Call to order

Approval of the minutes – 01.08.2020

Standing Agenda Items:

- 2019 BOD Quality Dashboard  J. Caldwell

New Business:

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

Next Scheduled Meeting: May 13, 2020 4:15 p.m.
Board Quality Committee
January 8, 2020
Minutes

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

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

Standing Agenda Items:

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

New Business:

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

- 2020 Risk Management Plan
- 2020 Infection Prevention Plan and 2019 Evaluation
- 2020 Environment of Care Plan and 2019 Evaluation
- 2020 Patient Safety and Quality Improvement Plan and 2019 Evaluation
**Board Quality Committee Charter Review**

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

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

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

**Risk Management Plan**

There are few changes in the Risk Management Plan CY2020.

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

**Utilization Plan**

Deferred to March

**Infection Prevention Plan**

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

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

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

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

Ms. Gribbon and Ms. Hargrave implemented a vigorous process that made a difference and helped achieve the goals.
Decrease the risk of acquiring health care associated C difficile Goal #3 – Goal met, 2018 HAI Rate is 2.08, 2019 HAI rate is 1.89 infections per 10,000 patient days. This is a 10% decrease.

The Emergency Supply Inventory project will be finished February 2020.

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

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

**Environment of Care Management Plan**

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

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

- **Security Management Mike Lopez**
  - The accomplishment for the committee were prioritization and initialization of afterhours lockdown program and security officer training with JPD for drug an paraphernalia identification. The three performance measures set by the committee for 2019 were met with partial compliance. The area in need of improvement was completion of department swarms. The committee is reevaluating the swarm process for 2020. The 2020 goals and opportunities for improvement set by committee are to Increase Facility-wide Security Afterhours, Improve Customer Satisfaction and Improve the Security Camera System Functionality.
• Hazardous materials and Waste Management John Fortin
  - The accomplishment included updating the Hazard Communication plan and clearing up processes around pharmaceutical waste disposal. The performance measures set for 2019 were met with varying degrees of success. The committee was fairly aggressive setting quite a few goals and falling just ever so slight short of their goals. Goals and Opportunities for improvement in 2020 mirror 2019 with new strategies for how to meet them.

• Life Safety Management Plan
  - The accomplishment of the committee are the following: completion of annual test, inspection, the repairs to fire alarm system per NFPA standards as well as assessed risk and implemented Interim Life Safety Measures (ILSM) for the BOPS temporary location in the Juneau Medical Center, and implemented a multi-day fire watch for RRC while the fire alarm system was being upgraded. There were three performance measures set and were met with varying degrees of success due to workloads and staffing shortages within the maintenance department. For 2020, the committee will be using the same Goals as set in 2019 including one new goal; proactively establishing fire response plan for the new RRC and BOPS locations.

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

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

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

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

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

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

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

**Adjourned at 5:30 pm**
RISK MANAGEMENT—lower is better

READMISSION RATES—lower is better

CORE MEASURES—higher is better

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

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

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

Screening for Metabolic Disorder: % of psychiatric patients with antipsychotics for which a metabolic screening was completed in 12 months prior to discharge.
Notes on Patient Experience:
Press Ganey is the vendor for CMS Patient Experience and HCAHPS Scores.
**publicly reported**
#1, #3, #4 and #5 benchmark is 2016. Benchmark for #2, not a full year r/t new domain added in 2016
HCAHPS: Hospital Consumer Assessment of Healthcare Providers and Systems: includes only Med/Surg, ICU and OB
Top Box: HCAHPS results are publicly reported on Hospital Compare as “top-box,” “bottom-box” and “middle-box” scores. The “top-box” is the most positive response to HCAHPS Survey items.

### HCAHPS Results 2018-2020 current

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Overall Rating (0-10)</td>
<td>74.1</td>
<td>72.3</td>
<td>70.6</td>
<td>79.1</td>
<td>75.0</td>
<td>69.4</td>
<td>71.6</td>
<td>80.8</td>
<td>71.6</td>
<td>82.1</td>
<td>70.85%</td>
<td>84.83%</td>
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<tr>
<td>Comm w/Nurses</td>
<td>81.4</td>
<td>82.8</td>
<td>77.3</td>
<td>85.6</td>
<td>80.6</td>
<td>85.3</td>
<td>84.2</td>
<td>85.2</td>
<td>88.5</td>
<td>95.1</td>
<td>78.69%</td>
<td>86.97%</td>
</tr>
<tr>
<td>Comm w/ Doctors</td>
<td>84.5</td>
<td>86.5</td>
<td>81.0</td>
<td>85.0</td>
<td>86.3</td>
<td>90.6</td>
<td>83.5</td>
<td>89.4</td>
<td>92.0</td>
<td>94.0</td>
<td>80.32%</td>
<td>88.62%</td>
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<tr>
<td>Response of Hosp Staff</td>
<td>76.3</td>
<td>72.6</td>
<td>77.8</td>
<td>80.3</td>
<td>73.9</td>
<td>83.8</td>
<td>68.6</td>
<td>78.4</td>
<td>77.7</td>
<td>84.3</td>
<td>65.16%</td>
<td>80.15%</td>
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<tr>
<td>Comm About Medicines</td>
<td>66.0</td>
<td>73.0</td>
<td>67.1</td>
<td>63.6</td>
<td>60.6</td>
<td>60.8</td>
<td>71.6</td>
<td>70.0</td>
<td>70.2</td>
<td>79.4</td>
<td>63.26%</td>
<td>73.53%</td>
</tr>
<tr>
<td>Cleanliness and Quietness of Hosp Environment</td>
<td>72.5</td>
<td>75.8</td>
<td>72.1</td>
<td>72.7</td>
<td>69.7</td>
<td>64.0</td>
<td>66.6</td>
<td>74.9</td>
<td>79.2</td>
<td>73.9</td>
<td>65.58%</td>
<td>79.06%</td>
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<tr>
<td>Discharge Information</td>
<td>86.8</td>
<td>85.3</td>
<td>87.7</td>
<td>87.2</td>
<td>86.9</td>
<td>88.3</td>
<td>88.6</td>
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<td>88.2</td>
<td>96.8</td>
<td>87.05%</td>
<td>91.87%</td>
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<td>Care Transitions</td>
<td>55.3</td>
<td>58.4</td>
<td>51.2</td>
<td>55.8</td>
<td>56.5</td>
<td>58.0</td>
<td>57.1</td>
<td>64.0</td>
<td>58.3</td>
<td>59.3</td>
<td>51.42%</td>
<td>62.77%</td>
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</table>
ESURVEY

Available in ED, Outpatient Services and Ambulatory Surgery
WHAT IS eSURVEY?

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

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

Based on mail dates 01/01/2019 to 12/31/2019

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Not Returned</th>
<th>Returned</th>
<th>Undeliverable</th>
<th>Mailed</th>
<th>Response Rate</th>
<th>National Average Response rates</th>
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<tbody>
<tr>
<td>Ambulatory Surgery</td>
<td>822</td>
<td>247</td>
<td>12</td>
<td>1081</td>
<td>23.1</td>
<td>30.6</td>
</tr>
<tr>
<td>Emergency</td>
<td>3602</td>
<td>350</td>
<td>239</td>
<td>4191</td>
<td>8.9</td>
<td>8.8</td>
</tr>
<tr>
<td>HCAHPS</td>
<td>834</td>
<td>328</td>
<td>84</td>
<td>1246</td>
<td>28.2</td>
<td>26.8</td>
</tr>
<tr>
<td>Inpatient Only</td>
<td>175</td>
<td>32</td>
<td>11</td>
<td>218</td>
<td>15.5</td>
<td>18.2</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>3563</td>
<td>691</td>
<td>74</td>
<td>4328</td>
<td>16.2</td>
<td>18.3</td>
</tr>
</tbody>
</table>
Overview of the Process, Text and Email

1. Patient schedules visit
2. Scheduler enters patient email address and mobile phone number in system. If already in system, confirm with patient
3. At patient visit, front desk confirms email address and mobile number (collects for walk-in patients)
   - Patient completes experience
4. Second invitation sent via email two days later if text undeliverable or no response
5. Press Ganey sends survey invitation to patient via SMS/text or email (for patients without mobile numbers)
6. Third invitation sent via email five days after first email attempt
7. Survey results added to database
8. Survey results are compiled and tabulated
   - Reports are available in online tool
9. Patient name, email and mobile number sent to Press Ganey after visit
e-Mail Notification

From: <Bartlett Regional Hospital> (noreply@patients.pgsurveying.com)
Subject: <Bartlett Regional Hospital> would like your feedback!

Dear {First_Name},

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

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

Click here to begin your survey

Thank you for your feedback.

Sincerely,
John Smith
CEO

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

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

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

CUSTOMIZABLE INVITATION TEXT MESSAGE

- Text message includes:
  - 160 character limit
  - 120 characters that can be customized (40 characters reserved for the URL)
  - Your organization’s name
  - Link to the survey itself!
1. Enter your date of birth

![Press Ganey image]

2. Read the letter and click “Start Survey”

![Press Ganey image]
Take the Survey in 5-10 Minutes!

3. Share your experience

EMERGENCY DEPARTMENT SURVEY

ARRIVAL

INSTRUCTIONS: Please rate the Emergency Department services you received from our facility. Select the response that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

1) Waiting time before staff noticed your arrival
2) Helpfulness of the person who first asked you about your condition
3) Comfort of the waiting area
4) Waiting time before you were brought to the treatment area
5) Waiting time in the treatment area, before you were seen by a doctor
6) Comments (describe good or bad experience):
Daily uploads are recommended

Patients who do not respond to the first online survey within 5 days will receive a second wave survey
- Survey link expires after 30 days

Ability to collect patient email addresses is vital! The more email addresses collected, the more surveys that will be sent, and the more returned surveys you will receive.

SURVEY PROCESS DETAILS
Census-Based Survey Reporting
Mean Score and Percentile Rank - In the beginning, we should expect mean scores and percentile rank drop due to a change in the population mix.

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**Adjusted DATA**

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

  All paper returns
  + This subset of esurveys
  Adjusted sample

**Unadjusted DATA**

- Includes all returned surveys
Every patient counts.

Every voice matters.
Bartlett Regional Hospital

Right Here In Your Hometown
SEC, SSER, and Joint Commission SAFER Matrix

AUTUMN MUSE, RN, BSN
MARY CRANN, RN, MSN, CPHRM
Foundation for Patient Safety Measurement

- The Safety Event Classification (SEC) and Serious Safety Event Rate (SSER) provide common definitions and an algorithm for the classification of safety events.

- It is a consistent methodology based on the degree of harm that results from a deviation of expected standard of care.
Assessing Outcome Algorithm

- **Outcome based**
  - Event is assessed for deviations from accepted performance and standards of care (GAPS)
  - Cause and effect relationship between deviation and outcome are identified
  - Classified according to level of patient harm

- Serious Safety Event results in moderate to severe harm or death
- Precursor Safety Event results in minimal, no detectable, or no harm
- Near Miss Safety Event the error is caught before it reaches the patient
Levels of Harm

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

• SEC is the foundation for calculating the Serious Safety Event Rate (SSER).

• SSER is a volume adjusted measure of Serious Safety Events occurring from a deviation of the standard resulting in moderate to severe patient harm or death.

• Calculated monthly as the number of Serious Safety Events for the previous 12 months per 10,000 adjusted patient days.

• Clear picture of trends and rewards sustained improvements.

Figure 3. Serious Safety Event Rate calculation

A rolling 12-month rate of Serious Safety Events per 10,000 adjusted patient days:

\[ \text{SSER} = \frac{\text{# SSE during past 12 months}}{\text{# APD for past 12 months}} \times 10,000 \]
Applying SEC and SSER

- Requires a culture that encourages reporting adverse outcomes and sharing information about errors and mistakes
  - Staff need to know what should be reported – events resulting in harm and events caught before harm reached the patient.
  - Staff less inclined to report events if seen as punitive and not opportunity for improvement.
  - Reporting must be simple.

- Effectiveness of the system is consistent application over time.
- Identification of trends and implementing corrective action can limit Joint Commission survey findings.
Survey Analysis for Evaluating Risk (SAFER) Matrix

- The Joint Commission (TJC) has developed the SAFER Matrix to provide health organizations with Requirements for Improvement (RFI) in a comprehensive visual representing the findings and identifying areas that are in most need of interventions to meet compliance.

- The RFIs are plotted on the Matrix based on the possible risk of harm to patients, staff, and/or visitors and how often it was observed.

- All RFIs will need to be addressed in a 60 day timeframe. The RFIs that are higher risk level will require additional detailed corrective action plans that the organization will be expected to sustain going forward.
Example of a SAFER Matrix Report

- Here is an example of what a finished TJC survey report would look like with identified RFIs.

- TJC surveyors will provide the organization with a preliminary report before they leave and then TJC will send an finalized report within 10 days of the survey.

- The organization will be required to submit an Evidenced of Standards Compliance (ESC) report on all RFIs identified on the Matrix. The ECS reports will identify the organization’s plan and data to demonstration that now they are in full compliance with TJC’s standards.
Bartlett Regional Hospital

Right Here In Your Hometown

QUALITY in Community Healthcare™
Bartlett Regional Hospital Response to Covid-19
### Current State

<table>
<thead>
<tr>
<th>Date</th>
<th># sick employee</th>
<th># total employee working</th>
<th># of + COVID in hospital</th>
<th># of deaths</th>
<th># COVID test pending</th>
<th># of patients with respiratory illness as a chief complaint</th>
<th># of ED visits</th>
<th># pts in MedSurg</th>
<th># pts in CCU</th>
<th># pts on vents</th>
<th># of patients in isolation</th>
<th>CCF R</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/3/2020</td>
<td>2</td>
<td>323</td>
<td>2</td>
<td>0</td>
<td>179</td>
<td>4</td>
<td>21</td>
<td>11</td>
<td>4</td>
<td>0</td>
<td>6</td>
<td>11</td>
<td></td>
</tr>
</tbody>
</table>

1 discharge; 1 possible discharge; 1 clinically stable w/o discharge from MS. 4 employees in quarantine due to close contact; 7 on travel quarantine.
Activation of Incident Command
• Weekly provider team calls lead by Dr. Benjamin with community providers including Searhe partners
Data / Patient Management

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

Communications

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

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

Moving into the Future
Quality in Community Healthcare
Right Here in Your Hometown

Bartlett Regional Hospital