

Bartlett Regional Hospital

Board Quality Committee

January 8, 2020

4:15 p.m.

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 – [November 13, 2019](#)

Standing Agenda Items:

- [2019 BOD Quality Dashboard](#) S. Hargrave

New Business:

- [Board Quality Committee Charter Review](#) S. Hargrave
- [Risk Management Plan](#) M. Crann
- [Utilization Management Plan](#) J. Lacey
- [Infection Prevention Plan](#) C. Gribbon
 - [Infection Control Risk Assessment](#)
- [Environment of Care Management Plan](#) M. Walker
- [Patient Safety and Quality Improvement](#) S. Hargrave

Next Scheduled Meeting: March 11, 2020 4:15 p.m.

Bartlett Regional Hospital

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

Board Quality Committee November 13, 2019 Minutes

Attendance: Rosemary Hagevig (BOD), Brenda Knapp (BOD), Kenny Solomon-Gross (BOD), Sarah Hargrave (Quality Director), Rose Lawhorne (CNO), Deborah Koelsch (Clinical Quality Coordinator), Gail Moorehead (Education Director), Mark Johnson (BOD), Billy Gardner (COO), Bradley Grigg (CBHO), Dr. Lindy Jones (BOD), Nancy Davis, (Person & Family Liaison)

Approval of the minutes – September 8, 2019 – *minutes approved as written.*

Standing Agenda Items:

Quality Dashboard (reported quarterly) – Ms. Hargrave reviewed the Board Quality Dashboard. The HCAHPS Quarter 3 results were strong, exceeding all CMS Achievement Benchmarks, and 2 areas meeting or exceeding the top performer benchmarks. Bedside Nurse Reporting has spread from MedSurg to Bartlett Beginnings. Ms. Hargrave thinks this will help us increase our HCAHPS score next quarter. Severe Sepsis/ Septic Shock Measure has exceeded our goal. There was a spike in Readmission rates for Quarter 3, and several cases are under review by Medical Staff Quality. The Screening for Metabolic Disorders measure continues to be a strong performer. In reviewing the slight drop in the Behavioral Health overall patient satisfaction scores, the committee the impact of a small denominators.

New Business:

2020 Priorities:

Ms. Hargrave reviewed progress on key goals from Focus and Execute under the responsibility of the Quality Department.

- Revision of Ongoing Provider Practice Evaluation (OPPE): Ms. Hargrave reports all medical staff service line committees have received information on OPPE and most are nearing completion of metric selection. In addition, the policy has been revised with input from medical staff, a scorecard template built, trainings completed, and process defined. Scorecards are sequentially being reported to physicians, starting with hospitalists and medicine.
- Revision of PI Methodology: As current process was working well, conversations between Quality Director and SLT determined no need to revise it, but to continue to do what we have been.

- Sepsis PI and Compliance: A multi-disciplinary team has been meeting throughout the year to address sepsis. At the end of September, the hospital implemented a Code Sepsis protocol to structure and streamline sepsis care. October showed the 6th month in a row with compliance scores over the prior median suggesting a statistically significant change in rates from 2018.
- Malnutrition Protocol: In June of 2019, the Dietitians were restructured under the Quality Department. Due to staffing shortages, no permanent programmatic changes could be made. The focus since June has been to recruit and hire Registered Dietitians and eliminate the need for travelers. As of mid-December, the final position will be filled. In addition, the department has been focusing implementation of software to allow automated nutrient analysis (rather than by hand).
- Improve Patient Safety: The focus of the year been on the Culture of Patient Safety through Team STEPPS. Team STEPPS is a collection of tools and strategies to enhance communication and teamwork, thereby improving the safety of the care. The goal is to move from a team of experts to expert teams. Staff Development that worked to assure that nearly all direct care staff receive training during 2019. Other strategies have been working their way into other policies and processes throughout the organization. Dr. Jones shared the impact of huddles as one of the Team STEPPS strategies being used during patient care in the Emergency Department.
- Reduce total numbers of healthcare acquired infections: Through the efforts of several departments and the leadership of the Infection Preventionist, our Surgical Site infection rate has dropped to less than 0.3/100 cases, well below national average. Strategies included Nose to Toes in pre-op, improved cleanliness with monitoring of ATP values, improving antibiotic selection and dosing preoperatively, and introduction of a UV light for use in the OR.

2020 Priorities:

Ms. Davis was welcomed as Person & Family Engagement Liaison to the Board. The Committee reviewed the CMS Patient and Family Engagement Handout. Open discussion of Board members' requests for Quality metrics and initiatives. The following were discussed:

- Sharing of efforts to continually improve
- Efforts to assist with health literacy
- Assessing and responding to community needs
- Keeping up with best practices in trauma and pediatric care. Consider moving to Level 3 Trauma Center.
- Continue review and analysis of 7-day readmissions, surgical site infections, 72 hour returns to the ED, surgical complication rates.
- Positive feedback from recent radio ads
- Further integration with Medical Staff Quality committee
- Visibility of Board members in Community groups- hospital visibility

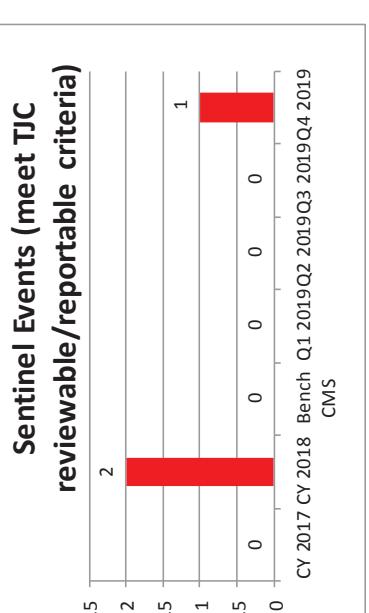
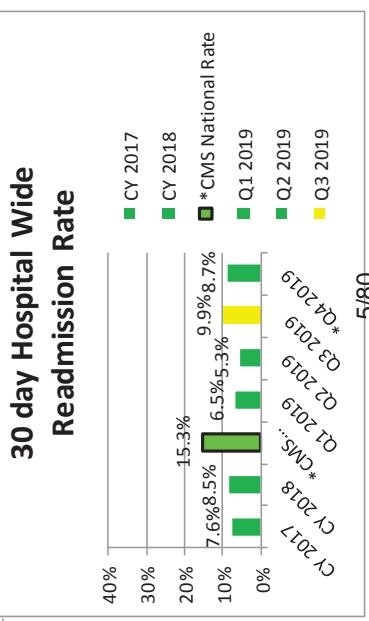
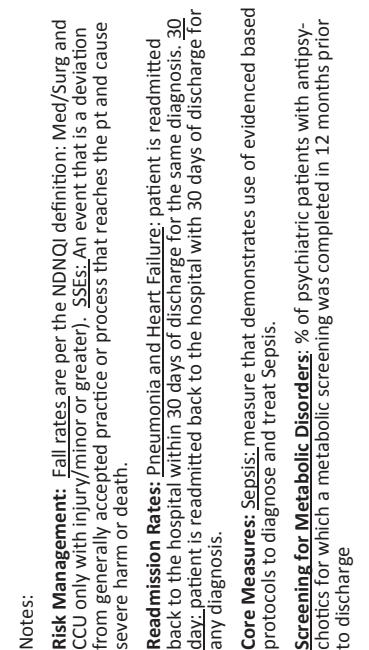
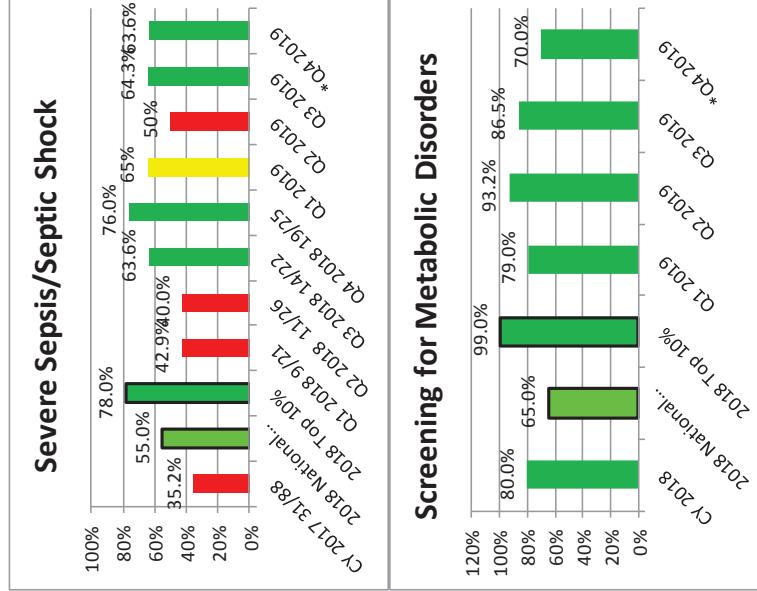
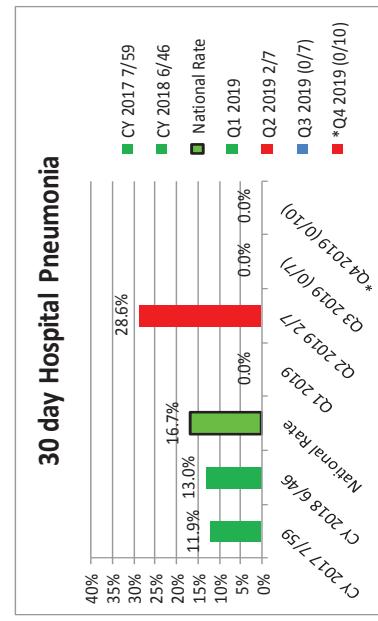
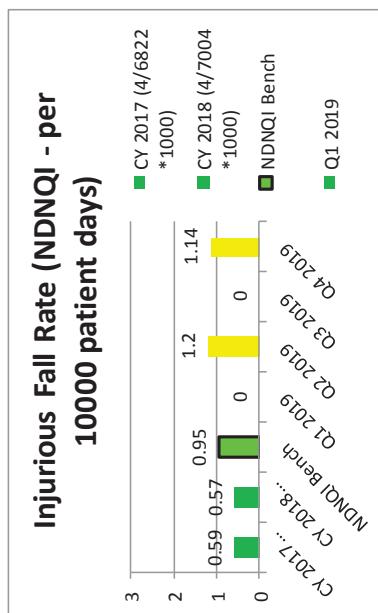
- Ads in paper to recognize BRH employees are very helpful so community members may recognize a friendly face when they come in
- Ophthalmology services a strong benefit to the community
- Continue efforts to show the patient as the center of our work. Ms. Davis shared the feeling that “What else can I help you with?” at the end of each encounter can bring to patients feeling that they are the center of care.
- Advertise how positively tourists feel about the care they receive from Bartlett.

Committee adjourned at 4:55 p.m.

Next Quality Board meeting: November 13, 2019 4:15PM

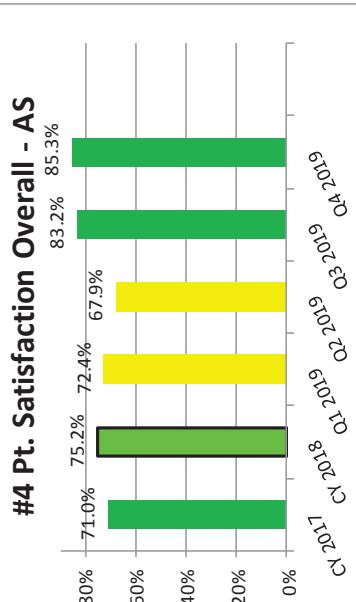
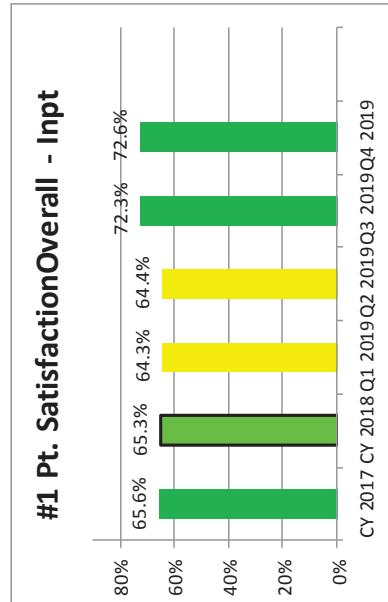
Adjourned at 5:00 pm

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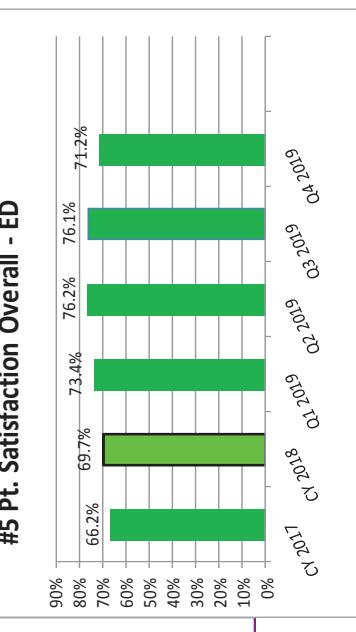
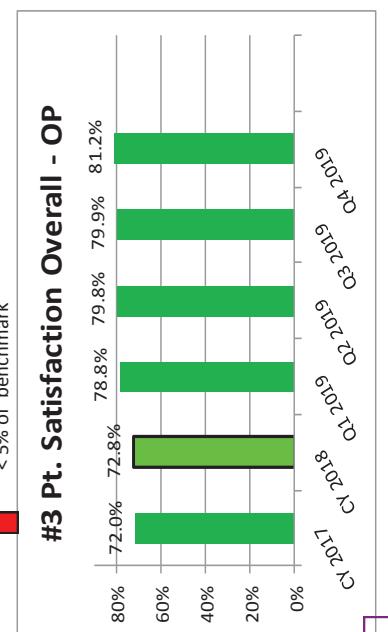
BOARD OF DIRECTORS QUALITY SCORECARD—

Indicates Benchmark 



CAHPS	2017	2018
	Top Box	Top Box
Overall Rating (0-10)	74.5 ▲	74.1 ▼
Comm w/ Nurses	82.5 ▲	81.4 ▼
Comm w/ Doctors	86.2 ▲	84.5 ▼
Response of Hosp Staff	75.7 ▼	76.3 ▲
Comm About Medicines	66.3 ▼	66.0 ▼
cleanliness and Quietness of Hosp Environment	70.4 ▼	72.5 ▲
Discharge Information	89.4 ▲	86.8 ▼
Care Transitions	55.8 ▲	55.3 ▼

- At or above benchmark
- Within 5 % of benchmark
- < 5% of benchmark



	Q3 2019	Q4 2020	CMS Achievement Threshold	CMS Benchmark (top perf.)
Box	Top Box	Top Box	01/2017-12/2017	01/2017-12/2017
6	80.8▲	71.6▼	70.85%	84.83%
2	85.2▲	88.5▲	78.69%	86.97%
5	89.4▲	92.0▲	80.32%	88.62%
6	78.4▲	77.7▼	65.16%	80.15%
6	70.0▼	70.2▲	63.26%	73.53%
6	74.9▲	79.2▲	65.58%	79.06%
6	89▲	88.2▼	87.05%	91.87%
1	64.0▲	58.3▼	51.42%	62.77%

Notes on Patient Experience:
Press Ganey is the vendor for CMS Patient Experience and HCAHPS Scores.

- ** publicly reported
- #1, #3, #4 and #5 benchmark is 2016. Benchmark for #2, not a full year r/t new domain added in 2016
- HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems: includes only Med/Surg, ICU and OB
- Top Box: HCAHPS results are publicly reported on Hospital Compare as “top-box,” “bottom-box” and “middle-box” scores. The “top-box” is the most positive response to HCAHPS Survey items.

HCAHPS Results 2017-2019 current

Bartlett Regional Hospital

Board Quality Committee Charter, 20192020

Scope/Role

The Board Quality Committee assists the Board of Directors in fulfilling its oversight responsibilities in the assurance of patient safety, quality patient care, and customer service provided throughout the organization. The committee will support the strategic direction for the Quality Program in accordance with the hospital administration. The committee reviews patient care data, including patient safety and quality of care from all areas of operations. The committee reviews trends, potential problem areas or deficiencies and helps to evaluate outcomes of any corrective actions taken. In addition, the committee makes recommendations to the Board on any matter referred to it by the Board.

Membership

Board Quality Committee Chair, Board Members, Department Head Directors, Person & Family Engagement Community Liaison, Quality Team and others upon invitation.

Meetings

Every two months and as requested by Committee Chair.

Authority and Responsibilities

1. Oversee hospital quality systems.
2. Ensure the direction ofProvide direction for quality and performance improvement activities related to the hospital strategic plan.
3. Identify and recognize successes.
4. Evaluate results of quality, patient safety, and performance improvement activities including making recommendations and reviewing follow-up actions.
5. Monitor and evaluate dashboard of key performance indicators compared to organizational goals and industry benchmarks.
6. Actively encourage development of hospital systems that provide person and family engagement along the continuum of care.Identify and provide direction to address deficiencies related to patient safety and quality patient care

Reports

1. Board Performance Improvement/Quality indicators in dashboard format to include:

- Patient Experience Metrics
- Patient Safety Metrics
- Pay for Performance and Quality Measures

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2. Organizational annual evaluations and plans for the following program areas:

• Patient Safety and Quality Improvement Plan

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• Utilization Review

• Risk Management

• Infection Prevention

 i. Antimicrobial Stewardship

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 • Environment of Care Plans:

 i. Emergency Management

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 ii. Hazardous Materials

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 iii. Life Safety

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 iv. Medical Equipment Management

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 v. Safety Management

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 vi. Security Management

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 vii. Utility Systems Management

2. Other reports as indicated

3. Other reports, as indicated

**Bartlett Regional Hospital
RISK MANAGEMENT PLAN
CY 202019**

Issued: July 1, 2010
Revised: December 183, 20198
Submitted by: Mary Crann, RN, MSN, CPHRM

AUTHORITY AND RESPONSIBILITY

Board of Directors

The Board of Directors of Bartlett Regional Hospital is responsible for the quality and effectiveness of the patient care provided by the medical staff and other professional and support staff. It sets expectations, directs, and supports Bartlett Regional Hospital's (BRH) governance and management activities which include supporting the Risk Management Program to minimize preventable harm to patients, employees, visitors and property. It has the final authority and responsibility for the program, but delegates the authority and accountability for the operation of the program to the Administrative and Medical Staff of BRH. It appoints, through the Chief Executive Officer, a Director of Quality. The Director of Quality is responsible for the Risk Management program. It recognizes the importance of a Risk Management Program and provides resources and support to prevent such events that may result in injury to patients, staff, or visitors, property damage, financial loss, or damage to the facility's reputation.

Risk Management Supervision

The Director of Quality supervises the Risk Manager and Patient Safety Officer (RM&PSO) and acts as a designee of the Chief Executive Officer. S/He has the responsibility for monitoring, coordinating, planning, and implementing all loss prevention activities and programs that have as their goal a safe environment for patients, employees, and visitors to the hospital. Trending and tracking of potential problems are included in this responsibility as well as the integration of information with the Performance Improvement Committee (PIC) and the Environment of Care (EOC) Committee.

Medical Staff

The Medical Staff actively participates in peer review via the identification of potential risk in clinical areas that represent a significant source of actual or potential patient injury. This is achieved through clinical criteria to identify specific cases with potential risk in the clinical aspects of patient care and safety.

PURPOSE AND PHILOSOPHY

The purpose of the Risk Management Plan is to support the mission and vision of Bartlett Regional Hospital to provide patient centered quality care in a sustainable manner. Risk Management fulfills this by acting to protect, patients, staff and visitors from injury, physical property from damage and financial assets from being wasted. Risk Management acts to support BRH's reputation and standing in the community.

The focus of the risk management plan is to provide an ongoing, comprehensive, and systematic approach to reducing vulnerabilities. Risk management activities include identifying, investigating, analyzing, and evaluating risks, followed by selecting and implementing the most appropriate methods for correcting, reducing, managing, transferring and/or eliminating them.

The philosophy of the Risk Management Program is that patient safety and risk management is the responsibility of each employee of Bartlett Regional Hospital. Teamwork and active participation among management, providers, and staff are essential for an efficient and effective risk management program. The Risk Manager plays a central role in leading the organization towards fulfilling the mission and vision of BRH to provide patient centered sustainable quality care.

SCOPE

Risk Management is a systematic process of identifying, evaluating and alleviating practices and/or situations that pose risk of harm to patients, visitors and staff of BRH. Emphasis is placed on advocating the exercise of loss prevention strategies intended to preserve the resources of Bartlett Regional Hospital and its professional staff from loss attributed to professional liability.

The Risk and Quality Management activities at BRH are mutually compatible and interdepartmental and are part of the organization's performance improvement system. BRH's Risk Management Program is designed to comply with all federal and state regulatory requirements. Resources are provided to the Quality and Risk Management Department via the Director of Quality. The integration of hospital risk management with quality assurance activities ensures information about patient care and safety are exchanged.

STRUCTURE

Risk management activities are established by BRH leaders, based on needs assessments, as guided by the mission, vision, and core values, and as defined by strategic and operational plans, budgets, resource allocation, and standards.

Board of Directors

The Board of Directors receives and reviews reports through the performance improvement structure, summarizing the findings of the Risk Management Program via the Hospital Performance Improvement Committee (PIC), the Environment of Care (EOC) Committee, and reports by the Risk Manager & Patient Safety Officer or Director of Quality. The Board of Directors designates the Director of Quality and the Risk Manager & Patient Safety Officer to function

as the Grievance Committee for complaint processing that cannot be resolved by the department managers.

Senior Leadership Team:

The Senior Leadership Team(SLT), comprised of the Chief Executive Officer, Chief Financial Officer, Chief Clinical Officer, Chief Behavioral Health Officer, Chief Legal Officer and Director of Human Resources, ensures that an integrated patient safety program is operationalized, and assumes responsibility for the strategic direction and integration of all Risk Management activities. Patient safety culture survey results provide feedback on workplace safety practices, communication, teamwork, adverse event reporting, and leadership to help guide vision and goals of the organization. The SLT is responsible to assure that key strategies and/or processes of the organization are identified and prioritized, and that the efforts of Risk Management support and integrate the strategic objectives of the organization and feedback from all community and hospital connections. SLT supports transparency in communication related to the risk management process.

Departments

Individual departments are responsible for quality management, regulatory compliance, and risk management activities relative to the services they provide. Progress on departmental risk management activities are submitted in writing when warranted to the Risk Manager and Director of Quality.

RISK MANAGEMENT PROCESS

Risk management and quality improvement are complementary and continuous processes that link activities to BRH's mission and strategic plan. The risk management process ensures all employees have a risk management philosophy and are the first line of defense. The process should be outcome oriented measured by quality indicators and dashboards.

METHODS

Establishing a consistent definition and measurement process supports the goal of preventing harm and delivering safe care to patients by allowing rapid identification of Serious Safety Events, quick mitigation to prevent further harm, and consistent evaluation of prevention methods. A clear and consistent plan for conducting investigations is imperative along with establishing common definitions and a shared mental model.

Risk Management activities include:

1. Review and triage occurrence reports completed by staff and providers in the occurrence reporting software system.
2. Prioritize events, hazards, and system vulnerabilities utilizing the Safety Assessment Code (SAC) Matrix.

3. Measure and report frequency and severity of events to transform risk management into a pro-active program.
4. Ensure timely execution of Root Cause Analysis, mitigation, and corrective action plans using the RCA2 guidelines and tools.
5. Collaborate with the Director of Quality identifying near misses or trends and utilizing evidence-based tools for process improvement and quality assessment activities.
6. Collaborate with the Director of Quality to communicate data and investigation findings to the BOD, SLT and staff.
7. Participation in litigation processes by attending depositions, supporting staff, providing documentation, and acting as liaison to BRH legal counsel.
8. Report potential medical malpractice liabilities to the risk manager at the City and Borough of Juneau and appropriate insurance liability carriers and agents.
9. Identify, investigate, and report Sentinel Events as required by Joint Commission standards.
10. Identify, investigate and report Serious Reportable Events required by the National Quality Forum.
11. Model and support evidence-based risk reduction concepts and tools to improve communication, and other high risk areas.
12. Review quality performance indicators to evaluate risks and strategies.
13. Review of patient grievances and responding following BRH policy, Centers for Medicare and the Medicaid Conditions of Participation Patient Rights regulations.
- 13.14. Evaluate grievance data using system analysis with a grievance committee and incorporate into QAPI
- 14.15. Collaborate with the Director of Quality in completing a patient safety culture survey and developing risk and quality plans that incorporate staff input and participation.
- 15.16. Collaborate with the City and Borough of Juneau (CBJ) risk managers in litigation, property damage, and employee events and attend and participate in Joint Safety meetings.

COMMUNICATION

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Communication of risk management availability and outcomes to all levels of BRH is vital. Conclusions, recommendations, and actions are communicated to leadership, and/or individuals responsible for implementing and coordinating improvements through various presentations or reports. Examples of meetings where relevant information may be reported include:

1. Medical Staff Service Line meetings
2. Individual Department Staff meetings (when appropriate)

3. Board and/or Hospital Quality Committee reports
4. Management Team meeting
5. Patient Safety Committee Meeting
6. Patient Grievance Committee

An annual review and revision of the risk management plan and objectives are provided to the Hospital Process Improvement Committee and forwarded to SLT and the Board of Directors.

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Bartlett Regional Hospital

Title: UTILIZATION MANAGEMENT PLAN

Department/s: All Clinical Departments

Original Date: 10/1997

Author: Jeannette Lacey, LMSW, ACM

Updated: 12/20198

PURPOSE:

1. The Utilization Management Plan is an organization wide, interdisciplinary approach to balancing the quality, cost, and risk concerns in the provision of patient care.
2. This plan strives to promote appropriate resource utilization and discharge planning in accordance with CMS and to maintain high levels of integrity in keeping with the mission statement and vision of **Bartlett Regional Hospital**.

DEFINITIONS: Milliman Care Guidelines (MCG): published by MCG Health, uses evidence-based best practices and care planning tools across the continuum of care to evaluate medical necessity and track length of stay (LOS).

Interqual Level of Care Criteria (IQ): published by McKesson Health Solutions, uses condition-specific, general and extended stay subsets to evaluate for medical necessity.

Utilization Management (UM) is evaluation of the medically necessary appropriateness and efficiency in the use of healthcare service, procedures and facilities.

Utilization Review (UR) is the process of determining whether all aspects of a patient's care, at every level, are medically necessary and appropriately delivered.

Secondary Review is a review performed by a physician with the contracted secondary review service, Sound-Physician Advisory Services, when the IQ or MCG screening criteria suggest a different patient status or level of care than that ordered by the patient's physician and/or for a potential quality concern.

Policy

- A. The Board of Directors of Bartlett Regional Hospital has delegated the responsibility for the performance of utilization review activities to the Case Managers (CM) with the **Health-Information Management/Case-Management (HIM/CM) Utilization Review** Committee as the oversight committee.
- B. The Utilization Management Plan is based on CMS conditions of participation, The Joint Commission standards, and Interqual and/or MCG criteria for healthcare utilization and seeks to resolve problems that cause or result in either deficient or excessive resource utilization. The plan will be reviewed at least annually by the **Health-Information Management/Case-Management Utilization Review** Committee.

Comment [JOLD1]: This change is to reflect the language in the Col's. Membership will be defined to include physician members, HIM, CM, and Quality staff.

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B.C. The Utilization Management Plan recognizes the authority of KEPRO and the assessment and monitoring of review activities performed by KEPRO.

Comment [JOLD2]: Our QIO changed from Livanta to KEPRO this year. The line about outliers was deleted because it is discussed below.

C. All patients, regardless of payment source, shall be evaluated to ensure that resources are utilized appropriately.

Comment [JOLD3]: This section was moved up out of the Scope of Review section.

D. The written Scope of Services will serve to identify and delineate the activities of the department.

Comment [JOLD4]: This section is added to E below.

E.D. Utilization management and review are integral parts of the Process Improvement Plan at BRH and will be under the auspices of the CFO with direct reporting to the HIM/CMUtilization Review Committee.

Comment [JOLD5]: This section was re-worded and re-ordered based on CoPs and to improve organization.

EF. Scope of Review: All patients, regardless of payment sources, shall be evaluated to ensure that resources are utilized properly. The Case Managers (CM) will be responsible for the process of measuring and assessing, maintaining and monitoring the effective utilization of hospital facilities, services, and resources related to inpatients and patients placed in observation status. This shall include, but not be limited to:

EF.1. Performing admission, concurrent, discharge and retrospective reviews to assess for medical necessity

Managing LOS

EF.2. Identifying the appropriate level of care

Monitoring use of bed days

EF.3. Managing length of stay

Managing Assessing potential transfers from lateral or higher levels of care

EF.4. Identifying the appropriate level of care

EF.5. Managing denials and appeals

EF.6. Performing admission, concurrent, discharge and retrospective reviews

EF.67. Tracking and monitoring cost and quality (including examining patterns of utilization) utilization patterns and professional services furnished, including drugs and biologicals.

EF.78. Identifying available discharge care resources and coordinating with Social Work Case Managers (SWCM) to develop a post-acute care plan that is compliant with CMS guidelines.

EF.89. Requesting secondary review or HIM/CMUtilization Review Committee involvement as necessary.

G. The Utilization Management Plan recognizes the authority of Livanta and the assessment and monitoring of review activities performed by Livanta. Outliers will be reviewed by the HIM/CM Committee.

Comment [JOLD6]: Our QIO changed from Livanta to KEPRO this year. The QIO section was moved up to section C. The line about outliers was deleted because it is discussed below.

H. Patient and physician confidentiality will be maintained at all times in accordance with the BRH compliance policy and peer review laws of the State of Alaska. Case Management daily work and/or studies will be available only to representatives of the Medicare intermediary, third party payers, Livanta, the attending physician, members of the HIM/CM Committee, the hospital administrator and the Bartlett Regional Hospital Board of Directors.

Comment [JOLD7]: Does not need to be included with this policy/plan.

F. The CM will keep the physician involved collaborate with physicians to support in the utilization management process by:

- F1.1. Maintaining open lines of communication.
- F1.2. Reviewing admission status based on accepted criteria and CMS rules and discussing concerns with the provider, clarifying admission status with physician if in question and recommending a change to an appropriate status (ultimately it is physician's prerogative to decide the status).
- F1.3. Reviewing continued stay documentation and identifying needed-possible changes or additions to ensure that documentation supports physician intent.
- F1.4. Coordinating care conferences with the physician and treatment team as indicated.
- F1.5. Involving physician in the discharge planning process.

F.6. Coordinating physician participation in the appeal process.

Comment [JOLD8]: Re-worded for clarity.

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J. The CM will consult with the appropriate physician(s) serving on the HIM/CM Committee regarding identified patient care matters.

Comment [JOLD9]: This section is moved below.

K. The CM will involve the medical staff in Appeals and Denials through direct communication to provide the information needed to deal with the appeal or denial.

Comment [JOLD10]: Added to the section above.

G. Patients that do not meet admission-inpatient criteria may be placed in admitted to observation status by the admitting provider if observation criteria are met. Those patients who do not meet criteria for inpatient care or observation services shall be notified by the CM that the services are not covered and that the individual or family may be responsible for payment of the services. The appropriate Hospital Issued Notice of Non Coverage(HINN) or Advanced Beneficiary Notification (ABN)will be given to the patient or their representative.

H. Utilization Review Committee Composition:

- H.1. Credentialed medical staff, at least 2 of which will be doctors of medicine or osteopathy.
- H.2. Staff from the Case Management (CM) Department
- H.3. Staff from the Health Information Management (HIM) Department
- H.4. Staff from the Quality Department.
- H.5. Reviews may not be conducted by any individual who has a direct financial interest in the hospital; or was professionally involved in the care of the patient whose case is being reviewed.

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I. Utilization Review Committee Functions: The Committee

- I.1. Will meet quarterly
- I.2. Will review
 - i. Outlier cases
 - ii. Denials
 - iii. Compliance with the 2-Midnight Rule
 - iv. Readmissions
- I.3. May make determinations regarding admissions or continued stays. These may be made by one physician member if the attending concurs with the determination or fails to present

their views when offered the opportunity; Determinations must be made with two physician members in all other cases. (See policies for CC44 and CCW2 for specific processes).

I.3. Support HIM, CM, and Clinical Documentation Integrity functions as defined in the Medical Staff Rules and Regulations.

I.4. Make recommendations regarding identified utilization or documentation matters.

I.5. Serve as a liaison to the medical staff regarding issues reviewed by the committee.

M.

Case Management will present a report at the quarterly HIM/CM Committee on these patients who are considered outliers in length of stay or costs (data as defined by HIM/CM Committee), with readmissions prioritized, and identify the reasons that caused the outlier status.

Comment [JOLD11]: Re-worked for clarity and to match language of CoP; moved up.

N. Members of the HIM/CM Committee (including physician members as needed) will perform chart reviews quarterly for identified outliers, utilizing the identified audit tool, and make recommendations for service improvement as identified.

SCOPE

Applies to Case Management Coordination for all BRH inpatients and observation patients.

PROCEDURE: Utilization Review

A. Preadmission certification for outpatient procedures, surgical procedures, specialties care and inpatient admissions (if required) will be the responsibility of the provider's office.

B. Patient Access Services will perform insurance verification and notify/inform the Case Management Department within 1 business day of required reviews requested by payers at the time of verification.

C. Medical Necessity: Hospital inpatient services under Medicare Part A, section 1814(a) of the Social Security Act requires physician certification of the medical necessity that such services be provided on an inpatient basis.

C.1. Registered Nurse Case Manager (RNCM) will determine if medical documentation supports medical necessity for admissions and continued stay based on established industry criteria that are intended for use as a guideline in conjunction with sound clinical judgment.

C.2. Admission reviews will be performed within the first business day following admission

C.3. If RNCM is unable to determine the necessity for admission RNCM will initiate a secondary review. A secondary review may be initiated if the RNCM is unable to determine medical necessity for the admission.

C.4. Concurrent stay reviews will be based on the attending physician's reasons and plan for continued stay, discharge plans, and other documentation. Case Management will remain in contact with the attending physician, the business office and the payer during the hospital stay to resolve questions and to share information regarding discharge plans.

References

- (1) [Certified Professional Utilization Review Study Guide](#)
Interqual Products Group 2013
- (2) [Federal Register Volume 66, No. 231](#)
- (3) [Livanta Quality Improvement Organization](#)
ICD-10-CM and ICD-10-PCS, current volume
- (4) [Interqual Level of Care Criteria: Acute Adult / Acute Pediatric](#)
McKesson Health Solutions 2016
- (5)(1) [Medicare Hospital Manual section 230-6E](#)
- (6) [Health Utilization Management Standards, Version 5.0](#)
URAC 2006
- (2)(7) [CMS Conditions of Participation 482.30 Utilization Review](#)
- (3) [CMS Conditions of Participation 412.80 Outlier Cases](#)
- (48) [Miliman Care Guidelines: Inpatient and Surgical Care, General Recovery Care and Behavioral Health Care, current edition, 2019](#)

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Attachments

- (1) Health Information Management/Care Management Committee report form templates:
 - 1. Denied Days Status Report
 - 2. Outlier Status Report
 - 3. Utilization Management Report with Medicare Monitoring Summary

Attachment #1

Bartlett Regional Hospital

HIM/UM Denied Days Status Report

Date:

Visit #	Admission Date	Discharge Date	LOS	Admitting Diagnosis	Days Auth	Days Denied	Insurance	Status

Attachment # 2

Bartlett Regional Hospital

Medicare Outlier Status Report

Patient Name	Account #	Admission Date	Discharge Date	LOS	ELOS	Charges	Admitting Diagnosis/Procedures	Disposition/Outlier Problem	CM Reviewer	Appropriate timing of D/C planning?	What else could have been done differently?	Reason for outlier

Attachment #3

**Bartlett Regional Hospital
Utilization Management Report**

Q4 CY2018

Denials

	<u>Reversed</u>	<u>Upheled</u>
Initial		
Aetna		
Blue Cross		
Medicaid		
Other		

Medicare Monitoring

Notes

CMI

1- day stays

Observation > 2MN

Outliers

Psych

Placement

EOL

Complex Medical

Social

Other

BARTLETT REGIONAL HOSPITAL
INFECTION PREVENTION and CONTROL PLAN 2020

This plan is developed with input and collaboration from the following:

- Infection Prevention and Control Committee
 - Quality and Process Improvement
- Medical Staff
 - Department Managers

Infection Prevention and Control Plan Reviewed by:

	Signature	Date
Infection Prevention and Control Committee Chair	Dr. David Miller	
Quality and Process Improvement Director	Sarah Hargrave RN, MSN	
Infection Preventionist	Charlee Gribbon RN, BSN	12/16/2019

December 16, 2019

Mission: To provide a safe environment across the continuum of settings for all patients, visitors, and healthcare workers through the prevention of infection transmission and the provision of a safe environment.

Objectives: The objectives of the Bartlett Regional Hospital (BRH) Infection Prevention and Control Program (IPC) are:

- 1 Early identification of infections, both expected and unexpected.
- 2 Timely implementation of interventions when infections or risks thereof are identified.
- 3 Analysis of organizational and individual practices that impact transmission of infection.
- 4 Implementation of evidence-based practices known to reduce the transmission of infection.
- 5 Education of healthcare workers, patient, families, and visitors on infection risk-reduction practices.
- 6 Limitation of unprotected exposure to pathogens throughout the organization.
- 7 Interact with community health agencies through activities such as surveillance and emergency preparedness to respond to community outbreaks and special pathogens (such as Ebola).
- 8 Manage effectively the seasonal influx of potentially infectious patients during Southeast Alaska's tourist season.
- 9 Enhancement of hand hygiene practices by all persons within the hospital system.
- 10 Minimization of the risk of transmitting infections associated with the use of procedures, medical equipment, and medical devices.
- 11 Incorporation of guidelines and recommendations published by regulatory or accrediting agencies, and professional organizations, to provide current evidence-based infection prevention strategies and policies.
- 12 Provision of Employee Health services, including appropriate screening, testing, immunization, counseling, and education for staff and others who have the potential for exposure to communicable disease.

Infection Prevention and Control Program Oversight and Organization Authority and Responsibility

PURPOSE: To institute any surveillance, prevention, and control measures when there is reason to believe that any patient or personnel may be in danger of a hospital acquired infection or infectious disease (IC 01.01.01)

- A. The Infection Prevention and Control (IPC) Committee:
 - A.1. The Infection Prevention team is made up of the Chair of the Infection Prevention and Control Committee (IPCC), which directs the IPC program and one full-time Infection Preventionist.
 - A.1.1. In accordance with Medical Staff Bylaws and/or Rules and Regulations, the physician members of the Infection Prevention and Control Committee are appointed by the Chief of the Medical Staff.
 - A.1.2. The appointed term is reevaluated on a yearly basis.
 - A.1.3. The IPC Program will identify and evaluate potential risk factors (including environmental factors) and monitor trends in incidence of epidemiologically relevant infections at BRH. This is achieved through effective surveillance, evaluation and communication to senior leadership, hospital stakeholders, medical staff, employees, and community.
 - A.1.4. The ICP Plan is updated on an annual basis, reviewed and approved by the IPC Committee. This update is based on a review of the prior calendar year's activities, surveillance program, risk assessments and goals (IC 01.05.01). The review of the prior calendar year's activities, surveillance program, risk assessments and goals will be completed and approved by the IPC Committee during the first quarter of the upcoming calendar year and will be implemented in second quarter of the calendar year. (IC 01.03.01)
 - A.2. Members of the Infection Prevention and Control (IC) Committee and/or the Infection Preventionist have the authority to institute surveillance, prevention, and control measures.

December 16, 2019

- A.2.1. Where there is reason to believe that any patient or personnel may be in danger of acquiring a hospital acquired infection or communicable disease; control measures may include closure of rooms, units, departments, or management of hospital visitors.
- A.2.2. The Chair of the IPC Committee and/or the Infection Preventionist (or designee) have the authority to establish controls to reduce and stop the spread of infection and communicable disease, including the ordering of microbiological cultures and TB testing when indicated.
- A.3. The IPC committee oversees the infection prevention process through evaluation, analysis and interpretation of the infection prevention data. The performance-improvement framework is used to design, measure, assess and improve the organization's performance of the surveillance, prevention and control of infection. The committee is responsible for approving and documenting the selection of surveillance programs designed to improve the quality of care.
- A.3.1. Clinical interaction through education, quality improvement efforts, and communication is maintained to increase the effective application of infection prevention and control principles.
- A.3.2. The BRH leadership provides adequate resources (human, informational, physical, and financial) to support infection prevention and control activities. (IC 01.02.01)
- A.4. BRH services include emergency care, surgical, critical care, obstetrics, general medical, diagnostic imaging (mammography, CT, MRI, ultrasound and radiology), laboratory, chemo/infusion therapy, oncology, hematology, physical/occupational/speech therapy, mental health inpatient treatment, outpatient psychiatric, chemical dependency residential and outpatient treatment, and sleep studies.
- A.4.1. New programs or services within the hospital will have to be evaluated by an Infection Control Risk Assessment (ICRA). More frequent reviews may be initiated depending on emerging diseases, changes in services or identification of specific risks in populations served. If significant change occurs, the IPC Program will respond in a timely manner, review/approve a plan with the multidisciplinary IPC Committee and re-prioritize risks as necessary.

A.5. Time-sensitive or critical issues:

A.5.1. The scheduled quarterly meeting of the IPC Committee may not be timely to address time-sensitive issues. In the event that time-sensitive issues endanger life or create a patient or employee safety concern, immediate action will be taken to alert those necessary to correct the situation.

A.5.2. Issues or situations of any level of criticality may be brought to the attention of the committee members through the Infection Preventionist, Case Managers, Department Directors, other medical or unit staff, or the Quality/ Risk Management department.

A.5.2.1. Critically significant situations should be brought to the attention of the IPC Committee physician chair as soon as they are identified.

A.5.2.2. The level of criticality should guide committee decisions for referral or action when an infection safety issue is identified.

A.5.2.3. Actions appropriate for the IPC Committee chair to take may include:

A.5.2.3.1.1. Calling an *ad hoc* IPC Committee meeting, if appropriate for timely response.

A.5.2.3.1.2. Directly contacting the physician chair of the committee that has authority over the situation.

A.5.2.4. The IPC Committee chair may directly contact another staff (physician or Senior Leaders) who has authority to correct the critical situation without further delay.

A.5.2.5. When a safety issue is identified, and the committee requires additional information or resources, the committee will bring the issue immediately to the attention of one of these functioning committees:

A.5.2.5.1.1. Committee Chair of the specific Service Line wherein the threat is occurring.

A.5.2.5.1.2. Medical Staff Quality Improvement Committee (MSQIC) Chair.

A.5.2.5.1.3. Medical Staff Executive Committee Chair.

- A.5.3. IPC Committee and medical staff will collaborate with others as appropriate to make decisions based on patient/employee safety.
- A.5.4. All situations that are identified, their level of criticality, actions taken, and any follow up recommendations will be reported through the IPC Committee to the MSQIC and/or Hospital Quality Council (HQC), as appropriate.
- A.6. The Infection Prevention and Control Committee reviews and approves, annually all hospital-wide and department-specific policies and procedures related to the infection surveillance, prevention, and control programs of the IPC Committee and all departments.
- A.7. Physicians, Quality Management, Nurses and the Infection Preventionist actively pursue continuing education in Infection Prevention and Control and collaborate with local, state, and national experts in infection prevention to maintain a working knowledge base. Competency and continuing education is required and is maintained annually.
- A.8. The IPC Committee operates as a review organization, and so is entitled to the protections offered by Alaska Statute (AS 18.23.030) and federal law.
- A.9. The minutes of the Infection Prevention Control Committee are forwarded to the Medical Staff Executive Committee.
- B. The Infection Preventionist is designated as the Infection Prevention and Control Officer, and is responsible to develop and implement policies governing control of infection and communicable disease.
 - B.1. In the absence of the Infection Preventionist (after hours or during periods of leave), the House Supervisor will assume responsibility for daily infection prevention and surveillance, ensuring that isolation protocols are initiated and/or discontinued for patients as indicated.
 - B.2. The Infection Preventionist will monitor infection prevention activities throughout the organization, with special emphasis on the surgical suite, central sterile processing, environmental services, the kitchen, and nursing units. This monitoring will include regular surveillance and observation activity. (NPSG 07.05.01)

- B.2.1. The IP will monitor hand hygiene compliance facility-wide on a monthly basis.
 - B.2.1.1. Department managers will assist in recruiting and retaining unit Hand Hygiene Champions.
 - B.2.1.2. IC will report compiled information obtained from these observations to department leaders, facility leadership, and all staff.
- B.2.2. The Infection Preventionist will notify the appropriate regulatory agency, to include but not limited to, the Alaska Department of Health and Social Services (DHSS), State of Alaska (SOA) Section of Epidemiology or Centers for Disease Control and Prevention (CDC) of any mandatory reportable disease or epidemiological important organism in a timely manner. (IC.01.05.01 & IC.02.01.01)
 - B.2.2.1. The IC program at BRH will use an epidemiological approach consisting of surveillance, routine analysis, and emerging threat identification through collaboration with microbiology, DHSS, SOA Section of Epidemiology, CDC, community partners, and employees.
 - B.2.2.2. BRH will communicate with community partners (DHHS, SOA, other facilities, physician's offices, clinics, and other hospitals) of known or discovered infectious events or patient movement in a timely manner for continual surveillance, education, and prevention of infectious disease transmission.
- B.2.3. The Infection Preventionist will act in an advisory and supportive role to ensure the safety and health of patients, employees, visitors, and contractors during renovation, construction, and maintenance at the hospital.
 - B.2.3.1. IC will collaborate with a multi-disciplinary team to perform Infection Control Risk Assessment (ICRAs) on all construction, renovation, and maintenance projects being performed at the hospital.
- B.2.4. The Infection Preventionist will act in an advisory and supportive role to ensure that high quality disinfection, sterilization, and safe use of non-critical, semi-critical, and critical reusable medical equipment (RME) is maintained.
- B.2.5. The Infection Preventionist will oversee and provide guidance to Employee Health and Infection Prevention that includes but is not limited to: Respiratory Protection Program, Immunization screening, TB screening, and correct PPE utilization (IC.02.04.01).

- B.2.6. The Infection Preventionist will assist in the organizational Emergency Preparedness to include, but not limited to, pandemic respiratory viral illness, emerging special pathogens, influx of infectious patients, and natural disasters. (IC.01.06.01).
- B.2.7. IPC will participate in the Clinical Product Review Committee to facilitate and approve new safety engineered devices/supplies.

Risk Assessment and Prioritization of Goals (IC 01.04.01)

The Infection Prevention and Control Committee, in collaboration with hospital leadership, identifies risks for transmitting and acquiring infection within the organization, based on the many factors discussed below. The Committee will develop a risk assessment at least annually, or when significant changes materially change risk prioritization (noted below), using information from all applicable committees and individuals as appropriate. Consideration will be given to those issues that are high risk, high volume, and/or problem prone, and to new techniques or procedures, or related to emerging trends. The Committee will develop action plans to address these issues (see Risk Assessment and current Prioritization List). The factors to be addressed in the risk assessment include, at a minimum: device related infections, antimicrobial stewardship plan, hand hygiene, influenza, medical devices, and transmission based organisms/diseases.

Geographic Location and Community Environment

Bartlett Regional Hospital is a community-owned acute care hospital licensed for a total of 56 inpatient beds and 16 residential substance abuse treatment facility beds in the Rainforest Recovery Center. In addition to the communities of Juneau and Douglas, we serve all the Southeast Alaska communities of Yakutat, Skagway, Haines, Sitka, Hoonah and Angoon. The primary and secondary service area has a combined population estimate of 52,771. Bartlett serves a 29,991-square-mile region in the northern part of Southeast Alaska. Juneau, the largest city in the region and the capital of Alaska is accessible only by water or air. The population of the city and borough of Juneau is 32,241 (CDRA, 2019) This includes 6% who are under 5 years of age, 18.7% that are aged 6-19 years, and 9.2% that are over 65 years of age. The underserved and disadvantaged population includes 7.9% with a disability and under 65 years of age, 13.4 % under 65 years of age without health insurance, and 7.3% (2365 persons) which live below the poverty line, and 9.8 % (3169 persons) below 125% of the poverty line.

Characteristics of the Population Served

Bartlett Regional Hospital is the largest provider of hospital services in Southeast Alaska. It serves a diverse community of residents. Tourism expands the service area population by approximately 30% from May to September each year, welcoming visitors from 50 or more countries. These include the workers for the fisheries and tourism agencies that are seasonal; approximately 27,000 people work seasonally in Southeast Alaska every year; 70% are non-residents, and many are foreign born from high TB incidence countries. The fisheries and cruise ships provide tight living quarters for their seasonal employees, which may increase the incidence of any disease. The cruise lines bring tourists and workers from many different countries. BRH must consider ship quarantine or influx of infectious diseases. This seasonal influx presents ongoing significant potential for mass trauma and communicable disease outbreak, requiring BRH to maintain careful surveillance, awareness of global emerging infectious disease trends (Pandemic or Novel strains of Influenza, MDR Tuberculosis, CRE, Ebola, etc.) and to maintain an updated emergency management and surge capacity plan.

The Alaska Department of Health and Social Services [2018](#) TB Summary Brief Report shows that Alaska's TB infection rate was 8.5 cases per 100,000 people, an increase from the previous two years (AK SOE, 2019). Alaska has the highest TB incidence rate in the nation, and is nearly three times the national average of 2.8 cases per 100,000 people. Southeast Alaska has an incidence rate of 2.7 cases per 100,000.

Results of Analysis of Bartlett Regional Hospital Infection Prevention Data

Bartlett Regional Hospital conducts hospital-wide surveillance for all types and categories of infection. The surveillance results from surgical site infections (SSI), device-related infections (Central Line Associated Blood Stream Infection[CLABSI], Catheter Associated Urinary Tract Infection [CAUTI], Ventilator Associated Events [VAE], Methicillin-Resistant Staphylococcus Aureus [MRSA], and Clostridium Difficile [C-Diff]) rates and communicable disease exposure events are reviewed for variance and reported to hospital leaders, the Patient Safety Committee, the Critical Care Committee, and medical staff as appropriate. A yearly Infection Prevention and Control Plan and a summary analysis of the prior year's plan, goals, strategies, activities, and issues are submitted annually to the Governing Board.

Evaluation of the Infection Control and Prevention Plan

Plan evaluation is an ongoing process that is measured and reported annually by comparing the described measurable objective to the observations/measurements as described in the plan. If the objective is met, then that particular goal is considered to be met for the plan year.

Care, Treatment, and Services Provided

Bartlett Regional Hospital's current strategic plan notes twenty-four services that are provided on campus. High-risk and high volume services are included in the risk assessment process.

Employee Health

Bartlett Regional Hospital provides a safe working environment for its approximately 670 employees, of which 493 (74%) are full or part time scheduled. This is accomplished through coordination of Infection Prevention policies and practices, and through the services provided by the Employee Health Program such as Hepatitis B vaccination, annual TB testing, and screening for immunity to vaccine-preventable diseases. Employee illnesses are categorized and logged daily by the House Supervisor, and analyzed by the Infection Preventionist. The goal is to identify and mitigate infectious conditions that may pose a risk to patients, visitors, or staff, and to ensure that staff are immune to vaccine-preventable diseases.

Emergency Preparedness

Bartlett Regional Hospital maintains readiness to respond to both internal and external threats and emergencies through its Emergency Management Plan, Emergency Management Team, Environment of Care Committees, and Infection Prevention Committee and Policy Manual.

December 16, 2019

2020

Infection Prevention and Control Plan

2020 Infection Control Plan Goals

Infection Prevention Goal #1	Measurable Objective	Strategies	Responsible Parties	Measurement/ Evaluation Goal Met or Unmet.
► Improve compliance with CDC Hand Hygiene Guidelines (NPSG 07.01.01, EP1).	<p>BRH hand hygiene rates will be improved by 5% over 2019's hand hygiene compliance rate by 12/31/2020.</p> <p>Press-Ganey hand hygiene scores will increase by 5 % over 2019's reported scores.</p>	<ol style="list-style-type: none"> 1. Continue with financial compensation for staff that observe hand hygiene. 2. Update Hand Hygiene Observer training with Staff Development. 3. Consistently and more directly meet with observers to encourage more observation. 4. Share data directly in a timely fashion with staff regarding compliance. 5. Work with Patient and Family Engagement Team to encourage more patient feedback regarding Hand Hygiene. 6. IP will talk directly with visitors, patients and families on proper hand hygiene. 7. IP will compare Press-Ganey reported hand hygiene. 	<p>Nursing Administration, Patient Care staff, Infection Prevention, Employee Health, Patients and visitors.</p> <p>Patient reported (Press-Ganey) hand hygiene scores will increase by 5% over 2019's reported rates.</p>	<p>BRH hand hygiene compliance rate will be \geq 75% hospital wide.</p>

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33/80

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Infection Prevention Goal #2	Measurable Objective	Strategies	Responsible parties	Measurement/ Evaluation
► Reduce surgical site infections by reducing risk of infection.	Maintain surgical site infection rate at or below 0.3 per 100 procedures by 12/31/2020.	<ol style="list-style-type: none"> 1. Monitor staff compliance with patient skin and nasal decolonization. 2. Reduce the number of sterile processing failures. 3. Continue to monitor ATP in OR suites and use Sterile Meryl daily in OR. 4. Develop glucose screening plan for all surgical patients with BMI ≥ 30. 5. Decrease the risk of contamination of surgical instruments. 	All nursing units, Surgical services, EVS, Medical Staff, and Pharmacy.	Measure surgical site infection rates and compare to 2019. Rate will be ≤ 0.3 infections per 100 procedures.
► Decrease the risk of acquiring health care associated C. difficile. (NPSG 07.03.01)	Limit the risk of HAI C. difficile transmission and maintain HAI CDI rates of 2 infections per 10,000 patient days by 12/31/2020.	<ol style="list-style-type: none"> 1. Continue to monitor compliance for recommended specimen testing. 2. Increase utilization of Sterile Meryl for all isolation terminal cleaning. 3. Ensure appropriate cleaning and disinfection products (bleach) are available for C. 	Nursing, EVS, Infection Prevention, pharmacy, medical staff, laboratory and all staff.	Measure C. difficile infection rates and compare to 2019 baseline. There will be no increase in HAI- C. difficile rates for 2020.

		difficile rooms and area is cleaned per protocol. 4. Prohibit unnecessary antibiotic use.		
Infection Prevention Goal #4	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
► Decrease the risk health care associated MRSA transmission in the facility. (NPSG 07.03.01)	Return to zero inpatient transmissions of healthcare-associated MRSA infections for 2020.	<ol style="list-style-type: none"> 1. Continue to measure and report MRSA infection transmission. 2. Encourage compliance with hand hygiene and appropriate glove use. 3. Continue to monitor effectiveness of surface cleaning and report monthly data to EVS manager. 4. Educate staff, patients, and visitors on hand hygiene compliance and surface cleaning with admission. 5. Continue to monitor MRSA infections and report via NHSN. 	All staff who enter patient rooms, patients, families and visitors. EVS and Infection Prevention.	There will be zero (0) transmission of MRSA or HAI MRSA infections in 2020.

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<p>community from influenza exposure at BRH in an efficient and safe manner. (IC.02.04.01)</p>	<p>influenza vaccination at rates 98 % or greater for the 2020-2021 influenza season.</p>	<p>2. Unvaccinated staff are required to wear barrier masks. 3. Continue to monitor and report pertinent information regarding illness trends in the community and at BRH. 4. Participate in state wide influenza infection prevention meetings. 5. Increase public awareness of importance of vaccination.</p>	<p>rate will be at 98% or greater by November 30, 2020. Report data via NHSN.</p>
Infection Prevention Goal #6	Measurable Objective	Strategies	Measurement/Evaluation

Infection Prevention Goal #7	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
Reduce the risk of HAI transmission attributable to surface contamination.	ATP pass rates will improve be 90% by 12/31/2020	1. Verification of cleaning will be audited with use of objective measures such as ATP swabbing of surfaces and observation of cleaning practices.	EVS, Infection Prevention, Education, Nursing Directors and all patient care staff.	Monthly surface cleaning audits will be done in 2020. All high touch surfaces will show a 90% ATP pass rate.

References:

Alaska Community Database Online DCRA Information Portal (2019) Juneau, Alaska. Retrieved from
<https://dcceed.maps.arcgis.com/apps/MapJournal/index.html?appid=3635942ba31c40f094e6249f9d07431c>

Section of Epi (2018) Alaska TB Summary Brief. Retrieved from
http://dhss.alaska.gov/dph/Epi/id/SiteAssets/Pages/TB/TB_SummaryBrief.pdf
<http://dhss.alaska.gov/dph/Epi/id/Pages/tb.aspx>

Bartlett Regional Hospital
INFECTION CONTROL RISK ASSESSMENT
Hospital Acquired Infections

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)				RISK
		HUMAN IMPACT		PREPAREDNESS	INTERNAL RESPONSE	
Likelihood this will occur	Possibility of morbidity or death			Processes in place to mitigate	Staff compliance with processes	Relative threat*
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High		0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Surgical Site Infection (SSI)	3	3		2	1	67%
Catheter Associated Urinary Tract Infection	2	2		2	1	37%
Central Line Infections	1	3		2	1	22%
Ventilator associated events	1	3		2	1	22%
Transmission of TB in the facility	1	1		2	1	15%
Transmission of c. difficile in the facility	2	3		2	2	52%
Transmission of MRSA in the facility	2	2		2	2	44%
AVERAGE	2.00	2.83	0.00	0.00	2.33	1.50
						49%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.49 0.67 0.74 0.74

BARTLETT REGIONAL HOSPITAL
INFECTION CONTROL RISK ASSESSMENT
Hospital Staff Exposure Risks

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)				RISK
		HUMAN IMPACT	PREPAREDNESS	INTERNAL RESPONSE		
Likelihood this will occur	Possibility of morbidity or death					Relative threat*
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%	
Norovirus Exposure	2	1		1	1	22%
Tuberculosis Exposure	1	1		1	1	11%
Pertussis Exposure	1	1		1	2	15%
Bloodborne Pathogen Exposure/Sharps Injuries	1	1		1	1	11%
Influenza Exposure	3	2		1	3	67%
Biological Terrorism Exposure	1	3		1	0	15%
AVERAGE	1.50	1.50	0.00	0.00	1.33	0.00

*Threat increases with percentage.

$$\text{RISK} = \text{PROBABILITY} * \text{SEVERITY}$$

0.21	0.50	0.43
------	------	------

BARTLETT REGIONAL HOSPITAL
INFECTION CONTROL RISK ASSESSMENT
Infectious Patients

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)				RISK
		HUMAN IMPACT	Possibility of morbidity or death	PREPAREDNESS	INTERNAL RESPONSE	
Likelihood this will occur	Possibility of morbidity or death			Processes in place to mitigate	Staff compliance with processes	Relative threat*
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High		0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Patients presenting with novel strain (avian and/or pandemic) influenza	2	3		1	2	44%
Patients with seasonal influenza / complications	2	2		1	1	30%
Patients with MRSA	3	1		1	2	44%
Patients with c. difficile infections	3	1		1	2	44%
Patients with Tuberculosis	2	1		1	1	22%
Patients with Norovirus Infection	2	1		1	1	22%
Patients affected by regional exposure of infectious diseases	2	1		1	1	22%
AVERAGE	3.20	2.00	0.00	0.00	1.40	2.00
					0.00	64%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.64 1.07 0.60

HAZARD AND VULNERABILITY ASSESSMENT TOOL
EVENTS INVOLVING HAZARDOUS MATERIALS

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)			RISK
		HUMAN IMPACT	PREPAREDNESS	INTERNAL RESPONSE	
Likelihood this will occur	Possibility of death or injury				Relative threat*
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Exposure to Fomulin	2	1		1	11%
Exposure to Cidex OPA	2	1		1	11%
Exposure to Biohazardous Waste	3	2		1	22%
Exposure to Sharps	3	2		1	22%
Breach of / Inappropriate/ Inadequate PPE use	2	2		1	19%
HLD Chemical exposures	2	1		1	11%
LLD Chemical exposures	2	1		1	11%
AVERAGE	1.78	1.11		0.78	0.89
					9%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.09 0.59 0.15

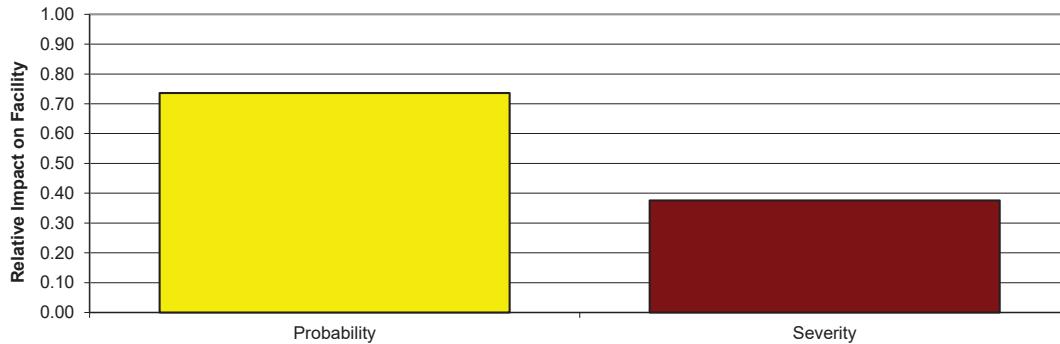
Summary of Bartlett Regional Hospital Infection Prevention Risk Analysis 2020

	Hospital Acquired Infections	Hospital Staff Exposure Risks	Infectious Patients	Total for Facility
Probability	0.67	0.50	1.07	0.59
Severity	0.74	0.43	0.60	0.15
Hazard Specific Relative Risk:	0.49	0.21	0.64	0.09
				0.28

Hazard Specific Relative Risk to Bartlett Regional Hospital 2020



Probability and Severity of Infection Control Risks Bartlett Regional Hospital 2017



Prioritized Risks For 2017

Risk	Score	Type
Influenza Exposure Staff	67	HS
Surgical Site Infections	67	HAI
Patients with C. diff infections	52	IP
Patients with novel strain of influenza (avian)	44	IP
Patients with MRSA	44	IP
Urinary Catheter Infections	37	HAI
Patients with regional infectious disease	22	IP
Central Line Infections	22	HAI
Transmission of TB	22	HAI

IP = Infectious Patients

HS = Hospital Staff Exposure Risks

HAI = Hospital Acquired Infections

Prioritized Risks for 2020 Plan:

1. Influenza Staff/Patient Exposure HS
2. Surgical Site Infections HAI
3. Patients with C. diff infections IP
4. Patients with novel strain influenza (avian) IP

BARTLETT REGIONAL HOSPITAL

Environment of Care

Annual Report

CY 2019

Approvals

Environment of Care Committee: November 17, 2019
Performance Improvement Council: (scheduled January 8, 2020)
Board Quality: (scheduled January 8, 2020)



INTRODUCTION

The goal of the Environment of Care (EOC) Program is to provide a safe, functional and effective environment for patients, staff and visitors. The EOC Program encompasses the following five programs/areas:

- Safety Management (Nathan Overson Director of Compliance and Employee Safety)
- Security Management (Mike Lopez Security Supervisor/Emergency Preparedness Coordinator)
- Hazardous Materials and Waste Management (John Fortin Laboratory Department Director)
- Medical Equipment Management (Kelvin Schubert Maintenance Supervisor)
- Utility Systems Management (Kelvin Schubert Maintenance Supervisor)

In addition, the BRH Emergency Management and Life Safety Management Programs are integrated with the EOC Program, ensuring the hospital's overall preparedness for emergencies and disaster response.

The EOC Program and work groups are overseen by the EOC Committee. The EOC Committee and work groups:

- Identify risks and implements systems that support safe environments.
- Works to ensure that hospital staff are trained to identify, report and take action on environmental risks and hazards.
- Sets and prioritizes the hospital's EOC goals and performance standards and assesses whether they are being met.
- Works with the BRH Joint Commission Coordinator to ensure the hospital is compliant with the EOC-related requirements of all applicable regulatory bodies.

Membership of the EOC Committee is comprised of:

- Program managers for each of the five EOC Management Programs, Emergency Management and Life Safety Management Programs.
- Representatives from Nursing, Infection Control, Clinical Laboratory, Environmental Services, Quality Management, Human Resources and Senior Leadership.

EOC projects and initiatives include opportunities for improvement identified during ongoing hazard surveillance, risk assessment and other EOC activities to promote a culture of safety awareness.

This report highlights the activities of the EOC Program in Calendar Year 2019. For each of the major areas, it is organized as follows:

- Scope
- Accomplishments
- Program Objectives
- Performance Measures
- Effectiveness
- Opportunities for Improvement

SAFETY MANAGEMENT

SCOPE

Bartlett Regional Hospital's commitment to a safety management plan is designed to provide a physical environment free of unmitigated hazards and to manage staff activities to minimize the risk of human injury. It shall ensure that personnel are trained to interact effectively in their environment and with the equipment they use. All elements of the Environment of Care (EOC) are incorporated or serve to support the BRH Safety Management Plan.

The Safety Management Plan incorporates an interactive process involving and affecting all of Bartlett Regional Hospital's employees, contractors, patients, and visitors.

ACCOMPLISHMENTS

- AKOSH consultation visit for health and safety compliance and identified hazard abatement was completed.
- A new Asbestos Management Program and Policy has been put into place.
- Analysis of hospital after-hours access was finalized.
- Establishment of Policy Management Committee.
- Duress Alarm program evaluation and enhancement
- Began workplace violence pilot through WSHA in the emergency department



PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments and Action Plans
Hire and orient an Employee Safety Officer.	Met	Nathan Overson has graciously accepted this role.
The hospital identifies safety and security risks. Departmental Safety Swarms are conducted in all areas of the work environment. Additional risk assessments are conducted when trend data suggests.	Met	Safety Swarms are conducted twice annually in patient care areas and annually in non-patient care areas. Enhancement to Duress Alarm procedures conducted.

Objectives	Met / Not Met	Comments and Action Plans
The Environmental of Care (EOC) rounds include all areas of the hospital. All patient care areas are inspected at least twice a year, and other areas are inspected annually.	Met	EOC Rounds were completed as required in all areas, and follow-up rounds were conducted to monitor specific regulatory survey findings. Action Plan: Update schedule to include Juneau Medical Center.
The hospital manages its environment during demolition, renovation, or new construction to reduce risks.	Met	Continue to incorporate Infection Prevention and Safety Management in Construction Planning.
An annual evaluation of the scope, objectives, key performance indicators, and the effectiveness of the Safety Management plan and programs is conducted.	Met	Completed via this document.

The Environment of Care Committee has evaluated these objectives for the Safety Management Program and determined that they have been met.

PERFORMANCE MEASURES

The following measures provide the Environment of Care Committee with information needed to evaluate performance of the Safety Management Program activities and to identify further opportunities for improvement:

Safety Management Performance Measures	Target	Outcome	Comments and Action Plan
Perform a BRH needs assessment from the Workforce Safety Measures evaluation performed by ASHNA; implement all required/prioritized elements.	Implement 100% of required and prioritized elements	100%	Met Still room to enhance identified elements.
Identify and assess BRH's compliance with AKOSH program requirements (goal outlined in Focus & Execute).	100% AKOSH programs assessed	100%	Met
Increase staff, visitor and patient safety by implementing an after-hours Facility Lockdown Program (goal outlined in Focus & Execute).	100%	100%	Met Project to be completed in house. Committee's new role is to advise priority of rollout and track progress of project.
Develop additional and more specific training to offer staff around De-Escalation/Crisis Intervention/Violence Reduction/Restraints.	100%	100%	Met Efficacy analysis ongoing

EFFECTIVENESS

Effectiveness is based on how well the goals are met and how well the scope of the performance metrics fit current organizational needs. The Safety Management Program has been evaluated by the Environment of Care Committee and is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2020:

- Reduce Workplace Violence: Combine and enhance all the workplace violence elements.
- Reduce Workforce Injuries: Create reports to review and analyze the following indicators with the intent to identify ways to reduce injuries.
- Safety: Implement a comprehensive working at heights program at BRH, aimed at improving staff safety.

The proposed performance measures for these goals are:

Safety Management Proposed Performance Measures for 2020	Target	Comments & Action Plan
AIM: Combine and enhance all the workplace violence elements (policies, procedures and related training curriculum) into a complete comprehensive program.	Complete 100%	All updates will be reviewed and approved by multi-disciplinary EOC Committee.
AIM: Create reports to review and analyze the following indicators with the intent to identify ways to reduce injuries: <ul style="list-style-type: none">• Number of recordable lost workdays• Injuries by cause• Injuries by body part• Needle sticks and body fluid exposures.	Complete 100%	A multi-disciplinary team will be used including members from Risk Management and Human Resources.
AIM: Implement a comprehensive working at heights program at BRH, aimed at improving staff safety.	Complete 100%	Continue to work with Facilities Management, CBJ Safety and AKOSH Consultation to improve existing plan.

SECURITY MANAGEMENT

SCOPE (No Change)

Bartlett Regional Hospital's Security Management Plan is to provide a program that shall protect employees, patients and visitors from harm, and define the responsibilities, reporting structure and action for maintaining a secure environment. This plan includes all facilities and activities directly related to Bartlett Regional Hospital.

ACCOMPLISHMENTS

- After-hours lockdown project initialized.
- Safety and security taskforce created new anti-violence signs and placed throughout the hospital.
- Class given on the topic of “De-Escalation of Extreme States – Communication with Aggressive, Mentally Ill and Emotionally Disturbed Individuals”.
- Juneau Police Department training for security officers on identification of Drugs and Paraphernalia Identification.



PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments and Action Plans
The hospital takes action to minimize or eliminate identified security risks in the physical environment.	Met	<p>BRH Security Supervisor attends daily safety huddles.</p> <p>BRH adjusts security patrols and response procedures as needed.</p> <p>e.g. Second security officer posted on night shifts with a priority to post in the ED.</p> <p>Progress continues towards achieving afterhours lock-down of the facility.</p>
When a security incident occurs, the hospital follows its identified procedures.	Met	Hospital staff follow established protocols for security incidents as outlined in the BRH Emergency Code Directory.
The hospital establishes a process for continually monitoring, internal reporting and proactive risk assessments to identify potential security risks.	Met	<p>Accomplished through reports to the EOC Committee and annual Security Management plan updates.</p> <p>Continue to use the BRH Occurrence Reporting System.</p>

Objectives	Met / Not Met	Comments and Action Plans
The hospital reports and investigates incidents of damage to its property or the property of others.	Met	Reports are reported through the BRH Occurrence Reporting System.
The hospital will utilize a multi-disciplinary safety and security team to review all policies, procedures and operations to identify and respond to hazards that exist currently and plan for future threats.	Met	The Safety and Security Committee meets to discuss violence prevention policies, education and exercises. Threats to public safety will be mitigated by a combination of physical and procedural controls. The Safety and Security Committee discusses potential solutions and makes recommendations to improve the safety and security of patients, visitors and staff.

PERFORMANCE MEASURES

An analysis of the program objectives and performance measures is used to identify opportunities to resolve security issues and evaluate the effectiveness of the program. Additionally, it provided the Environment of Care Committee with information that can be used to adjust the program activities to maintain performance or identify opportunities for improvement.

Security Management Performance Measures	Target	Outcome	Comments and Action Plan
Continue development of 1:1 sitters program to provide relief for Security Officers in the ED. Measure is percent of time Officers are relieved.	90%	95%	Met
Staff knowledge of Armed Intruder Procedures. Data collected during departmental swarms.	80%	96%	Met
Swarms completed and logged	100%	73%	Partially Met; committee membership changes drove new direction, this made swarm completion challenging. The committee will evaluate the process to possibly develop an alternative to swarms.

EFFECTIVENESS

Effectiveness is based on how well the goals are met and how well the scope of the performance measures fit current organizational needs. The Security Management Program has been evaluated by the Environment of Care Committee and is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2020

The following goals have been identified:

- **Increase Facility-wide Security Afterhours** – BRH has successfully identified process's and systems needed to better protect the hospital, patients and employees afterhours. The committee will continues assist in the prioritization of needed systems.
- **Improve Customer Satisfaction:** The Security Management Committee will help improve customer satisfaction by working towards decreasing the number of in-patient property loss incidents.
- **Improve the Security Camera System Functionality:** In order to ensure the security of BRH, the Security Camera System must be highly functional and reliable.

The proposed performance measures for these goals are:

Security Management Proposed Performance Measure for 2020	Target
Increase Facility-wide Security Afterhours AIM: BRH will complete prioritized security systems installations over the next year to equate to approximately 55% of the overall project. These installations will be as follows: <ul style="list-style-type: none">• Secure facility to limit after-hours access to the ED• Move Vending Machines• Development of patient visitor policy/procedure• Installation of select internal door security systems	55% of the overall project. = 20% = 10% = 5% = 20%
Improve Customer Satisfaction AIM: BRH will improve customer satisfaction by decreasing the number of in-patient property loss incidents.	BRH will be measured on its ability to prevent in-patient property loss incidents: Decrease incidents by 50% In 2019 there were 16 in-patient property loss incidents.
Improve the Security Camera System Functionality AIM: Assess the existing security camera systems to drive an improvement project recommendation. Steps to complete the assessment include: <ul style="list-style-type: none">• Inventory Systems 10%• Develop Needs Assessment 40%• Compare current capabilities against needs assessment to identify gaps 40%• Present recommendations 10%	The Security Committee will be measured on its ability to achieve the following: 100% Completion

HAZARDOUS MATERIALS & WASTE MANAGEMENT

SCOPE (No Change)

It is the practice of Bartlett Regional Hospital to comply with all federal and State of Alaska laws and regulations relating to the proper and safe handling and disposal of all hazardous materials and waste. Bartlett Regional Hospital provides comprehensive healthcare and health promotion for the people of Juneau and communities of northern Southeast Alaska.

To this effort Bartlett Regional Hospital provides a healthy and safe environment for our patients, visitors and staff by maintaining a process to effectively manage hazardous materials and waste throughout the facility.

The program also works to control the risk of exposures to hazardous components such as asbestos in existing building materials which may be disturbed during construction and renovation activities.

ACCOMPLISHMENTS

- Hazardous Communication Plan was updated.
- Better communication for follow up with Pharmaceutical waste, by assuring department labeling.
- The subcommittee maintained all policies and procedures as per compliance needs. Subcommittee will update policies and procedures as indicated by Risk or Quality.
- Assured that safety features (eye wash, showers) are maintained per compliance. Assured general knowledge of Haz-Mat concerns are brought to the employees through use of SWARMS.
- Review of all areas to assure they have current Safety Data sheets.



PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments & Action Plan
To assure items in departments have current SDS information in our system, and that staff are able to access the SDS.	Partially Met	Swarm data indicates this objective has been partially met. The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
To assure staff are able to safely identify spill clean-up resources.	Met	Staff were able to describe spill containment locations and competence in their use.

To assure staff understand waste streams: White, Red, Sharps and Liquids.	Met	This objective has been met as demonstrated by staff during swarms and as evidenced by compliance with disposal requirements.
To assure Nursing Departments are familiar with the pharmaceutical waste process.	Partially Met	Nearly all departments have demonstrated competency in this objective. Committee members will continue to work with Department Directors as needed and will continue to monitor compliance through swarms.

The Environment of Care Committee has evaluated the objectives and determined that there are minimal opportunities for improvement. The Program continues to direct hazardous materials and waste management in a positive proactive manner.

PERFORMANCE MEASURES

The following measure provide the Environment of Care Committee with information needed to evaluate performance of the Hazardous Materials and Waste Management Program activities and to identify further opportunities for improvement:

Security Management Performance Measures	Target	Outcome	Comments and Action Plan
Review area for products that need Safety Data Sheets. Ask staff to find one item in the system. Need to assure items are uploaded to MSDS Online. Ask when last time staff had Hazardous Communication training	100%	90.9%	Partially Met; The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
When would it be necessary to initiate a code “Orange”? Does staff know the difference between incidental vs non-incidental spill? Make sure to clarify this includes fumes as well.	95%	90.6%	Partially Met; The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
Staff identifies location and knows how to use spill buckets.	85%	90.5%	Met
Does staff know how to dispose of Hazardous materials, batteries, etc? Refer staff to Hazardous Material Disposal policy 8360.304. Note: only week supply of batteries at any time. Batteries should have taped ends	90%	87.7%	Partially Met; The committee will continue to provide department specific education as needed and monitor the results of the training efforts.

Eye wash and shower stations are checked weekly (ER, OB, Maintenance, Kitchen, Lab, Histo, Laundry, Pharmacy, Respiratory Therapy, INF, DI, BSSC)	100%	93.1%	Partially Met; The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
Nursing Departments – verify staff is familiar with the pharmaceutical waste process. Check area for organization	95%	93.6%	Partially Met; The committee will continue to provide department specific education as needed and monitor the results of the training efforts.
Does staff understand waste streams? White, Red and Sharps will go to local landfill. Liquids must be segregated or poured down drain. Cannot be in Sharps	85%	90.6%	Met

EFFECTIVENESS

Effectiveness is based on how well the scope fits current organizational needs and the degree to which current performance metrics result meet stated performance goals. The Environment of Care Committee has evaluated the Hazardous Materials and Waste Management Program and considers it to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2015-2016

- **(Continued from previous reporting year) Improve employee understanding of current hazardous spill cleaning practices.** During 2020 the committee will work to expand employee knowledge around hazardous spill cleanup.
- **(Continued from previous reporting year) Enhance (chemical) hazard communication at BRH.** During 2020 the committee will work to expand employee knowledge of the content and use of the SDSs and product labels.
- **(Continued from previous reporting year) Enhance waste stream segregation at BRH.** During 2020 the committee will work with departments as needed to assure understanding of waste stream segregation.
- **(Continued from previous reporting year) Assure safety systems are ready if needed.** During 2020 the committee will continue to monitor safety systems such as eye wash stations.

The proposed performance measures for these goals will include:

Hazardous Materials & Waste Management Proposed Performance Measures 2020	Target
<p>AIM: Review area for products that need Safety Data Sheets. Ask staff to find one item in the system. Need to assure items are uploaded to MSDS Online.</p> <p>Ask when last time staff had Hazardous Communication training</p>	100% Same as 2019
<p>AIM: When would it be necessary to initiate a code "Orange"? Does staff know the difference between incidental vs non-incidental spill?</p> <p>Make sure to clarify this includes fumes as well.</p>	95% Same as 2019
<p>AIM: Can staff identify the location and know how to use chemical spill buckets? Ask what could spill which bucket would be used.</p> <p><u>(MS, CCU, OB, ER, Laundry, Pharmacy, RT, INF, DI, BSSC, OR)</u></p>	90% Adjusted from 2019
<p>AIM: Does staff know how to dispose of Hazardous materials, batteries, etc? Refer staff to Hazardous Material Disposal policy 8360.304.</p> <p>Note: only one week supply of batteries at any time. Batteries should have taped ends.</p>	90% Same as 2019
<p>AIM: Eye wash and shower stations are checked weekly (ER, OB, Maintenance, Kitchen, Lab, Histo, Laundry, Pharmacy, Respiratory Therapy, INF, DI, BSSC)</p>	100% Same as 2019
<p>AIM: Nursing Departments – Verify staff familiar with pharmaceutical waste. Check area for labels on the disposal buckets. Pre-label before putting into use.</p>	95% Same as 2019
<p>AIM: Does staff understand waste streams. White, Red and Sharps will go to local landfill. Liquids must be segregated or poured down drain. Cannot be in Sharps.</p>	90% Adjusted from 2019

LIFE SAFETY MANAGEMENT

SCOPE (No Changes)

To provide an environment of care that is fire-safe and to design processes to prevent fires and protect patients, staff, and visitors in the event of a fire.

To assure that the building is in compliance with applicable Federal, state and local codes and standards, and National Fire Protection Association (NFPA) 101, 2012 standards for hospitals,

To provide education to personnel on the elements of the Life Safety Management Program including organizational protocols for response to, and evacuation in the event of a fire,

To assure that personnel training in the Life Safety Management Program is effective,

To test and maintain the fire alarm and detection systems,

To institute interim life safety measures during construction or fire alarm or detection systems failures.

ACCOMPLISHMENTS

- Completed annual test, inspection, and repairs to fire alarm system per NFPA standards.
- Assessed risk and implemented Interim Life Safety Measures (ILSM) for the BOPS temporary location in the Juneau Medical Center, and implemented a multi-day fire watch for RRC while the fire alarm system was being upgraded.
- Obtained funding to design and replace the JMC Fire Alarm system.
- Began integration of current campus-wide fire alarm systems to SARA (Situational Awareness Response Assistant).



PROGRAM OBJECTIVES

Objectives	Met/ Not Met	Notes/Action Plan(s)
The Life Safety Management Plan defines the hospital's method of protecting patients, visitors, and staff from the hazards of fire, smoke, and other products of combustion and is reviewed and evaluated at least annually.	Met	At a minimum, annually review the BRH Fire Plan.
The fire detection and response systems are tested as scheduled.	Met	The Fire Alarm system serving BRH is routinely tested and repaired as necessary.
Summaries of identified problems with fire detection, NFPA code compliance, fire response plans, drills and operations in aggregate, are reported to the EOC Committee.	Met	Any problems or deficiencies of the fire alarm system are reported to the Environment of Care (EOC) Committee.
Fire extinguishers are inspected monthly, and maintained annually, are placed in visible, intuitive locations, and are selected based on the hazards of the area in which they are installed.	Met	Fire extinguishers are inspected regularly, and as required. All extinguishers are appropriate to their use and location.
Annual evaluations are conducted of the scope and objectives of this plan, the effectiveness of the programs defined, and the performance measures.	Met	Items monitored in the annual report and fire drills are assessed for effectiveness and improvement.

PERFORMANCE MEASURES

Life Safety Management Performance Measures	Target	Outcome	Comments and Action Plan
Finalize, and use Life Safety work order report for better tracking and evaluation of Life Safety priorities.	100%	50%	Partially Met; the committee will continue to work closely with the Maintenance Supervisor to finalize the report layout.
Incorporate tracking and monitoring of regulated inspection and testing schedules for Life Safety systems/elements of the hospital into the agenda of the committee.	100%	95%	Partially Met; continue to refine the requirements with the assistance of the Joint Commission Survey Coordinator.
Replace all 50 year old sprinkler heads in the facility.	100%	100%	Met

EFFECTIVENESS

The multi-disciplinary Environment of Care Committee has evaluated the Life Safety Management Program and considers it to be effective based on the objectives and performance metrics indicated in the Plan.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2020

- Establish and incorporate Fire Response Plans for RRC/BOPS new locations.
- Monitor ILSM for on-going construction projects within.
- Monitor the replacement of the JMC fire alarm system to assure timely completion.
- Update Life Safety Swarms process and complete for all units/departments
- Finalize Life Safety work order report for better tracking and evaluation of Life Safety priorities.

The proposed performance metrics for these goals include:

Life Safety Proposed Performance Measures for 2020:	Target	Comments and Action Plan
AIM: Establish and incorporate Fire Response Plans for RRC/BOPS new location.	100%	Develop and implement staff trainings on revised fire response plans.
AIM: Update Life Safety Swarms process and complete for all units/departments.	100%	Review and revise swarm questions and continue to monitor outcomes from swarms for each department.

UTILITY SYSTEMS MANAGEMENT

SCOPE (No Changes)

The Utility Systems Management Plan monitors and evaluates the utility systems in use at Bartlett Regional Hospital. A safe, comfortable patient care and treatment environment shall be provided by managing the risks associated with safe operation and the functional reliability of the hospital's utility systems. The major utility systems include but are not limited to: electrical distribution, water and waste systems, vertical transportation (elevators), communication systems, heating, ventilation and air conditioning (HVAC) and medical gases.

ACCOMPLISHMENTS

- Removal of an old domestic hot water distribution manifold that had been abandoned in place.
- Replacement of domestic hot water recirculation piping, section by section, that have developed pinhole leaks. This will be an ongoing project due to the extent of the failure. We have replaced and repaired many other leaking pipe fittings
- Updating the lighting system with modern LED bulbs and fixtures. Areas still needing fluorescent T-12 bulbs removed are the three OR's, Laboratory and parts of the kitchen. Other fluorescent and high pressure lighting has been and will continue to be replaced as specific areas are identified.
- The hospital steam boiler fuel system has had major components replaced. The underground fuel tank dip port was updated. Both fuel feed pumps were replaced. Some plumbing was rerouted in an attempt to receive better draft of fuel from the tank. Replaced a defective fuel tank monitoring system for the purpose of watching the fuel level, bottom tank water level, and tank interstitial spaces.
- Installed a new steam boiler control system. The new Cleaver Brooks "Hawk 4000" is a PLC-based, complete control package for systems that require precise fuel-to-air ratio control with options for O2 trim and variable-speed drive controls in one integrated package. Advanced features include economizer control and draft control. It is anticipated that there will be a significant return on our investment.
- The main emergency generator control panel has been moved to a lower elevation into an adjacent room behind closed doors. This was a move to position the operator into an area where the sound dB level is within OSHA standards. The move has also allowed the operator to not stand on a ladder while recording meter readings during operation.
- Installation of energy efficient computer access layer switches around the hospital is now complete. They require less power consumption and the demand for facility cooling is also decreased.
- Deploying ultra-small-form-factor Personal Computers, PCs, with LED monitors requiring 40% less power consumption.
- We have been able to remove all battery operated exit lights within the hospital and replace them with lights that do not have batteries. Batteries are not required in these units because



they are energized by the electrical Critical Branch powered by the emergency generator.

PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments and Action Plans
The hospital minimizes the occurrence of unplanned utility systems failures or interruptions.	Met	Inventory of equipment for major utility systems maintained in equipment database including PM documentation.
The hospital provides preventative maintenance of the utility systems ensuring reliability.	Met	Documentation of activities is entered into TMS, the automated work order system.
The hospital monitors and investigates all utility system problems, failures or user errors to learn from each occurrence in order to minimize reoccurrence of failures or errors.	Met	Documentation of activities is entered into TMS, the automated work order system.
The hospital reduces the potential for organizational-acquired illness.	Met	This is assured through preventive maintenance and annual quality assurance check of ventilation system pressure relationships and air exchange rates.

The Environment of Care Committee has evaluated the objectives and determined that they have been met. The Program continues to direct utilities management in a proactive manner.

PERFORMANCE MEASURES

Utilities Management Performance Measures	Target	Outcome	Comments and Action Plan
Review and rewrite preventative maintenance procedures.	33%	30%	Partially Met; This will be a multi-year project to review and rewrite all procedure. (This year's goal was not met for lack of manpower to perform the work.)
Create and maintain an inventory control program in TMS for the Maintenance Department.	30%	25%	Partially Met; This will be a multi-year project to review and rewrite all inventories.

EFFECTIVENESS

The Utility Management Program has been evaluated by the EOC Committee and is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2020

- Replace (6) UPS units in the network closets with newer models that are more energy efficient.
- Removing (4) large UPS units in the datacenter and replacing with one UPS unit that has N+1 redundancy and is more energy efficient to support new network and server hardware infrastructure.
- (7) racks of computer equipment are being decommissioned and making space for the new VxBlock hardware.
- Replace feed piping to and from the underground fuel tank to bring it into compliance with EPA Standards.
- Replace fan unit AHU 11 which provides air to the Operation Rooms. This fan has failed many times in the past few years causing the OR surgical schedules to be canceled.
- Install a glycol heat exchanger on AHU 1 to prevent the freezing of the heating coil at cold temperatures. This is the oldest air handling unit in the hospital that services the Medical Surgical section of the hospital.
- Replace a closed-loop water chiller that has reached its end of life. It needs major components replaced and it is more cost effective to replace the unit rather than fix the failing or failed parts.
- Replace glycol feeder tank in Z1 that has come to end of life and needs to be replaced because of rust in the tank and old feed motor technology. This services the heat recovery system on Supply Fan 1.
- Design and install a workable ventilation system that services the Laboratory. This department is extremely hot in the summer and spaces exceed environmental limits for many of the reagents stored and used in the unit. This problem is closely related to the ventilation of the boiler room. The boiler room has historically been excessively hot and the Lab is located directly above

The proposed performance measures for the plan objectives include:

Utilities Management Proposed Performance Measures 2020	Target	Comments and Action Plan
AIM: Review and rewrite preventative maintenance procedures.	50%	The hospital identifies the activities and associated frequencies, in writing, for inspecting, testing, and maintaining all operating components and utility systems on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations. This will be a multi-year project.

AIM: Create and maintain an inventory control program in TMS for the Maintenance Department.	50%	Reducing the load of unused and outdated stock to help assure the maintenance of adequate stock for perform of necessary tasks. This will be a multi-year project to clean out old stock.
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MEDICAL EQUIPMENT MANAGEMENT

SCOPE

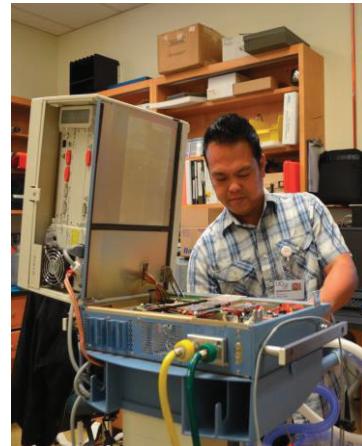
The Medical Equipment Management Plan is designed to define the processes by which Bartlett Regional Hospital provides for the safe and proper use of medical equipment used in the patient care setting.

The physical and clinical risks of all equipment used in the diagnosis, treatment, monitoring and care of patients will be assessed and controlled.

ACCOMPLISHMENTS

Program activities highlights for 2019 include:

- Approval for new anesthesia machines in the Operating Rooms.
- Placed into service, 100 new IV (Intravenous) pumps and poles. Training was performed for hospital staff on proper use of IV pumps.
- Placed into service 15 new PCA's (Patient-Controlled Analgesia) units for pain control.
- Received new ultrasound units for the CCU (Critical Care Unit) and OB (Obstetrics).
- Calibration of all Biomed Test Equipment.



PROGRAM OBJECTIVES

Objectives	Met/ Not Met	Comments and Action Plan
The hospital maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized by physical risk associated with use (including all life support equipment) and equipment incident history. The hospital evaluates new types of equipment before initial use to determine whether they should be included in the inventory.	Met	Inventory is kept in the Computerized Maintenance Management System Database (TMS), categorized by risk level and associated with all related historical records.
The hospital identifies, in writing, frequencies for inspecting, testing, and maintaining medical equipment on the inventory based on criteria such as manufacturers' recommendations, risk levels, or current hospital experience.	Met	As evident in TMS software
Annual evaluations are conducted of the scope, objectives of this plan, the effectiveness of the programs defined, and the performance monitors	Met	The Environment of Care Committee reviews and approves the annual plan.

The Environment of Care Committee has evaluated the objectives and determined that they have been met. The Medical Equipment Management Program continues to direct medical equipment procurement and maintenance in a proactive manner.

PERFORMANCE MEASURES

Equipment Management Performance Measures	Target	Outcome	Comments and Action Plan
Reduce the average level of “unable to locate for PM” items to below 5% per month.	80%	95%	Met ; This goal was met by removing equipment from PM inventory list that had not been found in many years.
Maintain semi-annual PM completion rate for life support equipment of 100%.	100%	100%	Met

Have all biomed personnel achieve at least two certifications within the next 12 months. Promoting a centralized system for receiving, assigning, monitoring end of life of medical unit and disposal of equipment.

EFFECTIVENESS

The Medical Equipment Management Program has been evaluated by the multi-disciplinary Environment of Care Committee and is considered to be effective.

GOALS AND OPPORTUNITIES FOR IMPROVEMENT FOR 2020

- Lead Biomed would like to take classes for the repair of the Drager Apollo Anesthesia Machine.
- Need to check Vents and Gas Analyzers from Respiratory Department. They need to be sent to Germany for service.
- Needing a larger Biomed shop.
- Needing a centralized system for receiving, assigning, monitoring end of life of medical unit and disposal of equipment
- Pharmacy needs to purchase new Vaporizers.

The proposed performance measures for 2020 are:

Medical Equipment Management Proposed Performance Measures	Target	Comments & Action Plan
AIM: To promote proactive equipment replacement. Medical equipment needs to be managed within a unified system. We propose to identify the unified system by February 2020	100%	Researching the market for capable systems that match the Biomedical department tasks and performance metrics, and develop a proposed solution.

AIM: Within the new system we propose to capture all new equipment at time of implementation and enter 100 pieces of existing equipment into the account by August 2020. The system should record the purchasing and receiving dates, implementation and assignment of equipment, monitor and document end of life and disposal of each piece of medical equipment.	100%	
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EMERGENCY MANAGEMENT

SCOPE (No Changes)

Bartlett Regional Hospital's Emergency Management Program is designed to assist the hospital in preparing for emergencies and disasters so the hospital experiences the least amount of damage to human lives and property, and maximizes the continuity of services. This effort is led by a multi-disciplinary team of staff through the Emergency Management Committee.

Emergency management is the art and science of managing complex systems and multi-disciplinary personnel to address events across "all-hazards," and through the phases of mitigation (including prevention), preparedness, response and recovery. This Emergency Management Program utilizes best practices to ensure the Program's activities are executed properly and consistent with other responding and receiving organizations.

The program considers a full range of risks that could potentially impact Bartlett Regional Hospital either directly or indirectly. The program and its efforts are designed to reduce risk to the organization's stakeholders, property and operations. This mission is fulfilled through an ongoing process of assessing threats, mitigating risk and reducing vulnerabilities, planning and policy development, capability and resource building and acquisition, training and practical application through drills and exercises.

The Emergency Management Plan and the Emergency Operations Plan apply to all members of hospital administration and staff, in all departments. In addition, this plan applies to all non-staff members who, in the course of their duties, find themselves performing work activities on hospital property, including (but not limited to) clinical providers, technicians, contractors, students, hospital ancillary staff, volunteers, and traveling or rotating personnel from other institutions.

ACCOMPLISHMENTS

- 10/16/19 three members (Charlee Gribbon, Megan Taylor and Mike Lopez) of the Hospital Emergency Management team attended Texas A&M Engineering Extensive service (TEEX) "Personal Protective measures for Biological events".
- 7/10/19 Emergency Management Team member (Megan Taylor) sent to Sitka and attend the Disaster Preparedness for Hospitals and Healthcare Organizations within the Community Infrastructure.
- EMT member Charlee Gribbon attended the "Communicable Disease Response Maritime Table Top Exercise Planning Meeting".
- Continued providing Hospital Incident Command System Basics training for BRH managers and supervisors.
- Hospital staff members attended Alaska Department of Health and Social Services, Section of Emergency Programs, 2019 Hale Borealis Forum.
- Hospital participated with the Juneau Airport Emergency plan activation with casualties transported to the Hospital.
- Conducted Closed Point of Distribution (POD) exercise. Surpassing last year's total of shots given.



PROGRAM OBJECTIVES

Objectives	Met/ Not Met	Comments and Action Plans
The hospital conducts an annual hazard vulnerability analysis (HVA) to identify potential emergencies that could affect demand for the hospital's services or its ability to provide those services, the likelihood of those events occurring, and the potential impact and consequences of those events. The HVA is updated when significant changes occur in the hospital's services, infrastructure, or environment.	Met	Updated and shared with CBJ.
<p>The hospital develops and maintains a written all-hazards Emergency Operations Plan that describes the response procedures to follow when emergencies occur. The plan and associated tools facilitate management of the following critical functions to ensure effective response regardless of the cause or nature of an emergency:</p> <ul style="list-style-type: none"> • Communications • Resources and Assets • Safety and Security • Staff Responsibilities and Support • Utilities and Critical Systems • Patient Clinical and Support Activities 	Met	Improved, tested, and revised PAS activation steps of the Emergency Operations Plan.
The hospital implements its Emergency Operations Plan when an actual emergency occurs.	Met	<p>11/5/19 - Hospital responded to an internal disaster, Sprinkler system discharged on the first floor due to vandalism.</p> <p>11/11/19 Network issues, creating downtime plan activation.</p>
BRH's emergency response plan and incident command system facilitate an effective and scalable response to a wide variety of emergencies and are integrated into and consistent with the Department of Public Health Disaster Plan and the City and Borough of Juneau Emergency Operations Plan, and are compliant with the National Incident Management System (NIMS).	Met	Demonstrated plan effectiveness and scalability during the 7/20/19 Juneau Airport Emergency Exercise with casualties transported to the Hospital and on a smaller scale the 11/11/19 Network issues, creating downtime plan activation.
The hospital trains staff for their assigned emergency response roles.	Met	<ul style="list-style-type: none"> • New Employee Orientation • HICS Section training conducted for ICS sections. • ICS 300 and 400 Training
The hospital conducts exercises and reviews its response to actual emergencies to assess the appropriateness, adequacy and effectiveness of the Emergency Operations Plan, as well as staff knowledge and team performance.	Met	Completed After Action Reports and performance evaluations for two actual emergencies and two multi-functional exercises.

Annual evaluations are conducted on the scope, and objectives of this plan, the effectiveness of the program, and key performance indicators.	Met	Annual Evaluation by the Emergency Management Committee completed on 11/06/19.
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The Emergency Management Team and the Environment of Care Committee have evaluated these objectives and determined that they have been met. The program continues to direct emergency management preparedness and response in a positive and proactive manner.

PERFORMANCE MEASURES

Performance Measures	2019 Goal	2019 Results	Comments & Action Plan
AIM: Measure Performance During Rounding. Minimum of 2 rounds per year in Patient Care Areas and one per year in Non-patient areas to demonstrate operational ability of the Emergency Management Plan by measuring the percent of general staff able to verbalize knowledge and duties related to activities required of them in a disaster	95%	90%	Partially Met. Continuing focus on department specific HICS trainings for staff. Primary issues are understanding the difference between department specific and hospital wide roles. Continue to monitor and assist Department Director with developing more clear Department Specific Plans to ensure critical actions are completed.

EFFECTIVENESS

The Emergency Management program has been evaluated and is considered to be effective by both the Emergency Management Committee and the Environment of Care Committee. The program continues to direct and promote emergency and disaster preparedness and response capabilities in a proactive manner.



GOALS AND OPPORTUNITIES FOR IMPROVEMENT IN 2020

- Continue providing training on the Hospital Incident Command System (HICS) for all Incident Management Team members, department supervisors and management level staff.
- Improve overall documentation of incident and completion of HICS Job Action Sheets and appropriate HICS forms.

The proposed performance metrics for these goals include:

Emergency Management Proposed Performance Measures for 2020	Target	Comments & Action Plan
AIM: Staff Will Be able to verbalize knowledge and duties related to activities required of them in a disaster. This measure demonstrates operational ability of the Emergency Management Plan.	95%	Continued from Prior Year due to Staff Turnover. Continue to monitor and assist Department Director with developing more clear Department Specific Plans to ensure critical actions are completed.
AIM: Management Staff (that are integral to the Incident Command structure) Will Be able to verbalize knowledge and duties related to activities required of them in a disaster. This measure demonstrates operational ability of the Emergency Management Plan.	95%	Implementation of new forms, repeated prompts during drills and activations, and new required check-out procedures should help to ensure more thorough completion of documentation.

PATIENT SAFETY and QUALITY IMPROVEMENT PLAN

CY 20192020

Issued: August 2010
Revised: December 20182019

Submitted by: Sarah Hargrave, MS, RN, CPHQ

Purpose

The purpose of the Patient Safety and Quality Improvement (PSQI) Plan for Bartlett Regional Hospital (BRH) is to describe how the organization monitors the care provided to our patients to assure that the BRH mission is fulfilled and to describe the components of the Quality Program.

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Mission of Bartlett Regional Hospital: To provide the community with quality, patient-centered care in a sustainable manner.

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The PSQI Plan is established by ~~the hospital and medical staff quality leadership bodies~~, and is supported and approved by the governing body, which has the responsibility of monitoring all aspects of patient care and services.

The Bartlett Regional Hospital Quality Program provides for the development, implementation, and maintenance of an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The program reflects the complexity of the hospital's organization and services; involves all hospital departments and services, (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

Quality Framework

The primary goals of the plan are to continually and systematically plan, design, measure, assess, and improve performance of critical focus areas, improve healthcare outcomes, reduce and prevent medical / health care errors. The BRH PSQI Plan uses the Institute of Medicine (IOM) framework to describe overarching aims of a quality health care system. The IOM identifies the following as key characteristics:

- Safe: Avoiding harm to patients from the care that is intended to help them
- Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- Patient-Centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely: Reducing waste and sometimes harmful delays for both those who receive and those who give care.
- Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy
- Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

To achieve these aims, the Quality Program works to:

- Establish and maintain a culture of patient safety to prevent inadvertent harm to patients. This culture focuses on safety where we openly report mistakes and take action to make improvements in our processes.
- Assure mechanisms are in place for staff and providers to provide safe, quality clinical services and demonstrate improvement in patient outcomes.
- Assess performance with objective and relevant measures to achieve quality improvement goals in an organization-wide, systematic approach in collaboration with patients and families.
- Continually assess and assure compliance with regulatory and accrediting bodies, including the CMS Conditions of Participation, The Joint Commission, and other regulatory bodies.
- Promote systems thinking and effective teamwork in care design and delivery.
- Monitor patient satisfaction, and support providers, staff, and departments to focus on areas

- where the patient experience may be improved.
- Optimize allocation of resources to reduce waste and ensure the delivery of safe, efficient, equitable, and effective care.
- Partner with colleagues, providers, staff, programs and services to help create and maintain a work environment that is safe, purposeful, meaningful and where we can take joy in our work.
- Annually evaluate the objectives, scope, and organization of the improvement program; evaluate mechanisms for reviewing monitoring, assessment, and problem-solving activities in the performance improvement program; and take steps to improve the program.

Authority and Scope

The Board of Directors of Bartlett Regional Hospital is ultimately responsible for the quality of care provided by the hospital. The Board of Directors provides that an ongoing, comprehensive and objective mechanism is in place to assess and improve the quality of patient care, to identify and resolve documented or potential problems and to identify further opportunities to improve patient care. The Board reviews the quality of patient care services provided by medical, professional, and support staff. The Board of Directors delegates operational authority and responsibility for performance improvement to the Chief Executive Officer and the Chief of the Medical Staff.

The Medical Staff, through its by-laws, rules and regulations, service lines, and committees, measures patient care processes, and assesses and evaluates quality and appropriateness, and is thus able to render judgments regarding the competence of individual practitioners. Coordination of these activities occurs through the Medical Staff Executive Committee and the Chief of the Medical Staff.

Organizational performance improvement is a hospital-wide activity under the direction of hospital leadership, and in collaboration with medical staff. Everyone at Bartlett Regional Hospital is responsible to improve the quality of care provided. It is the responsibility of hospital leadership to establish a culture of quality and assure performance improvement activities are given a high priority among department activities.

The scope of the Quality Program is broad to include any strategic or operational priorities, and all organizational departments and units that impact the aim of the IOM framework described earlier. Quality and safety activities are addressed throughout the organization and reported through the Hospital Performance Improvement Committee, which then reports to the Board of Directors.

The review and improvement of the Environment of Care (EOC) is under the direction of the Environment of Care Committee, which meets regularly and facilitates timely corrective action as environmental safety issues are identified. The EOC Team routinely reviews activities related to all seven Management Plans for the Environment of Care.

Structure and Reporting

The Board of Directors has established a Quality Committee to communicate information to the Board of Directors concerning the hospital quality program and the mechanisms for monitoring and evaluating quality, identifying and resolving problems, and identifying opportunities to improve patient care.

The Quality Program operations are carried out by the organization's administration, medical staff, clinical, and organizational support services. The Medical Staff Executive Committee and the Hospital Performance Improvement Committee provide the oversight responsibility for performance improvement activity monitoring, assessment and evaluation of patient care services provided throughout the organization. The Senior Director of Quality is responsible for the day-to-day operations of the Quality Program, and reports

directly to the Chief Executive Officer.

Components of the Program:

While having influence and supporting organizational quality across the hospital, the Quality Program is made up of a variety of components that broadly include: Core Measure monitoring, abstraction, and data submission; Patient Satisfaction, Accreditation (both Joint Commission and CMS); Risk Management; Patient Safety; Infection Prevention and Control; Complaint Management; and, Medical Staff Quality.

The medical staff monitors, assesses, and evaluates the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges through the medical staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important issues in patient care or safety are identified and resolved.

Medical Staff Service Line committees' roles and responsibilities as they relate to PI include: reviewing and analyzing data, making recommendations, taking actions where necessary and reporting to Medical Staff Executive Committee and the General Medical Staff through Committee chairs.

- At routine meetings of the medical staff or among its various committees, these quality of services will be reviewed, assessed and evaluated:
 - Operative / Invasive Procedure Monitoring
 - Medication Management
 - Information Management Function
 - Blood and Blood Product Use
 - Pharmacy and Therapeutics Function
 - Mortality Review
 - Risk Management
 - Infection Control
 - Utilization Management
 - Other processes as determined by the individual committee
 - Patient care and quality control activities in all clinical areas are monitored, assessed, and evaluated
 - Assessment of the performance of the patient care and organizational functions are included.
- As necessary, relevant findings from performance improvement activities performed are considered part of:
 - Reappraisal / reappointment of medical staff members, and
 - The renewal or revision of the clinical privileges.

The Hospital Performance Improvement Committee is an administrative committee responsible for identifying and reporting on performance improvement issues that affect patient care and services.

The purpose of the Hospital Performance Improvement Committee is to identify and prioritize performance improvement issues within each Department, encourage accountability, and review the effectiveness of performance improvement activities. Departments are responsible for conducting continuous quality improvement on services and care delivery.

Reporting:

The results of the department-level initiatives are reported to the Hospital Performance Improvement Committee on a regular schedule.

Data related to Patient Safety issues including (but not limited to) medication incidents are reviewed at the Hospital Performance Improvement Committee.

Functions involving both the Medical Staff and the hospital are addressed through a joint effort directed and organized by the Medical Staff leadership and the relevant hospital committees and/or administrative leadership. In these cases, reporting of results will be routed both through the relevant Medical Staff committee, and hospital committee or leadership team.

Relevant quality-related results of Medical Staff committees are reported to the Medical Executive Committee and General Medical Staff Body.

Patient Safety

The Patient Safety Program is designed to improve patient safety, reduce risk, and respect the dignity of those we serve by promoting a safe environment.

A culture of safety is a core value for the organization. Safety is led from the top. In an organization with a refined culture of patient safety, events are reported, safety is transparent and safety events are disclosed. Hospital leaders work to ensure the following characteristics exist in the organization:

- Everyone is empowered and expected to stop and question when things don't seem right
- Everyone is constantly aware of the risks inherent in what the organization does
- Learning and continuous improvement are true values. There is non-punitive response, feedback, and communication about errors.
- Effective teamwork is a requirement, and leadership provides mechanisms for staff to improve the functioning of teams.
- Removing ~~intimidating~~ behavior that might prevent safe behaviors
- Resources and training are provided to take on improvement initiatives

The scope of patient safety includes adverse medical / health care events involving patient populations of all ages, visitors, hospital / medical staff, students and volunteers. Aggregate data from internal (IT data collection, occurrence reports, questionnaires / surveys, clinical quality measure reports, etc.) and external resources (Sentinel Event Alerts, evidence-based medicine, etc.) are used for review and analysis in prioritization of improvement efforts, implementation of action steps and follow-up monitoring for effectiveness. The severity categories for medical / health care events include:

- No Harm – an act, either of omission or commission, either intended or unintended, or an act that does not adversely affect patients
- Mild to Moderate Adverse Outcome – any set of circumstances that do not achieve the desired outcome and result in an mild to moderate physical or psychological adverse patient outcome
- Hazardous (Latent) Conditions – any set of circumstances, exclusive of disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious adverse outcome
- Root Cause Analysis or Focused Review – Structured and systematic process for evaluating the steps, systems, and processes that led up to a Significant or Sentinel event, with an eye toward identifying root and proximal causes that are within the organization's control operationally or financially
- Significant Event – an unexpected occurrence of substantial adverse impact to patient safety or to organizational integrity that does not meet the definitions of "Sentinel Event" but that warrants intensive root cause analysis; or any process variation for which a recurrence carries a significant chance of a serious adverse outcome
- Sentinel Event – an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes the loss of life, limb, or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome resulting in the former. Additionally, any event otherwise defined by the Joint Commission as "reviewable / reportable," which may change from time to time.

The responsibilities of the Director of Quality include oversight of the Patient Safety Officer and compliance with patient safety standards and initiatives, evaluation of work performance as it relates to patient safety, reinforcement of the expectations of this plan, and acceptance of accountability for measurably improving safety and reducing errors. Tasks include, but are not limited to:

1. Discussion with the patient/family/caregivers regarding adverse outcomes:
 - a. Sentinel Events impacting the patient's clinical condition – The Patient Safety Officer or the Director of Quality notifies the care-giving physician about informing the patient / family / caregivers in a timely fashion (within 48-72 hours). Should the care-giving physician refuse or decline communication with the patient / family / caregivers, the Chief of Staff is notified by the Patient Safety Officer or the Director of Quality.
 - b. Events not impacting the patient clinical condition, but causing a delay or inconvenience – The Director of Quality or the Administrator On-Call determine the need for communication with the patient / family / caregiver in the interest of patient satisfaction.
2. Response to actual or potential patient safety risks is through a collaborative effort of multiple disciplines. This is accomplished by:
 - a. Reporting of potential or actual occurrences through the Occurrence Reporting system by any employee.
 - b. Communication between the Patient Safety Officer and the Facility Safety Officer (FSO) to assure a comprehensive knowledge of not only clinical, but also environmental, factors involved in providing an overall safe environment. Communication and consultation occurs with the City and Borough of Juneau's safety team for all environmental related issues.
 - c. Reporting of patient safety and operational safety measurements / activity to the performance improvement oversight group, the hospital Performance Improvement Committee.
3. The mechanism for identification and reporting a Sentinel Event / other medical error is indicated in policies, (*Sentinel Event Policy* and *Occurrence Reporting Policy*). A root cause analysis of

processes, conducted on either a Sentinel Event or Significant Event, are discussed with the Senior Leadership Team and the Medical Staff Quality Improvement Committee, as appropriate.

4. In support of our core values and belief in the concept that errors occur chiefly due to a breakdown in systems and processes, staff involved in an event with an adverse outcome are supported by:
 - a. A non-punitive approach and without fear of reprisal,
 - b. Resources such as EAP or Union representation, if the need to counsel the staff is required
5. Patient safety measures are a focus of our activities and may include review of adverse drug events, health care acquired infections, “never” events, CMS No Pay events, and other data and incidents. This may be based on information published by TJC Sentinel Event Alerts, and/or other sources of information including risk management, performance improvement, quality assurance, infection control, research, patient / family suggestions / expectations, or process outcomes.
6. Processes are assessed to determine the steps when there is or may be undesirable variation (failure modes). Information from internal or external sources is used to minimize risk to patients affected by the new or redesigned process.
7. Solicitation of input and participation from patients and families in improving patient safety are accomplished by:
 - a. Conversations with patients and families from nursing director on administrative rounds
 - b. Comments from Patient Satisfaction surveys, patient feedback forms, telephone or in-person conversations, or letters
 - c. Comments from patient Complaints or Grievances
8. Procedures used in communicating with families the organization’s role and commitment to meet the patient’s right to have unexpected outcomes or adverse events explained to them in an appropriate, timely fashion include:
 - a. Patient’s Rights statements
 - b. Patient Responsibilities—A list of patient responsibilities are included in the admission information booklet.
 - c. Evaluating informational barriers to effective communication among caregivers.
9. The following methods are used to maintain and improve staff competences in patient safety science:
 - a. Providing information and orientation to reporting mechanisms to new staff in orientation training.
 - b. Providing on-going training to staff on patient safety initiatives and methods as applicable.
 - c. Evaluating staff’s willingness to report medical errors through the AHRQ Culture of Patient Safety Survey.

10. Data Analysis:

e.a. The hospital routinely analyses data to identify quality and patient safety risks, and uses data analyses to develop and monitor responses.

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Failure Modes and Effects Analysis (FMEA):

Performance Improvement Methodology

The Bartlett Microsystems methodology is used to drive continuous performance improvement of systems and processes related to patient care, patient safety, and workflow efficiency throughout the organization. An accelerated approach may be used for improvement that has been identified through data-driven reports such as patient satisfaction surveys, improvement that may not require a multi-disciplinary approach, single-process improvement issues or goals, or where sufficient information is available to identify the improvements needed.

Quality improvement priorities are those areas and issues that are high risk, high volume, or problem prone areas. The following are routinely considered when selecting quality improvement initiatives: Incidence, prevalence, severity of problems; effect on health outcomes, patient safety and quality of care.

The Bartlett Microsystems methodology is a structured and systematic improvement process that includes:

1. **See:** Identifying opportunities for improvement
2. **Source:** Finding root causes of variation
3. **Solve:** Using manageable steps to get improvement ideas
4. **Sample:** Developing and testing changes
5. **Sustain:** Monitoring changes so improvements stick

Data Collection and Analysis

The data analysis program will include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes.

BRH measures, analyzes, and tracks quality indicators and other aspects of performance that assess processes of care, hospital service and operations. The data analysis in the Quality program incorporates quality indicator data including patient care data, and other relevant data. The hospital uses the data collected to monitor the effectiveness and safety of services and quality of care. The frequency and detail of data collection is specified by the hospital's governing body.

Performance measures for processes that are known to jeopardize the safety of patients or associated with sentinel events are routinely monitored. At a minimum, performance is monitored related to the following processes:

- Management of hazardous conditions
- Medication management
- Complications of operative and other invasive procedures
- Blood and blood product documentation
- Restraint use
- Outcomes related to resuscitation
- National Patient Safety Goals
- Organ procurement effectiveness: conversion rate data is collected and analyzed and when reasonable, steps are taken to improve the rate.
- Core Measures
- Healthcare Acquired Conditions

Other sources of data include (but are not limited to) the following:

- Indicators and screens including functions and services, which may be departmental, inter-departmental, Medical Staff related, or hospital-wide.
- Occurrence reports and risk management events
- Patient/customer complaint and grievance data
- Patient/customer, employee, and Medical Staff satisfaction data
- Resource utilization data
- National benchmark data

Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by the medical staff service line or clinical committees, are reported to the

Hospital Performance Improvement Committee or Medical Staff Quality Improvement Committee (MSQIC) on an annual or other basis as designated.

Strategic Quality Objectives

Please see Appendix A for the evaluation of the prior year plan, and the current year's objectives and measures.

Annual Evaluation

The organizational performance improvement program is evaluated for effectiveness at least annually and revised as necessary. This is to assure the appropriate approach to planning processes of improvement, setting priorities for improvement, assessing performance systematically, implementing improvement activities on the basis of assessment, and maintaining achieved improvements.

Confidentiality

All information related to performance improvement activities performed by the medical staff or hospital personnel in accordance with this plan is confidential per AS 18.23.030, AS 18.23.070(5), and 42 USC 11101 60.10 (HCQIA).

Confidential information may include (but is not limited to): medical staff committee meetings, dashboards, hospital committee minutes, electronic data gathering and reporting, occurrence reporting, and clinician scorecards.

Approval

The Performance Improvement Plan is approved by the Chief Executive Officer, Medical Staff Executive Committee, and the Board of Directors annually.

Chief Executive Officer

Date

Chief of Medical Staff

Date

Board Chair

Date

Appendix A

Evaluation of 2018-2019 PSQI Plan:

Accomplishments:

- Integration of department quality improvement reports in each board meeting

- Initiation of daily safety huddles
- Ongoing Antimicrobial Stewardship work group
- Successful metrics for Partnership for Patients ASHNA/WSHA collaborative
- Completion of AHRQ Culture of Patient Safety Survey

2019 Goals

Quality Goal	CY 2019 Metric	Outcome
Reduce Healthcare Acquired Infections	Reduce surgical site infection rate to 0.6/100 or less by 12/31/2019. (Source: Infection Preventionist)	Met. As of 11/30/19, the SSI rate for the year has fallen to 0.29/100 cases. Efforts to reduce SSIs included the implementation of a “Nose to Toes” program, increased environmental cleaning, improved antibiotic dosing, staff and physician education, and use of an UV light for disinfection.
Fully implement RCA2 methodology for occurrence reporting system to improve learning and action to improve safety.	Complete at least 5 root cause analyses using RCA2 methodology by 12/31/2019 (Source: Quality Director)	Met. As of 12/10/19, 13 analyses have been completed using the RCA2 methodology. In September the Patient Safety Committee reviewed the prior quarters' action plans. This feedback loop will continue regularly with the Patient Safety Committee.
Improve Bartlett's Culture of Patient Safety	Provide Team STEPPS training to 90% of staff by 12/31/19 (Source: Staff Development/ Relias software)	Not met. 80% of all staff have completed training. Training is ongoing. Managers have been given a list of staff that have not completed.
Demonstrate Antimicrobial Stewardship Leadership within the Juneau community	Maintain overall antimicrobial stewardship rate of 270 or less through 2019 (Source: QBS, Partnership for Patients)	Met. Bartlett has maintained an average of only 173 days of therapy/1,000 patient days, well below the goal of 270 days of therapy/1,000 patient days.
Assess need for PI Methodology and Infrastructure revision.	Initiate training for 50% of managers on PI methods by 12/31/2019. (Source: Quality Director)	Partially met. A general overview of Clinical Microsystems was provided to managers present at the Performance Improvement Committee in May, 2019.
Update Ongoing Professional Practice (OPPE) to include claims-based and patient experience metrics for relevant specialties	Revise Family Practice and Internal Medicine scorecards to include at least 1 claims-based metric and one patient experience metrics by 12/31/2019. (Source: OPAL scorecards through Credentialing Committee of provider types)	Met. Internal medicine and family practice scorecards were updated, reviewed and approved at committees and have begun to be distributed to physicians. In addition, we have metric approvals for surgeons, anesthesiologists, pediatrics, obstetrics, and eICU providers. We are in the final stages of approval for emergency physicians and psychiatry.
Improve compliance with Sepsis core measure	Increase annual percentage of compliance to at least 55% by 12/31/2019 (Source Encore D, Early Management Bundle/Severe Sepsis/Septic Shock, Annual Percentage)	Met. The calendar year average exceeds 56% compliance with the bundle elements. Ongoing efforts by the Sepsis PI team have resulted in additional education, documentation changes, and the implementation of a “Code Sepsis” checklist

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	<u>throughout the hospital. The monthly trendline slope from January to October is 2.15.</u>
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Quality Goal	CY 2020 Metric
<u>Demonstrate Antimicrobial Stewardship Leadership within the Juneau community</u>	<u>Maintain overall antimicrobial stewardship rate of 200 days of therapy/1000 patient days or less through 2020 (Source: QBS, Partnership for Patients)</u>
<u>Fully incorporate a cross-sectional Patient Safety Committee to review and assure corrective action plans from RCA2s are met and sustainable.</u>	<u>The Patient Safety Committee will meet at least twice to review RCA2 corrective action plans. (Source: Quality Director)</u>
<u>Improve Bartlett's Culture of Patient Safety</u>	<u>The Team STEPPS implementation team will implement at least 1 hand-off communication project to address intradepartmental communication. (Source: Staff Development Director)</u>
<u>Improve compliance with Sepsis core measure</u>	<u>Increase annual percentage of compliance to at least 58% by 12/31/2020 (Source Encore D, Early Management Bundle/Severe Sepsis/Septic Shock, Annual Percentage)</u>
<u>Assure workforce</u>	<u>Hire and onboard Quality Director</u>

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