Annual CAH Review 2014

PURPOSE:
- To document SHC’s compliance with Federal regulations and CAH Conditions of Participations for CAH (CFR §485.641): “The CAH carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year.”
- To provide a framework for all quality assessment and performance improvement activities throughout Syringa Hospital & Clinics (SHC).
- To determine whether the utilization of services was appropriate, that established policies were followed, and that any changes that were needed have been made.

DATA SOURCES:
Information used for this Annual Report was obtained through the following mechanisms:
(1) Utilization review, (2) Peer Review, (3) Committee, department, and/or team minutes, (4) Incident and variance reports, (5) Patient satisfaction and complaint data, (6) Statistical reports, and (7) Cerner reports and other sources as applicable.

PROCESS FOR CAH REVIEW AND FOLLOW UP:
- The Quality Department, under the direction of Director of Quality coordinates information gathering and develops an annual review report.
- This report is presented to the SHC Performance Improvement Committee for review and discussion.
- The report, with PI Committee findings and recommendations, are then presented to the Board and Leadership Team.
- The Board and Leadership team identify areas of focus for improvement which align with SHC strategic goals and objectives.
- The PI Committee uses Board and Leadership feedback to guide the subsequent year’s Performance Improvement Program Plan.
UTILIZATION of SERVICES
Current Scope of Services:

Emergency Services
- Hospital owned ambulance emergency and non-emergency transports
- EMS Director service for several outlying community EMS units

Medical services
- Inpatient
- outpatient
- Swingbed
- E-ICU (tele-consulting for critical care concerns)

Surgical services
- Inpatient surgery
- Outpatient “Same day” surgery & procedures
- Laparoscopic/Endoscopic services – laparoscopic cholecystectomy, colonoscopy, “EGD”
- OB-GYN surgery – open and laparoscopic – hysteroscopic procedures including ablation
- General surgery consultation

Obstetrical and Neonatal services
- Pregnancy care
- Childbirth education
- Lactation consultation
- Labor-Delivery
- C-sections
- Epidural
- Newborn

Ambulatory Care
- Grangeville Primary Care Clinic
- Kooskia Primary Care Clinic
- VA Clinic in Grangeville
- Same day appointments
- Family planning
- Infertility evaluations
- Annual exams and preventative health care
- Adult and pediatric immunization
- Incontinence diagnosis and treatment
- Telemedicine - Psychiatric consultation

Restorative & Therapy Services – Inpatient and outpatient

- Physical therapy
- Speech therapy
- Occupational therapy
- Social services
- School therapy services
- Dietician

Diagnostic Services
- Laboratory services
- Imaging
- General X-ray
- Computerized tomography “CT”
- Ultrasound
- Mobile mammography (host site)
- Mobile MRI (host site)
- Bone density screening

Hospice services
- Coordination of services
- Palliative care
- Nursing
- Aid/homemaker support
- Psychosocial services
- Counseling
- Spiritual care
- Bereavement services
- Pharmaceuticals, durable medical and medical supplies

Other Community Health services and programs
- Biggest Loser Weight Challenge
- Pharmacist based anticoagulation clinic – July 2013
- Diabetes self-management program
- Sports & Scouts physicals
- Nutritional counseling
- Annual health fairs (GEMS, Idaho Forest Group)
- Chaplaincy program
- Discharge planning & Social services
- Prescription assistance
- Financial assistance & counseling
- Telehealth education
- Support groups
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UTILIZATION of SERVICES cont’d

Notable trends in scope of service utilization fiscal YTD August 2014 For full report, see attached FY 2014 YTD Statistical Reports, which display data and % change for the current month and current year-to-date as well as the previous month and previous year-to-date.

ED visits ↓3.57%
Observation “admissions” ↓27.84%
Inpatient med-surg days of care ↓3.14%
OB deliveries: vaginal ↓21.43%
C-sect ↑100%

Swingbed days of care ↓40.91%
Surgical procedures: Inpt ↑6.67%
Outpt ↓31.03%
Endoscopies (colonoscopies, EGDs) ↑8.13%
Hospice patient ↑6.8%

MEDICAL STAFF CHANGES SINCE THE 2013 ANNUAL REVIEW:

The following joined the Medical Staff
K. Mayberry, MD Locum
J. Dardis, MD
G. Bigbsy, DO, OB/GYN, contracted
A. Bell, DO, Surgeon, contracted
P. Viavant, MD, Locum

The following joined the Allied Medical Staff
J. Jungert, FNP

The following providers resigned
J. Cleary MD, Orthopedist
M. Hiesterman, MD, Surgeon
A. Lorico, MD, GYN
CLINICAL RECORD REVIEW

In compliance with CAH regulation CFR 485.641(a)(1) (ii) a representative sample (at least 10%) of both active and closed clinical records were reviewed in in the past year. Records addressed included inpatient, emergency room, and ambulatory records. Both concurrent and retrospective reviews were conducted for completeness, accuracy, informed consent, medical necessity, and adherence to protocols and standards of care.

Indicators that trigger medical record review:
- Hospital deaths
- Complications
- Readmissions
- Transfusions
- Adverse drug events
- Hospital acquired conditions
- Patient safety indicators
- Clinical quality measures
- Sepsis
- Codes
- AMA (pts leaving against medical advice)
- Unplanned admission post outpatient surgery
- Cases involving patient and/or staff complaints about the clinical management of a case
- Pediatric admission
- Pediatric transfer
- Trauma transfer
- Miscellaneous review requests

Medical record review by Utilization Review ("UR")

100% review was performed for all ER, observation, acute inpatient cases, and all planned swingbed admits for documentation completeness, medical necessity, and billing compliance. See copies of Observation review audit and UR meeting minutes. Roughly 40 specific cases were discussed in the UR committee since last year’s annual review. Observation and acute inpatient review is conducted concurrently. Findings are reported to the board and medical staff. Nursing staff performs retrospective audits of a sampling of at least 25% of inpatient cases for documentation completeness. Findings are reported to the Nursing Administration and Quality Department. Documentation completeness by Medical Staff is tracked and reported by the HIM department. Deficiencies > 30 days are also reported to PI. See PI Dashboards.

* One area of concern is the admission order for in-patients, observation patients and Swing Bed patients. An order must be placed in the chart within 24hrs.
* Another area is isolation order. An order must be placed showing the start of isolation in order to bill for it.
* A task force is being developed to review documentation within the EHR that allows for better understanding of the patients experience, meets standards and needs of auditors and payers, and meets requirements for meaningful use.
* Our readmission rate for FY 2014 is 14.33%. The average national rate is about 17%. Though CAHs are not being held accountable at this time CMS is starting to look at it.

Medical case review by the Quality / Risk Management Department

Concurrent and retrospective record reviews are conducted by Quality department for the following clinical quality measures:
- 100% of AMI (heart attack) inpatient and ED
- 100% Stroke inpatient and ED
- 100% inpatient Pneumonia
- Applicable SCIP (surgical) applicable cases
- 100% inpatient Heart Failure
- 100% VTE (venous blood clot) prophylaxis for applicable patients
Other cases reviewed included those not meeting Meaningful Use criteria, RCA’s, (root cause analyses) mini RCA’s, and incidental and reported cases representing quality or risk management issues.

*Syringa has attested for Meaningful Use Stage 2 for the hospital and is now working on meeting the full year requirement.
*Syringa Eligible Providers attested to Meaningful Use Stage 1 and is currently working on meeting the full year requirement.
*Syringa is working with Cerner on three projects: Transfer of Care document-When a patient is transferred to another facility or discharged to an outside provider a transfer of care document is sent to ensure continuity of care. Accreditation/Survey readiness-we are working with Cerner to help develop process to maintain readiness for surveys. This is brand new for Cerner.
E-submission-Syringa reports data re: stroke, pneumonia and congestive heart failure, Cerner is uploading and sending this data for us. We are currently discussing the outpatient reporting system with Cerner that will allow the process to happen for acute myocardial infarction (heart attack), chest pain, and surgical interventions (currently this is happening by hand).
*Syringa is also reporting data to the HEN (Hospital Engagement Network)-Adverse drug events, catheter associated urinary tract infection, central line associated blood infection, elective deliveries between 37 and 39 weeks, OB trauma, OB transfusions, pressure ulcers, readmissions, and potentially preventable venous thrombotic embolism.
*Syringa is working with MBQIP(Medicare Beneficiary Quality Improvement Project) on ED transfer documentation

Medical Staff Peer Review
SHC performs Peer Review for both hospital cases and clinic encounters. SHC uses an internal Peer Review process supplemented by its participation in the IHA (Idaho Hospital Association) Peer Review Network. Active and closed clinical records undergo review according to criteria established by the SHC Peer Review Committee. Additional cases review selections come through requests from Compliance, Utilization Review, Risk Management, Medical and/or Nursing staffs. Peer Review findings are discussed in executive session meetings of the SHC Medical Staff. Findings are used in determination of clinical privileges, continued membership on SHC’s Medical Staff, or other corrective or remedial action as appropriate.

Indicators that trigger selection or consideration for Physician Peer Review:
- Unanticipated deaths, including patient suicide
- Unanticipated complications in patient condition and/or treatment that result in actual or potential prolongation of the patient’s stay, and/or major permanent loss of function.
- Surgery on the wrong patient or wrong body part
- Surgical and/or anesthesia related complications including unexpected return to surgery
- Five minute APGAR scores of six or less
- VBAC deliveries
- Unplanned re-admission within seven days of discharge for same or similar diagnosis (excludes Swingbed admissions)
- Moderate to severe adverse drug reactions
- Unplanned C-Section
- Delivery not attended by physician
- Stillbirth
- Neonate <36 week
- Blood transfusions cases not meeting generic screen criteria are reviewed by PR Committee
- Other cases requested by nurse managers, PI/Risk Manager, or medical staff
At least one each of a radiology-read case and an ER or inpatient case will be sent to the IHA Peer Review Network for review.

Cases reviewed by the Peer Review Committee this year included the following generic and targeted case types reviewed internally or via the IHA Peer Review network and totaled 165. Indicators that triggered these cases were:

- **ER:** unplanned return within 72 hour; trauma/transfer, generic medical, pediatric trauma/transfer, pregnancy emergency, missing documentation, generic transfer; patient complaint, AMI with thrombolytic use; septicemia; behavioral health/suicidal risk
- **Observation** – random sampling
- **Medical inpatient:** 30 day readmits, inpatient death, transfers, medical pediatric, newborn transfer, AMAs
- **Proctor** and peer review reports for locum ER providers and one Provisional Active Med Staff.
- **OB:** random sample, unplanned VBAC
- **Blood appropriateness** 100% review for appropriateness
- **Radiology cases:** random sample, reading discrepancy
- **Surgery** – random sample, post op complication, emergent OB surgery

**POLICY REVIEW**

Patient care and Board policies are added, reviewed, revised and/or deleted by action of the Board or by the appropriate SHC department or committee. Policies are scheduled for review at least annually and whenever need for modification is recognized. Compliance with timely policy review is tracked by the applicable department director or manager and reported to the Safety Committee.

The following policies were created, reviewed and/or revised in the past year:

(New competencies also noted)

- Competency Assessment for SH&C Laboratory Personnel
- SH&C Laboratory Employee Expectations
- Materials Management Competencies
- Isolation Procedure – Portable Imaging
- Radiation Monitoring Badge
- Approved Contrast Agent
- Radiation Safety
- C-ARM Radiation Dose Monitoring
- Bowel Preparation for Radiologic Procedure
- Department Staffing Plan(Rad)
- Cerner Competency(Rad)
- Personal Competency (Rad)
- Time Clock-call back & Job transfers
- CT Competency(Rad)
- Radius Competency(Rad)
- vRad Competency
- X-ray Competency
- EMT Competency
- Local Anesthetic Toxicity

*Managers are accountable to provide policy review status to the Quality Department.

*Mock Survey took place and cited that there was a lack of organization of hospital policies.
EVALUATION OF SERVICES/PI PROGRAM

The IHA CAH QA program oversight survey was conducted June 18, 2014. Mock State Survey and training was done at Syringa in August 2014. Because State Surveys are occurring as infrequently as every 9-10 years in many cases, this helps a site maintain proper standards.

See appendix for a copies of the follow-up letters from IHA surveyors.

Recommendations from these visits were shared with board, medical staff and employees. Notable findings/recommendations were:

- IHA – Recommended some changes in policy review by the Governing Board, currently reports are flowing from the Quality Management team to the Medical Staff and to the Governing Board in many different ways.
- Mock State Survey – by request of Quality Director the surveyors were very thorough. The 3 top areas for improvement were Infection Prevention issues, Medical record information management, and Medication management.

SUMMARY OF SHC PI EFFORTS, METRIC TRACKING AND OUTCOMES

- **Clinical Quality Measures** – See PI Key Metric Dashboard in appendix.
  - *There has been a low population of patients with the diagnosis being measured, one patient not meeting all criteria will lower our percentage significantly*
  - *Our scores are still lower in the ED with trouble meeting the goal in some areas.*
  - Hospital fall rate has increased significantly. Feel increased reporting is happening.
  - *Medication errors have increased*

- **Reducing patient harm**: SH&C has continued to work with the HRET-HEN program (Health Research & Education Trust-Hospital Engagement Network) but this will be discontinued in 2015 and HRET will be developing The All IN Improvement Network. They will be looking at many of the same things, expanding on using the data to improve patient safety and moving toward the Triple Aim (Better Healthcare, better health and lower cost)
  *The SHC quality department is continuing to work to establish a method to define, track and report “all patient harm events” to better assess improvement efforts. To then help SH&C better utilize the data for improvement.*

- **CAH National Patient Safety Goals (NPSG)**: See summary document in appendix. NPSG are tracked, facilitated, and reported through the Safety Committee.
  *Two new areas were added: NPSG.06.01.01 Reduce the harm associated with clinical alarm system. Both the clinic and the hospital have identified high risk alarms and have developed policies.*

- **Infection rates**: See PI dashboard data in appendix. Infection rates are tracked and reported through the Infection Prevention Committee. No trends or infection problems were noted in the past ear. Emphasis continues to be finding an effective way to monitor hand washing compliance, and implementation of the SHC CAUTI (catheter related urinary tract infection) program.
• **Pain management**: Patient satisfaction top box scores continue to show opportunity for improvement for pain management.
  *SH&C should continue to work with patients on alternative methods along with medication*
  *An area that may improve patient’s perception of pain management would be more discussion at the beginning of the stay on pain management and what can be expected.*

**PATIENT SATISFACTION**

*See Patient Satisfaction data in appendix.*

HealthStream surveying for inpatient HCAHPS reporting is producing reasonable return rates. Use of the top box scoring method makes identifying trend changes easier. SH&C has expanded the use of HealthStream to the clinic, emergency department, and therapy. In-patient remains by phone; the others are by e-survey. One major problem identified is in obtaining valid E-mails addresses. The Leadership team is developing a task force to try and identify ways to alleviate this problem.

*Medication teaching and patient understanding has been identified and has become a nursing PI project.*

*Another area for improvement is to increase organizational use and benefit of HealthStream information*

*When reviewing ED Scores (blue) note areas where SH&C’s Top Box scores dropped below 70% where highlighted.*

*When reviewing the in-patient results areas of highest and lowest amount of trending are also highlighted.*

*When reviewing Clinic Scores (purple) the areas where SH&C’s Top Box scores dropped below 70% were highlighted.*

*Only received 2 responses for Therapy, did not feel this would give useful data.*

**MISCELLANEOUS NOTABLE EVENTS & IMPROVEMENTS**

• E-ICU – gives the providers and nurses a support for more critical patients
• Switched from St. Luke’s Mammography to SJRMC
• KDF Architects prepared master plan for the renovation, formed Master Plan Project Team
• Initiated renovation plans – remodel of the Webb (old LeBlanc) building, started construction of new patient entrance area
• Child Psych – Dr. Germaine
• Clinical Nurse Council developed
• Behavioral Health Stakeholders meetings
• 340 B program
• New Nurse call system
• Started the patient portal – My SyringaChart
• F/T Pharmacist – Shane Henry
• Marketing Team
• Denial Management task force
• Resignation of Scott Scribner form the Governing Board and the appointment of Connie McLean
• Marsha Lance has obtained her Domestic Violence and Sexual Assault Certification
• New CT 128 slice – have had over 100 scans/month for Aug. and Sept., received a grant from the Murdock Charitable Trust
• Mock Survey
• Redesigned the Syringa website
• Leadership training classes
• Obtained Most Wired again – have moved out of Small and Rural category this year
• HIMSS Level 6 Hospital again
• Cerner Blood Bank module – help with patient safety
- Hired OB Coordinator – has her RNCOB (Registered Nurse Certified Obstetrics)
- Hired Physical Therapist
- Hired Providers for clinic
- Increase HIT department by 1
- Lynda Fox is our Certified Car Seat Tech. – has had a community open day to make sure car seats are fitted appropriately and has been able to give out needed car seats
- Moved to Xmedius digital faxing system
- Implemented eSignature on the iPad in Cerner
- Implemented Online Bill pay through Cerner
- New 4X4 ambulance
- Hospice/CR/Foundation into a more public accessible building
- Bill Spencer is on the State Time Sensitive Event council
- New facility Chiller unit
- New facility Emergency Generator
- Developed an RN Career Ladder
- Revised RN Wage Grid
- Yvonne Hoiland is on the IHA Transparency Committee