Mayers Memorial Hospital District

Quality Committee
Meeting Agenda

November 11, 2020 1:00 pm
Fully Remote Zoom Meeting: LINK
Call In Number: 1-669-900-9128
Meeting ID: 967 1033 7907

Attendees

Laura Beyer, Board Secretary
Jeanne Utterback, Director
Louis Ward, CEO
Jack Hathaway, Director of Quality

1	**CALL MEETING TO ORDER**		Chair Laura Beyer			**Approx. Time Allotted**
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**					
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting – October 14, 2020		Attachment A	**Action Item**	2 min.
4	**REPORTS: QUALITY FACILITIES: NO REPORTS**					
5	**REPORTS: QUALITY FINANCES: NO REPORTS**					
6	**QUALITY REPORTS**					
	6.1	Marketing	Val Lakey	Attachment B	Report	5 min.
	6.2	Safety Quarterly Report	Val Lakey	Attachment C	Report	5 min.
	6.3	Volunteer Services	Barbara Spaulding	Attachment D	Report	5 min.
7	**REPORTS: QUALITY STAFF**					
	7.1	Staff Development	Brigid Doyle	Attachment E	Report	5 min.
8	**REPORTS: QUALITY PATIENT SERVICES**					
	8.1	Activities	Sondra Camacho	Attachment F	Report	5 min.
	8.2	Social Services	Marinda May & Steve Bevier	Attachment G	Report	5 min.
	8.3	SNF Events/Survey	Candy Vculek		Report	5 min.
	8.4	Infection Control & Employee Health	Dawn Jacobson	Attachment H	Report	5 min.
9	**DIRECTOR OF QUALITY REPORT**		Jack Hathaway	Attachment I		
10	**NEW BUSINESS**					
	10.1	POLICIES: Conflict of Interest		Attachment J	**Action Item**	5 min.

	10.2	Patient Safety First: What will this report contain and who will provide it		Discussion	5 min.
11	**OTHER INFORMATION/ANNOUNCEMENTS**			Information	5 min.
12	**ADJOURNMENT:** Next Regular Meeting – December 9, 2020				

Chief Executive Officer
Louis Ward, MHA

Mayers Memorial Hospital District

Board of Directors
Quality Committee
Minutes
October 14, 2020 @ 12:00 PM
Fully Remote Zoom Meeting

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.

1	**CALL MEETING TO ORDER:** Board Chair Laura Beyer called the meeting to order at 12:05 pm on the above date.			
	BOARD MEMBERS PRESENT:		**STAFF PRESENT:**	
	Laura Beyer, Secretary Jeanne Utterback, Director		Louis Ward, CEO Candy Vculek, CNO Keith Earnest, CCO Jack Hathaway, Director of Quality Libby Mee, Director of HR Daryl Schneider, Physical Therapy David Ferrer, Respiratory Amanda Harris, Telemedicine Dawn Jacobson, Infection Control Jessica DeCoito, Board Clerk	
	ABSENT:			
2	**CALL FOR REQUEST FROM THE AUDIENCE – PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**			
	None			
3	**APPROVAL OF MINUTES**			
	3.1	A motion/second carried; committee members accepted the minutes of September 9, 2020	***Utterback, Ward***	**Beyer – Y** **Utterback – Y**
4	**REPORTS: QUALITY FACILITIES: NO DEPARTMENT REPORTS**			
	4.1	**Pharmacy - Hospital:** We had state inspection in July. Only issue was on Narcotic Reconciliation – mostly on how they wanted the report to look. State renewed on the 28th! Barrier Isolator issues were resolved.		
5	**REPORTS: QUALITY STAFF**			
	5.1	**Worker's Comp Quarterly Report:** Working with Dana and BETA on the work comp program. Working on directing this program to the wellness of our employees – lots of domains for our employee's wellness like ergonomics. Excited to have Dana on our team to help with employee wellness, especially in the COVID environment and the stress brought on by it.		
6	**REPORTS: QUALITY PATIENT SERVICES**			
	6.1	**Telemedicine:** Restarted the Take 4 Counseling at the school sites. Burney Elementary is short staffed, so Amanda is covering for the time being. Very busy in Telemed with Rheumatology appointments picking up. Working on carryover funds to offer services to staff and teachers at schools. Clinic Telemed options are being discussed.		
	6.2	**Cardiac Rehab:** equipment is being maintained with the help of maintenance.		
	6.3	**Physical Therapy:** Utilizing the Translator service on the phone to help with our language gaps with patients. This has helped with gaining more patients from the Hispanic community. Looking into a video service for our patients who use a translator, so we can have the visual presence.		

	6.4	**Respiratory:** Working on performing Pulmonary Function Tests and training Odessa to perform those on her own. Starting to plan something with Val to start marketing more for Respiratory. Wanting to open a Pulmonary Rehab Clinic but with COVID, we aren't able to start that process. Opportunities for Respiratory Fit Testing with farm workers and local chemical companies. Respiratory staff went around to the local schools and provided free of charge fit testing.
	6.5	**Retail Pharmacy:** While we have made great strides in the inventory process, we still have areas for improvement. And we are still experiencing issues with Frontier services. And creates an impact on software updates, workflow processes, etc. Flu Shots are occurring Tuesdays and Thursday from 2:00 pm to 4:00 pm – each time is around 10 to 20 individuals.
	6.6	**SNF Events/Survey:** Activities Director Sondra Camacho is working really hard to keep our Residents busy. Currently planning on a Haunted Halloween and Fall Festival. Trying to come up with alternate plans for the holiday season as we foresee no changes in the visiting restrictions. Standard workflows are being created for both facilities as we have noticed charting errors. Hired 3 of 4 positions for non-clinical staff, and have been very helpful thus far for our nursing staff. CNA's from Shasta College course has 4 from the previous class that will join our team. And we have 4 more students enrolled for the next class.
	6.7	**Infection Control:** In the middle of employee flu shots. COVID testing has been great so far with employees remembering to go.
	6.8	**Hospice Statistical Report:** Our average length of stay is very short compared to the national average. Patient Days fluctuate. But we would like our hospice patients to be referred earlier than what we are seeing now.
7	**REPORTS: QUALITY FINANCES: NO REPORTS**	
8	**DIRECTOR OF QUALITY**	
	8.1	Hospice: Mock Surveryor came in with Hospice and helped us work through our issues, so we can be prepared for our actual survey. Analyzed a lot of responses from family members and interesting to see that everyone should look at Hospice as a celebration of life. Prime updated: Prime submission has been reviewed for completion. Now moving into a deeper clinical aspect. And then will work into a closeout. Val has been creating a video for Prime.
9	**New Business**	
	9.1	**Patient Activation Measure:** Learned about this at the ACHD Conference. Thoughts were that this might be interesting and helpful for our patients in helping them manage their own health and healthcare.
10	**ADMINISTRATIVE REPORT:** COVID Update: big difference in the last month within Shasta. This time last month 612 cases (March to September), 17 active and 12 deaths. As of 10/14/2020: 1597 cases, 180 active, 25 deaths. Expected to move into the Purple Tier. This increase made us put a hold on our SNF visitation plans. We are hiring a screening position for the front lobby door to help. Testing guidelines are being discussed and based on the current resources we have. Setting up private area for individuals needing COVID testing to pull into the ER and call a number. Working on protocols for when Employees call in sick or have questions about symptoms they or their family members are experiencing. All vendors are going through the screening process for COVID reasons. Org Analysis is due October 19th. Employee Benefit Enrollment is due October 21st. Think Pink Day is October 15th. Burney Clinic is moving along nicely and excited for the progress in the next month. Nurse Call Project is going to begin in Acute wing.	
11	**OTHER INFORMATION/ANNOUNCEMENTS**: NONE	
12	**ANNOUNCEMENT OF CLOSED SESSION:**	
	Government Code Section 54962: Medical Staff Credentials <u>Staff Status Change to Inactive</u> 1. Kenneth Childers, CRNA 2. Darla Schmunk, NP 3. Thomas Peterson, NP 4. Kirk Lott, CRNA 5. Eric Stirling, MD 6. Chuck Colas, MD 7. Rebecca Dyson, MD 8. Peter Halt, MD 9. Michael Maloney, MD 10. Scott Bleazard, MD 11. Suzanne Aquino, MD 12. Hanna Bae, MD 13. Baharak Bagheri, MD 14. Daniel Baker, MD 15. John Boardman, MD 16. James Brull, DO 17. Annemarie Buady, MD	

	18. Dennis Burton, MD 19. Courtney Carter, DO 20. Lillian Cavin, MD 21. Charles Gould, MD 22. Todd Greenburg, MD 23. Jeff Grossman, MD 24. Kristen Grubb, MD 25. Morgan Haile, MD 26. James Haug, DO 27. Kyle Henneberry, MD 28. Miriam Hulkower, MD 29. Frederick A. Jones, MD 30. Perry Kaneirya, MD 31. Russell Kosik, MD 32. Bao Nguyn, MD 33. Austin Peters, DO 34. William Phillips, MD 35. Asti Pilika, MD 36. Teppe Popovich, MD 37. Peter Reuss, MD 38. Anjali Roy, MD 39. William Rusnack, MD 40. Shree Shah, MD 41. Frank Snyder, MD 42. Brent Tilseth, MD 43. Joseph Trudeau, MD 44. Charles Westin, MD 45. Aaron Wickley, MC 46. Anthony Willis, MD 47. Yuming Yin, MD <u>AHP Appointment</u> 1. Lewis Furber, JR, FNP <u>Medical Staff Reappointment</u> 1. David Panossian, MD – Pulmonary Care 2. Julia Mooney, MD – Pathology 3. Stephen McKenzie, MD – Family Medicine <u>Medical Staff Appointment</u> 1. Kelly Kynaston, DO – Infectious Disease 2. Mietsy Woodburn, MD – Neurology 3. Stephen Hofkin, MD – Radiology 4. Don Chin, MD - Radiology
13	**RECONVENE OPEN SESSION** - Approval of credentials were moved, seconded and carried.
14	**ADJOURNMENT: 2:00pm** - Next Regular Meeting – November 11, 2020

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	bƻØŜΥōŜ ммΣ нлнл
Department:	a ŀ ʅŜŭʎyƎ ŀ yŘ tdzōſʎŎ wŜſŀ ŭʎƻyã
Submitted By:	±ŀ ſŜʎŜ [ŀ ʅŜè

List up to three things that are going well in your department.

Communications are improving
Processes for Department Marketing are standardized
Advocacy & external networks are strong

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

Messaging for strategic plan - including what will happen with the old building.

How does this impact on patients? Do you think this is acceptable?

Perception will always affect patient care - so our message is important

How does this impact on staff? Do you think this is acceptable?

Staff needs to be informed and feel included.

What progress has been made on these projects since the last quality committee meeting?

Most all of what we have been doing has been related to COVID, legislation and managing a scenario that is very different. Although we have tried to be proactive, a lot is reactive.

Has anyone in particular been instrumental in helping to progress/improve the problem?

Support of management team.

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Have any new quality-related issues arisen? Briefly describe.

Consistency of messaging. Educating staff and community can be a challenge. In a time like this everyone wants to be a source of information.

Are there any other issues to be discussed with the Committee?

There has been significant work through this department with leglislative issues including seismic, AB890, PPE bills, etc.

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	November 11, 2020
Department:	Safety and Emergency Preparedness
Submitted By:	Valerie Lakey

List up to three things that are going well in your department.

Communication
Availability of EP resources to staff
Prioritization of EP and Safety projects and resources

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

Reorganizing of the EP binder to reference all EP tags for survey to make it user friendly for staff when in a survey. This will all be digitized.

How does this impact on patients? Do you think this is acceptable?

Very impactful to have resources related to patient safety readily available to staff

How does this impact on staff? Do you think this is acceptable?

This makes the staff's responsibility to access resources fro EP easily manageable

What progress has been made on these projects since the last quality committee meeting?

Slow but steady - due to COVID projects including reporting 7 days a week.

Has anyone in particular been instrumental in helping to progress/improve the problem?

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Have any new quality-related issues arisen? Briefly describe.

Security for new facility. We are going to be providing panic buttons for admitting and other key staff at FR and Annex

Are there any other issues to be discussed with the Committee?

In-person training has not been allowed. We hope to get back to that as soon as COVID restrictions allow.

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	
Department:	Volunteer Services
Submitted By:	Barbara Spalding
List up to three things that are going well in your department.	
Stores are doing well with volunteers	
Do you have any current quality improvement projects/activities underway? Please provide a brief description. **Is this a LEAN project? Y/N**	
No	
How does this impact on patients? Do you think this is acceptable?	
How does this impact on staff? Do you think this is acceptable?	
What progress has been made on these projects since the last quality committee meeting?	
Has anyone in particular been instrumental in helping to progress/improve the problem?	
Which Strategic Goal does your quality issue BEST relate to (choose one)?	
Have any new quality-related issues arisen? Briefly describe.	
Are there any other issues to be discussed with the Committee?	
Since COVID we have not had active volunteers except for our Thrift Store.	

I send out updates periodically to volunteers to stay connected. Not sure how many will come back after hospital allows them back in.

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	11/11/2020
Department:	Staff Development/Clinical Education
Submitted By:	Brigid Doyle RN, Clinical Nurse Educator/Director of Staff Development

List up to three things that are going well in your department.

1.) CNA staff are recertifying on time with online learning modules, despite CDPH issuing an All Facilities Letter (AFL) allowing them to continue to work without recertification during the pandemic
2.) Recent changes to the process of assigning competency assessments to Registry Staff has resulted in quicker onboarding and improved staff relief scheduling
3.) Training related to Infection Control, Covid19 Pandemic, psychosocial issues related to the pandemic are used to support staff to give excellent care to patients and prevent spread of the coronavirus with success.

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? NO

1. Competency-based New Nursing Employment Orientations initiated in 2019, have been updated in the Relias Learning Management System (RMLS) live classrooms trainings have been deferred related to Covid19 Coronavirus Pandemic, live trainings per RMLS and Zoom are used as needed.
2. In-services related to the Covid19 Coronavirus Pandemic…initiated in 2/2020 have continued with content updates in Relias Learning Management System (RMLS)
3. Competency Assessments for New Nursing Employees (100%) and Registry staff (98%) onboarding are ongoing, monitored by Clinical Educator.

How does this impact on patients? Do you think this is acceptable?

Nursing and clinical staff are continuing to be offered robust learning experiences and the impact on patient experience and quality care is minimal. The clinical nurse educator is contacted for quality issues that affect patient care, RMLS learning modules are sought and assigned if available, curriculum and training is developed and imported into the RMLS if needed. These trainings are evidence based and interdisciplinary when appropriate.
I think the impact is acceptable.

How does this impact on staff? Do you think this is acceptable?

Although orientation and live trainings have been cancelled during the pandemic, staff are utilizing the RMLS for recertification and licensure. Select staff voice their preference for live in-class trainings but understand the cancellation of them due to social distancing. I believe that the training needs of staff are meet with the RMLS and staff express satisfaction with the platform. On the other hand the social and team, rapport that occurs with classroom trainings cannot be replaced and until the safety of all can be assured, staff understand and accept this fact.

I think that the impact is acceptable.

What progress has been made on these projects since the last quality committee meeting?

1. New nursing staff are 100% compliant with competency assessments and orientation
2. In-service assignments and creation of curriculum by the Nurse Educator is ongoing working with Nursing and Clinical Leaders. Clinical Instructor has created and/or assigned modules regarding Infection Control, PPE, Covid19, Pharmaceutical Waste, Compounding Pharmacy for Injection, Surgical Suite Safety, Communication, Resident Rights and Respect, Abuse, Dementia, Wound Assessment, Port Access as requested by clinical staff and leaders.
3. The current staffing level has been positively impacted by an improved process for quicker onboarding of registry staff as it relates to competency assessment completions.

Has anyone in particular been instrumental in helping to progress/improve the problem?

Shay Herndon in HR has been instrumental in working with the Clinical Educator to ensure compliance with competency assessments and orientation.
Candy Vculek CNO has been instrumental in continuously improving the onboarding process for registry staff with HR, resulting in decreased onboarding time and improved staffing.

Which Strategic Goal does your quality issue BEST relate to (choose one)?

To provide outstanding patient-centered healthcare to improve the quality of life of our patients through dedicated, compassionate staff and innovative technology and become the employer of choice in the area.

Have any new quality-related issues arisen? Briefly describe.

Due to the current pandemic and the resultant deferment of live trainings (e.g. social distancing) the clinical nurse educator and staff have increased the use of online resources for training, recertification and license renewals. Staff continue to desire in vivo learning experiences with content experts and peers.
The Clinical Educator, Medical Staff and Nursing leaders are currently involved in planning the initiation of Grand Rounds in the clinical area. Staff will experience an important teaching tool for patient care, by presenting medical problems and treatment of patients, learning as a team using safe social distancing by 12/31/2020.

Are there any other issues to be discussed with the Committee?

Congratulations to the SNF on their CMS *** status! They are a wonderful team to work with and embrace training and learning!

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	November 11, 2020
Department:	ACTIVITIES
Submitted By:	Sondra Camacho

List up to three things that are going well in your department.

Social distancing Special events for the Residents, Families and Staff.
Zoom, window and door visits for the Residents and their families.
Activity aides no longer being in the dining room doing tasks that are out of their scope of practice and are able to have more time to accommodate the visits and spend more time on activity related functions and tasks.

Do you have any current quality improvement projects/activities underway? Please provide a brief description.
Is this a LEAN project? Y/N

The lean process that was implemented at the beginning of the year is showing results for the Activity department, Residents and Families.

How does this impact on patients? Do you think this is acceptable?

This has impacted the Residents and their Families in a positive way .The activity aides have more time to accommodate visits on top of getting all the activity related tasks done or started.

How does this impact on staff? Do you think this is acceptable?

I noticed this change made some of the CAN's and Nursing upset because they felt that activities should be in the dining room and they felt that it put more work on them. Mayer's hired a CNA assistant to pick up some of those duties. Sometimes it takes time for people to adjust to change and that had some challenges also……..

What progress has been made on these projects since the last quality committee meeting?

We continue to move forward and improve the quality of care that we provide here at Mayers

Has anyone in particular been instrumental in helping to progress/improve the problem?

CANDY V

Which Strategic Goal does your quality issue BEST relate to (choose one)?

Providing patient centered care and promoting a home like environment.

Have any new quality-related issues arisen? Briefly describe.

We need more tablets for the residents and the Activity aides need laptops to work on because they no longer have an office at the Burney Annex.

Are there any other issues to be discussed with the Committee?

N/A

Mayers Memorial Hospital District Quality Committee Report

Meeting Date:	November 11, 2020
Department:	Acute / LTC
Submitted By:	Steve Bevier & Marinda May
List up to three things that are going well in your department.	
Improved turn-around times for admissions to LTC Resident and family support during COVID pandemic	
Do you have any current quality improvement projects/activities underway? Please provide a brief description. **Is this a LEAN project? Y/N**	
We have been able to create a workflow that has allowed for better acceptance of residents into long-term care without significant delays. We were able to identify gaps and create processes that have eliminated those gaps and allowed families and residents to feel supported and admitted in a timely manner.	
How does this impact on patients? Do you think this is acceptable?	
It has given residents a positive admission process without feeling rushed, or unsupported.	
How does this impact on staff? Do you think this is acceptable?	
COVID has presented its own challenges in regards to admissions. It has been awesome to watch ST 1 and ST 2 come together and do the admits together and provide care to the residents.	
What progress has been made on these projects since the last quality committee meeting?	
Has anyone in particular been instrumental in helping to progress/improve the problem?	
Candy, Steve, Marinda, Shelley, and Diana have all played a HUGE role in accomplishing this. It has been wonderful to have a team of individuals who want to see positive changes within LTC.	
Which Strategic Goal does your quality issue BEST relate to (choose one)?	
Have any new quality-related issues arisen? Briefly describe.	
COVID has of course had a significant impact on the ability for residents to have their families in the building to see them. We have created 2 ways in which families and residents can have some face-to-face time. Our maintenance crew built an insert for the dining room door that allows residents to hold hands with loved ones. The other was with a speaker phone for a window visit in our activities room.	
Are there any other issues to be discussed with the Committee?	
Not at this time.	

Infection Control/Employee Health

SNF: One positive employee, prompted response driven testing for 14 days at seven day intervals until two sequential rounds completed and all staff and residents negative. All testing completed awaiting results.

Staff: we have had 3 staff members test positive since august and 12 on quarantine due to exposure. All isolated staff have returned and there are only 3 currently on quarantine. Staff has been much better about testing weekly.

There have been a lot of questions concerning isolation and quarantine of employees so a new policy has been created to assist managers in the process. (see attached)

Influenza Vaccines: All but five employees are in compliance with flu vaccines. Managers are aware of who needs them.

Trends: There has been a nasty cold going around that has a lot of similar symptoms to Covid-19 that has affected numerous employees.

We are still not doing annual employee physicals at this time but we are still doing new hire physicals. Erica is facilitating that.

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

COVID-19 GUIDELINES FOR QUARANTINED FOR COVID POSITIVE EMPLOYEES

Exposure:

1. An exposure requires **all** three of the following: 1) being less than 6 feet apart, 2) for longer than 15 minutes, 3) without wearing a mask.
2. Notification of an exposure may occur in a variety of manners.
    a. An employee may be notified by either the state, county, workplace, or positive person to whom they have been exposed.
    b. If this occurs, he or she should immediately notify their supervisor. Their supervisor will remove them from the schedule and notify Infection Prevention of the exposure.
    c. Infection Prevention will notify HR and validate that the employee has been taken off the work schedule for the appropriate time period.
    d. HR will maintain tracking of both quarantined and isolated employees on a log.
    e. HR will contact the positive employee and assist them with any questions or concerns related to use of paid time during their absence.
3. Length of Quarantine
    a. The employee will be quarantined for 14 days as long as they do not become symptomatic.
    b. The quarantine period for an exposed individual may be longer if one of their family members within their household is COVID positive.
        i. The quarantined individual cannot start the 14-day period until their family members isolation period is complete unless the COVID positive individual is able to isolate away from the employee.
        ii. If the quarantined individual begins to exhibits signs and symptoms of COVID-19, they should be tested and, if positive, he or she will move into the isolation protocols listed below. The quarantined individual is expected to notify Employee Health and HR if they convert to positive.
    c. The employee is expected to continue with weekly COVID testing on day 7 and day 14 of quarantine. The testing protocol is outlined below
        i. Do not enter the hospital.
        ii. Park in the hospital parking lot
        iii. Notify the front desk via telephone that they need a COVID test,
        iv. The front desk will notify the lab and the employee will receive all care within their car.

v. If the employee tests positive during their quarantine then they are moved to isolation (see below).

4. It is important for employees who become ill outside of work to be tested prior to returning to work.
    a. They should use the same lab testing protocol as outlined above in section 3c.
    b. Even employees who are testing weekly should retest if they develop symptoms consistent with COVID-19 less than 7 days after their last test. They should remain at home until the results are back.

Isolation:

Individuals who test positive for COVID-19 will be place in isolation. Notification of a positive COVID-19 test may come from Employee Health at MMHD, a clinic or county health department, depending upon where the test was conducted.

1. If an employee tests positive for Covid-19 during routine testing:
    a. Employee Health will notify the employee and he or she will be removed from the schedule immediately for 10 days from the date of the test.
    b. Employee Health will notify HR and the employees supervisor of the need to remove from the schedule
    c. Employee Health will contact the positive employee for contact tracing to determine if other staff members have been exposed.
    d. HR will track positive employees on a log.
    e. HR will contact the positive employee and assist them with any questions or concerns related to use of paid time during their absence.
2. If an employee is notified of a positive test done outside of the facility:
    a. The employee should immediately notify their supervisor
    b. The supervisor will remove the employee from the schedule for 10 days from the date of the test.
    c. The supervisor must notify Employee Health/Infection Prevention and HR.
    d. The employee must contact Employee Health/Infection Prevention for contact tracing within the facility.
    e. If the employee does not have any symptoms during the 10-day isolation period, they may return to work after the isolation period ends.
    f. Employees who test positive for COVID-19 and have symptoms during their 10 day isolation period may return to work once all the following conditions are met:
        i. At least 24 hours have passed since recovery, defined as resolution of fever without the use of fever-reducing medications
        ii. Improvement in symptoms
        iii. At least 10 days have passed since symptoms first appeared.

Employees who have tested positive should not be tested again for 90 days because they will continue to shed the virus and will keep testing positive. This policy is subject to revision based on changes in regulations.

Committee Approvals:
IC:
P&P:
BOD:

CMS Core Measure Report

The Quality Department is constantly working to make reporting seamless and mechanical. Currently we are meeting all CMS Core Measure reporting, by reporting on EDTC (Emergency Department Transfer Communications) on a quarterly basis and reporting HCP (formerly OP-27 [OP stands for Outpatient and this measure counts the number of health care professionals that work for the district that received a flu shot or declined and agreed to mask throughout flu season]) and HCAHPS on an annual basis. Even though we do not have a sufficient number of HCAHPS responses to be counted towards stars – the fact that we are reporting is enough to satisfy the requirement that is applicable to critical access hospitals like ours.

There are 8 metrics in the EDTC measure that are addressing the communications out of our ED to other hospitals who are receiving patients from Mayers. There are a number of legally required forms (transfer forms) that must be sent with the patient to the receiving hospital. Additionally, there are required events that must be documented in order to be counted as complete for every patient that is transferred. The metrics and our performance on each as have been reported, recorded and returned (through Q3 of 2020) are as follows:

Quarter	Q1 2020		Q2 2020		Q3 2020		Q4 2020	
Number of Records	49		51		57		N/A	
	#	%	#	%	#	%	N/A	N/A
1) Home Medications	42	86%	48	94%	50	88%	N/A	N/A
2) Allergies and Reactions	46	94%	48	94%	49	86%	N/A	N/A
3) Meds given in ED	43	88%	43	84%	39	68%	N/A	N/A
4) ED Provider Note	45	92%	49	96%	47	82%	N/A	N/A
5) Mental Status Assessment	41	84%	38	75%	36	63%	N/A	N/A
6) Reasons for Transfer & POC	47	96%	51	100%	55	96%	N/A	N/A
7) Tests & Procedures Preformed	46	94%	50	98%	52	91%	N/A	N/A
8) Results	46	94%	50	98%	53	93%	N/A	N/A
Overall Met Measures	29	59%	31	61%	27	47%	N/A	N/A

The HCP (OP-27), and various other infection prevention measures such as surgery site infections, will be complied and ready to report in February of next year, as they are only reported annually in March.

HCAHPS reporting looks like this:

Survey Type	Section Current	n	Current Period (Q3-20)	Previous Period (Q2-20)	Change
CAHPS	Comm w/ Nurses	5	80.00%	86.67%	-6.67%
CAHPS	Response of Hosp Staff	5	70.00%	73.33%	-3.33%
CAHPS	Comm w/ Doctors	5	73.33%	86.67%	-13.33%
CAHPS	Hospital Environment	5	60.00%	70.00%	-10.00%
CAHPS	Comm About Medicine	4	37.50%	0.00%	37.50%
CAHPS	Discharge Information	5	80.00%	67.50%	12.50%
CAHPS	Care Transitions	5	65.00%	33.33%	31.67%

As you can see our numbers are pretty good considering that we have such a small n value for each measure. Looking at the information in total we can safely score our hospital at a 75% overall 75.35% to be exact – so that puts us on the upper half, but we have room for improvement all the way around. With an increase in numbers, we can expect our data to be more meaningful. On that front, we do know that we are allowed to call and notify people that they will be receiving the survey, however, we can discuss nothing more than the fact that it will be arriving via mail or by a phone call.

We are looking at the process for collection of other core measures still and working to determine which others would be most beneficial for us as a hospital, there are 117 total measures so it will take a bit of time to run data for all of them, but I hope to have a good set of 4 additional measures to attempt reporting on the February submission to CMS.

Stars.

Stars for the Hospital are all dependent on the core measure work above, and as we advance there I will keep you all informed. I am curious to see if there is a GACH (General Acute Care Hospital) version of the stars report we get for the SNF with specific data points for us to work – again as I learn more I will keep you all informed.

Stars for the SNF – as I am sure you have heard we have moved to 3 stars!! I am very excited. Now that we have picked all of the low hanging fruit on that tree we have to start being more deliberate on how we move forward with advancing. Currently, we are 40-50 points away from a 4 star rating in the quality domain and there are three specific measures we will be looking to improve there to help gain that 4th star in that domain 1) Residents with a decline in ADLs (Activities of Daily Living) 2) Antipsychotics prescribed, luckily we have a good system tracking all of these already in place so we just have to work

with the right people and get some GDRs (Gradual Dose Reductions) moving in the right direction and we should see some good work being accomplished there, and 3) Loss of mobility. We believe that having more RNA time will help with 1 and 3 on that list – so that is something that we are looking at to assist with the work.

Additionally, 2 of the major harm tags from the past in October and November of 2017 will be falling off if the health inspection domain so we should see an improvement there as well. All things considered, if we are able to maintain the current pace, there is potential that we could see another star bump in the beginning of the year. I have to look specifically at the numbers, however, at this time I believe that we are only 1 or 2 points away from the bump line in the health inspection domain and that could be a big win for us on top of the quality domain work that we are beginning.

That is about all – if you have any questions please reach out to me.

Thank you!

Jack Hathaway DOQ MMHD.

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

CONFLICTS OF INTEREST

DEFINITIONS:

Patients - All customers receiving health care services in our facilities, including inpatients, outpatients, residents and clients.

Appearance of a Conflict of Interest - When it appears to a third person, regardless of whether a conflict exists, that an individual's professional judgment or decision-making is influenced.

Conflict of Interest - A conflict of interest arises when personal or financial interests influence professional judgment or decision-making.

Conflicts of Interest Questionnaire (COl Questionnaire) - Questionnaire document(s) approved by the MMHD Board of Directors designed to facilitate written disclosure of existing or potential conflicts of interest.

Conflicts of Interest Selection Criteria Document - A listing of categories of employees covered by the requirement to complete a COI Questionnaire. (Appendix 1)

Executives - MMHD employees whose compensation is administered through Executive Compensation.

Ongoing Conflicts of Interest Disclosures - Disclosures that are made by employees outside the annual Conflicts of Interest Questionnaire process.

Potential Conflict of Interest - A potential conflict of interest exists when personal or financial interests may, at some time in the future influence professional judgment or decision-making.

PROVISIONS:

Requirements for employee disclosures of potential conflicts of interest and
An accountability structure for the administration and management of the annual Conflicts of Interest Questionnaire are outlined below.

On-going Conflicts of Interest Disclosures

Employees covered by this policy have an ongoing duty to promptly disclose actual or potential conflicts of interest, and situations that may cause the appearance of a conflict of interest to designated Individuals in accordance with the MMHD compliance and ethics program. Designated individuals include: supervisors; managers; human resources, compliance and the MMHD Compliance Hotline. Standards for disclosure requirements are provided in Appendix 2.

Conflicts of Interest Questionnaires

Annual Conflicts of Interest (COl) Questionnaires

COl Questionnaire is required annually from employees selected in accordance with the Conflicts of Interest Selection Criteria Document. Administration and Accountabilities are described in Appendix 3.

The Compliance Officer administers the MMHD Conflicts of Interest Questionnaire program.

Employees who are notified of the requirement to complete an annual COl questionnaire must complete the questionnaire and respond to requests for clarification or additional information regarding their disclosure as a condition of continued employment.

Executive Conflicts of Interest Questionnaires

Executives are required to complete a COl Questionnaire at the time of hire or promotion to executive level. Executives are required to complete the questionnaire and respond to requests for clarification as a condition of employment.

Other Required Conflicts of Interest Questionnaires

Employees may be required to complete a COR Questionnaire outside the annual process due to: changes in the regulatory requirements; the need to update status of previous disclosures of potential conflicts of interest; or for other disclosure requirements. Upon request of the Compliance Officer or designee, employees are required to complete the questionnaire and respond to requests for clarification.

Review/Management/Resolutions of COl Disclosures

Disclosures received outside the annual COI Questionnaire process (see 5.1) are addressed by the employee's manager or Compliance Officer. Any action taken for these disclosures are documented in the designated system of record.

Review/Management/Resolution of COI Questionnaire disclosures are made at the appropriate level of the organization.

Executives' disclosures are addressed by the Compliance Officer in consultation with the Board of Directors.

Employee disclosures are reviewed by a Compliance Officer.

The COI Questionnaire disclosures and actions taken are documented in the designated system of record. Please refer to Appendix 2: Standards for Disclosure, Assessment and Action regarding Conflicts of Interest.

Reports to the MMHD Board

The Compliance Officer submits annual conflicts of interest reports to the MMHD Board of Directors. Reports summarize disclosures, trends, actions taken to manage/resolve identified conflicts of interest or potential conflicts of interest, and recommendations for program improvements.

POLICY
Mayers Memorial Hospital District (MMHD) employees are required to promptly disclose situations that may present a conflict of interest or the appearance of a conflict of interest. It is the policy of MMHD to identify conflicts of interest and situations that may give rise to conflicts of interest and to address such situations to ensure decisions made on behalf of MMHD are made in the best interests of the organization, and its members and patients.

PURPOSE
The purpose of this policy is to address federal laws and regulations and accreditation standards for conflicts of interest (See Section 6, References) by ensuring that processes are in place for the disclosure and management of situations that may lead to a Conflict of Interest.

SCOPE/COVERAGE
This policy applies to all employees of Mayers Memorial Hospital District (MMHD) and any member of Directing Boards.

REFERENCES/ APPENDICES

The Joint Commission Standard LD.02.01

Medicare Part D Prescription Drug Benefit Manual (Chapter 6, Part D Drugs and Formulary Requirements, Section 30.1.2) of the Medicare Modernization Act. 42 C.F.R. § 423.120(b)(ii)

COMMITTEE APPROVALS:
P&P: 6/7/2018
Quality: 10/24/2018