

Bartlett Regional Hospital

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Board Quality Committee January 13, 2021 Minutes

Called to order at 3:30 pm by Board Quality Committee Chair, Rosemary Hagevig

Board Members: Rosemary Hagevig (Chair), Kenny Solomon-Gross, Hal Geiger, Mark Johnson, Lindy Jones

Staff: Gail Moorehead, Director of Quality, Billy Gardner, COO, Kevin Benson, CFO, Dallas Hargrave, Director of HR, Deborah Koelsch, RN Clinical Quality Data Coordinator, Rebecca Embler, Quality Systems Analyst

Approval of the minutes – 11 18 2020 Quality Committee Meeting – *minutes approved as written.*

Old Business: No old business discussed.

New Business:

BOD Quality Dashboard

Deb Koelsch presented the Quality Scorecard measure results for Q4 2020.

- For Risk Management measures, Injurious Fall Rate was 2.15 (total of 4 falls, all in the minor category; 1 unexpected) and there were 0 Serious Safety Events and 1 Sentinel Event. For Readmission Rate measures, 30-day Hospital Pneumonia rate was 0%, 30-day Hospital Heart Failure Rate was 0%. 30-day Hospital-wide Readmission Rate was 8.5%, slightly increased from 7.8% in Q2 2020.
- For Core Measures, Severe Sepsis/Septic Shock was 60%, which changed from last reporting by +7% and is at the national average of 60%, and Screening for Metabolic Disorders was 88%, decreased from 100% in Q2 2020. Great job to Behavioral Health for this metric.
- Mr. Kendziorek asked for clarification on what the Screening for Metabolic Disorders metric is looking at, and Deb described that sometimes it's just hidden information; MHU has a great process for looking up that data. Dr. Jones also clarified that this metric is just individuals admitted to MHU, and are on anti-psychotics.
- Ms. Hagevig asked if we will see changes in scores now that BH is back up and running, but we don't expect to.
- Ms. Hagevig asked about Sepsis measure; how much control do we have over it; Ms. Koelsch described that the number of cases is usually low and there are many factors that can make this metric have a fallout.

Rebecca Embler presented the Patient Experience and HCAHPS results for Q4 2020.

- For Patient Experience results, scores for all service areas except Emergency Department were above benchmark for Q4 2020. It was noted that this is due to lower scores in two survey questions; *Doctor's concern to keep you informed* and *Nurses attention to your needs*.
- For HCAHPS results, it was noted all scores are below the previous period for Q4 2020. This was due to Q3 2020 being a 6-quarter high-point, as well as COVID impacts on quality of communication, and is expected to increase in the coming quarters.
- Mr. Solomon-Gross asked if we expect survey return rates to be higher because of COVID considerations, and it was noted that we are seeing higher return rates due to electronic surveys, and also may expect to be getting more feedback due to the frustrating nature of the COVID situation.

Risk Management Plan

- Ms. Moorehead presented on the updates to the Risk Management Plan. The Risk and Compliance roles were combined this year, and some other small grammatical changes were made. There were some changes to the way information is reported to the BOD. Quality and Risk are still highly collaborative. The Safety Assessment Code (SAC) Matrix was removed as a required tool. Risk reporting will now be included in Performance Improvement committee meetings.
- Ms. Hagevig asked how approval for these updates happen. Ms. Moorehead said that this will be approved at this BOD Committee meeting and any changes will be incorporated into the report before going to the BOD.
- Mr. Solomon-Gross asked to clarify if any of the changes are substantive other than the PIC reporting. Ms. Moorehead confirmed. Mr. Johnson asked for a motion to approve the plan as written, and motion was approved.

Infection Prevention Plan

- Minor grammatical changes and community risk assessment. Expressly called out that we are in a pandemic, and dealing with a novel strain, so objectives reflect that. Structure of the department is not changing, but staffing has changed with the addition of a full-time Employee Health nurse and part-time Program Specialist for data entry and auditing.
- The Juneau community demographics haven't changed a lot; some decline in overall population, and some growth in the senior age group. Ms. Gribbon noted that the plan did not include employee travel considerations in previous years, and that has now been added.
- The Bartlett workforce size had increased since last year to 743 employees, of which 611 are full or part time and working on campus. This is the population that needs to be screened for vaccination and other diseases.
- 2021 Infection Control Plan Goals: 1) Improve compliance with CDC hand hygiene guidelines, 2) Reduce surgical site infections by reducing risk of infection, 3) Decrease risk of acquiring health care associated C diff, 4) Prepare for a protect staff, patients and community from influenza exposure at Bartlett, 5) Maintain established COVID

prevention policies, 6) Reduce the risk of HAI transmission risk attributable to surface contamination.

- New to the plan this year is Water Management-related risk.
- Mr. Geiger asked about goal to not have any hospital-acquired COVID in 2021; Ms. Gribbon clarified that this is any new illness, not a patient admitted with COVID. We have had staff acquire COVID.

Environment of Care Management Plan

Deferred to March

Patient Safety and Quality Improvement Plan

- Ms. Moorehead noted that the 2020 Patient Safety Plan was reviewed and no changes were made because all components are still applicable. For the evaluation of 2020 Plan, it was noted that there were a few accomplishments; re-establishing the Patient Safety Committee with a focus on targeted taskforces (Restraints, Falls, Inpatient Glycemic Controls), improving Press Ganey patient surveys to try to hone-in on the feedback we are getting from patients and implement improvements based on that, utilizing Smartsheet to make data more accessible and collaborative; and working to create successful metrics with ASHNA on Partnership for Patients.
- 2020 Goals include: 1) Demonstrate Antimicrobial Stewardship leadership within Juneau community, 2) Incorporate cross-sectional Patient Safety committee to review and assure Corrective Action plans are met and sustainable, 3) Improve Bartlett's Culture of Safety, 4) Improve compliance with Sepsis core measure
- 2021 Goals include: 1) Develop Performance Improvement onboarding methodology for all new management team members in order to enable them to identify PI opportunities, 2) Reduce Inpatient Fall rates via cross-departmental taskforce, 3) Update Provider review process, specifically around metrics and accessibility to data, 4) Maintain Sepsis core measure compliance at National Average.
- Mr. Solomon-Gross asked for clarification on Antimicrobial Stewardship, and it was noted that our pharmacy looks at all antibiotics that are used in our hospital to make sure we are using the right type and dosage for the infection we're trying to treat. Dr. Jones added that this is mostly for 24-hour pharmacy, and it's a great program we're doing at Bartlett to make sure we're not overprescribing antibiotics.
- Mr. Solomon-Gross asked about what types of falls are included in our metric, and it was noted that all falls are included, even if at Physical Therapy, but the ones we focus on are the anticipated falls, based on patient condition, medication, etc. Some of the unanticipated falls are behavioral and that is why we have 1:1 sitters.

Note: Will defer to send Annual Plan packet to the BOD until March meeting, after Environment of Care Management Plan is presented to this committee.

Adjourned at 4:40 pm

Next Quality Board meeting: March 10, 2021 @ 3:30pm