TAHOE FOREST HOSPITAL DISTRICT

2016-08-16 Board Quality Committee

Tuesday, August 16, 2016 at 12:00 p.m.

Eskridge Conference Room - Tahoe Forest Hospital

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2016-08-16 Board Quality Committee

8/16/16 Quality Committee

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE AGENDA

Tuesday, August 16, 2016 at 12:00 p.m.
Eskridge 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: 6/14/2016 ..... **ATTACHMENT**

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Quality Committee Charter and Goals 2016 ..... ATTACHMENT
The *Quality Committee Charter and Goals 2016 were* approved by the Committee at the February 9, 2016 meeting. Review progress toward achieving the established goals.

6.2. Patient & Family Centered Care (PFCC)

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

6.2.2. Patient Experience Presentation
Identify patients that may be interested in sharing their healthcare story at an upcoming TFHD Board of Directors (BOD) meeting.

6.3. HCAHPS Star Rating Report ..... ATTACHMENT
The Centers for Medicare & Medicaid Services (CMS) has developed HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) star ratings to make it easier for consumers to use the information on the Hospital Compare website and to spotlight excellence in healthcare quality. A review of the 10/1/14 through 9/30/15 CMS Star Rating Report and plans for improvement.

6.4. BOD Quality & Service Excellence Dashboard ..... ATTACHMENT
Discuss the quality and service excellence dashboard and the process for BOD review including content, quality metrics, benchmarks, and plans for improvement.

6.5. Healthcare Facilities Accreditation Program (HFAP) Survey

An update will be provided on the preparation for the unannounced triennial HFAP accreditation survey in the spring of 2017. The Committee will discuss providing an accreditation survey process educational training to the Board of Directors in February 2017.

6.6. Board Quality Education .....ATTACHMENT

The Committee will review and discuss key learning points from the following articles:

6.6.1. Sikka, R., Morath, J., & Leape, L. *The Quadruple Aim: care, health, cost and meaning in work* BMJ Quality & Safety (2015)

6.6.2. Institute for Healthcare Improvement, *Always Events Getting Started Kit* (2014).

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE

The date and time of the next committee meeting, Tuesday, October 11, 2016, at 12:00 p.m. will be proposed and/or confirmed.

9. ADJOURN

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

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

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

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
DRAFT MINUTES

Tuesday, June 14, 2016 at 12:00 p.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER
Meeting was called to order at 12:03 p.m.

2. ROLL CALL
Board: Greg Jellinek, M.D., Chair; Karen Sessler, M.D., Board Member

Staff: Harry Weis, CEO; Janet Van Gelder, Director of Quality; Dr. Julie Conyers, Dr. Shawni Coll; Dr. Peter Taylor; Trish Foley, Patient Advocate; John Rust, Director of Emergency Department; Jan Iida, IVCH Director of Patient Care; Karen Gancitano, Executive Director of Post-Acute Services

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: 4/5/2016
Director Sessler moved approval of the April 5, 2016 minutes, seconded by Director Jellinek.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION
6.1. Quality Committee Charter and Goals 2016
No discussion was held on this item.

6.2. Patient & Family Centered Care (PFCC)
6.2.1. Patient & Family Advisory Council Update
Trish Foley provided an update on the Patient and Family Advisory Council (PFAC).

The PFAC celebrated one year in April. There are currently 8 members and recruiting more. The PFAC should ideally be 15 members.

Cathey Bervid and Jason Grosdidier spoke at the May 17, 2016 PFAC meeting and provided updates to PFAC on the Cancer Center and Respiratory Services/Environmental Services respectively.

Director Jellinek inquired if the District had a booth at Truckee Thursday where PFAC members could be recruited. CEO indicated the District will be a participant at Truckee Thursdays.

6.3. BOD Quality & Service Excellence Dashboard
The Committee discussed what information can be shared for the public in open session.

The dashboard has publicly reported data listed on it.

Director Jellinek inquired about stroke care as a core measure. Janet Van Gelder stated stroke data is generally not reported at TFHD because we do not routinely care for these patients; they are transferred out of the ED for a higher level of care.

Discussion was held about the stroke care measure. The public should know if they had a stroke they would come to the Emergency Room and then get transferred to an appropriate facility for stroke care.

Dr. Coll commented there should be no acronyms or acronyms should be spelled out. There should also be an explanation that the data is 18 months old. A plan should be highlighted if there is a data outlier. The dashboard should point out things the District is proud of so it is a marketing piece as well.

Dr. Taylor asked if the ratings on home health should be combined into one.

Director Sessler commented the quarterly trend box should have the most recent quarter to the right and not have empty columns.

Discussion was held that the dashboard should be easy to navigate and easy to understand.

CEO stated that stroke care and heart attack care are not current inpatient care programs.

Director Sessler stated the dashboard should communicate that our goals are much more stringent than the national average.

Discussion was held regarding how the dashboard should be presented at Board Meetings.

Director Sessler noted she saw 2014 data on the District's website.

Dr. Conyers shared that the Hospital Compare web site shows N/A for TFHD and is not helpful.

Discussion was held that the dashboard should show more current data.

Patients are using the data to make decisions about their care.

CEO felt the District "should look at ourselves from the outside in". Dr. Taylor commented the BOD QAC reviewed healthcare data web sites about 2 years ago to see what patients can find. Director Jellinek stated this topic might be something for a subcommittee to address.

PFAC reviewed a new TFHD website design almost a year ago but it has not rolled out yet.

Director Sessler commented that the District has not done a community perception study.

A Subcommittee could be assisted by PFAC to determine what patients are looking for when they come to TFHD.

The Quality Committee will keep this topic on the agenda until it decides how best to handle.

John Rust shared that there is a difference between second homeowners and locals. Locals are not over what happened at the hospital last year. The more we can talk about our quality of care and the safety of our environment the better.

CEO stated a number of mail communication letters will go out to educate the residents of the District. He has received positive feedback thus far.

The goal of the District is to proactively share data with the community.

Discussion was held about the public wanting the District to "prove itself". The leadership issues had nothing to do with the quality of care but the community cannot separate the two. The District should not underestimate the effect the last year had on the community.

Dr. Conyers commented about the District not being in the 4th of July parade. CEO shared that a list was picked of the events the District would participate in. The District will not have a float in the parade but will be passing out sunscreen and lip balm to parade attendees.

Director Sessler asked if a discussion about the dashboard should be held at the upcoming board meeting. The Board will be able to discuss it under the Quality Meeting recap.

Dr. Coll felt the presenter of the Quality Dashboard at BOD meetings should have clinical background.

6.4. Healthcare Facilities Accreditation Program (HFAP) Survey

Provide an update on preparation for the unannounced triennial HFAP accreditation survey in the spring of 2017.

At the last Quality Committee meeting, Ms. Van Gelder discussed the District was exploring having complimentary mock survey done by AAHHS. The thought was that a complimentary survey would be beneficial. We recently discovered that this would be full accreditation survey for AAHHS to gain their CMS deemed accredited status and have decided to utilize HFAP consultants for our mock survey instead. The District needs to focus on HFAP survey preparation and offered to assist AAHHS in the fall of 2017 instead. Our triennial unannounced HFAP survey will be in the spring of 2017.

BOD Quality Committee will evaluate which organization should conduct our accreditation surveys in the future.

6.5. Board Quality Education

6.5.1. The Committee will review and discuss key learning points from the following articles:

6.5.1.1. BMJ Article *Medical Error—the third leading cause of death in the US* (May 3, 2016)

Mr. Rust stated the District should develop list of "never" events.

Discussion was held on the strong focus in the past and whether or not staff should go back and revaluate process.

Dr. Coll and Karen Gancitano agreed this is an opportunity to look at processes.

Director Sessler commented on the perception created by the media on this topic.

Director Jellinek stated the information should be put in a format the public can digest.

Dr. Conyers stated the District should make it clear it will share if there is a medical error.

Director Sessler commented that these articles undermine the public's trust.

Dr. Conyers shared that patients have increasingly complex medical care these days and some take multiple medications and attempting to obtain accurate information is always a challenge for physicians.

6.5.1.2. National Patient Safety Foundation (NPSF) Article *Shining a light: Safer healthcare through transparency* (2015)

Janet Van Gelder, Carl Blumberg, and Drs. Taylor, Conyers, and Alpert attended a BETA workshop about disclosure last September. We have updated our policy and educated the Medical and Nursing staff on the revised process. Additional staff were sent to a recent one day workshop.

The District has completed the actions for stakeholders listed in the article's Executive Summary.

Discussion was held on item 10 – Link hiring, firing, promotion and compensation of leaders to results in cultural transformation and transparency. Director Jellinek felt the District should work this in to show that it has made changes to rebuild public trust.

Ms. Gancitano commented the communication to the public should be "We've heard you and these are the things we are doing to be transparent."

Dr. Conyers shared that Dignity Health would report all events to all facilities. Not all events reports were sentinel events.

Director Sessler stated item 16 is challenging for us to share more.

Director Jellinek suggested the District make bullet points and give references to where the rest of the data can be found.

Dr. Conyers inquired when the new website will up. Discussion was held regarding the website update. No exact date given release of the new site.

Director Jellinek inquired if the District monitors Yelp. Marketing does monitor Yelp.

6.5.1.3. CHA's *Governance Role in Quality and Performance Improvement* Webinar presentation (June 1, 2016)

The slides from the webinar are included in the packet for those who did not attend on June 1, 2016.

Ms. Van Gelder pointed out the Hospital Quality Institute's Board Compact.

The presentation highlighted Quadruple AIM. This will be brought forward to Medical Staff.

Director Sessler asked that two slides be shared with all Board Members in the next Board Meeting packet.

6.5.2. Committee will review and discuss future topics for Board Quality education.

Committee was asked to send any quality related articles to Ms. Van Gelder to share at future committee meetings.

Director Sessler suggested there should be a patient experience shared at the Board Meeting at least once a year.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

None.

8. NEXT MEETING DATE

The date and time of the next committee meeting, Tuesday, August 16, 2016, will be proposed and/or confirmed.

9. ADJOURN

Meeting adjourned at 1:33 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.

Quality Committee Charter

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

Approved January 22, 2014

2016 PFAC PROCESS IMPROVEMENT LOG

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

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

2016 PFAC PROCESS IMPROVEMENT LOG

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

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

2016 PFAC PROCESS IMPROVEMENT LOG

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

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

2016 PFAC PROCESS IMPROVEMENT LOG

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

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
4/19/2016	Year Celebration of PFAC! Extended Care Center Hospice/Home Health Wellness Neighborhood	ALL Sarah Jane Stull Max Hambrick Maria Martin	Celebration of the one year anniversary of the council and acknowledgments to the members and team for their contribution and support! Guest speakers Sarah Jane, Max, and Maria. Information was provided on Hospice/Home Health Services, the Extended Care Center (ECC), and the Community Health and Wellness Program. We spent time discussing noise reduction in the ECC, timely initiation to care, and 7 day/week coverage for Hospice/Home Health Services. Suggestions for noise reduction included awareness of loud doors and perhaps identifying an app. on the iPad for white noise or soothing noise. Also, the group explored how to provide more outreach/education to the community regarding the Community Health and Wellness Program. Suggestions included Facebook, TFHD website, and advertising with local community groups. Participants acknowledged how all the services are addressing community needs and how lucky we are to live in an area where we have these services!	

2016 PFAC PROCESS IMPROVEMENT LOG

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

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
5/17/2016	Cancer Center Environmental Services Respiratory Therapy	Cathey Bervid Jason Grosdidier Jason Grosdidier	Guest speakers Cathey and Jason. Cathey provided an overview of the Cancer Center services for patients and the community, and discussed areas they are working on for process improvements. This included developing a newsletter for patients, increasing the frequency of distress screening for patients, scheduling patients for initial appointments sooner, and reviewing treatment costs (co pays, deductibles, out of pocket expenses, etc.) with patients. Jason provided information on Environmental Services and Respiratory Therapy. Environmental Services are provided 24 hours/day at the Cancer Center, Main Hospital, and at Incline Village Community Hospital. They are constantly evaluating the best products and equipment to use, to ensure effectiveness, cleanliness, and safety for patients and staff. Respiratory Therapy is provided for all hospital areas treating patients. The hope is to expand services to include more extensive pulmonary function testing and also to bring the sleep program provided at IVCH to the Tahoe Forest Hospital Truckee location. Participants acknowledged how fortunate we are to have these services in our community, and feedback was also provided that hospital staff seems to enjoy their jobs and provide a great service ☺ Also, a suggestion was brought up about the possibility of having a 'starter pack' for medications when patients are discharged from the hospital to bridge the time until patients or family members are able to obtain prescriptions from a pharmacy. The idea would be for perhaps a two day supply if this would be possible. Reminder was given for anyone interested in being a council representative on a Committee (Ethics, Safety, and Board Quality) to contact Trish or Janet.	Hillary was contacted and she reports TFHD Pharmacy is already looking into a discharge medication to bedside program with our Retail Pharmacy. Great minds think alike! ☺

2016 PFAC PROCESS IMPROVEMENT LOG

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

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
6/21/2016	Community Views Concussion Program Multi Specialty Clinics	Greg Jellinek Nina Winans Sandy Walker	Guest speakers Dr. Jellinek, Dr. Winans and Sandy. Dr. Jellinek led a discussion on community perceptions of the hospital (views from the 'outside in') and we explored areas for community education including the costs and value of the services we provide. There was discussion about how we can strengthen the community by serving locally, and improve navigation of scheduling, referrals, billing and collaboration of departments and services. We have decided to keep an 'outside in, views of the community' topic on our agenda to review at all meetings! Dr. Winans presented information on a Comprehensive Concussion Program that has been developed at Tahoe Forest Hospital. She reviewed a team approach to concussion care, including but not limited to; sports medicine, neurology, physical and speech therapy, athletic trainer, and nutritionist. Sandy started to review the services provided at each MSC location, along with the care providers, highlighting we now have urology services. Sandy will join us in August to obtain feedback regarding MSC services. As follow up from last meeting, the Pharmacy Department did respond that we are working on a discharge prescription to bedside program to assist patients and family members with obtaining prescriptions prior to leaving the hospital.	Emphasis on Patient Navigation throughout Health System
3rd Quarter 2016				
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2016 PFAC PROCESS IMPROVEMENT LOG

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

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

Medicare.gov | Hospital Compare

The Official U.S. Government Site for Medicare

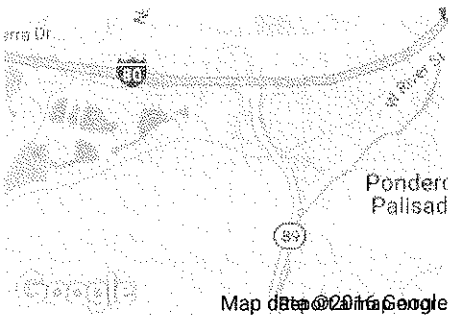
General information

TAHOE FOREST HOSPITAL

10121 PINE AVE
TRUCKEE, CA 96161
(530) 587-6011

Overall rating: *4 out of 5 stars*[17]
Learn more about the overall ratings

Distance: 1.4 miles



General information

- Hospital type: Critical Access Hospitals
- Provides emergency services: Yes
- Able to receive lab results electronically: Not Available
- Able to track patients' lab results, tests, and referrals electronically between visits: Not Available
- Uses outpatient safe surgery checklist: Not Available
- Uses inpatient safe surgery checklist: Not Available

Survey of patients' experiences

TAHOE FOREST HOSPITAL

10121 PINE AVE
TRUCKEE, CA 96161

Survey of patients' experiences

(530) 587-6011

Overall rating: *4 out of 5 stars*[17]
Learn more about the overall ratings

Distance: 1.4 miles

Hospital type: Critical Access Hospitals
Provides emergency services: Yes

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) is a national survey that asks patients about their experiences during a recent hospital stay. Use the results shown here to compare hospitals based on 11 important hospital quality topics.

Find out why these measures and the star ratings are important.

Learn more about the data and star ratings.

Get the current data collection period.

Get tips for printing star images.

	TAHOE FOREST HOSPITAL	CALIFORNIA AVERAGE	NATIONAL AVERAGE
Patient survey summary star rating. More stars are better. Learn more	*4 out of 5 stars*		
Patients who reported that their nurses "Always" communicated well	87%	75%	80%
Patients who reported that their doctors "Always" communicated well	85%	78%	82%
Patients who reported that they "Always" received help as soon as they wanted	79%	62%	68%

	TAHOE FOREST HOSPITAL	CALIFORNIA AVERAGE	NATIONAL AVERAGE
Patients who reported that their pain was "Always" well controlled †	74%	68%	71%
Patients who reported that staff "Always" explained about medicines before giving it to them	73%	61%	65%
Patients who reported that their room and bathroom were "Always" clean	86%	70%	74%
Patients who reported that the area around their room was "Always" quiet at night	65%	51%	62%
Patients who reported that YES, they were given information about what to do during their recovery at home	90%	85%	87%
Patients who "Strongly Agree" they understood their care when they left the hospital	56%	48%	52%

	TAHOE FOREST HOSPITAL	CALIFORNIA AVERAGE	NATIONAL AVERAGE
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	86%	68%	72%
Patients who reported YES, they would definitely recommend the hospital	88%	69%	71%

Timely & effective care

TAHOE FOREST HOSPITAL

10121 PINE AVE
TRUCKEE, CA 96161
(530) 587-6011

Overall rating : *4 out of 5 stars*[17]
Learn more about the overall ratings

Distance : 1.4 miles

Hospital type: Critical Access Hospitals
Provides emergency services: Yes

Timely & effective care

These measures show how often hospitals provide care that research shows gets the best results for patients with certain conditions. This information can help you compare which hospitals give recommended care most often as part of the overall care they provide to patients.

Colonoscopy follow-up

A colonoscopy is one test doctors can use to find precancerous polyps (abnormal growths) or colorectal cancer. Scientific evidence shows that the following measures represent best practices for follow-up colonoscopies.

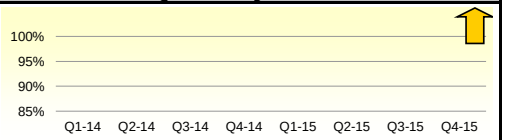
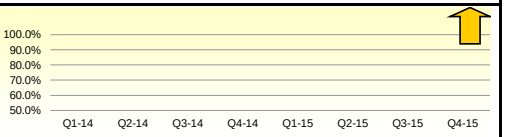
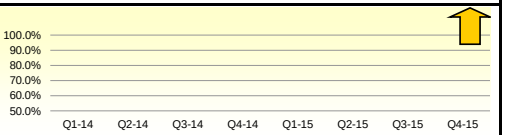
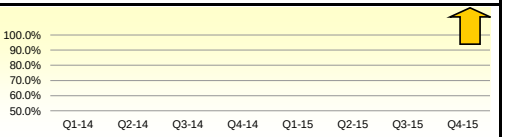
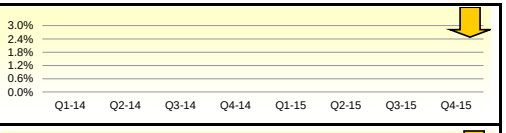
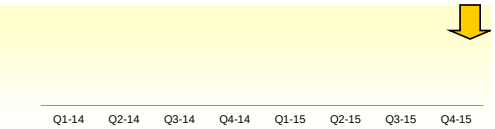
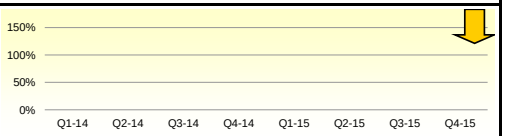
Find out why these measures are important.

TFHS BOD Quality Scorecard

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

TFHS Goal*
Benchmark*
Quarterly Performance

* Unless Noted Otherwise

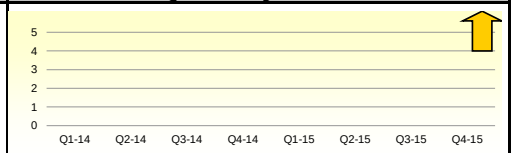
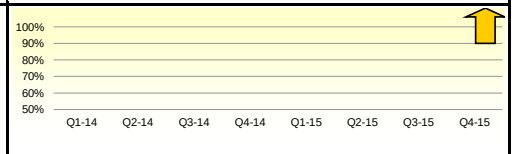
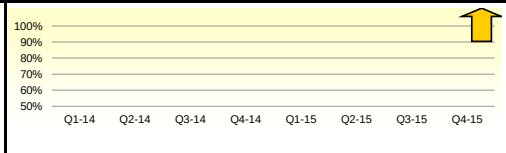
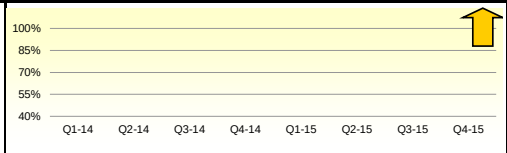
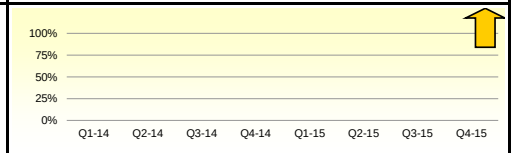
Quality Measures	Q4-2015	Goal	Goal Description and Quarterly Events	Quarterly Trend
Heart Attack Care (0 pt)		96.7%	Goal: To meet/exceed the national average for recommended evidence-based care provided for heart attack patients. This number represents a roll-up of 4 AMI measures. National Average = 88.5% (T, E,P) Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
TFH Immunizations		100.0%	Goal: To vaccinate 100% of all appropriate consenting inpatients for pneumonia and influenza. This number is a roll up of both IMM measures (T, E, Ef, Eq, P) National Average Flu = 93% & Pneumo = 88.2% Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
TFH VTE Care (# pts)		100.0%	Goal: To achieve 100% of all six process measures associated with VTE Care. (T, E, Ef, Eq, P) National Average = Unknown Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
TFH Stroke Care (0 pts)		100.0%	Goal: To achieve 100% of all five process measures associated with Stroke Care. (T, E, Ef, Eq, P) National Average = 96.4% Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
TFH Hospital Acquired Surgical Infections		1.0%	Goal: SSI 0% or a procedure-specific Standardized Infection Ratio (SIR) <1 when # of surgeries allows for SIR calculation. (replaces national average) Q1: PI: Continue to review trends at the Quarterly Medical Staff meeting.	
TFH Hospital Acquired non-Surgical Infections		0.0%	Goal: device-related HAI and AIM 0% and SIR <1; SIR is calculated when predicted # of infections is greater or = to 1. represents a roll-up of device-related infections: CLABSI, VAE, CAUTI, and MRSA infections. Q1: PI: Continue to review trends at the Quarterly Medical Staff, Nursing Staff & Infection Control Committee meeting.	
IVCH Hospital Acquired Surgical Infections		1.0%	Goal: SSI 0% or a procedure-specific Standardized Infection Ratio (SIR) <1 when # of surgeries allows for SIR calculation. Q1: PI: Continue to review trends and areas of concern at the Quarterly Medical Staff, Nursing Staff & Infection Control Committee meeting.	

TFHS BOD Quality Scorecard

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

TFHS Goal*
Benchmark*
Quarterly Performance

* Unless Noted Otherwise

Quality Measures	Q4-2015	Goal	Goal Description and Quarterly Events	Quarterly Trend
SNF 5-Star Quality Rating		5	Goal: To maintain an overall 5-Star rating for the CMS Nursing Home Criteria. This includes Health Inspection deficiencies, Nursing Home Staffing Measures (4), Quality Measures (19), and Fire Inspection deficiencies (S, T, E, E, E, P) Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
Home Health Percentage Improvement in Pain		64.0%	Goal: P4P measurement, managing pain and treating symptoms, how often patients had less pain when moving around. Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
Home Health Percentage Improvement in Bathing		64.0%	Goal: P4P measurement, managing daily activities, how often patients go better at bathing. Q1: PI: Continue to review at the Quarterly Medical Staff & Nursing Staff meeting.	
Home Health Percentage Improvement in Ambulation/ Locomotion		44.0%	Goal: P4P measure, managing daily activities, how often patients got better at walking or moving around. Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	
Home Health Percentage Improvement in Surgical Wounds		80.0%	Goal: P4P measure, treating wounds and preventing pressure sores, how often patients wounds improved or healed after an operation. (S, T, E, P) Q1: PI: Continue to review trends at the Quarterly Medical Staff & Nursing Staff meeting.	

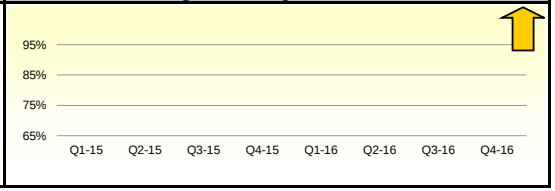
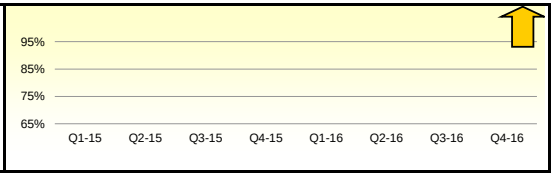
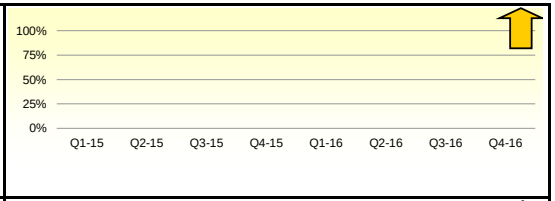
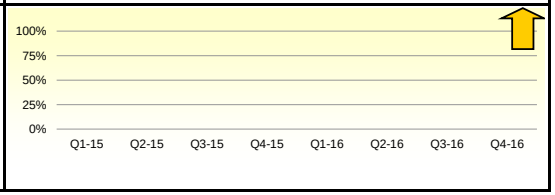
S-safe, T-timely, E-effective, EF-efficient, EQ-equitable, P-patient centered

TFHS BOD Service Excellence Scorecard

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

TFHS Goal*
Benchmark*
Quarterly Performance

* Unless Noted Otherwise

Quality Measures	Q1-2016	Goal	Goal Description and Quarterly Events	Quarterly Trend
HCAHPS Top Box Score, reported by Press Ganey, "Recommend this Hospital"		90.0%	Goal: To meet/exceed a "Top Box" score of 90% for inpatient satisfaction. National Score = 71% (S, T, EQ, P) Q1: PI: Director/Manager daily patient rounds. Patient follow up phone calls after discharge. Quiet environment initiative using visual and verbal cues.	
HCAHPS Top Box Score, reported by Press Ganey, "Rate this Hospital 9 or 10"		90.0%	Goal: To meet/exceed a "Top Box" score of 90% for inpatient satisfaction. National Score = 72% (S, T, EQ, P) Q1: PI: Director/Manager daily patient rounds. Patient follow up phone calls after discharge. Quiet environment initiative using visual and verbal cues.	
Home Health HHCAHPS "Rate this Agency 9 or 10" Top Box Score		90.0%	Goal: To meet/exceed a "Top Box" score of 90% for Home Health Patient satisfaction. HHCAHPS national average is 84% (S, T, EQ, P) Q1: PI: Results reviewed at staff meeting with a focus on MDS metric education & scripting of key areas noted on survey responses. Director patient rounding. Follow up phone calls.	
Home Heath HHCAHPS "Recommend this Agency" Top Box Score		90.0%	Goal: To meet/exceed a "Top Box" score of 90% for Home Health Patient satisfaction. HHCAHPS national average is 79% (S, T, EQ, P) Q1: PI: Results reviewed at staff meeting with a focus on on MDS metric education & scripting of key areas noted on survey responses. Director patient rounding. Follow up phone calls.	

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

The Quadruple Aim: care, health, cost and meaning in work

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In 2008, Donald Berwick and colleagues provided a framework for the delivery of high value care in the USA, the Triple Aim, that is centred around three overarching goals: improving the individual experience of care; improving the health of populations; and reducing the per capita cost of healthcare.[1] The intent is that the Triple Aim will guide the redesign of healthcare systems and the transition to population health. Health systems globally grapple with these challenges of improving the health of populations while simultaneously lowering healthcare costs. As a result, the Triple Aim, although originally conceived within the USA, has been adopted as a set of principles for health system reform within many organisations around the world.

The successful achievement of the Triple Aim requires highly effective healthcare organisations. The backbone of any effective healthcare system is an engaged and productive workforce.[2] But the Triple Aim does not explicitly acknowledge the critical role of the workforce in healthcare transformation. We propose a modification of the Triple Aim to acknowledge the importance of physicians, nurses and all employees finding joy and meaning in their work. This 'Quadruple Aim' would add a fourth aim: improving the experience of providing care.

The core of workforce engagement is the experience of joy and meaning in the work of healthcare. This is not synonymous with happiness, rather that all members of the workforce have a sense of accomplishment and meaning in their contributions. By meaning, we refer to the sense of importance of daily work. By joy, we refer to the feeling of success and fulfilment that results from meaningful work. In the UK, the National Health Service has captured this with the notion of an engaged staff that 'think and act in a positive way about the work they do, the people they work with and the organisation that they work in'.[3]

The evidence that the healthcare workforce finds joy and meaning in work is not encouraging. In a recent physician survey in the USA, 60% of respondents indicated they were considering leaving practice; 70% of surveyed physicians knew at least one colleague who left their practice due to poor morale.[2] A 2015 survey of British physicians reported similar findings with approximately 44% of respondents reporting very low or low morale.[4] These findings also extend to the nursing profession. In a 2013 US survey of registered nurses, 51% of nurses worried that their job was affecting their health; 35% felt like resigning from their current job.[5] Similar findings have been reported across Europe, with rates of nursing job dissatisfaction ranging from 11% to 56%.[6]

This absence of joy and meaning experienced by a majority of the healthcare workforce is in part due to the threats of psychological and physical harm that are common in the work environment. Workforce injuries are much more frequent in healthcare than in other industries. For some, such as nurses' aides, orderlies and attendants, the rate is four times the industrial average.[7] More days are lost due to occupational illness and injury in healthcare than in mining, machinery manufacturing or construction.[7]

The risk of physical harm is dwarfed by the extent of psychological harm in the complex environment of the healthcare workplace. Egregious examples include bullying, intimidation and physical assault. Far more prevalent is the psychological harm due to lack of respect. This dysfunction is compounded by production pressure, poor design of work flow and the proportion of non-value added work.

The current dysfunctional healthcare work environment is in part a by-product of the gradual shift in healthcare from a public service to a business model that occurred in the latter half of the 20th

century.[8] Complex, intimate caregiving relationships have been reduced to a series of transactional demanding tasks, with a focus on productivity and efficiency, fuelled by the pressures of decreasing reimbursement.

These forces have led to an environment with lack of teamwork, disrespect between colleagues and lack of workforce engagement. The problems exist from the level of the front-line caregivers, doctors and nurses, who are burdened with non-caregiving work, to the healthcare leader with bottom-line worries and disproportionate reporting requirements. Without joy and meaning in work, the workforce cannot perform at its potential. Joy and meaning are generative and allow the best to be contributed by each individual, and the teams they comprise, towards the work of the Triple Aim every day.

The precondition for restoring joy and meaning is to ensure that the workforce has physical and psychological freedom from harm, neglect and disrespect. For a health system aspiring to the Triple Aim, fulfilling this precondition must be a non-negotiable, enduring property of the system. It alone does not guarantee the achievement of joy and meaning, however the absence of a safe environment guarantees robbing people of joy and meaning in their work. Cultural freedom from physical and psychological harm is the right thing to do and it is smart economics because toxic environments impose real costs on the organisation, its employees, physicians, patients and ultimately the entire population.

An organisation focused on enabling joy and meaning in work and pursuit of the Triple Aim needs to embody shared core values of mutual respect and civility, transparency and truth telling and the safety of the workforce. It recognises the work and accomplishments of the workforce regularly and with high visibility. For the individual, these notions of joy and meaning in healthcare work are recognised in three critical questions posed by Paul O'Neill, former chairman and chief executive officer of Alcoa. This is an internal gut-check, that needs to be answered affirmatively by each worker each day:[2]

1. Am I treated with dignity and respect by everyone, everyday, by everyone I encounter, without regard to race, ethnicity, nationality, gender, religious belief, sexual orientation, title, pay grade or number of degrees?
2. Do I have the things I need: education, training, tools, financial support, encouragement, so I can make a contribution this organisation that gives meaning to my life?
3. Am I recognised and thanked for what I do?

If each individual in the workforce cannot answer affirmatively to these questions, the full potential to achieve patient safety, effective outcomes and lower costs is compromised.

The leadership and governance of our healthcare systems currently have strong economic and outcome motivations to focus on the Triple Aim. They also need to feel a parallel moral obligation to the workforce to create an environment that ensures joy and meaning in work. For this reason, we recommend adding a fourth essential aim: improving the experience of providing care. The notion of changing the objective to the *Quadruple* Aim recognises this focus within the context of the broader transformation required in our healthcare system towards high value care. While the first three aims provide a rationale for the existence of a health system, the fourth aim becomes a foundational element for the other goals to be realised.

Progress on this fourth goal in the Quadruple Aim can be measured through metrics focusing on two broad areas: workforce engagement and workforce safety. Workforce engagement can be assessed through annual surveys using established frameworks that allow for benchmarking within industry and with non-healthcare industries.[9] Measures should also be extended to quantify the opposite of engagement, workforce burn-out. This could include select questions from the Maslach Burnout Inventory, the gold standard for measuring employee burn-out.[10] In the realm of workforce safety, metrics should include quantifying work-related deaths or disability, lost time injuries, government mandated reported injuries and all injuries. Although these measures do not completely quantify the experience of providing care, they provide a practical start that is familiar and allow for an initial baseline assessment and monitoring for improvement.

The rewards of the Quadruple Aim, achieved within an inspirational workplace could be immense. No other industry has more potential to free up resources from non-value added and inefficient production practices than healthcare; no other industry has more potential to use its resources to save lives and reduce human suffering; no other industry has the potential to deliver the value envisioned by The Triple Aim on such an audacious scale. The key is the fourth aim: creating the conditions for the healthcare workforce to find joy and meaning in their work and in doing so, improving the experience of providing care.

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GETTING STARTED KIT

Always Events®
Getting Started Kit

February 2014

Institute *for* Healthcare Improvement

Contents

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Background

The patient and family experience has increasingly become a focus for health care organizations, in part because of novel reimbursement programs that tie payment to patient experience scores, but also because leading health care organizations note the research that indicates improved experiences lead to better outcomes and management of chronic conditions, safer care, fewer readmissions, greater trust in health care systems, and greater joy in work for those providing care.[1] A 2012 survey of health care leaders found that 85 percent indicated that they had invested additional time and resources over the past 12 months to improve the patient experience.[2] Despite this heightened awareness and increased efforts to make improvements, gaps continue to exist between the care patients desire and the care they receive. For example, hospital patients desire physical comfort, but on average only 71 percent of inpatients across the United States report that their pain is well controlled and that hospital staff members do everything they can to help manage the pain.[3]

An approach that may help your patient and family experience improvement efforts is IHI's Always Events® framework. The National Quality Forum's Serious Reportable Events in health care are often referred to as "never events." Few would disagree that incidents such as performing surgery on the wrong site or a death caused by a medication error are not only tragic and harmful, but they should never, ever happen. On the flip side, IHI's Always Events framework provides clarity about what should happen for every person, every time they encounter the health care system. Based on decades of research by The Picker Institute on the patient and family experience, an Always Event is a practice or set of behaviors that, when implemented reliably, will ensure an optimal patient and family experience and improved outcomes. The goal of the process is an "Always Experience"; the Always Event is a tool for achieving this goal.

Implementing individual actions for patients and families, even if thoughtful and well intentioned, is not enough to ensure an optimal care experience for every patient, every time. Instead, health care leaders and providers must take a proactive, disciplined, and systemic approach to identifying the actions that, when implemented reliably, translate into optimal care experiences for patients and families. A key distinction of the Always Event is that it is designed based on the patient's desires and preferences for care, rather than what providers think or assume patients and their families want and need.

The organizations initially involved in the Always Events initiative received grants from The Picker Institute to implement and study the use of Always Events. Although these projects reflect early efforts, many of them give indications of the potential of Always Events to positively transform the care experience. The innovative approaches used to implement Always Events are described in the Always Events Healthcare Solutions Book.[4] Although the work of translating patient and family preferences into reliably executed care processes is challenging, any degree of identifying and addressing patient and family concerns about care is an improvement on what has historically been a provider-centric rather than a patient-centric system.

Effectively identifying and implementing an Always Event has the power to revolutionize care. A suboptimal care experience can threaten the patient-provider connection, lead to poor outcomes, and result in unsafe care. It obstructs the full engagement of patients and families in their care. In contrast, enlisting proactive involvement by providing a positive care experience is a prerequisite for high-quality, safe, compassionate, person- and family-centered care.

Purpose of This Getting Started Kit

Use of Always Events to improve the patient and family experience is an emerging field; there are few examples in health care of highly reliable (Always Event) processes and long-term improvement studies have not been conducted to evaluate their efficacy or inform care providers about best practices for implementing an Always Event initiative. Similarly, a comprehensive How-to Guide does not yet exist. However, we believe that the experience to date of organizations that have implemented Always Events strongly suggests their effectiveness as a foundation for optimizing the care experience.

An Always Event is a practice or set of behaviors that, when implemented reliably, will ensure an optimal patient and family experience and improved outcomes.

In the belief that doing something positive with a high likelihood of success is preferable to delaying improvement while waiting for definitive results, IHI has created this Getting Started Kit. The purpose of the Kit is to help providers at the front lines of care understand what an Always Event is, how to select a set of practices for an Always Event initiative, and the steps for implementing the initiative. To help providers understand the process of implementation in the real world, this Kit includes two case studies of organizations that have successfully implemented Always Events initiatives.

Defining an Always Event

A key distinction of an Always Event is that it is designed based on the patient's desires and preferences for care, rather than what providers think or assume patients and their families want and need.

The IHI Always Events framework is a strategy to help health care leaders identify, develop, and achieve reliability in a person- and family-centered care delivery process. An Always Event is a clear, action-oriented, and pervasive practice or set of behaviors that provides the following:

- A foundation for partnering with patients and their families;
- Actions that will ensure optimal patient experience and improved outcomes; and
- A unifying force for all that demonstrates an ongoing commitment to person- and family-centered care.

Always Events are aspects of the patient experience that are so important to patients and families that health care providers must perform them consistently for every patient, every time. An Always Event meets four criteria — important, evidence-based, measurable, and affordable and sustainable — as described in more detail below.

Important: Patients and families have identified the experience as fundamental to their care. This specification is designed to ensure that any event that is successfully implemented will have a meaningful impact on improving the patient experience.

Evidence-based: The experience is known to be related to the optimal care of and respect for the patient.

Measurable: The experience is specific enough that it is possible to accurately and reliably determine whether or not it occurred. This specification is necessary to ensure that Always Events are not merely general aspirations, but are translated effectively into care processes.

Affordable and Sustainable: The experience can be achieved and consistently sustained by any organization without substantial renovations, capital expenditures, or the purchase of new equipment or technology. This specification acknowledges the financial challenges of many organizations and encourages organizations to focus on leveraging the many opportunities to improve the care experience that are based on changes in practice, not infusions of capital.

Examples of Always Events

Examples of some of the Always Events implemented by organizations in The Picker Institute's pilot initiative include the following:

- UPMC's Transplant Guardian Angel Always Event provides patients and families in the organ transplant program with accurate, real-time updates and clinical information, reducing anxiety and increasing effective communication between care delivery teams.
- UCSF Medical Center's Partner with Me staff customize care provided to patients diagnosed with dementia, based on information obtained by communicating with family members about the patient's preferences and routines.
- Dartmouth-Hitchcock Medical Center uses the acronym "ALWAYS" as a framework for six observable, patient-centered communication behaviors: 1) **A**ddress and refer to patients by the name they choose, not their disease; 2) **L**et patients and families know who you are and your role in the patient's care; 3) **W**elcome and respect those defined by the patient as "family"; 4) **A**dvocate for patient and family involvement in decision making to the extent they choose; 5) **Y**our name badge, make sure patients can read it; and 6) **S**how patients and families the same respect you would expect from them.

See the case studies at the end of this Kit for additional examples of Always Events.

Implementing an Always Event Initiative

The approach used with Always Events is fundamentally different from many patient experience initiatives in that its genesis is a need or preference as expressed by patients and families. As illustrated in the left side of the figure below, the process for implementing an Always Event begins with listening to patients and families to capture their values and preferences — "What matters to me" — in their own words. The team then translates these words into actions — the Always Event — that can be reliably performed and measured. The final steps are implementation — making the actions and behaviors a reliable part of the daily work of the care team — and measurement.

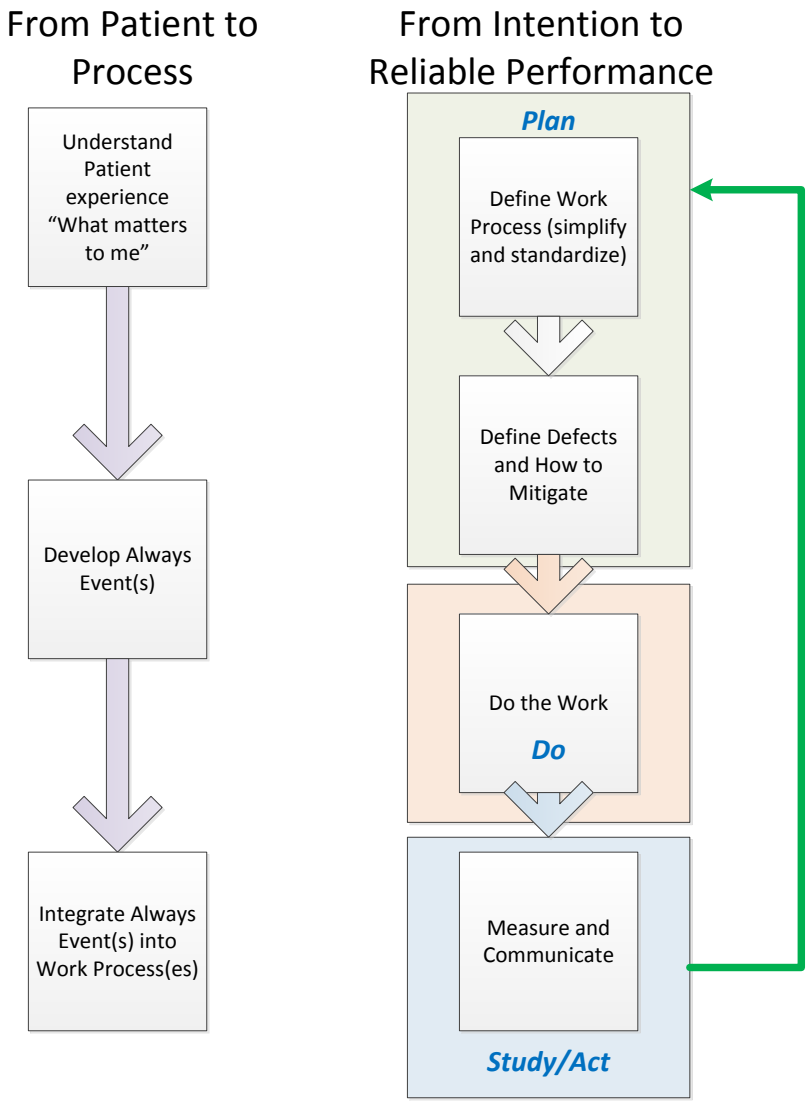
Big Picture:

Link Between

Always Events

and

Reliable Process Performance



The right side of the figure shows how teams can use Plan-Do-Study-Act (PDSA) cycles to move from intention (the care processes identified as exemplifying the chosen Always Event) to reliable performance of the relevant provider actions and behaviors to ensure optimal care experiences for patients and families, in every care interaction. As an example, a team starts with the patient's preference expressed in his or her own words — "I want to understand what to do after I am discharged from the hospital" — and translates these words into a series of actions for caregivers, such as the reliable use of Teach Back for educating patients and their families about discharge instructions, to ensure understanding of what to do after discharge. (Teach Back is a technique asking patients to repeat instructions using their own words, to ensure understanding.)

The team would then use PDSA cycles to ensure that reliable processes are in place such that the Teach Back occurs for 100 percent of patients before they are discharged from the hospital. When selecting metrics, the team should ensure that they assess both process measures (such as the percentage of patients who receive Teach Back at discharge) and outcomes measures (such as the percentage of patients who understood and could repeat back 75 percent of the discharge instructions content, and the percentage of patients who respond affirmatively to "Do you understand what to do after discharge?"). The team should also assess delayed outcomes, such as the degree of understanding at two days after discharge and the 30-day readmission rate.

The Fundamental Elements for Success

Although the use of Always Events to improve patient and family experience is relatively new, it is rooted in evidence-based principles of patient-centered care that The Picker Institute researched over many years. The data show that organizations that are successful at providing patient-centered care focus on four key elements that are critical to success: leadership, patient and family partnership, staff engagement, and measurement. It is reasonable to believe that these same elements will promote success in launching and maintaining an Always Event initiative. Organizations should consider how each of these four elements will be engaged or employed during implementation of an Always Event initiative (see the Table below from the *Blueprint for Action*[5]).

Fundamental Elements	Leadership	Patient and Family Partnership	Staff Engagement	Measurement
Phase 1: Identify an Always Event	Set positive tone Emphasize importance Provide focus, resources, sustained commitment Define scope and scale Consider building on others' tools	Ask patients and families to identify what is important Validate that proposed Always Event addresses an unmet need	Involve staff at all levels in identification of the Always Event	Use data to identify and prioritize opportunities for improvement Begin to identify metrics to evaluate the Always Event initiative
Phase 2: Develop and Implement an Always Event	Align Always Event initiative with other organizational goals Identify leaders at all levels and incorporate opportunities for leadership development Model appropriate behaviors Put the right structure in place	Include patients and family members on the team to design, refine, and evaluate the Always Event initiative Develop new roles for patients and family members in implementing the initiative (e.g., as faculty, mentors) and provide support	Create a process/ structure for the initiative Build an interdisciplinary team Incorporate real-world experience from all disciplines Provide targeted education, role modeling, support, and coaching Translate ideas into concrete, accountable behaviors Use patient and family stories to motivate and inspire Identify peer champions	Select meaningful metrics Collect baseline data Develop evaluation tools Collect qualitative and quantitative information Respond to suggestions and concerns raised during implementation and adapt the initiative as necessary

Fundamental Elements	Leadership	Patient and Family Partnership	Staff Engagement	Measurement
Phase 3: Evaluate an Always Event Initiative	Reinforce a culture of continuous organizational learning Learn from both successes and failures Set realistic expectations Provide resources to conduct a credible evaluation Recognize and reward both effort and achievement	Include patients and family members in the evaluation process Consider qualitative and quantitative feedback Consider using patients and family members as direct observational evaluators Involve patients and family members in interpreting the data	Include multidisciplinary staff in the evaluation process Consider qualitative and quantitative feedback Explore staff needs and implementation barriers Evaluate impact of educational interventions on changing attitudes and behavior	Report meaningful information Acknowledge the limitations of the metrics Integrate qualitative and quantitative metrics Measure consistency of implementation as well as impact
Phase 4: Sustain and Spread the Always Event	Transition the Always Event from an initiative to an integral part of the daily work/care processes Communicate the organization-level impact on improving patient experience Embed the Always Event into organizational systems and processes Apply for Always Event Recognition Program	Continue to use patient and family stories to motivate the team Bring patients and families affected by the Always Event to team meetings or all staff meetings to share their experiences Expand the role of the patient and family and recruit more participants	Discuss Always Event spread progress openly with all staff Build Always Events into technology (e.g., the electronic health record) Modify the Always Event initiative based on feedback	Continue to monitor and report on implementation and impact metrics

Leadership: To be successful at implementing an Always Event initiative, organizational leaders must define the purpose of the initiative for their organization and model desired behaviors. Leaders need to set the right tone for identification of an Always Event, positioning the initiative as a positive way to enhance both the patient and staff experience rather than one more "flavor of the month" to-do list item.

Leaders need to ensure that the organization's selected Always Event initiative is realistically designed and capable of being achieved within a defined time period. Tackling large core issues like patient-centered care can seem overwhelming if the issue is not broken down into achievable components. Carefully defining the scope and scale of the Always Event, as well as defining measures of success, helps to keep the initiative from becoming too broad and diffuse to have an

impact. Leaders also can encourage teams to think broadly about Always Event opportunities, including those that build on others' tools.

Framing of the Always Event initiative by leaders is essential for success. Without this clarity of purpose, organizations may pursue a variety of well-intentioned actions that fail to achieve positive patient experiences on a consistent basis. Instead, what results are "random acts of goodness."[6]

During implementation, leaders are essential in sustaining the focus and commitment to the initiative, providing the necessary resources and aligning the initiative with other organizational priorities. During the evaluation phase, it is important for leaders to reinforce a culture of continuous organizational learning. Leaders should ensure that appropriate resources are made available for a credible evaluation of the Always Events initiative. To sustain the momentum, leaders can communicate the bigger picture impact of the initiative and can help put it in the context of achieving the broader goals of improving the patient experience, as well as advancing quality and patient safety.

Patient and Family Partnership: Both care providers and leaders must take steps to engage patients and families in the Always Event initiative. Without such participation, improvement efforts, no matter how successfully implemented, may not reflect the true needs and values of patients and their families, and what matters to them when it comes to their desired care experience. Their input is critical to ensure the relevance and ultimate success of the initiative.

Partnership with patients and family members can take many forms. Health care organizations with existing Patient and Family Advisors or Advisory Councils integrated into hospital operations can involve these advisors in designing, implementing, and refining their Always Events initiatives. Organizations also can seek patient and family involvement through other formal and informal mechanisms such as focus groups, surveys, and interviews.

Patients and family members also play a key role in evaluating an Always Event initiative. Providers should use both qualitative and quantitative feedback mechanisms to ask patients and families whether the Always Event occurred and, if so, what impact it had on the patient experience. To maintain the momentum of the initiative, providers can reinforce the impact of the Always Event on the patient experience through relaying patient stories.

Staff Engagement: When identifying an Always Event, leaders must engage staff at all levels in defining what important aspects of care they are able to commit to providing consistently. Leaders should identify an interdisciplinary team to lead implementation of the Always Event; the team should include members with a variety of perspectives and skills. Frontline staff participation is essential. Leaders should develop a process and structure for the initiative, such as a meeting schedule and division of responsibilities, including the designation of a team leader. Education of staff in the new behaviors and expectations is an important component of successful implementation of an Always Event.

During evaluation, invite staff to share their perspectives on the Always Event. In particular, ask staff what needs to be in place to enable them to consistently perform the Always Event for patients and what barriers, if any, are preventing them from achieving consistent performance. To maintain momentum, leaders should empower the team to modify the Always Event based on staff and patient and family feedback, and build the Always Event into the information technology system to help ensure reliable implementation.

Measurement: Successful Always Event initiatives use data and performance improvement techniques in a variety of ways throughout all stages of the initiative. Leaders should use data to identify opportunities for improvement that are likely to make Always Event initiatives successful and determine which metrics will be used to evaluate the initiative. Some organizations have implemented Always Events on selected units and compared performance to similar "control units" in which the Always Event was not implemented.

Health care organizations tend to rely heavily on quantitative information, but qualitative information provides important insights into whether an Always Event is having the intended effect of creating a positive Always Experience. Throughout the development and implementation phase, the team should refine the Always Event based on this qualitative feedback from patients and families. Maintaining open lines of communication during the implementation phase will help to ensure that any suggestions or concerns raised are addressed.

During the evaluation phase, it is important for leaders to put the data in perspective. Staff members who have been enthusiastically participating in an Always Event initiative may be expecting to see big improvements in quantitative performance and may be disappointed by small, incremental changes. Incremental improvement is an expected part of the PDSA process for testing and refining the Always Event, leading ultimately to its reliable implementation. It is helpful to integrate qualitative and quantitative data to gain a more complete perspective on an implemented Always Event.

Continued monitoring and reporting of performance metrics will help to keep an organization focused on sustaining an Always Event. Although the evaluations may be scheduled to take place less frequently, continued evaluation ensures that the organization is able to take action if performance becomes more variable or is no longer having the desired impact.

Conclusion

Always Events offer health care providers the opportunity to make improvements in care that really matter to patients and their families. A variety of practices can serve as the focus of an Always Event; what's important is that the selection is driven by the preferences and needs of those at the center of care: patients and their family members. The first step is to listen to patients, to learn what matters to them. This Kit can help teams translate patient desires and preferences into meaningful improvements in care. For more help in getting started, see Always Events at ihi.org.

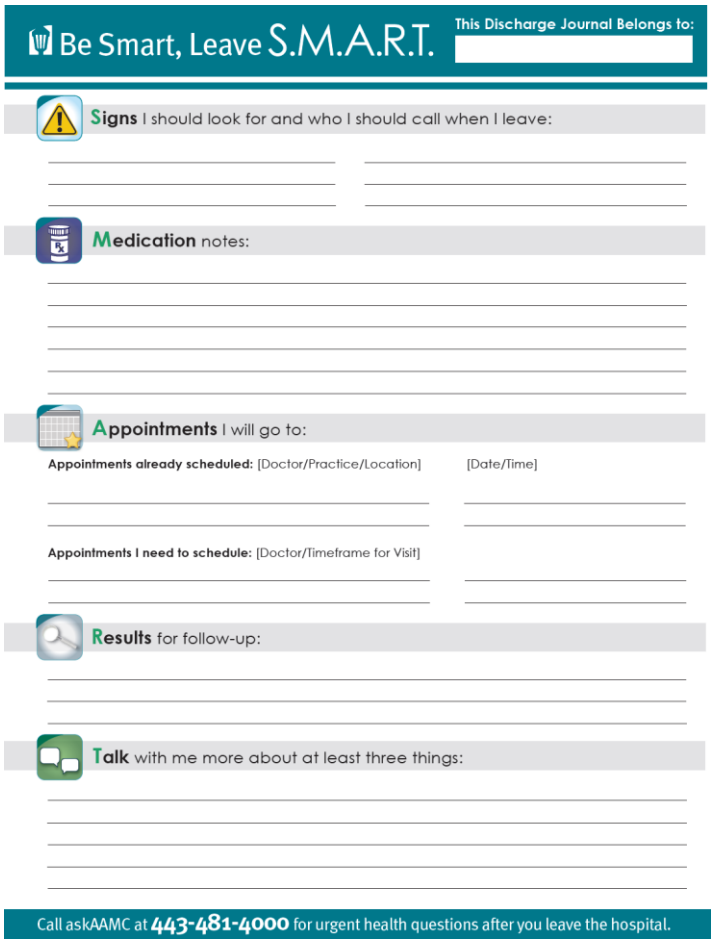
The following two case studies are structured according to the fundamental elements for success of an Always Event initiative: leadership, patient and family partnership, staff engagement, and measurement (see page 8 for more detail). Both organizations were recipients of Always Events grants from The Picker Institute.

Case Study: Anne Arundel Medical Center: SMART Discharge

Leadership

The chief nursing officer/chief operating officer (CNO/COO) and the chief medical officer (CMO) of Anne Arundel Medical Center (AAMC) in Annapolis, Maryland, recognized tremendous variation in the information given to patients and families upon discharge. With the input of several organizational leaders, including the chief informatics officer (CIO), director of nursing quality and research, physician chair of community integration, and executive director of marketing, they developed an Always Event initiative that addresses this information gap: SMART Discharge.

"SMART" is an acronym for **S**ymptoms, **M**edications, **A**ppointments, **R**esults, and **T**alk with me. The leadership team envisioned SMART Discharge as a way to ensure that these five key areas were always addressed with patients and families during hospitalization and at discharge.


Be Smart, Leave S.M.A.R.T.

This Discharge Journal Belongs to:

Signs I should look for and who I should call when I leave:

Medication notes:

Appointments I will go to:

Appointments already scheduled: [Doctor/Practice/Location] [Date/Time]

Appointments I need to schedule: [Doctor/Timeframe for Visit]

Results for follow-up:

Talk with me more about at least three things:

Call askAAMC at **443-481-4000** for urgent health questions after you leave the hospital.

Soon after receiving an Always Events grant from The Picker Institute in the spring of 2011, AAMC convened a steering committee for the initiative. The steering committee consisted of all members of the leadership team, including the CNO/COO, CMO, SMART Discharge project coordinator, a consultant from the Institute for Patient- and Family-Centered Care, and four patient/family advisors. The committee met twice a month for the first year and every other month for the second year, with the CNO/COO or CMO present at the majority of the meetings. The steering committee was responsible for developing the SMART Discharge curriculum and tools, selecting the pilot units, and monitoring progress and outcomes.

During curriculum and tool development, committee members realized that significant alterations to the electronic medical record (EMR) were needed for SMART Discharge to succeed. The CNO/COO and CMO supported these changes by making SMART Discharge an organizational priority. They ensured that resources were allocated to the information systems department to complete the EMR-related changes and assigned champions to educate staff on the changes.

The CNO/COO and CMO believed that creating a more consistent approach to care during hospitalization would lead to a more consistent discharge process. Thus, over the course of the Always Event grant, leaders and the steering committee focused on the development of geographical rounding for physicians (i.e., hospital doctors are always near their patients and spend less time walking between floors, bedside shift report for nursing, and interdisciplinary rounds on all inpatient units).

Leadership appointed a senior unit charge nurse as the SMART Discharge project coordinator to assume responsibility for managing all aspects of the Always Event grant. The project coordinator recruited four patient/family advisors, led the steering committee meetings, and provided status reports to leadership. In addition, clinical nursing directors from three pilot areas were intimately involved with the implementation and monitoring of SMART Discharge on their respective units.

Patient and Family Partnership

The SMART Discharge project coordinator recruited four patient and family members to become advisors on the steering committee. Two advisors were former patients; the other two were a mother and wife of a patient, respectively. They represented diverse ages, sexual orientation, gender, diagnoses, and experiences. The four patient/family advisors (PFAs) were offered a small monetary stipend for their participation.

The PFAs selected the dates and times for the steering committee meetings and attended regularly. Over the course of the grant, the PFAs gave input on focus group questions, promotional signage, EMR changes, and all aspects of the SMART Discharge curriculum and tools.

Information gathered from former patients and family members during focus group sessions on the “ideal discharge” and SMART Discharge curriculum helped guide the actions of the steering committee throughout the year. The PFAs provided specific feedback, such as the need to improve physician attention to medication lists upon discharge, the need to better promote the “Ask a Nurse” service, and the observation that communication with patients and families varied drastically during hospitalization. In addition, the PFAs on the steering committee continually helped identify critical elements of the discharge process that needed to be evaluated and corrected from the perspective of the patient and family.

The PFAs on the steering committee were critical to the training and recruitment strategy. They served as faculty members at every staff training session and provided feedback to nurses and

physician champions. They also described their personal hospital discharge experiences for a training video, helping to emphasize the importance of the SMART Discharge program.

Staff Engagement

Once the steering committee selected the three pilot units for SMART Discharge, the group identified project champions from nursing, medical, pharmacy, and care management staff. Clinical nursing directors were responsible for recommending staff members whom they felt would best promote the new initiative. In addition, members of the informatics department were present whenever changes to the electronic medical record were discussed.

To determine the most appropriate method for educating staff about the initiative, the SMART Discharge project coordinator met with the staff champions of each unit prior to training and implementation. The champions identified the days and times that would be best for training and the types of media to be used and helped develop measurement strategies. In addition, unit champions trained staff members whenever possible and provided feedback to the project coordinator and steering committee members.

Once SMART Discharge was implemented on a pilot unit, the project coordinator met with the unit champions at least monthly to review progress, identify challenges, and celebrate successes. The coordinator monitored the percentage of staff members who completed training and the team used a variety of strategies to track compliance, including chart audits, charge nurse rounds with patients, weekly staff huddles, and post-discharge phone calls.

The project coordinator and unit champions discussed SMART Discharge progress during staff meetings and in notices on bulletin boards, in blog articles, and in email messages. In addition, they conducted presentations and webinars both internally and externally to promote SMART Discharge and describe the work completed to date.

Measurement

The Always Events grant proposal defined the outcomes measures that the team would monitor:

- 31-day readmission rate;
- 31-day post-hospitalization ED visit rate;
- Patient satisfaction scores related to discharge (from HCAHPS); and
- Percentage of patients who were aware of receiving SMART Discharge education.

Over the course of the grant, the team realized that the fourth outcome measure would be the most challenging. Initially, the team crafted a simple yes/no survey for use at the time of discharge to measure patient awareness of SMART Discharge education. However, patients and family members from the focus groups and the steering committee reported that they found the survey to be unnecessary and bothersome. The team ultimately removed this outcome measure and retained the other three.

The team anticipated that implementation of SMART Discharge would result in an increase in patientand family satisfaction with discharge and a decrease in 31-day readmission and 31-day post-hospitalization ED visit rates. The team engaged a biostatistician to analyze results in these areas for the first year of the Always Event grant.

In June 2013, staff in all inpatient units began providing SMART Discharge education to patients. Over the next year, the project coordinator will monitor patient satisfaction with discharge and 31-day readmission and 31-day post-hospitalization ED visit rates. In addition, the team will implement other measurement strategies to determine whether recent hospital initiatives have had a positive effect on the patient experience.

Receiving an Always Events grant allowed AAMC to examine gaps in the discharge process and initiate changes to increase safety and improve the patient experience. By working closely with patients and families, leaders and staff were able to implement SMART Discharge throughout the institution. The organization will continue to focus discharge education on the five key areas outlined by the SMART Discharge initiative — Symptoms, Medications, Appointments, Results, and Talk with me — with the hope that use of the tool will spread throughout the community.

Case Study: UnityPoint Health: Always Use Teach Back!

UnityPoint Health (formerly Iowa Health System) relied on principles of health literacy and behavior change to develop an Always Event called the Always Use Teach Back! Toolkit. The toolkit is a free, online, interactive website that supports the use of Teach Back in the inpatient, home care, and office practice settings. The website (www.teachbacktraining.com) includes tools that help learners differentiate between effective and ineffective use of Teach Back. It also contains content that helps staff provide Teach Back to every patient, every time it is indicated.

Leadership

Leadership at the regional affiliates of UnityPoint Health and at the systemwide Center for Clinical Transformation enabled the participation of other leaders throughout the organization on the Always Use Teach Back! grant initiative. In addition, leaders partnered with community organizations such as Des Moines University and Health Literacy Iowa to access ideas and resources that enriched the initiative.

UnityPoint Health built on partnerships with patients and families spanning more than eight years to identify useful teaching methods and tools, design patient-friendly informed consent processes and documents, and implement extensive use of Teach Back in the hospital setting. When system and regional executives realized that the use of Teach Back was not reaching every patient, every time, they identified the Always Event initiative as a means for achieving this goal.

The regional nursing executive for the pilot area recorded a video message describing her convictions about the importance of Teach Back and providing directions to staff for learning to use Teach Back reliably. The organization now holds clinical supervisors accountable for ensuring the competent, reliable use of Teach Back on their units.

The corporate steering team developed key messages and communicated them to pilot organizations and testing sites, the quality committee of the health system's board of directors, the system-wide clinical council (which includes chief nurse and physician executive representatives from all system entities), systemwide reducing readmissions and health literacy teams, representatives from the CMS Pioneer ACO program, and external partners.

Systemwide chief nursing executives supported the initiative by keeping it in the forefront of the organizational agenda and ensured protected time for staff to participate. They continue to assist the spread and sustainability of the initiative. Executives from the clinic practices, home care facilities, and the hospitals identified pilot locations, enabled observations and testing in the three targeted care settings, and provided leadership for mid-level managers.

Leaders also directed resources for electronic medical record programming, which enabled the system's electronic capture of the use of Teach Back and patient responses. Additionally, www.teachbacktraining.com was incorporated into the systemwide learning management system (LMS) to enable tracking of every clinical caregiver and to enable tracks for both learners and coach-trainers. Coach-trainers recorded results of their staff observations in the LMS for data capture and reporting.

Based on participant input and to increase competence and consistent use of the toolkit, the team engaged instructional design experts to develop logic-based, interactive, online educational modules for the three sites of care. The team also developed a standard observation tool for gathering consistent baseline data on participants' use of Teach Back with patients (see www.teachbacktraining.com).

Senior executives supported the competent, consistent use of Teach Back by adding coaching responsibilities to the role of unit managers and overseeing the creation of a one-page project description communication tool for participating care sites.

Sustainment efforts include on-site coaching to support building the habit of patient teaching with use of Teach Back and helping providers to form new daily habits. Coach/peer training requirements include completing the online Teach Back modules in the LMS and attending a face-to-face roundtable meeting. Managers are held accountable for performing the frontline observations of their staff nurses.

Systemwide spread is being managed regionally and supervised by the chief nursing executives, with help from the regions' health literacy teams. Some regions expect completion of spread to all units in 2013, while others will finish in 2014.

Patient and Family Partnership

The ready availability of patient and family members to provide input for developing the Always Event greatly facilitated implementation. A number of activities during the previous years had reinforced the critical importance of partnering with patients and families at every step for all health literacy activities. The New Readers of Iowa and other community groups helped the grant team with language development and other elements of the online, interactive toolkit.

The Iowa New Readers have an established history of working with UnityPoint to discover new ways to gather information from patients and report back to the health literacy teams about patients' interactions with providers and staff.

The team used care-site-specific and cross-continuum observations to understand current practices and to see patient teaching from patient, family, and frontline clinician perspectives. Patient and family advisors helped staff understand patient and family needs and their responses to the Teach Back training development.

Chief nursing executives and the health literacy teams enable the ongoing dialogue and feedback to support the spread of the Always Event. In addition, some of the system entities have connected this initiative to their local and service-specific patient and family advisory councils, which has helped sustain the initiative.

Staff Engagement

Learning that Teach Back was not being used with every patient, despite this being a staff expectation, was a strong stimulus for staff engagement and change.

The involvement of frontline staff, including nurses, physicians, and mid-level providers in hospitals and the home care setting, was critical to the development and testing of the Always Event and gathering data on its consistent use. Frontline staff shared these observations with providers participating in the pilot. The team used feedback from clinical and patient participants on the draft toolkit to refine it and reinforce the need for interactive "how-to" scenarios and supplementary coaching support materials.

The team observed that practitioners wanted to learn more about improving their patient teaching. The team, assisted by an experienced Teach Back coach, worked with staff to problem solve and learn how to observe and give feedback in ways that engaged and honored the learners. Story sharing and reinforcement of leader-learner activities helped staff with problem solving and reinforced the attitude of "this is the way we do it here." Long-standing personal habits regarding patient teaching can be difficult to change. Static, one-time education does not fully engage learners in practicing Teach Back skills and may explain why Teach Back is not used consistently.

The Always Events initiative reinforced a growing understanding of the need for a new way to teach new processes, one that involves teaching to competence at the frontlines of care and assisting staff in building daily habits. The team believes that interactive learning modules, along with coaching at the front lines for competence and habit building, are making a difference.

Leaders of the home care service line identified a program leader who began Phase 1 by training peer coach/trainers in the home care agency, including home care nursing staff, respiratory therapists, palliative care staff, hospice staff, and direct caregivers, such as nurses who provide telemonitoring services. Phase 2 training includes those who speak with patients and families but do not provide health care services, such as staff members who perform intake triage and billing personnel. The team modified the basic training Teach Back modules by adding additional scripting to help these staff members relate Teach Back to their own work. In Phase 3 the team will gather data through electronic medical record data capture to assess the reliability of the use of Teach Back for all patients.

Office practice spread began with the pilot physician, physician assistant, and the office manager. Roll-out for training of all staff across UnityPoint primary care and specialty clinics is being designed with a completion goal in 2014. Mechanisms for spreading this learning include use of the existing reducing readmissions initiative that uses the IHI STAAR How-to Guide for office practices and the deployment within the structure of primary care medical homes.

Measurement

At the outset, only 38 percent of pilot unit observations showed competent, reliable use of the Teach Back method, and 80 percent use of questions that yielded yes-or-no responses.

After observed staff used the Teach Back training interactive learning modules, 82 percent used competent, reliable Teach Back methods and the use of yes/no questions fell to 20 percent. The proportion of clinical encounters in which Teach Back was used increased significantly after the initiative ($p<.05$).

The team developed a process for online data collection through the electronic medical record to assess whether all patients or their family members received Teach Back and the degree to which the patient or family member was able to repeat back the instructions in their own words.

UnityPoint built process-sustaining learning activities into the organization's orientation programs, electronic medical records, and related written materials, as well as included the initiative in ongoing reporting throughout the system entities.

The team learned that many health care providers thought they were using Teach Back when, in fact, they were not. Instead, providers were delivering good patient education content and then asking if the patient/family had any questions or if they understood, but were not asking patients to explain back in their own words what they needed to know or do (i.e., the essence of the Teach Back method).

The health system's vision, Best Outcomes Every Patient Every Time, is an overarching support to achieving frontline process reliability. In addition, the system's Clinical Council and the health literacy teams, which have been actively working to implement health literacy principles, techniques, and tools for more than eight years, provided considerable support for the Always Use Teach Back! initiative.

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