Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Davis County Hospital and Clinics

Fiscal Year 2023 Annual Evaluation of Services

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Executive Summary

This Critical Access Hospital (CAH) Annual Report for Davis County Hospital and Clinics (DCHC) has summarized the utilization of services, quality activities, and strategic direction activities for the year July 1st, 2022, through June 30th, 2023.

Network

Davis County Hospital and Clinic's management and network agreements are with MercyOne. MercyOne provides affinity meetings for their rural affiliates. The affinity groups meeting in person or via webinars include chief executive officers, chief financial officers, chief nursing executives, human resource professionals, quality, infection prevention, lab, purchasing, health information managers, cardiac rehab, credentialing, education, radiology, pharmacy, food and nutrition, emergency department, surgery, medical surgical department, utilization review, compliance, informational technology, and performance excellence professionals.

Leadership Transitions

The 2022–23 fiscal year included the following leadership changes at DCHC:

- Roxanne Lefler, BSN, RN, was hired to fill the role of surgery, infusion, and specialty clinic manager.
- Lisa Warren transitioned from accounting controller to chief financial officer (CFO) following the retirement of the prior CFO, Kendra Warning.

Board of Trustees

- Kevin Cook, Board Chair
- Heath Greiner, Vice Chair
- Nolan Eakins, Secretary/Treasurer
- Donna Olinger
- Bailey Westfall

Credentials

The Medical Staff recommended, and the Board of Trustees granted, final approval for the following:

- Twelve (12) initial provider appointments
- Thirty (30) provider reappointments
- Mercy Medical Center/MercyOne's credentialing decisions for sixteen (16) initial practitioners who are providing telemedicine services.
- Mercy Medical Center/MercyOne's credentialing decisions for thirty-five (35) reappointment practitioners who are providing telemedicine services.
- The Board of Trustees accepted four (4) provider resignations.

Physicians and Services Providers

- Robert Floyd, D.O., Chief of Staff
- Sarah Brewer, D.O.
- Trina Settles, D.O.
- Mary Graeff, M.D.
- Ronald Graeff, M.D.
- Donald Wirtanen, D.O.
- Beverly Oliver, ARNP
- Paige Helton, ARNP
- Megan Whisler, ARNP
- John DeLeeuw, D.O.
- Ryan Van Maanen, D.O.
- Phillip Ross Hurd, ARNP
- Joseph Jeremy Kruser, ARNP

Master Facilities Plan

The COVID pandemic continued to have an impact on small facility projects. The following areas have had some modifications, improvements, or remodeling in the fiscal year 2023:

- A portion of the south parking lot was repaired.
- Roof top units (RTU) numbers five and six were replaced.
- The north ambulance garage had a mini-split air conditioner unit installed.
- Medical Associated Clinic expanded. Four (4) exam rooms were created by converting provider offices to make exam rooms at the north end of the clinic area. Minor construction was done by DCHC staff for staff workspaces, hand washing, and other flow efficiencies.
- The air conditioner unit was replaced on the Senior Life Solutions building.

The overall Master Plan Project continued to be on hold through the first part of the fiscal year due to a volatile construction market. The Master Facilities Committee did resume discussions concerning moving forward with a master plan in February 2023. The committee also worked with financial consultants for debt capacity evaluations to determine the amount of debt the facility could take on for new or remodeled construction.

Strategic Planning

The Strategic Planning Council (SPC) began a three-year goal period (January 1, 2022–December 31, 2024). Each chapter reports progress towards goals during scheduled quarterly SPC meetings. Although many goals were achieved during the period, staff turnover and COVID-19 continued to impact the ability to have chapter meetings, make progress, and achieve the goals thus far. The following changes have been made to the new strategic planning period (January 1, 2022–December 31, 2024).

- The Strategic Planning Committee now consists of five (5) chapters:
  - Growth
  - Finance
  - Quality and safety
  - Employees
  - Patients

- Strategic planning will continue to incorporate the Community Health Needs Assessment (CHNA) goals that were developed. The CHNA goals are adapted into the different chapters of the strategic plan as necessary.
- Each chapter has established new goals for the new period.
- The committee is now using Microsoft Teams to track goals and the progress of tasks for each chapter.
- Efforts are ongoing to recruit DCHC staff to become active members of chapters.

Departments and Services

Acute Care

Acute Care provides extended recovery, observation, inpatient, and skilled services for our patients and is staffed by registered nurses, licensed practical nurses, and certified nurse's aides around the clock. The average daily census for acute (inpatient) and skilled patients for fiscal year 2023 (FY23) was 2.09 patients. This was comparable to the prior year, where the average daily census was 2.08. Observation days were down thirty-six percent compared to the year prior, with 227.5 patient days in FY23 compared to 356.6 in FY22.

Acute Care focused on fall prevention and medication processes, including the completion of medication histories and barcode scanning of medications at administration. Acute Care ended the fiscal year with six inpatient falls, or 6.33 falls per 1,000 patient days. This goal was not achieved and will continue to be monitored with interventions in fiscal year 2024. A medication history was completed on 95.25 percent of patients admitted; the goal for this measure was one hundred percent. While falling short, improvements were made to processes throughout the year and will continue to be monitored outside of the Quality Assurance Performance Improvement (QAPI) program, with feedback to staff provided as the need arises. Of all medications administered in acute care, eighty-six percent were scanned. Issues were identified with medications that would not scan; facilitation with Pharmacy and Cerner, the electronic health record, is ongoing to resolve these issues. The sustainability of improvements made to medication processes will be ensured by continuous monitoring and feedback from employees.

During fiscal year 2024, Acute Care will focus on ensuring nutritional assessments are completed thoroughly and accurately on all patients admitted, thus ensuring dietitian consultation when appropriate based on assessment findings. Nutrition plays a key role in ensuring overall health and improving healing. Prevention of falls and medication errors will also continue to be a focus.

Discussion and action towards improvement of urinary catheter processes was a focus area for Acute Care this year and continues as we move forward into the next fiscal year. An alternative to urinary catheters, called Purewicks, was added to the supplies available to staff to provide a less invasive device that keeps patients clean and dry while simultaneously reducing the risk of infection. Another focus area has been to improve the capture of advanced directive documents at this point of care.

Lippincott, a resource for nursing procedures and competencies, has been utilized throughout the year as a tool to assist in ensuring competent medical care is provided by staff.

Utilization Review/Discharge Planning

Davis County Hospital and Clinics admitted 133 patients to inpatient care, thirty-five patients to skilled care, and observation stays were equivalent to 227.5 days in fiscal year 2023. For each of those patients, the utilization review/discharge planning coordinator was involved in their care. Discharge planning begins upon admission to ensure that appropriate support is provided and aligned with the planned date and goals for discharge. In addition to evaluating and coordinating discharge needs, this service line monitors the appropriateness of admissions as outlined in the Millman Care Guidelines, and evidence-based application for level of care decisions, with input from members of medical staff.

An evaluation of whether the services provided meet the needs of the patient is the readmission rate. The fiscal year-end hospital all-cause readmission rate was 3.38 percent, just over the 3.22 percent goal, with five patients being readmitted within thirty days of discharge. The average inpatient length of stay for FY23 was 2.69 days.

In fiscal year 2024, this service line will continue to monitor and evaluate readmissions, length of stay, and compliance with scheduling a follow-up appointment prior to discharge.

Allergy and Pulmonology

Allergy and pulmonology services are provided by a full-time advanced registered nurse practitioner (ARNP) and a part-time allergist/pulmonologist. Dr. Ron Graeff reduced his hours beginning in May 2023 in plans for his upcoming retirement. The addition of an ARNP was pursued to sustain the service to the community. The clinic provides allergy testing and prevention services, as well as pulmonary assessment and follow-up.

Volumes for the allergy clinic have increased slightly from FY22 to FY23, as noted below:

Specialty Clinic	FY20	FY21	FY22	FY23	Change from FY22 to FY23
Allergy/Pulmonology (R. Graeff)	1877	1768	1944	1957	13

In the allergy and pulmonary clinic, quality improvement focused on medication processes. Increasing barcode (scanning) medication administration rates and reviewing patients' home medications (medication history completion) were the two areas measured. Medication safety was a focus throughout the facility over the past fiscal year due to reported near-miss errors or medication errors. Utilizing safety tools such as barcode medication administration decreases the risk of incorrect medication, or an incorrect dose being administered. The allergy/pulmonology clinic did an exceptionally good job of scanning medications, exceeding the goal.

The second measure involved a review of medications by nursing staff (medication history). In the allergy/pulmonology clinic, there was a gap in completing a review of home medications for each visit related to allergy injections. In Dr. Graeff's clinic, medication history began at seventy-nine percent completion and saw a steady increase throughout the fiscal year. There was a drop in compliance in May when there was the addition of a new provider to the allergy clinic. After education, medication history was completed in nearly every encounter, which increased the overall safety practices in this area. Both will continue to be monitored, with feedback provided as needed to ensure the improvements are sustained.

In fiscal year 2024, multiple areas - including the allergy and pulmonary clinics - will focus on the creation of standard work for processes that occur within the department. The goal was set to create four standard work documents per month, focusing on high-risk and/or high-volume procedures performed in the department as well

as problem-prone areas. This goal was chosen due to a new provider in the clinic as well as the plan to add additional staff to the clinic. Standard work benefits include reducing waste, establishing predictability and consistency in the care provided, and aiding in preventing error.

Staff maintain Basic Life Support (BLS) certification. Providers attended conferences by AAAAI (American Academy of Allergy, Asthma, and Immunology).

Biomedical

The Biomedical improvement process focused on the total pieces of equipment that were unable to be located for preventative maintenance (PM) service. For the fiscal year, Renovo, who is contracted for biomedical needs, performed PMs on 436 pieces of equipment, with 432 located during the month they were due.

In August 2022, two monitors that were due for PM could not be found. The following month they were located, and preventative maintenance was performed. In October 2022, there were two items unable to be located for preventative maintenance. These were subsequently found, taken out of service, and in December the appropriate PM was performed before placing them back in use. Equipment maintenance completion will continue to be a focus for biomedical services in the next fiscal year.

Cardio-Pulmonary

For the fiscal year 22-23, the cardio-pulmonary department focused on improving the notification process when respiratory equipment was used in the emergency department or acute care. This is important so that the Cardio-Pulmonary Department can ensure the machines are ready for the next use, preventing delays in care, preventing errors, and overall improving outcomes for patients needing this equipment. The goal was one hundred percent compliance. Improvements were seen early in the year as nursing and emergency providers helped to achieve the goal.

For cardiac and pulmonary rehabilitation, compliance with the completion of recommended pulmonary rehabilitation sessions was monitored, with improvement measures implemented to improve patient outcomes. A second focus area was compliance with a one-on-one meeting with a dietitian during the program and implementing improvement measures if determined necessary. This study alerted staff to the importance of encouraging cardiac and pulmonary patients to finish their sessions and to make time to meet with the dietitian. Cardiac rehab volumes are up 18.9 percent compared to FY22. Pulmonary rehab is eighty-six percent busier than last fiscal year.

Sleep study patients were analyzed to determine if the availability of our sleep services was meeting the needs of our patients. Days from the time that the order was given to SomniTech, the contracted service utilized to perform this service, to the time the sleep study was performed were measured. Since DCHC contracts in-lab sleep studies with SomniTech, there is little control over this timeframe. Clinic nurses were asked to inform patients that they would receive a phone call from SomniTech, which is an out-of-area phone number, so that the patient would be more likely to answer and get their appointment scheduled sooner. This has helped with timeliness in scheduling. In-lab sleep testing is up by twenty-six percent compared to last year.

Home sleep test patients are given a satisfaction survey at the time of their test, which shows a ninety-eight percent satisfaction rate. Home sleep procedures are down 42.2 percent compared to FY22.

Stress test patients are given a satisfaction survey after their test. A satisfaction mailbox was installed on the wall, where patients anonymously provided feedback as to how their test went. Stress tests are down thirty-one percent from last year, as in the first quarter we experienced staffing challenges and new staff had to be trained to perform stress tests.

The fiscal year 2023-2024 quality plan for cardio-pulmonary is incorporating the use of incentive spirometry for swing bed patients, as it has been effective in reducing the risk of lung infections in hospitalized patients, (especially in the post-surgical setting) keeping the alveoli healthy in patients with chronic lung disease and breaking up mucus buildup. By utilizing an incentive spirometer in our skilled population (in combination with ambulation) the risk of hospital-acquired complications such as pneumonia will be decreased. The goal is for one hundred percent of skilled patients to have an incentive spirometer initiated within forty-eight hours of admission.

In cardiac and pulmonary rehabilitation, a six-minute walk test is a tool for assessing exercise tolerance. Both populations undergo a six-minute walk test prior to initiating rehab as well as upon completion of the program to assess improvement in exercise tolerance. Cardiac rehab and pulmonary rehab will be comparing pre- and post-results to determine if improvements are needed to the program to improve patient outcomes. The goal is that at least ninety percent of patients completing the entire program show an improvement of forty-five meters, or 147 feet, in distance walked during the six-minute walk test (pre-vs. post-program). The second goal is that at least ninety percent of patients completing the entire program show an improvement in maintaining their oxygen saturation, staying above ninety percent for the entirety of the six-minute walk test.

SomniTech has a quality goal: to create cohesiveness between partnered facilities and the contracted sleep services to develop and maintain effective organization-wide performance improvement. They will measure and track quality indicators that enable them to assess processes of care, service, and operation. This will include ongoing monitoring of client/patient grievances and satisfaction, the function of the sleep equipment, turnaround times, scoring reliability, clinical competency, and a review of patient records.

Home sleep study patients will be surveyed related to the ease of making their appointment, friendliness of staff, wait time from arrival until the technician comes, demonstration comprehension, and rating their experience with the visit overall. This questionnaire is an effective way for cardio-pulmonary staff to know how to improve.

Responsibilities of cardiopulmonary also include completion of nuclear stress tests, stress echocardiograms, and treadmill tracings. Patients with stress tests will continue to be surveyed for their satisfaction with the accommodation provided, friendliness of staff, effectiveness of education provided, privacy, communication of results, and their overall experience with the visit.

Education

The employee education department measured the percentage of new hires completing assigned education in CareLearning, the annual education requirement system used, within the first ninety days of employment. It is important to ensure that new employees have the required training. A process for reminders for completion was established within an electronic tool utilized at the facility. Those reminders are sent to the employee, their supervisor, and the education coordinator at intervals leading up to the ninety-day completion deadline. Additional contact is made two weeks before the deadline. The goal was achieved and sustained within three months of initiating this new process.

Education also measured the percentage of employees completing annual education assignments through CareLearning within the specified timeframe. It is important to ensure that employees obtain the required ongoing training. A reminder process for employees was implemented utilizing the same system described prior. Supervisors were included in communication as the deadline for education approached. One hundred percent of employees had completed the assigned classes in CareLearning by the deadline of December 15. Improvements will be sustained through continued refinement of the process. Quarterly reminders of staff progress with education assignments will be sent to supervisors to allow timely review of progress.

Monthly lunch and learn training sessions were reinstated after a hiatus related to COVID-19. Topics have included sepsis, differentiating respiratory versus cardiac conditions, and advanced directives.

Lippincott Professional Development collection and Lippincott Advisor were made available to staff. These are resources for nursing to stay up to date with evidence-based practices and gain access to nursing education. Prior to this, Lippincott Procedures was available as a resource for up-to-date evidence-based practice for nursing procedures.

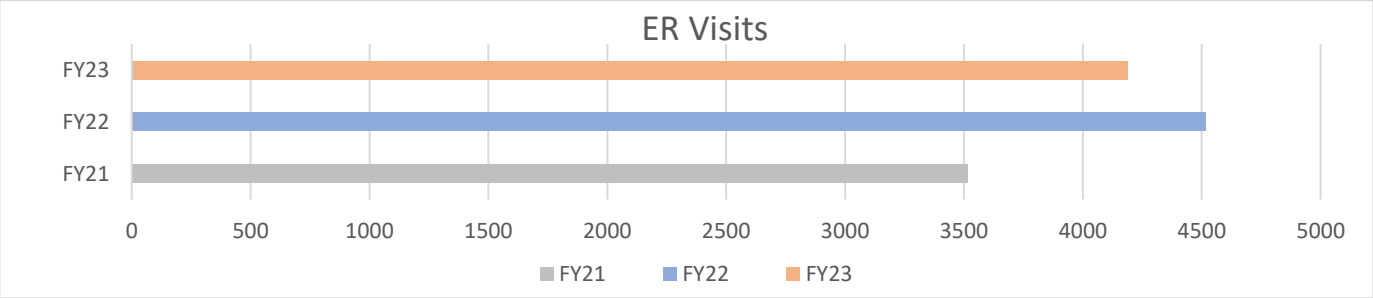
Competencies and trainings during fiscal year 2023 included:

- Increased use of Lippincott for evaluation and competencies
- The Shared Governance Committee is working to develop an orientation procedure and evaluation.
- Two new instructors were certified to teach Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS) classes.
- The University of Iowa Mobile Simulation Lab was here for training on two occasions.
- The Iowa Donor Network provided training on organ donation.

Emergency Department

The Emergency Department (ED) is available twenty-four hours a day, seven days a week, to provide medical screening examinations and necessary treatment to patients presenting. This department is staffed by mid-level providers and physicians, registered nurses, and emergency medical staff.

Volumes were slightly down for the year compared to fiscal year 2022 but remain higher than fiscal year 2021 and previous years.



Quality improvement studies focused on electrocardiogram (EKG) times (one hundred percent of patients with eligible chest pain will have an EKG within ten minutes of arrival) and arrival-to-head computed tomography (CT) read times (one hundred percent of patients suffering from acute stroke symptoms will have a door-to-CT read time of forty-five minutes or less). Both quality improvement projects were aimed at ensuring timely care for time-sensitive diagnoses. The outcome for the set goals was 83.5 percent of patients presenting to the emergency department with chest pain receiving an EKG within ten minutes. All fallouts were communicated to the

department manager and/or staff involved for review. The door-to-CT read goal was achieved on seven out of ten qualifying patients, excluding those whose symptom onset was greater than two hours prior to arrival at the emergency department. One fallout was due to the need to stabilize the patient prior to the CT scan being performed. Both measures will continue to be reported to the MercyOne network and reviewed monthly.

Another focus area was improvement in barcode administration of medications, with a goal of ninety percent or more of medications scanned. This project was focused on all clinical areas administering point-of-care medications through Cerner. The fiscal year started with seventy percent compliance in July and sixty percent compliance in August. Staff were distributed individual achievements on barcode scanning monthly, and it was discovered that there were issues with frequently used medications in the Emergency Department scanning appropriately. A work request with our electronic health record was placed for resolution of this issue and is still pending. To reflect compliance more accurately with scanning medications, doses of the medications known not to scan were removed from the numerator and denominator beginning in December. From there, the goal was met in six of the seven remaining months. To ensure there is no drift in practice, compliance reports will continue to be run, with feedback given to staff as issues are seen.

During the year, an issue was found with pending results going to the queue monitored by nursing staff. This queue allows the Emergency Department to ensure that all results are followed up on and communicated to patients. This issue was brought to the attention of the Information Technology (IT) department, and a resolution was promptly facilitated between IT and Cerner.

The quality focus for the ED in FY24 is sepsis, ensuring that eighty percent of patients meeting criteria for sepsis meet the three-hour sepsis bundle measure. This was identified as an opportunity for improvement through ongoing monitoring of quality and safety issues conducted at the facility.

eAvel Behavioral Health Services

eAvel provides twenty-four-hour coverage for our emergency department via telemedicine for behavioral health assessments as needed. In fiscal year 2023, forty-six video encounters for full assessment and evaluation, two condensed assessments, three consultations, and one contact to aid with placement were made. Twenty-six of the patients evaluated were under the age of eighteen.

In November 2022, this service was expanded from nurse-only coverage to assessments being conducted by psychiatric providers. The top five diagnoses listed as reasons for visit are: signs and symptoms involving the emotional state; conduct disorder; anxiety disorder; depressive disorder; and schizophrenia. This information is provided by eAvel and reported monthly at the Quality Committee meeting.

eAvel Emergency Department Telemedicine

eAvel Telemedicine in the Emergency Department provides access to Certified Emergency Nurses and Board-Certified Emergency Room physicians twenty-four hours per day. This service was utilized 182 times during the fiscal year, including 178 phone consultations and fifty-four video encounters.

Quality measures reported by eAvel for this service include median time to encounter, median time to EKG, acute myocardial infarction (AMI) fibrinolysis compliance, AMI median time to fibrinolysis, and intubation success rate on first pass and subsequent passes for those patients whom the service is utilized on. These measures are reported to the Quality Committee monthly.

Docs Emergency Medicine

Docs Emergency Medicine provides adjunct provider coverage in our Emergency Department, filling needs not staffed by employed providers, primarily night shift and weekends. Every month, the Emergency Department Medical Director reviews at least ten percent of charts for mid-levels employed by Docs Emergency Medicine, and feedback is supplied as called for. This process is ongoing.

Additionally, in fiscal year 2024, the performance improvement focus for Docs Emergency Medicine providers will be to activate tele-medicine services on camera for seventy-five percent or more transfers from the Emergency Department. A physician must authorize transfers from the Emergency Department, and video assessment versus phone consultation is preferred.

Trauma

Throughout the fiscal year 2023, the ED studied time to definitive care for trauma patients. There is a concept in trauma care called 'the golden hour' suggesting that critically injured patients receive definitive treatment in sixty minutes. With the rural location of DCHC, the goal was set at three hours, leaving adequate time for transport to a Level one trauma center. The goal was met in twenty-five of thirty-six patients. Bed availability in the state and staffing challenges contributed to falling short of the goal. By monitoring this, it provided opportunities to evaluate where delays were and if there were opportunities for improvement in transferring patients to definitive care more quickly. This study does not account for patients who were triaged and transferred to a trauma center from the scene of an accident.

An additional aim for improvement related to the trauma program was the documentation of height and weight for all trauma patients. Improvements were made throughout the year, falling out on eight of thirty-nine patients. With each fallout, communication was sent to staff members involved in the care. Overall, the goal was ninety percent compliance, and the outcome was eighty percent. This will continue to be monitored through the trauma program.

During fiscal year 2024, Trauma Services is monitoring the performance improvement audit filters outlined in the Trauma Performance Improvement Patient Safety (PIPS) plan and will adjust practices as needed throughout the year to ensure high-quality trauma care is delivered. These audit filters include ED provider response times, arrival to definitive care, measurement of blood alcohol, transfers, diversions, and deaths; for pediatric patients, whether telemedicine was utilized and how many attempts were made to obtain intravenous access were also included in the audit.

Emergency Medical Services (Ambulance)

Emergency Medical Services (EMS) provides 911 coverage for Davis County as well as transfers to tertiary care. This department also provides public safety and public education, including Basic Life Support (BLS) instruction, to community organizations.

EMS dispatched 788 calls in FY23, compared to 893 the prior year. Call volumes are difficult to predict, but with some variation, the average is typically 800.

The quality focus in FY23 aimed at ensuring staffing challenges within the department were not having a negative impact on the community we serve. The goals were that one hundred percent of EMS transfers left the Emergency Department within sixty minutes of calling to report to the receiving facility on transfers, and one hundred percent of second crew dispatches were enroute within twenty minutes. For transfers, the average was

eighty-four percent leaving within sixty minutes, with improvements made as staffing challenges were resolved. Trends identified when the goal was not met later in the year include weekend and second crew transfer needs. Second crew dispatched within twenty minutes was achieved 95.5 percent of the time on average for the fiscal year, and second crew calls averaged four per month.

EMS transfers and second-out dispatches are very dependent on staffing. To ensure sustained improvement, retaining staff should be our highest priority. EMT and paramedics are very sought after in the job market, and it is important that we stay competitive. Current staffing will enable better coverage for both transfers and second-out calls. The discussion of changing on-call to a transfer-on-call may be a nice compromise. Further evaluation and planning are ongoing.

Additional improvements made during the fiscal year include improvements to the call sheet utilized in finding coverage when needed, making it easier for staff other than EMS to assist in obtaining the needed resources. An EMT was also brought in-house overnight to increase the coverage and safety of staff in the emergency department. EMS updated the monthly quality assurance and equipment maintenance program for more successful completion. DCHC also actively participated in the EMT internship program to increase the number of trained staff in our region and grow interest in the EMS career field.

Peer reviews were completed on one hundred percent of EMS calls. Ten percent of those are sent to the medical director for review, including all ACLS II calls, including codes, trauma alerts, and intubations, as well as all those determined to be deceased upon arrival.

Education and competencies performed include ACLS, PALS, and Neonatal Resuscitation Protocol (NRP) completed by paramedic staff, and BLS as needed by all staff. The University of Iowa Health Care Mobile Simulation Lab came to the facility three times and gave scenarios in trauma, pediatrics, and medical to EMS, emergency, and acute staff. Skills maintenance was completed for needle decompression, needle cricothyrotomy, intubation, and placement of intravenous catheters. Additional competencies have been started using Lippincott procedures.

The quality plan for EMS in FY24 is to focus on pre-hospital EKG completion within ten minutes for all chest pain complaints. The goal is ninety percent compliance, as early recognition, and transport decisions for ST segment-elevation myocardial infarctions (STEMIs) have been associated with better patient outcomes.

Health Information Management

Health Information Management (HIM) is responsible for the coding of charts, scanning records, record retrieval and release of information, chart deficiency management, forms, collection, and coordination of shredding protected health information, purging of records, and reporting of information to multiple external sources. Patient visits at Davis County Hospital and Clinics totaled 43,113 for the fiscal year. Over 150,000 pages of records were scanned into the electronic health record.

The quality focus for fiscal year 2023 involved GF modifiers, which are required on all mid-level evaluation and management lines in coding of records. During the second quarter, there were five accounts out of 115 that did not populate. For the third quarter, there were three. With support from our electronic health record vendor, the workflow was changed, and in the fourth quarter there was only one account that did not populate, but after researching, it was decided to be a coder error. It looks as if this process has been corrected but will continue to be reviewed outside of quality for the proper population of the modifier.

Also focused on early in the year were signature deficiencies. This was initiated and completed within three months due to new employees not allowing ample time for them to complete the scanning before checking for deficiencies. Once staff got through their probationary period and became more familiar with their duties, and the deficiency clerk allowed more time before checking for deficiencies, the failed records became null.

Improvement activities completed during the fiscal year include:

- Improved the workflow process for scheduling future orders.
- Improved process for off-site visits to ensure that the notes reflect the proper place of service and that the charging is correct.
- Improved process for charging and processing of Iovera injections, which are utilized prior to total joint replacements.
- Initiated weekly coder meetings to go over the Discharged Not Final Billed report and accounts, and review denied accounts for potential rebill opportunities.
- Initiated monthly meetings with each staff member to explore any issues or needs for assistance.
- Initiated bi-weekly meetings with the HIM supervisor to discuss topics of interest, audit results, problem accounts, staffing issues, and anything else that may pertain to the revenue cycle.
- Incorporated into the new-hire orientation is the proper way to correct an error.
- Educated all staff in the proper way to correct an error in the record, the importance of never using whiteout, what it means to be court-ready, and the business record exception concept.

Competencies and trainings attended by HIM staff include:

- Proper assignment of Modifier 25, an evaluation and management code utilized by hospital coders.
- Fracture care
- Eide Bailly Day of Education for Coders
    - Anesthesia coding education
    - Drug and blood administration
    - ED and observation
    - Inpatient and Swing Bed
    - Surgical Services
    - Therapy
- Staff attended the State IaHIMA Annual Meeting with coders.
- The coder and manager attended the Fall Hometown Health Conference.
- The manager attended the Spring Hometown Health Conference.
- Staff attended the monthly virtual Trinity Health Coding and Billing Roundtable education opportunities.
- Staff attended monthly virtual Hometown Health Medicare updates.
- The manager attended quarterly virtual Hometown Health Rural Health Care meetings.
- Staff attended the quarterly virtual Hometown Health Iowa Revenue Cycle series.
- Staff attended quarterly virtual hometown health coding updates.
- Education was completed on the new Current Procedural Terminology (CPT) codes that took effect January 1, 2023

For the fiscal year 2024, the focus will be on improving the process for placing admission and discharge orders on inpatients. Admission and discharge order accuracy impacts length of stay reports, coding, billing, and patients' fiscal responsibility to the organization. Accuracy in orders is important to the transition of care, avoids waste in the revenue cycle, and ensures billing is correct.

Infection Prevention:

The Infection Prevention Department monitored the following, with no reported incidents:

- Hospital-acquired infections
- Catheter-associated urinary tract infections
- Surgical site infections
- Central line-associated blood stream infections

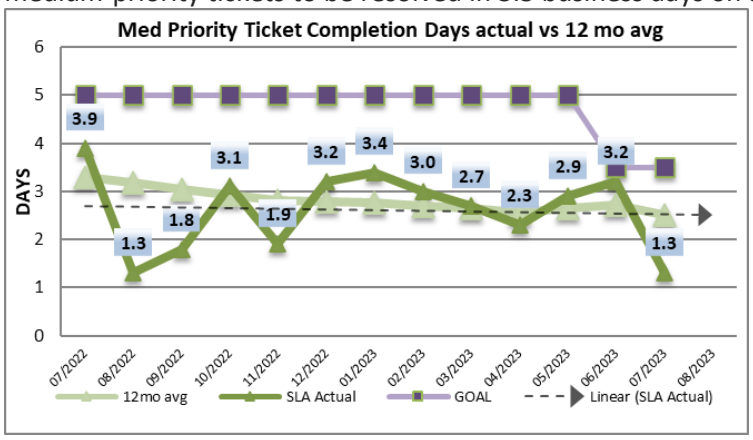
Infection Prevention also monitored employee hand hygiene to ensure that precautions were taken to prevent the spread of pathogens and urinary catheter utilization for appropriate indications for use. Using monthly hand-hygiene surveillance, staff were observed to have ninety-seven percent compliance with performing appropriate hand hygiene at key points of care. Urinary catheter documentation was closely examined, revealing a lack of supporting evidence for catheter use in approximately half of Foley catheters inserted. The infection prevention nurse transitioned catheter surveillance from monthly to daily and began attending daily patient rounding allowing conversations with providers and nurses about catheter use throughout the hospital stay. A workgroup was developed to assess catheter use and ways to improve compliance.

Information Technology/Security

In FY23, Information Technology (IT) set out to identify and reduce sensitive data exposure by abating the amount of sensitive, confidential data that is archived or stale that is stored outside the EHR. Properly classifying and reducing the amount of unneeded confidential information stored on systems is critical to maintaining and improving the commitment to protecting patients' privacy and personal information safety. The goal was to achieve an overall reduction in the exposure of sensitive data by greater than thirty percent as measured using a data classifier utility.

After the twelve-month goal measurement period, the data reduction project fell short of the objective set. Work continues to assist staff and folder owners with locating files and sifting through false positives, along with deleting and purging old files. A full re-index was performed on Exchange and File Server/Sharepoint data. By the end of the goal period, an overall twelve percent reduction was realized from the May baseline scan. Much was out of the control of IT on this goal, but awareness was significantly improved on sensitive data storage and IT will continue to work towards data classification efforts. Information Technology remains committed to sustained usage and monitoring of the data classification tool and is working to build a key performance indicator (KPI) into the department dashboard for organization awareness and education among staff.

Looking forward to FY24, Information Technology has set a goal to improve average completion times of medium-priority support ticket service level agreements (SLAs) with the organization. The goal established was for medium-priority tickets to be resolved in 3.5 business days on average each month.



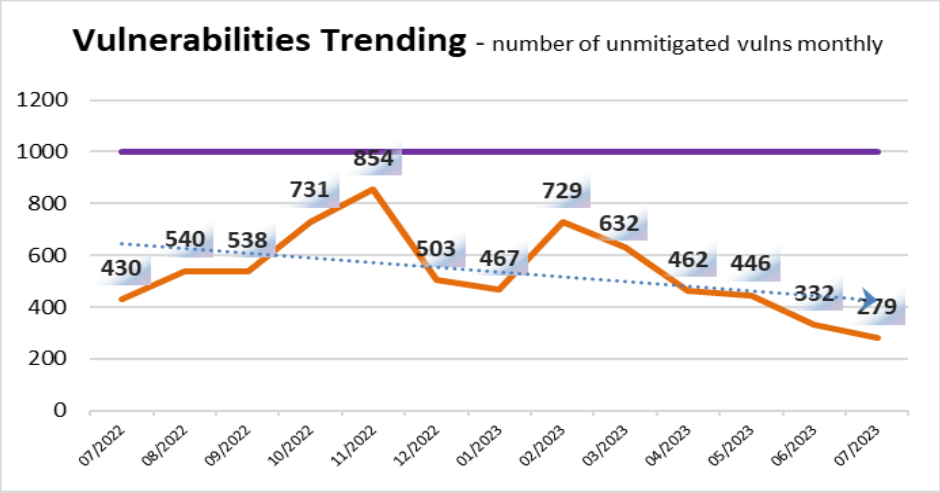
Great technology support is essential for hospital clinicians and staff as it can help them deliver better patient care, improve communication and collaboration, and enhance their workflows. Benefits of improving support service level agreements for nurses and physicians include:

- Better patient care: Great technology support provides nurses and providers with access to reliable and secure devices such as tablets and laptops, which helps them access patient electronic health records, diagnostic lab results, predictive analytics, and patient monitoring. These devices can improve the quality and safety of patient care by reducing errors, enhancing diagnosis, personalizing treatment, and increasing patient engagement.
- Improved communication and collaboration: Great technology support can enable nurses and providers to communicate and collaborate more effectively with each other and with other healthcare professionals. For example, great IT support can facilitate higher adoption of EHR, which can allow nurses and providers to consult with specialists, provide continuity of care, and expand their reach to underserved areas.

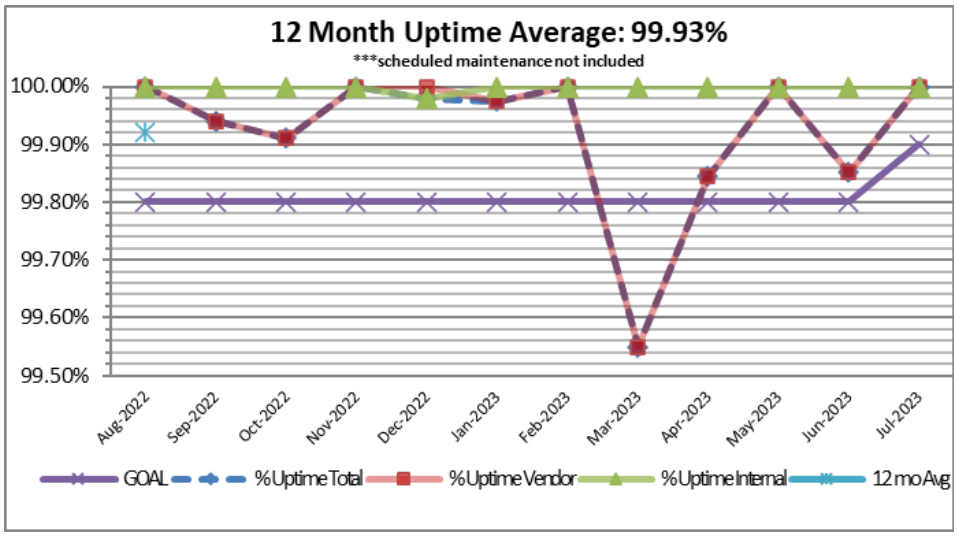
- Enhanced workflows: Great technology support can streamline the workflows of nurses and providers by automating tasks, reducing paperwork, and increasing efficiency. For example, high uptimes and prompt resolution to technology issues can provide nurses and providers with high-functioning barcode scanners, computing devices, voice assistants, and artificial intelligence tools that can help them scan medications, track inventory, document care, and perform clinical decision support, further increasing patient safety and improving clinical outcomes.

Davis County Hospital & Clinics invests in information technology systems and software for the betterment of patients. Specific technology investments and efforts in FY23 include:

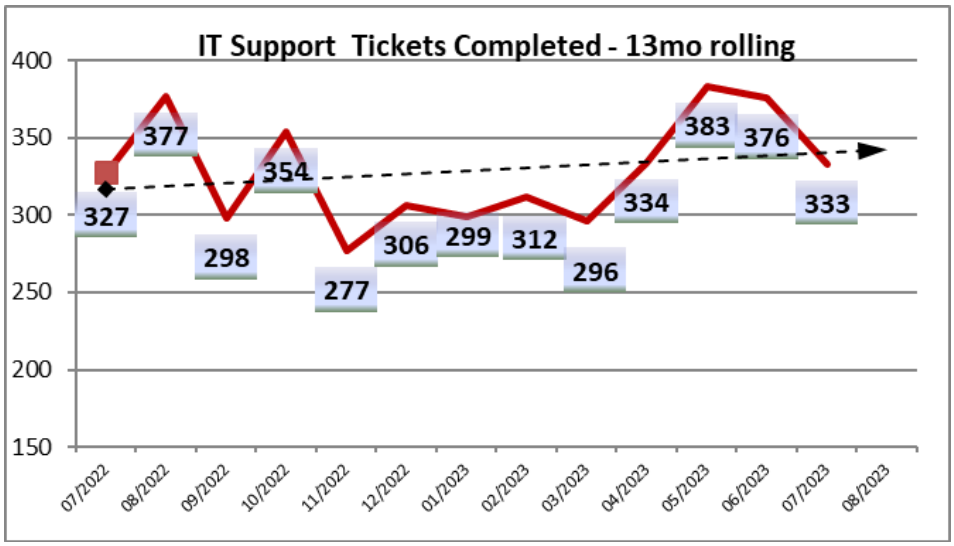
- Sixty-one percent reduction in software and hardware security vulnerabilities via concentrated efforts in patching and vulnerability analysis and mitigation. Security vulnerabilities are trending positively downward compared to the prior year.



- Achieved a twelve-month average system uptime of 99.93 percent. The organization worked through a couple rare vendor downtime events while holding internal system uptime incredibly high. This has remained flat compared to the previous year.



- Completion of 3,939 support tickets as measured via the organization's ServiceDeskPlus Tracking tool. Ticket volumes continue to trend slightly higher.



- Successfully attestation to another calendar year of EHR usage in support of the Centers for Medicare and Medicaid Services (CMS) Promoting Interoperability program with a score of eighty-nine Merit-based Incentive Payment (MIPS) points, with a score of sixty being the minimum to qualify.
- Performed an initial Safety Assurance Factors for EHR Resilience (SAFER) Guides measure assessment and shared results with stakeholders, EHR superusers, and EHR vendor leadership to impact the potential safe use of EHR change.
- Performed an annual IT security risk assessment using a third-party cybersecurity vendor, FRSecure. While improvement gaps remain, results were favorable and above average as compared to healthcare facility peers.

- In support of the IT risk assessment results, several additional IT security controls were implemented, further enhancing patient information security and the reliability and availability of systems to increase patient safety and continuity of care.
- Completed sixty desktop and laptop hardware replacements for organization staff to ensure technology currency, efficiency, and security of protected health information.
- Implemented improved vaccine temperature monitoring equipment for public health.
- Upgraded or revised prescription drug monitoring gateway components are built into the Cerner EHR.
- Refreshed multiple network switches and routers with new, state-of-the-art enterprise network equipment.
- Upgraded to Cerner ePayments Plus, modernizing the ability to take credit card payments for patient convenience along with enhanced security.
- Added additional badge/gate access security controls to multiple areas of the facility.
- Implemented an automated syndromic surveillance system via an EHR interface for CDC-regulated reporting requirements.
- Performed a Multiview Financials system upgrade to version twenty-two.
- Implemented a new IT support ticketing system for improved tracking and prompt resolution of operational support issues.
- Performed several Windows Server operating system upgrades for currency and the security of protected health information.

Interpretation Services

Language Line is the service utilized to provide translation for patients who speak languages other than English. This service was utilized 176 times in fiscal year 2023, with one hundred percent of utilization contributing to a Spanish-speaking population.

Davis County Hospital and Clinics will continue to utilize this service in the upcoming year and report utilization and trends to the Quality Committee.

General Laboratory & Microbiology

Laboratory services are readily available to meet both inpatient and outpatient needs. The laboratory is open twenty-four hours a day, seven days a week. Outpatient testing is available from 7:00 a.m. to 5:00 p.m. Services offered include hematology, chemistry, microbiology, blood bank and transfusion services, blood gases, coagulation, urinalysis, serology, viral polymerase chain reaction (PCR) testing, therapeutic drug monitoring, drug screen collections, and pathology services. Chain of Custody drug screen collections are available by appointment only Monday through Friday. Testing that is not performed in-house is sent to our reference laboratory in Des Moines daily.

The laboratory performs in-house urine, throat, wound, blood, eye, ear, sputum, and nasal cultures, as well as Methicillin-Resistant Staphylococcus Aureus (MRSA) screening. Cultures include gram stains if needed and identification if necessary. Susceptibilities are performed if applicable. Body fluid, stool, fungal, and other cultures are sent to a reference lab for work-up.

The volume of services performed was slightly down, showing an overall decrease in procedures of five percent compared to last fiscal year. Microbiology procedures were also slightly down at 4.3 percent.

The laboratory tracked rejected specimens through the year to see if there were any concerns regarding sample integrity, either due to the collection of samples or the proper handling of samples. Overall, for the year, there were a total of sixty-seven specimens that were rejected and required recollection out of 60,050, for a rejection percent of 0.11 percent. No concerns or trends resulting in sample rejection were found. The lab continues to monitor rejected specimens each month as part of their quality assurance plan.

Microbiology monitored the turnaround times on microcultures (excluding blood cultures) to ensure cultures were turned out within ninety-six hours of collection. Outcomes were that ninety-nine percent of our cultures we perform in house were being reported in ninety-six hours or less. No concerns were found from monitoring this throughout the year.

Each month, as part of the Laboratory Quality Assurance Plan, the department completes a quality assurance audit throughout the entire department and testing process, including pre-analytical, analytical, and post-analytical. This serves to improve the reliability, efficiency, and quality of laboratory operations through ongoing monitoring that identifies, evaluates, and resolves problems. This is an ongoing review process that encompasses all areas of the laboratory's technical and non-technical functions. Audits are rotated throughout all staff to be completed, then reviewed by the laboratory manager and medical director.

Outside of projects reported to the Quality Committee, adjustments in processes and workflows are made as needed based on incident reports, quality audit findings, written order audits, etc. The frequency and number of written order audits were changed due to multiple findings in the audits that were reviewed. Previously, twenty percent of written orders were reviewed monthly. Now all written orders are reviewed on a weekly basis, thus enabling the lab to correct findings right away.

It was found that the laboratory department was struggling to maintain adequate levels of supplies. Previously, inventory was manually counted or checked once a month by one or two staff members. If they did not have time due to being busy with patient testing, it was not completed. The inventory system was redone, establishing a quick way for all staff to notice when supplies were at their reorder point and initiate that order to be placed right away. There are inventory audits to review the effectiveness of the system. Each member of staff has a department they are responsible for auditing. Audits involve making sure order cards are being pulled correctly at the correct par levels, orders are being returned upon the arrival of supplies, all supplies are labeled properly and with a received date, items are being rotated appropriately when new stock arrives, backorder supply concerns, and making sure all expired supplies are being disposed of timely and communicating this to the entire team.

Chart reviews and written order audits are performed monthly as part of the lab's quality assurance. All written orders that are entered into the EHR by laboratory staff are reviewed for completeness and accuracy. Any discrepancies found between what is on the order and what was entered into the EHR are investigated and corrected. All instances are discussed with the department, and if any trends are identified, additional steps are taken to improve.

The laboratory has added a cystatin-c assay, a test that helps evaluate kidney function and improve accuracy on estimated glomerular filtration rate (eGFR) measurements. The laboratory also moved brain natriuretic peptide (BNP) testing from the Triage analyzer to the Access 2 Chemistry analyzer. This improved the accuracy and turnaround time on the BNP assay, allowing us to get results to providers quickly.

New staff perform training upon starting. They complete competencies in all areas within six months of completing training and then again in one year. After the two initial competencies, all testing staff complete annual competencies in all areas of testing. Any new instrumentation that is brought in has training documented.

Laboratory staff also maintain a strict proficiency testing program, which serves as an external check to verify the accuracy of the laboratory's results by providing specimens with unknown values. The values obtained by the laboratory are then compared against peer group results and expected results. A determination is then made as to the accuracy of the results submitted.

The laboratory conducted a Clinical Laboratory Improvement Amendments (CLIA) survey in January. CLIA regulates facilities that test human specimens for health assessment or to diagnose, prevent, or treat disease. Overall, the findings were good. The laboratory received three standard-level deficiencies, all of which were addressed and corrected immediately. As a result of those findings, additional monthly checks have been added to the monthly quality assurance audit.

Blood Bank

The lab performs blood type and Rh factor testing, antibody screening, crossmatch (if the antibody screen is negative), and direct antiglobulin testing onsite. The lab maintains a stock of Rhogam, packed red blood cells, and plasma units that are provided to us by LifeServe Blood Center. Platelet units are ordered on an as-needed basis from LifeServe. Any positive antibody screens are sent to LifeServe for identification and cross-matching of units. Comparative statistics show an overall decrease in transfusion services performed in FY23 compared to the prior year.

LifeServe, our blood product supplier, reports a quarterly excellence report that includes suspected transfusion-related lung injury cases (patient safety), any new guidance implemented, product recalls or market withdrawals (regulatory compliance), and fill rate (product availability).

Internally, the laboratory looked at transfusion criteria and evaluated each case based on whether the patients met transfusion criteria. Overall, for FY23, ninety-five percent of patients transfused met transfusion criteria, with three patients that did not meet transfusion criteria based on the limited information that was available to us. These three patients were sent for transfusions from another facility.

In FY24, LifeServe will continue to provide a quarterly Quality Excellence Report. Internally, the lab will continue to audit each month to make sure that all quality control and maintenance are performed and acceptable. Lab also completes a monthly Blood Bank Quality Report that includes statistics of all procedures performed, product utilization, transfusion criteria and crossmatch-transfusion ratio (CTR).

New equipment added to the laboratory for blood bank purposes included a new freezer for plasma units. This new freezer is specifically designed for transfusion products and includes an audible temperature alarm as well as an electronically monitored alarm that will notify you via email and text messaging if the temperature is nearing the upper temperature limit. A plasma unit thawing system was also purchased. This system decreases the time to thaw units by more than half. This was previously done manually and took approximately an hour. It was difficult to maintain a controlled temperature for the thawing. With the new thawing system, the temperature is controlled, and our time for thawing units is approximately twenty minutes.

The competency and proficiency of new staff are ensured by completing competencies in all areas within six months of completing training and then again in one year. After the two initial competencies, all testing staff complete annual competencies in all areas of testing. Any new instrumentation that is brought in has training documented.

Laboratory staff also maintain a strict proficiency testing program, which serves as an external check to verify the accuracy of the laboratory's results by providing specimens with unknown values. The values obtained by the laboratory are then compared against peer group results and expected results. A determination is then made as to the accuracy of the results submitted.

Pathology

Pathology collection supplies are maintained at the DCHC Laboratory. All pathology specimens are sent to our reference lab, and testing is performed by Pathology Associates of Central Iowa in Des Moines. There was a seven percent increase in pathology cases from last year to this year.

Each month, Pathology Associates of Central Iowa monitors the turn-around times (TAT) for pathology cases and reports to DCHC. The goal for TAT on pathology cases is ninety-two percent reported in seventy-two hours or less. In addition to the monthly TAT report, Pathology Associates of Central Iowa completes a quarterly peer review of at least ten percent of cases and reports to DCHC. For FY23, they met their goal overall on turnaround time, with 96.8 percent of pathology cases being reported in seventy-two hours or less. For the quarterly peer reviews that were conducted, a total of sixty-six cases were reviewed. The signing pathologist and reviewing pathologist agreed one hundred percent of the time.

The plan for FY24 is to incorporate the monthly report from Pathology Associates of Central Iowa into the Quality Committee.

Laundry

Denman Linen Service is utilized for the laundering needs at Davis County Hospital and Clinics. During FY24, the quality assurance report provided by this contracted service will be incorporated into the QAPI program. Monitoring of reject percentages due to quality of linens received, cleanliness of linens, client satisfaction, and complaints are all pertinent to the services provided to DCHC by Denman.

Materials Management

Materials Management had two quality improvement projects this year. The first measured the number of supplies taken from the storeroom after hours. This assisted in ensuring the supplies needed to care for patients were readily available and there would be no delays in patient care. The number of supplies checked out would be less than ten items retrieved after hours each month. Supplies retrieved varied from one to ten monthly, with an average of 4.8 overall for the year. Materials will continue to monitor the clipboard, where staff write down what is taken from the storeroom and adjust stock in applicable departments as necessary.

Materials Management's second quality improvement project involved going through the supplies in the electronic systems to make sure there were no errors. Multiview, one of those systems, is where most time is spent making supplies, especially cost changes. Every night, Multiview uploads any changes made to Cerner. It was noticed that there were unit of measure and pricing discrepancies found in Cerner. This can negatively impact our patient outcomes. Every month, the goal was to check at least twenty supplies. The execution of this project started with the most expensive supplies, working down in monetary value. To sustain this process, there will be a scheduled time weekly to run the Upload Manager report in Cerner, which will show if items are flowing through systems appropriately.

Davis County Medical Associates Clinic

Services provided at Davis County Medical Associates Clinic (DCMA) include, but are not limited to, primary care for patients from birth to death, including visits to nursing homes and a local state home. Procedures performed include joint injections, simple skin procedures including cryotherapy, osteopathic manipulation, adult and child vaccines, continuous glucose monitoring, and insulin pump management. Other services offered include twenty-four-hour pediatric triage call services and chronic care management calls.

DCMA is designated as a rural health clinic (RHC), providing primary care services in rural, underserved areas. Volumes of services were up by approximately 500 patients in FY23. The Rural Health Clinic served 18,484 patients during the fiscal year, compared to 17,997 patients the year prior.

Davis County Medical Associates (DCMA) quality projects for FY22–23 focused on the completion of medication histories, medication reconciliation, and scheduling follow-up appointments for patients diagnosed with hypertension. The completion of the Rural Health Clinic annual report was also included as a goal.

Medication history completion by the nursing staff at each appointment ensures that the provider has an accurate medication list to review and base medical decisions upon and to reduce instances of medication-related errors. The outcome showed an average of eighty-seven percent being completed. Improvements were made throughout the year, but the goal was not always met. It was discovered that the report was not always accurate, and this contributed to not achieving the goal. We will continue to monitor this periodically over the next year to ensure that no drift in practice is seen and sustained improvement is maintained.

Medication reconciliation being completed by the provider at each appointment ensures patients and healthcare professionals have an up-to-date list of medications to prevent adverse drug events. The outcome showed an average of eighty-four percent of the time. We will continue to monitor the completion of medication reconciliation periodically throughout the next fiscal year.

Eighty-four percent of patients diagnosed with hypertension had a follow-up appointment scheduled. The significance of this measure is related to patient outcomes. Keeping an appointment scheduled for patients with a hypertension diagnosis allows providers to manage their hypertension and decreases the risk for patients to experience adverse effects of the diagnosis more effectively. The rural health clinic will continue to monitor compliance with scheduling hypertension follow-up appointments.

The RHC annual report was completed this fiscal year. The annual report is a regulatory requirement for the RHC to be done every two years. It tells us what other services may be needed by looking at referrals outside of the facility. It gives payer information as well as demographics for the last two years, allowing us to know more about the patients we are seeing. It has information on the top ten diagnoses for each provider and clinic. The annual report will be due again in 2025.

Additional improvements made to processes and services for our patients include process improvements in the way sample medication is bagged and handled, chart preparation for each visit, and documentation for state facility patients.

The RHC reviews at least ten random charts per quarter that include all providers. There were some changes in how often the patient signed a consent to treat. The chart reviews found a couple of missing consents, and this was discussed with our patient access staff. The reviews also found a couple of results that had not been called to patients; this was rectified and discussed with everyone on how to keep track of what was outstanding.

A new body mass/muscle scale was acquired to help analyze body fat and allow providers the ability to help patients with better choices in treatment plans that will ultimately improve outcomes in diagnosis' such as diabetes, hypertension, obesity, etc.

Competencies and training were done on all lab tests required to be performed in the Rural Health Clinic, including hematocrit, pregnancy tests, cultures, hemoccult studies, urine dipstick tests, and blood glucose. Competencies are also done on bladder scanning and EKG's.

The FY23–24 quality project will work with diabetic and hypertension registries. The registries pull data for diabetics that have had hemoglobin A1C in the last twelve months, if those patients have a follow-up scheduled, and if the A1C was high or low. Monitoring hypertension patients will include follow-up appointments, patients that have had visits in the past twelve months, and what the systolic and diastolic pressures are. We will be monitoring all this data and focusing on any issues found. Both diabetes and hypertension are high-risk and high-volume diagnoses that can cause multiple serious complications.

Night Nurse

Night Nurse is an after-hours triage service for pediatric patients served by the rural health clinic. For the year, twenty-two calls were attributed to patients whose primary care provider was in our rural health clinic. We continue to monitor utilization for this low-volume service.

X-Ray

Within the X-ray modality, plain x-rays of the head, thorax, spine, abdomen, and extremities are performed, as well as fluoroscopic procedures. In FY23, 4,702 x-rays were performed. This was a 2.9 percent decrease in volume compared to the prior year.

Throughout the fiscal year, one hundred percent of exams were reviewed for radiologist feedback relating to the poor quality of the examination. Poor-quality exams have the potential to have a negative impact on patient outcomes. Fortunately, during this fiscal year, there were no exams that were considered poor quality and submitted to the radiologists. We will continue to monitor reports and revisit this if an incidence of poor-quality feedback is received.

Outside of the quality program, reviews of physician orders, prior authorization information, examination results, and image link availability are done daily for all imaging procedures. When issues are identified, they are addressed and resolved in real time. X-ray exam imaging critique competencies were performed during this reporting period. Exams were evaluated for proper protocol use, exam technique, and positioning.

During FY24, portable chest x-rays (ten percent per month) will be studied to ensure care (image or technique) does not vary in quality depending on the staff performing the exam. Imaging utilizing the best technique also helps to ensure radiologists can provide an accurate read of the film, thus decreasing the potential for error.

Ultrasound (US)

Services provided within the ultrasound modality include general ultrasound examinations of the heart, vascular system, abdomen, and obstetrics and gynecology. Ultrasound-guided procedures include prostate biopsies, thoracentesis/paracentesis, and nerve blocks. From July 1, 2022, to June 30, 2023, 1,369 exams were performed, a 9.6 percent decrease from the prior year.

Service line goals track turnaround times for reports. The goal was met in all twelve months of the year, with average turnaround times each month ranging from two hours thirty minutes to ten hours six minutes. This goal was met. I will continue to informally spot-check this in the future and/or as issues arise with turnaround times.

Heather attended ultrasound applications training in November at General Electric (GE) headquarters in Milwaukee. This was an in-depth training of the software applications that were on the new ultrasound machine.

The fiscal year 2024 plan was determined based on an issue identified surrounding the weekly documentation of cleaning processes for ultrasound probes. To prevent hospital-acquired conditions and ensure the safety of patients, this will be the focus of the ultrasound service year in 2024.

Computed Tomography (CT)

Services provided within the CT modality include general and angiography imaging of the head, neck, chest, abdomen, pelvis, and extremities, as well as lung cancer screenings and gout analysis studies. CT scan volumes were up 4.3 percent compared to the prior year, completing 1,858 exams in FY23.

Throughout the fiscal year, one hundred percent of exams were reviewed for radiologist feedback relating to the poor quality of the examination. Poor-quality exams have the potential to have a negative impact on patient outcomes. Fortunately, during this fiscal year, there were no exams that were considered poor quality and submitted to the radiologists. We will continue to monitor reports and revisit this if an incidence of poor-quality feedback is received.

As a push for patient safety and back injury prevention among staff, the medical imaging department produced a video to demonstrate the use of the Hovermat to aid in the transfer of patients. This helped provide training to new and current staff on the benefits of its use for patients and staff.

The fiscal year 2024 plan was determined based on an issue identified in ordering tests outside of outlined protocols for diagnosis. Providing care that is evidence-based and avoiding services that are likely not to benefit the patient is a QAPI program goal. More data is needed to evaluate the root of the issue and implement actions for improvement, which will be monitored and addressed throughout this fiscal year.

All information may not be available for each service line, especially those provided under an arrangement or agreement.

Mammography

Screening and diagnostic examinations of the breast are performed within this service line. During FY23, 942 exams were performed, a twelve percent increase in volume over the prior fiscal year.

Image quality, or repeat/reject examinations, was the focus of last year's quality improvement for mammography. Overall, the goal was met in two of three quarters. The repeat/reject rate for the third quarter did not meet the goal due to weekly quality control testing also counting in the repeat/reject rates. A part was replaced with the mammography machine, forcing radiology to perform a new five-day average, which increased the repeat rejection rate for that quarter.

The Iowa Department of Public Health annual inspection for fiscal year 2023 was performed in July. This inspection reviews the facility's adherence to the MQSA requirements and standards. Our facility received a "no findings" survey, which means we were following the required standards.

During fiscal year 2024, a clinical image review of four exams per month per technologist will be completed. This review assesses mammogram quality based on positioning, compression, exposure level, contrast, sharpness, noise, artifacts, and exam identification.

Magnetic Resonance Imaging (MRI)

MRI exams performed include imaging of the body, neuro, and musculoskeletal systems (including arthroscopic examinations). One technologist provides this service and performed 405 exams in fiscal year 2023, nine percent less than the prior year.

Throughout the fiscal year, one hundred percent of exams were reviewed for radiologist feedback relating to the poor quality of the examination. Poor-quality exams have the potential to have a negative impact on patient outcomes. Fortunately, during this fiscal year, there were no exams that were considered poor quality and submitted to the radiologists. We will continue to monitor reports and revisit this if an incidence of poor-quality feedback is received.

The focus for fiscal year 2024 was based on an issue identified in ordering tests outside of the outlined protocols for diagnosis. Providing care that is evidence-based and avoiding services that are likely not to benefit the patient is a Quality Assurance Performance Improvement (QAPI) program goal. More data is needed to evaluate the root of the issue and implement actions for improvement, which will be monitored and addressed throughout this fiscal year.

Dual-Energy X-Ray Absorptiometry (DEXA)

Under this modality, screening bone density examinations are performed on the lumbar spine, both hips, and the non-dominant wrist, if needed. 252 exams were completed during FY23, twelve less than the prior fiscal year.

The quality project was initiated in response to an issue identified related to patients presenting for services who were not properly prepared for their DEXA exam. This caused medical imaging to not be able to complete the exams on the day they were scheduled, delaying the patient from getting tested. None of the incidents reported throughout this fiscal year were related to improper preparation; therefore, no action was taken to improve the education process.

In FY24, the quality plan determined was in response to an issue (problem-prone area) related to patients being scheduled prior to eligibility. The rules surrounding eligibility differ if the patient is on treatment or if it is a screening exam. Ensuring patients are provided testing when eligible (not before) prevents medical error, avoids error, and is patient centered.

Mobile Magnetic Resonance Imaging (MRI)

This mobile service is used to supplement our in-house machine by providing exams close to home for claustrophobic and obese patients. In addition to helping provide uninterrupted MRI service in the event of extended machine downtime and the MRI technologists absence, The mobile MRI service was utilized for thirty-two patients this fiscal year and for thirty-four patients the prior fiscal year.

Ensuring patients get tests on time is a key aspect of preventing delays in care. Our mobile MRI service is offered on a limited basis, so our medical imaging department set out to ensure that the limited availability was not causing significant delays in care. Overall, for the year, fifty-six mobile MRI scans were ordered. All patients received their tests within the two-week time frame.

During fiscal year 2024, a quality assurance summary report and an exam analytics report from Shared Medical will be included in the Quality Committee packet quarterly and reviewed. This is a contracted service available on an as-needed basis.

Mobile Positron Emission Tomography (PET)/Computed Tomography (CT)

A mobile contracted service available every other Saturday as needed is utilized to provide PET scans, which include skulls from base to mid-thigh and the whole body. This service was utilized for eighteen patients during fiscal year 2023, down thirty-five percent from the year prior.

Ensuring patients get tests on time is a key aspect of preventing delays in care. Our mobile PET service is offered on a limited basis, so our medical imaging department set out to ensure that the limited availability was not causing significant delays in care. Overall, for the year, nineteen PET scans were ordered. Four of those nineteen patients did not receive their test within the two-week time frame. In all these instances, the necessary medication could not be obtained by the company providing this mobile service.

A quality assurance (QA) summary report and exam analytics report from Shared Medical will be included in the QA packet quarterly and reviewed during fiscal year 2024.

Nuclear Medicine

Davis County Hospital contracts with DMS Mobile Nuclear Medicine Services to provide various examinations, including gallbladder, kidney, and thyroid functions, gastric emptying, bone scans, and cardiac imaging. This service was utilized on sixty-five patients, a thirty-nine percent decrease from the year prior.

DMS Mobile Nuclear Medicine Services monitors incomplete and completed exams per month. During this FY reporting period, one exam out of sixty-five was not completed. All nuclear medicine patients receive a reminder appointment call in the afternoon prior to the exam. This is to confirm the appointment time with the patient and the acknowledgement from the patient that they will be coming to their appointment. This occurrence appears to be an isolated incident, as the patient did acknowledge their appointment but did not call or show up on the day of the exam.

A medical emergency drill was performed in the mobile truck. There were several things that went well, but we also found a few areas for improvement. It was found that the mobile truck is only supplied with limited equipment and that all essential lifesaving equipment needed to be taken to the patient when responding. These items include a jump bag, a crash cart, and a cart to transport the patient.

During fiscal year 2024, a report generated from DMS Health for review in the QAPI program will be utilized. Any issues identified will be addressed by the contracted service.

Medical Nutritional Therapy

DCHC continued to contract shared dietitian services with Angela Birkner, RDN, LD, of Birkner Consulting and with a newly hired prn dietitian, Samantha Thomas, RDN, LD. During FY23, the dietitians consulted thirty outpatients, forty-eight acute care patients, and fifty-two skilled patients. Volumes remained comparable to the prior year, with five additional patients in fiscal year 2023 compared to fiscal year 2022.

Angela also completed training to be a preceptor for a dietetic intern during FY23. The intern spent approximately sixty hours with the dietitians at Davis County Hospital & Clinics from October to December of 2022.

The dietitians approved the menus for regular and therapeutic diets provided to patients by Food & Nutrition in addition to approving the Annual Diet Menu Attestation. The newest, thirteenth edition of the Simplified Diet Manual was also reviewed and approved for use.

The quality improvement goal for medical nutrition therapy this fiscal year focused on monitoring nursing compliance with completing the nutrition screening portion of the admission history form. This quality activity was chosen as it affects the identification of nutritionally high-risk patients, is thus associated with improved health outcomes, and can play a role in the prevention of readmissions. In addition, the completion of this task is a problem-prone area.

Overall, only forty-five percent of charts revealed a fully completed nutritional screen, and though improvements were made, sustainability's were not achieved. During FY23, the dietitian provided feedback monthly to the acute care manager on how to implement measures to improve these results. Feedback included monthly visuals of the percent of nutrition screens that nursing staff completed, and in October 2022, the dietitian provided educational materials to be presented to the nursing staff. For FY24, this goal was transitioned to acute care, as this is the department that has control over the outcomes of the goal.

The quality assessment and performance improvement project in FY24 is twofold. The first goal is to complete a post-visit phone call within two weeks for one hundred percent of diabetic patients who meet with a dietitian in person. During that phone call, an additional in-person visit will be offered, which is an improvement on the current process. The second goal is that those patients who meet with the dietitian see an improvement in their hemoglobin A1C. Results will be reported to the Quality Committee on a quarterly basis.

Food & Nutritional Services

Food & Nutrition Services had two quality focus areas for the fiscal year. The first was aimed at ensuring the diets served to patients matched their orders. Seventy-seven of the eighty-one trays inspected passed without intervention. The four that did not pass inspection were corrected prior to reaching the patient. The second quality improvement focus was aimed at increasing the patient satisfaction "meals overall" question. An increase of two percent was the goal, which was achieved two out of three months in the last quarter of the year. Food and Nutrition continues to make serving high-quality nutritious meals tailored to our patients' desires a priority.

The focus for the new fiscal year is to incorporate more improvements to meals provided to patients while creating a list of menu items, expanding from the current selection being offered, performing a nutritional analysis on those items, and implementing the new expanded menu.

Medical Staff Services

Peer review was conducted as per policy, sending selected charts for either internal or external review throughout the year. Ten percent of patients who received care from a mid-level provider in the emergency department were reviewed by the ED medical director. The medical director also reviewed returns to the emergency department within forty-eight hours of their initial visit. Additionally, external reviews were sent to MercyOne for credentialing, quality concerns, and other peer review triggers as indicated by policy. Feedback was provided to providers involved in care based on the results of the review.

Outpatient Infusion

The outpatient infusion center provides wound care, urinary catheter changes, intravenous hydration, intravenous antibiotics, allergy shots, and various other injections and infusions.

In the Outpatient Infusion Center, a total of 3,040 infusions, injections, and procedures were performed. This is a decrease of 373 from last fiscal year, but volumes remain higher than in fiscal year 2021.

The focus on quality assurance and performance improvement for outpatients mimicked many of the other clinical departments focusing on medication history documentation and medication barcode scanning. Med scanning consistently improved throughout the year, and the medication history goal was consistently met for several months. These two areas will continue to be monitored periodically to ensure sustained improvement. During the fiscal year, Outpatient also began sending a copy of all visit notes to the referring providers to improve continuity of care and communication. A new scale was also purchased after experiencing two patient falls due to issues with the prior scale in the department.

A focus on standard workflows within the department is the improvement area for outpatients during fiscal year 2024. This will help with onboarding new staff as well as staff assisting in the department to ensure things are done consistently and correctly, reducing variation in care.

Patient Access

The Patient Access Department, responsible for registration for all services at DCHC, has had almost a complete turnover of registration staff throughout 2023. All but one position has been filled.

The Patient Access Department set a goal to reduce insurance errors to less than one percent per month. This is important as it affects our facility as providers use this information ordering service for their patients, as well as our days in accounts receivable. This goal was tracked through a daily monitoring report of encounters registered by each registrar. Registrars would then review another team member's encounters searching for the correct insurance listed if they were listed in the correct order and if eligibility was run. We were able to successfully meet this goal for two consistent quarters.

Registration is implementing a new patient intake software, Phreesia, which will allow patients to receive electronic registration via their mobile devices. This will cut down on the number of incorrect phone numbers or demographics we currently have in our EHR. 74,097 visits were registered in FY23, compared to 65,832 encounters the year prior. This is an increase of over 8,000 visits throughout the facility.

The Patient Financial Services Department experienced turnover in one position during fiscal year 2023. With the addition of staff in Patient Access, the Patient Financial Services team was able to focus on our claims and daily encounters to work down our days in accounts receivable (AR days). Billers were assigned new metric goals to meet to help stay on target. AR days were 52.81 at the end of the last fiscal year. At the end of this fiscal year, they were forty-five.

The Patient Financial Services department worked on decreasing denials falling into the not medically necessary category. A shared denial report spreadsheet was created in which billers would track denials into the spreadsheet. The denial spreadsheets were then uploaded to a specific department for their review. Our target goal was to be five percent or less for medical necessity denials, which were not met. We continue to communicate with the departments.

Pharmacy

Pharmacy provides prospective review of medication orders, retrospective medication use evaluation, medication reconciliation, drug information, pharmacokinetic dosing, renal dosing, sterile and non-sterile compounding, procurement, and management of pharmaceutical inventory.

The areas supplied most by pharmacy with medications include acute care, emergency, and outpatient departments. We have seen a decline in the number of complex admixtures completed for our outpatient department as we no longer have any patients receiving Krystexxa, Actemra, or Benlysta. Visits to the outpatient most generally now involve simple injections and infusions such as Prolia, Evenity, and intravenous iron supplements.

Quality improvement focus areas:

- Adverse drug events (ADE): Surveillience for adverse drug events, classifying them according to the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Index as category A–I. It is important that we monitor ADEs and track trends so that we can create process changes to mitigate and prevent future instances of similar errors. Two patients experienced ADEs, one each in August and April, accounting for an approximate error rate of 1.30 percent in those months. We will continue to monitor and track trends to ensure that our process changes are effective in preventing and mitigating potential harm to patients.

- Antibiotic days: The number of patient days is calculated when any antimicrobial was prescribed or administered (alone or in combination). This is important from an antimicrobial stewardship perspective to ensure that prescribers are not overutilizing antibiotics, potentially increasing the likelihood of drug resistance in our community. Antibiotic days fluctuate greatly with our patient census and their respective indications for antibiotic use. However, we generally see an approximate monthly antibiotic day result of between fifty and eighty. The results are shared at our quarterly Pharmacy and Therapeutics Committee meetings. If we ever discover a potential issue with overutilization of antibiotics, we will address it among committee members and be able to act in terms of limited prescribing or formulary changes.

- Discharged opioids: A report is run each month to determine how many patients were discharged from acute care with a prescription for opioids beyond ninety mg of morphine equivalent (MME). It is important to ensure that prescribers do not overuse opioids for unnecessary reasons. Two patients were prescribed high-dose opioids, but in both cases, the patients were palliative. This will continue to be monitored and reported to the Iowa Healthcare Collaborative. Results will be reported to Quality on a quarterly basis.

- 48-hour time-out for antibiotics: Pharmacy tracks and counts the number of patients that have a 48-hour timeout completed while they are hospitalized and receiving antibiotics versus the total number of patients who receive antibiotics while hospitalized. Early in fiscal year 2023, approximately fifty percent of patients on antibiotics received this time out. An adjustment to our practice was made to ensure that the weekend house supervisor completes such time outs when the pharmacist is not available. Since that time, the antibiotic time-out percentage has climbed to and remained at one hundred percent. This will continue to be tracked and monitored, and adjustments will be made if our percentage decreases.

- Overrides from Omnicell: The pharmacy runs a report each month to determine the total quantity of retrievals made from the Acute Care Omnicell, the medication dispensing system, and the number of those retrievals that were made via override of the requirement of an electronic order. It is important

that we monitor overrides and limit them to instances of emergency only so that staff do not mistakenly retrieve something that does not have a corresponding patient order; it is a matter of patient safety. Overrides from Acute Care Omnicell are always minor compared to the overall number of retrievals made. For six months, overrides accounted for one percent of total retrievals, and for the remaining six months, overrides accounted for less than one percent. Pharmacy will continue to monitor this number and percentage and adjust the list of medications for which override is allowed as needed.

- Barcode scanning issues: In approximately January of this past year, Pharmacy noticed a significant rise in the number of medications that were not recognized via barcode scanning and received many complaints from nursing regarding such issues. However, when checked, it appeared that the barcodes on items were indeed recognizable, and other underlying issues within Cerner were at fault. Therefore, a barcode scanning issue form was created with which nurses could notify pharmacy and IT of instances of barcode scanning difficulty. The forms included space for nursing staff to indicate the time or date of scanning and the exact error message received to help pharmacy or IT staff pinpoint the underlying problem.

- Pharmacy continues to receive approximately ten barcode scanning issue forms per month. The underlying problems often involve Cerner, and many of the issues have been rectified. In addition, nurses that turned in a barcode scanning issue form were not docked for not scanning the item in their barcode scanning percentages in comparison to other nurses. This is an ongoing effort. Barcode scanning issues will continue to be investigated and addressed as they arise.

- Heparin drip standard operation procedure (SOP): A recommendation was made to the Pharmacy and Therapeutics Committee to develop a standard operating procedure for heparin. Over the course of several committee meetings, a low-dose and high-dose heparin drip protocol was developed to be used in instances of need in both our ER and acute care areas. This was important given that usage of infused heparin was beginning to increase to levels not seen prior to the COVID pandemic, as it is more difficult to transfer mildly critical patients out of our facility and, instead, we are managing them here. This protocol has been utilized several times since, with great success.

The pharmacy also acquired new trays for medications to be maintained in a second surgery cart and made some adjustments to the medications maintained within the surgery and post-anesthesia care units following an adverse drug event in that area.

Competencies performed within the department include an annual evaluation of pharmacy staff and annual media fill and gloved fingertip sampling for all staff who complete sterile compounding within the clean rooms.

The Iowa Board of Pharmacy conducted an inspection with Officer Jean Rhodes, initiated on August 1, 2022. However, the DCHC pharmacist-in-charge was on vacation at that time. Therefore, Officer Rhodes and a training officer return on November 29, 2022, to complete the inspection. The main findings during this inspection were as follows, though many were rectified prior to the return visit in November:

- Annual observation/training checklist specific to HD sterile compounding. Discussed on November 29,2022 and implemented.
- US Pharmacopeia (USP) 797 and sterile hazardous drug (HD) compounding room was found to have no disposable nail pictures. Disposable nail pictures were ordered on November 29, 2022, and are in use.
- In the sterile HD room, no hand sanitizer was available. On November 29, 2022, hand sanitizer was made available and is being used.
- Primary Engineering Controls (PECs) shall maintain International Organization of Standardization (ISO) Class 5 or better conditions for 0.5-µm particles (dynamic operating conditions) while preparing

compounded sterile preparations (CSPs). Secondary engineering controls such as buffer areas and ante-areas generally serve as a core for the location of the PEC. Buffer areas are designed to maintain at least ISO Class 7 (see Table 1) conditions for 0.5-µm particles under dynamic conditions and ISO Class 8 (see Table 1) conditions for 0.5-µm and larger particles under dynamic conditions for the ante-areas. dynamic operating conditions, including transferring ingredients, components, and devices into and out of the isolator and during the preparation of CSPs. During the recent hood and cleanroom certification on August 1, 2023, Wendy mimicked compounding while the service technician tested the room(s), so this is now satisfied.

During fiscal year 2024, Pharmacy will continue to monitor and report the number of patient days a broad-spectrum antibiotic was prescribed. Specific explanations for such usage are given to medical staff each month so that they can review for unnecessary broad-spectrum usage and address it if needed. Also monitored and reported will be the number of patient days when any antimicrobial was prescribed or administered, the number of antibiotic time-outs performed, and the number of patients discharged with an opioid prescription greater than ninety MME daily. Concerns identified with corrective action will be reported through the Quality Committee.

Tele-Pharmacy

CHI Virtual Health is used for after-hours pharmacist coverage. Primary responsibilities include processing orders and visual verification of medications. During fiscal year 2023, CHI processed 8,098 medication orders for Davis County Hospital with an average turnaround time of thirteen minutes. Sixteen visual verifications of medications were provided. CHI logged 222 interventions while processing medications to clarify orders, change medications to those available on formulary, adjust doses, and prevent medication errors. This will continue to be watched throughout the fiscal year 2024.

Physical, Occupational, and Speech Therapy

Kincart Physical Therapy Services (KPTS) provides physical therapy, occupational therapy, and speech and language pathology services for outpatient, observation, inpatient, and swing bed levels of care. The volume of services provided is outlined in the chart below.

	FY 22	FY23
PT Outpatient	7,230	6,956
PT Inpatient	615	700
OT Outpatient	259	346
OT Inpatient	168	135
ST Outpatient	67	66
ST Inpatient	27	19
Outpatient Total	7,556	7,368
Inpatient Total	810	854
Total	8,366	8,222

For the disciplines of physical therapy (PT), occupational therapy, etc., and speech therapy, the QAPI projects reviewed the days until the finalization of our documentation. KPTS first assessed the percent compliance with documentation being completed on the day of treatment, and then the percent compliance with documentation being completed within one day of treatment. This project was important to ensure all documents are available as soon as possible for other providers, insurance, and other entities that need access to patients' medical records for the continuum of care.

The goals for physical therapy were ninety-two percent same day and ninety-seven percent day one; occupational therapy was seventy-five percent same day and eighty-five percent day one; and speech therapy was ninety-six percent same day and ninety-eight percent day one. For a twelve-month period, physical therapy averaged 91.25 percent documentation completed the same day and 98.25 percent documentation completed by day one. For a twelve-month period, occupational therapy averaged forty-four percent documentation completed the same day and 75.75 percent documentation completed by day one. For a twelve-month period, speech therapy averaged 95.75 percent documentation completed the same day and 98.75 percent documentation completed by day one. KPTS will continue to periodically monitor completion percentages through WebPT analytics and address variances and anomalies accordingly.

Chart reviews of ten percent of the patient population for PT, OT, and ST are completed monthly. All charts in the reviews were one hundred percent compliant during the fiscal year.

In November 2022, the staff at KPTS partnered with Amy Tyson from employee education, for the renewal of basic life support certification and mandatory reporting certification for both dependent adults and children.

During fiscal year 2023, KPTS purchased two bariatric high-low treatment tables with power backs for patient use. These tables ensure proper support, comfort, and stability for our patients and allow for improved ease in maintaining body mechanics and reducing injury for staff. Four new TheraTouch CX4 units for patient use were purchased. These units are combined ultrasound and electrical stimulation units. Also purchased were a new workout bench that inclines to various angles, a measuring wheel for measuring distance for patient ambulation and other forms of mobility, a Micro-Fet 3 handheld dynamometer and inclinometer, and multiple pictures to display on the walls of the main PT department and in the PT2/Speech Therapy room.

During fiscal year 2024, Physical Therapy will assess the percentage of patients reporting their physical therapy treatment goals were completely met during their physical therapy plan of care. Goal: Sixty-two percent of the time; current within this calendar year is fifty-eight percent. Occupational Therapy will assess the percentage of patients reporting that their occupational therapy treatment goals were completely met during their occupational therapy plan of care. Goal: Seventy-eight percent of the time; current within this calendar year is seventy-five percent. Speech therapy will assess the percentage of patients meeting their outcome measure goal set during their speech therapy plan of care. Goal: Sixty percent of the time without baseline data available. These measures are important to continue to monitor patient satisfaction and ensure our plans of care are individualized, patient-centered, and evidence-based.

Plant Operations

The Plant Operations Improvement Process this year focused on making sure the water temperatures for the domestic hot water in the facility stayed within the acceptable temperature range of 110–120 +/- 2 degrees. The department checked the domestic hot water temperature at random sinks three times a week. We have four different domestic hot water heaters in the facility, which resulted in a total of 154 spot checks for each hot water unit for the year, with all of them following the regulations for water temperatures. This will continue to be the focus in FY24.

Public Health

Public Health had a total of 1,323 home visits this year, 566 skilled nurses, and 757 homemakers and homecare aides. This is up 13.2 percent over fiscal year 2022.

President Biden allowed the COVID public health emergency to end on May 11, 2023. COVID is still a reportable disease in Iowa, but cases have drastically decreased. The COVID vaccine is still highly encouraged and is the best way to prevent COVID illness.

A communicable disease case investigation was performed on a total of eighteen cases this year, other than COVID. Public Health and the hospital provided wellness screenings to a total of 102 city and county employees and 201 community members for a total of 303 health screenings, audited a total of 1,567 school immunization records, held one drive-through flu shot clinic, and held three public flu shot clinics, as well as provided flu and COVID vaccines for four local businesses.

Public Health, along with hospital volunteers and three community volunteers, delivered 5,035 home meals on wheels over the past year, which is up from 4,986 the previous year.

During COVID, Public Health had to cancel vaccination clinics held within the hospital, so they began offering home visits. Nearly all the immunizations given through public health are for Amish children, so home visits are much easier for both families and public health staff. This year, staff have made seventy-five home visits for immunizations and three visits for Pertussis testing, which is up from twenty-three total visits last year. A total of 172 children have been immunized this year, with a total of 387 doses of vaccine provided. This is up from 101 children and 226 doses of vaccine last year.

A total of 450 adult doses of vaccine were provided this year, which includes all adult vaccines. Last year, there were 488 adult doses administered (other than COVID). We saw a significant reduction in the amount of flu vaccine that was requested this year. A total of 206 doses of flu vaccine were administered this year, compared to 405 doses administered last year.

The quality improvement projects this year focused on ensuring that every public health client had a fall and home risk assessment performed at the time of admission, with education provided on anything identified as a fall risk. Also, to review I-POST information, an advance directive document, with patients or families, have their primary care provider sign this and place information on the patient's refrigerator for first responder staff to review if needed. The Centers for Disease Control (CDC) requested a year-long audit of two and thirteen-year-olds listed in Iowa's immunization reporting system, IRIS, and shown as "active" for public health. Efforts have been made to follow up with these families. If they are no longer receiving immunization through public health or getting vaccines through their primary care provider (PCP), then they have changed to "inactive" for public health and will then show "active" with their PCP.

To make public health forms more specific to public health and not the hospital, all public health forms were reviewed, updated, and the logo changed from hospital to public health. After reviewing with the compliance officer, we were able to reduce the number of documents that we used by incorporating our consent for treatment, release of information, patient rights, advance directives, and privacy policy all into one consent form. Due to all the legal requirements on the forms, it was decided that public health will continue to utilize the hospital non-discrimination form and the notice of privacy policy. All public health forms have been updated to reflect the new public health logo, and we have also updated the letterhead paper, which has both the hospital and public health logo printed on the top.

Public health also continues to audit immunization records routinely and send reminder cards when immunizations are due. During the audit process, they will continue to work to clean up information in the IRIS system to make it more accurate for the children served by public health.

Senior Life Solutions (SLS)

The Senior Life Solutions patient census for the fiscal year July 1, 2022, to June 30, 2023, showed a steady increase throughout the year. In July 2022, there were six full-time patients, which increased to ten patients for each group therapy day, serving sixteen total patients during the year.

Quality improvement focus areas for fiscal 2023 included a monthly audit of thirty percent or greater of patient charts, utilizing an audit tool, with audit measures ranging from 303 to 354 points, and our scores ranged from ninety-eight to one hundred percent each month, with heavy emphasis on evaluating treatment plans, treatment plan updates, therapy notes, and doctor's notes.

An additional focus was bringing awareness to the community and providers about mental health and increasing referrals to the program, which will also increase billing units and improve the quality of life of the patients we serve. The target is a minimum of forty education contacts monthly, and results ranged from forty-six to ninety-eight per month.

Senior Life Solutions also focused on signatures on treatment plans and treatment plan updates. Expectations are that staff, patients, and the doctor all sign reports within one business day, and results were anywhere from fifteen to forty-five documents needing signatures per month, with completion ranging from sixty-eight to one hundred percent.

Finally, monthly assessment testing was monitored on each patient, which is used to evaluate each patient's progress toward individualized goals. Results ranged from eighty-six to one hundred percent.

Competencies and training performed within our department included a variety of topics. For the period of July 1, 2022, through June 30, 2023, SLS staff completed monthly clinical education from the parent company, PMC. These training courses focused on Lewy Body Dementia, suicide first aid, evidence-based assessments, the top Joint Commission survey results, self-care for the holidays, bipolar disease, suicide prevention, understanding bias, ethics, and workplace resilience.

Throughout fiscal year 2024, medication list reconciliation will be performed weekly on each patient, and all medication lists will be shared for our provider to access upon any medication change to assure accuracy of medications and dosages as well as to monitor for any adverse drug reactions. Monthly medication logs are kept for all current patients.

Dermatology

Goals were set for the dermatology service to evaluate utilization of the service and wait times for patients seeking it. The provider set a goal to see eighteen patients a month. Volumes varied throughout the year, with an average of seventeen patients each day the provider was here. An additional goal was set surrounding new patient appointments, with a goal for less than 12.5 percent of patients to not have to wait more than sixty days to see the dermatology provider. This goal was not met. After discussion, the provider is not available for additional days at our facility. Dermatology is a service that expansion may be of benefit for the community.

Obstetrics and Gynecology

This service line was lost in April due to the relocation of the provider out of state. This is a service that is utilized by an average of ten patients per month and is a service that we are open to replacing if a provider is available through Ottumwa OB/GYN. Prior to losing this service, ninety-five patients were served.

Allergy, Orthopedics, Otolaryngology, Podiatry, and Urology

Combined goals for specialty service lines were set around medication processes. After a series of medication errors, actions were put in place to improve patient safety, one of which was improving compliance with medication barcode scanning. Compliance was improved through training, education, and giving personal feedback to nurses related to their personal barcode scanning percentages. The goal was met for the second two quarters of the year after these interventions. During the fourth quarter, an issue arose with lidocaine scanning, of which the pharmacy was aware. Overall, the goal was successful in improving medication safety practices within this department, despite falling just shy of the ninety percent goal. This goal encompassed all providers documenting in Cerner in the specialty clinic, including allergy, orthopedics, urology, otolaryngology, and podiatry.

The second medication process goal was to complete the medication history of ninety-five percent or more of the patients seen. This goal was put in place throughout clinical areas as an action to improve patient safety and decrease errors in medication administration. Steady progress was made toward the goal throughout the first three quarters. During the fourth quarter, turnover in staff affected compliance, and pulling and reviewing the data became infrequent after March. This is an area that still needs improvement. These processes have since been reviewed with staff, and we will continue to monitor compliance quarterly throughout FY24 and provide direct feedback to staff.

Volumes by provider for the specialty clinic were as follows:

PROVIDER	PATIENTS SERVED	PRIOR YEAR
Dr. Whitman, ENT	472	441
Dr. Ciesemier, Allergy	193	130
Dr. Holte, Podiatry	128	151
Dr. Homedan, Orthopedics	495	582
Dr. Remis, Urology	300	228

The fiscal year 2024 plan for specialty providers is to incorporate QAPI data from Premier Specialty Network, the contracted provider for allergy, podiatry, and urology, into our internal quality program. InReach will be providing data for the orthopedics service line.

Surgery

Within the surgery service line, orthopedic, urologic, ear, nose, and throat, podiatric, endoscopic, epidural, nerve blocks, and ablations are performed. Surgical procedures totaled 506 in fiscal year 2023, up from 478 the year prior.

Quality projects for surgery focused on medication safety with the completion of medication histories and barcode scanning of medications. Ninety-four percent of patients' medication histories were completed, falling just short of the ninety-five percent goal. Ninety-four percent of medications given were administered via barcode scanning, above the ninety-percent goal that was established.

Additional safety measures were implemented in the surgery department throughout the year, including the removal of all latex-containing catheters from stock and replacing them with silicone, as well as changes to the medication strengths stocked in the surgery in response to a medication error. Additionally, new hire orientation documents were revised to assist with staff onboarding and ensure a safe, high-quality orientation process.

Plans for fiscal year 2024 include the addition of new Stryker power tools, which will improve the quality of care provided with orthopedic procedures. A new Medivator is also a planned addition to surgery to ensure continued safe outcomes for endoscopic patients.

Quality focus will be on the creation of standard workflows for all areas of the department, including pre- and post-op, putting charts together, circulating, and PACU. It will help with onboarding staff and making sure everything is done correctly and uniformly by everyone in the department.

Anesthesia

Anesthesia services are provided by the Bloomfield Anesthesia Group (BAG). BAG is a group of certified registered nurse anesthetists serving multiple facilities in southeast Iowa. Services supplied include general, spinal, regional, local, and sedation anesthesia for surgical cases. Also provided are peripherally inserted central catheter placements, as requested.

Throughout fiscal year 2024, anesthesia quality and appropriateness will be monitored by a peer review process. Monitored includes procedure performed, type of anesthesia provided, peri-operative glycemic control, circulatory, airway, or regional anesthesia events. This retrospective review was completed by an anesthesia provider from Bloomfield Anesthesia Group.

Central Sterile

Central Sterile is responsible for sterilizing instruments for surgery, emergency, acute, Medical Associates Clinic, and other departments as needed. Central Sterile is staffed Monday through Friday during normal business hours.

The quality focus for fiscal year 2023 was aimed at ensuring humidity and temperature within the surgery department were within a specified range. Out of 207 days monitored, 187 days were initially within range. In all instances where the humidity was out of range, maintenance was notified, and the issue was corrected. This will continue to be monitored and reported in the upcoming fiscal year.

Additional quality focus is aimed at the creation of standard workflows for all processes, equipment tests, and general department tasks. This will assist with onboarding new staff and ensuring that all sterile techniques are safely followed by everyone in the department.

Swing Bed

The Swing Bed, or Skilled Care, service line provides post-acute services aimed at ensuring a successful transition to home after an inpatient stay. This service allows patients to receive physical, occupational, and speech therapy services as needed during their stay, including continued intravenous antibiotics, wound care, and nursing services. Thirty-three patients were discharged from the Swing Bed program in fiscal year 2023, down 10.8 percent from the prior fiscal year.

Nursing peer chart reviews were completed monthly, aimed at identifying and correcting issues with documentation. A step counter was added in response to issues identified in accurately recording the distance walked for this patient population.

The quality goal was to ensure one hundred percent of discharged patients have follow-up appointments scheduled with their primary care provider prior to discharge to ensure continuity of care and decrease readmissions. Results were just shy of the established goal of 98.75 percent. This will continue to be monitored and reported in the next fiscal year.

Additionally, in fiscal year 2024, a quality goal was established to ensure all ordered ambulation is documented to ensure follow-through on orders to aid skilled patients in meeting goals prior to discharge.

Review of the FY23 Quality Improvement Plan

The Quality Assessment and Performance Improvement Program (QAPI) of Davis County Hospital & Clinics provides the framework to assess, evaluate and improve structure, process, and outcome-related activities both in care and services, using an organization-wide approach which is collaborative, and data driven systematically and continuously. On an annual basis, the Quality Improvement Plan is reviewed and updated to reflect priorities in providing quality care in a safe environment to all patients.

Executive Summary

The primary goal of the Quality Assurance Performance Improvement program is to provide care that is safe, effective, patient-centered, timely, efficient, and equitable.

The objectives of the QAPI program are as follows:

- To design an effective process of improvement that is consistent with the organization's mission, vision, and values and the needs and expectations of the customers.
- To plan a systemic, organization-wide approach to continuous quality improvement that is ongoing and comprehensive.
- To emphasize the role of leadership in improving quality.
- To expand the scope of assessment and improvement activities beyond the strictly clinical to the interrelated governance, managerial, support, and clinical processes that affect patient outcomes and customer satisfaction identified as major functions of care and service
- To aggregate and analyze data by utilizing appropriate statistical techniques and acceptable internal and external benchmarks.
- To identify and resolve any breakdowns that may result in suboptimal patient care and safety, including the supervision and monitoring of the peer review process.
- To assure compliance with the requirements of federal, state, and accrediting agencies regarding quality monitoring and improvement activities.
- To use objective measures to evaluate organizational processes, functions, and services.
- To address outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, CAH-acquired conditions, and transitions of care, including readmissions.

Strategic Goals

Quality and Safety

- Conduct safety rounds in each department on an annual basis.
    - Results: Safety rounds were conducted on a routine (monthly) schedule focusing on fire code, outdated materials, quality improvement projects, and regulatory/survey readiness.
- Create and implement a nursing shared governance committee by June 30, 2023.
    - Results: A nursing shared governance committee was created and implemented in December 2022. Turnover among employees and time constraints have impacted participation.
- Patient satisfaction top box scores for 'Would Recommend" are in the eightieth percentile or higher for each service line by June 30, 2023.
    - Results for the top box 'would recommend' for fiscal year service dates received by September 1, 2023:

Department	Top Box	Number of Responses
Inpatient	70%	30
Emergency Department	84.65%	215
Ambulatory Surgery	81.76%	170
Outpatient Services	84.34%	945
Medical Practice	83.18%	672

Quality and safety strategic priority focus areas shifted to zero patient harm, measuring and implementing measures to reduce adverse drug events, falls, prevent hospital-acquired conditions, and ensuring the utilization of two patient identifiers at each point of care. The culture of safety work, including improvements in handoff communication, standardization, and injury prevention, will be focused on in fiscal year 2024.

Patients

1. Determine ways to incorporate patient and family involvement into existing structures and committees at Davis County Hospital & Clinics. by July 31, 2023
    1. Results: A patient currently sits on the Quality Committee and the Rural Health Policy Review Committee. Davis County Hospital auxiliary members provide input on processes and services as representatives of the community. We continue to evaluate ways to incorporate patients and families into our decision-making processes.
2. Provide community education and training.
    1. Results: Stop the Bleed training was provided for elementary and middle school staff. Basic life support training was provided for bus drivers, fire departments, coaches, and other members of the community. The hospital worked with high school students from Davis County and Cardinal to provide job shadow opportunities and internships. An internship program was developed jointly with Appanoose, Van Buren, and Wapello counties, providing paid education for sixteen local students to obtain their EMT.
3. Work collaboratively with the community and formulate a plan to increase overall health and wellness by June 1, 2023.

    2024. Results: The pandemic has placed this goal behind the timeline as collaboration with the community was limited. Will continue to evaluate and work towards this goal in fiscal year 2024.

Growth

- Increase utilization of Dr. Brewer's lifestyle practice service by December 31, 2024.
    - Results: Service has grown over the past fiscal year to the extent that it has become difficult for new patients to access service.
- Improve diabetic services and teaching by implementing a certified diabetic teaching course by December 31, 2024.
    - Results: This continues to be in progress. A position is posted for a registered nurse for this program, and the dietitian is working towards other aspects of the requirements to provide education through a certified diabetic education program.
- Work with the CEO, patients, and families to determine the need for additional services and physician recruitment.
    - Results: Rural Health Clinic providers are meeting the needs of the community to the extent that no recruitment efforts were needed in fiscal year 2023.

Finance

- Hire an external vendor to conduct a chargemaster review by December 31, 2023.
    - Results: remains in progress as DCHC is currently seeking a vendor.
- Implement software for no surprise billing by January 1, 2023.
    - Results: CMS halted the January 1, 2023, rule changes for no surprise billing in December 2022. DCHC is currently working with our vendor to alter the current software product for more compliance.
- Implement ePayments Plus by June 30, 2023.
    - Results: Implemented in the spring of 2023.

Employees

- Develop an employee mentoring program by June 30, 2023.
    - Results: After reaching out to a couple of resources, the committee produced a "draft" idea of what a mentoring program might look like. The committee sent a survey to thirty-seven employees who had been here for a year or less to get their input on having a mentoring program and whether they thought it would be beneficial to them. Based on the small number of responses as well as the feedback that was received, the committee decided not to move forward with this project at that time.
- Increase employee morale throughout DCHC by December 31, 2024.
    - Results: The committee has not started to focus on this goal yet.
- Improve communication by December 31, 2024, to break down silos in departments.

Results: One initiative that the committee has been working on to improve communications is "Meet Your Neighbor Lunches" The committee started inviting employees to "Meet Your Neighbor Lunches" in May 2023. As of the middle of September, 137 employees have been invited to these lunches; fifty-four employees have attended, and twenty-eight have asked to be rescheduled for a different date.

Iowa Healthcare Collaborative

Davis County Hospital and Clinics partners with a hospital quality improvement contractor, the Iowa Healthcare Collaborative. Through this partnership, organizational priorities are established that align with departmental goals established through the Quality Assurance Performance Improvement program.

Priorities were as follows:

- Patient Safety and Harm Reduction Goals
    - DCHC will maintain no hospital-acquired pressure injuries throughout 2023.
        - Results: Goal achieved
    - DCHC will have an inpatient fall rate of 1.92 per 1,000 patient days or less during FY23.
        - Results: Fall rate: 6.33 per 1,000 patient days for the fiscal year, experiencing six falls.
    - DCHC will maintain one hundred percent discharge medication reconciliation for inpatients in FY23.
        - Results: The Cerner report reveals 83.62 percent completion of medication reconciliation by providers for inpatients. Upon further review, one hundred percent of patients discharged home had medication reconciliation completed. Instances where this was not completed were changes in level of care, transfers, and patients who died during their stay.

- Patient and family advisory
    - DCHC will incorporate patients and families into existing structures for collaboration and feedback on current services and efforts to reduce harm.
        - Results: A patient currently sits on the Quality Committee and the Rural Health Policy Review Committee. Davis County Hospital auxiliary members provide input on processes and services as representatives of the community. We continue to evaluate ways to incorporate patients and families into our decision-making processes.

- Pandemic/Public Health Emergency Response
    - DCHC will continue with COVID-19 Preparedness Team Meetings to coordinate and educate patients, staff, and the community on COVID-19 during 2022.
        - Results: The COVID-19 team met as needed in response to the pandemic, implementing changes and providing communication as necessary.

Also monitored through reporting to the Iowa Healthcare Collaborative are adverse drug events, antibiotic stewardship, catheter-associated urinary tract infection, central line-associated blood stream infections, incidents of Clostridium difficile, methicillin-resistant staphylococcus aureus infections, readmissions, severe sepsis and septic shock bundle compliance, surgical site infections, and venous thromboembolism prevention measures.

Mercy One

Each month, DCHC reports quality measures to Mercy One for comparison to the network in achieving the outlined quality goals. Results were reviewed at the Quality Committee meeting. Goals that did not meet the outlined targets were tracked and trended. Departments work collaboratively to improve compliance with target goals. This data is also analyzed and utilized to aid in establishing internal quality goals and priorities for improvement each year.

Internal Quality Monitoring and Reporting

Davis County Hospital and Clinics has ninety internal departmental goals organization-wide that were monitored through the internal quality assessment performance improvement program for fiscal year 2023. Each departmental goal was tied to one or more strategic objectives or key results, one or more outcome indicators, and one or more priorities listed below.

- Key Results:
  - Be One
  - Personalize Care
  - Own It!
  - Improve Daily
  - Innovate
- Outcome Indicators:
  - Improved health outcomes
  - Prevention and reduction of medical errors
  - Adverse event reduction
  - Critical access hospital acquired condition prevention.
  - Transitions of care
- Priorities:
  - High risk
  - High volume
  - problem-prone area

In addition to the goals established, process improvement activities, patient safety, or process changes are reviewed at the quality committee meetings. Results from external reporting to the Iowa Healthcare Collaborative and MercyOne were also reviewed at the monthly quality committee meetings.

Internal Priorities:

In review of the strategic objectives, externally reported data, and collaboration from the DCHC team, the following were identified as priorities for improvement during fiscal year 2023: Outcomes, or results of established priorities, are listed.

Department	Aligns With	Measure	Target	FY Result
ACUTE CARE	IHC	DCHC will maintain no hospital-acquired pressure injuries throughout 2023.	0	0
ACUTE CARE	MercyOne IHC	Fall rate of 1.92 per 1,000 pt days or less in FY23	≤1.92	6.33
ACUTE, ED, CLINIC, OP, OR, SPECIALTY	Strategic Plan IHC	95% compliance with med history completion	95%	87.5%
EMERGENCY DEPARTMENT (EMS)	MercyOne	Eligible chest pain and AMI patients will have an EKG within ten minutes of arrival to ED	100%	89%

Department	Aligns With	Measure	Target	FY Result
INFECTION PREVENTION	IHC	Patients at DCHC will experience no healthcare associated infections during FY23	0%	0%
INFECTION PREVENTION	IHC	Patients at DCHC will experience no catheter-associated urinary tract infections during FY23	0%	0%
INFECTION PREVENTION	IHC	All catheters inserted during FY23 will be due to appropriate reasons for use	100%	29%
INFECTION PREVENTION	IHC	Patients at DCHC will experience no central line associated infections during FY23	0	0
INFECTION PREVENTION	IHC	Patients at DCHC will experience no surgical site infections during FY23	0	0
INFECTION PREVENTION	IHC	DCHC employees will practice hand hygiene at every opportunity during FY23	100%	94%
HUMAN RESOURCES	Strategic Plan	Rounding percent complete at the end of the 3-week period each quarter (manager sign off)	90%	89%
HUMAN RESOURCES	Strategic Plan	Employee retention rate ≥ 98.5percent each month	98.50%	98.47%
PHARMACY	MercyOne	Zero Category D-I ADEs during FY 2023	0	2
ALL SERVICE LINES	Strategic Plan	Patient satisfaction top box scores for 'Would Recommend" are in the 80th percent or higher for each service line by June 30, 2023.	100% of service lines	80% (4 of 5)

A fall reduction workgroup will be formed in fiscal year 2024 to focus on the prevention of falls in hospitalized patients. Medication history completion will continue to be reviewed. Eligible chest pain patient fallouts are communicated with staff involved in care. This measure will continue to be reported to MercyOne monthly and reviewed by the Quality Committee. The appropriateness of catheter utilization is monitored each month by infection prevention. A workgroup was established during the fiscal year to improve documentation surrounding the appropriateness of urinary catheters. It was discovered during this process that the review of the chart was insufficient, accounting for the reported twenty-nine percent compliance rate. This has since been resolved. Work towards the implementation of a nurse-driven protocol for urinary catheter removal is also in progress. Both adverse drug events resulted in a change to current practice.

Drills and emergency preparedness activities include but are not limited to:

- Medical Emergency Drill on August 1, 2022
- Medical Emergency Drill on August 3, 2022
- Severe Weather Drill on September 18, 2022
- Fire Drill on September 30, 2022
- Medical Emergency Drill on October 17,2022
- Medical Emergency Drill in conjunction with Nuclear Med service on October 26, 2022

- Bomb threat drill on October 21, 2022
- Medical emergency drill on November 16, 2022
- Surgical fire drill on November 23, 2022
- Fire drill on December 7, 2022
- Fire drill on December 31, 2022
- Medical emergency drill on January 11, 2023
- HazMat drill on January 16, 2023
- Medical emergency drill on March 7, 2023
- Fire drill on March 30, 2023
- Severe weather drill on March 29, 2023
- Severe weather event (tornado warning) with evacuation on March 31, 2023
- Aggressive intruder facility wide classroom and practical training completed March 2023
- Malignant Hyperthermia tabletop exercise on May 19, 2023
- Fire drill on May 13, 2023
- Fire drill on June 11, 2023
- Missing person, emergency department patient elopement, on June 21, 2023
- Severe weather warning on June 29, 2023
- Medical emergency event on June 22, 2023

Policies and Procedures

Policies and procedures are reviewed and revised at least biennially, more often as needed, and as required by policy. The following department's policies and procedures underwent a review during this fiscal year:

- Employee Health
- Medical Imaging Services
- Patient Financial Services
- Food and Nutrition Services
- Laboratory
- Nursing
- Pharmacy
- Plant Operations
- Skilled Care
- Medical Associates Clinic
- Administration/Critical Access Hospital
- Emergency Medical Treatment and Labor Act (EMTALA)
- Health Information Management
- Materials Management
- Cardio-Pulmonary
- Cardiac Rehab
- Medical nutrition therapy
- Surgical Services
- Public Health
- Quality Assessment and Performance Improvement Program

All policies and procedure revisions are reviewed by the senior leader, medical director of the department (if applicable), and the Critical Access Hospital Committee, where clinical policies are reviewed and revised based on

input from both mid-level practitioners as well as MDs and/or DOs. From there, these reviews and revisions pass through the medical staff and the board of trustees, as applicable.

Quality Reporting to the Board

Board member Nolan Eakins began attending monthly Quality Committee meetings in July 2023. Departments reporting at Board of Trustees meetings this fiscal year include Patient Financial Services, Health Information Management, Information Technology, Human Resources, Utilization Review, Discharge Planning, and the Swing Bed service lines. Specific quality reporting and data presented to the board includes average length of stay, compliance with scheduling follow-up appointments prior to discharge, thirty-day readmissions, adverse drug events, falls, aggressive intruder training, patient satisfaction, infection prevention, antibiotic stewardship, completion of medication history, pressure injuries, and eligible chest pain patients receiving an EKG within ten minutes of arrival to the emergency department. Also presented were patient safety and performance improvement activities, including a change in process surrounding advance directive documentation to improve patient safety, changing from add-mix intravenous potassium infusions to a pre-mixed solution, and a malignant hyperthermia tabletop exercise that was recently conducted. Pharmacy goals to reduce high-dose opioid prescriptions at discharge, forty-eight-hour antibiotic timeout completion, and medication override reduction from the medication dispensing machines located in Acute and ED.

Summary

The Critical Access Hospital (CAH) Annual Report in-part allows the opportunity to develop, implement, and maintain an effective, ongoing, CAH-wide, data-driven quality assessment and performance improvement (QAPI) program by evaluating volumes of services provided, investigating additional need for services, review issues discovered within departments and corrective actions taken, as well as collect and analyze data for each service line within the organization. Each department within the organization is committed to providing high-quality, patient centered care with integrity and trust. An annual total program evaluation assists in assuring Davis County Hospital and Clinics carries out their mission.