Bartlett Regional Hospital

AGENDA
QUALITY BOARD TEAM MEETING
Wednesday, September 9, 2020 – 3:30 p.m.
Bartlett Regional Hospital Boardroom / Zoom Video Conference

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

Adjournment

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

Bartlett Regional Hospital

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

Board Quality Committee
July 15, 2020
Minutes

Called to order at 4:15 pm by Board Quality Committee Chair, Rosemary Hagevig

Board Members: Rosemary Hagevig (Chair), Kenny Solomon-Gross, Lindy Jones, Iola Young, Deborah Johnston

Patient & Feedback Representative: Nancy Davis

Staff: Charles Bill, CEO, James Caldwell, Director of Quality, Rose Lawhorne, CNO, Bradley Grigg, CBHO, Dallas Hargrave, HR Director, Deborah Koelsch, RN Clinical Quality Data Coordinator, Kevin Benson, CFO, Rebecca Embler, Quality Systems Analyst

Approval of the minutes – 05 13 2020 Quality Committee Meeting – *minutes approved as written.*

Old Business: No old business discussed.

New Business:
BOD Quality Dashboard
Deb Koelsch presented the Quality Scorecard measure results for Q2 2020.

- For Risk Management measures, Injurious Fall Rate was 0 and there were 0 Serious Safety Events and 1 Sentinel Event. The details of the Sentinel Event will be discussed in the next Executive Board Meeting. For Readmission Rate measures, 30-day Hospital Pneumonia was 0%, 30-day Hospital Heart Failure Rate was 11.1%, which is a slight uptick but still below the CMS rate, and 30-day Hospital-wide Readmission Rate was 5.8%, improved from 8% in Q1 2020.
- For Core Measures, Severe Sepsis/Septic Shock was 50%, which could change because the period is not closed yet, and Screening for Metabolic Disorders was 92.3%, improved from 90% in Q1 2020. Deb explained that we will be getting new benchmarks soon, and Dr. Gartenberg is doing a lot with her team to improve on this metric.

Rebecca Embler presented the Patient Experience and HCAHPS results for Q2 2020.

- For Patient Experience results, Inpatient and Ambulatory Services scores decreased from Q1 2020 and Outpatient and Emergency Department scores increased. It was noted that there is no score this quarter for Inpatient – Behavioral Health because Press Ganey had not provided MHU with updated mailing envelopes, so results were being submitted but not received. Quality and MHU have identified this issue and are working with Press

Ganey to establish a new customized survey, and will receive correct mailing envelopes. E-surveys will also be explored.

- For HCAHPS results, it was noted that scores are below last quarter for each of the survey areas. Last quarter showed exceptional performance, reaching 2-year highs for most survey areas, so although scores are down from last quarter, they are all above the CMS Achievement Threshold and two are above the CMS Top-performers Benchmark. It was discussed that COVID-19 impacts may be drivers here in terms of Care Transitions and Communication with Nurses and Doctors, and the question was brought forward about how do we keep quality of communication high during the pandemic. It was noted that we are already using creative solutions like communicating via iPads, etc.

Hospital Compare Website

Ms. Embler and Ms. Koelsch described the purpose and features of the Medicare.gov Hospital Compare tool. This is a website provided to the public to compare scores and ratings of any hospital across the nation, as well as state and national averages. Ms. Embler opened the website live and Ms. Koelsch explained the search function. 99801 was used as an example, and Bartlett and Petersburg Medical Center were selected. On the compare page, the Timely & Effective Care section was selected to review. Ms. Hagevig asked and was confirmed that Bartlett's AHA Region includes Alaska and Western Washington. She also asked how Physicians and Hospital Staff can use the Hospital Compare data. Ms. Koelsch explained that this is publicly reported data, so hospital staff can use this to see results against other hospitals and make quality and service improvements based on areas that could use improvement. Iola Young asked where the data comes from that is not on the Quality Scorecard (presented earlier). Ms. Koelsch explained that most of the data is submitted directly from our internal databases, and some data is claims-based so is submitted outside of our process. Ms. Embler and Ms. Koelsch encouraged Board members to explore the site and follow-up with the Quality team if any questions arise.

Press Ganey Patient Feedback Update

Ms. Embler presented the Press Ganey Patient Feedback update, highlighting the increase in total surveys returned and return rate since implementing e-Surveys in Ambulatory Services, Emergency Department and Outpatient. Kenny Solomon-Gross requested a breakout of e-Survey numbers by Email versus Text. Ms. Hagevig and others agreed that e-Surveys are a very good improvement for our hospital. The collection method is much fresher, faster and we will not lose opportunities for feedback because mail gets lost. Ms. Hagevig mentioned that she had a technical error with her survey not loading when she received it by text, and thus abandoned the survey. Lindy Jones asked if e-Survey results are skewed more positive or negative, and Ms. Embler replied that a correlation has not been seen with Positive or Negative results, but we have seen more Mixed and Neutral comments than with traditional paper surveys. Overall survey response rate with e-Surveys is 32% higher than with Paper surveys.

Value-based Purchasing Overview

Ms. Koelsch introduced Value-based Purchasing (VBP), describing that it is an important program for all hospitals that have Medicare reporting. The program is part of the CMS Quality Reporting Programs and Quality Initiatives, and is one that incentivizes hospitals to provide quality of care and improve on processes. The program utilizes performance evaluations

compared against other hospitals' performance (Achievement) as well as improvement against our own (Improvement). A Benchmark and Achievement Threshold are set each year, based on the total scores for all hospitals nationwide during the Baseline period, which is usually score data from 3-10 years prior. The scores used for current FY funding are from the Performance period, which is usually score data from 2 years prior. This is done so that there is time to validate absolute accuracy of the data.
The program assigns each hospital a score based on 4 domains; Clinical Outcomes, Person & Community Engagement, Safety, and Efficiency & Cost Reduction; each making up 25% of the total evaluation score. This score determines the amount of Medicare funding the hospital receives, based on a pool of funds that is funded from 2% withholds of every hospital's Medicare payments. Each patient transaction gets a Medicare-adjusted pay rate, so Bartlett is paid the VBP-adjusted rate on each payment. When reviewing our current score, James Caldwell noted that this program rewards good hospitals, and our scores have been consistently high. Ms. Hagevig asked for clarification that the 2% is pooled from ALL hospitals and then reallocated based on scores. Mr. Caldwell confirmed, and stated that this program accelerates and encourages change. Nancy Davis asked whether the Rural Demonstration Project is part of the VBP criteria, and Chuck Bill described that it is not a direct part of the program, but it is a project that will improve the quality of our hospital, and therefore will indirectly benefit our VBP scores and payment.
Ms. Koelsch presented an example of a measure from each of the 4 domains; Elective Primary Total Hip Arthroplasty/Total Knee Arthroplasty Complication Rate for Clinical Measures, Communication with Nurses for Person & Community Engagement, Clostridium difficile (C-Diff) Infection for Safety, and Medicare Spending per Beneficiary for Efficiency & Cost Reduction. Mr. Caldwell noted that the VBP program is about 10 years old, and is being continually reevaluated by CMS to make sure the program is evaluating hospitals' ability to provide effective care and make improvements.

Adjourned at 5:15 pm

Next Quality Board meeting: September 9, 2020 @ 4:15pm.

Board Quality Committee Meeting

September 9, 2020

Bartlett Regional Hospital

QUALITY in Community Healthcare™

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Agenda

• BOD Quality Scorecard	pgs. 3-5	D. Koelsch / R. Embler
• COVID Hospital Portal	pg. 6	R. Embler
• Patient Safety Committee Revision	pg. 7-8	G. Moorehead

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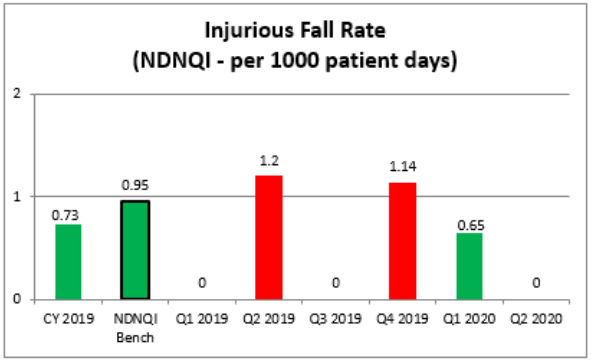
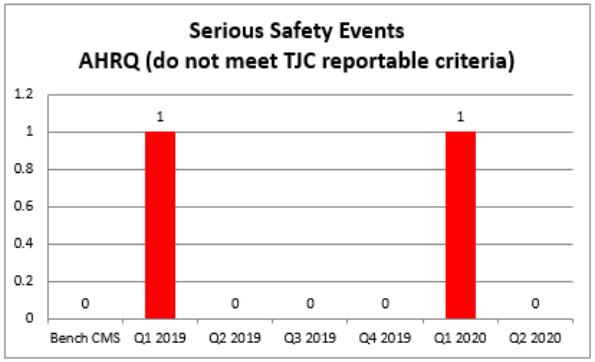
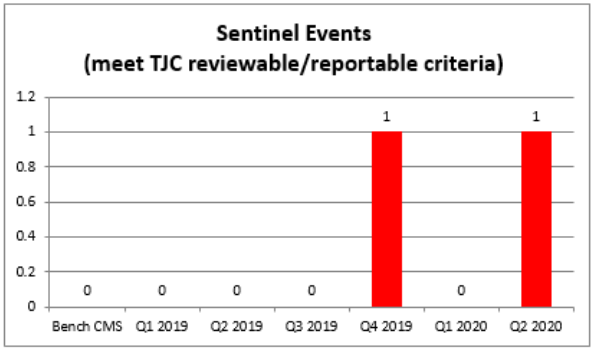
Quality Scorecard

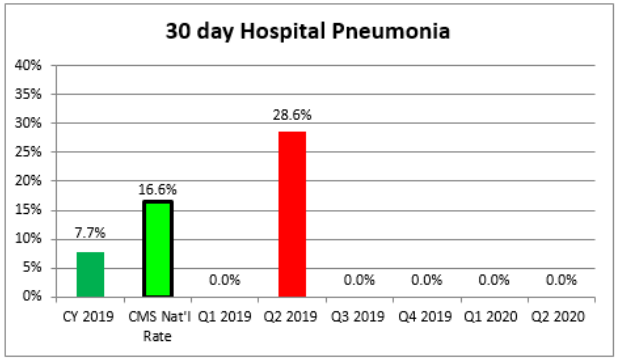
RISK MANAGEMENT – *lower is better*

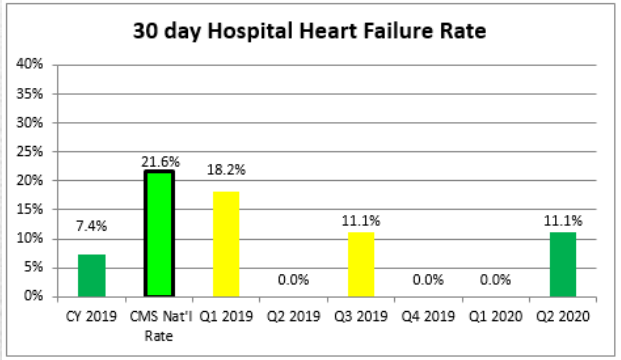


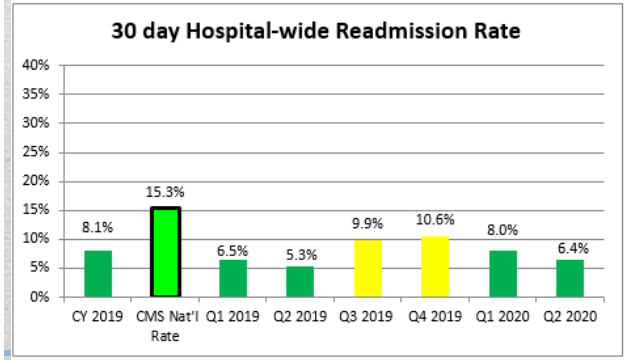




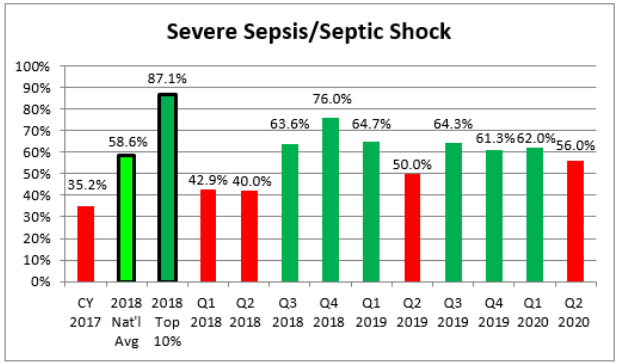
READMISSION RATES – *lower is better*

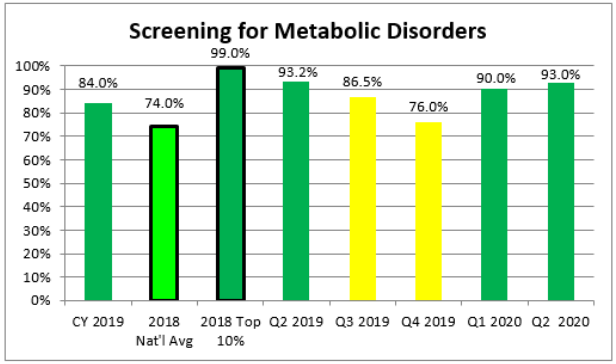






CORE MEASURES – *higher is better*





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

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

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

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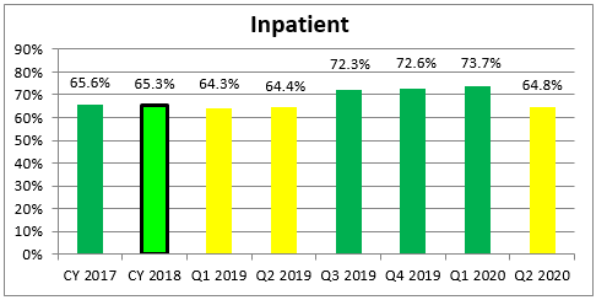
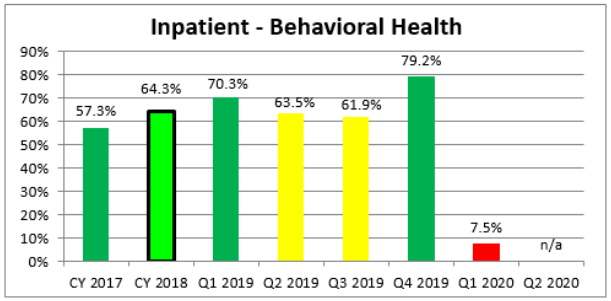
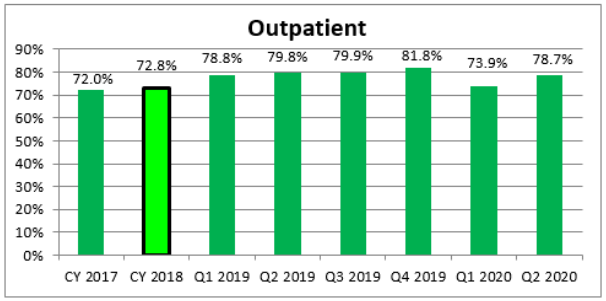
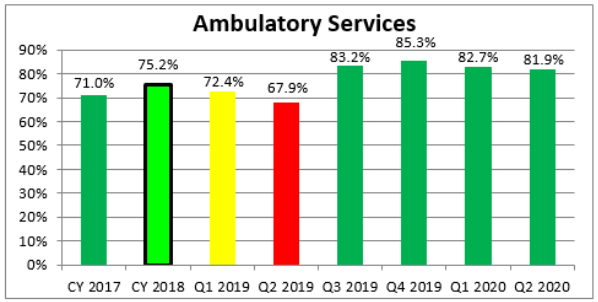
Quality Scorecard

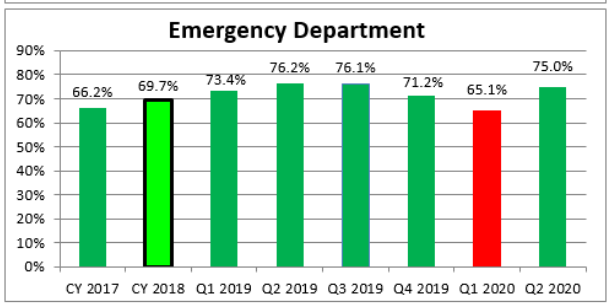
PATIENT EXPERIENCE











Notes:

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

HCAHPS RESULTS

CAHPS	2018	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	CMS Achievement Threshold	CMS Benchmark (Top Perf.)
	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Top Box	Jan - Dec 2018	Jan - Dec 2018
Overall Rating (0-10)	74.1	69.4 ▼	71.6 ▲	80.8 ▲	71.6 ▼	82.1 ▲	76.4 ▼	71.4	85.2
Comm w/Nurses	81.4	85.3 ▲	84.2 ▼	85.2 ▲	88.5 ▲	95.1 ▲	86.1 ▼	79.2	87.5
Comm w/ Doctors	84.5	90.6 ▲	83.5 ▼	89.4 ▲	92.0 ▲	94.0 ▲	85.9 ▼	79.7	87.9
Response of Hosp Staff	76.3	83.8 ▲	68.6 ▼	78.4 ▲	77.7 ▼	83.6 ▲	78.7 ▼	66.0	81.3
Comm About Medicines	66.0	60.8 ▲	71.6 ▲	70.0 ▼	70.2 ▲	80.3 ▲	67.8 ▼	63.6	74.3
Cleanliness & Quietness of Hospital Environment	72.5	64.0 ▼	66.6 ▲	74.9 ▲	79.2 ▲	73.9 ▼	73.6 ▼	65.5	79.4
Discharge Information	86.8	88.3 ▲	88.6 ▲	89.0 ▲	88.2 ▼	96.1 ▲	89.0 ▼	87.1	92.0
Care Transitions	55.3	58.0 ▲	57.1 ▼	64.0 ▲	58.3 ▼	59.3 ▲	46.4 ▼	51.7	63.1

Notes:

- CMS Achievement Threshold and CMS Benchmark are color-scored based on comparison against current period
  - Green: current pd => CMS
  - Yellow: current pd is up to 5% < CMS
  - Red: current pd 5%+ < CMS

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Current Scores

Performance Period
January 1, 2018 – December 31, 2018

Base Operating DRG Payment Amount Reduction	Value-Based Incentive Payment Percentages	Net change in Base Operating DRG Payment Amount
2.0000000000%	3.4310998595%	+1.4310998595%

Performance Period
January 1, 2019 – December 31, 2019

Base Operating DRG Payment Amount Reduction	Value-Based Incentive Payment Percentages	Net change in Base Operating DRG Payment Amount
2.0000000000%	3.1969996904%	+1.1969996904%

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COVID Hospital Portal

https://app.smartsheet.com/b/publish?EQBCT=c8f25f1dadb7457a8254428da50385be

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Patient Safety Committee Revision

Patient Safety

Scope

- The overriding focus of the Patient Safety Committee is the promotion of systems-based safety measures through discussion of risk, patient safety, and process/performance improvement activities identified by the Process Improvement Committee (PIC) or other sources, and support the initiatives necessary to address them.
- To protect patients from preventable harm.
- To support clinical compliance with regulatory standards for safety.
- To create or implement sustainable systems that promote patient safety and prevent patient harm.
- **Membership:** includes front line staff
- Meets bi-monthly

Performance Improvement Council

Authority and Responsibilities

- Identify areas for departmental performance improvement (PI) activities and ensure PI is data driven
- Monitor departmental PI activities
- Offer support and make recommendations related to PI activities and directs Patient Safety activities through Patient Safety Committee
- Identify, monitor and recommend reporting of PI projects to the Board Quality Committee
- Quarterly Report to the Board of Directors (roll up of key risk related issues during executive session)
- Approval of annual reports
- **Membership:** Quality Director Chair, Board Member, Department Directors, Quality Team
- Meets opposite month of Patient Safety Meeting

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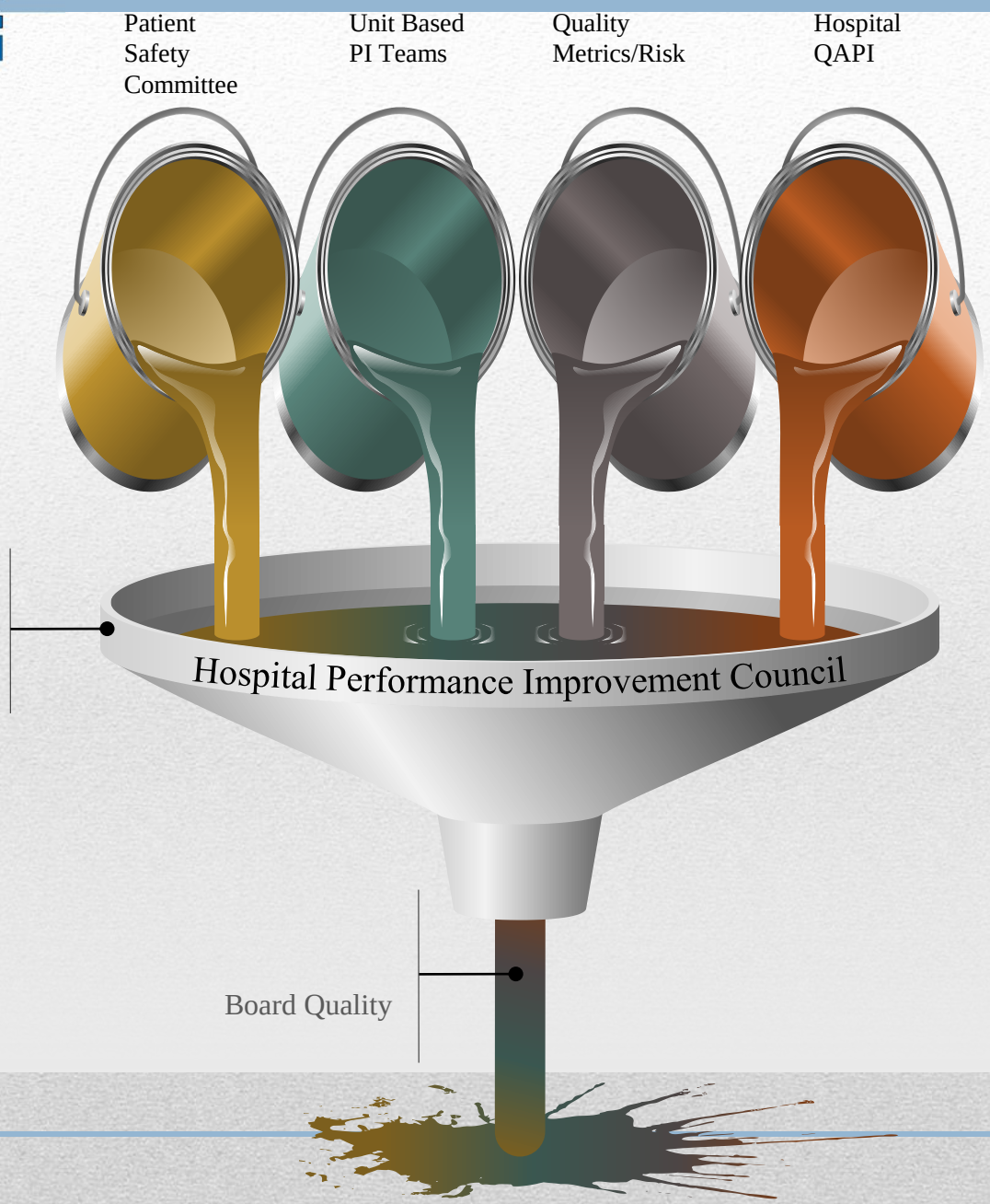

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