TAHOE FOREST HOSPITAL DISTRICT

2018-05-08 Board Quality Committee Meeting

Tuesday, May 8, 2018 at 12:00 p.m.

Pine Street Cafe Conference Room - Tahoe Forest Hospital

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2018-05-08 Board Quality Committee Meeting

05/08/18 Board Quality Meeting

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
AGENDA

Tuesday, May 8, 2018 at 12:00 p.m.
Pine Street Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
Alyce Wong, RN, Chair; Charles Zipkin, M.D., Board Member

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

4. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. APPROVAL OF MINUTES OF: 02/01/2018 ..... **ATTACHMENT**

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Patient & Family Centered Care (PFCC)

6.1.1. Patient Experience Presentation TIMED ITEM – 12:05 p.m.
Patient will present his story navigating through Tahoe Forest Health System.

6.1.2. 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. Performance Improvement Initiatives ..... ATTACHMENT
Quality Committee will receive a status report on the Quality Assurance/Performance Improvement Plan (#AQPI-05) priorities for 2018.

6.3. Quality Metric for CEO Incentive Compensation
Committee will discuss and recommend a quality metric for CEO incentive compensation FY2019.

6.4. Annual Quality Assurance/Performance Improvement Report to Board of Directors
Committee will discuss the annual report to the Board of Directors and any recommendations for future reporting.

6.5. Patient Safety ..... ATTACHMENT

6.5.1 Beta HEART Program
Committee will provide an update regarding the Beta Healthcare Group culture of safety program.

6.6. Healthy People 2020 Recognition.....ATTACHMENT
Committee will review the Smart Care California recognition letter for low risk first birth Cesarean section rate.

6.7. Board Quality Education .....ATTACHMENT
Committee will discuss topics for future board quality education. The committee will also review the following articles:

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

6.7.2. Patient Safety Network (2017). High Reliability. *Patient Safety Primer,* 31.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE
The date and time of the next committee meeting, Thursday, August 9, 2018 at 9:00 a.m. will be confirmed.

9. ADJOURN

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

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

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

BOARD QUALITY COMMITTEE
DRAFT MINUTES

Thursday, February 1, 2018 at 9:00 a.m.
Eskridge Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER
Meeting was called to order at 9:03 a.m.

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

Staff in attendance: Harry Weis, Chief Executive Officer; Judy Newland, Chief Operating Officer; Janet Van Gelder, Director of Quality & Regulations; Jean Steinberg, Director of Medical Staff Services; Carl Blumberg, Risk Manager & Patient Safety Officer; Lorna Tirman, Patient Experience Specialist; Martina Rochefort, Clerk of the Board

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA
No changes were made to the agenda.

4. INPUT – AUDIENCE
No public comment was received.

5. APPROVAL OF MINUTES OF: 12/12/2017
Director Zipkin moved approval of the Board Quality Committee minutes for December 12, 2017, seconded by Director Wong.

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

No discussion was held on this item.

6.2. Quality Assurance Process Improvement (QA/PI) Plan
The 2018 Quality Assurance Process Improvement Plan went to the Medical Staff Quality Committee for approval already.

QAPI plan is a dynamic document and routinely updated.

Patient Experience Specialist will attend a Patient Family Coordinated Care conference in a few weeks and will develop more on this program after the conference.

The QA/PI promotes lean principles. Discussion was held about whether lean principles was a given and should be removed from the document. COO stated that is what we need to do constantly and consistently and is concerned it would get lost if removed. It should still be stated as a priority.

In an effort to improve patient safety, Quality will start to embed the High Reliability Organization (HRO) system into its processes. Just Culture is a component of high reliability organizations. Abandoning the "Just Culture" terminology will create confusion for staff.

Nine staff members are attending the BETA conference next week.

There is work to be done to embed HRO into the fabric of the organization.

Medi-Cal PRIME program is a five year program and every year has different measurements. Director of Quality and Regulations is trying to find out from the CNO if this needs to stay in the plan.

The committee noted they did not receive a redline version. Quality Analyst works on the updates to the attachments. Attachment C was added to performance improvement committee. Quality asked every department to report through performance priorities that were just discussed.

Quality Committee asked for changes made from year to year to be highlighted.

CEO inquired about adding audiology to Attachment B.

The committee reviewed the following edits:
-On page 41 of the packet, "Surgery is not the first course of treatment for cN2, M0 lung cases" is repeated.
-On page 59 of the packet, "Adenoma detection rate" is the more appropriate measure to be used.
-Abbreviations need to be spelled out the first time used throughout the document.
-On page 65 of the packet, there is a discrepancy between the 20mL/kg of crystalloid listed and Attachment D references 30mL/kg of crystalloid.

The plan will go to Medical Executive Committee (MEC) for approval and then on to the Board of Directors.

Quality Committee recommended this move on to MEC and then to full board.

6.3. Patient & Family Centered Care (PFCC)

6.3.1. Patient & Family Advisory Council Update

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

Wendy Buchanan from Center for Health presented at the January PFAC meeting. PFAC provided good feedback about how to get info back to community.

Ms. Buchanan presented on the Customer Care Navigator program. They field questions about services and how to access the services.

Ryan Solberg, Director of Therapies also came to present about his area and how EPIC is affecting therapies. The Truckee location will be renovated in June.

Two potential members attended to see if they would like to participate.

Patient Experience Specialist plans to review the role of an advisor at the February PFAC meeting. It will be a little bit of a switch in direction for the next meeting.

Director Zipkin asked if the navigators follow up with patients. Patient Experience Specialist would have to confirm with Ms. Buchanan. Director Zipkin would like the navigators to have the initiative to follow up.

6.3.2. Patient Experience Presentation

None.

6.4. ABD-10 Emergency On-Call policy

Quality Committee reviewed ABD-10 Emergency On-Call policy.

COO commented these are services we have to provide via EMTALA. The policy highlights we state what services we have on-call.

Director of Medical Staff Services noted that Medical Staff has requirement of 30 minutes for an on-call physician to come to the hospital.

Committee does not want to add verbiage about physician response time. COO said it is not the purpose of the policy.

Quality Committee recommended the following edits to the policy:
-delete “every” on F
-delete “current” and “preferred” under F

Quality Committee recommended ABD-10 to move forward to the board with changes noted above.

6.5. General Acute Care Relicensing Survey

Tahoe Forest is due for an unannounced triennial GACH Relicensing survey from CDPH. The hospital had its first Medication Error Reduction Plan (MERP) survey about nine years ago.

Director of Quality assumes they will be coming sometime this fall. She feels confident the hospital will do well since it just went through an HFAP survey. The hospital needs to be sure we are compliant with these particular regulations.

Surveyors focus on medication administration practices and documentation.

Quality Department does survey preparedness rounds twice monthly.

Surveyors usually go back 6 months in medical records.

6.6. Quadruple Aim

Quadruple AIM will be a standing item on the quality agenda.

Director Wong inquired about the review of the employee engagement survey and would like to see follow up on the action plans.

CEO agreed there needs to be a thorough review of these items. COO stated the Chief Human Resources Officer should attend whatever committee reviews the surveys.

Full board will receive an update on action plan.

It was suggested that Medical Staff send out a survey to get a check on improvement in the fall.

6.7. Own the Bone

TFHD achieved "Star Performer" status on the American Orthopedic Association's Own the Bone program (www.ownthebone.org).

The District was recognized for outstanding quality in fragility fracture care.

Director Wong observed that a facility only has to meet five measures at 75%. She inquired where Tahoe Forest falls within that measurement. Dan Coll is the head of the orthopedic service line and he would have to give that update.

6.8. Board Quality Education

The Committee reviewed the following articles:

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

Director Wong questioned what information in quality would the board really to want see. She would like to bring this topic to the board retreat for discussion.

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

This article should be forwarded to the full board for reading.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

-Committee would like to have reports on PRIME in the future.

8. NEXT MEETING DATE

The Board Quality Committee will meet on May 8, 2018 at 12:00 p.m.

9. ADJOURN

Meeting adjourned at 10:04 a.m.

2018 PFAC PROCESS IMPROVEMENT LOG

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

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
Jan-April 2018				

2018 PFAC PROCESS IMPROVEMENT LOG

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

1/20/2018	Center for Health	Wendy Buchanan	Center for Health and Wellness Presentation of Programs and shared brochure filled with courses for wellness. She talked about the 2 grants we received to help patients with substance abuse/ addiction and we have had 17 patients participate in this new program with 16 patients successfully off specific substances for several months. We also received a grant for community health programming and identify via a community survey what our biggest opportunities for community health education are. In our community the survey identified Nutrition, Substance abuse and exercise as the biggest areas of health coaching opportunities. So programs are targeted to our community in these specific areas. We discussed how some of the programming is free but not all of it. The council suggested that in the brochure we could identify which classes are Free of charge and which you need to call for pricing, to indicate some classes you will have to pay for. The education and courses are focused in 4 areas, Motivate, Move, Eat and Restore. Along with specific areas for new moms, and breastfeeding, etc. The council suggested that we need to look at ways to get these courses and brochure out to the community. Some of the Advisors were not aware of all the courses available. Wendy stated that she is working with Marketing to better communicate all that is offered. Wendy also presented the Customer Care Navigators program and discussed that it is fairly new and growing day by day as a resource to both physicians as well as the community to help navigate health needs in our community. This role changed from front "office staff" to non-clinical Navigators. They work 7 days a week and field phone calls from physicians and patients who have questions about services and how to access what they need. They are not able to actually schedule appointments for patients, however they can direct them to that service. They also do not handle any billing questions or concerns	Market Courses to community Market Navigators to community Consider putting pricing information in brochure or at least the free classes state Free and the ones you pay for say call for pricing.

			but give the patients the information they need to call someone who can help with those issues. The Navigator role started last February 2017 and in the first few months fielded about 6 calls per month, and now they handle about 80 calls per month. The navigator services will be expanding to Tahoe City soon. There is some cross over of services between the cancer center and center for health, which came up as question from the group.	
	Physical Therapy, Speech Therapy, Wound Therapy and Occupational Therapy	Ryan Solberg	6:25 pm Ryan Solberg presented his role as Director over Physical therapy, Occupational therapy, speech therapy and wound care services. He spoke about our change in the electronic medical record system to EPIC and how that has changed our work flow in PT, OT and ST. Although it is a change, it is going to be very helpful for his clinicians to see records for their patients wherever they have been seen prior to coming to our facility. His focus is on the quality of the care his clinicians provide as well as being fully transparent with pricing and the patients care plan. In June we will be remodeling this clinic site in Truckee which should help with flow of check in and check out. One of the Advisors asked about employee moral given the change in leadership over these therapy services. Ryan says they have been discussing this at staff meetings and he feels it has improved. He agreed it is something he continues to monitor and work to improve again quality, moral and transparency of pricing and services. Input by Council	Transparency of Cost of treatment Include patients on care plan when possible. Lorna Tirman

2018 PFAC PROCESS IMPROVEMENT LOG

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

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
	Review Charter, Role of Advisors, Discuss Goals for 2018	Lorna Tirman		
			Next Meeting February 20th, will discuss Charter, Role of Advisors and Goals for 2018 to help improve patient experiences. Share results from Employee focused forums on Perfect Care Experience.	

2018 PFAC PROCESS IMPROVEMENT LOG

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

Date	Topic	Forwarded to/Department	Discussion/Status	Process Improvement
I. February 20, 2018 Call to Order 5:30 pm		Eskridge Conference Room		
II. Attendance (invited)		Members ~~Doug Wright, Karen Caton, Sherilyn Laughlin, Anne Liston, Sandra Dorst,~~ Mary Jones, Jay Shaw, ~~PFCC team Heidi Standteiner, Tammy Melrose, Eileen Knudson,~~ Lorna Tirman, Jim Sturtevant, ~~Kerry Milligan, Janet Van Gelder~~, Harry Weis, ~~Peter Taylor, Judy Newland, Jeremy Bennett, Sandy Walker;~~ Guest Pati Johnson		
III. Introductions		Pati Johnson introduced herself to the group as a new member, waiting to go through volunteer training		
V. Standing Items/New Items		Two new members will begin as soon as volunteer training is completed. New members: Pati Johnson and Helen Shadowens		
VI. Other		Next meeting Agenda Items: 1. Review Role of Advisors and Rules of Meetings 2. Review Survey History: Quality Chasm and To Err Is Human. How surveys were created to improve quality In healthcare 3. Review services that we will do journey mapping on to look for input on opportunities for improvement.		
VII. Adjournment		Next Meeting March 20 , 2018		

IV. March 20, 2018 Call to Order 5:30 pm	Eskridge Conference Room		PFCC team
V. Attendance (invited)	Members Doug Wright, Sherilyn Laughlin, Anne Liston, Sandra Dorst, Mary Jones, Jay Shaw, PFCC team ~~Heidi Standteiner, Tammy Melrose~~, Eileen Knudson, Lorna Tirman, Jim Sturtevant, ~~Kerry Milligan~~, Janet Van Gelder, Harry Weis, Peter Taylor, Judy Newland, ~~Jeremy Bennett, Sandy Walker~~, Pati Johnson, Helen Shadowens		
VI. Introductions			

2018 PFAC PROCESS IMPROVEMENT LOG

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

IV. Topics for Discussion	1. We will be reviewing our new ***Rules for Meetings*** and make any edits necessary a. Everyone should have equal time to give input. b. Listen to others to fully understand. c. Everything discussed is only to be shared by others who have a ***Need or Right*** to know. d. Our communications are confidential unless we determine you can share certain things outside this venue. e. If you have personal story or complaint about an experience at TFH, please meet with Lorna privately to discuss and resolve, the PFAC is not the venue for complaining or resolving. f. Stay positive g. Bring your thoughts and outside eyes and solutions h. Thank you for your time and input. 2. Any updates from the group 3. Lorna will give an update on a Patient and Family Advisory Meeting she attended in Los Angeles. 4. Discuss PFAC strategies for 2018 to include how you can all help improve our Patient's Experiences in outpatient, medical practice offices, and ambulatory surgery setting. 5. Begin journey mapping out the perfect care experience in all our settings. 6. Patient Experience Week April 23- 27th, 2018		Lorna Tirman
V. Standing Items/New Items	Ongoing New Member Search		

2018 PFAC PROCESS IMPROVEMENT LOG

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

VI. Other			Lorna Tirman
VII. Adjournment	Next Meeting April 17th , 2018		

2018 PFAC PROCESS IMPROVEMENT LOG

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

VII. Call to Order April 17, 2018 5:30 pm	Eskridge Conference Room		PFCC team
VIII. Attendance (invited)	Members ~~Doug Wright, Karen Caton, Sherilyn Laughlin~~, Anne Liston~~, Sandra Dorst~~, Mary Jones, Jay Shaw, ~~Helen Shadowens,~~ Pati Johnson, PFCC team ~~Heidi Standteiner, Tammy Melrose, Eileen Knudson,~~ Lorna Tirman, ~~Jim Sturtevant, Kerry Milligan, Janet Van Gelder, Harry Weis~~, Peter Taylor, Judy Newland, ~~Jeremy Bennett~~, ~~Sandy Walker~~		
IX. Introductions	No New Members to introduce		

IV. Topics for Discussion	Report on Feedback from our patients for Ambulatory Surgery: improvements by leaders rounding on staff and patients Improving Outpatient and Medical Practice Experiences using CARE Connect, Ask, Respect and Respond, Empathy and Educate Scripting Behaviors that matter	-Welcome immediately with acknowledgement and eye contact -Make everyone feel welcome -Ask "How can I help you?" -Pay attention to me and keep me informed. -Remember that people are not at their best, they are scared, anxious and in general do not want to be here. They may be afraid of getting bad news from their tests. Communication is the key - Use volunteers for wayfinding	Lorna Tirman PFAC
V. Standing Items/New Items	Ongoing New Member Search		

2018 PFAC PROCESS IMPROVEMENT LOG

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

VI. Other			Lorna Tirman
VII. Adjournment	Next Meeting May 15, 2018		

	Tahoe Forest Health System				
	Title: Quality Assurance / Performance Improvement (QA/PI) Plan			**Policy/Procedure #: AQPI-05**	
	Responsible Department: Quality & Regulations				
Type of policy		Original Date:	Reviewed Dates:	Revision Dates:	
☒	Administrative	9/96		12/14; 2/16; 2/17; 1/18	
☐	Medical Staff				
☐	Departmental				
Applies to: X System ☐ Tahoe Forest Hospital ☐ Incline Village Community Hospital					

PURPOSE

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

POLICY:

MISSION STATEMENT

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

VISION STATEMENT

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

VALUES STATEMENT

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

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

FOUNDATIONS OF EXCELLENCE

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

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

PERFORMANCE IMPROVEMENT INITIATIVES

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

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

Priorities identified include:

- Top decile quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
    - Perfect Care Experience

- Sustain a Just Culture philosophy that promotes a culture of safety, transparency, and system improvement
    - Participate in Beta HEART (healing, empathy, accountability, resolution, trust) program

- Ensure Patient Safety across the entire Health System with a focus on High Reliability Organizational thinking
    - Preoccupation with failure
    - Reluctance to simplify
    - Sensitivity to operations
    - Deference to expertise

        - Commitment to resilience

- Implement user friendly incident reporting system with a goal to increase reporting of events
- Identify best practice plan related to Co-Management of Hospitalized Patients
- Support Patient and Family Centered Care and the Patient and Family Advisory Council
    - Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
    - Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
    - Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
    - Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.
- Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
- Identify gaps in the Epic electronic health record implementation and develop plans of correction
- Maximize Epic reporting functionality to improve data capture and identification of areas for improvement
- Achieve Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Project Initiatives

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

BETA HEART℠
Healing • Empathy • Accountability • Resolution • Trust

Year One
Opt-In Agreement

Overview
BETA Healthcare Group (BETA) through a coordinated effort, guides member healthcare organizations through the implementation of a reliable and sustainable culture of safety that is grounded in a philosophy of HEART: **H**ealing, **E**mpathy, **A**ccountability, **R**esolution, and **T**rust.

The overall goals of the program are to develop an empathic and clinically appropriate process that supports healing of both the patient and clinician after an adverse event. BETA HEART℠ (HEART), seeks to ensure accountability for the development of reliable systems that support the provision of safe care; provide a mechanism for early, ethical resolution when harm occurs as a result of medical error or inappropriate care; and instill trust of all clinicians and patients.

BETA HEART, a multi-year program is an interactive and collaborative process that supports organizational leadership and staff in the development of a true culture of safety and transparency. The program will encompass strategies to achieve the following:

- Administration of a scientifically validated, psychometrically sound culture of safety survey and sharing of results utilizing a debrief methodology
- A process for early identification and rapid response to adverse events to include an investigatory process that integrates human factors and systems analysis while applying Just Culture principles
- A commitment to honest and transparent communication with patients and family members after an adverse event
- An organizational program that ensures support for caregivers involved in an adverse event
- A process for early resolution when harm is deemed a result of inappropriate care or medical error

Incentive Structure
Members are required to opt in and meet specific requirements to be considered HEART members. With full participation, HEART members will have the opportunity to qualify for a contribution renewal credit of up to 10%.

Renewal credits will be based on meeting specified criteria within each domain and include the following:

Domain	Incentive/Renewal Credit
Culture measurement and debrief	2%
Comprehensive process for early identification and investigation of harm events	2%
Core team measured and developed in empathic communication techniques. Formal disclosure process in place	2%
Care for the Caregiver program (C4C)	2%
Early resolution process	2%
Total potential renewal credits	**10%**

Coverage Modifications
Members that meet all BETA HEART domain components, confirmed through an annual validation survey, will receive policy modifications that require a minimum deductible of $15,000, indemnity and expense, and a pre-claim self-insured retention (SIR) of $30,000. This SIR and other coverage modifications will provide the structure and incentives that support the early resolution component of BETA HEART. Additional coverage modification details are available upon request.

Timeline
- Members must opt in by October 15, 2017 and participate in all aspects of BETA HEART to be eligible to apply for annual renewal credits, beginning with policy year 2018
- Domain specific workshops will be held quarterly starting in the first quarter of 2018
- Validation assessments by BETA Risk Directors will take place annually in April and May

BETA Responsibilities
- Develop and coordinate overall program structure, implementation guideline, and toolkits
- Conduct an organizational readiness assessment and gap analysis
- Host three two-day workshops, led by expert faculty in each of the defined domains
- Host monthly collaborative calls/webinars
- Set measurement criteria that will be used to evaluate the participating member's eligibility for renewal credits
- Complete an annual validation survey and provide member/insured with results
- Provide ongoing support and consultation

HEART Member Responsibilities
- Obtain commitment to implement all HEART domains from executive leadership as evidenced by a signature on the Opt-In Agreement
- Identify a project leader and key contact
- Participate in a gap analysis and complete a readiness assessment prior to Workshop One
- Administer a scientifically validated, psychometrically sound culture of safety survey annually
    - Members may use results obtained through surveys administered within six months prior to Workshop One (scheduled for Q1 2018).
    - If the culture survey was not completed within six months prior to Workshop One, the HEART member will administer a scientifically validated and psychometrically sound culture of safety survey (such as SCOR-E, SAQ, AHRQ HSOPS) prior to Workshop Two.
    - BETA strongly encourages and will sponsor the SCOR-E Survey Instrument for HEART members fully committed to survey administration. Survey administration will take place in spring, 2018.
    - Members electing to use the SCOR-E Survey will communicate their commitment to doing so at the time of opting in.
- Core Team Members will complete a communication assessment prior to Workshop Two
- Attend all fundamentals workshops as a team, which will include at a minimum: an executive leader, physician leader, nursing leader, risk manager or patient safety officer. Members are encouraged to send additional staff, up to a total of six, that will take key roles in implementing the domain specific strategies addressed at each workshop. As an example, additional participants may include culture administration leads, quality leaders, communication resource team members and designated caregiver support champions.
    - Subsequent to workshop attendance, implement domain-specific strategies as defined in the individual domain criteria
- Participate in monthly collaborative calls/webinars
- Provide program related metrics
- Participate in the validation process

Getting Started
Organizations must opt in annually to BETA HEART. Opting in indicates your responsibility and commitment to participate in all aspects of BETA HEART that are noted above and detailed in steps one through three on the pages that follow. Please review the full program description prior to opting in.

Regardless of your level of participation in BETA HEART, all members will have access to the educational workshops designed to address individual HEART domains. As a benefit to organizations that opt into the full program, workshop related expenses are covered as per BETA's Workshop Travel Expense Policy.

Step One: Preliminary and Annual Assessments

Preliminary assessments will be completed prior to Workshop One scheduled to be held in Q1 2018:

Readiness Assessment
Upon receipt of the organization's Opt-In Agreement, a change readiness self-assessment will be sent to several groups within the HEART member organization and may include:

- Executive leadership team
- Medical staff – including leadership, attending physicians and resident physicians (if residency program)
- Vice presidents for clinical services
- Senior leadership
- Safety, Risk Management, Quality, Legal and Ethics personnel
- Unit/department managers
- Unit/department directors and educators
- Members of the Patient and Family Advisory Group

Change readiness assessments must be completed and returned to BETA for analysis before November 15, 2017. Change readiness assessment results are an integral part of the gap analysis that will follow.

Gap Analysis
BETA will conduct a gap analysis for each HEART participant. In addition to the gap analysis, BETA completes an off-site review of specific program related organizational policies and procedures. Following this analysis, BETA conducts on-site, facilitated focus group discussions, findings which are organized in a SWOT analysis matrix. These focus groups are conducted to identify: strengths, weaknesses, opportunities, and threats. The senior leaders at your organization will receive the confidential gap analysis results.

Annual and Periodic Assessments:

Culture of Safety Survey
All participants must complete an annual scientifically validated, psychometrically sound culture of safety survey (SCOR-E, SAQ, AHRQ HSOPS), analyze results, and share their results in focus group setting(s) utilizing a debrief model.

- If the culture survey was not completed six months prior to Workshop One, the HEART member will administer a scientifically validated and psychometrically sound culture of safety survey (such as SCOR-E, SAQ, AHRQ HSOPS) prior to Workshop Two.
- BETA will sponsor the SCOR-E integrated survey tool for members and insureds who opt into HEART. For purposes of comparison measurement over time, we strongly encourage HEART participants to utilize the SCORE-E Survey instrument.

Communication Assessment
BETA HEART depends upon good communicators to deliver person-centered messages to patients and staff involved in patient harm events. Some staff will communicate more consistently and skillfully than others. HEART Core Team Members will complete a communication assessment and receive written results prior to Workshop Two. The organization will receive aggregated assessment results along with interpretation and instructions for applying the results to the organization's HEART program.

Step Two: Organizational Learning: Introduction to Individual Domains Through Consecutive Workshops

During 2018, BETA will host HEART workshops. Each workshop, two days in length, introduces HEART members to individual HEART domains. The workshops held on a quarterly basis require HEART members to send a minimum of four attendees comprised of organizational, medical staff and nursing executive leadership as well as risk management/patient safety leaders to participate in the workshops. HEART members are encouraged to send additional staff, up to a total of six, that will take leadership roles in implementing the domain specific strategies addressed at each workshop. Appropriate additional attendees may include culture administration leads, communication resource team members and designated caregiver support champions.

BETA HEART Fundamentals Workshop
Workshop One: Q1 – 2018 Day One - Culture: Creating a “fair and accountable culture” in the context of high reliability/identification, reporting, and investigation of adverse events. This workshop includes an overview of the measurement and analysis of staff perceptions of safety and employee engagement using validated survey instrument.
Workshop One: Q1 – 2018 Day Two - Rapid Response to Harm Events Introduction to human factors and cognitive ergonomics in medicine
Workshop Two: Q2 – 2018 Day One - Person-Centered, Empathic Communications Introduction to person-centered communications, including simulated conversations with patients and family members after harm, and support for caregivers after harm Simulated conversations will entail increasing complexity in communication and transparency
Workshop Two: Q2 – 2018 Day Two - Care for Caregiver Overview of care for caregiver program development
Workshop Three: Q3 – 2018 Day One - Early Resolution Introduction to the Early Resolution process

After each workshop, HEART members are expected to implement the distinct strategies designed to instill core competencies that the workshops provide. After completing all workshops, HEART members will be able to implement the comprehensive suite of BETA HEART domains fully.

Step Three: Monitoring Effectiveness/Organizational Metrics

HEART members are required to evaluate and measure, on an ongoing basis, the level to which they implement strategies and will assess the effectiveness of the program’s implementation. In addition to organizational culture measurement strategies, HEART members in collaboration with BETA personnel will select, at the time of opting in, a minimum of two additional measurements by which they will evaluate the impact of HEART implementation.

Validation Process

- Ongoing measurement of organizational metrics defined at the time of opting in will be evaluated on a quarterly basis. Results of each will be shared with BETA.
- HEART members will repeat a culture of safety survey one year after conducting the preliminary survey. Results will be analyzed and debriefings completed at all levels of the organization, evidence of which will be provided to BETA.
- BETA will complete onsite validation assessments measuring the extent to which the member/insured has successfully achieved individual HEART domain criteria.
- Validation assessments will be completed and findings provided to the member at least one month prior to contract/policy renewal.
- The results of the validation assessment will determine the incentive/renewal credit the HEART member receives.

BETA HEART℠

Healing • Empathy • Accountability • Resolution • Trust

Year One
Opt-In Agreement

_____

(Facility/Organization name)

would like to take advantage of the opportunity to opt into and participate in BETA Healthcare Group's HEART program.

By signing below, the following executive and key leaders indicate their commitment to full participation in and support of implementation of BETA HEART.

Your organization must provide following information to BETA Healthcare Group at the time of opting in.

Title	Name	Signature	Phone Number	Email address
Chief Executive Officer				
Chief Operating Officer				
Chief Nurse Executive				
Chief Financial Officer				
Chief Medical Officer				
Chief of Staff				
Director, Human Resources				
Risk Director/Manager				
Patient Safety Officer				
Physician Lead for Patient Safety (if not PSO)				
Quality Mgmt./PI Leader				
Culture Survey Champion				
Organizational HEART Project Leader/Contact				
Patient Relations/ Experience Leader				

BETA will sponsor SCORE Integrated Survey for all BETA HEART participants in spring, 2018.

All members participating in SCORE must indicate their interest at the time of opting in.

_____

(Facility/Organization name)

( ) will ( ) will not participate in SCORE Integrated Survey administration in 2018.

Number of licensed beds = _____ (indicate acute, SNF, behavioral health, etc.) Average daily census _____

Your signature below indicates your organization's interest to opt in to BETA Healthcare Group's HEART program and commitment and agreement to actively participate in all components of said program.

By signing below, you agree to complete all preliminary assessments prior to implementation of training and to send an organizational team as referenced in the Opt-In Agreement to participate in all workshops.

Name (Printed) **Chief Executive Officer/Chief Operating Officer**	**Signature**	**Date**

To opt-in, the above form and this signature page must be completed and along with the most recent culture of safety survey results, must be submitted by October 15, 2017 to Brenda McGuire, Project Director at Brenda.McGuire@betahg.com or via fax at 925-838-6088.

For questions regarding BETA HEART, contact Deanna Tarnow, Director of Risk Management & Patient Safety at deanna.tarnow@betahg.com.

Beta HEART Program Update

HEART = Healing, Empathy, Accountability, Resolution, Trust

Dawn Lockwood, Patient Safety Specialist

- 7 TFHD staff, including 2 providers and CMO, attended Beta HEART Conference #1 in February
    - Focus on Culture of Safety and initial discussion of Rapid Response to Events

- SCORE (*Safety, Communication, Operational Reliability, and Engagement)* Culture of Safety Survey completed in March
    - 64% response rate, with 48 providers
    - Preliminary results have been received: we are in the process of reviewing and analyzing the data, then presenting to leadership team
    - Leadership will be sharing department specific results with staff and developing action plans

- Next Beta HEART conference scheduled for May 9-10
    - Focus on Rapid Event Response, Care for the Caregiver, and in depth Communication and Transparency training
    - Team includes 5 TFHD staff and 3 providers

- Future conference in early September

EDMUND G. BROWN JR.
GOVERNOR

State of California
HEALTH AND HUMAN SERVICES AGENCY

DIANA S. DOOLEY
SECRETARY

January 31, 2018

Dear Hospital CEO,

On behalf of Smart Care California, I am pleased to recognize your hospital with a 2017 achievement award for achieving the Healthy People 2020 target for low-risk, first-birth Cesarean sections (C-sections). By reaching this target, your team is delivering safer and more affordable care for Californians.

Smart Care California is a public-private partnership that promotes safe and accessible health care. It is co-chaired by the California Department of Health Care Services, Covered California, and the California Public Employees Retirement System. Together, the groups leading and participating in Smart Care California purchase or manage health care for 16 million Californians, or 40 percent of the covered lives in California.

To receive this award, a California hospital must have achieved a C-section rate of 23.9 percent or lower for low-risk, first-birth deliveries. This year, we are recognizing 111 hospitals that have achieved the goal, which is up from the 104 hospitals recognized for the inaugural award last year. In future years, we hope to be able to give this award to all 242 maternity hospitals in California.

Please extend our congratulations to all of your hospital's physicians, nurses, midwives, other clinical staff, and administrators who have made this achievement possible. I also encourage you to share the news of your award with your patients and in your community.

Sincerely,

Diana S. Dooley

Diana S. Dooley
Secretary

Aging
Child Support Services
Community Services and Development
Developmental Services
Emergency Medical Services Authority
Health Care Services
Managed Health Care
Office of Law Enforcement Services
Office of Patient Advocate
Office of Systems Integration
Public Health
Rehabilitation
Social Services
State Hospitals
Statewide Health Planning and Development

1600 Ninth Street · Room 460 · Sacramento, CA 95814 · Telephone (916) 654-3454 · Fax (916) 654-3343
Internet Address: www.chhs.ca.gov

SMART CARE CALIFORNIA

Tahoe Forest Hospital District

2017 Achievement Award

For Meeting or Exceeding the Healthy People 2020 Target for Low-Risk, First-Birth Cesarean Deliveries

To receive this award, a California hospital must achieve a Cesarean section (C-section) rate of 23.9 percent or lower for low-risk, first-birth deliveries. The award is based on 2016 data reported by hospitals to the Office of Statewide Health Planning and Development and the California Department of Public Health-Vital Records.

Diana S. Dooley

Secretary, California Health and Human Services Agency

Sentinel Event Alert

A complimentary publication of The Joint Commission
Issue 57, March 1, 2017

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

Please route this issue to appropriate staff within your organization. *Sentinel Event Alert* may be reproduced if credited to The Joint Commission. To receive by email, or to view past issues, visit www.jointcommission.org.

The essential role of leadership in developing a safety culture

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

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

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

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

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

The Joint Commission

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

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

Safety culture foundation

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

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

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

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

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

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

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

Actions suggested by The Joint Commission

The Joint Commission recommends that leaders take actions to establish and continuously improve the five components of a safety culture defined by Chassin and Loeb: ***trust, accountability, identifying unsafe conditions, strengthening systems, and assessment.***[18] These actions are not intended to be implemented in a sequential manner. Leaders will need to address and apply various components to the workforce simultaneously, using tactics such as board engagement, leadership education, goalsetting, staff support, and dashboards and reports that routinely review safety data.[12]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Safety Culture Key to High Reliability

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

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

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

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

LD.03.01.01: Leaders create and maintain a culture of safety and quality throughout the organization.

EP 1. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.

EP 4. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.

EP 5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

Resources
Hospital Survey on Patient Safety Culture (HSOPS) – Identifies 12 dimensions of safety culture (10 climate dimensions and two outcomes variables):[53]

- Communication openness
- Feedback and communication about error
- Frequency of events reported
- Handoffs and transitions
- Management support for patient safety
- Non-punitive response to error
- Organizational learning (continuous improvement)
- Overall perceptions of safety
- Staffing
- Supervisor/manager expectations and actions promoting safety

- Teamwork across units
- Teamwork within units

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

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

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

- Leadership commitment
- Safety culture
- Performance improvement

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

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

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

Safety Culture Project, The Joint Commission Center for Transforming Healthcare – Seven participating organizations focused on identifying unsafe conditions before they reached the patient and finding reliable, sustainable solutions. The organizations found that reporting back to team members about how their suggestions improved care increased team member satisfaction, particularly if the feedback included praise, either public or private as appropriate, for those who spoke up.[29] The project utilized The Joint Commission's Robust Process Improvement® (RPI®), a blended approach to improve business and clinical processes and outcomes using Lean, Six Sigma and change management methodologies. RPI is intended for all staff, including leaders.

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

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

PSNet
PATIENT SAFETY NETWORK

Patient Safety Primer Last Updated: November 2017

High Reliability

Background

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

Characteristics of High Reliability Organizations

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

Table. Characteristics of High Reliability.

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

	organizational state—i.e., what is going on around them—and how the current state might support or threaten safety.
Deference to Expertise	People in HROs appreciate that the people closest to the work are the most knowledgeable about the work. Thus, people in HROs know that in a crisis or emergency the person with greatest knowledge of the situation might not be the person with the highest status and seniority. Deference to local and situation expertise results in a spirit of inquiry and de-emphasis on hierarchy in favor of learning as much as possible about potential safety threats. In an HRO, everyone is expected to share concerns with others and the organizational climate is such that all staff members are comfortable speaking up about potential safety problems.
Commitment to Resilience	Commitment to resilience is rooted in the fundamental understanding of the frequently unpredictable nature of system failures. People in HROs assume the system is at risk for failure, and they practice performing rapid assessments of and responses to challenging situations. Teams cultivate situation assessment and cross monitoring so they may identify potential safety threats quickly and either respond before safety problems cause harm or mitigate the seriousness of the safety event.
*HROs: High reliability organizations Sources: Weick et al 2007; Hines et al 2008; Chassin et al 2013; Rochlin 1999.	

Current Context

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

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

Editor's Picks

CASE

Wrong-side Bedside Paravertebral Block: Preventing the Preventable

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PERSPECTIVE

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