TAHOE FOREST HOSPITAL DISTRICT

2016-04-05 Board Quality Committee Meeting

Tuesday, April 5, 2016 at 12:00 p.m.

Tahoe Conference Room - Tahoe Forest Hospital

10054 Pine Avenue, Truckee, CA 96161

Meeting Book - 2016-04-05 Board Quality Committee Meeting

04/05/16 Quality Committee

TAHOE FOREST HEALTH SYSTEM

QUALITY COMMITTEE AGENDA

Tuesday, April 5, 2016 at 12:00 p.m.
Tahoe Conference Room - Tahoe Forest Hospital
10054 Pine Avenue, Truckee, CA

1. **CALL TO ORDER**

2. **ROLL CALL**
   Greg Jellinek, M.D., Chair; Karen Sessler, 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: 2/9/2016** ..... **ATTACHMENT**

6. **ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION**

6.1. **Quality Committee Charter and Goals 2016 ..... ATTACHMENT**
The *Quality Committee Charter and Goals 2016 were* approved by the Committee at the February 9, 2016 meeting. Informational for reference during the meeting if needed.

6.2. **Patient & Family Centered Care (PFCC)**

6.2.1. **Patient & Family Advisory Council Update ..... ATTACHMENT**
An update will be provided related to the activities of the Patient and Family Advisory Council (PFAC) and next steps for PFCC.

6.3. **4th Quarter 2015 BOD Quality Dashboard ..... ATTACHMENT**
Review the quality dashboard and plans of correction for any identified outliers.

6.4. **HCAHPS Star Rating Report ..... ATTACHMENT**
The Centers for Medicare & Medicaid Services (CMS) has developed HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) star ratings to make it easier for consumers to use the information on the Hospital Compare website and to spotlight excellence in healthcare quality. A review of the 4/1/14 through 3/31/15 CMS Star Rating Report and plans for improvement.

6.5. **Credentialing & Peer Review Process .....ATTACHMENT**
Review the Medical Staff credentialing, privileging, and peer review process to gain an understanding of this function.

6.6. **Accreditation Association for Hospitals and Health Systems .....ATTACHMENT**
AAHHS was founded in February 2014 to help small hospitals, surgical specialty hospitals, and critical access hospitals and health systems better serve their community through accreditation, education, and research. AAHHS is in the process of obtaining deemed accreditation status from CMS and has offered to provide a free 'mock' survey at TFH and IVCH in June 2016.
A review and discussion of the AAHHS survey as part of our HFAP preparation. The unannounced triennial HFAP survey will be in the spring of 2017.

6.7. **Patient Safety Report .....ATTACHMENT**
A review of the National Quality Forum Endorsed Set of 34 Safe Practice and report on process improvement activities within each category.

6.8. **Community Education**
The Committee will discuss forums to educate the community regarding the Quality and Service provided at TFHD.

6.9. **Board Quality Education .....ATTACHMENT**
The committee will review and discuss topics for future Board quality education.

7. **REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS**

8. **NEXT MEETING DATE**
The date and time of the next committee meeting, Tuesday, June 14, 2016, will be proposed and/or confirmed.

9. **ADJOURN**

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

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

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Clerk of the Board at 530-582-3481 at least 24 hours in advance of the meeting.

TAHOE FOREST HEALTH SYSTEM

QUALITY COMMITTEE
DRAFT MINUTES

Tuesday, February 9, 2016 at 12:00 p.m.
Eskridge Lobby 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: Greg Jellinek, M.D., Chair; Chuck Zipkin, M.D., Board Member

Staff: Harry Weis, CEO; Judy Newland, CNO/COO; Dr. Peter Taylor, Quality Medical Director; Dr. Shawni Coll; Dr. Julie Conyers; Jen Tirdel, Clinical Informatics Analyst; Martina Rochefort, Clerk of the Board

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

Items 6.4. and 6.5. will be presented first to accommodate doctor's schedule.

4. **INPUT – AUDIENCE**

No public comment was received.

5. **APPROVAL OF MINUTES OF: 12/16/2015**

Director Jellinek moved to approve the Quality Committee minutes of December 16, 2015, seconded by Dr. Taylor.

6. **ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION**

6.1. Quality Committee Goals 2016

The Board Quality Committee reviewed their 2016 goals.

The following goals were added for 2016:

- Promote a culture of openness and transparency related to quality of care and patient safety.
- Oversee the integrity and reliability of the credentialing and peer review process.

Director Jellinek moved to approve board quality goals for 2016, seconded by Dr. Taylor.

6.2. Patient & Family Centered Care (PFCC)

6.2.1. **Patient & Family Advisory Council Update**

An update was provided related to the activities of the Patient and Family Advisory Council (PFAC) and next steps for PFCC.

At its January meeting, the PFAC reviewed PFAC orientation process, signage for health alerts (use "reminder" messaging versus "Stop") and visitor policy.

Group meeting tomorrow to discuss direction PFCC is heading next.

Agenda for the future PFAC meetings will include inviting different Department Director/Managers to request feedback on a department specific process of interest and to educate the PFAC members on their operations.

6.3. Quality Assurance/Performance Improvement Plan 2016

Discussion was held on the proposed Quality Assurance/Performance Improvement (QA/PI) Plan (AQPI-05).

An update will need to be made to the Vision and Mission Statement once the Board approves the new statements at the February Board Meeting.

It is a regulatory requirement for the Board and Medical Staff to approve every year.

Attachments to the policy are quality initiatives.

Ms. Van Gelder will present the policy for approval to Med Staff on Thursday, then Medical Executive Committee on 2/17 and the full board on 2/25 for final approval.

The only item updated in the policy from 2014 was the priorities listed under Performance Improvement Initiatives on page 2 and the 4 attachments to reflect current practice.

Director Zipkin moved to approve the Quality Assurance/Performance Improvement (QA/PI) plan as presented, seconded by Director Jellinek.

6.4. Physician Quality Reporting System

Ms. Tirdel reviewed the Physician Quality Reporting System (PQRS) is a federally mandated program. CAH hospitals were not eligible to participate until 2014. Information is reported to CMS annually. PQRS works in a similar way to Meaningful Use. There are benchmarks they want you to meet or exceed with incentive payments for exceeding measures and penalties for not meeting targets.

Our registry believes we may receive incentive payments for 2015.

Eligible providers are MD, PA, NP and audiologists.

Report on 9 clinical quality measures through all providers.

- Screening for Osteoporosis for Women 65-85
- Breast Cancer Screening
- Colorectal Cancer Screening
- Influenza Immunization
- Pneumonia IZ Status for Older Adults
- Body Mass Index Screening and Follow-Up
- Screening for Unhealthy Alcohol Use (measure will be replaced for 2016)

- Tobacco Use: Screening and Cessation Intervention
- Documentation of Current Medications in Medical Record

Data is submitted through a registry because of the various EMR systems being used.

Providers met or exceeded benchmarks for 8 of the 9 measures.

Discussion was held regarding who selects the measures. Measures are chosen from a list of approximately 400 measures. When TFHD was first eligible to participate, Executive Director, Medical Director, Clinical Director and Informatics (Jen Tirdel) had 30 days to choose measures, gather data and submit reports.

6.5. Meaningful Use Quality Reporting

Jen Tirdel presented on Meaningful Use Quality Reporting.

Providers have to see at least 30% Medicaid patients.

Measures for Meaningful Use I and II are essentially the same. All but one of the Medicare attestations have been completed. Medicaid attestations will take place late spring/early summer.
Jen does not believe we will not receive any penalties.

We have had challenges with having CPSI comply with Meaningful Use mandates.

Quality Committee would like an update on Meaningful Use.

6.6. Beta Disclosure & Communication Program

Ms. Van Gelder gave an update on the lessons learned at the BETA program including the Care for the Caregiver program.

The goal of the organization is to err on side of disclosing if sentinel or adverse event occurs.

Dr. Taylor spoke of the recent BETA program and reviewed the disclosure process.

The Care for the Caregiver program needs to be formalized more and have a better reporting process. This is an important initiative to support physicians.

Carl Blumberg reviews all risk and BETA insurance issues.

All information being disclosed is discoverable.

6.7. Board Quality Education

Ms. Van Gelder presented the Executive Summary of *Free from Harm: Accelerating Patient Safety Improvement.*

The following are highlights that TFHD should be focused on:

- Ensure that leaders establish and sustain a safety culture

- Create centralized and coordinated oversight of patient safety
- Create a common set of safety metrics that reflect meaningful outcomes
- Increase funding for research in patient safety and implementation science
- Address safety across the entire care continuum
- Support the health care workforce
- Partner with patients and families for the safest care
- Ensure that technology is safe and optimized to improve patient safety

6.8. Quality Metrics Discussion

Committee discussed quality metrics to be incorporated into the CEO Compensation Goal structure by the Board of Directors.

CEO suggested using Baldridge overall quality score (HCAPS) and Press Ganey satisfaction scores to measure Quality metrics.

Suggestions were made by Dr. Coll and Dr. Conyers to look at areas where could we truly improve quality and to look at the quality data and see where are we red.

Patient Satisfaction results are so important.

Dr. Conyers felt they are all great measures but all are based on patient perception of their care and experience.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

None discussed.

8. NEXT MEETING DATE

Committee discussed meeting schedule for 2016. Lunch time works best for physicians. Next meeting will be Tuesday, April 5, 2016 from 12:00 to 1:30 pm in Eskridge Lobby CR.

9. ADJOURN

Meeting adjourned at 1:15 p.m.

Quality Committee Charter

Tahoe Forest Hospital District is committed to performance excellence, to delivering the highest quality care and service, and to exceeding the expectations of our patients, physicians, employees, and community. This committee will provide leadership, oversight, and accountability for organization wide quality improvement processes and programs. We will regularly assess the needs of our stakeholders, evaluate proposed quality initiatives, openly debate options, and assure the production of an organization wide strategic plan for quality. We will set expectations, facilitate education, and support the monitoring of the quality of care, service excellence, risk reduction, safety enhancement, performance improvement, and healthcare outcomes. Because of our efforts Tahoe Forest Hospital District will be the best place to receive care, the best place to work, the best place to practice medicine, and a recognized asset to all in our community.

Approved January 22, 2014

Board Quality Committee Goals 2016

1. Provide appropriate resources to assist the Patient & Family Advisory Council (PFAC) improvement initiatives.

2. Monitor quality and patient safety metrics and support processes, with a focus on outliers, to achieve top decile performance.

3. Provide direction on the Quality and Service elements of the Health System strategic plan and the Quality Assurance/Performance Improvement (QA/PI) Plan.

4. Review quality and service metrics with the community through multi-media venues (i.e., web site, public speaking, social media, quarterly magazine, newspaper articles, etc.).

5. Utilize Just Culture principles when notified of sentinel/adverse events, including the disclosure of medical errors, and when patients share their experience.

6. Promote a culture of openness and transparency related to quality of care and patient safety.

7. Oversee the integrity and reliability of the credentialing and peer review process.

    a. Utilizing best practice protocols where applicable and following quality and safety standards, i.e., demonstrating training and use of SBAR and handoff communication.

8. Request that the Quality Department evaluate Patient Satisfaction survey vendors and determine if a change in vendor is warranted.

9. Prepare for Critical Access Hospital's participation in CMS Hospital Value-Based Purchasing program through the monitoring of Clinical Process of Care, Patient Experience, and Outcome measures.

2016 PFAC PROCESS IMPROVEMENT LOG

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

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
1st Quarter 2016				
1/19/16	Orientation/Recruitment Signage for Health Alerts Visitor Policy	PFAC Laurel Homer Nursing Leadership	Discussed the option for council members to become hospital volunteers vs. a revised orientation for members who wish to volunteer only for the council. The option was discussed for council members to participate in recruitment of new members if available and interested. Signage was reviewed for patient care areas to include a 'Reminder' message of keeping our patients healthy vs. a 'STOP' message. Visitor Policy was reviewed with the goal to be more Patient and Family Centered by identifying 'visitors' as partners and/or guests and recognizing family and guest presence as essential to patient care, quality, and safety (*Better Together* concept through the Institute of Patient and Family Centered Care). Ideas were explored about the next steps for the PFAC to include inviting members to attend various meetings at the hospital (i.e. Board Quality and Safety Committee) and scheduling Department Directors to attend the PFAC meetings to gain input on any areas for process improvement.	Pending Visitor Policy update Pending signage for Infection Control

2016 PFAC PROCESS IMPROVEMENT LOG

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

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
2/16/16	ED Review/Feedback Lab Review/Feedback PFAC Charter Committee Representatives	John/Jan Vern/Sharon PFAC PFAC	Guest speakers John and Jan, from the Tahoe Forest and Incline Village Emergency Departments and Sharon and Vern, from Tahoe Forest Laboratory Services provided information about their departments and obtained feedback from PFAC members. John and Jan are looking into headphones for the ED to help with noise reduction. Both ED locations are addressing wait times and keeping patients informed of delays. Also, trying to decrease the amount of discharge information or highlighting the important aspects of instructions provided to patients. Sharon and Vern provided information on laboratory scheduling and we reviewed the online process which was patient-user friendly! The front desk now has another staff member assisting with releasing lab orders so the process can move more quickly and hope to minimize wait times. We reviewed the PFAC Charter to encourage interested members who wish to either be Co-Chair or Secretary to participate in these roles. Also, inquired if anyone was interested in attending an upcoming Women and Family meeting, and Inpatient Unit meetings to share their experience with the Whiteboard process. Times will also be provided for other Committee Meetings (Ethics, Board Quality, and Safety) for interested members who would like to participate.	Headphones in ED to offer to patients for noise control Pending attendance from PFAC members on Committees

2016 PFAC PROCESS IMPROVEMENT LOG

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

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
3/15/2016	Foundation Gift Items DI//Patient Registration (Review/Feedback) Dietary Review/Feedback Photography Signage	Martha Pete/Tory Coni/Tammy Mike Ruggiero	Guest speakers; Martha, Pete, Tory, Coni, and Tammy. Martha reviewed the Grateful Patient Program and inquired ideas on a small 'gift' item that could be provided to inpatients with Foundation information. Suggestions were chap stick, lotion, eye masks, earphones, robes and gowns. Pete and Tory relayed information on the services provided from the Diagnostic Imaging and Patient Registration Departments. Information was provided about pricing, time for appointments, radiation doses, and authorizations that can take time to obtain. There was discussion about authorizations for observation patients and whether this was needed depending on insurance benefits. Coni presented information on the Dietary Department and their goals of increasing the amount of homemade products, improving top box scores from patient surveys, and changing scheduled mealtimes to more of a 'room service' environment. Both Coni and Tammy were available to answer questions. Signage for 'no photography' was reviewed with suggestions to have patient and family friendly wording to 'kindly refrain from photography to protect patient, family and staff privacy.....' with perhaps a fun picture of a person with too many cameras vs. a 'NO photography' sign. Reminder to PFAC members about council representation on various Committees if interested.	Pending notification sent to Financial Counselor of observation vs. inpatient status change to start any required authorizations asap. Pending signage for photography guidelines
2nd Quarter 2016				

2016 PFAC PROCESS IMPROVEMENT LOG

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

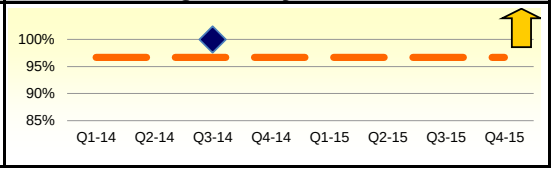
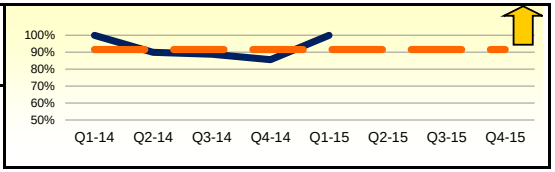
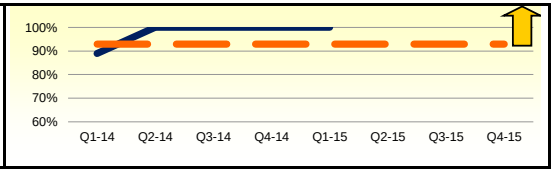
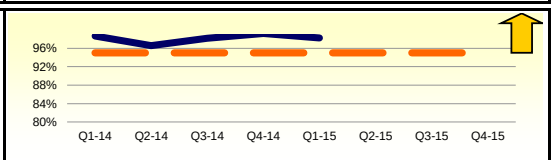
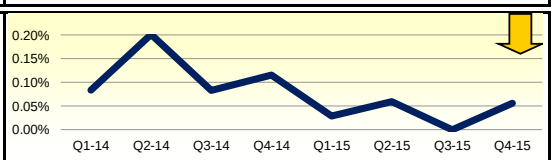
Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
3rd Quarter 2016				
			.	
4th Quarter 2016				

TFHS BOD Quality Scorecard

- Goal Met or Exceeded
- Within 10% Negative Variance of Goal
- Greater than 10% Negative Variance

TFHS Goal*
Benchmark*
Quarterly Performance

* Unless Noted Otherwise

Quality Measures	Q4-2015	Goal	Goal Description and Quarterly Events	Quarterly Trend
Heart Attack Care (0 pt)	No Patients	96.7%	Goal: To meet/exceed the national average for recommended evidence-based care provided for heart attack patients. This number represents a roll-up of 5 AMI measures. Natl. Ave = 96.7% (T, E,P) Q3: No Patients	
Heart Failure Care	Measure Discontinued		Goal: Measure Set Discontinued by CMS	
TFH Pneumonia Care	Measure Discontinued		Goal: Measure Set Discontinued by CMS	
SCIP Care	Measure Discontinued		Goal: Measure Set Discontinued by CMS	
TFH Medication Errors	0.056%	0.0%	Goal: To minimize the rate of medication errors that reach the patient and require additional monitoring. (S, T, E) NOTE - star indicates change in denominator. Q4: There were 2 medication errors that required monitoring.	

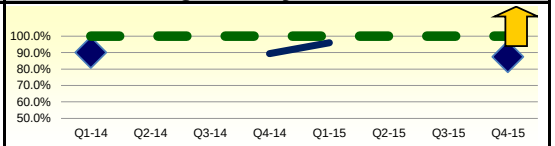
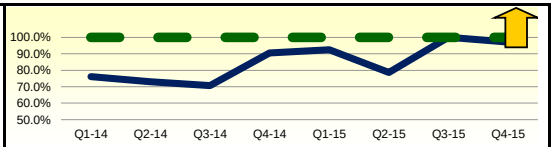
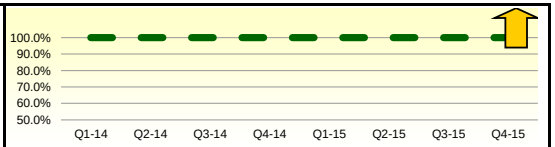
S-safe, T-timely, E-effective, EF-efficient, EQ-equitable, P-patient centered

TFHS BOD Quality Scorecard

- Goal Met or Exceeded
- Within 10% Negative Variance of Goal
- Greater than 10% Negative Variance

TFHS Goal*
Benchmark*
Quarterly Performance

* Unless Noted Otherwise

Quality Measures	Q4-2015	Goal	Goal Description and Quarterly Events	Quarterly Trend
TFH Immunizations	87.4%	100.0%	Goal: To vaccinate 100% of all appropriate consenting inpatients for pneumonia and influenza. This number is a roll up of both Immunization measures (T, E, Ef, Eq, P) Q4: results posted in Q4	
TFH VTE Care (24 pts)	97.1%	100.0%	Goal: To achieve 100% of all six process measures associated with VTE Care. (T, E, Ef, Eq, P) Q4: There were 34 compliant process measures and 35 opportunities noted.	
TFH Stroke Care (0 pts)	No Patients	100.0%	Goal: To achieve 100% of all six process measures associated with Stroke Care. (T, E, Ef, Eq, P) Q4: There were no applicable stroke cases	

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TFHS Goal*
Benchmark*
Quarterly Performance

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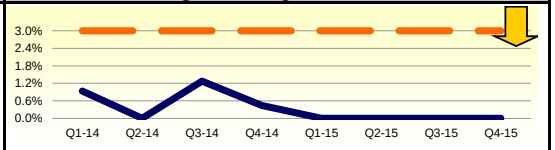
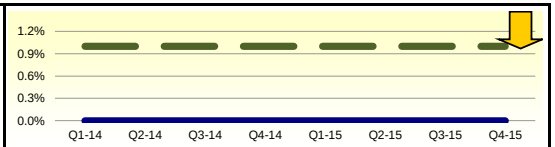
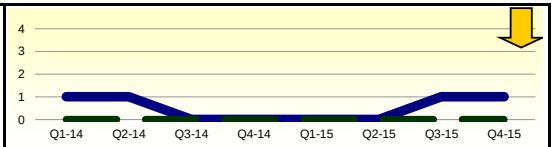
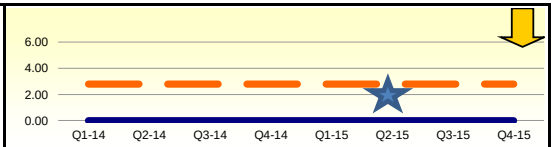
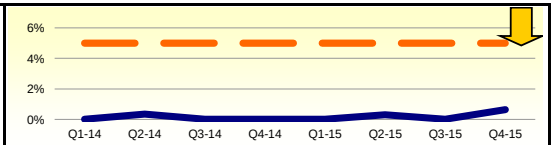
Quality Measures	Q4-2015	Goal	Goal Description and Quarterly Events	Quarterly Trend
TFH Hospital Acquired Surgical Infections	0.00%	1.0%	Goal: SSI 0% or a procedure-specific Standardized Infection Ratio (SIR) <1 when # of surgeries allows for SIR calculation. (replaces national average) Q4: There were no surgical infections noted	
TFH Hospital Acquired non-Surgical Infections	0.0%	0.0%	Goal: device-related HAI and AIM 0% and SIR <1; SIR is calculated when predicted # of infections is greater or = to 1. represents a roll-up of device-related infections: CLABSI, VAE, CAUTI, and MRSA infections. Q4: There were no HAI noted that met surveillance definitions.	
TFH Hospital Acquired Conditions	Data not available	0	Goal: To minimize hospital acquired conditions. This number represents a roll up of air embolism, blood incompatibility, DVT & pulmonary emboli following ortho surgery & foreign object retained after surgery (S) Q4: There was 0 Hospital Aquired Condition noted.	
TFH Falls Rate with Moderate/Severe Injury	0.00	0.00	Goal: To minimize the number of inpatient falls that result in moderate or severe injury. Rate is represented at a rate per 1000 inpatient days. The National Average is 2.48 falls per 1000 patient days.(S, P) Q4: There were 0 inpatient falls with Moderate to Severe Injury noted.	
TFH Pressure Ulcers Rate	0.65%	4.15%	Goal: To minimize the number of inpatient pressure ulcers. Rate is represented as a percentage of inpatient admissions. National Average Estimate = 4.15% (S, E, P) Q4: There were 2 pressure ulcers noted.	

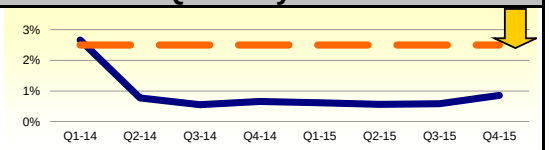
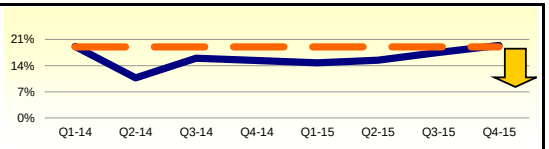
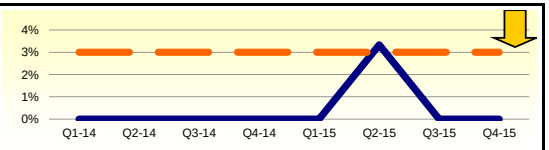
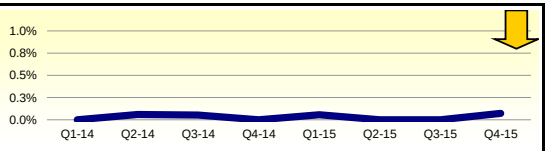
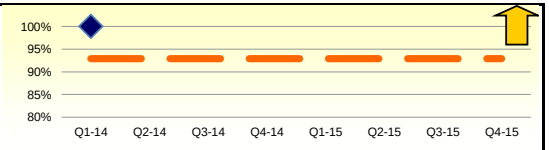
S-safe, T-timely, E-effective, EF-efficient, EQ-equitable, P-patient centered

TFHS BOD Quality Scorecard

- Goal Met or Exceeded
- Within 10% Negative Variance of Goal
- Greater than 10% Negative Variance

TFHS Goal*
Benchmark*
Quarterly Performance

* Unless Noted Otherwise

Quality Measures	Q4-2015	Goal	Goal Description and Quarterly Events	Quarterly Trend
Patients returning to ED wihting 72hrs with same complaint requiring inpatient admission	0.9%	2.5%	Goal: To minimize the number of ED patients who return within 72 hrs of discharge with the same diagnosis. This rate is represented as a percentage of ED registrations. National Average = 2.5% (EQ, P) Q4: 27 readmissions of 3174 patients within 72 hours were noted.	
Primary C-Section Rate	17.5%	19.0%	Goal: To minimize the number of primary C-Sections. This rate is represented as a percentage of neonatal deliveries. National Average = 19% (S, EF) Q4: There were 19 primary cesarean sections and 98 deliveries.	
IVCH Hospital Acquired Surgical Infections	0.0%	1.0%	Goal: SSI 0% or a procedure-specific Standardized Infection Ratio (SIR) <1 when # of surgeries allows for SIR calculation. Q4: 0 Surgical Site Infection noted	
IVCH Medication Errors	0.1%	0.0%	Goal: To minimize the rate of medication errors that reach the patient. National Average Estimate = 5% (S, T, E) Q4: There was 1 medication error requiring monitoring.	
IVCH Pneumonia Care (0 pts)	Measure Discontinued		Goal: Measure Set Discontinued by CMS	

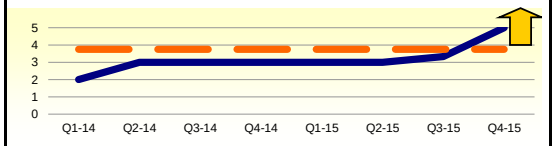
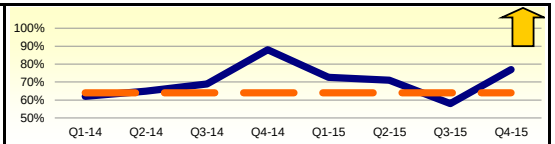
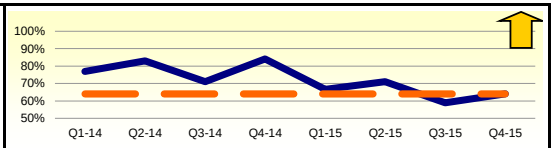
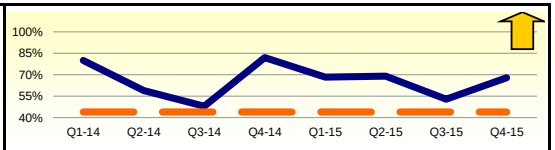
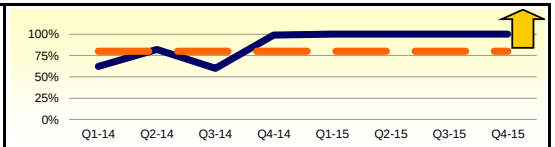
S-safe, T-timely, E-effective, EF-efficient, EQ-equitable, P-patient centered

TFHS BOD Quality Scorecard

- Goal Met or Exceeded
- Within 10% Negative Variance of Goal
- Greater than 10% Negative Variance

TFHS Goal*
Benchmark*
Quarterly Performance

* Unless Noted Otherwise

Quality Measures	Q4-2015	Goal	Goal Description and Quarterly Events	Quarterly Trend
SNF 5-Star Quality Rating	5	5	Goal: To maintain an overall 5-Star rating for the CMS Nursing Home Criteria. This includes Health Inspection deficiencies, Nursing Home Staffing Measures (4), Quality Measures (19), and Fire Inspection deficiencies (S, T, E, E, E, P) Q4: Improved to 5 stars in October	
Home Health Percentage Improvement in Pain	77.0%	64.0%	Goal: P4P measurement, managing pain and treating symptoms, how often patients had less pain when moving around. Q4: Increase from 58.0% to 77.0%	
Home Health Percentage Improvement in Bathing	64.0%	64.0%	Goal: P4P measurement, managing daily activities, how often patients go better at bathing. Q4: Increase from 59.0% to 64.0%	
Home Health Percentage Improvement in Ambulation/ Locomotion	68.0%	44.0%	Goal: P4P measure, managing daily activities, how often patients got better at walking or moving around. Q4: increase from 53.0% to 68.0%	
Home Health Percentage Improvement in Surgical Wounds	100.0%	80.0%	Goal: P4P measure, treating wounds and preventing pressure sores, how often patients wounds improved or healed after an operation. (S, T, E, P) Q4: maintained performance at 100%	

S-safe, T-timely, E-effective, EF-efficient, EQ-equitable, P-patient centered

Medicare Beneficiary Quality Improvement Project (MBQIP): Improving Care Through Information

Hospital IQR Hospital Performance - Survey Completion and Response Rate

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures and Star Ratings: Third Quarter 2014 through Second Quarter 2015 Discharges

051328 - Tahoe Forest Hospital
Truckee, CA 96160

Number of Completed Surveys	430
Survey Response Rate	34
HCAHPS Summary Star Rating	**4 Stars**

		HCAHPS Star Rating	Your Hospital's adjusted score			State Average			National Average		
HCAHPS Composites		**Star Rating (0 out of 5)**	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Composite 1 (Q1 to Q3)	Communication with Nurses	5	2	10	88	6	19	75	4	16	80
Composite 2 (Q5 to Q7)	Communication with Doctors	4	4	11	85	6	16	78	4	14	82
Composite 3 (Q4 & Q11)	Responsiveness of Hospital Staff	4	6	16	78	12	26	62	9	23	68
Composite 4 (Q13 & Q14)	Pain Management	4	4	20	76	8	23	69	7	22	71
Composite 5 (Q16 & Q17)	Communication about Medicines	4	13	15	72	20	19	61	18	17	65
Hospital Environment Items		**Star Rating (0 out of 5)**	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Q8	Cleanliness of Hospital Environment	4	5	10	85	10	20	70	8	18	74
Q9	Quietness of Hospital Environment	4	7	30	63	16	33	51	9	29	62

Star Ratings Legend
5 Stars: Excellent
4 Stars: Above Average
3 Stars: Average
2 Stars: Below Average
1 Star: Poor

Please direct questions regarding your MBQIP data reports to the Flex Coordinator in your State. You can find contact information for your Flex Coordinator at: http://www.ruralcenter.org/tasc/flexprofile/2011.

Medicare Beneficiary Quality Improvement Project (MBQIP): Improving Care Through Information

Hospital IQR Hospital Performance - Survey Completion and Response Rate

Hospital CAHPS (HCAHPS) Survey

Reporting Period for HCAHPS Measures and Star Ratings: Third Quarter 2014 through Second Quarter 2015 Discharges

051328 - Tahoe Forest Hospital
Truckee, CA 96160

		HCAHPS Star Rating	Your Hospital's adjusted score			State Average			National Average		
Discharge Information Composite		**Star Rating (0 out of 5)**	**% Yes**		**% No**	**% Yes**		**% No**	**% Yes**		**% No**
Composite 6 (Q19 & Q20)	Discharge Information	4	89		11	85		15	86		14
Care Transition Composite		**Star Rating (0 out of 5)**	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always	% Sometimes to Never	% Usually	% Always
Composite 7 (Q23 & Q25)	Care Transition	4	2	41	57	7	44	49	5	43	52
HCAHPS Global Items		HCAHPS Star Rating	Your Hospital's adjusted score			State Average			National Average		
Q21	Overall Rating of Hospital	Star Rating (0 out of 5)	% 0 to 6 rating	% 7 and 8 rating	% 9 and 10 rating	% 0 to 6 rating	% 7 and 8 rating	% 9 and 10 rating	% 0 to 6 rating	% 7 and 8 rating	% 9 and 10 rating
Overall Rating of Hospital (1 = Worst Hospital 10 = Best Hospital)		5	4	13	83	10	22	68	8	21	71
Q22	Willingness to Recommend this Hospital	Star Rating (0 out of 5)	% No: Definitely or Probably Not Recommend	% Yes: Probably Recommend	% Yes: Definitely Recommend	% No: Definitely or Probably Not Recommend	% Yes: Probably Recommend	% Yes: Definitely Recommend	% No: Definitely or Probably Not Recommend	% Yes: Probably Recommend	% Yes: Definitely Recommend
Willingness to Recommend this Hospital		5	1	13	86	7	24	69	5	24	71

Star Ratings Legend
5 Stars: Excellent
4 Stars: Above Average
3 Stars: Average
2 Stars: Below Average
1 Star: Poor

Please direct questions regarding your MBQIP data reports to the Flex Coordinator in your State. You can find contact information for your Flex Coordinator at: http://www.ruralcenter.org/tasc/flexprofile/2011.

Patient Sticker

Date: _____ Room#_____ Rounding completed by:_____

Daily Leadership Rounding Questions:

1. How is your overall experience? How would you rate our hospital on a scale of 1 to 5?

---

2. Are you "always" receiving help as soon as you wanted?_____
If no, details: _____

3. Are you "always" having your pain well controlled? _____ What is your goal/expectation? _____
_____

4. Are staff "always" explaining about medicines before giving them to you?_____
If no, details _____

5. How is the cleanliness of your room? Is it "always" meeting your expectations?_____

6. How are we doing keeping the unit noise under control? Is it "always" quiet at night?_____

7. Explain they will be given information about what to do during their recovery at home. Explain that the staff will be available to answer any questions. Explain that follow-up numbers to call will be provided should they have question arise once they are home. ☐ Done

8. We would like to call you at home within a couple of days after your discharge. Is this alright with you? _____if yes, best phone number to reach you at: _____

Follow-up calls will be made to every inpatient after discharge within 48 hours to check on condition and readdress any concerns related to the above questions.

Follow-up call: Date: _____ Call made by: _____(please print name)

1. How are you feeling? _____
2. Did anyone from our leadership visit you during your stay? _____
3. Do you have any questions related to your discharge that I can have a nurse call you back about? _____if so, what? _____
   (RN will enter name and date below when call is completed)
4. You will be receiving a survey in the mail related to your stay. We would greatly appreciate you filling it out so we can follow-up on any feedback you have and continue to improve our service to you.

Follow up to question # 3:
Discharge question(s) answered by: _____ (please print name) Date_____

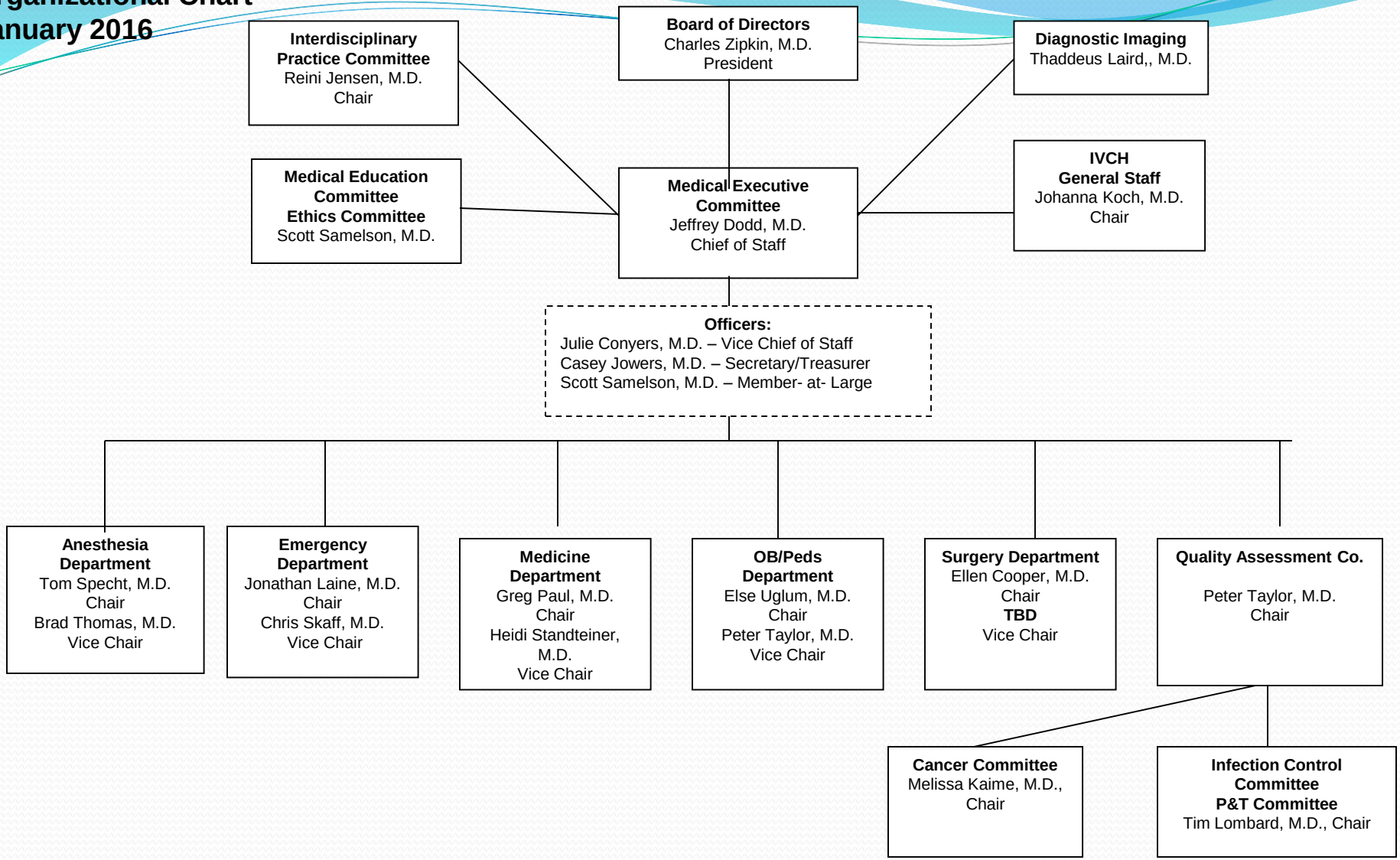
CREDENTIALING PRIVILEGING & PEER REVIEW PROCESS

TAHOE FOREST HOSPITAL DISTRICT

Tahoe Forest Hospital

Incline Village Community Hospital

Tahoe Forest Hospital District Medical Staff Organizational Chart January 2016



Definitions

1) **Credentialing** – a standardized process of inquiry which validates the candidates identity, background, education and training

2) **Privileging** – a standardized process determining the boundaries of each applicant's clinical knowledge, skills, competency, and as granted by the governing board to render specific professional, diagnostic, therapeutic, medical, surgical l, or dental services in a TFHD facility or in connection with its programs

3) **Appointment** – determining whether a candidate will be a member of the medical staff and if so, in what membership category

4) **Peer Evaluation** – Formal documentation received during the initial & re-appt for staff privileges process.

5) **Peer Review** – A participatory process that monitors important aspects of care provided by a hospital's individual practitioners. Results of peer review are used in the medical staff reappointment process as well as for ongoing professional practice evaluation. When the results of peer review indicate a need for performance improvement at the individual and/or aggregate levels, appropriate quality improvement activities are undertaken to ensure that improvement occurs.

6) **Performance Indicator/Measure -** A clearly defined statement describing Information to be collected for purposes of improving processes and outcomes of care.

7) **Quality Assurance -** Systematic monitoring and evaluation of the various aspects of a project or service.

8) **Quality Improvement -** The practice of continuously assessing and adjusting performance using statistically and scientifically accepted procedures.
An ongoing process to measure and improve performance.

9) **QA+QI (OPPE – Ongoing Professional Practice Evaluation) –** A screening tool to evaluate all practitioners who have been granted privileges and to identify those clinicians who might be delivering an unacceptable quality of care. [Note: May also be used to identify those who have no quality of care issues.]

Credentialing's Triple Aim

- Protect the patient
- Facilitate clinical practice
- Support organizational goals

Granting clinical privileges requires :

First , that the requestor is qualified to apply

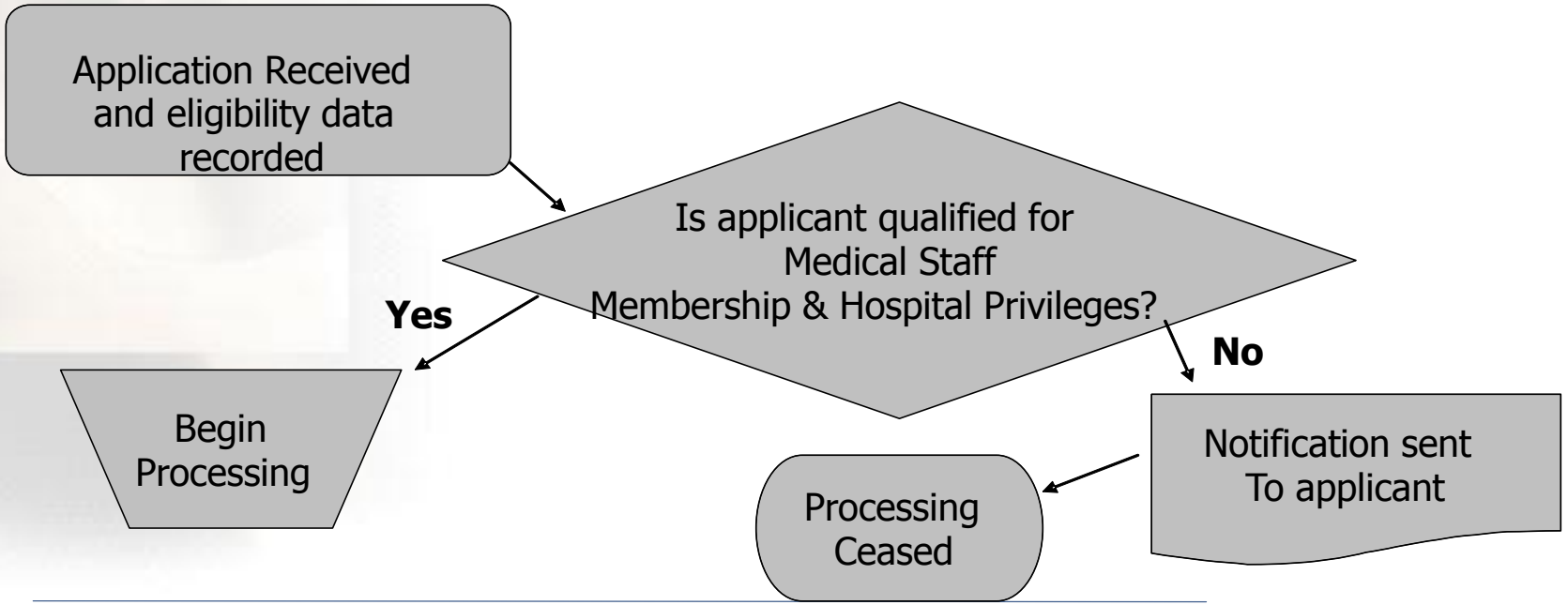
Second , the requestor has direct or relevant recent Experience (training, experience, judgment)

Third , the experience has been of acceptable quality (competency)

Application for Appointment

Step One Qualifications for Membership

"No one is permitted to practice without a ticket"



Privileging – Governing Regulations

- Privileges must be individually assessed
- Privileges granted and renewed on the basis of criteria that cite training and demonstrated competence
  - Not all practitioners in a specialty can be assumed to have equivalent competence
  - Some privileges may be performed by practitioners in more than one specialty (cross specialty lines)

AN APPLICATION IS INCOMPLETE IF:

- Supporting information is not supplied
- Concerns are not resolved
- There are gaps in professional experience
- There are unanswered questions

Qualifications for Membership

1) Unrestricted Licensure in California and/or Nevada
2) Unrestricted DEA (CA and/or NV)
3) Not terminated from another staff for competency or behavioral concerns
4) Not excluded from CMS (Medicare)
5) Board Certification or Admissibility
6) Appropriate training and demonstrated current competence
7) Willingness to discharge the responsibilities of the medical staff
8) No felony convictions.
9) Request consistent with the hospital's mission and resources

FOCUSED PROFESSIONAL PRACTICE EVALUATION

- Assess privilege specific competence
- Proctoring
- Provide guidance
- Identify and address concerns:

Cases that fall out because of perceived problems, undesirable outcomes, or are part of a disturbing trend will be reviewed

CATEGORICAL REVIEW [Initial Applicants]
Category 1 (clean file-no issues)

a) Consecutively completed all training within 3 years of submitting application

b) Privileges requested are consistent with core as defined for that specialty

d) No suggestions of potential problems & no prior malpractice or disciplinary actions, licensure restrictions or any type of investigations in last 2 years

CATEGORICAL REVIEW [Initial Applicants]
Category 2 (questions)

a) Training not consecutive or completed training more than 3 years before receipt of application

b) Has greater than 4 current medical licenses

c) Has requested privileges that vary from those consistent with core for that specialty or varies substantially

d) Evaluation not received in prescribed format or negative responses

e) A Cat 1 application in which any of the recommendations of the chairman vary

f) Applicant has a malpractice claims history

CATEGORICAL REVIEW [Initial Applicants] Category 3 (controversial)

:

a) Current or previously successful challenge to license or registration

b) Involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity

c) An unusual pattern of, or an excessive # of, professional liability actions, resulting in a final judgment against applicant

d) Practitioner who is currently or previously participated in a health professionals assistance program

CATEGORICAL REVIEW [Reappointments]
Category 1 (clean file-no issues)

a) Requested privileges that are consistent with core

b) All references contain only favorable or neutral evaluations

c) No pending or past investigations or reports of disciplinary action

d) No questions raised about qualifications or privileges

e) No negative findings, e.g. quality of care, behavior, compliance with regulations

f) No malpractice claims in last 2 years

CATEGORICAL REVIEW [Reappointments]

Category 2, Cont'd

a) Applicant has requested privileges that vary from those consistent with the core privileges as defined for that specialty

b) Evaluation contained neutral or negative responses

c) Pending or past investigations or reports of disciplinary action

d) Questions have been raised by a member of medical staff regarding applicant's qualifications for appointment or clinical privileges

e) Peer review information contains negative findings, regarding quality of care, behavior, or compliance with regulations.

CATEGORICAL REVIEW [Reappointments]
Category 2 (cont'd)

f) Has less than 20 hospital encounters in previous 2 years (low volume practitioner)

g) Any other concern raised by any person which may cause concern to Credentials/MEC

h) Currently participating in a health professional's assistance or diversion program

CATEGORICAL REVIEW [Reappointments] Category 3 (controversial)

<u>One or more of the following not previously reported</u> :

a)Current or previously successful challenge to any license or registration

b)Involuntary termination, limitation, reduction, denial, or loss of appointment or privileges t any other hospital or entity

c)Unusual pattern of, or an excessive number of, professional liability actions, resulting in a final judgment against the applicant

The Power of the Pyramid

QUESTIONS?

ACCREDITATION ASSOCIATION FOR
HOSPITALS / HEALTH SYSTEMS

Achieve AAHHS Accreditation

SHOW THE WORLD YOUR RURAL HOSPITAL IS WORLD CLASS

HELPING HOSPITALS HELP THEIR COMMUNITIES

Your hospital is a vital part of your community. Not only the hub for the health and well-being of your area, but also a deeply-rooted source of pride for every inhabitant. A place where patients are your neighbors and physicians your friends.

There is no better way to demonstrate to your community that the quality of care you deliver is truly world class than to attain accreditation from the Accreditation Association for Hospital and Health Systems (AAHHS).

What Makes AAHHS Accreditation Different?

- Our surveys are collaborative and consultative rather than prescriptive or dictatorial. We are not here to look for ways to catch you out, but to help you raise the bar on the care your staff provides.
- Our surveyors are healthcare professionals, highly experienced in the small hospital environment, and have gone through a rigorous training program to conduct surveys at hospitals like yours.
- Our staff has over 50 years of experience in accreditation, along with intensive knowledge of working with government agencies.
- Much like the one-on-one care you deliver to your patients, we also bring a more personal touch to our surveys. That's why we offer a consultative conference call with your staff prior to the survey as a helpful, value-added part of the process.
- As we developed our accreditation program, we reached out to the smaller hospital community to seek their input on our Standards, the survey process, and the pilot surveys, to ensure that our accreditation approach was perfectly tailored to the world of small hospitals.
- Our focus is wholly on the rural hospital, critical access hospital (CAH), and small surgical/specialty hospital.
- Our staff is always ready to help you whenever you have questions or need more information.

SHOW YOUR PRIDE AND YOUR CONFIDENCE IN THE CARE YOU DELIVER TO YOUR COMMUNITY.

How AAHHS was Created

AAHHS is a sister organization to the Accreditation Association for Ambulatory HealthCare (AAAHC), the leading accrediting organization for ambulatory care. AAAHC has been around since 1979 and grown rapidly to become the nation's leading accrediting body for all types of ambulatory centers including ambulatory surgery centers, office-based surgery centers, college health centers, medical and dental groups, community and Indian health centers, military health clinics and health plan organizations, among others.

AAAHC saw that rural hospitals, critical access hospitals (CAH), and small specialty/surgical hospitals are often below the radar where accreditation is concerned – even though they maintain extremely high standards of care. In 2012, AAHHS was created specifically to fill this need. At AAHHS, we offer an accreditation process that was designed from the outset to evaluate the personal approach to patient care typical of hospitals like yours. We bring the same personal touch to our accreditation process.

SHOW THE WORLD YOUR RURAL HOSPITAL IS WORLD CLASS

AAHHS Standards

Our Standards, which are contained in the AAHHS Accreditation Handbook, have been meticulously tailored to suit the prevailing patient care approach of the small hospital, and based on the CMS Conditions of Participation (CoP). They are written in simple, non-technical language with worksheets and resources included for easy reference, making it easy for you to perform a self-assessment to get your hospital ready for the AAHHS survey.

As mentioned earlier, we reached out to the smaller hospital community to seek feedback on our Standards. This made sure that our Standards were tailored to your hospital environment.

Types of Survey

We offer accreditation for both the newly-opened hospital as well as for the established hospital in a survey that can be immensely beneficial in its consultative nature.

Accreditation Survey

This is the regular survey for hospitals that have been open for six months or more.

Early Option Survey

The early option survey is designed for hospitals newly-opened, or under new ownership, that require accreditation for third party payers, insurance reimbursement, or licensing purposes.

For both types, we offer a three-year term of accreditation.

SHOW YOUR PRIDE AND YOUR CONFIDENCE IN THE CARE YOU DELIVER TO YOUR COMMUNITY.

The Survey Process

Compared to other types of accreditation, the AAHHS Survey process may just be one of the simplest and easiest paths to attaining accreditation for your hospital. As mentioned previously, the Standards Handbook is written in understandable, non-technical language and laid out in a way that is easy to follow.

Once you obtain the AAHHS Standards Handbook, we encourage you to conduct a self-assessment. This enables you to feel confident that you are ready for a survey. After you submit your application, we offer a consultative conference call with your staff prior to your survey to assist you with any questions you may have. We are also exploring the feasibility of reducing the amount of on-site survey time by performing some interviews via telecommunication. This process may be offered to you when you apply for the accreditation survey.

Additionally, the Chair of the surveyor team will call you approximately one week before the survey to review any questions you have about the survey. This new process is intended to shorten the time of the subsequent on-site visit, and reduce the time your staff is distracted from their day-to-day responsibilities.

Six Simple Steps to AAHHS Accreditation

1. Obtain the AAHHS Accreditation Handbook and conduct a self-assessment of your facility. (This is strongly recommended.)
2. Make any adjustments or changes you deem necessary to comply with our Standards.
3. Complete the online Application for Survey and submit to AAHHS.
4. AAHHS contacts you to arrange a mutually convenient date for the announced survey.
5. The survey team conducts the survey.
6. AAHHS informs you of the accreditation decision.

SHOW THE WORLD YOUR RURAL HOSPITAL IS WORLD CLASS

Why You Should Seek AAHHS Accreditation

1 AAHHS accreditation can help you raise the bar in providing safe, high quality care. It ensures that your hospital adopts best practice and delivers patient care at nationally-recognized Standards.

2 AAHHS accreditation brings you public recognition and helps give your hospital a competitive edge against larger metro hospitals.

3 Our accreditation process is collaborative and consultative. AAHHS surveyors frequently offer suggestions on ways to improve your systems without it being part of the accreditation decision; simply a suggestion from one peer to another.

4 We offer educational seminars taught by expert faculty members who take you step by step through the accreditation process. These sessions discuss the Standards in detail, focus on quality improvement (QI) and demonstrate best practices. The seminars also provide small breakout groups in which you can network with members of other hospitals like yours.

5 AAHHS accreditation not only boosts the self-esteem of your staff by knowing that your hospital delivers care at nationally-recognized Standards, but it can also be a powerful incentive for attracting the best and brightest as you recruit new staff members.

6 Our accreditation is competitively priced and we offer payment plans to make the expense easier on your bottom line.

7 If you are wondering why you should attain AAHHS accreditation when you can get a State inspection at no expense, here's why: AAHHS accreditation is a far truer test of your care protocols. You are reviewed by your peers - professionals whose opinion means more than bureaucrats. The consultative comments alone that AAHHS surveyors can provide are worth every penny. Hospitals that have achieved AAHHS accreditation say they reaped huge benefits from the surveyors' suggestions.

SHOW YOUR PRIDE AND YOUR CONFIDENCE IN THE CARE YOU DELIVER TO YOUR COMMUNITY.

AAHHS MISSION

To help hospitals and health systems better serve the community through accreditation, education and research.

AAHHS VISION

All hospitals and health systems will deliver patient care that exceeds universally recognized standards.

The AAHHS Board of Directors

Our Board of Directors was established to meet a need for peer-based, quality-driven accreditation for smaller hospitals. It comprises highly experienced professionals representing the hospital community.

The Board saw a crucial need to develop measurable Standards of care and promote a culture of excellence in the rural hospital community.

Archer Rose, FACHE; Member: Former Hospital CEO in Georgia and Virginia.

Pat Schou, RN, MS, FACHE; Member: Executive Director at the Illinois Critical Access Hospital Network.

Brock Slabach, MPH, FACHE; Member: Senior Vice-President for member services of the National Rural Hospital Association (NRHA); former CEO of a rural hospital in Mississippi.

Jack Egnatinsky, MD; Member: Anesthesiologist with extensive experience in the ambulatory surgery arena, both HOPD and ASC; Fellow of the American Board of Anesthesiology.

Mark S. DeFrancesco, MD, MBA; Member: Chief Medical Officer of Women's Health Connecticut; National Past Secretary of the American College of Obstetricians and Gynecologists.

John Burke, PhD, President & CEO, AAHHS: Ex-Officio Member.

SHOW THE WORLD YOUR RURAL HOSPITAL IS WORLD CLASS

Show your pride and your confidence in the care you deliver to your community. Achieve AAHHS accreditation and let the whole world know that your hospital is truly world class.

ACCREDITATION ASSOCIATION FOR
HOSPITALS / HEALTH SYSTEMS

If you would like more information or have questions, please contact Meg Gravesmill at 847-853-6073 or **mgravesmill@aahhs.org;** or Marci Ramahi at 847-853-6082 or **mramahi@aahhs.org**.
For general information, visit our web site at **www.aahhs.org.**

HELPING HOSPITALS HELP THEIR COMMUNITIES

National Quality Forum (NQF) Endorsed Set of 34 Safe Practices*

HFAP Acute Care Accreditation Hospital Manual

NQF Endorsed Set of Safe Practices		*2015 Summary of Activities*
1.	**Leadership Structures and Systems** Leadership structures and systems must be established to ensure that there is organization-wide awareness of patient safety performance gaps, direct accountability of leaders for those gaps, and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.	PS/RM Plans approved by BOD in Jan 2015. Quarterly reports to all levels of the organization.
2.	**Culture Measurement, Feedback, and Intervention** Healthcare organizations must measure their culture, provide feedback to leadership and staff, and undertake interventions that will reduce patient safety risk.	AHRQ Culture of Safety Survey; internal and external risk assessments.
3.	**Teamwork Training and Skill Building** Healthcare organizations must establish a proactive, systematic, organization- wide approach to developing team-based care through teamwork training, skill building, and team-led performance improvement interventions that reduce preventable harm to patients.	BETA staff communication education focused RCT to PI specific issues
4.	**Identification and Mitigation of Risks and Hazards** Healthcare organizations must systematically identify and mitigate patient safety risks and hazards with an integrated approach in order to continuously reduce preventable patient harm.	Safety surveillance in Quantros; RCA & case conf when indicated; summary & action plans reported to departments
5.	**Informed Consent** Ask each patient or legal surrogate to "teach back," his or her own words, key information about the proposed treatments or procedures for which he or she is being asked to provide informed consent.	Policy & forms revised; staff Educated. Consent " Teach back" Initiative pending
6.	**Life-Sustaining Treatment** Ensure that written documentation of the patient's preferences for life- sustaining treatments is prominently displayed in his or her	Initiative pending.
7.	**Disclosure** Following serious unanticipated outcomes, including those that are clearly caused by systems failures, the patient and, as appropriate, the family should receive timely, transparent, and clear communication concerning what is known about the event.	Policy & process revised. Team training from BETA & process in operation.

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8.	**Care of the Caregiver** Following serious unintentional harm due to systems failures and/or errors that resulted from human performance failures, the involved caregivers (clinical providers, staff, and administrators) should receive timely and systematic care to include: treatment that is just, respect, compassion, supportive medical care, and the opportunity to fully participate in event investigation and risk identification and mitigation activities that will prevent future events.	Assessed in #7; Nursing CE series scheduled.
9.	**Nursing Workforce** Implement critical components of a well-designed nursing workforce that mutually reinforce patient safeguards, including the following: • A nurse staffing plan with evidence that it is adequately resourced and actively managed and that its effectiveness is regularly evaluated with respect to patient safety. • Senior administrative nursing leaders, such as a Chief Nursing Officer, as part of the hospital senior management team. • Governance boards and senior administrative leaders that take accountability for reducing patient safety risks related to nurse staffing decisions and the provisions of financial resources for nursing services. • Provision of budgetary resources to support nursing staff in the ongoing acquisition and maintenance of professional knowledge	NLC/HR plan in place
10.	**Direct Caregivers** Ensure that non-nursing direct care staffing levels are adequate, that staff is competent, and that they have had adequate orientation, training, and education to perform their assigned direct care duties.	NLC/HR plan in place
11.	**Intensive Care Unit Care** All patients in general intensive care units (both adult and pediatric) should be managed by physicians who have specific training and certification in critical care medicine.	Policies in place; audit by Medical Staff Services
12.	**Patient Care Information** Ensure that care information is transmitted and appropriately documented in a timely manner and in a clearly understandable form to patients and to all of the patient's healthcare providers/professional, within and between care settings, who need that information to provide continued care.	EMR eval in process. SBAR, CUS & handoff policies & forms in place. Education complete.

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13.	**Order Read-Back and Abbreviations** Incorporate within your organization a safe, effective communication strategy, structures, and systems to include the following: • For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person who is receiving the information record and "read-back" the complete order or test result. • Standardize a list of "**Do Not Use**" abbreviations, acronyms, symbols, and dose designations that cannot be used throughout the organization.	Policy in place; staff educated. Audited compliance in process. Quality criteria in physicians' contracts.
14.	**Labeling of Diagnostic Studies** Implement standardized policies, processes, and systems to ensure accurate labeling of radiographs, laboratory specimens, or other diagnostic studies, so that the right study is labeled for the right patient at the right time.	Policy & process in place. Staff educated.
15.	**Discharge Systems** A "discharge plan" must be prepared for each patient at the time of hospital discharge, and a concise discharge summary must be prepared for and relayed to the clinical caregiver accepting responsibility for post-discharge in care in a timely manner. Organizations must ensure that there are confirmations of receipt of the discharge information by the independent licensed practitioner who will assume the responsibility for care after discharge.	Policy & process in place; staff educated. Newly implemented Care Coordination Program.
16.	**Safe Adoption of Computerized Prescriber Order Entry** Implement a computerized prescriber order entry (CPOE) system built upon the requisite foundation of re-engineered evidence-based care, an assurance of healthcare organization staff and independent practitioner readiness, and an integrated information technology infrastructure.	Pending on eval of new EMR.
17.	**Medication Reconciliation** The healthcare organization must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care.	Policy, education & audit in place. RCT PI teams for in-patient and out-patient.
18.	**Pharmacist Leadership Structures and Systems** Pharmacy leaders should have an active role on the administrative leadership team that reflects their authority and accountability for medication management systems performance across the organization.	In Revision by NQF. Manages MERP at TFHS. Co-chairs P&T. Member of NLC.

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19.	**Hand Hygiene** Comply with current Centers for Disease Control (CDC) and Prevention Hand Hygiene Guidelines, World Health Organization (WHO) Guidelines on Hand Hygiene and Institute for Healthcare Improvement (IHI) – Improving Hand Hygiene – Improving Hand Hygiene.	Policy, staff education and audit in place. Approved & reported to IC Comm.
20.	**Influenza Prevention** Comply with current Centers for Disease Control and Prevention (CDC) recommendations for influenza vaccinations for healthcare personnel and the annual recommendations of the CDC Advisory Committee on Immunization Practices for individual influenza prevention and control.	Same as #19.
21.	**Central Line-Associated Bloodstream Infection Prevention** Take actions to prevent central line-associated bloodstream infection by implementing evidence-based intervention practices.	Same as # 19.
22.	**Surgical-Site Infection Prevention** Take action to prevent surgical-site infections by implementing evidence- based intervention practices.	Same as #19.
23.	**Care of the Ventilated Patient** Take actions to prevent complications associated with ventilated patients: specifically, ventilator-associated pneumonia, venous thromboembolism, peptic ulcer disease, dental complications, and pressure ulcers.	Policy, education, order set & audit in place.
24.	**Multidrug-Resistant Organism Prevention** Implement a systematic multi-drug resistant organism (MDRO) eradication program built upon the fundamental elements of infection control, an evidence-based approach, and a re-engineered identification and care process for those patients with or at risk for MDRO infections. Note: This practice applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant *Staphylococcus aureus*, vancomycin-resistant *enterococci*, and *Clostridium difficile*. Multidrug-resistant gram-negative bacilli, such as *Enterobacter* species, *Klebsiella* species, *Pseudomonas* species, and *Escherichia coli*, and vancomycin-resistant *Staphylococcus aureus*, should be evaluated for inclusion on a local system level based on organizational risk assessments."	Abx. Stewardship Policy in place. New ID consultants on staff. Lab & Pharmacy monitoring. Reported to IC Comm.

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25.	**Catheter-Associated Urinary Tract Infection Prevention** Take actions to prevent catheter-associated urinary tract infection by implementing evidence-based intervention practices.	Order set, education & monitoring in IC Plan.
26.	**Wrong-Site, Wrong-Procedure, Wrong-Person Surgery Prevention** Implement universal guidelines for preventing surgery on the wrong person or the wrong site or for performing the wrong procedure for all invasive practices.	Policy & form revision; staff education complete.
27.	**Pressure Ulcer Prevention** Take actions to prevent pressure ulcers by implementing evidence-based intervention practices.	Initiative pending. Admit assessment monitoring in place.
28.	**Venous Thromboembolism Prevention** Evaluate each patient upon admission, and regularly thereafter, for the risk of developing venous thromboembolism. Utilize clinically appropriate, evidence-based methods of thromboprophylaxis.	VTE order set; staff education & monitoring.
29.	**Anticoagulation Therapy** Organizations should implement practices to prevent patient harm due to anticoagulant therapy.	Same as #28.
30.	**Contrast Media-Induced Renal Failure Prevention** Utilize validated protocols to evaluate patients who are at risk for contrast media-induced renal failure and gadolinium-associated nephrogenic systemic fibrosis, and utilize a clinically appropriate method for reducing the risk of adverse events based on the patient's risk evaluations.	Policy and staff education complete.
31.	**Organ Donation** Hospital policies that are consistent with applicable law and regulations should be in place and should address patient and family preferences for organ donation, as well as specify the roles and desired outcomes for every stage of the donation process.	Policy & staff education in place.
32.	**Gylcemic Control** Take actions to improve glycemic control by implementing evidence-based intervention practices that prevent hypoglycemia and optimize the care of patients with hyperglycemia and diabetes.	Initiative pending.
33.	**Fall Prevention** Take actions to prevent patient falls and to reduce fall-related injuries by implementing evidence-based intervention practices.	Policy, Yellow ID plan, nursing assessment in process. Audit in Quantros

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34.	**<u>Pediatric Imaging</u>** When CT imaging studies are undertaken on children, "child-size" techniques should be used to reduce unnecessary exposure to ionizing radiation.	Policy & staff education in place.

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The Roles of Quality, Safety, and Technology as Financial Risks Are Shifted to Hospitals

BY WILLIAM C. MOHLENBROCK, M.D., FACS, VERRAS HEALTHCARE INTERNATIONAL

The entire American healthcare system and hospital boards in particular are again at a crossroads. Both were irrevocably transformed in 1965 by the introduction of Medicare and the *Darling* legal decision. Medicare began the shift from private to public funding and *Darling* shifted responsibilities for hospitals' quality of care from physicians to "hospital governing boards."[1] Now, 2016 launches a massive expansion of board responsibilities to include taking full financial risks for Medicare's Comprehensive Care for Joint Replacement (CJR) patients. This latest iteration represents a new healthcare financing model that imposes tremendous economic risks on CJR designated hospitals. But, great risks are accompanied by great opportunities for those who are prepared. CMS will reward hospitals and their medical staffs for delivering high-quality, cost-efficient outcomes, the net saving of which can then be legally shared with physicians.

Quality, Costs, and the CJR Episode

Beginning April 1, 2016, over 800 hospital boards in 67 U.S. regions will experience the full weight of their quality and fiduciary responsibilities. This date begins a preparatory year before CMS mandates the transfer of all financial risks to these hospitals for total hips and knees, including all costs incurred during patients' 90-day post-discharge period. Moreover, CJR heightens the focus on two of the most fundamental, inpatient cost components for which boards are also responsible: quality of care and patient safety. The nexus of medical quality and costs are profound. Over time, high quality is invariably cost-efficient in all industries, but especially in healthcare. This is because one complication or safety infraction doubles or triples a patient's hospital costs. Additionally, high-quality, cost-efficient outcomes define value, which fulfills the highest aspirations of both patients and payers.

All hospitals should use this preparatory year in the likely event the CJR bundle will soon be mandated for all U.S. regions. Under these pressures, collaboration between hospital administrators, boards, and physicians will be paramount. Each hospital should objectively and dispassionately assess its current levels of clinical quality and cost efficiencies, then make whatever course corrections are necessary to ensure net savings are generated. Lower extremity, total joint patients are often the hospitals' largest revenue source and for which negative cash flow could result in extreme financial hardships. Fortunately, CJR providers have a year's preparation to achieve these savings. Also, administrations will need to provide an objective means to equitably distribute the net savings among the hospital and physicians to avoid disputes over money. Clinical quality, patient safety, and cost efficiencies are disciplines in which modern information technology plays a critical role as hospital management and clinicians respond to the challenges posed by bundle payments.

Key Board Takeaways

Medicare's CJR will create significant financial risks for hospital boards and administrations in selected regional areas of the U.S. But, these risks can be offset by reimbursement opportunities for those who are prepared. This is due to the fact that CMS will reward hospitals and their medical staffs for delivering high-quality, cost-efficient outcomes, the net saving of which can then be legally shared with physicians. Three objectives the board should have for CJR and future bundles include:

- Provide physicians with clinical data to reliably produce bundled payment net savings.
- Objectively define clinical quality improvements on which to distribute net savings.
- Transparently share net savings among hospital and physicians, based on quality outcomes.

The Board's Three Objectives for CJR and Future Bundles

1. Provide information technologies for physicians to achieve net savings. The first hospital imperative is to ensure clinical and operational net savings are achieved for CJR patients, including inpatient, physician, and readmission costs. Without a positive cash balance there will be no dollars to offset the hospital's financial risks or to share with doctors. Inpatient expenses are usually over 50 percent of total CJR costs, so clinical and operational efficiencies are critical. Physicians admit, discharge, and direct 75 percent to 85 percent of all inpatient costs; therefore, a net savings at the physician level is key to financial success.

The most effective way to achieve a positive cash flow is for hospital information systems to demonstrate each physician's best-documented use of diagnostic and treatment resources (i.e., labs, pharmaceuticals, etc.). When doctors have their individual risk-adjusted, patient-specific data, they are able to collaborate among themselves and with hospital personnel to construct the most efficient two-level order sets for treating future patients. One order set is for less acutely ill patients and the other for severely ill patients within each diagnostic group, such as pneumonia or total hips.

2. Provide objective and transparent means to distribute net savings among the hospital and physicians. Since hospitals are at risk, they will receive any year-end net savings that are created by efficient patient care. Typically physicians believe their ordering patterns are responsible for generating the majority of these savings. In order to ensure the success of bundle payment episodes, doctors must trust the hospital administrators to accurately reward them with their fair share of net savings, based not only on financial, but also on clinical outcomes. This provider collaboration is a key component of the CJR risk-sharing model that incentivizes doctors to exert extra efforts in order to generate savings for the hospital, for themselves, and ultimately for CMS. Interestingly, net savings can be shared during 2016, a year before the start of hospital risk sharing.

3. Furnish oversight for selecting post-acute providers to manage CJR's 90-day, post-discharge phase. Board oversight for the post-acute selection process is important to current CJR designated hospitals and eventually to all hospitals. Deciding on which nursing homes, home health agencies, and physical therapists for contracting is generally not the expertise of hospital

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1 Darling v. Charleston Community Memorial Hospital, 211 N.E.2d 253 (1965).

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personnel. Administrators and board members need a strategy with possible outside consulting assistance to select and manage the most effective and efficient providers and agencies that can produce savings in the post-discharge phase. Once identified, physicians will be attentive as to which post-acute care providers they choose when discharging their patients, as prudent selections will increase their share of the episode's net savings.

Quality, Safety, Technology, and the Future of Inpatient Care

Physicians and hospitals are voluntarily pursuing risk-bearing, commercial contracts in order to maintain their incomes, but CJR is not voluntary. For the first time in its history, Medicare is mandating that selected hospitals accept inpatient and post-discharge financial risks for total hips and knees, which are usually a large portion of their businesses. Now that CMS has developed CJR as a working model that transfers significant financial risks onto hospitals, most physicians and healthcare executives believe it is going to be extended, first to other hospitals, then to additional patient groups.

Viability under CJR and future bundle payment models requires conservation of hospitals' finite resources. These efficiency efforts create net savings that are achieved primarily at the physician level. Distributing net savings among the hospital and physician participants using an objective, quality-based method will virtually guarantee physician endorsement and the success of any bundle payment model. To accomplish these quality improvements, patient safety, and efficiency goals, hospital administrations and boards must equip doctors with technologies that produce reliable clinical information for individual physicians, including down to individual lab test and X-ray levels. These tools plus inpatient and post-acute provider collaboration will ensure hospitals' ongoing success as they approach this latest crossroads of American healthcare.

The Governance Institute thanks William C. Mohlenbrock, M.D., FACS, Founder and Chief Medical Officer, Verras Healthcare International, for contributing this article. He can be reached at bmohlenbrock@verras.com.

Leading Operational Change at the Board Level…

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There are many similar victim variations, none your friends. It is not compassionate to avoid conflict in these situations, when a simple "no" is the necessary response. This small percentage consumes a great deal of board and leadership time and energy, seldom accepting the changes required wholly and completely. It is ineffective to organize your approaches or invest time in those who do not have the organization's interests in mind. If your goal is to please or satisfy them, they will continue to ask you to do so, regardless of your or your organization's needs. Consider helping these people find success somewhere else.

Five Steps to Take in the "First Critical Mile" of Major Change

Boards and leaders can ensure changes have a higher probability of success. These five steps will get things off to a good start:

1. **Listen respectfully to all stakeholders**, especially opponents and adversaries. These teachers will inform your plan.
2. **Assess "readiness,"** and expect variation in differing parts of the organization. Respond to capacity issues with resources, training, and coaching. Respond to desire issues with listening, and kind insistence that change be accomplished, that personal enrollment is expected. Be prepared to negotiate and conciliate. Ensure attention is paid to "endings" (emotions around what people are letting go of) as you prepare for new beginnings.
3. **Respectfully help those who cannot accept the change** to be successful elsewhere. After effort has been made, in the final analysis, if you can't change the people, you have to change the people.
4. **Ensure a balance of leader styles**, leaders who can, by virtue of their natural styles, offer multiple approaches to the changes required. Autocratic leaders are highly effective for low readiness, while participative leaders are more effective for a high level of readiness.
5. **Fully support board/executive decisions**, regardless of your own personal opinions regarding those decisions. Leaders must speak with one voice. Failure to visibly support the change in the eyes of those who must execute and then live with the changes undermines everyone.

Change leaders recognize that different types of change demand different approaches. Proper diagnosis of readiness and the ability to use more than one leadership style is complex. It requires that board and executive leaders build balanced executive and management teams with differentiated skills and styles to offer an array of leadership possibility for what might occur. Leading change requires time and patience in a world that offers little of either. Leaders set a pace allowing for successful integration ("re-freezing") and the "final miles" of realizing and sustaining the benefits of change. This also takes talent and experience, recognizing change leadership as a practice learned over time.

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