TAHOE FOREST HOSPITAL DISTRICT

2018-02-01 Board Quality Committee Meeting

Thursday, February 1, 2018 at 9:00 a.m.

Eskridge Conference Room - Tahoe Forest Hospital

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2018-02-01 Board Quality Committee Meeting

2/1/18 Board Quality Committee

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
AGENDA

Thursday, February 1, 2018 at 9:00 a.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. **APPROVAL OF MINUTES OF: 12/12/2017** ....**ATTACHMENT**

6. **ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION**
   6.1. **Quality Committee Charter** ....**ATTACHMENT**
   BOD Quality Committee Charter was approved on November 30, 2017 and available for reference during the meeting.

   6.2. **Quality Assurance Process Improvement (QA/PI) Plan**……………………………………………….**ATTACHMENT**
   Review the QA/PI Plan 2018, discuss the priorities for 2018, and recommend approval to the full BOD.

   6.3. **Patient & Family Centered Care (PFCC)**
       6.3.1.   **Patient & Family Advisory Council Update** ....**ATTACHMENT**
   An update will be provided related to the activities of the Patient and Family Advisory Council (PFAC).
       6.3.2.   **Patient Experience Presentation**
   Identify patients that may be interested in sharing their healthcare story at an upcoming TFHD Board of Directors (BOD) or BOD Quality Committee meeting.

   6.4. **ABD-10 Emergency On-Call policy** ....**ATTACHMENT**
   Review policy, discuss any necessary changes, and refer to the Board of Directors for final approval.

6.5. General Acute Care Relicensing Survey ....**ATTACHMENT**

Discuss the 2018 unannounced GACH Relicensing Survey (GACHRLS). The purpose is to promote quality of care in hospitals, verify compliance with State regulations and statutes, and ensure a program wide consistency in the hospital survey methodology. The GACH Relicensing Survey was implemented on March 1, 2016 and merged California's licensing regulations and statue requirements with elements of the former stand-alone Medication Error Reduction Plan (MERP) survey and Patient Safety Licensing Survey (PSLS) into one survey process.

6.6. Quadruple Aim

Provide update on the employee engagement and physician engagement survey action plans. Discuss how to incorporate the Quadruple Aim tenets in our Foundations of Excellence model.

6.7. Own the Bone……………………………………………………………………………………….**ATTACHMENT**

TFHD achieved "Star Performer" status on the American Orthopedic Association's Own the Bone program. You can read more about the program at http://www.ownthebone.org/.

6.8. Board Quality Education ....**ATTACHMENT**

The Committee will review and discuss topics for future board quality education. Identify best practice topics for review at future meetings.

a. Pugh, M. (2011). How to Ensure Quality (Chapter 5) *Healthcare Governance: A Guide for Effective Boards.* Chicago, IL: Health Administration Press

b. The Joint Commission (2017). The essential role of leadership in developing a safety culture. *Sentinel Event Alert*, 57.

7.   REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8.   NEXT MEETING DATE

The date and time of the next committee meeting will be confirmed.

9.   ADJOURN

QUALITY COMMITTEE
DRAFT MINUTES

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

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: Harry Weis, Chief Executive Officer; Janet Van Gelder, Director of Quality and Regulations; Jean Steinberg, Director of Medical Staff Services; Lorna Tirman, Patient Experience Specialist; Martina Rochefort, Clerk of the Board

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
The agenda was reordered as the patient experience presenter had not arrived.

4. INPUT – AUDIENCE
No public comment was received.

5. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION
Item 5.2. and 5.3. were reviewed while waiting for patient experience presentation.

5.1. Patient & Family Centered Care (PFCC)
5.1.1. Patient Experience Presentation
Patient Experience Presentation did not occur.

5.1.2. Patient & Family Advisory Council (PFAC) Update
Patient Experience Specialist provided an update on the activities of the PFAC.

At the November meeting, PFAC did a tour from the lobby to the ER to focus on improvement opportunities. PFAC provided improved signage feedback as well as other improvement opportunities. Opportunities are listed on pages 15-17 of the PFAC log.

COO will be looking at changing the time for the front doors to close.

Nancy Woolf and Kathy Avis have resigned as PFAC members.

Director Zipkin asked if the PFAC is receiving feedback as to why they are leaving. Ms. Woolf is moving out of the area.

5.2. Quality Committee Charter and 2017 Focus
Quality Committee reviewed its committee charter.

QA/PI plan will be reviewed and approved in February.

Josh Fetbrandt, Quality Specialist, joined at 12:04 p.m.
Dr. Shawni Coll, Chief Medical Officer, joined the meeting at 12:06 p.m.

Director of Quality will send out priorities prior to the meeting for review.

5.3. BOD Quality & Service Dashboard

Committee reviewed the Board Quality & Service dashboards.

Judy Newland, Chief Operating Officer, joined at 12:08 p.m.

Director of Quality said the dashboards for the board have historically rolled up data. This is an opportunity to get input on what metrics the board would like to see. The Medical Staff dashboard was included as an example.

Director Zipkin asked how the measures were chosen. Director of Quality noted the dashboard go back some time when the objective was a higher level view. The measures are items the District reports to CMS, etc for regulatory purposes.

Discussion was held on whether quality's reporting is following relevant issues. The board would like to know why particular metrics are chosen.

Sentinel events would be reported to the board in real time.

Orthopedic, home health and hospice service lines and quality star rating will be added to the dashboard.

COO asked if the board would benefit in getting more detail. Director Wong said more detail is beneficial only when there is fallout and what was done to improve the score.

Karen Baffone, Chief Nursing Officer, joined the meeting at 12:28 p.m.

COO asked if the board has any interest on what roll ups mean. Director Wong thought the question could be asked but her gut is that because most board members are not clinical people that they will be overwhelmed.

CNO said there are many complicating factors related to coding. For example, is a fallout on c. diff because of coding or the disease itself?

CMO changed the process when cases fallout. The providers have been asked to go back to the reviewer and present their case. This allows for a positive "ah ha" moment for the providers. The process is new to medical staff. Director Zipkin said it would be helpful to hear about the process.

CMO reported that more complaints (from Just Culture training) means that people are comfortable reporting and feel like their complaints are being heard. CMO wants to see an increase in complaints.

Discussion about how few are coming from Quantros. Quantros is hard to use. People are deterred from reporting.

The Quality Department is looking at new software that is user friendly.

5.4. Board Quality Education

CEO sent article "Monitoring Quality of Healthcare" by Michael Pugh to be included in the packet as it is still relevant and current.

Dr. Peter Taylor joined the meeting at 12:46 p.m.

CEO felt this is a thought provoking article. The Board of Directors should ask to see all harm events.

Director Wong referenced what patients want from the article:
1. Don't hurt me.
2. Help me.
3. Be nice to me.

CEO said if we identify where we are and grow then we will improve happiness of patients and providers.

Director of Quality is hopeful quality data can be pulled out of Epic now.

Director Zipkin referred to the CEO's point on silos of information. Discussion was held about the need to communicate more. The board needs to know how they can help.

Director Zipkin noted the only time the board hears about an event is when a lawsuit comes forward.

CEO referenced a line from the article "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."

Director of Quality wants to pose that question to medical staff.

6.   APPROVAL OF MINUTES OF: 9/19/2017
Director Zipkin moved approval of Board Quality Committee minutes of September 19, 2017, seconded by Director Wong.

Director of Medical Staff, CMO, and CNO departed at 1:08 p.m.

Director Zipkin feels the board should hear directly from the Patient Experience Specialist on complaints.

7.   REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS
None.

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

9. **ADJOURN**
Meeting adjourned at 1:10 p.m.

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.

	Tahoe Forest Health System	
	Title: Quality Assurance / Performance Improvement (QA/PI) Plan	**Policy/Procedure #: AQPI-05**
	Responsible Department: Quality & Regulations	

Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
☒	Administrative	9/96		12/14; 2/16; 2/17; 1/18	
☐	Medical Staff				
☐	Departmental				

Applies to: X System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital

PURPOSE

The purpose of the Quality Assurance/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. The goals are to proactively reduce risk to our patients by eliminating or reducing factors that contribute to unanticipated adverse events and/or outcomes and provide high quality care and services to ensure a perfect care experience for our patients and customers. This will be accomplished through the support and involvement of the Board of Directors, Administration, Medical Staff, Management, and employees, in an environment that fosters collaboration and mutual respect. This collaborative approach supports innovation, data management, performance improvement, proactive risk assessment, commitment to customer satisfaction, and use of the Just Culture model to promote and improve awareness of patient safety. Tahoe Forest Health System has an established mission, vision, values statement, and utilizes a foundation of excellence model, which are used to guide all improvement activities.

POLICY:

MISSION STATEMENT

The mission of Tahoe Forest Health System is *"To serve our region by striving to be the best mountain health system in the nation."*

VISION STATEMENT

The vision of Tahoe Forest Health System is *"We exist to make a difference in the health of our communities through excellence and compassion in all we do."*

VALUES STATEMENT

Our vision and mission is supported by our values. These include:

- Quality – holding ourselves to the highest standards and having personal integrity in all we do
- Understanding – being aware of the concerns of others, caring for and respecting each other as we interact
- Excellence – doing things right the first time, on time, every time, and being accountable and responsible
- Stewardship – being a community steward in the care, handling and responsible management of resources while providing quality healthcare
- Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do

FOUNDATIONS OF EXCELLENCE

Our foundation of excellence includes: Quality, Service, People, Finance and Growth

- Quality – provide excellence in clinical outcomes
- Service – best place to be cared for
- People – best place to work, practice and volunteer
- Finance – provide superior financial performance
- Growth – meet the needs of the community

PERFORMANCE IMPROVEMENT INITIATIVES

The 2018 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations;
- Reducing the per capita cost of health care;
- Staff engagement and joy in work.

Priorities identified include:

- Top decile quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
  - Perfect Care Experience
- Sustain a Just Culture philosophy that promotes a culture of safety, transparency, and system improvement
  - Participate in Beta HEART (healing, empathy, accountability, resolution, trust) program
- Ensure Patient Safety across the entire Health System with a focus on High Reliability Organizational thinking
  - Preoccupation with failure
  - Reluctance to simplify
  - Sensitivity to operations
  - Deference to expertise
  - Commitment to resilience
- Implement user friendly incident reporting system with a goal to increase reporting of events
- Identify best practice plan related to Co-Management of Hospitalized Patients
- Support Patient and Family Centered Care and the Patient and Family Advisory Council
- Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
- Identify gaps in the Epic electronic health record implementation and develop plans of correction
- Maximize Epic reporting functionality to improve data capture and identification of areas for improvement
- Achieve Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Project Initiatives

Tahoe Forest Health System's vision will be achieved through these strategic priorities. Each strategic priority is driven by leadership oversight and teams developed to ensure improvement and implementation (see Attachment A).

ORGANIZATION FRAMEWORK

Processes cross many departmental boundaries and performance improvement requires a planned, collaborative effort between all hospital-based departments, services, and outside Tahoe Forest Health System, including third-party payors and other physician groups. Though the responsibilities of this plan are delineated according to common groups, it is recognized that true process improvement and positive outcomes occur only when each individual works cooperatively and collaboratively to achieve improvement.

Governing Board

The Board of Directors (BOD) of Tahoe Forest Health System has the ultimate responsibility for the quality of care and services provided throughout the system *(See Attachment B – CAH Services)*. The BOD assures that a planned and systematic process is in place for measuring, analyzing and improving the quality and safety of the Health System activities.

The Board:

- Delegates the authority for developing, implementing, and maintaining performance improvement activities to administration, medical staff, management, and employees;
- Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
- Provides direction for the organization's improvement activities through the development of strategic initiatives;
- Evaluates the organization's effectiveness in improving quality through reports from the various board committees, Medical Executive Committee and Medical Staff Quality Committee.

Administrative Council

The Administrative staff creates an environment that promotes the attainment of quality and process improvement through the safe delivery of patient care, quality outcomes, and patient satisfaction. The Administrative Council sets expectations, develops plans, and manages processes to measure, assess, and improve the quality of the Health System's governance, management, clinical and support activities. The Administrative Council ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.

The Administrative Council has developed a culture of safety by embracing the Just Culture model and has set behavior expectations for providing no less than Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP^{TM}).   They ensure compliance with regulatory, statutory and contractual requirements.

Board Quality Committee

The Board Quality Committee is to provide oversight for the Health System QA/PI Plan and set expectations of quality care, patient safety, environmental safety, and performance improvement throughout the organization. The committee will monitor the improvement of care, treatment and services to ensure that it is safe, timely, effective, efficient, equitable and patient-centered. They will oversee and be accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities. The committee will assure the development and implementation of ongoing education focusing on service and performance excellence, risk-reduction/safety enhancement, and healthcare outcomes.

Medical Executive Committee

The Medical Executive Committee shares responsibility with the BOD Quality Committee and senior management for the ongoing quality of care and services provided within the Health System.

The Medical Executive Committee provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the medical performance of all individuals with delineated clinical privileges. These mechanisms function under the purview of the Medical Staff Peer Review Process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.

The Medical Executive Committee delegates the oversight authority for performance improvement activity monitoring, assessment, and evaluation of patient care services provided throughout the system to the Medical Staff Quality Committee (MS QAC).

Department Chairs of the Medical Staff

The Department Chairs:

- Provide a communications channel to the Medical Executive Committee;
- Monitor Ongoing Professional Performance Evaluation and Focused Professional Performance Evaluation and make recommendations regarding reappointment based on data regarding quality of care;
- Maintain all duties outlined by appropriate accrediting bodies.

Medical Staff

The medical staff is expected to participate and support performance improvement activities. The medical staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the medical staff peer review process.   Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.   Annually, the Departments will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.

The Medical Director of Quality provides physician leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the medical staff and Health System leaders, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the medical staff and engages them in improvement activities. The Director chairs the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Supervisors)

Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the medical staff. They are expected to do the following:

- Foster an environment of collaboration and open communication with both internal and external customers;
- Participate and guide staff in the patient advocacy program;
- Advance the philosophy of Just Culture within their departments;
- Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process improvement activities for department-specific performance improvement initiatives;
- Establish performance and patient safety improvement activities in conjunction with other departments;
- Encourage staff to report any and all reportable events including "near-misses";
- Participate in the investigation and determination of the causes that underlie a "near-miss" / Sentinel/Adverse Event/Error or Unanticipated Outcome as recommended by the Just Culture model and implement changes to reduce the probability of such events in the future.

Employees

The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing and supporting the Standards of Business Conduct: Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.

The Nursing Quality and Peer Review Council consist of registered nurses from each service area. This Council is an integral part of reviewing QA/PI data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.

Employees are expected to do the following:

- Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect care experience for patients and customers;
- Make suggestions/recommendations for opportunities of improvement or for a cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Director or Manager, the Director of Quality and Regulations, the Medical Director of Quality, or an Administrative Council Member.

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

With designated authority from the Medical Executive Committee, the Medical Staff Quality Assessment Committee (MS QAC) is responsible for prioritizing the performance improvement activities in the organization, chartering cross-functional teams, improving processes within the Health System, and supporting the efforts of all performance improvement activities. The MS QAC is an interdisciplinary committee led by the Medical Director of Quality. The committee has representatives from each Medical Staff department, Health System leadership, nursing, ancillary and support services ad hoc. Meetings are held at least quarterly each year. The Medical Director of Quality, Medical Director of Strategic Planning & Innovation, and the Vice Chief of staff are members of the Board of Director's Quality Committee.

The Medical Staff Quality Assessment Committee:

1.0   Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Alternate Life Safety Measures Plan, Utilization Review Plan, Risk Management Plan, and the Patient Safety Plan.
2.0   Regularly reviews progress to the aforementioned plans.

3.0 Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;

4.0 Reviews recommendations for performance improvement activities based on patterns and trends identified by the proactive risk reduction programs and from the various Health System committees;

5.0 Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety standards that may require further investigation;

6.0 Reviews and approves chartered Performance Improvement Teams as recommended by the Performance Improvement Committee (PIC). Not all performance improvement efforts require a chartered team;

7.0 Reviews progress reports from chartered teams and assists to address and overcome identified barriers;

8.0 Reviews summaries and recommendations of Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.

9.0 Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates the services provided and make recommendations to the MEC.

Performance Improvement Committee (PIC)

The Medical Staff Quality Assessment Committee provides direct oversight for the PIC. The PIC is an executive committee with departmental representatives, within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participates in performance improvement activities. Departmental Directors or their designee review assigned quality metrics biannually at the PIC (*See Attachment C – QA PI Reporting Measures)*. Performance improvement includes collecting data, analyzing the data, and taking action to improve. The Director of Quality and Regulations is responsible for processes related to this committee.

The Performance Improvement Committee will:

- Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders
- Set performance improvement priorities and provide the resources to achieve improvement
- Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;
- Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

Tahoe Forest Health System utilizes DMAIC Rapid Cycle Teams (Define, Measure, Analyze, Improve, Control). The BOD, Administrative Council Members, or the Medical Staff Quality Committee charter formal cross-functional teams to improve current processes and design new services, while each department utilizes tools and techniques to address opportunities for improvement within their individual areas.

Performance Improvement Teams

Teams are cross-functional and multidisciplinary in nature. The priority and type of team are based on the strategic initiatives of the organization, with regard to high risk, high volume, problem prone, and low volume.

Performance Improvement Teams will:

- Follow the approved team charter as defined by the BOD, Administrative Council Members, or MS QAC;
- Establish specific, measurable goals and monitoring for identified initiatives;
- Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT EDUCATION

Training and education are essential to promote a culture of quality within the Tahoe Forest Health System. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees and Medical Staff receive additional annual training on various topics related to performance improvement.

A select group of employees have received specialized facilitator training in using the DMAIC rapid cycle process improvement and utilizing statistical data tools for performance improvement. These facilitators may be assigned to chartered teams at the discretion of the PIC, MS QAC and Administrative Council Members. Staff trained and qualified in Lean/Six Sigma will facilitate the chartering, implementation, and control of enterprise level projects.

Team members receive "just-in-time" training as needed, prior to team formation to ensure proper quality tools and techniques are utilized throughout the team's journey in process improvement.

Annual evaluation of the performance improvement program will include an assessment of needs to target future educational programs. The Director of Quality and Regulations is responsible for this evaluation.

PERFORMANCE IMPROVEMENT PRIORITIES

Improvement activities must be data driven, outcome based, and updated annually. Careful planning, testing of solutions and measuring how a solution affects the process will lead to sustained improvement or process redesign. Improvement priorities are based on the mission, vision, and strategic plan for Tahoe Forest Health System. During planning, the following are given priority consideration:

- Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
- Processes that affect patient safety and outcomes
- Processes related to patient advocacy and the perfect care experience
- Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices
- Processes related to patient flow
- Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome

Because Tahoe Forest Health System is sensitive to the ever changing needs of the organization, priorities may be changed or re-prioritized due to:
- Identified needs from data collection and analysis
- Unanticipated adverse occurrences affecting patients
- Processes identified as error prone or high risk regarding patient safety
- Processes identified by proactive risk assessment
- Changing regulatory requirements
- Significant needs of patients and/or staff
- Changes in the environment of care
- Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/SERVICES

Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:

1.0   Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.

2.0   An external consultant is utilized to provide technical support, when needed.

3.0 The design team develops or modifies the process utilizing information from the following concepts:
- It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
- It is clinically sound and current
- Current knowledge when available and relevant i.e. practice guidelines, successful practices, information from relevant literature and clinical standards
- It is consistent with sound business practices
- It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
- Conducts an analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
- It incorporates the results of performance improvement activities
- It incorporates consideration of staffing effectiveness
- It incorporates consideration of patient safety issues
- It incorporates consideration of patient flow issues

4.0 Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
- They can identify the events it is intended to identify
- They have a documented numerator and denominator or description of the population to which it is applicable
- They have defined data elements and allowable values
- They can detect changes in performance over time
- They allow for comparison over time within the organization and between other entities
- The data to be collected is available
- Results can be reported in a way that is useful to the organization and other interested stakeholders

An individual with the appropriate expertise within the organization is assigned the responsibility of developing the new process.

PROACTIVE RISK ASSESSMENTS

Risk assessments are conducted to proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:

- A Failure Effect Mode Analysis (FMEA) will be completed based on the organization's assessment and current trends in the healthcare

industry and as approved by PIC or the MS QAC.

- The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.

    1. The process is assessed to identify steps that may cause undesirable variations, or "failure modes".
    2. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
    3. Potential risk points in the process will be closely analyzed including decision points and patient's moving from one level of care to another through the continuum of care.
    4. For the effects on the patient that are determined to be "critical", a root cause analysis is conducted to determine why the effect may occur.
    5. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
    6. The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
    7. Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

- Ongoing hazard surveillance rounds including Environment of Care Rounds and departmental safety hazard inspections are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
- The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
- The Infection Control Practitioner and Environment of Care Safety Officer complete a written infection control and preconstruction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

Tahoe Forest Health System chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, the following:

- Medication therapy
- Infection control surveillance and reporting
- Surgical/invasive and manipulative procedures
- Blood product usage

- Data management
- Discharge planning
- Utilization management
- Complaints and grievances
- Restraints/seclusion use
- Mortality review
- Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
- Needs, expectations, and satisfaction of individuals and organizations served, including:
  - Their specific needs and expectations
  - Their perceptions of how well the organization meets these needs and expectations
  - How the organization can improve patient safety
  - The effectiveness of pain management
- Resuscitation and critical incident debriefings
- Performance measures from acceptable data bases/comparative reports, i.e., Quantros, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN 2.0, and Press Ganey
- Summaries of performance improvement actions and actions to reduce risks to patients

In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:

- Quality measures delineated in clinical contracts will be reviewed annually
- Pharmacy transactions as required by law and to control and account for all drugs
- Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
- Records of radio nuclides and radiopharmaceuticals, including the radionuclide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal
- Reports of required reporting to federal, state, authorities
- Performance measures of processes and outcomes, including measures outlined in clinical contracts

These data are reviewed regularly by the PIC, MSQAC, and the BOD with a goal of 100% compliance. The review focuses on any identified outlier and the plan of correction.

AGGREGATION AND ANALYSIS OF DATA

Tahoe Forest Health System believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, run charts (SPC), histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience (See Attachment D for QI PI Indicator definitions).

Data is analyzed in many ways, including:

- Using appropriate performance improvement problem solving tools
- Making internal comparisons of the performance of processes and outcomes over time
- Comparing performance data about the processes with information from up-to-date sources
- Comparing performance data about the processes and outcomes to other hospitals and reference databases

Intensive analysis is completed for:

- Levels of performance, patterns or trends that vary significantly and undesirably from what was expected
- Significant and undesirable performance variations from the performance of other operations
- Significant and undesirable performance variations from recognized standards
- A sentinel event which has occurred (see Sentinel Event Policy)
- Variations which have occurred in the performance of processes that affect patient safety
- Hazardous conditions which would place patients at risk
- The occurrence of an undesirable variation which changes priorities

The following events will automatically result in intense analysis:

- Significant confirmed transfusion reactions
- Significant adverse drug reactions
- Significant medication errors
- All major discrepancies between preoperative and postoperative diagnosis
- Adverse events or patterns related to the use of sedation or anesthesia

- Hazardous conditions that significantly increase the likelihood of a serious adverse outcome
- Staffing effectiveness issues
- Deaths associated with a hospital acquired infection
- Core measure data, that over two or more consecutive quarters for the same measure, identify the hospital as a negative outlier

REPORTING

Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by medical staff, ancillary, and nursing services, in addition to outcomes of performance improvement teams, will be reported to the MS QAC on a quarterly basis. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC and Medical Staff annually.

The MS QAC will provide their analysis of the quality of patient care and services to the Medical Executive Committee on a quarterly basis. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD at least quarterly relevant findings from all performance improvement activities performed throughout the System.

Tahoe Forest Health System also recognizes the importance of collaborating with state agencies to improve patient outcomes and reduce risks to patients by participating in voluntary quality reporting initiatives (*See Attachment E for External Reporting listing).*

CONFIDENTIALITY AND CONFLICT OF INTEREST

All communication and documentation regarding performance improvement activities will be maintained in a confidential manner. Any information collected by any Medical Staff committee, the Administrative Council, or Health System department in order to evaluate the quality of patient care, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure. Access to peer review information is limited to review by the Medical Staff and its designated committees and is confidential and privileged. No member of the Medical Staff shall participate in the review process of any case in which he/she was professionally involved unless specifically requested to participate in the review. All information related to performance improvement activities performed by the Medical Staff or Health System staff in accordance with this plan is confidential and are protected by disclosure and discoverability through California Evidence Code 1156 and 1157.

ANNUAL ASSESSMENT

The Quality Assurance program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at

least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.

The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The Quality Assurance program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes. An annual report summarizing the improvement activities and the assessment will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

The Quality Assurance Performance Improvement Plan will be reviewed, updated, and approved annually by the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

Related Policies/Forms:
Medication Error Reduction Plan (MERP); *See also* Medication Error Reporting APH-24
Infection Control Plan
Alternate Life Safety Measures (ALSM) Program
Utilization Review Plan
Risk Management Plan
Patient Safety Plan
References: HFAP and CMS
Policy Owner: Director of Quality & Regulations
Approved by: Chief Operating Officer

ATTACHMENT A

Quality Initiatives 2018

	Initiative	Agency	Inclusive Of
1.	Patient Safety Initiative	National Quality Forum (NQF) Endorsed Set of 34 Safe Practices	NQF Endorsed Set of 34 Safe Practices • Leadership Structures and Systems • Culture Measurement, Feedback, and Intervention • Teamwork Training and Skill Building • Identification and Mitigation of Risk and Hazards • Informed Consent • Life-Sustaining Treatment • Disclosure • Care of the Caregiver • Nursing Workforce • Direct Caregivers • Intensive Care Unit Care • Patient Care Information • Order Read-Back and Abbreviations • Labeling of Diagnostic Studies • Discharge Systems • Safe Adoption of Computerized Prescriber Order Entry • Medication Reconciliation • Pharmacist Leadership Structures and Systems • Hand Hygiene • Influenza Prevention • Central Line-Associated Bloodstream Infection Prevention • Surgical-Site Infection Prevention • Care of the Ventilated Patient

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Quality Plan Attachment A: Quality Initiatives 2018

	Initiative	Agency	Inclusive Of
			• Multidrug-Resistant Organism Prevention • Catheter-Associated Urinary Tract Infection Prevention • Wrong-Site, Wrong-Procedure, Wrong-Person Surgery • Pressure Ulcer Prevention • Venous Thromboembolism Prevention • Anticoagulation Therapy • Contrast Media-Induced Renal Failure Prevention • Organ Donation • Glycemic Control • Fall Prevention • Pediatric Imaging
2.	Patients, Service & Quality TFHS Strategic Plan		Achieve goals as outlined on the Fiscal Year 2018 approved Strategic Plan
3.	Orthopedic & Sports Medicine Service Line	American Joint Replacement Registry (AJRR) American Orthopaedic Association	• CA Joint Replacement Registry • Own the Bone QI Program • Orthopedic continuum of care for orthopedic surgery patients as part of the integrated care coordination project • Optimization of orthopaedic orders sets to improve patient satisfaction, pain control, and outcomes
4.	Navigator Program		• Cancer Center • Orthopedic & Sports Medicine • Perinatal
5.	Integrated Care Coordination Project		Institute comprehensive continuum of care management system that addresses

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Quality Plan Attachment A: Quality Initiatives 2018

ATTACHMENT A

Quality Initiatives 2018

	Initiative	Agency	Inclusive Of
			disease while maintaining low cost, high quality of care for the communities we serve.
6.	Chronic Pain Management Program		Develop a comprehensive pain management program across the continuum of care. Addition of part time primary care specialist with special interest in pain management.
7.	Service Excellence	Press Ganey	Patient feedback received and quarterly report shared at BOD, Medical & Clinical staff meetings. Service Excellence PI team meets quarterly to review results and identify areas for organizational improvement.
8.	Patient & Family Centered Care	Patient & Family Centered Care Partners & Patient's On Board	Patient Advisory Council meet ten times a year
9.	Event Analysis/ Debriefing Process		As outlined in the Sentinel/Adverse Event (AGOV-35) & Root Cause Analysis policy (AGOV-46) or as requested by the Medical Staff and Directors. Plan of action reviewed with Medical and Clinical staff as appropriate.
10.	OPPE/FPPE Department Specific Quality Indicators	Medical Staff Committee approve indicators	Cases reviewed, data collected, tracked, trended, and reviewed with Medical Staff as outlined in the Peer Review policy (MSGEN-1401).

Quality Plan Attachment A: Quality Initiatives 2018

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ATTACHMENT A

Quality Initiatives 2018

	Initiative	Agency	Inclusive Of
11.	Sanctioned Rapid Cycle Teams or Performance Improvement Teams	Performance Improvement Committee (PIC) prioritizes and sanctions teams as requested	Armband/Two Patient Identifier Outpatient Service Excellence MSC Service Excellence Culture of Patient Survey Core Measures
12.	Failure Mode Event Analysis (FMEA)	PIC prioritizes and sanctions teams as requested	Information Technology breaches
13.	Department Specific Metrics and Quality Dashboard	2018 Reporting Matrix outlines the matrix and reporting schedule to PIC	Attachment C
14.	Core Measure Reporting	CMS	Quality data collected and submitted to CMS, through Quantros vendor, and posted on the Compare web site.
15.	Choose Wisely	Medical Staff Committee approval then develop an implementation plan	Specialty medical societies have created lists of "Things Physicians and Patients Should Question" that provide specific, evidence-based recommendations physicians and patients should discuss to help make wise decisions about the most appropriate care.
16.	Health Information System (HIS)	Mercy Epic	Identify gaps in the Epic electronic health record implementation and develop plans of correction Maximize Epic reporting functionality to improve data capture and identification of areas for improvement Cancer Center implementation (September)

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Quality Plan Attachment A: Quality Initiatives 2018

ATTACHMENT A

Quality Initiatives 2018

	Initiative	Agency	Inclusive Of
17.	Centralized Scheduling		Implementation to improve ED follow up, access, referrals within Health System, revenue, and no-show rates.
18.	Incident Reporting System		Implement user friendly incident reporting system with a goal to increase reporting of events

Quality Plan Attachment A: Quality Initiatives 2018

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

PURPOSE:

To identify providers who provide patient care services through agreements or arrangements.

POLICY:

The Chief Executive Officer or designee is principally responsible for the operation of Tahoe Forest Hospital District and the services furnished with providers or suppliers participating under Medicare to furnish other services to its patients by agreement or arrangement. All agreements or arrangements for providing health care services to the CAH's patients must be with a provider or supplier that participates in the Medicare program, except in the case of an agreement with a distant-site telemedicine entity. A list will be maintained that describes the nature and scope of the services provided and the individual assigned to oversee the contract.

TAHOE FOREST HOSPITAL

1.0 The following services are available directly at Tahoe Forest Hospital:

    1.1 Emergency Services

    1.2 Inpatient Medical Surgical Care

        1.2.1 Medical Surgical Pediatric care

    1.3 Intensive Care and Step Down

        1.3.1 Step Down Pediatric care (age 7-17)

    1.4 Swing Program

    1.5 Obstetrical Services

    1.6 Inpatient and Outpatient Surgery

    1.7 Outpatient Observation Care

    1.8 Inpatient and Outpatient Pharmacy Service

    1.9 Medical Nutritional / Dietary Service

    1.10 Respiratory Therapy Services

    1.11 Rehabilitation Services that includes Physical, Occupational and Speech Therapy

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Quality Plan Attachment B: Available CAH Services

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

1.12   Inpatient and Outpatient Laboratory Services

1.13   Diagnostic Imaging Services that includes: PET CT, Radiation, CT Scan, MRI, Mammography and Ultrasound, Fluoroscopy, and Nuclear Medicine

1.14   Home Health

1.15   Hospice

1.16   Skilled Nursing Care

1.17   Outpatient Services that includes Wellness program, Cardiac Rehabilitation,

        Occupational Health Services, Multispecialty Clinics

1.18   Medical and Radiation Oncology Services

2.0   Transfer Agreements provide other needed services as outlined in the Transfer Agreements

2.1   Renown Medical Center (Reno, NV)

2.2   Saint Mary's Regional Medical Center (Reno, NV)

2.3   Carson Tahoe Regional Healthcare (Carson City, NV)

2.4   UC Davis Medical Center (Sacramento, CA)

2.5   Sutter Memorial (Sacramento, CA)

2.6   Sutter Roseville Medical Center (SRMC) (Roseville, CA)

2.7   Incline Village Community Hospital (IVCH) (Incline Village, NV)

2.8   California Pacific Medical Center (Davies, CA)

2.9   Eastern Plumas District Hospital (Portola, CA)

2.10   Truckee Surgery Center (Truckee, CA)

2.11   Northern Nevada Medical Center (Sparks, NV)

2.12   Children's Hospital & Research Center at Oakland dba: UCSF Benioff Children's Hospital Oakland (Oakland, CA)

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Quality Plan Attachment B: Available CAH Services

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

2.13   Davies Medical Center (San Francisco, CA)

2.14   Western Sierra Medical Clinic (Grass Valley, CA)

2.15   Emergency Transportation Agreements with:

    2.15.1 Truckee Fire Protection District

    2.15.2 Care Flight

3.0   The following services are provided to patients by Agreement or Arrangement:

3.1   Emergency Professional Services

3.2   On Call Physician Program

3.3   Hospitalist Services

3.4   Pathology and Laboratory Professional Services

3.5   Blood and Blood Products Provider: United Blood Services Reno, NV

3.6   Diagnostic Imaging Professional Services

3.7   Anesthesia Services

3.8   Rehabilitation Services

3.9   Pharmacy Services

3.10   Tissue Donor Services

3.11   Biomedical Services

3.12   Interpreter Services

Incline Village Community Hospital

4.0   The following services are available directly at Incline Village Community Hospital:

4.1   Emergency Services

4.2   Inpatient Medical Surgical Care

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Quality Plan Attachment B: Available CAH Services

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

4.3   Outpatient Observation Care

4.4   Inpatient and Outpatient Surgery

4.5   Inpatient Pharmacy Service

4.6   Rehabilitation Services including Physical Therapy

4.7   Laboratory Services

4.8   Diagnostic Imaging Services including CT

4.9   Home Health and Hospice

4.10   Sleep Disorder Clinic

4.11   Outpatient Services that include Occupational Health Services and a Multispecialty Clinic

5.0   Transfer Agreements provide other needed services as outlined in the Transfer Agreements

5.1   Renown Regional Medical Center (Reno, NV)

5.2   Saint Mary's Regional Medical Center (Reno, NV)

5.3   Carson Tahoe Hospital (Carson City, NV)

5.4   Tahoe Forest Hospital (Truckee, CA)

5.5   Northern Nevada Medical Center (Sparks, NV)

5.6   Emergency Transportation Agreement with:

       5.6.1   North Lake Tahoe Fire Protection (Incline Village, NV)

6.0   The following services are provided to patients by Agreement or Arrangement:

6.1   Emergency Professional Services

6.2   Medicine – On Call

6.3   Pathology and Laboratory Professional Services

6.4   Blood and Blood Products Provider: United Blood Services Reno, NV

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Quality Plan Attachment B: Available CAH Services

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

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Quality Plan Attachment B: Available CAH Services

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

Title	Scope of Services	TFHD/IVCH/System	Responsible
California Emergency Physicians	24/7 Physician Service for ED	TFHD	CEO
North Tahoe Emergency	24/7 Physician Service for ED	IVCH	CEO
North Tahoe Anesthesia Group	24/7 Anesthesia services	System	CEO
Hospitalist Program	24/7 Physicians Services for TFHD (Individual Contracts)	TFHD	CEO
Western Pathology Consultants	Pathology Consults and Reports	System	CEO
Quest Diagnostics	Labs not performed at TFHD	System	COO/Director of Lab Services
Virtual Radiologic	Read diagnostic imaging tests after hours	System	COO/Director of DI Services
North Tahoe Radiology Medical Group	Read diagnostic imaging tests during normal business hours	System	CEO
Cardinal Health	After hour pharmacist services	System	COO/Director of Pharmacy Services
Nevada & Placer Co. Mental Health	Mental Health assessments in the ER	TFHD	CEO
Truckee North Tahoe Rehabilitation	Provide rehab services for inpatient and outpatients	System	COO
Sierra Donor Services	24/7 Organ Donor Services	System	CNO
Adventist Health Biomedical Services	Electrical Safety for patient equipment	System	Facilities Development Chief

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Quality Plan Attachment B: Available CAH Services

Attachment C

2018 QA/PI Reporting Measures

January and July			
Person	Category	Date	Time Slot
Davis, A.	Falls	Second Wednesday	7:50 AM
Davis, A.	Organ Donation	Second Wednesday	8:00 AM
Davis, A.	Restraints	Second Wednesday	8:10 AM
Davis, A.	Resuscitation Outcomes	Second Wednesday	8:20 AM
Milligan, K.	ICU	Second Wednesday	8:30 AM
Milligan, K.	Med Surg and Swing	Second Wednesday	8:40 AM
Cooper, S.	Pharmacy	Second Wednesday	8:50 AM
Grow, K.	Case Management	Second Wednesday	9:00 AM
Baker, S.	Palliative Care	Second Wednesday	9:10 AM
		Second Wednesday	9:20 AM

February and August			
Person	Category	Date	Time Slot
Fetbrandt, J.	Core Measures	Second Wednesday	7:50 AM
Buchanan, W	Cardiac Rehabilitation	Second Wednesday	8:00 AM
Buchanan, W	Wellness at Work	Second Wednesday	8:10 AM
Grosdidier, J.	Environmental Services	Second Wednesday	8:20 AM
Grosdidier, J.	Respiratory Therapy	Second Wednesday	8:30 AM
Oelkers, M.	Rehabilitation Therapy	Second Wednesday	8:40 AM
Lockwood, D.	MIPS	Second Wednesday	8:50 AM
Lockwood, D.	Patient Safety	Second Wednesday	9:00 AM
Schopp, S.	Infection Control	Second Wednesday	9:10 AM
Blumberg, C.	Risk	Second Wednesday	9:20 AM

March and September			
Person	Category	Date	Time Slot
Epstein, K.	Foundation - IVCH	Second Wednesday	7:50 AM

Simon, M.	Foundation - TFH	Second Wednesday	8:00 AM
Rouse, M.	Materials Management	Second Wednesday	8:10 AM
Ruggiero, M.	Facilities	Second Wednesday	8:20 AM
Ruggerio, M.	Life / Safety	Second Wednesday	8:30 AM
MacLennan, A.	HR	Second Wednesday	8:40 AM
MacLennan, A.	Education	Second Wednesday	8:50 AM
Mazzini, A.	Volunteer Services	Second Wednesday	9:00 AM
O'Hanlon, J.	Information Technology	Second Wednesday	9:10 AM
		Second Wednesday	9:20 AM

April and October			
Person	Category	Date	Time Slot
Blake, K.	Emergency Department	Second Wednesday	7:50 AM
Blake, K.	Women and Family	Second Wednesday	8:00 AM
Iida, J.	IVCH	Second Wednesday	8:10 AM
Lutz, H.	Dietary and Nutrition Services	Second Wednesday	8:20 AM
Link, M.	ECC / LTC / SNF	Second Wednesday	8:30 AM
Sturtevant, J.	Home Health	Second Wednesday	8:40 AM
Sturtevant, J.	Hospice	Second Wednesday	8:50 AM
Barnes, V.	Laboratory	Second Wednesday	9:00 AM
Stokich, P.	Diagnostic Imaging	Second Wednesday	9:10 AM
		Second Wednesday	9:20 AM

May and November			
Person	Category	Date	Time Slot
Freeman, J.	Sleep Center	Second Wednesday	7:50 AM
Weeks, K.	ENDO	Second Wednesday	8:00 AM
Weeks, K.	PACU	Second Wednesday	8:10 AM
Weeks, K.	PAIN CLINIC	Second Wednesday	8:20 AM
Weeks, K.	SPD	Second Wednesday	8:30 AM

Weeks, K.	Surgery	Second Wednesday	8:40 AM
Coll, D.	Orthopedic Service Line	Second Wednesday	8:50 AM
		Second Wednesday	9:00 AM
		Second Wednesday	9:10 AM
		Second Wednesday	9:20 AM

June and December			
Person	**Category**	**Date**	**Time Slot**
Bennett, J.	Business Office	Second Wednesday	7:50 AM
Bennett, J.	HIM	Second Wednesday	8:00 AM
Jefferson, C.	Patient Registration	Second Wednesday	8:10 AM
Jefferson, C.	Financial Counselors	Second Wednesday	8:20 AM
McMullen, S.	Employee Health	Second Wednesday	8:30 AM
Steinberg, J.	Physician Services	Second Wednesday	8:40 AM
Walker, S.	MSC	Second Wednesday	8:50 AM
Bottomley, K.	Cancer Center	Second Wednesday	9:00 AM
		Second Wednesday	9:10 AM
		Second Wednesday	9:20 AM

Business Office	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH				Bennett, J.			June	December
Cancer Center	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Combination Chemo-Therapy is considered or administered within 4 months of diagnosis for women under 70 with AJCC1cMOMO, or stage II or III hormone receptor negative breast cancer	TFH		Internal	PIC	Bottomley, K.		90%	June	December

2018 QA/PI Reporting Measures

Radiation therapy is administered within 1 year of diagnosis for women under age 70 receive breast conserving surgery for breast cancer	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Radiation therapy is considered or administered following any mastectomy within 1 year of diagnosis of breast cancer for women with 4 or more positive regional lymph nodes	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Tamoxifen or third-generation aromatase inhibitor is considered or administered within one year of diagnosis for women with AJCCT1cMOMO or stage II or III hormone receptor positive cancer	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Breast conservation surgery rate for women with AJCC clinical stage 0, I, II breast cancer	TFH		Internal	PIC	Bottomley, K.		TBD	June	December
Image or palpation-guided needle biopsy to the primary site is performed to establish diagnosis of breast cancer	TFH		Internal	PIC	Bottomley, K.		85%	June	December
Adjuvent chemotherapy is considered or administered within 4 months of diagnosis for patients under the age of 80 with AJCC stage III (lymph node positive) colon cancer	TFH		Internal	PIC	Bottomley, K.		90%	June	December
% of patients w/ resected colon cancer that have at least 12 regional lymph nodes removed & pathologically examined	TFH		Internal	PIC	Bottomley, K.		85%	June	December

Attachment C

2018 QA/PI Reporting Measures

Preoperative chemo and radiation are administered for clinical AJCC T3N0, T4N0, or Stage III; or Postoperative chemo and radiation are administered within 180 days of diagnosis for clinical AJCC T1-2N0 with pathologic AJCC T3N0, T4N0, or Stage III; or treatment is recommended; for patients under the age of 80 receiving resection for rectal cancer	TFH		Internal	PIC	Bottomley, K.		85%	June	December
At least 15 regional lymph nodes are removed and pathologically examined for resected gastric cancer	TFH		Internal	PIC	Bottomley, K.		85%	June	December
Surgery is not the first course of treatment for cN2, M0 lung cases	TFH		Internal	PIC	Bottomley, K.		85%	June	December
Surgery is not the first course of treatment for cN2, M0 lung cases	TFH		Internal	PIC	Bottomley, K.		85%	June	December
At least 10 regional lymph nodes are removed and pathologically examined for AJCC stage IA, IB, IIA, and IIB resected NSCLC	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Radiation therapy completed within 60 days of initiation of radiation among women diagnosed with any stage cervical cancer	TFH		Internal	PIC	Bottomley, K.		TBD	June	December

Attachment C
2018 QA/PI Reporting Measures

Chemotherapy administered to cervical cancer patients who received radiation for stages IB2-IV cancer (Group I) or with positive pelvic nodes, positive surgical margin, and/or positive parametrium (Group 2)	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Use of Brachytherapy in patients treated with primary radiation with curative intent in any stage of cervical cancer	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Endoscopic, laproscopic, or robotic performed for all Endometrial cancer (excluding sarcoma and lymphoma), for all stages except stage IV	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Chemotherapy and/or radiation administered to patients with Stage IIIC or IV Endometrial cancer	TFH		Internal	PIC	Bottomley, K.		90%	June	December
Salpingo-oophorecrtomy, debulking cytroreductive surgery, or pelvic exenteration in Stages I-IIIC Ovarian cancer	TFH		Internal	PIC	Bottomley, K.		100%	June	December
Number of New Consults with documented vaccination status.	TFH		Internal	PIC	Bottomley, K.		100%	June	December
Rate of infection for patients with peripherally inserted central lines and implanted ports	TFH		Internal	PIC	Bottomley, K.		0%	June	December

2018 QA/PI Reporting Measures

% of patients w/ resected colon cancer that have at least 12 regional lymph nodes removed & pathologically examined.	TFH		Internal	PIC	Bottomley, K.		100%	June	December
% of patients, regardless of age, w/ a dx of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate. OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since dx of prostate cancer	TFH		Internal	PIC	Bottomley, K.		100%	June	December
Radiation therapy is administered within 1 year of diagnosis for women under age 70 receive breast conserving surgery for breast cancer	TFH		Internal	PIC	Bottomley, K.		100%	June	December
Combination Chemo-Therapy is considered or administered within 4 months of diagnosis for women under 70 with AJCC1cMOMO, or stage II or III hormone receptor negative breast cancer	TFH		Internal	PIC	Bottomley, K.		100%	June	December
Tamoxifen or third-generation aromatase inhibitor is considered or administered within one year of diagnosis for women with AJCCT1cMOMO-or stage II or III hormone receptor positive cancer	TFH		Internal	PIC	Bottomley, K.		100%	June	December

Adjuvant chemotherapy is considered or administered within 4 months of diagnosis for patients under the age of 80 with AJCC stage III (lymph node positive) colon cancer	TFH		Internal	PIC	Bottomley, K.		100%	June	December
Cardiac Rehabilitation	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Percent Top Box Patient Satisfaction			Internal	PIC	Buchanan, W.		100%	February	August
Average change in lower body strength			Internal	PIC	Buchanan, W.			February	August
Average change in upper body strength			Internal	PIC	Buchanan, W.			February	August
Average change in aerobic endurance			Internal	PIC	Buchanan, W.			February	August
Average change in lower body flexibility			Internal	PIC	Buchanan, W.			February	August
Average change in upper body flexibility			Internal	PIC	Buchanan, W.			February	August
Average change in dynamic balance and agility			Internal	PIC	Buchanan, W.			February	August
Case Management	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
HFAP NQF - Disclosure	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
HFAP NQF - Patient Care Information	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
HFAP NQF - Order Read-Back and Abbreviations	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
HFAP NQF - Discharge Systems	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Inpatient mortality percentage	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.	3.00%	January	July

Medicare average LOS	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Notification of a denial - (not based on the month of stay)	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of CODE 44 patients (indicating those that were inpatient and should be observation)	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of pts receiving comprehensive discharge planning based on high risk screening criteria (measurement is by sample)	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of pts needing comprehensive discharge planning based on high risk screening criteria (measurement is by sample)	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Medicare patients receiving second IM after 2 day IP stay	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Medicare patients needing second IM after 2 day IP stay	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Medicare CAH Certification compliance all physicians/all Medicare Patients	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Medicare CAH certification compliance hospitalist/all Hospitalist Medicare Patients	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Inpatient Admissions Medicare FFS age 65	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Medicare Readmissions FFS age 65	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July

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30 day readmission / Pneumonia primary dx	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission / CHF primary diagnosis	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission/ AMI primary dx	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission /Total Knee Arthroplasty	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission /Total HIP Arthroplasty	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission /COPD	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission all cause and payers/hospital wide readmission	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Readmission by Hospitalists	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of readmits- Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of readmits - non Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of readmits - all payers	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total inpatient days Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total inpatient days for all payers, all patients	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total inpatient Medicare admits all physicians	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total Inpatients Medicare admits by hospitalists	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July

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Total Inpatient admits all payers hospitalist	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total inpatient admits, all payers, all patients	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total number of patients > 4 days, all payers	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total number of patients > 4 days, Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Total Observation Services Admissions (this included those that become inpatient)	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Obs Pts 1 day	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Obs Pts 2 days	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Number of Obs Pts > 2dys	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Swing Admissions	TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Swing Days	TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Swing Conversion Patient Notification	TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Code 44 percentage	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Comprehensive discharge planning compliance rate	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Second IM delivery accuracy percentage	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Percentage of all readmission all cause /TFHD hospitalist	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July

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	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
30 day Readmission Rate from all payers	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Average Inpatient LOS Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Average Inpatient LOS for all payers	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
Percentage of Obs patients > 2 days	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.		January	July
30 day readmission rate - non Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.	100%	January	July
Rate of Stays > 4 days, all payers	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.	100%	January	July
Rate of Stays > 4 days, Medicare	IVCH; TFH		Internal	PIC	Grow, K.	Schnobrich, B.	16%	January	July
Core Measures	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Aspirin at arrival	IVCH; TFH	OP-4	External	CMS; MBQIP; PIC	Fetbrandt, J.		100%	February	August
Aspirin at discharge	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
ACEI or ARB for LVSD	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Beta blocker at discharge	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Fibrolytic therapy received within 30 mins of arrival	IVCH; TFH	OP-2	External	MBQIP; PIC	Fetbrandt, J.		100%	February	August
Influenza Vaccine	IVCH; TFH	IMM-2	External	CMS; MBQIP; PIC	Fetbrandt, J.		100%	February	August

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VTE Prophylaxis	IVCH; TFH	VTE-1	External	CMS; MBQIP; PIC	Fetbrandt, J.		100%	February	August
ICU VTE Prophylaxis	IVCH; TFH	VTE-2	External	CMS; MBQIP; PIC	Fetbrandt, J.		100%	February	August
VTE Patients w/Anticoagulation Overlap Therapy	IVCH; TFH	VTE-3	External	PIC	Fetbrandt, J.		100%	February	August
VTE Patients receiving UFH w/Dosages/ Platelet Count monitoring	IVCH; TFH	VTE-4	External	PIC	Fetbrandt, J.		100%	February	August
VTE Discharge Instructions	IVCH; TFH	VTE-5	External	PIC	Fetbrandt, J.		100%	February	August
Incidence of potentially preventable VTE	IVCH; TFH	VTE-6	External	PIC	Fetbrandt, J.		0%	February	August
Discharged on Antithrombotic Therapy	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Anticoagulation Therapy for Atrial Fibrillation/Flutter	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Thrombolytic Therapy	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Antithrombotic Therapy by End of Hospital Day 2	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Discharged on Statin Medication	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Stroke Education	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Assessed for Rehabilitation	IVCH; TFH		Internal	PIC	Fetbrandt, J.		100%	February	August
Sepsis Bundle	IVCH; TFH	SEP-1	Internal	PIC	Fetbrandt, J.			February	August

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Early Elective Delivery	TFH	PC-01	External	CMS; PIC	Fetbrandt, J.		0%	February	August
Median Time to Fibrinolysis	IVCH; TFH	OP-1	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Fibrinolytic Therapy received within 30 Minutes	IVCH; TFH	OP-2	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Median Time to Transfer to another Facility for Acute Coronary Intervention	IVCH; TFH	OP-3	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Median Time to ECG	IVCH; TFH	OP-5	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Median Time from ED Arrival to ED Departure for Discharged ED Patients - Overall Rate	IVCH; TFH	OP-18a	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Median Time from ED Arrival to ED Departure for Discharged ED Patients - Reporting Measure	IVCH; TFH	OP-18b	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Door to Diagnostic Evaluation by a Qualified Medical Personnel	IVCH; TFH	OP-20	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Median Time to Pain Management for Long Bone Fracture	IVCH; TFH	OP-21	External	CMS; MBQIP; PIC	Fetbrandt, J.			February	August
Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival	IVCH; TFH	OP-23	External	MBQIP; PIC	Fetbrandt, J.			February	August

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Safe Surgery Checklist Use	IVCH; TFH	OP-25	External	MBQIP; PIC	Fetbrandt, J.			February	August
Influenza Vaccination Coverage Among Healthcare Personnel	IVCH; TFH	OP-27	External	MBQIP; PIC	Fetbrandt, J.			February	August
Diagnostic Imaging	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
HFAP NQF - Labeling of Diagnostic Studies			Internal	PIC	Stokich, P.	Esparza, L.		April	October
HFAP NQF - Pediatric Imaging			Internal	PIC	Stokich, P.	Esparza, L.		April	October
HFAP NQF - Contrast Media-Induced Renal Failure Prevention			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Plain Film Cone Use			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Number of Cone Use Sampled Studies			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Technician Marker Use			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Number of Marker Use Sampled Studies			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Technician Pregnancy Documentation			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Number of Pregnancy Documentations Sampled Studies			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Successful IRAD cases without complication			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Total # of IRAD cases			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Patients Requiring ASA or Airway Classification			Internal	PIC	Stokich, P.	Esparza, L.		April	October
ASA Class Documented			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Airway Class Documented			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Number of Procedural Sedation Charts Reviewed			Internal	PIC	Stokich, P.	Esparza, L.		April	October

	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Significant Hypoxemia Pulse Ox < 85% for >3min			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Reversal Agent Used			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Procedural Sedation Adverse Outcome Documented			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Patient Satisfaction Measures			Internal	PIC	Stokich, P.	Esparza, L.		April	October
ER TOP BOX OF DI			Internal	PIC	Stokich, P.	Esparza, L.		April	October
DI TECH TOP BOX			Internal	PIC	Stokich, P.	Esparza, L.		April	October
ER TECH TOP BOX			Internal	PIC	Stokich, P.	Esparza, L.		April	October
Mammography Measures	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
775 # of mammography recalls	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
775 # of mammographys	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
435 # of mammography recalls	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
435 # of mammographys	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
608 # of mammography recalls	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
608 # of mammographys	TFH		Internal	PIC	Stokich, P.	Esparza, L.		April	October
Rate of Success full cases w/o complication			Internal	PIC	Stokich, P.	Esparza, L.	100%	April	October
Rate of ASA Documentation			Internal	PIC	Stokich, P.	Esparza, L.	100%	April	October
Rate of Airway Class Documentation			Internal	PIC	Stokich, P.	Esparza, L.	100%	April	October
Rate of Procedural Sedation Significant Hypoxemia			Internal	PIC	Stokich, P.	Esparza, L.	0%	April	October
Rate of Reversal Agents Used			Internal	PIC	Stokich, P.	Esparza, L.	0%	April	October
Adverse Outcomes Documented			Internal	PIC	Stokich, P.	Esparza, L.	0%	April	October
DI Top Box Percent Total			Internal	PIC	Stokich, P.	Esparza, L.	90%	April	October
Dietary - Nutrition and Food Services	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
STD Meals top box score	TFH		Internal	PIC	Lutz, H.			April	October
Temperature of food top box score	TFH		Internal	PIC	Lutz, H.			April	October
Quality of Food top box score	TFH		Internal	PIC	Lutz, H.			April	October

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Courtesy of person serving food top box score	TFH		Internal	PIC	Lutz, H.			April	October
Small PG DM Rank	TFH		Internal	PIC	Lutz, H.			April	October
CA Peer Group Rank	TFH		Internal	PIC	Lutz, H.			April	October
Malcolm Baldrige Peer Group Rank	TFH		Internal	PIC	Lutz, H.			April	October
Café Net Sales	TFH		Internal	PIC	Lutz, H.			April	October
Number of Café transactions	TFH		Internal	PIC	Lutz, H.			April	October
Number of Items Audited	TFH		Internal	PIC	Lutz, H.			April	October
Number of items not meeting minimal qualitative temperature standard at 30 minutes	TFH		Internal	PIC	Lutz, H.			April	October
ICU	TFH		Internal	PIC	Lutz, H.			April	October
Med/Surg			Internal	PIC	Lutz, H.			April	October
OB	TFH		Internal	PIC	Lutz, H.			April	October
Patient Days			Internal	PIC	Lutz, H.			April	October
Trays per patient day			Internal	PIC	Lutz, H.			April	October
ICU	TFH		Internal	PIC	Lutz, H.			April	October
Med/Surg			Internal	PIC	Lutz, H.			April	October
OB	TFH		Internal	PIC	Lutz, H.			April	October
ED			Internal	PIC	Lutz, H.			April	October
ASU			Internal	PIC	Lutz, H.			April	October
ECC	TFH		Internal	PIC	Lutz, H.			April	October
Number patients identified with malnutrition			Internal	PIC	Lutz, H.			April	October
Number of nutrition assessments			Internal	PIC	Lutz, H.			April	October
Number of patients accepting obesity nutrition intervention			Internal	PIC	Lutz, H.			April	October
Number of patients with BMI >35			Internal	PIC	Lutz, H.			April	October
Patient Tray Audit Accuracy/Temperature			Internal	PIC	Lutz, H.			April	October
Number of Trays Prepared for IVCH			Internal	PIC	Lutz, H.			April	October

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	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Additional Meals (staff, catering)			Internal	PIC	Lutz, H.			April	October
Clinical Nutrition			Internal	PIC	Lutz, H.			April	October
Emergency Department			Internal	PIC	Lutz, H.			April	October
Number of initial RN nutritional screens documented			Internal	PIC	Lutz, H.			April	October
Number of Charts Audited			Internal	PIC	Lutz, H.			April	October
Rate of patients identified with Malnutrition			Internal	PIC	Lutz, H.			April	October
Rate of patients accepting nutrition intervention			Internal	PIC	Lutz, H.			April	October
Items not meeting minimum qualitative temperature standard			Internal	PIC	Lutz, H.			April	October
IVCH Initial Nutritional Screen Compliance			Internal	PIC	Lutz, H.			April	October
TFH Acute meals per patient day			Internal	PIC	Lutz, H.			April	October
Initial Nutritional Screen Compliance			Internal	PIC	Lutz, H.		100%	April	October
MS Initial Nutritional Screen Compliance			Internal	PIC	Lutz, H.			April	October
Items not meeting minimum qualitative temperature standard			Internal	PIC	Lutz, H.			April	October
Catering Error Rate			Internal	PIC	Lutz, H.			April	October
IVCH Initial Nutritional Screen Compliance			Internal	PIC	Lutz, H.			April	October
IVCH Tray Utilization Rate			Internal	PIC	Lutz, H.			April	October
ECC / LTC / SNF	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Percent of patients who develop pressure ulcers	TFH		Internal	PIC	Link, M.		12.00%	April	October
Pressure ulcer percentage	TFH		Internal	PIC	Link, M.		4.20%	April	October
Residents with a urinary tract infection percentage	TFH		Internal	PIC	Link, M.		9.00%	April	October

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	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Inpatient falls per 1000 patient days rate	TFH		Internal	PIC	Link, M.		2.79	April	October
Percent of residents who experience unplanned weight loss	TFH		Internal	PIC	Link, M.		8.00%	April	October
Percentage of Falls	TFH		Internal	PIC	Link, M.		13.10%	April	October
SNF 5-Star Quality Rating	TFH		Internal	PIC	Link, M.			April	October
Rate of residents who experience a UTI	TFH		Internal	PIC	Link, M.		9%	April	October
Rate of residents who experience significant weight loss	TFH		Internal	PIC	Link, M.		8%	April	October
Rate of resident Falls	TFH		Internal	PIC	Link, M.		7%	April	October
Number of patient visits to the emergency department	TFH		Internal	PIC	Link, M.		0%	April	October
Rate of catheter related UTI's	TFH		Internal	PIC	Link, M.		0%	April	October
Staff Turn Over Rate	TFH		Internal	PIC	Link, M.			April	October
Rate of Fluvac Administered	TFH		Internal	PIC	Link, M.		89%	April	October
Rate of Pneumovax Administered	TFH		Internal	PIC	Link, M.		94%	April	October
HFAP NQF - Fall Prevention	TFH		Internal	PIC	Link, M.			April	October
HFAP NQF - Pressure-Ulcer Prevention	TFH		Internal	PIC	Link, M.			April	October
HFAP NQF - Venous Thromboembolism Prevention	TFH		Internal	PIC	Link, M.			April	October
Education	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH				MacLennan, A.	Stone, D.		March	September
Emergency Department	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Reversal Agent Used	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	5%	April	October

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Propofol MD, RN and RT or 2nd MD documented	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	95%	April	October
Time out documented just prior to medication administration	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	100%	April	October
Restraint usage percentage	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	5.00%	April	October
End Tidal CO2 documented	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	100%	April	October
Sedation Scale criteria met	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	100%	April	October
TFH ED Overall Percentile Rank	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.		April	October
Mean arrive to MD time (mins)	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.		April	October
ED throughput Mean LOS	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.		April	October
Mean Inpatient Decision to Admission Time	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.		April	October
Percent of ER Patients leaving against medical advice 'AMA'	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	1%	April	October
Percent ER patients leaving without being seen by a physician	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	2%	April	October
Patients readmitted to ER within 72 hours	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	2%	April	October
ER Readmission within 72 hours with same diagnosis	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.	3.60%	April	October
Percent of ER Patients Transferred	IVCH; TFH		Internal	PIC	Blake, K.	Morgan, J.		April	October
Median time from ED Arrival to ED Departure for Discharged ED Patients	IVCH; TFH	OP-18	External	CMS; MBQIP; PIC	Blake, K.	Morgan, J.		April	October

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Door to Diagnostic Evaluation by a Qualified Medical Professional	IVCH; TFH	OP-20	External	CMS; MBQIP; PIC	Blake, K.	Morgan, J.		April	October
Patient Left Without Being Seen	IVCH; TFH	OP-22	External	CMS; MBQIP; PIC	Blake, K.	Morgan, J.		April	October
Median Time from ED Arrival to ED Departure for Admitted ED Patients	IVCH; TFH	ED-1	External	MBQIP; PIC	Blake, K.	Morgan, J.		April	October
Admit Decision Time to ED Departure Time for Admitted Patients	IVCH; TFH	ED-2	External	MBQIP; PIC	Blake, K.	Morgan, J.		April	October
Administrative Communication	IVCH; TFH	EDTC-1	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Patient Information	IVCH; TFH	EDTC-2	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Vital Signs	IVCH; TFH	EDTC-3	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Medication Information	IVCH; TFH	EDTC-4	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Physician or Practitioner Generated Information	IVCH; TFH	EDTC-5	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Nurse Generated Information	IVCH; TFH	EDTC-6	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Procedures and Tests	IVCH; TFH	EDTC-7	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
Composite of All 27 EDTC Data Elements	IVCH; TFH	All-EDTC	External	MBQIP; PIC	Blake, K.	Burks, T.		April	October
ER Patient Restraint Rate	IVCH; TFH		Internal	PIC	Blake, K.	Burks, T.		April	October
Rate of Alternative Interventions Documented	IVCH; TFH		Internal	PIC	Blake, K.	Burks, T.	100%	April	October

MD Restraint Order Documented and Signed	IVCH; TFH		Internal	PIC	Blake, K.	Burks, T.	100%	April	October
Documented q15 min assessment for need	IVCH; TFH		Internal	PIC	Blake, K.	Burks, T.	100%	April	October
Release of Restraints q2hours documented	IVCH; TFH		Internal	PIC	Blake, K.	Burks, T.	100%	April	October
Employee Health	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Rate of Events Reviewed by Employee Health	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
Rate of Events with Manager Review/Response	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
Rate of Near miss event review/response with manager	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
Non clinical employees TB Screening compliance	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
Clinical employees TB screening compliance	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
Employee influenza vaccination	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
Medical Staff influenza vaccination	IVCH; TFH		Internal	PIC	McMullen, S.		100%	June	December
ENDO	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Number of Moderate Sedations (d)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
MS > Mac Cases (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Respiratory Cause (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Cardiac Cause (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Other Cause (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of Charts Reviewed	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Reversal Agent Used	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November

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BVM (Bag/Valve/Mask) Required	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Quality Measures Physician # 678	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of Screening Colons (d)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of Charts with appropriate Quality Preparation documented (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of Screening Adenomas (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of female screening Adenomas (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of male screening Adenomas (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Cecal intubation rate w/photo documented (n)	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Complications	TFH		Internal	PIC	Weeks, K.	Cooper, K.		May	November
Environmental Services	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Room Cleanliness	IVCH; TFH		Internal	PIC	Grosdidier, J.	Esparza, J	100%	February	August
Courtesy of Person Cleaning Room	IVCH; TFH		Internal	PIC	Grosdidier, J.	Esparza, J	100%	February	August
HCAHPS - "Room and Bathroom Kept Clean"	IVCH; TFH		Internal	PIC	Grosdidier, J.	Esparza, J	100%	February	August
Percentage of checklists 100% complete	IVCH; TFH		Internal	PIC	Grosdidier, J.	Esparza, J	100%	February	August
Facilities	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH				Ruggiero, M.			March	September
Falls	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Total # non-patient (visitor) falls	IVCH; TFH		Internal	PIC	Davis, A.		0%	January	July

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Total # of patient falls (by department and injury severity)	IVCH; TFH		Internal	PIC	Davis, A.			January	July
Rate of inpatient falls per 1000 patient days.	IVCH; TFH		Internal	PIC	Davis, A.			January	July
Rate of inpatient falls with Moderate+ injury per 1000 patient days.	IVCH; TFH		Internal	PIC	Davis, A.			January	July
Financial Counselors	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH		Internal	PIC	Jefferson, C.			June	December
Foundation	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH				Epstein, K.			March	September
	TFH				Simon, M.			March	September
HIM	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Consult Ordered (yes or no)	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.		June	December
If yes, consult present on chart within 48 hours.	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.		June	December
All orders signed, dated and timed?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Discharge instructions on chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Documented that discharge instructions were given to the patient?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Physician report on the chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December

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Admit order on Chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Discharge order on chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Progress notes legible?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
HP on the chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Chief Complaint on HP in patient's own words?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
How many days to dictation?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.		June	December
Discharge Summary on the chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
How many days to chart completion?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.		June	December
Surgery report dictated within 24 hours of surgery?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Date of surgery/procedure on chart and accurate?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Anesthesiologist assessment signed?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Pre and post op diagnoses on the OP report or in the progress notes?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Operative consent on the chart?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Progress notes present for each day in the hospital during post op period?	IVCH; TFH		Internal	PIC	Bennett, J.	Hambrick, M.	100.00%	June	December
Home Health	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Improved Ambulation	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	44.00%	April	October

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	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Patients with emergency care needs percentage	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	22.00%	April	October
HHCAHPS - Rate this agency 9 or 10	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	84.00%	April	October
HHCAHPS - Recommend this agency	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	80.00%	April	October
HCAHPS "Recommend this Hospital" Percentile Rank	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
HCAHPS "Rate this Hospital 9-or-10" Percentile Rank	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Improvement in Pain	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	71%	April	October
Improvement in Bathing	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	74%	April	October
Improvement in Transferring	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	57%	April	October
Improvement in Ambulation / Locomotion	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	65%	April	October
Improvement in Management of Oral Medications	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	51%	April	October
Improvement in Surgical Wounds	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	93%	April	October
Home Health unplanned readmission within 30 days of discharge	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	13%	April	October
Emergency Care Visits related to wound deterioration	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Increase in Number of Pressure Ulcers	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
HHCAHPS - Care of patients	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	86%	April	October
HHCAHPS - Communication between pts and providers	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	84%	April	October
HHCAHPS - Specific Care issues	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	86%	April	October
Hospice	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Match MAR vs Physician Orders	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
HFAP NQF - Glycemic Control	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Hospice Patient UTI Rate	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October

Hospice Patient Vascular Device Infection Rate (TPD)	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Match MAR vs Physician Orders	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	95%	April	October
Follow through on assessed pt needs	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	95%	April	October
Patients Pain goals are met within 48 hours	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	95%	April	October
Hospice Patient CA-UTI Rate	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	0%	April	October
Hospice Patient CLABSI Rate (per 1000 device days)	TFH		Internal	PIC	Sturtevant, J.	Raber, J.	0%	April	October
Hospice Compare Star Rating	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Patients or caregivers who were asked about treatment preferences like hospitalization and resuscitation at the beginning of hospice care	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Patients who were checked for pain at the beginning of hospice care	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Patients taking opioid pain medication who were offered care for constipation	TFH		Internal	PIC	Sturtevant, J.	Raber, J.		April	October
Human Resources	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH				MacLennan, A.	Waters, J.		March	September
ICU	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Rate of Etomidate Adverse Events	TFH		Internal	PIC	Milligan, K.		0%	January	July
Rate of Reversal Agents Used	TFH		Internal	PIC	Milligan, K.		0%	January	July
Rate of Propofol MD, RN & RT or 2nd MD Documented	TFH		Internal	PIC	Milligan, K.		100%	January	July
Rate of Propofol Adverse Events	TFH		Internal	PIC	Milligan, K.		0%	January	July

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Alternative Interventions Documented	TFH		Internal	PIC	Milligan, K.		100%	January	July
MD Order documented and signed every 24 hours non violent/q 4hours for violent	TFH		Internal	PIC	Milligan, K.		100%	January	July
Documentation of q15 min/assessment for need	TFH		Internal	PIC	Milligan, K.		100%	January	July
Release of restraints 2q hours documented	TFH		Internal	PIC	Milligan, K.		100%	January	July
Need for restraints q 4 hours	TFH		Internal	PIC	Milligan, K.		100%	January	July
Plan of Care Initiated	TFH		Internal	PIC	Milligan, K.		100%	January	July
Baseline Pain Goal & Problem initiated for Patients in Pain	TFH		Internal	PIC	Milligan, K.		100%	January	July
PRN Medications with proper frequency and dose	TFH		Internal	PIC	Milligan, K.		100%	January	July
Physician notified if pain goal not met	TFH		Internal	PIC	Milligan, K.		100%	January	July
PCA documentation appropriate	TFH		Internal	PIC	Milligan, K.		100%	January	July
PCA Documentation Vital signs per PCA protocol and Range Orders	TFH		Internal	PIC	Milligan, K.		100%	January	July
PCA Documentation VTBI	TFH		Internal	PIC	Milligan, K.		100%	January	July
PCA Documentation Time cleared	TFH		Internal	PIC	Milligan, K.		100%	January	July
PCA Documentation Inject and attempts	TFH		Internal	PIC	Milligan, K.		100%	January	July
PCA Documentation volume/dose delivered for shift	TFH		Internal	PIC	Milligan, K.		100%	January	July
Physician Order Clarification Compliance	TFH		Internal	PIC	Milligan, K.		100%	January	July
Rate of Age Related Developmental Needs Assessment	TFH		Internal	PIC	Milligan, K.		100%	January	July
Number of Sepsis Patients	TFH		Internal	PIC	Milligan, K.		N/A	January	July
Serum lactate measured	TFH		Internal	PIC	Milligan, K.		100%	January	July

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2018 QA/PI Reporting Measures

Blood cultures obtained prior to antibiotic administration	TFH		Internal	PIC	Milligan, K.		100%	January	July
Improve time to broad-spectrum antibiotics: within 3 hours for ED admissions and 1 hour for non-ED ICU admissions	TFH		Internal	PIC	Milligan, K.		100%	January	July
In the event of hypotension and/or lactate >4 mmol/L (36mg/dl): Deliver an initial minimum of 20 ml/kg of crystalloid (or colloid equivalent) Apply vasopressors for hypotension not responding to initial fluid resuscitation to maintain mean arterial pressure (MAP) >65 mm Hg.	TFH		Internal	PIC	Milligan, K.		100%	January	July
Sepsis Pre-printed Orders Used - First hour/Admission	TFH		Internal	PIC	Milligan, K.		100%	January	July
Survived?	TFH		Internal	PIC	Milligan, K.		100%	January	July
HFAP NQF - Intensive Care Unit Care	TFH		Internal	PIC	Milligan, K.			January	July
Infection Control	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Total SSI rate All Classes	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
Class I	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
Class II	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
Class III	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
Class IV	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August

ICU CLA-BSI	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
Non-ICU CLA-BSI	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
ICU VAP	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
ICU cath-associated UTI Rate per 1000 device days	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
Med-Surg cath-associated UTI per 1000 device days	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
OB cath-associated UTI per 1000 device days	IVCH; TFH		External	PIC	Schopp, S.		0%	February	August
MRSA Admission Screen Compliance	IVCH; TFH		External	PIC	Schopp, S.		100%	February	August
MRSA Discharge Screen Compliance	IVCH; TFH		External	PIC	Schopp, S.		100%	February	August
HAC MRSA Infection Rate per 1000 Pt Days	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
Acute Care Hand Hygiene Med Pass Compliance Rate	IVCH; TFH		Internal	PIC	Schopp, S.		100%	February	August
MSC Care Hand Hygiene Med Pass Compliance	IVCH; TFH		Internal	PIC	Schopp, S.		100%	February	August
LTC Catheter Associated UTI	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
LTC HAC-MRSA Infection Rate per 1000 Pt Days	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
LTC Hand Hygiene Compliance	IVCH; TFH		Internal	PIC	Schopp, S.		100%	February	August
Rate of Respiratory Infection	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August

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Rate of UTI without catheter	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
Rate of GI Tract infection	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
Rate of Skin Infection	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
Class I surgical site infection rate	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
ICU CLABSI	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
VAP (Ventilator Associated Pneumonia)	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
ICU Catheter Associated UTI (CAUTI)	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
Health Care Acquired MRSA (per 1000 pt-days)	IVCH; TFH		Internal	PIC	Schopp, S.		0%	February	August
HFAP NQF - Hand Hygiene	IVCH; TFH				Schopp, S.			February	August
HFAP NQF - Influenza Prevention	IVCH; TFH				Schopp, S.			February	August
HFAP NQF - Central Line-Associated Bloodstream Infection Prevention	IVCH; TFH				Schopp, S.			February	August
HFAP NQF - Surgical Site Infection Prevention	IVCH; TFH				Schopp, S.			February	August
HFAP NQF - Care of the Ventilated Patient	IVCH; TFH				Schopp, S.			February	August
HFAP NQF - Multidrug-Resistant Organism Prevention	IVCH; TFH				Schopp, S.			February	August
HFAP NQF - Catheter-Associated Urinary Tract Infection Prevention	IVCH; TFH				Schopp, S.			February	August

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Information Technology	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
	IVCH; TFH				O'Hanlon, J.			March	September
IVCH	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Nursing Services	IVCH		Internal	PIC	Iida, J			April	October
IVCH ED Overall Percentile Rank	IVCH		Internal	PIC	Iida, J				
Laboratory / Pathology	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Amended Report Rate Overall			Internal	PIC	Barnes, V.		0.15%	April	October
Blood Incompatibility			Internal	PIC	Barnes, V.		0%	April	October
Amended Report Rate TFH			Internal	PIC	Barnes, V.		0.15%	April	October
Amended Report Rate IVCH			Internal	PIC	Barnes, V.		0.15%	April	October
Amended Report Rate ONC			Internal	PIC	Barnes, V.		0.15%	April	October
Overall Rate of CBCs (Order to Result)<60Min			Internal	PIC	Barnes, V.		95%	April	October
Rate of STAT TFH CBCs (Order to Result)<60Min			Internal	PIC	Barnes, V.		95%	April	October
Rate of STAT IVCH CBCs (Order to Result)<60Min			Internal	PIC	Barnes, V.		95%	April	October
Overall Rate of CMPs (Order to Result)<70Min			Internal	PIC	Barnes, V.		95%	April	October
Rate of STAT TFH CMPs (Order to Result)<70Min			Internal	PIC	Barnes, V.		95%	April	October
Rate of STAT IVCH CMPs (Order to Result)<70Min			Internal	PIC	Barnes, V.		95%	April	October
Overall Rate of Troponins (Order to Result)<70Min			Internal	PIC	Barnes, V.		95%	April	October
Rate of STAT TFH Troponins (Order to Result)<70Min			Internal	PIC	Barnes, V.		95%	April	October

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Rate of STAT IVCH Troponins (Order to Result)<70Min			Internal	PIC	Barnes, V.		95%	April	October
Troponin Results received within 60 mins of ED arrival for AMI pts			Internal	PIC	Barnes, V.		100%	April	October
Overall Lab Error Rate			Internal	PIC	Barnes, V.		0.40%	April	October
Error Rate of TFH			Internal	PIC	Barnes, V.		0.40%	April	October
Error Rate of IVCH			Internal	PIC	Barnes, V.		0.40%	April	October
Error Rate of ONC			Internal	PIC	Barnes, V.		0.40%	April	October
Percent TFH Pre-Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent TFH Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent TFT Post Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent IVCH Pre-Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent IVCH Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent IVCH Post Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent ONC Pre-Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent ONC Analytical Errors			Internal	PIC	Barnes, V.			April	October
Percent ONC Post Analytical Errors			Internal	PIC	Barnes, V.			April	October
Rate of Inpatient routine MSN/ICU reports on unit by 7AM			Internal	PIC	Barnes, V.		90%	April	October
Rate of routine AM Labs Drawn in MSN/ICU by 6AM			Internal	PIC	Barnes, V.		90%	April	October
Top Box Outpatient Satisfaction with Lab Wait Times			Internal	PIC	Barnes, V.		90%	April	October
Number of Blood Cultures			Internal	PIC	Barnes, V.		0%	April	October
Lookback for Blood Transfusions			Internal	PIC	Barnes, V.			April	October
Rate of Contaminated Blood Cultures			Internal	PIC	Barnes, V.			April	October
Rate of TFH Staff Proficiency			Internal	PIC	Barnes, V.			April	October
Rate of IVCH Staff Proficient			Internal	PIC	Barnes, V.			April	October

Quality Plan Attachment C: QA/PI Reporting Measures

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2018 QA/PI Reporting Measures

Life / Safety	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Employee RACE response to Code Red	IVCH; TFH		Internal	PIC	Ruggerio, M.		100%	March	September
Regulatory Preventive Maintenance On Time Percentage	IVCH; TFH		Internal	PIC	Ruggerio, M.		100%	March	September
Non-Regulatory Preventive Maintenance On Time Percentage	IVCH; TFH		Internal	PIC	Ruggerio, M.		90%	March	September
Material Management	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH				Rouse, M.			March	September
Med Surg / Swing	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Receipt of Patient Right is present on chart	TFH		Internal	PIC	Milligan, K.		100%	January	July
Activities Evaluation Form is present and Complete	TFH		Internal	PIC	Milligan, K.		100%	January	July
Plan for Recreational Therapy is documented by Activities Coordinator	TFH		Internal	PIC	Milligan, K.		100%	January	July
Care Plan Conference held within 7-days of resident stay	TFH		Internal	PIC	Milligan, K.		100%	January	July
Admission Evaluation and Interim Care Plan Present and Completed	TFH		Internal	PIC	Milligan, K.		100%	January	July
TFH Swing/ECC Interdisciplinary Care Plan Present and Completed	TFH		Internal	PIC	Milligan, K.		100%	January	July
Plan of Care Initiated	TFH		Internal	PIC	Milligan, K.		100%	January	July
Baseline Pain Goal & Problem initiated for Patients in Pain	TFH		Internal	PIC	Milligan, K.		100%	January	July

	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
PRN Medications with proper frequency and dose	TFH		Internal	PIC	Milligan, K.		100%	January	July
Physician notified if pain goal not met	TFH		Internal	PIC	Milligan, K.		100%	January	July
PCA documentation appropriate	TFH		Internal	PIC	Milligan, K.		100%	January	July
Age related developmental needs assessments compliance	TFH		Internal	PIC	Milligan, K.		100%	January	July
MIPS	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH			PIC	Lockwood, D.		100%	February	August
MSC	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Time Cycle Study			Internal	PIC	Walker, S.		100%	June	December
Diabetes tracking			Internal	PIC	Walker, S.		100%	June	December
Influenza Vaccine			Internal	PIC	Walker, S.		100%	June	December
MSC Overall Percentile Rank			Internal	PIC	Walker, S.			June	December
Organ Donation	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
HFAP NQF - Organ Donation			Internal	PIC	Thomas, A.			January	July
Deaths			Internal	PIC	Davis, A.			January	July
Referrals			Internal	PIC	Davis, A.		100%	January	July
Missed Referrals			Internal	PIC	Davis, A.		0%	January	July
Donors			Internal	PIC	Davis, A.			January	July
Orthopedic Service Line	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	TFH		Internal	PIC	Coll, D.			May	November
PACU	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Phase II Recovery > 1.5 hours. plus reasons			Internal	PIC	Weeks, K.	Cooper, K.	5%	May	November

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Total number of outpatient surgeries			Internal	PIC	Weeks, K.	Cooper, K.			May	November
PRN Medication Administration Phase I			Internal	PIC	Weeks, K.	Cooper, K.			May	November
Number of PRE Pain Scales documented			Internal	PIC	Weeks, K.	Cooper, K.	100%		May	November
Number of POST pain scales/Effect Documented			Internal	PIC	Weeks, K.	Cooper, K.	100%		May	November
Number given with correct dose per orders			Internal	PIC	Weeks, K.	Cooper, K.	100%		May	November
Number given with correct frequency/interval per orders			Internal	PIC	Weeks, K.	Cooper, K.	100%		May	November
Total doses PRN Meds Administered			Internal	PIC	Weeks, K.	Cooper, K.			May	November
PRN Medication Administration Phase II			Internal	PIC	Weeks, K.	Cooper, K.			May	November
Number of PRE pain scales documented			Internal	PIC	Weeks, K.	Cooper, K.	100%		May	November
Number of POST pain scales/Effect Documented			Internal	PIC	Weeks, K.	Cooper, K.	100%		May	November
Number given with correct dose per orders			Internal	PIC	Weeks, K.	Cooper, K.	100%		May	November
Number given with correct frequency/interval per orders			Internal	PIC	Weeks, K.	Cooper, K.	100%		May	November
Total Doses PRN Meds Administered			Internal	PIC	Weeks, K.	Cooper, K.			May	November
Total Number of PACU's			Internal	PIC	Weeks, K.	Cooper, K.			May	November
Number of extended Stays - longer than 90 minutes			Internal	PIC	Weeks, K.	Cooper, K.			May	November
Unit not ready for patient - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.			May	November

	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Cardiac Dysrhythmia - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Catheterization - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Emergence Delirium - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
High Dermatome level - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Hemodynamic Instability - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Hemorrhage - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
IV Complications - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Pain Control - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Respiratory Insufficiency - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Nausea / Vomiting - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Unplanned Admission - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Other - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
No Reason - Reasons for Extended Stays			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Pain Clinic	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Patient Receiving Moderate Sedation			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Palliative Care	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
				PIC	Baker, S.	Schnobrich, B.		January	July

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Patient Registration	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
				PIC	Jefferson, C.			June	December
Patient Safety	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
			Internal	PIC	Lockwood, D.			February	August
Pharmacy	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
HFAP NQF - Medication Reconciliation	IVCH; TFH		Internal	PIC	Cooper, S.			January	July
HFAP NQF - Pharmacist Leadership Structure and Systems	IVCH; TFH		Internal	PIC	Cooper, S.			January	July
HFAP NQF - Anticoagulation Therapy	IVCH; TFH		Internal	PIC	Cooper, S.			January	July
Medication error rate (D+)	IVCH; TFH		Internal	PIC	Cooper, S.		5.00%	January	July
TFHS Medication Error Rate Category A+B	IVCH; TFH		Internal	PIC	Cooper, S.			January	July
TFHS ADR Reported	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
TFH Error Free Override Medication Rate	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Rate of Correctly resolved narcotic discrepancies	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Acute Warfarin Compliance	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Maintenance Warfarin Compliance	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Ketorolac Compliance	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July

	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Aminoglycoside Compliance	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Vancomycin Compliance	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
TPN Compliance	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Renal Function dosing appropriateness	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
Electrolyte Dosing Appropriateness	IVCH; TFH		Internal	PIC	Cooper, S.		100%	January	July
IVCH - Medication Error Rate	IVCH		Internal	PIC	Cooper, S.		0%	January	July
IVCH - Total Number of IVCH ADRs Reported	IVCH		Internal	PIC	Cooper, S.		100%	January	July
IVCH - Rate of Orders Documented on Log	IVCH		Internal	PIC	Cooper, S.		100%	January	July
IVCH - Rate of Medications Left for Audit	IVCH		Internal	PIC	Cooper, S.			January	July
Physician Services	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH				Steinberg, J.	Ward, R.		June	December
Rehabilitation Therapy	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Truckee PT-OP patients showing significant improvement on the Patient Specific Functional Scale			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
Tahoe City PT-OP patients meeting improvement criteria			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
Incline Village PT-OP patients meeting improvement criteria			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August

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OT Outpatients improving by 10% In the DASH			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
85% of patients after TKA and THA will score a '5' on the Walk section of the FIM (IP PT)			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
85% of patients after TKA and THA will score a '6' on the Dressing section of the FIM (IP OT)			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
Patient Overall Satisfaction Top Box Score (all facilities)(P)			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
Patient Satisfaction Top Box Score - Truckee			Internal	PIC	Solberg, R.	Oelkers, M.	90%	February	August
Patient Satisfaction Top Box Score - Tahoe City			Internal	PIC	Solberg, R.	Oelkers, M.	90%	February	August
Patient Satisfaction Top Box Score - Incline			Internal	PIC	Solberg, R.	Oelkers, M.	90%	February	August
Truckee Utilization - High & Expected Percentage			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Truckee Utilization - National Percentile Ranking			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Truckee Effectiveness - FS Change			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Truckee Effectiveness - Predicted			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Truckee Efficiency - Average number of Visits			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Truckee Efficiency - Average Predicted Visits			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Tahoe City Utilization - High & Expected Percentage			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
Tahoe City Utilization - National Percentile Ranking			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Tahoe City Effectiveness - FS Change			Internal	PIC	Solberg, R.	Oelkers, M.		February	August

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	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Tahoe City Effectiveness - Predicted			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Tahoe City Efficiency - Average number of Visits			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Tahoe City Efficiency - Average Predicted Visits			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Incline Utilization - High & Expected Percentage			Internal	PIC	Solberg, R.	Oelkers, M.	85%	February	August
Incline Utilization - National Percentile Ranking			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Incline Effectiveness - FS Change			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Incline Effectiveness - Predicted			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Incline Efficiency - Average number of Visits			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Incline Efficiency - Average Predicted Visits			Internal	PIC	Solberg, R.	Oelkers, M.		February	August
Respiratory Therapy	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
O2 Monitoring			Internal	PIC	Grosdidier, J.		100%	February	August
SBT monitoring trial			Internal	PIC	Grosdidier, J.		100%	February	August
Vent Patient with Stable FIO2 and PEEP			Internal	PIC	Grosdidier, J.		100%	February	August
O2 Ordering Compliance			Internal	PIC	Grosdidier, J.		100%	February	August
Restraints	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Initiation by unit			Internal	PIC	Davis, A.		100%	January	July
Initiation by day of week			Internal	PIC	Davis, A.		100%	January	July
Initiation by shift			Internal	PIC	Davis, A.		100%	January	July
Injury to patient or staff			Internal	PIC	Davis, A.		100%	January	July
Restraint-related death			Internal	PIC	Davis, A.		100%	January	July
Average length of episode (hours)			Internal	PIC	Davis, A.		100%	January	July

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2018 QA/PI Reporting Measures

Resuscitation Outcomes	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Total # of resuscitations			Internal	PIC	Davis, A.			January	July
Survival rate (12 hours) or transfer to higher level of care			Internal	PIC	Davis, A.		100%	January	July
Total # of critical incidents reported			Internal	PIC	Davis, A.		100%	January	July
Patient outcomes from critical incidents			Internal	PIC	Davis, A.			January	July
Critical incident event type			Internal	PIC	Davis, A.			January	July
Risk	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Total number of patient safety events	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August
Number of patient safety events per 1000 patient days	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August
Number of AMA from in-patient units per 1000 patient days	IVCH; TFH		Internal	PIC	Blumberg, C.		0%	February	August
Number of new professional liability (PL) claims	IVCH; TFH		Internal	PIC	Blumberg, C.		0%	February	August
Number of new PL claims for which the event is unknown prior to claim	IVCH; TFH		Internal	PIC	Blumberg, C.		0%	February	August
HFAP NQF - Leadership Structure and Systems	IVCH; TFH		Internal	PIC	Newland, J.			February	August
HFAP NQF - Culture Measurement, Feedback, and Intervention	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August
HFAP NQF - Teamwork Training and Skill Building	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August
HFAP NQF - Identification and Mitigation of Risks and Hazards	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August
HFAP NQF - Informed Consent	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August

HFAP NQF - Life-Sustaining Treatment	IVCH; TFH		Internal	PIC	Blumberg, C.			February	August
HFAP NQF - Direct Caregivers	IVCH; TFH		Internal	PIC	Blumberg, C.	Lockwood, D.		February	August
HFAP NQF - Care of the Caregiver	IVCH; TFH		Internal	PIC	Blumberg, C.	Lockwood, D.		February	August
HFAP NQF - Nursing Workforce	IVCH; TFH		Internal	PIC	Baffone, K.			February	August
HFAP NQF - Safe Adoption of Computerized Prescriber Order Entry	IVCH; TFH		Internal	PIC	Cooper, S.			February	August
Sleep Center	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH				Freeman, J.			May	November
SPD	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Total Loads (d)			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Immediate Use Cycles (n)			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Immediate Use Cycle Rate			Internal	PIC	Weeks, K.	Cooper, K.	10%	May	November
Surgery	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
HFAP NQF - Wrong-Site, Wrong-Procedure, Wrong-Person Surgery Prevention			Internal	PIC	Weeks, K.	Cooper, K.		May	November
ASD Overall Percentile Rank			Internal	PIC	Weeks, K.	Cooper, K.		May	November
DVT & Pulmonary Emboli following Ortho Surgery			Internal	PIC	Weeks, K.	Cooper, K.	0%	May	November
Foreign Object Retained After Surgery			Internal	PIC	Weeks, K.	Cooper, K.	0%	May	November
Total number of cases (d) - PREOP Antibiotic Administration			Internal	PIC	Weeks, K.	Cooper, K.		May	November

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Preop Antibiotics administered per policy (n) - PREOP Antibiotic Administration			Internal	PIC	Weeks, K.	Cooper, K.		May	November
ABX too early (n) - PREOP Antibiotic Administration			Internal	PIC	Weeks, K.	Cooper, K.		May	November
ABX too late(n) - PREOP Antibiotic Administration			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Number of Charts Audited (d) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
procedure correct (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
OR number correct (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
anesthesia provider correct (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
anesthesia type correct (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Surgery Start Time Correct (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Time out correct (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Surgical Safety Checklist Complete (n) - Documentation Measures			Internal	PIC	Weeks, K.	Cooper, K.		May	November
On time - Start Time			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Surgeon - Reason			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Anesthesiologist - Reason			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Labor Epidural - Reason			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Equipment - Reason			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Patient issue - Reason			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Other - Reason			Internal	PIC	Weeks, K.	Cooper, K.		May	November

	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Physician Timeliness, Opportunities - By physician			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Physician Timeliness, Total Late - By physician			Internal	PIC	Weeks, K.	Cooper, K.		May	November
Preop ABX administered on time plus reasons			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
ABX Too Early			Internal	PIC	Weeks, K.	Cooper, K.	0%	May	November
ABX Too Late			Internal	PIC	Weeks, K.	Cooper, K.	0%	May	November
OR Number Correct			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Anesthesia Provider Correct			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Anesthesia Type Correct			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Surgery Start Time Correct			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Time Out Correct			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Surgical Safety Checklist Complete			Internal	PIC	Weeks, K.	Cooper, K.	100%	May	November
Volunteer Services	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
	IVCH; TFH				Mazzini, A.			March	September
Wellness at Work	**Hospital Collected**	**Measure ID**	**Reporting Status**	**Reported To**	**Responsible**	**Appointed**	**Benchmark**	**First Report**	**Second Report**
Percentage of Cohort group with 0 or 1 risk factor			Internal	PIC	Buchanan, W.			February	August
Percentage of Cohort group with 2 risk factors			Internal	PIC	Buchanan, W.			February	August
Percentage of Cohort group with 3 risk factors			Internal	PIC	Buchanan, W.			February	August
Percentage of Cohort group with 4 risk factors			Internal	PIC	Buchanan, W.			February	August
Percentage of Cohort group with 5 risk factors			Internal	PIC	Buchanan, W.			February	August

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Women and Family - Obstetrics	Hospital Collected	Measure ID	Reporting Status	Reported To	Responsible	Appointed	Benchmark	First Report	Second Report
Neonatal Mortality Rate per 1000 live births	TFH		Internal	PIC	Blake, K.		70%	April	October
Primary Cesarean Section Rate	TFH		Internal	PIC	Blake, K.		19%	April	October
RN Deliveries	TFH		Internal	PIC	Blake, K.		0%	April	October
Scheduled Deliveries (elective inductions & C-Sections) >=37 wks and <39 Weeks	TFH		Internal	PIC	Blake, K.		0%	April	October
APGARS=<7@5min	TFH		Internal	PIC	Blake, K.			April	October
Weight=<1500 Grams	TFH		Internal	PIC	Blake, K.			April	October
Baby Friendliness Assessment	TFH		Internal	PIC	Blake, K.		80%	April	October
PPH≥1500	TFH		Internal	PIC	Blake, K.			April	October
Shoulder Dystocia	TFH		Internal	PIC	Blake, K.			April	October
Primary C-Section percentage	TFH		Internal	PIC	Blake, K.		19.00%	April	October
Medically Indicated Inductions	TFH		Internal	PIC	Blake, K.			April	October
CCHD Screen Negative	TFH		Internal	PIC	Blake, K.		99%	April	October
CCHD Screen Positive	TFH		Internal	PIC	Blake, K.		1%	April	October

Attachment D

2018 Quality Improvement Indicator Definitions

Indicator Title	CMS Core Measure #	Inclusive Of	Measurement Explanation and Notes
Patient Safety Index Detail	PSI-1 PSI-2 PSI-3 PSI-4	• Restraint usage percentage • Medication error rate (D+) • Pressure ulcer percentage • Inpatient falls per 1000 patient days	Medication error rate: Sum of medication errors that reached the patient & divide this sum by the total # of medications dispensed.
TFH Heart Attack Care	AMI-1 AMI-5 AMI-7a AMI-8 AMI-8a	• Aspirin at arrival • Beta Blocker prescribed at discharge • Fibrinolytic therapy within 30 minutes of arrival • Median Time to PCI • Primary PCI with/in 90 min of hospital arrival	Sum of times recommended evidence-base care was provided to patients & divide this sum by the total # of opportunities to provide this care.
Sepsis	SEP-1	Within three hours • Initial lactate measurement • Broad spectrum or other antibiotic • Blood cultures within 6 hours & prior to antibiotic • Repeat lactate level if elevated • 30 ml/kg crystalloid fluid • Vasopressors if hypotensive	
Immunizations	IMM-2	• Influenza Vaccine	Calculated for both TFH and IVCH. Sum of times recommended evidence-base care was provided to patients & divide this sum by the total # of opportunities to provide this care
Venous Thrombosis	VTE-1 VTE-2 VTE-3 VTE-5 VTE-6	Core Measures: • VTE Prophylaxis • ICU VTE Prophylaxis • VTE Patients with Anticoagulation Overlap Therapy • VTE Discharge Instructions • Incidence of potentially preventable VTE	VTE 6 is the measure required by CMS beginning CY 2018. We will continue to track compliance with VTE 1-5 through CY 2018 and will drop in CY 2019. VTE-1 is an eCQM we will use for Meaningful Use compliance.
		•	

Quality Plan Attachment D: QI Indicator Definitions

Emergency Department	ED-1a ED-1b ED-2a ED-2b	• Median time ED Arrival to ED departure for Admitted ED Patients – Overall Rate • Median time ED Arrival to ED departure for Admitted ED Patients – Report • Admit decision time to ED depart time for admitted patients – Overall Rate • Admit decision time to ED depart time for admitted patients – Report Measure	These are all eCQM measures and will be collected from Epic and submitted directly to our QIO every quarter.
Emergency Department	OP-18 OP-20 OP-21	• Median time ED arrival to ED departure for discharged ED patient • Door to door diagnostic evaluation by a qualified medical professional • Median time to pain management for long bone fracture	OP-20 and OP-21 will no longer be collected after 1Q18 for OQR. We typically do not abstract patients that fall into OP-1 or OP-4, but both of these will be removed from all cases beginning 2Q18. We do not typically abstract OP-25 or OP-26 patients, but both have been removed effective beginning 1Q18.
Excellent Care Index Detail	ECI-1 ECI-2 ECI-3 ECI-4	• Inpatient mortality percentage • Primary C-Section percentage • Medicare average LOS • ER Readmission within 72 hours with same diagnosis	
TFH Hospital Acquired Surgical Infection	IC-1	Class 1 surgical site infection rate	Sum of times surgical infection occurred & divide this sum by the total # of surgical cases classified as Class 1.
TFH Hospital Acquired Infection - Nonsurgical	HA-NSI-1 HA-NSI-2 HA-NSI-3 HA-NSI-4	• ICU CLR-BSI • Ventilator-Associated pneumonia • ICU Cath Associated Urinary Tract Infection • Health Care acquired MRSA (per 1000 patient days)	Sum of times hospital acquired infections occurred & divide this sum by the total # of opportunity days an infection could occur x 1000 pt. days

Quality Plan Attachment D: QI Indicator Definitions

Attachment D

2018 Quality Improvement Indicator Definitions

TFH Hospital Acquired Conditions		• Foreign object retained after surgery • Air Embolism • Blood incompatibility • DVT & pulmonary emboli following orthopedic surgery	Numbers of occurrences – since many of these HACs are never events.
Patient Satisfaction	PtS-1 PtS-2 PtS-3 PtS-4 PtS-5 PtS-6 PtS-7	• HCAHPS "Recommend this Hospital" Percentile Rank • HCAHPS "Rate this Hospital 9-or-10" Percentile Rank • Outpatient Percentile Rank • TFH ED Overall Percentile Rank • IVCH ED Overall Percentile Rank • ASD Overall Percentile Rank • MSC Overall Percentile Rank	
IVCH Infection Control	IVC-1	Class 1 Surgical Site Infection Rate	Sum of times surgical infection occurred & divide this sum by the total # of surgical cases classified as Class 1.
IVCH Average LOS	IVC-9	• Average Length of Stay	
IVCH Pressure Ulcers	IVC-10	• Pressure ulcer percentage	
IVCH Inpatient Falls	IVC-11	• Inpatient falls per 1000 patient days rate	
IVCH Restraint Usage	IVC-12	• Restraint usage per 100 patient days	
IVCH Laboratory	IVC-13	• STAT CBC TAT < 60 minutes	
IVCH Pharmacy	IVC-15	• Medication error rate	
IVCH Inpatient Mortality	IVC-16	• Inpatient mortality number	
Skilled Nursing Facility	LTC1 LTC4 LTC5 LTC6 LTC7	• Percent of patients who develop pressure ulcers • Residents with a urinary tract infection percentage • Percent of residents who experience unplanned weight loss • Percentage of Falls • SNF 5-Star Quality Rating	SNF Star Rating is calculated by CMS using a standardized algorithm.

Quality Plan Attachment D: QI Indicator Definitions

Attachment D

2018 Quality Improvement Indicator Definitions

Home Health	HH1 HH2 HH3 HH4 HH5 HH6 HH7 HH8 HH9 HH10	• Improvement in Pain • Improved Bathing • Improved Transferring • Improved Ambulation • Management of Oral Medications • Improve in Surgical Wounds • Patients with emergency care needs percentage • HHCAHPS - Rate this agency 9 or 10 • HHCAHPS - Recommend this agency • Compare Star Quality Rating	The Star Rating is calculated by CMS using a standardized algorithm.
Hospice	H1 H2 H3 H4 H5	• Match MAR vs Physician Orders • Follow through on assessed patient needs • Patients pain goals are met within 48 hours • Hospice Patient UTI Rate • Hospice Patient Vascular Device Infection Rate (TPD)	

Specifications Manual for National Hospital Quality Measures Discharges 01-01-18 through 12-31-18

Quality Plan Attachment D: QI Indicator Definitions

	Title	Acronym	Sponsor	Indicators
1	Collaborative Alliance for Nursing Outcomes (Voluntary) http://www.calnoc.org/	CALNOC	CHA	• Clinical Staffing • Patient falls (incidence) • Pressure ulcers (point prevalence) • Physical restraints (point prevalence) • CAUTI (NHSN) • CLABSI (NHSN) • MRSA (NHSN) • Clostridium difficile (NHSN) • *Infection prevention data submitted to CALNOC by NHSN*
2	National Database of Nursing Quality Indicators (Voluntary) http://www.pressganey.com/solutions/clinical-quality/nursing-quality	NDNQI		• Clinical Staffing • Patient falls (incidence) • Pressure ulcers (point prevalence) • *Data submitted to NDNQI by CALNOC*
3.	CA – Quality Healthcare Indicators www.qualityhealthindicators.org	QHi		• Participate in quarterly conference calls but are not submitting data due to participation in CMS Compare
4.	Nevada Flex Program http://med.unr.edu/rural-health/flex	Medicare Beneficiary Improvement Project (MBQIP)	CMS	• Emergency Department Transfer Communication (EDTC) • HCAHPS Inpatient Satisfaction
5.	Home Health Consumer Assessment of Providers and Systems (HHCAPs)	HHCAPS	CMS	• Care of patients • Communication between providers and patients • Specific care issues • % of patients who gave agency 9 or 10 • % patient who reported YES they would definitely recommend agency Star rating measures: • Improvement in ambulation • Improvement in bed transferring • Improvement in bathing • Improvement in pain • Improvement in Dyspnea • Timely initiation of care • Drug education all meds • Flu vaccine received • 60 day hospitalization

Quality Plan Attachment E: External Reporting

	Title	Acronym	Sponsor	Indicators
				• 30 day re hospitalization
6.	Hospice Quality Reporting Program (HQRP)	HQRP	CMS	• Care of patients • Hospice team communication • Getting timely care • Treating family member with respect • Providing emotional support • Getting help for symptoms • Getting hospice care training
7.	Hospital Care Quality Information from the Consumer Perspective (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html	HCAHPS	CMS AHRQ DHHS JC	• Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Cleanliness and Quietness of the Physical Environment • Pain Control • Communication About Medicines • Discharge Information
8.	Hospital Compare (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare.html		CMS HQA	• Heart attack care - 8 measures • VTE - 7 measures • Immunizations – 2 measures • Sepsis – 6 measures
9.	Nursing Home Compare https://www.medicare.gov/nursinghomecompare/search.html?		CMS	• Health & fire safety inspections • Staffing • Quality Measures • Penalties
10.	Home Health Compare https://www.medicare.gov/homehealthcompare/search.html		CMS	• General Information • Quality of Patient Care • Patient Survey Results
11.	National Healthcare Safety Network http://www.cdph.ca.gov/programs/hai/Pages/NHSNGuidanceSpecifictoCaliforniaHospitals.aspx	NHSN	CDPH	Statewide Indicators: • Central Line-associated Bloodstream Infection (CLABSI) • Methicillin-resistant Staphylococcus aureus (MRSA) Bloodstream Infection (BSI) • Vancomycin-resistant Enterococci (VRE) Bloodstream Infection (BSI) • Clostridium difficile infection (C. difficile, C. diff, CDI, CDAD) • Surgical Site Infection (SSI)

Quality Plan Attachment E: External Reporting

	Title	Acronym	Sponsor	Indicators
12.	Minimum Data Sets (MDS) 3.0 https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html	MDS	CMS	**Short Stay Quality Measures** • Percent of Residents who Self-Report Moderate to Severe Pain (Short Stay) • Percent of Residents with Pressure Ulcers that are New or Worsened (Short Stay) • Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) • Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Short Stay) • Percent of Short-Stay Residents Who Newly Received an Antipsychotic Medication **Long Stay Quality Measures** • Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) • Percent of Residents who Self-Report Moderate to Severe Pain (Long Stay) • Percent of High-Risk Residents with Pressure Ulcers (Long Stay) • Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (Long Stay) • Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Long Stay) • Percent of Residents with a Urinary Tract Infection (Long Stay) • Percent of Low-Risk Residents Who Lose Control of Their Bowels or Bladder (Long Stay) • Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long Stay) • Percent of Residents Who Were Physically Restrained (Long Stay) • Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay) • Percent of Residents Who Lose Too Much Weight (Long Stay) • Percent of Residents Who Have Depressive Symptoms (Long Stay) • Percent of Long-Stay Residents Who Received An Antipsychotic Medication

Quality Plan Attachment E: External Reporting

	Title	Acronym	Sponsor	Indicators
13.	Office of Statewide Planning & Development http://www.oshpd.ca.gov/	OSHPD	State of California	Statewide Indicators: • Prevention QI: avoidable IP admissions • Pediatric QI: avoidable IP admissions • IP QI: over or under use of procedures • Patient Safety: Preventable adverse events Facility Level Indicators: • IP Mortality • Volume Indicators • Utilization Indicators
14.	Outcome & Assessment Information Set http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html	OASIS	CMS	• Demographic information • History, Assessment and Social support • Diagnostic coding information • Clinical information upon transfer to acute • Discharge information
15.	Outcome Based Quality Improvement (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/HHQIOBQIManual.pdf	OBQI	CMS MedQIC	• Improvement in Bathing • Improvement in Transferring • Ambulation/Locomotion Improvement • Improvement in Mgmt. of Oral Meds • Improvement in Pain Interfering with Activity • Status Improvement-Surgical Wounds • Improvement in Dyspnea • Improvement in Urinary Incontinence • Acute Care Hospitalization • Discharge to Community

Quality Plan Attachment E: External Reporting

	Title	Acronym	Sponsor	Indicators
16.	California Hospital Innovation Improvement Network	CalHIIN	HQI	• Adverse drug events (ADE), to focus on at least the following three medication categories: opioids, anticoagulants, and hypoglycemic agent • Central line-associated blood stream infections (CLABSI) in all hospital settings, not just Intensive Care Units • Catheter-associated urinary tract infections (CAUTI) in all hospital settings, including avoiding placement of catheters, both in the emergency room and in the hospital • *Clostridium difficile* bacterial infection, including antibiotic stewardship • Injury from falls and immobility • Pressure Ulcers • Sepsis and Septic Shock • Surgical Site Infections (SSI), to include measurement and improvement of SSI for multiple classes of surgeries • Venous thromboembolism (VTE), including, at a minimum, all surgical settings • Ventilator-Associated Events (VAE), to include Infection-related Ventilator-Associated Complication (IVAC) and Ventilator-Associated Condition (VAC) • Readmissions
17.	Million Heart Initiative (Medi-Cal patients)	PRIME	CMS NQF PQRS	• NQF 0018: Controlling Blood Pressure • NQF 0068 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic • NQF 0028: Tobacco Assessment and Counseling • PQRS # 317 Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Quality Plan Attachment E: External Reporting

	Title	Acronym	Sponsor	Indicators
18.	Chronic Non-Malignant Pain Management (Medi-Cal Patients)	PRIME	CMS NQF	• NQF 0418: Screening for Clinical Depression and follow-up Patients screened for clinical depression using a standardized tool such as the PHQ2 AND, if positive, a follow-up plan is documented on the date of the positive screen. • Patients with Chronic Pain on long term opioid therapy checked in PDMPs • Treatment of Chronic Non-Malignant Pain with Multi-Modal Therapy: percentage of patients diagnosed with chronic pain prescribed multi-modal therapy • Alcohol and Drug Misuse (SBIRT) • Assessment and management of chronic pain: percentage of patients diagnosed with chronic pain who are prescribed an opioid who have an opioid agreement form and an annual urine toxicology screen documented in the medical record.
19.	EHR Incentive Program (2018) https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2018ProgramRequirements.html	MU	CMS	• Protect Patient Health Information • Clinical Decision Support • Computerized Provider Order Entry • ePrescribing • Patient Education • Medication Reconciliation • Patient Electronic Chart Access • Secure Messaging • Public Health Reporting • Clinical Quality Measures (eCQM's)
20.	MIPS/MACRA (2018) https://qpp.cms.gov/#/	MIPS/QPP	CMS	• Clinical Quality Measures (formerly PQRS) • Advancing Care Information (formerly Meaningful Use/MU) • Clinical Practice Improvement Activities • Cost

Quality Plan Attachment E: External Reporting

Quality Assurance / Performance Improvement (QA/PI) Plan
Priorities

2017	2018
• Top decile quality of care and patient satisfaction metric results.	• Top decile quality of care and patient satisfaction metric results with a focus on process improvement & performance excellence o Perfect Care Experience
• Sustain a Just Culture philosophy that promotes patient safety, openness, & transparency	• Sustain a Just Culture philosophy that promotes a culture of safety, transparency, and system improvement o Participate in Beta HEART (healing, empathy, accountability, resolution, trust) program
• Ensure Patient Safety across the entire Health System	• Ensure Patient Safety across the entire Health System with a focus on High Reliability Organizational thinking o Preoccupation with failure o Reluctance to simplify o Sensitivity to operations o Deference to expertise o Commitment to resilience
• Facilitate integrated continuum of care management system	• Implement user friendly incident reporting system with a goal to increase reporting of events • Identify best practice plan related to Co-Management of Hospitalized Patients
• Support Patient and Family Centered Care	• Support Patient and Family Centered Care and the Patient & Family Advisory Council
• Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies	• Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
• Implement the Epic electronic health record to enable integration of medical services at all levels of the organization	• Identify gaps in the Epic electronic health record implementation and develop plans of correction • Maximize Epic reporting functionality to improve data capture and identification of areas for improvement
• Achieve Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Project Initiatives	• Achieve Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Project Initiatives

PSNet
PATIENT SAFETY NETWORK

Ո **Patient Safety Primer**   Last Updated: November 2017

High Reliability

Background

High reliability organizations are organizations that operate in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures. The concept of high reliability is attractive for health care, due to the complexity of operations and the risk of significant and even potentially catastrophic consequences when failures occur in health care. Sometimes people interpret high reliability as meaning effective standardization of health care processes. However, the principles of high reliability go beyond standardization; high reliability is better described as a condition of persistent mindfulness within an organization. High reliability organizations cultivate resilience by relentlessly prioritizing safety over other performance pressures. A classic example is that of the military aircraft carrier: despite significant production pressures (aircrafts take off and land every 48 –60 seconds), constantly changing conditions, and hierarchical organizational structure, all personnel consistently prioritize safety and have both the authority and the responsibility to make real-time operational adjustments to maintain safe operations as the top priority.

Characteristics of High Reliability Organizations

High reliability organizations use systems thinking to evaluate and design for safety, but they are keenly aware that safety is an emergent, rather than a static, property. New threats to safety continuously emerge, uncertainty is endemic, and no two accidents are exactly alike. Thus, high reliability organizations work to create an environment in which potential problems are anticipated, detected early, and virtually always responded to early enough to prevent catastrophic consequences. This mindset is supported by five characteristic ways of thinking: preoccupation with failure; reluctance to simplify explanations for operations, successes, and failures; sensitivity to operations (situation awareness); deference to frontline expertise; and commitment to resilience (Table).

Table. Characteristics of High Reliability.

Characteristic	Description
Preoccupation With Failure	Everyone is aware of and thinking about the potential for failure. People understand that new threats emerge regularly from situations that no one imagined could occur, so all personnel actively think about what could go wrong and are alert to small signs of potential problems. The absence of errors or accidents leads not to complacency but to a heightened sense of vigilance for the next possible failure. Near misses are viewed as opportunities to learn about systems issues and potential improvements, rather than as evidence of safety.
Reluctance to Simplify	People resist simplifying their understanding of work processes and how and why things succeed or fail in their environment. People in HROs* understand that the work is complex and dynamic. They seek underlying rather than surface explanations. While HROs recognize the value of standardization of workflows to reduce variation, they also appreciate the complexity inherent in the number of teams, processes, and relationships involved in conducting daily operations.
Sensitivity to Operations	Based on their understanding of operational complexity, people in HROs strive to maintain a high awareness of operational conditions. This sensitivity is often referred to as "big picture understanding" or "situation awareness." It means that people cultivate an understanding of the context of the current state of their work in relation to the unit or

	organizational state—i.e., what is going on around them—and how the current state might support or threaten safety.
Deference to Expertise	People in HROs appreciate that the people closest to the work are the most knowledgeable about the work. Thus, people in HROs know that in a crisis or emergency the person with greatest knowledge of the situation might not be the person with the highest status and seniority. Deference to local and situation expertise results in a spirit of inquiry and de-emphasis on hierarchy in favor of learning as much as possible about potential safety threats. In an HRO, everyone is expected to share concerns with others and the organizational climate is such that all staff members are comfortable speaking up about potential safety problems.
Commitment to Resilience	Commitment to resilience is rooted in the fundamental understanding of the frequently unpredictable nature of system failures. People in HROs assume the system is at risk for failure, and they practice performing rapid assessments of and responses to challenging situations. Teams cultivate situation assessment and cross monitoring so they may identify potential safety threats quickly and either respond before safety problems cause harm or mitigate the seriousness of the safety event.

*HROs: High reliability organizations

Sources: Weick et al 2007; Hines et al 2008; Chassin et al 2013; Rochlin 1999.

Current Context

It is important to recognize that standardization is necessary but not sufficient for achieving resilient and reliable health care systems. High reliability is an ongoing process or an organizational frame of mind, not a specific structure. AHRQ has outlined practical strategies for health care organizations aiming to become highly reliable in their report of practices employed by hospitals in the High Reliability Organization Learning Network. The Joint Commission suggests that hospitals and health care organizations work to create a strong foundation before they can begin to mature as high reliability organizations. Such foundational work includes developing a leadership commitment to zero-harm goals, establishing a positive safety culture, and instituting a robust process improvement culture. The Joint Commission also provides metrics for

assessing the maturity of an organization's leadership, safety culture, and process improvement culture as preconditions to high reliability.

Editor's Picks

▉ CASE

Wrong-side Bedside Paravertebral Block: Preventing the Preventable

≡ JOURNAL ARTICLE › STUDY

Journey toward high reliability: a comprehensive safety program to improve quality of care and safety culture in a large, multisite radiation oncology department.
Woodhouse KD, Volz E, Maity A, et al. J Oncol Pract. 2016;12:e603-e612.

▉ JOURNAL ARTICLE › COMMENTARY

Creating highly reliable accountable care organizations.
Vogus TJ, Singer SJ. Med Care Res Rev. 2016;73:660-672.

▟ BOOK/REPORT

Leading High-Reliability Organizations in Healthcare.
Morrow R. Boca Raton, FL: Productivity Press; 2016. ISBN: 9781466594883.

▟ BOOK/REPORT

Managing the Unexpected: Sustained Performance in a Complex World, 3rd edition.
Weick KE, Sutcliffe KM. San Francisco, CA: John Wiley & Sons; 2015. ISBN: 9781118862414.

≡ JOURNAL ARTICLE › STUDY

Seeking high reliability in primary care: leadership, tools, and organization.
Weaver RR. Health Care Manage Rev. 2015;40:183-192.

≡ JOURNAL ARTICLE › STUDY

Health care huddles: managing complexity to achieve high reliability.
Provost SM, Lanham HJ, Leykum LK, McDaniel RR Jr, Pugh J. Health Care Manage Rev. 2015;40:2-12.

≡ JOURNAL ARTICLE › STUDY

High-reliability health care: getting there from here.
Chassin MR, Loeb JM. Milbank Q. 2013;91:459-490.

◉ PERSPECTIVE

Update on Safety Culture

■ JOURNAL ARTICLE › COMMENTARY

Building high reliability teams: progress and some reflections on teamwork training.

Salas E, Rosen MA. BMJ Qual Saf. 2013;22:369-373.

■ CASE

Right Regimen, Wrong Cancer: Patient Catches Medical Error

◢ BOOK/REPORT

Becoming a High Reliability Organization: Operational Advice for Hospital Leaders.

Hines S, Luna K, Lofthus J, Marquardt M, Stelmokas D. Rockville, MD: Agency for Healthcare Research and Quality; February 2008. AHRQ Publication No. 08-0022.

■ JOURNAL ARTICLE › COMMENTARY

Creating high reliability in health care organizations.

Pronovost PJ, Berenholtz SM, Goeschel CA, et al. Health Serv Res. 2006;41:1599-1617.

■ JOURNAL ARTICLE › COMMENTARY

Risk mitigation in large scale systems: lessons from high reliability organizations.

Grabowski M, Roberts KH. Calif Manage Rev. 1997;39:152-162.

2018 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 Dept.	Discussion/ Status	Process Improvement
1/16/2018	**Introductions**		Everyone introduced themselves and stated what they have gotten out of the PFAC during the time they have been on it.	
	Wendy Buchanan	**Center for Health**	Center for Health and Wellness Presentation of Programs and shared brochure filled with courses for wellness. She talked about the 2 grants we received to help patients with substance abuse/ addiction and we have had 17 patients participate in this new program with 16 patients successfully off specific substances for several months. We also received a grant for community health programming and identify via a community survey what our biggest opportunities for community health education are. In our community the survey identified Nutrition, Substance abuse and exercise as the biggest areas of health coaching opportunities. So programs are targeted to our community in these specific areas. We discussed how some of the programming is free but not all of it. The council suggested that in the brochure we could identify which classes are Free of charge and which you need to call.

The education and courses are focused in 4 areas, Motivate, Move, Eat and Restore. Along with specific areas for new moms, and breastfeeding, etc. The council suggested that we need to look at ways to get these courses and brochure out to the community. Some of the Advisors were not aware of all the courses available. Wendy stated that she is working with Marketing to better communicate all that is offered. Wendy also presented the Customer Care Navigators program and discussed that it is fairly new and growing day by day as a resource to both physicians as | **Market Courses to Community**

Consider putting pricing information in brochure or at least the free classes state Free and the ones you pay for say call for pricing.

Market Navigators to community |

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			well as the community to help navigate health needs in our community. This role changed from front "office staff" to non-clinical Navigators. They work 7 days a week and field phone calls from physicians and patients who have questions about services and how to access what they need. They are not able to actually schedule appointments for patients, however they can direct them to that service. They also do not handle any billing questions or concerns but give the patients the information they need to call someone who can help with those issues. The Navigator role started last February 2017 and in the first few months fielded about 6 calls per month, and now they handle about 80 calls per month. The navigator services will be expanding to Tahoe City soon. There is some cross over of services between the cancer center and center for health, which came up as question from the group.	
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	Ryan Solberg	**Center for Health, PT, OT, ST and Wound Care**	6:25 pm Ryan Solberg presented his role as Director over Physical therapy, Occupational therapy, speech therapy and wound care services. He spoke about our change in the electronic medical record system to EPIC and how that has changed our work flow in PT, OT and ST. Although it is a change, it is going to be very helpful for his clinicians to see records for their patients wherever they have been seen prior to coming to our facility. His focus is on the quality of the care his clinicians provide as well as being fully transparent with pricing and the patients care plan. In June we will be remodeling this clinic site in Truckee which should help with flow of check in and check out. One of the Advisors asked about employee moral given the change in leadership over these therapy services. Ryan says they have been discussing this at staff meetings and he feels it has improved. He agreed it is something he continues to monitor and work to improve again quality, moral and transparency of pricing and services. Input by Council	**Include patients on care plan when possible.** **Transparency of Cost of treatment**

3

	Lorna Tirman	Quality/ Patient Experience	New Member Search Two prospective members came to the meeting to see what the PFAC is about to decide if they want to be involved. Patti Johnson and Helen Shadowens. If they decide to pursue their application we will consider them using the Charter Interview protocol.	**New Flyers in all MD offices.** **Two guest members attended and will go to interview step**
	Lorna Tirman	Quality/ Patient Experience	Meeting was adjourned following lots of discussion around Wellness center programming as well as PT services.	
	Lorna Tirman	Quality/ Patient Experience	Next Meeting February 20 , 2018 Will review Charter, role of advisors and 2018 goals and direction of PFAC for this year.	**Lorna Tirman to train on Charter, Advisor Role and guide discussion on 2018 Goals for PFAC to align with goals of health system.**

4

Origination Date:	*04/2001*
Last Approved:	*03/2017*
Last Revised:	*03/2017*
Next Review:	*03/2018*
Department:	*Board - ABD*
Applies To:	*System*

TAHOE FOREST HEALTH SYSTEM

ABD-10 Emergency On-Call

PURPOSE:

Tahoe Forest Hospital District has an ethical, moral, social, and legal responsibility to provide screening examination and care to patients presenting to its facilities with emergency conditions. The Board understands the Emergency Medical Treatment and Active Labor Act ("EMTALA" or "Act"), and federal and state regulations, require hospitals with a dedicated emergency department to maintain a list of physicians who are on call to come to the hospital and provide treatment as necessary to stabilize an individual with an emergency medical condition, within the capabilities of the District.

POLICY:

A. Patients who present to the Tahoe Forest Hospital District facilities requesting emergency care are entitled to a "Medical Screening Examination" as described in the Act, regardless of their ability to pay.

B. The District's Board of Directors, Administration and Medical Staff leadership will work collaboratively to determine the District's capabilities for providing 24-hour emergency health care.

C. Tahoe Forest Hospital District operates Tahoe Forest Hospital and Incline Village Community Hospital.

   1. Tahoe Forest Hospital (TFH), a Critical Access Hospital has been licensed by the State of California to provide Basic Emergency Services. TFH will provide on-call physician coverage in the Emergency Department for the basic services and supplemental services listed on the hospital license:

      a. Emergency Medicine

      b. General Medicine

      c. General Surgery

      d. Radiology

      e. Anesthesia

      f. Pathology

      g. OB/Gyn

      h. Pediatrics

      i. Orthopedics

   2. Incline Village Community Hospital, in Incline Village, Nevada will provide 24-hour physician coverage for Emergency and Medicine Services.

   3. TFH may provide specialty activation coverage for emergency consultations and services according

to the capabilities of members of the medical staff who have privileges in that specialty.

D. The Chief Executive Officer will work with the Medical Staff to provide emergency consultative coverage that meets federal and state laws, licensing requirements and the needs of the community. To achieve these goals, the Chief Executive Officer may utilize, but not be limited to:

   1. Stipends for call coverage

   2. Contracts for professional services

   3. Locum tenens privileges

   4. Transfer agreements with other healthcare facilities

E. At least annually, Tahoe Forest Hospital District Board of Directors will review and approve the level of emergency on-call services available. We will utilize the hospital's quality assurance system to monitor emergency on-call practices.

F. In order to provide this coverage, every effort will be made to create a system that is voluntary, fair and equitable without imposing an undue burden on physicians or on the Tahoe Forest Hospital District. Collaboration with current members of the Tahoe Forest Hospital District's Medical Staff will be the preferred method for providing these services, with recruitment of new physicians as needed.

G. Physicians who seek charity care fund reimbursement at Medicare rates for emergency services provided in the hospital to indigent patients, should refer to *Financial Assistance Program Full Charity Care And Discount partial Charity Care (ABD-09)* for guidance and distribution criteria. Tahoe Forest Hospital District will keep abreast of other funds, state or otherwise, that might be available for the purpose of providing payment to physicians who treat the under/uninsured population.

H. A roster and procedure are in place to address the provision of specialty medical care when services are needed which are outside the capabilities of the Tahoe Forest Hospital District and its Medical Staff.

| Related Policies/Forms: Emergency Condition: Assessment and Treatment Under EMTALA/COBRA, AGOV-18 |
| References: EMTALA-California Hospital Association manual |
| Policy Owner: Clerk of the Board |
| Approved by: Chief Executive Officer |

All revision dates: 03/2017, 11/2015, 01/2014, 01/2012, 02/2010

Attachments:
No Attachments

Approval Signatures

Step Description	Approver	Date
	Harry Weis: CEO	03/2017
	Martina Rochefort: Clerk of the Board	03/2017

General Acute Care Hospital Relicensing Survey (GACHRLS)

Janet Van Gelder, RN, DNP, CPHQ

Director of Quality & Regulations

Survey Objective

- Required by statute H & S 1279

- Promote and ensure quality of care in hospitals

- Verify compliance with State statutes and regulations

- Ensure program wide consistency in the survey methodology

Survey specifics

- Unannounced survey will occur no less than every three years

- Currently follow the MERP survey consultant schedule

- 3-5 day survey depending on the size and complexity of the hospital

- Evaluate compliance with statutory & regulatory requirement, especially those related to quality of care

- Review Nursing, Pharmacy, and any identified compliance concern from previous surveys or substantiated patient complaints

- Review current nursing staffing on the day of the survey

- Team consists of an RN, Medical, Nutrition, Pharmacy Consultant

Survey specifics (cont.)

- Patient record review 6-10% of the current inpatient census with a minimum of 30 patient record reviews

- Entrance conference to review their schedule and request documents

- Survey inpatient, outpatient, and other services

- Observe and Interview patients and staff

- Team will review findings and determine potential administrative penalties (minor violation; severity level 1-6)

- CMS may be contacted if surveyors identify COP violations or immediate jeopardy (IJ) situations

- Exit conference

- Written report within 10 business days or 30 if a non-IJ

Resources

- G: Public: Accreditation Materials: CDPH: GACHLRS

- https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/GeneralAcuteCareRelicensingSurvey.aspx

- Staff Education include trifold; staff meetings; electronic mail

California Department of Public Health

Center for Health Care Quality
General Acute Care Hospital Relicensing Survey
Process Guidance

Definition of a General Acute Care Hospital (GACH)

A GACH means a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services (Health and Safety Code §1250(a)).

Authority

Health and Safety Code §1254 provides that the California Department of Public Health (CDPH), Licensing and Certification Program (L&C) has the authority to inspect and license health facilities to provide their respective basic services and to approve a general acute care hospital to provide special services.

Health and Safety Code §1279 provides that every health facility for which a license or special permit has been issued shall be periodically inspected by the department or by another government entity under contract with the department. Inspections shall be conducted no less than every three years and as often as necessary to ensure quality of care.

The statutory requirements for GACH licensure are defined in California Health and Safety Code, Division 2, Chapter 2, Articles 1 through 10, and Chapter 2.05, as well as additional sections identified in the GACH Comprehensive Licensing Survey Guidelines.

The regulatory requirements for GACH licensure, including supplemental service approval are defined in Title 22, California Code of Regulations, Division 5, Chapter 1, relating to General Acute Care Hospitals, §70001-70923.

Purpose of GACH Relicensing Survey

The purpose of a GACH Relicensing Survey is to promote quality of care in hospitals, verify compliance with state statutes and regulations, and ensure a program wide consistency in the hospital survey methodology. In order to ascertain compliance, hospitals are surveyed no less than every three years using the GACH Relicensing Survey. The GACH Relicensing Survey incorporates elements of the former stand-alone Medication Error Reduction Plan (MERP) survey and Patient Safety Licensing Survey (PSLS).

The GACH Relicensing Survey will not be used in place of the GACH Initial Licensing Survey.

3/11/16

Survey Protocol

All GACH Relicensing Surveys shall include, but not be limited to the facility's compliance with statutory and regulatory requirements of licensure, particularly those addressing quality of care. Each survey will consist of a review of nursing services, pharmacy, and identified compliance concerns obtained during offsite preparation. CDPH will not provide GACHs with advance notice of the survey.

Task 1	Off-Site Survey Preparation (pg. 3)
Task 2	Entrance Activities (pg. 5)
Task 3	Information Gathering/Investigation (pg. 6)
Task 4	Preliminary Decision Making and Analysis of Findings (pg. 10)
Task 5	Exit Conference (pg. 11)
Task 6	Post-Survey Activities (pg. 13)

Survey Team

Composition. The recommended team size shall be comprised of a Registered Nurse, Medical Consultant*, and Pharmaceutical Consultant. At least one member of the team must have knowledge and experience in evaluating hospital administration and environmental inspections. Additional members will be added based on the size of the hospital, facility's compliance history, number and complexity of approved supplemental services, distance of locations that will be visited during the survey, and if indicated, those with subject matter expertise to evaluate facility operations (e.g. nutrition consultant, medical record consultant, rehabilitation therapist, Life Safety Code personnel, etc.).

Size. Team size is based upon the number of beds, number of campuses, units/locations, services to be surveyed, compliance history, and other pertinent factors. To determine the team size and composition, the initial team size starts with the following:

Size of Hospital	Recommended Minimum Survey Team
Small – 100 beds or less	- Registered Nurse (RN) (Team Coordinator) - Medical Consultant * - Nutrition Consultant* - Pharmaceutical Consultant - Additional RN surveyor with experience, if the Team Coordinator does not have knowledge and experience in evaluating hospital administration and environment - Additional team members as indicated
Medium – 101 -199 beds	- Registered Nurse (RN) (Team Coordinator) - Medical Consultant * - Nutrition Consultant* - Pharmaceutical Consultant - Two additional RN surveyors, at least one with experience, if the Team Coordinator does not have knowledge and experience in evaluating hospital administration and environment - Additional team members as indicated

Size of Hospital	Recommended Minimum Survey Team
Large – 200 or more beds	- Registered Nurse (RN) (Team Coordinator) - Medical Consultant * - Nutrition Consultant* - Pharmaceutical Consultant - Three additional RN surveyors, at least one with experience if the Team Coordinator does not have knowledge and experience in evaluating hospital administration and environment. Additional team members as indicated

* Medical Consultant and Nutritional Consultant may be onsite or remote.

Survey Team Coordinator

The GACH Relicensing Survey is performed under the leadership of a Team Coordinator. The Team Coordinator is responsible for ensuring that all survey preparation and survey activities are completed.

The responsibilities of the Team Coordinator include, but are not limited to:
- Scheduling the date and time of the survey activities
- Serving as spokesperson for the team
- Planning and coordinating survey plan, including identifying team members' responsibilities.
- Assist with managing process and time
- Fostering on-going communication among team members and hospital staff.
- Evaluating team progress and coordinating daily team meetings
- Coordinating any on-going conferences with hospital leadership and providing on-going feedback, as appropriate to hospital leadership on the status of the survey
- Coordinating Entrance Conference
- Facilitating Preliminary Decision Making
- Coordinating Exit Conference
- Coordinating the preparation of the Statement of Deficiencies and any other Task 6 documentation
- Delegating any items to survey team members as needed

When is a GACH Relicensing Survey indicated?
- No less than every three years; and/or,
- As often as necessary to ensure quality of care

Task 1   Off-Site Survey Preparation

The purpose of this task is to analyze information about the hospital in order to develop a plan for investigation that considers both the best approach for inspecting the facility's unique layout and/or multiple campuses, and that will address any identified areas of potential concern.

Pre-Survey Analysis and Planning

The Team Coordinator should review and consider any past non-compliance trends or recurrent issues as can be identified in the hospital's facility file and/or are available in the databases available to L&C surveyors. The following lists are intended to help to identify documents or information that the Team Coordinator should review and/or provide to the other team members, as may be useful to the team. The district office support staff should be notified of the survey, and produce a survey shell to include team member names and all applicable regulation sets.

Information from Hospital's File: License
- Basic services and supplemental services
- Number of beds, including any that may be on suspense
- Outpatient services
- Facility layout (including any negative pressure rooms) and locations of outpatient services
- Program flexibility approvals
- New construction or services
- Hospital website

Information from Hospital's File: Past Three Years' Compliance
- Substantiated adverse events
- Administrative Penalties (Breaches, Immediate Jeopardy, Failure to Report)
- Medication Error Reduction Plan surveys
- Complaints and Entity Reported Incidents (ERIs) (note locations of any complaint related to failure to meet the staffing ratios)
- Patient Safety Licensing Survey
- ELMS facility profile report
- Current situation reports
- Recertification or validation surveys (particularly any Condition Level findings)

Documents for Team members
- Facility license
- Facility layout (determine the number of campuses to be surveyed)
- Other documents as needed

Off-Site Survey Team Meeting
The Team Coordinator will convene an off-site meeting (may be a teleconference) in advance of the survey with as many of the survey team members as possible. During this meeting, the Team Coordinator will provide information about and facilitate discussion of the survey plan. This may include, but is not limited to:

- Written summary of identified issues for team members
- Process of General Acute Care Relicensing Survey and all relevant (and available) survey tools
- Survey roles and responsibilities for each team member
- The list of required hospital documents that the Team Coordinator will provide the hospital administration upon entrance

- Number of and type of patient assignments/units to be surveyed based on compliance history, and other areas of concern
- Pertinent State and Federal Statements of Deficiencies/Plans of Corrections (POCs)
- Means of contact for all team members during the survey (best telephone numbers, email addresses, etc.)
- Date, location and time team members will meet to enter the facility
- Date, location and time for the daily team meetings
- Potential exit date and time for the exit conference
- Post-survey document preparation timelines and expectations

Task 2   Entrance Activities

The purpose of this task is to explain the survey process to the hospital, introduce the survey team members, and to obtain information needed to conduct the survey.

Arrival

The entire survey team should enter the hospital together, and the surveyors should present their business cards/identification. The Team Coordinator will inform the hospital administrative designee in charge at the time of entrance that a General Acute Care Relicensing Survey is being conducted.

Entrance Conference

The entrance conference sets the tone for the entire survey. The team must be courteous and professional when requesting items needed for the team. The entrance conference should be specific, brief, and concise. Introductions of the survey team can be done by the Team Coordinator or by the individual survey team members. If other disciplines/consultants are to join the survey at a later time, inform the hospital's administration.

During the entrance conference, the Team Coordinator will:
- Introduce members of the survey team
- Explain the purpose and scope of survey
- Explain the survey process, the facility and file access that surveyors must have, and the confidentiality of interviews with patients, family, and staff
- Provide the general schedule of services to be reviewed during the survey
- Provide the Entrance List
- Determine how surveyors will access electronic medical records (EMR) and request staff resources to assist surveyors
- Verify licensing information and services
- Request a meeting area for the survey team to use during the survey
- Request a conference call system, if necessary, when more than one campus in a consolidated license is being surveyed to facilitate communication

Hospital Tours

A group tour of the hospital could consume a number of hours allocated to conduct the survey. Refrain from engaging in formal hospital guided tours.

Team Meeting

After the entrance conference with the hospital administrative staff, the team will evaluate the information gathered and modify the surveyor assignments as needed. During this on-site team meeting, the team members will:

- Review the scope of hospital services
- Identify/confirm hospital locations to be surveyed, including any off-site locations
- Set the next team meeting time and date

Additionally, the Team Coordinator will remind all team members that observations drive the investigation and survey process and that they are to:

- Follow sampled patients through hospital settings: surgery, radiology/imaging, etc. to determine appropriateness of the care and services rendered
- Observe individual treatments, care, and interaction with hospital staff
- Review closed records as indicated or if no open records are available

Sample Size and Selection

In selecting the patient sample, the individual surveyors will select patients from the service areas to which the surveyors are assigned. The patient selection should represent a cross-section of the patient population and the services provided by the facility. A total sample size will consist of 6 to 10% of the current inpatient census with a minimum of 30 patients for patient record review, and expand the sample size as necessary. For a facility with an inpatient census of fewer than 30 patients, the minimum sample selection of 30 patients shall include closed records.

Whenever possible, select patients who are in the facility during the time of the survey. Open records allow surveyors to conduct a patient-focused survey and enable surveyors to validate the information obtained through observations, record reviews, and interviews with patient/staff/family.

Observations of the sample patient will determine how the surveyor proceeds with patient reviews and surveying units/locations and services.

Task 3   Information Gathering/Investigation

The purpose of this task is to determine compliance with the statutory and regulatory requirements for GACH relicensure and/or supplemental service approval in California. The survey team will perform this task through observation, interviews, and document review.

During the Survey

In performing this task, all members of the survey team are expected and required to:

- Focus attention on actual and potential patient outcomes and patient safety, as well as, required processes. In the case of findings of patient harm, the team should consider the severity and scope of the harm

- Assess the care and services provided, including the appropriateness of the care and services within the context of the regulations
- Visit patient care settings as decided by the survey team, including inpatient units, outpatient clinics, anesthetizing locations, emergency departments, imaging, rehabilitation, remote locations, satellites, etc.
- Observe the actual provision of care and services to patients and the effects of that care in order to assess whether the care provided meets the needs of the individual patient
- Bring significant issues or adverse events to the Team Coordinator's attention immediately. Use the State IJ Policy and Procedure (P&P) if Immediate Jeopardy is suspected
- Respect patient privacy and maintain patient confidentiality at all times
- Be in daily contact with the Team Coordinator and other team members (ideally at a daily team meeting) to communicate survey progress and areas of concern
- Maintain a professional working relationship with facility staff, including conferencing with facility staff regarding survey findings (which may allow them to present additional information or offer explanations for identified issues)
- Exercise discretion as to whether to allow facility staff to accompany surveyors performing survey tasks

Survey Locations
Survey departments, services, and locations that are identified on the facility license. Decide as a team which units/services will be visited in order to address compliance decisions.

- The consideration to visit services and locations could include: departments, services, and locations on the primary hospital campus and/or immediately adjacent to the primary hospital campus
- Inpatient care locations of the hospital
- Outpatient surgery locations of the hospital
- Locations where complex outpatient services, including emergency care, is provided by the hospital
- Supplemental service locations

Additional sites may be added, depending on how sampled patients interact with hospital services and/or if the team becomes aware of off-campus services to which licensing requirements apply that are not identified on the facility license.

Patient Review
The hospital survey should include a comprehensive review of basic care and services received by each patient in the sample. This entails:

- Observations of care/services provided to the patient
- Patient and/or family interview(s)
- Staff interview(s)
- Medical record review

The data gathered from these means must be integrated to develop the survey findings.

Page **7** of **13**

Observations. Observation is the best means of collecting first-hand knowledge of hospital practice. Surveyors should remain alert to all opportunities to note observations relevant to patient care, regardless of the specific activity in which they are engaged. For example, while conducting a chart review, a surveyor should simultaneously remain alert to the environment and patients in the surveyor's immediate vicinity, noting staff interactions, as well as, safety hazards or infection control practices employed. Additionally, surveyors should take all opportunities to note observations regarding staffing sufficiency, equipment condition, building structure, sounds and smells, and the security and confidentiality of medical records.

Observations must be noted with as much detail as possible. The following data are especially important to document: the date and time of observation; location; individuals present during observation; and activity being observed (such as the type of treatment modality, therapy, etc.). The validity of a surveyor's observation is greatly increased by verification. Surveyors are encouraged to verify their observations with the patient, family, facility staff, other survey team members, or by other means. For example, a surveyor who observed administration of an outdated medication should validate the observation by asking a nursing staff member to verify that the drug is outdated.

Except in certain circumstances, surveyors must not examine patients in order to determine the patient's health status or assess whether appropriate health care is being provided. Acceptable circumstances include ensuring a patient's welfare where he/she appears to be in immediate jeopardy. When a patient's examination is relevant to the survey, the surveyor may request that a patient is examined by a staff member of the facility in the surveyor's presence, but only after obtaining the patient(s)/family(ies) permission. The health and dignity of the patient must always be the survey team's first concern. Surveyors must respect a patient's right to refuse to be examined.

When a patient does provide permission, surveyors must:
- Introduce him/herself to the patient
- Interview the patient, staff, and family members, as appropriate, to determine if care needs are being met and verify observations

Interviews. Interviews are another method for collecting information and are useful for verifying or validating information obtained through observations. Throughout the survey, surveyors should take every opportunity to conduct informal interviews for the purposes of determining what additional observations, interviews, and record reviews may prove useful.

When conducting patient interviews, it is essential that the interviews are conducted in private and with the patient(s)/family(ies) prior permission. Patient interviews should include questions specific to the patient's condition, reason for hospital admission, quality of care received, and the patient's knowledge of their plan of care. For instance, a surgical patient should be asked about the process for surgery preparation, his or her knowledge of and consent for the procedure, pre-operative patient teaching, and post-operative patient goals and discharge plan. In general, all patient interviews should include questions designed to assess patients' knowledge of their plans of care, the implementation of those plans, and the quality of the services received. It is also important to ask questions of both patients and family members regarding their knowledge of patient rights, advanced directives, and the facility's grievance/complaint procedure.

When conducting staff interviews, it is important to elicit the desired information quickly and succinctly, out of respect for staff time and in order to return them to patient care. Taking the time to

anticipate the most effective phrasing is worthwhile. For example, a surveyor attempting to determine whether a staff member is aware of the facility's policy for reporting medication errors and his/her role in such an event, could ask, "If you became aware that a patient had received a medication that was not prescribed for them, what would you do?" Interviews with direct care staff should be directed at obtaining information of the patient's needs, plans of care, and progress toward goals. Further, it is important to address problems or concerns identified during a patient or family interview in the staff interview in order to validate the patient's perception or to gather additional information.

The following are important additional considerations for ensuring the validity of data collected by interviews:

- Surveyors must maintain detailed documentation of each interview conducted, including: the interview date, time, and location, the full name and title of the person interviewed, and key points made and/or topics discussed. Whenever possible, document the exact words used by the interviewee
- When evaluating patient care, be sure to include interviews with staff who work most closely with the patient
- Ask open-ended, non-leading questions or rephrase the question(s) to obtain the needed information
- Validate all information obtained, either by verifying that it is consistent with other interviews, or supported by observation and documentation
- To the extent possible, conduct all interviews in-person. Telephone interviews should only be conducted if necessary

Document Review. Document review is essential to validate data obtained through observations and interviews for the purposes of evaluating hospital compliance with the requirements for licensure. Surveyors should obtain copies of all documents needed to support survey findings. If a digital or electronic record is viewed and a copy is requested, verify that the copy provided is identical to the record before exiting the facility.

When conducting document review, it is important that the surveyor notes the source and date of any documents and records received.

The following are some examples of documents that the survey team may need to review and, as necessary, to demonstrate noncompliance, obtain copies:

- Patient's clinical records, to validate information gained during the interviews, as well as, for evidence of advanced directives, discharge planning instructions, and patient teaching. This review will provide a broad picture of the patient's care
- Plans of care and discharge plans that demonstrate whether they have been initiated immediately upon admission and modified as patient care needs change
- All of the relevant documentation for each stage of a patient's progress through a process of care. For example, record review for a sampled surgical patient would include the pre-surgical assessment, informed consent, anesthesia notes, etc., as needed.
- Personnel files to determine if staff members have the appropriate competencies, have had the necessary training required, and are licensed, if it is required

- Credential files to determine if the facility follows its own written policies for medical staff privileges and credentialing
- Maintenance records to determine if equipment is periodically examined and in good working order, and if environmental requirements have been met
- Staffing documents to determine if adequate numbers of staff are provided according to the number and needs of the patients
- When reviewing applicable policy(ies) and procedure(s), ensure the material is current and up to date

<u>Task 4</u> **Preliminary Decision Making and Analysis of Findings**

The purpose of this task is to assist the team in preparing the exit conference report by beginning an analysis of findings and preliminary decision-making. Depending on the team's decisions, this task will identify any additional activities that may need to be initiated.

Discussion Meeting
The Team Coordinator will schedule this meeting to occur after the survey team assignments have been completed. All team members are required to attend, if at all possible. Prior to the meeting, each team member should review his/her notes, worksheets, records, observations, interviews, and document reviews to assure that all investigations are complete and organized for presentation to the team.

During the meeting, surveyors will share their findings, evaluate the evidence, and make team decisions regarding the facility's compliance with the requirements of licensure. For any issues of noncompliance, the team needs to reach a consensus.

The team must assure that their findings are supported by adequate documentation of observations, interviews, and document reviews, including any needed evidence such as photocopies. At the discussion meeting, the team will also determine which team members will be responsible for presenting certain areas of findings during the exit conference. During this meeting, the team should also discuss any difficulties anticipated during the exit conference based on interactions during the survey. The presentation of findings should be concise and factual, and presented in a professional manner. If the team anticipates that the exit conference will be contentious, the Team Coordinator should contact the supervisor.

Determining Deficiencies
Each deficiency of hospital licensing requirements occurring on or after April 1, 2014 must be evaluated to determine whether an administrative penalty for the deficient practice will be applied. Per Title 22, Division 5, Chapter 1, Article 10, any deficiency that the survey team agrees is more than a minor violation, should be considered for an administrative penalty. For situations/events that may result in death, serious injury, or potential for serious injury or death, see P&P 800.3.3 (GACH State Administrative Penalty Process for Immediate Jeopardy Violations) to determine if the deficiency should be considered for an Immediate Jeopardy (IJ) Administrative Penalty (AP). For situations/events that do not rise to the level of an IJ AP, but result in patient harm, potential for more than minimal patient harm, or patient financial harm, see P&P 800.3.7 (GACH State Administrative Penalty Process for Non-Immediate Jeopardy Violations) to determine if the deficiency should be considered for a Non-IJ AP. Both P&P 800.3.3 and 800.3.7 are available at:
http://cdphintranet/sites/lncintranet/Pages/PPManualVolumeandFacilityType.aspx.

Other Deficiency Issues to Consider

- If the survey team discovers any adverse events, the team shall identify if the adverse event was reported to the Department. If the adverse event was not reported to the Department, verify whether the patient was notified and the date the adverse events should have been reported to the Department. See H & S Code 1279.1 Adverse Events. Hospitals are required to report an adverse event:
  - If the adverse event was an on-going urgent or emergent threat to the welfare, health or safety of patients, personnel or visitors, not later than 24 hours after the hospital has detected the adverse event
  - In all other circumstances, not later than five (5) days after the hospital detected the adverse event
- If the survey team discovers deficient practices that rise to a Federal Condition of Participation level of non-compliance, inform your District Office supervisor, so that they may communicate with the Federal Regional Office for further instructions

Gathering Additional Information

If it is determined that the survey team needs additional information to determine facility compliance or noncompliance, the team should decide the best way to conduct the additional review prior to the exit conference.

Task 5   Exit Conference

The purpose of this task is to inform the facility staff of the team's preliminary findings, which will be finalized in Task 6.

Exit Conference Preparation

All team members should attempt to attend the exit conference in person. If necessary, some team members may conduct their exit conference ahead of the team with administration or participate remotely. The Team Coordinator has responsibility for organizing the presentation of material and information to be shared during the exit conference.

During the Exit Conference

The following principles apply when conducting the exit conference:

- Thank everyone for their cooperation during the survey
- Introduce all team members, mentioning any that have concluded their portion of the survey and have left the facility
- Request that all facility representatives introduce themselves. Note: The facility determines which hospital staff will attend the exit conference. This may include the facility's attorney
- Explain that the exit conference is a meeting to present preliminary findings subject to District Office supervisory review and approval
- Advise that official findings will be presented in writing on the Statement of Deficiency and will be mailed within approximately 10 working days to the facility
- Clarify that the provider will have an opportunity to present any new or additional information and/or evidence of compliance for consideration prior to the team exiting the facility

- Explain any ground rules and how the team will present the preliminary findings. Ground rules may include waiting until the surveyor and/or team finishes discussing the deficiencies before accepting comments from facility staff
- Present the findings of noncompliance, including the basis of the findings with enough information for the facility to initiate their plan of correction. Avoid referring to specific regulatory section by number, unless requested
- Do not reveal the identity of an individual patient or staff member in discussing survey results. Identity includes not only the name of an individual patient or staff member, but also includes any reference by which identity might be deduced
- Refrain from making any general comments (e.g., "Overall the facility is very good"). Stick to the facts
- If an immediate jeopardy or non-immediate jeopardy deficiency was identified during the survey, use the exit script provided in the P&P for GACH Administrative Penalty State Immediate Jeopardy (800.3.3), attachment B, or GACH Administrative Penalty State Non-Immediate Jeopardy (800.3.7), attachment B, available at: http://cdphintranet/sites/lncintranet/Pages/PPManualVolumeandFacilityType.aspx The facility must be informed that an administrative penalty may be imposed.
- At the conclusion of exit conference, request that the facilities complete the " GACH Comprehensive Licensing Survey Evaluation Form"—indicate that submission of this form is voluntary, but important to CDPH in its own quality improvement processes

Discontinuation of an Exit Conference

Surveyors may choose to interrupt or halt the exit conference when the facility or its attorney is creating an environment that is hostile, intimidating, or inconsistent with the informal and preliminary nature of an exit conference.

Under such circumstances, it is suggested that the Team Coordinator stop the exit conference and call the District Office for further direction. If appropriate, the entire survey team should leave the facility until further direction is provided.

Recording the Exit Conference

If the facility wishes to record the conference, it must agree to do so in a manner that will produce two identical copies of the recording immediately following the exit conference's conclusion. The surveyors should take one copy with them at the conclusion of the conference. It is at the sole discretion of the surveyor(s) to determine if videotaping is permitted. Videotaping is permitted if it is not disruptive to the conference, and a copy is provided at the conclusion of the conference.

Exit Survey Conclusion

All team members should leave the facility together immediately following the exit conference. The Team Coordinator should decide the best way to conduct the further review if the facility provides additional information.

<u>Task 6</u>   **Post Survey Activities**

The purpose of this task is to complete the licensing survey.

Completion of Survey Activities

The survey team completes the written Statement of Deficiencies so that it can be mailed to the facility within 10 business days from the date of the exit conference. The district office will transmit the Statement of Deficiencies with a letter that indicates the facility's timeline to submit a Plan of Correction, the requirements of an acceptable Plan of Correction, and a notice of intention to issue any Administrative Penalties, if applicable.

Upon receipt of the facility's Plan of Correction, the district office will review and provide the facility with a response indicating approval of the Plan of Correction or identify areas requiring further development or clarification and request that the facility resubmit an appropriate Plan of Correction.

Issuance of Administrative Penalties

Any deficiency occurring on or after April 1, 2014, for which the survey team agrees, has more than a minimal relationship to the health or safety of hospital patients shall be considered for an administrative penalty (Title 22, Division 5, Chapter 1, Article 10). For further guidance, consult the respective P&Ps regarding the process of preparing and issuing administrative penalties. For immediate jeopardy deficiencies see P&P 800.3.3 and for non-immediate jeopardy deficiencies see P&P 800.3.7. Both P&Ps are available at:
http://cdphintranet/sites/lncintranet/Pages/PPManualVolumeandFacilityType.aspx.

September 18, 2017

Dan Coll, PA-C
Tahoe Forest Hospital District
PO Box 759
Truckee, CA 96160

Dear Mr. Coll,

2017 marks the eighth year of operation of the American Orthopaedic Association's Own the Bone program. We proudly celebrate the work that sites like yours have been doing to improve fragility fracture patient care and track these improvements in the Own the Bone registry.

Semi-Annual Data Report through June 30, 2017

Enclosed is a customized report regarding your institution's registry participation compared to the aggregate data from all Own the Bone participants through June 30, 2017.

Similar real-time reporting can also be accessed by logging in to the Own the Bone registry and clicking on "Benchmarking Reports" in the menu on the left. If you have any questions on accessing these reports, please don't hesitate to contact us.

Recognition in *U.S. News & World Report* "Best Hospitals" Guide 2018 Edition

Once again, The American Orthopaedic Association has recognized institutions enrolled in Own the Bone in the annual *U.S. News & World Report* "Best Hospitals" guide (2018 Edition), published this month. We have enclosed a copy of this year's guide for you to keep and share with your administrators and colleagues, while noting our recognition piece on page **127**.

This year, Tahoe Forest Hospital District is among the 75 instutions which received *Star Performer* recognition. As you know, only sites that have achieved a 75% compliance rate with at least 5 of the 10 Own the Bone prevention measures qualify. We congratulate you on your achievement.
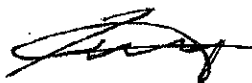
Star Performer Media Toolkit

The Star Performer media toolkit is available only to institutions with this special recognition. The toolkit will include a "2018 Star Performer" logo and press releases for you to publicize your new designation. We've also included an Own the Bone 2018 Star Performer Certificate in this mailing that you may display proudly in your office or waiting room!
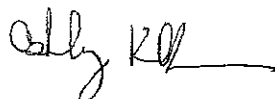
The rest of the media kit will be e-mailed to you and your institution's Own the Bone day-to-day contact soon. You can also contact Senior Program Coordinator Jessica Yanik (her contact information is below) for more details or assistance in marketing your achievement.

Once again, thank you for choosing to implement Own the Bone to improve the bone health care of your fragility fracture patients.

Best Regards,

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Own The Bone Star Performer

Certificate of Recognition
Outstanding Quality in Fragility Fracture Care

presented to

Tahoe Forest Health System

For Achieving an Exceptional Compliance Rate on the 10 Prevention Measures
Outlined by the American Orthopaedic Association's Own the Bone Program

September 18, 2017
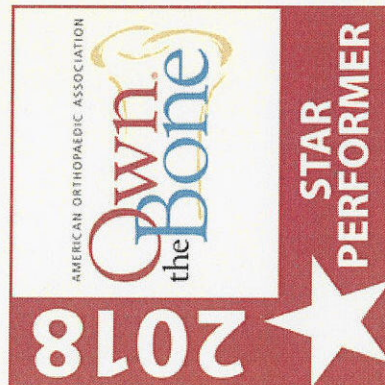
Regis J. O'Keefe

Regis J. O'Keefe, MD, PhD, FAOA
President, The American Orthopaedic Association

AMERICAN ORTHOPAEDIC ASSOCIATION
Own the Bone
2018 STAR PERFORMER

U.S.News & WORLD REPORT

2018 EDITION

Best Hospitals

EXCLUSIVE RANKINGS

10 Health Care Trends That Will Affect You

Facing **Surgery?** Key Questions to Ask

New Ways to Battle **Cancer**

Plus: Can't Lose Weight? Your **DNA** May Offer a Fix

YOUR GUIDE TO TOP CARE
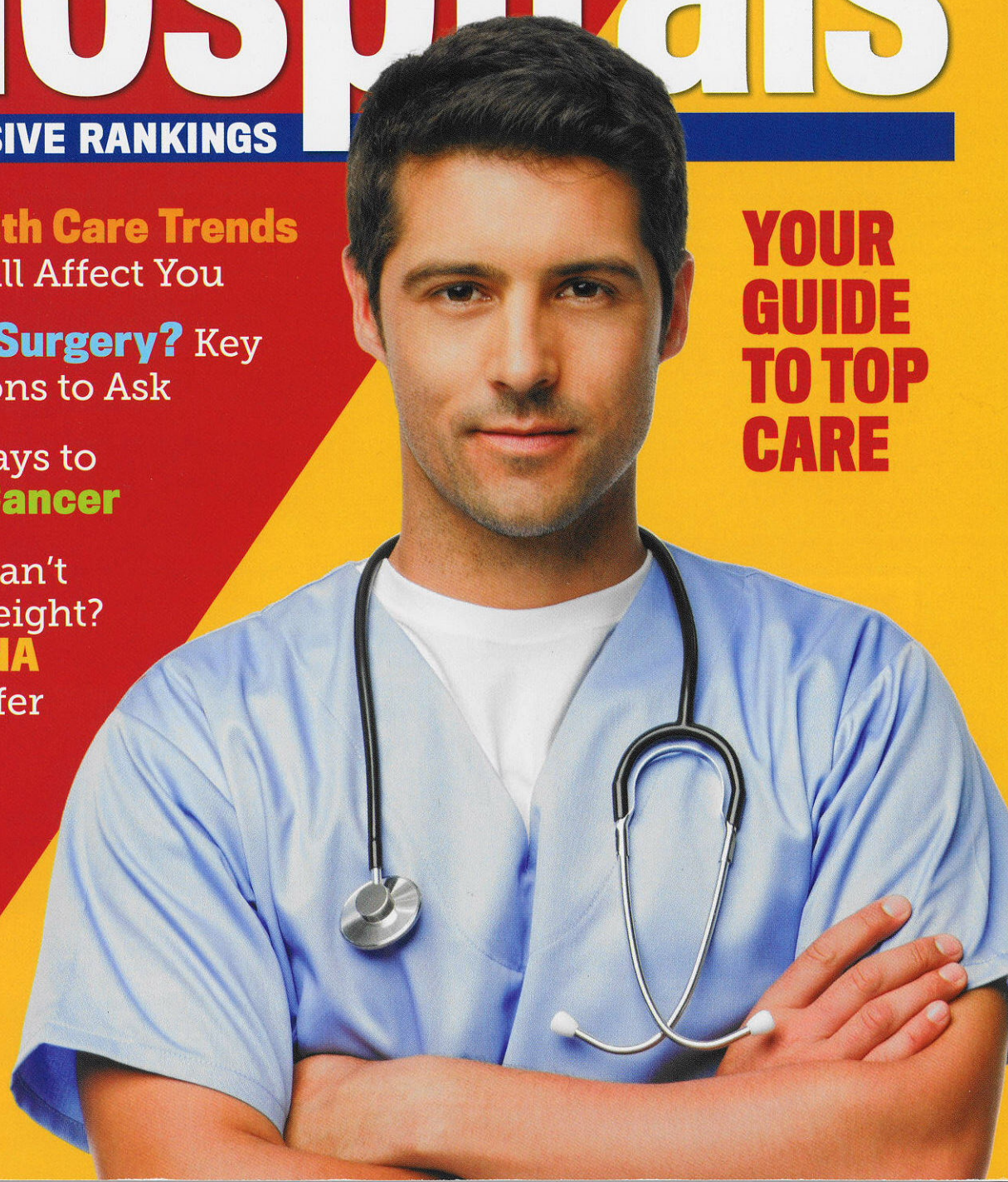
OUTSTANDING HOSPITALS DON'T SIMPLY TREAT FRAGILITY FRACTURES—THEY PREVENT FRACTURES FROM RECURRING

THE BEST HOSPITALS AND PRACTICES OWN THE BONE.

AMERICAN ORTHOPAEDIC ASSOCIATION

Own the Bone

Providers & patients united for improved care.

The American Orthopaedic Association applauds the following institutions for their achievements and participation in the Own the Bone® quality improvement program:

STAR PERFORMERS

Institutions are recognized for at least 75% compliance on 5 of the 10 recommended measures over the last year.

Akron General Medical Center - Akron, OH
Allina Health-Buffalo Hospital - Buffalo, MN
Anne Arundel Medical Group Orthopedics and Sports Medicine Specialists - Annapolis, MD
Berkshire Medical Center - Pittsfield, MA
Chippenham & Johnston Willis Hospitals/CJW Medical Center - Richmond, VA
^Christiana Hospital - Greenville, DE
Coastal Fracture Prevention Center - Sebastian, FL
Colorado Spine Institute PLLC - Loveland, CO
Concord Hospital - Concord, NH
Cooper Health System - Camden, NJ
Cox Medical Center Branson - Branson, MO
Crystal Clinic Orthopaedic Center - Akron, OH
Doylestown Health - Doylestown, PA
ETMC First Physicians Orthopedic Institute - Tyler, TX
Forsyth Medical Center - Winston Salem, NC
Good Samaritan Hospital - San Jose - San Jose, CA
^Greenville Hospital System University Medical Center - Greenville, SC
Herrin Hospital - Herrin, IL
Hoag Orthopedic Institute - Irvine, CA
Huntington Hospital - Northwell Health - Huntington, NY
^Huntsville Hospital - Huntsville, AL
Illinois Bone & Joint Institute, LLC - Morton Grove, IL
Jefferson Hospital - Pittsburgh, PA
JPS Health Network - Fort Worth, TX
Lakeshore Bone and Joint Institute - Chesterton, IN

LewisGale Medical Center - Salem, VA
MaineGeneral Medical Center - Augusta, ME
Marshfield Clinic - Marshfield, WI
Medical Center Arlington - Arlington, TX
Medical University of South Carolina - Charleston, SC
Memorial Regional Hospital - Hollywood, FL
Mercy Regional Medical Center - Durango, CO
Michigan Neurosurgical Institute - Grand Blanc, MI
Mission Hospital - Asheville, NC
NewYork-Presbyterian/Queens - Flushing, NY
Northwestern Medicine Central DuPage Hospital - Winfield, IL
Northwestern Medicine Delnor Hospital - Geneva, IL
Norton Women's and Children's Hospital - Louisville, KY
Norwalk Hospital - Norwalk, CT
NWIA Bone, Joint & Sports Surgeons - Spencer, IA
OhioHealth Grant Medical Center - Columbus, OH
^Oklahoma Sports and Orthopedics Institute - Bone Health Clinic - Norman, OK
Orthopaedic Associates of Michigan - Grand Rapids, MI
Palmetto Health - Columbia, SC
Paramount Care, Inc. - Maumee, OH
^Park Nicollet Methodist Hospital - Minneapolis, MN
Parkview Regional Medical Center - Fort Wayne, IN
Peninsula Regional Medical Center - Salisbury, MD
ProMedica Toledo Hospital - Toledo, OH

Regions Hospital/HealthPartners Orthopaedic and Sports Medicine - Minneapolis, MN
Sacred Heart Hospital - Pensacola - Pensacola, FL
^Sanford Medical Center Fargo - Fargo, ND
Southeast Georgia Health System - Brunswick, GA
St. Luke's Boise Medical Center - Boise, ID
St. Luke's University Hospital and Health Network - Bethlehem, PA
St. Vincent's Medical Center - Bridgeport, CT
Tahoe Forest Health System - Truckee, CA
Tallahassee Memorial HealthCare - Tallahassee, FL
The CORE Institute - Arizona - Phoenix, AZ
The Medical Center of Aurora - Aurora, CO
The Methodist Hospitals Spine Care Center - Merrillville, IN
The Ohio State University Medical Center - Columbus, OH
^The Queen's Medical Center - Honolulu, HI
University Hospital - San Antonio, TX
University of Michigan Hospitals & Health Centers - Ann Arbor, MI
University of Wisconsin Hospitals and Clinics - Madison, WI
UW Medicine Northwest Hospital and Medical Center - Seattle, WA
VCU HealthSystem - Richmond, VA
Western Reserve Hospital - Cuyahoga Falls, OH
^Wilmington Hospital - Wilmington, DE
Winthrop-University Hospital - Mineola, NY
^WVU Hospitals, Department of Orthopaedics - Morgantown, WV

NEWLY ENROLLED INSTITUTIONS

Eastern Maine Medical Center - Bangor, ME
Florida Hospital Flagler Orthopedics & Sports Medicine - Palm Coast, FL
Heiden Orthopedics - Cottonwood Heights, UT
Hilo Medical Center - Hilo, HI
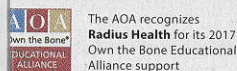Mendelson Kornblum Orthopedic & Spine Specialists - Livonia, MI

^Mountain View Regional Hospital & Clinic - Casper, WY
*Newton Medical Center - Newton, KS
Northwest Orthopaedic Specialists - Spokane, WA
*NYU Langone Health - New York City, NY

Providence St. Vincent Medical Center - Portland, OR
Sturgis Orthopedics - Sturgis, MI
^*The University of Vermont Health Network - Central Vermont Medical Center - Berlin, VT

^First in State to enroll in Own the Bone®
*Also a Star Performer

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

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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).

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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.

Chapter Five: How to Ensure Quality Care 89

The essential role of leadership in developing a safety culture

In any health care organization, leadership's first priority is to be accountable for effective care while protecting the safety of patients, employees, and visitors. Competent and thoughtful leaders* contribute to improvements in safety and organizational culture.[1,2] They understand that systemic flaws exist and each step in a care process has the potential for failure simply because humans make mistakes.[3-5] James Reason compared these flaws – latent hazards and weaknesses – to holes in Swiss cheese. These latent hazards and weaknesses must be identified and solutions found to prevent errors from reaching the patient and causing harm.[6] Examples of latent hazards and weaknesses include poor design, lack of supervision, and manufacturing or maintenance defects.

The Joint Commission's Sentinel Event Database reveals that leadership's failure to create an effective safety culture is a contributing factor to many types of adverse events – from wrong site surgery to delays in treatment.[7]

In addition, through the results of its safety initiatives, The Joint Commission Center for Transforming Healthcare has found inadequate safety culture to be a significant contributing factor to adverse outcomes. Inadequate leadership can contribute to adverse events in various ways, including but not limited to these examples:

- Insufficient support of patient safety event reporting[8]
- Lack of feedback or response to staff and others who report safety vulnerabilities[8]
- Allowing intimidation of staff who report events[9]
- Refusing to consistently prioritize and implement safety recommendations
- Not addressing staff burnout[10,11]

In essence, a leader who is committed to prioritizing and making patient safety visible through every day actions is a critical part of creating a true culture of safety.[12] Leaders must commit to creating and maintaining a culture of safety; this commitment is just as critical as the time and resources devoted to revenue and financial stability, system integration, and productivity. Maintaining a safety culture requires leaders to consistently and visibly support and promote everyday safety measures.[13] Culture is a product of what is done on a consistent daily basis. Hospital team members measure an organization's commitment to culture by what leaders do, rather than what they say should be done.

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* The Joint Commission accreditation manual glossary defines a leader as: "an individual who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization's governance, management, and clinical and support functions and processes. At a minimum, leaders include members of the governing body and medical staff, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization."

The Joint Commission introduced safety culture concepts in 2008 with the publication of a Sentinel Event Alert on behaviors that undermine a culture of safety.[14] Further emphasis was made the following year with a Sentinel Event Alert on leadership committed to safety (this Alert replaces and updates that one), and the establishment of a leadership standard requiring leaders to create and maintain a culture of safety. The Patient Safety Systems (PS) chapter of The Joint Commission's *Comprehensive Accreditation Manual for Hospitals* emphasizes the importance of safety culture. As of Jan. 1, 2017, the chapter expanded to critical access hospitals, and to ambulatory care and office-based surgery settings.

Safety culture foundation

Safety culture is the sum of what an organization *is* and *does* in the pursuit of safety.[15] The PS chapter defines safety culture as the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety. Organizations that have a robust safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.[16] The safety culture concept originated in the nuclear energy and aviation industries, which are known for their use of strategies and methodologies designed to consistently and systematically mitigate risk, thereby avoiding accidents.[17,18] The Institute of Nuclear Power Operations defined safety culture characteristics[19] that are adaptable to the health care environment:

1. Leaders demonstrate commitment to safety in their decisions and behaviors.
2. Decisions that support or affect safety are systematic, rigorous and thorough.
3. Trust and respect permeate the organization.
4. Opportunities to learn about ways to ensure safety are sought out and implemented.
5. Issues potentially impacting safety are promptly identified, fully evaluated, and promptly addressed and corrected commensurate with their significance.
6. A safety-conscious work environment is maintained where personnel feel free to raise safety concerns without intimidation,

harassment, discrimination, or fear of retaliation.
7. The process of planning and controlling work activities is implemented so that safety is maintained.

Leaders can build safety cultures by readily and willingly participating with care team members in initiatives designed to develop and emulate safety culture characteristics.[13] Effective leaders who deliberately engage in strategies and tactics to strengthen their organization's safety culture see safety issues as problems with organizational systems, not their employees, and see adverse events and close calls ("near misses") as providing "information-rich" data for learning and systems improvement.[3-5] Individuals within the organization respect and are wary of operational hazards, have a collective mindfulness that people and equipment will sometimes fail, defer to expertise rather than hierarchy in decision making, and develop defenses and contingency plans to cope with failures. These concepts stem from the extensive research of James Reason on the psychology of human error. Among Reason's description of the main elements of a safety culture[20] are:

- **Just culture** – people are encouraged, even rewarded, for providing essential safety-related information, but clear lines are drawn between human error and at-risk or reckless behaviors.
- **Reporting culture** – people report their errors and near-misses.
- **Learning culture** – the willingness and the competence to draw the right conclusions from safety information systems, and the will to implement major reforms when their need is indicated.

In an organization with a strong safety culture, individuals within the organization treat each other and their patients with dignity and respect. The organization is characterized by staff who are productive, engaged, learning, and collaborative.[19] Having care team members who gain joy and meaning through their work has been found to have an important role in establishing and maintaining a safe culture. The Lucien Leape Institute's Joy & Meaning in Workforce Safety initiative addresses clinician burnout, which is at record highs.[11,21] Clinician burnout is associated with lower perceptions of patient safety culture and may directly or indirectly affect patient outcomes.[22]

Joy and meaning will be created when the workforce feels valued, safe from harm, and part of the solutions for change. When team members know that their well-being is a priority, they are able to be meaningfully engaged in their work, to be more satisfied, less likely to experience burnout, and to deliver more effective and safer care.[11,21] Leaders who encourage transparency in response to reports of adverse events, close calls and unsafe conditions, and who have established processes that ensure follow-up to ensure reports are not lost or ignored (or perceived to be lost or ignored), help mitigate intimidating behaviors because transparency of action itself discourages such behavior. On the opposite end of the spectrum, intimidating and unsettling behaviors causing emotional harm, including the use of inappropriate words and actions or inactions, has a detrimental impact on patient safety[10] and should not occur in a safety culture. This includes terminating, punishing or failing to support a health care team member who makes an error (the "second victim").

Unfortunately, as attention to the need for a culture of safety in hospitals has increased, "so have concomitant reports of retaliation and intimidation targeting care team members who voice concern about safety and quality deficiencies," according to a National Association for Healthcare Quality report.[9] Intimidation has included overtly hostile actions, as well as subtle or passive-aggressive behaviors, such as failing to return phone calls or excluding individuals from team activities. Survey results released by the Institute for Safe Medication Practices (ISMP) show that disrespectful behavior remains a problem in the health care workplace. Most respondents reported experiences with negative comments about colleagues, reluctance or refusal to answer questions or return calls, condescending language or demeaning comments, impatience with questions or hanging up the phone, and a reluctance to follow safety practices or work collaboratively.[23]

Actions suggested by The Joint Commission
The Joint Commission recommends that leaders take actions to establish and continuously improve the five components of a safety culture defined by Chassin and Loeb: ***trust, accountability, identifying unsafe conditions, strengthening systems, and assessment.***[18] These actions are not intended to be implemented in a sequential manner. Leaders will need to address and apply various components to the workforce

simultaneously, using tactics such as board engagement, leadership education, goalsetting, staff support, and dashboards and reports that routinely review safety data.[12]

1. Absolutely crucial is a transparent, non-punitive approach to reporting and learning from adverse events, close calls and unsafe conditions,[16,24] states the Patient Safety Systems (PS) chapter of The Joint Commission's *Comprehensive Accreditation Manual for Hospitals*. Develop ***trust and accountability*** through an organizational-wide and easy-to-use reporting system. This reporting system should be accessible to everyone within the organization. Having this system is essential for developing a culture in which unsafe conditions are identified and reported without fear of punishment or reprisal for unintentional mistakes, leading to proactive prevention of patient harm.[14,18,25,26] Leaders can augment voluntary reporting by using other methods, such as trigger tools and observational techniques, to proactively address risk and identify potential errors.[27]

2. Establish clear, just, and transparent risk-based processes for recognizing and separating human error and error arising from poorly designed systems from unsafe or reckless actions that are blameworthy.[18] Mistakes, lapses, omissions and other human errors are opportunities for improvement and lessons learned from them should be shared. Punishing, terminating or failing to support an employee who makes a mistake during the course of an adverse event can erode leadership's credibility and undermine organizational safety culture.[28] The [Incident Decision Tree], from the United Kingdom's National Patient Safety Agency, is one example that supports the aim of creating an open, fair and accountable culture, where employees feel able to report patient safety incidents without undue fear of the consequences, and health care organizations know where to draw the accountability line.

3. To advance trust within the organization, CEOs and all leaders must adopt and model appropriate behaviors and champion efforts to eradicate intimidating behaviors.[18,25,26] These behaviors include demonstrating respect in all interactions, personally participating in activities and programs aimed at improving safety culture, and by making sure safety-related feedback from staff is acknowledged and, if appropriate,

implemented. Leadership must maintain a fair and equitable measure of accountability to all.

4. Establish, enforce and communicate to all team members the policies that support safety culture and the reporting of adverse events, close calls and unsafe conditions.[19]

5. Recognize care team members who report adverse events and close calls, who _identify unsafe conditions,_ or who have good suggestions for safety improvements. Leaders can recognize "good catches" – in which adverse events are avoided – and share these "free lessons" with all team members (i.e., feedback loop).[29] The Joint Commission Center for Transforming Healthcare's [Safety Culture project](#) found that two effective ways of reporting back to team members who raised safety issues were through 1) shift and unit huddles, and 2) visual management boards. They found that care team members stopped making suggestions when they received no feedback from team or hospital leaders.

Also useful toward recognizing safety initiatives and promoting safety culture are activities involving leaders, such as team safety briefings and planning sessions,[17,30] huddles[31,32] about safety threats or issues, debriefs to learn from identified errors or safety defects,[30,33] and safety rounds or walkarounds.[34-36]

6. Establish an organizational baseline measure on safety culture performance using the Agency for Healthcare Research and Quality (AHRQ) [Hospital Survey on Patient Safety Culture](#) (HSOPS) or another tool, such as the [Safety Attitudes Questionnaire](#) (SAQ).[37-39] A summary of these tools can be found in the Resources section of this alert.

7. Analyze safety culture survey results from across the organization to find opportunities for quality and safety improvement.[33,39-40] Analyzing data in this manner enables an organization to find improvement opportunities and solutions in line with organizational priorities and needs. This analysis must drill down to local unit levels so that unit-specific solutions can be developed and implemented.[41] Share the results with frontline staff throughout the organization and with governing bodies, including the board.

8. In response to information gained from safety assessments and/or surveys, develop and implement unit-based quality and safety improvement initiatives designed to improve the culture of safety.[33,39-40,42-46] Examples from Joint Commission-accredited organizations include:

- An obstetrics service line created a multidisciplinary code of professionalism as a mechanism to address unprofessional behavior. Physicians, nurses, and support staff underwent education that addressed why and how to report unprofessional behavior. Leadership followed up on all reports concerning unprofessional behavior with coaching. As a result of the education, reporting and coaching, statistically significant improvement was shown on the following AHRQ Hospital Survey on Patient Safety Culture dimensions: teamwork within units, management support, organizational learning, and frequency of events reported.[47]

- The Rhode Island Intensive Care Unit (ICU) Collaborative conducted a study to examine the impact of a Safety Attitudes Questionnaire Action Plan (SAQAP) on ICU central-line associated blood stream infections (CLABSIs) and ventilator-associated pneumonia (VAP) rates. Teams that developed SAQAPs improved their unit culture and clinical outcomes. Units that developed SAQAPs demonstrated higher improvement rates in all domains of the SAQ, except working conditions. Improvements were close to statistical significance for teamwork climate (+18.4 percent in SAQAP units versus -6.4 percent in other units, p = .07) and job satisfaction (+25.9 percent increase in SAQAP units versus +7.3 percent, p = .07). Units with SAQAPs decreased the CLABSI rates by 10.2 percent in 2008 compared with 2007, while those without SAQAP had a 2.2 percent decrease in rates (p = .59). Similarly, VAP rates decreased by 15.2 percent in SAQAP units, while VAP rates increased by 4.8 percent in units without SAQAP (p = .39).[48]

- An academic medical center developed a comprehensive unit-based safety program that included steps to identify hazards, partnered units with a senior executive to fix hazards, learned from defects, and implemented communication and teamwork tools. In 2006, 55 percent of units achieved the SAQ-measured safety climate goal of meeting or exceeding a 60 percent positive

score or improving the score by 10 or more percentage points. In 2008, 82 percent of units achieved the goal. For teamwork climate, the two-year improvement was 61 to 83 percent. Scores improved in every SAQ domain except stress recognition.[39]

Many other examples of successful and measurable safety culture initiatives can be found in health care literature. Some of these initiatives[39,49] successfully used tactics such as walkarounds,[34-36] huddles,[31,32] employee engagement,[50,51] team safety briefings and planning sessions,[17,30] debriefs to learn from identified errors or safety defects,[30,33] and safety ambassadors[52] to improve various aspects of safety culture. Improvement on safety culture measures is associated with positive outcomes, such as reduced infection rates,[38,53] fewer readmissions,[38,53] decreased care team member turnover,[39] better surgical outcomes,[54] reduced adverse events,[55,56] and decreased mortality.[55] Health care organizations in which care team members have positive perceptions of safety culture tend to have positive assessments of care from patients as well.[57]

9. Embed safety culture team training into quality improvement projects[33,39-40,49] ***and organizational processes to <u>strengthen safety systems.</u>***[17,18,30] Team training derived from evidence-based frameworks can be used to enhance the performance of teams in high-stress, high-risk areas of the organization – such as operating rooms, ICUs and emergency departments – and has been implemented at many health care facilities across the country.[17,30]

> ### Safety Culture Key to High Reliability
>
> The Joint Commission established a theoretical framework that emphasizes safety culture, leadership and robust process improvement as three domains that are critical to high reliability within a health care organization.[18] By promoting the core attributes of trust, report and improve,[15] high-reliability organizations create safety cultures in which team members trust peers and leadership; report vulnerabilities and hazards that require risk-based consideration; and communicate the benefits of these improvements back to involved staff. Leaders can self-assess performance and improvements relating to high reliability by using the Oro™ 2.0 High Reliability Organizational Assessment and Resources Tool. See this alert's Resources section for more information.

10. Proactively assess system (such as medication management and electronic health records) strengths and vulnerabilities and prioritize them for enhancement or improvement.[18,58]

11. Repeat organizational <u>assessment of safety culture</u> every 18 to 24 months to review progress and sustain improvement.[38] Ensure that the assessment drills down to unit levels,[41] and make these assessments part of strategic measures reported to the board.[18]

Related Joint Commission requirements
Many Joint Commission standards address issues related to the design and management of patient safety systems. These requirements and elements of performance, which include the following, can be found in the Patient Safety Systems (PS) chapter of The Joint Commission's accreditation manuals for hospitals and critical access hospitals, and for ambulatory care and office-based surgery settings:

> **LD.03.01.01:** Leaders create and maintain a culture of safety and quality throughout the organization.
>
> EP 1. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.
>
> EP 4. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
>
> EP 5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

Resources
Hospital Survey on Patient Safety Culture (HSOPS) – Identifies 12 dimensions of safety culture (10 climate dimensions and two outcomes variables):[53]
- Communication openness
- Feedback and communication about error
- Frequency of events reported
- Handoffs and transitions
- Management support for patient safety
- Non-punitive response to error
- Organizational learning (continuous improvement)
- Overall perceptions of safety
- Staffing
- Supervisor/manager expectations and actions promoting safety

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- Teamwork across units
- Teamwork within units

United Kingdom's National Patient Safety Agency's Incident Decision Tree – Supports the aim of creating an open culture, where employees feel able to report patient safety incidents without undue fear of the consequences. The approach does not seek to diminish health care professionals' individual accountability, but encourages key decision makers to consider systems and organizational issues in the management of error.[28]

Institute for Healthcare Improvement's Joy in Work initiative – Addresses clinician burnout.

The Joint Commission Center for Transforming Healthcare's Oro™ 2.0 High Reliability Organizational Assessment and Resources application – High reliability organizations routinely self-assess. This self-assessment tool is intended for hospital leadership teams. It can be used in combination with tools (such as HSOPS and SAQ) that measure the perceptions of staff at all levels of the organization. The tool evaluates:

- Leadership commitment
- Safety culture
- Performance improvement

Patient Safety Systems (PS) chapter of The Joint Commission's *Comprehensive Accreditation Manual for Hospitals* (as of Jan. 1, 2017, also applicable to critical access hospitals, and to ambulatory care and office-based surgery settings)

Safety Attitudes Questionnaire (SAQ) – Measures six culture domains:

- Teamwork climate
- Safety climate
- Perceptions of management
- Job satisfaction
- Working conditions
- Stress recognition

Safety Culture Project, The Joint Commission Center for Transforming Healthcare – Seven participating organizations focused on identifying unsafe conditions before they reached the patient and finding reliable, sustainable solutions. The organizations found that reporting back to team members about how their suggestions improved care increased team member satisfaction, particularly if the feedback included praise, either public or private as appropriate, for those who

spoke up.[29] The project utilized The Joint Commission's Robust Process Improvement® (RPI®), a blended approach to improve business and clinical processes and outcomes using Lean, Six Sigma and change management methodologies. RPI is intended for all staff, including leaders.

Strategies for Creating, Sustaining, and Improving a Culture of Safety in Health Care – Published by Joint Commission Resources, this second edition book expands the idea of "building" a culture of safety by spotlighting the best articles related to this topic from *The Joint Commission Journal on Quality and Patient Safety*. These articles provide unique perspectives of challenges inherent when establishing and maintaining a culture of safety.

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Patient Safety Advisory Group
The Patient Safety Advisory Group informs The Joint Commission on patient safety issues and, with other sources, advises on topics and content for *Sentinel Event Alert*.