THE QUALITY INSIDER

Oct 2020- Sept 2021 | Issue 10

Year in Review FY 2021

QUALITY UPDATES

- Summary of Quality Improvement Projects
- Fall Leapfrog Score A

HQIC

- Compass HQIC performance

PERFORMANCE METRICS

- Time Sensitive
- Quality Dashboard
- Patient Experience

PRMC Accreditation

September 2021, PRMC was awarded accreditation through DNV. The last time PRMC was accredited by a third party was over 20 years ago. Our community now can enjoy benefits of in network provider status for some commercial payers.

DNV accreditation also focuses on sustained improvement in processes that make healthcare safer, more effective, patient-centered, timely, efficient with resources, and more equitable. We are proud of this accomplishment and look forward to the journey with DNV.

This initiative was a focus of the Quality Pillar in 2020-202. DNV was selected as the third party contractor of choice by the accreditation task force.

Accreditation efforts continue in many areas of the organization to prepare for our next survey in the Summer of 2022.

DNV

HEALTHCARE CERTIFICATE

Certificate no.:
10000460769-MSC-CMS-USA

Initial certification date:
08 September, 2021

Valid:
08 September, 2021 – 08 September, 2024

This is to certify that the management system of

Pratt Regional Medical Center
200 Commodore, Pratt, KS, 67124, USA

has been found to comply with the requirements of the:

NIAHO® Hospital Accreditation Program

Pursuant to the authority granted to DNV Healthcare USA Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Hospitals (42 C.F.R. §482).

Place and date:
Milford, OH, 14 September, 2021

ACCREDITED Hospital

CMS

For the issuing office:
DNV Healthcare USA Inc.
400 Techne Center Drive, Suite 100,
Milford, OH, 45150, USA

Patrick Horine
Management Representative

Lack of fulfillment of conditions as set out in the Certification Agreement may render this Certificate invalid.
ACCREDITED UNIT: DNV Healthcare USA Inc., 400 Techne Center Drive, Suite 100, Milford, OH, 45150, USA - TEL: +1 513 947 8943, www.dnvhealthcare.com

Summary of Quality Improvement Projects

Direct Care

Falls Prevention – The Med/Surg unit has been working to improve patient safety for inpatient hospital stays by improving the use of current safety techniques, bed/chair alarms, and 1:1 care with confused patients. The goal is to reduce the number of falls by 30% by the beginning of FY 2022.

Nulliparous C-Section Rates – Our current rate of nulliparous c-sections deliveries is 48%, with the goal being 38% or less. To achieve this, the LDRP team has implemented a Pre-C-Section Checklist to gather data on nulliparous mothers and the reason for c-section created more standardization within the nursing process, and asked for provider input.

Surgical cancelation reduction - Elective surgical cancelation reached a peak of 38%. This project has helped reduce cancellations to an average of 12.4%. Surgical navigators, reauthorization coordinators, and surgical services have been working on this project.

Safe Medication Administration - Safe medication administration project has focused on increasing the bar code scanning rate, monitoring the percentage of medications given too early or too late, and adjusting policies to support safe medication practices.

Operations

Centralized Coding –The Health Information Management department has been working to streamline the coding process to yield more efficient and effective coding. This will include reducing the days uncoded for clinic claims and decreasing turnaround between coding and claim submission. The redefined clinic goals include a decrease in charge entry log from the average of 17 days to 4, with a goal to completion within 45 days. To support this goal, a flex workflow has been implemented based on volume to reduce the backlog of coding in the clinics. More coders have been cross-trained to cover absences.

Surgery Inventory Process – The surgery department inventory has been consistently off, with a discrepancy of $180,000 for FY 2020. The Surgery and Materials Management departments have been working together to correct this by increasing the frequency of inventory and creating tools to ensure accuracy.

Financial Clearance – In October 2020 – June 2021, there has been $446,000 in initial denials due to the lack of prior authorization. The goal is to decrease the average amount of dollars denied due to no prior authorization to less than $25,000/month from a baseline of $50,000/month. To support this goal, a new Hard Stop policy will be drafted, a centralized prior authorization position will be created, and a clear and concise framework for ordering elective procedures will be communicated to providers.

Medical Assistant Competency – There are approximately 45 employees that fill a clinical role in the clinics. There has not been a hands-on skills fair/competency training completed in the clinic for several years. A skills fair will be conducted, and staff competency validated by 12/31/21 on the 7 most common delegated tasks that have been identified.

Mammography volume growth - Increasing the volume of mammography procedures has been undertaken to increase the availability of this service to our community, decrease wait time for service, and streamline appointments. The possibility of self-referral of screening mammography is in the works.

Support Services

BioFire Blood Pathogen – The current process for the identification of pathogens in sepsis patients is between 36-45 hours. The goal is to reduce this to 24 hours or less which will reduce the length of stay and improve patient care by identifying proper antibiotics. With the BioFire Blood Pathogen Assay, the time to identifications will be between 18-24 hours.

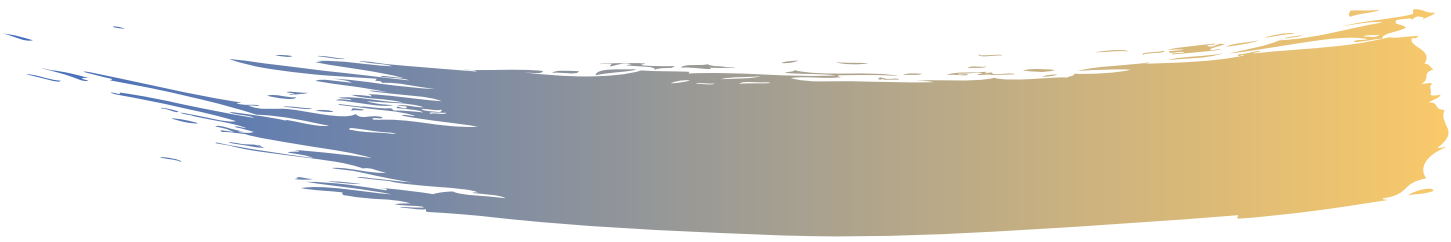
Chargemaster – The Current Procedural Terminology (CPT) codes have not been updated in 2021. A scheduled audit has been put in place to ensure the codes are updated on a regular basis.

EKG Interpretation – The interpretation time for EKGs should be within 3 days, with our current time being between 7-30+ days. The goal is to reduce the EKD interpretation time to 4 days or less by creating a scheduled time for providers to interpret each day and creating a backup plan for EKGs that are not read within 72 hours.

New User Setup – As part of our onboarding process, notifications are sent via email to several departments at different times. This process has left gaps allowing several new hires to not be set up correctly when arriving for a shift. An increase in communication has improved the process, with more changes to come.

XENEX Use – Before August 1st, the use of the XENEX sterilization robot was at 10% for all inpatient dismissals. Training is being done in the EVS department to increase usage to 80% or greater within the next year.

Culture of Safety – As a result of the most recent Culture of Safety survey, there has been a focus on improving communication regarding errors. A comprehensive communication plan will be created..



LEAPFROG HOSPITAL SURVEY

NATIONALLY RECOGNIZED A FALL 2021 LEAPFROG HOSPITAL SAFETY GRADE

Preventing and Responding to Patient Harm

Measure name	Leapfrog's Standard	Hospital's Progress
Effective Leadership to Prevent Errors	Hospitals should take meaningful steps to raise awareness about patient safety, hold leadership accountable for reducing unsafe practices, provide resources to implement a patient safety program, and develop systems and structures to support action to improve patient safety.	ACHIEVED THE STANDARD
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	
Staff Work Together to Prevent Errors	Hospitals should assess their culture of safety and hold leadership accountable for implementing policies, procedures, and staff education to improve the culture of safety.	ACHIEVED THE STANDARD
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	
Support for Nursing Workforce	Hospitals should assess their nursing staff levels and core competencies, included nurses in leadership, and develop and implement plans to address any areas of improvement.	ACHIEVED THE STANDARD
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	
Handwashing	Hospitals should regularly monitor hand hygiene practices for everyone interacting with patients, and give feedback to ensure compliance. Hospitals should foster a culture of good hand hygiene, offer training and education, and provide equipment, such as paper towels, soap dispensers, and hand more	SOME ACHIEVEMENT
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	
Responding to Never Events	Hospitals should have a never events policy that includes all nine (9) actions that should occur following a "never event," which includes apologizing to the patient and not charging for costs associated with the never event.	ACHIEVED THE STANDARD

Medication Safety

Measure name	Leapfrog's Standard	Hospital's Progress
Safe Medication Administration	Hospitals should have nurses and other clinicians use BCMA in all medical/surgical units, intensive care units, and labor and delivery units to scan the patient and medication prior to administration at least 95% of the time. The BCMA system includes decision support to prevent errors and the hospital has more	CONSIDERABLE ACHIEVEMENT
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	
Safe Medication Ordering	Hospitals should enter at least 85% of inpatient medication orders through the CPOE system.	ACHIEVED THE STANDARD
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	
Medication Reconciliation	Hospitals should have a rate of unintentional medication discrepancies per medication that is lower than or equal to the 50th percentile (where lower performance is better) nationally.	ACHIEVED THE STANDARD
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	
Medication Documentation for Elective Outpatient Surgery Patients	Hospitals should document 90% or more of home medications, visit medications, and allergies/adverse reaction(s) in the patients' clinical record.	ACHIEVED THE STANDARD
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	

Maternity Care

Measure name	Leapfrog's Standard	Hospital's Progress
Cesarean Sections	This is defined as first-time mothers giving birth to a single baby, at full-term, in the head-down position deliver their babies through a C-section. Hospitals should have a rate of C-sections of 23.6% or less.	LIMITED ACHIEVEMENT
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	
Early Elective Deliveries	This is defined as mothers being scheduled for cesarean sections or medication inductions prior to 39 weeks gestation without a medical reason. Hospitals should have a rate of early elective deliveries of 5% or less.	ACHIEVED THE STANDARD
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	
Episiotomies	This is defined as mothers having an incision made in the perineum (the birth canal) during childbirth. Hospitals should have a rate of episiotomies of 5% or less.	ACHIEVED THE STANDARD
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	
Screening Newborns for Jaundice Before Discharge	Hospitals should screen at least 90% of babies for jaundice.	ACHIEVED THE STANDARD
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	
Preventing Blood Clots in Women Undergoing Cesarean Section	At least 90% of women undergoing a cesarean section receive treatment to prevent blood clots.	ACHIEVED THE STANDARD
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	

Complex Adult and Pediatric Surgery

Measure name	Leapfrog's Standard	Hospital's Progress
Total Hip Replacement Surgery	Hospitals should perform at least 50 procedures annually, and as part of their process for privileging surgeons, ensure that each surgeon performs at least 25 procedures annually.	ACHIEVED THE STANDARD
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	
Total Knee Replacement Surgery	Hospitals should perform at least 50 procedures annually, and as part of their process for privileging surgeons, ensure that each surgeon performs at least 25 procedures annually.	ACHIEVED THE STANDARD
	SHOW MORE ON THIS HOSPITAL'S PERFORMANCE	

Care for Elective Outpatient Surgery Patients

Measure name	Leapfrog's Standard	Hospital's Progress
Elective Outpatient Surgery Recovery Staffing - Adult	Hospitals should ensure that a specially certified clinician and at least one physician or nurse anesthetist are present and immediately available while an adult patient is present until discharge.	ACHIEVED THE STANDARD
Elective Outpatient Surgery Recovery Staffing - Pediatric	Hospitals should ensure that a specially certified clinician and at least one physician or nurse anesthetist are present and immediately available while a pediatric patient is present until discharge.	ACHIEVED THE STANDARD
Safe Surgery Checklist - Elective Outpatient Surgery	Hospitals should go through all the elements of a complete safe surgery checklist on all patients every time a procedure is performed.	ACHIEVED THE STANDARD

Five years running PRMC has received an A safety grade from the Leapfrog Hospital Survey. In almost every qualifying measure we receive the full score available. Thank you for making patient safety a top priority.

HQIC Performance

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

Kansas Healthcare COLLABORATIVE

Pratt Regional Medical Center participates in the Compass hospital quality improvement collaborative. The collaborative provides PRMC support through education on best practices and comparison data on how PRMC compares to similar hospitals in the midwest.

Medication safety

In all ten measured Adverse drug event categories, PRMC has performed very well. We have either maintained a very low baseline event record or reduced the number of adverse drug events.

Focus Area	Measure	Source	Time Period	Rate	Improvement (%)
ADE	Adverse Drug Events Originating During Hospital Stay	Claims	Baseline (Jan 19 - Dec 19)	0.00	Ref.
			Project (Sep 20 - Aug 21)	0.00	Baseline 0
			Current streak of zero events		24
ADE	Adverse Drug Event Rate	Self-report	Baseline (Jan 21 - Mar 21)	4.55	Ref.
			Project (Apr 21 - Jul 21)	4.06	10.9%
ADE	Opioid-Related Adverse Drug Events	Claims	Baseline (Jan 19 - Dec 19)	0.00	Ref.
			Project (Sep 20 - Aug 21)	0.00	Baseline 0
			Current streak of zero events		24
ADE	Opioid Mortality	Claims	Baseline (Jan 19 - Dec 19)	0.00	Ref.
			Project (Sep 20 - Aug 21)	0.00	Baseline 0
			Current streak of zero events		24
ADE	Stat Naloxone Administration - Emergency Department	Self-report	Baseline (May 21 - Jul 21)	0.08	Ref.
			Project (Aug 21 - Aug 21)	0.00	100.0%
			Current streak of zero events		2
ADE	Stat Naloxone Administration - Inpatient	Self-report	Baseline (Mar 21 - May 21)	0.00	Ref.
			Project (Jun 21 - Aug 21)	0.00	Baseline 0
			Current streak of zero events		5
ADE	Blood Glucose Less Than 50	Self-report	Baseline (Mar 21 - May 21)	0.00	Ref.
			Project (Jun 21 - Aug 21)	0.00	Baseline 0
			Current streak of zero events		6
ADE	Manifestations of Poor Glycemic Control	Claims	Baseline (Jan 19 - Dec 19)	0.00	Ref.
			Project (Sep 20 - Aug 21)	0.00	Baseline 0
			Current streak of zero events		24
ADE	INRs Greater Than 5	Self-report	Baseline (Mar 21 - May 21)	3.57	Ref.
			Project (Jun 21 - Aug 21)	0.00	100.0%
			Current streak of zero events		2
ADE	Anticoagulant Related Adverse Drug Events per 1,000 Acute Inpatient Admissions	Claims	Baseline (Jan 19 - Dec 19)	0.00	Ref.
			Project (Sep 20 - Aug 21)	0.00	Baseline 0
			Current streak of zero events		24

HQIC Performance

COMPASS | HOSPITAL QUALITY IMPROVEMENT CONTRACTOR

Kansas Healthcare COLLABORATIVE

Healthcare Acquired Condition Reduction

PRMC has performed very well on maintaining very low rates of healthcare acquired conditions. We track over 15 event categories that may be acquired during healthcare services. Our patient fall rate is up slightly, the increase in falls does coincide with an increase in patient volume and increased number of patients on isolation precautions. The number one cause identified in the increased number of falls has been patients going to the restroom without calling for help.

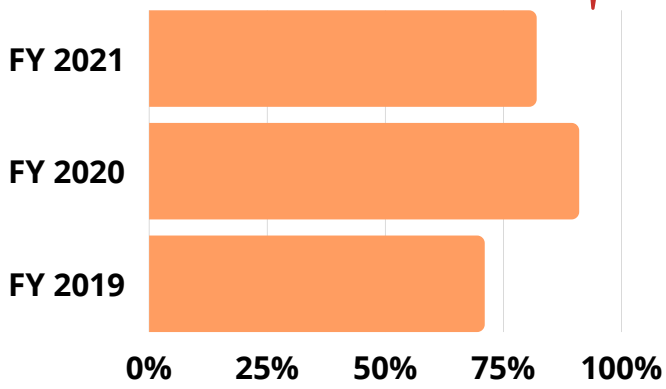
C. diff	Healthcare Facility-Onset *C. difficile* Infection Rate	NHSN	Baseline (Jan 19 - Dec 19)	0.00	Ref.
			Project (Sep 20 - Jul 21)	0.00	Baseline 0
			Current streak of zero events		23
C. diff	Hand Hygiene Compliance	Self-report	Baseline (Jan 19 - Nov 19)	80.79	Ref.
			Project (Oct 20 - Jul 21)	82.69	2.3%
CAUTI	Catheter-Associated Urinary Tract Infection Rate	NHSN	Baseline (Jan 19 - Dec 19)	0.89	Ref.
			Project (Sep 20 - Jul 21)	0.00	100.0%
			Current streak of zero events		21
CAUTI	Catheter Utilization Ratio - All Units	NHSN	Baseline (Jan 19 - Dec 19)	0.28	Ref.
			Project (Sep 20 - Jul 21)	0.18	35.9%
CLABSI	Central-Line-Associated Bloodstream Infection (CLABSI) Rate	NHSN	Baseline (Jan 19 - Dec 19)	0.00	Ref.
			Project (Sep 20 - Jul 21)	0.00	Baseline 0
			Current streak of zero events		19
CLABSI	CLABSI Utilization Ratio - All Units	NHSN	Baseline (Jan 19 - Dec 19)	0.02	Ref.
			Project (Sep 20 - Jul 21)	0.02	10.5%
Falls	Falls with Injury	Self-report	Baseline (Jan 19 - Dec 19)	1.89	Ref.
			Project (Sep 20 - Aug 21)	2.42	28.0%
Falls	Falls with or without injury	Self-report	Baseline (Jan 19 - Dec 19)	3.30	Ref.
			Project (Sep 20 - Aug 21)	6.08	84.0%
Falls	Fall Rate Resulting in Fracture or Dislocation (CMS HAC)	Claims	Baseline (Jan 19 - Dec 19)	0.00	Ref.
			Project (Sep 20 - Aug 21)	0.00	Baseline 0
			Current streak of zero events		24
Falls	Fall Risk Assessment on Admission	Self-report	Baseline: Insufficient data		
			Project (Aug 21 - Aug 21)	98.44	Optional
HAPI	Pressure Ulcer Rate, Stage 3+, (AHRQ PSI-03)	Claims	Baseline (Jan 19 - Dec 19)	0.00	Ref.
			Project (Sep 20 - Aug 21)	0.00	Baseline 0
			Current streak of zero events		24
HAPI	Acute Inpatients with a Hospital-Acquired Pressure Ulcer Stage II	Claims	Baseline (Jan 19 - Dec 19)	0.00	Ref.
			Project (Sep 20 - Aug 21)	0.00	Baseline 0
			Current streak of zero events		24
HAPI	Risk Assessment within 24 hours	Self-report	Baseline (Mar 21 - May 21)	0.00	Ref.
			Project (Jun 21 - Aug 21)	0.00	Baseline 0
SSI	Hip Replacement Surgical Site Infection Rate	NHSN	Baseline (Jan 19 - Dec 19)	0.00	Ref.
			Project (Sep 20 - Aug 21)	1.03	Baseline 0
			Current streak of zero events		8
SSI	Knee Replacement Surgical Site Infection Rate	NHSN	Baseline (Jan 19 - Dec 19)	0.00	Ref.
			Project (Sep 20 - Aug 21)	0.00	Baseline 0
			Current streak of zero events		24

Time Sensitive Diagnosis

FY 2021 Data from Oct 2020-Sep 2021

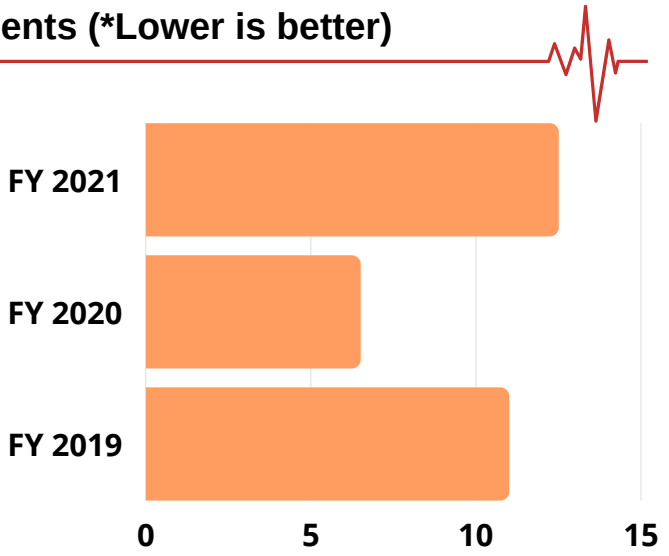
Aspirin Administration to Chest Pain Patients (*Higher is better)

Every patient presenting to the Emergency Department with a complaint of chest pain should receive 324 mg Aspirin during their ED visit. This bar-graph (*right)* shows our most recent percent compliance comparative to the National Benchmark.



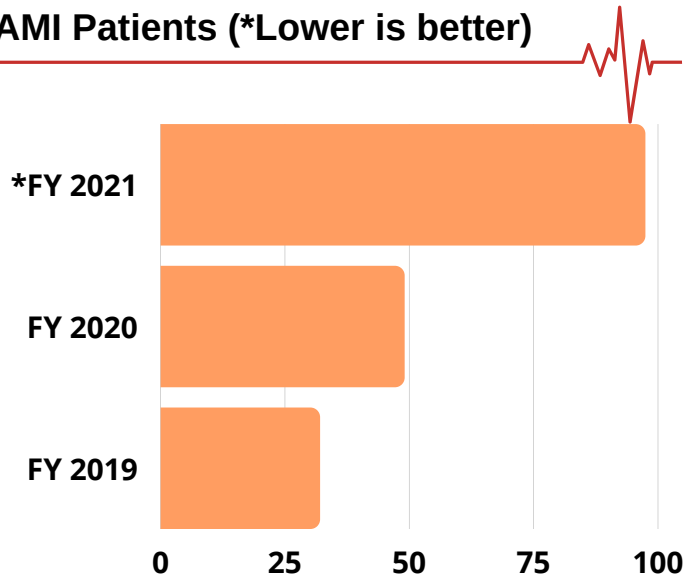
Average Time to EKG for Chest Pain Patients (*Lower is better)

Every patient presenting to the Emergency Department with a complaint of chest pain should receive a 12-lead EKG. A 12-lead EKG is the 'gold standard' diagnostic tool for cardiac events. This bar-graph (*right)* shows the speed at which PRMC obtains an EKG compared to the National Benchmark.



Average Time to Clot Busting Medication for AMI Patients (*Lower is better)

Every patient presenting to the Emergency Department with a diagnosed STEMI should receive either cath-lab intervention or clot busting medication as soon as possible. This bar-graph (*right)* shows the speed at which PRMC administers a clot busting medication compared to the National Benchmark. Our goal is 30 minutes to TNKase .* very small sample size

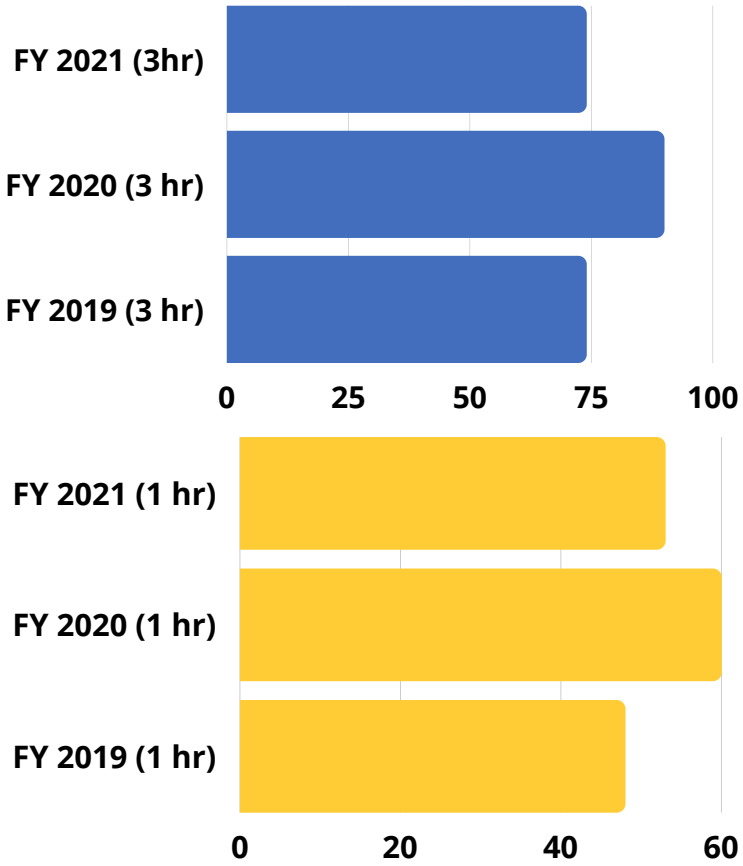


Sepsis Bundle (*Higher is better)

Every patient who is identified as meeting "Severe Sepsis' criteria should receive all elements of the Sepsis Bundle. Severe Sepsis is a life-threatening condition that if left untreated can develop into Septic Shock and/or death. The Sepsis Bundle elements include:

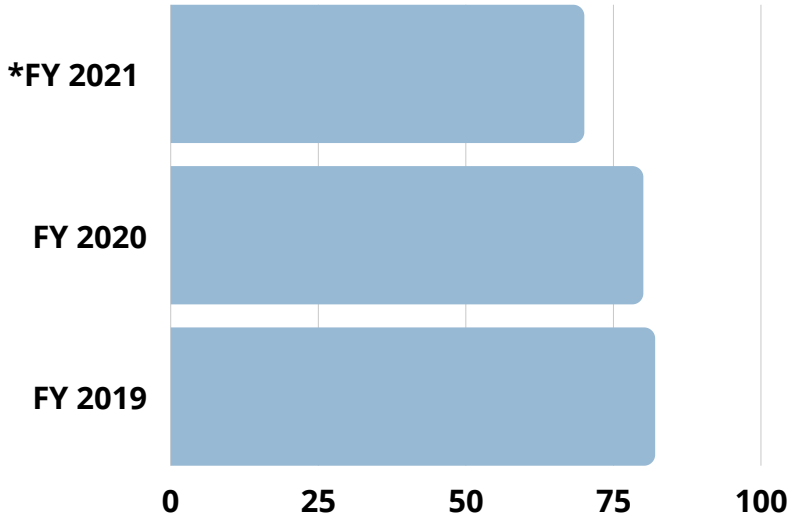
- Blood Culture Collection
- Lactic Acid Testing
- Antibiotic Administration
- Intravenous Fluid Resuscitation (30ml/kg)

This bar-graphs (*right*) show the percentage of patients who received all 4 sepsis bundle elements within a 3-hour window (*upper*) and those that received them within a 1-hour window (*lower*) of Severe Sepsis identification.



Average Time to Head CT/MRI Interpretation for Stroke Patients (*Lower is better)

Every patient who is presenting with stroke-like symptoms should receive a head CT or MRI as soon as possible. This diagnostic tool helps to differentiate the type of stroke and possible treatment options. This bar-graph (*right)* shows the speed at which a head CT or MRI is completed and interpreted compared to the National Benchmark.
*very limited number of cases



Quality Dashboard FYTD 2021

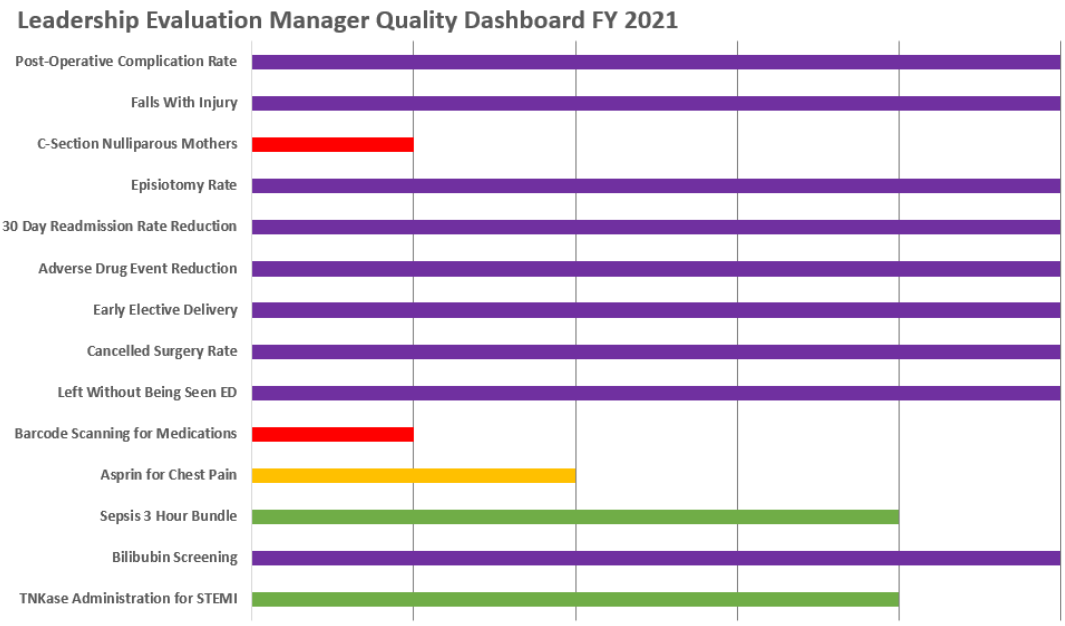
This year we implemented a quality dashboard with fourteen quality measures. These goals were tracked in each leader's LEM. The LEM is a tool that we use to create alignment in goal development through the organization. In 2020 we set goals based on national benchmarks, historic performance, and targets for improvement. Many of these goals have been on our radar in the past and some were new to us. We scored each measure on a 1-5 scale with our goal being 3 or better. Year-end performance was 4.07 overall.

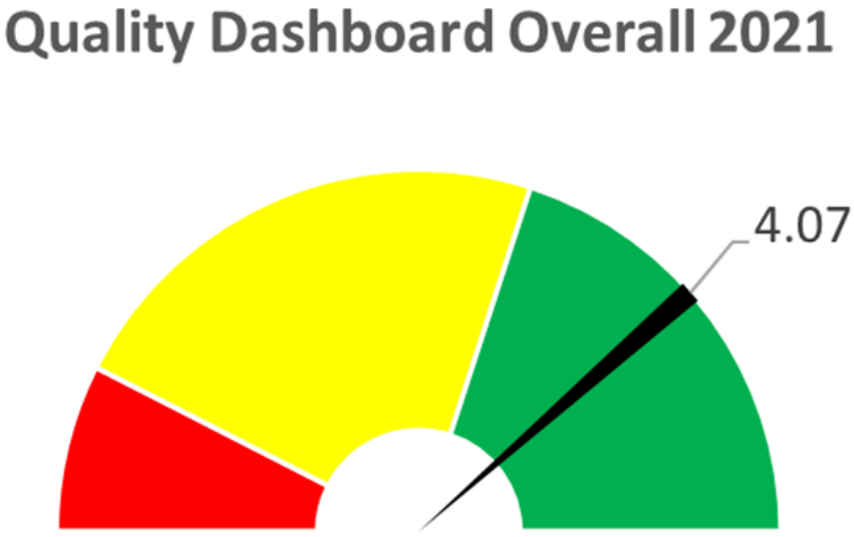
Needs improvement

Missed goal

Met or better than goal

Knocked out of park!

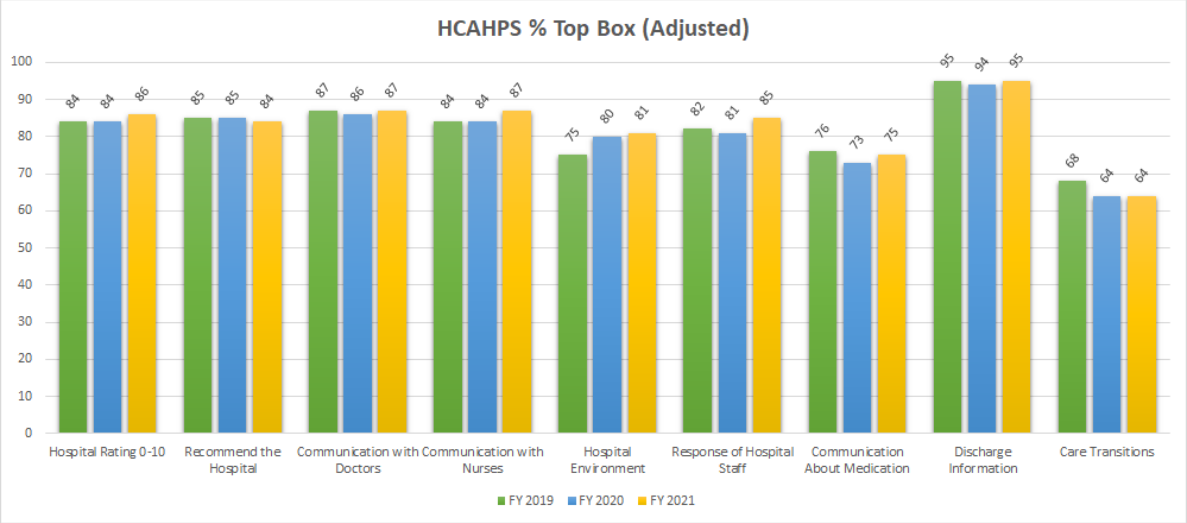




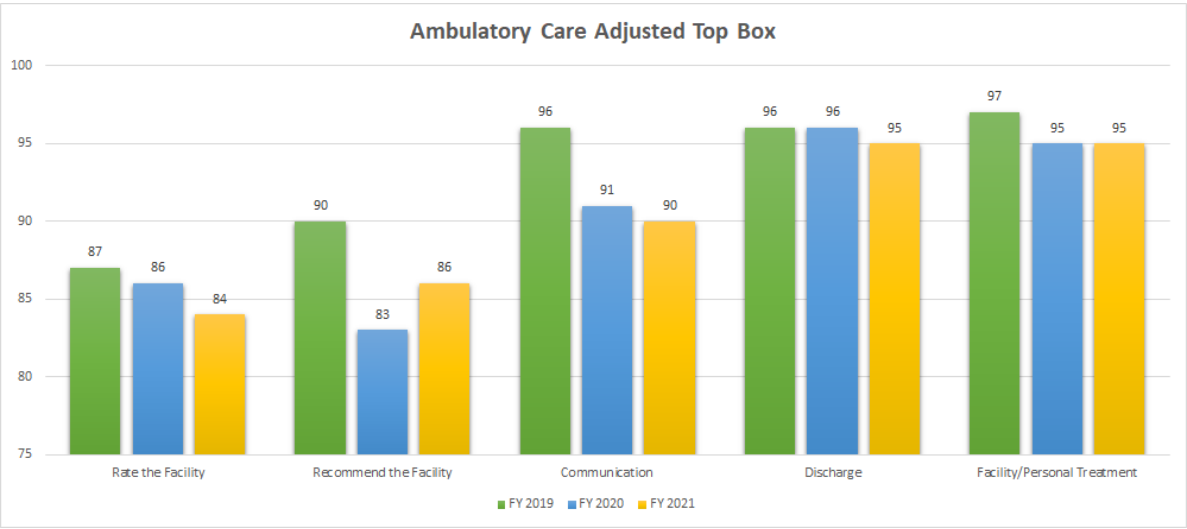
PRMC is very proud of the dedication to excellence we see daily in leadership and staff that contribute to meeting and exceeding these organizational goals.

Patient Experience

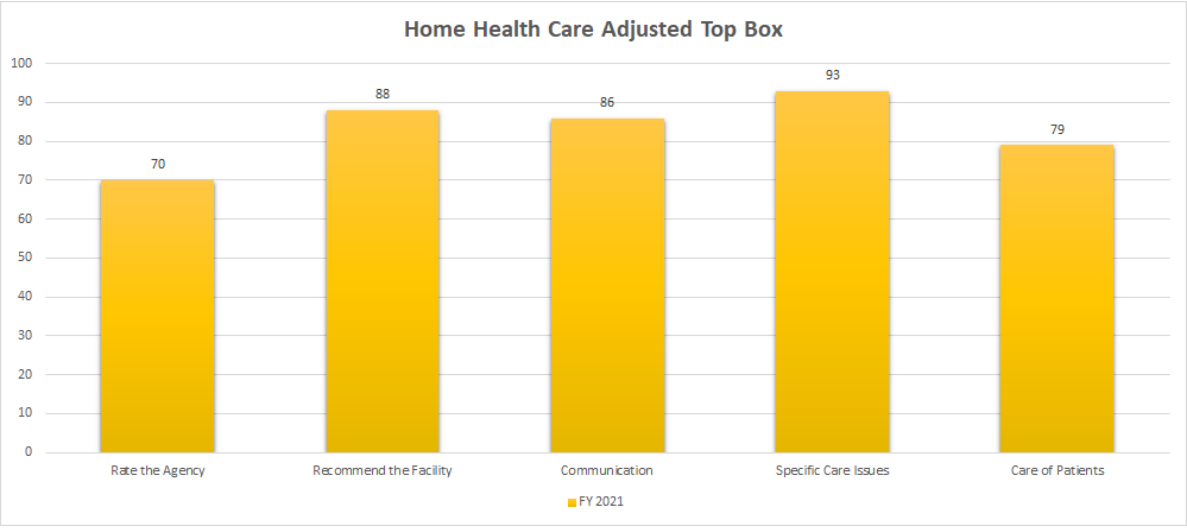
The patient experience is a critical component of the quality of care at PRMC. As you can see inpatient experience in almost every domain the patient experience is better or the same as 2019, and 2020.



The patient experience survey in the ambulatory care domains competes with free standing ambulatory surgery centers. This is historically a very competitive domain. PRMC offers a competitive experience to ambulatory surgery centers throughout the nation.

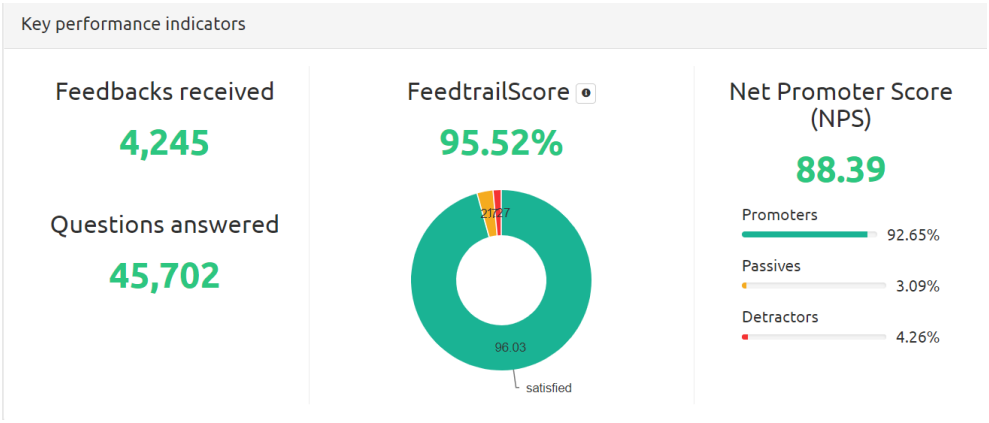


Home Health services provide an excellent value to patients promoting improved health in the comfort of ones own home. This survey demonstrates improvement in specific care issues for the patients in Home Health and likelihood to recommend the service to others.



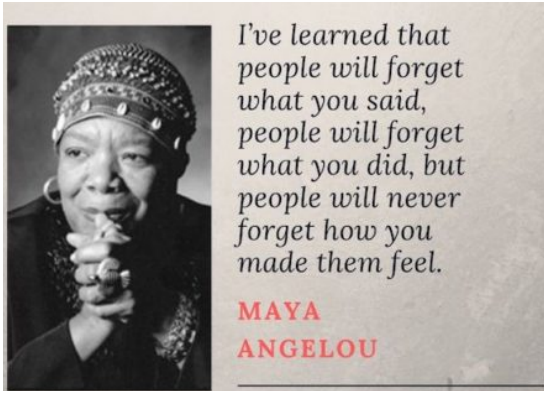
Outpatient Feedtrail Scores

Outpatient FeedTrail Scores in this chart are the percent of overall satisfaction with the service received for each quarter for FY 2021. During this time 4,245 patients responded back to PRMC with feedback about their experience. They answered over 45,000 questions. Over 92% of those patients would recommend PRMC to a friend or family member.



#	Location	Score	Change	Total questions answered
1	Imaging Services (x-ray, CT, Ultrasound, MRI, and Nuclear Medicine)	98.14	0.07	3,657
2	Laboratory Services	97.11	0.37	7,067
3	Clinic Services, outpatient therapy services	97.00	0.02	15,405
4	Surgery and Outpatient Care	96.10	0.40	4,571
5	Other	94.43	3.09	262
6	PRMC Hospital Billing	89.91	-	801
7	Emergency Department	88.59	0.60	1,483

We have learned so much these past several months. How to be a better organization through teamwork and determination. Showing our grit by being measured by an accrediting body during a pandemic. Learning to change and be open to new possibilities through transparency. The year 2020 will live in our minds as a year we wish to forget. Pratt Regional Medical Center has hundreds of examples of courage, professionalism, compassion, and service in face of daunting challenges. I hope we remember the amazing ways PRMC met the challenges head on.



Published by Kris Davis, Jo Stevenson, & Paul Carrington
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