Bartlett Regional Hospital

Board Quality Committee
July 14, 2021
3:30 p.m.
Agenda

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

ZOOM Link: https://bartletthospital.zoom.us/j/93135229557
Call in Number: 1-253-215-8782
Meeting ID #: 931 3522 9557
Join Zoom Meeting

I. Call to order

II. Approval of the minutes – May 12, 2021

III. Standing Agenda Items:

- 2021 BOD Quality Dashboard Q1 Update — Deb Koelsch

IV. New Business:

- Patient/Family Engagement Annual Update — Autumn Muse

V. Executive Session
  a. Sentinel Event Report — Autumn Muse
  b. Update on Employee Health and Safety Manager Role — Gail Moorehead

Next Scheduled Meeting:

Bartlett Regional Hospital

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

Board Quality Committee
May 12, 2021
Minutes

Called to order at 3:34 pm by Board Quality Committee Chair, Rosemary Hagevig

Board Members: Rosemary Hagevig* (Chair), Mark Johnson*

Staff: Kim McDowell, Chief Nursing Officer, Gail Moorehead, Quality Director, Dallas Hargrave, Director of Human Resources, Deb Koelsch, Clinical Quality Coordinator, Rebecca Embler, Quality Systems Analyst

Guests: Cindy Carte, Director of Human Resources

Approval of the minutes – 03 10 2021 Quality Committee Meeting – *minutes approved as written.*

Old Business: No old business discussed.

New Business:
New Employee Orientation (NEO)

- Cindy Carte presented on NEO process updates rolled out in March 2021; worked with Staff Development and Quality departments to get well-rounded approach; looked at old versions of the orientation, sent survey to new hires, and sent surveys to supervisors and managers to understand deficiencies and areas for improvement; did research on best practices across the industry and with recent changes due to COVID and other developments.
- Survey results
    - Positive: schedule, info provided, detail adequate, length of program adequate, presenters professional and knowledgeable.
    - Gaps: employees want the orientation schedule before getting to campus, want more information about what will be covered, want to understand what tools are needed and provided to be successful on the job, and requested a brief quiz/re-cap at end of orientation.
- In the new orientation structure, the schedule lasts a full week instead of 2 days; each day is a half day of orientation, so employees can spend the second half of the day on their unit; also added: a session at the end of the 2nd week to sit with payroll and understand corrections and updates to be made to timecards, sessions with current employees to talk about what they like about working at BRH, and a raffle at the end for extra fun, with the winner getting a BRH hoodie!

- This is a continuous process improvement, so it will be iterative.
- Also, have restructured the HR department to better accommodate current employees, and well as new employees through onboarding.
- Rosemary Hagevig asked how often NEO is held. The current schedule is a session every other Monday, but to optimize for managers, if a Monday falls on a holiday, the week that NEO is scheduled is adjusted.

BOD Quality Dashboard

- Deb Koelsch presented on Quality Dashboard Q1 2021.
    - Risk Management:
        - 0 falls with injury; 0 serious safety events; 0 sentinel events
    - Readmission Rates:
        - 0 cases for heart failure; 0 cases pneumonia
        - 30-day hospital readmission came down considerably compared to past quarters due to cases that are exclusions that were being included before; worked with BRH report writer and removed those cases; this is a more accurate representation of readmissions, so we can identify true process improvement opportunities
    - Core Measures:
        - Sepsis had 16 cases in total that met CMS criteria (total sepsis cases is probably about 30-40 per quarter), we passed 8; Deb attended PNW sepsis conference and heard from a steward for sepsis from CMS speaker, and took away many learnings; two changes: 1. Antibiotics use – once patient meets all criteria for sepsis/septic shock, physician must order any antibiotic that they choose, then we will pass the measure; 2. Fluids – as of Jul 1, 2021, physician just needs to document that fluids will be detrimental if patient has heart failure or renal failure; These are positive changes that will help us on this measure
        - Screening for Metabolic disorders; great job to team and Q2 looking good
- Rebecca Embler presented on Quality Dashboard Q1 2021.
    - Patient Experience metrics increased over Q4 2020 across all service lines. As a reminder, Press Ganey patient surveys are how we collect this data, and the data we show for this report is called “top-box”, which represents the percentage of survey responses that were marked as a “Very Good”, or 5/5, rating.
    - HCAHPS scores also increased against Q4 2020, except for in Discharge and Care Transitions sections. We have identified discharges as an area for improvement but understand it is a complex process that can vary from patient to patient according to their post-stay needs. As a reminder, HCAHPS questions are standard across all hospitals.
    - Response rates on the surveys are provided monthly, and we are higher than national average across all service lines except for Inpatient because there is no eSurvey for that service line. In February, ~3,000 surveys were sent out (mail, email, text) and we received back 520, for a response rate of 17%. This is great!

Patient Comments and Thank You Cards

- Rebecca Embler then presented on patient comments received from Press Ganey patient surveys and the Thank You card process. In Q1 2021, we received ~1,000 patient comments across all service lines. Press Ganey identifies when there is a specific care provider name called out in the comments, and we use that report to create customized Thank You cards for each employee who was recognized by the patient they served. There are a number of employees and teams who are named multiple times month after month, which shows they are going above and beyond in their patient care!
- The Thank You cards are printed with the patient comment included, and mailed to each staff member. There is opportunity here to do more for these employees! There were ~50 Thank You cards mailed in Q1.
- Mark Johnson asked how negative comments are handled. We review all comments received through Press Ganey and send any negative feedback to department directors, or contact the patient directly through the Quality department if there is a system-level issue identified. We also have in-house Patient Feedback forms that patients can fill out to provide either negative or positive feedback. If a patient expresses concern or provides feedback on social media or elsewhere, it is more difficult direct action to be taken.

Survey of Patient Safety

- Gail Moorehead presented on Survey of Patient Safety. Every two years, this is a standardized survey through AHRQ that is sent out to staff to collect feedback, then is sent in to compile and compare BRH to other hospitals nationally. We are past due since Fall 2020 due to COVID (last survey was completed in November 2018).
- Why measure Patient Safety culture and what is it? This is how we show patient safety as a part of our own values and collectively as Bartlett culture.
- Rosemary asked how this relates to our OSHA survey and observations. This survey is more of a high-level assessment of overall sentiment, versus actual safety status.
- Demographics of survey responses were 34% RNs and 40% 1-5 years span at BRH and also in current unit.
- Major changes since 2018: frequency of events reported (safety issue) increased; management promoting safety decreased; management support of safety overall as a hospital decreased; information regarding handoffs and transitions increased.
- Added an optional survey for Electronic Medical Record; the Meditech system upgrade was done in March, so this was an optimal time to assess staff sentiment on this.
    - Findings: information not accurate or complete, or entered into wrong patient record
    - Observations: adequate training, adequate workstations, not too many alerts/flags, staff made aware of issues
    - There is an overall opportunity for improvement and optimization, because 41% fall into "Neutral" category for Agree/Disagree on overall satisfaction of EMR.
- Mark asked about benchmarks for comparison against other institutions. We are currently in waiting period for AHRQ to compile results and release those benchmarks.
- Highlights:

    - Staff are involved in process improvement and feel included in decision making related to patient safety.
    - Patient-centered care and efficiency has room for improvement in working with patient families and patients themselves.
- Strengths:
    - 86% strongly agree that there is teamwork within departments; "positive and pleasant place to work"
    - 79% say events are always or almost always reported
    - 72% staff feel units are good or excellent
    - 63% favorable rating on handoffs and transitions
    - 62% have made a suggestion for a process improvement
- Opportunities:
    - Occurrence report response/timeliness improvement
    - Greater open communication and feedback
    - Support with aggressive and threatening behavior from patients
- Follow-up based on feedback from 2018:
    - Lack of security 24/7 in ED -> now have 2 security guards 24/7 and PES in ED
    - Effective interface between ED and rest of hospital info systems -> still in-work
    - Lack of pharmacist 24/7 -> 24/7 pharmacist on-site
    - Lack of attention to signage regarding safety -> have made improvements, like door openings, etc.
    - Lack of effective communication on plan of care between physician and care team -> Hospitalist program!

Other Discussion

Rosemary asked about Joint Commission schedule. Gail said their window closes May 31, 2021 so they will be here soon. Mark asked about if results of past survey are reviewed. They are and our regulatory specialist Autumn Muse and Dianne Bigge have been working to make sure we are in a good position for the survey.

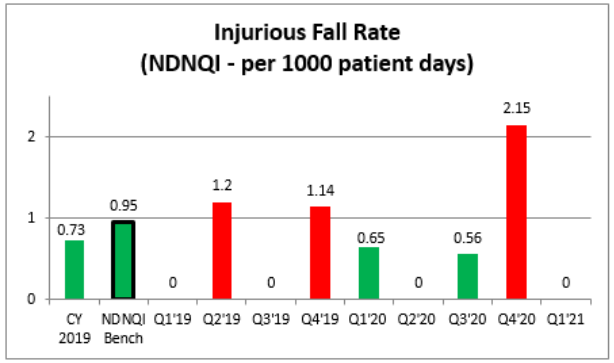
Adjourned at 4:33 pm

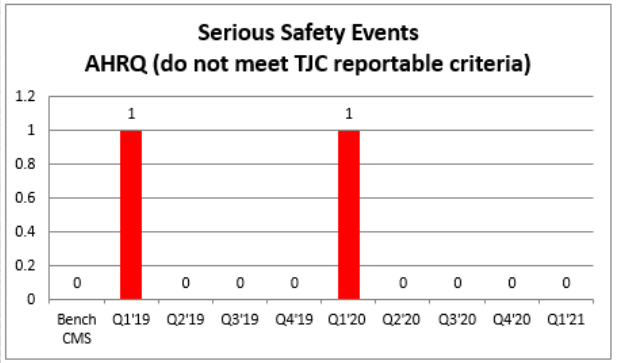
Next Quality Board meeting: July 14, 2021 @ 3:30pm

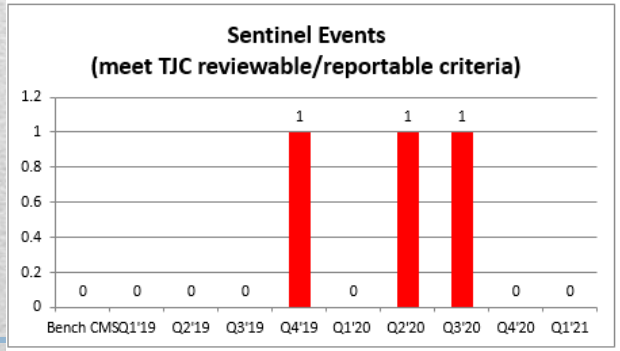
Bartlett Regional Hospital

Quality Dashboard

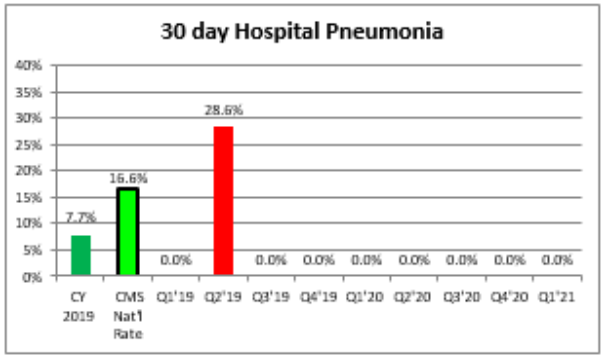
RISK MANAGEMENT – *lower is better*

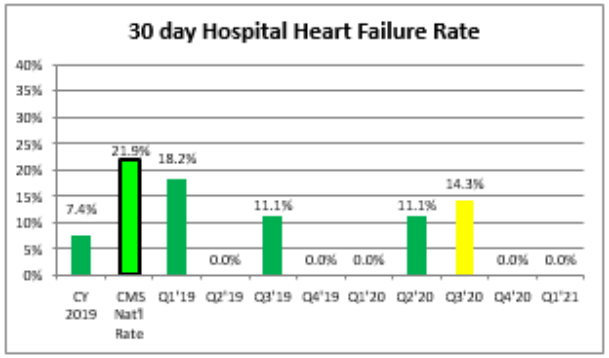


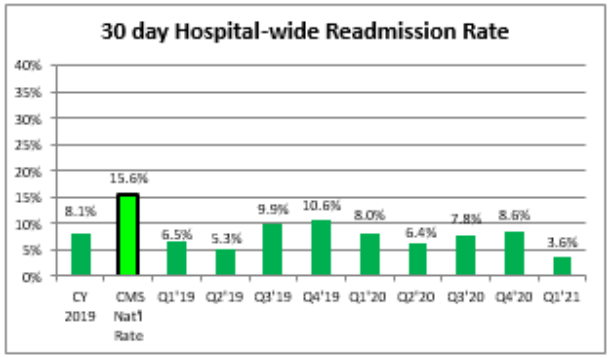




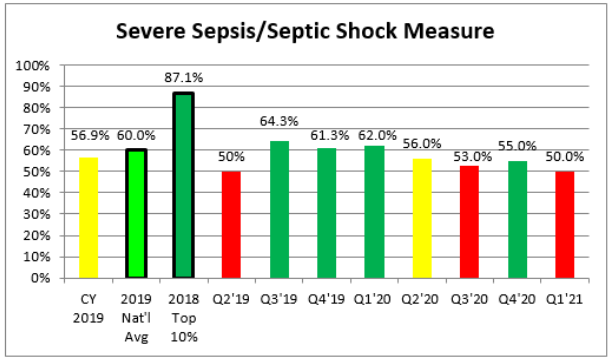
READMISSION RATES – *lower is better*

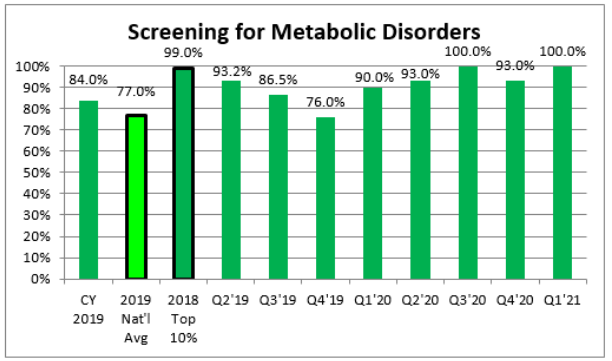






CORE MEASURES – *higher is better*





Sepsis: measure that demonstrates use of evidenced based protocols to diagnose and treat Sepsis.
Screening for Metabolic Disorders: % of psychiatric patients with antipsychotics for which a metabolic screening was completed in 12 months prior to discharge.

Fall rates: Per the NDNQI definition, Med/Surg and CCU *only* with injury minor or greater.
SSEs: An event that is a deviation from generally accepted practice or process that reaches the patient & cause severe harm or death.

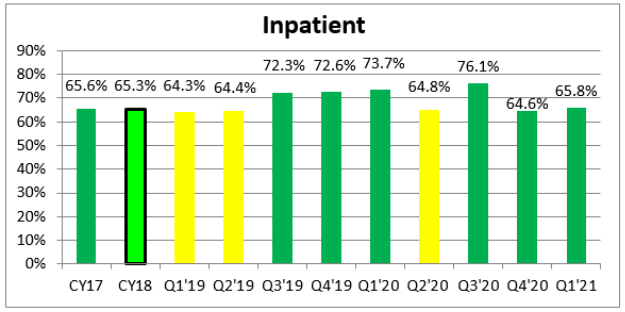
Pneumonia and Heart Failure: patient is readmitted back to the hospital within 30 days of discharge for *the same diagnosis*.
Hospital-wide: patient is readmitted back to the hospital within 30 days of discharge for *any* diagnosis.

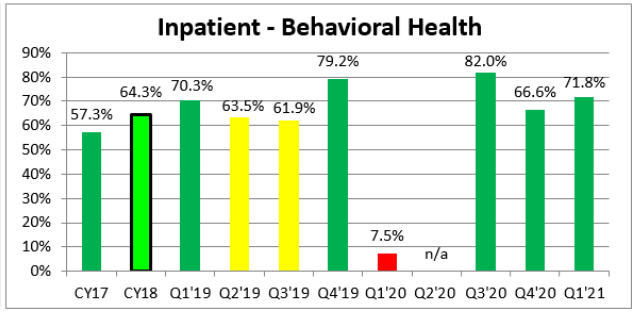
CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

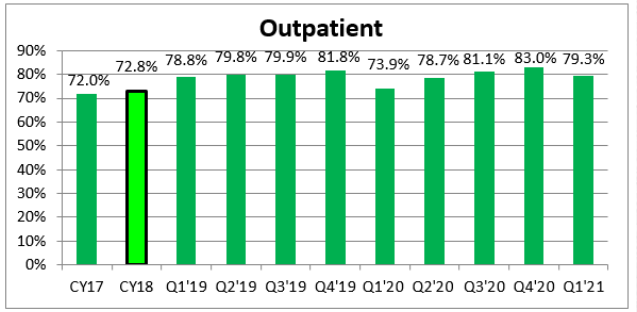
Bartlett Regional Hospital

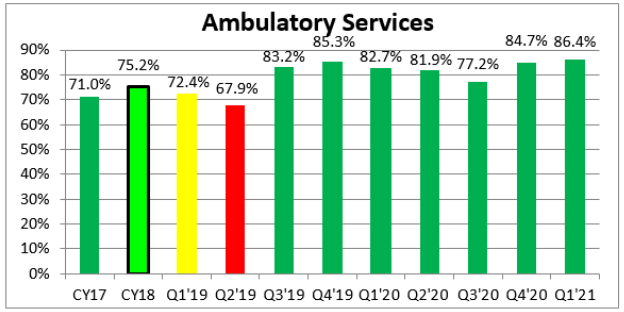
Quality Dashboard

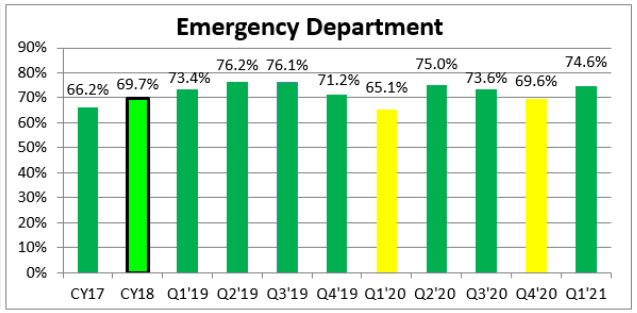
PATIENT EXPERIENCE











Notes:

- **Press Ganey** is the vendor for CMS Patient Experience and HCAHPS Scores. The data are publically reported.
- **HCAHPS =** Hospital Consumer Assessment of Healthcare Providers & Systems; includes only Med/Surg, ICU and OB.
- **Top Box** HCAHPS results are reported on Hospital Compare as "top-box," "bottom-box" and "middle-box" scores. The "top-box" is the most positive response to Survey items.

HCAHPS RESULTS

	Current Quarter		QoQ	YoY	CMS Achievement Threshold	CMS Benchmark	Baseline Period
	Q1 2021	Percentile	Q4 2020	Q1 2020	50th %ile	Mean of Top 10th %ile	2018
Overall Rating (0-10)	**82.1%**	89	69.2%	82.1%	▲	▼	▲
Comm w/Nurses	**88.9%**	95	77.2%	95.1%	▲	▲	▲
Comm w/ Doctors	**83.6%**	76	79.7%	94.0%	▲	▼	▼
Response of Hosp Staff	**72.9%**	85	72.9%	84.3%	▲	▼	▼
Comm About Medicines	**67.3%**	84	58.4%	79.4%	▲	▼	▲
Hospital Environment	**75.3%**	87	63.9%	73.9%	▲	▼	▲
Discharge Information	**84.0%**	25	85.6%	96.8%	▼	▼	▼
Care Transitions	**52.3%**	54	56.8%	59.3%	▲	▼	▼

CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

Patient and Family Engagement

BRH's **PFA** (Patient and Family Advisor): Nancy Davis

-Our PFA sits on Board Quality to provide a patient's viewpoint and presence

Projects:

-Bedside reporting brochure

-Patient's Rights and Responsibilities brochure updates

-Comfort Menu

-Patient COVID-19 masking brochure

-Patient COVID-19 masking flier

-Patient experience during COVID staff presentation

We are currently working on developing a BRH PFA committee this year