Davis County Hospital and Clinics

Fiscal Year 2022 Annual Evaluation of Services

Prepared by:

Amy Marlow, BSN, RN, Quality Director

Executive Summary

This Critical Access Hospital Annual Report for Davis County Hospital and Clinics (DCHC) has summarized utilization of services, quality activities, and strategic direction activities for the year July 1st, 2021, through June 30th, 2022.

Network

Davis County Hospital and Clinic's Management and Network Agreements are with Mercy One. Mercy One provides affinity meetings for their rural affiliates. The affinity groups meet in person or via webinars and groups include CEO's, financial officers, nurse executives, human resources, quality, infection prevention, lab, purchasing, health information managers, cardiac rehab, credentialing, education, radiology, pharmacy, food and nutrition services, emergency department, surgery department, medical surgical department, utilization review, compliance, informational technology, and performance excellence.

Leadership Transitions

The 2021-22 fiscal year included the following leadership changes at DCHC:

- Tara Porter, RN, transitioned to the role of Patient Services Manager, overseeing Acute Care and the Emergency Department.
- Amy Marlow, BSN, RN, transitioned into the role of Quality Director.
- Lisa Warren, MBA, accepted the Chief Financial Officer position to replace Kendra Warning when she retires in FY 2023.

Board of Trustees

Tom Prosapio, Board Chair
Kevin Cook, Vice-Chair
Brenda Johnson, Secretary/Treasurer
Members: Heath Greiner, Donna Olinger, and Brad Woolard

Credentials

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

- Five (5) Initial Appointments
- Twenty-nine (29) Reappointments
- Mercy Medical Center/MercyOne's credentialing decisions for seven (7) initial practitioners who are providing telemedicine services.
- Mercy Medical Center/MercyOne's credentialing decisions for twenty-two (22) reappointment practitioners who are providing telemedicine services.
- BOT accepted two (2) resignations

Physicians and Services Providers

Davis County Hospital and Clinics employs the following providers:

- Dr. Robert Floyd, Internal Medicine
- Dr. Sarah Brewer, Internal Medicine
- Dr. Mary Graeff, Pediatrician
- Dr. Trina Settles, Family Medicine
- Dr. Ron Graeff, Allergy and Pulmonology
- Dr. Donald Wirtanen, Emergency Medicine
- Dr. Ryan VanMaanen, Emergency Medicine, Hospitalist
- Haleigh Skaggs, Family Nurse Practitioner
- Beverly Oliver, Family Nurse Practitioner
- Megan Whisler, Pediatric Nurse Practitioner
- Phillip Hurd, DNP, Emergency Medicine
- Joseph Kruser, ARNP, Emergency Medicine

Davis County Hospital and Clinics also provides specialty services including podiatry, orthopedics, urology, rheumatology, allergy, ear, nose, and throat, obstetrics and gynecology, dermatology, and cardiology. These providers practice out of the Specialty Clinic at Davis County Hospital and Clinics and are here on a part-time basis.

Master Facilities Plan

- The COVID pandemic continued to make an impact on Master Facilities projects.
- The Master Facility Plan continues to be on hold due to a volatile construction market. Until such time as the committee feels that market has somewhat stabilized for associated costs, only small projects will be completed as needed.
- The following areas have had some modifications/remodeling in FY 2022
    - Greeter/screener relocated to north side of outpatient entrance (Door B3)
    - Additional Patient Registration desk added
    - Centralized Scheduling relocated to old Gift Shop area. A sliding patient window was added for ease of access for patients.
    - Medical Imaging office/workspace remodeled
    - East Maintenance Garage
        - Insulated
        - City gas trenched for future heating of the building
    - Human Resources space remodeled. Moved into Conference Room C space. Compliance Officer moved into former HR Manager space.
    - Replaced roof top AHU #9 for Patient Access area
    - Replaced Kitchen walk-in cooler/freezer units
    - Relocated Handicap parking spaces in south parking lot
    - Repainted south parking lot lines
    - Generator capacity study completed to review options for emergency 480-volt generation possibilities. This would allow Medical Imaging equipment to remain on-line during power outages.

Strategic Planning

The Strategic Planning Steering Council (SPC) concluded a four-year goal period (January 1, 2018 - December 31, 2021) the end of December 2021.
Each Chapter reports goals progress 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, progress, and meet the goals for that period.

The following changes have been made to the new Strategic Planning period (January 1, 2022 – December 31, 2024).

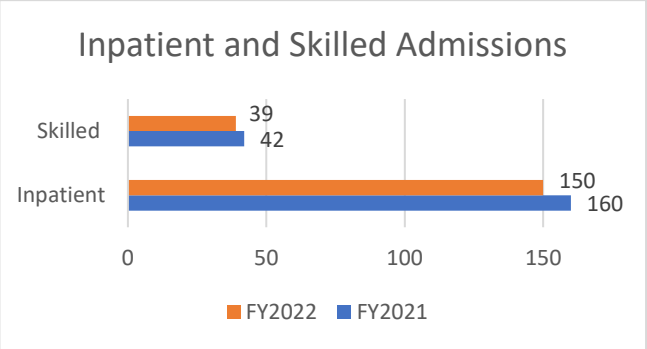
- The committee agreed to dissolve the "IT Chapter". This is due to this Chapter and its team members being directly involved with most of the other Chapter's goals/tasks and was not feasible to facilitate the IT Chapter separately.
- The Strategic Planning Committee now consists of five (5) Chapters:
    - Growth
    - Finance
    - Quality & Safety
    - Employees
    - Patients

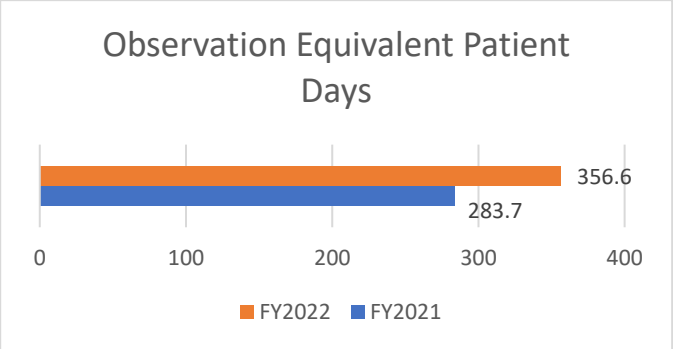
- Strategic Planning will continue to incorporate the Community Health Needs Assessment (CHNA) goals that were developed. The CHNA Goals are adapted into the different chapters of the Strategic Plan as necessary.
- Each Chapter has established new goals for the new period.
- The Committee is now using Microsoft Teams for tracking goals and progress of tasks for each Chapter.
- Efforts are on-going to recruit DCHC staff to become active members in each of the Chapters.

Departments and Services

Acute Care

Acute care had an overall reduction in acute and skilled admissions by 6.3 and 7.1% respectively. However, observation equivalent patient days increased by 25.7%. Census peaked in January 2021 with an average daily census of 4.61.





Quality Improvement focus areas for FY 2021 included 100% completion of medication reconciliation, hospital acquired pressure injury prevention and fall rates below 1.92%. Utilization Review and Discharge Planning focused on reducing all-cause same hospital readmission rate and our skilled study focused on follow-up appointments being scheduled at the time of discharge.

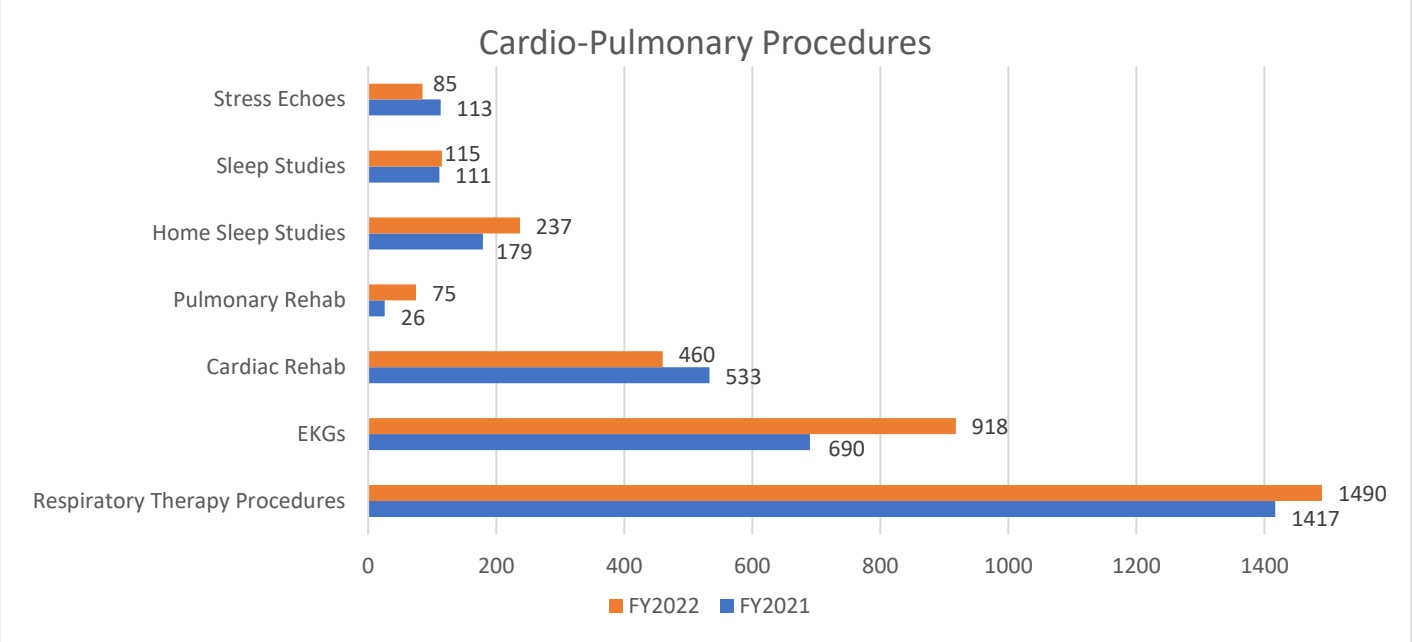
Results of quality projects included a 0.83% fall rate for the year, well under the Mercy One goal of 1.92%. Readmissions were just above the 3% Mercy One goal at 3.1%, or five readmissions for the fiscal year. Ninety-eight percent of patients were scheduled for a follow-up appointment prior to discharge. The 100% goal for medication reconciliation prior to discharge fell short at 91%. We continue to monitor this and strive for improvement.

Acute Care was able to secure additional equipment including additional patient monitoring equipment, a bladder scanner, and a glide scope to assist in intubations.

Chart reviews were completed throughout FY2022. Special attention was paid to completion of the Medicare Outpatient Observation Notice, the Important Message from Medicare, and the Inpatient Lay Caregiver designation form. All applicable charts were reviewed. Process improvements were made throughout the year to improve compliance, resulting in no MOON forms or Important Message from Medicare forms being incomplete in the fourth quarter of this fiscal year.

Cardio-Pulmonary

The Cardio-Pulmonary department performed 3,380 procedures during fiscal year 2022. The Pulmonary Rehab service line saw tremendous growth this year, seeing a 188.5% increase. There was a 33% increase in EKGs as well. All other service lines within Cardio-Pulmonary stayed relative to last year's volumes or showed a slight decrease.



Cardio-Pulmonary was able to host a Freedom from Tobacco class in January and are celebrating that the one participant remains smoke free after the class.

As a result of quality improvement goals related to continuous chart audits, checklists were created to ensure documentation has been completed on all home sleep and in-house sleep studies. This documentation is reviewed prior to submitting to medical records, which is a proactive approach to ensuring chart completion and avoiding medical record deficiencies. The cardio-pulmonary department met these goals at 100% for each measure during fiscal year 2022.

For fiscal year 2023, the focus has changed to patient outcome-based measures including compliance with recommended rehab, turn-around times for sleep studies, and working with Acute Care and ER to ensure equipment is always ready for use preventing delays in care.

Education

Education is provided throughout the year and includes a variety of topics. For the period of July 1, 2021, through June 30th, 2022, these topics included but were not limited to:

- Mo-Lift and Geri Chair usage
- Medication dosage calculation
- Glucometer competency—2 different types of glucometers
- Mercy trauma education
- COVID education

DCHC has two staff who are Advanced Cardiac Life Support (ACLS) instructors to train staff and provide training to the community and two staff who are Pediatric Advanced Life Support Instructors. There are a total of 5 staff who are trained Basic Life Support Instructors. Heart code BLS skills verifications have been conducted multiple times throughout the fiscal year.

Total certifications completed during period of July 1, 2021, through June 30, 2022:

- ACLS-22
- PALS-13
- BLS-90
- Heartsaver-40

These totals include both hospital employees and community members that received training by DCHC employed instructors.

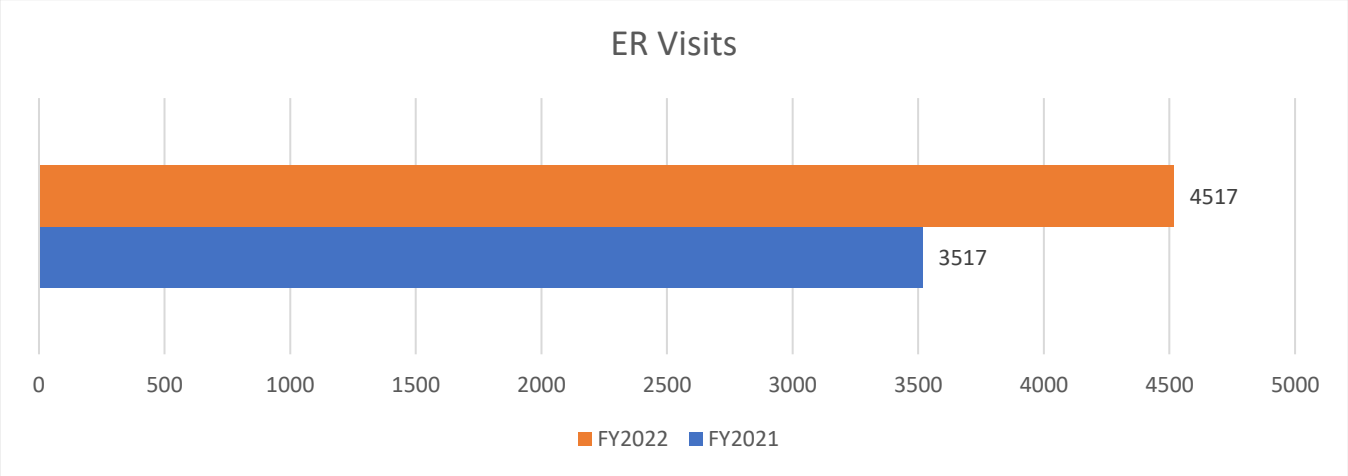
Care Learning is utilized to provide staff the mandated education requirements. Courses are assigned according to clinical and non-clinical settings and are conducted throughout the year to ensure that hospital staff completes annual competencies in:

- Abuse and neglect
- ADA
- Blood borne pathogens
- COVID-19 Coronavirus Disease
- Criminal Record History
- Cultural Competence in the Workplace
- Customer Service
- Donation 101: the Hospital's Role
- Fire and electrical safety
- Emergency Preparedness
- EMTALA

- Identity Theft Prevention
- FMLA
- Hand hygiene
- Hazard communication
- HIPAA
- Influenza
- Isolation and standard precautions
- IT Security and Awareness training
- Medical radiation safety
- Medication Administration
- Moving, lifting, and repetitive motions
- Pain Management
- Patient's rights
- Population specific care- adults and pediatrics
- Restraint and seclusion
- Sexual Harassment
- Slips, trips, and falls
- TB prevention
- Workplace diversity
- Workplace violence

Emergency Department

Emergency department volumes increased by 28.4% seeing one-thousand patients more than the prior fiscal year. The significant volume increase without adjustments to staffing levels proved challenging for the emergency department but they rose to the occasion.



Quality improvement measures for the emergency department and trauma program included the goal of 100% of chest pain patients receiving an EKG within 10 minutes of arrival. There have been some equipment issues and staff education throughout the year to improve compliance with this goal. Overall year-to-date results were nearly 80%. The thirty minute in-the-door out-the-door goal for STEMI patients was not met. We continue to drill and educate on this topic.

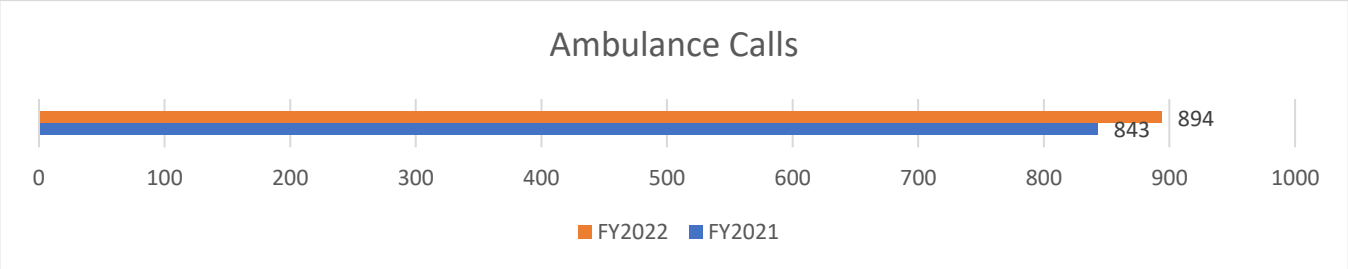
The Emergency Department celebrated a deficiency free Trauma Level IV reverification during this fiscal year. Trauma performance improvement goals include getting patients to definitive care within three hours, and documenting heights and weights on trauma patients consistently. We continue to see some internal and external factors affecting our ability to get patients to a level II or III trauma center within 3-hours, meeting this goal only 52% of the time during FY 2022. We will continue to strive for improvement in the upcoming year. Height and weight documentation compliance was nearly 80%, falling 10% below the goal.

The chart reviews conducted for quality improvement metrics, along with periodic review of documentation allows for identification of trends and gives us the opportunity to implement measures to improve performance.

The Medical Director of the Emergency Department reviews ten percent of each mid-level providers charts each month. If any issues are seen, the chart is reviewed with the mid-level provider. This process works well for the emergency department and allows our medical director to be actively involved in the oversight of the department.

Emergency Medical Services (Ambulance)

Ambulance call volume increase by 6% compared to the prior year. This has been taxing to the service as staffing has been a challenge. The shortage of EMS throughout the state, along with the shortage of beds at tertiary facilities has proved difficult to navigate over the past year. We have overcome these struggles by altering staffing models and schedules to meet the needs of both the patients and our staff.



Quality improvement measures for EMS included EKG obtained within 10-minutes of arrival on all chest pains and activation of alerts on all applicable patients. EKG goal was met at 98%, missing obtaining 1 of 56 EKGs within ten minutes. Four of five alerts were called prior to arrival to the emergency department resulting in falling short of the goal by 10%. These chart reviews allow the department to track and trend for issues beyond the established quality improvement goals, and provide us the opportunity to console, congratulate, or coach staff as needed.

Human Resources

Davis County Hospital and Clinics hired forty employees from July 1, 2021, to June 30, 2022, and three employees retired. Fiscal year turnover was 25%. The first day of new hire orientation is offered every Monday, and the second day of orientation is offered every fourth Tuesday of the month.

Twenty-nine employees were recognized for employee milestones at the annual recognition event in November 2021. The recognition event had to be held virtually again because of COVID. The 5th annual Lighting the Way award was presented on November 2nd. There were nineteen nominations for the Lighting the Way Award for 2021. The award winner, Libbie Johnson, was selected by DCHC staff based on who most exuded behaviors that replicate a Culture of Ownership.

DCHC was named a Top Workplace in Iowa for the fourth time in September 2021.

Employees were treated to a pizza party for achieving 100 % participation in the Press Ganey Employee Satisfaction Survey spring of 2021.

Quality improvement metrics for Human Resources included auditing files for completion of an I-9 form in which one hundred percent of audited files had. Ninety-seven percent of audited files had a completed SING form, missing three of one-hundred and two. This was just under the one-hundred percent goal.

Infection Prevention

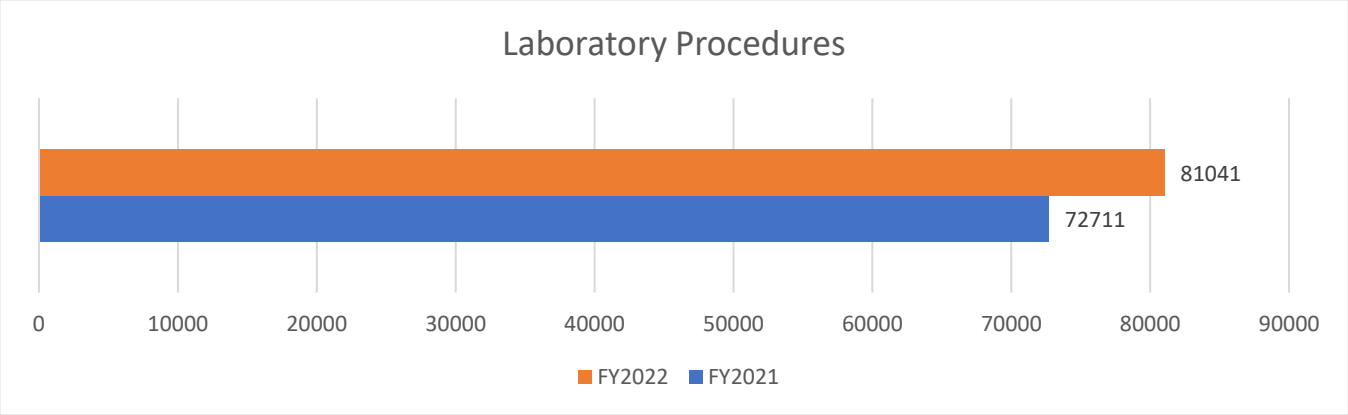
The Infection Prevention service is proud to report that during fiscal year 2022, the facility experienced no healthcare associated infections, no catheter-associated urinary tract infections, no central line infections, no post-operative infections, and monitored to ensure 100% compliance with properly placed urinary catheters.

There is a hand-hygiene compliance monitoring system in place which showed 97% compliance with performing hand hygiene at key points of care.

Infection Prevention continues to stay in-tune to any changes in recommendations due to the COVID-19 pandemic and worked to ensure compliance with healthcare vaccine requirements.

Laboratory

The laboratory department saw an overall increase in procedures by 11.5% during fiscal year 2022. Blood bank units, including packed red blood cells, platelets, and fresh frozen plasma experienced a decreased of forty units compared to last fiscal year. Pathology cases remained comparable at two hundred and sixty-five in fiscal year 2022 compared to two hundred and eight-three the year prior. Microbiology cases significantly increased with a volume of one thousand, three hundred four this year compared to nine hundred and fifty-three last year.



Quality improvement projects resulted in meeting all four established goals. Blood bank crossmatch-transfusion ratio rate was 1.08, under the 2.0 goal. Laboratory aimed to achieve 88% of STAT samples resulted within acceptable turnaround time and exceed that goal by 6%. 99% of urine cultures were turned around in ninety-six hours or less, and 98% of pathology results were resulted in seventy-two hours or less.

Chart reviews consisted of checking test requisitions (orders) for completeness, verifying orders were placed correctly and on the correct encounter, confirming that all charges dropped accurately and/or were manually input timely and that test reports for complete with results and all required information.

Laboratory found multiple concerns, specifically with written orders. This has resulted in a monthly written order audit, focusing on orders that are not placed electronically by a provider in-house, but rather a paper order that is placed by lab staff. The written order audit brought several concerns that resulted in staff education and review of all standing orders. All standing orders are in the process of being renewed with all required information. A written order audit will continue each month.

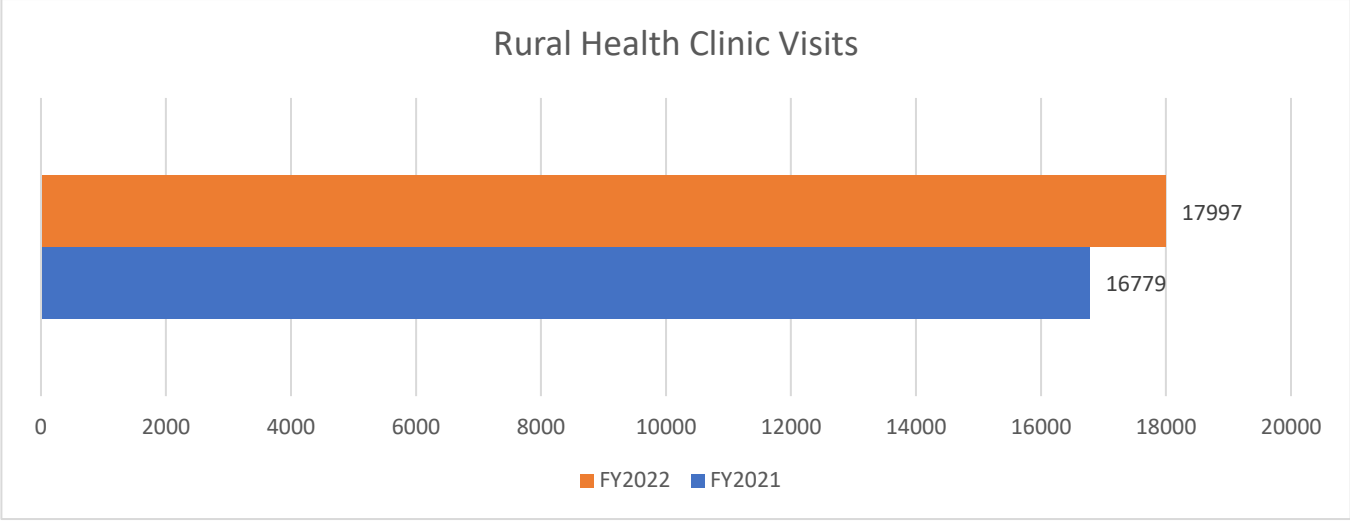
Other areas of concern discovered and addressed through the chart review process were missing charges, charges with incorrect CPT codes, partial charges, and duplication of charges. This led to process improvement with charge reconciliation. With the help of Information Technology, lab was able to get a charge reconciliation report that automatically runs daily and is shared with all lab staff. Any flags are addressed promptly.

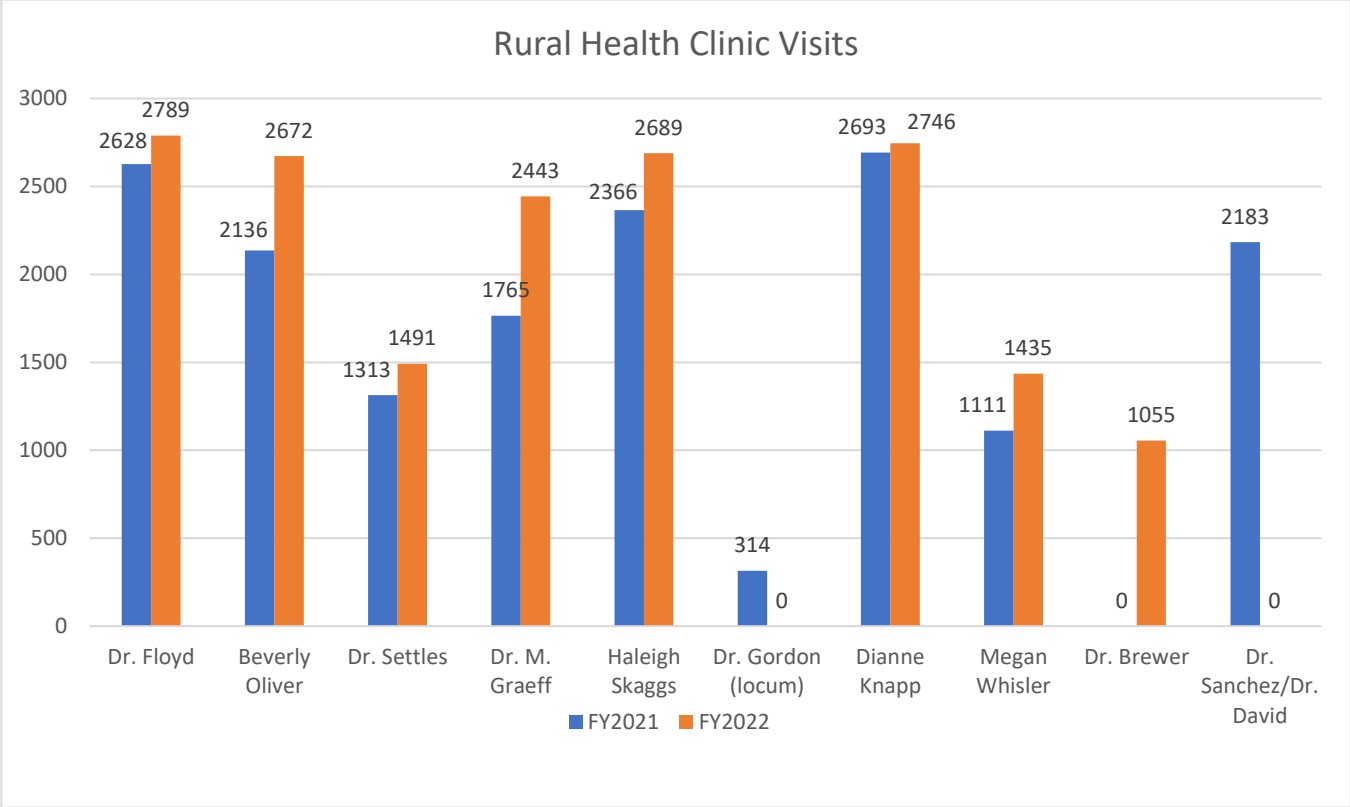
Additionally, lab has been working on improvement opportunity for non-patient draw fees, or duplicate draw fees, to get those credited within 24 hours. Each month the non-patient and add-on labs are audited and reviewed. At this time, lab is still adjusting the process to catch all fees that need to be credited. New approaches are discussed and trialed each month. This continues to be a process improvement project.

Written order audits will continue, as well as non-patient and add on fee monthly audits, and daily charge review. Lab Chargemaster reviews to verify all CPT codes is also still in progress.

Medical Associates Clinic

Rural Health Clinic (RHC) visits increased by 7.3% compared to the previous year. The addition of Dr. Brewer in August of 2021 has contributed to this increase. The total RHC numbers include not only provider visits, but nursing visits as well.





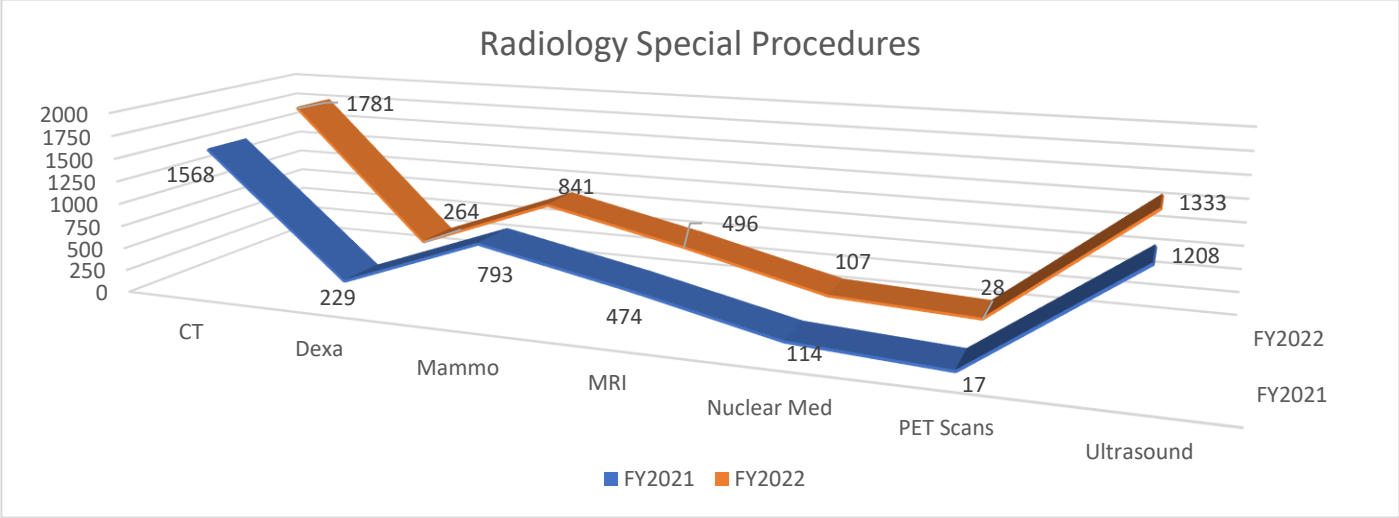
Volumes for each provider were as shown above. Dr. Sanchez left in FY 2021. Dr. David and Dr. Gordon were locum providers assisting with that gap. The addition of Dr. Brewer alone in FY 2022 allowed us over one thousand more patient visits, along with all other providers growing their volumes.

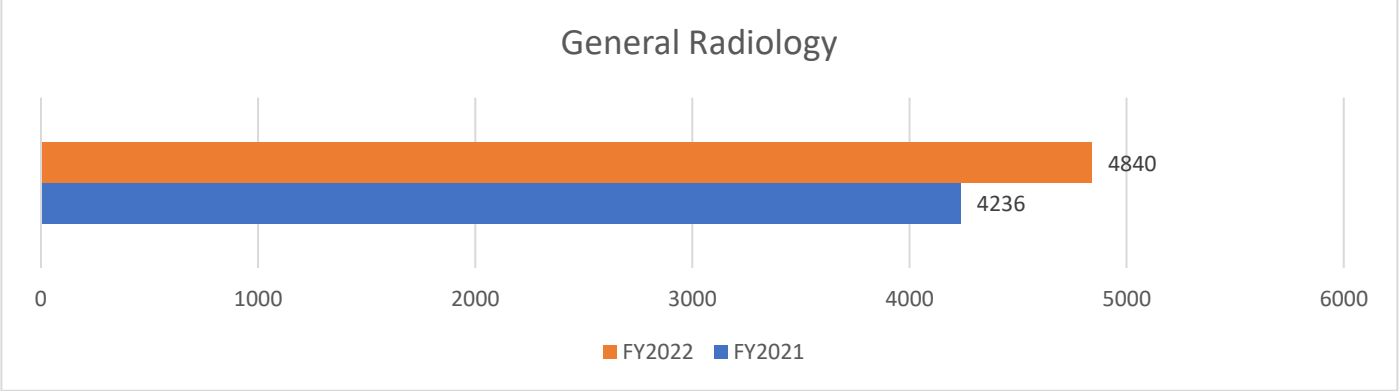
Quality improvement goals were established to monitor percent of charts passing audit checks, and next third available appointment for each provider. The chart audit goal missed the target by 3%, or one chart falling just short of the 90% goal. Dr. Floyd's next available appointment was on average 26 days out, well over the established five-day goal, though all other providers remained at or under goal. Provider recruitment efforts have continued throughout FY2022 to improve the availability of appointments in the Rural Health Clinic.

Chart reviews conducted during fiscal year 2022 included forty-two active, and ten inactive charts. Social data, history and physical, allergies, chief complaint, physical exam, and evaluation of problem was present on all charts. Five charts revealed no follow-up was scheduled or the patient did not come to the scheduled follow-up appointment. Three charts were missing the consent to treat. Three charts did not have documentation of test results being addressed. RHC will continue to track and trend these occurrences. Of the charts reviewed, referrals were made to asthma/allergy, general surgery, cardiology, orthopedics, oncology, behavioral health, dermatology, physical therapy, and speech therapy.

Medical Imaging Services

Radiology volumes increased in every modality in FY 2022. PET scan procedures showed the highest increase at 64.7%. Total volume for all modalities increased by 2,259 procedures. Overall, radiology volumes were up by 30%. This includes Radiography, CT, MRI, DEXA, Mammography, Ultrasound, Nuclear Medicine, PET\CT, and epidurals. We continue to utilize our contract with Shared Medical to provide our customers with mobile PET\CT and wide-bore MRI services.





IDPH (Iowa Department of Public Health) was on-site to perform the annual Mammography inspection in July of 2021. A "No Findings" on the quality control manual shows compliance with the State of Iowa and FDA regulations.

The annual Walk for Life event was held in-person on Saturday October 2nd, 2021, at Mustang Stadium. Upcoming milestone celebration for this event includes the 25th anniversary this fall.

Quality Improvement measures went well this year. Highlights include that less than 2% of DEXA patients were improperly prepped for their exam, 94% of the MRIs ordered at DCHC were able to be performed in-house, and average STAT turnaround time for general radiography exams was only 16 minutes.

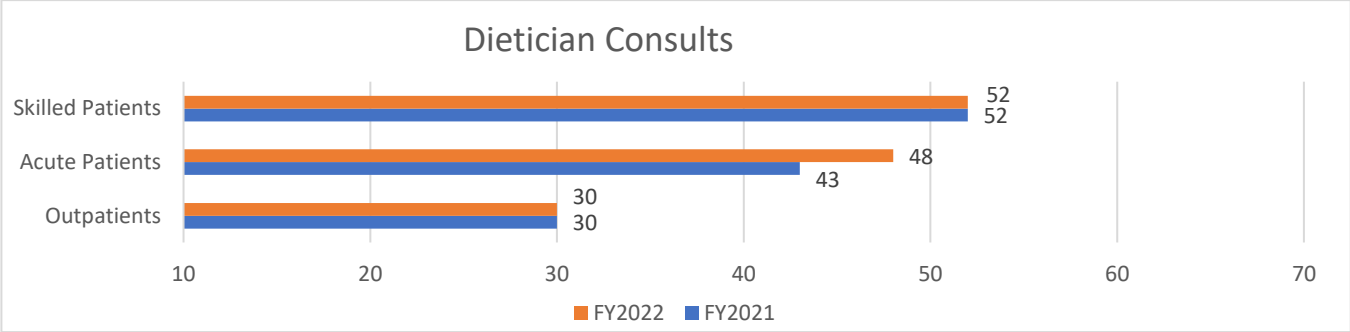
The mammography year to date overall percentage was just under the 60% goal. With care facility and body habitus factors not being able to be excluded, another improvement area will be monitored next fiscal year. Three Nuclear medicine studies were not completed as ordered due to isolated issues. This caused the percentage to come in just under the goal at 89.72%.

Chart review this year included verifying that there was an order for each exam, the images were sent to PACS, the results attached to the patient's chart, the results faxed to the provider, and the correct charge dropped on the account. No trends in issues were identified, though isolated charging errors did occur and were corrected.

New equipment during this fiscal year includes a GE Zenition 70 mobile C-arm was. This device has radiographic capabilities, primarily used for intra-operative imaging during surgical and orthopedic procedures.

Medical Nutritional Therapy

In FY 2022, DCHC continued to contract shared Dietitian services with Angela Birkner, RD, LD, of Birkner Consulting, and with Brittany Carnahan, RDN, LD. In March of 2022, Brittany resigned, leaving Angela to finish the year while recruiting efforts were initiated. During FY 2022, the dietitians consulted on thirty outpatients, forty-eight Acute Care patients, and fifty-two skilled patients. Volumes remained comparable to the prior year, seeing five additional patients in fiscal year 2022 compared to fiscal year 2021.

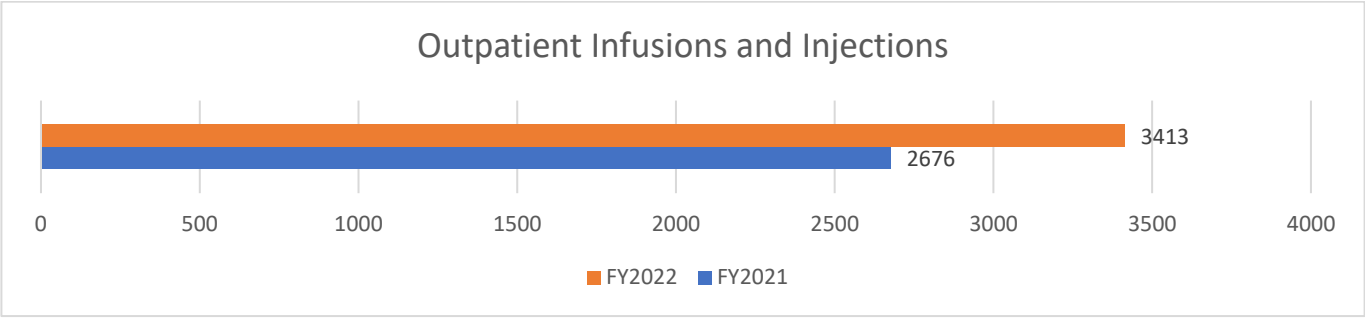


The quality improvement goal for medical nutritional therapy focused on monitoring nursing compliance with completing certain aspects of the nutritional evaluation on admission to Acute Care. Only forty-five percent of charts revealed a fully completed nutritional evaluation. Medical Nutritional Therapy will work with the Acute Care Manager during FY 2023 to implement measures to improve these results.

The Dietitian's approved the diet menus provided to patients by Food & Nutrition. They also approved the Annual Diet Menu Attestation.

Outpatient Infusion

In the Outpatient Infusion Center, a total of 3,413 infusions, injections, and procedures were performed. This is an increase of 737 from last fiscal year. As a response to the increased volumes, a third nurse was hired in this department to support the growth as well as support the surgery team with pre- and post-operative care as needed.



During FY 2022 a process issue in documenting patient education was discovered. The Clinical Support Coordinator provided education to staff on how to ensure documentation was saved in the record. Auditing of this process improvement was completed, and the issue has been resolved. Additionally, audits revealed an issue with treatment orders versus written protocols. This was communicated with staff and has since been resolved. Procedures for monitoring allergy serums and outdates were revised during this fiscal year as well.

Patient Access/Patient Financial Services

The Patient Access Department has added three additional full-time employees due to ramping up for the new CMS No Surprise Billing Act, as well as the increasing patient volumes throughout the facility. Centralized scheduling re-located so they could be in the same location, increasing privacy and facilitating better communication.

Registration has fully implemented utilizing JellyFish Health, now known as Millennia, to aide in patients flowing from one department to the next within our healthcare facility. A new process was implemented, requiring consent to treat at each encounter versus annually for certain patient types. 65,832 visits were registered in FY 2022 compared to 41,357 encounters the year prior. This is an increase of over 24,000 visits throughout the facility.

The Patient Financial Services Department experienced turnover in a position during fiscal year 2021. The open position, combined with aiding in filling open positions in Patient Access has contributed to an increase in AR days from last year. Days in Accounts Receivable were 49.30 at the end of last FY. At the end of this fiscal year, they were 52.81.

Pharmacy

This past year in the pharmacy, we experienced an upgrade to our Omnicell automated medication dispensing cabinets. This was completed in March 2022. The new Acute Care cabinet presently holds 737 items while the ER cabinet holds 456 items. Each cabinet has additional capacity above and beyond that which we had earlier. An ongoing project will be to determine what additional items need to be stocked in each cabinet and to accomplish such overstocks.

We continue to see patients struggling with COVID-19. Fortunately, those that we have seen recently don't seem to require hospitalization as frequently as those patients who were afflicted early in the pandemic. Therefore, pharmacy is very much involved in dispensing and helping with administration of monoclonal antibody products in the outpatient setting (ER and outpatient departments). In total, we have administered 365 doses of monoclonal antibody since the pandemic began.

Some pertinent statistics to share with regards to our current volume of service and number of patients served are as follows:

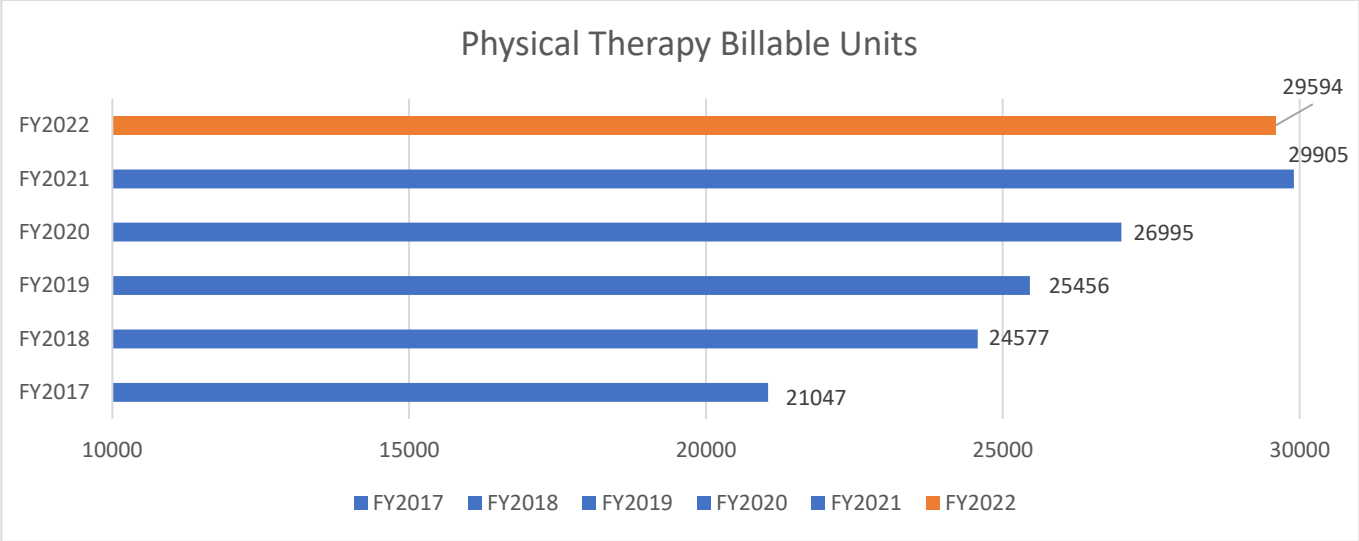
- Compounded sterile products admixed in calendar year 2021 = 985
- Compounded sterile products admixed in fiscal year 2022 = 970
- Adverse drug events in fiscal year 2022 = 20
- Medications dispensed from Omnicell in fiscal year 2022
    - 21,907 from Acute Care
    - 7,010 from the Emergency Department

As an ongoing quality improvement project, we continue to discuss the Institute for Safe Medication Practices (ISMP) Targeted Best Practices for Hospitals list at our quarterly Pharmacy and Therapeutics Committee meetings. There are a total of sixteen best practice recommendations from ISMP. To date, we have fully accomplished eleven of those recommendations.

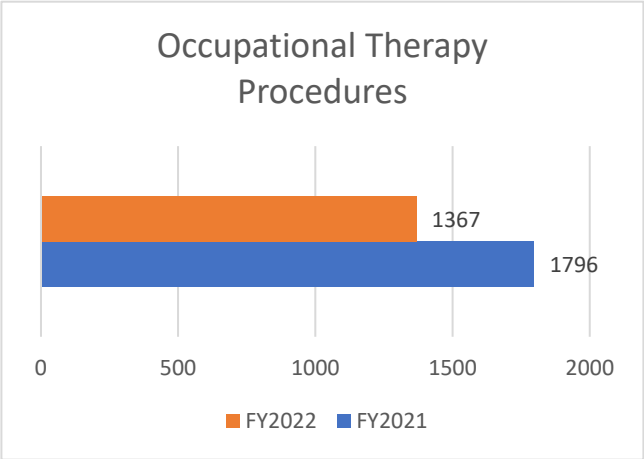
Quality improvement focus areas for this year included reduction of adverse drug events, reducing antibiotic days of therapy, monitoring the instance of high dose opioid prescriptions upon discharge, and completing a 48-hour antibiotic timeout. Pharmacy was able to meet each of their QI goals for FY 2022.

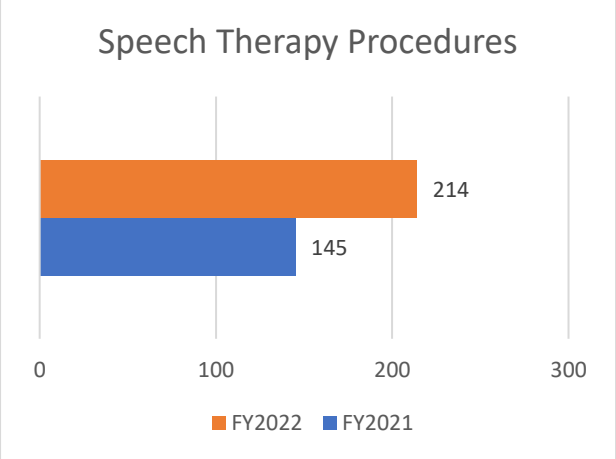
Physical, Occupational, and Speech Therapy

Physical therapy volumes remained comparable to last year with less than one percent difference. This averages to over 2,400 billable units per month. Kincart Physical Therapy Services (KPTS) has grown to a practice with four Physical Therapists over the past few years, allowing them to better serve the needs of the community.



Occupational Therapy volumes were down by twenty-four percent while Speech Therapy volumes increased by forty-seven percent.





Quality improvement projects during FY 2022 included increasing compliance with their reconciliation process for charges in which the 95% goal was exceeded. Also exceeding the 95% goal, Physical Therapy, Occupational Therapy, and Speech Therapy successfully incorporated the use of standardized assessment tools into the goals for all recurring and non-preoperative outpatient evaluations.

This year, Karen Sloan-Kincart, PT, LAT, completed a monthly review of 10% of active and closed charts for physical therapy, occupational therapy, and speech therapy.

In October 2021, Jacqueline Wells, DPT, CLT, completed the ACOLS course, passing the exam to become certified as a complete lymphedema therapist, which has helped KPTS better serve patients with lymphedema and related conditions in the surrounding area.

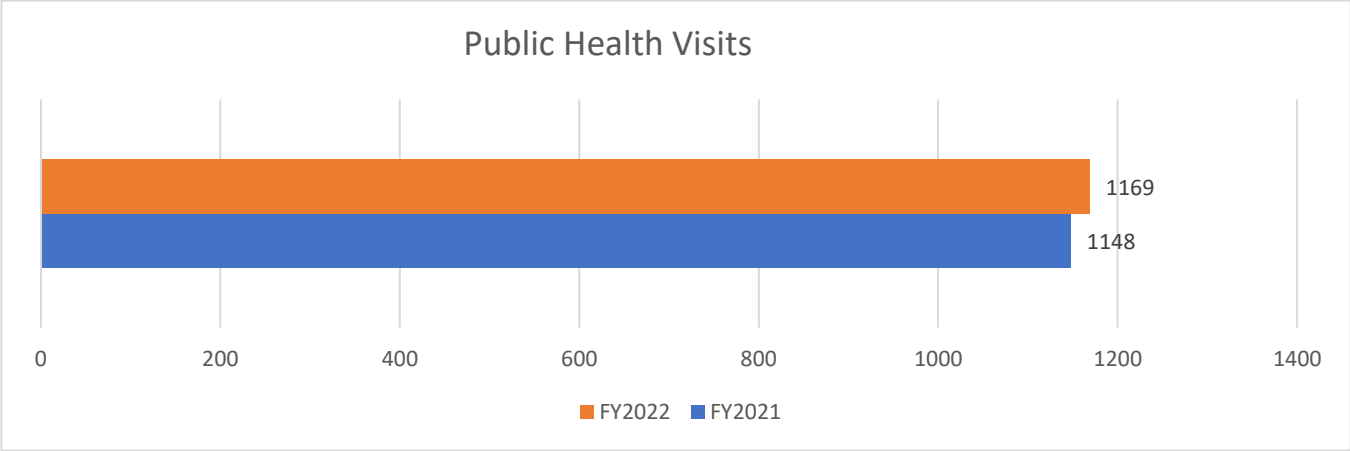
In March 2022, KPTS purchased and received a Shuttle MVP Pro for patient use to challenge patients with various upper and lower extremity strengthening, stabilization, and plyometric training with gravity elimination and/or added resistance.

In April 2022, KPTS purchased and received a new Nautilus Freedom Trainer for patient use to challenge patients mostly with upper extremity strength, and stabilization functional training.

In June 2022, KPTS purchased and received a new blanket warmer placed in the main physical therapy department, which is more energy efficient, takes up less space, and allows them to continue to provide warm blankets to patients for improved comfort.

Public Health

Public Health had a total of 1,169 scheduled home visits this year, which was slightly up from 1,148 last year.



Contact tracing for the pandemic was turned over to the State of Iowa during the last fiscal year and has eventually ceased completely. The COVID-19 virus remains a concern in the community, and we continue to offer vaccinations and boosters per request. Since the beginning of the pandemic, Public Health has administered 3,414 total COVID-19 vaccination doses. 650 of those were administered in fiscal year 2022.

Case investigation was performed for four Communicable Disease reports other than COVID this year. Public Health also provided wellness screenings to a total of 84 city and county employees, audited a total of 1,529 school immunization records, conducted the annual drive through flu shot clinic, and held an additional four flu shot clinics.

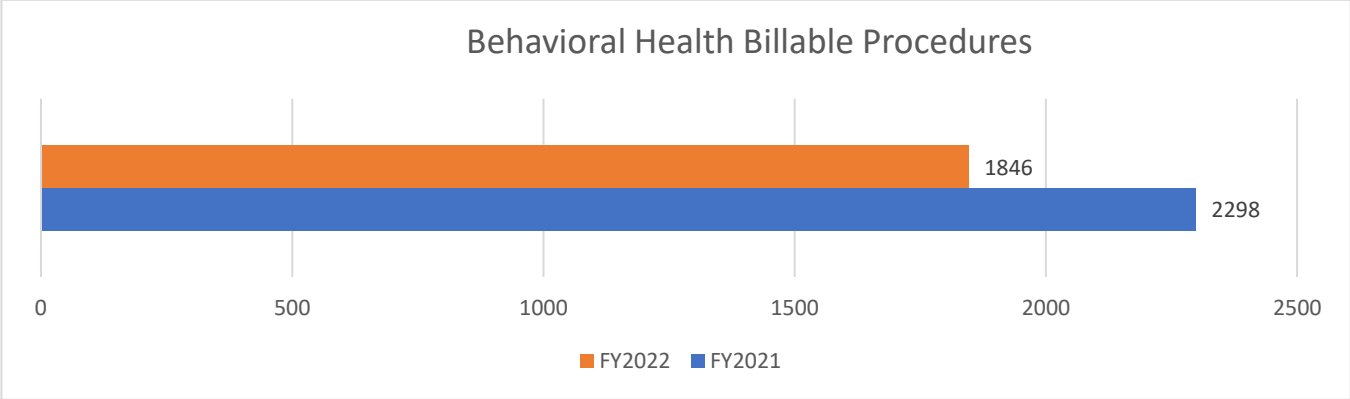
Due to COVID, Public Health did not resume regularly scheduled Immunization Clinics over the past year. Instead, they have scheduled appointments in the office as needed and provided vaccinations to several Amish families in their homes.

Quality assurance and performance improvement focus for Public Health included attempts to increase response to reminders for immunizations. The goal set for response to immunization reminders was ten percent. Public Health was able to exceed that goal, falling at nineteen percent for the year. They provided 787 total vaccinations, a decrease from the prior year which could be explained by the volumes of COVID vaccine administered during FY 2021 and children receiving vaccines at primary care versus Public Health.

Additional quality assurance and performance improvement performed includes continuous monitoring and auditing of patient records. Processes that were improved as a results of these audits include ensuring an order is present for Public Health services, and solidifying a process for ensuring an i-POST is executed for each of their patients.

Senior Life Solutions

Senior Life Solutions patient census for the fiscal year July 1, 2021, to June 30th, 2022, ranged from four to seven patients each group therapy day, resulting in 1,846 billable units for the year. This service continues to run with a team of three. Rhonda Roberts RN, Program Director, Rachael Holton, LISW, Therapist and Anna Creath, Office Patient Coordinator.



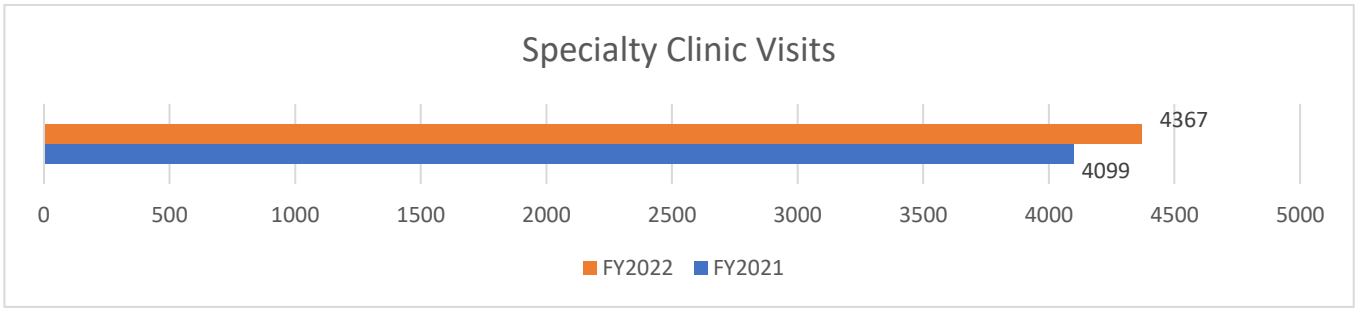
Group therapy has transitioned this past year. They were able to have some patients on-site for group therapy. Social distancing was maintained during these sessions. Others were still able to join via telehealth. Senior Life Solutions has been able to resume transporting patients to and from group therapy with the hospital van, as well as resume offering lunch for our in-house patients in attendance. Currently, we are about fifty percent in-person, fifty percent telehealth. Dr. Nina Jordania remains our Medical Director and meets with patients monthly via telehealth.

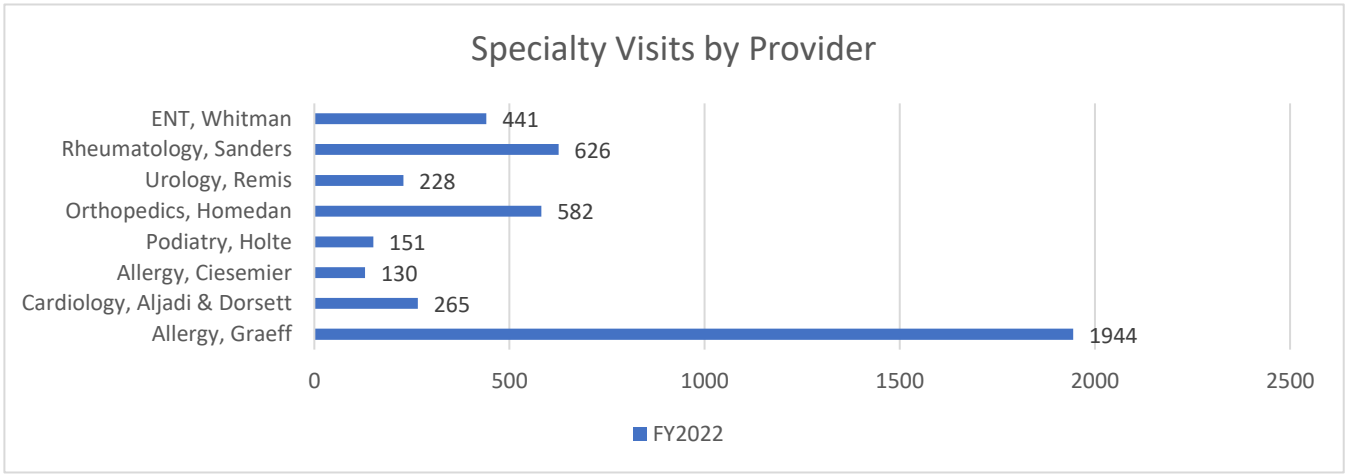
Senior Life Solutions performs thorough chart review of 30-50% of current patient's charts every month with a company pre-determined audit tool. Scores range from 98.48-100%. Out of the charts audited, 4,402 points were obtained out of a possible 4, 431, resulting in a score of 99% overall. A second quality assurance, performance improvement goal was established to solicit this service by intentionally making community contacts. Community contacts range from communicating with hospital employees regarding the service, to attending events in the community. In total, Senior Life Solutions staff had 940 community contacts during FY 2022.

We celebrate May as Mental Health Awareness Month, and September as Suicide Awareness and Prevention Month. SLS continues to promote community education and awareness to help reduce and eliminate the stigma surrounding mental health illness in our community, specifically addressing the unique needs of individuals typically 65 and older experiencing depression and/or anxiety related to life changes often associated with aging. SLS routinely engages with local hospital and clinic staff to bring awareness to our program, as to be able to serve a larger number of patients and assist in their improved over-all quality of life.

Specialty Clinic

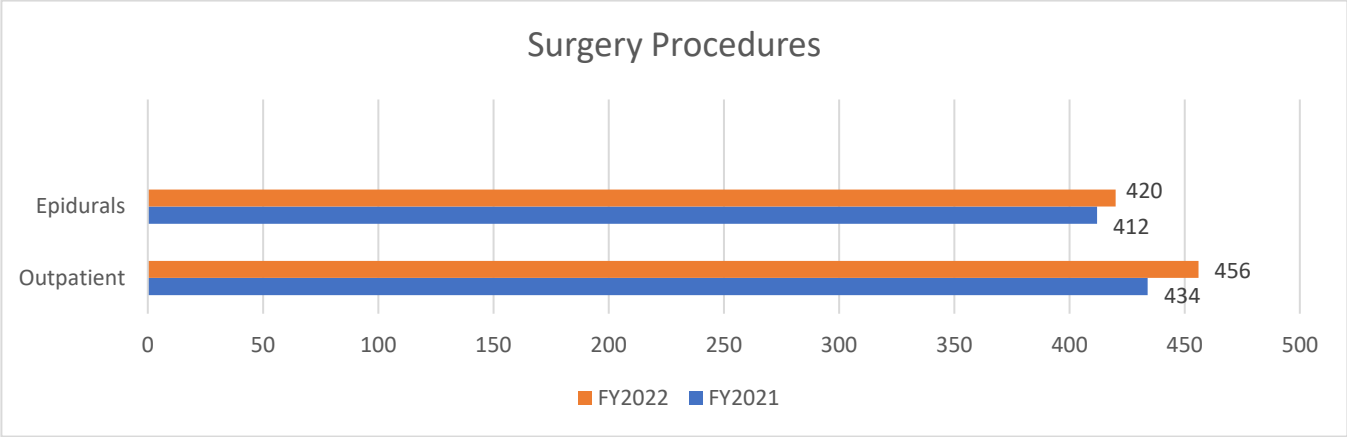
Specialty Clinic visits increased by 6.5% compared to the previous year. Specialty service lines include ear, nose and throat, rheumatology, urology, orthopedics, podiatry, allergy, and cardiology. Providers who rent space in our specialty clinic include an OB/GYN provider as well as a dermatology provider. Dr. Graeff is a full-time provider at Davis County Hospital and Clinics which explains his volumes seen. Rheumatology and Orthopedics are among our busiest visiting specialties, accounting for nearly half of the remaining volumes in the Specialty Clinic.





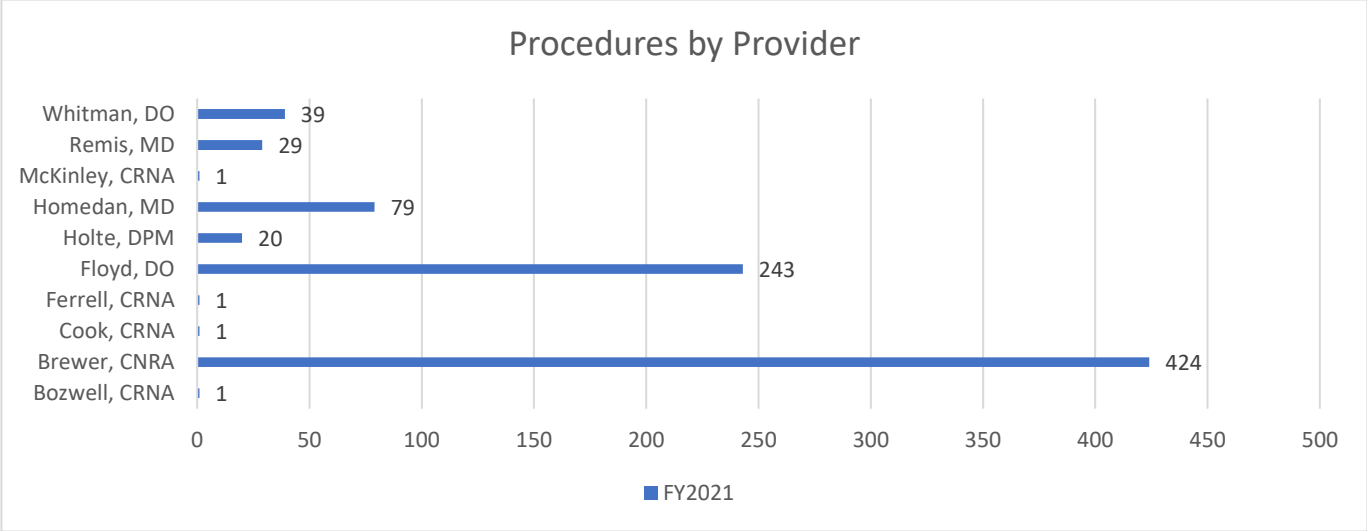
Quality improvement goals in the specialty clinic varied by provider. Some saw great successes, such as Dr. Graeff completing medication reconciliation on 100% of his patients, while others struggled to meet established goals. Some success in quality improvement and chart review outcomes includes altering processes for pre-op endoscopy documentation to ensure completion. The first two months of the fiscal year some aspect was missing, but after correcting the process issue, 100% were completed the remainder of the year. Additionally, an issue was identified with the procedure for informed consent in the Specialty Clinic. That continues to be an area of focus to improve.

Surgery



Outpatient surgeries above include total joint replacements who are kept for an extended period post-operatively to ensure safety in ambulation prior to discharge, colonoscopies, EGDs, ear, nose, and throat procedures, podiatry, and urology procedures.

Dr. Whitman, DO, performed thirty-nine ENT procedures. Dr. Remis, MD, Urology, performed twenty-nine procedures. Dr. Homedan, MD, performed one hundred and eleven orthopedic procedures, and Dr. Floyd, DO, performed two hundred forty-three scopes. Jay Brewer, CRNA performed four hundred and twenty-four procedures including epidurals. Dr. Holte, DPM, performed twenty podiatry procedures in the operating room. The remaining CRNAs performed peripherally inserted intravenous catheter placements.



Quality improvement for Surgery this year focused on improving compliance with consent to treat. Processes went into place effective January 1, 2022, and since that point all surgical patients have had a consent to treat signed just prior to their procedure.

Anesthesia's focus area for improvement was documentation driven. Nursing and Bloomfield Anesthesia Group worked closely to monitor and improve the percent of charts with correct start and stop times documented. The first month compliance was 86%. A process change went into effect and since there has been 100% compliance.

Central Sterile monitors the compliance with humidity being within range in the operating room. When out of range, corrective action is immediately taken.

Chart auditing in surgery revealed issues with documentation. Documentation of blood glucose before and after surgery on diabetic patients was a trend that was discovered. A reminder flag on chart preps was implemented to correct this process and auditing reveals it has been resolved. Similarly, pre-, and post-procedure pain rating documentation was missed at times. Education to staff resolved this issue. Lastly, documentation of deep-vein thrombosis prevention device application was being missed which staff education resolved.

Quality Improvement Program and Plan

The Quality Assessment and Performance Improvement Program (QAPI) of Davis County Hospital & Clinics (DCHC) 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.

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 sub-optimal 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 process, 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.

Review of FY2022 Quality Improvement Plan and Program

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 are as follows:

1. Maintain 100% medication reconciliation upon discharge for all inpatients.
    a. Outcome:
        i. Medication reconciliation was completed on 91% of discharged patients in fiscal year 2022.
2. Elect fall champion to review all inpatient falls and introduce interventions for fall reduction.
    a. Outcome:
        i. Inpatient falls were reduced to five in fiscal year 2022 compared to eight in fiscal year 2021.
        ii. Standard operating procedure for falls was revised three times in 2020, each time implementing procedures and processes to reduce falls. The most recent revision was August of 2020 and most recent review was May of 2022.
3. Maintain no hospital-acquired pressure injuries.
    a. Outcome:
        i. A risk assessment for pressure injuries was completed within twenty-four hours on every admission except for one fall-out.
        ii. A skin assessment for pressure injuries was completed within twenty-four hours on every admission apart from one fall-out.
        iii. No patients suffered a stage II, or III hospital acquired pressure ulcer in fiscal year 2022.

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. See fiscal year 2022 data in graphs below.

Hospital Quality Improvement Collaborative (HQIC) Dashboard:

Each month, hospital departments, in collaboration with the QAPI program director, gather data to submit to the Hospital Quality Improvement Collaborative. Data on the below dashboard reports is a result of a combination of self-reported measures and information pulled from claims data. Results for FY 2022 follow.

COMPASS | DATA PORTAL

HQIC Dashboard
604 - Davis County Hospital and Clinics

Focus Area	Measure	Data Source	Improvement (%)	Num / Den	Multiplier	Baseline	Baseline Rate	Facility Rate	Peer Average	Compass Average
Adverse Drug Events	Adverse Drug Event Rate	Self-Reported	-648.30	8/1069	1,000	Jan 2019 - Dec 2019	0.00	7.48	1.36	1.40
Adverse Drug Events	Adverse Drug Events Originating During Hospital Stay, (AHRQ Statistical Brief #109)	Statewide Database	-45.66	1/184	100	Jan 2019 - Dec 2019	0.00	0.54	0.00	0.01
Adverse Drug Events	Anticoagulant Related Adverse Drug Events per 1,000 Acute Inpatient Admissions	Statewide Database	0.00	0/144	1,000	Jan 2019 - Dec 2019	0.00	0.00	0.26	0.96
Adverse Drug Events	Blood Glucose Less Than 50	Self-Reported		8/3471	100			0.23	0.37	0.49
Adverse Drug Events	High-Dose Opioid Prescribing Upon Discharge	Self-Reported		2/83	1,000			24.10	36.49	30.61
Adverse Drug Events	High-Dose Opioid Prescribing Upon Discharge - Medicare	Statewide Database	25.00	8/237	1,000	Jan 2019 - Dec 2019	45.01	33.76	47.80	38.99
Adverse Drug Events	INRs Greater Than 5	Self-Reported	89.36	5/188	100	Jan 2019 - Dec 2019	25.00	2.66	2.70	1.12
Adverse Drug Events	Manifestations of Poor Glycemic Control	Statewide Database	0.00	0/144	1,000	Jan 2019 - Dec 2019	0.00	0.00	0.04	0.04
Adverse Drug Events	Opioid Mortality	Statewide Database	0.00	0/144	1,000	Jan 2019 - Dec 2019	0.00	0.00	0.00	0.04
Adverse Drug Events	Opioid-Related Adverse Drug Events	Statewide Database	0.00	0/144	1,000	Jan 2019 - Dec 2019	0.00	0.00	0.01	0.03
Antibiotic Stewardship	Antimicrobial Days of Therapy (DOT)	Self-Reported	4.93	519/926	1,000	Jan 2019 - Dec 2019	589.55	560.48	594.54	592.14
Antibiotic Stewardship	Core Elements	National Healthcare Safety Network		6/7	100			85.71	97.14	97.11
Antibiotic Stewardship	Hospital-Acquired Carbapenem-resistant Enterobacteriaceae (CRE) Prevalence	National Healthcare Safety Network		0/330	1,000			0.00	0.00	0.00
Catheter-Associated Urinary Tract Infection	Catheter Utilization Ratio - All Units	National Healthcare Safety Network		253/730	10,000			3,465.75	1,514.00	2,145.98
Catheter-Associated Urinary Tract Infection	Catheter-Associated Urinary Tract Infection Rate	National Healthcare Safety Network		0/253	1,000			0.00	0.78	0.61
Catheter-Associated Urinary Tract Infection	Emergency Department Catheter Utilization	Statewide Database	100.00	0/4401	100	Jan 2019 - Dec 2019	0.03	0.00	1.07	1.02
Catheter-Associated Urinary Tract Infection	NHSN CAUTI Rate - ICU + Other Units	National Healthcare Safety Network		0/253	1,000			0.00	0.79	0.63
Catheter-Associated Urinary Tract Infection	NHSN CAUTI SIR - ICU Units + Other Units, (NQF 0138)	National Healthcare Safety Network		0/0	1			0.00	0.78	0.66

COMPASS | DATA PORTAL

HQIC Dashboard
604 - Davis County Hospital and Clinics

Focus Area	Measure	Data Source	Improvement (%)	Num / Den	Multiplier	Baseline	Baseline Rate	Facility Rate	Peer Average	Compass Average
Catheter-Associated Urinary Tract Infection	Unnecessary Urinary Catheters	Self-Reported	-300.00	3/75	100	Jan 2019 - Dec 2019	0.00	4.00	2.48	1.79
Central Line Associated Blood Stream Infection	Central Line-Associated Bloodstream Infection (CLABSI) Rate	National Healthcare Safety Network		0/60	1,000			0.00	0.23	0.58
Central Line Associated Blood Stream Infection	CLABSI Utilization Ratio - All Units	National Healthcare Safety Network		60/730	10,000			821.91	775.93	1,353.11
Central Line Associated Blood Stream Infection	NHSN CLABSI Rate - ICU + Other Units	National Healthcare Safety Network		0/60	1,000			0.00	0.23	0.57
Central Line Associated Blood Stream Infection	NHSN CLABSI SIR - ICU Units + Other Units, (NQF 0139)	National Healthcare Safety Network		0/0	1			0.00	0.71	0.69
Clostridium Difficile	ACS-CDC CDIFF SIR	National Healthcare Safety Network		0/0	1			0.00	0.76	0.59
Clostridium Difficile	Clostridium Difficile Prevalence	National Healthcare Safety Network		0/92	100			0.00	0.32	0.37
Clostridium Difficile	Hand Hygiene Compliance	Self-Reported	-3.00	194/200	100	Jan 2019 - Dec 2019	100.00	97.00	93.57	92.76
Clostridium Difficile	Healthcare Facility-Onset Clostridium Difficile Infection Rate	National Healthcare Safety Network		0/330	100			0.00	0.02	0.03
Falls	Fall Rate Resulting in Fracture or Dislocation (CMS HAC)	Statewide Database	0.00	0/144	1,000	Jan 2019 - Dec 2019	0.00	0.00	0.39	0.37
Falls	Fall Risk Assessment on Admission	Self-Reported	53.33	560/560	100	Jan 2019 - Dec 2019	65.22	100.00	97.77	97.68
Falls	Falls with Injury	Self-Reported	0.00	0/917	1,000	Jan 2019 - Dec 2019	0.00	0.00	1.42	1.13
Falls	Falls with or without injury	Self-Reported	-9.59	5/917	1,000	Jan 2019 - Dec 2019	4.98	5.45	4.98	4.40
Methicillin-resistant Staphylococcus aureus	NHSN CDC Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia Rate	National Healthcare Safety Network		0/92	1,000			0.00	0.11	0.17
Pressure Ulcers	Acute Inpatients with a Hospital-Acquired Pressure Ulcer Stage II	Statewide Database	0.00	0/144	100	Jan 2019 - Dec 2019	0.00	0.00	0.01	0.05
Pressure Ulcers	Pressure Ulcer Rate, Stage 3+, (AHRQ PSI-03)	Statewide Database	0.00	0/92	1,000	Jan 2019 - Dec 2019	0.00	0.00	0.61	0.97
Pressure Ulcers	Risk Assessment within 24 hours	Self-Reported		500/501	100			99.80	96.85	96.02
Pressure Ulcers	Skin Assessment within 24 hours	Self-Reported		522/523	100			99.81	97.43	93.89

COMPASS | DATA PORTAL

HQIC Dashboard
604 - Davis County Hospital and Clinics

Focus Area	Measure	Data Source	Improvement (%)	Num / Den	Multiplier	Baseline	Baseline Rate	Facility Rate	Peer Average	Compass Average
Readmissions	Post-Hospital Follow-Up Appointment	Self-Reported	1.60	178/180	100	Jan 2019 - Dec 2019	97.33	98.89	76.97	70.07
Readmissions	Unplanned All-Cause, 30-Day Readmissions Any Hospital	Statewide Database	7.43	14/123	100	Jan 2019 - Dec 2019	12.30	11.38	8.24	9.14
Readmissions	Unplanned All-Cause, 30-Day Readmissions Same Hospital	Statewide Database	20.65	4/123	100	Jan 2019 - Dec 2019	4.10	3.25	5.40	6.76
Severe Sepsis and Septic Shock	Postoperative Sepsis Rate (AHRQ PSI 13)	Statewide Database	0.00	0/11	1,000	Jan 2019 - Dec 2019	0.00	0.00	1.62	3.26
Severe Sepsis and Septic Shock	Sepsis Mortality	Statewide Database	45.24	2/42	1,000	Jan 2019 - Dec 2019	86.96	47.62	81.52	124.75
Severe Sepsis and Septic Shock	Severe Sepsis and Septic Shock 3-Hour Management Bundle Compliance (NQF 0500)	Self-Reported	79.31	26/29	100	Jan 2019 - Dec 2019	50.00	89.66	71.95	68.68
Surgical Site Infection	Surgical Safety Checklist Compliance	Self-Reported	0.00	24/24	100	Jan 2019 - Dec 2019	100.00	100.00	99.79	98.96
Venous Thromboembolism	Post-Operative Pulmonary Embolism (PE) or Deep Venous Thrombosis (DVT) Rate, (AHRQ PSI-12), (NQF 0450)	Statewide Database	0.00	0/14	1,000	Jan 2019 - Dec 2019	0.00	0.00	2.11	3.33
Venous Thromboembolism	VTE Appropriate Prophylaxis	Self-Reported	48.86	139/149	100	Jan 2019 - Dec 2019	62.67	93.29	91.34	90.96

Legend		
Symbol	Color	HQIC Improvement
↑		Improvement goal achieved or exceeded goal
↔		Maintaining or showing progress toward goal
↓		No Improvement

Dashboard Glossary	
Improvement %:	The percent changed from the baseline period.
Multiplier:	Used to create comparable rates for each measure.
Baseline Rate:	An aggregated rate of facility data for the baseline period.
Facility Rate:	An aggregated rate of facility data for the timeframe pulled.
Peer Average:	An aggregate of peer group data is divided by hospital Medicare class and combined into two groups:
	1. Critical Access + Rural
	2. Rural Referral + Urban
Compass Average:	An aggregated rate including overall averages for the Compass network.

Timeframe: Jul 2021 to Jun 2022

Quality Assurance Performance Improvement Committee Department Specific Goals

Measure	Goal	Source		Overall YTD
Accounting				
% of Productivity Reports received by due date	50%	Internal	NUM	173
			DEN	228
			%	76%
% of vouchers approved in Multiview within 7 days	95%	Internal	NUM	4585
			DEN	4649
			%	99%
Acute Care				
% of Medication Reconciliation completed	100%	Internal	NUM	510
			DEN	560
			%	91%
Hospital Acquired Pressure Injuries	0	Internal	#	2
Fall Reduction	1.92%	HQIC/Mercy	NUM	8
			DEN	959
			%	0.83%
Emergency Department				
Time to EKG (chest pain diagnosis and AMI patients)	100%	Mercy	NUM	144
			DEN	182
			%	79%
Transferred within 30 mins (STEMI patients)	75%	Mercy	NUM	0
			DEN	7
			%	0%
Door to CT read time of 45 minutes (Acute Stroke patients)	100%	Mercy	NUM	5
			DEN	11
			%	45%
Utilization Review				
Readmission Reduction	3%	Mercy	NUM	5
			DEN	161
			%	3.1%
Swingbed Services				
% of discharged pts with scheduled F/U appt prior to discharge	100%	Internal	NUM	268
			DEN	272
			%	99%
Trauma				
% of patients to definitive care within 3 hours	90%	Internal	NUM	14
			DEN	27
			%	52%
% of charts that have a ht/wt documentated in chart	90%	Internal	NUM	22
			DEN	28
			%	79%
Ambulance				
% chest pain pts that get EKG withing 10 min. of EMS arrival	80%	Internal	NUM	55
			DEN	56
			%	98%
% of STEMI, Stroke and Trauma Alerts called prior to arrival as appropriate	90%	Internal	NUM	4
			DEN	5
			%	80%

Measure	Goal	Source		Overall YTD
Cardiac Rehab				
% of charts that pass monthly chart audit	100%	Internal	NUM	20
			DEN	20
			%	100%
Cardiopulmonary				
% of charts with correct order AND results sent	100%	Internal	NUM	174
			DEN	174
			%	100%
Pulmonary Rehab				
% of charts that pass monthly chart audit	100%	Internal	NUM	6
			DEN	6
			%	100%
Sleep Lab				
Home Sleep Studies: % of charts that pass monthly chart audit	100%	Internal	NUM	244
			DEN	244
			%	100%
Somnitech: % of charts that pass monthly chart audit	100%	Internal	NUM	118
			DEN	118
			%	100%
Stress Echo				
Average score form all surveys in stress test dept.	4.5	Internal	#	5
Dietician				
% of charts that pass monthly chart audit	100%	Internal	NUM	33
			DEN	73
			%	45%
Anesthesia				
% of charts with correct start and stop times	100%	Internal	NUM	128
			DEN	129
			%	99%
Central Sterile				
% compliance with humidity in OR	100%	Internal	NUM	395
			DEN	426
			%	93%
Nursing Home Rounds-Wirtanen				
% of Medication Reconciliation completed	90%	Internal	NUM	141
			DEN	173
			%	82%
Outpatient Infusion				
% of charts with documented patient education	100%	Internal	NUM	268
			DEN	288
			%	93%

Measure	Goal	Source		Overall YTD
Specialty Clinic				
Allergy-Ciesemier % charts with documented procedural consent	100%	Internal	NUM DEN %	3 17 18%
Allergy-Graeff % charts with med rec completed	100%	Internal	NUM DEN %	252 252 100%
Cardiology % pts that show to sched. appts	90%	Internal	NUM DEN %	264 289 91%
Dermatology (Cleaver) % pts that show to sched. Appts	90%	Internal	NUM DEN %	0 0 0%
Dermatology (Shilling) % pts that show to sched. appts	90%	Internal	NUM DEN %	204 220 93%
ENT % charts with documented procedural consent	100%	Internal	NUM DEN %	22 23 96%
OBGYN % pts that show to sched. appts	90%	Internal	NUM DEN %	122 132 92%
Orthopedics % charts with documented procedural consent	100%	Internal	NUM DEN %	22 23 96%
Pain Clinic % of charts with all required pain-levels documented	100%	Internal	NUM DEN %	36 48 75%
Podiatry % charts with documented procedural consent	100%	Internal	NUM DEN %	2 4 50%
Rheumatology % charts with documented procedural consent	100%	Internal	NUM DEN %	0 0 0%
Endoscopy % with required pre-op documentation	100%	Internal	NUM DEN %	40 42 95%
Urology % charts with med history completed	100%	Internal	NUM DEN %	26 36 72%
Surgery				
% charts with documented consent to treated signed prior to procedure	100%	Internal	NUM DEN %	96 174 55%
Education				
% of employee files audited and complete	100%	Internal	NUM DEN %	2160 2437 89%

Measure	Goal	Source		Overall YTD
Infection Prevention				
HAI Infection Rate	0.00	NHSN	NUM	0
			DEN	740
			Rate	0.00
% CAUTI Infections	0%	NHSN	NUM	0
			DEN	250
			Rate	0%
% properly placed catheters	100%	NHSN	NUM	74
			DEN	74
			Rate	100%
% Central Line Infections	0%	NHSN	NUM	0
			DEN	5
			Rate	0%
% surgeries performed without post-op infection	100%	NHSN	NUM	520
			DEN	520
			Rate	100%
% of appropriate hand hygiene observations	100%	NHSN	NUM	194
			DEN	200
			Rate	97%
Employee Health				
% of employees completing assessment within 30 days	100%	Internal	NUM	24
			DEN	59
			%	41%
% of employees obtaining the TDAP booster within 30 days	100%	Internal	NUM	16
			DEN	28
			%	57%
Public Health				
% of responses to immunization reminders	10%	Internal	NUM	29
			DEN	156
			Percent	19%
# of immunizations given monthly	^			787
Environmental Services				
% of area audits that pass the inspection test	95%	Internal	NUM	47
			DEN	48
			%	98%
FNS				
Customer Satisfaction Survey	80%	Internal	Score	111
			Rating	161
				69%
% of patient trays that passed the internal audit	80%	Internal	Num	577
			Den	581
			%	99%
HIM				
% of charts that pass internal audit	100%	Internal	NUM	130
			DEN	152
			%	86%

Measure	Goal	Source		Overall YTD
Human Resources				
% of audited files that contain a completed I-9 form	80%	Internal	NUM	102
			DEN	102
			%	100%
% of files that contain completed SING Form	100%	Internal	NUM	99
			DEN	102
			%	97%
Information Technology				
Fully patched Windows Servers and Windows Endpoints	≥94%	Internal	NUM	3200
			DEN	3442
			%	93%
Laboratory				
Bloodbank Crossmatch-Transfusion Ratio (CTR)	≤ 2.0	internal	NUM	210
			DEN	194
			RATE	1.08
Laboratory % of charts with STAT samples resulted within acceptable TAT	88%	internal	NUM	2671
			DEN	2849
			%	94%
Microbiology % or Urine Cultures with TAT of 96 hrs or less	≥ 95%	internal	NUM	671
			DEN	675
			%	99%
Pathology % of Pathology casses with TAT of 72 hrs or less	92%	internal	NUM	259
			DEN	265
			%	98%
Marketing				
Increase the # of Likes on Facebook page using Insights program	10 new Likes monthly	Internal	#	169
Materials Management				
% of items backordered monthly	≤5%	Internal	NUM	412
			DEN	5749
			%	7%
Medical Imaging				
CT % CT exams in which the DLP is recorded	100%	Internal	NUM	1781
			DEN	1781
			%	100%
DEXA % of patients improperly prepped for scheduled appts	≤ 2%	Internal	NUM	4
			DEN	260
			%	2%
General Radiography Average turnaround time for STAT imaging results	60 min	Internal	# Min	16.1667
Mammography % of quality "good and perfect positioned" images	≥60%	Internal	%	56%
Mobile MRI % of scan performed at the start time they were scheduled	75%	SMS	%	83%
Mobile PET-CT % of scan performed at the start time they were scheduled	75%	SMS	%	92%

Measure	Goal	Source		Overall YTD
Medical Imaging				
MRI % of MRIs that are unable to be performed in house	≤ 10%	Internal	NUM DEN %	29 494 6%
Nuclear Medicine % of procedures completed as ordered	90%	Internal	NUM DEN %	96 107 90%
Ultrasound Average turnaround time for Echocardiogram interpretations	24 hours/ 1,440 min	Internal/ IA Heart	# Min	257.625
Rural Health Clinic				
% of charts that pass chart audits performed	90%	Internal	NUM DEN %	52 60 87%
Next 3rd available appt slot for full time provider RDF	≤5 days	Internal	#	26
Next 3rd available appt slot for full time provider BOL	≤5 days	Internal	#	4
Next 3rd available appt slot for full time provider MG	≤5 days	Internal	#	2
Next 3rd available appt slot for full time provider HS	≤5 days	Internal	#	2
Next 3rd available appt slot for full time provider DK	≤5 days	Internal	#	5
Next 3rd available appt slot for full time provider MW	≤5 days	Internal	#	1
Medical Staff Services				
% of Peer Reviews completed within 60 days or less	100%	Internal	NUM DEN %	1 2 50%
% of applications that exceed 90 days for verification	100%	Internal	NUM DEN %	3 3 100%
Physical Therapy				
% compliance with reonciliation process for charges	95%	Internal	NUM DEN %	30580 30643 100%
% use of standardized test in goals for outpt evaluations	95%	Internal	NUM DEN %	912 919 99%

Measure	Goal	Source		Overall YTD
Occupational Therapy				
% compliance with reconciliation process for charges	95%	Internal	NUM	1626
			DEN	1628
			%	100%
% use of standardized test in goals for outpt evaluations	95%	Internal	NUM	109
			DEN	114
			%	96%
Speech Therapy				
% compliance with reconciliation process for charges	95%	Internal	NUM	215
			DEN	216
			%	100%
% use of standardized test in goals for outpt evaluations	95%	Internal	NUM	36
			DEN	36
			%	100%
Patient Access				
% of needed corrections on WIN32 registered patients	≤ 0.3%	Internal	NUM	68
			DEN	13455
			%	0.505%
Patient Financial Services				
AR Days	≤ 42 days	Internal	#	53.57
Pharmacy				
Reduction of Adverse Drug Events	≤ 1	HQIC/Mercy	NUM	20
			DEN	959
			RATE	0.02
Antibiotic Days of Therapy (DOT)	trending down	HQIC	NUM	663
			DEN	959
			RATE	0.69
% of high Dose opioid presecribing upon discharge	≤ 25%	HQIC	NUM	2
			DEN	83
			RATE	2%
% of patient that have a 48-hour timeout completed	≥ 90%	HQIC	NUM	205
			DEN	225
			RATE	91%
Plant Ops				
% of water temp checks within range	100%	Internal	NUM	139
			DEN	142
			%	98%
Biomed				
% of equipment recovered from "unable to locate" list	100%	Internal	NUM	13
			DEN	13
			%	100%
Senior Life Solutions				
Monthly chart audit score %	95%	Internal	NUM	4402
			DEN	4431
			%	99%
Number of Community Ed contacts	40	Internal	#	940

Mercy One

Each month, DCHC reports quality measures to Mercy One for comparison to the network in achieving outlined quality goals. Achievements include a readmission rate of 3.2%, which is 0.8% less than the network average. DCHC experienced no falls with injury during this fiscal year and had no prescriptions for high-dose opioids beyond the outlined threshold.

We continue to educate and drill on ST Elevation Myocardial Infarction (STEMI) best practices for achieving the thirty-minute in the door out the door time, as well as achieving EKG goals for chest pain patients. Each quality measure fall-out is reviewed and communicated to the department manager.

Mercy One Rural Quality Scorecard

MERCYONE

For FYTD Ending Jun-2022

Affiliate Name	MercyOne Target	Desired Trend	Davis County Hospital and Clinics	*MercyOne*
Location			Bloomfield	
Region			Central	
Readmissions Originating Facility	3.22%	↓	3.2%	*4.0%*
ADE D-I Rate	1.0	↓	3.2	*0.9*
Total Fall Rate	TBD	↓	9.7	*5.2*
Falls with Injury Rate	0.737		0.0	*1.3*
CP FYTD MEDIAN	10		6	
CP/Angina/Acute Coronary % meeting ECG	100.0%	↑	79.1%	*83.6%*
AMI FYTD MEDIAN	10		2	
AMI % meeting ECG	100.0%	↑	76.9%	*76.8%*
STEMI FYTD MEDIAN	30		88.5	
STEMI % meeting transfer	100.0%	↑	0.0%	*4.7%*
Stroke Avg time to read	45	↓	53	*41*
Stroke % meeting read	100.0%	↑	50.0%	*71.2%*
High Dose Opioid Prescribing Upon Discharge Rate	4.9		0.0	30.1

FAVORABLE TO MercyOne Goal
UNFAVORABLE TO MercyOne Goal

Mercy One Behavioral Health Scorecard

The behavioral health average hold time for DCHC is above the network average. DCHC transferred twenty-one behavioral health patients this fiscal year, with an average time to transfer of 17.2 hours.

MERCYONE

For FYTD Ending Jun-2022

Affiliate Name	Davis County Hospital and Clinics	*MercyOne Total*
Region	Central	
Location	Bloomfield	
Behavioral Health total time in ED (minutes)	21,674	*900,477*
Behavioral Health # of eligible patients	21	*1,039*
Behavioral Health Avg Time per Patient (hours)	17.2	*14.4*

Department Process Improvement Projects

Davis County Hospital and Clinics takes pride in delivering high-quality, patient-centered care. To do so, departments are continuously making improvements to workflows and procedures to improve the quality of care provided, and the patient experience.

Examples of improvement projects for fiscal year 2022 include but are not limited to:

- An initiative to decrease outpatient falls by increasing efforts to step down medications through collaboration with Mercy One, University of Iowa, and DCHC Medical Associates Clinic.
- Transitioning to the use of TNK for strokes through collaboration with Mercy One.
- Revision of process for sending burn photographs to the University of Iowa through collaboration with University of Iowa burn unit director.
- Acute care worked with information technology to reschedule a task reminder to 0500 from 0900 to improve workflow and compliance with daily weight orders.
- Acute Care worked on improvement efforts to ensure all required aspects of admissions were completed.
- Communication with Acute Care staff the clinical significance of hygiene completion along with a recent audit of their documented results. Periodic evaluation of compliance with this continues in FY 2023.
- Work was performed to improve medication administration processes to reduce adverse drug events.
- Obtained an EKG machine designated for Acute Care to decrease time to EKG for admitted patients.
- Obtained sit-to-stand equipment to increase patient comfort and decrease risk of injury for both patients and staff.
- Revised behavioral health processes in the Emergency Department to streamline care.
- Revised process for in-hand lab orders at the point of registration to decrease delays to the patient.

Drills and Emergency Preparedness Activities include but are not limited to:

- July 2021: Tabletop exercise, multi-car accident
- September 2021: Missing person drill
- September 2021: Fire drill, day shift and night shift
- November 2021: Medical emergency event
- December 2021: Fire drill, day shift and night shift
- December 2021: Tornado watch issued
- December 2021: Severe thunderstorm warning issued
- December 2021: Equipment failure in lab
- February 2022: Medical emergency drill
- February 2022: Trauma alert drill
- March 2022: Fire drill, day shift and night shift
- April 2022: Tabletop disaster exercise with SA1C Healthcare Emergency Response Coalition
- April 2022: Fire drill, night shift
- April 2022: Trauma alert drill, ED
- June 2022: Medical emergency drill
- June 2022: Missing person drill
- June 2022: Severe weather alert
- June 2022: Fire drill, day shift

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:

- Emergency Department
- Public Health
- Quality Improvement
- Risk Management
- Accounting
- Infection Prevention
- Information Technology
- Medical Associates Clinic
- Senior Life Solutions
- Trauma
- Education
- Marketing
- Medical Staff
- Utilization Review
- Emergency Medical Services
- Med-Surg
- Physical Therapy
- Safety and Security
- Sleep Lab
- Speech Therapy

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 they 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 Medical Staff and the Board of Trustees as applicable.

Quality Reporting to the Board

The Quality Director or designee is responsible for sharing quality data to the Board of Trustees. Examples of information shared during fiscal year 2022 include Acute Care, Emergency Department, Utilization Review, Swing Bed, Trauma, Ambulance, Accounting, Dietitian, Environmental Services, Pharmacy, Outpatient Infusion, Specialty Clinic, Surgery, Anesthesia, and Central Sterile Quality Improvement goals and outcomes year to date. Mercy One Scorecard readmission, adverse drug event, fall, chest pain, acute myocardial infarct, stroke, opioid discharge prescription and patient satisfaction data were also shared with the Board.

Summary

The Critical Access Hospital 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.

FY2023 Quality Improvement Plan

The Quality Assessment and Performance Improvement Program (QAPI) of Davis County Hospital & Clinics (DCHC) 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 sub-optimal 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 process, 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

1. Quality and Safety
    a. Conduct safety rounds in each department on an annual basis.
    b. Create and implement a Nursing Shared Governance committee by June 30, 2023.
    c. Patient satisfaction top box scores for 'Would Recommend" are in the 80th percentile or higher for each service line by June 30, 2023.

2. Patients
    a. Determine ways to incorporate patient and family involvement into existing structures and committees at Davis County Hospital by July 31, 2023
    b. Provide community education and training.
    c. Work collaboratively with the community and formulate a plan to increase overall health and wellness by June 1, 2023.
3. Growth
    a. Increase utilization of Dr. Brewer's lifestyle practice service by December 31, 2024.
    b. Improve diabetic services and teaching by implementing a certified diabetic teaching course by December 31, 2024
    c. Work with CEO, patients, and families to determine need for additional services and physician recruitment.
4. Finance
    a. Hire an external vendor to conduct a chargemaster review by December 31, 2023
    b. Implement software for no surprise billing by January 1, 2023
    c. Implement ePayments plus by June 30, 2023.
5. Employees
    a. Develop an employee mentoring program by June 30, 2023
    b. Increase employee moral throughout DCHC by 12.31.24
    c. Improve Communication by 12.31.24 to break down silos in depts

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 for calendar year 2022 are as follows:

1. Patient Safety and Harm Reduction goals
    a. DCHC will maintain no hospital-acquired pressure injuries throughout 2023.
    b. DCHC will have an inpatient fall rate of 1.92% or less during FY 2023.
    c. DCHC will maintain 100% discharge medication reconciliation on inpatients in 2022.
        i. A medication history goal was established for each clinical department internally. To complete med reconciliation, nursing staff must first obtain a correct medication history.
2. Patient and Family Advisement
    a. DCHC will incorporate patients and families into existing structures for collaboration and feedback on current services and efforts to reduce harm.
3. Pandemic/Public Health Emergency Response
    a. DCHC will continue with COVID-19 Preparedness Team Meetings to coordinate, and educate patients, staff, and community on COVID-19 during 2022.

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. This data is analyzed and utilized to aid in establishing internal quality goals and priorities for improvement each year.

Mercy One

Each month, DCHC reports quality measures to Mercy One for comparison to the network in achieving outlined quality goals. Results will be reviewed at the Quality committee meeting. Goals that are not meeting outlined targets will be 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 have ninety internal departmental goals organization-wide that are being monitored through the internal quality assessment performance improvement program for fiscal year 2023. Each departmental goal is 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:
  - Improve health outcomes
  - Prevention and reduction of medical error
  - Adverse event reduction
  - CAH 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 and a summary report will be provided to Medical Staff and the Board of Trustees. Results from external reporting to the Iowa Healthcare Collaborative and MercyOne will also be 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 have been identified as priorities for improvement during fiscal year 2023.

Department	Aligns With	Measure	Target Goal
ACUTE CARE	IHC	DCHC will maintain no hospital-acquired pressure injuries throughout 2023.	0%
ACUTE CARE	MercyOne IHC	Fall rate of 1.92% or less in FY 2023	≤1.92%
ACUTE CARE, ED, CLINIC, OUTPATIENT, SURGERY, SPECIALTY	Strategic Plan IHC	95% compliance with med history completion	95%
EMERGENCY DEPARTMENT (EMS)	MercyOne	Eligible chest pain and AMI patients will have an EKG within ten minutes of arrival to ED	100%
INFECTION PREVENTION	IHC	Patients at DCHC will experience no healthcare associated infections during FY2023	0%
INFECTION PREVENTION	IHC	Patients at DCHC will experience no catheter-associated urinary tract infections during FY2023	0%
INFECTION PREVENTION	IHC	100% of catheters inserted during FY2023 will be due to appropriate reasons for use	100%
INFECTION PREVENTION	IHC	Patients at DCHC will experience no central line associated infections during FY2023	0%
INFECTION PREVENTION	IHC	Patients at DCHC will experience no surgical site infections during FY2023	0%
INFECTION PREVENTION	IHC	DCHC employees will practice hand hygiene at every opportunity during FY2023	100%
HUMAN RESOURCES	Strategic Plan	Rounding percent complete at the end of the 3-week period each quarter (manager sign off)	90%
HUMAN RESOURCES	Strategic Plan	Employee retention rate ≥ 98.5% each month	98.50%
PHARMACY	MercyOne IHC	Zero Category D-I ADEs during FY 2023	0%
ALL SERVICE LINES	Strategic Plan	Patient satisfaction top box scores for 'Would Recommend" are in the 80th % or higher for each service line by June 30, 2023.	≥80%

MERCYONE

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MercyOne.org

Annual Quality Assurance Program Evaluation **October 21, 2022**

Facility: Davis County Hospital & Clinics Bloomfield, Iowa

During this time period, the following MercyOne representatives may have participated and/or provided input into the organization's quality assurance program and/or credentialing process:

Tonya Clawson Elizabeth Skinner Jacquie Brunssen
Sandra Christensen Michael Trachta

Quality Assurance Program Evaluation

Based upon our observation of and/or participation in this organization's quality assurance program/s, discussions, and/or committee meetings, as well as interactions in the MercyOne – Central Iowa affinity team meetings, the organization's quality assurance program appears to be in compliance with written policies and procedures and the annual Quality Assurance and Performance Improvement Plan and appears to meet the necessary elements and expectations for an effective quality assurance program. Davis County Hospital & Clinics, under the direction of their quality improvement plan, is working diligently to assess, identify, prioritize, improve, evaluate and sustain improvements toward optimal quality care for the patients that they serve.

MercyOne engages annually in the review of the organization's Quality Assurance and Performance Improvement plan and is available, upon request, to collaborate and support the organization's quality initiatives upon request.

Credentialing Process Evaluation

Based on our observation and awareness of the organization's review of credentialing and privileging processes, procedures, applicants, and reappointments, the program appears to be in compliance with the written policies and procedures and meets the necessary elements for an appropriate credentialing process.

Physician Clinical Quality Assurance

When deemed necessary and/or appropriate for follow-up, and after local review is conducted, medical records are forwarded to MercyOne for review of quality and appropriateness of care.

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