



TAHOE FOREST HOSPITAL DISTRICT

2017-07-11 Board Quality Committee Meeting

Tuesday, July 11, 2017 at 12:00 p.m.

Human Resources Conference Room - Tahoe Forest Hospital

10024 Pine Avenue, Truckee, CA 96161

Meeting Book - 2017-07-11 Board Quality Committee Meeting

07/11/17 Board Quality Committee

AGENDA

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No related materials.

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No related materials.

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No related materials.

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No related materials.

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QUALITY COMMITTEE AGENDA

Tuesday, July 11, 2017 at 12:00 p.m.
Human Resources Conference Room, Tahoe Forest Hospital
10024 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: 5/9/2017 ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. 2017 Quality Committee Focus ATTACHMENTS

Discuss status of BOD bylaw changes specific to the BOD Quality Committee focus, membership, meetings, and accountability.
BOD Quality Committee Focus 2017 was approved on March 14, 2017 and available for reference during the meeting.

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).

6.2.2. 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.

6.3. BOD Quality Reporting Calendar ATTACHMENT

Review the proposed quality reporting calendar and discuss topics of interest, the frequency of reports, and if this should be shared during open or closed session.

6.4. Hospice/Palliative Care Program

Provide an update of these programs and the plan to educate our community about access to these services.

6.5. Patient SafetyATTACHMENT

6.5.1 Educational Article

Review the *No Room for Error* article at <http://www.hopkinsmedicine.org/news/articles/no-room-for-error> and discuss lessons learned and areas for improvement for our organization.

6.5.2 AHRQ Patient Safety Culture Survey

Provide a status report on the biennial survey conducted in April/May 2017.

6.6. Quality Metrics.....ATTACHMENT

Review key quality and service metrics, how this is shared throughout the organization, and how plans for improvement are developed and monitored.

6.7. Medical Staff Quality Committee (MSQAC)

Discuss the option of having two Board members attend the MSQAC closed session to discuss case review process improvement.

6.8. Board Quality Education

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

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE

The date and time of the next committee meeting, Tuesday, September 19, 2017, at 12:00 p.m. will be confirmed.

9. ADJOURN

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

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

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

QUALITY COMMITTEE

DRAFT MINUTES

Tuesday, May 9, 2017 at 12:00 p.m.
Human Resources Conference Room, Tahoe Forest Hospital
10024 Pine Avenue, Truckee, CA 96161

1. CALL TO ORDER

Meeting was called to order at 12:01 p.m.

2. ROLL CALL

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

Staff: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operating Officer; Janet Van Gelder, Director of Quality and Regulations; Dr. Shawni Coll, Chief Medical Officer; Jean Steinberg, Director of Medical Staff Services; Trish Foley, Patient Advocate; Martina Rochefort, Clerk of the Board

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

No changes were made to the agenda.

4. INPUT – AUDIENCE

No public comment received.

5. APPROVAL OF MINUTES OF: 3/14/2017

Director Zipkin moved approval of the March 14, 2017 Quality Committee minutes, seconded by Director Wong.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Quality Committee Charter and 2017 Focus

Discussion was held about a possible future restructure of board committees. The Quality Committee should continue to exist.

Discussion was held of the Board of Directors Bylaws as they relate to the Board Quality Committee.

Committee provided the following suggested edits of the bylaws:

- Remove “minimum of two” and replace with “shall comprise of two board members”.
- Add Chief Medical Officer as a standing members of committee
- continue to meet at least 4 times per calendar year.
- reword 3d and add Quadruple AIM and STEEP

Quality Committee provided the following suggested edit for the draft charter:

- change “Process Improvement and Quality Assurance Programs” to “QAPI Plan”

Director Wong moved to strike the Quality Committee charter approved in 2014.

6.2. Patient & Family Centered Care (PFCC)

6.2.1. Patient & Family Advisory Council Update

TFHD Patient Advocate provided an update related to the activities of the Patient and Family Advisory Council (PFAC).

PFAC just celebrated its two year anniversary.

PFAC continues to have TFHD Department Directors attend their meetings.

Karen Aaron reviewed cancer center services and navigation at the last meeting.

Disclosure and care for the caregiver programs were also highlighted.

In September, BETA offers a complimentary program for training.

There will be a PFAC presentation to the board at some point in the future.

PFAC will meet next Tuesday.

6.2.2. Patient Experience Presentation

No discussion was held.

6.3. Credentialing & Peer Review Process

Director Zipkin requested that the Director of Medical Staff Services give the presentation before the full Board of Directors.

This will be an educational session to the board in open session after the new board member is seated.

Discussion was held about the Medical Staff Executive Committee organization structure.

6.4. Healthcare Facilities Accreditation Program (HFAP) Survey

Director of Quality and Regulations provided a summary report on the triennial HFAP accreditation survey conducted April 24-28, 2017.

The HFAP survey occurred April 24-26 at Tahoe Forest Hospital and April 27-28 at Incline Village Community Hospital.

The final report for Tahoe Forest was received yesterday and overall the hospitals did very well. The report noted some deficiencies and a plan of correction will be sent in by next Friday.

IVCH also had an exceptional review.

Administration would like to extend appreciation to staff.

Director of Medical Staff Services commented the HFAP Physician Surveyor liked our credentialing program.

Home Health also had a CDPH survey last week.

6.5. Medical Staff Quality Committee (MSQAC)

Committee discussed the option of having two Board members attend the open session bimonthly MSQAC meeting instead of having a separate Board Quality Committee meeting.

Committee discussed a proposal to have three quality meetings occur on the same morning. It was suggested Medical Staff would arrive early to have closed session which no board members would be involved. Then a combined open session meeting with board members to discuss topics applicable to both groups. The Board Quality Committee could continue the meeting if they had additional topics to discuss further.

Board Quality Committee members are in attendance at MSQAC.

Discussion was held about MSQAC's consent agenda. MSQAC has gotten to be efficient.

Director Wong expressed she did not want to have the board committee immediately jump in to the medical staff's committee.

Discussion was held about whether the Joint Conference Committee is a better venue for this type of meeting structure.

The topic will be tabled for further discussion.

6.6. Quadruple Aim

Director of Medical Staff Services provided an update on the physician satisfaction survey.

Medical Staff Services is working with Press Ganey to develop a survey.

The last time a survey like this was done was in 2008. Press Ganey has the same process as they did in 2008 and a similar process to the TFHD employee survey.

Medical Staff has chosen a longer survey (approximately 57 questions) to get more information out of it. Two question will be open ended/free text.

The survey will launch on June 27, 2017 and physicians will be given three weeks to complete it. Allied Health Professionals will be included.

The results will go back to the Medical Executive Committee.

In the past, a Press Ganey representative presented the survey results to Med Exec then they provided the results to the Board of Directors. A Press Ganey rep will now call in to present the results.

The staff engagement survey went out in February. Press Ganey is currently compiling the data. A meeting has been set to review the results with Administration.

Physician satisfaction survey results will go to quality committee and the employee engagement survey results will go to personnel committee.

Patient safety culture survey results will also come to Quality Committee for review.

Discussion was held about adding “joy at the workplace/well-being”.

Committee would like to see TFHD Foundations of Excellence added to the website.

Committee discussed listing Quadruple AIM on the website. Dr. Taylor suggested to outline quadruple AIM explicitly on website, possibly via a link.

Quadruple AIM is internal jargon.

Director Wong suggested adding it to the website.

Director Zipkin will also like it to appear in the strategic goals. Quadruple AIM should be part of the board’s long term strategy.

6.7. Board Quality Education

6.7.1. Future Board Quality Education

Quality Committee would like to receive a presentation on the Million Hearts program.

The presentation on credentialing will go forward at the June Board of Directors meeting if the new board member is seated.

CEO suggested the Director of Quality should ask if one of top 15 national health systems would provide their quality committee agenda to see what their committee content looks like. Director Wong agreed and would like to see that as well.

CEO would like to see how patients and their families are involved in quality.

CMO indicated she would ask various health systems about the composition of their quality committees.

Dr. Christenson from UC Davis will present on the California End of Life Option Act on May 17th at 6:00 p.m. Please email Jean or Robin if you would like to attend.

6.7.2. Hospital Quality Institute Conference

Director of Quality and Regulations noted the Hospital Quality Institute Annual Conference is on November 1-3, 2017, in Monterey, CA.

Generally, it is a very good conference but not governance specific.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

None.

8. NEXT MEETING DATE

The date and time of the next committee meeting was confirmed for Tuesday, July 11, 2017, at 12:00 p.m.

9. ADJOURN

Meeting adjourned at 1:21 p.m.

DRAFT

Board Quality Committee

2017 QA/QI Plan Focus

1. Top decile quality of care and patient satisfaction metric results
2. Support Patient and Family Center Care
3. Sustain a Just Culture philosophy that promotes patient safety, openness and transparency
4. Promote lean principles to improve processes, reduce waste and eliminate inefficiencies
5. Implement the Epic electronic health record to enable integration of medical services at all levels of the organization
6. Facilitate integrated continuum of care management system
7. Ensure Patient Safety across the entire Health System
8. Achieve Public Hospital redesign and Incentives in Medi-Cal (PRIME) project initiative

2017 Board Quality Committee Focus

1. Monitor Quality, service and patient safety metrics and support processes, with a focus on outliers to achieve top decile performance and measurable improvement
4. Provide appropriate resources to assist the Patient and Family Advisory Council (PFAC)
6. Support the Epic electronic health record implementation with a focus on quality, service and patient safety
2. Monitor the Patient Safety Culture Survey plan for improvement progress
3. Support the Quadruple Aim, including improving the experience of providing care and workforce engagement
5. Provide direction on how to best educate the community about the TFHD quality and service metrics (ie website, public speaking, social media, quarterly magazine, newspaper articles, etc.)

Tahoe Forest Hospital District Board Quality Committee Charter

Draft

The Board Quality Committee was established by the Tahoe Forest Hospital District Board of Directors to assist the Board in fulfilling its oversight and accountability for the organization-wide Process Improvement and Quality Assurance Programs. The committee considers operational and clinical quality, patient safety, patient and family engagement/satisfaction, and risk management, regulatory preparedness and compliance across the continuum of care in the organization.

Membership

The Committee membership shall be comprised of a minimum of two members of the Board of Directors as appointed by the Board President and two members of the Tahoe Forest Hospital Medical Staff as appointed by the Medical Executive Committee. (Recommended Chief of Staff or designee and the Chairperson of the Quality Assessment and Improvement Committee)

Meetings

The committee shall meet a minimum of four times per calendar year.

Accountability

The Committee is accountable to the Board of Directors for the following:

1. Provide oversight for the organization-wide Quality Assessment and Performance Improvement Plan.
2. Set expectations of quality care, patient safety, environmental safety and performance improvement throughout the organization.
3. Ensure the provision of organization-wide quality of care, treatment and services provided and prioritizing of performance improvement throughout the organization.
4. Monitor the improvement of care treatment and services to ensure that it is safe, beneficial, patient-centered, customer focused, timely efficient and equitable.
5. Oversees and accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs and subsequent quality improvement activities.
6. Ensures the development and implementation of ongoing education focusing on service excellence, performance improvement, risk-reduction/safety enhancement and healthcare outcomes

Board Quality Committee Focus 2017

1. Monitor quality, service and patient safety metrics and support processes, with a focus on outliers, to achieve top decile performance and measurable improvement.
2. Monitor the Patient Safety Culture Survey plan for improvement progress.
3. Support the Quadruple Aim, including improving the experience of providing care and workforce engagement.
4. Provide appropriate resources to assist the Patient & Family Advisory Council (PFAC) improvement initiatives.
5. Provide direction on how to best educate the community about the TFHD quality and service metrics (i.e., web site, public speaking, social media, quarterly magazine, newspaper articles, etc.).
6. Support the Epic electronic health record implementation with a focus on quality, service, and patient safety.

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

2017 PFAC PROCESS IMPROVEMENT LOG

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

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

2017 PFAC PROCESS IMPROVEMENT LOG

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

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

2017 PFAC PROCESS IMPROVEMENT LOG

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

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
3/21/17	(continued)		Max discussed a challenge with response rates to surveys that will hopefully be increased as it was determined a registration and mailing issue was affecting the number of people who were receiving surveys. There was a group discussion about how to educate the community about the services Hospice provides and how to increase the notion that the service offers comfort care and quality of life vs. a perception that once you accept the service it is only about a potential time frame of survival. We also reviewed a whiteboard that will soon be utilized at the Incline Village Community Hospital Emergency Department with a goal of keeping patients informed during their stay. Suggestions included adding wait times vs. 'expected' times, including a personal goal for the visit, asking if there is anything else one might need, and having a yes/no box for food allowed or if a patient could be mobile during the visit. Thank you to PFAC members: Nancy for attending the Board Quality Committee meeting this month and Doug for filming a TV segment about PFAC!	Relayed suggestions to Jan Iida
2nd Quarter 2017				
4/18/17	2 Year Anniversary Celebration!!! Cancer Center/Navigator Program BETA Healthcare Group/HEART	PFAC Karen Aaron Deanna Tarnow	Acknowledged 2 years of PFAC!!!! Karen reviewed the services provided at the Cancer Center including, but not limited to, Medical Oncology, Radiation Oncology, lab services, financial counseling, and our affiliation with UC Davis.	

2017 PFAC PROCESS IMPROVEMENT LOG

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

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

2017 PFAC PROCESS IMPROVEMENT LOG

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

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

2017 PFAC PROCESS IMPROVEMENT LOG

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

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

2017 PFAC PROCESS IMPROVEMENT LOG

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

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
3rd Quarter 2017				
July/August	NO MEETING-Summer!			
4th Quarter 2017				
12/19/17	NO MEETING-Holiday			

Quality Reporting Schedule 2017 To the Board of Directors

January 26, 2017: Patient Complaint report July-Dec 2016 (closed session)

February 23, 2017: 4th quarter 2016 Service Excellence report (closed session)
HFAP overview (open session)
Risk Management Report (open session)

March 23, 2017: Infection Control Plan (open session)

April 27, 2017: 2016 Annual Quality Assurance/Performance Improvement Report (closed session) with Dr. Taylor

May 25, 2017: 1st quarter 2017 Service Excellence & Quality report (closed session)

July 27, 2017: 1st quarter 2017 Quality report (closed session)

August 24, 2017: Cancer Center Quality Report (closed session) with Kelley Bottomley and Dr. Kaime
2nd Quarter 2017 Service Excellence & Quality report (closed session)

September 28, 2017: PRIME & Care Coordination Quality Annual Report
Navigation Program

October 26, 2017: Orthopedic Services Quality Report with Dan Coll & Kathy Avis (???)

November 16, 2017: 3rd Quarter 2017 Service Excellence & Quality report (closed session)

December 21, 2017: Post-Acute Services Quality & Service Excellence report (closed session)
with Jim Sturtevant

January 25, 2018: 2017 Annual Patient Complaint report

No Room for Error

By Karen Nitkin and Lisa Broadhead; additional reporting by Linell Smith and Patrick Smith

Date: 01/08/2016



This group comprises Johns Hopkins Medicine's first patient safety workforce. Each individual saw opportunities and challenges 15 years ago, and has been leading patient safety interventions ever since. Back row, from left: Richard "Chip" Davis, Albert Wu, George Dover and Dan Ford. Middle row, from left: Ronald R. Peterson, Rhonda Wyskiel, C. Michael Armstrong and Cheryl Connors. Front row, from left: Peter Pronovost and Sorrel King, holding a picture of Josie King.

Fifteen years ago, a “moral moment” transformed patient safety at Johns Hopkins Medicine and around the world. Since then, Johns Hopkins has systemically eradicated errors by changing procedures, equipment, even the culture within units. The Armstrong Institute for Patient Safety and Quality leads these efforts.

“The Armstrong Institute has a single purpose: To eliminate harm.”

- C. Michael Armstrong, former board chairman of Johns Hopkins Medicine

On March 4, 2001, George Dover stood outside a Baltimore county home, rang the doorbell and changed the future of Johns Hopkins Medicine.

The director of the Johns Hopkins Children’s Center had come to the home of Tony and Sorrel King to apologize to the grieving parents.

Six weeks earlier, the Kings’ 18-month-old daughter Josie had wandered into an upstairs bathroom, turned on the hot water and climbed into the tub. By the time her screams brought her mother, Josie had second-degree burns on more than half of her body. The toddler was rushed by ambulance to The Johns Hopkins Hospital, where she received skin grafts and healed. Within weeks, she was acting like her old self. Then her condition deteriorated. Josie grew pale and unresponsive. She died Feb. 22 of what was ultimately identified as septic shock, just days before she was scheduled to return home.

The day Josie died, her Johns Hopkins-affiliated pediatrician, Lauren Bogue, walked into Dover’s office. She encouraged him to visit the King family and accept responsibility on behalf of Johns Hopkins. The unusual proposal quickly won full support from Johns Hopkins leadership—even its lawyers. Bogue arranged the meeting and accompanied Dover.

“I remember it was pouring rain and cold,” says Bogue. “Baltimore at its worst.” The pain inside the house was palpable, she recalls.

“The first thing I said to the Kings was that I was terribly sorry,” says Dover. “In those days, that was not fashionable. We told Tony and Sorrel we would find out exactly what had happened, we would communicate what we found and we would do our best to make sure it never happened again.”

Dover kept his word, telephoning Sorrel every Friday morning, even when there was little to report.

On June 2, a second tragedy occurred. Ellen Roche, a healthy 24-year-old, died of lung failure less than a month after inhaling an irritant medication while participating in an asthma research study.

Ten days after Roche’s death, the U.S. Office for Human Research Protections suspended all federally funded human subject research at Johns Hopkins, halting nearly 2,500 investigations for several months.

The two deaths shattered Johns Hopkins, propelling what some consider the most significant culture change in its history.

“These events created a moral moment where we had to make a choice,” says Peter Pronovost, director of the Armstrong Institute for Patient Safety and Quality. “It was: Are we going to openly address our shortcomings? Or are we going to hide behind our brand and say all is well? Leadership stood up and said, ‘We need to start talking about this.’”

In the 15 years since that fateful crossroads, as the health care system expands, Johns Hopkins Medicine has pioneered a culture of accountability and patient safety advances. By 2015, all six Johns Hopkins hospitals were recognized by the Joint Commission in its Top Performer on Key Quality Measures program. Johns Hopkins programs and safety metrics were adopted around the world.

But before that could happen, safety had to become the top priority.

Research oversight became more stringent; two Institutional Review Boards became seven.

“We have a whole process to identify a high-risk protocol like the one Ellen Roche was in,” says Dan Ford, vice dean for clinical investigation—a position created after Roche’s death. “We conduct research in the safest possible setting. Each research team has to know how it would handle an emergency.”

On the clinical side, opportunities for error continue to be systemically eradicated by changing procedures, equipment, even the culture within units. The Armstrong Institute, founded in 2011, leads this effort while training a new generation of patient safety innovators. Clinicians receive emotional support after adverse patient events. Family members are encouraged to assist with care and speak up if something doesn’t look right.

Making Safety the Top Priority

These changes might have saved the fathers of Ronald R. Peterson and Pronovost. Peterson, president of The Johns Hopkins Hospital and Health System and executive vice president of Johns Hopkins Medicine, lost his father to sepsis, a bacterial bloodstream infection acquired after surgery. Pronovost's father died at age 50 after being diagnosed with leukemia instead of lymphoma.

But the pervasiveness of these deadly mistakes didn't become clear until the 1999 release of "To Err is Human." The headline-grabbing report from the Institute of Medicine asserted that as many as 98,000 people perished in American hospitals each year because of preventable errors. "The culture seemed to be—I hate to say it—that a certain amount of bad stuff happens in medicine," says Peterson.

The deaths of King and Roche made patient safety personal—and urgent. "We took the position that the buck had to stop at the top of the organization," says Peterson. "It was our responsibility to take definitive steps to address this."

The effort began with three bold steps: Make safety the No. 1 priority of Johns Hopkins Medicine. Start every board of trustees meeting with a safety report instead of a financial review. And create a safety-focused Center for Innovation in Quality Patient Care, funded with \$500,000 each from The Johns Hopkins Hospital, the Johns Hopkins University School of Medicine and The Johns Hopkins University.

Richard "Chip" Davis became the center's executive director, and Pronovost, its medical director. "Improving patient safety wasn't a choice at Johns Hopkins," says Lori Paine, who filled the newly created role of patient safety coordinator and is now director of patient safety for The Johns Hopkins Hospital and Armstrong Institute. "It was an obligation."

When Tony and Sorrel King received a settlement from Johns Hopkins, they created the Josie King Foundation and donated money to Johns Hopkins for patient safety programs. "She held us accountable," Pronovost says of Sorrel King. "She didn't want what happened to Josie to happen to anybody else."

A Comprehensive Approach

Nearly 200 separate tasks are required to reduce preventable harm for a single intensive care patient, notes the Armstrong Institute. Johns Hopkins began treating safety like a science, collecting data to find, test and deploy systemic improvements.

An early target for this approach: bloodstream infections acquired through central-line catheters. In 2001, Pronovost and his infection control colleagues distilled 120 pages of information from the Centers for Disease Control and Prevention into a five-step checklist that was distributed to intensive care units.

Moveable carts were created with all the tubes, drapes and other equipment necessary for insertions. Doctors would no longer have to search for items in eight separate locations.

But the key step was empowering nurses to act if they saw doctors skipping items on the checklist. "People need to know that if someone they see above them is doing something that is dangerous to the patient, they have every right to speak up," says Edward Miller, former CEO of Johns Hopkins Medicine and dean of the school of medicine.

It was a major culture shift, embraced by top leadership but resisted by some physicians.

"Some of the senior doctors said, 'I'll be darned if some nurse is going to tell me what to do,'" recalls William Brody, former president of The Johns Hopkins University. "One time I got a complaint from a doctor, and I said to the nurse, 'Just put my name and phone number up on the nursing station. Call me, even if its 2 in the morning, and I'll come in and have a conversation.' I never had to."

Compliance skyrocketed. Pronovost and his colleagues estimated that the checklist prevented 43 infections and eight intensive care unit (ICU) deaths over two years, saving the hospital \$2 million in health care costs. The dramatic results were featured in a *New Yorker* article and helped Pronovost win a \$500,000 "Genius Grant" from the MacArthur Foundation. More important, checklists became a standard, lifesaving component of health care nationwide.

The new culture of accountability led to the creation of the Comprehensive Unit-based Safety Program (CUSP), developed at Johns Hopkins more than 10 years ago. CUSP gives all caregivers tools and support to address problems such as hospital-acquired infections, medication administration errors or communication breakdowns.

More than 170 CUSP teams have been activated at Johns Hopkins Medicine, and hundreds more have been organized in hospitals internationally. The results are striking. With CUSP teams and checklists in 1,100 ICUs in 44 U.S. states, bloodstream infections are down by 40 percent in those hospitals, saving 500 lives and \$34 million.

In another strategy to improve the safety of systems, The Johns Hopkins Hospital hired Peter Doyle in 2007 as its first human factors engineer. A goal of his profession, Doyle explains, is to optimize patient safety by studying how clinicians interact with medical devices in complex, interconnected and often hectic work environments. This includes working with nurses and clinical engineers to reduce

unnecessary patient monitoring alarms, assisting in the selection of the safest pumps for infusing medications, and assuring that laboratory specimens are properly labeled for diagnostic accuracy.



1

Train staff members in the science of safety.

CUSP

Today, there are more than 170 CUSP teams across the health system—and hundreds more outside of Johns Hopkins. Critical to the program are five steps:

The Armstrong Institute

Medical mistakes nearly killed C. Michael Armstrong. First, doctors at another hospital missed signs that he had leukemia. Then he developed a serious infection post-chemotherapy. After a tough battle in the ICU, he lived. Years later, he was belatedly diagnosed with advanced cancer and given a 50-50 chance of living five years. If he survived, he vowed, he would “do something big” for patient safety.

Armstrong finished treatment in 2009. Two years later, he donated \$10 million to Johns Hopkins to create the Armstrong Institute for Patient Safety and Quality.

The institute, headed by Pronovost, combines safety specialists from across Johns Hopkins, bringing “common purpose, programs, education, training, objective measurements and, probably more important than anything, accountability,” says Armstrong, former CEO and chairman of AT&T and Hughes Electronics and chairman of Johns Hopkins Medicine’s board of trustees from 2005 to 2013. For example, he says, prescription errors were dramatically cut by automating the multistep process with barcodes, scanners and confirmation checks.

The institute’s Patient Safety and Quality Leadership Academy, a nine-month multidisciplinary training program for future quality and safety leaders, has trained 60 employees so far, says Melinda Sawyer, assistant director of patient safety for the institute. Of those, she says, 94 percent now lead quality and safety projects at Johns Hopkins Medicine.

They are working to improve patient experiences, prevent harm during handoffs, minimize health care disparities between populations and decrease the number of missed diagnoses.

Active Patient Safety Projects

Johns Hopkins Medicine leads international safety projects to reduce preventable harm and improve patient and clinical outcomes.

Taking Care of Second Victims

When terrible things happen in hospitals, doctors, nurses and other members of the care team often suffer remorse and confusion. Sometimes the stress prevents them from doing their best work or prompts them to leave the profession.

Now, such “second victims” can find help in a program at The Johns Hopkins Hospital. Resilience in Stressful Events (RISE) uses trained peer responders to provide psychological first aid and emotional support whenever hospital staff members are traumatized by patient-related events.

Cheryl Connors, a patient safety specialist with the Armstrong Institute, teamed with Albert Wu, a Johns Hopkins professor of health policy and management, to create RISE in 2011. The program, supported in part by the Josie King Foundation, is based on Wu’s research on second victims, a term he coined in a *British Medical Journal* article in 2000. “RISE appeals to the best instincts of clinicians to support one another after adverse events,” he says.

RISE’s trained volunteers are available around the clock to speak confidentially with staff members, offering coping strategies and listening without judgment. The 30-member team at Johns Hopkins includes nurses, doctors, therapists, chaplains, pharmacists and others.

In the past four years, the team has received about 100 calls and met with close to 300 people, says Connors.

Family Involvement

Rhonda Wyskiel was a nurse at The Johns Hopkins Hospital when her 48-year-old mother was admitted, fighting for her life after surgery at another institution. Wyskiel tip-toed into the room where her mother was sleeping and whispered a request to her co-workers.

“I said, ‘I need to part her hair on the other side.’ They had it parted on the wrong side,” recalls Wyskiel. “I wanted to put ChapStick on. And the nurses told me not to touch her. I was only allowed in her room for 15 minutes at a time, and I couldn’t help.”

For Wyskiel, whose mother died at home a short while later, the experience was a turning point. She began involving family members in patient care, encouraging loved ones to ask questions, share observations and take on tasks, such as applying lotion and helping with feeding.

In 2010, Wyskiel formalized the approach with the Family Involvement Menu, a list of care activities for family members. The menu improves the hospital experience for patients and loved ones while enhancing patient safety, says Wyskiel. Family members know the patient’s medical history, can coax reluctant eaters to take one more bite and often are the first to recognize signs of distress, she says.

“I could give you 100 examples of times when family members have spoken up about a process or something we’re going to do to a patient where it could cause potential harm,” she says. “Family members are the real experts in the room.”

She now teaches other health care organizations how to involve families in care. “I would like to see the cultural shift occur where family members really are members of the health care team,” she says. “Families really want to be included.”

To make sure their voices are heard, the Children’s Center created the Pediatric Family Advisory Council. Started in 2007 as an eight-member steering committee, it has grown to a council of more than 50 parents and staff members. By 2013, similar Patient and Family Advisory Councils were active in every Johns Hopkins Medicine hospital, community physicians group and home care group.

Four years after her daughter’s death, Sorrel King asked Pronovost a question that haunts him to this day: “Would Josie be less likely to die now?” Pronovost and others at Johns Hopkins continue working to ensure that the answer is yes.



Josie King

The Johns Hopkins Hospital admitted Josie King on Jan. 30, 2001, her 18-month-old body covered in second-degree burns from a bathtub accident.

The first few days were rough, but over time the little girl healed. Then, just days before her scheduled release, Josie's heart stopped. She died on Feb. 22.

An initial in-depth review, called a root cause analysis, pinpointed dehydration and an unnecessary dose of methadone as the culprits. A second analysis, released in 2010, revised that conclusion, adding septic shock from a hospital-acquired infection and saying that the narcotic was not to blame. The larger picture: Systems had failed. Communications had broken down, and a parent's repeated pleas that her daughter was thirsty were not heeded.

Josie's parents, Tony and Sorrel King, channeled their grief into action, creating the Josie King Foundation to fight against medical errors.

Sorrel gave time and money to Johns Hopkins, working closely with Peter Pronovost to bring patient safety programs to the institution that had caused her so much pain. Her 2009 book, *Josie's Story*, is both memoir and call to action. She created the Josie King Hero Award for caregivers who create a culture of safety and gave the first one to Pronovost.

Fifteen years after her daughter's death, Sorrel King offers this advice to everyone involved in patient care: "Slow down and take your eyes off the computer. Look at the patient in the bed and listen. Listen to that mother who is saying something is wrong."

Ellen Roche

Ellen Roche, a technician in the Asthma and Allergy Center at Johns Hopkins Bayview Medical Center, was a lifelong animal lover who planned to become a veterinarian. In 2001, the 24-year-old Reisterstown resident volunteered for an asthma study that would measure how healthy lungs respond to a chemical irritant, hexamethonium.

Roche, who had participated in other studies previously, was the third research subject. The first had developed a dry cough, and the second seemed fine. Roche fared far worse. She was admitted to intensive care on May 5, the day after she inhaled the chemical. She died of lung failure on June 2.

In October 2001, the Roche family received an undisclosed financial settlement from Johns Hopkins and established a scholarship fund in her name for students interested in veterinary medicine or related fields.



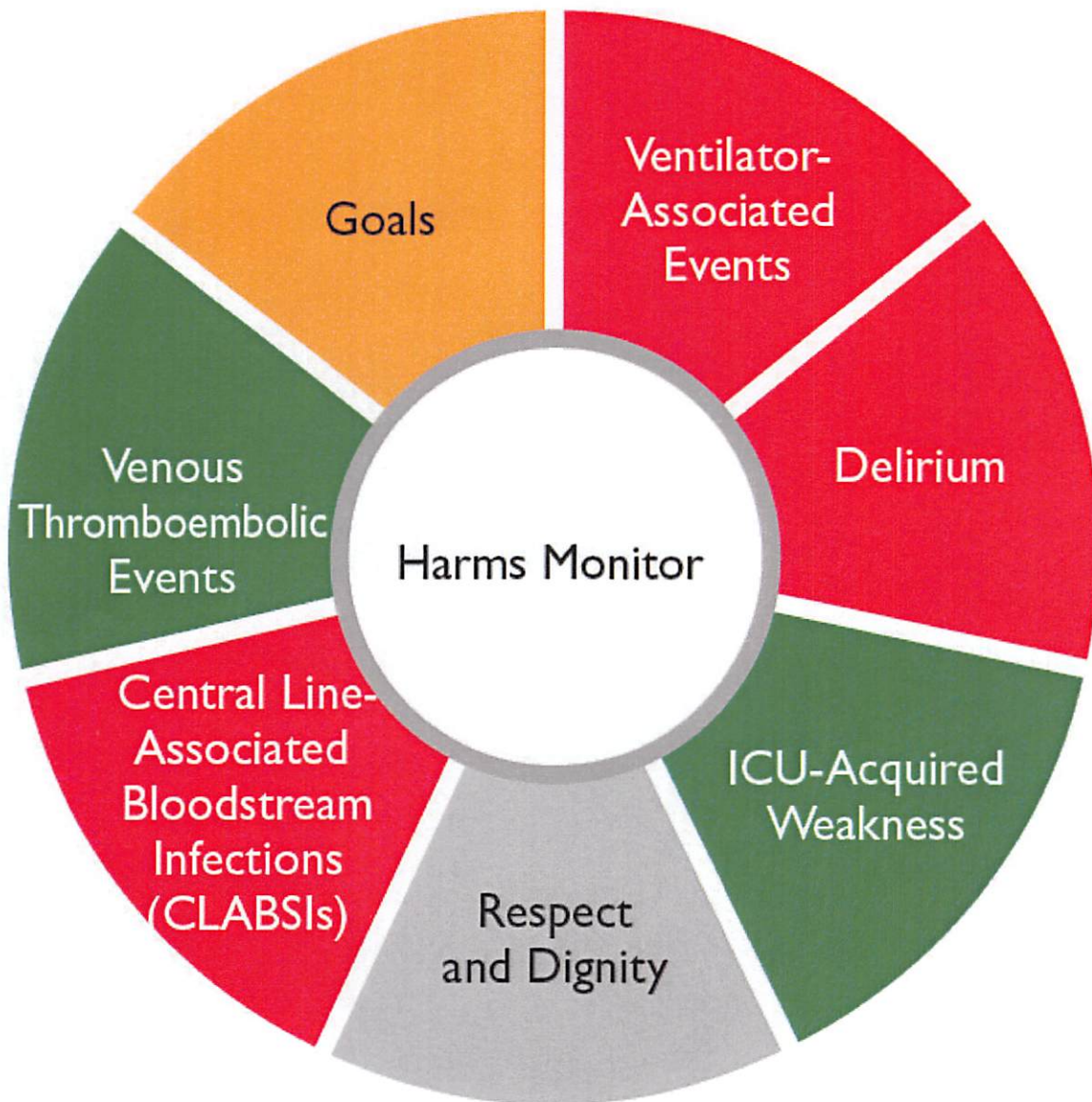
Project Emerge

In 2013, the Armstrong Institute created Project Emerge, a tablet-based application that shows clinicians what actions are needed to prevent harm. The system integrates more than 200 safety procedures, as well as patient information from multiple sources, into two dashboards.

The "harms monitor" allows staff members to track seven harms, including any setbacks to physical therapy regimens. It also determines the number of days since a central line was inserted.

Patients and loved ones use the family involvement portal to ask questions of the care team and upload photographs.

Microsoft will collaborate with Johns Hopkins to bring Project Emerge to intensive care units nationwide.



Special Report

[Perspectives on Patient Safety](http://www.hopkinsmedicine.org/news/articles/perspectives-on-patient-safety) - (<http://www.hopkinsmedicine.org/news/articles/perspectives-on-patient-safety>) Voices from across Johns Hopkins Medicine share memories of transformation and look to the future.

[Patient Safety Across Johns Hopkins Medicine](http://www.hopkinsmedicine.org/news/articles/patient-safety-across-johns-hopkins-medicine) - (<http://www.hopkinsmedicine.org/news/articles/patient-safety-across-johns-hopkins-medicine>) At every Johns Hopkins hospital, new programs are improving patient experience and reducing opportunities for error.

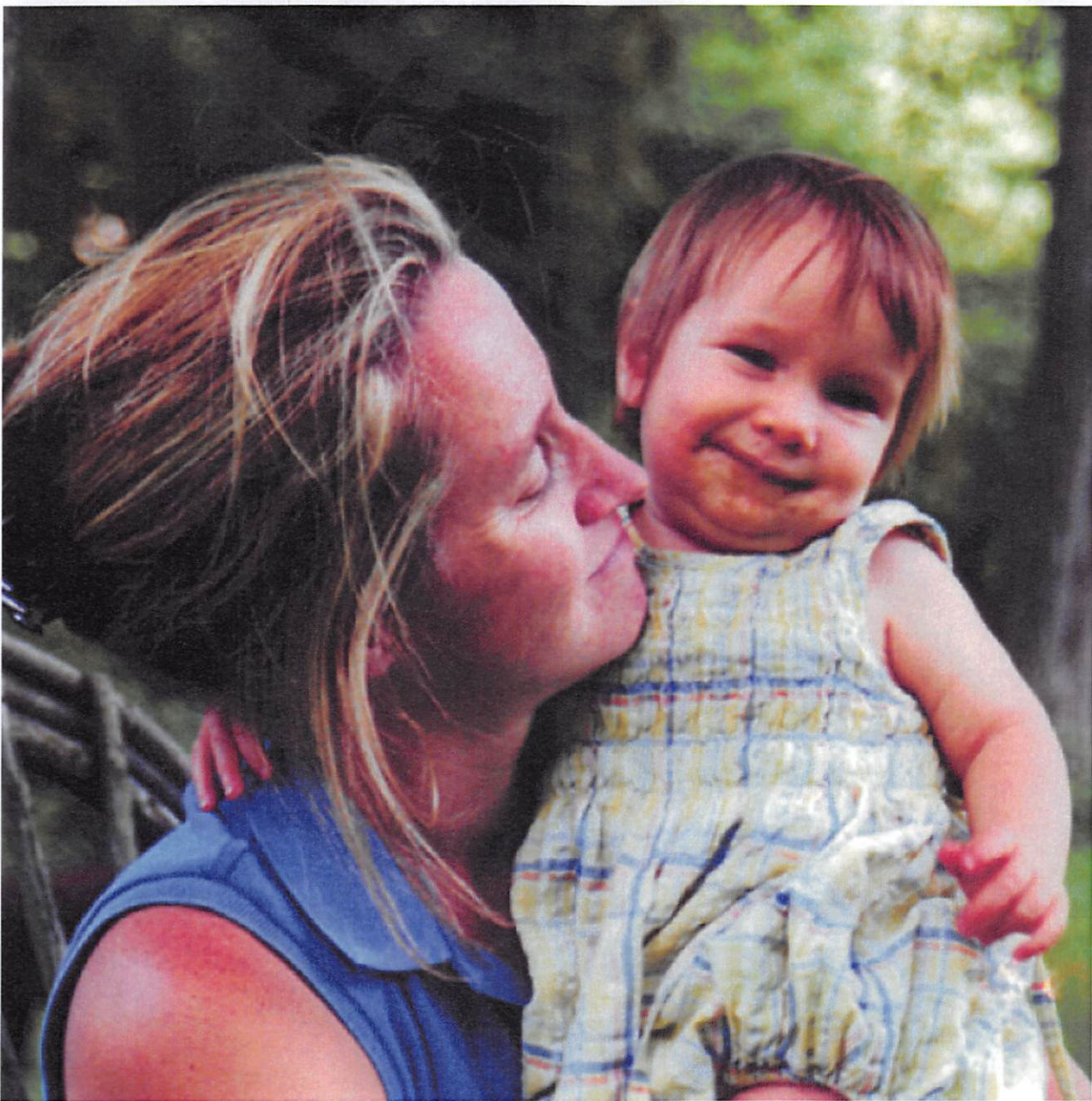
[Special Report: Fifteen Years of Patient Safety Milestones](http://www.hopkinsmedicine.org/news/articles/special-report-fifteen-years-of-patient-safety-milestones) - (<http://www.hopkinsmedicine.org/news/articles/special-report-fifteen-years-of-patient-safety-milestones>) Learn how Johns Hopkins has built a culture of accountability and advanced patient safety.

[Strengthening a Culture of Safety](http://www.hopkinsmedicine.org/news/articles/strengthening-a-culture-of-safety) - (<http://www.hopkinsmedicine.org/news/articles/strengthening-a-culture-of-safety>) Ensuring patient safety is a goal for which all staff members are responsible.



[January/February 2016 -
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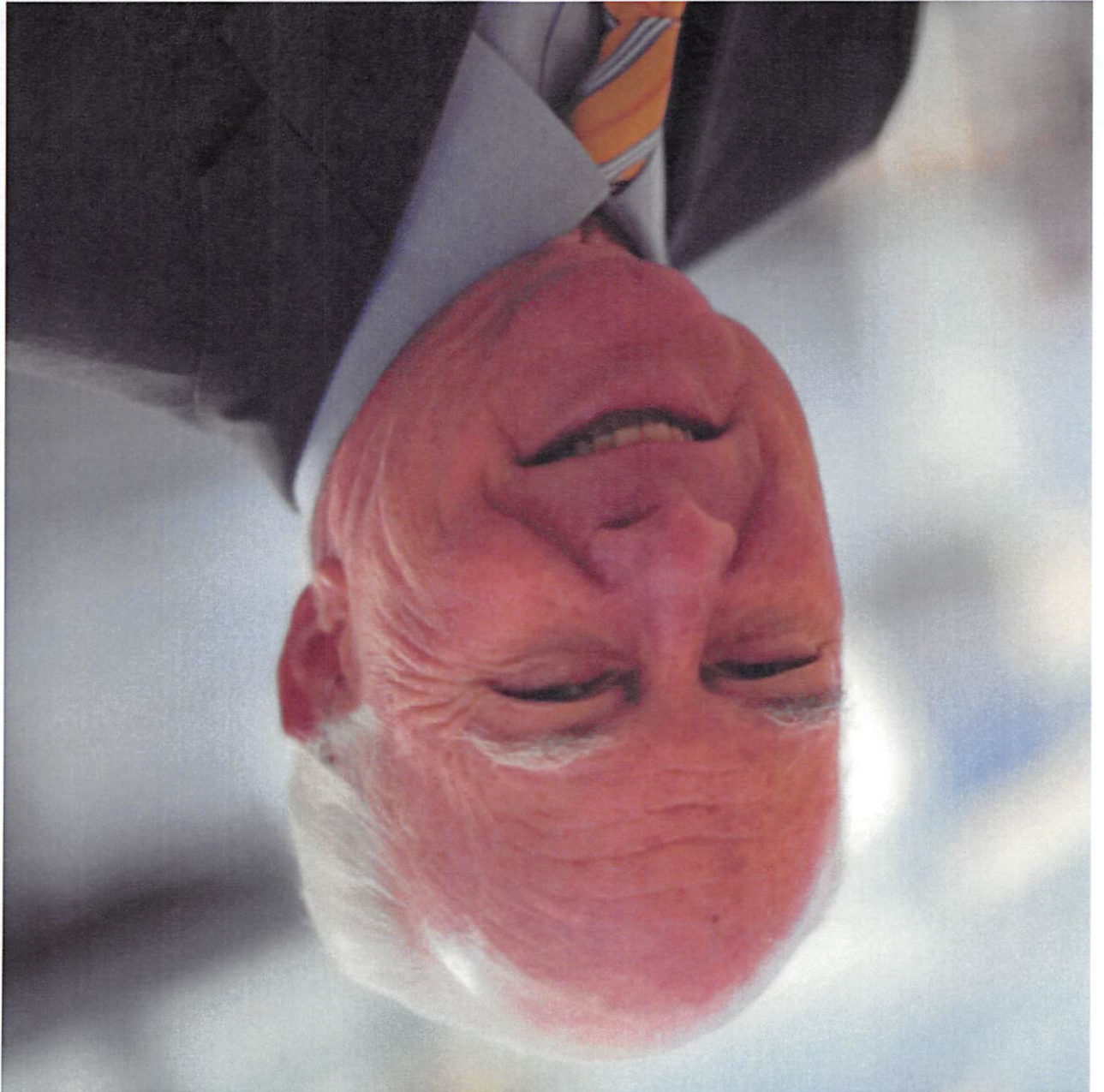
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Special Report:



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	Q1-2017	Goal	Goal Description and Quarterly Events	Quarterly Trend
Heart Attack Care (0 pt)		96.7%	<p>Goal: To meet/exceed the national average for recommended evidence-based care provided for heart attack patients. This number represents a roll-up of 4 AMI measures. National Average = 88.5% (T, E,P)</p> <p>Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.</p>	<p>100% ———— ↑</p> <p>95% ————</p> <p>90% ————</p> <p>85% ————</p> <p>Q1-14 Q2-14 Q3-14 Q4-14 Q1-15 Q2-15 Q3-15 Q4-15</p>

TFHS BOD Quality Scorecard

- Goal Met or Exceeded
- Within 10% Negative Variance of Goal
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Quality Measures	Q1-2017	Goal	Goal Description and Quarterly Events	Quarterly Trend
TFH Immunizations		100.0%	Goal: To vaccinate 100% of all appropriate consenting inpatients for pneumonia and influenza. This number is a roll up of both IMM measures (T, E, Ef, Eq, P) National Average Flu = 93% & Pneumo = 88.2% Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
TFH VTE Care (24 pts)		100.0%	Goal: To achieve 100% of all six process measures associated with VTE Care. (T, E, Ef, Eq, P) National Average = Unknown Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
TFH Stroke Care (0 pts)		100.0%	Goal: To achieve 100% of all five process measures associated with Stroke Care. (T, E, Ef, Eq, P) National Average = 96.4% Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
TFH Hospital Acquired Surgical Infections		1.0%	Goal: SSI 0% or a procedure-specific Standardized Infection Ratio (SIR) <1 when # of surgeries allows for SIR calculation. (replaces national average) Q1: PI: Continue to review trends at the Quarterly Medical Staff meeting.	
TFH Hospital Acquired non-Surgical Infections		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. Q1: PI: Continue to review trends at the Quarterly Medical Staff, Nursing Staff & Infection Control Committee meeting.	
IVCH Hospital Acquired Surgical Infections		1.0%	Goal: SSI 0% or a procedure-specific Standardized Infection Ratio (SIR) <1 when # of surgeries allows for SIR calculation. Q1: PI: Continue to review trends and areas of concern at the Quarterly Medical Staff, Nursing Staff & Infection Control Committee meeting.	

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	Q1-2017	Goal	Goal Description and Quarterly Events	Quarterly Trend
SNF 5-Star Quality Rating		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) Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
Home Health Percentage Improvement in Pain		64.0%	Goal: P4P measurement, managing pain and treating symptoms, how often patients had less pain when moving around. Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
Home Health Percentage Improvement in Bathing		64.0%	Goal: P4P measurement, managing daily activities, how often patients go better at bathing. Q1: PI: Continue to review at the Quarterly Medical Staff & Nursing Staff meeting.	
Home Health Percentage Improvement in Ambulation/ Locomotion		44.0%	Goal: P4P measure, managing daily activities, how often patients got better at walking or moving around. Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
Home Health Percentage Improvement in Surgical Wounds		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) Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	

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

TFHS BOD Service Excellence 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	Q1-2017	Goal	Goal Description and Quarterly Events	Quarterly Trend
HCAHPS Top Box Score, reported by Press Ganey, "Recommend this Hospital"		90.0%	Goal: To meet/exceed a "Top Box" score of 90% for inpatient satisfaction. National Score = 71% (S, T, EQ, P) Q1: PI: Director/Manager daily patient rounds. Patient follow up phone calls after discharge. Quiet environment initiative using visual and verbal cues.	
HCAHPS Top Box Score, reported by Press Ganey, "Rate this Hospital 9 or 10"		90.0%	Goal: To meet/exceed a "Top Box" score of 90% for inpatient satisfaction. National Score = 72% (S, T, EQ, P) Q1: PI: Director/Manager daily patient rounds. Patient follow up phone calls after discharge. Quiet environment initiative using visual and verbal cues.	
Home Health HHCAHPS "Rate this Agency 9 or 10" Top Box Score		90.0%	Goal: To meet/exceed a "Top Box" score of 90% for Home Health Patient satisfaction. HHCAHPS national average is 84% (S, T, EQ, P) Q1: PI: Results reviewed at staff meeting with a focus on MDS metric education & scripting of key areas noted on survey responses. Director patient rounding. Follow up phone calls.	
Home Health HHCAHPS "Recommend this Agency" Top Box Score		90.0%	Goal: To meet/exceed a "Top Box" score of 90% for Home Health Patient satisfaction. HHCAHPS national average is 79% (S, T, EQ, P) Q1: PI: Results reviewed at staff meeting with a focus on MDS metric education & scripting of key areas noted on survey responses. Director patient rounding. Follow up phone calls.	

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

TFHS BOD Service Excellence 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	Q1-2017	Goal	Goal Description and Quarterly Events	Quarterly Trend
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