Bartlett Regional Hospital

AGENDA
QUALITY BOARD TEAM MEETING
Wednesday, November 18, 2020 – 3:30 p.m.
Bartlett Regional Hospital Boardroom / Zoom Video Conference
Meeting ID: 955 5431 0922

Public may participate telephonically by calling 1-253-215-8782

Mission Statement

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

Call to Order

- **Approval of the minutes:** 09.09.2020 **Page 2**

- Board Quality Presentation **Page 4**

  Standing Agenda Items:
  - BOD Quality Scorecard — D Koelsch / R Embler

  New Business:
  - Patient Safety Taskforce Updates — G Moorehead
  - Joint Commission/Sentinel Event Process — A Muse
  - QAPI Reporting Schedule 2021 — G Moorehead

Adjournment

Next Scheduled Meeting: January 13, 2020 3:30 p.m.

Bartlett Regional Hospital

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

Board Quality Committee
September 9, 2020
Minutes

Called to order at 3:30 pm by Board Quality Committee Chair, Rosemary Hagevig

Board Members: Rosemary Hagevig (Chair), Kenny Solomon-Gross, Marshal Kendziorek, Iola Young

Patient & Feedback Representative: n/a

Staff: Charles Bill, CEO, Gail Moorehead, Director of Quality, Bradley Grigg, CBHO, Dallas Hargrave, HR Director, Billy Gardner, COO, Rose Lawhorne, CNO, Kevin Benson, CFO, Megan Costello, Chief Legal Officer, Deborah Koelsch, RN Clinical Quality Data Coordinator, Rebecca Embler, Quality Systems Analyst

Approval of the minutes – 07 15 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 were discussed in the July 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 6.4%, improved from 8% in Q1 2020. Ms. Moorehead noted that we will have one injurious fall for Q3.
- For Core Measures, Severe Sepsis/Septic Shock was 56%, which changed from last reporting by +6%, and Screening for Metabolic Disorders was 93%, improved from 90% in Q1 2020.

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 identified this issue and have worked with Press Ganey to establish a new customized survey, which was received this week.

- For HCAHPS results, it was noted that scores are below last quarter for each of the survey areas, and also below the CMS Benchmark. It was brought to attention that the scores are based on survey Received Date, so are delayed slightly from when the actual care was provided. Ms. Moorehead noted that our HCAHPS scores will not be reported for Q1 or Q2 2020 because of a waiver available from CMS for reporting due to COVID.

Deb Koelsch reported on Current Scores for Value Based Purchasing bonus payment for 2019. This is positive net change of ~$200K, verified by Mr. Benson. Ms. Hagevig requested that an abbreviated presentation of Value Based Purchasing is given to the BOD once in-person meetings are happening again.

COVID Portal

Ms. Embler presented an overview of the BRH COVID Portal that is a resource for staff to more easily access Incident Directives, education links, Infection Prevention updates, data dashboards and the Employee Health Screening form. The portal is hosted in Smartsheet, which is a new tool that both Bartlett and CBJ are using for data sharing and collaboration. Ms. Hagevig asked about the practical use of the Portal for front-line staff; Ms. Moorhead responded that the items listed above are used by staff on daily to weekly basis, and were often hard to locate before. Ms. Moorehead requested that the link to the COVID Portal be shared with Board Quality members. https://app.smartsheet.com/b/publish?EQBCT=c8f25f1dadb7457a8254428da50385be

Patient Safety Committee Revision

Ms. Moorehead presented on the recent update to the Patient Safety Committee charter, and the renewed focus of Patient Safety for the Quality team and front-line staff. Ms. Moorehead explained that the drive for updating the charter is to encourage the organization to be more proactive with Patient Safety, rather than reactive to events that occur. The Board Quality Committee all agreed that they fully support this approach and look forward to seeing the changes that come from the Patient Safety Committee.

Next Meeting

The next scheduled meeting date was November 11th, which is Veteran's Day. It was decided that the meeting should be moved, so a tentative date of November 18th was chosen. Ms. Moorehead will confirm. The meeting needs to be before the November BOD meeting. Tentaive schedule items were discussed as well; Sentinel Event Update based on Joint Commission meeting on October 21st, and Mr. Solomon-Gross requested an educational piece.

Adjourned at 4:15 pm

Next Quality Board meeting: November 18th, 2020 @ 3:30pm - *TENTATIVE*

Board Quality Committee Meeting

November 18, 2020

Bartlett Regional Hospital

QUALITY in Community Healthcare™

CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

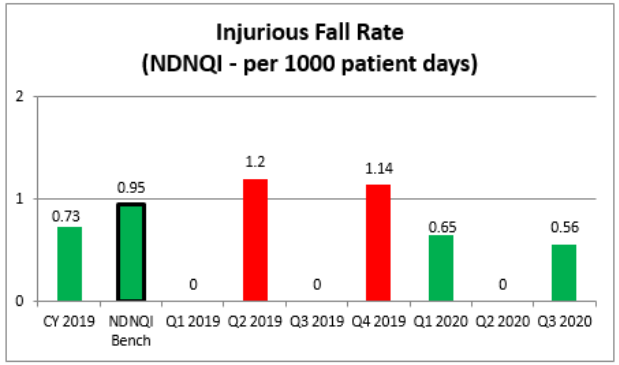
Agenda

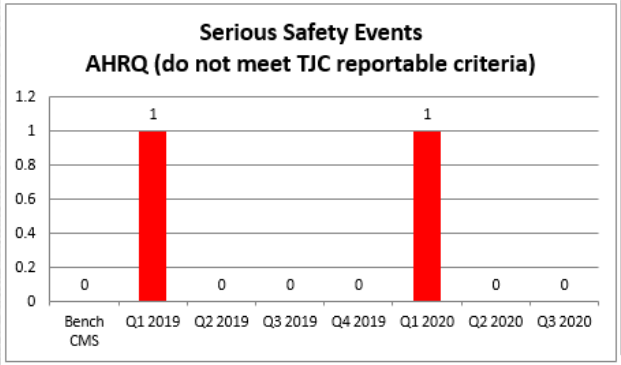
• BOD Quality Scorecard	D. Koelsch
• Patient Safety Taskforce Updates	G. Moorehead
• Joint Commission/Sentinel Event Process	A. Muse
• QAPI Reporting Schedule 2021	G. Moorehead

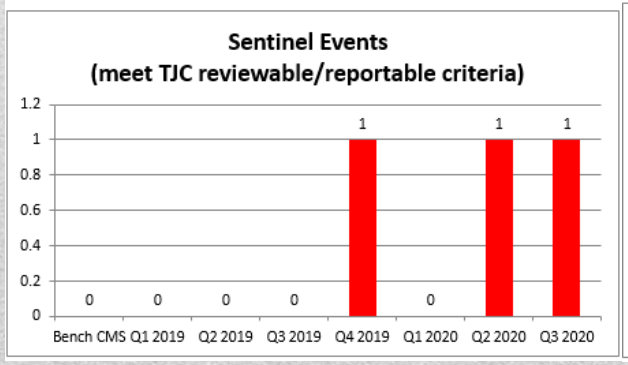
Bartlett Regional Hospital

Quality Scorecard

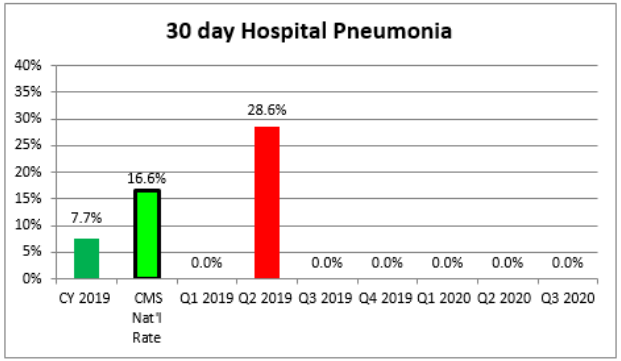
RISK MANAGEMENT – *lower is better*

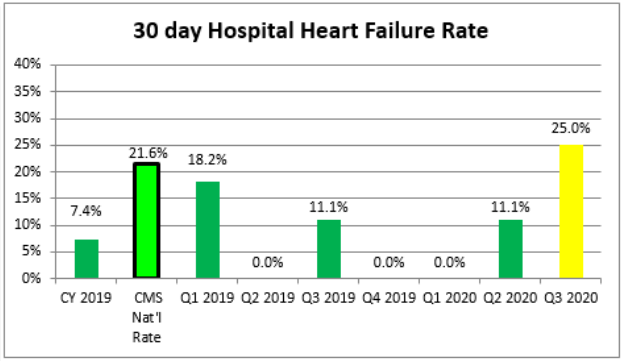


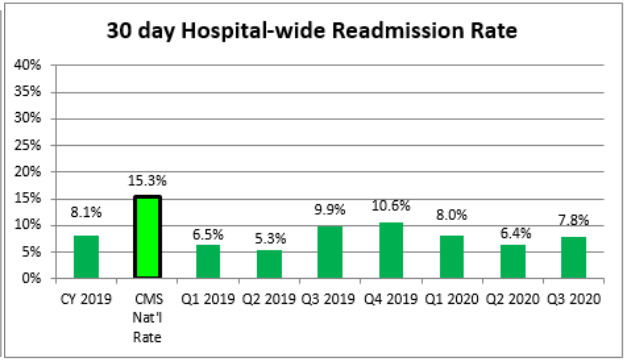




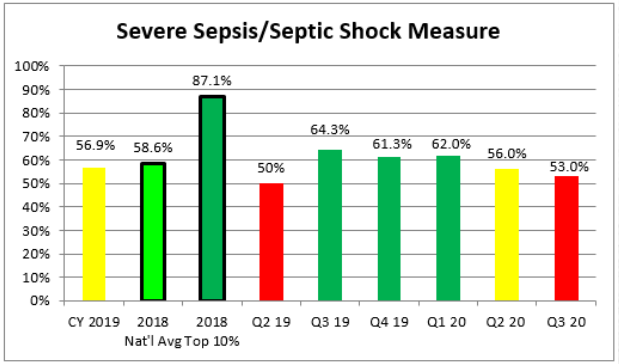
READMISSION RATES – *lower is better*

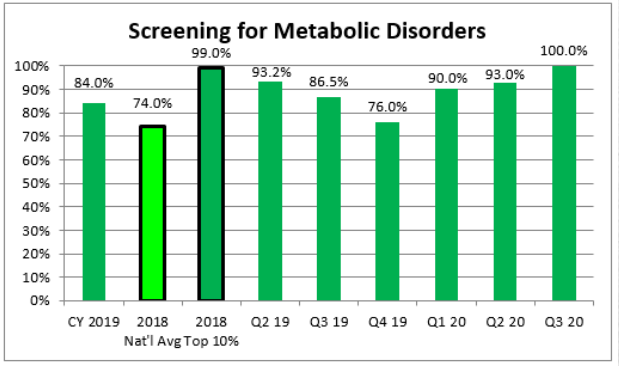






CORE MEASURES – *higher is better*





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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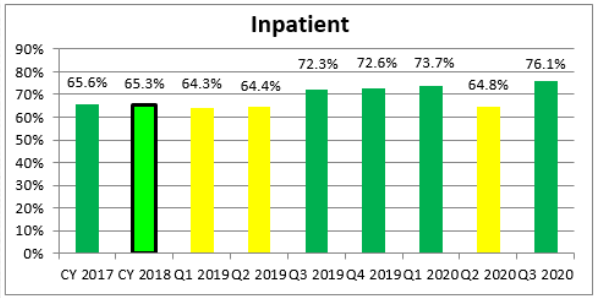
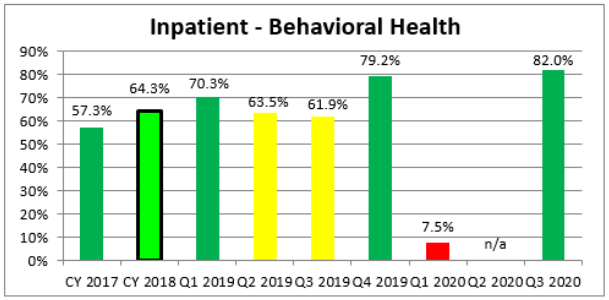
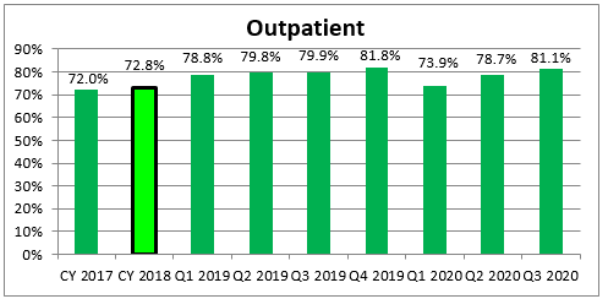
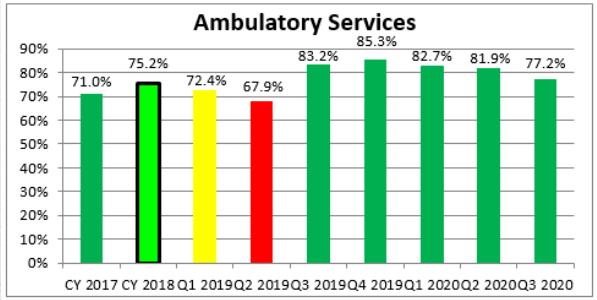
Quality Scorecard

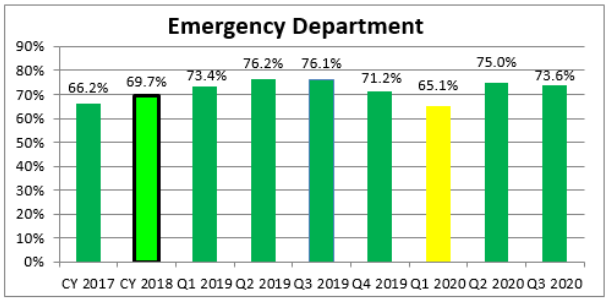
PATIENT EXPERIENCE











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

	Current Quarter		QoQ	YoY	CMS Achievement Threshold	CMS Benchmark	Baseline Period	
	Q3 2020	Percentile	Q2 2020	Q3 2019	50th %ile	Mean of Top 10th %ile	2018	Comments
Overall Rating (0-10)	85.3	93	▲	▲	▲	▲	▲	Q3'20 score is a 6-quarter high point
Comm w/Nurses	88.7	95	▲	▲	▲	▲	▲	*Nurses treat you with courtesy/respect* and *listen carefully to you* both at 97 percentile
Comm w/ Doctors	88.6	93	▲	▼	▲	▲	▲	*Doctors treat you with courtesy/respect* at 97 percentile
Response of Hosp Staff	80.0	94	▲	▲	▲	▼	▲	*Help toileting as soon as you wanted* down 4% from last quarter; metric still up overall
Comm About Medicines	75.7	97	▲	▲	▲	▲	▲	*Tell you what new medicine was for* at 99 percentile
Hospital Environment	75.7	86	▲	▲	▲	▼	▲	*Quietness of hospital environment* at 77 percentile
Discharge Information	85.9	40	▼	▼	▼	▼	▼	*Info regarding symptoms/problems to look for* at 25 percentile
Care Transitions	67.2	97	▲	▲	▲	▲	▲	*Understood purpose of taking meds* at 99 percentile

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Patient Safety Taskforce Updates

Patient Safety Committee (PSC)

The PSC is comprised of frontline staff and directors from all clinical and support departments. It meets every other month to review patient safety data and create focused work groups to improve patient safety within the organization.

Currently we have three Patient Safety Taskforces

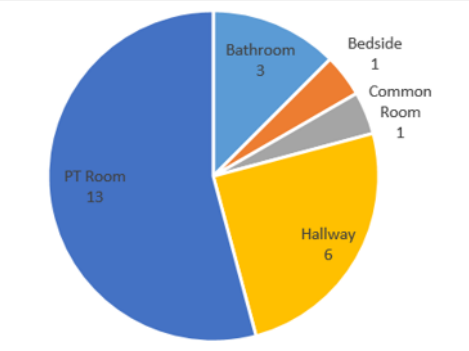
- Restraints/Seclusion
- Falls
- Glycemic Control for Inpatients

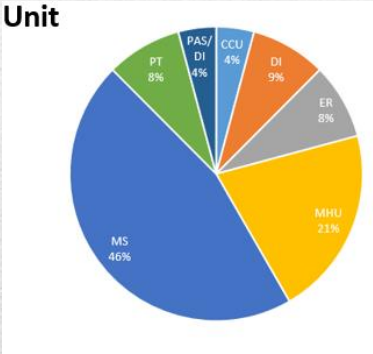
These taskforces are designed to be rapid action groups that look at processes/systems and follow our QAPI process to implement lasting improvements. After the work of the taskforce is complete the continued monitoring of the changes are monitored by the committee as a whole.

Patient Safety Taskforce Updates

Falls Taskforce Update

- Reviewed Falls from April-September (6 month benchmark)
- Analyzed data from chart reviews





- Developing action plans within units to address findings
- Subdivided group to address environmental/outpatient issues
- Established goals for measuring falls/inpatient days for units based on national averages

Patient Safety Taskforce Updates

Restraint Taskforce Update

Created in September with staff from Med/Surg, MHU, ED, CCU, House Supervisors, Risk and Quality.

- **Goals are to assess :**
  1. BRH's process and practice of restraint use
  2. Compliance of CMS regulations and TJC Standards
  3. Compliance of BRH's Restraint and Seclusion Policy
  4. Needed education and support for staff related to restraint use and documentation
  5. Create standardized process for documentation auditing

- **Taskforce projects:**

1. Surveyed staff and providers on restraint knowledge, areas of challenges, and areas of needed improvement

2. Created a consolidated log for auditing restraint documentation for House Supervisors and department directors into a shared Smartsheet

3. Working on identifying a restraint documentation auditing tool that covers our policy and standards and regulations- currently doing chart audits to assess the tool to our policy and Meditech documentation

4. Updating our Policy to follow new standards and assessing how we can make the required documentation policy and process more supportive for staff

TJC/Sentinel Event Reporting Process

According to TJC: A sentinel event is a Patient Safety Event that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm and intervention required to sustain life
- An event can also be considered sentinel even if the outcome was not death, permanent harm, severe temporary harm and intervention required to sustain life. These examples are listed in the TJC accreditation manual.

- Bartlett is strongly encouraged, but not required, to report sentinel events to The Joint Commission. To hold our facility to a higher safety standard and promote a culture of safety Bartlett's Sentinel Event policy states that we will report all defined sentinel events to TJC.
- If an event occurs that meets the criteria of sentinel, Bartlett's Risk and Quality departments will support a debrief of the event if not already done, interview the staff involved, investigate the event and documentation, host a RCA to identify system level areas of improvement and with leadership's involvement create a Corrective Action Plan to resolve the areas of improvement.
- With reporting sentinel events, TJC provides the hospital with support and expertise of a patient safety expert from the Office of Quality and Patient Safety. They work with our hospital to help assess our RCA findings and our Corrective Action Plan and provide feedback.
- TJC also collects data on the sentinel events reported to help identify high risk patient safety areas and to share overall data to organizations.

QAPI Reporting Schedule 2021

Since the beginning of COVID with virtual meetings, the QAPI updates were put on hold pending what the future held for BRH. How can we integrate these reports back to the board in the future?

- Process for 2021 for reports from departments
- Quality committee or Board as a whole?

- Thoughts?

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