Teton Valley Health Care
Board of Trustees
Quality Services Committee Meeting
November 29, 2011

Minutes

Attendees: Deborah Ray-Malheiro, Laura Piquet, Virgil Boss, Angela Booker, Sandra Woolstenhulme, Michelle Campbell, Marjean Barnet, Matthew Eagens, Robert Veilleux

Meeting called to order at 4:05 pm by chairman, Deborah Ray-Malheiro

► Welcome to all members present and thank you for your participation

► Utilization Statistics

- Utilization stats for fourth quarter, FY 2011 were presented and reviewed. The following trends were noted:
  - total admissions were increased 12%, total patient days decreased by 31%,
  - swing bed patient days increased by 71%, in part due the successful return of patient from EIRMC who has been in house since September, this should set a good example for the future for patients sent out to EIRMC or Madison to be able to return for rehab and continued care here
  - orthopedic surgeries increased substantially (51%), overall outpatient surgeries were same due to decrease in specialists cases
  - laboratory was busy once again with 40% increase in volume
  - radiology procedures were stable with few more MRI's, no change in mamo or US exams and fewer CT and diagnostic X-rays, have not yet seen an increased number of exams with new equipment
  - rehab referrals were decreased again – seem to go up an down, possibly related to fluctuations in orthopedic surgery volume
  - RN procedures including IV therapy numbers were high again this quarter, a good trend
  - Driggs clinic saw an increase in specialists visits (41%) and mid level visits (12%) with decrease in physician visits (7%), overall visits approximately the same; should begin to see an increase in physician visits as Dr. Levanger builds his practice, he accounted for 169 visits in his first month with increased volume since then
  - Victor clinic saw decrease in visits by 17%, although the specialists and midlevel visits were increased they did not make up for the decrease in physician visits that resulted from the change in staffing model of care
  - Overall, clinic visits were stable, compared to FY 2010
- Utilization stats for FY 2011 were presented and reviewed. The following trends were noted:
  - comparison by quarter revealed Q1 and Q4 (Jul to Dec) to have the most "highest" numbers by quarter; most likely represents a combination of busier summer months especially for outpatients and an increase in clinic visits and elective surgeries at the

end of the calendar year as people take advantage of exceeded their deductible amounts
    - steady increase in laboratory tests noted over the course of FY, related in part to increased labs ordered by specialists
    - comparison to FY 2010:
    - total admissions and patient days decreased 15-20%, shorter LOS for non-swing patients and longer LOS for swing patients; many regulatory and reimbursement factors support shorter LOS, LOS > 4.0 days results in automatic Medicare review
    - there were fewer observation patients that stayed longer with an increase in observation hours
    - surgeries were increased across the board, 10% increase in outpatient surgery lead by 25% increase in orthopedic surgeries
    - ambulance runs, ER visits, ER admits as well as percent of visits that resulted in an admission (6% to 4%) were all decreased, these numbers may increase again through the winter with the re-establishment of the terrain park at Grand Targhee
    - laboratory tests increased by nearly 20%
    - radiology exams decreased by 8% with decrease in CT, mamo and diagnostic x-rays; numbers for CT and mamo appear to be increasing now with new equipment
    - Driggs clinic visits were stable; reduction in physician visits was off set by substantial increase in specialist visits and mid level visits
    - Victor clinic visits were slightly decreased with a decrease in physician visits expected with the change in staffing model not quite off set by an increase in specialists visits and mid level visits
    - overall clinic visits were stable, both Driggs clinic and Victor clinic with the new staffing model operated in the black
    - V. Boss reported that with the current and projected economic conditions in the Valley, maintaining the current volume through next year will be successful with expectation for increases in 2013
- TVHC Surgery statistics were presented and review. The following trends were noted:
    - Q4 numbers revealed a significant decrease in specialists surgeries and revenue (70%); this was off set by the increase in staff surgical cases (40%) with an increase in revenue of 11% compared to FY10
    - specialists cases are improving in Q1 FY12; a new ENT (Dr. Trott) will be starting in January; Dr. Zoe who is no longer doing procedures at TVHC will no longer be seeing patients at TVHC
    - V. Boss reported that he is working collaboratively with Madison to recruit additional specialists, in particular a General Surgeon and Urologist
    - Overall compared to FY10, specialists cases decreased 12%, the small increase in revenue resulted from 1 case in Q3 that generated $58,000; staff surgical cases and revenue increased by nearly 20%; overall revenue of $3.5 mil was a 17% increase

Plan: D. Ray-Malheiro will present a review of the utilization and surgery stats to the board at the next meeting.

►Quality Indicators:
- Reporting to IHA is up to date as of October. L. Piquet presented progress with reporting the following indicators:

- Nosocomial infection rate – has not yet been reported to IHA, stats are gathered on a quarterly basis, still working on how the denominator is determined, will try to obtain data quarterly by month in order to report this to IHA; since our infection rate is very low, this is good data to report publically
- Surgical site infection rate – reported as "no population" in IHA database for Aug to Oct, since this includes all surgical cases this is incorrect; this data is a subset of nosocomial infection rate data, should be able to collect this data quarterly as well when letters are sent out to physicians for patient follow-up information, if there is no answer to letters a phone call is made to obtain follow-up
- VTE prophylaxis data – should report even if there are only very few cases that meet criteria since this is only BCI measure reported to IHA; reviewed the criteria and there are a few cases in FY 11 that should qualify, will look into these and report them to IHA

- The Blue Cross of Idaho (BCI) Rural Hospital Incentive Program measures were reviewed.
  - Readmission rates (if applicable) and pressure ulcer data are automatically collected by BCI; L. Piquet will investigate if readmission rates are applicable for rural hospitals
  - VTE Prophylaxis data will be collected automatically by BCI if reported to IHA
  - WHO Surgical checklist: M. Campbell reported that the OR has adopted the WHO Surgical checklist, methods of documentation were discussed, should qualify for this incentive if the documentation of implementation is submitted
  - Targeted intervention for bloodstream catheter-related infections is only for central and PICC lines which are not inserted at TVHC, very low volume does not support having providers do this since they can not maintain competency
  - Participation in the Boards on Board initiative is now a requirement for any payout, a "threshold" measure, the BOT must implement 3 of 6 governance leadership measures; implementation of #3 and #5 are already underway with the development of the new QI program and Studer Pillar goals targeting patient safety and board education on quality, patient safety and compliance; discussed other measures – all would like to incorporate patient stories into board reports, however, concerns were raised about maintaining confidentiality in small hospital and community and potential adverse effects if miss-interpreted by the press; all agreed that for 2011 measure #6 "Establishing executive accountability" was more attainable as we have already established this with the Quality Services Committee and QI program development

Plan: L. Piquet will continue to work on reporting to IHA and the BCI Quality Indicator program. L. Piquet and D. Ray-Malheiro will work on documentation for BCI Boards on Boards measures.

► Studer Pillars / Quality Improvement program:

- L. Piquet reported that there has been progress with 4 of the 5 committee having had a initial meeting to begin development of Studer Pillar goals, she will be following up with the committee leaders in the next week, the objective is to have measurable goals defined and in place by January.

- D. Ray-Malheiro stressed the importance of defining the role of individual departments involved in each of the goals.
- L. Piquet stressed the importance of involvement of all committee members and additional staff from involved departments in the process of setting up goals and targets
- All agreed with the necessity for individual staff members to identify and take ownership of the goals that pertain to their department
- L. Piquet reported that the new Studer Pillar goals should be in place by January, 2012

Plan: L. Piquet will continue to work with the five committees to develop the Studer Pillar goals for the Quality Improvement program.

► Patient Satisfaction:

- A. Booker reported the return rate for the inpatient survey continues to fluctuate with low numbers in part due to low patient census, and nothing new with the surgical services / OR survey. We will plan to review survey results after the first of the new calendar year and generate a report for the BOT with 1 year of data.
- Clinic survey: L. Ricks was not present. A. Booker reported that work continues on the wording of the questions and getting the survey into the Survey Monkey program to allow electronic completion of the survey by patients before leaving the office. The computer is available. Some of the logistics of utilizing this method of survey completion were discussed. The benefit of feedback from other individuals was discussed. A. Booker will send out the survey to several committee members for their feedback in refining the questions.

Plan: A. Booker with continue to work with L. Ricks and IT on implementation of the clinic survey and will distribute the survey to committee members for feedback. A. Booker will continue to work with the nursing staff and OR staff to support the use of the patient satisfaction surveys.

► National Patient Safety Goals

- D. Malheiro discussed the objective of reviewing all the NPSG to ensure TVHC is in compliance with the recommendations for these patient safety measures. The goals that will be evaluated and measured through the Quality Improvement program as Studer Pillar goals do not need to be addressed by the committee. The P&P for the other goals can be evaluated and revised or updated as needed by the Quality Services Committee.
- The 2011 version of the NPSG was reviewed:

NPSG #1 Identify patients correctly

01 – Use at least two patient identifiers when providing care, treatment and services.

02 – Eliminate transfusion errors related to patient misidentification

The P&P relating to this goal were reviewed through the Quality Services Committee. The **Patient Safety Committee** has chosen patient identification as a Studer Pillar goal which will allow measurement of success.

NPSG #2 Improve staff communication

03 – Report critical results of tests and diagnostic procedures on a timely basis

The P&P for this goal was created through the Quality Services Committee. Correct implementation should be evaluated at some time in the future.

NPSG #3 Use medications safely

03 – Label all medications, medication containers, and other solutions on and off the sterile field in peri-operative and other procedural settings

05 – Reduce the likelihood of patient harm associated with the use of anticoagulant therapy

06 – Maintain and communicate accurate patient medication information

The **Patient Safety Committee** has requested the Pharmacy & Therapeutics Committee on Medication Safety review their goals and choose at least one as a Studer Pillar goal.

NPSG #7 Prevent infection

01 – Comply with either the current CDC or WHO hand hygiene guidelines

03 – Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms (MRSA, CDI, VRE and multidrug-resistant gram-negative bacteria)

04 – Implement evidence-based practices to prevent central line-associated bloodstream infections

05 – Implement evidence-based practices for preventing surgical site infections

06 – Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI)

The **Patient Safety Committee** addressed hand hygiene and has taken it on as a facility-wide initiative rather than a Studer Pillar goal. The P&P for these infection prevention goals could be evaluated through the Quality Services Committee.

UP #1 Universal Protocol

01 – Conduct a pre-procedure verification process

02 – Mark the procedure site

03 – A time out is performed before the procedure

This is standard practice in our OR. The **Patient Safety Committee** has identified marking the procedure site as a Studer Pillar goal. The P&P for Universal Protocol could be reviewed by the Quality Services Committee.

Plan: After the Quality Improvement program Studer Pillar goals have been finalized the committee will decide on which goal or goals to evaluate next.

► Next meeting will be scheduled in January or February, date and time TBA.