Bartlett Regional Hospital

Board Quality Committee
April 8, 2020
12:00 p.m.
Agenda

Public may participate telephonically by calling 1-800-315-6338 – Access code 86591

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

Call to order

Approval of the minutes – 01.08.2020

Standing Agenda Items:

- 2019 BOD Quality Dashboard — J. Caldwell

New Business:

- Press Ganey Update — C. Clark
- Joint Commission Update Safer Matrix — A. Muse / M. Crann
- Resuscitation Quality Improvement / (RQI) — G. Moorehead
- Sepsis Update — D. Koelsch
- Overview of Covid -19 — J. Caldwell

Next Scheduled Meeting: May 13, 2020 4:15 p.m.

Bartlett Regional Hospital

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

Board Quality Committee
January 8, 2020
Minutes

Attendance: Rosemary Hagevig (BOD), Charles Bill (CEO), Sarah Hargrave (Quality Director), Rose Lawhorne (CNO), Deborah Koelsch (Clinical Quality Coordinator), Carmi Clark (Quality Data Analyst), Gail Moorehead (Education Director), Billy Gardner (COO), Bradley Grigg (CBHO), Lindy Jones, MD (BOD), Mary Crann (Risk Manager), Charlee Gribbon (Infection Preventionist), Marc Walker (Facilities Director), Megan Costello (Chief Legal Officer)

Approval of the minutes – November 13, 2019 – *minutes approved as written.*

Standing Agenda Items:

Quality Dashboard (reported quarterly) – Ms. Hargrave reviewed the Board Quality Dashboard. Patient Satisfaction Overall from all areas in the hospital looks very strong. The HCAHPS Quarter 4 results shows outstanding scores for Communication with Nurses and Communication with Doctors. The Bedside Shift reporting facilitated by Autumn Muse (RN Clinical Program Specialist) and nursing unit directors likely helped increase our HCAHPS scores. There is a dip on the Care Transition section, but after looking on the report, there was only one patient who answered "disagree". Most of the patients answered "agree" instead of the top box "strongly agree". We will continue to monitor this domain. Severe Sepsis/ Septic Shock Measure has exceeded our goal. The 30-day Hospital Heart Failure Rate looks good. The Screening for Metabolic Disorders Quarter 4 results data is incomplete. There is one Sentinel Event this quarter; follow up meeting with The Joint Commission is scheduled early February.

New Business:

The following documents need to be formally approved by the Board at the next meeting. Board Quality approved January 8, 2020.

- 2020 Risk Management Plan
- 2020 Infection Prevention Plan and 2019 Evaluation
- 2020 Environment of Care Plan and 2019 Evaluation
- 2020 Patient Safety and Quality Improvement Plan and 2019 Evaluation

Board Quality Committee Charter Review

Board Quality Committee Charter Review changes are approved by the Board Quality Committee.

The Person and Family Engagement Community Liaison added to the Board Quality Committee Charter membership.

Ms. Hargrave explained the CMS Partnership for Patients Adaptation and adding patients' voice to the decision table. Additionally, Bedside Shift reporting and Social determinants of health have also been implemented in the hospital.

Risk Management Plan

There are few changes in the Risk Management Plan CY2020.

Ms. Crann added that Ms. Hargrave's Leadership heavily affected the Just Culture of the hospital. The number of occurrence reports are increasing, as a sign of increased transparency.

Utilization Plan

Deferred to March

Infection Prevention Plan

The 2019 and 2020 Infection Prevention and Control Goals and Plans were presented.

Infection Prevention Goal #1 – Improve compliance with CDC Hand Hygiene Guidelines – BRH hospital wide compliance is 71%, goal not met. The plan for improvement is to share data directly with bedside staff electronically and post in staff areas. The issue that Ms. Gribbon came across is there is no consistent observer.

Press Ganey patient survey results for the question "staff washed their hands" increased by 3% over 2018 reported rates. Inpatient "Staff wash their hands before exam" top box scores shows 73% for 2018 and 79% for 2019.

Infection Prevention Goal #2 – Reduce surgical site infection by Improving patient skin prep and decolonization; Improving surface cleaning and disinfection; implementing a nasal decolonization protocol for all NHSN/high risk procedures. The Goal Met, 2019 SSI Rate is 0.29 infections per 100 procedures. The 2018 rate is 0.83

Ms. Gribbon and Ms. Hargrave implemented a vigorous process that made a difference and helped achieve the goals.

Decrease the risk of acquiring health care associated C difficile Goal #3 – Goal met, 2018 HAI Rate is 2.08, 2019 HAI rate is 1.89 infections per 10,000 patient days. This is a 10% decrease.

The Emergency Supply Inventory project will be finished February 2020.

Ms. Gribbon also presented the 2020 Infection Control Plan Goals. Furthermore, Ms. Gribbon mentioned a few strategies that she wants to incorporate in her FY2020 goals for example; monitor staff compliance with patient skin and nasal decolonization, increase utilization of Sterile Meryl, improve staff, patient and visitor knowledge and utilization of transmission-based isolation PPE and signage.

Ms. Hargrave announced that Ms. Gribbon received her certification in Infection Control and Prevention this month. Ms. Hagevig has asked that the Board be made aware that Ms. Gribbon has obtained her Certification in Infection Control and Prevention (CIC).

Environment of Care Management Plan

The goal of the Environment of Care (EOC) Programs are to provide a safe, functional and effective environment for patients, staff and visitors. The EOC Program encompasses five programs; Safety Management, Security Management, Hazardous and Waste Management, Utilities Management and Medical Equipment Management. In addition, two other areas are included in the environment of care. Emergency Management and Life Safety Management.

- Safety Management Chaired by Nathan Overson
  - The accomplishment for the committee in 2019 include completing a comprehensive AKOSH consultation and the implementation of a revised Asbestos Management program. There were four-performance measure set by the committee last year and they were all met. Based on 2019 outcomes the Safety Committee has develop three areas of focus for 2020. These areas are to Reduce Workplace Violence, Reduce Workforce Injuries and update our working at heights program to increase employee safety.

- Security Management Mike Lopez
  - The accomplishment for the committee were prioritization and initialization of afterhours lockdown program and security officer training with JPD for drug an paraphernalia identification. The three performance measures set by the committee for 2019 were met with partial compliance. The area in need of improvement was completion of department swarms. The committee is revaluating the swarm process for 2020. The 2020 goals and opportunities for improvement set by committee are to Increase Facility-wide Security Afterhours, Improve Customer Satisfaction and Improve the Security Camera System Functionality.

- Hazardous materials and Waste Management John Fortin
  - The accomplishment included updating the Hazard Communication plan and clearing up processes around pharmaceutical waste disposal. The performance measures set for 2019 were met with varying degrees of success. The committee was fairly aggressive setting quite a few goals and falling just ever so slight short of their goals. Goals and Opportunities for improvement in 2020 mirror 2019 with new strategies for how to meet them.

- Life Safety Management Plan
  - The accomplishment of the committee are the following: completion of annual test, inspection, the repairs to fire alarm system per NFPA standards as well as 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. There were three performance measures set and were met with varying degrees of success due to workloads and staffing shortages within the maintenance department. For 2020, the committee will be using the same Goals as set in 2019 including one new goal; proactively establishing fire response plan for the new RRC and BOPS locations.

- Utilities Management Program
  - Accomplishments include installation of a new steam boiler control system increasing fuel efficiency. As well as installation of energy efficient computer access layer switches around the hospital. These systems require less power and the demand for facility cooling is reduced. Performance measures set were partially met. These goals are multi-year projects that have seen substantial movement in the right direction. Goals and Opportunities for improvement in 2020 include UPS replacements, computer system and mechanical system upgrades.

- Medical Equipment Management and Utilities Management chaired by Kelvin Schubert
  - The accomplishment of the group includes implementation of several new medical equipment systems as well as being part of the team evaluating new anesthesia machines. Goals and Opportunities for Improvement for 2020 have been established and include providing training opportunities for Biomed staff on specialty pieces of medical equipment and develop a process for receiving, assigning, monitoring end of life and disposal of medical equipment.

- Emergency Management
  - The accomplishment of the committee includes specialty training, community and regional involvement in emergency planning as well as conduction a closed point of distribution exercise.

Patient Safety and Quality Improvement

There are few changes on the CY2020 Patient Safety and Quality Improvement Plan compared to CY2019 Goals.

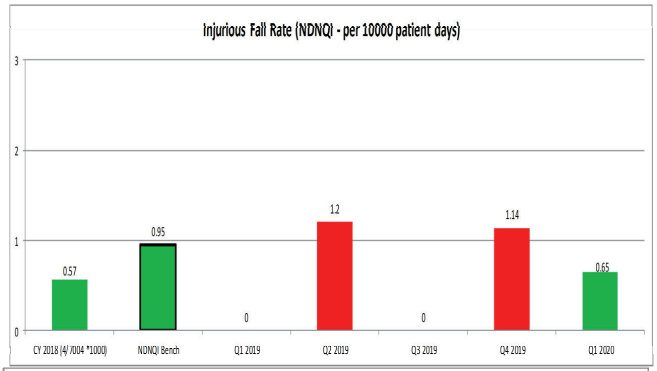
All CY 2019 Metrics have been met. Ms. Hargrave presented the CY2020 Metrics.

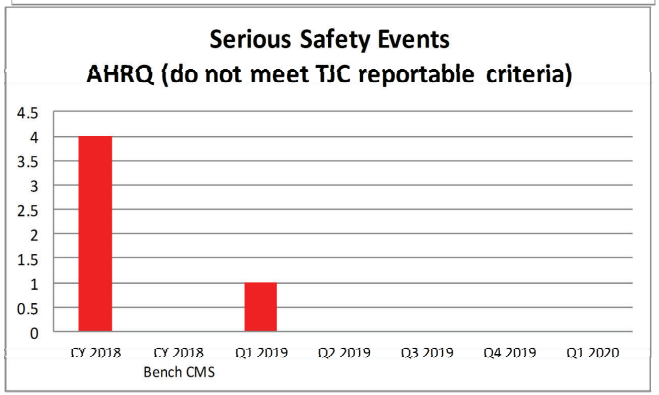
Mr. Bill shared how Ms. Hargrave helped make positive changes in our hospital's culture. This will be the last Quality Board meeting for Ms. Hargrave.

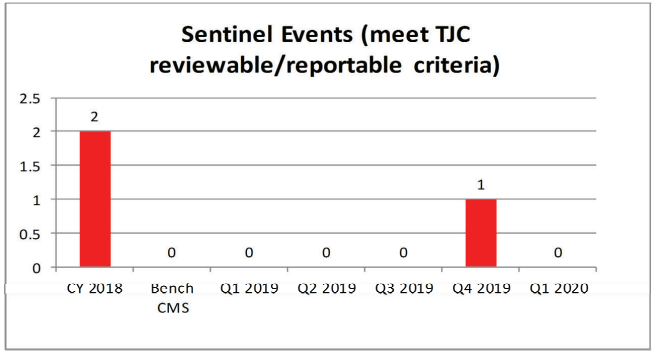
Next Quality Board meeting: March 11, 2020 4:15PM

Adjourned at 5:30 pm

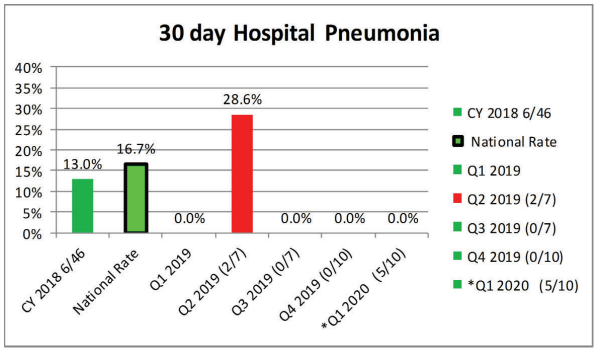
RISK MANAGEMENT-lower is better

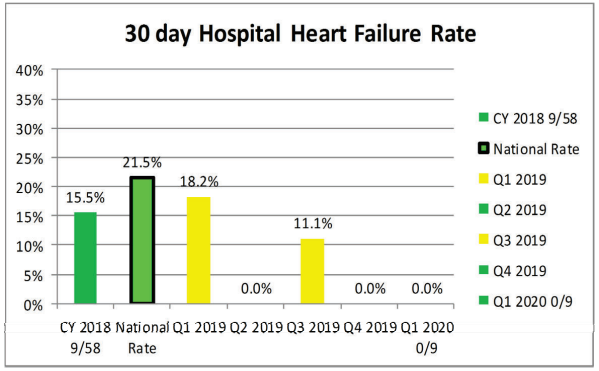


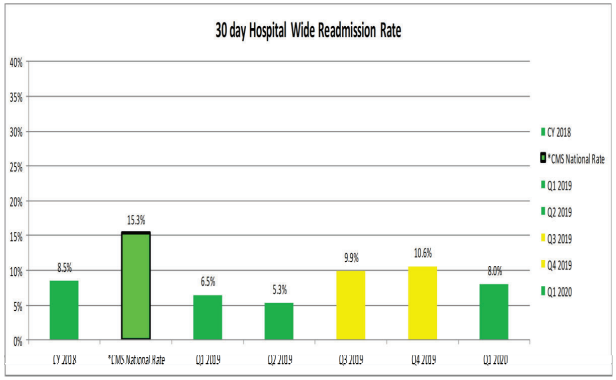




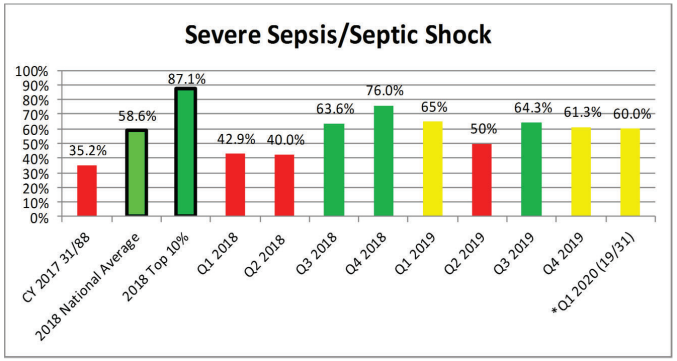
READMISSION RATES– lower is better

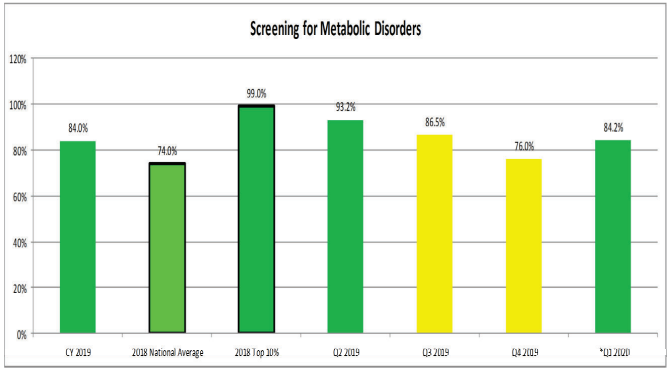






CORE MEASURES—higher is better





Notes:

Risk Management: Fall rates are per the NDNQI definition: Med/Surg and CCU only with injury/minor or greater). SSEs: An event that is a deviation from generally accepted practice or process that reaches the pt and cause severe harm or death.

Readmission Rates: Pneumonia and Heart Failure: patient is readmitted back to the hospital within 30 days of discharge for the same diagnosis. 30 day: patient is readmitted back to the hospital with 30 days of discharge for any diagnosis.

Core Measures: Sepsis: measure that demonstrates use of evidenced based protocols to diagnose and treat Sepsis.

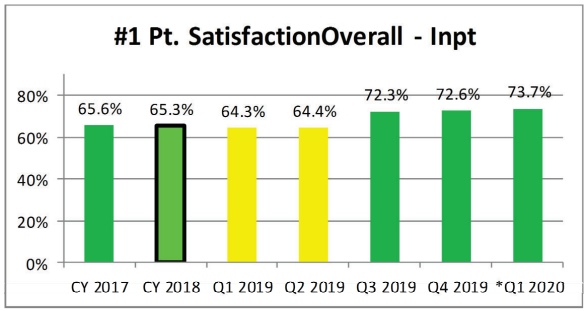
Screening for Metabolic Disorder s: % of psychiatric patients with antipsychotics for which a metabolic screening was completed in 12 months prior to discharge

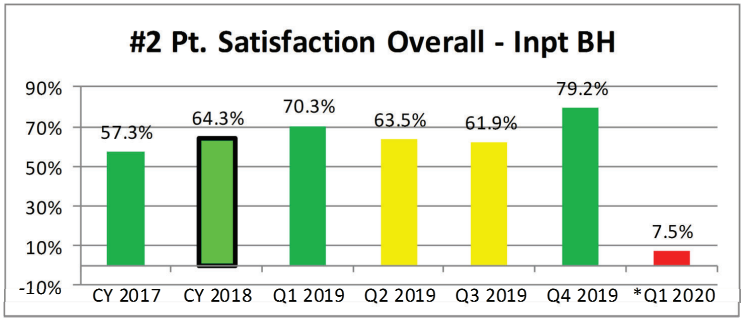
Indicates Benchmark

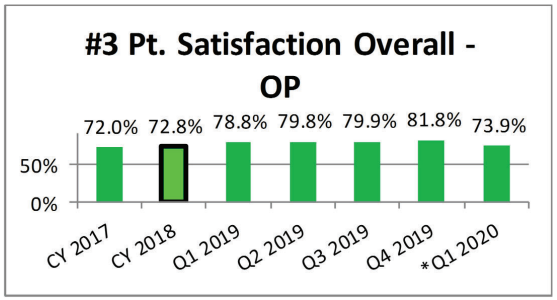
https://www.medicare.gov/hospitalcompare/search.html?

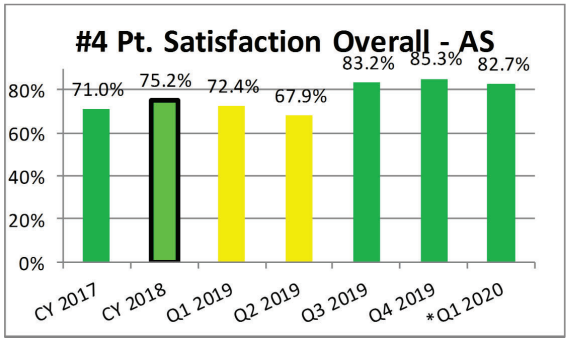
BOARD OF DIRECTORS QUALITY SCORECARD—

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









Notes on Patient Experience:

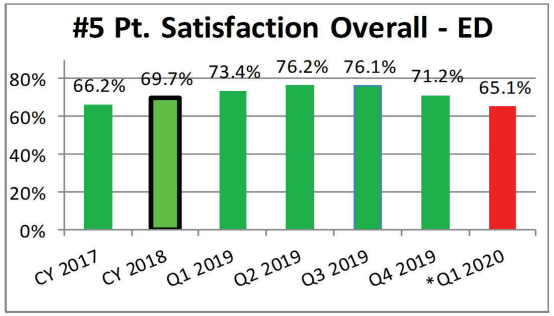
Press Ganey is the vendor for CMS Patient Experience and HCAHPS Scores.

** publically 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 2018-2020 current

CAHPS	2018	Q1 2018	Q2 2018	Q3 2018	Q4 2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	CMS Achievement Threshold	CMS Benchmark (top perf.)
	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	01/2017-12/2017	01/2017-12/2017
Overall Rating (0-10)	74.1 ☐	72.3 ☐	70.6 ☐	79.1☐	75.0 ☐	69.4 ☐	71.6☐	80.8☐	71.6☐	82.1 ☐	70.85%	84.83%
Comm w/Nurses	81.4 ☐	82.8☐	77.3☐	85.6☐	80.6 ☐	85.3 ☐	84.2☐	85.2☐	88.5☐	95.1 ☐	78.69%	86.97%
Comm w/ Doctors	84.5 ☐	86.5 ☐	81.0☐	85.0☐	86.3 ☐	90.6 ☐	83.5☐	89.4☐	92.0☐	94.0 ☐	80.32%	88.62%
Response of Hosp Staff	76.3 ☐	72.6 ☐	77.8 ☐	80.3☐	73.9 ☐	83.8 ☐	68.6☐	78.4☐	77.7☐	84.3 ☐	65.16%	80.15%
Comm About Medicines	66.0 ☐	73.0 ☐	67.1☐	63.6☐	60.6 ☐	60.8 ☐	71.6☐	70.0☐	70.2☐	79.4 ☐	63.26%	73.53%
Cleanliness and Quietness of Hosp Environment	72.5 ☐	75.8 ☐	72.1 ☐	72.7 ☐	69.7 ☐	64.0 ☐	66.6☐	74.9☐	79.2☐	73.9 ☐	65.58%	79.06%
Discharge Information	86.8 ☐	85.3 ☐	87.7 ☐	87.2☐	86.9 ☐	88.3 ☐	88.6☐	89☐	88.2☐	96.8 ☐	87.05%	91.87%
Care Transitions	55.3 ☐	58.4 ☐	51.2☐	55.8☐	56.5 ☐	58.0 ☐	57.1☐	64.0☐	58.3☐	59.3 ☐	51.42%	62.77%

PRESS GANEY UPDATE

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QUALITY in Community Healthcare™

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ESURVEY

Available in ED, Outpatient Services and Ambulatory Surgery

Bartlett Regional Hospital

WHAT IS eSURVEY?

eSurvey is the Press Ganey survey process that enables you to collect patient feedback via email survey. When used in conjunction with paper surveys, esurvey allows you to:

- Send and receive more surveys. This increase in surveys enables you to target more specific improvements efforts within your demographic areas (i.e. unit, specialty, provider).
- Improve staff and physician buy-in due to the increase in returned surveys.
- Reach patients who are less likely to respond via paper.
- Collect a high volume of robust survey comments.
- Reduce the cycle time for data collection and improvement initiatives.
- Offer convenient ways for patients to complete the survey, such as on a personal computer, smart phone, or tablet.

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RESPONSE RATE REPORT
Based on mail dates 01/01/2019 to 12/31/2019

Service Type	Not Returned	Returned	Undeliverable	Mailed	Response Rate	National Average Response rates
Ambulatory Surgery	822	247	12	1081	23.1	30.6
Emergency	3602	350	239	4191	8.9	8.8
HCAHPS	834	328	84	1246	28.2	26.8
Inpatient Only	175	32	11	218	15.5	18.2
Outpatient Services	3563	691	74	4328	16.2	18.3

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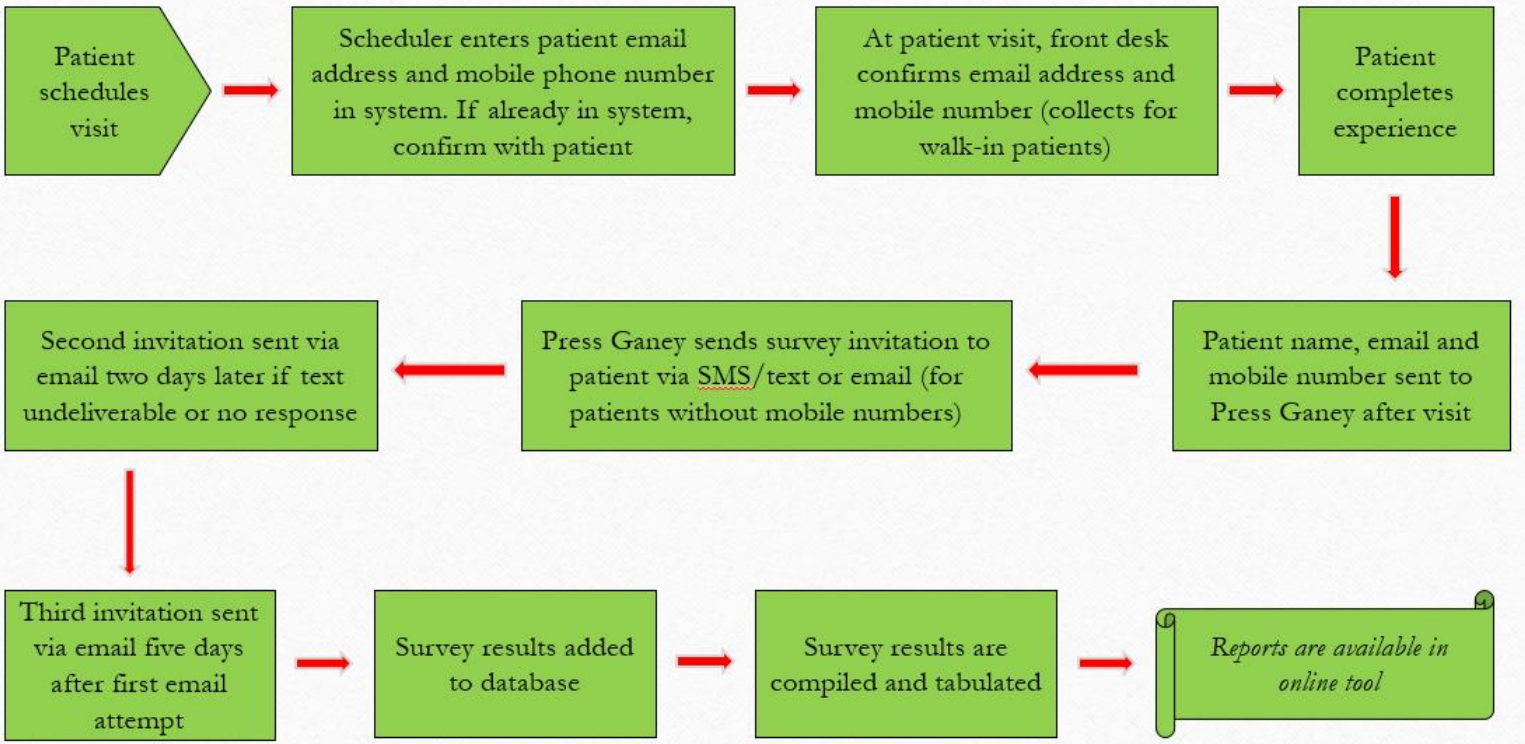
Overview of the Process, Text and Email



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Bartlett Regional Hospital

e-Mail Notification

From: <Bartlett Regional Hospital> (noreply@patients.pgsurveying.com)

Subject: <Bartlett Regional Hospital> would like your feedback!

Dear {First_Name}

You recently visited *Bartlett Regional Hospital* and we need your feedback. Please take a few minutes to answer a brief survey and share your thoughts about your recent visit. Your input will help us to understand what we do well and what we can do better. If you have received this email regarding a minor child's visit, please complete the survey on their behalf.

To ensure confidentiality, this survey is administered by an independent third-party, Press Ganey Associates, Inc. Your participation will help us to improve the quality of care that we provide to you, your family, friends, and neighbors.

Click here to begin your survey

Thank you for your feedback.

Sincerely,

John Smith

CEO

If clicking the above link does not take you to the survey or a verification screen, please go to https://esurvey.pressganey.com and enter the following PIN: {PIN}

This is an unmonitored email box, please do not reply to this email. If you have specific questions for your healthcare provider, please contact them directly.

To unsubscribe from future Press Ganey online patient satisfaction survey notices, click here.

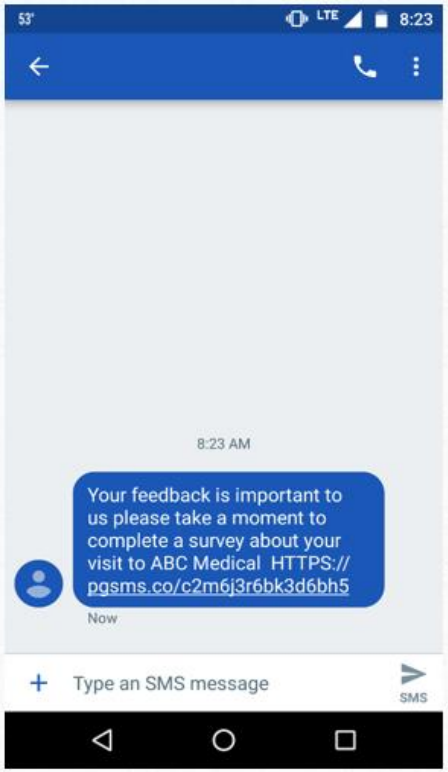
PRESS GANEY

Bartlett Regional Hospital

Text Message Notification

CUSTOMIZABLE INVITATION TEXT MESSAGE

- Text message includes:
  - 160 character limit
  - 120 characters that can be customized (40 characters reserved for the URL)
  - Your organization's name
  - Link to the survey itself!



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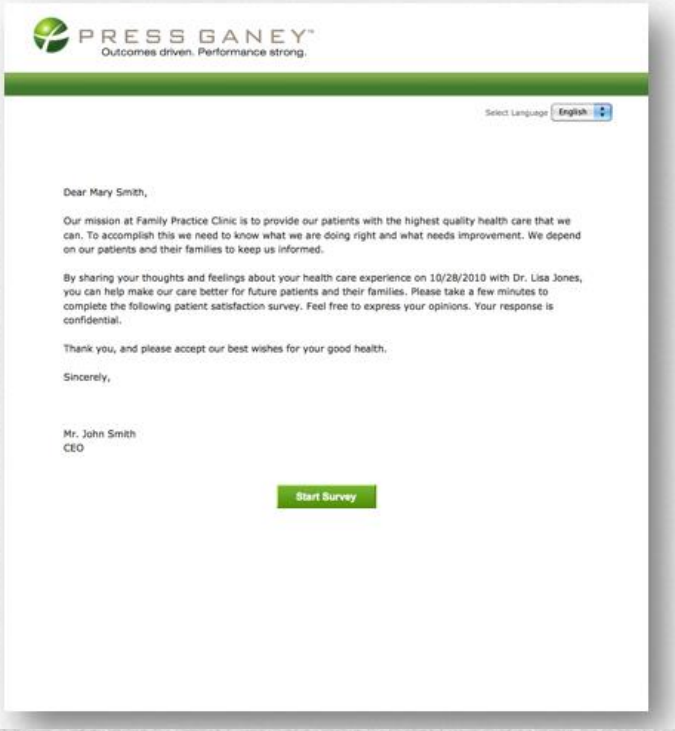
eSurveys Are "*As Easy As 1-2-3*"

1. Enter your date of birth

2. Read the letter and click "Start Survey"



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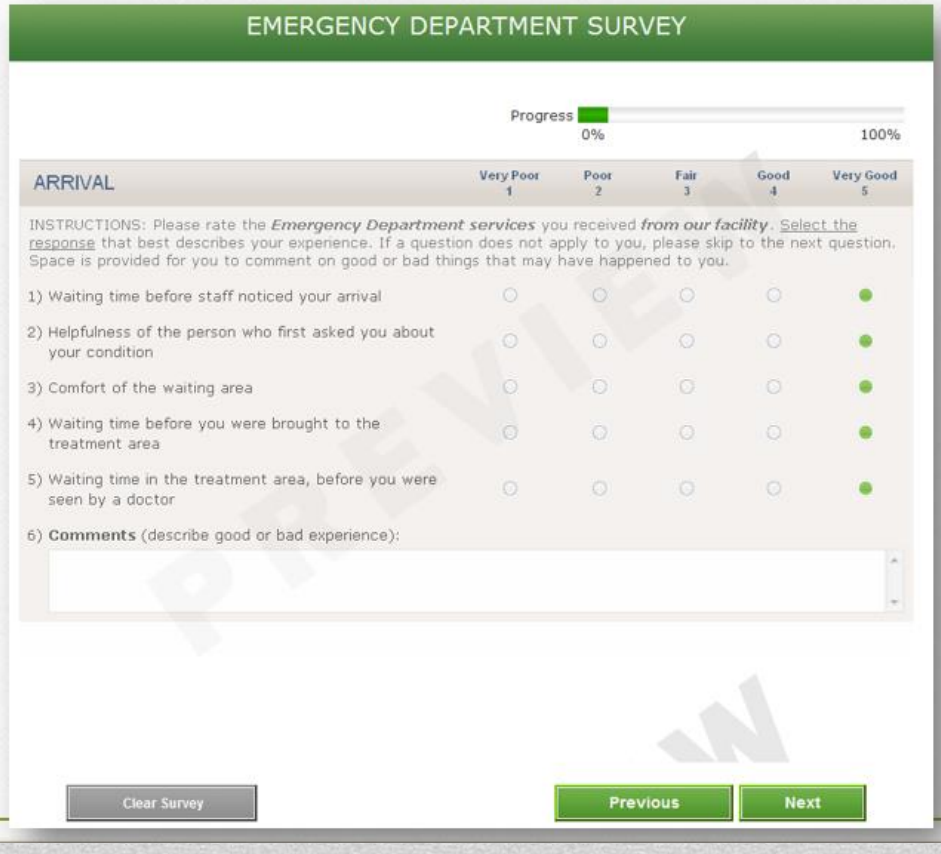
Take the Survey in 5-10 Minutes!

3. Share your experience



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- Daily uploads are recommended
- Patients who do not respond to the first online survey within 5 days will receive a second wave survey
  - Survey link expires after 30 days
- Ability to collect patient email addresses is vital! The more email addresses collected, the more surveys that will be sent, and the more returned surveys you will receive.

SURVEY PROCESS DETAILS

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Census-Based Survey Reporting

Mean Score and Percentile Rank - In the beginning, we should expect mean scores and percentile rank drop due to a change in the population mix.

Adjusted DATA

- Includes all paper surveys and a subset of esurveys received.

All paper returns
\+ This subset of esurveys
Adjusted sample

Unadjusted DATA

- Includes all returned surveys

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Every patient counts.

Every voice matters.

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QUALITY in Community Healthcare™

Right Here in Your Hometown

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SEC, SSER, and Joint Commission SAFER Matrix

AUTUMN MUSE, RN, BSN
MARY CRANN, RN, MSN, CPHRM

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Foundation for Patient Safety Measurement

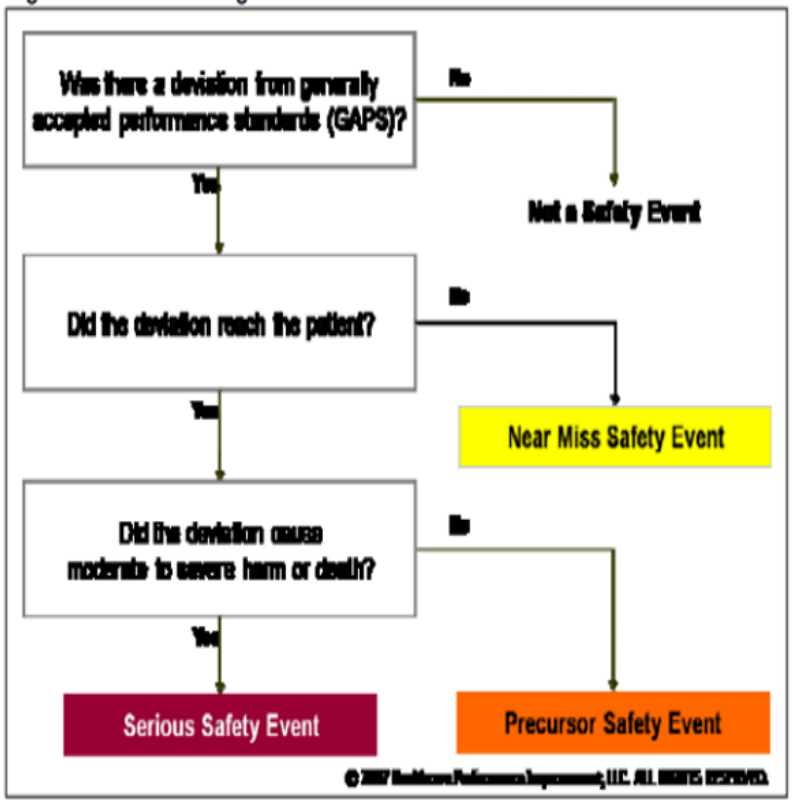
- The Safety Event Classification (SEC) and Serious Safety Event Rate (SSER) provide common definitions and an algorithm for the classification of safety events.
- It is a consistent methodology based on the degree of harm that results from a deviation of expected standard of care.

Figure 1. HPI Safety Event Classification (SEC)

Assessing Outcome Algorithm

- Outcome based
  - Event is assessed for deviations from accepted performance and standards of care (GAPS)
  - Cause and effect relationship between deviation and outcome are identified
  - Classified according to level of patient harm
- Serious Safety Event results in moderate to severe harm or death
- Precursor Safety Event results in minimal, no detectable, or no harm
- Near Miss Safety Event the error is caught before it reaches the patient

Figure 2. HPI SEC Algorithm



Levels of Harm

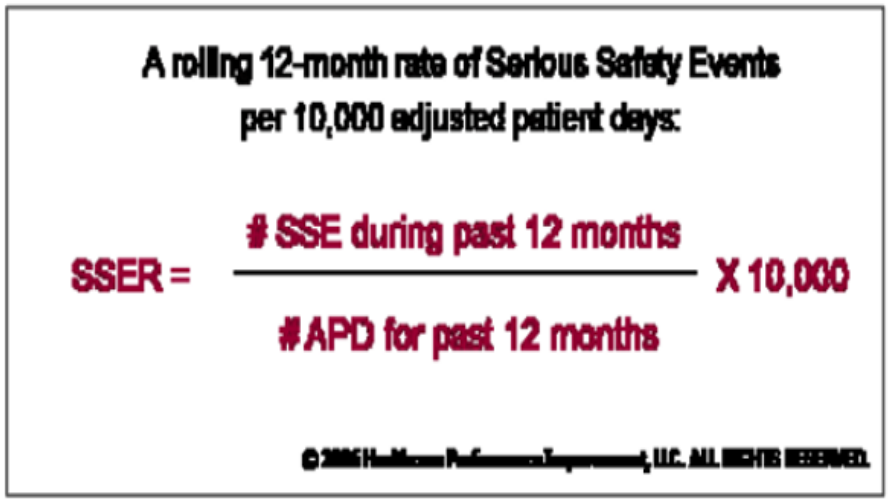
- Joint Commission uses the SAFER Matrix to identify findings using the same color coding
- Most significant is unplanned catch caught by chance – no safety nets
- Last strong barrier catch should be identified earlier in the process
- Earlier barrier catch represents a well-functioning process

HPI SEC	Code	Level of Harm
Serious Safety Event (SSE)	SSE 1	Death
	SSE 2	Severe Permanent Harm
	SSE 3	Moderate Permanent Harm
	SSE 4	Severe Temporary Harm
	SSE 5	Moderate Temporary Harm
Precursor Safety Event (PSE)	PSE 1	Minimal Permanent Harm
	PSE 2	Minimal Temporary Harm
	PSE 3	No Detectable Harm
	PSE 4	No Harm
Near Miss Safety Event (NME)	NME 1	Unplanned Catch
	NME 2	Last Strong Barrier Catch
	NME 3	Early Barrier Catch

Serious Safety Event Rate (SSER)

- SEC is the foundation for calculating the Serious Safety Event Rate (SSER).
- SSER is a volume adjusted measure of Serious Safety Events occurring from a deviation of the standard resulting in moderate to severe patient harm or death.
- Calculated monthly as the number of Serious Safety Events for the previous 12 months per 10,000 adjusted patient days.
- Clear picture of trends and rewards sustained improvements.

Figure 3. Serious Safety Event Rate calculation

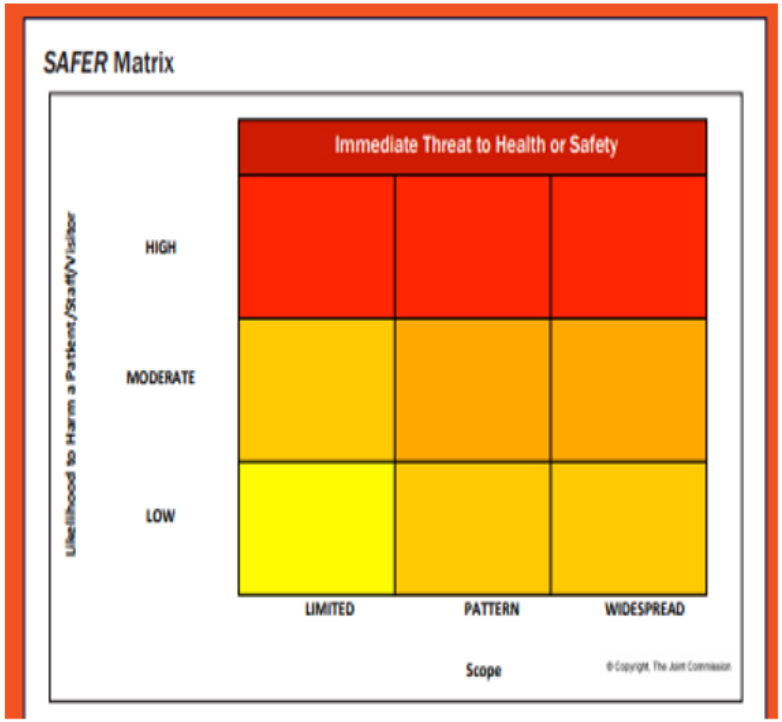


Applying SEC and SSER

- Requires a culture that encourages reporting adverse outcomes and sharing information about errors and mistakes
  - Staff need to know what should be reported – events resulting in harm and events caught before harm reached the patient.
  - Staff less inclined to report events if seen as punitive and not opportunity for improvement.
  - Reporting must be simple.
- Effectiveness of the system is consistent application over time.
- Identification of trends and implementing corrective action can limit Joint Commission survey findings.

Survey Analysis for Evaluating Risk (SAFER) Matrix

- The Joint Commission (TJC) has developed the SAFER Matrix to provide health organizations with Requirements for Improvement (RFI) in a comprehensive visual representing the findings and identifying areas that are in most need of interventions to meet compliance.
- The RFIs are plotted on the Matrix based on the possible risk of harm to patients, staff, and/or visitors and how often it was observed.
- All RFIs will need to be addressed in a 60 day timeframe. The RFIs that are higher risk level will require additional detailed corrective action plans that the organization will be expected to sustain going forward.



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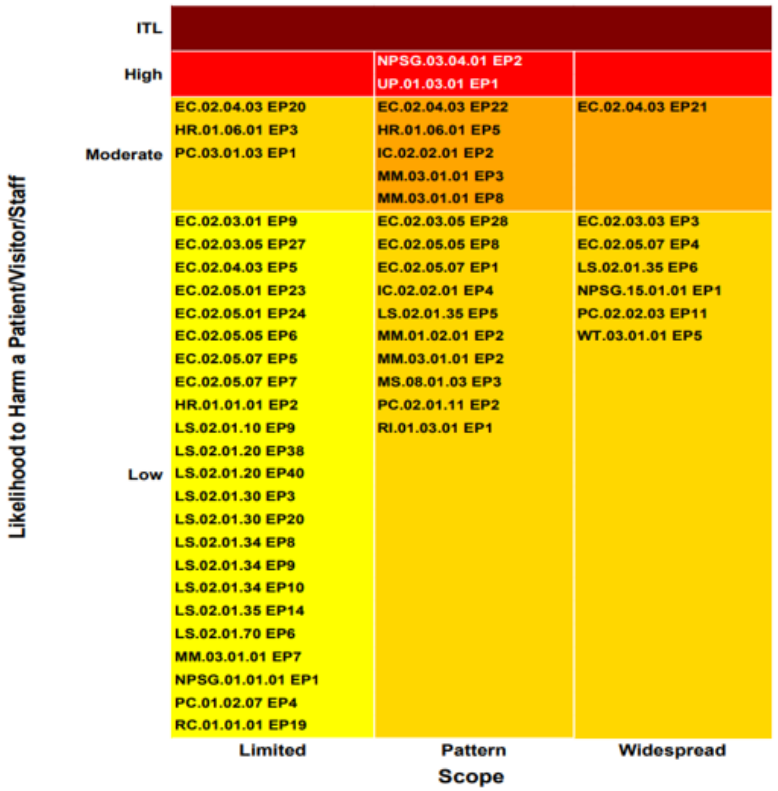
Example of a SAFER Matrix Report

- Here is an example of what a finished TJC survey report would look like with identified RFIs.
- TJC surveyors will provide the organization with a preliminary report before they leave and then TJC will send an finalized report within 10 days of the survey.
- The organization will be required to submit an Evidenced of Standards Compliance (ESC) report on all RFIs identified on the Matrix. The ECS reports will identify the organization's plan and data to demonstration that now they are in full compliance with TJC's standards.



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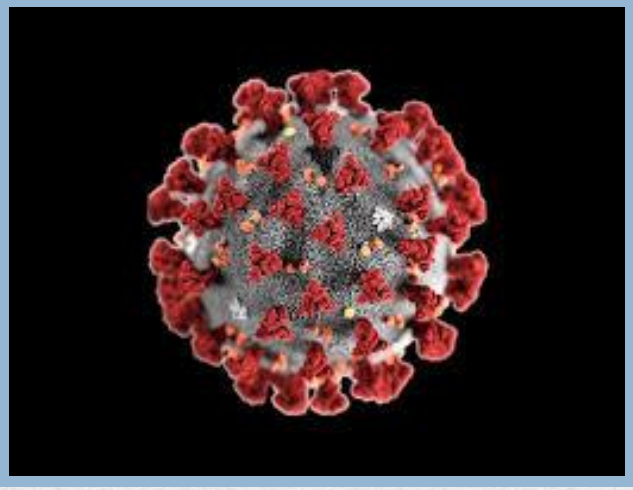
Bartlett Regional Hospital Response to Covid-19



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Date	# sick employee	# total employee working	# of + COVID in hospital	# of deaths	# COVID test pending	# of patients with respiratory illness as a chief complaint	# of ED visits	# pts in MedSurg	# pts in CCU	# pts on vents	# of patients in isolation	CCF R	Notes
4/3/2020	2	323	2	0	179	4	21	11	4	0	6	11	1 discharge; 1 possible discharge; 1 clinically stable w/o discharge from MS. 4 employees in quarantine due to close contact; 7 on travel quarantine.

Current State

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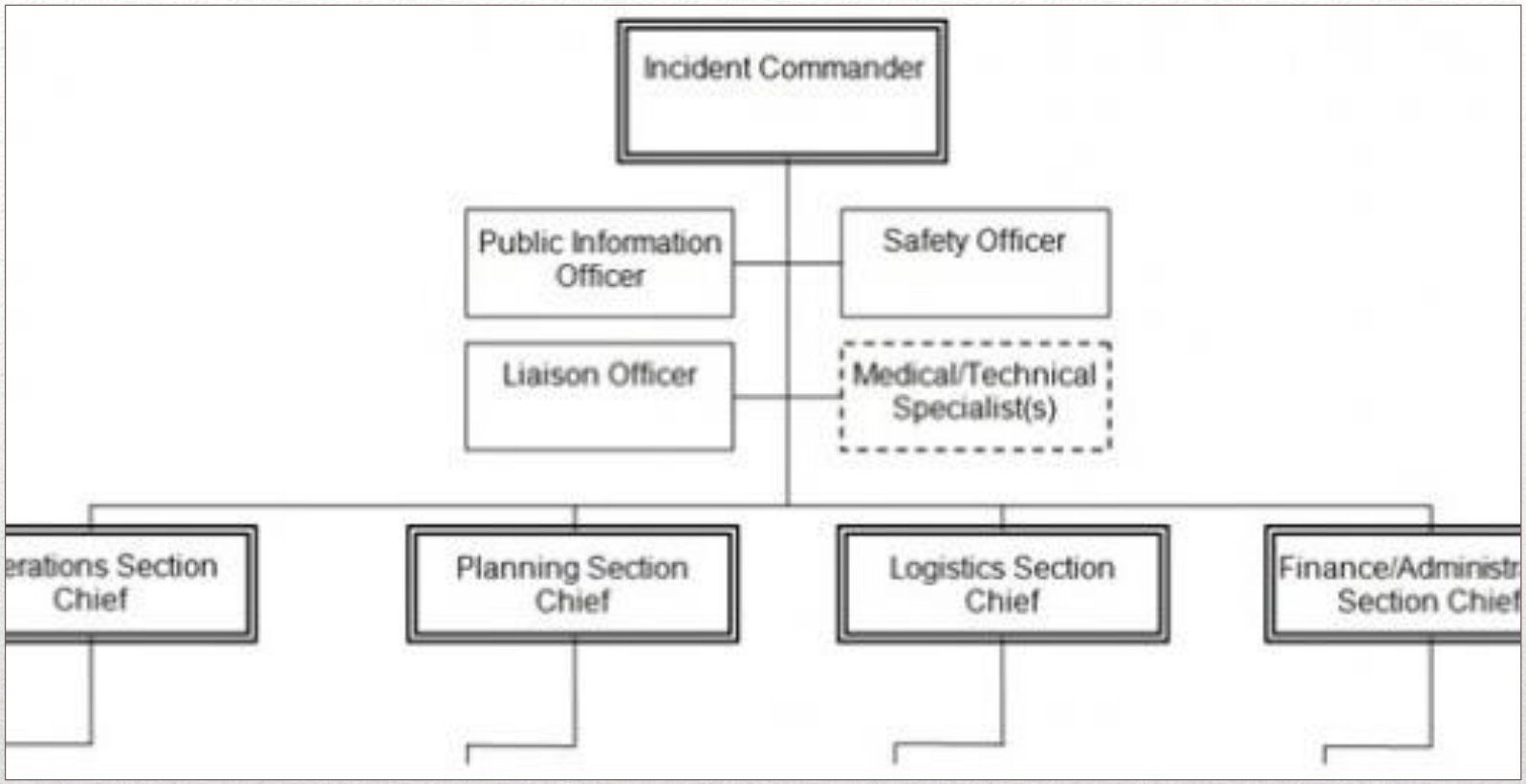

Activation of Incident Command

Community Providers Stepping Up

Physician Leadership

- Weekly provider team calls lead by Dr. Benjamin with community providers including Searhc partners

Average Day In the Life

Data / Patient Management

- Looking at connecting patients with appropriate level of care at the appropriate time
- Reporting data to correct sources as needed
- Assuring we have staff to care for our patients on the property and those that may arrive
- Surge planning and materials acquisition

Communications

- Conference calls with multiple agencies daily
- Conference calls Unified Incident Command
- Updating the Covid folder / Hospital Incident Directives distributed

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- Potential patient volume is unknown to date
- Continued refining of processes in operations, communications
- Planning for surges of critically ill
- Facilities changes to structure to accommodate isolation
- Using off site areas creatively
  - Rain Forrest
  - BOPS
  - Improved ER structure

Moving into the Future

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