TAHOE FOREST HOSPITAL DISTRICT

2016-02-09 Board Quality Committee Meeting

Tuesday, February 9, 2016 at 12:00 p.m.

Eskridge Conference Room - Tahoe Forest Hospital

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2016-02-09 Board Quality Committee Meeting

02/09/2016 Quality Committee

Agenda

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TAHOE FOREST HEALTH SYSTEM

QUALITY COMMITTEE
AGENDA

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**

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: 12/16/2015** ..... **ATTACHMENT**

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

6.1. **Quality Committee Goals 2016.....ATTACHMENT**
The *Quality Committee 2016 Goals* for review and approval.

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. **Quality Assurance/Performance Improvement Plan 2016 .....ATTACHMENT**
The purpose of the Quality Assurance/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. The Quality Assurance Performance Improvement Plan will be reviewed, updated, and approved annually by the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

6.4. **Physician Quality Reporting System .....ATTACHMENT**
The Physician Quality Reporting System (PQRS) is a quality reporting program that encourages individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare. PQRS gives participating EPs and group practices the opportunity to assess the quality

of care they provide to their patients, helping to ensure that patients get the right care at the right time. An update will be provided on the Quality metrics that TFHD is submitting

6.5. **Meaningful Use Quality Reporting .....ATTACHMENT**
Meaningful use is using certified electronic health record (EHR) technology to improve quality, safety, efficiency, and reduce health disparities; engage patients and family; improve care coordination, and population and public health; and maintain privacy and security of patient health information. Eligible professionals, eligible hospitals, and CAHs are required to report clinical quality measures (CQMs) during each year of participation in order to receive an incentive.

6.6. **Beta Disclosure & Communication Program .....ATTACHMENT**
The Committee will be provided an update on the lessons learned at this program including the Care for the Caregiver program.

6.7. **Board Quality Education .....ATTACHMENT**
The Committee will review the National Patient Safety Foundation Executive Summary *Free from Harm: Accelerating Patient Safety Improvement.*
The committee will review and discuss topics for future Board quality education.

6.8. **Quality Metrics Discussion .....ATTACHMENT**
The Committee will discuss quality metrics to be incorporated into the CEO Compensation Goal structure by the Board of Directors.

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

8. **NEXT MEETING DATE**
The Committee will discuss meeting schedule for 2016.

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

Wednesday, December 16, 2015 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 12:05 p.m.

2. **ROLL CALL**

Board: Greg Jellinek, M.D., Chair; Dale Chamblin, Treasurer

Staff: Judy Newland, CNO/COO; Janet Van Gelder, Director of Quality and Regulations; John Rust, Director, Emergency Services; Trish Foley, Patient Advocate; Catherine Hammond, Interim Director of Medical Staff Services; Dr. Julie Conyers; Dr. Peter Taylor; 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 was received.

5. **APPROVAL OF MINUTES OF: 10/20/2015**

Director Jellinek and Dr. Taylor recommended approval of October 20, 2015 Quality Committee minutes.

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

6.1. **Quality Committee Goals 2015 & Charter**

2016 goals for the Quality Committee will be reviewed at the February meeting. No further discussion took place on 2015 goals.

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

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

Trish Foley gave an update related to the activities of the Patient and Family Advisory Council (PFAC).

Discussion took place on how complaints are handled and whether or not there should a single point of contact for complaints.

At their last meeting, PFAC reviewed a website update from marketing and a lean project regarding customer service.

Feedback on PBX operator system was shared. Calls are not being routed to correct departments and creating frustration for patients.

Feedback on layout for board meetings was shared. From patient's perspective, the setup of board meeting feels like a courtroom. It was suggested to move the lectern to the side of the room.

Janet Van Gelder shared that BETA asked TFHD to present at their annual conference on the creation of our PFAC. A TFHD Patient Advocate volunteer attended to share her experience as a member of our council.

6.3. **Patient Satisfaction Surveys**

Press Ganey patient satisfaction surveys were reviewed.

Certain questions cannot change because they are benchmarked against other hospitals around the country. Discussion regarding evaluating decreasing the number of questions on the surveys.

Director Jellinek inquired whether or not the survey could be done as part of discharge. CMS mandates that the HCAPHS surveys cannot be completed by the patient at discharge. Press Ganey sends the survey within 48 hours after patient demographic upload from District occurs.

Janet Van Gelder has asked the District's Press Ganey account manager to review our contract with Press Ganey and revisit the process. Currently look at other vendors such as Gallup, Avatar, and Healthstream. CMS requires independent surveyor. As a CAH we are only required to survey inpatient.
Ms. Van Gelder will follow up at the next meeting.

6.4. **Beta Disclosure & Communication Program**

Janet Van Gelder, along with Drs. Conyers, Taylor and Alpert, attended a BETA Disclosure Communication conference. Topics included disclosure during an adverse or sentinel event and Care for the Caregiver program.

Quality will educate physicians about this policy and process at upcoming med staff meetings.

Disclosure during an adverse event focuses on transparency. Information that is being disclosed is everything that would be discoverable anyway. Disclosure has been around for hospitals for about 15 years but it is a paradigm shift for the liability carrier to support transparency.

John Rust shared he is navigating the road of discussion and respecting the peer review process.

The District has three people that can be contacted right away to assist with disclosure.

TFHD was asked to present during BETA's conference follow up webinar on January 12, 2016.

6.5. **Annual Board Policy Review**

6.5.1. **ABD-20 Patient Satisfaction**

Quality Committee reviewed the policy and discussed if this should continue as a Board policy or be moved to an administrative (AGOV) policy.

Director Jellinek and Director Chamblin feel it is an administrative policy and not a board policy.

Quality Committee recommends bringing to full board for vote at December 21, 2015 meeting.

6.6. **Board Quality Education**

Committee reviewed and discussed the Governance Institute's white paper on *Maximizing the Effectiveness of the Board's Quality Committee*.

Dr. Conyers commented she sees this as coming above the weeds to where we want to be.

Discussion took place on how the Board wants to proceed with Quality Committee. One of the Board's Quality Committee goals will be to adjust quality website and content. CEO will help direct overall path.

Director Jellinek felt the Board needs to get out more in the community. Hospital 101 classes would be a good way to address community questions. Presentations at Rotary and Good Morning Truckee meeting.

Director Chamblin inquired about including community members on the committee. Patient Family Advisory Council (PFAC) is the start to involving community members.

Dr. Taylor feels Quality Committee should have some oversight of credentialing process.

CAH requirement to have annual credentialing and quality review. Currently that review is completed by attorney, Linda Garrett. Ms. Van Gelder just received the report yesterday for this year's review and will add to agenda for next meeting. Credentialing being brought back in house as of January 1, 2016. OPPE/FPPE is currently conducted by Sandi Spaich.

Former Board felt that the quarterly quality dashboard should go to full board. Discussion took place on what should go up to full board in the future. Deeper dive and review at committee level.

Discussion took place about committee members staying on committees. Dr. Conyers suggested a board member that is also on finance committee would be helpful.

Judy Newland stated it is the Board's job to ask hard questions. Data should come to Quality Committee.

A goal about transparency and disclosure should be added.

Adopt "patients-as-only-customer" mantra.

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

8. **NEXT MEETING DATE**

The next Quality committee meeting is tentatively set for Wednesday, February 9, 2016 at 12:00 p.m. Physicians prefer meeting stays at 12:00 p.m.

9. **ADJOURN**

Meeting adjourned at 1:28 p.m.

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.

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.

	Topic	Forwarded to/Department	Discussion/Status
PFAC PI Log 1st Quarter 2015			
	PFAC 1st Meeting April 2015		
PFAC PI Log 2nd Quarter 2015			
4/14/15	Orientation	N/A	
5/19/15	White Boards - Inpatient Interpreter Services	Jim, Kerry Pete Stokich	PFAC reviewed mock-up whiteboards. Discussed adding goals and blank area for patient questions that could be written down by RNs to discuss during Hospitalist rounding. PFAC suggestion to have 'in person' interpreters again; discussed with Pete and this is not feasible or cost effective; reminder to staff of language line and iPads
6/23/15	Inpatient Discharge Process Service Excellence Report	Jim Trish/Jake/Alex, Human Resources	PFAC reviewed d/c process, discussed ways to facilitate process and avoid time delays. Suggestions to providing realistic time frame, update patients when d/c orders signed, and note time on whiteboards. Service Excellence Quarterly Report was reviewed with PFAC. Discussion followed regarding patient perception of the service provided by front desk staff. Jake to follow up with Alex about Customer Service Training starting with MSC, Occupational Health, and Cancer Center.
PFAC PI Log 3rd Quarter 2015			
7/21/15	No meeting scheduled		

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.

	Topic	Forwarded to/Department	Discussion/Status
8/18/15	Preoperative Process ABN Subcommittee questions ED noise reduction suggestion	Linda, Denise-Ambulatory Surgery, Stephanie-ABN John -ED	PFAC provided feedback on Preoperative process including interaction with Pre-Admit RN, scheduling appt for lab work, financial questions being answered prior to procedure, and avoiding repetition in discussing patient med hx. ABN feedback provided in regards to reminder of medication lists at appts and addressing 3rd party insurance coverage. PFAC member suggested iPods/headphones in ED patient area; at this time ED focusing on noise reduction curtain.
9/15/15	ICD 10, Press Ganey Survey letter Grateful Patient Program	Tory, Registration Martha Simon, Foundation	PFAC commented on information sheet that was going to be given out on start date of ICD-10 that may have affected wait time. Information was condensed, 'less is more'. Press Ganey Survey letter reviewed; determined no change due to limits by vendor. PFAC reviewed Grateful Patient Program and commented on presentation of brochures; suggestion to provide in d/c packets from inpatient units.
PFAC PI Log 4th Quarter 2015			
10/20/15	MyChart introduction page Patient concern response letters	Jen Tirdel, MSC Trish Foley, Quality	PFAC reviewed the introduction page for the MyChart patient portal. Suggestions were made to keep page informative yet not be intimidating with the login process, and clearly define what the portal does and does not provide. Also, listing providers by clinic/specialty for ease of contact information. Patient response letters were also reviewed for language and format to help provide a feeling that concerns are acknowledged and addressed (in a sensitive manner) in addition to providing the required elements of the grievance process and contact information for CDPH.

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.

	Topic	Forwarded to/Department	Discussion/Status
11/17/15	TFHD Website BETA Symposium	Paige Thomason, Marketing	PFAC reviewed drafts for upcoming changes to TFHD website. Suggestions were made to include staff in review of content in addition to Directors to foster pride and ownership of information. Also, include a drop down button for translation to Spanish. PFAC provided feedback on their experience to date on the council for Karen (member) to share at the BETA Symposium (11/20/15) during a presentation on starting a PFAC. Positive feedback included follow through of inpatient whiteboards and members feeling like their voice make a difference ☺ Constructive advice to streamline PFAC orientation process as it appears to be excessive in requirements.
12/15/15	Meeting cancelled/holiday month		
	PFAC PI Log 1st Qtr 2016		
1/19/16	PFAC 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

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.

	Topic	Forwarded to/Department	Discussion/Status
			Directors to attend the PFAC meetings to gain input on any areas for process improvement.

	Tahoe Forest Health System				
	Title: Quality Assurance / Performance Improvement (QA/PI) Plan			**Policy/Procedure #: AQPI-05**	
	Responsible Department: Quality & Regulations				
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
☒	Administrative	9/96		02/14; 12/14; 1/16	
☐	Medical Staff				
☐	Departmental				
Applies to: X System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital					

PURPOSE:

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

POLICY:

VISION STATEMENT

The vision of Tahoe Forest Health System is "to be the best mountain community health system in the nation."

MISSION STATEMENT

Tahoe Forest Health System is "Devoted to Excellence - Your Health, Your Life, Our Passion".

VALUES STATEMENT

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

1.0 Quality – holding ourselves to the highest standards and having personal integrity in all we do.

2.0 Understanding – being aware of the concerns of others, caring for and respecting each other as we interact.

3.0 Excellence – doing things right the first time, on time, every time; and being accountable and

responsible.

4.0 Service – service with a smile, appreciating differences and anticipating needs.

5.0 Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do.

FOUNDATIONS OF EXCELLENCE

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

1.0 Quality – provide excellence in clinical outcomes

2.0 Service – best place to be cared for

3.0 People – best place to work and practice

4.0 Finance – provide superior financial performance

5.0 Growth – meet the needs of the community

PERFORMANCE IMPROVEMENT INITIATIVES

The 2016 performance improvement priorities are based on the principles of STEEEP™,(Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the IHI Triple Aim:

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

Priorities identified include:

1.0 Top decile quality of care and patient satisfaction metric results.

2.0 Support Patient and Family Centered Care

3.0 Sustain a Just Culture philosophy that promotes patient safety, openness, & transparency

4.0 Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies

5.0 Optimize technology to integrate medical services at all levels of the organization

6.0 Facilitate integrated continuum of care management system

7.0 Ensure Patient Safety across the entire Health System

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

ORGANIZATION FRAMEWORK

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

Governing Board

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

The Board:

1.0 Delegates the responsibility for developing, implementing, and maintaining performance improvement activities to administration, medical staff, management, and employees;

2.0 Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;

3.0 Provides direction for the organization's improvement activities through the development of strategic initiatives;

4.0 Evaluates the organization's effectiveness in improving quality through reports from the various board committees, Medical Executive Committee and Medical Staff Quality Committee.

Administrative Council

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

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

Board Quality Committee

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

Medical Executive Committee

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

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

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

Department Chairs of the Medical Staff

The Department Chairs:

1.0 Provide a communications channel to the Medical Executive Committee;

2.0 Monitor Ongoing Professional Performance Evaluation and Focused Professional Performance Evaluation and make recommendations regarding reappointment based on data regarding quality of care;

3.0 Maintain all duties outlined by appropriate accrediting bodies.

Medical Staff

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

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

Hospital Management (Directors, Managers, and Supervisors)

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

1.0 Foster an environment of collaboration and open communication with both internal and external customers;

2.0 Participate and guide staff in the patient advocacy program;

3.0 Advance the philosophy of Just Culture within their departments;

4.0 Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process improvement activities for department-specific performance improvement initiatives;

5.0 Establish performance and patient safety improvement activities in conjunction with other departments;

6.0 Encourage staff to report any and all reportable events including “near-misses”;

7.0 Participate in the investigation and determination of the causes that underlie a “near-miss” /

Sentinel/Adverse Event/Error or Unanticipated Outcome as recommended by the Just Culture model and implement changes to reduce the probability of such events in the future.

Employees

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

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

Employees are expected to do the following:

1.0 Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect care experience for patients and customers;

2.0 Make suggestions/recommendations for opportunities of improvement or for a cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Director or Manager, the Director of Quality and Regulations, the Medical Director of Quality, or an Administrative Council Member.

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Committee

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

The Medical Staff Quality Committee:

1.0 Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Alternate Life Safety Measures Plan, Utilization Review Plan, Risk Management Plan, and the Patient Safety Plan.

2.0 Regularly reviews progress to the aforementioned plans.

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

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

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

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

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

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

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

Performance Improvement Committee (PIC)

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

The Performance Improvement Committee will:

1.0 Oversee the Performance Improvement activities of TFHS including data collection, data analysis, improvement, and communication to stakeholders

2.0 Set performance improvement priorities and provide the resources to achieve improvement

3.0 Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;

4.0 Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

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

Performance Improvement Teams will:

1.0 Follow the approved team charter as defined by the BOD, Administrative Council Members, or MSQC;

2.0 Establish specific, measurable goals and monitoring for identified initiatives;

3.0 Report their findings and recommendations to key stakeholders, PIC, and the MSQC.

PERFORMANCE IMPROVEMENT EDUCATION

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

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

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

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

PERFORMANCE IMPROVEMENT PRIORITIES

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

1.0 Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas

2.0 Processes that affect patient safety and outcomes

3.0 Processes related to patient advocacy and the perfect care experience

4.0 Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices

5.0 Processes related to patient flow

6.0 Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome

Because Tahoe Forest Health System is sensitive to the ever changing needs of the organization, priorities may be changed or re-prioritized due to:

1.0 Identified needs from data collection and analysis

2.0 Unanticipated adverse occurrences affecting patients

3.0 Processes identified as error prone or high risk regarding patient safety

4.0 Processes identified by proactive risk assessment

5.0 Changing regulatory requirements

6.0 Significant needs of patients and/or staff

7.0 Changes in the environment of care

8.0 Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/SERVICES

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

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

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

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

3.0 The design team develops or modifies the process utilizing information from the following concepts:

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

4.0 Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:

- 4.1 They can identify the events it is intended to identify
- 4.2 They have a documented numerator and denominator or description of the population to which it is applicable
- 4.3 They have defined data elements and allowable values
- 4.4 They can detect changes in performance over time
- 4.5 They allow for comparison over time within the organization and between other entities

4.6 The data to be collected is available

4.7 Results can be reported in a way that is useful to the organization and other interested stakeholders

PROACTIVE RISK ASSESSMENTS

1.0 Risk assessments are conducted to proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. At least one Failure Effect Mode Analysis will be completed every 18 months.

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

2.1 The process is assessed to identify steps that may cause undesirable variations, or "failure modes".

2.2 For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.

2.3 Potential risk points in the process will be closely analyzed including decision points and patient's moving from one level of care to another through the continuum of care.

2.4 For the effects on the patient that are determined to be "critical", a root cause analysis is conducted to determine why the effect may occur.

2.5 The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.

2.6 The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.

2.7 Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

3.0 Ongoing hazard surveillance rounds including Environment of Care Rounds and departmental safety hazard inspections are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.

4.0 The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.

5.0 The Infection Control Practitioner and Environment of Care Safety Officer complete a written infection control and preconstruction risk assessments for interim life safety for new construction or renovation projects.

DATA COLLECTION

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

1.0 Medication therapy

2.0 Infection control surveillance and reporting

3.0 Surgical/invasive and manipulative procedures

4.0 Blood product usage

5.0 Data management

6.0 Discharge planning

7.0 Utilization management

8.0 Complaints and grievances

9.0 Restraints/seclusion use

10.0 Mortality review

11.0 Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints

12.0 Needs, expectations, and satisfaction of individuals and organizations served, including:

- 12.1 Their specific needs and expectations
- 12.2 Their perceptions of how well the organization meets these needs and expectations
- 12.3 How the organization can improve patient safety
- 12.4 The effectiveness of pain management

21.0 Resuscitation and critical incident debriefings

22.0 Performance measures from acceptable data bases/comparative reports, i.e., Quantros, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN 2.0, and Press Ganey

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

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

24.0 Summaries of performance improvement actions and actions to reduce risks to patients

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

AGGREGATION AND ANALYSIS OF DATA

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

Data is analyzed in many ways including:

1.0 Using appropriate performance improvement problem solving tools

2.0 Making internal comparisons of the performance of processes and outcomes over time

3.0 Comparing performance data about the processes with information from up-to-date sources

4.0 Comparing performance data about the processes and outcomes to other hospitals and reference databases

Intensive analysis is completed for:

1.0 Levels of performance, patterns or trends that vary significantly and undesirably from what was expected

2.0 Significant and undesirable performance variations from the performance of other operations

3.0 Significant and undesirable performance variations from recognized standards

4.0 A sentinel event which has occurred (see Sentinel Event Policy)

5.0 Variations which have occurred in the performance of processes that affect patient safety

6.0 Hazardous conditions which would place patients at risk

7.0 The occurrence of an undesirable variation which changes priorities

The following events will automatically result in intense analysis:

1.0 Significant confirmed transfusion reactions

2.0 Significant adverse drug reactions

3.0 Significant medication errors

4.0 All major discrepancies between preoperative and postoperative diagnosis

5.0 Adverse events or patterns related to the use of sedation or anesthesia

6.0 Hazardous conditions that significantly increase the likelihood of a serious adverse outcome

7.0 Staffing effectiveness issues

8.0 Deaths associated with a hospital acquired infection

9.0 A sentinel event (see Sentinel Event Policy)

10.0 Core measure data, that over two or more consecutive quarters for the same measure, identify the hospital as a negative outlier

REPORTING

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

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

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

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

ANNUAL ASSESSMENT

The Quality Assurance program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.

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

PLAN APPROVAL

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

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

Attachment A
Quality Initiatives
2016

	Initiative	Agency	Inclusive Of
1.	Patient Safety Initiative	National Quality Forum (NQF) Endorsed Set of 34 Safe Practices	NQF Endorsed Set of 34 Safe Practices • Leadership Structures and Systems • Culture Measurement, Feedback, and Intervention • Teamwork Training and Skill Building • Identification and Mitigation of Risk and Hazards • Informed Consent • Life-Sustaining Treatment • Disclosure • Care of the Caregiver • Nursing Workforce • Direct Caregivers • Intensive Care Unit Care • Patient Care Information • Order Read-Back and Abbreviations • Labeling of Diagnostic Studies • Discharge Systems • Safe Adoption of Computerized Prescriber Order Entry • Medication Reconciliation • Pharmacist Leadership Structures and Systems • Hand Hygiene • Influenza Prevention • Central Line-Associated Bloodstream Infection Prevention • Surgical-Site Infection Prevention • Care of the Ventilated Patient • Multidrug-Resistant Organism Prevention • Catheter-Associated Urinary Tract Infection Prevention • Wrong-Site, Wrong-Procedure, Wrong-Person Surgery • Pressure Ulcer Prevention • Venous Thromboembolism Prevention • Anticoagulation Therapy • Contrast Media-Induced Renal Failure Prevention • Organ Donation • Glycemic Control • Fall Prevention • Pediatric Imaging

Attachment A
Quality Initiatives
2016

	Initiative	Agency	Inclusive Of
2.	Healthcare Provider Communication	Communication PI Team	Reinforce standardized approach for critical conversations utilizing SBAR & CUS
3.	Patients, Service & Quality TFHS Strategic Plan	Approved by the BOD in June 2016	Achieve goals as outlined on the Fiscal Year 2015-2017 approved Strategic Plan
4.	Medical Staff Strategic Plan	Approved by the BOD in June 2016	Achieve goals as outlined on the Fiscal Year 2015-2017 approved Strategic Plan
5.	Surgery Services Process Improvement Team		• Improve Teamwork and workplace behavior within Perioperative Services Team • Streamlined Pre-Op process in coordination with Orthopedic physican, MSC, and independed primary care providers.
6.	Orthopedic & Sports Medicine Service Line	California Orthopaedic Association American Orthopaedic Association	• CA Joint Replacement Registry • Own the Bone QI Program • Orthopedic continuum of care for orthopedic surgery patients as part of the integrated care coordination project.
7.	Navigator Program		• Cancer Center • Orthopedic & Sports Medicine
8.	Integrated Care Coordination Project		Institute comprehensive continuum of care management system that addresses disease while maintaining low cost, high quality of care for the communities we serve.
9.	Service Excellence	Press Ganey	Patient feedback received and quarterly report shared at BOD, Medical & Clinical staff meetings. Service Excellence PI team meets monthly to review results and identify areas for organizational improvement.
10.	Patient & Family Centered Care	Patient & Family Centered Care Partners & Patient's On Board	Patient Advisory Council meet monthly
11.	Root Cause Analysis/ Debriefing Process		As outlined per the Sentinel Event policy or as requested by the Medical Staff and Directors. Plan of action reviewed with Medical and Clinical staff as appropriate.
12.	OPPE/FPPE Department Specific Quality Indicators	Medical Staff Committee approve indicators	Cases reviewed, data collected, tracked, trended, and reviewed with Medical Staff as outlined in the Peer Review policy.
13.	Sanctioned Rapid Cycle Teams	Performance Improvement Committee (PIC) prioritizes and sanctions	Med Reconciliation PI Team Discharge Planning PI Team Communication PI Team MSC Medication Reconciliation PI Team

Attachment A
Quality Initiatives
2016

	Initiative	Agency	Inclusive Of
		teams as requested	Laboratory Patient Scheduler PI Team MSC Service Excellence PI Teams
14.	Failure Mode Event Analysis (FMEA)	PIC prioritizes and sanctions teams as requested	Need to identify a process to review
15.	Department Specific Metrics and Quality Dashboard	2016 Reporting Matrix outlines the matrix and reporting schedule to PIC	
16.	Core Measure Reporting	CMS	Quality data collected and submitted to CMS, through Quantros vendor, and posted on the Compare web site.
17.	Choose Wisely	Medical Staff Committee approval then develop an implementation plan	Specialty medical societies have created lists of "Things Physicians and Patients Should Question" that provide specific, evidence-based recommendations physicians and patients should discuss to help make wise decisions about the most appropriate care
18.	Health Information System (HIS) Alternatives Evaluation		Identification of and recommendation for alternate EMR and General Financial solutions as potential to replace current core systems for evolving district needs. This project falls under the IT strategic initatives.

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

PURPOSE:

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

POLICY:

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

TAHOE FOREST HOSPITAL

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

- 1.1 Emergency Services
- 1.2 Inpatient Medical Surgical Care
  - 1.2.1 Medical Surgical Pediatric care
- 1.3 Intensive Care and Step Down
  - 1.3.1 Step Down Pediatric care (age 7-17)
- 1.4 Swing Program
- 1.5 Obstetrical Services
- 1.6 Inpatient and Outpatient Surgery
- 1.7 Outpatient Observation Care
- 1.8 Inpatient and Outpatient Pharmacy Service
- 1.9 Medical Nutritional / Dietary Service
- 1.10 Respiratory Therapy Services
- 1.11 Rehabilitation Services that includes Physical, Occupational and Speech Therapy
- 1.12 Inpatient and Outpatient Laboratory Services
- 1.13 Diagnostic Imaging Services that includes: PET CT, Radiation, CT Scan, MRI, Mammography and Ultrasound, Fluoroscopy, and Nuclear Medicine
- 1.14 Home Health
- 1.15 Hospice
- 1.16 Skilled Nursing Care
- 1.17 Outpatient Services that includes Wellness program, Cardiac Rehabilitation, Occupational Health Services, Multispecialty Clinics
- 1.18 Medical and Radiation Oncology Services

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

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

- 2.1 Renown Medical Center (Reno, NV)
- 2.2 Saint Mary's Regional Medical Center (Reno, NV)
- 2.3 Carson Tahoe Hospital (Carson City, NV)
- 2.4 UC Davis Medical Center (Sacramento, CA)
- 2.5 Sutter Memorial (Sacramento, CA)
- 2.6 Sutter Roseville Medical Center (SRMC) (Roseville, CA)
- 2.7 Incline Village Community Hospital (IVCH) (Incline Village, NV)
- 2.8 California Pacific Medical Center (Davies, CA)
- 2.9 Eastern Plumas District Hospital (Portola, CA)
- 2.10 Truckee Surgery Center (Truckee, CA)
- 2.11 Northern Nevada Medical Center (Sparks, NV)
- 2.12 Emergency Transportation Agreements with:
  - 2.12.1 Truckee Fire Protection District
  - 2.12.2 Care Flight

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

- 3.1 Emergency Professional Services
- 3.2 On Call Physician Program
- 3.3 Hospitalist Services
- 3.4 Pathology and Laboratory Professional Services
- 3.5 Blood and Blood Products Provider: United Blood Services Reno, NV
- 3.6 Diagnostic Imaging Professional Services
- 3.7 Anesthesia Services
- 3.8 Rehabilitation Services
- 3.9 Pharmacy Services
- 3.10 Tissue Donor Services
- 3.11 Biomedical Services
- 3.12 Interpreter Services

Incline Village Community Hospital

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

- 4.1 Emergency Services
- 4.2 Inpatient Medical Surgical Care

- 4.3 Outpatient Observation Care
- 4.4 Inpatient and Outpatient Surgery
- 4.5 Inpatient Pharmacy Service
- 4.6 Rehabilitation Services including Physical Therapy
- 4.7 Laboratory Services
- 4.8 Diagnostic Imaging Services including CT
- 4.9 Home Health and Hospice
- 4.10 Sleep Disorder Clinic
- 4.11 Outpatient Services that include Occupational Health Services and a Multispecialty Clinic

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

- 5.1 Renown Regional Medical Center (Reno, NV)
- 5.2 Saint Mary's Regional Medical Center (Reno, NV)
- 5.3 Carson Tahoe Hospital (Carson City, NV)
- 5.4 Tahoe Forest Hospital (Truckee, CA)
- 5.5 Emergency Transportation Agreement with:
  - 5.5.1 North Lake Tahoe Fire Protection (Incline Village, NV)

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

- 6.1 Emergency Professional Services
- 6.2 Medicine – On Call
- 6.3 Pathology and Laboratory Professional Services
- 6.4 Blood and Blood Products Provider: United Blood Services Reno, NV
- 6.5 Diagnostic Imaging Professional Services
- 6.6 Anesthesia Services
- 6.7 Pharmacy Services
- 6.8 Rehabilitation Services
- 6.9 Tissue Donor Services
- 6.10 Biomedical Services
- 6.11 Interpreter Services

ATTACHMENT B

CAH SERVICES BY AGREEMENT OR ARRANGEMENT

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

Attachment C
Tahoe Forest Health System 2016 QA/PI Reporting Measures

CANCER CENTER	Responsible	Benchmark (as available)	2015	1st QTR	2nd QTR	3rd QTR	4th QTR
Number of New Consults with documented vaccination status.	Bottomley, K	100%			May		Nov.
Rate of infection for patients with peripherally inserted central lines and implanted ports	Bottomley, K	0%			May		Nov.
% of patients w/ resected colon cancer that have at least 12 regional lymph nodes removed & pathologically examined.	Bottomley, K	100%			May		Nov.
% of patients, regardless of age, w/ a dx of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate. OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since dx of prostate cancer	Bottomley, K	100%			May		Nov.
Radiation therapy is administered within 1 year of diagnosis for women under age 70 receive breast conserving surgery for breast cancer	Bottomley, K	100%			May		Nov.
Combination Chemo-Therapy is considered or administered within 4 months of diagnosis for women under 70 with AJCC1cMOMO, or stage II or III hormone receptor negative breast cancer	Bottomley, K	100%			May		Nov.
Tamoxifen or third-generation aromatase inhibitor is considered or administered within one year of diagnosis for women with AJCCT1cMOMO-or stage II or III hormone receptor positifive cancer	Bottomley, K.	100%			May		Nov.
Adjuvent chemotherapy is considered or administered within 4 months of diagnosis for patients under the age of 80 with AJCC stage III (lymph node positive) colon cancer	Bottomley, K	100%			May		Nov.
CARDIAC REHABILITATION	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Percent Top Box Patient Satisfaction	Buchanan, W	100%		Feb		Aug	
Average change in lower body strength	Buchanan, W			Feb		Aug	
Average change in upper body strength	Buchanan, W			Feb		Aug	
Average change in aerobic endurance	Buchanan, W			Feb		Aug	
Average change in lower body flexibility	Buchanan, W			Feb		Aug	
Average change in upper body flexibility	Buchanan, W			Feb		Aug	
Average change in dynamic balance and agility	Buchanan, W			Feb		Aug	
CASE MANAGEMENT - UTILIZATION REVIEW & DISCHARGE PLANNING	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**

Denials Percentage of Admissions (Final)	Schnobrich, B			Mar.		Sep.	
CAH Certification Compliance - percentage of Admissions	Schnobrich, B	100%		Mar.		Sep.	
Comprehensive discharge planning compliance rate - Percentage of High Risk Patient	Schnobrich, B	100%		Mar.		Sep.	
30-day Readmission Rate - Medicare	Schnobrich, B	<16%		Mar.		Sep.	
30-day Readmission Rate - Total	Schnobrich, B	<16%		Mar		Sep	
Swing Patients Readmitted to the Acute Hospital - Percentage of Swing Pt to Swing Admissions	Schnobrich, B	0		Mar		Sep	
Code 44 Status Changes - Percentage of Medicare Admissions	Schnobrich, B	0		Mar		Sep	
CORE MEASURES	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Inpatient							
AMI							
Apirin at arrival	Sturtevant, J.	100%		March		Sept	
Aspirin at discharge	Sturtevant	100%		March		Sept	
ACEI or ARB for LVSD	Sturtevant	100%		March		Sept	
Beta blocker at discharge	Sturtevant	100%		March		Sept	
Fibrolytic therapy received within 30 mins of arrival	Sturtevant	100%		March		Sept	
Immunizations							
Influenza Vaccine	Sturtevant, J.	100%		March		Sept	
VTE							
VTE Prophylaxis	Sturtevant, J.	100%		March		Sept	
ICU VTE Prophylaxis	Sturtevant	100%		March		Sept	
VTE Patients w/Anticoagulation Overlap Thearpy	Sturtevant	100%		March		Sept	
VTE Patients receiving UFH w/Dosages/ Platelet Count monitoring	Sturtevant	100%		March		Sept	
VTE Discharge Instructions	Sturtevant	100%		March		Sept	
Incidence of potentially preventable VTE	Sturtevant	0%		March		Sept	
Stroke							
VTE Prophylaxis	Sturtevant, J.	100%		March		Sept	
Discharged on Antithrombotic Therapy	Sturtevant	100%		March		Sept	

Anticoagulation Therapy for Atrial Fibrillation/Flutter	Sturtevant	100%		March		Sept	
Thrombolytic Therapy	Sturtevant	100%		March		Sept	
Antithrombotic Therapy by End of Hospital Day 2	Sturtevant	100%		March		Sept	
Discharged on Statin Medication	Sturtevant	100%		March		Sept	
Stroke Education	Sturtevant	100%		March		Sept	
Assessed for Rehabilitation	Sturtevant	100%		March		Sept	
Sepsis Bundle							
Perinatal Care - Mother							
Early Elective Delivery	Sturtevant, J.	0%		March		Sept	
CORE MEASURES	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Outpatient							
Median Time from ED Arrival to ED Departure for Discharged ED Patients - Overall Rate	Rust, J.			March		Sept	
Median Time from ED Arrival to ED Departure for Discharged ED Patients - Reporting Measure	Rust, J.			March		Sept	
Door to Diagnostic Evaluation by a Qualified Medical Personnel	Rust, J.			March		Sept	
Median Time to Pain Management for Long Bone Fracture	Rust, J.			March		Sept	
Outpatient Percentile Rank							
Rate of Mammography Recalls	Stokich, P.	11%		March		Sept	
Rate of Success full cases w/o complication	Stokich, P.	100%		March		Sept	
Rate of ASA Documentation	Stokich, P.	100%		March		Sept	
Rate of Airway Class Documentation	Stokich, P.	100%		March		Sept	
Rate of Procedural Sedation Significant Hypoxemia	Stokich, P.	0%		March		Sept	
Rate of Reversal Agents Used	Stokich, P.	0%		March		Sept	
Rate of Procedural Sedation Adverse Outcomes Documented	Stokich, P.	0%		March		Sept	
Rate of Correct Injections	Stokich, P.	100%		March		Sept	
Rate of time background checked >mR/h	Stokich, P.			March		Sept	
DI TOP BOX PERCENT TOTAL	Stokich, P.	90%		March		Sept	
DIETARY - NUTRITION & FOOD SERVICES	**Responsible**	**Benchmark**	**2015m**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**

Initial Nutritional Screen Compliance	Lutz, H.	100%		Feb.		Aug.	
MS Initial Nutritional Screen Compliance	Lutz, H.			Feb.		Aug.	
Items not meeting minimum qualitative temperature standard	Lutz, H.			Feb.		Aug.	
Catering Error Rate	Lutz, H.			Feb.		Aug.	
IVCH Initial Nutritional Screen Compliance	Lutz, H.			Feb.		Aug.	
IVCH Tray Utilization Rate	Lutz, H.	NA		Feb.		Aug.	
ECC - SKILLED NURSING FACILITY	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Rate of residents who experience a UTI	Stull, SJ	9%			April		Oct
Rate of residents who experience significant weight loss	Stull	8%			April		Oct
Rate of resident Falls	Stull	7%			April		Oct
Number of patient visits to the emergency department	Stull	0%			April		Oct
Rate of catheter related UTI's	Stull	0%			April		Oct
Staff Turn Over Rate	Stull				April		Oct
Rate of Fluvac Administered	Stull	89%			April		Oct
Rate of Pneumovax Administered	Stull	94%			April		Oct
EMERGENCY DEPT. - TFH	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Reversal Agent Used (S)	Rust, J.	5%			Apr.		Oct.
Propofol MD, RN and RT or 2nd MD documented (S)	Rust, J.	95%			Apr.		Oct.
Time out documented just prior to medication administration	Rust, J.	100%			Apr		Oct
End Tidal CO2 documented	Rust, J.	100%			Apr		Oct
Sedation Scale criteria met	Rust, J.	100%					
Mean arrive to MD time (mins)	Rust, J.	NEW			Apr.		Oct.
ED throughput Mean LOS	Rust, J.	NEW			Apr.		Oct.
Mean Inpatient Decision to Admission Time	Rust, J.	NEW			Apr.		Oct.
Percent of ER Patients leaving against medical advice 'AMA' (P)	Rust, J.	1%			Apr.		Oct.
Percent ER patients leaving without being seen by a physician (P)	Rust, J.	2%			Apr.		Oct.
Patients readmitted to ER within 72 hrs (E)	Rust, J.	2%			Apr.		Oct.

Percent of ER Patients Transferred (E, Ef, P)	Rust, J.	no goal			Apr.		Oct.
EMERGENCY DEPT. - TFH RESTRAINT USE	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
ER Patient Restraint Rate	Rust, J.				Apr.		Oct.
Rate of Alternative Interventions Doc'd (S)	Rust, J.	100%			Apr.		Oct.
MD Restraint Order Doc'd and Signed (S)	Rust, J.	100%			Apr.		Oct.
Doc'd q15 min assessment for need (S)	Rust, J.	100%			Apr.		Oct.
Release of Restraints q2hrs documented (S)	Rust, J.	100%			Apr.		Oct.
ENVIRONMENTAL SVCS	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Room Cleanliness	Ruggiero, M.	100%			May		Nov
Courtesy of Person Cleaning Room	Ruggiero, M.	100%			May		Nov
HCAHPS - "Room and Bathroom Kept Clean"	Ruggiero, M.	100%			May		Nov
Percentage of checklists 100% complete	Ruggiero, M.	100%			May		Nov
HIM	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Average AR Total - ER	Hunt, D.			Mar.		Sep.	
Average AR Total - IP	Hunt, D.			Mar.		Sep.	
Average AR Total - OP	Hunt, D.			Mar		Sep	
Average AR TOTAL	Hunt, D.			Mar		Sep	
Average Uncoded Records - ER	Hunt, D.			Mar		Sep	
Average Uncoded Records - IP	Hunt, D.			Mar		Sep	
Average Uncoded Records - OP	Hunt, D.			Mar		Sep	
Average Uncoded Records	Hunt, D.			Mar		Sep	
Average Days Out in Coding - ER	Hunt, D.			Mar		Sep	
Average Days Out in Coding - IP	Hunt, D.			Mar		Sep	
Average Days Out in Coding - OP	Hunt, D.			Mar		Sep	
Average Days Out in Coding	Hunt, D.			Mar		Sep	
HOME HEALTH	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**

Improvement in Pain	Gancitano, K.	71%			Apr.		Oct.
Improvement in Bathing	Gancitano, K.	74%			Apr.		Oct.
Improvement in Transferring	Gancitano, K.	57%			Apr.		Oct.
Improvement in Ambulation / Locomotion	Gancitano, K.	65%			Apr.		Oct.
Improvement in Management of Oral Medications	Gancitano, K.	51%			Apr.		Oct.
Improvement in Surgical Wounds	Gancitano, K.	93%			Apr.		Oct.
Home Health unplanned readmission within 30 days of discharge	Gancitano, K.	13%			Apr		Oct.
Emergency Care Visits related to wound deterioration	Gancitano, K.	Under Research			Apr.		Oct.
Increase in Number of Pressure Ulcers	Gancitano, K.	Under Research			Apr.		Oct.
HHCAHPS - Care of patients	Gancitano, K.	86%			Apr.		Oct.
HHCAHPS - Communication between pts and providers	Gancitano, K.	84%			Apr.		Oct.
HHCAHPS - Specific Care issues	Gancitano, K.	86%			Apr.		Oct.
HHCAHPS - Rate agency 9 or 10	Gancitano, K.	78%			Apr.		Oct.
HHCAHPS - Recommend this agency	Gancitano, K.	81%			Apr.		Oct.
HOSPICE	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Match MAR vs Physician Orders	Gancitano, K.	95%			Apr.		Oct.
Follow through on assessed pt needs	Gancitano, K.	95%			Apr.		Oct.
Patients Pain goals are met within 48 hrs	Gancitano, K.	95%			Apr.		Oct.
Hospice Patient CA-UTI Rate	Gancitano, K.	0%			Apr.		Oct.
Hospice Patient CLABSI Rate (per 1000 device days)	Gancitano, K.	0%			Apr.		Oct.
ICU	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Rate of Etomidate Adverse Events	Sturtevant, J	0%		Jan		July	
Rate of Reversal Agents Used	Sturtevant, J	0%		Jan		July	
Rate of Propofol MD, RN & RT or 2nd MD Documented	Sturtevant, J	100%		Jan		July	
Rate of Propofol Adverse Events	Sturtevant, J	0%		Jan		July	

Alternative Interventions Documented	Sturtevant, J	100%		Jan		July	
MD Order documented and signed every 24 hrs non violent/q 4hrs for violent	Sturtevant, J	100%		Jan		July	
Documentation of q15 min/assessment for need	Sturtevant, J	100%		Jan		July	
Release of restraints 2q hrs documented	Sturtevant, J	100%		Jan		July	
Need for restraints q 4 hrs	Sturtevant, J	100%		Jan		July	
Plan of Care Initiated	Sturtevant, J	100%		Jan		July	
Baseline Pain Goal & Problem initiated for Patients in Pain	Sturtevant, J	100%		Jan		July	
PRN Medications with proper frequency and dose	Sturtevant, J	100%		Jan		July	
Physician notified if pain goal not met	Sturtevant, J	100%		Jan		July	
PCA documenation appropriate	Sturtevant, J	100%		Jan		July	
PCA Documentation Vital signs per PCA protocol and Range Orders	Sturtevant, J	100%		Jan		July	
PCA Documentation VTBI	Sturtevant, J	100%		Jan		July	
PCA Documentation Time cleared	Sturtevant, J	100%		Jan		July	
PCA Documentation Inject and attempts	Sturtevant, J	100%		Jan		July	
PCA Documentation volume/dose delivered for shift	Sturtevant, J	100%		Jan		July	
Physician Order Clarification Compliance	Sturtevant, J	100%		Jan		July	
Rate of Age Related Developmental Needs Assessment	Sturtevant, J	100%		Jan		July	
Number of Sepsis Patients	Sturtevant, J	N/A		Jan		July	
Serum lactate measured	Sturtevant, J	100%		Jan		July	
Blood cultures obtained prior to antibiotic administration	Sturtevant, J	100%		Jan		July	
Improve time to broad-spectrum antibiotics: within 3 hours for ED admissions and 1 hour for non-ED ICU admissions	Sturtevant, J	100%		Jan		July	
In the event of hypotension and/or lactate >4 mmol/L (36mg/dl): Deliver an initial minimum of 20 ml/kg of crystalloid (or colloid equivalent) Apply vasopressors for hypotension not responding to initial fluid resuscitation to maintain mean arterial pressure (MAP) >65 mm Hg.	Sturtevant, J	100%		Jan		July	
Sepsis Pre-printed Orders Used - First hour/Admission	Sturtevant, J	100%		Jan		July	
Survived?	Sturtevant, J	100%		Jan		July	
INFECTION CONTROL	**Responsible**	**Benchmark**	**2015**	**1st**	**2nd**	**3rd**	**4th QTR**

Attachment C
Tahoe Forest Health System 2016 QA/PI Reporting Measures

				QTR	QTR	QTR	
Total SSI rate All Classes	Holmer, L.	0%			May		Nov.
Class I	Holmer, L.	0%			May		Nov.
Class II	Holmer, L.	0%			May		Nov
Class III	Holmer, L.	0%			May		Nov
Class IV	Holmer, L.	0%			May		Nov
ICU CLA-BSI	Holmer, L.	0%			May		Nov
Non-ICU CLA-BSI	Holmer, L.	0%			May		Nov
ICU VAP	Holmer, L.	0%			May		Nov
ICU cath-associated UTI Rate per 1000 device days	Holmer, L.	0%			May		Nov
Med-Surg cath-associated UTI per 1000 device days	Holmer, L.	0%			May		Nov
OB cath-associated UTI per 1000 device days	Holmer, L.	0%			May		Nov
MRSA Admission Screen Compliance	Holmer, L.	100%			May		Nov
MRSA Discharge Screen Compliance	Holmer, L.	100%			May		Nov
HAC MRSA Infection Rate per 1000 Pt Days	Holmer, L.	0%			May		Nov
Acute Care Hand Hygiene Med Pass Compliance Rate (S, E, P)	Holmer, L.	100%			May		Nov
MSC Care Hand Hygiene Med Pass Compliance	Holmer, L.	100%			May		Nov
LTC Catheter Associated UTI	Holmer, L.	0%			May		Nov
LTC HAC-MRSA Infection Rate per 1000 Pt Days	Holmer, L.	0%			May		Nov
LTC Hand Hygiene Compliance	Holmer, L.	100%			May		Nov
Rate of Respiratory Infection	Holmer, L.	0%			May		Nov
Rate of UTI without catheter	Holmer, L.	0%			May		Nov
Rate of GI Tract infection	Holmer, L.	0%			May		Nov
Rate of Skin Infection	Holmer, L.	0%			May		Nov
IVCH	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Directors report for both TFH & IVCH during their respective months	Dept Director						
Nursing Services	Iida, J				Apr.		Oct.

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Tahoe Forest Health System 2016 QA/PI Reporting Measures

LABORATORY	Responsible	Benchmark	2015	1st QTR	2nd QTR	3rd QTR	4th QTR
Amended Report Rate Overall	Barnes, V.	0.15%			April		Oct
Amended Report Rate TFH	Barnes, V.	0.15%			April		Oct
Amended Report Rate IVCH	Barnes, V.	0.15%			April		Oct
Amended Report Rate ONC	Barnes, V.	0.15%			April		Oct
Overall Rate of CBCs (Order to Result)<60Min	Barnes, V.	95%			April		Oct
Rate of STAT TFH CBCs (Order to Result)<60Min	Barnes, V.	95%			April		Oct
Rate of STAT IVCH CBCs (Order to Result)<60Min	Barnes, V.	95%			April		Oct
Overall Rate of CMPs (Order to Result)<70Min	Barnes, V.	95%			April		Oct
Rate of STAT TFH CMPs (Order to Result)<70Min	Barnes, V.	95%			April		Oct
Rate of STAT IVCH CMPs (Order to Result)<70Min	Barnes, V.	95%			April		Oct
Overall Rate of Troponins (Order to Result)<70Min	Barnes, V.	95%			April		Oct
Rate of STAT TFH Troponins (Order to Result)<70Min	Barnes, V.	95%			April		Oct
Rate of STAT IVCH Troponins (Order to Result)<70Min	Barnes, V.	95%			April		Oct
Troponin Results received within 60 mins of ED arrival for AMI pts	Barnes, V.	100%			April		Oct
Overall Lab Error Rate	Barnes, V.	0.40%			April		Oct
Error Rate of TFH	Barnes, V.	0.40%			April		Oct
Error Rate of IVCH	Barnes, V.	0.40%			April		Oct
Error Rate of ONC	Barnes, V.	0.40%			April		Oct
Percent TFH Pre-Analytical Errors	Barnes, V.				April		Oct
Percent TFH Analytical Errors	Barnes, V.				April		Oct
Percent TFT Post Analytical Errors	Barnes, V.				April		Oct
Percent IVCH Pre-Analytical Errors	Barnes, V.				April		Oct
Percent IVCH Analytical Errors	Barnes, V.				April		Oct
Percent IVCH Post Analytical Errors	Barnes, V.				April		Oct
Percent ONC Pre-Analytical Errors	Barnes, V.				April		Oct
Percent ONC Analytical Errors	Barnes, V.				April		Oct

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Tahoe Forest Health System 2016 QA/PI Reporting Measures

Percent ONC Post Analytical Errors	Barnes, V.				April		Oct
Rate of Inpatient routine MSN/ICU reports on unit by 7AM	Barnes, V.	90%			April		Oct
Rate of routine AM Labs Drawn in MSN/ICU by 6AM	Barnes, V.	90%			April		Oct
Top Box Outpatient Satisfaction with Lab Wait Times	Barnes, V.	90%			April		Oct
Number of Blood Cultures	Barnes, V.	0%			April		Oct
Lookback for Blood Transfusions (S, E, P)	Barnes, V.				April		Oct
Rate of Contaminated Blood Cultures (S, E, Ef, P)	Barnes, V.				April		Oct
Rate of TFH Staff Proficiency (E, Ef, P)	Barnes, V.				April		Oct
Rate of IVCH Staff Proficient (E, Ef, P)	Barnes, V.				April		Oct
LIFE/SAFETY	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Employee RACE response to Code Red	Ruggerio, M.	100%			May		Nov
Regulatory Preventive Maintenance On Time Percentage	Ruggerio, M.	100%			May		Nov
Non-Regulatory Preventive Maintenance On Time Percentage	Ruggerio, M.	90%			May		Nov
QUALITY	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Patient Safety Index Detail							
Restraint usage percentage	Sturtevant	5.00%		Jan		July	
Medication error rate (D+)	Ward, H.	5.00%		Feb		Aug	
Pressure ulcer percentage	Sturtevant	4.20%		Jan		July	
Inpatient falls per 1000 patient days rate	Sturtevant	2.79		Jan		July	
Excellent Care Index Index Detail							
Inpatient mortality percentage	Hunt, D.	3.00%			April		Oct
Primary C-Section percentage	Sturtevant, J	19.00%			April		Oct
Medicare average LOS	Gancintano, K.				April		Oct
ER Readmission within 72 hrs with same diagnosis	Rust, J.	3.60%			April		Oct
Hospital Acquired Surgical Infection							
Class I surgical site infection rate	Holmer, L.	0%			April		Oct
Hospital Acquired Non-Surgical Infection							

Attachment C
Tahoe Forest Health System 2016 QA/PI Reporting Measures

ICU CLABSI	Holmer, L.	0%			April		Oct
VAP (Ventilator Associated Pneumonia)	Holmer, L.	0%			April		Oct
ICU Catheter Associated UTI (CAUTI)	Holmer, L.	0%			April		Oct
Health Care Acquired MRSA (per 1000 pt-days)	Holmer, L.	0%			April		Oct
Hospital Acquired Conditions							
Foreign Object Retained After Surgery	Weeks, K	0%			April		Oct
Air Embolism	Van Gelder	0%			April		Oct
Blood Incompatibility	Barnes, V.	0%			April		Oct
DVT & Pulmonary Emboli following Ortho Surgery	Weeks, K	0%			April		Oct
Patient Satisfaction							
HCAHPS "Recommend this Hospital" Percentile Rank	Sturtevant, J.	SmPG DB			April		Oct
HCAHPS "Rate this Hospital 9-or-10" Percentile Rank	Sturtevant, J.	SmPG DB			April		Oct
OutPT Percentile Rank	Outpatient Director	Malcolm Baldridge			April		Oct
TFH ED Overall Percentile Rank	Rust, J.	SmPG DB			April		Oct
IVCH ED Overall Percentile Rank	Iida, J.	Malcolm Baldridge			April		Oct
ASD Overall Percentile Rank	Weeks, K	SmPG DB			April		Oct
MSC Overall Percentile Rank	Dorst, J.	15K-25K visits/yr			April		Oct
Long Term Care							
Percent of patients who develop pressure ulcers	Stull, SJ	12.00%			April		Oct
Residents with a urinary tract infection percentage	Stull, SJ	9.00%			April		Oct
Percent of residents who experience unplanned weight loss	Stull, SJ	8.00%			April		Oct
Percentage of Falls	Stull, SJ	13.10%			April		Oct
SNF 5-Star Quality Rating	Stull, SJ				April		Oct
Home Health							
Improvement in Pain	Gancitano, K.	64.00%			April		Oct

Improved Bathing	Gancitano, K.	64.00%			April		Oct
Improved Transferring	Gancitano, K.	53.00%			April		Oct
Improved Ambulation	Gancitano, K.	44.00%			April		Oct
Management of oral medications	Gancitano, K.	43.00%			April		Oct
Improve in Surgical Wounds	Gancitano, K.	80.00%			April		Oct
Patients with emergency care needs percentage	Gancitano, K.	22.00%			April		Oct
HHCAHPS - Rate this agency 9 or 10	Gancitano, K.	84.00%			April		Oct
HHCAHPS - Recommend this agency	Gancitano, K.	80.00%			April		Oct
Hospice							
Match MAR vs Physician Orders	Gancitano, K.				April		Oct
Follow through on assessed pt needs	Gancitano, K.				April		Oct
Patients Pain goals are met within 48 hrs	Gancitano, K.				April		Oct
Hospice Patient UTI Rate	Gancitano, K.				April		Oct
Hospice Patient Vascular Device Infection Rate (TPD)	Gancitano, K.				April		Oct
MED SURG & SWING	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Receipt of Patient Right is present on chart (Eq, P)	Sturtevant, J	100%		Jan		July	
Activities Evaluation Form is present and Complete (T, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	
Plan for Recreational Therapy is documented by Activities Coordinator (T, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	
Care Plan Conference held within 7-days of resident stay (S, T, E, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	
Admission Evaluation and Interim Care Plan Present and Completed (S, T, E, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	
TFH Swing/ECC Interdiciplinary Care Plan Present and Completed (S, T, E, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	
Plan of Care Initiated	Sturtevant, J	100%		Jan		July	
Baseline Pain Goal & Problem initiated for Patients in Pain	Sturtevant, J	100%		Jan		July	
PRN Medications with proper frequency and dose	Sturtevant, J	100%		Jan		July	
Physician notified if pain goal not met	Sturtevant, J	100%		Jan		July	
PCA documentation appropriate	Sturtevant, J	100%		Jan		July	
Age related developmental needs assessments compliance (S, T, E, Ef, Eq, P)	Sturtevant, J	100%		Jan		July	

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MULTISPECIALTY CLINICS	Responsible	Benchmark	2015	1st QTR	2nd QTR	3rd QTR	4th QTR
Time Cycle Study	Walker, S	100%		Feb		Aug.	
Diabetes tracking	Walker, S	100%		Feb		Aug.	
Influenza Vaccine	Walker, S	100%		Feb		Aug.	
EMPLOYEE HEALTH	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Rate of Events Reviewed by Employee Health	McMullen, S	100%			May		Nov.
Rate of Events with Manager Review/Response	McMullen, S	100%			May		Nov.
Rate of Near miss event review/response with manager	McMullen, S	100%			May		Nov.
Non clinical employees TB Screening compliance	McMullen, S	100%			May		Nov.
Clinical employees TB screening compliance	McMullen, S	100%			May		Nov.
Employee influenza vaccination	McMullen, S	100%			May		Nov.
Medical Staff influenza vaccination	McMullen, S	100%			May		Nov.
ORGAN DONATION	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Deaths	Thomas, A.			Jan		July	
Referrals	Thomas, A.	100%		Jan		July	
Missed Referrals	Thomas, A.	0%		Jan		July	
Donors	Thomas, A.			Jan		July	
PERIOPERATIVE SERVICES	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Surgery							
Preop ABX administered on time plus reasons	Weeks, K	100%			June		Dec.
Not Ordered (S, T, P)	Weeks, K	0%			June		Dec.
Incomplete Order (S, E, P)	Weeks, K	0%			June		Dec.
Order Unclear (S, E, P0	Weeks, K	0%			June		Dec
ABX Too Early (S, T, E)	Weeks, K	0%			June		Dec
ABX Too Late (S, T, E)	Weeks, K	0%			June		Dec
OR Number Correct (E, Ef)	Weeks, K	100%			June		Dec

Header for Procedure Correct (E, Ef)	Weeks, K	100%			June		Dec
Anesthesia Provider Correct (Ef)	Weeks, K	100%			June		Dec
Anesthesia Type Correct (S, E, Ef)	Weeks, K	100%			June		Dec
e-Signature Present (Ef)	Weeks, K	100%			June		Dec
Surgery Start Time Correct (Ef)	Weeks, K	100%			June		Dec
Time Out Correct (Ef)	Weeks, K	100%			June		Dec
Preop ABX Name and Time Documented (T, Eq, P)	Weeks, K	100%			June		Dec
Surgical Safety Checklist Complete (S, T, E, Eq, P)	Weeks, K	100%			June		Dec
PAAS							
Phase II Recovery > 3 hrs. plus reasons	Weeks, K	100%			June		Dec.
Number of PRE Pain Scales documented	Weeks, K.	100%			June		Dec.
PRN Medication Administration Phase I	Weeks, K	100%			June		
ENDO							
Moderate Sedation Reversal Aged Required	Weeks, K	0%			June		Dec.
Moderate Sedation BVM Required	Weeks, K	0%			June		Dec.
Moderate Sedations to MAC	Weeks, K	1%			June		Dec.
Respiratory Cause (n)	Weeks, K	NA			June		Dec
Medicine History (n)	Weeks, K	NA			June		Dec
Cardiac Cause (n)	Weeks, K	NA			June		Dec
Surgical History Cause (n)	Weeks, K	NA			June		Dec
Other Cause (n)	Weeks, K	NA			June		Dec
ORTHOPEDIC SERVICE LINE							
	Coll, D				June		Dec
	Coll, D				June		Dec
	Coll, D				June		Dec
PAIN CLINIC							
Patient Receving Sedation	Weeks, K				June		Dec.
Reversal Agent Required	Weeks, K	0%			June		Dec.

BVM Required	Weeks, K.	0%			June		Dec.
SPD							
Immediate Use Cycle Rate	Weeks, K	10%			June		Dec.
PHARMACY	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
TFHS Medication Error Rate Category A+B	Ward, H.			Feb		Aug	
TFHS ADR Reported	Ward, H.	100%		Feb		Aug	
TFH Error Free Override Medication Rate	Ward, H.	100%		Feb		Aug	
Rate of Correctly resolved narcotic discrepancies	Ward, H.	100%		Feb		Aug	
Acute Warfarin Compliance	Ward, H.	100%		Feb		Aug	
Maintenance Warfarin Compliance	Ward, H.	100%		Feb		Aug	
Ketorolac Compliance	Ward, H.	100%		Feb		Aug	
Aminoglycoside Compliance	Ward, H.	100%		Feb		Aug	
Vancomycin Compliance	Ward, H.	100%		Feb		Aug	
TPN Compliance	Ward, H.	100%		Feb		Aug	
Renal Function dosing appropriateness	Ward, H.	100%		Feb		Aug	
Electrolyte Dosing Appropriateness	Ward, H.	100%		Feb		Aug	
IVCH - Medication Error Rate	Ward, H.	0%		Feb		Aug	
IVCH - Total Number of IVCH ADRs Reported	Ward, H.	100%		Feb		Aug	
IVCH - Rate of Orders Documented on Log	Ward, H.	100%		Feb		Aug	
IVCH - Rate of Medications Left for Audit	Ward, H.			Feb		Aug	
PHYSICAL THERAPY	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Truckee PT-OP patients showing significant improvement on the Patient Specific Functional Scale	Larson, M.	85%			Apr.		Oct.
Tahoe City PT-OP patients meeting improvement criteria	Larson, M.	85%			Apr.		Oct.
Incline Village PT-OP patients meeting improvement criteria	Larson, M.	85%			Apr		Oct
OT Outpatients improving by 10% I nthe DASH	Larson, M.	85%			Apr		Oct
85% of patients after TKA and THA will score a '5' on the Walk section of the FIM (IP PT)	Larson, M.	85%			Apr		Oct

85% of patients after TKA and THA will score a '6' on the Dressing section of the FIM (IP OT)	Larson, M.	85%			Apr		Oct
Patient Overall Satisfaction Top Box Score (all facilities)(P)	Larson, M.	85%			Apr		Oct
Patient Satisfaction Top Box Score - Truckee	Larson, M.	90%			Apr		Oct
Patient Satisfaction Top Box Score - Tahoe City	Larson, M.	90%			Apr		Oct
Patient Satisfaction Top Box Score - Incline	Larson, M.	90%			Apr		Oct
Truckee Utilization - High & Expected Percentage	Larson, M.				Apr		Oct
Truckee Utilization - National Percentile Ranking	Larson, M.				Apr		Oct
Truckee Effectiveness - FS Change	Larson, M.				Apr		Oct
Truckee Effectiveness - Predicted	Larson, M.				Apr		Oct
Truckee Efficiency - Average number of Visits	Larson, M.				Apr		Oct
Truckee Efficiency - Average Predicted Visits	Larson, M.				Apr		Oct
Tahoe City Utilization - High & Expected Percentage	Larson, M.	85%			Apr		Oct
Tahoe City Utilization - National Percentile Ranking	Larson, M.				Apr		Oct
Tahoe City Effectiveness - FS Change	Larson, M.				Apr		Oct
Tahoe City Effectiveness - Predicted	Larson, M.				Apr		Oct
Tahoe City Efficiency - Average number of Visits	Larson, M.				Apr		Oct
Tahoe City Efficiency - Average Predicted Visits	Larson, M.				Apr		Oct
Incline Utilization - High & Expected Percentage	Larson, M.	85%			Apr		Oct
Incline Utilization - National Percentile Ranking	Larson, M.				Apr		Oct
Incline Effectiveness - FS Change	Larson, M.				Apr		Oct
Incline Effectivenss - Predicted	Larson, M.				Apr		Oct
Incline Efficiency - Average number of Visits	Larson, M.				Apr		Oct
Incline Efficiency - Average Predicted Visits	Larson, M.				Apr		Oct
RESPIRATORY THERAPY	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
O2 Monitoring	Grosdidier, J.	100%		Jan		July	
SBT monitoring trial	Grosdidier, J.	100%		Jan		July	
Vent Patient with Stable FIO2 and PEEP	Grosdidier, J.	100%		Jan		July	

O2 Ordering Compliance	Grosdidier, J.	100%		Jan		July	
RESTRAINTS	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Initiation by unit	Thomas, A.	100%		Jan		July	
Initiation by day of week	Thomas, A.	100%		Jan		July	
Initiation by shift	Thomas, A.	100%		Jan		July	
Injury to patient or staff	Thomas, A.	100%		Jan		July	
Restraint-related death	Thomas, A.	100%		Jan		July	
Average length of episode (hours)	Thomas, A.	100%		Jan		July	
RESUSCITATION OUTCOMES	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Total # of resuscitations	Thomas, A.			Jan		July	
Survival rate (12 hours) or transfer to higher level of care	Thomas, A.	100%		Jan		July	
Total # of critical incidents reported	Thomas, A.	100%		Jan		July	
Patient outcomes from critical incidents	Thomas, A.			Jan		July	
Critical incident event type	Thomas, A.			Jan		July	
RISK	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Total number of patient safety events	Blumberg, C.			Mar.		Sep.	
Number of patient safety events per 1000 patient days	Blumberg, C.			Mar.		Sep.	
Number of AMA from in-patient units per 1000 patient days	Blumberg, C.	0%		Mar.		Sep.	
Number of new professional liability (PL) claims	Blumberg, C.	0%		Mar.		Sep.	
Number of new PL claims for which the event is unknown prior to claim	Blumberg, C.	0%		Mar.		Sep.	
FALLS							
Total # non-patient (visitor) falls	Thomas, A.	0%		Jan		July	
Total # of patient falls (by department and injury severity)	Thomas, A.			Jan		July	
Rate of inpatient falls per 1000 patient days.	Thomas, A.			Jan		July	
Rate of inpatient falls with Moderate+ injury per 1000 patient days.	Thomas, A.			Jan		July	
Skin breakdown / decubitus							

Total # of hospital-acquired pressure ulcers	Thomas, A.	0%		Jan		July	
WOMEN & FAMILY - OBSTETRICS	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Neonatal Mortality Rate per 1000 live births	Sturtevant, J	70%		Jan		July	
Primary Cesarean Section Rate	Sturtevant, J	19%		Jan		July	
RN Deliveries	Sturtevant, J	0%		Jan		July	
Scheduled Deliveries (elective inductions & C-Sections) >=37 wks and <39 Weeks	Sturtevant, J	0%		Jan		July	
APGARS=<7@5min	Sturtevant, J			Jan		July	
Weight=<1500 Grams	Sturtevant, J			Jan		July	
Baby Friendliness Assessment	Sturtevant, J	80%		Jan		July	
CCHD Screen Negative	Sturtevant, J	100%		Jan		July	
CCHD Screen Positive	Sturtevant, J	100%		Jan		July	
PPH≥1500	Sturtevant, J	NEW		Jan		July	
Shoulder Dystocia	Sturtevant, J	NEW		Jan		July	
Medically Indicated Inductions	Sturtevant, J	NEW		Jan		July	
CCHD Screen Negative	Sturtevant, J	99%		Jan		July	
CCHD Screen Positive	Sturtevant, J	1%		Jan		July	
HFAP National Quality Forum Endorsed Set of Safe Practices	**Responsible**	**Benchmark**	**2015**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
1. Leadership Structure and Systems							
	Blumberg, C.			March		Sept	
2. Culture Measurement, Feedback, and Intervention							
	Blumberg, C.			March		Sept	
3. Teamwork Training and Skill Building							
	Blumberg, C.			March		Sept	
4. Indentification and Mitigation of Risks and Hazards							
	Blumberg, C.			March		Sept	
5. Informed Consent							
	Blumberg, C.			March		Sept	

Attachment C
Tahoe Forest Health System 2016 QA/PI Reporting Measures

6. Life-Sustaining Treatment							
	Blumberg, C.			March		Sept	
7. Disclosure							
	Blumberg, C.			March		Sept	
8. Care of the Caregiver							
	Blumberg, C.			March		Sept	
9. Nursing Workforce							
	Newland, J			March		Sept	
10. Direct Caregivers							
	Blumberg, C.			March		Sept	
11. Intensive Care Unit Care							
	Sturtevant, J			March		Sept	
12. Patient Care Information							
	Blumberg, C.			March		Sept	
13. Order Read-Back and Abbreviations							
	Blumberg, C.			March		Sept	
14. Labeling of Diagnostic Studies							
	Stokich, P.			March		Sept	
15. Discharge Systems							
	Blumberg, C.			March		Sept	
16. Safe Adoption of Computerized Prescriber Order Entry							
	Mather, T.			March		Sept	
17. Medication Reconciliation							
	Ward, H.			March		Sept	
18. Pharmacist Leadershhip Structure and Systems							
	Ward, H.			March		Sept	
19. Hand Hygiene							
	Holmer, L			March		Sept	

Attachment C
Tahoe Forest Health System 2016 QA/PI Reporting Measures

20. Influenza Prevention							
	Holmer, L			March		Sept	
21. Central Line-Associated Bloodstream Infection Prevention							
	Holmer, L			March		Sept	
22. Surgical Site Infection Prevention							
	Holmer, L			March		Sept	
23. Care of the Ventilated Patient							
	Sturtevant, J			March		Sept	
24. Multidrug-Resistant Organism Prevention							
	Ward, H.			March		Sept	
25. Catheter-Associated Urinary Tract Infection Prevention							
	Holmer, L			March		Sept	
26. Wrong-Site, Wrong-Procedure, Wrong-Person Surgery Prevention							
	Weeks, K.			March		Sept	
27. Pressure-Ulcer Prevention							
	Thomas, A.			March		Sept	
28. Venous Thromboembolism Prevention							
	Sturtevant, J.			March		Sept	
29. Anticoagulation Therapy							
	Ward, H.			March		Sept	
30. Contrast Media-Induced Renal Failure Prevention							
	Stokich, P.			March		Sept	
31. Organ Donation							
	Thomas, A.			March		Sept	
32. Glycemic Control							
	Sturtevant, J			March		Sept	
33. Fall Prevention							
	Thomas, A.			March		Sept	

Attachment C
Tahoe Forest Health System 2016 QA/PI Reporting Measures

34. Pediatric Imaging							
	Stokich, P.			March		Sept	

Attachment D
Quality Improvement Indicator Definitions
2016

Indicator Title	CMS Core Measure #	Inclusive Of	Measurement Explanation
Patient Safety Index Detail	PSI-1 PSI-2 PSI-3 PSI-4	Core Measures: • Restraint usage percentage • Medication error rate (D+) • Pressure ulcer percentage • Inpatient falls per 1000 patient days	Medication error rate: Sum of medication errors that reached the patient & divide this sum by the total # of medications dispensed.
TFH Heart Attack Care	AMI-1 AMI-5 AMI-7a AMI-8 AMI-8a	Core Measures: • Aspirin at arrival • Beta Blocker prescribed at discharge • Fibrinolytic therapy within 30 minutes of arrival • Median Time to PCI • Primary PCI with/in 90 min of hosp arrival	Sum of times recommended evidence-base care was provided to patients & divide this sum by the total # of opportunities to provide this care.
Sepsis		Core Measures	
CMS Core Measure Index - Immunizations	IMM-2	Core Measures: • Influenza Vaccine	
CMS Core Measure Index - Venous Thrombosis	VTE-1 VTE-2 VTE-3 VTE-5 VTE-6	Core Measures: • VTE Prophylaxis • ICU VTE Prophylaxis • VTE Patients with Anticoagulation Overlap Therapy • VTE Discharge Instructions • Incidence of potentially preventable VTE	
CMS Core Measure Index - Perinatal Care Mother	CalHEN2.0	Core Measures: • Elective Delivery	
Excellent Care Index Detail	ECI-1 ECI-2 ECI-3 ECI-4	• Inpatient mortality percentage • Primary C-Section percentage • Medicare average LOS • ER Readmission within 72 hrs with same diagnosis	
TFH Hospital Acquired Surgical Infection	IC-1	Class 1 surgical site infection rate	Sum of times surgical infection occurred & divide this sum by the total # of surgical cases classified as Class 1.
TFH Hospital Acquired Infection - Nonsurgical	HA-NSI-1 HA-NSI-2 HA-NSI-3 HA-NSI-4	• ICU CLR-BSI • Ventilator-Associated pneumonia • ICU Cath Associated Urinary Tract Infection • Health Care acquired MRSA (per 1000 pt days)	Sum of times hospital acquired infections occurred & divide this sum by the total # of opportunity days an infection could occur x 1000 pt. days
TFH Hospital		• Foreign object retained after surgery	Numbers of occurrences – since

Attachment D
Quality Improvement Indicator Definitions
2016

Indicator Title	CMS Core Measure #	Inclusive Of	Measurement Explanation
Acquired Conditions		• Air Embolism • Blood incompatibility • DVT & pulmonary emboli following orthopedic surgery	many of these HAC's are never events.
Patient Satisfaction	PtS-1 PtS-2 PtS-3 PtS-4 PtS-5 PtS-6 PtS-7	• HCAHPS "Recommend this Hospital" Percentile Rank • HCAHPS "Rate this Hospital 9-or-10" Percentile Rank • OutPT Percentile Rank • TFH ED Overall Percentile Rank • IVCH ED Overall Percentile Rank • ASD Overall Percentile Rank • MSC Overall Percentile Rank	
IVCH Infection Control	IVC-1	Class 1 Surgical Site Infection Rate	Sum of times surgical infection occurred & divide this sum by the total # of surgical cases classified as Class 1.
IVCH CMS Core Measure Index - Immunizations	IMM-2	Core Measures • Influenza vaccine administration percentage	Sum of times recommended evidence-base care was provided to patients & divide this sum by the total # of opportunities to provide this care
IVCH Average LOS	IVC-9	• Average Length of Stay	
IVCH Pressure Ulcers	IVC-10	• Pressure ulcer percentage	
IVCH Inpatient Falls	IVC-11	• Inpatient falls per 1000 patient days rate	
IVCH Restraint Usage	IVC-12	• Restraint usage per 100 pt days	
IVCH Laboratory	IVC-13	• STAT CBC turn around time < 60 minutes	
IVCH Pharmacy	IVC-15	• Medication error rate	
IVCH Inpatient Mortality	IVC-16	• Inpatient mortality number	
Skilled Nursing Facility	LTC1 LTC4 LTC5 LTC6 LTC7	• Percent of patients who develop pressure ulcers • Residents with a urinary tract infection percentage • Percent of residents who experience unplanned weight loss • Percentage of Falls • SNF 5-Star Quality Rating	Rate calculated per CMS.

Attachment D
Quality Improvement Indicator Definitions
2016

Indicator Title	CMS Core Measure #	Inclusive Of	Measurement Explanation
Home Health	HH1 HH2 HH3 HH4 HH5 HH6 HH7 HH8 HH9	• Improvement in Pain • Improved Bathing • Improved Transferring • Improved Ambulation • Management of Oral Medications • Improve in Surgical Wounds • Patients with emergency care needs percentage • HHCAHPS - Rate this agency 9 or 10 • HHCAHPS - Recommend this agency	Rate calculated per CMS
Hospice	H1 H2 H3 H4 H5	• Match MAR vs Physician Orders • Follow through on assessed pt needs • Patients Pain goals are met within 48 hrs • Hospice Patient UTI Rate • Hospice Patient Vascular Device Infection Rate (TPD)	

Updated 1/21/16 Specification Manual NQR Discharges 1-1-2016 to 9-31-2016

Attachment E
2016 External Reporting

	Title	Acronym	Sponsor	Indicators
1	California Nursing Outcome Coalition (Voluntary) http://calnoc.org/	CalNOC	CHA	• Nursing Staff satisfaction • Clinical Staffing • Patient falls • Pressure ulcers • Physical restraints
2	CA – Quality Healthcare Indicators www.qualityhealthindicators.org	QHi		QHi has both quality and performance data/measures. Provides rural/CAH hospitals an economical instrument to evaluate internal processes of care and seek ways to improve practices by comparing specific measures of quality with like hospitals. Currently 13 states participating. • Healthcare Associated Infections per Patient Day • PN pts. given antibiotics within 6 hrs. of admission • PN pts. receiving Pn Immunization • Unassisted Pt. Falls • Benefits as % of Salary • Staff Turnover • Gross Days in AR • Days Cash on Hand
3.	Home Health Consumer Assessment of Providers and Systems (HHCAPs)	HHCAPS	CMS	• Care of patients • Communication between providers and patients • Specific care issues • % of patients who gave agency 9 or 10 • % patient who reported YES they would definitely recommend agency Star rating measures: • Improvement in ambulation • Improvement in bed transferring • Improvement in bathing • Improvement in pain • Improvement in Dyspnea • Timely initiation of care • Drug education all meds • Flu vaccine received • 60 day hospitalization • 30 day re hospitalization
4.	Hospice Quality Reporting Program (HQRP)	HQRP	CMS	• Care of patients • Hospice team communication • Getting timely care • Treating family member with respect • Providing emotional support • Getting help for symptoms • Getting hospice care training

Attachment E
2016 External Reporting

	Title	Acronym	Sponsor	Indicators
5.	Hospital Care Quality Information from the Consumer Perspective (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html	HCAHPS	CMS AHRQ DHHS JC	• Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Cleanliness and Quietness of the Physical Environment • Pain Control • Communication About Medicines • Discharge Information
6.	Hospital Compare (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare.html	CMS Collaborative	CMS HQA	• Heart attack care - 8 measures • VTE - 7 measures • Immunizations – 2 measures • Sepsis – 6 measures
7.	Minimum Data Sets (MDS) http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MDSPubQIandResRep/index.html	MDS	CMS	The MDS Quality Indicator (QI) Report summarizes, by state, the average percentage of nursing home residents who activate (trigger) one of 24 quality indicators (32 with subcategories) during a quarter. QIs are triggered by specific responses to MDS elements and identify residents who either have or are at risk for specific functional problems needing further evaluation. QIs are aggregated across residents to generate facility level QIs, which is the proportion of residents in the facility with the condition.
8.	National Healthcare Safety Network http://www.cdph.ca.gov/programs/hai/Pages/NHSNGuidanceSpecifictoCaliforniaHospitals.aspx	NHSN	CDPH	Statewide Indicators: • Central Line-associated Bloodstream Infection (CLABSI) • Methicillin-resistant Staphylococcus aureus (MRSA) Bloodstream Infection (BSI) • Vancomycin-resistant Enterococci (VRE) Bloodstream Infection (BSI) • Clostridium difficile infection (C. difficile, C. diff, CDI, CDAD) • Surgical Site Infection (SSI)
9.	Office of Statewide Planning & Development http://www.oshpd.ca.gov/	OSHPD	State of California	Statewide Indicators: • Prevention QI: avoidable IP admissions • Pediatric QI: avoidable IP admissions • IP QI: over or under use of procedures • Patient Safety: Preventable adverse events Facility Level Indicators: • IP Mortality • Volume Indicators • Utilization Indicators
10.	Outcome & Assessment Information Set http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html	OASIS	CMS	• Demographic information • History, Assessment and Social support • Diagnostic coding information • Clinical information upon transfer to acute • Discharge information

Attachment E
2016 External Reporting

	Title	Acronym	Sponsor	Indicators
11.	Outcome Based Quality Improvement (Voluntary) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/HHQIOBQIManual.pdf	OBQI	CMS MedQIC	• Improvement in Bathing • Improvement in Transferring • Ambulation/Locomotion Improvement • Improvement in Mgmt. of Oral Meds • Improvement in Pain Interfering with Activity • Status Improvement-Surgical Wounds • Improvement in Dyspnea • Improvement in Urinary Incontinence • Acute Care Hospitalization • Discharge to Community

Tahoe Forest Health System Meaningful Use and PQRS for Eligible Providers

Meaningful Use

- Federally mandated
- Payments for successful attestations and penalties for non-participation
- Eligible: MDs, NPs with >= 30% Medicaid volumes
- Clinical Quality Measures (CQMs) are part of program – requires we report on 9 measures across three National Quality Strategy (NQS) domains, which represent the Department of Health and Human Services' NQS priorities for health care quality improvement.
- No performance thresholds
- OCHIN selects and builds the measures

Meaningful Use CQMs – Clinical Process/Effectiveness

- CMS122 - Diabetes: Hemoglobin A1c Poor Control
  - % of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.
- CMS123 - Diabetes: Foot Exam
  - % of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period.
- CMS125 - Breast Cancer Screening
  - % of women 40–69 years of age who had a mammogram to screen for breast cancer.
- CMS127 - Pneumonia Vaccination Status for Older Adults
  - % of patients 65 years of age and older who have ever received a pneumococcal vaccine.
- CMS130 - Colorectal Cancer Screening
  - % of adults 50-75 years of age who had appropriate screening for colorectal cancer.

MU CQMs – Clinical Process/Effectiveness (Cont'd)

- CMS134 - Diabetes: Urine Protein Screening
  - % of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy.
- CMS135 - Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
  - % of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy within a 12 month period.
- CMS144 - Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
  - % of patients >= 18 years with a diagnosis of heart failure (HF) with left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blockers.

MU CQMs – Clinical Process/Effectiveness (Cont'd)

- CMS163 - Diabetes: Low Density Lipoprotein (LDL) Management
  - Percentage of patients 18–75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL).
- CMS165 - Controlling High Blood Pressure
  - Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg).
- CMS146 - Appropriate Testing for Children with Pharyngitis
  - % of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test.
- CMS154 - Appropriate Treatment for Children with Upper Respiratory Infection (URI)
  - % of children 3 mos-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.

MU CQMs – Patient Safety

- CMS68 - Documentation of Current Medications
  - % of visits for patients >= 18 years for which a list of current medications is documented. Include ALL known prescriptions, over-the-counters, herbals, and nutritional supplements AND must contain the medications' name, dosage, frequency and route of administration.

MU CQMs – Population/Public Health

- CMS117 - Childhood Immunization (IZ) Status
  - % of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) IZs by their second birthday.
- CMS138 - Tobacco Use: Screening and Cessation Intervention
  - % of patients >= 18 years old who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.
- CMS147 - Influenza Immunization
  - % of patients >= 6 months old seen for a visit between October 1 and March 31 who received an influenza immunization.

Physician Quality Reporting System (PQRS)

- Federally mandated program. CAHs not eligible or required to participate until 2014.
- Incentive payments for performance in the areas of quality metrics and cost reduction, & penalties for non-participation
- Eligible: MDs, PAs, NPs, Audiologists
- Can be individual or as a group. We have chosen the latter and report on the same 9 CQMs for all our providers.
- We report through a registry – our data goes to them, they submit to CMS in the correct format.

PQRS Measures – Effective Clinical Care

- Measure #39: Screening for Osteoporosis for Women Aged 65-85
  - % of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis.
- Measure #112: Breast Cancer Screening
  - % of women 50 through 74 years of age who had a mammogram within 27 months of visit.
- Measure #113: Colorectal Cancer Screening
  - % of patients 50-75 years of age who had appropriate screening for colorectal cancer.

PQRS Measures – Community/Population Health

- Measure #110: Influenza Immunization
  - % of patients >= 6 months old who received an influenza immunization.
- Measure #111: Pneumonia IZ Status for Older Adults
  - % of patients >= 65 years who have ever received a pneumococcal vaccine.
- Measure #128: Body Mass Index (BMI) Screening and Follow-Up Plan
  - % of patients >= 18 years with a BMI documented, and if BMI is outside of normal parameters, a follow-up plan is documented.
- Measure #173: Screening for Unhealthy Alcohol Use
  - Measure DELETED for 2016 and we are in process of choosing a replacement measure.

PQRS Measures – Community/Population Health

- Measure #226: Tobacco Use: Screening and Cessation Intervention
  - Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.

PQRS Measures – Patient Safety

- Measure #130: Documentation of Current Medications in the Medical Record
  - % of visits for patients >= 18 years for which a list of current medications is documented. This list must include all known prescriptions, over-the-counters, herbals, and nutritional supplements and must contain the medications' name, dosage, frequency and route of administration.

Questions?

Disclosure of Error or Unanticipated Outcome to Patients/Families

PETER TAYLOR, MD
JANET VAN GELDER, RN

Policy Purpose

- Process of disclosure
- Standardized Mechanism
- Provide meaningful information
  - Check list

Disclosure Support

- Contact Disclosure Staff (available 24/7)
  - Either by:
    - Contact the House Supervisor (to do on your behalf)
    - Call Carl or Janet directly
      - Carl Blumberg (817-846-9445),
      - Janet Van Gelder (530-412-4036)
    - Discuss which physician advocate to include
      - Peter Taylor MD
      - Julie Conyers MD
      - Ricki Alpert MD
      - Shawni Coll DO

Disclosure

- Should occur as soon as possible
- With at least 2 people
- Factual explanation of the circumstances
  - an explanation of the impact on the patient's:
    - Treatment
    - Prognosis
    - Steps taken to mitigate the harm

Disclosure (cont.)

- Share
  - “This is the FIRST of many meetings”
  - “Review will take place”
  - Information regarding resources available
  - Support and comfort the patient and/or family
- Apology, as appropriate for the circumstances
- Follow up meetings

Care for the Caregiver

- For Physicians
  - Well Being Committee support and assistance
- For Staff
  - Peer support process EAP

Download the full report at www.npsf.org/free-from-harm

Free from Harm

Accelerating Patient Safety Improvement Fifteen Years after *To Err Is Human*

Report of an Expert Panel Convened by
The National Patient Safety Foundation

NPSF
National Patient Safety Foundation®

Free from Harm

Accelerating Patient Safety Improvement Fifteen Years after *To Err Is Human*

Executive Summary

Patient safety is a serious public health issue. Like obesity, motor vehicle crashes, and breast cancer, harms caused during care have significant mortality, morbidity, and quality-of-life implications, and adversely affect patients in every care setting. Although patient safety has advanced in important ways since the Institute of Medicine released *To Err Is Human: Building a Safer Health System* in 1999, work to make care safer for patients has progressed at a rate much slower than anticipated.

Despite demonstrated improvement in specific problem areas, such as hospital-acquired infections, the scale of improvement in patient safety has been limited. Though many interventions have proven effective, many more have been ineffective, and some promising interventions have important questions still unresolved. The health care system continues to operate with a low degree of reliability, meaning that patients frequently experience harms that could have been prevented or mitigated.

While the release of *To Err Is Human* significantly heightened the focus on patient safety, the expectation at the time was that expanded data sharing and implementing interventions to solve specific concerns would result in substantial, permanent improvement. In the intervening decade and a half, it has become increasingly clear that safety issues are far more complex—and pervasive—than initially appreciated. Patient safety comprises more than just mortality; it also encompasses morbidity and more subtle forms of harm, such as loss of dignity and respect. It involves more than inpatient care; it includes safety in every care setting: ambulatory care clinics, freestanding surgical and diagnostic centers, long-term care facilities, and patients' homes as well as hospitals and other locations.

Although our understanding of the problem of patient harm has deepened and matured, this progress has been accompanied by a lessening intensity of focus on the issue. Patient safety must not be relegated to the backseat, proceeding haphazardly toward only those specific harms currently being measured and targeted for improvement by incentives. Advancement in patient safety requires an overarching shift from reactive, piecemeal interventions to a total systems approach to safety. Adopting such an

approach would mean leadership consistently prioritizing safety culture and the well-being and safety of the health care workforce. It means more complete development of the science, measurement, and tools of patient safety. To ensure maximal impact, moving from competition on safety to coordination and collaboration across organizations will be important. Such an approach also means thinking about safety in all aspects of care across the continuum, not just in hospitals. To ensure that the patient voice is heard, it must also include partnering with patients and families at all points along the journey.

This report recognizes areas of progress, highlights remaining gaps, and most importantly, details specific recommendations to accelerate progress. These recommendations are based on the establishment of a total systems approach and a culture of safety:

1. **Ensure that leaders establish and sustain a safety culture**
2. **Create centralized and coordinated oversight of patient safety**
3. **Create a common set of safety metrics that reflect meaningful outcomes**
4. **Increase funding for research in patient safety and implementation science**
5. **Address safety across the entire care continuum**
6. **Support the health care workforce**
7. **Partner with patients and families for the safest care**
8. **Ensure that technology is safe and optimized to improve patient safety**

Success in these actions will require active involvement of every player in the health care system: boards and governing bodies, leadership, government agencies, public-private partnerships, health care organizations, ambulatory practices and settings, researchers, educators, the health care workforce, and patients and their families. Our hope is that these recommendations and the accompanying specific tactics for implementation will spur broad action and prompt substantial movement towards a safer health care system. Patients deserve nothing less.

AIG

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EIGHT RECOMMENDATIONS FOR ACHIEVING TOTAL SYSTEMS SAFETY

1. ENSURE THAT LEADERS ESTABLISH AND SUSTAIN A SAFETY CULTURE

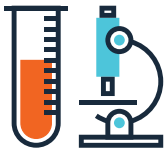
Improving safety requires an organizational culture that enables and prioritizes safety. The importance of culture change needs to be brought to the forefront, rather than taking a backseat to other safety activities.

2. CREATE CENTRALIZED AND COORDINATED OVERSIGHT OF PATIENT SAFETY

Optimization of patient safety efforts requires the involvement, coordination, and oversight of national governing bodies and other safety organizations.

3. CREATE A COMMON SET OF SAFETY METRICS THAT REFLECT MEANINGFUL OUTCOMES

Measurement is foundational to advancing improvement. To advance safety, we need to establish standard metrics across the care continuum and create ways to identify and measure risks and hazards proactively.



4. INCREASE FUNDING FOR RESEARCH IN PATIENT SAFETY AND IMPLEMENTATION SCIENCE

To make substantial advances in patient safety, both safety science and implementation science should be advanced, to more completely understand safety hazards and the best ways to prevent them.

5. ADDRESS SAFETY ACROSS THE ENTIRE CARE CONTINUUM

Patients deserve safe care in and across every setting. Health care organizations need better tools, processes, and structures to deliver care safely and to evaluate the safety of care in various settings.

6. SUPPORT THE HEALTH CARE WORKFORCE

Workforce safety, morale, and wellness are absolutely necessary to providing safe care. Nurses, physicians, medical assistants, pharmacists, technicians, and others need support to fulfill their highest potential as healers.

7. PARTNER WITH PATIENTS AND FAMILIES FOR THE SAFEST CARE

Patients and families need to be actively engaged at all levels of health care. At its core, patient engagement is about the free flow of information to and from the patient.

8. ENSURE THAT TECHNOLOGY IS SAFE AND OPTIMIZED TO IMPROVE PATIENT SAFETY

Optimizing the safety benefits and minimizing the unintended consequences of health IT is critical.