TAHOE FOREST HOSPITAL DISTRICT

2017-12-12 Board Quality Committee Meeting

Tuesday, December 12, 2017 at 12:00 p.m,

Eskridge Conference Room - Tahoe Forest Hospital

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2017-12-12 Board Quality Committee Meeting

12/12/17 Board Quality Committee

AGENDA

TAHOE FOREST HEALTH SYSTEM

QUALITY COMMITTEE AGENDA

Tuesday, December 12, 2017 at 12:00 p.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Alyce Wong, RN, Chair; Charles Zipkin, M.D., Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

5.1. Patient & Family Centered Care (PFCC)

5.1.1. Patient Experience Presentation
Community member will share his healthcare experience at Tahoe Forest Hospital District.

5.1.2. Patient & Family Advisory Council (PFAC) Update ..... ATTACHMENT
An update will be provided related to the activities of the PFAC.

5.2. Quality Committee Charter and 2017 Focus ..... ATTACHMENT
BOD Quality Committee Focus 2017 was approved on March 14, 2017 and available for reference during the meeting. Provide status report and accomplishments for each Focus 2017.

5.3. BOD Quality & Service Dashboard ..... ATTACHMENT
Review the BOD Quality & Service dashboard and discuss additions or deletion of key quality metrics.

5.4. Board Quality Education ..... ATTACHMENT
The Committee will review topics for future board quality education and identify best practice topics for review at future meetings. The Committee will also review Pugh, M. (2011). How to Ensure Quality (Chapter 5) *Healthcare Governance: A Guide for Effective Boards.* Chicago, IL: Health Administration Press.

6. APPROVAL OF MINUTES OF: 9/19/2017 ..... **ATTACHMENT**

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE
The date and time of the next committee meeting, Tuesday, February 1, 2018 at 9:00 a.m. will be confirmed.

9. ADJOURN

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

2017 PFAC PROCESS IMPROVEMENT LOG

The identified topics are noted on this log and the information is forwarded to the responsible Director/Manager for their review and follow up.

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
1st Quarter 2017				
1/17/17	Laboratory Services Emergency Department Hand Cleaning Signage Wellness Community Resources	Vern Barnes Sharon Sutich John Rust PFAC PFAC	Guest speakers Vern Barnes, Sharon Sutich, and John Rust. Vern and Sharon provided an update for on-line scheduling of laboratory appointments and discussed ways to increase participation. The lab administers a single question survey to inquire about services and anything that can be done to improve experiences. Feedback from the group included the importance of Spanish speaking staff and ways for patients to understand what labs they are having done and what orders say from the physicians (i.e. whether they need to fast). John relayed year end Press Ganey scores for the Emergency Department which were favorable! We discussed patient perceptions and how outliers can drastically affect survey results; also acknowledging how the same experience can elicit different responses or expectations. Areas for process improvements include noise reduction at the nurse's station, keeping patients informed about delays, and utilizing private rooms when possible to address privacy. We revisited the hand washing signage discussed in November for patient rooms and it was identified that the inpatient white boards do include signage that is adequate for patient rooms. Staff will be reminded to review this information with patients. There was discussion about how to involve/include Incline Village Community Hospital (IVCH) patients and families in the PFAC.	Continued focus on noise reduction in ED; use of private rooms when possible Relayed information to Jan Iida for consideration

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Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
1/17/17	(continued)		It was determined perhaps quarterly focus groups at IVCH may be helpful to provide information about the services and also obtain feedback for process improvements. We also discussed how important it is for the Wellness Neighborhood to educate our clinics on ways for patients to seek services for depression. Other items: PFAC member Nancy Woolf accepted the opportunity to be a representative on the Board Quality Committee! Also, we have a new member, Sandra Dorst, who will be joining us once her orientation is complete!	Relayed information to Maria Martin
2/21/17	Meeting Cancelled (weather)			

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3/21/17	Community Health and Wellness Extended Care Center Home Health/Hospice IVCH Whiteboards	Maria Martin/ Eileen Knudson Sarah Jane Stull Max Hambrick	Maria and Eileen provided an overview of programs that offer access to services for high risk patients including care coordination and transitional care (hospital to home). New programs include orthopedic, perinatal, and wound care coordination, as well as a diabetic prevention program. They were also awarded a grant a year ago that funds projects related to pain management, blood pressure guidelines/education, and counseling services for mental health. A challenge has been getting the information out to the community. Feedback and ideas from the group highlighted the use of social media including podcasts, a 'did you know' email to patients/community members, and the hospital website/Facebook page. Sarah Jane relayed the services that are provided by the Extended Care Center including long term care, post-operative rehabilitation, and hospice. She asked for input about a wait list process for long term care; the current process is in order of chronology and spots are held if families decline the need for service when a bed becomes available. The group discussed options for a wait list that may include assessing patient needs more regularly and offering available beds based on a priority assessment of needs. Also, it was suggested to benchmark best practice and consider what other rural hospitals are doing. Max spoke about Home Health/Hospice and clarified the difference in services based on geographical regions. This can be affected by the amount of services needed and the staff required to implement the services.	Relayed ideas to Marketing

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3/21/17	(continued)		Max discussed a challenge with response rates to surveys that will hopefully be increased as it was determined a registration and mailing issue was affecting the number of people who were receiving surveys. There was a group discussion about how to educate the community about the services Hospice provides and how to increase the notion that the service offers comfort care and quality of life vs. a perception that once you accept the service it is only about a potential time frame of survival. We also reviewed a whiteboard that will soon be utilized at the Incline Village Community Hospital Emergency Department with a goal of keeping patients informed during their stay. Suggestions included adding wait times vs. 'expected' times, including a personal goal for the visit, asking if there is anything else one might need, and having a yes/no box for food allowed or if a patient could be mobile during the visit. Thank you to PFAC members: Nancy for attending the Board Quality Committee meeting this month and Doug for filming a TV segment about PFAC!	Relayed suggestions to Jan Iida
2nd Quarter 2017				

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Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
4/18/17	2 Year Anniversary Celebration!!! Cancer Center/Navigator Program BETA Healthcare Group/HEART	PFAC Karen Aaron Deanna Tarnow	Acknowledged 2 years of PFAC!!!!! Karen reviewed the services provided at the Cancer Center including, but not limited to, Medical Oncology, Radiation Oncology, lab services, financial counseling, and our affiliation with UC Davis.	

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4/18/17	(continued)		She discussed her role as Nurse Navigator and being the 'point person' to answer questions and guide patients through their care, with the intention to facilitate continuity of care and meet patient needs. A challenge has been transportation for patients who live in outlying areas and also ensuring patients are informed of her role. Feedback from the group highlighted the notion of a FACT Sheet with the main responsibilities of her role (she is currently revising one and will send to the PFAC for review). Ideas for transportation included connecting with community groups to see their availability and Karen is also working with the American Cancer Society on this issue. Deanna introduced the HEART (healing, empathy, accountability, resolution, and trust) Program offered by BETA Healthcare Group that supports healing of both the patient and caregiver after an adverse event happens. The goal is to be transparent, timely, and thorough when communicating with patients and families. This is a program we may enroll in next year! Other topics discussed included the process for refunds from the billing office and how to best communicate to patients what the refunds are for, or what date of service they are related to. We also reviewed a nursing rounds card to place in patients' rooms in the evening if patients are sleeping when the nurse is rounding. Suggestions will be forwarded to the Chief Nursing Officer.	Relayed information to Patient Financial Services Met with Barb to review suggestions

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Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
5/16/17	Environmental Services/Respiratory Therapy John Hopkins Article – No Room for Error	Jason Grosdidier PFAC	Jason reviewed the services/tests provided by Respiratory Therapy including an EEG (electroencephalogram test to measure brain activity), pulmonary function tests, and a neonate vent. They have been updating equipment with modern technology and plan to add asthma and stress testing in the near future. At this point they have been marketing services to physicians and case managers. The group relayed marketing to the community and patients when possible would be beneficial. Jason also reviewed Environmental Services (EVS) and how they are utilizing a new cleaning solution that kills bacteria with no residue or odor. They are upgrading equipment (carts, etc.) that is safer for employees, trialing a disposable curtain in patient rooms that can be replaced more conveniently, is more cost effective and recyclable, and are in the process of replacing carpets. EVS staff is also placing courtesy bags from the Foundation in patient rooms that include toiletries and other items. Jason shared there is a plan for a TV screen to be placed on the wall near the restrooms in the main lobby of the hospital. The group agreed how this will be a great opportunity for sharing the hospital services and perhaps health topics in a 'did you know' format. There were suggestions for a bench to be located outside the main entrance and possibly the Emergency Department area, as well as public art in the entrance way. Jason will look into these possibilities. We reviewed the John Hopkins article '*No Room for Error'* and the concept of a Family Involvement Menu.	Sent reminder to Jason to follow up (per Jason, approval was obtained for a bench outside the main hospital doors!)

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5/16/17	(continued)		The group discussion centered around the feeling that we do encourage family involvement and did not need to have a laminated card with ideas of family involvement per se, rather remind staff to say to family members/caregivers that we welcome their involvement and continue to promote patient and family centered care. There was a consensus of 'signage fatigue' and a more personal note of encouraging involvement via staff and family conversations. It was also suggested to educate all staff on our visitor policy so if a question was asked about whether family members of patients could stay the night, we could all answer the question. Other topics discussed included our performance excellence scores of 'quietness' and suggestions for keeping noise levels down. Suggestions included having white noise boxes available upon request for patients, reminding staff to be conscious of their conversations (especially personal), and utilizing more Yacker Tracker devices that identify high volumes of noise.	Relayed to Department Directors and will meet with Alex for him to share information during Values/Orientation class Relayed to Department Directors

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6/20/17	Case Management Women and Family Center	Bev Schnobrich Kristy Blake	Bev reviewed the services offered by Case Management that include assessing patient needs prior to discharge and creating a plan of care for patients that may involve transitional care coordinators. If patients have Medicare, the Case Management team follows regulations and guidelines that may involve reviewing charts and patient needs to justify patient stays and also reviewing other options for patients who may be eligible for transfers to other facilities. The overall goal is to get patients home safely and avoid readmissions. We discussed how it would be beneficial to offer a class or Mountain Health talk to educate patient and families in the community on Medicare benefits and supplements. Kristy reviewed the services provided by the Women and Family Department and was happy to report the new area should be opening soon! Tahoe Forest has about 365 deliveries a year and the new area will have 4 labor rooms and 4 postpartum rooms. There will also be an operating area for caesarean sections. We are a 'baby friendly' hospital which encourages breast feeding and patients will have access to a Perinatal Coordinator. The group discussed community outreach and marketing services to the community and how it would be nice to tour the new area. Kristy will have the council review marketing items when available. We also discussed having field trips to other departments (this was a suggestion from our Chief Operating Officer, Judy Newland and the PFAC group). There was more discussion about television monitors to highlight hospital services and programs, as well as office binders and sharable documents on the website to promote department services.	Relayed to Ted Owens Relayed to IT for 'after EPIC' agenda, and Marketing

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Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
3rd Quarter 2017				
July/August	NO MEETING-Summer!		.	
9/19/2017	Meeting called to order 5:30 pm Introductions Review PFAC Projects; what is working well, what can we work on to improve services at TFHD	Lorna Tirman PFAC Members Input	Welcome new members and thank all volunteers for their service to improve TFHD Suggestions to improve the registration process in front main lobby to make it easier and more efficient. Frustration by patients when they cannot find orders, we are supposed to have orders, wait time in lobby with no communication about why or how long. Also work on employees who can be perceived as rude when patients are registering. Access to Physicians in the MSC as well as time for appointments not always long enough to address all patient concerns Harry talked about our care coordination and addition of patient care liaisons in the community to help keep people out of the	Lorna will work with Leaders in these areas, OU, Lab, Registration and DI to improve patient experiences, from check in to procedure. Will work with Leaders in MSC to review patient feedback and improve access where possible.

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Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
			hospital and out of the ER to improve health at home whenever possible. # 1 Goal is Patient Safety and also patient experience. Dr. Taylor expressed concern about a loud door outside of Ambulatory Surgery. Concerns about scripting prior to Mammography to alert patients they cannot get their Mammography if within a certain window of breastfeeding. This could be part of initial scheduling screening questions so patients do not come to get this test and then are not able to have it done at this time, leading to decreased satisfaction with TFHD. Concerns were brought up about the time it takes for tests to be received as well as if they are sent to providers for review and follow up Members expressed what is going well for them with our PFAC the past 2 years. Great attendance and engagement by members and leaders at TFHD. Learning about services provided has been very helpful and enlightening. Lab, DI and Briners all give great service once you get in for tests. Seem very customer centered in the care and services they provide.	Lorna to work with leaders to get this door to close more quietly for our patients and guests. Lorna to work with leaders in DI and Mammography to add scripting to screening if possible to prevent people from not being able to have Mammography when they arrive for appointment. Lorna to work with MSC and Lab to make sure we collect names of Physicians for labs and test results to go to and Physicians are following up with patients in a timely manner. Lorna will share with leaders in these areas.
	EMR: EPIC Update and Input by PFAC	Judy Newland	Judy presented the go live with EPIC November 1st and highlighted benefits of an Electronic Medical Record that can help communicate patient care and coordination	Judy to work with Marketing and EPIC go live team.

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	Announced Next Meeting October 17th Meeting adjourned 7 pm		with many other large health systems for improved continuity of care for our patients. We currently use many different systems that do not communicate with each other which is not efficient for caregivers or our patients. Judy asked for feedback on the best way to communicate our implementation to our patients during our transition. She presented a proposed flyer and scripting. Feedback from group was very helpful. Don't forget to bring dinner if you like from Café.	Judy to alter the flyer and messaging to patients to reflect the feedback from PFAC members. Flyer will be a more calming color so as not to alarm patients but remind them of this transition and thank them for their patience.
4th Quarter 2017				
10/17/2017	Infection Control	Svieta Schopp	**Infection control Review:** Svetlana Schopp, Manager of Infection Control; showed the group posters on sepsis and asked them for where to put these to educate the public. Feedback included public places in community and on our website in a format that we can download and share in our own places of work etc. Will work with Marketing to see if we can place posters and information on web site in format that Patients, visitors, staff can easily download and post or share. They also suggested Physician offices, library, Post-office and make sure they are in Spanish and English. Consider going on Local Radio about Sepsis	Svieta to work on communication in the community regarding sepsis and will work with Marketing to make sure appropriate materials are made available to community when identified as opportunities. Svieta also looking at

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			education. Discussed Education and Posters when Patients are on isolation in the hospital setting: Feedback was that signage needs to be Larger and more clear about what visitor's precautions need to be to protect patients and visitors. Svetlana will network with other hospitals on signage and precautions and get back to us with her proposed changes on larger and clearer signage. Consider signs like "DO NOT ENTER" without reporting to RN.	signage on doors of isolation patients to make sure all patients and visitors are aware of isolation precautions and policies related to them.
	Medical Practice Access and patient experience	Sandra Walker	**Medical Practice Report/ Access and Time for Visits** Sandy Walker presented on new additions to medical practice with 13 specialties and 30 providers. Dr. Taylor's office of women and family will fall under Tahoe Forest starting November 1st. We discussed that Access to Providers is one of our biggest areas for opportunity for our patients and families in Tahoe. Judy and Harry addressed office space issues. Many providers will be moving to above the Outpatient Oncology center to be accessible to those patients in the near future. Hospitalists who work in the hospital, now are not as able to see patients in their office settings every day presenting decreased access to certain primary care providers. We discussed opportunities to "manage up" other providers, like our PA's and NP's who are more readily accessible when a patient needs to be seen sooner than their primary is available. We discussed opportunities to train and script our front line staff for best ways to manage up providers and access to patients. One challenge discussed was high turnover of Medical Office staff at around 40% turnover. Harry	Lorna to work with Sandra and her Leads to improve training for all front line staff and continue to improve patient's experiences in all our clinics.

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		Judy Newland	addressed this stating he is aware of this and we will be looking at ways to decrease turnover in all areas of the hospital. Doug Wright shared that at his place of business he rounds on his staff regularly and gets to know them on a personal level so they feel cared about and appreciated. Will plan to meet with Medical Practice leaders to develop a plan for training and supporting employees in these areas as well as train physician leaders to help with retention of employees. "treat your staff better than you treat your customers, and your staff will take care of the patients" Doug Wright **Judy Newland** shared the updated go live posters for our EPIC transition given the feedback from the PFAC members in September. They look much better and PFAC happy about how they look and how Judy included their feedback to make the changes to them. Update regarding EPIC go live Electronic Medical Records system and flyers for patients Feedback from last meeting issues: 1. Starting Outpatient Improvement team: would like a patient/ family member involved. Goal to improve registration process/ and welcoming behaviors by staff 2. Educated Mammography employees to screen for breast feeding moms to prevent patients coming in for services and then not being able to perform test.	Feedback on posters positive!
			Topics for next meeting: Review of patient feedback data and comments	Lorna Tirman

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Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
	Meeting adjourned 7 pm		for all service areas. Will get PFAC input for improvement and action planning ER leaders to talk about privacy in the ER: PFAC suggested ear plugs Possible tour from the main lobby to X Ray and ER for input from PFAC on signage Updates from leaders of surgery Possible tour of women and family or main lobby Strategic Building Plan by Judy Newland Other suggestions: Next Meeting November 14 2017	
11/14/2017	EPIC Go Live Update Outpatient Improvement team to begin meeting in January. Will have leaders and staff from registration, lab and DI on team as well as a patient or family member Tour of facility from ER to Main Lobby and from Main Lobby to ER. De Brief on observations of signage and what we can do to improve wayfinding for patients and visitors	Judy Newland Lorna Tirman PFAC	Update regarding EPIC go live Electronic Medical Records Go live is going very well! Feedback from last meeting issues: 3. Starting Outpatient Improvement team: would like a patient/ family member involved. Goal to improve registration process/ and welcoming behaviors by staff Input by Council on areas to focus improvement on in the outpatient setting/ main lobby: Feedback from tour this evening: 1. No signage in main lobby to indicate location of inpatient rooms or where Emergency Room is. Lack of large signs for anything. 2. When you come in to lobby, no signage for Pine Street Café. 3. No good signage for location of patient/ family elevators to first floor and patient	Judy Newland Lorna Tirman Judy Newland to meet with interior designer regarding signage and will use feedback given tonight by PFAC to integrate into improving wayfinding and signage. Judy will give an update to PFAC at January

			rooms 4. Sign from ER to inpatient rooms, not in an obvious place, and possibly too much information 5. There is inconsistency with using terms radiology, Imaging, x-ray: consider using same terminology in every location and consistency of signage type and wording. 6. Possible to post signage on upper walls above doorways for increased visibility. 7. Not a lot of signs for where rest rooms are located. 8. Many paper (Unprofessional appearing) signs taped on doorways and walls in hallway, on Lab door and in Emergency Room lobby which could be improved. 9. Tart sign in ER lobby needs to be improved in location and way it is pinned to the wall. (Sign is curling and holes in wall from pins) 10. Consider more pamphlets with information on hotels, transportation than signs on the walls. 11. By the time card in hallway signs on how to clock in should be in the more professional covers to improve professional look. Why is there a call back instruction on wall by time clock? Is there a better place or way to have that information posted? 12. Consider if black and white signs are more effective and larger print on signs to see from farther away. 13. Sign for visitor check in and or information desk so patients and visitors know where to check in and for what. 14. Fresh paint in some areas where walls are marked up or stained. 15. Bathroom doors by Pharmacy need to be	Meeting.

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			stained. 16. Why is the 10 steps for successful breastfeeding in the Stanchion outside the Emergency Room, is there a better place for that information. 17. There is no good signage from the Emergency Room Lobby to take you to Inpatient areas and other departments. 18. Emergency exit signs have no references to where you are and need to go.	
	Review of Patient Feedback from Press Ganey surveys. Will continue to discuss top opportunities for improvement with PFAC for input		Review of all services/ patient feedback and areas for improvement to get input from members of PFAC Good discussion around the patient experience feedback and how to best display data, with the mean score and the rank to better tell the story of our performance. Lorna to update graphs to reflect that suggestion. Will come back to PFAC once all leaders know what questions they will work to improve and get input from this group on specific ways to improve perception of care and service for specific questions on each of the surveys.	Lorna Tirman Will have leaders present their action plans around improving in areas of opportunity to improve patient experiences in all services and settings.
	Update on PFAC membership		Nancy Woolf put in her resignation as she is moving out of the area. We thanked her for her service on the PFAC and the Quality team. Kathy Avis also sent via email her notice of resignation as of today. Topics for next meeting: Review of 2018 Agenda and change in location Input from PFAC on topics Update on Interior Design Meeting using our	 Lorna Tirman Judy Newland Wendy Buchanan Ryan Solberg

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			input Community Wellness, Director, Wellness Program, Wellness Neighborhood Physical Therapy Will increase recruiting efforts. Flyers updated with Lorna Tirman contact name, email and phone. Outreach to clinics and community. Next Meeting January 16, 2018 in the Eskridge Conference Room in main lobby of hospital Happy Holidays	
12/19/17	NO MEETING-Holiday			

Board Quality Committee

2017 QA/QI Plan Focus	2017 Board Quality Committee Focus
1. Top decile quality of care and patient satisfaction metric results	1. Monitor Quality, service and patient safety metrics and support processes, with a focus on outliers to achieve top decile performance and measurable improvement
2. Support Patient and Family Center Care	4. Provide appropriate resources to assist the Patient and Family Advisory Council (PFAC)
3. Sustain a Just Culture philosophy that promotes patient safety, openness and transparency	
4. Promote lean principles to improve processes, reduce waste and eliminate inefficiencies	
5. Implement the Epic electronic health record to enable integration of medical services at all levels of the organization	6. Support the Epic electronic health record implementation with a focus on quality, service and patient safety
6. Facilitate integrated continuum of care management system	
7. Ensure Patient Safety across the entire Health System	2. Monitor the Patient Safety Culture Survey plan for improvement progress
8. Achieve Public Hospital redesign and Incentives in Medi-Cal (PRIME) project initiative	
	3. Support the Quadruple Aim, including improving the experience of providing care and workforce engagement
	5. Provide direction on how to best educate the community about the TFHD quality and service metrics (ie website, public speaking, social media, quarterly magazine, newspaper articles, etc.)

6/30/2017 aw

Charter

Quality Committee
Tahoe Forest Hospital District
Board of Directors

PURPOSE:

The purpose of this document is to define the charter of the Quality Committee of the District's Board of Directors and, further, to delineate the Committee's duties and responsibilities.

RESPONSIBILITIES:

The Quality Committee shall function as the standing committee of the Board responsible for providing oversight for Quality Assessment and Performance Improvement, assuring the hospital's quality of care, patient safety, and patient experience.

DUTIES:

1. Recommend to the Board, as necessary, policies and procedures governing quality care, patient safety, environmental safety, and performance improvement throughout the organization.
2. Assure the provision of organization-wide quality of care, treatment, and service provided and prioritization of performance improvement throughout the organization.
3. Monitor the improvement of care, treatment, and services to ensure that it is safe, beneficial, patient-centered, customer-focused, timely, efficient, and equitable.
4. Monitor the organization's performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities.
5. Monitor the development and implementation of ongoing board education focusing on service excellence, performance improvement, risk-reduction/safety enhancement, and healthcare outcomes.

COMPOSITION:

The Committee is comprised of at least two (2) board members as appointed by the Board President and two (2) members of the Tahoe Forest Hospital District Medical Staff as appointed by the Medical Executive Committee (Recommend Chief of Staff or designee and Chairperson of the Quality Assessment Committee).

MEETING FREQUENCY:

The Committee shall meet quarterly.

Board of Directors Quality Measures Data Entry 2017

ENTER DATA ONLY INTO YELLOW CELLS

Data Source	MEASURE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
CMS Collaborative Measures - Quatros Core Measure Data	Heart Attack Care												
	Total Heart Attack opportunities												
	Sepsis Early Management Bundle												
	Total Sepsis/Septic Opportunites												
	TFH Pneumonia Care												
	TFH Total Pneumonia Opportunities												
	IVCH Pneumonia Care												
	IVCH Total Pneumonia Opportunities												
	SCIP Care												
	Total SCIP Opportunities												
	TFH Immunization Care												
	Total TFH Immunization Opportunities												
	IVCH Immunization Care												
	Total IVCH Immunization Opportunities												
	VTE Care												
	Total VTE Care Opportunities												
	PC Mother Care												
	Total PC Mother Opportunities												
	Stroke (Appropriateness of Care)												
	Total Stroke Opportunities												

Data Source	MEASURE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Pharmacy Quality Tool	TFH Medication Errors D+												
	TFH Medication opportunities												
	IVCH Medication Errors D+												
	IVCH Medication Administration Opportunities												

Data Source	MEASURE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
TFH Infection Control Quality Tool	TFH Hospital Acquired Surgical Infections												
	TFH - Surgical Infection total opportunites - Class I												
	Hospital Acquired non-surgicial infection (devices)												
	Total Device Days												
	MDROs												
	Total Inpatient Days												

Data Source	MEASURE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
IVCH Infection control Tool	IVCH Hospital Acquired Surgical Infections												
	IVCH Hospital Acquired Surgical Infection total opportunites - Class I												

Data Source	MEASURE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Clinical Quality Tool in Dept PI	Hospital Acquired Conditions												
	Inpatient Admissions												

Data Source	MEASURE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Nursing Services Quality Tool in Dept. PI	Total Falls with Mod/Sev Injury												
	Total Patient Days												
	Total Pressure Ulcers												
	Total Inpatient Admissions												

Data Source	MEASURE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
ED Quality Tool in Dept. PI	Readmission to ED with same diagnosic within 72 hours of prior discharge												
	ED Admissions												

Data Source	MEASURE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
OB Quality Tool in Dept PI	Primary C-Sections												
	Number of Deliveries												

Data Source	MEASURE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Nursing Home Compare	SNF 5-Star Quality Rating												

Data Source	MEASURE	Q1	Q2	Q3	Q4
Home Health Tool in Dept PI	Percent Improvement in Pain				
	Percent improvement in Bathing				
	Percent Improvement in Ambulation/Locomotion				
	Percent Improvement in Surgical Wounds				

TFHS QUALITY DASHBOARD 2017

N/A No patients

TAHOE FOREST HOSPITAL								
Category:	**#**	**Measure:**	**Benchmark**	**TFHD Goal**	**2016**	**Q1-17**	**Q2-17**	**Q3-17**
Patient Safety Index Detail	PSI-1	Restraint usage percentage	At 4.95%	At or Below 4.21%				
	PSI-2	Medication error rate (D+)	At 5.00%	At 0.00%				
	PSI-3	Percentage of patient developing a pressure ulcer	At 0.27%	At 0.00%				
	PSI-4	Inpatient falls with mod to sev injury per 1000 patient days rate	At 2.48	At 0.00				
CMS Acute Myocardial Infarcation	AMI-1	Aspirin at arrival	At 96.50%	At 100.00%				
	AMI-3	ACEI or ARB for LVSD	N/A	At 100.00%				
	AMI-5	Beta blocker at discharge	At 99.00%	At 100.00%				
	AMI-7a	Fibrolytic therapy received within 30 mins of arrival	At 59.50%	At 100.00%				
CMS Sepsis Bundle	SEP-1	Sepsis early management bundle, severe sepsis/septic	N/A	At 100.00%				
CMS Core Measure Index - Immunizations	IMM-2	Influenza Vaccine	At 99.90%	At 100.00%				
CMS Core Meaure Index - Venous Thrombosis	VTE-1	VTE Prophylaxis	At 99.90%	At 100.00%				
	VTE-2	ICU VTE Prophylaxis	At 99.90%	At 100.00%				
	VTE-3	VTE Patients w/Anticoagulation Overlap Therapy	At 95.70%	At 100.00%				
	VTE-4	VTE Patients receiving UFH w/Dosages/ Platelet Count monitoring	N/A	At 100.00%				
	VTE-5	VTE Discharge Instructions	At 99.80%	At 100.00%				
	VTE-6	Incidence of potentially preventable VTE	At 0.20%	At 0.00%				
CMS Core Measure Index - Perinatal Care Mother	PC-1	Elective Delivery	NEW	At 0.00%				
CMS Core Measure Index - Emergency Department Admissions	ED-1a	Median Time from ED Arrival to ED Departure for Admitted ED Patients - Overall Rate	N/A	N/A				
	ED-1b	Median Time from ED Arrival to ED Departure for Admitted ED Patients - Reporting Measure	At 257	At or Below 218				
	ED-1c	Median Time from ED Arrival to ED Departure for Admitted ED Patients - Psychiatric/Mental Health Patients	N/A	N/A				
	ED-2a	Admit Decision Time to ED Departure Time for Admitted Patients - Overall Rate	N/A	N/A				
	ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients - Reporting Measure	At 86	At or Below 73				
	ED-2c	Admit Decision Time to ED Departure Time for Admitted Patients -Psychiatric/Mental Health Patients	N/A	N/A				
Outpatient Emergency Core Measures - TFH	OP-18a	Median Time from ED Arrival to ED Departure for Discharged ED Patients - Overall Rate	At 114.00	At or Below 96.90				
	OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients - Reporting Measure	At 134	At or Below 114				
	OP-18c	Median Time from ED Arrival to ED Departure for Discharged ED Patients - Psychiatric/Mental Health Patients	N/A	N/A				
	OP-18d	Median Time from ED Arrival to ED Departure for Discharged ED Patients - Transfer Patients	N/A	N/A				
	OP-20	Door to Diagnostic Evaluation by a Qualified Medical Personnel in minutes	At 20	At or Below 17				
	OP-21	Median Time to Pain Management for Long Bone Fracture	At 49	At or Below 42				
Excellent Care Index Detail	ECI-1	Inpatient Mortality Rate	At 3.00%	At or Below 2.55%				
	ECI-2	Primary C-Section Rate	At 19.00%	At or Below 16.15%				
	ECI-3	Medicare average LOS	N/A	Below 4 days				
	ECI-4	Patients returning to the ED within 72 hrs with same complaint requiring inpt admission	At 2.5%	At or Below 2.13%				
Hospital Acquired Surgical Infection	IC-1	Class I surgical site infection rate	At 3.00%	At or Below 2.55%				
Hospital Acquired Non-Surgical Infection	HA-NSI-1	ICU CLR-BSI	At 1.50%	At or Below 1.28%				
	HA-NSI-2	VAP (Ventilator Associated Pneumonia)	At 2.30%	At or Below 1.96%				
	HA-NSI-3	ICU Catheter Associated UTI	At 3.10%	At or Below 2.64%				
	HA-NSI-4	Health Care Acquired MRSA (per 1000 pt-days)	At 3.40%	At or Below 2.89%				
HACs	HAC-1	Foreign Object Retained After Surgery	At 0	At 0				
	HAC-2	Air Embolism	At 0	At 0				
	HAC-3	Blood Incompatibility	At 0	At 0				
	HAC-4	DVT & Pulmonary Emboli Post Surgery	At 0	At 0				
	PtS-1	HCAHPS "Recommend this Hospital" Percentile Rank	N/A	At or Above 90.00%				
	PtS-2	HCAHPS "Rate this Hospital 9-or-10" Percentile Rank	N/A	At or Above 90.00%				

TFHS QUALITY DASHBOARD 2017

N/A No patients

Patient Satisfaction	PtS-3	OutPT Percentile Rank	MB	At or Above 90th Percentile				
	PtS-4	TFH ED Overall Percentile Rank	SmPG DB	At or Above 90th Percentile				
	PtS-5	IVCH ED Overall Percentile Rank	MB	At or Above 90th Percentile				
	PtS-6	ASD Overall Percentile Rank	SmPG DB	At or Above 90th Percentile				
	PtS-7	MSC Overall Percentile Rank	15K-25K visits	At or Above 90th Percentile				
	PtS-8	Outpatient Oncology Percentile Rank	All Facilities	At or Above 90th Percentile				
CMS 4-star rating for patient satisfaction		CMS 4-star rating for patient satisfaction	At 4 Stars	At 5 Stars				

INCLINE VILLAGE COMMUNITY HOSPITAL								
Category:	**#**	**Measure:**	**Benchmark**	**TFHD Goal**	**2016**	**Q1-17**	**Q2-17**	**Q3-17**
IVCH Infection Control	IVC-1	Class I Surgical Site Infection Rate	At 1.50%	At or Below 1.28%				
IVCH CMS Core Measure Index - Immunizations	IMM-2	Influenza vaccine administration percentage	At 99.90%	At 100.00%				
IVCH Average LOS	IVC-9	Average Length of Stay (Days)	N/A	At or Below 4 Days				
IVCH Pressure Ulcers	IVC-10	Percentage of patient developing a pressure ulcer	At 0.27%	At or Below 0.23%				
IVCH Inpatient Falls	IVC-11	Inpatient falls per 1000 patient days rate	At 2.79%	At or Below 2.37%				
IVCH Restraint Usage	IVC-12	Restraint usage per 100 pt days	At 5.00%	At or Below 4.25%				
IVCH Laboratory	IVC-13	STAT CBC turn around time < 60 minutes	N/A	At or Above 95.00%				
IVCH Pharmacy	IVC-15	Medication error rate	At 5.00%	At 0.00%				
IVCH Inpatient Mortality	IVC-16	Inpatient mortality number	N/A	At 0				
Outpatient Emergency Core Measures - IVCH	OP-18a	Median Time from ED Arrival to ED Departure for Discharged ED Patients - Overall Rate	At 114	At or Below 97 minutes				
	OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients - Reporting Measure	At 134	At or Below 114 minutes				
	OP-18c	Median Time from ED Arrival to ED Departure for Discharged ED Patients - Psychiatric/Mental Health Patients	N/A	N/A				
	OP-18d	Median Time from ED Arrival to ED Departure for Discharged ED Patients - Transfer Patients	N/A	N/A				
	OP-20	Door to Diagnostic Evaluation by a Qualified Medical Personnel	At 20	At or Below 17 minutes				
	OP-21	Median Time to Pain Management for Long Bone Fracture	At 49	At or Below 42 minutes				

TFHS QUALITY DASHBOARD 2017

N/A No patients

Long Term Care								
Category:	**#**	**Measure:**	**Benchmark**	**TFHD Goal**	**2016**	**Q1-17**	**Q2-17**	**Q3-17**
Skilled Nursing Facility	LTC1	Percent of patients who develop pressure ulcers	At 12.00%	At or Below 10.20%				
	LTC4	Residents with a urinary tract infection percentage	At 9.00%	At or Below 7.65%				
	LTC5	Percent of residents who experience unplanned weight loss	At 8.00%	At or Below 6.80%				
	LTC6	Percentage of Patients to Experience one or more Falls	At 13.10%	At or Below 11.14%				
	LTC7	SNF 5-Star Quality Rating	N/A	At 5 Stars				

Home Health/Hospice								
Category:	**#**	**Measure:**	**Benchmark**	**TFHD Goal**	**2016**	**Q1-17**	**Q2-17**	**Q3-17**
Home Health	HH1	Improvement in Pain	At 64.00%	At or Above 73.60%				
	HH2	Improved Bathing	At 74.40%	At or Above 85.56%				
	HH3	Improved Transferring	At 53.00%	At or Above 60.95%				
	HH4	Improved Ambulation	At 71.30%	At or Above 82.00%				
	HH5	Management of oral medications	At 43.00%	At or Above 49.45%				
	HH6	Improve in Surgical Wounds	At 90.60%	At 100.00%				
	HH7	Patients with emergency care needs percentage	At 12.50%	At or Below 10.63%				
	HH13	HHCAHPS - Rate this agency 9 or 10	At 84.00%	At or Above 96.60%				
	HH14	HHCAHPS - Recommend this agency	At 78.00%	At or Above 89.70%				
		CMS Home Health Star Rating	At 3.50 Stars	At 5 Stars				
Hospice	H1	Match MAR vs Physician Orders	N/A	At or Above 95.00%				
	H2	Follow through on assessed pt needs	N/A	At or Above 95.00%				
	H3	Patients Pain goals are met within 48 hrs	N/A	At or Above 95.00%				
	H4	Hospice Patient UTI Rate	N/A	At 0.00%				
	H5	Hospice Patient Vascular Device Infection Rate (TPD)	N/A	At 0.00%				

Cancer Center

CHAPTER FIVE

How to Ensure Quality Care

MONITORING QUALITY OF HEALTHCARE

Michael Pugh, president, Verisma Systems, Inc., Pueblo, Colorado

Board Responsibility for Quality and Performance

"Isn't that what the doctors and nurses are supposed to be doing?" is a common first thought when new hospital board members are told that patient safety and the quality of care are ultimately the board's legal responsibility. While physicians and nurses are critical to the quality process, and having well-trained and appropriately credentialed professionals on the staff is important, considerably more is required for boards to carry out their legal and fiduciary responsibilities for quality. Boards must have a broad view and understanding of quality to ensure that patient care is safe, effective, and reliable.

For many years, graduate programs in healthcare administration taught a model of hospital organization using the metaphor of a three-legged stool, with the administration, the board, and the medical staff as the legs of the stool supporting a platform for patient care delivery. The board was responsible for fundraising and gathering community input, the administration for staffing and operating the hospital, and the medical staff for bringing patients to the hospital and providing care. Board members assumed the quality was high if the hospital had well-trained doctors, state-of-the art technology and facilities, low staff turnover, satisfied patients, and generally clean reports from auditors, regulators, and accreditation agencies. While these proxies for describing good quality are important and contribute to high-quality patient care and experiences, simply equating quality to facilities, doctors, or reputation does not fulfill the board's responsibility for ensuring that patient

Brief History of Quality in Hospitals

I am called eccentric for saying in public that hospitals, if they wish to be sure of improvement,

- Must find out what their results are.
- Must analyze their results to find their strong and weak points.
- Must compare their results with those of other hospitals.
- Must care for what cases they can care for well, and avoid attempting to care for cases which they are not qualified to care for well.
- Must welcome publicity not only for their successes, but for their errors, so that the public may give them their help when it is needed.
- Must promote members of the medical staff on the basis which gives due consideration to what they can and do accomplish for their patients.

Such opinions will not be eccentric a few years hence.

Source: Codman (1916).

care is safe and every patient gets exactly the right care, every time.

For more than 200 years, the "three-legged stool" description, sometimes called the Franklin Model (based on the hospital concept used by Benjamin Franklin when he founded The Pennsylvania Hospital in the late 1700s), paralleled the basic legal responsibilities of doctors and hospitals. But beginning in the 1960s a series of legal decisions, most notably *Darling v. Charleston Community Memorial Hospital* (211 N.E.2d 253,1965), established the hospital board was ultimately responsible for the outcomes of patient care.

Credentialing. During the 1970s and 1980s, the primary tool for ensuring quality was the medical staff appointment and reappointment process. Sometimes referred to as credentialing, this process established the level of care and procedures that individual physicians were allowed to perform based on their training and experience. Physicians would apply for membership to the medical staff, and the hospital board would rely on a recommendation from the existing medical staff to allow physicians to admit patients to the hospital. The underlying hospital quality theory in the 1970s and 1980s: Keep the "bad" physicians off the medical staff.

Peer review. As an extension of the credentialing process, hospitals and medical staffs established peer review and other mechanisms to investigate and monitor individual physician performance; these efforts focused on the mistakes or errors a physician might have made in the care of patients. Recommendations to the governing board for corrective action might range from no action to relatively

benign corrective actions, such as a letter to reprimand a physician or requirements for additional training. In some cases, recommendations might involve limiting privileges to perform certain procedures, or in extreme cases, terminating all care privileges and expulsion from the medical staff. The more punitive the potential board action, the greater the risk the board, hospital, or physicians involved in the peer review might be sued for violating the due process standards in the medical staff bylaws, which are meant to ensure fairness and impartiality in the review process.

In most states, the deliberations and investigations surrounding peer review have some measure of confidentiality and protection from legal discovery. But that is cold comfort for most physicians asked to be involved in the process. While the intent of peer review is good, the process is sometimes difficult and potentially flawed. Fear of lawsuits, potential conflicts of interest, variations in the professional knowledge of the reviewers, social relationships, closed sessions without nurses or others with a perspective present, and an unspoken but inherent reluctance among physicians to criticize their colleagues tend to diminish the potential impact and benefit of peer review on overall quality. Occasionally, suggestions do come out of the peer review process that might improve the care for all patients, but such suggestions are a byproduct of the process and not the focus of the effort.

Quality assurance. In the 1970s and 1980s, a quality control process known as quality assurance (QA) also emerged. In the QA process, patient charts were pulled after the patient was discharged and reviewed for the appropriateness and quality of care. The charts selected for review might have been pulled because of a patient complaint or known problem with the care, were sometimes selected for a routine review of specific types of admissions or might have been a random selection of charts. In some hospitals, but not all, efforts were made to ensure that every physician on the active medical staff had at least a few charts reviewed each year. Generally, the criteria for chart selection was determined by a committee of the medical staff and the charts were prescreened by a registered nurse (RN) employed by the hospital looking for specific issues, usually related to compliance with Medicare and Medicaid regulations. If the nurse noted a problem or gap in care, the chart was referred to a physician reviewer. If the physician reviewer felt the physician care was inadequate, the chart might be referred to a peer review committee that would investigate further. If the care by the hospital staff was poor or something bad had happened such as a fall, but it was not a physician mistake, the chart might be sent to risk management or referred to someone in management. Because Medicare and Medicaid reimbursement was often at stake, efforts were usually focused on improving documentation and payment issues. While some useful information was occasionally gleaned, leading to overall improvements in

care, for the most part QA used the same quality theory as peer review: Find and eliminate the bad apples.

However, removing the bad apple from the barrel does nothing to improve the quality of the rest of the apples in the barrel. Credentialing, peer review, and QA remain important and necessary, but these efforts generally do not result in quality improvement for all patients, and they are not processes that completely fulfill the board's ultimate responsibility for quality care.

A Different View of Hospital Quality

In the late 1980s, the theories and methods to improve quality and reduce manufacturing defects began to be understood and adapted in healthcare. The key breakthrough in thinking about quality in healthcare was the realization that poor quality outcomes were most often the result of system or process failure rather than individual physician or staff failure or just bad luck. Quality became a process problem, not a people problem. Physicians are a critical part of the process, but not the entire care process—a lot of other people are involved.

As an example, surgeons are sometimes compared or judged by their surgical-site infection rate. However, the surgeon rarely cleans the equipment, cleans the operating room, maintains the ventilation system, shaves the patient, prepares the surgical site, starts the prescribed antibiotic in the effective window prior to surgery, or controls the glycogen levels of the patient during surgery. How well these tasks are carried out is known to decrease the probability of a surgical site infection by as much as 90 percent, but they are out of the effective control or direct influence of the surgeon. So while surgical technique and maintaining a sterile field during surgery are clearly important, are surgical site infections a doctor problem or a hospital system problem? The answer is likely some unknown and unknowable combination. However, across the country, the rigorous adherence to a set of simple basic operating room tasks—such as hand washing, proper preparation of the surgical site, and the timely administration of antibiotics—has been shown to dramatically reduce the overall incidence of surgical-site infections.

Dr. Paul Batalden, a cofounder and the first chair of the board of the Institute for Healthcare Improvement (IHI), said it best: "Every system is perfectly designed to produce the results it gets" (McInnis 2006). Batalden's observation is grounded in statistical process control theory, which postulates that any stable process produces variation in outputs—some will be good and some will be bad. The required management action is not to chase the bad results but to change the process so it consistently produces the desired results. While perfectly logical, the

idea that processes, rather than doctors, are the root of many of the poor outcomes in healthcare has been slow to take root.

System and process thinking got a major boost in 2000 when the government-sponsored Institute of Medicine (IOM) published *To Err Is Human* and in 2002 followed up with a second report, *Crossing the Quality Chasm*. The first report highlighted how error and poor quality were rampant in healthcare and reported that between 98,000 and 140,000 patients died unnecessarily each year in US hospitals, making hospital deaths the eighth leading cause of death, ahead of motor vehicle fatalities. As expected, there were fierce attacks on the report and challenges to the estimated number of preventable deaths and the ideas presented. However, since the original publication, other studies and estimates suggest the IOM understated the enormity of the problem.

The second report advocated healthcare redesign along the principles of safe, effective, efficient, patient-centered, cost-efficient, and equitable care for all. While initially controversial, the IOM reports served as a wake-up call for hospitals to begin thinking about quality and patient outcomes much differently. In the decade since the IOM reports, awareness has developed that many of the things we used to consider complications in the treatment of patients are actually avoidable patient-harm events. Potentially fatal hospital-acquired conditions—such as ventilator-associated pneumonia, sepsis, infections associated with venous catheters, and medication errors—can effectively be eliminated by strict adherence to simple care and procedure protocols.

Dr. Donald Berwick (2003), the founder and former president of IHI and now administrator of the Centers for Medicare & Medicaid Services (CMS), has said when you strip everything else away, what patients are really saying is

1. Don't hurt me.
2. Help me.
3. Be nice to me.

These three patient-centered elements, in the order of priority listed, redefine how we think about quality in healthcare. "First, do no harm" is part of the Hippocratic Oath all physicians take upon graduation—an old idea. But for healthcare organizations, "Don't hurt me" is a relatively new foundation to organizational quality improvement efforts. Unfortunately, as reported by the IOM, patient harm is widespread and insidious. In 2006, IHI launched its 5 Million Lives Campaign, aimed at encouraging hospitals to take steps to significantly reduce harm to patients. As part of that campaign, IHI (2006) adopted and published a broad and inclusive definition of patient harm:

> Unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or that results in death. Such injury is considered harm whether or not it is considered preventable, resulted from a medical error, or occurred within a hospital.

Hospitals and other healthcare organizations typically keep track of the number of falls, infections, medication errors, wrong-site surgeries, delayed treatments, bed sores, procedural mishaps, and other potential patient-harm events. However, this information may be gathered by different people for disparate purposes and is rarely compiled on an organization-wide basis. Reports on falls are separate from reports on infections, which are separate from reports on medication errors and so on. To further muddy the waters, harm is often reported as a rate per 1,000 patient days or some other denominator that tends to diminish the impact of the data. Board members, management, and medical staff leadership are routinely shocked the first time the aggregate actual number of harm events is presented—almost always much higher than expected. Boards need to ask to see the actual number of harm events and then set aggressive targets for reduction.

The second plea, "Help me," is typically why most individuals choose healthcare as a career—they want to help other people. "Help me" does not mean "cure me." Most patients are realistic in their expectations of what medicine can and cannot do. What they really want is for the healthcare system to reliably deliver everything that is known to help. Hospitals face two problems in meeting this need. The first is defining what is known to help. Numerous studies over the past decade have shown tremendous geographic variation in the treatment for almost all medical conditions and wide disparities in healthcare costs (Dartmouth 2011). The second problem is, after defining what is known to help based on clinical evidence, building the processes and systems to ensure that the "right care" is always delivered.

The IOM has estimated 30 percent of what is spent on healthcare in the United States adds no clinical value. Other studies suggest only about 50 percent of all care delivered is actually evidence-based, meaning there is hard, replicable science linking the treatment and the outcome.

The practical application of evidence-based medicine had its roots in an obstetrics malpractice insurance crisis in the late 1970s and early 1980s. In response, the American College of Obstetrics and Gynecology began publishing guidelines to help practicing physicians who agreed to practice according to the guidelines to obtain or maintain malpractice insurance. Next, in 2004, Medicare began measuring the quality of care in hospitals with a set of core measures that tracked whether the common evidence-based clinical treatment elements were delivered for the conditions of heart attack, pneumonia, congestive heart failure, and stroke.

Medicare's action helped hospitals and physicians begin to think differently about the use of protocols and standardized care plans and spurred the concept of the "right care"—delivering evidence-based care every time for every patient.

Many hospitals have fallen into the trap of looking at the percentage of time individual care elements were delivered rather than how often patients receive all of the required care elements. If a patient qualifies for six elements in an evidence-based care plan, but the hospital only delivers four, did the patient get the right care? Numerous studies have shown hospitals that can reliably deliver all of the care according to the evidence have lower mortality and complication rates (Mukherjee et al. 2004; Eagle et al. 2005).

The third patient desire—"Be nice to me"—is reflected in patient satisfaction data. During the 1990s, almost all hospitals began focusing on patient satisfaction, conducting surveys and adapting service techniques from other industries to improve the patient experience. In 2009, Medicare began publishing comparative patient satisfaction statistics for all hospitals, available on the CMS website. Service quality and amenities are important, but a smiling nurse and valet parking will not likely offset the experience from a hospital-acquired infection, a wrong-site surgery, or a medication error resulting in harm.

Board Strategies for Measuring and Improving Quality

The board is ultimately responsible for everything happening in the hospital, including reducing harm and ensuring care is delivered appropriately and according to the evidence. There are four common challenges with which boards and new board members may struggle:

1. **Getting comfortable with the board's responsibility for the care and safety of patients.** Getting comfortable requires boards to have good processes in place for credentialing, discussing difficult issues, and resolving conflicts. There is no ambiguity about a board's legal responsibility for care and outcomes. But it takes a strong management and medical staff team and good board relations to be transparent and openly discuss patient harm and poor quality outcomes—topics that in most hospital environments have not traditionally engendered trust between the board, management, and physician leadership. As the nursing staff plays such an important role in the delivery of quality patient care on a 24-hour-a-day, 7-day-a-week basis, the board must be willing to appropriately involve nursing leadership in these discussions as well. Most CEOs did not get to be the CEO by delivering bad news. Boards have a responsibility to create a board meeting environment in which difficult issues can be discussed without fear of punishment.

The way to begin to build the right board environment is by asking inquiry questions, not attack questions. Board members should feel comfortable asking governance questions about quality, such as

- How many patients were harmed last month?
- How does that compare to the previous six months?
- Are we trending downward?
- What are the plans for the next wave of efforts to reduce patient falls, medication errors, hospital-acquired infections?
- What percentage of the care delivered in our cardiac program was "right care"?

These questions are no different from the types of questions the finance committee asks about financial issues: Where are we, are we getting better, what is your strategy for improvement?

2. **Setting the right expectations for the organization's leadership and medical and nursing staffs.** Setting the right quality expectations and having a good process to monitor progress are the two most important things a board can do in exercising its responsibility for quality patient care and preventing harm. Recent studies have shown that better outcomes are associated with hospitals in which:

   - The board spends more than 25 percent of its time on quality issues.
   - The board receives a formal quality performance measurement report.
   - There is a high level of interaction between the board and the medical staff on quality strategy.
   - The senior executives' compensation is based in part on quality improvement (QI) performance.
   - The CEO is identified as the person with the greatest impact on QI, especially when so identified by the QI executive (usually a physician on the hospital payroll who has responsibility for implementing QI programs).

   The key is setting the right governance aims. Hospital boards should set aggressive aims seeking to dramatically reduce levels of harm to patients. External comparative data are not necessary and, in fact, counterproductive when it comes to harm—there is no appropriate level of harm, especially if you are the patient. All that is required is a simple monthly or quarterly count of the number of patients who experienced harm. Some organizations have developed composite indicators that measure not only patient harm but also the number of serious safety events whether the patient was harmed or not,

on the theory that the focus should be on preventing any event that could lead to harm.

The board must also set "what by when" targets (e.g., reduce all harm events by 50 percent by December 2013), which will create the expectation that significant process change is required to reach the targets, not an incremental or marginal approach to improvement.

3. **Getting useful information and monitoring performance.** The board should also focus on what is important—high-level outcomes rather than detail. For far too long, hospital boards have suffered from an excess of data and a dearth of information from quality reports. Instead, the board should focus its review and discussion on a few high-level outcome measures that can be presented in a fairly simple scorecard or report format. The scorecard should include measures and targets for the following:

   - Hospital mortality tracked over time (run chart)
   - Number of patient safety and harm events, tracked over time
   - Unplanned hospital readmission rate
   - Percentage of time care is provided according to the evidence (right care)
   - Patient satisfaction

   Measures on the board's quality scorecard should be limited to the most important areas to provide governance and not management oversight. The organization's quality and operating strategies should be linked and should drive the measures in the desired direction.

   In some organizations, boards may need to add a few other measures specific to the mission of the organization or challenges faced by the organization. Those types of measures might include the following:

   - A measure that represents access or waiting time in clinics or emergency facilities
   - A measure representing culture or staff satisfaction
   - A measure representing cost efficiency or value
   - A measure representing equity in care across demographics

   The most effective boards have active quality committees that begin their meetings with a brief story of a patient experience, effectively putting a face on the data. The committee typically reviews the board's quality aims and targets and progress toward achieving those quality aims. It also reviews the execution and quality improvement plans the medical staff and management propose for

the next month or quarter. Further, the committee should review sentinel events and reports of harm and review regulatory dashboards for compliance exceptions; it may also periodically receive reports from risk management. Finally, the committee should consider any policy change recommendations which may require full board approval. Some boards use the quality committee to review medical staff credentialing recommendations prior to a vote by the full board. The chair of the quality committee, not the management team, should make the committee report to the full board.

Dr. James Reinertsen (2011), a senior fellow at IHI, advocates including patients on the quality committee of the board. Board members may occasionally be patients, but their experiences, because of their access and status in the organization, often do not represent the experiences of other patients. More importantly, a board member's fiduciary duty is to the organization. Patients in the boardroom tend to reduce self-serving conversations and add a perspective no one else in the room is free to deliver.

4. **Creating accountability for quality results.** The final challenge is to create accountability for quality results. Many hospitals are beginning to tie CEO and senior leader compensation to the achievement of strategic and quality goals. When structured correctly, compensation can align management actions with the board's goals and expectations. Organization-wide accountability is also created through transparency of aims, targets, and progress. Boards that spend as much time discussing quality issues at their meetings as they do financial and operating issues send a clear message to the organization, which can drive cultural change and foster accountability.

The Business Case for Quality

Whether or not there is a financial case supporting a specific improvement strategy, there is always a business case for improving quality in healthcare. Poor quality represents waste in the hospital and healthcare system. Across the country, hospitals are learning that when they eliminate or dramatically reduce ventilator-associated pneumonias, central line infections, medication errors, and patient falls, operating costs go down, not up. Quality in healthcare does cost less when waste in the form of patient harm is reduced.

In 2008, Medicare began eliminating payment when any "never events" occur and reducing payment for complications that occur in the hospital. Depending on state regulations the event may be reportable to a public agency or to The Joint Commission.

Never-Event CMS Regulatory Categories

1. Air embolisms
2. Mediastinitis—surgical site infection after coronary artery bypass graft
3. Catheter-associated urinary tract infections
4. Vascular catheter-associated infections
5. Blood incompatibility
6. Objects left in the patient during surgery
7. Falls, trauma
8. Pressure ulcers
9. Poorly controlled blood sugar
10. Infections after elective orthopedic and bariatric surgery
11. Deep vein thrombosis or pulmonary embolisms following total hip and knee replacement

Other payers have followed with even more restrictive policies. Under the 2009 healthcare reform legislation, the pressures ratchet up on hospitals with increasing payment reductions if the hospital has a higher-than-expected rate of readmissions, and expands those quality penalties to the Medicaid program. Not many carrots, but lots of sticks. Healthcare reform also envisions value purchasing—forcing hospitals to reduce costs to show greater value. Improving quality and reducing harm may be the most powerful value strategy on the board's strategy scorecard.

The Board and Healthcare Quality

New board members generally face a steep learning curve for ensuring quality in healthcare. But that curve can be flattened if they keep a few things in mind and in perspective:

1. Ultimately the board is legally responsible for the quality of care and service provided.
2. Medical staff credentialing and peer review are important but alone are insufficient to ensure good quality. Having good doctors does not automatically equate to decreased harm and better outcomes.
3. Every system is perfectly designed to produce the results it gets. Poor quality and patient harm are generally the results of flawed systems and processes.
4. Patients have three requirements: Don't hurt me, help me, and be nice to me. Quality in healthcare is about delivering on all three.
5. The board should track a few key quality metrics and set aggressive targets to set expectations and create organizational and strategic focus.
6. The quality committee of the board is the primary mechanism for monitoring quality performance and improvement efforts.
7. There is a strong business case for improving quality and reducing harm.
8. Ask lots of questions. The only dumb question is the one not asked.

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
DRAFT MINUTES

Tuesday, September 19, 2017 at 12:00 p.m.
Foundation Conference Room, Tahoe Forest Hospital
10976 Donner Pass Road, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 12:00 p.m.

2. ROLL CALL
Board: Alyce Wong, RN, Chair; Charles Zipkin, M.D., Board Member

Staff in attendance: Harry Weis, Chief Executive Officer; Janet Van Gelder, Director of Quality and Regulations; Jean Steinberg, Director of Medical Staff Services; Carl Blumberg, Patient Safety & Risk Manager; Scott Cooper, Director of Pharmacy; Lorna Tirman, Patient Experience Specialist; Damara Stone, Education Coordinator; Martina Rochefort, Clerk of the Board

Other: Nancy Woolf, Patient Family Advisory Council member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
No changes were made to the agenda.

4. INPUT – AUDIENCE
No public comment was received.

5. APPROVAL OF MINUTES OF: 7/11/2017
Director Zipkin moved approved the Quality Committee minutes of July 11, 2017, seconded by Director Wong.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION
***6.1.* Quality Committee 2017 Focus**
BOD Quality Committee Focus 2017 was approved on March 14, 2017 and available for reference during the meeting.

The Quality Committee focus for 2017 is based on the Quality Assurance/Performance Improvement Plan.

No further discussion was held.

6.2. Patient & Family Centered Care (PFCC)
6.2.1. Patient & Family Advisory Council Update
Patient Experience Specialist provided update related to the activities of the Patient and Family Advisory Council (PFAC).

Judy Newland, Chief Operating Officer, joined the meeting at 12:05 p.m.

PFAC has a meeting this evening.

Currently, there are eight active members. Dr. Shaw (dentist) and Mary Jones (attorney) are the newest members to join PFAC. We have had some attrition and it is time to step up our recruitment efforts for new members.

Patient Experience Specialist will take the opportunity to get to know the PFAC members and why they want to be on PFAC.

6.2.2. Patient Experience Presentation

Sam Smith, PA, recommended a patient to present to the Board Quality. We are waiting to hear back from patient regarding their availability to attend our next meeting.

6.3. Epic Quality Reports

Discuss the quality reports that Epic is able to provide us when the system is implemented in November 2017.

Karen Baffone, Chief Nursing Officer, joined the meeting at 12:08 p.m.

Director of Quality has been working with Epic on quality reporting.

Director Zipkin asked if the quality reports are customizable. The District can make custom reports but most of them are standard in the industry. All reports that Quality currently needs are available. COO added that a team of three will be trained to write a customizable reports.

Dr. Peter Taylor, Medical Director of Quality, joined at 12:12 p.m.

There will be a board presentation this month by CIIO on Epic.

Director Wong asked if the Quality Department is happy with the reports. Director of Quality will participate in training next week and has not yet worked with the reports.

Drs. Coll and Scholnick joined the meeting at 12:14 p.m.

CNO noted the Epic system is very efficient.

Discussion was held about upcoming Epic training for the staff.

6.4. Patient Safety

6.4.1 Sepsis Bundle

Director of Quality reviewed the sepsis bundle quality metrics. The bundle is all or nothing. All five metrics have to be met to be compliant.

An Interdisciplinary team is meeting regularly to discuss the sepsis bundle and how to improve compliance with the metrics.

Education Coordinator, presented September is Sepsis Awareness Month. The Sepsis Alliance was

started by a dentist in his daughter's memory. Red educational flyers are being posted throughout the hospital.

Human Resources hosted a lunch and learn where a sepsis education video was shown and TFHD's sepsis survivor Barbara Widder shared her story.

We disseminated a pocket laminated card with sepsis treatment overview to all clinical staff.

Mortality goes up 8% every hour sepsis is not diagnosed.

The hospital has a roving sepsis education cart which has a binder with case studies and patient stories Clinical staff was asked to read one but most end up reading 3-5 of them.

There has also been weekly email blasts on the topic.

Director Wong noted sepsis is an evolving diagnosis.

Dr. Taylor inquired how many sepsis patients the hospital treats. Director of Quality noted approximately 5-8 patients quarterly.

CMO noted the EHR has best practice alerts so when a nurse takes vitals a message will pop up that the patient is possibly septic and to speak with physician.

Education Coordinator departed the meeting at 12:34 p.m.

6.4.2 AHRQ Patient Safety Culture Survey

Risk and Patient Safety Officer provided a summary on the biennial AHRQ survey conducted in May 2017.

TFHD had an improved response rate to the survey.

The survey gave remarkable results. 81% respondents rated patient safety grade as excellent.

Four domains improved from 2015 – organization learning and continuous improvements, patient safety, communication openness, handoffs and transitions.

Director Wong inquired when this will be presented to the board. Risk and Patient Safety Officer indicated the survey will be presented to board in October.

There will be a focus group meeting to look at priorities and areas for improvement.

Nancy Woolf noted from a public perspective that community members hear talk and it would be interesting to circle back to it.

CNO and Dr. Scholnick departed the meeting at 12:45 p.m.

Risk and Patient Safety Officer said there is a move industry wide towards openness.

Director Wong commented on the quality and safety information on the District's website. The Quality Department will be updating information on website more frequently.

Dr. Taylor circled back to Ms. Woolf's comment and questioned how the District could best dispel rumors. A concern about HIPAA violations was noted if the rumor mill is being addressed. CEO said the outgoing message has to be carefully approved.

Director Zipkin asked if it time for us to increase visibility and be more transparent. Risk and Patient Safety Officer was in agreement.

Settlements and insurance costs are less due to disclosure.

CMO attended BETA conference recently and said the District is doing leaps and bounds better than other organizations. There are checklists to utilize in the back of the disclosure policy.

There will be more to come on this topic in the future.

6.5. Medication Safety Committee

Director of Pharmacy, reviewed the current activities of the Medication Safety Committee.

The pharmacy has improved safety of handling hazardous drugs. Personal protective equipment implementation goes live on November 1.

Patient Safety and Risk Manager departed 12:59 p.m.

CMO inquired if nurses will be provided with scripting when interacting with patients. This will be a big change in the Women and Family department as nurses administering Pitocin will now have to wear protective equipment.

A message will pop up in EPIC to tell the nurses how much protective gear they need to wear depending on what medicine is being administered.

Patient Advocate and COO departed at 1:03 p.m.

Working to reduce errors in EHR. The charge will now be on administration of a drug (instead of charging on dispensing). This will reduce billing errors.

Pharmacy survey is due in August 2018.

Director of Pharmacy reviewed process of monitoring of medication errors.

6.6. Medical Staff Quality Assurance Committee (MSQAC)

BOD Quality Committee will meet after each Medial Staff Quality Assurance Committee. MSQAC will invite committee members to join their meeting from time to time.

6.7. Board Quality Education

Quality Committee discussed sepsis, its related core measure and ongoing education.

CMO noted there has been repeat education to the ER physicians and hospitalists.

The sepsis core measure fell out at repeating lactic acid test.

Director Wong would like to learn more about the HEART program at the next quality committee meeting.

Discussion was held about educating the full board. A BETA representative could come present.

CEO felt the community needs to hear about the District's robust program.

It was suggested that this may be a good topic for an episode of Mountain Health Today.

CMO suggested sending a community member, ER physicians, Incline, Board Quality Committee member to BETA conference.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

None.

8. NEXT MEETING DATE

The next Quality Committee meeting will be Tuesday, December 12, 2017, at 12:00 p.m.

9. ADJOURN

Meeting adjourned at 1:30 p.m.