

Bartlett Regional Hospital

Board Quality Committee

October 24, 2022

1:00 p.m.

This virtual meeting is open to the public and may be accessed via the following link:

<https://bartlethospital.zoom.us/j/93135229557>

Agenda

Mission Statement

Bartlett Regional Hospital provides its community with quality, patient-centered care in a sustainable manner.

Call to order

[Approval of the minutes](#) – July 13, 2022

pg. 2

New Business:

Departmental Annual Quality Assurance/Process Improvement Reports:

1. [Critical Care](#)
2. [Respiratory Therapy](#)
3. [Laboratory](#)

A. Rasmussen
N. Fenumiai
C. Habig

pg. 5
pg. 12
pg. 19

Strategic Plan Initiative Report

- 3.1 [Resolve electronic Medical Record Concerns](#)

S. Norton

pg. 26

Standing Agenda Items:

- [2022 BOD Quality Dashboard](#)

G. Moorehead/D. Koelsch pg. 33

Next Scheduled Meeting: TBD

Board Quality Strategic Plan Initiative Oversight Summary

People:

- 3.1 Resolve electronic medical record concerns
- 3.2 Expand workforce development programs

Quality and Safety:

- 5.1 Stay current on technology and resources to facilitate risk management, data security, employee safety
- 5.2 Develop quality initiatives that exceed accreditation and regulatory requirements

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

Board Quality Committee July 13, 2022 Minutes

Called to order at 3:30 p.m. by Hal Geiger

Patient safety results will be postponed to September.

Mr. Geiger introduced Lisa Peterson as a new member of the committee. Lisa is an RN with over 30 years of experience. She is the lead nurse for the Juneau School District.

Board Members: *Hal Geiger**, *Kenny Solomon Gross**, *Lisa Peterson**, *Lindy Jones**, *Mark Johnson**

Staff: Gail Moorehead, Autumn Muse, Miranda Dumont, Jerel Humphrey, Charlee Gribbon, Sara Dodd, Latrice Hay, Evan Price, Jenny Twito, Lauren Beason, Audrey Rasmussen, Erin Hardin, Jerel Humphrey, Kim McDowell, Tracy Dompeling, Dallas Hargrave

Guests: none

Kenny Solomon Gross made a MOTION to approve the minutes from May 11, 2022 Board Quality Meeting. Mark Johnson seconded, minutes are approved.

Old Business: None

New Business:

Voice of Patient

A. Muse

Ms. Muse shared patient experience and feedback from a letter we received from a patient. She explained what Bartlett is doing to improve our processes and thinking of the patient's perspective. She shared multiple positive patient comments from our Press Ganey surveys. Ms. Moorehead explained that the Voice of the Patient will be a standing agenda item. Mr. Johnson thanked Ms. Moorehead for this. Mr. Solomon Gross said that he liked that Ms. Muse wasn't asking for solutions from the Board Members, but that she wanted to bring the information to them. Mr. Geiger agreed.

Fireweed Recognition
L. Beason

R. Rasmussen, E. Hardin,

Ms. Rasmussen, Ms., Beason, and Ms. Hardin introduced themselves. Ms. Rasmussen explained the background for the benefits of meaningful recognition. She explained that employees find peer and patient and family recognition means more than from managers. Ms. Rasmussen described the award and how it is targeted at the entire hospital, not just the nurses. She named the members of the group that are putting this award together.

Ms. Beason explained the award will be given out quarterly. She explained how someone is nominated and chosen for the award. The winners will be chosen by random drawing in two categories; peer nomination and community nomination. She described what the winners will receive: A baked good, a celebration, a pin, a gift card from the Bartlett Foundation, and a designated parking spot for the quarter. Everyone who is nominated will receive a card letting them know they were nominated. Ms. Beason thanked the Bartlett Foundation for their generous gift cards.

Ms. McDowell thanked the committee and how quickly they had this come to fruition. Mr. Johnson says this sounds great. Ms. Moorehead added that any community member who nominated a winner will be invited to give the award. Ms. Peterson says she liked how inclusive this is.

QAPI Reports:

1. Physician Services

S. Dodd, L. Hay

Ms. Hay introduced the Physician Services Process Improvement project. The project is designed around the Ophthalmology clinic. She gave background information about the Ophthalmology clinic and how it runs. The providers are only here 4 days a month and the project is how the scheduling case log can be optimized.

BRH went from having 4 providers serving Juneau, to one. This gives continuity of care and lets staff learn the process of this physician. She explained what the group did to increase patient visits without decreasing the quality of care. Patients, staff and providers were very happy with the changes. Go live was in June, and everyone had increased satisfaction. The project has been successful and Ms. Hay believes this improvement is sustainable. The scheduling model will continue and they will continue to gather data.

Mr. Johnson asked how reducing the provider numbers came about. Ms. Hay explained that continuity of care would be better achieved with one provider. Mr. Johnson asked if this will continue indefinitely. Mr. Solomon Gross asked if it has been determined how many days our town can sustain giving this service. Ms. Hay shared there is a long waiting list for cataract surgeries. Ms. Dodd said that they have been approved to recruit a full-time ophthalmologist.

Standing Agenda Items:

- **Hand Hygiene Project Overview**

C. Gribbon

Ms. Gribbon presented the current data on Hand Hygiene. We have not increased data collection to her standards. She does not have dedicated staff to collect this information. She explained what she is doing to remind staff to wash their hands. She has trained a few staff members to collect this data.

- **2022 BOD Quality Dashboard**

D. Koelsch

.Ms. Moorehead presented the Quality Dashboard. The Dashboard has some updates given the feedback that was given during past meetings. Mr. Geiger asked for clarification on the Sepsis graphic. Ms. Peterson asked if these are patients who are admitted with sepsis, or people who develop it while in the hospital. It is both. Our fall rate with injury is below 5%. Mr. Solomon Gross asked for clarification on the graph. Mr. Solomon Gross noted that we are below that goal. Gail explained the Readmissions graphic. We are below the CMS national rate but we are still trying to improve our rate.

Strategic Plan:

Mr. Solomon Gross noted that Dr. Jones volunteered himself and the committee to work with staff on the EMR.

Dr. Jones moved that the meeting be adjourned.

Adjournment: 4:38 p.m.

The next Quality Board meeting date will be set by correspondence.

Healthy Work Environment

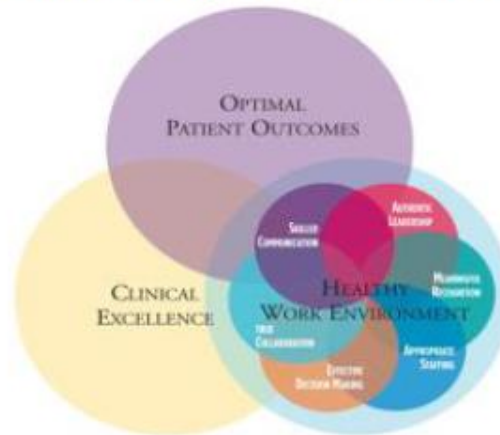
Critical Care Unit

Improvement Goal

- ▶ We are working to enhance the work environment in CCU.
- ▶ We chose this project because it is one of AACN's (American Association of Critical Care Nurses) standards and will help with staff retention and improve patient outcomes.
- ▶ AIM Statement: **CCU will score excellent (4-5) in all six standards of AACN's Healthy Work Environment by February 2024.**

AACN Healthy Work Environment Standards

- Skilled communication
- True collaboration
- Effective decision making
- Appropriate staffing
- Meaningful recognition
- Authentic leadership



Establishing Measures

- ▶ HWE assessment completed in CCU in Feb 2022
- ▶ Overall score 3.91
 - 1-2.99 needs improvement
 - 3-3.99 Good
 - 4-5 excellent

BRH CCU score vs National results 10/21

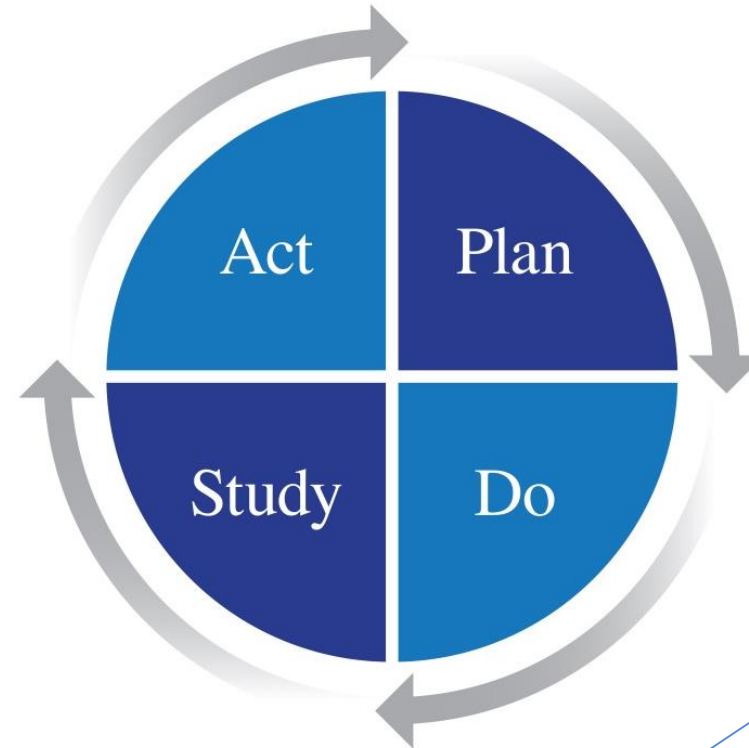
- Skilled Communication 3.96 vs 2.84
- True Collaboration 3.71 vs 2.80
- Effective Decision Making 3.98 vs 2.44
- Appropriate Staffing 4.02 vs 2.33
- Meaningful Recognition 3.69 vs 2.81
- Authentic Leadership 4.11 vs 2.48

Selecting Changes

- ▶ Lowest score was in Meaningful Recognition (3.69).
- ▶ Lowest individual item score was if there is a formal reward and recognition system to make sure nurses and other staff feel values (score 3.27)
- ▶ Skilled Communication scored 3.96, however issues have arisen between communication with other departments.

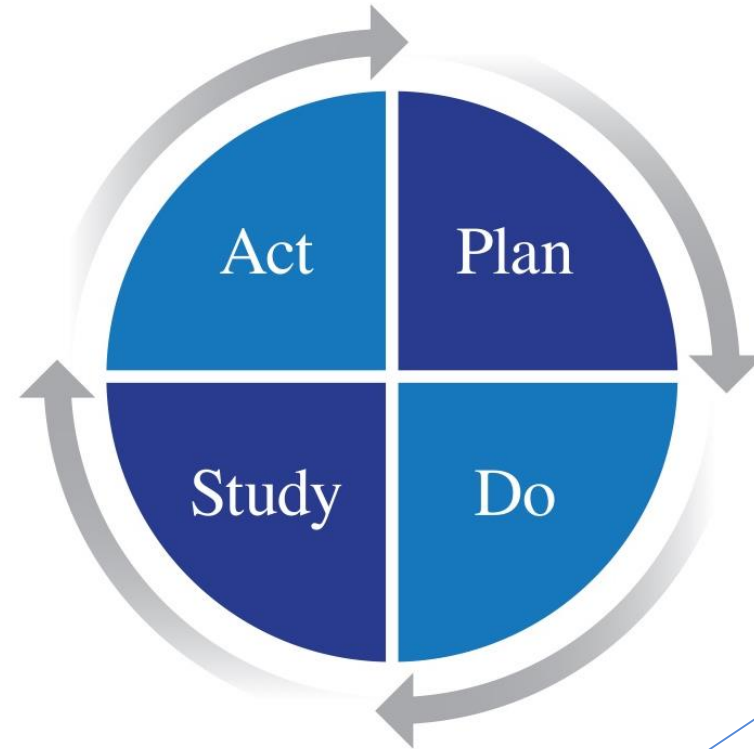
Testing Changes Meaningful Recognition

- ▶ **Plan:** Worked with other department leaders and CCO to create Fireweed Award, a formal recognition program that allows patients and family to recognize staff.
- ▶ **Do:** Opened nominations for Fireweed Award in July. First group of employees honored in October. 71 nominations obtained. Excellent feedback from staff.
- ▶ **Study:** Re-evaluate HWE in CCU by completing assessment in Feb 2023
- ▶ **Act:** Work with SLT and department directors to implement changes based on AACN recommendations.



Testing Changes Skilled Communication

- ▶ **Plan:** Look at Communication training available. Discuss with staff communication workflow ideas
- ▶ **Do:** Ensure all staff had TEAM/ STEPPS training. Reviewed Critical Conversations topic at staff meeting June. Implemented different strategies for communication with HS.
- ▶ **Study:** Reassess work environment by sending out survey in Feb 2023. Watch for communication issues
- ▶ **Act:** Work with other departments following AACN guidelines



Project Summary

- ▶ What were the outcomes of the project? Implemented Fireweed Award
- ▶ Did you achieve the project goals? Partly, still awaiting reassessment results
- ▶ What were the main lessons learned? Overall, we have pretty healthy work environment
- ▶ Are the improvements or changes sustainable? Yes
- ▶ How will you or have you implemented/spread the identified improvements?
- ▶ What are your next best steps? Work on True Collaboration standard

Cardiac and Pulmonary Rehabilitation Quality Improvement Project

RT

Improvement Goal

- ▶ We are working to improve department performance thus improving care for Cardiac and Pulmonary Rehabilitation Patients in our community.
- ▶ We chose this project because: We expect it to improve patient outcomes and quality of life. As evidenced by the research published by American Association of Cardiovascular and Pulmonary Rehabilitation which shows Cardiac and Pulmonary rehabilitation Programs reduce morbidity, mortality and disability from cardiovascular and pulmonary disease through education, prevention, rehabilitation, research and disease management. These programs have a strong potential for improvement in quality of life for patients and their families. Patient participation is key to improving outcomes.
- ▶ AIM Statement: Our goal is to have increased patient visits for Cardiac and Pulmonary Rehab patients in our community by 50% by September of 2022. And to have patients that begin the program graduate or attend at least 6 sessions increased by 30% by October 1st 2022.

Data Collection

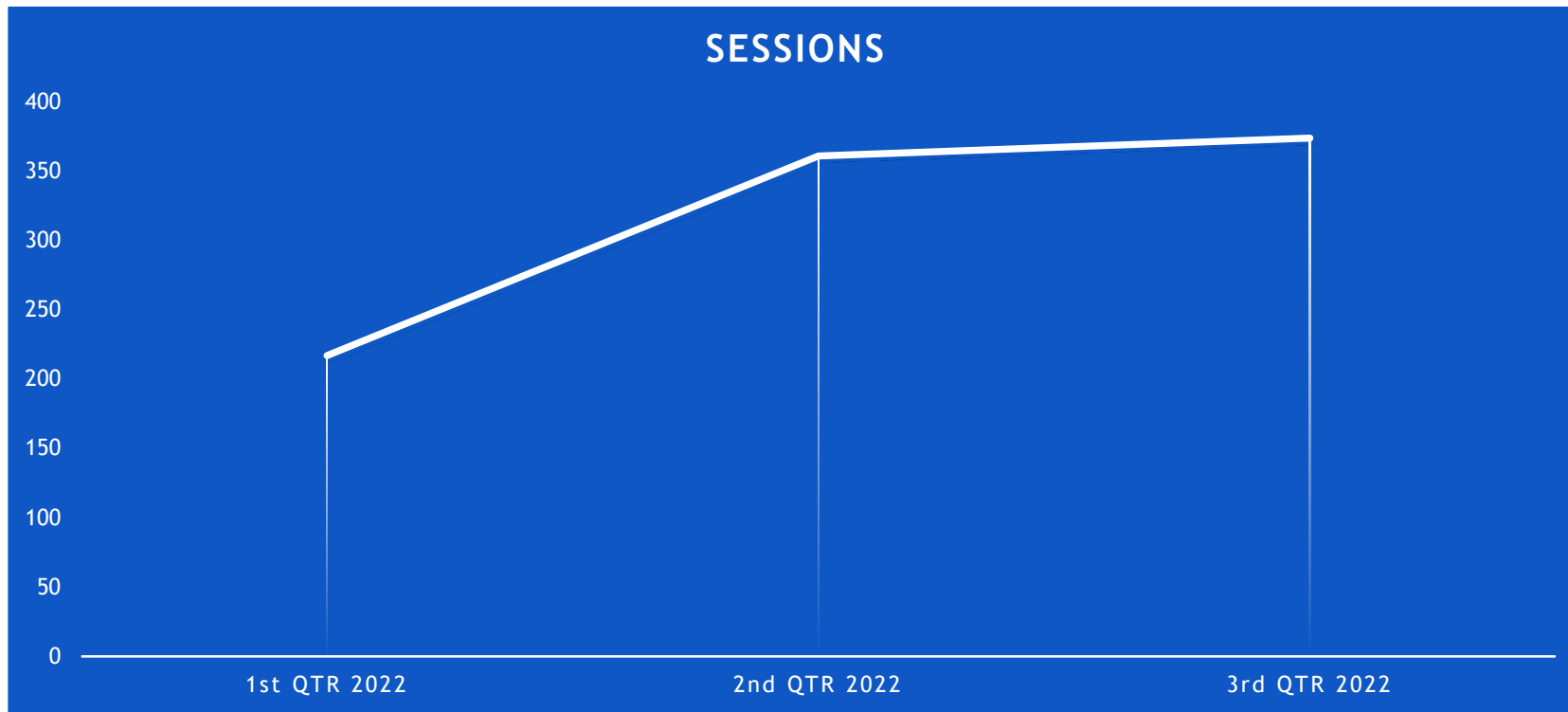
- ▶ **Baseline:** Cardiac Rehab phase II and Pulmonary Rehab patient visits to the program in the first quarter of 2020: 217. This is the best quarter on record from Q4 2019 to Q1 2022. And Cardiac Rehab phase II and Pulmonary Rehab patients that had 6 or more visits to the program in 2021 vs those that had at least one visit: 7 vs 16 or 44%.
- ▶ **Data collection method and frequency:** Number of Cardiac Phase II and Pulmonary Rehab patient visits, per month. And Number of Cardiac Phase II and Pulmonary Rehab patients in the first 9 months of 2022 that had at least one visit vs those that had 6 or more visits.
- ▶ **Scope:** All Cardiac Rehab Phase II and Pulmonary Rehab Patients that qualify for the program per CMS guidelines.
- ▶ **Validity:** Registration records by month of Cardiac and Pulmonary rehab patients. Pre pandemic data analyzed and COVID related impacts ruled out as a primary factor.

Changes Made

- ▶ New Director takes the helm with a vision for increased growth in this department and increasing services to the community.
- ▶ Director begins to align Cardiac & Pulmonary Rehab Coordinator to new vision for the department and community.
- ▶ Cardiac & Pulmonary Rehab Coordinator Resigns.
- ▶ Recruitment begins while department is closed due to staffing.
- ▶ Recruitment focused on bringing in the right person with the right skillsets and attributes that align with the vision.
- ▶ New Cardiac & Pulmonary Rehab Coordinator hired.
- ▶ Director and new Coordinator develop and execute shared vision.

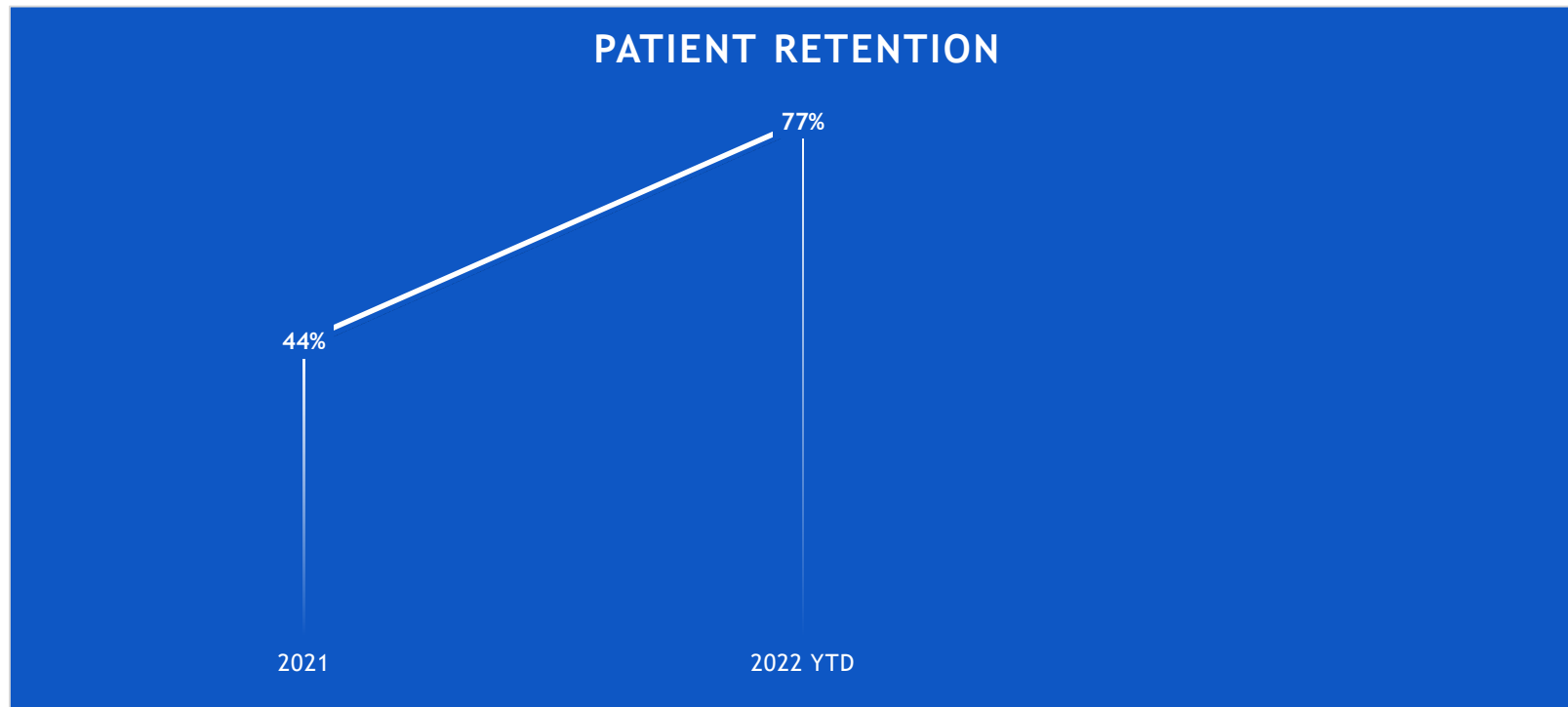
Project Summary

- ▶ Cardiac and Pulmonary Rehab visits for 2nd QTR 2022 361 visits, 3rd QTR 2022 374 This is a 66% & 72% increase respectively.



Project Summary

- ▶ Cardiac and Pulmonary Rehab patients that had at least one visit for first 9 months of 2022 (45) vs patients that had 6 or more visits (35) or 77% . This is a 33% increase.



Project Summary

- ▶ New Coordinator Jedd Beros EP-C.
- ▶ FTE's reduced by 50%
- ▶ Continue to refine program to help patients meet goals in a more efficient manner.
- ▶ Assess cyclical patient patterns (snowbirds, summer) etc.
- ▶ Continue to train float nurses to ensure program coverage.

Method change to in house direct antiglobulin test (DAT)

Laboratory

Improvement Goal

- ▶ We are working to improve in house direct antiglobulin test (DAT)
- ▶ We chose this project because in 2021 approximately 60% of cord blood DATs had to be rejected or recollected.
- ▶ **AIM statement:** The laboratory aims to reduce cord blood specimen rejection to 0% for the in-house direct antiglobulin test (DAT) by June 2022.

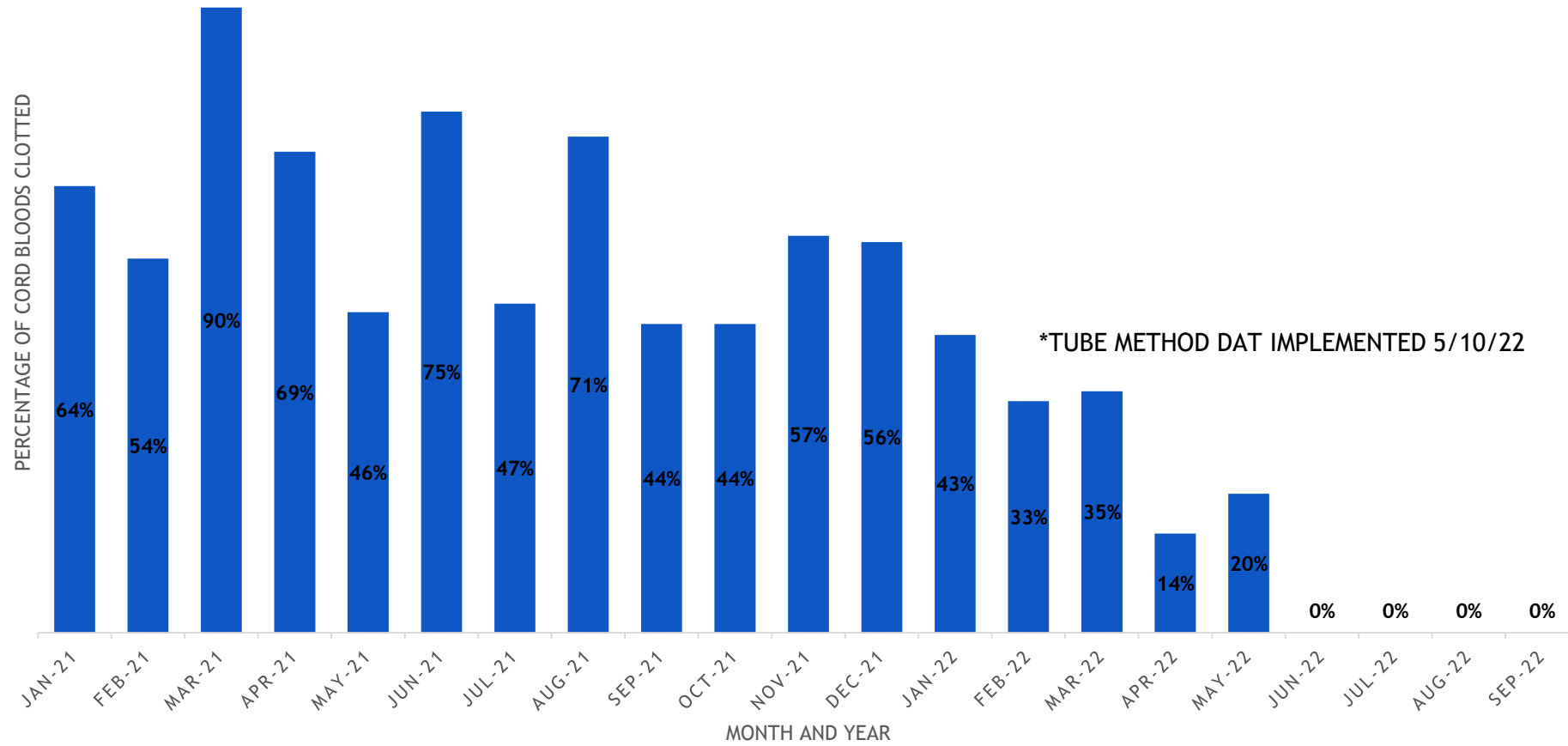
Project Summary

- ▶ DAT common blood banking test.
- ▶ Cord blood is collected after birth and tested from certain mothers to monitor the baby for hemolytic disease of the newborn (HDN)
- ▶ Previous method had to be rejected if they were clotted.
 - ▶ Potential false positive results with a clotted specimen.
 - ▶ Clotted specimens primarily came from cord blood samples.
- ▶ If the specimens were clotted the baby had to have a new sample drawn (heel stick) or monitored for HDN by other methods.
- ▶ With the new method results are not affected by a clotted sample.

Project Summary

- ▶ A new cell washer needed to be purchased and validated.
- ▶ More complex testing came with the new method.
- ▶ The new method was validated and implemented on 5/10/22.
- ▶ Under the new method no samples need to be rejected because of clotting.
 - ▶ There is no risk of false positive results because of clotting.

PERCENTAGE OF CLOTTED CORD BLOODS



Conclusions

- ▶ Project was successful.
- ▶ The cell washer brought the blood bank lab more up to date.
- ▶ More complex DAT testing offered to providers
 - ▶ Can differentiate positive DAT due IgG or Complement
- ▶ Newborns have no unnecessary repeat testing and can have their DAT done with the cord blood.

Thank you!

Contributing lab staff: Llyod Pontines, Blood Band Supervisor
John Fortin, Laboratory Director
Cassidy Habig, QA Analyst

Information Technology Update of IT Goals

October 2022

Sam Norton, IT Director (interim)

Strategic Initiative 3.1

Resolve electronic medical record system concerns

IT Goal - Improve performance of Meditech Expanse for BRH

Action Items -

- Postpone Expanse version 2.2 update (previously set for Oct 22'-Mar 23'), allowing time to thoroughly review and improve the current EMR (2.1).
- Assess Expanse technically, functionally and from a “usage” perspective and develop specific optimization and improvement objectives.
- Develop specific improvement objectives based on assessment
- In cooperation with IT Governance, prioritize and implement improvements in patient care as well as revenue cycle applications

Strategic Initiative 3.1

Resolve electronic medical record system concerns

IT Goal - Improve EMR integration, including Emergency Department

Action Items -

- In collaboration with Medical Staff, review and recommend replacement of T-Systems with an integrated Meditech Emergency Module helping ensure prompt and effective patient care communication and decision making.
- Review additional opportunities to gain more value from Meditech Expanse; the enterprise electronic health record
- Review existing connectivity and data exchange and recommend improvements for patient care transition locally and in the region

Strategic Initiative 3.1

Resolve electronic medical record system concerns

IT Goal - Engage Physicians more effectively in Expanse

Action Items -

- Establish IT governance, include (re)constituted Physician EHR Advisory Committee
- Review and improve computer training opportunities for providers
- Evaluate and update the end-user application support structure and process and make improvements
- Provide monthly updates to Medical Executive Committee on progress and seek feedback

Strategic Initiative 5.1

Stay current on technology and resources to facilitate risk management, data security, and employee safety

IT Goal - Update technologies and capacities to support current and planned initiatives as approved.

Action Items -

- Plan for and complete upgrades and expansion of storage, backup, processing and communications as needed.
- Revisit operational procedures to ensure maintenance occurs as needed to keep technology up-to-date and provide optimal performance.
- Review existing, and already available vendor product and service capabilities to enhance features and functions available to BRH.

Strategic Initiative 5.1

Stay current on technology and resources to facilitate risk management, data security, and employee safety

IT Goal - Prepare and execute IT Security plan

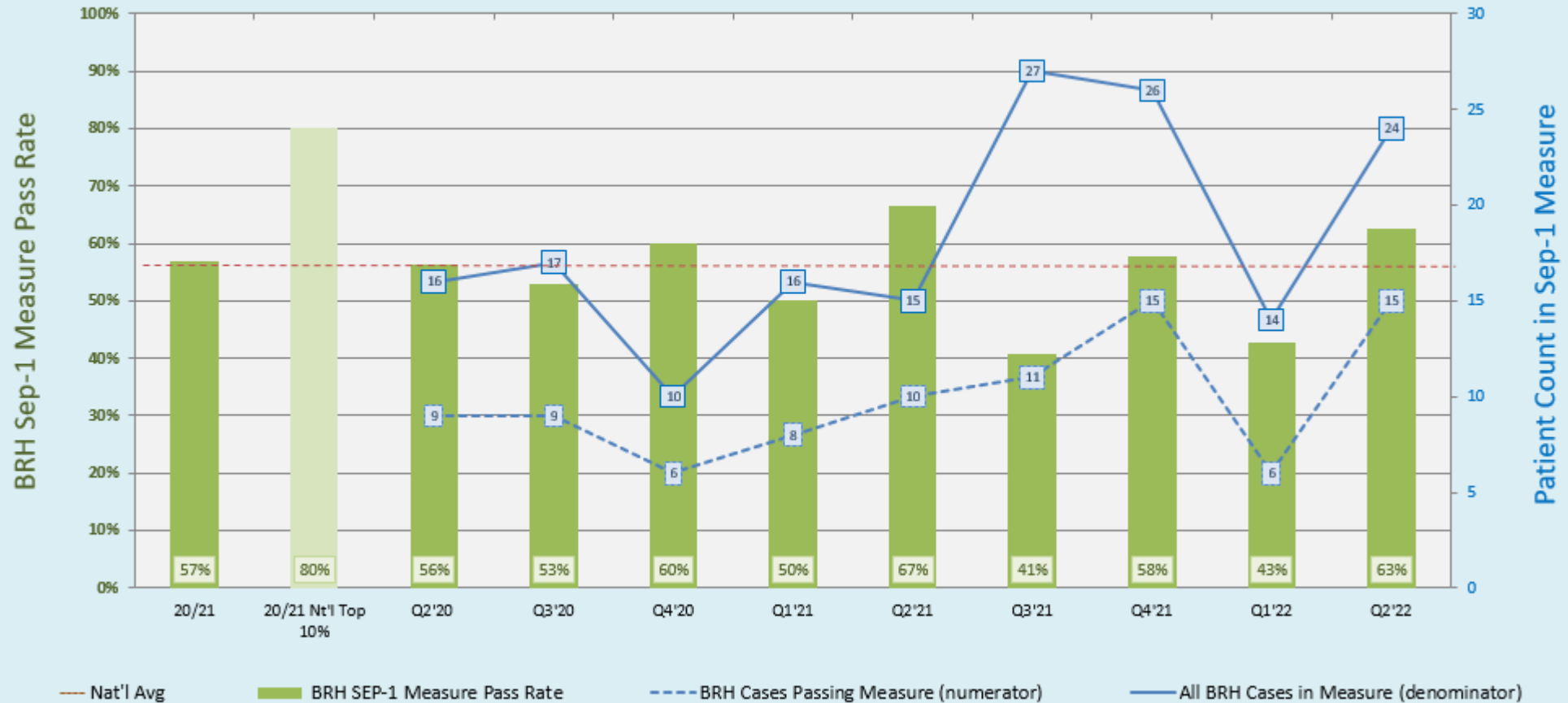
Action Items -

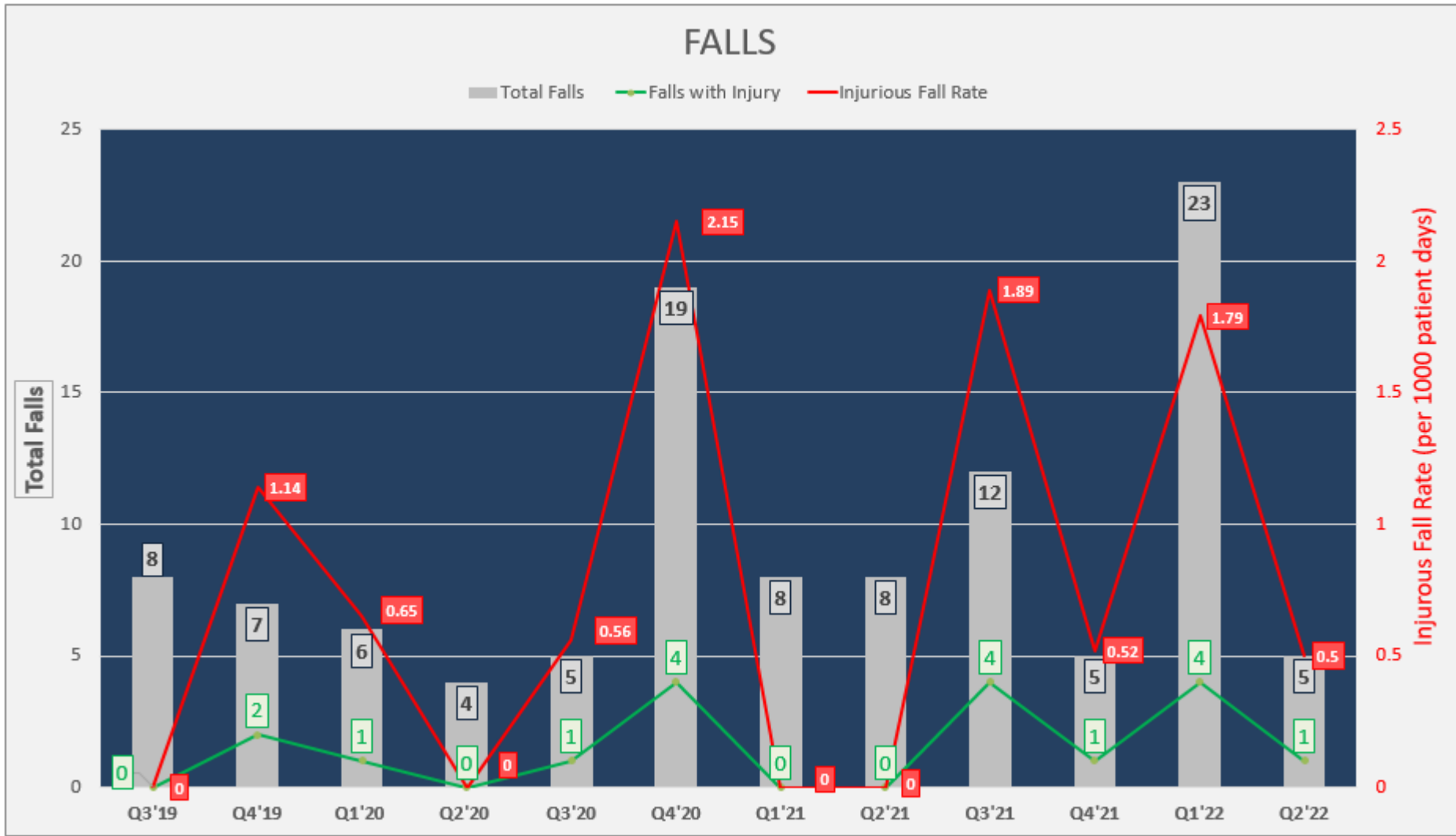
- Ensure device inventory and encryption is in place
- Based on recent 3rd-party risk assessment prepare plan for remediation of highest priority items and include risk of ransomware compromise. Implement approved additional protective measures.
- Review access control and provisioning processes and update as needed.
- Institute a more formal change control process.

Board Quality Dashboard

October 2022

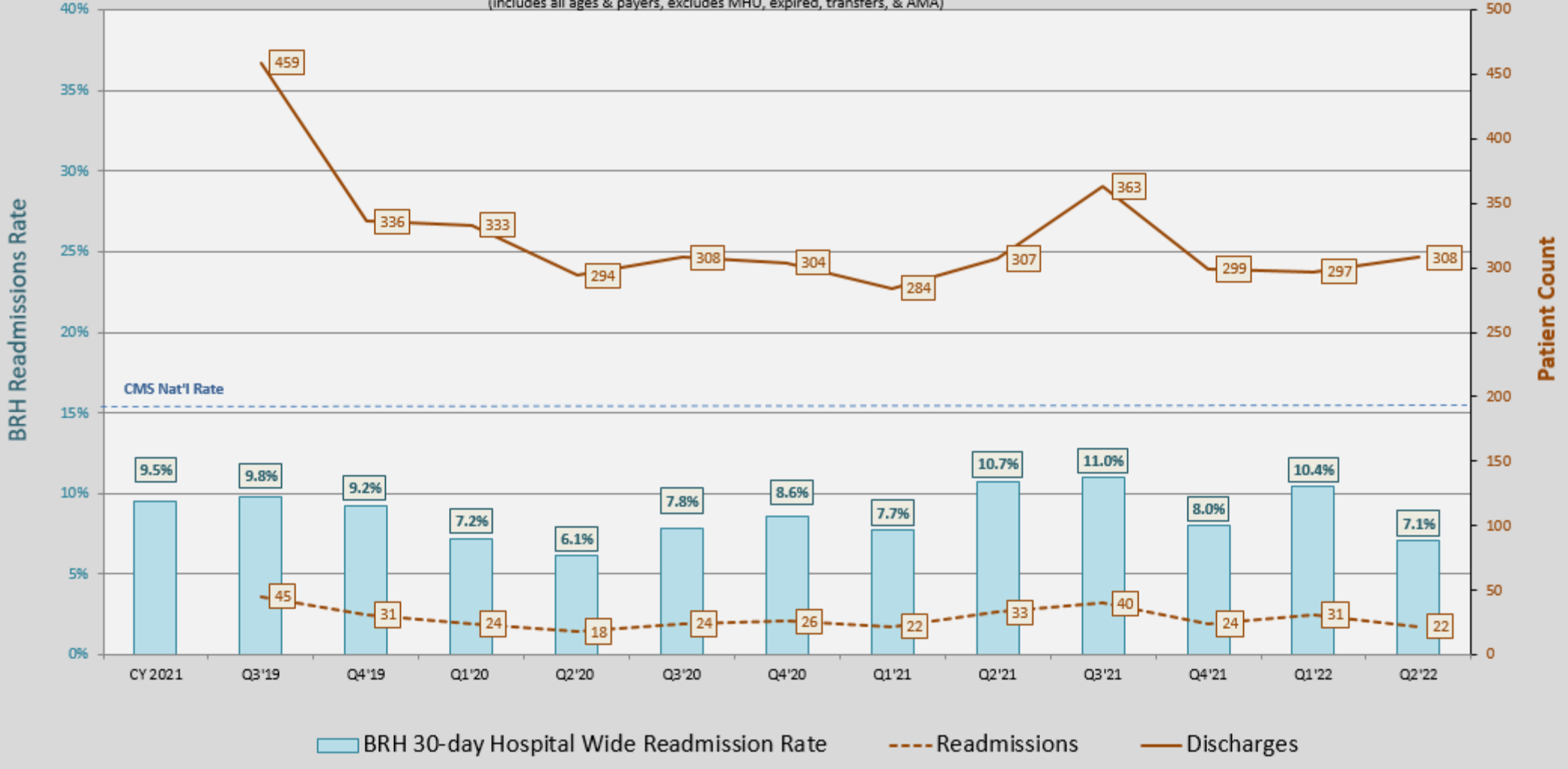
CMS Sep-1 Severe Sepsis Septic Shock Measure (includes BRH patients who met criteria for the Sep-1 measure)



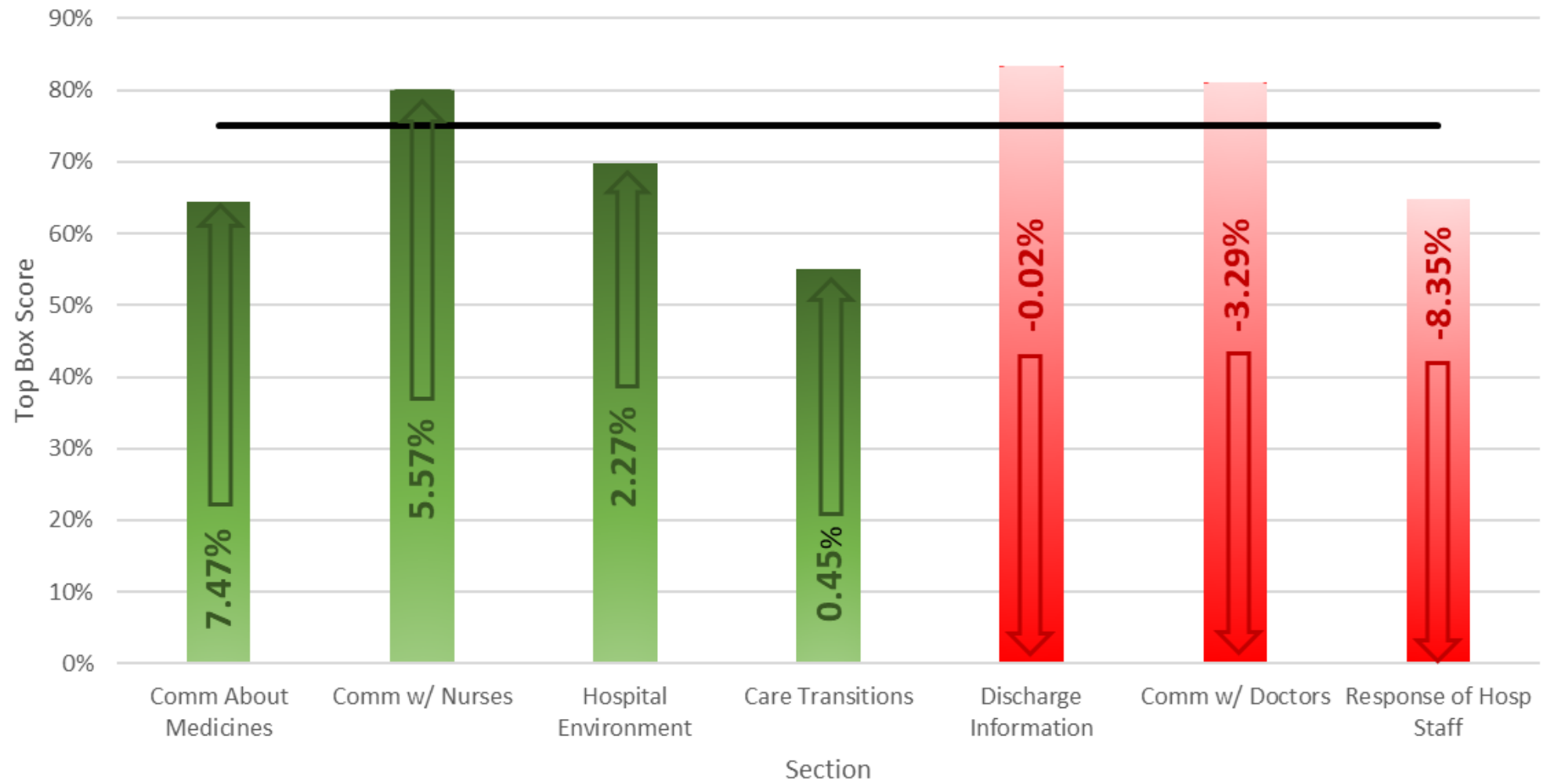


BRH 30-Day All-Cause Hospital-Wide Readmissions

(includes all ages & payers, excludes MHU, expired, transfers, & AMA)



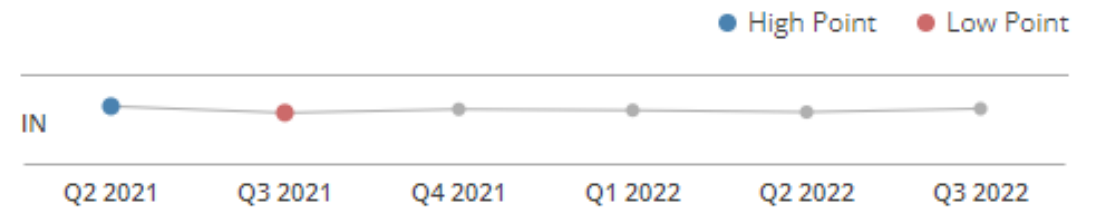
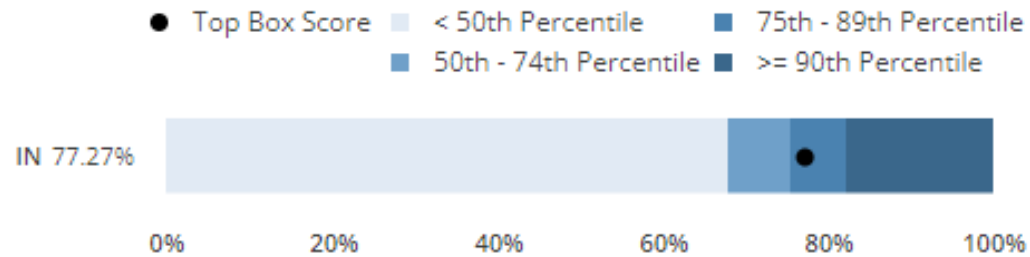
HCAHPS Section Performance



— Goal

Service Line Performance ⓘ

Primary Measure: CAHPS Likelihood to Recommend



Secondary Measure: PG Likelihood to Recommend

