MAYERS MEMORIAL HOSPITAL DISTRICT

Quality Committee Meeting
Wednesday, January 11 *(12:00 pm)*

Meeting called by:	Vasquez	**Type of meeting:**	BOD Committee
		Board Clerk:	Valerie Lakey
Attendees:	Beatriz Vasquez, PhD, Committee Chair, Board Member Laura Beyer, Board Member Louis Ward, CEO	Tom Watson, MD, Chief of Staff Sherry Wilson, CNO, Quality Designee Jack Hathaway, Director of Quality	
Please bring:	Agenda & Attachments		

----- Agenda Topics -----

Meeting Called to Order		Vasquez	
Requests from audience to speak to issues/agenda items		Vasquez	
Approval of Minutes – December 14, 2016 (Attachment)	A	Vasquez	Action
Departmental Reports (Business Office, Hospice, Respiratory, SNF Activities, Staff Development) • Report on quality data • Report on quality issues and/or quality projects		T Lakey, Ranquist, Dendauw, Burks, Johnson	Report
Quarterly Reports • Safety • Workers Compensation		V. Lakey Mee	Reports
Standing Reports: Monthly— • SNF Events/Survey • Quality – Performance Improvement • Infection Control • PRIME • Administrative Report		 Wilson Hathaway Lee Hathaway Ward	 Report Report Report Report Report
New Business: • 2017 Quality Projects, Topics, etc.		Vasquez	Discussion
Closed Session Announcement, Government Code 54962, Medical Staff: • Chief of Staff Report (Health & Safety Code §32155) **Physician Reappointment:** David Panossian, MD (Pulmonary Care) **Change in Staff Category:** Tom Harmon, CRNA - Move to Inactive Gary Treibswetter, MD - Move to Inactive Jose Barrios, MD - Move to Inactive		Watson, Wilson, Overton	Reports/Action
Reconvened to Open Session – Report Action(s)		Vasquez	
Announcements: Next meeting: Wednesday, February 8, 2017 – Fall River			
Adjournment		Vasquez	

Posted
01/05/2017

MAYERS MEMORIAL HOSPITAL DISTRICT
QUALITY COMMITTEE MEETING
MINUTES – DECEMBER 14, 2016

DRAFT
Attachment A

QC Attendance	Other Staff Present	Absent
Mike Kerns, Board Chair	Valerie Lakey	
Beatriz Vasquez, PhD, Committee		
Louis Ward		
Laura Dolman-Beyer		
Sherry Wilson		
Jack Hathaway		
Shelley Lee		

(These minutes are not intended to be a verbatim transcription of the proceedings and discussions associated with the business of the board's agenda; rather, what follows is a summary of the order of business and general nature of testimony, deliberations and action taken.)

SUBJECT	DISCUSSION	
CALL TO ORDER	The meeting was called to order at 12:04 pm by Kerns in Fall River Mills	
Public Request to Speak	None	
Opening Remarks by Chairman Kerns	None	
Minutes	Minutes from the October 24, 2016 quality committee meeting were approved. **M/S/C (Hathaway, Ward).** ***All Approved***	**Approved**
Department Reports	**Med/Surg, Swing, Theresa Overton:** Acute ADC is 2.61, Swing is 2.81; Average length of stay 12.4 (October). Overton is working with Hathaway on several quality projects. Restraints policy is 11 pages long and all of the information is important. Established an easy algorithm to decide about restraints. Established a restraint log. Will be discussing at Med Exec. Kerns asked about training – Overton said they will be providing training. Mock survey – looking a Swing packet for patients. There was a Med pass with no hand washing – education was provided. Swing patients can be assessed by LVN but cannot be a part of the care plan. Working on items from the mock survey. Working on Qualitick. There will be a discharge survey on the tablets. There was a HIPAA breach and there has been training and a letter that has to be signed by all employees. Two employees were suspended. **ER, Gonzo Solorio:** 35 ambulance calls in November. Pyxsis – ongoing training. Working well so far. Changing triage some. Seeing the most urgent patients first. Have been informing people about wait times, etc. Added OB equipment and supplies to triage room. Working on making the room efficient and effective. Paramedics and RN's to get Neonatal certification. SEMSA meeting next week. **Cardiac Rehab, Trudi Burns:** No falls since last quality report. Using all safety practices. Walking patients to cars. Grant purchased new treadmill	**Reports**

	and arm ergo. There is a patient that wants to buy the department a second treadmill. There have been some problems with chairs, all have been inspected. Chairs will all be replaced gradually. One skin tear on the weight machine. This has been fixed. Working on Million Hearts program. Kerns asked about a summary of Million Hearts. Hathaway will break down the information so it can be easily explained. A certain population is being targeted. Monitored patients – there are 7, waiting for 2 to be cleared. Stress Treadmill – Dr. Dahle has been to Texas to be trained. Working on P & P. Dr. Khan has agreed to read stress treadmill tests. Will need an assistant to help Dr. Dahle. Has to be read by a cardiologist. **HIM, Travis Lakey:** ***Written Report (Exhibit A)*** **Patient Access, Travis Lakey:** ***Written Report (Exhibit B)*** **Med Staff, Pam Sweet:** ***Written Report (Exhibit C)*** Sweet was present to answer questions. Reports were given on Med Staff and Policies & Procedures. Ward questioned how many policies on average other hospitals have. Sweet also addressed peer reviews. Working on re-doing the process and P &P. Ward said there are a couple of options regarding peer review. It will be discussed at Med Exec. Supposed to do 10% on each department – that is our policy. **Outpatient, Kay Shannon:** ***Written Report (Exhibit D)*** Markers for quality in outpatient. Cost capture collaborative effort is ongoing with billing department. Anita and Kay meet once a week to review billing for accuracy. Outpatients seen in ED – some charges are not being captured. Needs to be an ongoing effort. Paper billing – for Burney patients. McKesson is not built for outpatients. Looking at a new software program. Vasquez asked if McKesson could add components to make it work. She was concerned about having another program. Kerns asked if MVHC system has wound care capability. Staff has gained a lot of training from Dr. Zittel. **Surgery:** ***Written Report (Exhibit E)*** **Social Services, BJ Burks:** ***Written Report (Exhibit F)***	
Quarterly Reports	None	**Reports**
Standing Reports	**SNF – Sherry Wilson:** POC Fire and Life safety due December 16th. Gradual Dose Reductions were a topic and the SNF Quality Care meeting. **Administrative – Louis Ward:** Ward gave a summary of current happenings around the facility. **Quality – Jack Hathaway:** Hathaway discussed the Quality monitors that will be placed in the facility highlighting quality statistics. **Infection Control – Shelley Lee:** absent **PRIME – Jack Hathaway:** Hathaway elaborated n the Million Hearts project.	
New Business	**Policies & Procedures (Vasquez, Beyer)** ***Approved All*** Admission Information MMH460	**ACTION**

	Admission Policy, Acute Admissions Forms Checklist MMH459 Annual Employee Influenza Vaccination Burney Facility Map Care Plan - Fall With Injury MMH130P Conditions of Admissions MMH458 Consent, Informed Patient Fall Interventions, Standard and High Risk FALL RISK ASSESSMENT Form MMH186 Fall River Mills Facility Map Fire, Fire Drill -Internal Disaster Plan FOCUS-PDCA-handout2 IC Brochure MMH456 Important Message from Medicare CMS-R-193 01-2003 Infection Prevention Plan Investigation Tool Form SNF MMH314 Mayers Organization Chart Medical Management Conflict of Pt. Care Guidelines for Staff Pain Management MMH453 Patient Responsibility MMH452 Performance Improvement Plan ER Nursing Services Post Hospital Care MMH461 Proctorship Program - Non-Surgical MMH528 Restraint Record, Med-Surg Acute Care FORM MMH250 Service Recovery Form (Complaint Non-Employee) MMH55 SKIN EVALUATION AND ASSESSMENT MMH128 Telephone Followup Progress Note MMH499	
Closed Session	**Adjourned to Closed Session at 1:55 pm** **(Vasquez, Kerns) – To Approve Privileges - *Approved All*** **Physician Reappointment** Julia Mooney, MD - Pathology **New Physician Appointment** Paul Davainis, MD, Emergency Care	
Announcements;	Next meeting: Wednesday, November 9, 2016 in Fall River Mills	
Adjournment	Meeting adjourned 2:00 pm	

Minutes By: Valerie Lakey

EXHIBIT A

HIM Update 12-14

1. The majority of coding has been shifted back in house. Inpatient and some surgeries are coded by Anthelio but the rest is done here.
2. Lori is hoping to take her test to become an RHIT in January. On the last Acute survey they told us we were required to have one onsite and appeased them by having one come quarterly to review our coding and processes.
3. We have weekly if not daily issues with Papervision which is our official medical records software. We have been considering going with the Mckesson option but it's 432K. It would be a better workflow as the documents automatically index themselves and are automatically accessible through the different Mckesson applications. This means much easier access to the clinical staff.
4. Lori and IT have worked together to submit all of our Quarterly and semi-annual OSHPD reports in a timely manner.
5. Monthly HIM has been meeting its goals for timely coding to ensure the revenue cycle runs quickly and smoothly.

EXHIBIT B

Admitting Update

1) A phone tree was implemented in order to enhance the patient experience as previously the admitting clerks had to have the admit process interrupted multiple times per patient in order to answer the phones. A high percentage of phone calls are from vendors and the phone tree is meant to automatically route those calls to their intended location. We will need to change the options as the ER is getting calls that don't belong there just because they are one of the first choices.

2) Scheduling is now under the direction of Michelle King who reports to the CFO. Scheduling is a vital part of the revenue cycle as all non-emergent procedures need to be cleared to ensure payment. There will continue to be a scheduler in Radiology and Physical Therapy who report to Michelle as the lead. This decision was made as we had a change in the Rad Scheduler position and a medical leave in PT. These absences quickly showed us that the function was being performed in three different ways and no one was familiar with the different processes in each location. The purpose of the new structure is to make the process standardized and to cross train multiple employees so admitting clerks can fill in occasionally for schedulers and vice versa. Michelle has been scheduling for multiple departments on Station 3 and has a good process that actually uses Mckesson versus appointment books and Outlook. With departments not using the system it has been hard to use the system reports Mckesson provides to track productivity.

EXHIBIT C

Board Quality Report
By Med Staff
December 14, 2016

Providers

We have a total of 35 providers
10 emergency physicians
Plus 2 applications pending
10 pathologists & radiologists
6 family medicine practitioners
1 - leaving soon
1 - PAs
3 - don't do rounds at MMHD's Acute (Richert, Arnold, Goodwin)
1 wound care physician
2 CRNAs
1 dentist
1 psychologist
2 surgeons

Policies and Procedures

Final step
In May, 2016 we had 364 policies awaiting final approval with an average age of 388 days
Currently, we have 218 policies 283 days

That's 147 fewer polices and 105 days newer.

First step
In May 2016, we had 518 policies at step 1 with an average age of 546 days
Currently, we have 527 policies 577 days

9 more policies and 31 days older

EXHIBIT 10

Board Quality Report
November 4, 2016

Patient satisfaction surveys have been made available to Outpatients at the time of their discharge from outpatient services. This was our goal last year, to implement a consistent system that offered anonymous (if desired) patient satisfaction surveys to our patients. (Staff previously called patients at discharge) That goal was met and all surveys that have been returned have had responses in the all categories as either "good" or "excellent". These are a few of the comments: "great visit, everyone was very helpful"..."Very lucky to have them available"... " I come from the Susanville area and prefer to come to Mayers...I am content with the treatment". There were no negative or "constructive criticism" comments submitted. Future patient satisfaction surveys will be under the direction of the Transitional Care Nurse. All patient responses will be tracked and graphed as part of the Qual-Tek program being used hospital wide.

The cost-capture collaborative effort between Outpatient and Billing, initiated by Kay Shannon, Outpatient Manager and Anita Bottorff, Revenue Data Specialist continues. This was reported on last year after the 1st 6 weeks, $17,000+ dollars in revenue had been identified and recouped at that time. We did not continue to identify the revenue changes in the "clean bills" that are created after our reviews, but we do continue to meet weekly and review charges as an audit for correct charge capture. We have found two areas for concern that have launched two separate projects. One is Outpatients that are seen in the ED. We believe there is a revenue loss when physicians order patients to return to the ED and be seen as an outpatient. Attempts at RN staff training to chart so as to capture correct charges has had limited success. Also, without the proper insurance authorizations, services can and have been denied. While primarily this is a revenue stream issue, it becomes a quality issue when patients are unaware that they may be responsible for the bill they thought their insurance would cover. We have no idea how many patients this represents, so a preliminary study is underway with the cooperation of the Admissions Department and HIM. Second project is a collaborative effort of Administration and Outpatient. We are looking into the Wound Expert ® software program. This program is one that Dr. Zittel is familiar with. It will capture

diagnosis code in the ICD-10 format and that drives the CPT codes for billing. The billing is CMS compliant, and updated automatically within the system. Use of this program will assure that we are billing appropriately, and not loosing revenue from the physician visits. As we currently practice, the wound care physician completes a written superbill. There has been debate whether a facilty fee can be charged in addition to the physician fee on some procedures. Meetings with CFO, Quality Manager, and Revenue Specialist, Dr. Zittel and myself were inconclusive on this topic as we are limited by our knowledge and available resources.. Administration was approached with the idea that use of this program will help us clinically, by expediting our charting, it auto loads nursing documentation for physician review. It will fix our HIPPA compliance concerns with use of paper charts transported to Burney, and it will address the problem identified above and eliminate it.

EXHIBIT E

Anesthesia Quality Report 12-14-16

Adverse drug events continue to be the single leading cause of medical injuries with intravenous infusions and injectable forms of medications presenting the greatest potential for harm due to their quick onset times, and often concentrated forms. Improving the delivery methods, increasing the safety in delivering medications, and restricting access is constantly under close scrutiny of Hospital Certifying approval boards such as the Center for Medicare & Medicaid Services (CMS). In an effort to reduce these errors and to increase patient safety, Anesthesia departments across the country are continually adjusting their practices by implementing safer medication delivery methods.

Here at Mayers Memorial Hospital (MMH), several measures have recently been utilized to help reduce delivery errors as well as restricting access. Locking up the refrigerator in the operating room (OR), which has induction and paralyzing agents, was the first task. On a recent survey, our OR refrigerator was found to be out of compliance. Even though access to the OR was restricted and locked, additional locks were needed for the refrigerator that contained these potent medications. This would eliminate the access by housekeeping and non-medical personnel who have access to the OR. The key to access the refrigerator lock is now located in our Pyxis medication delivery unit in the OR, and a digital record is obtained for access to the Pyxis which is restricted to only those users who should have access.

Secondly, up until now, the anesthesia department had only one anesthesia syringe pump. This pump was constantly being shared between our main OR and our endoscopy suite. Transferring the pump between rooms placed undue stress on the power cords and pole clamps, as well as the delicate delivery mechanism and keypad. It also placed the pump at risk for being dropped, bumped, etc. Not only was this a factor, but the software was not user friendly, outdated, and very time consuming. This all added to the risk of keying in incorrect delivery data, which was not stored as soon as the unit was powered down. This information then had to be reentered each and every time the unit was turned on. Unfortunately, the old anesthesia syringe pump, which was over 15 years old, finally failed. Fortunately, it failed on booting up, and not during the delivery of an anesthetic. It was removed from service, and through the grant assistance program here at MMH, two refurbished Medfusion 3500 pumps were purchased. This was a much needed addition to our OR facilities.

Now, by having two pumps, sharing between OR suites would stop, reducing the risk of mechanical failure. Also, the user software includes "Smart Pump" technology which has defined hard and soft limits for programmed medications. This helps reduce user input errors and the pumps have stored customizable drug libraries for the more commonly used medications. By being able to store preprogrammed infusion rates and concentrations, all one needs to do now is enter the patients weight and select the drug of choice. This has greatly reduced the chance of entering data incorrectly, and now multiple syringe sizes and brands can be used, eliminating waste. These pumps also meet the Anesthesia Patient Safety Foundation recommendation for improving medication delivery.

Not only has there been the reduction for potential errors, but also an improvement in patient outcomes by delivering a more consistent anesthetic. Bolus dosing of intravenous anesthesia has been shown to create peaks and troughs in the anesthetic endpoint, and by having a more continuous and consistent delivery, it reduces the dramatic swings in blood pressure and depth of anesthetic. This is especially true during endoscopic procedures where there are periods of very little stimulus followed by intense patient stimulus. It also aides the anesthesia provider by freeing up his or her hands. This is important when the need arises to pull up additional medications, to help support the patients airway, or to help position the patient, etc. Finally, recovery and emergence from anesthesia is usually reduced, since less medication is often used when given by an infusion device.

Lastly, the hospital has recently purchased a new Mindray ultrasound machine for the Emergency Room and Anesthesia departments. The use of ultrasound guidance for peripheral nerve blockade in anesthesia practice has been shown to shorten the block onset time, reduce the number of needle passes to locate the nerve, and reduce the amount of local anesthetic used. Vascular puncture is a frequent occurrence in nerve blockade due to the close proximity of the nerve bundle to the veins and arteries that travel with it. Ultrasound use reduces this risk of puncture, hematoma, or inadvertent injection of local anesthetic intravascularly by allowing the practitioner to visualize the structures. Also, the use of ultrasound allows a more precise delivery of the local anesthetic, which often provides a more adequate level of anesthesia with less local anesthetic. This reduces the failure rate of nerve blockade, improves patient satisfaction, and reduces the risk of injury when compared to peripheral nerve blocks without ultrasound.

As you can see, there have been several changes within the anesthesia department that have been implemented or are being implemented to increase the quality of anesthesia here at MMH. Hopefully by instituting these measures, patient safety can be increased, potential medication errors will be reduced, and patient satisfaction will be improved. Thank you for your time.

Benjamin Nuti MSN, CRNA
Chief Anesthetist MMH

Valerie Lakey

From: Stacie Warnock
Sent: Monday, December 12, 2016 1:04 PM
To: Valerie Lakey; Jeanette Rodriguez
Subject: Nov Surg Stats and Board Report
Attachments: FY 2017 Surgery Stats.xls

Good Afternoon,

Please see attached file for Nov Surg Stats.

- As a team we were able to streamline our Colonoscopy process for Dr. Pafford and his clientele, so that there would be no Pre-Op Visit.
    - Keith and Val worked together and handled the "PR", getting informational pamphlets about the importance of a Screening Colonoscopy, Services available as MMH, and a note of "Thanks" for choosing MMH for you procedure
    - Ben Nuti CRAN and Keith Earnest also went to the Canby Clinic and personally met with Dr. Pafford, who was pleased with the efforts of our facility to accommodate his Clinic needs and looked forward to sending referrals to MMH
    - Dr. Pafford also informed Keith and Ben during this visit that he is planning on splitting his time between the Canby Clinic and the Surprise Valley Facility
        - The following week Keith was notified that Dr. Pafford would be leaving the Canby Clinic and it was confirmed that December 9th would be his last day.
        - OP Surg had received in this time, 4 Colonoscopy Referrals from Dr. Pafford. When patients were call to be scheduled: 1 was scheduled and has cancelled twice(also Pt did not receive the prep kit), 1 was currently in an ICU, and 2 have been contacted in regards to scheduling numerous times with no return calls. Those two patient will be called one more time this week, if they fail to contact us by the end of the week those referrals will be sent back to the Canby Clinic with notifications that they failed to schedule their procedure, despite multiple attempts made by our facility.
    - The admit process for Dr. Guthrie "Totals" have been changed from being admitted directly to the floor and then taken back for Surgery. Patients will now be admitted as Out Patient Surgical status and then after surgery, patients will be admitted to the floor by Dr. Guthrie. It was brought to my attention per Travis Lakey that we were having difficulties receiving adequate reimbursement. It was found to be due to "Bill Type" for the surgical services when pts were admitted via In Patient status. Some of these past accounts were able to be re-billed, however I have yet to be notified of back payments (Travis Lakey might have more info on that).
    - Mock Survey went well, with findings mostly charting issues with the MD's in regards to H&P timeliness. This will be addressed with the individual MD. Some quick fixes were needed in regards to CRNA medications and those have already be corrected.

Thanks,

Stacie Warnock, RN. | Surgery Lead
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GO TEAM MAYERS!!!!

EXHIBIT F

Quality Meeting December 14, 2016

Following the national (Obra) and state (Title Twenty Two) regulations, the Social Service Department of Mayers Memorial Hospital is consistently striving to deliver the highest quality of services to our patients and residents. During the last six months this department has used several opportunities to improve and enhance the role of Social Services for the patients and residents.

Education:

Educational Day at Valley West, Williams Ca.

Valley West is a Long Term Care facility located in Williams Ca. It is ranked as a 5 star facility and highly recommended by the previous State Survey Team. They were a very gracious facility that shared forms and a great deal of information to improve the process and quality of this department. This trip developed a resource and support system for all departments that went.

Music and Memory:

This program is in the development stages at this time. The program is based on the connection of music to improve the quality of life for dementia residents and patients. Training has been completed with various departments and equipment is arriving at this time. More employees will be trained as the program develops. This is an exciting new step of collaboration with multiple departments to enrich the lives of our residents and patients.

Insurance:

With changes being discussed in the new country's administration insurance coverage for residents and patients is always a new and developing area. The prospect of change is being addressed by this department through attending upcoming workshops offered along with collaboration and developing working relationships with the insurance companies point person.

These steps, along with utilizing other opportunities for growth and education, will continue to assure the highest quality service offered to our patients and residents. The opinion offered many times by family, patient and residents are positive statements related to the quality of care and service offered by Mayers Memorial Hospital.

Respectfully submitted

BJ Burks MSSW

BJ Burks Social Services