carts, to the more complex system in TeleICU, where every bed in a remote location is wired to provide both video and monitoring capability.

Curtis: There are varying opinions about the difference between telehealth and telemedicine. In my mind, telemedicine is a live, interactive audio visual interaction that includes elements of consultation, diagnosis and/or care over a secure platform. Telehealth is that and more, and can include remote patient monitoring, store-and-forward image review and consultation, education such as Project ECHO (which links expert specialist teams at an academic hub with primary care clinicians in local communities), and mHealth smart phone and smart watch apps that can involve a clinician or be self-directed.

Can you provide an example of D-HH's telehealth services in action?

Oseid: In TeleED, if a patient is in crisis, the bedside team requests assistance by pressing a button, and a board-certified physician or nurse is connected remotely to provide consultation. This gives the bedside team an extra set of hands to do things like documenting for nurses or assigning tasks. It also provides an extra set of eyes. For example, with TeleICU, we are monitoring patients 24/7 and notifying the bedside team when needed. We can keep that patient in their local hospital, and it also helps hospitals address the rural health crisis, because patients can stay in their own community for care.

Curtis: For TeleNeurology, from the patient's standpoint, if you come into an Emergency Department with signs and symptoms that suggest a stroke, the local team can immediately bring a telehealth cart into the room and contact a tele-

neurologist. CT scan results can be sent to the neurologist for review, and the neurologist can be involved in the decision about whether to administer tPA (the clot busting medication used for some stroke patients). Because of this, we are seeing community hospitals that are using tele-neurologists to administer tPA at the same rate as stroke specialty centers.

How do patients react to telehealth services?

Oseid: Appointments go much like they do in person, except that they are handled remotely. Data shows that patients nationally are accepting of the concept and like remote care. Once they experience it, they want to do it more, because it is convenient and they have greater access to care.

Curtis: Telemedicine is at an exponential growth point. The technology has caught up and there is such a familiarity with things like FaceTime (a video product that allows people to talk face-to-face via computers or smartphones) that to mimic it now in the medical space is making sense to both patients and providers. As one example, at Cedarcrest Center in Keene, children with a variety of medical and developmental conditions visit with pediatric specialists via our TeleSpeciality service. Without telemedicine, a child at Cedarcrest has to take a long van ride up to DHMC, which is quite stressful for the child and takes two staff members away from the facility. TeleSpecialty also allows the clinicians to evaluate children in their normal environment. The Cedarcrest staff have been incredibly positive about the experience.

How is telehealth impacting the future of health care?

Oseid: I think we are increasingly going to see that there is growth in remote care. Patients will be expecting care in their homes and communities. There will be a continuum of care where you can see your doctor in a clinic, a hospital, in surgery or remotely on your phone or computer. This will continue to drive down costs and improve outcomes. Once people adopt it and accept it, it could become part of our standard of care.

Curtis: I believe telehealth will be such an integral part of achieving the right care for patients that it will no longer be thought of as unique. Patients will access optimal care independent of location, and it may outpace traditional care. We pay a lot of attention to how we are achieving the health outcomes that matter to patients, and how we can get the same outcomes at the same or lower cost.

How will it improve health care delivery to rural populations?

Oseid: First, I think telehealth allows patients to stay local and get their care closer to home. This improves outcomes. For example, stroke victims can get immediate care, and have a shorter hospital stay. It also helps support infrastructure for hospitals that have difficulty in recruiting doctors. So, telehealth keeps patients local, improves outcomes, drives down costs and improves access and convenience for patients.

Curtis: Fifty percent of the hospitals in northern New England are critical access hospitals. They provide truly outstanding care but tend to be smaller, rural and under-resourced. We partner with them in the telehealth space, and have our specialists bring their expertise to those communities enhancing the experience for patients, families and local clinicians.

What are the most important reasons for supporting and expanding telehealth services?

Oseid: Part of our D-HH Strategic Plan is our commitment to rural health. Telehealth absolutely supports that and is a big part of what we are accomplishing. We are also committed to improving access, and this is another way to provide patients with more convenient care and access. We are focused on workforce development, and this provides a mechanism to make the best use of our workforce. And as always, we are committed to improving quality, improving outcomes and reducing the time patients are in the hospital. This is really the underpinning of what we are trying to accomplish—getting patients the best care possible.

Curtis: Access and convenience are huge benefits. Telehealth also meets all three aspects of Triple Aim: of improving the quality of health care, enhancing the patient and family experience and reducing costs. Our approach is to focus on the

care first and the technology later. We first ask about what gaps in care delivery exist, then we identify which of those gaps telemedicine might help solve, we design the approach and then we wrap technology around it. If we are successful, patients are not even focused on the telehealth piece, they just see it as part of their care.

The System Pharmacy and Therapeutics Committee: Creating a Consistent Formulary

With thousands of FDA-approved medications available and more coming to market every year, how do clinicians keep track of those that are most effective, safe and cost efficient? How do they know what their hospital pharmacy stocks?

The answer to all those questions is the formulary, a Joint Commission-required listing of medications that meet all the requirements of being effective, safe, cost efficient and in stock for inpatient care.

Staci Hermann, chief pharmacy officer, and Michael Calderwood, MD, MPH, regional hospital epidemiologist, serve as co-chairs of the System Pharmacy and Therapeutics Committee. *D-HH Connections* talked with them to better understand this committee's efforts to create and maintain a D-HH formulary and the benefits it delivers.

Did D-HH have a formulary before the System Pharmacy and Therapeutics (P&T) Committee began its work?

Hermann: The Joint Commission and CMS (Centers for Medicare & Medicaid Services) require all hospitals to maintain a formulary, so there was a local formulary in each member location. In 2017, the committee was established to create and maintain a formulary that is consistent across all D-HH locations focusing initially on the inpatient space, and then spreading out to the clinic areas.

Who participates in committee work?

Hermann: Chief medical officers and chief nursing officers participate along with representatives from each pharmacy across the D-HH System. Each member location also has a hospital P&T committee that collaborates with the system P&T committee.

How do the hospital and system committees collaborate?

Calderwood: Hospitals and the medical center all have committees and working groups that offer specific expertise in areas like antimicrobials, pain medication and chemotherapy drugs. They are able to evaluate new therapies and make recommendations, as well as review policies and procedures for how inpatient therapies are used. That collective expertise benefits patients at every member location.

Once a medication or therapy has moved through one of those committees, a recommendation about its inclusion in the formulary goes to the system committee. Recommendations are often taken after discussion and a vote, but the system committee sometimes comes back with questions.

Hermann: Local sites can also bring issues back to the system committee. Once the system-wide committee has decided to include a medication in the formulary, member hospitals can choose to stock the medication(s) at their respective sites. This allows for flexibility at the site given the different patient population seen at each one. Nothing can be added to formulary at any site without first going through the system committee.

Can you give an example of the system formulary at work?

Calderwood: During a recent Hepatitis A outbreak, we had to quickly stock a vaccine as vaccination was recommended for all community members experiencing homelessness or using drugs. We had been using a vaccine in the outpatient space and were able to add it to the formulary for inpatient stocking across the system.

Why is system formulary consistency important?

Calderwood: The system formulary ensures that clinicians across all sites have access to the same information about drug efficacy, toxicity, safety and cost when making prescribing decisions.

Hermann: Patients often move across the D-HH system from the medical center to other sites or vice versa. The formulary helps ensure that medications and their uses are aligned across locations so that patients receive consistent care-no matter what facility they are receiving treatment at.