Bartlett Regional Hospital

Board Quality Committee
January 12, 2022
3:30 p.m.
Agenda
https://bartletthospital.zoom.us/j/93135229557

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 18 , 2020

Standing Agenda Items:

- 2021 BOD Quality Dashboard — D. Koelsch

New Business:

- Utilization Management Plan — J. Lacey
- Infection Prevention Plan — C. Gribbon
- Environment of Care Management Plan — M. Walker
- Patient Safety and Quality Improvement — G. Moorehead
- Environmental Health and Safety Program Plan — G. Moorehead

Next Scheduled Meeting: March 9, 2022 3:30 p.m.

Board Quality Committee
November 10, 2021
Minutes

Called to order at 3:28 p.m. by Board Quality Committee Chair, Rosemary Hagevig

Board Members: Rosemary Hagevig, Mark Johnson, Hal Geiger, Mark Johnson

Staff: Deborah Koelsch, Autumn Muse, Gail Moorehead*, Jerel Humphrey, Holly Cockerill, Jeannette Lacey, Racheal Gladhart, Karen Forrest*, Kim McDowell*, Dallas Hargrave*, Vlad Toca*

Guests: Bridgett Dowd, KTOO

Mark Johnson made a MOTION to approve the minutes from September 8, 2021 Board Quality Meeting. Kenny Solomon Gross seconded, they are approved.

Old Business: None

Standing Agenda Items:
- None

New Business:
QAPI Presentation – Case Management
- Ms. Lacey presented on three Case Management process improvement projects. She provided an overview of the Case Management department and their contributions to the hospital and our patients. The discharge planning and outlier chart reviews was the first project presented. Our geographic location is a barrier to transition patients to the next level of care. The improvement opportunities include earlier discharge planning, provider participation with the discharge planning process and demonstrating the severity of illness with documentation and coding. The department worked on streamlining their processes by working with Clinical IT by adding a facility referral section. This ensures that things don't fall through the cracks. Patients are provided a provider list and the CMS ratings on possible placement options.
- The Hello B.A.B.Y. Plan of Safe Care Program was presented by Ms. Gladhart. The program is meant to engage families with perinatal substance use and develop plans to keep babies safer and families healthier. BRH partners with ROCK Juneau to provide this program. BRH has had 42 families referred, 81% of the referrals were enrolled in the program. This program lets us reach a vulnerable population of Juneau. Bartlett will participate in the state-wide process improvement program the Alaska's Perinatal Quality

DRAFT

Collaborative. We currently meet five of the 11 key changes the program is targeting. Ms. Gladhart shared the major gaps we are experiencing within our community including transportation, respite childcare, parenting skills, diaper insecurities and mental health in the fourth trimester.

- The Oncology Program presentation will be sent to the Board of Directors via email.

Fall Vaccine Update

- Tabled to next BOD meeting

Update on JC New Board Requirements

- Ms. Muse gave an update on The Joint Commission's possible plan to do a hybrid survey. Our survey schedule will remain the same. Ms. Muse gave an update of new standards. In July of 2022, there will be a large overhaul in the Emergency Management requirements. Ms. Muse invited the Board of Directors to the Joint Commission Survey Boot Camp and the upcoming Breakfast Briefings. There was a request to have the boot camp recorded and provided to the board at a later date. Ms. Hagevig responded that watching it at a later date would remove the chance to have an interaction with staff. Mr. Hargrave will check with Mr. Palmer regarding the posting of the meeting.

Review of Current CMS Quality Measures/Reporting

- Ms. Moorehead gave an overview of the current CMS quality measures and reporting and using measurement for quality improvement. The three aims for the National quality strategy are better health, better care and lower costs. We make care safer by improving support for a culture of safety, reducing inappropriate and unnecessary care and preventing and minimizing harm in all settings. Ms. Moorehead shared our current objectives to promote effective safe care. Ms. Moorehead shared her vision for future reporting to the Board of Directors regarding Quality measures.
- Discussion surrounding Sentinal Event reporting and how that information is provided to the Board of Directors.

Review of the Governance Conference

- Ms. Hagevig would like to review the presentations provided today again and share them with Strategic Planning. Mr. Solomon-Gross expressed how important Quality is to the hospital. Ms. Hagevig would like to share the recordings from the conference with the Quality Department.

Adjournment: 5:06 p.m.

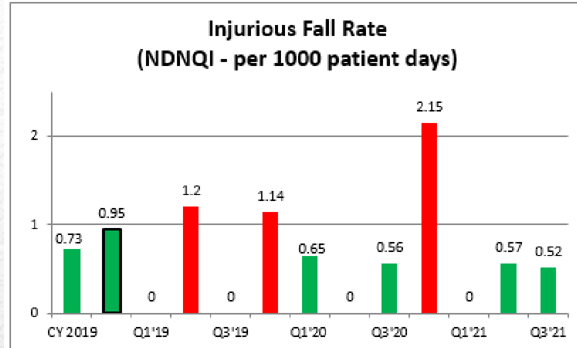
Next Quality Board meeting:__________ at 3:30 pm

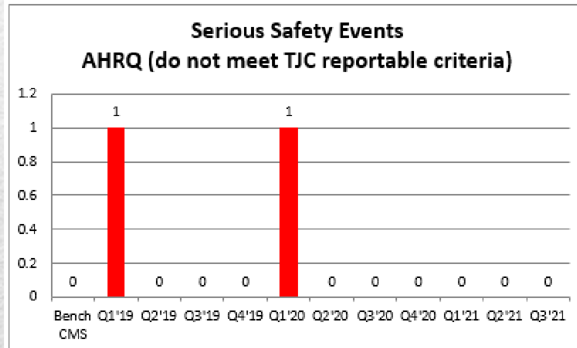
DRAFT

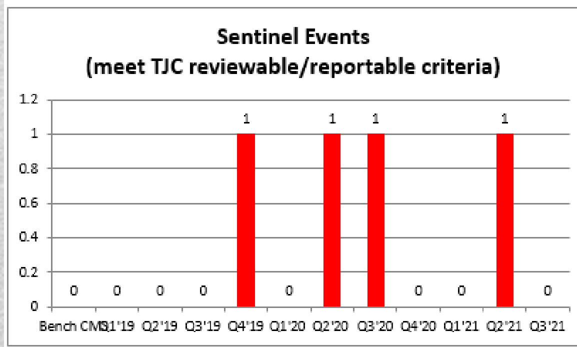
Bartlett Regional Hospital

Quality Dashboard

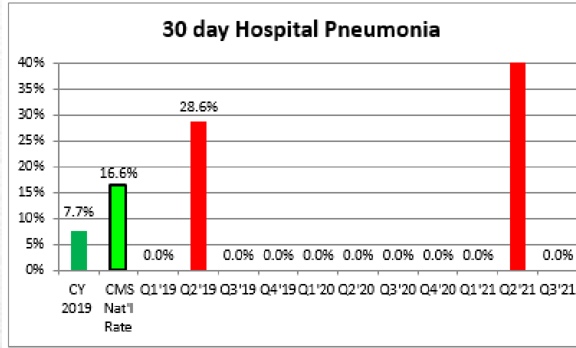
RISK MANAGEMENT – *lower is better*

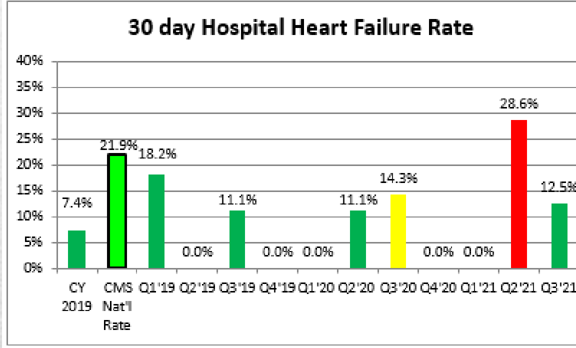


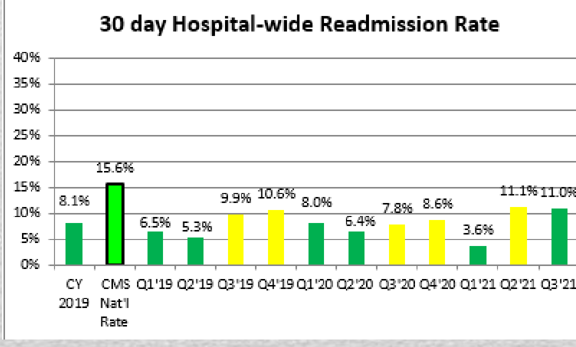




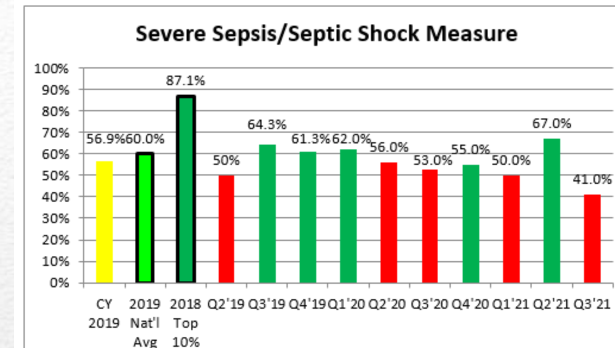
READMISSION RATES – *lower is better*

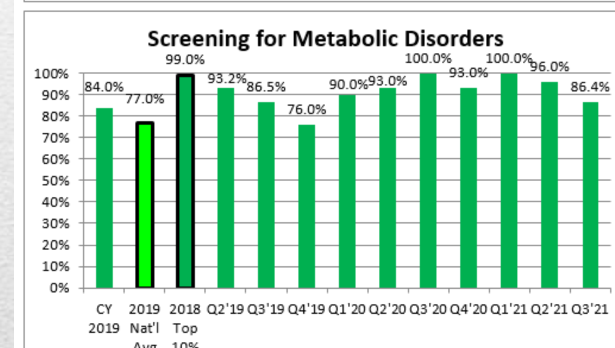






CORE MEASURES – *higher is better*





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

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

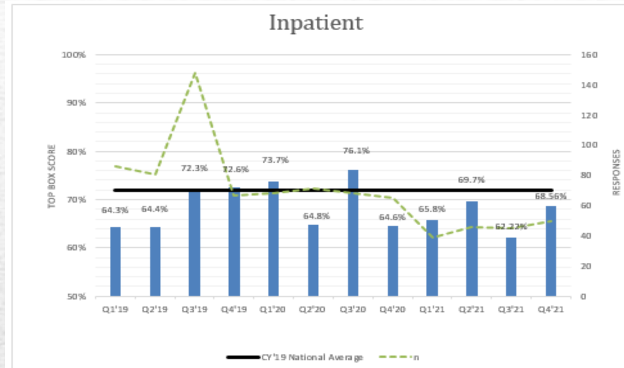
Pneumonia and Heart Failure: patient is readmitted back to the hospital within 30 days of discharge for any diagnosis.
Hospital-wide: patient is readmitted back to the hospital within 30 days of discharge for *any* diagnosis.

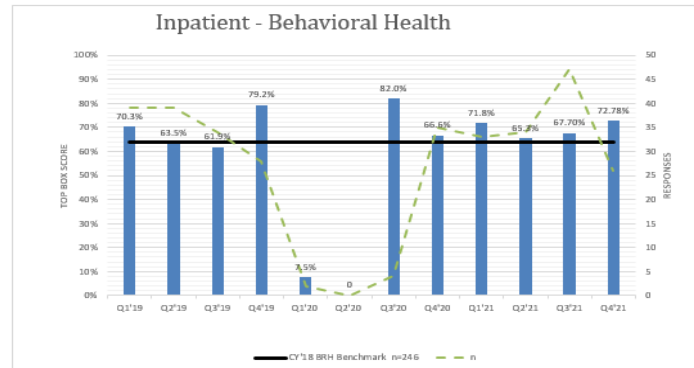
City and Borough of Juneau – Alaska's Capital City

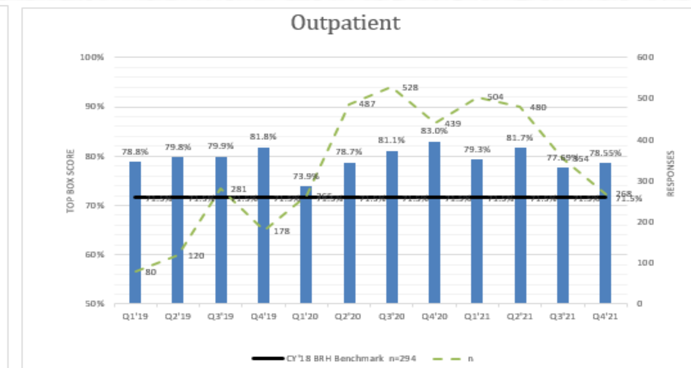
Bartlett Regional Hospital

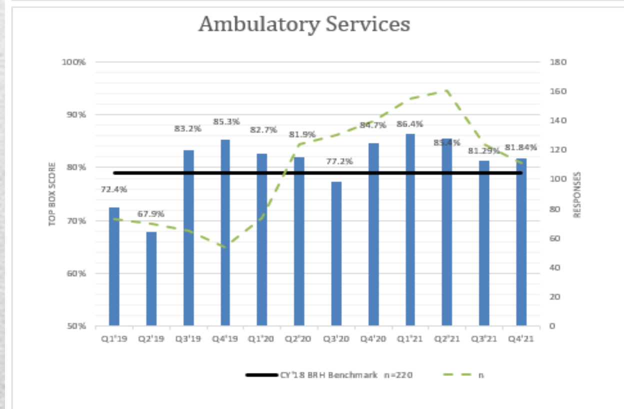
Quality Dashboard

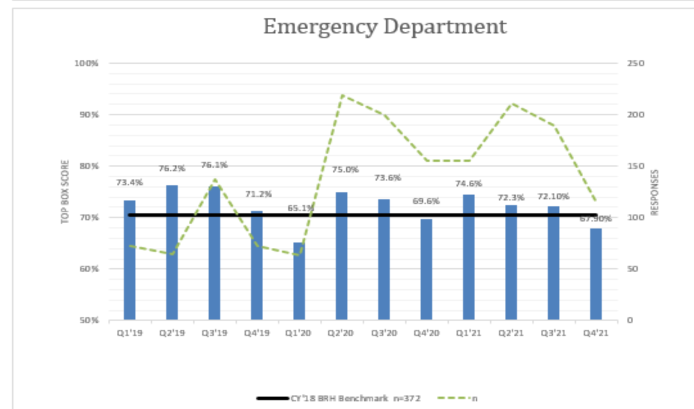
PATIENT EXPERIENCE











Notes:

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

CITY AND BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

Bartlett Regional Hospital
Title: **UTILIZATION MANAGEMENT PLAN**
Department/s: All Clinical Departments
Original Date: 10/1997 Author: Jeannette Lacey, LMSW, ACM
Updated: 12/2021~~0~~

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 other 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 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 Utilization Review Committee.

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

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 Utilization Review Committee.

E. 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 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:
   - E.1. Performing admission, concurrent, discharge and retrospective reviews to assess for medical necessity
   - E.2. Identifying the appropriate level of care
   - E.3. Managing length of stay
   - E.4. Assessing potential transfers from lateral or higher levels of care
   - E.5. Managing denials and appeals
   - E.6. Tracking and monitoring utilization patterns and professional services furnished, including drugs and biologicals.
   - E.7. Identifying available discharge care resources to develop a post-acute care plan that is compliant with CMS guidelines.
   - E.8. Requesting secondary review or Utilization Review Committee involvement as necessary.

F. CM will collaborate with physicians to support the utilization management process by:
   - F.1. Maintaining open lines of communication.
   - F.2. Reviewing admission status based on accepted criteria and CMS rules and discussing concerns with the provider.
   - F.3. Reviewing continued stay documentation and identifying possible changes or additions to ensure that documentation supports physician intent.
   - F.4. Coordinating care conferences with the physician and treatment team as indicated.
   - F.5. Involving the physician in the discharge planning process.
   - F.6. Coordinating physician participation in the appeal process.

G. Patients that do not meet inpatient criteria may be placed in 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.

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 and applicable hospital policies.
   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.
   I.6. Provide education and communicate with individual providers when rules or polices are not followed. Escalate concerns when recurrent or significant.

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 the Case Management of reviews requested by payers at the time of verification.

C. Medical Necessity: Hospital inpatient services under Medicare Part A, section1814(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. 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) Medicare Hospital Manual section 230

(2) CMS Conditions of Participation 482.30 Utilization Review

(3) CMS Conditions of Participation 412.80 Outlier Cases

(4) Miliman Care Guidelines: Inpatient and Surgical Care, General Recovery Care~~ and Behavioral Health Care~~, current edition, 2021~~19~~

Attachments

(1) Health Information Management/Case 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

Q3 CY2021

Denials

	Initial Days Denied	Days Reversed/obs/in appeal	Days Upheld
Totals			
Aetna			
Blue Cross			
Medicaid			
UHC			
Other			

Medicare Monitoring		Notes
CMI		
1- day stays		
Observation >/= 2MN		
Outliers- Total		
Psych		
Placement		
EOL		
Complex Medical		
Social		
Other		

Readmissions		Notes
All Cause		
Medicare Readmissions		
AMI		
HF		
Pneumonia		
COPD		
THA/TKA		
Sepsis		
Stroke		
Other		

BARTLETT REGIONAL HOSPITAL
INFECTION PREVENTION and CONTROL PLAN 2022 Draft

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	David Miller MD	1/7/2022
Quality and Process Improvement Director	Gail Moorehead MSN, NPD-BC, CMSRN, CPHQ	1/7/2022
Infection Preventionist	Charlee Gribbon RN, MPH, CIC	1/7/2022

Bartlett Regional Hospital

Infection Prevention and Control Plan 2022

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 (novel strains such as COVID-19, or 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.

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, enhanced cleaning methods, and/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, respiratory pathogens 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 services, 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 (SOE), 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 Occupational Health and Safety Program Specialist is coordinating the health and safety program for patients, employees, visitors, and contractors during renovation, construction, and maintenance 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 current Risk Assessment and Prioritization List). The factors to be addressed in the risk assessment include, at a minimum: Hospital Acquired Infections, Antimicrobial Stewardship, Hand Hygiene, influenza and novel respiratory pathogens, medical devices, occupational exposures, and infectious organisms/diseases.

Geographic Location and Community Environment

Bartlett Regional Hospital is a community-owned acute care hospital licensed for a total of 71 inpatient beds and 10 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 46,653. 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 31,848 (US Census, 2021) This includes 5.8 % who are under 5 years of age, 21.5% persons who are under 18 years, and 12.5 % that are over 65 years of age. (US Census, 2021) The underserved and disadvantaged population includes: 7.9% with a disability and under 65 years of age; and 11.8 % under 65 years of age without health insurance. (US Census, 2021) Additionally, 7.7% of Juneau residents are living in poverty (US Census, 2021).

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, mining 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, mining 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 in local population 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, COVID-19, MDR Tuberculosis, CRE, Ebola, etc.) and to maintain an updated emergency management and surge capacity plan.

The Alaska Department of Health and Social Services 2019 TB Summary Brief Report shows that Alaska's TB infection rate was 7.9 cases per 100,000 people, representing a slight decrease from the previous year (AK SOE, 2020). Alaska still has the highest TB incidence rate in the nation, and is nearly three times the national average of 2.7 cases per 100,000 people. Southeast Alaska's incidence rate has decreased from 2.7 to 1.4 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 *Clostridioides difficile* [CDI]) 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 745 employees and 79 licensed independent providers. 567 (76 %) are full or part time scheduled and working on campus. 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, TB testing, and screening for immunity to vaccine-preventable diseases. Employees that handle or contact hazardous drugs participate in the medical surveillance program. Employee illnesses are categorized and logged daily by the Central Staffing Office and Employee Health Nurse, and analyzed by Employee Health. 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.

2022

Infection Prevention and Control Plan

Draft

2022 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).	BRH hand hygiene rates will be improved by 10% over 2021's hand hygiene compliance rate by 9/30/2022. Directors of units that have direct contact with patients will contribute to data collection, with the shared goal of observing 200 hand hygiene moments per unit, per month.	1. Enlist Hand Hygiene Observations from directors of patient care areas. 2. Utilize Smartsheets to collect data and share compliance rates. 3. Plan and implement Hand Hygiene awareness and educational campaign. 4. Work with Patient and Family Engagement Team to encourage more patient feedback regarding Hand Hygiene.	Nursing Administration, Directors & Supervisors, Patient Care staff, Infection Prevention.	BRH hand hygiene compliance rate will increase by 10% over 2021 (65%) hospital wide rates. Patient reported (Press-Ganey) hand hygiene scores will increase by 5% over 2021's reported rates. (72.3%) Observations collected in each unit, per month will meet or exceed 200.

Infection Prevention Goal #2	Measurable Objective	Strategies	Responsible parties	Measurement/ Evaluation
► Reduce surgical site infections by reducing risk of infection.	Reduce surgical site infection rate at or below 0.3 per 100 procedures by 12/31/2022.	1. Monitor staff compliance with pre procedural bathing. 2. Utilize dietary consult pre-op to reduce risk of perioperative hyperglycemia. 3.	All nursing units, Surgical services, EVS, Medical Staff, and Pharmacy.	Measure surgical site infection rates and compare to 2021. Rate will be ≤ 0.3 infections per 100 procedures.

Infection Prevention Goal #3	Measurable Objective	Strategies	Responsible parties	Measurement/Evaluation
►Decrease the risk of acquiring health care associated C. difficile. (NPSG 07.03.01)	Limit the risk of HAI C. difficile transmission and reduce HAI CDI rates to 2 infections per 10,000 patient days by 12/31/2022.	1. Ensure adherence to testing only symptomatic patients. 2. Utilize 2 step testing to identify only toxigenic cases. 3. Increase utilization of Sterile Meryl for all terminal cleaning. 4. Ensure appropriate cleaning and disinfection products (sporicidal) are available for C. difficile rooms and area is cleaned per protocol. 5. Prohibit unnecessary antibiotic use.	Nursing, EVS, Infection Prevention, pharmacy, medical staff, laboratory and all staff.	Measure C. difficile infection rates and compare to 2021 baseline. There will be no increase in HAI- C. Difficile rates for 2021.

		6. Increase hand hygiene compliance		
Infection Prevention Goal #4	**Measurable Objective**	**Strategies**	**Responsible parties**	**Measurement/Evaluation**
► Prepare for and protect staff, patients and our community from respiratory pathogens in a efficient and safe manner. (IC.02.04.01)	1. Maintain full time/ part time scheduled staff influenza & COVID vaccination at rates 98 % or greater for the 2022-2023 season.	1. Participation in the influenza and COVID-19 prevention plan is mandatory. 2. Unvaccinated staff are required to wear barrier masks. 3. Enforce standard precautions are in use for any aerosol-generating procedure. 4. Continue to monitor and report pertinent information regarding illness trends in the community and at BRH.	Leadership, all staff, IC, and employee health	Full time/ part time scheduled staff compliance rate will be at 98% or greater by November 30, 2022. Report data via NHSN.

References:

Alaska Community Database Online DCRA Information Portal (2021) Juneau, Alaska. Retrieved from https://dcced.maps.arcgis.com/apps/MapJournal/index.html?appid=3635942ba31c40f094e6249f9d07431c

Section of Epi (2019) Alaska TB Summary Brief. Retrieved from
http://dhss.alaska.gov/dph/Epi/id/SiteAssets/Pages/TB/2019%20AK%20TB%20Summary.pdf
http://dhss.alaska.gov/dph/Epi/id/Pages/tb.aspx

United States Census Bureau. (2020) Quick Facts: Juneau City and Borough, Alaska. Retrieved from:
https://www.census.gov/quickfacts/juneaucityandboroughalaskacounty (Census)

BARTLETT REGIONAL HOSPITAL

Environment of Care

Annual Report

CY 2021

Approvals
Environment of Care Committee: December 16, 2021
Performance Improvement Council: (scheduled January 12, 2022)
Board Quality: (scheduled January 12, 2022)

Bartlett
Regional Hospital

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 (Gail Moorehead Sr. Director Quality Review)
- Security Management (Gail Moorehead Sr. Quality Review)
- 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 Life Safety Management Program is integrated with the EOC Program.

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 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 2021. For each of the major areas, it is organized as follows:

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

SAFETY MANAGEMENT

SCOPE

No Changes

Bartlett Regional Hospital's (BRH) commitment to a safety management plan is designed to provide a physical environment free of hazards. 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

- Development of Environmental Health and Safety Program
- Creation of Environmental Health and Safety Manager Role
- Ongoing workplace violence work through WSHA in the Emergency Department
- Workplace Violence Prevention Plan in development
- Hazard risk assessments performed for new or changed workflow or spaces due to COVID-19

PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments and Action Plans
Identify opportunities to improve safety performance	**Met**	Hazard risk assessments performed for new or changed workflow or spaces due to COVID-19Hazard
Provide regular safety education to all staff	**Met**	New employee education and required annual safety education

Objectives	Met / Not Met	Comments and Action Plans
Enforce current safety practices for staff, patients, physicians, and visitors	**Met**	EOC Rounds were completed as and follow-up rounds were conducted to monitor specific regulatory survey findings.
Comply with all relevant safety standards and regulations	**Met**	Continue Safety Program development by Environmental Health and Safety Manager
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 2021	Target	Outcome	Comments and Action Plan
Create a new and efficient way to meet the Joint Commission requirements to collect information on staff's knowledge of Employee Safety topics and to survey the physical environment (replace SWARMS)	100%	100%	**Met** There is a new Relias employee swarm online for staff to complete in December. This will be uploaded and reevaluated annually.
Reduce OSHA recordable injuries to staff by 50% (7 for 2020)	3 or less	6	**Not Met** The past year had 6 OSHA reportable cases. The committee has determined that this goal will continue for 2022 and they will dive deeper into the cases to determine what further actions need to be taken to reduce this number.

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 2022:

- Development of Tracking and evaluation of workplace violence incidents and review of post event interventions.
- Create more opportunities for frontline staff participation in the program

The proposed performance measures for these goals are:

Safety Management Proposed Performance Measures for 2022	Target	Comments & Action Plan
AIM: Recruit and retain frontline worker for the workforce safety and security committee to meet OSHA standards.	**Complete 100%**	
AIM: Reduce OSHA recordable injuries to staff by 30% in 2022 (6 for 2021)	**4 or less**	
AIM: Conduct a Risk Assessment on at least one high risk process area per year.	**Complete 1 FMEA**	
AIM: Complete a ligature risk assessment and mitigation of ligature risks on MHU. This will include any identified concerns from 2021 survey.	**Complete 100%**	

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

- PES program implemented in the Emergency Room to respond to patients in behavior crisis.
- Additional employee badge proximity readers have been added to security doors throughout the hospital to enhance security in those areas. More to be added in 2022 along with enhanced lockdown capabilities.
- Security response to physically limit control points to the hospital as a response to COVID-19 safety precautions.

- The hospital appropriately responded to dynamic visitor policy and visitor incident directives based on needs assessment.
- New Psychiatric Emergency Services staff has supported the security response requests in the Emergency room.

PROGRAM OBJECTIVES

Objectives	Met / Not Met	Comments and Action Plans
To provide education to personnel on the elements of the Security Management Plan	**Met**	New employee education and required annual safety/security education
To control access to and egress from sensitive areas	**Met**	Secure and Sensitive areas policy

Objectives	Met / Not Met	Comments and Action Plans
To reduce the risk of security incidents	**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.
To address security concerns of patients, visitors, personnel and property.	**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 2021	Target	Outcome	Comments and Action Plan
Create variable lock down procedures for active threat events to the hospital, RRC, BSSC, BMOC and both admin buildings. All external exits to hospital, RRC, and both admin buildings are to have badge reader access capabilities	Procedure In place and hardware installed	Complete	**Met** Badge readers: 100% complete. Current lockdown options adequate, but in the process of requesting additional devices which will expand lockdown options.
Finalize disruptive patient contract, including actionable consequences to enable staff to maintain a safe and secure environment independent of calling for law enforcement.	Complete Document	Partially Complete	**Partially Met** Risk Management is in contact with CBJ Legal to finalize the document.

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 2022

The following goals/opportunities for improvement have been identified:

- **Improve Safety**: Ensuring staffing for two security guards per shift for greater than 60% of shifts and have all security personnel attend advanced de-escalation training.
- **Decrease Potential for Workplace Violence:** Implementation of virtual patient sitter equipment in our inpatient units. Development of tools to share patient alters throughout the entire organization

The proposed performance measures for these goals are:

Security Management Proposed Performance Measure for 2022	Target
Improve Safety Through Security **AIM:** Staff 2 security guards per shift	60%
Improve Safety Through Security **AIM:** Have all security personnel attend advanced de-escalation training.	100%
Decrease Potential for Workplace Violence **AIM:** Implementation of virtual patient sitter equipment in our inpatient units.	Implement program
Decrease Potential for Workplace Violence **AIM:** Development of tools to share patient alters throughout the entire organization (Edie or other program) that will share potential concerns for patient violence and history.	Develop tools and implement

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 review completed in November 2021
- Continued 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 Relias.
- 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**	Relias 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.

Objectives	Met / Not Met	Comments & Action Plan
To assure Nursing Departments are familiar with the pharmaceutical waste process.	**Met**	Nearly all departments have demonstrated competency in this objective.

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.

PER*FORMANCE 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:

HazMat Management Performance Measures 2021	Target	Outcome	Comments and Action Plan
AIM: How do you find a Safety Data Sheet at Bartlett Regional Hospital?	100%	89%	Continue Educating Staff
AIM: How many elements are included in a Safety Data Sheet?	86%	81%	Continue Educating Staff
AIM: What section on a Safety Data Sheet addresses First Aide?	83%	83%	
AIM: Have you had or have you reviewed Hazardous Communication with your direct supervisor in the last 12 months?	100%	63%	Continue Educating Staff
AIM: What is the difference between an Incidental Spill/Fumes vs a Non Incidental Spill/Fumes?	59%	50%	Continue Educating Staff
AIM: How often must an eyewash, shower or personal wash bottle be checked?	100%	71%	Continue Educating Staff
AIM: If your unit has a common bottle of Methanol, you must have at a minimum a plumbed eyewash station on the unit?	13%	88%	

HazMat Management Performance Measures 2021	Target	Outcome	Comments and Action Plan
AIM: You are wasting a partial dose of Phenergan. Where do you waste this liquid medication?	75%	98%	
AIM: You are giving a half dose of Coumadin and you need to waste the other half. Where do you waste it?	63%	97%	
AIM: You are cleaning up after a procedure. There are 4x4 gauzes saturated with body fluids/blood. Where do you throw away the saturated gauzes?	95%	99%	

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 2022

- Based on review of results, the committee will review Relias training in December 2021. The current training can be modified to assure understanding of staff for specific topics.
- Review of SDS in each department
- Moving Bartlett's SDS's to CBJ MSDS online. This will allow more access by Bartlett Staff.

The proposed performance measures for these goals will include:

Hazardous Materials & Waste Management Proposed Performance Measures 2022	Target
AIM: How do you find a Safety Data Sheet at Bartlett Regional Hospital?	100%
AIM: How many elements are included in a Safety Data Sheet?	81%
AIM: What section on a Safety Data Sheet addresses First Aide?	83%
AIM: Have you had or have you reviewed Hazardous Communication with your direct supervisor in the last 12 months?	100%
AIM: What is the difference between an Incidental Spill/Fumes vs a Non Incidental Spill/Fumes?	50%
AIM: How often must an eyewash, shower or personal wash bottle be checked?.	100%
AIM: At locations where hazardous chemicals are handled by employees **proper eyewash and body drenching equipment** shall be available no more than 10 feet from the work station(s).	88%
AIM: You are wasting a partial dose of Phenergan. Where do you waste this liquid medication?	98%
AIM: You are giving a half dose of Coumadin and you need to waste the other half. Where do you waste it?	97%
AIM: You are cleaning up after a procedure. There are 4x4 gauzes saturated with body fluids/blood. Where do you throw away the saturated gauzes?	98%

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

- Life Safety Code requirements reviewed as compliant with current TJC standards.
- Life safety walk-through of the ABA office completed. Fire plan and evaluation completed for ABA office and is being put into policy.
- Assessed our business occupancy buildings' compliance with TJC's new standards. Collaborated with the property owners to ensure compliance and safety of the buildings.
- We have been using Smartsheets to collect data and evaluate the knowledge of Life Safety topic of employees.
- Life Safety Day was a successful educational opportunity for staff/ departments. Staff and providers were very engaged.
- Facilities hands-on training for staff to practice PASS with a fire extinguisher was a success
- Provided numerous TJC safety topics to staff on Life Safety standards and compliance.

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.

The Environment of Care Committee has evaluated the objectives and determined that there are minimal opportunities for improvement. The Program continues to Life Safety 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 Life Safety Management Program activities and to identify further opportunities for improvement:

Life Safety Management Performance Measures	Target	Outcome	Comments and Action Plan
AIM: Refine the process for accounting for all people following a fire evacuation.	100%	80%	This measure is an on-going process. During our Life Safety Day, we swarmed staff and asked about whom their designated person was to account for staff. We sent out a smartsheet to staff with our Life Safety day swarm questions for a larger feedback

			for staffs' understanding. We provided just in time training on this process and encouraged departments to identify a designated person for both shifts. In our swarm we discussed when a department would actually be evacuating the hospital/ building and our process based on policy.
AIM: Provide an education campaign to clinical staff to learn about what is expected with an evacuation, where the fire containments are, and how to horizontal or vertically evacuate when needed.	100%	100%	During our Life Safety Day, we provided just in time training to all departments in the hospital on these processes and surveys staff for their understanding. We used a visual to provide the education and gave real examples. This topic was also identified to be discussed in NEO
AIM: Refine our process for horizontal and vertical evacuations of patients and collaborate with facilities to support providing a follow-up education plan to staff on our current process through Relias.	100%	80%	This topic and process was discussed during our life safety day to staff. We are working with Staff Development on including the different evacuation types to the regulatory Fire Safety training for staff in Relias.
AIM: Work with Facilities to support updating the addressable locations system in the Administration Building to have up-to-date titles, fire pull and fire point locations.	100%	33%	We have 33% completed. This will continue to be a work in progress and stay on our performance measures for 2022.

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 2022

- Continue to work with Staff Development to complete Relias education for evacuations and hospital specific training.
- Recruiting more subcommittee members and avoid cancelling monthly meetings due to no attendance.
- Complete updating the addressable location system in the Administration Building.
- Review all fire drill reports to ensure compliance and identify topics for staff education.

The proposed performance measures for these goals include**:**

Life Safety Proposed Performance Measures for 2022:	Target	Comments and Action Plan
AIM: Work with Facilities to support updating the addressable locations system in the Administration Building to have up-to-date titles, fire pull and fire point locations	100%	
AIM: Provide annual hands-on training to staff for using PASS with a fire extinguisher.	100%	
AIM: The subcommittee will review 100% of the fire drill reports and use reports to identify areas to provide education to staff.	100%	
AIM: Track, monitor and report required fire inspections and corrective actions to the subcommittee to ensure compliance and identify topics for staff education.	100%	

UTILITY SYSTEMS MANAGEMENT

SCOPE (Grammatical Changes Only)

The scope of the Utility Systems Management Plan is to define the process by which utility systems in use at Bartlett Regional Hospital are monitored and maintained. 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.

ACCOMPLISHMENTS

- Successfully migrated systems to our VxBlock
- Completed upgrade of all UPS units across the hospital
- Changed our Wi-Fi network to WiFI-6
- Boosted the cellular signal into the basement level of the hospital
- Several upgrades to systems including a new firewall set
- Upgraded AHU-11 Supply and Return Fan (Operating Rooms) to house new Nortek wall fans with Variable Frequency Drives with electronic controls.
- Improved plumbing to domestic hot water heat exchanges, making it easier to service and disassemble each unit.
- Hosted Cole Industrial, Inc. to receive factory boiler training for three maintenance mechanics.
- Installed an emergency water feed port for steam boilers
- Installed a glycol system upgrade to ASU#1 heating coil

Maintenance Storeroom before

Maintenance Storeroom after

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

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

Utilities Management Performance Measures 2021	Target	Outcome	Comments and Action Plan
AIM: Review and rewrite preventative maintenance procedures.	70%	60%	**Partially Met**; This will be a multi-year project to review and rewrite all procedure
AIM: Create and maintain an inventory control program in TMS for the Maintenance Department.	50%	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 2022

- Continue working toward completion of the multiyear goals
- 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.

The proposed performance measures for the plan objectives include:

Utilities Management Proposed Performance Measures 2022	Target	Comments and Action Plan
AIM: Review and rewrite preventative maintenance procedures. Make certain all utility equipment has an asset number assigned with a PM schedule in the Electronic Equipment Management Program (TMS). 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 or with strategies of an alternative equipment maintenance program.	**90%**	This will be a multi-year project to review and rewrite all inventories. (It was learned through experience this year that reviewing all assets with their preventative maintenance procedures was a loftier goal than possible to achieve. Adding new assets to the mix caused the opportunity of improvement to be even greater. Work this year has been focused on writing procedures for new assets as they are added to the management program. Ongoing
AIM: Create and maintain an inventory control program in TMS for the Maintenance Department. For all parts: reducing the load of unused and outdated stock as well as maintaining adequate stock to perform necessary tasks. This has been a multi-year project. Last year we remodeled the storeroom: walls painted, floor floated and painted, and new racks and shelving installed. This year we were able to organize stock and reduce the amount of unused and outdated inventory.	Percent of the overall project	See comparative photos contained in this report.

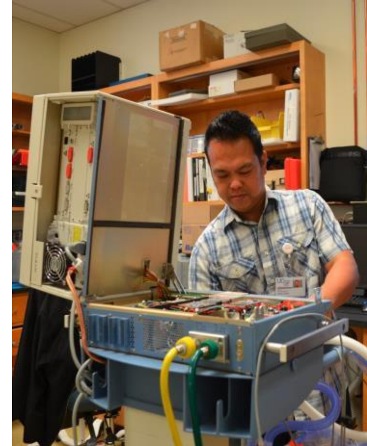
We have divided this project into smaller sections. 1. Sort and condense inventory into a smaller footprint. This will not only include the main stock room but items yet left in the basement of the old Bartlett Outpatient Services building (BOPS). We will be moving and organizing inventory into the refrigeration container located next to the Bartlett House. Last year we completed 50% of step 1. We look forward to completing 100% as of November 2022. 2. Quantify each item with manufacturer description and stock numbers. This will include placing each item into a known "warehouse" and known "bin location". We have purchased supporting hardware to begin making location and UPC labels. We are working toward completing 50% of Section 2 by November 2023. 3. Enter inventory into the TMS system, learn how to add and remove supplies, and assign their use to an individual work order with replacement pricing. This process will allow us to monitor minimum inventory stock levels. We are anticipat this to be completed by November 2024.	Nov 2022 100% Nov 2023 50% Nov 2024 100%	
AIM: Document and report all utility failures during the year 2022	100%	

MEDICAL EQUIPMENT MANAGEMENT

SCOPE (NO CHANGE)

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 2021 include:

- Placed into service, 13 new Hill-Rom Stretchers.
- Placed in service a new Steris Washer in CSR.
- Placed into service new beds in MS department.
- 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
AIM: Within a 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 2021. 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%	10%	**Not Met** System needs to be coordinated with Material Management, Accounting and Biomed. Being a multi-department project adds complexity and time. This system is still considered a priority and work will continue towards completing this goal in 2022.
AIM: Work with Material Management to develop a process for disposing of surplus medical equipment and implement disposal within 3 months of removing it from the Medical Equipment inventory.	100%	100%	**Met**
AIM: To organize and complete TMS PM updates by the end of the March 2021.	100%	100%	**Met** This process is still considered as needing improvement and work will continue in 2022.

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 2022

- Continue to improve TMS PM updates.
- Have all Biomed personnel achieve at least two certification within the next 12 months.
- Schedule in house TMS training by (June 1 2022)

The proposed performance measures for 2022 are:

Medical Equipment Management Proposed Performance Measures	Target	Comments & Action Plan
AIM: Review and update preventative maintenance procedures. These activities and associated frequencies are in accordance with manufacturers' recommendations.	**100%**	By march of 2022, develop a plan to update all risk one preventive maintenance procedure.
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 December 2022. 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%**	Action Plan for 2022 to improve implementation and assignment of 100 pieces of new equipment.
AIM: • Continue to improve TMS PM updates.	**100%**	Ongoing process

Page intentionally left blank.

A.

QUALITY MANAGEMENT PLAN

Patient Safety, Process Improvement

CY 2022

Issued: August 2020
Revised: December 27,2021

Submitted by: Gail Moorehead, MHL, RN, NPD-BC, CMSRN, CPHQ, CPPS

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.

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

The PSQI Plan is established by the hospital 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. We strive to maintain a Just Culture within our entire hospital.
- 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, and 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

The Board of Directors of Bartlett Regional Hospital is 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.

Scope

The Quality Management Program has been laid out by the Center for Medicaid and Medicare services (CMS) in the Conditions of Participation. CMS 482.21 states that we must "*develop, implement, and maintain an effective, ongoing, hospital-wide, data driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involved 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. The hospital must maintain and demonstrate evidence of its program for review by CMS*". PSQI is a systematic process that identified, evaluated and alleviates systems, processes or situations that pose risk of harm to patients, visitors and staff of BRH.

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. The activities of the PSQI are connected with Quality and all departments of the hospital and are overseen by the Quality Director and the Quality Department. 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

Board of Directors

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 Board of Directors receives and reviews reports through the quality QAPI reporting structure.

Senior Leadership

The Senior Leadership Team (SLT), comprised of the Chief Executive Officer, Chief Financial Officer, Chief Operations Officer, Chief Nursing Officer, Chief Behavioral Health Officer, and Chief Human Resources Officer ensure that an integrated patient safety program is institutionalized and assumes the responsibility for the strategic direction and development of the patient safety program. Patient safety culture survey results provide feedback on patient safety practices, communication, teamwork, adverse event reporting, and leadership to help guide the 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. SLT supports transparency in communication related to patient safety and potential process changes.

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.

Departments

Individual departments are responsible for the quality management, regulatory compliance and risk reduction/identification activities related to the service lines they provide. Progress on department based activities are reported through the Quality committee structures.

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 The Joint Commission and CMS CoPs); Risk Management; Patient Safety; Infection Prevention and Control;and, Medical Staff Quality.

Medical Staff

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 QAPI 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 functions
  - Blood and blood Product Use
  - Pharmacy and therapeutics Functions
  - 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
  - Renewal or revision of 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 as described in the Medical Staff Bylaws and Rules and Regulations.

Hospital Performance Improvement Committee

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 which 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 while providing patient centered quality care in a sustainable manner.

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– 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
- Serious Safety 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 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 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 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. Review and triage reports of potential or actual occurrences through the Occurrence Reporting system by any employee.
   b. Prioritize events, hazards and system/process weaknesses using the Safety Assessment Code (SAC) Matrix.
   c. Measure, report and collaborate with key stakeholder the frequency and severity of events to facilitate QAPI opportunities.
   d. Identify, investigate and report Sentinel Events to the Joint Commission based on our policy.
   e. Identify, investigate, and report serious reportable events required by the National Quality Forum.
   f. Communication between the Director of Quality 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.
   g. 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 based on a Just Culture
   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, healthcare 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:
    a. The hospital routinely analyses data to proactively identify quality and patient safety risks, and uses data analyses to develop and monitor responses.
    b. Reporting our data to a patient safety organization (PSO) to provide comparison and benchmarks against state and national standards.
    c. Review quality performance indicators to evaluated potential risks and opportunities to develop strategies to reduce risk and improve patient safety.

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 process improvement 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 (NPSG)
- 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 (HAI)

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 (HPIC)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 2021 PSQI Plan:

Accomplishments:

- AHRQ Culture of Patient Safety Survey completed
- Reduction of total patient falls
- Implementation of Smart Sheet Dashboards for communication related to COVID.
- Development and creation of Environmental Health and Safety Program Plan and dedicated position
- Successful metrics with the Partnership for Patients ASHNA/Telligen collaborative

Quality Goal	CY 2021 Metric	Outcome
Fully incorporate a cross-sectional Patient Safety Committee to review and assure corrective action plans from RCA2s are met and sustainable.	The Patient Safety Committee will meet at least twice to review RCA2 corrective action plans. (Source: Quality Director)	Exceeded. Patient Safety Committee has identified and completed three RCA2 and developed corrective action plans. (Source: Quality Director)
Culture of Patient Safety Survey	AHRQ Culture of Patient Safety Survey will be administrated to all clinical staff and providers.	Completed in May 2021. Evaluated and feedback provided to units. Next Survey will be 2023
Improve compliance with Sepsis core measure	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)	Met. The annual compliance for the Sepsis core measure was 58% for all quarters of 2020. (Source Encore D, Early Management Bundle/Severe Sepsis/Septic Shock, Annual Percentage)
Reduce Inpatient Fall Rates	Reduce inpatient total fall rate to 5/1000 patient days by 7/31/2021. Maintain rate through 12/31/2021. (Source: Patient Harm Dashboard, QBS)	Our total fall rate for 2021 is 4.3 per 1000 patient days.

2022 Goals

Quality Goal	CY 2022 Metric
Develop PI Methodology onboarding orientation for all new management team members	Initiate training for new management team to include: Directors, Supervisors and Leads by July 2022. Provide training for 75% of new leaders within 90 days of hire by 12/31/2022(Source: Quality Director)
Update Ongoing Professional Practice (OPPE) to include metric comparison with peers	Revise scorecards and provide data to providers based on metrics that include personal scores and

	peer based rates. (Source: Scorecards through Credentialing Committee of provider types)
Maintain Sepsis core measure compliance at or above national average. Current national average 60%.	Maintain annual percentage of compliance to at least 60% through 12/31/2022. (Source: Encore D, Early Management Bundle/Severe Sepsis/Shock, Annual Percentage)

Environmental Health and Safety Program Plan

Bartlett Regional Hospital

CY 2022

Environmental Health and Safety Program

Mission

Bartlett Regional Hospital strives to create a safe work environment for all employees through increased staff awareness and accountability, improved notification and investigation which results in continual development of safety programs and procedures.

Purpose

- Ensure safe and healthful working conditions for BRH employees, contractors.
- Establish and maintain an effective and comprehensive EHS program.
- Promote specific opportunities for employee involvement in the operation of the EHS program.
- Prevent or minimize the number of occupationally related illnesses or injuries among BRH personnel. Improve staff experience and morale while decreasing amount of time lost from work and workers' compensation claims due to occupational illness and injury.
- Prevent or minimize the number of injuries and illnesses of patients, consultants, employees, private contractors, visitors, and other members of the public within BRH facilities.

Establishment and Maintenance of Required OSHA programs.

- Development and implementation of Occupational Safety and Health (OSH) programs and procedures applicable to local operations.
- Employee safety and health orientation and training.
- Development, promotion, and distribution of educational materials and activities designed for patients, employees, and the general public.
- Reporting and analysis of injuries, occupational diseases, and property damage incidents.

Technical Assistance.

- On OSH problems to establish acceptable procedures, work methods, and personal protective equipment, thus integrating sound OSH principles into operational instructions and processes.
- This incudes but is not limited to support documents and consultations from National Institute of Occupational Safety and Health (NIOSH), Federal Occupational Health Program, AKOSH, American Hospital Association, and The Joint Commission.

EHS Goal #1	Strategies	Responsible Parties	Evaluation
Collaborate with Human Resources, Department Directors, and staff to complete Job Safety Analyses-Foundation for entire OSHA program.	-Collaborate to group jobs into classifications. -Collaborate to fill out template for each classification. -Include staff and Directors to provide direct insights regarding hazards in the workplace.	-EHS Program Manager -Human Resources -Department Directors -Applicable Staff	-Jobs grouped into classifications -Templates filled out. -Staff input solicited and documented. Jobs sorted into appropriate OSHA required programs.
EHS Goal #2	Strategies	Responsible Parties	Evaluation

Review and Revise Bloodborne Pathogen (BBP) Program	-Provide deep dive on AKOSH and OSHA BBP program requirements. -Provide deep dive on BRH's current practices -Revise BRH program, policies, and procedures to match AKOSH and OSHA requirements - Collaborate with applicable parties to integrate program elements into BRH operations	-EHS Program Manager -Applicable Directors -Infection Prevention -Employee Health	Complete, comprehensive, functional BBP program that meets all necessary requirements.
EHS Goal #3	Strategies	Responsible Parties	Evaluation
Revise as needed Respiratory Protection Program (RPP) and Bloodborne Pathogen (BBP) program Training	-Review AKOSH and OSHA requirements for awareness and task trainings. -Review required curriculum -Collaborate with Staff Development to Identify trainers and ensure they are trained. -Collaborate with applicable parties to ensure trainings are taken and documentation is available for all regulatory agencies.	-EHS Program Manager -Staff Development	Complete, comprehensive, functional training programs for RPP and BBP programs that meet AKOSH and OSHA requirements.
EHS Goal #4	Strategies	Responsible Parties	Evaluation
Oversee CBJ Safety Officer role within BRH	-Weekly Meetings -CBJ Safety Officer Logic Model that outlines duties at BRH	-EHS Program Manager -CBJ Safety Officer	CBJ role increased and documented by weekly accomplishments and developed programs.
EHS Goal #5	Strategies	Responsible Parties	Evaluation
Work with BRH staff to assist in developing Workplace Violence Prevention program that meets AKOSH recommendations.	-Review OSHA guidelines regarding Workplace Violence -Collaborate with staff and Directors to advance Workplace Violence prevention strategies.	-EHS Program Manager -Chief Nursing Officer -Applicable Staff and Director	-Identified Program Elements -Documentation of program elements in operation.

EHS Goal #6	Strategies	Responsible Parties	Evaluation
Chair the Safety and Security Subcommittee of the EOC	Regularly held Meetings	-EHS Program Manager -S&S Committee Members	-Meeting minutes as documentation of regularly held meetings.
EHS Goal #7	Strategies	Responsible Parties	Evaluation
Provide safety walk-throughs of building with Staff Development and TJC point person.	Monthly Walk-throughs through identified departments.	-EHS Program Manager	-Documentation of monthly walk through of respective departments.
EHS Goal #8	Strategies	Responsible Parties	Evaluation
Review and Revise Hazwoper Program at BRH	-Provide deep dive of what AKOSH and OSHA requires for Hazwoper Program -Provide deep dive of what BRH has in place for current Hazwoper program -Revise current BRH program to meet AKOSH program requirements. -Collaborate with applicable parties to integrate program elements into BRH operations	-EHS Program Manager -Respective Directors	-Complete, comprehensive, functioning Hazwoper program that meets all AKOSH and OSHA requirements.
EHS Goal #9	Strategies	Responsible Parties	Evaluation
Collaborate with team to complete Water Management Plan.	-Review requirements. -Collaborate to ensure complete plan -Collaborate to Integrate water monitoring, testing, and corrective actions into BRH operations	-EHS Program Manager -Water Management Taskforce	-Completed Plan -Elements integrated within BRH Operations
EHS Goal #10	Strategies	Responsible Parties	Evaluation
Member of the Environment of Care (EOS) Committee	-Attend meetings -Chair Safety and Security subcommittee -Provide updates to the EOC meeting as needed.	-EHS Program Manager -EOC Committee Members	-Attendance at meetings