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North Dakota Critical Access Hospital Quality Network's Implementation and Use of the Healthcare SafetyZone® Portal

2011 Program Report

April 2010 – March 2011

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Introduction

This Program Report for the year April 2010-March 2011of the Healthcare SafetyZone® (HCSZ) Portal, in part with the North Dakota Critical Access Hospital (CAH) Quality Network, provides a description of the program's purpose, the role of the CAH Quality Network in the implementation of the Portal and use of the data, and summarizes the project's goals while highlighting the program's year-end progress.

In addition, this Program Report presents the output data derived from the thirteen CAHs participating in the Portal. An analysis of the data is provided and is offered as evidence for documented, year-two goals. Finally, user satisfaction is addressed through a survey of participating CAHs. The intent of the survey is to evaluate use of, and satisfaction with, the HCSZ Portal. User testimonials support the research results and also contribute to the closing conversation which outlines the ND CAH Quality Network's future objectives.

The Program Report is intended to inform participating CAHs of the progress that has been made, while also offering evidence of the program's success for those interested in future implementation of the Portal. In addition, it provides an opportunity for the CAH Quality Network to evaluate and assess the output data, and the implementation of the Portal itself, lending to improvement of the process and maintenance of the program.

Improved quality of care in health facilities cannot be achieved through implementation and use of reporting systems alone. It is imperative that the program, process, and outputs are analyzed, shared, and utilized to develop suggestions for future practice.

Section 1

Project & System Overview

1.1 Clarity Group and the Healthcare SafetyZone® Portal

The Healthcare SafetyZone® Portal is a web-based application for integrated event data collection and analysis provided by Clarity Group. Clarity is self-described as a "healthcare resource specializing in integrated risk/quality/safety systems and captive insurance company development and management." Clarity has been working in healthcare risk and quality management for more than 30 years and was developed to enable "healthcare organizations to stabilize professional and general liability financial costs and execute on their vision for healthcare excellence as they transform their organizations into a Healthcare Safety Zone for their patients, residents, staff and visitors" (http://www.claritygrp.com/).

As a service provided by Clarity, the Portal enables participating health facilities to gather data on all events that impact both patient and visitor safety. It is intended for use to capture data that may provide actionable information in an efficient and productive way. The tool is customizable, easy to establish and use, and requires little training or IT support.

The Portal collects on the following event measures: behavioral, dietary, elopement, employee incident, equipment, facility/security, falls, HIPAA, infections, violations, medications, patient/family concerns, and procedural/clinic events.

The Healthcare SafetyZone® Portal is a practical tool for clinics, hospitals, and long-term care facilities regardless of patient population size. It has been shown to improve communication both within the given healthcare setting and across facilities while also encouraging collaboration to identify best practices in preventing patient, visitor, and staff events.

1.2 The Role of the North Dakota Critical Access Hospital Quality Network in Support of the Healthcare SafetyZone® Portal

The ND CAH Quality Network (also referenced as the Network) was established in 2008 through the voluntary efforts of critical access hospitals throughout the state of North Dakota intending to create a network that would support CAH quality improvement activities. The Network now serves as a common place for North Dakota's CAHs to share best practices, tools, and resources related to providing quality of care, and supports quality improvement activities of CAH Network members. A goal of the Network is to improve information sharing and networking at the regional and state level among tertiary facilities and stakeholders.

In partner with Clarity Group, the Network provides technical support to participating facilities. Currently, there are thirteen CAHs inputting and collecting event data in the Portal. See Table 1 for a list of the participating CAHs and their location.

Table 1
North Dakota Critical Access Hospitals Participating in the Healthcare SafetyZone® Portal

Health Facility	**North Dakota City**
Southwest Healthcare Services	Bowman
Towner County Medical Center	Cando
Jacobson Memorial Hospital	Elgin
Unity Medical Center	Grafton
St. Aloisius Medical Center	Harvey
Hillsboro Medical Center	Hillsboro
Sanford Hospital Mayville	Mayville
Nelson County Health System	McVille
Northwood Deaconess Health Center	Northwood
First Care Health Center	Park River
Heart of America Medical Center	Rugby
Tioga Medical Center	Tioga
McKenzie County Healthcare System	Watford City

It is the Network's responsibility to encourage and assist participating CAHs in workgroup sharing of best practices on events. To facilitate communication between CAHs and with Clarity, monthly meetings are held via conference call with the Network, a HCSZ Portal representative (Nick Hajek), and participating healthcare/long-term care facilities. More information regarding these meetings may be found in the discussion of the Program Plan in Section 2.5.

The output data provided by Clarity is further analyzed by one of the Network's Coordinators to provide results summaries to the CAHs. Information is used to determine if any participating facility may have a best practice in place that has been successfully maintaining a low rate of a particular event. As part of the program in 2010-2011, it has been the Network's role to identify a best practice from data that has emerged regarding patient falls in long-term care and outpatient facilities. The focus on falls will carry over into the next year's Program Plan with additional attention being paid to events related to medication and infection. The selection of these three initial events as a primary focus of the Network is supported by the events data that will be shared in a later discussion.

With the HCSZ Portal, the Network is able to utilize events data and identify measures that require special attention while also using the information provided to drive enhancement in the quality and safety of participating organizations. The data is assessed by the Network to not only identify best practices working at a particular facility, but to also recognize and utilize good practice among particular physicians who may present a significantly low number of a given event. The Network, along with Clarity, is also able to infer variables that may be influencing a given event rate. As an example, past Portal data had illustrated that within one particular facility, events related to medication errors were more prevalent when administered at a shift change. This information provides an opportunity to develop a protocol related to medication distribution.

The Network also supports the Portal by working to create shared definitions of events. Currently, falls is the one event the Network has developed a definition for that is consistent across all reporting facilities in North Dakota. Goal three of the Network's Program Plan with Clarity addresses this topic further, providing the definition for falls, and is found in Section 2.3.

Finally, the Network also provides technical assistance to participating, and interested ND CAHs. The Network Coordinator responds to username/password inquiries and works with the HCSZ Portal's systems developer to maintain a website relevant to the ND program.

Additional technical support is provided through the HCSZ Portal webpage under the "resources" tab. Initially, this tab was intended to house any protocols and/or best practices identified through analysis of the data. This resource is being modified to partner with the Virtual Library of Shared Tools through the CAH Quality Network. More will be addressed concerning this service in Section 5.

Section 2

ND CAH Quality Network: Healthcare SafetyZone® Portal Program Plan

In partnership with Clarity, a Program Plan was developed for 2010-2011. The plan includes an identification of four program goals for the year, the plan for the program along with the roles assigned to Clarity and the Network, a description of the process to be followed, and a list of methods for evaluation of the plan. It is imperative the Network, along with Clarity, fulfill their agreements identified in this Program Plan and continue to progress and meet a majority of the identified goals in order to improve the quality of patient care as it relates to events.

2.1 Goal One

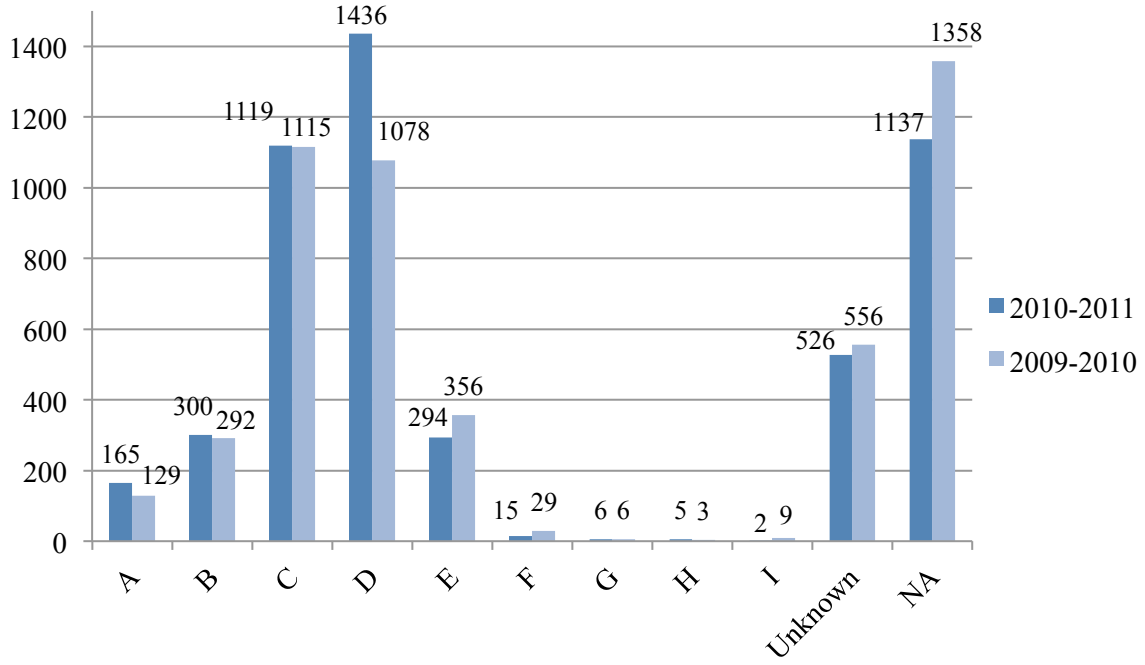
Increase reporting of events across the Quality Network participants and see an increase in Near Misses alongside a decrease in High Harm, Unknown and NA events.

Summary of Results that Illustrate Progress under Goal One:

- Increase in overall events reported by 222
- Increase in near misses (categorized as event A) from 129 events in 2009-2010 to 165 reported in 2010-2011
- Increase of eight in near misses identified under category B
- The number of total reported high harm events decreased by 20.1 percent (high harm events are events labeled as E, F, G, H, and I in Figure 1)
- The number of events identified with an "unknown" severity decreased from 556 events in 2009-2010 to 526 events in 2010-2011
- Events reported with a severity rank as being "not applicable" to the event decreased from 1,358 events in 2009-2010 to 1137 in 2010-2011

Figure 1

Number of Events by their Reported Severity in 2009-2010 & 2010-2011
(See Table 2 for the Severity Definition of Each Category)



This goal has been met as is made evident by the number of events reported by participating CAHs. In 2009-2010, a total of 5,386 events were reported among participating CAHs compared to 2010-2011 in which 5,608 events were recorded. This has been attributed to increased reporting, and not an actual increase in occurrences.

Category A and category B may both be identified as a near miss as no individuals were harmed in the reported event (definitions for each category may be found in Table 2). Near misses, as defined above, increased from 421 reported events in 2009-2010 to 465 near misses in 2010-2011.

In addition, as the bar graph clearly illustrates, the number of events with an unknown severity level reported decreased from the prior year by 5.4 percent while the number of events noting that the severity identification was not applicable to the given event decreased by 16.3 percent – evidence that participating CAHs have met the requirements identified under goal one.

Finally, as is also noted under this goal, there was an observable decrease in overall events categorized as high harm between 2009-2010 and 2010-2011. Categories that have been identified as high harm include E, F, G, H, and I. The only increase in reported high harm events occurred among those that required intervention to sustain life; however, it was a small increase with only 2 additional cases in 2010-2011. Overall, the incidence of high harm events decreased by 20.1 percent, from 403 total events categorized as E, F, G, H, and I reported in 2009-2010 to 322 events in 2010-2011.

Table 2
Definition of Event Severity as Assigned to each Category

Category	Severity Definition
A	Circumstances or events have the capacity to cause harm (unsafe situation, not individual related)
B	Event occurred but did not reach the individual
C	Event occurred that reached the individual but did not cause harm
D	Event occurred that reached the individual and required monitoring to confirm no harm
E	Event occurred that may have contributed to temporary harm to individual requiring intervention
F	Event occurred that may have contributed to temporary harm requiring prolonged hospitalization
G	Event occurred that may have contributed to permanent harm to individual
H	Event occurred that required intervention to sustain life
I	Event occurred that may have contributed to individual death
N/A	Severity is not applicable to this event
Unknown	The severity of the event is unknown

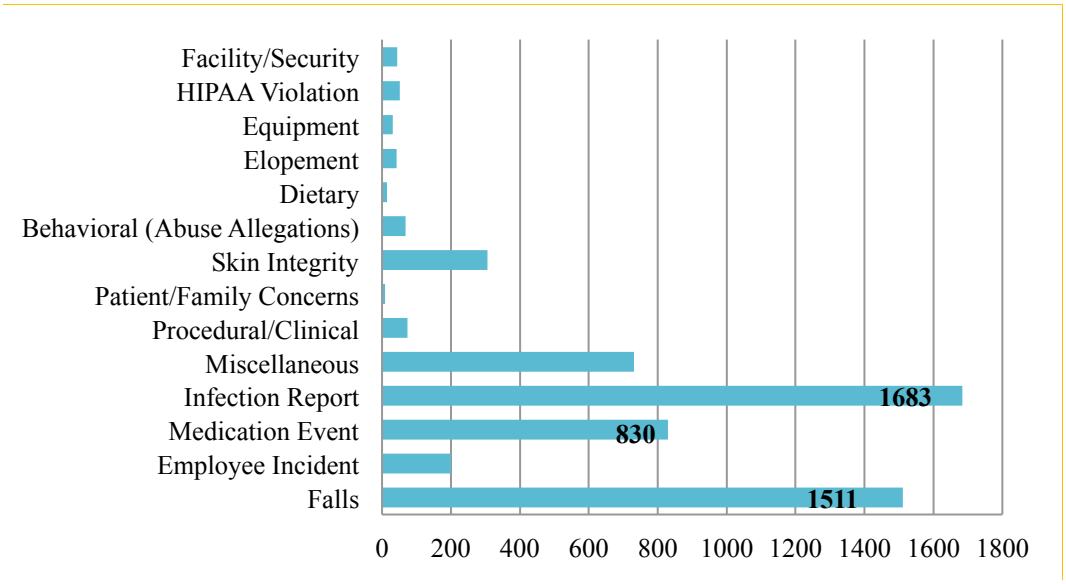
2.2 Goal Two

Quality Network to develop one evidenced based best practice protocol for the group to share that addresses an area that emerged from Portal data collected.

This goal was not entirely met, due to implementation and start-up of the Portal taking longer than anticipated. As a result, enough viable data had not been identified for analysis until quarter four. However, progress has still been made under goal two.

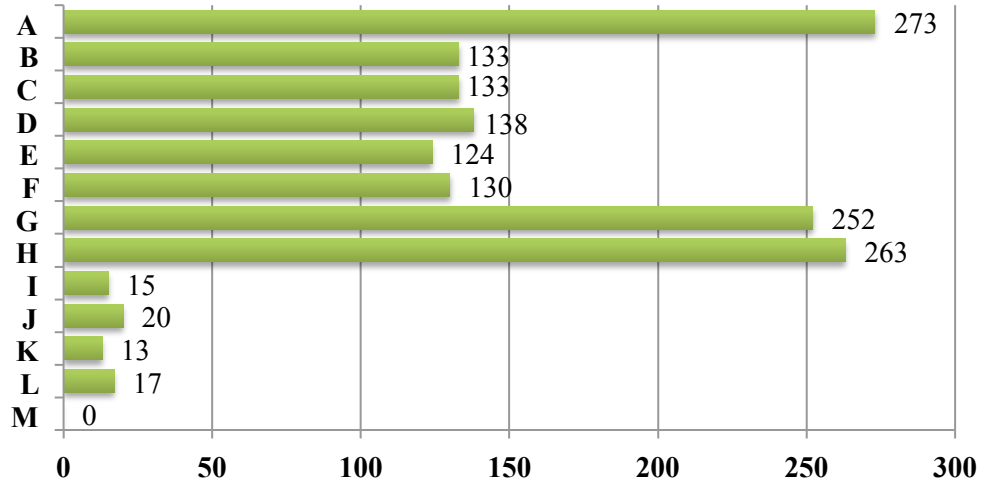
Under goal two, the Network has identified evidence of an event that requires development or recognition of a best practice/protocol in the coming year. In quarter four alone, of the 1,213 events reported in the participating CAHs, 31 percent were falls related. As made evident in Figure 2, falls accounted for 1,511 (or 27 percent) of all events for 2010-2011 at all facilities. Events related to medications and infection are the only two other categories that report high incident rates. These events have been identified as areas of interest for the coming year.

Figure 2
Total Reported Events by Participating CAHs in 2010-2011



In an effort to meet this goal, the Network did identify facilities that may have a best practice in use as made evident by their lower rate of falls. Figure 3 illustrates the number of falls by facility for this reporting year. Facilities appear in the following figure in no particular order and with no identifiable variables. From this graph it may be discerned that facility M may potentially have a best practice/protocol in place to prevent falls. It is evident that this is a facility that should be contacted as they are currently reporting no occurrence of this event.

Figure 3
Number of Falls by Facility in 2010-2011



It is also important to note what percent of a given facilities' events are categorized as a fall because Figure 3 may be misinterpreted if the particular facility has a higher volume of patients or events overall. As an example, facility H appears to have the second highest number of falls when looking at Figure 3. However, when we looked at what percent of their events are falls related, they have a lower percentage of this event than six other facilities.

What has been made clear by observing the data in various formats is that facilities B, I, K, L, and M may be able to provide a protocol for other facilities that have been identified as struggling in this area (facilities A, E, F, G). In the coming year, the Network will continue to focus on falls and make contact with facilities reporting low rates in order to determine a best practice/protocol to make available across all participating facilities.

2.3 Goal Three

Utilize the Healthcare SafetyZone® Portal and the data collected to create a series of benchmarking reports. Develop set of common definition for events being reported in the Portal.

This two-part goal was met and the Network will continue to make progress on this goal in the future. Benchmark reports were developed by Clarity quarterly and shared with participating facilities in partner with the Network. In 2010-2011, user meetings were also held monthly with stakeholders and participating CAHs, in which Benchmark Reports also were reviewed. Each user meeting had a specified agenda but included elements from these areas:

1. Form/Template Review
2. Feedback on revision made to templates
3. Update from Network Coordinator and Clarity
4. Review of Benchmark Report
5. Discussion of the Special Topic
6. "Spotlight Moment" to highlight a lesson learned by the participants since the last meeting

Agenda item four was presented through a slide presentation prepared by Clarity to share output results with the participants. As the program has progressed and CAHs have become both familiar and comfortable with the system, user meetings will continue to be held, but quarterly (not monthly) in partner with the Benchmark Reports.

As the primary event of focus this year was falls, a common definition was adopted by all participating facilities. An initial definition was tested and after feedback from health professionals, it was adapted and the final definition chosen was that proposed and employed by the Centers for Medicare and Medicaid Services (CMS).

FALL: "Refers to unintentionally coming to rest on the ground, floor or other lower level, not as a result of an overwhelming external force"

– CMS –

Though goal three was met by developing this shared definition, the Network, along with the participating CAHs and Clarity, will continue to develop shared definitions across all reporting events in the future.

2.4 Goal Four

Gradually update the forms being utilized in the Portal

At each user meeting, as identified above, users were, and are, encouraged to address concerns with the Portal or mention additional resources that would be helpful. In response to inquiries and discussions held during the user meetings, forms utilized in the Portal were, and continue to be, updated. As an example, the drop down definition for falls on the reporting form was changed to reflect that which was agreed upon by the participating CAHs. In addition, employee forms were updated to reflect changes mentioned during a user group meeting and events that did not require a severity scale or type were revised within the Portal for clearer reporting.

Early in 2010-2011, a system had been developed as a communication forum for participating CAHs. This service was to encourage discussion and identification/development of shared tools/protocols as they relate to reported events. This service was not utilized, and as a result has been removed. In the future, CAHs will be encouraged to make use of the Virtual Library of Shared Tools provided through the CAH Quality Network. Additional information on the Virtual Library of Shared Tools may be found in Section 5.4.

2.5 User Meetings & Web-Based Education

Under the Program Plan for 2010-2011, it is written that Clarity would provide one web-based education program in the fourth quarter of 2010. This agreement was fulfilled on September 30, 2010 as Clarity presented a webinar entitled, "Evidence Based Care Webinar Series, Part 1 – Fundamentals of Evidence Based Care: Mission, Vision and Culture." In this webinar the presenters provided information for participating members that would improve their understanding of what evidenced based care is and how it is appropriately used by providers. Other goals of this webinar included participants gaining a better understanding of the challenges encountered when promoting use of evidence based practices and ways to overcome these barriers, and a new level of awareness of the risks associated with ignoring evidence based care.

As previously mentioned, monthly user meetings were held with all participants and the Network. The agenda may be found in Section 2.3. Though held monthly in this reporting year, meetings will be held quarterly moving forward. These meetings serve as an opportunity for Clarity and the Network to share some of the results related to the events of focus, discover if any facility may have a best practice, identify any problem areas, brainstorm solutions for identified problems, and voice any concerns or questions related to the use of the Portal.

2.6 Process & Evaluation

The process, as written in the Program Plan, reads: "Clarity will provide the data analysis required for the Benchmark Reports and for the Quarterly Focused Reviews. Clarity will work with Jody (Quality Network Coordinator) to suggest actions to take based on the data analysis and to determine which practice protocol might be a good one to focus on with the QN Portal Participants. Jody will work with the group to facilitate the protocol development using the group's resources (clinicians). Clarity will work with Jody and the group to ensure the topics discussed at the monthly meetings are timely and relevant to needs being expressed in the data or by the group."

Clarity has, and continues, to not only provide data for the Benchmark Reports but also shares the information with the participants. In addition, they have worked closely with the Network to identify an event (falls) in need of a practice protocol. The Network Coordinator (Jody Ward)

began to look into identifying best practices as they relate to falls, but did not complete this part of the process. Enough viable data had not been accessible for analysis until late in the contract year which left little time to develop a protocol with the assistance of health professionals. This will continue to be a part of the next year's (2011-2012) process. Enough data was not available for Clarity to identify any areas of need for discussion at monthly meetings; however, participants' concerns and needs as group were still addressed.

There are six identified methods of evaluation for this system and its use. The Program Plan lists the following forms of evaluation: 1) monthly reviews of incidents reported by harm score; 2) completion of one evidenced based protocol; 3) evidence of changes made by use of the Portal data; 4) education program evaluation; 5) review of areas identified in the 2009/2010 evaluation survey; and 6) the year-end report.

System use was assessed through incidents reported (as mentioned in Section 2.1) though no evidence based protocol was developed to illustrate progress being made. The Portal was able to identify changes that were/are occurring as a result of the data, though no best practices have yet been identified. One change is the move for some facilities to paperless reporting through use of the Portal. The education program addressed in the evaluation section of the Program Plan relates to the webinar held in September. Finally, the previous year's survey (2009-2010) implemented among participating CAHs pointed to the need for facilities to make better use of the data results. The 2010-2011 Program Plan then addressed the need to use the data and this topic was covered in the monthly user meetings.

Section 3

Additional ND CAH Results from 2010-2011

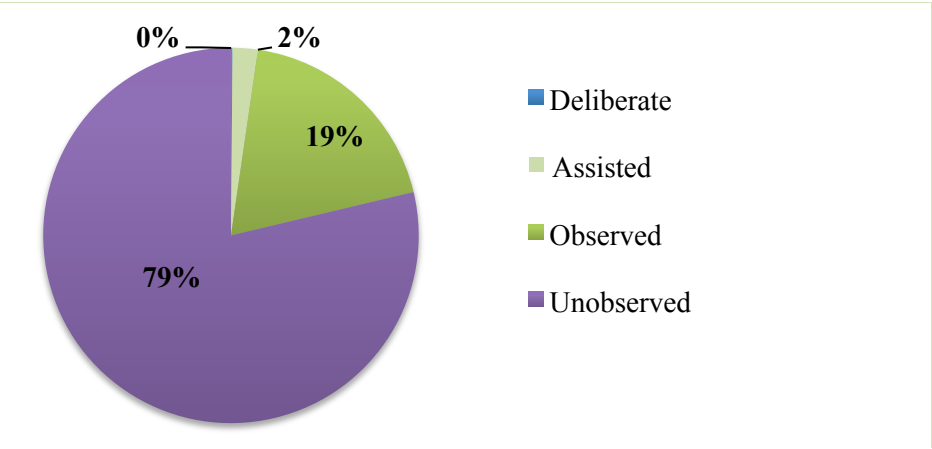
Though the focus of this year's Program Plan centered on falls data, other valuable information was discerned from the year's reported events. The following discussion presents other information and analysis related to falls data, and also addresses numbers related to medication and infection events to support the decision to make these two events a stronger focus in the future. It is important to note that data will not be presented in this discussion by facility to protect the privacy and anonymity of reporting for the participating CAHs. However, the report will address how facility specific information and data were, and will be, used.

3.1 Falls

Figure 4 presents all falls for all participating facilities by type. A total of 1,475 falls were reported in 2010-2011. Of those falls, 79 percent were unobserved. Under goal two, the Network identified falls as an event of focus in which protocol must be identified or developed. The data presented in Figure 4 then illustrates specific types of falls that require immediate

attention. This information allows the Network to focus more specifically on providing protocols related to falls that are both observed and unobserved while recognizing that less attention is required for deliberate and assisted falls as they account for only a small percentage of the overall event.

Figure 4
Falls by Type in 2010-2011



Additional analysis of the data illustrated the number of falls by type for each facility. With this information, the Network can identify a facility that is reporting low rates of both observed and/or unobserved falls to inquire further if there may be a best practice in place at the identified locations.

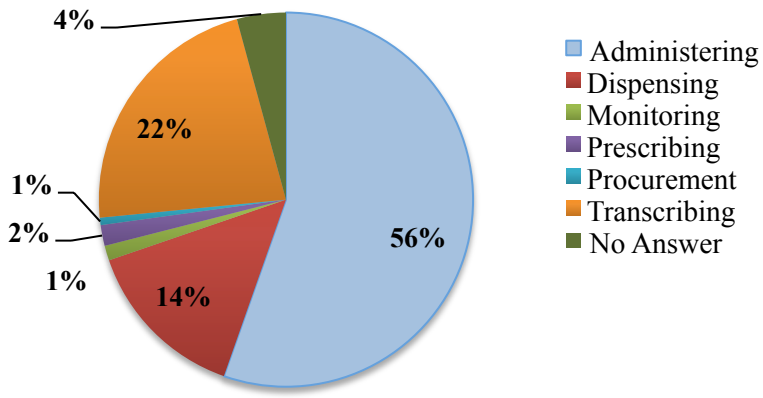
3.2 Medication

As previously noted, 15 percent (830) of all events for the 2010-2011 year were medication related, following just behind infections (30 percent) and falls (27 percent). As evident in Figure 5, more than half of medication errors occurred at the point of administering the drugs. Again, as was discussed in relation to falls data, these further categorized results allow the Network to identify a more specific issue related to the quality of patient care. The information presents an opportunity for improvement while also noting areas that the participating CAHs are thriving. Medication errors were not occurring with any regularity at the point of prescribing, procurement or monitoring. This information is valuable as it informs facilities of areas that do not require extra attention or resources at this time.

The Network is able to take this information and breakdown the number of medication events by the point of error for each facility. These outputs then illustrate which CAHs are not reporting high incidents of events related to administering, transcribing or dispensing medication. It is these facilities that may then provide a best practice or protocol for those that are struggling in this area of care.

Figure 5

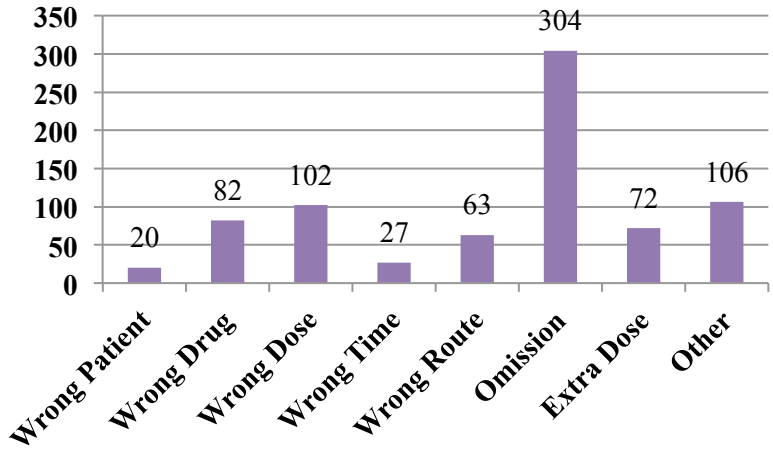
Percent of the Point at Which the Medication Error Occurred for 2010-2011



Medication errors have also been categorized by the type of error made as illustrated in Figure 6. A majority of all medication errors are the result of omission. What is important to note from this data is that though omission accounts for a majority of all events related to medication, all errors are relatively high. It is evident that all medication errors will need to be addressed as the Network, participating CAHs, and Clarity to identify best practices and protocols in the future.

Figure 6

Types of Medication Errors Made in 2010-2011

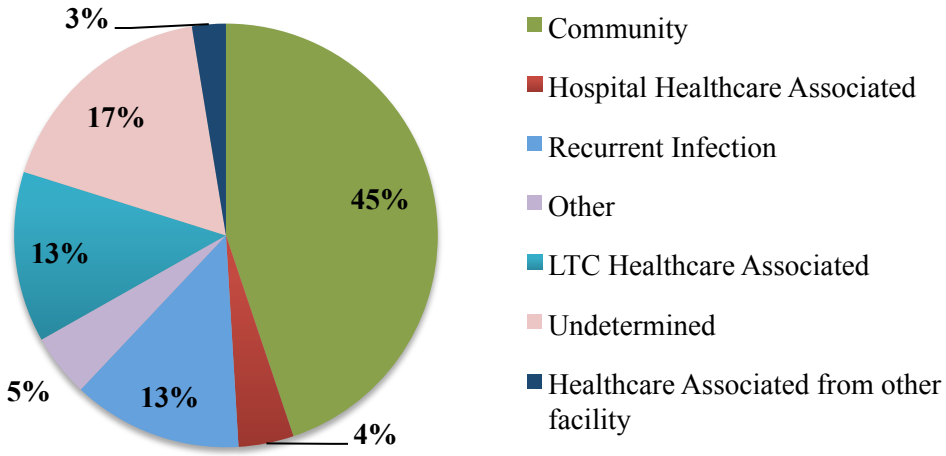


3.3 Infection

Infection was the most common event in 2010-2011 with participating CAHs reporting 1,683 incidents. Figure 7 illustrates the data that assists in identifying where the patient is attracting the infection. It is valuable for providers to recognize how many infections are obtained in association with a healthcare facility so they may develop system changes to address the issue. Reports indicate that 20 percent of infections are occurring within healthcare facilities (those

infections categorized as hospital healthcare associated, long-term care (LTC) healthcare associated, and healthcare associated from other facility). The results also indicate that a majority of all infections reported occurred in the community (45 percent) which may point to the need for facilities to adopt a best practice around educating their patients on how to avoid said infections.

Figure 7
Infections by Type for 2010-2011



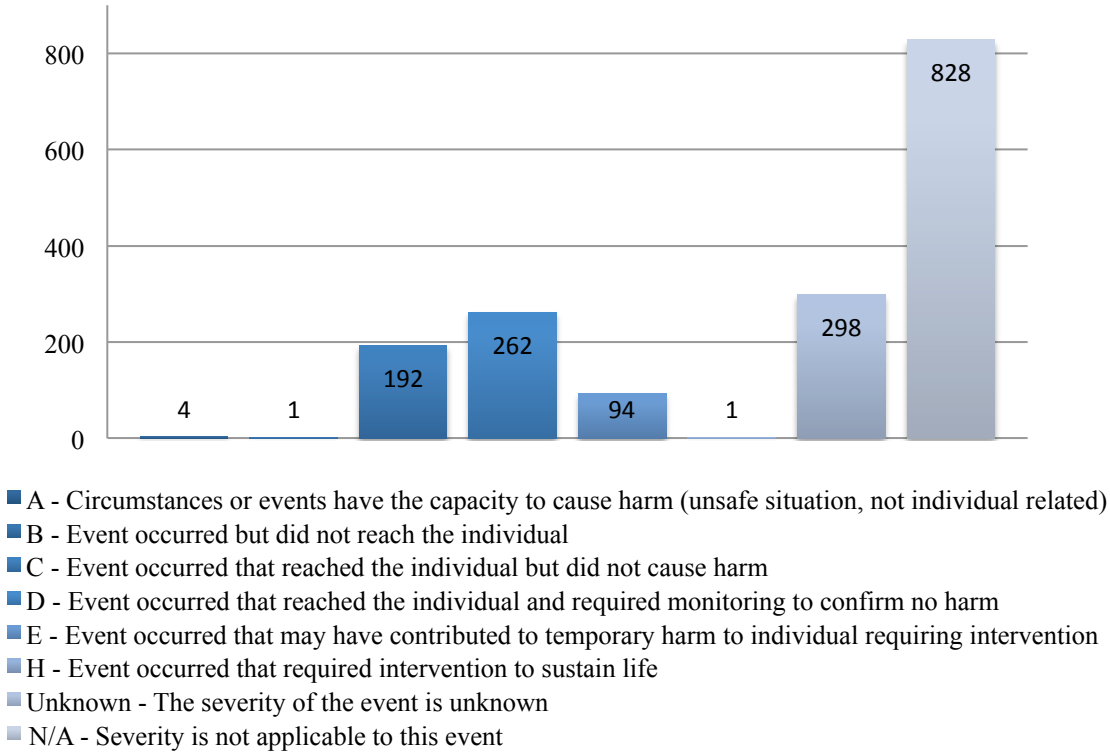
Reports provided through the Portal also point to trends in the severity of infections in the given year. No infections were reported to have contributed to individual death (category I), permanent harm (category G), or to temporary harm requiring prolonged hospitalization (category F). See Figure 8.

Two additional inferences may be drawn from this data. First, this information points to a need for the Network and Clarity to address the means by which infections are reported. If an infection occurs and is reported in the Portal, facilities must be encouraged to also report on the severity of the infection. As is noted in the Program Plan for both 2010-2011 and the coming year, it is a goal of the Network to decrease N/A and Unknown reports. It is evident that infection events have a high rate of cases reported in both categories. The Network is able to look at this data by facility and identify those that reported high incidents of infections with an unknown severity, or no severity category applicable for the particular event. To meet goal one under the Program Plan, the Network may use this information to identify opportunities for education and training on Portal use.

To improve quality of care, this data also makes evident the need to address an infection protocol to reduce the number of infections that contribute to temporary harm, requiring intervention as

94 infections were reported with this level of severity. It should also be noted that facilities are reporting low incidents of near misses under infections; five cases in 2010-2011. Goal one of the Program Plan seeks to see an improvement in this rate over time.

Figure 8
Number of Infections by Severity in 2010-2011



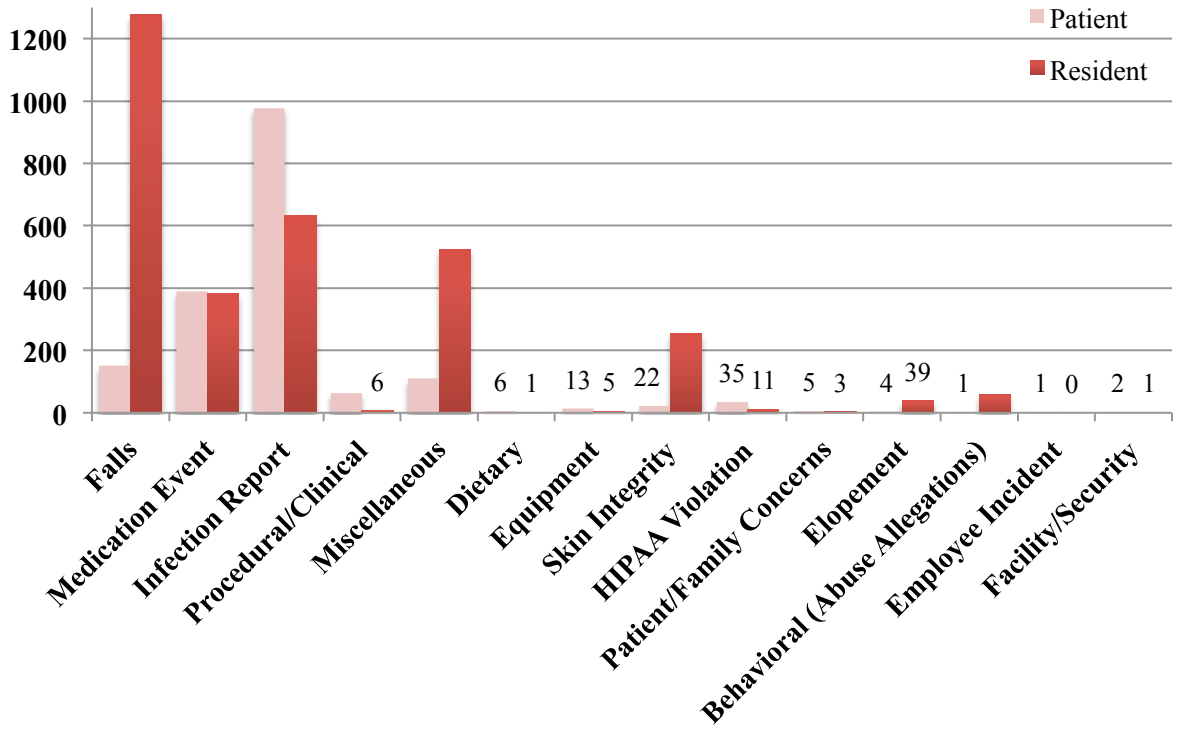
3.4 Multiple Variables

Though it was not a focus of the Program Plan for 2010-2011, Portal data has also been able to differentiate between and compare events by who was involved. An event has the potential to harm either a patient or a resident. For the purpose of reporting in the Portal, a resident is an individual residing in a long-term care facility while a patient refers to any individual in a general health facility.

Focusing on falls, as was the intent for 2010-2011, Figure 9 makes it clear that a majority of all falls involved residents (89.4 percent). It is then necessary to identify a fall protocol specific to long-term care facilities. In addition, the data also identifies patients as the primary source of infections (977 reported patient infections compared to 633 infections involving residents). Here, a patient specific protocol may improve overall infection rates.

Figure 9

Number of Events for Patients and Residents in 2010-2011

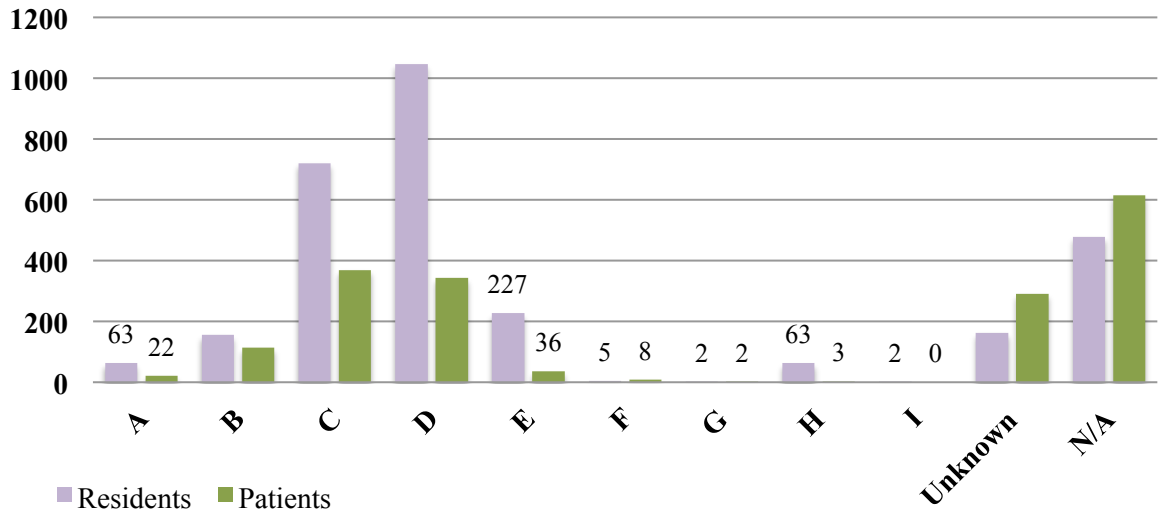


The aforementioned data has also been broken down and compared by severity. The data presented in Figure 10 helps to identify areas of focus when working toward goal one – decreasing the number of events categorized as high harm and increasing events identified as near misses. High harm events (as described earlier) occurred more frequently, or as often, among residents in all high harm classifications (E, G, H, and I) except for category F in which 3 more events were reported for patients. For a definition of severity classifications, please see Table 2. The data makes evident that residents are at an increased risk for high harm events compared to patients, making a case for improved protocol in long-term care facilities.

Finally, the graph found in Appendix B provides an overview of all Portal data acquired in the 2010-2011 year, other than those reports that are facility specific. For the purpose of the Program Report, no shared data is to identify particular facility outputs.

Figure 10

Comparison of Reported Event Severity between Patients and Residents in 2010-2011



Section 4

ND CAH Satisfaction with the Healthcare SafetyZone® Portal

As in previous years, participating CAHs have reported satisfaction with the Portal and note the ways in which its implementation has improved the quality of care for their patients and those that work at, and visit, their facilities. One of the benefits of the Portal the Network has identified is its ability to generate data for state reporting which saves time for participating facilities. The Portal also provides instant notification of events. While EMRs are employed to encourage continuity of care, the Portal has the ability to address quality of care by generating output data to identify areas of care needing improvement and those that are best practices, allowing for comparisons, growth and progress in all participating facilities.

4.1 User Survey Results

The CAH Quality Network at the North Dakota Center for Rural Health employed a Healthcare SafetyZone® Portal Participant Survey to assess the users' satisfaction and use of the system. See Appendix A for a copy of the survey. At the time of this report, 54 percent of participating CAHs had completed the assessment.

Of those who responded to the survey, 71 percent reported using the information provided through the Portal for review at nursing meetings while 86 percent have used the information to initiate quality improvement project(s) based on the data. One respondent identified reviewing Portal data at a board meeting.

Medication is the only event currently being reported on by all surveyed participants. Elopement, employee incidents, equipment, falls, infection, miscellaneous and procedural/clinical events are being recorded by at least 70 percent of those surveyed. Dietary and facility/security events are the two events that are currently being reported by the least number of respondents (43 percent) and may be an area for discussion at future meetings.

As a Network, it is important to assist CAHs in their transition to paperless reporting. When asked about event recording techniques, no surveyed facility reported recording all events paperless. No event is currently being recorded paperless by all facilities, or even half of those surveyed. The information provided here makes it evident that though the transition is occurring, more needs to be done to encourage and assist CAHs to move to paperless reporting.

All CAHs that responded to the assessment identified their director of nursing, a CEO or administrator, and a QI coordinator as being involved in the data review and initiatives that have resulted from the Portal. See Figure 11 for a complete picture of who has been involved in the review of the information. Figure 12 then provides a report of the number of CAHs recording events information for particular individuals – meaning, the number of CAHs reporting events involving patients, visitors and/or employees, etc.

Figure 11

Percent of ND CAHs that Involve this Individual in Data Review and Quality/Safety Initiatives

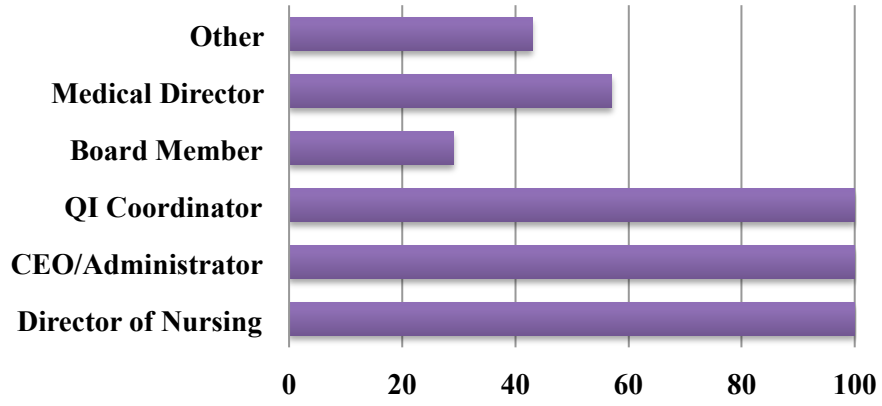
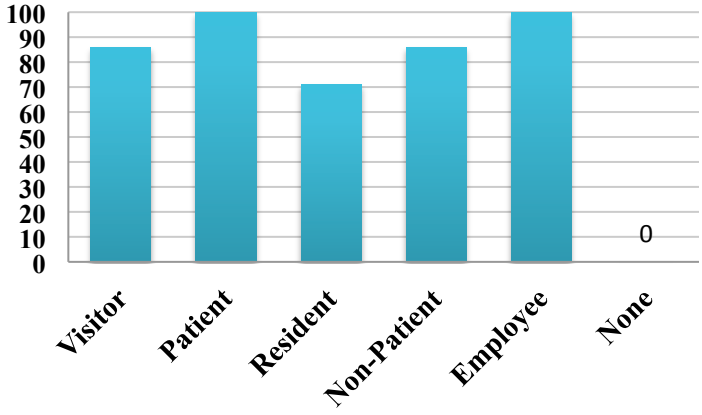


Figure 12

Percent of ND CAHs Reporting Events for the Identified Individual



When assessing the service provided by Clarity, participating CAHs rated Clarity's performance as either "good" or "excellent" in all categories other than in their data analysis, the value of the content shared, and the length and frequency of meetings which all received a "fair" rating by either one or two facilities. Finally, an area for improvement is evident in participants' response to the value of the overall monthly meetings in which 33 percent gave a "fair" rating (the reaming 66 percent rated the value as "good" or "excellent").

The Network's performance was also rated by those surveyed and in every performance area, other than data analysis, the Network received a "good" or "excellent" rating by all respondents. In data analysis, 28 percent of those surveyed gave a rating of "fair" which illustrates an area the Network can look to improve on in the coming year.

Most notable would be the response received when current Portal users were asked if they would recommend the Healthcare SafetyZone® to other ND CAHs; all but one respondent said "Yes" while the remaining participant was "unsure".

4.2 Testimonials

Those completing the survey were asked to provide examples of how they are using the Portal. In addition, the Network held follow-up conversations with two Portal users to obtain testimonials.

Paula Brown is the Quality Improvement Coordinator for McKenzie County Health Care System in Watford City and she stated "The Portal has really helped McKenzie County Health Care System move off of paper reporting. It is a great time saving device and has also helped us to have more complete incident reports with fewer go-betweens. The out-put reports are really nice and are more complete than what we had before. It has led to better communication between departments and shows trigger areas where more education needs to be done to improve quality."

Coleen Bomber also emphasizes how using the Portal can save a facility time. As the Director of Nursing at Northwood Deaconess Health Center, Coleen commented, "On the whole, I really do like the Portal and appreciate the fast reporting of employee incidents. Because you have the opportunity to create your own templates, the Portal really helps and saves time when it comes to state reporting."

From the administered survey, two individuals highlighted the use of the Portal in infection control. One wrote that the Portal "Has enabled us to have an electronic Infection Log and Staff Illness Log. This is useful in evaluation of infection patterns and to meet State requirements for licensing." An additional comment by another participating facility reiterates the ease of use in state reporting and infection control as they write that the Portal "Had given our infection control and QA people a better way to track and pull data for reporting. All appropriate parties are notified quickly of an event so communication is improved."

Better communication and faster reporting are the two qualities most frequently mentioned when ND CAH Portal users are asked about their use of and satisfaction with the Healthcare SafetyZone®. In addition, it is important to note that users are also seeing results and improved quality, not just saved time as one facility mentions that "Use of the SafetyZone has provided immediate notification to all parties needed to be involved in an incident. Having the immediate notification allows for immediate response and implementation of corrective actions."

Section 5

Program Plan for 2011-2012

As a result of the progress made this year, and in response to the data that has been found, the Network, along with Clarity, has developed a Program Plan for the 2011-2012 year. The Program Plan was developed in partner with Jody Ward (Quality Network Coordinator). In response to new staffing at the North Dakota Center for Rural Health, Shawnda Schroeder (Quality Network Coordinator) is now the point person for the Portal. It is important to note that as the Program Plan for 2011-2012 was written prior to the new hire, it still addresses Jody Ward as the primary Network contact partnered with Clarity.

The goals outlined in the Program Plan for 2011-2012 mirror those set for the previous year with one addition.

5.1 Goal One

Increase reporting of events across the Quality Network (QN) participants and see an increase in Near Misses alongside a decrease in High Harm, Unknown and NA events.

Remains the same.

5.2 Goal Two

QN to develop one evidenced based best practice protocol for the group to share that addresses an area that emerged from Portal data collected.

As this goal was not fulfilled in the past year, the Network, along with Clarity, will continue to identify protocols as they relate to falls. In addition, as the evidence supports, work will also begin to identify best practices as they relate to events reported in both the medication and infection event categories.

5.3 Goal Three

Utilize the Healthcare SafetyZone® Portal and the data collected to create a series of benchmarking reports. Develop a set of common definitions for events being reported in the Portal.

Currently, falls is the one event with a shared definition in the Portal. Work will be done in the coming year to identify events that require a shared definition for more accurate reporting. When events are identified, the participants, Clarity and the Network will work to develop shared meaning.

5.4 Goal Four

Gradually update the forms being utilized in the Portal.

To respond to the lack of participation in the communication forum in the previous year, the Network has identified the Virtual Library of Shared Tools as a valuable resource to be made available on the Portal webpage. The Virtual Library is a collection of shared tools and resources submitted by, and for, North Dakota CAHs. Access is limited to critical access hospitals in the state and is password protected. Some of the materials already provided address agreements, medication protocols, policies and procedures, risk management, respite care and quality tools among others.

5.5 Goal Five

Track use of Electronic Medical Records and how it affects data being collected.

During monthly meetings held in the past year, several participants voiced concern over the influence electronic medical records (EMRs) may have on use and reporting in the Portal. To

address this issue, the Network along with Clarity, have identified the tracking of these changes and influences as a fifth goal under the Program Plan. Efforts will be made to to track what influence, if any, implementation of EMRs may have on event reporting in the Portal.

5.6 Program Plan, Process, & Evaluation for 2011-2012

The Program Plan for 2011-2012 is similar to that of 2010-2011. The agenda for the user meetings remains the same, though meetings will now be held quarterly and as needed instead of monthly. To maintain the lines of communication, Clarity will continue to make contact monthly via e-mail with both participating CAHs and the Network. The Process and Evaluation as written in the 2011-2012 Program Plan remains the same and appears in the plan as follows:

Process

Clarity will provide the data analysis required for the Benchmark Reports and for the Quarterly Focused Reviews. Clarity will work with Jody to suggest actions to take based on the data analysis and to determine which practice protocol might be a good one to focus on with the QN Portal Participants. Jody will work with the group to facilitate the protocol development using the group's resources (clinicians). Clarity will work with Jody and the group to ensure the topics discussed at the monthly meetings are timely and relevant to needs being expressed in the data or by the group.

Evaluation

- Monthly review of incidents reported by harm score
- Completion of one evidenced based protocol
- Evidence of changes made by the use of the Portal Data – Spotlight Moments
- Education Program Evaluation
- Review of areas to address from the 2010/2011 evaluation (March 2011: Program)
- Evaluation Survey from Center for Rural Health
- Year-end report: April 2012

In addition to the aforementioned goals, the Network will be working to increase the number of CAHs participating in the Healthcare SafetyZone® Portal while also making an effort to increase the level of event reporting in those CAHs that are already Portal members. The Network also anticipates assisting users to move to paperless reporting in an effort to save time and avoid double charting. Finally, in partner with goal two, the Network expects to see more shared protocols in the coming year and to begin to address events as they relate to medications and infections in addition to falls.

Appendix A

ND CAH Evaluation of the Healthcare SafetyZone ® Portal

1. How are you using information from the Healthcare SafetyZone ® Portal?
Please mark all that apply.

- € Review at Nursing Meetings
- € Review at Board Meetings
- € Develop Goals/Targets to Address Data that the Portal Provides
- € Initiate Quality Improvement Project Based on Data
- € Other

2. Which types of events are being collected in the Healthcare SafetyZone® Portal?
Please mark all that apply.

- € Employee incidents
- € Medication events
- € Falls
- € Patient/Family Concerns
- € Equipment
- € Procedure/Clinical
- € Facility/Security
- € Infection Report
- € Miscellaneous
- € Dietary
- € HIPAA Violation
- € Skin Integrity
- € Behavioral (Abuse Allegations)
- € Elopement

3. Which events, if any, are currently being reported paperless (only recorded electronically)?

- € Employee incidents
- € Medication events
- € Falls
- € Patient/Family Concerns
- € Equipment
- € Procedure/Clinical
- € Facility/Security
- € Infection Report
- € Miscellaneous
- € Dietary
- € HIPAA Violation
- € Skin Integrity
- € Behavioral (Abuse Allegations)
- € Elopement

4. What are you reporting for "to whom" the event happened to?
   - € Visitor
   - € Patient
   - € Resident
   - € Non-patient
   - € Employee
   - € None

5. Who has been involved in the data review and quality/patient safety initiatives that have resulted from use of the Portal? Please mark all that apply.
   - € DON
   - € CEO/Administrator
   - € QI Coordinator
   - € Board Member
   - € Medical Director
   - € Other

6. Level of service that Clarity has provided in the areas:

	Excellent	**Good**	**Fair**	**Poor**	**N/A**
Training on the use of the Portal					
Responsiveness to Questions (Content and Usefulness)					
Responsiveness to Questions (Timeliness)					
Technical Support/Help Desk					
Data Analysis					
Risk, Quality & Safety (RQS) Knowledge					

7. Evaluation of monthly meetings

	Excellent	**Good**	**Fair**	**Poor**
Value of Content Shared				
Length of Meetings				
Frequency of Meetings				
Overall Value of Meetings				

8. Level of service that the Network has provided in the areas:

	Excellent	Good	Fair	Poor	N/A
Training on the use of the Portal					
Responsiveness to Questions (Content and Usefulness)					
Responsiveness to Questions (Timeliness)					
Technical Support					
Data Analysis					
Sharing of Information					

9. Would you recommend the Portal to other ND CAHs?

- € Yes
- € No
- € Unsure

10. Please provide a concrete/tangible result of what your organization has done as a result of using the information from the Portal and/or how use of the Portal has impacted your organization or patients/residents (e.g., improved communication, collaborative solutions, staff education).

11. Please share any additional comments or concerns you have about the Portal.

Appendix B

Number of Reported Events by Type & Severity in 2010-2011