TAHOE FOREST
HOSPITAL DISTRICT

Meeting Book - 2026-02-11 Board Quality Committee

Wednesday, February 11, 2026, at 12:00 p.m.

Aspen Conference Room – Tahoe Forest Hospital

10800 Donner Pass Rd, Suite 200, Truckee, CA 96161

Meeting Book - 2026-02-11 Board Quality Committee

TAHOE FOREST
HOSPITAL DISTRICT

QUALITY COMMITTEE
AGENDA

Wednesday, February 11, 2026, at 12:00 p.m.
Aspen Conference Room – Tahoe Forest Hospital
10800 Donner Pass Rd, Suite 200, Truckee, CA 96161

1. CALL TO ORDER

2. ROLL CALL
Alyce Wong, Chair; Rob Darzynkiewicz, MD, 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◈: 11/06/2025 ..... ATTACHMENT

6. CLOSED SESSION

6.1. Hearing (Health & Safety Code § 32155)
Subject Matter: Case Review
Number of items: One (1)

6.2. Hearing (Health & Safety Code § 32155)
Subject Matter: 2025 Case Review Summary Report
Number of items: One (1)

6.3. Approval of Closed Session Minutes◈
6.3.1. 11/06/2025 Closed Session Board Quality Committee

7. OPEN SESSION

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

9. INFORMATIONAL REPORTS

9.1. Patient & Family Centered Care

9.1.1. Patient & Family Advisory Council (PFAC) Update
Quality Committee will receive a brief verbal update on the initial calendar year activities of the Patient and Family Advisory Council (PFAC).

◈ Denotes Action Item

10. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION ◈

10.1. Safety First ..... ATTACHMENT
Review and discuss the significance of accurate patient weights.

10.2. Board Quality Committee Charter and Goals ..... ATTACHMENT
The Committee will review the Board Charter and Goals. The Committee will recommend updates are approval for Calendar Year 2026.

10.3. Quality Assessment Performance Improvement (AQPI-05) ..... ATTACHMENT
The Committee will review the QA PI plan and attachments and provide input on the 2026 attachments.

10.4. Available CAH Services, AGOV-06 Policy ..... ATTACHMENT
The Committee will review the policy and recommend approval of the TFH and IVCH services as listed.

10.5. CAH National Patient Safety Goals ..... ATTACHMENT
The Committee will Review the National Patient Safety Goals and provide an update on the strategies to address each goal at TFHD.

10.6. Quality / Patient Safety / Risk Roundtable
The Committee will conduct roundtable discussion on insights, identification of emerging challenges, and strategic opportunities to enhance care delivery and organizational safety culture.

10.7. Board Quality Education ..... ATTACHMENT
The Committee will review the educational article listed below and discuss topics for future board quality education.

American Hospital Association. *Learnings from AHA's Quality Collective* (2024).

11. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

12. NEXT MEETING DATE

The next committee date and time will be confirmed for May TBD, 2026 at 1200 p.m.

13. ADJOURN

◈ Denotes Action Item

TAHOE FOREST
HOSPITAL DISTRICT

QUALITY COMMITTEE
DRAFT MINUTES

Thursday, November 6, 2025 at 12:00 p.m.
Aspen Conference Room – Tahoe Forest Hospital
10800 Donner Pass Rd, Suite 200, Truckee, CA 96161

1. CALL TO ORDER
Meeting was called to order at 12:00 p.m.

2. ROLL CALL
Board Alyce Wong, Chair; Robert Darzynkiewicz, Board Member

Staff in attendance: Anna Roth, President & CEO; Dr. Brian Evans, Chief Medical Officer; Janet Van Gelder, Director of Quality & Regulations; Tena Mather, _____; Jan Iida, Chief Nursing Officer; Christine O'Farrell, Risk Manager; Sarah Jackson, Executive Assistant / Clerk of the Board

Other: Mr. Kevin Ward, PFAC representative.

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

4. INPUT – AUDIENCE
None

5. APPROVAL OF MINUTES OF: 08/21/2025
Director Darzynkiewicz moved to approve the Open Session Board Quality Committee Minutes of August 21, 2025, seconded by Director Wong.

Open Session recessed at 12:01 p.m.

6. CLOSED SESSION
6.1. Hearing (Health & Safety Code § 32155)
Subject Matter: Case Review
Number of items: One (1)
Discussion was held on a privileged item.
6.2. Approval of CLOSED Session Minutes
6.2.1. 05/07/2025 Closed Session Board Quality Committee
6.2.2. 08/21/2025 Closed Session Board Quality Committee

7. OPEN SESSION
Open Session reconvened at 12:15 p.m.

8. REPORT OF ACTIONS TAKEN IN CLOSED SESSION

No reportable actions for 6.1. Item 6.2.1 and 6.2.2. Closed Session Minutes of May 7, 2025 and August 21, 2025 were recommended for approval.

9. INFORMATIONAL REPORTS

9.1. Patient & Family Centered Care

9.1.1. Patient & Family Advisory Council (PFAC) Update

Quality Committee review the attached update related to the activities of the Patient and Family Advisory Council (PFAC).

Discussion was held. Board members had previously requested feedback from the PFAC to be presented to the Committee. The Clinical Patient Experience Advisor has been summarizing the PFAC Committee feedback in the report.

The PFAC will be presenting their annual report to the Board of Directors at the December 18, 2025 Board Meeting.

The CEO has recommended inclusion of a PFAC member in various hospital committees and evaluations. PFAC member Alan Kern has been invited to join the IT Decision committee and was requested to attend the Virginia Mason Learning Institute field trip.

Mr. Kevin Ward, PFAC representative joined the meeting at 12:22 p.m.

Mr. Ward shared the change of the committee from the original purpose to give a voice to the patients to active involvement of the patient in the direction of the Health System.

9.2. Patient Safety

9.2.1. BETA HEART Program Progress Report

Janet Van Gelder, Director of Quality & Regulations Quality Committee provided a progress report regarding the BETA Healthcare Group Culture of Safety program.

Discussion was held. This year will be a Pulse survey which will be 10-12 Departments versus the whole Health System.

10. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

10.1. Safety First

Review and discuss the Interpreter services available at Tahoe Forest Health System.

Janet Van Gelder, Director of Quality & Regulations Quality Committee provided a history of the Safety First flyers and weekly reports. Ashley Davis creates the Safety First.

Damara Stone through Education is creating an interpreter service certification. The certified staff member will receive a certification pay differential and will replace the language line iPad where appropriate.

Feedback has been universally positive towards adoption of this service.

10.2. Board Quality Committee Charter and Goals

The Committee will review and provide input on the Board Quality Committee Charter and goals.

Director Wong reviewed the Draft charter. She requested any final edits before requesting adoption.

Director Darzynkiewicz moved to approve the adopt draft Board Quality Committee Charter and send to November Board Meeting for approval, seconded by Director Wong.

10.3. Health Equity Report

The Committee will review the health equity summary report required by AB1204 and posted on the tfhd.com website.

Tena Mather, Clinical Quality Analyst reviewed the Health Equity Report. She reviewed the data that required to be submitted to HCAI. Based on our data we only have 5 disparities to report and address.

Extensive discussion was held regarding the data and reporting requirements.

Board Members requests that an update be provided quarterly on the Health Equity Report.

10.4. Quality / Patient Safety / Risk Roundtable

The Committee will hold discussion on insights, identification of emerging challenges, and strategic opportunities to enhance care delivery and organizational safety culture.

Director Darzynkiewicz opened roundtable discussion on the Third Next Available Appointments as an agenda topic for the Board Quality Committee. Discussion was held was held on the Access to Care project.

Extensive discussion was held regarding process improvement, quality & regulations departmental work, operational work versus and regulatory requirements.

Dr. Aaron Gladman joined the meeting at 12:54 pm

10.5. Board Quality Education

The Committee will review the educational article listed below and discuss topics for future board quality education.
Kennedy, M., et. al. *Reach and Adoption of a Geriatric Emergency Department Accreditation Program in the United States.* Ann Emerg Med. 2022 April; 79(4): 367–373.

Dr. Gladman provided education on why pursing a Geriatric Emergency Department Accreditation is important.

There are 3 levels, Bronze, Silver, Gold or Levels III, II, I. Bronze or Level III Geriatric Emergency Department has 6 criteria, and Silver and Gold both have increased criteria.

Extensive discussion was held about GEDA vs CMS Age Friendly Certifications. He believes that TFH should be able to receive this accreditation by the end of this Fiscal Year.

Dr. Aaron Gladman departed the meeting at 1:12 pm

11. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

12. NEXT MEETING DATE
The next committee date and time will be confirmed for February XX, 2026 at 1200 pm.

13. ADJOURN
Meeting adjourned at 1:32 p.m.

Safety First

tip of the week

Significance of Accurate Patient Weights

Accurate patient weight is critical for safe care. It ensures correct medication dosing, supports nutritional assessment, and helps monitor fluid balance. In pediatrics, weight also tracks growth. Missing or inaccurate weights can lead to significant dosing errors, especially in vulnerable populations such as oncology, elderly, pediatric, and neonatal patients, whose weights may change frequently.

Barriers include emergency admissions, non-ambulatory patients, and lack of appropriate scales (e.g., bed or wheelchair scales). When actual weights aren't obtained, practitioners often estimate—an approach proven to be unreliable.

Recommendations

1. **Weigh and document the weight of each patient as soon as possible on admission and during each outpatient or emergency department encounter. Ask patients to remove heavy articles of clothing (i.e boots, jackets, items in pockets)**
2. **Avoid the use of a stated, estimated, or historical weight. Do not rely on a patient's stated weight, a healthcare provider's estimated weight, or a documented weight from a previous encounter.**
3. Weigh patients at risk for weight changes such as neonates and oncology more frequently and according to policy.
4. Have appropriate metric scales (e.g., standing scales, chair scales, beds/stretchers with scales, built in floor scales) available in all areas where patients are admitted or encountered.
5. Implement automated decision support (CDS) rules to alert practitioners to significant changes in patient weight (e.g., a 10% or greater change for patients younger than 1 year).
6. For patients under 18 years of age, implement CDS to rules compare entered weight with expected weight (e.g., based on growth charts) and alert practitioners to unexpected discrepancies.
7. Ensure that printed material, information system screens, medication device screens (e.g., infusion pumps), and order sets list or prompt for the patient's weight

Source: www.nccmerp.org

Questions? **Call the Quality Department** Janet Van Gelder x6629, Ashley Davis x6635, Christine O'Farrell x6637, Alix Bezaire x6423, Tena Mather x6764, Svieta Schopp x8231, Stephen Hicks x3272

Charter

Quality Committee
Tahoe Forest Hospital District
Board of Directors

PURPOSE:

The purpose is to define the duties, responsibilities, and scope of authority of the Quality Committee.

RESPONSIBILITIES:

The Quality Committee serves as the standing committee of the Board of Directors, providing oversight of Quality Assessment and Performance Improvement (QAPI), assuring the delivery of high-quality care, promotes patient safety, and enhances the overall patient experience across the Health System.

DUTIES:

1. Recommend to the governing Board, action items and recommendations regarding any policies and procedures governing quality, patient safety, environmental safety, and performance improvement throughout the organization.
2. Assure the provision of organization-wide quality of care, treatment, and service provided and prioritization of performance improvement throughout the organization.
3. Steward the improvement of care, treatment, and services to ensure that it is safe, beneficial, patient-centered, customer-focused, timely, efficient, and equitable and it reflects the community.
4. Monitor the organization's performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities adheres to the mission, vision, and values.
5. Whenever quality goals/benchmarks are not met, recommend corrective actions to the governing Board to address deficiencies, mitigate risks, and improve performance.
6. Ensure the development and implementation of ongoing board education, focusing on service excellence, performance improvement, risk reduction/safety enhancement, and healthcare outcomes.

COMPOSITION:

The Committee is comprised of at least two (2) board members as appointed by the Board Chair, the Medical Director of Quality, and Vice Chief of Staff or designee.

MEETING FREQUENCY:

The Committee shall meet quarterly.

REVISED – Approved by the TFHD Board of Directors 11/20/2025

Status **Draft** PolicyStat ID **19296284**

Origination Date	N/A
Last Approved	N/A
Last Revised	N/A
Next Review	N/A

Department	Quality Assurance / Performance Improvement - AQPI
Applicabilities	System, Truckee Surgery Center

Quality Assessment/ Performance Improvement (QA/PI) Plan, AQPI-05

RISK:

~~Organizations who respond reactively, instead of pro-actively, to unanticipated adverse events, and/or outcomes, lack the ability to mitigate organizational risks by reducing or eliminating contributing factors. This is a risk for poor quality care and patient outcomes.~~

Risks to patient safety, clinical outcomes, operational efficiency, and regulatory compliance may arise from variations in care delivery, human factors, system failures, environmental conditions, or breakdowns in communication. These risks have the potential to result in patient harm, decreased quality of care, workflow inefficiencies, financial loss, or reputational damage if not proactively identified and managed.

POLICY:

The Quality Assessment/Performance Improvement (QA/PI) plan provides 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. An effective plan will pro-actively mitigate organizational risks by eliminating, or reducing factors that contribute to unanticipated adverse events and/or outcomes, in order to provide the highest quality care and service 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 High Reliability principles 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~~winning aspirations model, which are utilized to guide all improvement activities.

MISSION STATEMENT

The mission of Tahoe Forest Health System is *"To enhance the health of our communities through excellence and compassion in all we do*."

VISION STATEMENT

The vision of Tahoe Forest Health System is *"To strive to be the health system of choice in our region and the best mountain health system in the nation."*

VALUES STATEMENT

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

A. Quality – holding ourselves to the highest standards, committing to continuous improvement, and having personal integrity in all we do
B. Understanding – being aware of the concerns of others, demonstrating compassion, respecting and caring for each other as we interact
C. Excellence – doing things right the first time, every time, and being accountable and responsible
D. Stewardship – being a community partner responsible for safeguarding care and management of health system resources while being innovative and providing quality healthcare
E. Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do

WINNING ASPIRATIONS

A. Our winning aspirations includes:
    1. Community – aspire to be an integrated partner in an exceptionally healthy and thriving community
    2. Service – aspire to deliver a timely, outstanding patient and family experience
    3. Quality – aspire to deliver the best possible outcomes for our patients
    4. People – aspire for a highly engaged culture that inspires teamwork and joy
    5. Finance – aspire for long-term financial strength

PERFORMANCE IMPROVEMENT INITIATIVES

A. The ~~2025~~2026 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the ~~Quadruple~~Quintriple Aim (IHI, 2022):

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving ~~the~~population health ~~of populations~~;
3. Reducing the per capita cost of health care;
4. ~~Staff engagement and joy in work.~~
5. Improving workforce well-being;
6. Advancing health equity.

B. Priorities identified include:

1. Exceed national ~~benchmark with~~benchmarks for quality of care and patient satisfaction ~~metric results with a focus~~by focusing on process improvement and performance excellence .
    a. ~~Striving for the Perfect Care Experience~~
    b. Achieve bronze level Geriatric Emergency Department accreditation (GEDA)
    c. Strengthen access to care and provider capacity by reducing appointment delays and improving same day access
    d. Highlight standard work process improvement, utilizing improvement science principles, to improve quality, access, and efficiency
    e. Emphasis on health equity in order to attain the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (Health equity | CMS).
    f. Identify and promote best practice and evidence-based medicine in every service line
    g. Focus on CMS quality ~~star~~Star rating improvements, within the measure groups~~,~~ that fall below benchmark
    h. ~~Highlight Management Systems and standard work process improvement, utilizing lean principles, to improve quality, access, and efficiency~~
    i. ~~Emphasis on health equity in order to attain the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (Health equity | CMS).~~
    j. Improving care coordination and reducing avoidable readmissions and hospital transfers

2. ~~Continued focus on quality and patient/employee safety related to infectious diseases, following CDC, State, and County Health guidelines, and utilizing the following strategies:~~

~~a. Strengthen the system and environment~~
~~b. Support patient, family, and community engagement and empowerment~~
~~c. Improve clinical care~~
~~d. Reduce harm~~
~~e. Boost and expand the learning system~~Continued focus on quality and patient/ employee safety related to infectious diseases by adhering to State, County Health, and Federal requirements. These efforts will be supported through proactive prevention, early detection, rapid response, and ongoing education to protect patients, staff, and the wider community.

3. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial ~~General Acute~~Accreditation Commission for Health Care ~~Hospital Relicensing~~ (~~GACHLRS~~ACHC) ~~and Rural Health Clinic~~ re-accreditation survey
4. Sustain a culture of safety, transparency, accountability, and system improvement
    a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
    b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
    c. Continued focus on the importance of event reporting, including near misses
5. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
    a. Proactive, not reactive
    b. Focus on building a strong, resilient system
    c. Understand vulnerabilities
    d. Recognize bias
    e. Efficient resource management
    f. Evaluate system based on risk, not rules
6. Emphasis on achieving highly reliable health care through the following:
    a. A commitment to the goal of zero harm
    b. A safety culture, which ensures employees are comfortable reporting errors without fear of retaliation
    c. Incorporate highly effective process improvement tools and methodologies into our work flows
    d. Ensure that everyone is accountable for safety, quality, and patient experience
7. ~~Support Patient and Family Centered Care and the Patient and Family Advisory Council~~
    ~~a. 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.~~

~~b. 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.~~

~~c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.~~

~~d. 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.~~

8. ~~Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies~~
9. Integrate Patient and Family Centered Care principles to promote dignity, transparent communication, meaningful participation, and collaborative decision-making. Through engagement of patients, families, and the Patient and Family Advisory Council, the health system enhances care quality, safety, access, and the overall patient experience.
10. Identify areas for system improvement based on patient, family, and community input
11. Implement system-wide changes in strategy, structure, processes, culture, and leadership to adapt to external drivers such as market demands, technology advancements, and public health emergencies. Identified initiatives focus on improving employee engagement, performance, and innovation through structured change management, strong leadership alignment, and HR-supported transition planning to ensure sustainable, organization-wide improvement.
12. Utilize improvement science principles to streamline work-flows, reduce waste, improve efficiency, and enhance patient-centered care through continuous performance improvement.
13. Maximize Epic reporting functionality to ~~improve~~enhance data capture ~~and identification of areas for~~, strengthen clinical and operational visibility, and more effectively identify opportunities for quality improvement.
14. ~~Develop an enterprise wide data governance strategy~~Develop an enterprise-wide data clinical governance, and Business Intelligence strategy to ensure consistent data standards, improve data quality, support regulatory compliance, and strengthen organizational decision-making.

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

ORGANIZATION FRAMEWORK

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

Governing Board

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

B. The BOD has responsibility for ensuring that CAH services are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by CAH employees or indirectly by agreement or arrangement.

C. The BOD must take actions through the CAH's QA/PI Program to:

1. Assess services furnished directly by CAH staff, and those services provided under agreement or arrangement
2. Identify quality and performance problems
3. Implement appropriate corrective or improvement activities
4. Ensure monitoring and the sustainability of those corrective or improvement activities

D. The Board:

1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to Administration, Medical Staff, Management, and employees;
2. Responsible for determining, implementing, and monitoring policies governing the Critical Access Hospital (CAH) and Rural Health Clinic (RHC) total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment (CMS 485.627(a))
3. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
4. Provides direction for the organization's improvement activities through the development of strategic initiatives;
5. Evaluates the organization's effectiveness in improving quality through reports from Administration, Department Directors, Medical Executive Committee, and Medical Staff Quality Committee.

Administrative Council

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

B. Administrative Council ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.

C. Administrative Council has developed a culture of safety by embracing High Reliability tenets and has set behavior expectations for providing Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care (STEEEP^{TM}), supporting Triple Aim, and ensures compliance with regulatory, statutory, and contractual requirements.

Board Quality Committee

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

Medical Executive Committee

A. The Medical Executive Committee shares responsibility with the BOD Quality Committee, and the Administrative Council, for the ongoing quality of care and services provided within the Health System.

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

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

Department Chairs of the Medical Staff

A. The Department Chairs:
    1. Provide a communications channel to the Medical Executive Committee;
    2. Monitor Ongoing Professional Performance Evaluation (OPPE) and Focused Professional Performance Evaluation (FPPE) and make recommendations regarding reappointment based on data regarding quality of care;
    3. Maintain all duties outlined by appropriate accrediting bodies.

Medical Staff

A. The Medical Staff is expected to participate and support performance improvement activities.
B. The Medical Staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the Medical Staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the Departments will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.
C. The Medical Director of Quality (Director) provides physician leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the Medical Staff and Health System leaders, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the Medical Staff and engages them in improvement activities. The Director chairs the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Supervisors)

A. Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:
    1. Foster an environment of collaboration and open communication with both internal and external customers;
    2. Participate and guide staff to focus on patient safety, patient and family centered care, service recovery, and patient satisfaction;
    3. Advance the philosophy of High Reliability within their departments;
    4. Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process improvement activities for department-specific performance improvement initiatives;

5. Establish performance and patient safety improvement activities in conjunction with other departments;
6. Encourage staff to report any and all reportable events including "near-misses";
7. Participate in the investigation and determination of the causes that underlie a "near-miss" / Sentinel/Adverse Event/Error or Unanticipated Outcome and implement changes to reduce the probability of such events in the future.

Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing, and supporting, the *Code of Conduct* (ACMP-1901), and *Chain of Command for Medical Plan of Care* (ANS-1404) policies. All employees must feel empowered to report, correct, and prevent problems.

B. The multidisciplinary Patient Safety Committee consists of staff from each service area. This Committee will assist with quality, patient safety, patient experience, and infection prevention. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve practice across the Health System.

C. The multidisciplinary Patient Experience Committee consists of staff from each service area. The Committee will assist with patient satisfaction, and service excellence. They will evaluate processes, provide recommendations, identify process improvement opportunities, and communicate their findings with peers to improve service excellence across the Health System.

D. Employees are expected to do the following:
    1. Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect care experience for patients and customers;
    2. Make suggestions/recommendations for opportunities of improvement or for a cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Director or Manager, the Director of Quality and Regulations, the Medical Director of Quality, or an Administrative Council Member.

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

With designated authority from the Medical Executive Committee, the Medical Staff Quality Assessment Committee (MS QAC) is responsible for prioritizing the performance improvement activities in the organization, chartering cross-functional teams, improving processes within the Health System, and supporting the efforts of all performance improvement activities. The MS QAC is an interdisciplinary committee led by the Medical Director of Quality. The committee has representatives from each Medical Staff department, Health System leadership, nursing, ancillary, and support services ad hoc. Meetings

are held at least quarterly each year.

The Medical Staff Quality Assessment Committee:

A. Annually review and approve the *Quality Assurance Performance Improvement Plan* (AQPI-05), *Medication Error Reduction Plan* (APH-34), *Medication Error Reporting* (APH-24), *Infection Control Plan* (AIPC-64), *Environment of Care Management Program* (AEOC-98), *Emergency Operations Plan* (AEOC-17), *Utilization Review Plan* (DCM-1701), *Discharge Plan* (ANS-238), *Risk Management Patient Safety Plan* (AQPI-04), *Employee Health Plan* (DEH-39), *Trauma Performance Improvement Plan*, *Home Health Quality Plan* (DHH-1802), and the *Hospice Quality Plan* (DHOS-1801).

B. Regularly reviews progress to the aforementioned plans;

C. Reviews quality indicator reports to evaluate patient care, and the delivery of services, and takes appropriate actions based on patient and process outcomes;

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

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

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

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

H. Reviews summaries and recommendations of Event Analysis/Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities;

I. Oversees the radiation safety program, including nuclear medicine and radiation oncology, and evaluates the services provided and makes recommendations to the MEC;

J. Oversees the Infection Control, Pharmacy & Therapeutics, and Antibiotic Stewardship program and monitors compliance with their respective plans;

K. Oversees the multidisciplinary Cancer Committee and monitors compliance with the Cancer Center quality plan;

L. Oversees the Trauma Program and monitors compliance with the Trauma Performance Improvement plan~~.~~;

M. Oversees the Stroke Program and monitors compliance with the Stroke QA/PI plan;

N. Oversees the Interdisciplinary Practice Committee (AQPI-2401) and RN standardized procedure approvals.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives within the Tahoe Forest Health

System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participate in performance improvement activities. Departmental Directors, or their designee, review assigned quality metrics annually at the PIC (See Attachment C – QA PI Reporting Measures). Performance improvement includes collecting data, analyzing the data, and taking action to improve. Director of Quality and Regulations is responsible for processes related to this Committee.

B. The Performance Improvement Committee will:
    1. Oversee the Performance Improvement activities including data collection, data analysis, improvement, and communication to stakeholders;
    2. Set performance improvement priorities that focus on high-risk, high volume, or problem prone areas;
    3. Guide the department to and/or provide the resources to achieve improvement;
    4. Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;
    5. Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

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

B. Performance Improvement Teams will:
    1. Follow the approved team charter as defined by the Administrative Council Members, or MS QAC
    2. Establish specific, measurable goals and monitoring for identified initiatives
    3. Utilize lean principles to improve processes, reduce waste, and eliminate inefficiencies
    4. Report their findings and recommendations to key stakeholders, PIC, and the MS QAC.

PERFORMANCE IMPROVEMENT EDUCATION

A. Training and education are essential to promote a culture of quality within the Tahoe Forest Health System. All employees and Medical Staff receive education about performance

improvement upon initial orientation. Employees and Medical Staff receive additional training on various topics related to performance improvement.

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

C. DMAIC (Define, Measure, Analyze, Improve, Control):
a. Define: identify the problem and project goals
b. Measure: collect data to understand current performance
c. Analyze: identify root causes of defects and issues
d. Improve: develop and implement solutions to address root causes
e. Control: monitor the improvement to sustain gains and ensure consistent performance

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

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

PERFORMANCE IMPROVEMENT PRIORITIES

A. The QA PI program is an ongoing, data driven program that demonstrates measurable improvement in patient health outcomes, improves patient safety by using quality indicators or performance improvement measures associated with improved health outcomes, and by the identification and reduction of medical errors.

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

1. Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
2. Processes that affect health outcomes, patient safety, and quality of care
3. Processes related to patient advocacy and the perfect care experience
4. Processes related to the Critical Access Hospital (CAH) National Patient Safety Goals (NPSGs)
5. Processes related to patient flow
6. Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome

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

1. Identified needs from data collection and analysis
2. Unanticipated adverse occurrences affecting patients
3. Processes identified as error prone or high risk regarding patient safety
4. Processes identified by proactive risk assessment
5. Changing regulatory requirements
6. Significant needs of patients and/or staff
7. Changes in the environment of care
8. Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/ SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:
    1. Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
    2. An external consultant is utilized to provide technical support, when needed.
    3. The design team develops or modifies the process utilizing information from the following concepts:
        a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
        b. It is clinically sound and current
        c. Current knowledge when available and relevant, i.e., practice guidelines, successful practices, information from relevant literature and clinical standards
        d. It is consistent with sound business practices
        e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
        f. Conducts an analysis, and/or pilot testing, to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
        g. Incorporates the results of:
            i. performance improvement activities
            ii. consideration of staffing effectiveness
            iii. consideration of patient safety issues
            iv. consideration of patient flow issues

4. Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
    a. identify the events it is intended to identify
    b. a documented numerator and denominator or description of the population to which it is applicable
    c. defined data elements and allowable values
    d. detect changes in performance over time
    e. allow for comparison over time within the organization and between other entities
    f. data to be collected is available
    g. results can be reported in a way that is useful to the organization and other interested stakeholders

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

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to pro-actively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:
    1. A Failure Mode and Effect Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.
    2. The Medical Staff Quality Committee, and other leadership committees, will recommend the processes chosen for proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the CAH National Patient Safety Goals (NPSGs).
        a. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.
        b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.
        c. Potential risk points in the process will be closely analyzed, including decision points and patient’s moving from one level of care to another through the continuum of care.
        d. For the effects on the patient that are determined to be “critical”, an event analysis/root cause analysis is conducted to determine why the effect may occur.
        e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure

modes.

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

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

3. Ongoing hazard surveillance rounds, including Environment of Care Rounds, and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
5. The Infection Preventionist, and Environment of Care Safety Officer, or designee, complete a written infection control and pre-construction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

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

1. Medication therapy
2. Adverse event reports
3. National patient safety goals
4. Infection control surveillance and reporting
5. Surgical/invasive and manipulative procedures
6. Blood product usage, including transfusions and transfusion reactions
7. Data management
8. Discharge planning
9. Utilization management
10. Complaints and grievances
11. Restraints/seclusion use
12. Mortality review
13. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
14. Needs, expectations, and satisfaction of individuals and organizations served, including:

a. Their specific needs and expectations
b. Their perceptions of how well the organization meets these needs and expectations
c. How the organization can improve patient safety
d. The effectiveness of pain management

15. Resuscitation and critical incident debriefings
16. Unplanned patient transfers/admissions
17. Medical record reviews
18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, QCentrix, NDNQI, HCAHPS, Care Compare, QualityNet, HSAG HIIN, MBQIP, HCAI, and Press Ganey, etc.
19. Summaries of performance improvement actions and actions to reduce risks to patients

B. In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:
    1. Quality measures delineated in clinical contracts will be reviewed annually
    2. Pharmacy transactions as required by law and to control and account for all drugs
    3. Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
    4. Records of radionucleotides and radiopharmaceuticals, including the radionucleotide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal
    5. Reports of required reporting to federal, state, authorities
    6. Performance measures of processes and outcomes, including measures outlined in clinical contracts

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

AGGREGATION AND ANALYSIS OF DATA

A. Tahoe Forest Health System believes that excellent data management, and analysis, are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, run charts (SPC), histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate.

B. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards and benchmarks, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and

promote a perfect care experience (See Attachment D for QI PI Indicator definitions).

C. The data is used to monitor the effectiveness and safety of services, and quality of care. The data analysis identifies opportunities for process improvement, and changes in patient care processes. Adverse patient events are analyzed to identify the cause, implement process improvement and preventative strategies, and ensure that improvements are sustained over time.

D. Data is analyzed in many ways including:

1. Using appropriate performance improvement problem solving tools
2. Making internal comparisons of the performance of processes and outcomes over time
3. Comparing performance data about the processes with information from up-to-date sources
4. Comparing performance data about the processes and outcomes to other hospitals, benchmarks, and reference databases

E. Intensive analysis is completed for:

1. Levels of performance, patterns or trends that vary significantly and undesirably from what was expected
2. Significant and undesirable performance variations from the performance of other operations
3. Significant and undesirable performance variations from recognized standards
4. A sentinel event which has occurred (see Sentinel Event Policy)
5. Variations which have occurred in the performance of processes that affect patient safety
6. Hazardous conditions which would place patients at risk
7. The occurrence of an undesirable variation which changes priorities

F. The following events will automatically result in intense analysis:

1. Significant confirmed transfusion reactions
2. Significant adverse drug reactions
3. Significant medication errors
4. All major discrepancies between preoperative and postoperative diagnosis
5. Adverse events or patterns related to the use of sedation or anesthesia
6. Hazardous conditions that significantly increase the likelihood of a serious adverse outcome
7. Staffing effectiveness issues
8. Deaths associated with a hospital acquired infection
9. Core measure data, that over two or more consecutive quarters for the same measure, identify the hospital as a negative outlier

REPORTING

A. Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by Medical Staff, ancillary, and nursing services, in addition to outcomes of performance improvement teams, will be reported to the MS QAC at a minumum of annually.

B. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the MS QAC at a minimum of annually.

C. The MS QAC will provide their analysis of the quality of patient care and services to the Medical Executive Committee regularly.

D. The Medical Executive Committee, Quality Medical Director, or the Director of Quality & Regulations will report to the BOD regularly relevant findings from all performance improvement activities performed throughout the System.

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

CONFIDENTIALITY AND CONFLICT OF INTEREST

A. All communication and documentation regarding performance improvement activities will be maintained in a confidential manner. Any information collected by any Medical Staff Department or Committee, the Administrative Council, or Health System department in order to evaluate the quality of patient care, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure.

B. Access to peer review information is limited to review by the Medical Staff and its designated committees and is confidential and privileged. No member of the Medical Staff shall participate in the review process of any case in which he/she was professionally involved unless specifically requested to participate in the review. All information related to performance improvement activities performed by the Medical Staff or Health System staff in accordance with this plan is confidential and are protected by disclosure and discover-ability through California Evidence Code 1156 and 1157.

ANNUAL ASSESSMENT

A. The Critical Access Hospital (CAH), and Rural Health Clinic (RHC), Quality Assessment Performance Improvement (QA PI) program, and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually (CMS485.641(b)(1)).

B. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services. Refer to *Available CAH Services* (AGOV-06) policy.

C. The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The findings of the evaluation and corrective actions, if necessary, are reviewed. The Quality Assessment program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes.

D. An annual report summarizing the improvement activities, and the assessment, will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

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

Related Policies/Forms:

Available CAH Services, TFH & IVCH, AGOV-06

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management and Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Discharge Planning, ANS-238

Employee Health Plan, DEH-39

Quality Assurance and Performance Improvement Program, DHH-1802

Quality Assurance and Performance Improvement Program, DHOS-1801

References:

ACHC, CMS COPs, CDPH Title 22, HCQC NRS/NAC

Attachments

A. Quality Initiatives 2026.docx

B. QA PI Reporting Matrix 2026.xlsx

C. QI Indicator Definitions 2026.docx

D. External Reporting 2026.docx

E. Quality Reporting Programs 2026.xlsx

Approval Signatures

Step Description	Approver	Date

Status **Draft** PolicyStat ID **19407774**

Origination Date	N/A	Department	Governance - AGOV
Last Approved	N/A	Applicabilities	System
Last Revised	N/A		
Next Review	N/A		

Available CAH Services, TFH & IVCH, AGOV-06

RISK:

If we do not review and approve providers who provide patient care services, through agreements or arrangements, we risk not serving our community and patient population needs.

POLICY:

A. The President & Chief Executive Officer, or designee, is principally responsible for the operation of Tahoe Forest Hospital District, and the services furnished with providers or suppliers participating under Medicare to furnish other services to its patients by agreement or arrangement. All agreements or arrangements for providing health care services to the CAH's patients must be with a provider or supplier that participates in the Medicare program, except in the case of an agreement with a distant-site telemedicine entity.

B. The Board of Directors has responsibility for ensuring that CAH services are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by CAH employees or indirectly by agreement or arrangement.

C. The Board of Directors must take actions through the CAH's QA/PI Program to:

1. Assess services furnished directly by CAH staff and those services provided under agreement or arrangement
2. Identify quality and performance problems
3. Implement appropriate corrective or improvement activities
4. Ensure monitoring and the sustainability of those corrective or improvement activities

D. A list will be maintained that describes the nature, and scope of the services provided, and the individual assigned to oversee the contract.

E. An annual review of contracted services, either under agreement or under arrangement, will be

completed, including quality, timeliness, and accuracy of services provided, responsiveness, pricing, accuracy of billing, and protection of patient privacy feedback from key stakeholders. This review will be summarized and reviewed by the Medical Staff Quality Committee, Medical Executive Committee, the Chief Medical Officer on behalf of the Administrative Council, and the Board of Directors. If any issues or concerns are identified from this review, a process improvement plan will be developed with the contracted service, the respective Director/ Manager, and Administrative Chief. This will include biannual, or quarterly reviews, until the issues or concerns are resolved.

TAHOE FOREST HOSPITAL DISTRICT

A. The following services are available directly at Tahoe Forest Hospital:

1. Emergency Services
2. Inpatient Medical Surgical Care
    a. Medical Surgical Pediatric care
3. Intensive Care and Step Down
    a. Step Down Pediatric care (age 7-17)
4. Swing Program
5. Obstetrical Services
6. Inpatient and Outpatient Surgery
7. Outpatient Observation Care
8. Inpatient and Outpatient Pharmacy Service
9. Medical Nutritional / Dietary Service
10. Respiratory Therapy Services
11. Rehabilitation Services that includes Physical, Occupational,~~and~~ Speech Therapy, and Wound Care
12. Inpatient and Outpatient Laboratory Services, including blood transfusion
13. Diagnostic Imaging Services that includes: PET CT, Radiation, CT Scan, MRI, Mammography, Ultrasound, Fluoroscopy, Bone Density Scan (DEXA), and Nuclear Medicine
14. Cancer Center, including Outpatient and Inpatient infusion therapy, and Radiation Oncology Center
15. Home Health
16. Hospice
17. Palliative Care
18. Skilled Nursing Care
19. Outpatient Services that includes Wellness ~~program~~Programs, Cardiac & Pulmonary Rehabilitation, Occupational Health Services, Multispecialty Clinics, Rural Health ~~Clinic~~Clinics including Behavioral Health and Addiction Medicine Clinics, and Audiology

20. ~~Medical and Radiation Oncology Services~~Urgent Care Services

B. Transfer Agreements at Tahoe Forest Hospital provide other needed services as outlined in the Transfer Agreements:
    1. Renown Medical Center (Reno, NV)
    2. Saint Mary's Regional Medical Center (Reno, NV)
    3. Carson Tahoe Regional Healthcare (Carson City, NV)
    4. UC Davis Medical Center (Sacramento, CA)
    5. Sutter Roseville Medical Center (Roseville, CA)
    6. Sutter Memorial Hospital (Sacramento, CA)
    7. Incline Village Community Hospital (IVCH) (Incline Village, NV)
    8. Barton Healthcare System (South Lake Tahoe, CA)
    9. California Pacific Medical Center (San Francisco, CA)
    10. Eastern Plumas District Hospital (Portola, CA)
    11. Plumas District Hospital (Quincy, CA)
    12. Truckee Surgery Center (Truckee, CA)
    13. Northern Nevada Medical Center (Sparks, NV)
    14. Northern Nevada Sierra Medical Center (Reno, NV)
    15. Children's Hospital & Research Center at Oakland dba: UCSF Benioff Children's Hospital Oakland (Oakland, CA)
    16. Davies Medical Center (San Francisco, CA)
    17. Western Sierra Medical Clinic (Grass Valley, CA)
    18. Tahoe Forest MultiSpecialty Clinics - Incline (Incline Village, NV)
    19. Banner Health
    20. Mercy San Juan
    21. Non-Emergent Patient Transport:
        a. Med-Express Transport
    22. Emergency Transportation Agreements with:
        a. Truckee Fire Protection District
        b. North Tahoe Fire Protection District
        c. Care Flight
        d. CALSTAR

C. Telemedicine Agreements at Tahoe Forest Hospital:
    1. Psychiatric Telemedicine Services (CEP-America Psychiatry PC d/b/a Vituity)
    2. Tele-Stroke and Emergent Tele-Neurology Services (Telespecialists, LLC)

3. Oncology Telemedicine Services (UC Davis)
4. Neonatal & Pediatric ICU Telemedicine Services (UC Davis)
5. Anthem Blue Cross of California
6. Alina Telehealth
7. Plumas District Hospital
8. Barton Memorial Hospital

D. The following services are provided to patients by Agreement or Arrangement at Tahoe Forest Hospital:
    1. Emergency Professional Services
    2. On Call Physician Program
    3. Hospitalist Services
    4. Pathology and Laboratory Professional Services
    5. Blood and Blood Products Provider: United Blood Services Reno, NV
    6. Diagnostic Imaging Professional Services
    7. Anesthesia Services
    8. Pharmacy Services
    9. Telehealth Services
    10. Tissue Donor Services
    11. Biomedical Services
    12. Interpreter Services
    13. Audiology Services
    14. Dosimetry and Physics Services

E. The following services are available directly at Incline Village Community Hospital:
    1. Emergency Services
    2. Inpatient Medical Surgical Care
    3. Outpatient Observation Care
    4. Inpatient and Outpatient Surgery
    5. Inpatient Pharmacy Service
    6. Laboratory Services
    7. Diagnostic Imaging Services, including CT Scan, Ultrasound, and Mammography
    8. Home Health
    9. Hospice
    10. Palliative Care Services
    11. Outpatient Services that include Occupational Health Services, Multi-specialty Clinic, Rural Health Clinic, and Rehabilitation Services that includes Physical, Occupational,

and Speech Therapy

F. Transfer Agreements at Incline Village Community Hospital provide other needed services as outlined in the Transfer Agreements:
    1. Renown Regional Medical Center (Reno, NV)
    2. Saint Mary's Regional Medical Center (Reno, NV)
    3. Carson Tahoe Hospital (Carson City, NV)
    4. Carson Valley Medical Center (Gardnerville, NV)
    5. Tahoe Forest Hospital (Truckee, CA)
    6. Barton Healthcare System (South Lake Tahoe, CA)
    7. Northern Nevada Medical Center (Sparks, NV)
    8. Northern Nevada Sierra Medical Center (Reno, NV)
    9. Hearthstone of Northern Nevada (Sparks, NV)
    10. Banner Health
    11. Emergency Transportation Agreement with:
        a. North Lake Tahoe Fire Protection (Incline Village, NV)
        b. Careflight

G. Telemedicine Agreements at Incline Village Community Hospital:
    ~~1. Hospitalist Telemedicine Services (Vituity-Nevada (Koury & Partners), PLLC, a Nevada professional limited liability company ("Vituity-Nevada") and CEP America-Telehealth, PC d/b/a Vituity ("CEP America-Telehealth")) through 3/31/2025~~
    ~~2. Tele-Stroke and Emergent Tele-Neurology (Telespecialists LLC)~~
    1. Tele-Stroke and Emergent Tele-Neurology (Telespecialists LLC)

H. The following services are provided to patients by Agreement or Arrangement at Incline Village Community Hospital:
    1. Emergency Professional Services
    2. Medicine – On Call
    3. Pathology and Laboratory Professional Services
    4. Blood and Blood Products Provider: United Blood Services Reno, NV
    5. Diagnostic Imaging Professional Services
    6. Anesthesia Services
    7. Pharmacy Services
    8. Telehealth Services
    9. Tissue Donor Services
    10. Biomedical Services
    11. Interpreter Services

12. Dosimetry and Physics Services

References:

Accreditation Requirements for Critical Access Hospitals (2025). Accreditation Commission for Health Care (ACHC)

Title	Scope of Services	TFHD/ IVCH/ System	Responsible
Vituity	24/7 Physician Service for ED	System	CEO
Hospitalist Program	24/7 Physicians Services for TFHD (Employees & Individual Contracts)	TFHD	CEO
Western Pathology Consultants	Pathology Consults and Reports	System	CEO
Shuff California Corporation	Radiation Oncology	TFHD	CEO
Dosimetry & Physics Services	Landauer; Ramphysics; RadPhysics	System	COO/Director of DI Services
Silver State Hearing & Balance, Inc.	Audiology	TFHD	CEO
Quest Diagnostics	Labs not performed at TFHD	System	COO/Director of Lab Services
Virtual Radiologic	Read diagnostic imaging tests after hours	System	COO/Director of DI Services
Cardinal Health	After hour pharmacist services	System	COO/Director of Pharmacy Services
Nevada & Placer Co. Mental Health	Mental Health assessments in the ED	TFHD	CEO
Sierra Donor Services	24/7 Organ Donor Services	System	CNO

Approval Signatures

Step Description	Approver	Date

2025 Critical Access Hospital

National Patient Safety Goals*

Updated for Tahoe Forest Hospital District CY 2025

National Patient Safety Goals	*Summary of Activities Calendar Year 2025*

Improve the accuracy of patient identification
• Use at least two patient identifiers when providing care, treatment, and services.
• Use at least two identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures
• Patient's room number or physical location is not used as an identifier
• Label containers used for blood and other specimens in the presence of the patient
• Use distinct methods of identification for newborn patients
	• Safety First on two patient identifiers every time.
	• Safety First, and re-education on proper specimen labeling.
	• Customization/standardization to provider documentation for notes to pull in adequate patient information.
	• RMT subgroup collaborating on standard work for labeling specimens.
	• Re-education of Lab and Truckee ED staff for specimen labeling and blood culture collection.
	• Policies:
	  ○ Floor collected Specimen, ANS-43
	  ○ Specimen Collection and Handling, DOR-2015
	  ○ Patient Identification and Specimen Labeling, PHL-S0030
	  ○ Patient Identification and Arm Banding, AGOV-1801
	  ○ Neonate – Patient Admission Care and Discharge of, DWFC-1449
	  ○ Postpartum – Patient Care and Discharge of, DWFC-1466

Improve the effectiveness of communication among caregivers • Report critical results of tests and diagnostic procedures on a timely basis • Develop and implement written procedures for managing the critical results of tests and diagnostic procedures • Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures	• Emergency Departments in Truckee and Incline Village collaborating with Beta Zero Harm Collaborative on diagnostic safety. • All clinical staff attend 3.5 hours of Clinical Orientation on hire. Training includes: clinical resources**, SBAR/CUS and chain of command**, ancillary departments, infection prevention, medical codes and code response, safe patient handling, O2 safety, MRI safety and other topics. • SBAR, CUS & handoff policies in place. Ongoing education of these principals in weekly huddles, Pacesetter, Medical Staff meetings, clinical orientation, unit skills days and mock codes. • DI/Lab performs monthly quality checks with follow up for non-compliance. • Continued efforts to improve and

** National Patient Safety Goals® Effective January 2025 for the Critical Access Hospital Program*
Last updated by A. Davis, January 2026

	standardize handoff; including promoting bedside shift report, provider-MA use of SBAR in clinics, improved handoff between ED and OR.
	• Process mapping for DI incidental findings
	• Policies:
	  ○ Critical Value Reporting, ALB-S1700
	  ○ Critical Results Reporting Radiology, DXR-66

Improve the safety of using medications • Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up. • Take extra care with patients who take medicines to thin their blood. • Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.	• Pump Integration governance integrated into Medication Safety Committee. • Biweekly medication event reviews with pharmacy, quality, and nursing leadership. • Monitoring bar code scanning rates and processes by caregivers to identify areas for improvement. • Continue to maintain and improve our current CPOE system, as evidence-based recommendations evolve, or in response to event reports. • Medication Reconciliation Process Improvement team continues to work diligently to improve the efficiency and accuracy • Monitoring and review of smart infusion pump data • Quarterly Med Safety & P&T Committee, which oversees MERP • Director of Pharmacy (DoP) attends all Medical Staff Meetings and daily Admin Huddle • DoP is the antimicrobial stewardship leader and reports through P & T committee • DoP is member of Inpatient Glycemic Management • DoP is member of order set team • VTE order set • Staff VTE education & monitoring • Daily EMR surveillance and reporting on compliance of VTE prophylaxis and antibiotics in the safety rounds. • Pharmacy monitoring protocols for dosing anticoagulants.

2025 Critical Access Hospital

National Patient Safety Goals*

Updated for Tahoe Forest Hospital District CY 2025

	• Pre-Admit and total joint navigators giving specific parameters for stopping medications prior to surgery.
	• Policies:
	  ○ Medication Administration, APH-23
	  ○ Reconciliation of Medications, APH-31
	  ○ Label Medications and Solutions on the Sterile Field, DOR-2205
	  ○ Anticoagulation Protocol, APH-1401
	  ○ Outpatient RN Anticoagulation Protocol, APH-1701

Reduce patient harm associated with clinical alarm systems • Leaders establish alarm system safety as a critical access hospital priority • Make improvements to ensure that alarms on medical equipment are heard and responded to on time	• Training and education related to alarms and monitoring provided as new equipment is introduced in health system. • Policies: ○ Audibility of Clinical Monitoring, ANS-7
Reduce the risk of health care-associated infections • Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization • Set goals for improving hand cleaning	• Policy, staff education, and audit in place for influenza prevention. Approved & reported to IC Committee. • Continued work by Infection Preventionist on hospital-wide flu vaccination program and monitoring. • Flu vaccines mandatory for employees. • Policy, staff education, and unit-based hand hygiene compliance observation and self-reporting in place. Approved & reported to IPC Committee. • DI auditing sterile technique compliance for all PICC lines placed. • Using CLIP for all central line insertions. • Chlorhexidine Gluconate (CHG) bathing of ICU patients, and patients with devices, (e.g. central lines, indwelling catheters) or on contact precautions. • Central line competency and return-demonstration for all new hire RNs. • Sepsis initiatives ongoing including case reviews and September Sepsis Awareness month. • All clinical staff attend 3.5 hours of Clinical Orientation on hire. Training includes:

	clinical resources, SBAR/CUS and chain of command, ancillary departments, infection prevention, medical codes and code response, safe patient handling, O2 safety, MRI safety and other topics. • CHG bathing policy and nursing staff provided ongoing education. • Decolonization practices: CHG bathing, oral and nasal decolonization. • Policy, staff education, and audit in place. Approved & reported to IPC Committee & NHSN. • EMR surveillance and monthly post discharge surveillance reports to surgeons to identify SSIs. • SSI track & trend report reviewed with Medical Staff and areas for improvement discussed. • As part of AHRQ MRSA prevention program, Standardize and monitor MRSA screen testing on planned inpatient admissions on total joint arthroplasty patients. • Obstetrics department participated in CMQCC maternal sepsis initiative. • Surveillance on MDROs – electronic and by walking around to ensure transmission-based precautions are followed for applicable patients, hand hygiene is performed, and PPE is selected and used appropriately; NHSN reporting of Healthcare Associated conditions. • Foley justification addressed at daily interdisciplinary huddles. • Tuberculosis incident command event. • Foley Policy, education, order set & audit in place. • Policies: ○ Hand Hygiene and Glove Use, AIPC-46 ○ Chlorhexidine (CHG) Bathing, AIPC-2003 ○ Ultrasound Transducers/Probes Cleaning and Disinfection, AIPC-2301 ○ Central Line Insertion Practices (CLIP), AIPC-11

2025 Critical Access Hospital

National Patient Safety Goals*

Updated for Tahoe Forest Hospital District CY 2025

	○ Infection Prevention and Control Plan, AIPC-64
The critical access hospital identifies safety risks inherent in its patient population • Reduce the risk for suicide	• Zero Suicide Initiative Leadership meets monthly and promotes education, awareness, and policy and practice guideline improvement through data analytics, consistent feedback and collaboration with community partners throughout the year. • Member of peer support trained as a Group Crisis Interventionist • Member of peer support trained as Mental Health First Aid Instructor to provide in-house education and expand mental health first aid instruction opportunities inside the organization. • Peer Support team grew to include Med Staff support members in 2025. • Representative from The Speedy Foundation attends Peer Support Team meetings for collaboration. • Policies: ○ Management and Screening of Mental Health Patients at Risk for Suicide/Self-Harm/Harm to Others, AGOV-2101
Improve health care equity • Improving health care equity is a quality and patient safety priority. For example, health care disparities in the patient population are identified and a written plan describes ways to improve health care equity	• Community Health Advocates supporting patients with complex medical and health-related social needs by providing culturally appropriate education and support to improve patient comprehension and health outcomes. • Groups working to improve use of language line and plan for staff to obtain medical translation certification. • "Everyone" education via Safety First about language line and interpreter services available at TFHD. • Policies: ○ Standards of Professional Performance, ANS-109 ○ Interpreter and Translator Services, DPTREG-2001
Prevent mistakes in surgery	• Continued focus on proper informed consent processes in procedural areas. • Ongoing review of Consent processes and

• Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
• Mark the correct place on the patient's body where the surgery is to be done.
• Pause before the surgery to make sure that a mistake is not being made
	ensuring best practices are followed; altering forms and process as needed to keep up with best practice recommendations.
	• Timeout policy and checklist available with ongoing staff education, and auditing of practice.
	• Patient Safety Advocate and HIPESAC timeout checklist program piloted in Diagnostic Imaging.
	• Policies:
	  ○ "Time-Out" for Invasive Procedures, DED-36
	  ○ Time Out for Surgical and Invasive Procedures, DOR-2209
	  ○ Time-Out for Procedures Done Outside the OR, ANS-114
	  ○ RT – Patient, Procedure, Site, Side Verification, DCC-119

AMERICAN HOSPITAL ASSOCIATION

LEARNINGS FROM AHA'S QUALITY COLLECTIVE

Strategies and insights from health care leaders exploring quality and performance improvement

American Hospital Association™

Advancing Health in America

A Letter from AHA's Quality Leadership Team

The American Hospital Association recognizes the unwavering commitment of hospitals and health systems to ensure all patients receive safe, high-quality care. The COVID-19 pandemic significantly impacted every aspect of health care delivery, both within the field and among the general population. This evolving landscape has presented hospitals and health systems with the dual challenge of implementing and sustaining quality improvement objectives.

As part of AHA's work on performance improvement, the Quality Collective (QC) was launched to provide a collaborative platform for leaders in quality improvement to engage deeply with their peers, collectively strategizing on the most pressing health care quality-related issues. Over the course of three months, the QC assembled some of the brightest minds in health care quality leadership. Their collaborative efforts were focused on co-designing strategies that not only address the current needs of the field but also shape its trajectory into the future.

Throughout this initiative, QC members candidly shared successes, explored innovative solutions and focused on redefining a culture rooted in quality and performance.

With the understanding that the field's approach to defining, measuring, and advancing quality continued to evolve during the pandemic, these discussions aimed to reshape perceptions and expectations.

It is our honor to share highlights from the insightful deliberations of QC members in this report. The AHA extends its heartfelt gratitude to all participants for their expert and candid contributions and their unwavering commitment to providing safe, quality care to patients. Your energy powers our work to foster a just society of healthy communities, where all individuals reach their highest potential for health.

With gratitude,

Marie Cleary-Fishman
Vice President, Clinical Quality
AHA Center for Health Innovation
American Hospital Association

Michelle Hood
Executive Vice President
and Chief Operating Officer
American Hospital Association

Chris DeRienzo, M.D.
Senior Vice President and Chief Physician Executive
American Hospital Association

Executive Summary

The American Hospital Association (AHA) is pleased to present insights derived from the Quality Collective (QC), a collaborative platform facilitating in-depth engagement among leaders in health care quality improvement. In response to the profound impact of the COVID-19 pandemic, the QC embarked on a three-month initiative to address evolving challenges in quality improvement and collectively strategize on pressing health care quality-related issues.

Shifting Perspectives on Quality

The report highlights a dynamic shift in the definition of quality among QC members, with a majority acknowledging a change or evolution over the past three years. Notably, a small percentage of QC members maintain a consistent definition but have adapted their approach to quality. These findings underscore the transformative nature of health care organizations in responding to the evolving landscape.

Areas of Success and Opportunities for Improvement

In clinical domains, QC members reported that their organizations excel in patient safety, infection prevention and emergency preparedness. Opportunities for improvement were identified in population health management, behavioral health and health equity. Culture, executive leadership commitment and performance improvement infrastructure were identified as strengths, while community engagement, technology and board involvement emerged as areas for enhancement.

Key Priorities and Future Focus Areas

QC members outlined priorities for the next three to five years, envisioning a hospitalwide and systemwide commitment to providing care that is safe, timely, effective, efficient, equitable, patient- and family-centered and affordable. The future agenda emphasizes embedding quality into the care journey, fostering engagement, promoting patient safety, advancing health equity and strengthening resiliency.

Digital Transformation and Emerging Innovations

The QC members anticipate an increasing prevalence of artificial intelligence and other technological innovations in disinfection practices. They recognize the need for additional resources to improve quality, enabling a focus on high-risk patient rounding, compliance with evidence-based bundles and value stream improvement efforts.

AHA Patient Safety Initiative

Building on the success of the QC, AHA has introduced the Patient Safety Initiative, a collaborative effort empowering hospitals to influence national health care safety discussions. It aims to enhance engagement, public trust and data accuracy while reducing preventable harms, inequities and administrative burdens. The initiative focuses on fostering a safety culture, addressing safety inequities and improving workforce safety. The AHA, with its extensive membership, leads this initiative through research, collaboration and data-sharing to transform patient safety, reinforcing commitment and leadership in the health care field.

Table of Contents

Introduction

In March 2023, the AHA invited health care quality leaders from its member hospitals and health systems to participate in the QC for focused discussions and exploration of quality issues over three months. In total, 104 leaders joined the QC, which launched on April 5, 2023.

Methodology

The QC provided opportunities for members to collaborate on health care quality topics they identified and shared as priorities, focusing on strategies for success and opportunities for improvement.

Outcomes

The goal of the QC was to promote engagement and collaboration with participants on health care quality issues that matter most to them and also to share feedback from the discussions via a number of actionable resources, including this report.

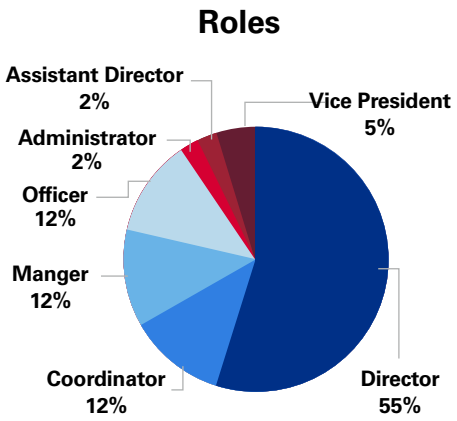
Discovery

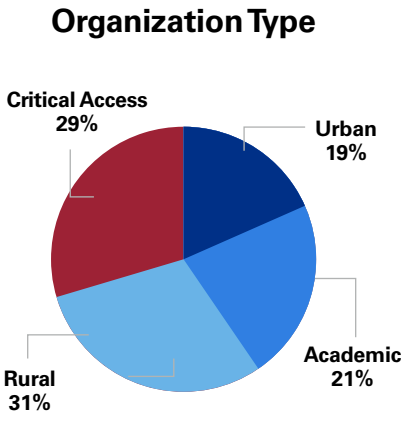
As the QC first convened, members received a brief discovery form designed to illuminate their priorities and inform discussions; 42 individuals completed this survey. Topics covered included:

- member demographics, including roles and organization types;
- definitions of quality and performance improvement and how those definitions may have shifted throughout the COVID-19 pandemic;
- members' organizational quality priorities for 2024;
- clinical and cultural quality areas, ranked in order of successes and opportunities for improvement; and
- members' quality "wins."

Demographics

QC members reported holding a variety of roles within health care quality, with the majority being a director (55%). Other roles include coordinator, manager and quality officer. Among QC members, 60% of members classified their organization as rural or critical access with 40% being academic and/or urban organizations.





Defining Quality

In health care, quality can be subjective, with varying definitions among organizations, providers and patients. Through feedback on the discovery form and focused discussions, the QC aimed to collectively define quality from health care leaders' perspectives. QC members were asked to define quality, and key words emerged, including "patient," "outcomes" and "care."

COLLECTIVE INSIGHTS

> The extent to which health care services provided to individuals and populations of **patients** increase the **likelihood of a desired outcome** and are consistent with current, **evidence-based practices**.

> Providing the **best health care possible** within the scope of the organization, implementing a model of **continuous improvement** in health outcomes and ensuring that **all patients are treated with dignity and respect**.

> **Patient-centered** care **that exceeds expectation**.

> Providing the **safest care** in the most **effective way**.

> The degree to which health services for individuals and populations increase the likelihood of **desired and equitable health outcomes**.

Quality Definition Shift

When asked how the definition of quality has shifted in the last three years, a majority of QC members said their quality definition had changed or evolved. Some QC members said their definition had not changed and a small group said their definition had not changed, but their approach to quality had.

COLLECTIVE INSIGHTS

> The methods and strategies employed to achieve quality have changed — greater consideration for the **bandwidth of work teams** and **need for more focused approaches**.

> We've recognized the importance of **taking into account the patient's definition of quality**. What they want may not be what we think they want.

> I have been enlightened in a more **comprehensive view of health equity** and what that means for the population we serve.

> More focused on **front-line teammate engagement** and taking staff and environment into consideration.

> The COVID-19 pandemic has heightened health care organizations', patients' and consumers' awareness of the **quality** of health care.

Defining Performance Improvement

QC members were asked to define performance improvement, and key themes emerged, including "processes," "improvement" and "better outcomes."

COLLECTIVE INSIGHTS

> Being **better today** than we were yesterday.

> The consistent effort to identify opportunities for improvement within our work and develop **effective, sustainable solutions**.

> The continuous study and adaptation of the functions and processes of a health care organization to increase the probability of achieving desired outcomes and to **better meet the needs of patients**.

> Finding **perception versus reality**, reducing waste within processes and improving or creating processes for patients and staff.

> Striving to **continually improve**, learn from mistakes and near misses.

> The redesign of a process, workflow and/or tool with the intention of **improving overall outcomes**.

Organizational Quality Priorities

Members shared their organization's top three priorities in quality and performance improvement in 2023. Priorities shared by members include:

- Reduction in readmissions
- Reduction in harms/zero harm
- Reduction in HAIs and improved antibiotic stewardship
- High reliability
- Improved patient experience
- Operational excellence
- Health equity
- Workplace violence prevention

COLLECTIVE INSIGHTS

> Identifying a new electronic health record system.

> Enhancement of patient experience, focusing on transition of care and patient education.

> Hardwiring the use of the Hierarchy of Reliability in process improvement and process changes.

> Prioritizing just culture and increasing reporting.

> The Joint Commission survey preparedness.

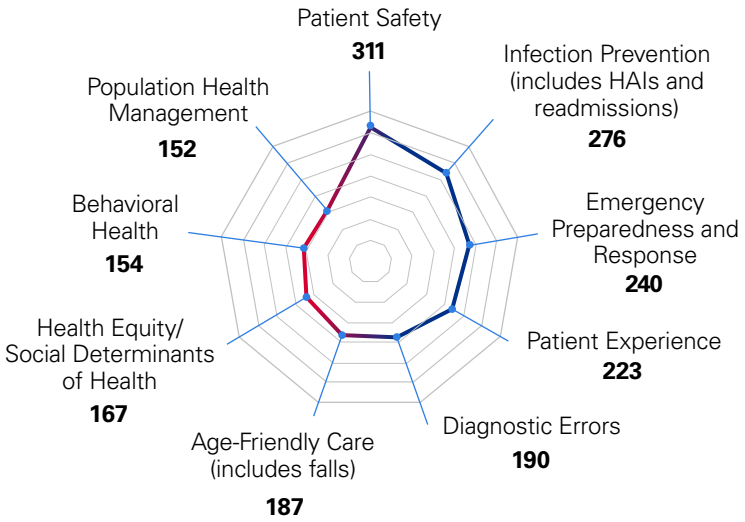
> Identifying health care disparities and social determinants of health and improving health equity.

Deep-Dive Discussions

AHA's performance improvement coaches (PICs) relied on member feedback to inform QC deep-dive discussion topics. Throughout the QC, PICs facilitated 12 deep-dive sessions focused on results on member quality topic rankings (success areas and opportunities for improvement) as well as members' organizational priorities. These discussions offered participants a real-time platform to connect and collaborate with peers, share success strategies, address improvement opportunities and outline quality plans for the future.

Radar charts were used to visually represent the collective rankings and to weight and present the data across multiple variables. The charts below show how members collectively ranked the clinical and cultural quality topic areas — the higher the ranking of success, the further away from the center of the chart.

Clinical Quality Ranking



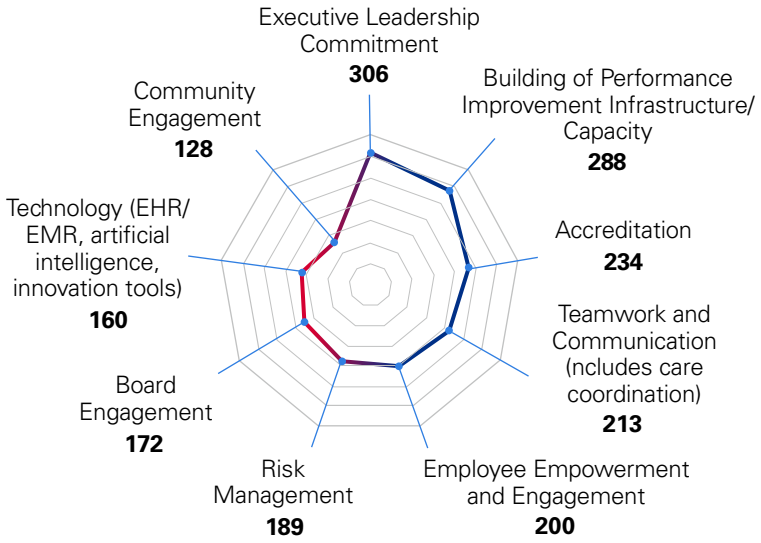
Top three success areas

1. Patient safety
2. Infection prevention (including HAIs and readmissions)
3. Emergency preparedness and response

Top three opportunities for improvement

1. Population health management
2. Behavioral health
3. Health equity/social determinants of health

Cultural Quality Ranking



Top three success areas

1. Executive leadership commitment
2. Building of performance improvement infrastructure/ capacity
3. Accreditation

Top three opportunities for improvement

1. Community engagement
2. Technology
3. Board engagement

Patient Safety

QC members ranked patient safety as the number one clinical quality area of success within their hospitals and health systems. Several members also listed patient safety as a top organizational priority for 2024, with goals including zero harm, maintaining a good catch rate and achieving the best quality and safety patient outcomes in the U.S.

Strategies for Success

- **Focus on culture.** Members report that their success in patient safety is a direct result of their culture of all team members always wanting to do the right thing for their patients.
- **Engage the front line.** Including front-line workers on committees and task forces for improvement correlates with success for many members. The front-line team provides valuable insights and ideas.
- **Engage leadership.** Presenting patient safety topics to the executive leadership team and the hospital or health system board regularly helps keep patient safety topics at the forefront.
- **Celebrate good catches.** Recognizing team members who take corrective or timely actions to protect a patient from a potential harm or an adverse event helps improve engagement in performance improvement and patient safety.
- **Dedicate staffing and resources.** Members report that assigning dedicated roles to team members helps improve patient safety. Examples include assigning a patient safety officer to each facility and assigning clinical quality nurses to lead performance improvement initiatives and real-time education at the unit level.

Improvement in Action: Examples from QC Members

The following are examples from QC members of actions they have taken to advance improvement in their organizations.

- **Converting patient data into a unit safety score** enables measuring and accelerating improvements in patient safety performance. The aim of the unit safety score is to ensure consistency, transparency and objectivity, while delivering actionable insights for busy health care professionals. This data also offers staff feedback on hand hygiene and near misses, and it is publicly displayed for all unit leaders and front-line personnel to access.

- **Decreasing median door-to-needle time** to 33 minutes in stroke unit (goal was 100% of alteplase administration in less than 45 minutes), achieved through staff education, reinforcement and a mock drill program.
- "While we have struggled with getting back to basics post pandemic, along with significant staffing challenges in both nurses and techs, we have seen **successes in fall injury reduction, venous thromboembolism prevention**, among others. We educate, recognize, provide feedback and are very transparent with our data. Our focus this year is all about accountability at every level."
- "**Patient safety engagement** has remained a paramount focus at our hospital, shaping our daily efforts. We've established daily huddles and initiated patient safety and process improvement endeavors encompassing all staff, fostering committee participation and open dialogue. Our commitment to transparency spans all levels. Notably, our most recent culture of safety survey yielded the best results we've witnessed in years — an achievement I find truly significant."

AHA Resources

- AHA Patient Safety Initiative

Infection Prevention and Control

Members ranked infection prevention and control (including health care-associated infections and readmissions) as one of their top three successful quality areas. Members shared that they have been successful in implementing dedicated infection prevention initiatives, reducing health care-associated infection rates and emphasizing infection prevention strategies and data in quality and board meetings.

Strategies for Success

- **Ensure frequent and transparent communication.** Daily rounding and huddles support just-in-time education and engagement with staff.
- **Engage patients and family members in the treatment and prevention of health care-associated infections** as part of the infection prevention control team.
- **Use nurse-driven protocols.** Such protocols empower nurses to identify risks and take action to prevent infections, such as assessing patients for C. *diff* based on a testing algorithm or removing indwelling catheters based on appropriateness.
- **Prioritize collaboration with multidisciplinary teams.** This kind of collaboration maintains working relationships and encourages open feedback among different departments, such as patient care services and pharmacy, while also supporting quality coordination of infection prevention efforts.
- **Encourage friendly competition to engage employees.** Friendly competition and employee engagement can help incentivize infection prevention behaviors such as hand hygiene compliance and HAI prevention. Using competition/prizes and recognition engages employees to participate actively as part of the infection prevention team.
- **Provide education, audits and feedback.** Schedule annual staff trainings and frequent just-in-time education on infection prevention basics, policies and procedures, as well as on emerging topics of focus, such as multidrug-resistant organisms and Candida auris. Conduct regular audits and provide feedback to staff for transparency.

Improvement in Action: Examples from QC Members

The following are examples from QC members of actions they have taken to advance improvement in their organizations.

- **Reduced MRSA rates by 54% and increased full decolonization from 16% to 50%** in three months by 1) moving accountability from infection prevention team to nursing executives to report out in daily safety huddles and communicate with clinicians regarding decolonization, 2) implementing best-practice advisories in the EMR to initiate testing, 3) tying unit goals to HAIs and MRSA specifically for units with high infection rates and 4) using electronic hand hygiene technology with weekly unit and individual reports to improve hand hygiene.
- **Reduced CAUTI and ventilator-associated events from 2022 to 2023** by establishing an infection prevention coach training program. This program aimed to enhance nursing staff's knowledge of infection control practices, bolster hand hygiene compliance, nurture leadership skills for coaching colleagues and physicians in their hospital departments, educate patients and families about hospital infection control, and foster collaboration with the infection prevention and control coordinator to mitigate preventable safety issues and HAIs. The participating nurses displayed heightened engagement in patient and family education, staff guidance and action planning in response to HAIs.
- **Increased hand hygiene compliance rates across all departments,** from approximately 60% and 70% to over 95%, by 1) implementing additional training with "secret shoppers" to ensure standardization of observations, 2) rolling out an organization-wide recognition program for compliance and 3) providing scripting and awareness around hand hygiene, including how to approach a colleague if they are observed not washing their hands.

AHA Resources

- **AHA Infection Prevention and Control**
- **AHA Infection Prevention and Control Success Stories**
- **Project Firstline**

Emergency Preparedness

QC members ranked emergency preparedness among their top three areas of success in clinical quality topics. They noted consistent improvement and heightened focus in this quality area throughout the COVID-19 pandemic, despite such challenges as staffing and budgetary resources.

Strategies for Success

- **Allocate dedicated resources for emergency preparedness.** The pandemic underscored the need to include focused, full-time employee resources for emergency preparedness within budget. Integrate quality and emergency preparedness by involving quality staff on the emergency preparedness team; quality staff can help conduct real-time, small tests of change to improve preparedness response time and effectiveness.
- **Include the entire organization in emergency preparedness efforts** and encourage staff to volunteer.
- **Prioritize real-time communication and include it in the emergency preparedness plan.** Ensuring immediate communication with leaders in your hospital, health system or region is essential for receiving timely notifications about emergent situations and taking necessary actions.
- **Conduct risk assessments and benchmarking.** Annually review risk assessments and identify any changes from the previous year. Embrace best practices by connecting with partner hospitals and examining how they assess risk.

Improvement in Action: Examples from QC Members

The following are examples from QC members of actions they have taken to advance improvement in their organizations.

- "We activate a command center when an event occurs as outlined in our emergency preparedness plan. This brings together a **broad array of leaders** from across the organization, including affiliate hospitals and skilled nursing facilities. As the command center operates, we do many **rapid tests of change** as needed based on the situation. As each stage of the response plan is rolled out, we monitor the outcome and make adjustments as needed."
- "Our emergency preparedness full-time employee is in the quality department, so we work very closely by virtue of being in the department. We also report issues related to emergency preparedness or upcoming drills and responses to drills during our **daily safety huddle**, which includes top administration and is very **interdisciplinary**. Doing so definitely brings attention to any failures we've had on drills. For example, our emergency alert system was related to color codes so everyone would get confused. People would have to look up the color system to remember what color code stands for. We changed to plain language codes such as 'Security Alert.'"
- "We're doing a **monthly policy review** in our leadership council. We are finding that not all of our telephone numbers are exactly right; so, if we need our staff members to call an emergency to the right place at the right time, then we need those documents to be up to date. By doing these small things in the quality world we know need to be done and applying them to our emergency plan, we'll be better set up for the future."

AHA Resources

- **AHA Convening Leaders for Emergency and Response (CLEAR) Initiative**
- **AHA CLEAR Field Guide for Emergency Preparedness**
- **AHA CLEAR Crisis Leadership Video Series**

Executive Leadership Commitment

QC members ranked executive leadership commitment as the number one cultural quality area of success within their hospitals and health systems. Through commitment, strategic guidance and resources, the executive leadership team lays the foundation and structure for quality outcomes and empowers teams for continuous improvement.

Strategies for Success

- **Empower and celebrate staff in quality improvement.** Quality thrives when leadership teams empower staff and celebrate victories. This in turn encourages employee engagement in the performance improvement/quality improvement process.
- **Support educational growth and development.** Executive leadership can provide financial support for building performance improvement capacity and carve out protected time for front-line teams from nursing, food services, rehab services, environmental services and other units to participate in performance improvement trainings and organizational initiatives to address quality concerns.

Improvement in Action: Examples from QC Members

The following are examples from QC members of actions they have taken to advance improvement in their organizations.

- "Executive leadership continues to make our "Reaching for Zero" journey a priority by **infusing safety into everything we do** — from starting every meeting with a safety story to standardizing daily safety huddles at each facility."
- "Our quality and safety culture is supported by our executive leadership team, which always focuses on what is best for the patients and community and consistently **strives to maintain focus on our core values** and doing the right thing."
- "Our success has really come from getting back to the basics and engaging all levels of staff and departments within the organization. This has been fully supported by our executive leadership team, which **conducts rounds on an ongoing basis with all of the departments** to develop that rapport with staff, as well as to keep a pulse on what is happening as it pertains to patient safety, or potential risks that could negatively impact patient safety."

AHA Resources

- **AHA Leadership Dialogue**
- **AHA Physician Alliance**
- **American Organization for Nursing Leadership**

Workplace Violence

Workplace violence was selected by QC members as a top priority area for their organizations in 2024, and most shared their active involvement in addressing workplace violence. Hospital teams recognize their facilities are not immune to violence and are actively working to enhance plans and prioritize this critical issue. As one member said, "No one comes to work to not go home."

Strategies for Success

- **Survey front-line staff.** Hospitals and health systems use independent surveys and culture of safety surveys to better understand staff experiences and gather improvement suggestions regarding workplace violence. Some members indicated workplace violence is underreported by front-line staff, which has prompted awareness campaigns and interviews with staff, followed by additional surveys to assess the impact.
- **Build alliances on workplace violence.** Forming subcommittees focused on workplace violence prevention within hospital teams has enabled hospitals and health systems to complete risk assessments, address staff concerns and present top recommendations to executive leaders.
- **Create and update policies.** Establishing a code of respect as part of organizational policy provides staff with clear procedures for responding to violent incidents.
- **Use technology support** for mitigating workplace violence. To enhance prevention efforts, hospital and health systems can employ electronic medical record safety screening tools and use QR code systems for reporting violence, bullying and incivility.
- **Provide staff training and education.** Trainings can help by providing strategies to de-escalate a situation through practiced scripting and role modeling as well as empowering staff to speak up about any discomfort, emphasizing the importance of reporting workplace violence. Frequent workplace violence trainings and drills can be organized into "safety weeks" to provide an engaging way to bring awareness and educate staff on workplace violence.
- **Communicate and coordinate with the local police department.** Strategies include collaborating closely with local police to share strategies for emergency preparedness, defining roles during an emergency event, prioritizing de-escalation tactics before police involvement and installing panic buttons that contact the police directly and immediately.

Improvement in Action: Examples from QC Members

The following are examples from QC members of actions they have taken to advance improvement in their organizations.

- **Reduced injuries to staff and others and improved treatment time** by implementing an initiative to place all patients who are violent or actively on illicit drugs in the adult ICU (staffed 1-to-1), as opposed to placing them on other units where staff nurses have three to five patients.
- "**We have implemented a BIRT team (behavioral intervention response team)**, a multidisciplinary team of behavioral health leaders, security and nursing leadership to support a patient or family member exhibiting violent behavior. We call a BIRT after our team attempts de-escalation .There are things we try to do first before we do something physical like medication or restraints."
- "**We use the Broset violence checklist.** We have a Broset score for every patient that is admitted and assessed to help staff understand if a patient is at risk for any violent behavior. This helps us be aware of situations that might come up or things that might need more attention. We have banners in the Epic chart for those moderate or higher risk patients so everyone who logs in is aware."
- "**Annually we conduct a workplace violence risk assessment across all shifts and departments**. Following this, we formulate improvement recommendations that we present to our executive committee and board subcommittee. This initiative is supplemented by Safety Week, an engaging event where we address gaps through a combination of enjoyable activities and focused training. Our approach extends to emergency preparedness as well, with follow-up drills across all facilities and departments. It's a concerted effort to underline the importance of mutual safety, addressing both workplace violence concerns and emergency preparedness needs."

AHA Resources

- AHA Hospitals Against Violence

Building Performance Improvement Infrastructure and Capacity

Building PI capacity was ranked highly as a success area among QC members. Many members included the topic as a priority for their hospital in 2024. As noted by one member, "The days of retrospective process improvement are behind us; it's imperative to scrutinize care in real time, rectifying and offering feedback as events unfold."

Strategies for Success

- **Provide resources and structure dedicated to quality and PI.** Some members reported that assigning quality staff to specific units or departments can help facilitate projects when a unit/department identifies a need, or if there is a trend or issue across multiple departments. One hospital shared their experience using performance improvement nurses in units, noting that having a PI leader at the bedside to provide real-time feedback and share data and education is most effective.
- **Provide PI education for staff and leaders.** Educating leaders and staff on basic quality improvement methodologies, metrics and tools is important for awareness and building a culture of PI. Keep the information easy to understand and user-friendly so that staff can eventually integrate PI into daily work.
- **Engage leadership.** Presenting improvement projects and metrics to executive leadership and the hospital or health system board regularly helps keep quality and PI at the forefront. Involving executive leadership in quality committees and task forces also provides top-down support and commitment to quality.
- **Share stories.** Collecting and highlighting stories of performance improvement projects across the organization is a great way to recognize those teams and share ideas across other areas. One hospital presents PI projects to its board at least quarterly to share updates on progress and successes.

Improvement in Action: Examples from QC Members

The following are examples from QC members of actions they have taken to advance improvement in their organizations.

- "I'm the quality director and performance improvement committee chair at a small critical access hospital. My main focus has been on **providing useful tools and educating directors on performance improvement**, as it might not be intuitive for everyone, especially those without prior education or background in the field. The hardest part lies in helping people realize they're already engaged in performance improvement; they just need to connect it to a PDSA format. We work together on establishing priority concerns to focus on for each department, developing SMART goals, determining and addressing the root cause to optimize the initiatives' success, etc. Accountability is maintained by requiring submission of annual storyboards to recognize people's improvement efforts, displayed publicly to celebrate our achievements."

- "While our formal continuous improvement projects and quality reporting structure are impressive, I truly appreciate that our organization has taken significant strides to truly **engage our front-line teams** and ensure that they are not only informed about quality metrics and data but also are **personally guiding the improvements.** At these sessions, there is an opportunity for educating teams around quality and PI topics, but also time for teams to assess identified concerns, discuss current processes and assist to develop solutions. These teams also are supported to **pilot solutions** on the units. Additionally, our organization sponsors quality awards to engage teams in quality competitions and provide monetary gifts for units to spend on anything that the winning team wishes."

AHA Resources

- AHA Living Learning Network

Behavioral Health

The vast majority of QC members integrate behavioral health into their organization-wide quality improvement initiatives. Members emphasized that accurate and suitable data play a pivotal role in the success of behavioral health interventions, and some data might be outdated

Strategies for Success

- **Update unit types to align with high-volume patient demographics.** Members found that updating unit types and patient approaches to better align with demographic realities can foster an environment conducive to kick-start improvement efforts. For instance, reclassifying a general psychiatric unit as a geriatric unit enabled members to gather more precise data on falls and adverse events, facilitating the implementation of targeted interventions tailored to older adult patients.
- **Create cohorts for psychiatric and behavioral health patients.** Members shared that grouping patients into specialized cohorts and allocating dedicated spaces for them resulted in enhanced outcomes.
- **Look to front-line team for answers.** Collect feedback and meet in person to capture a complete perspective about your organization's behavioral health unit from nurses, mental health technicians, social workers and others working directly with patients. Then use this information to develop an action plan, improve processes or develop quality metrics.
- **Use antipsychotic medications appropriately.** Members found that there can be a lack of understanding between patients and their families and, at times, with caregivers on the side effects and appropriate use of antipsychotic medications. Educating teams about alternative approaches and interventions, along with revaluating appropriate use for antipsychotic medications across different care settings, can help ensure patients receive the right care at the right time.
- **Investigate disparities to drive behavioral health interventions.** Use root cause analysis to identify where your organization is underperforming to reveal if there are health disparities and social factors influencing patients' health outcomes. Using a root cause analysis tool can help shape your approach to using behavioral health interventions.
- **Integrate physical health and behavioral health screenings and referrals.** Integrating these screenings and referrals in the emergency department and in primary care settings can improve access to care upstream for all individuals.

Improvement in Action: Examples from QC Members

The following are examples from QC members of actions they have taken to advance improvement in their organizations.

- "We had **success with fall prevention** when we shifted our general psychiatric unit to geriatric-psych. We had to focus on specific geriatric interventions, such as nonslip shoes versus nonskid socks, removing blankets in the common room to avoid tripping, among other things. It made a big difference."
- **Reduced antipsychotic medication usage** by 25% while maintaining a high quality of care for patients by exploring appropriate use of antipsychotic medications alongside reevaluating medications.
- "We are participating in the Hospital Quality Improvement Project, which has an entire section on **Zero Suicide**. This section entails all aspects of performance improvement — leadership involvement, policy, training, implementation, data collection, evaluation, etc. Currently, challenges are getting the team together. "

AHA Resources

- **AHA Behavioral Health**
- **AHA Behavioral Health: Physical and Behavioral Health Integration**
- **AHA Suicide Prevention in the Health Care Workforce**

Employee Engagement in Quality Improvement

QC members emphasized that establishing a culture of open and transparent communication with employees is essential for effective engagement in quality improvement. Implementing a feedback system and using evaluation surveys — and subsequently taking concrete action based on identified trends and engagement opportunities — have proved highly successful among QC members. When aligning organizational interventions and improvements, engaging staff — particularly team members responsible for implementation — can proactively address challenges before they escalate.

Strategies for Success

- **Feedback and evaluation surveys.** Using survey and evaluation forms can effectively capture feedback from employees on how they would like to be engaged and how they would like to participate in the organization's culture of quality improvement.
- **Pulse surveys.** Quicker pulse surveys can assess how staff are receiving new standards of procedures, interventions or organizational changes.
- **Meals with leadership.** This strategy involves selecting specific employees, four or five at a time, to have a breakfast or lunch with leadership, guided by an appropriate meeting cadence for open discussions on what's going on at care sites and what kind of support staff and patients need.
- **Messaging groups.** Many QC members are implementing a group messaging function for smaller teams to maintain a constant stream of communication that's faster than email. Members are using organization-sanctioned messaging platforms to keep staff in the loop and respond to any issues as they arise.

Improvement in Action: Examples from QC Members

The following are examples from QC members of actions they have taken to advance improvement in their organizations.

- "We implemented **Gemba boards** in each department last year to give front-line staff insights into the key performance indicators their leaders are working on, **engage them in process improvements** and **celebrate their successes**. These have been very successful in some departments. **Engaged leaders equal engaged staff.**"
- "We began to **implement a tiered huddle process pre-pandemic**. While the forward progress was slowed a bit through the last couple of years [during the pandemic], we have adapted the Cleveland Clinic model to meet our organizational needs and reflect our staff structure. We initially had great success with our upper-level, tiered huddles with the administrative team members, but had a harder time achieving consistency with the front-line team members directing their concerns up through the tiers. We have been working with our leaders from the nursing assistant team and asked for their input on how to better facilitate a consistent process. They've developed a new board system for their units that they feel will allow **contributions from all shifts** and can be driven by our lead nursing assistants and charge nurse team representatives."
- "Our greatest quality win for 2022 was **better engagement from staff in quality and harm prevention**. We rolled out what we call we call 'harms rounds,' where front-line nursing staff are assigned as a harms nurse and delegated to actively review patient safety efforts and follow up with staff on any opportunities. For example, if a patient is at high risk for a fall and the bed alarm is not on, the harms nurse would follow up with the bedside nurse to address this. This not only gets **front-line nursing staff better engaged in understanding quality and harm prevention**, but also creates a peer-to-peer evaluation where trust is already built and **buy-in is more successful.**"

AHA Resources

- **AHA Health Care Workforce Scan**
- **AHA Strengthening the Health Care Workforce Guide**
- **AHA Workforce**

Patient Experience

All QC members consistently place patients at the core of their quality definitions. Responses to "What constitutes a patient experience of quality?" included receiving timely, suitable care in a friendly and appropriate manner and fulfilling patient and family expectations or effectively managing these expectations. Notably, patient experience ranks within the top three organizational priorities by QC members.

Strategies for Success

- **Address issues in real time.** QC members noted that patient satisfaction surveys and related data typically arrive after patients are discharged, making timely responses challenging. Proactively addressing patient needs as they arise greatly enhances the patient experience.
- **Remember that first impressions are important.** Innovative approaches to real-time interventions involving a whole-team approach around patient experience are important to consider.
- **Use volunteers.** Volunteers or staff with available time can check on patients and convey their needs accordingly. This practice has been used by some QC members who noted improved patient satisfaction scores.

Improvement in Action: Examples from QC Members

The following are examples from QC members of actions they have taken to advance improvement in their organizations.

- "We use **real-time patient satisfaction surveys**. Any low scores or comments are addressed by the manager of that department, usually by a phone call. Patients have been very pleased that we have followed up with their concern."
- "Staff are educated to reach out to their leaders if they discover a patient or family member has a concern or complaint. Our goal is to try to connect with this patient or family member as soon as possible. We then listen to their story and find a mutually agreed upon resolution. Often, **patients just want to be heard and want us to know their experience**, so it doesn't happen to someone else. We follow up with any staff involved in the situation and let them know of the opportunity for improvement."

- "As participants in the quality consortium known as the Seniors Quality Leap Initiative, **we gather, analyze and compare both clinical and quality of life data across similar organizations**. We conduct monthly patient surveys and analyze the collected data to identify trends in patient-reported care experiences. We complement these formal surveys with patient council meetings, which center around survey topics and actively seek feedback on meaningful ways to enhance patient experiences. Our primary obstacles include workforce shortages affecting both nursing and ancillary teams. Ensuring the engagement of front-line teams also is crucial to sustain the improvements we enact."

- "Our med-surg/ICU/SNF unit initiated **real-time patient satisfaction meetings** with our inpatient census. The director does a random sample of patients to talk about their experience of their hospital stay. This allows us to address any concerns they may have immediately before they have been discharged to show we care about their experience. This had made a huge impact to our PSAT (patient satisfaction) scores. Fixing a problem before they leave makes a big difference. Sometimes it just entails an explanation and understanding. We also are implementing real-time surveys this year. We are really hoping to get responses from our patients to initiate some change. "
- "The biggest impact to patient experience has been **patient advisory councils (PACs)** focused on specific experiences, e.g., Deaf PAC, Black/African American PAC, Transgender PAC."
- "Conducting pharmacy rounds to **educate patients about medications** yielded significant results. Furthermore, **implementing executive rounds** also positively influenced our scores."

AHA Resources

AHA Patient and Family Advisory Councils: Resources for the Field

Health Equity

Many members shared common challenges in establishing consistent and reliable methods for collecting and assessing health equity data and statistics. Common obstacles included incomplete ethnicity identification upon admission, suboptimal electronic health record capabilities for gathering health equity data and difficulties in effectively using the collected data. Generating written reports from EHRs and connecting to race and ethnicity are difficult, often requiring manual labor that adds to time and resource constraints.

Strategies for Success

- **Create a team.** Health equity work is multifactorial and very expansive. Creating a team focused on health equity is necessary in order to address equitable and inclusive organizational policies, collect and use data to drive action, ensure diverse representation in leadership and governance, and provide culturally appropriate patient care.
- **Community collaboration.** Partnering with community organizations in collaborative leadership, innovation solutions, evaluation and sustainability of solutions is crucial in improving the overall health of patients and their communities. A QC member shared that they partnered with their local transportation authority to help patients return home after their visit to the hospital. This alleviated congestion in waiting rooms and emergency departments.
- **Use the Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry Social Vulnerability Index**. This tool provides racial, ethnic, minority, and socioeconomic status information by county to help target interventions.

Improvement in Action: Examples from QC Members

The following are examples from QC members of actions they have taken to advance improvement in their organizations.

- "We **assess social determinants of health and address needs** at every outpatient clinic visit, as well as inpatient, via case management. We share resources with patients and set them up for any needs while they are with us. We are in the process of collecting and analyzing data to identify our highest need, and health equity is a focus of our quality plan for 2024."
- "Health equity has been a new topic this last year with The Joint Commission and Centers for Medicare & Medicaid Services. We have used community health assessment data along with state data in our organization. We took this initial data and created a SDOH team to do an analysis of our community needs and create an action plan. We then started collecting the **REAL (race, ethnicity and language) data** as mandatory fields. Our team reports their data to our quality committee, up to the board. Health equity is included in our quality plan as an organization. Currently our team has implemented an inpatient and outpatient food bank based on our initial assessment and action plan."
- "The community I serve is in a very country setting — there are no taxi, Uber or Lyft services in this community. **Our director worked with Michigan Transportation Connection to provide patients with transport to and from our care center**. Now we no longer have patients sitting in the waiting room for hours on end waiting for family to come get them. "
- "We are implementing an intervention using **natural language processing solutions** to identify patients who are at risk for SDOH. The NLP solution uses AI to learn identifiers of SDOH through the EHR and alerts clinicians, social workers and other health professionals to take action and get a meeting or intervention scheduled. It takes data from Epic, and the NLP churns through all the notes to find words and phrases that indicate SDOH and pushes that back into Epic. This technology has high confidence standards in recognizing SDOH, but it also learns from the input of health professionals as it is being used, to become more and more accurate in identifying SDOH and patients who need action."

AHA Resources

- **AHA Community Health Improvement**
- **AHA Health Equity Roadmap**
- **AHA Institute for Diversity and Health Equity**

Age-Friendly Care

With the older adult population increasing, ensuring hospitals and health systems have the structure and systems in place to address this urgent need is vital. QC members emphasized that initiating collaboration with the quality department and starting to segment data by age are essential first steps in addressing the health care needs of older adults. Using the Age-Friendly Health Systems movement's 4Ms framework — "what matters" to the patient, medications, mentation and mobility — can help improve care and health outcomes for patients age 65 or older. Additionally, capturing data tailored to this demographic has empowered age-friendly care teams with actionable insights to create targeted interventions for this population.

Strategies for Success

- **Start with the work you already do.** Effective age-friendly care practices typically align with high-quality care. There is no need to "recreate the wheel." Health care teams can start with a gap analysis checked against the 4Ms framework to find opportunities to align their organization with Age-Friendly Health Systems recognition requirements. Most organizations find they're already doing a lot of this work.
- **Collect, stratify and use data.** Several small interventions can align an organization's care with the 4Ms. The first step is ensuring data is collected and segmented by age (patients 65 years or older) and using that data to guide care plans and interventions for older adult patients.
- **Formalize a structure to include older adult voices.** Creating quality committees that include patients, family members and caregiver voices and experiences can help meet the needs of older adult patients.
- **Align your EHR with the 4Ms framework.** Taking the time to implement the 4Ms framework within the EHR is a great way to meet the needs of older adult patients. Being able to see a patient's "what matters" goals across the care continuum is especially vital to aligning the care provided with the patient's goals and needs.
- **Create a 4Ms dashboard.** Having one central location for older adult patients' data, goals and progress is an excellent way to monitor and track age-friendly care outcomes while implementing interventions to meet patients' needs.
- **Work toward becoming recognized as an age-friendly care site.** The Institute for Healthcare Improvement (IHI) offers care sites the opportunity to be recognized as an Age-Friendly Health Systems "Participant" or "Committed to Care Excellence." AHA and IHI lead Age-Friendly Health Systems action communities that provide free webinars, 1-to-1 coaching and resources on implementing the 4Ms framework.

Improvement in Action: Examples from QC Members

The following are examples from QC members of actions they have taken to advance improvement in their organizations.

- **Reduced falls/injuries by 75%** by engaging unit staff in root cause analysis and asking for feedback on how to address issues. Transparency through data was key.
- "**We implemented an Age-Friendly Advisory Committee** to leverage work across the continuum of care settings. This is an approach that looks forward and more in line with failure mode and effects analysis versus root cause analysis — looking forward to anticipate issues versus looking back to address them (in retrospect). Our entire continuum of care shares the same EHR, so it's easier for us to manage this intervention."
- "As a post-acute provider of geriatric care, age-friendly care is right up our alley. **We began to pursue formal recognition as an Age-Friendly Health System in the last two years**, and securing that recognition has been our biggest achievement in this space. The acknowledgment has driven a concerted effort to continue to excel in this space and lead the way. As part of this, we have created an interdisciplinary committee to drive forward all age-friendly work and projects and analyze metrics and progress. We also have begun implementation of EHR documentation specific to the 4Ms to include nursing team interventions and team flowsheets."

AHA Resources

- AHA Age-Friendly Health Systems

Board Engagement

During a deep-dive session on board engagement, most QC members said they are involved with informing and supporting their board on quality initiatives and concerns. Many voiced, however, that there is still room for further engagement of board members to increase their involvement and understanding of quality and performance improvement.

Strategies for Success

- **Create and maintain a culture of transparent communication.** Ensuring direct and transparent communication and sharing data with the board on a regular cadence fosters a relationship of shared accountability and also pushes forward a patient-centric agenda. QC members reported strong board engagement in a culture where knowledge, especially from outside the health care field, is valued and used to create a collaborative learning environment.
- **Establish an orientation process for new board members.** Formally onboarding board members to quality and performance improvement in health care ensures that board members are well informed and quality regulations are met, so they are valuable contributors in meetings. Not all board members start their terms with an extensive knowledge of health care field terms, topics and data expertise. Providing a process and dedicated time for education and encouraging communication can be key to establishing a strong relationship with the board.
- **Make quality a priority.** Quality needs to be a topic on every meeting agenda to discuss ongoing performance improvement work, key performance indicators, adverse events, rising trends in quality as well as feedback from patients and community members.

Improvement in Action: Examples from QC Members

The following are examples from QC members of actions they have taken to advance improvement in their organizations.

- "Once a quarter, we have a special meeting before the board meeting that's dedicated to patient safety and quality. This is an interactive session where we review our **quality metrics** (both internal and publicly reported), performance improvement projects, root cause analysis, etc. We also talk about things like culture of safety survey results, Leapfrog and disease-specific care certification. It usually leads to good dialogue and keeps the board engaged in our quality efforts. Just as we train our employees, we also **provide training to our quality board on process improvement** and trends or benchmarks we are trying to meet. I also fill the compliance role, so I always encourage our board to ask questions and dig deeper around identified gaps and issues we report. And if we don't follow up with some improvement, they should be asking us for it."
- "We have a very **transparent and collaborative** environment, and that is a key part of the culture leading to this organization's success in engaging the board. This relationship is ever evolving, but you need to have that trust with the CEO to be able to put your quality team in front of the board. Everyone in the room wants to do the right thing, and this provides positive feedback to keep the culture that way."
- "We have a specific **onboarding process for new board members that is orientation for quality** and metrics and regulations. We educate the board on the dashboards and metrics and what everything means."

AHA Resources

AHA Trustee Services: Helping Boards Have Productive Conversations about Quality of Care

AHA Trustee Services: Understanding Quality Scorecards: A Primer for Boards

AHA Trustee Services: You Have a Quality and Safety Report. Now What?

Future of Quality in Health Care

Throughout the QC, members shared their thoughts on the future of quality in health care, identifying top priorities for the next three to five years and key focus areas to build quality back to pre-pandemic levels and surpass them, which aligns closely with what is identified in **AHA's 2024 Environmental Scan**.

- **Encourage a hospital-wide or system-wide commitment to providing STEEEP.** Promote access to exceptional quality — that is, safe, timely, effective, efficient, equitable, patient- and family-centered (STEEEP) and affordable care.
- **Embed quality into the care journey.** Develop and promote new and innovative care models, services and collaboration to provide seamless care.
- **Foster engagement.** Increase engagement among providers, patients and their families to promote informed and collaborative decision-making.
- **Promote patient safety.** Continue to strive to prevent all harm or death from health care errors through quality improvement efforts, just culture and team communication.
- **Encourage leadership involvement in quality.** Engage hospital and health system leadership in quality improvement initiatives.
- **Advance health equity.** Create a care journey that is free from inequity while optimizing opportunities, access and outcomes for historically marginalized and under-resourced communities.
- **Community partnerships.** Lead and partner with other community organizations to coordinate health care and address health care disparities to improve the health status of the community.
- **Strengthen resiliency.** Develop metrics and quality improvement programs that evaluate and promote the ability of health care systems and providers to be prepared for a changing health care ecosystem and to adapt to future emergencies or challenges.
- **Embrace the digital age.** Electronic data, which is standardized, interoperable and shared, is essential to promote seamless care coordination and communication.

Further Insights from Members on the Future of Quality

- **The role of technology.** QC members see artificial intelligence and emerging innovations in disinfection practices becoming more prevalent. In addition to examples of AI guiding health equity solutions via natural language processing, members think there's room for AI to guide clinicians in evidence-based medicine. Innovations such as the emerging dry hydrogen peroxide disinfection technology can be explored to improve infection prevention and reduce HAI rates. With the increase in telehealth during the COVID-19 pandemic, it's important to continue developing telehealth and engaging patients with their care at home.
- **Innovation and quality.** One QC member shared that the COVID-19 pandemic brought the field together in a unique way under unique circumstances that required us to innovate to meet patients' needs. Without the pandemic as an existential community-wide focal point — and everything that went along with it — sustaining forward momentum on some initiatives has been challenging. QC members wondered how we could capture the positive aspects of the pandemic's all-in mindset to continue driving quality in this next phase of healthcare improvement.
- **Additional resources for quality impact.** If given five extra full-time equivalents, one QC member said they would spend those resources on rounding for high-risk patients, using rounding to influence compliance with evidence-based bundles and expand value stream improvement efforts. Other members would spend the extra resources on department-specific "champions" to ensure interventions have follow-through. Others would spend the extra resources on adding clinical quality nurses on every unit and/or adding dedicated pharmacists on high-risk units such as the emergency department. Overall, QC members emphasized that more resources should be put into quality improvement support for implementing interventions and collecting and analyzing the data.

AHA Patient Safety Initiative

QC members have consistently emphasized the pressing need for increased collaboration and a stronger sense of community in the realms of health care quality and performance improvement. Throughout the QC discussions, it has become evident that candid, informal dialogues on clinical and cultural aspects of quality have illuminated the myriad challenges and opportunities that confront the field. These discussions also have offered valuable insights and strategies along with examples of successful initiatives and interventions, fostering a culture of shared learning.

Building on the success of the QC, the AHA is further amplifying the impact of quality improvement through its new Patient Safety Initiative. By seamlessly integrating insights from this collective, the AHA has created a comprehensive approach that not only addresses the evolving landscape of health care quality but also enhances patient safety on a broader scale. Together, this work will fortify the commitment of hospitals and health systems to deliver exceptional care in the face of current challenges and future uncertainties. For more information please visit: **https://www.aha.org/aha-patient-safety-initiative**.