El Camino Health

AGENDA

SPECIAL JOINT MEETING TO CONDUCT A STUDY SESSION OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS AND THE QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE

Wednesday, October 23, 2019 – 6:00pm
El Camino Hospital | Conference Rooms E&F (ground floor)
2500 Grant Road Mountain View, CA 94040

EL CAMINO HOSPITAL BOARD MISSION: To heal, relieve suffering, and advance wellness as your publicly accountable health partner.

QUALITY COMMITTEE PURPOSE: To advise and assist the El Camino Hospital (ECH) Board of Directors ("Board") in constantly enhancing and enabling a culture of quality and safety at ECH, and to ensure delivery of effective, evidence-based care for all patients. The Quality Committee helps to assure that excellent patient care and exceptional patient experience are attained through monitoring organizational quality and safety measures, leadership development in quality and safety methods and assuring appropriate resource allocation to achieve this purpose.

	AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
1.	**CALL TO ORDER/ ROLL CALL/WELCOME**	Lanhee Chen, Board Chair		**6:00 – 6:30pm**
2.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Lanhee Chen, Board Chair		**information 6:03 – 6:04**
3.	**GOALS OF THE SESSION** ATTACHMENT 3	Dan Woods, CEO		**information 6:04 – 6:10**
4.	**LEVEL SETTING** a. Current State of the Organization b. Strategic Plan – Quality Pillar	Mark Adams, MD, CMO		**information 6:10 – 6:35**
5.	**ROUNDTABLE – REACTIONS TO PRE-READING MATERIAL** ATTACHMENT 5	Guy Masters, Premier, Inc.		**discussion 6:35 – 7:00**
6.	**ROLE OF GOVERNANCE IN QUALITY AND SAFETY**	Guy Masters, Premier, Inc.		**discussion 7:00 – 8:29**
7.	**ADJOURNMENT**	Lanhee Chen, Board Chair	*public comment*	**motion required 9:14 – 9:15pm**

Upcoming Meetings:

Regular Meetings: November 6, 2019; December 11, 2019; February 12, 2020; March 11, 2020; April 15, 2020; May 13, 2020; May 26, 2020*; June 10, 2020 *Joint Meeting with Finance Committee

Education Sessions: April 22, 2020

A copy of the agenda for the Special Board Meeting will be posted and distributed at least twenty four (24) hours prior to the meeting.
In observance of the Americans with Disabilities Act, please notify us at (650) 988-7504 prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

El Camino Health's Quality and Safety Journey and the Role of the Governing Board

Dan Woods, Chief Executive Officer
Mark Adams, MD, Chief Medical Officer

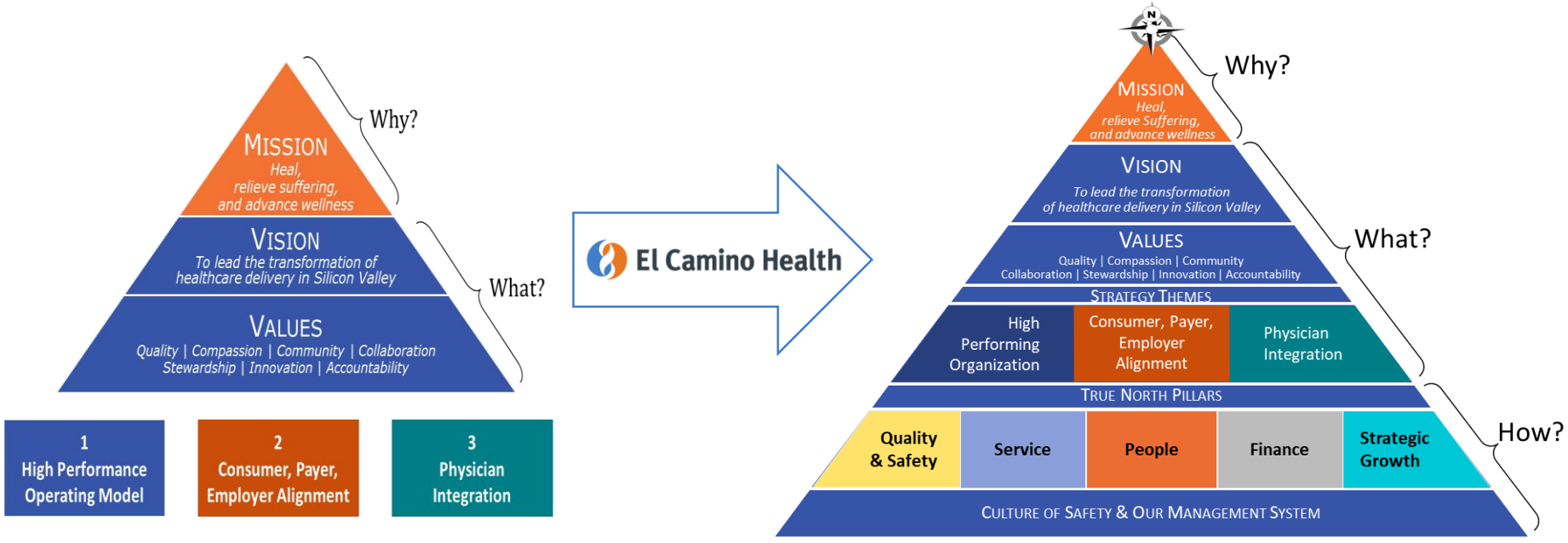
Special Joint Meeting to Conduct a Study Session
of the El Camino Hospital Board of Directors
and the Quality, Patient Care and Patient Experience Committee

October 23, 2019

Schedule

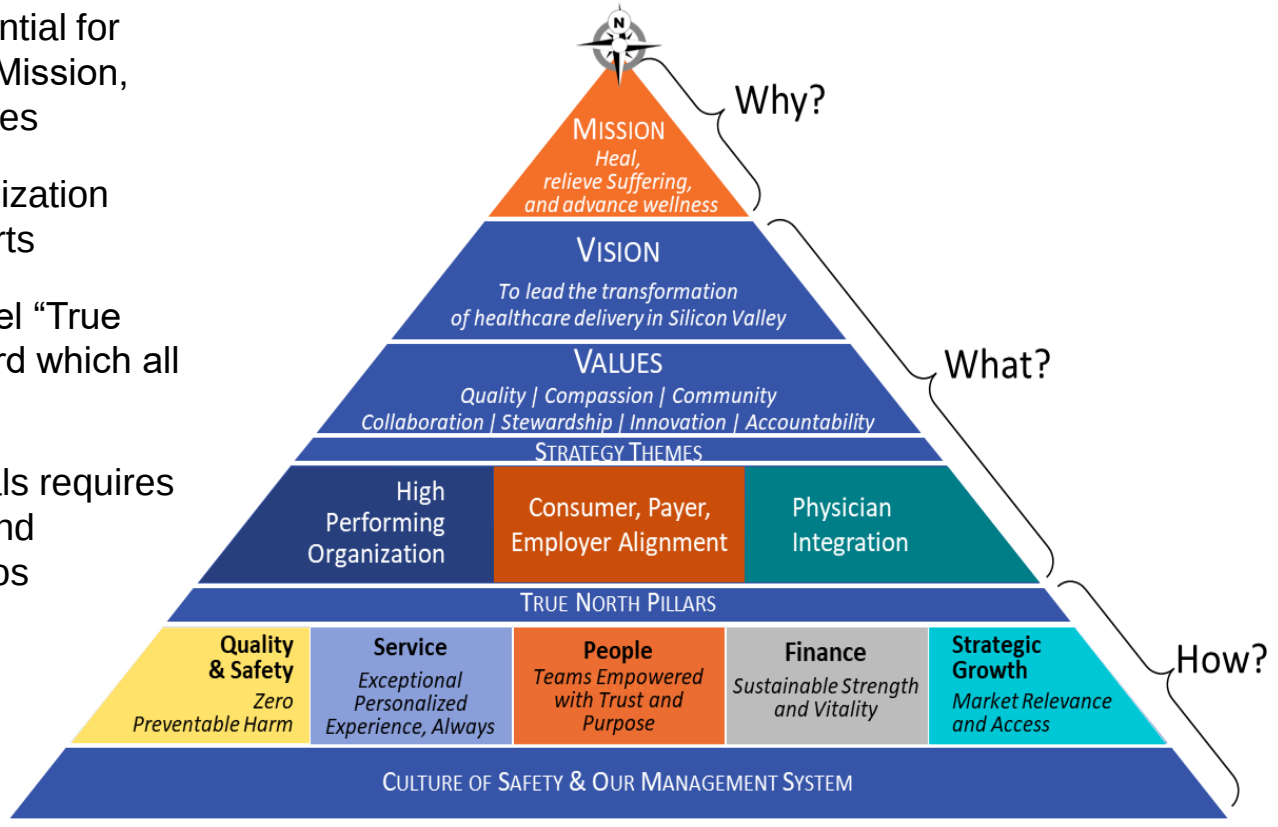
1. 5:30pm: Dinner and socializing
2. 6:00pm: **Welcome** – Lanhee Chen
3. 6:04pm: **Goals of the Meeting** – Dan Woods
4. 6:10pm: **Quality and Safety Level Setting**: Current State of the Organization (including regional and national comparisons) – Mark Adams, MD
5. 6:25pm: **Strategic Plan/Quality Pillar** – Mark Adams, MD
6. 6:35pm: **Roundtable** (each participant to share one question or reaction to the pre-reading materials – Guy Masters
7. 7:00pm: **Role of Governance** (Board and Committee) in oversight of Quality and Safety – Guy Masters
8. 7:30pm: **Group Discussion** (how do we fulfill our roles) – Guy Masters
9. 8:30pm: Adjourn

As We Shift to a Health System, We Look To Implementing a new Strategy Execution Methodology – True North



The True North Pyramid Provides a Model to Align Organizational Effort to Achieve Our Mission

- The Five Pillars are each essential for achieving El Camino Health's Mission, Vision, and upholding our Values
- The Pillars also allow all organization stakeholders to align their efforts
- Each Pillar contains a high level "True North goal" or ideal state toward which all effort should be focused
- Attaining these True North goals requires coordination between teams and elimination of management silos



El Camino Health

Quality and Safety – True North: Zero Preventable Harm

	Organizational Goal	Baseline	FY2020 Target	Measure Period
H	**Risk Adjusted Mortality Index**	FY 2019 = 0.97	≤ 0.90	YTD
H	**Risk Adjusted Readmissions Index**	FY 2019 = 0.99	≤ 0.96	YTD
H	**Rate of Serious Safety Events (SSEs)**	New Program	Establish a baseline for SSE rate Proxy Measure: 95% classified within 30-days or report	YTD
E	**Culture of Safety Score**	FY19 = 4.03	≥ 4.06	May 2020
A	**To Be Determined**	TBD	TBD	YTD

FY2020 Metric Explanation

Quality and Safety Pillar: Highest quality care is an expectation; our ultimate goal is to assure patients we are eliminating any preventable harm. This requires a culture of safety and High Reliability. We are early in this journey, and are developing baseline metrics and capabilities prior to aligning incentive goals with High Reliability Organization (HRO) metrics

Proposed Metrics:

- **Risk Adjusted Mortality Index** – Nationally recognized metric for understanding observed mortality in relation to what was expected from the diagnosis. This is one of the metrics that impacts our Value Based Purchasing performance. Current performance
- **Risk Adjusted Readmissions Index–** Nationally recognized metric that impacts the readmission penalty program; serves as a proxy for quality of care
- **Rate of Serious Safety Events –** This is a fundamental performance metric of a HRO, which El Camino Health is aspiring to become. As most HROs begin measuring Serious Safety Events (SSE), they see an increase in SSEs as employees report more readily. To discourage undesired punitive actions against those reporting, experts recommend starting by reporting on a proxy measure - percentage of SSEs classified into the HRO subcategories within 30 days of report.
- **Culture of Safety Score** – Culture of Safety is a subset of the employee and physician engagement surveys.
- **Ambulatory Measure –** We are working with Ambulatory Leadership to identify what the highest priority Quality Metrics will be for FY20

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THE BOARD'S ROLE IN QUALITY

SECOND EDITION

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Acknowledgements

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Introduction

The responsibility for quality of care and patient safety lies with the hospital/health system board. This responsibility cannot be delegated to management or the medical staff. Ensuring quality and safety—ensuring that quality continues to improve, and sustaining those improvements—*requires* leadership from the highest level of the organization—the board. A seemingly overwhelming task, especially given many board members' discomfort with medical terminology and clinical protocols, it nonetheless can and must be accomplished.

As part of its leadership role, the board should establish a formal policy or statement that puts quality of care, which includes patient safety and patient experience, at the forefront of the organization's priorities. This goes beyond approving the organization's strategic plan or quality improvement plan. It involves a formal declaration by the board to everyone in the organization that quality is the primary purpose of the hospital or health system. That's the first step. Experts agree that boards prefer to leave clinical decision making to the clinicians. But board oversight entails broad strategic direction setting of the processes that ensure continuous quality improvement in the organization—that safeguard each and every patient and protect the organization as it fulfills its mission. The board can be a uniquely effective partner with medical staff and administration in building a culture of quality, accountability, and safety.

This *Elements of Governance*® provides an overview of the board's role in overseeing and ensuring quality of care. Some of the information in this 2nd edition is excerpted from *Quality,* The Governance Institute's 2006 signature publication; the new edition provides updated information related to the board's role in monitoring quality in the context of population health and value-based care metrics that are priorities for most hospitals and health systems today. We outline key components of the board's role in quality, the role of the board quality committee and a checklist for its actions, and the board's role in physician credentialing, and suggest questions boards can ask to help guide their oversight and decisions.

The Board's Role in Quality

The governing board has a fiduciary responsibility to maintain the hospital in good order. We tend to think of this fiduciary responsibility in terms of maintaining capital assets, financial planning, the bottom line.

Actually, the board's fiduciary responsibility is far more extensive. The word fiduciary roughly means to "hold in trust." Of course, the board is responsible for financial stability; without that, it couldn't carry out any of its responsibilities. But more broadly, the governing board is responsible to the community for all activities of the organization. This means a hospital governing board has an ethical obligation to ensure it is doing everything it can to keep patients safe and offer the highest quality care. Moreover, today's research continues to show that poor quality costs more (especially as payers continue to move towards value-based care payment models). Thus, ensuring quality is an integral part (if not the most important part) of the board's fiduciary responsibility.

Because the board is responsible for financial oversight, it needs to establish key financial objectives and monitor financial measures related to organizational goals. Similarly, because the board is responsible for quality oversight, the board needs to define key quality objectives and regularly monitor relevant measures of quality to ensure goals and targets are being met.

An engaged board should be asking three questions:

- Is there a process in place so the board can assure itself that the outcomes and processes being measured for quality are the most relevant ones?
- Can management and the medical staff adequately articulate the outcome and process improvement goals they are setting for themselves—and how these will be measured?
- Is there a process in place so the board can determine over time whether the medical staff and management team are accomplishing their goals?

—Thomas Priselac, President & CEO, Cedars-Sinai Medical Center

The board's responsibility for quality of care is both an *ethical* and *legal* obligation. A landmark court case, Darling versus Charleston Community Memorial Hospital (1965), placed responsibility for quality of care on the hospital board, which has the ultimate responsibility for ensuring the quality of patient care. Standards set by The Joint Commission specify that a hospital or health system's leaders, *including the governing body,* evaluate how effectively they fulfill their responsibilities for: creating and maintaining a culture of safety, fostering the use of data, creating and supporting processes for communication, and designing and staffing work processes to promote safety and quality. Joint Commission Leadership Standard LD.03.06.01 EP6 states, "Leaders evaluate the effectiveness of those who work in the hospital to promote safety and quality."

What does this mean in relation to quality oversight?

The board needs to:

- Ensure that an efficient and effective quality program is in place and operating as charged, in all care settings where the organization's patients may receive care.
- Know that the hospital has effective mechanisms to measure, maintain, and improve quality, safety, and patient experience.
- Approve quality improvement plans and goals.
- Monitor performance in relation to those goals.
- Exercise accountability in seeing that goals become a reality.
- Credential (appoint, reappoint, and determine privileges of) the medical staff.
- Ensure that quality and cost are appropriately related and that the organization's culture and strategy support the need for all staff and physicians to understand and focus on efforts related to increasing quality, improving the patient experience, and reducing cost.

The placement of quality and safety issues for discussion on the board's meeting agenda, and the attention they get at the board table, say everything about the priorities for quality and safety in the organization.

Taking responsibility for quality of care doesn't mean that board members have to master all the clinical details. They definitely don't need to participate in debates over the best medication for a particular condition, or discuss a stent versus a cardiac bypass, or any of the other myriad details that comprise high-quality medical care. They don't need to review quality-related operational reports. But the board should know that someone in the organization is accountable for the details and that those individuals, departments, or committees are doing their jobs effectively. The board has and should use its authority to ask for evidence of effective measurement and improvement efforts. Don't accept "continue to monitor" as a never-ending refrain in response to sub-par results. The board has to exercise its accountability as assertively for quality as it does for finance.

Challenges

The following are typical barriers board members experience in overseeing quality of care:

- Board members who do not have a clinical or healthcare background often assume that they cannot oversee quality. But this is not the case, and board members have a fiduciary duty to oversee quality; it cannot and should not be delegated to the medical staff. Asking tough questions is the best way to hold management and physicians accountable to the quality of care being provided.
- Similarly, board members assume that they cannot take part in the credentialing process because they do not know enough about clinical practice, relying on the medical staff leadership to make recommendations. This results in physicians reappointing their colleagues because they are liked and well known, not because they meet the criteria for being reappointed.
- Quality is an ongoing effort and requires continuous monitoring. It should be given the most amount of time and attention by the board. System boards must clearly delineate the roles of the system board and the subsidiary boards so that metrics are standardized and work is not duplicated.

Hospitals and health systems across the country are now being charged to deliver not only high quality but also value. As part of the new "value equation," healthcare leaders are evaluating their care delivery systems and using the Institute for Healthcare Improvement's (IHI's) Triple Aim framework and assessing whether they are able to provide care that 1) enhances the patient experience (i.e., accessible and affordable care centered on the needs of the individual patient); 2) enhances the overall health of a population; and 3) simultaneously reduces the per-capita cost of care.

This responsibility is now enhanced due to value-based payment models tying reimbursement to quality outcomes, and the increasing need to address quality and cost simultaneously.

What Is Quality?

The IOM defined quality of care using the STEEEP acronym in 2001, which is still widely used today:

- **Safe**: the patient's safety comes first
- **Timely**: care should be delivered in the timeliest manner possible
- **Effective**: care is based on the best scientific knowledge currently available
- **Efficient**: care is not wasteful of time, money, and resources
- **Equitable**: care does not vary in quality because of patient characteristics, such as ethnicity, ability to pay, or geographic location
- **Patient-centered**: care is respectful and responsive to individual preferences, needs, and values

Ask the Right Questions to Get the Job Done

Across the broad landscape of quality, the board should start by considering the following three questions:

- What are we trying to accomplish? (The aim)
- How will we know that a change is an improvement? (The measures or indicators)
- What changes can we make that will result in improvement? (The action plan)

(From G.L. Langley and colleagues, *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*)

Big Picture Questions

Boards should ask big-picture questions to get a sense of the quality "status" of their organizations, for example:

- How much variation is there in what we do?
- Is there evidence to support what we do?
- In situations where the best practice is well-defined, how often do we actually follow best practices?
- Are we efficient compared to our competitors?
- Do we have a plan to improve quality and efficiency—and has this plan actually been put into action?
- What key measures do we use to evaluate the quality of care we offer? How do we rank on those measures today, compared to a year ago, or five years ago?

Specific Questions

- What is our mortality rate (and other clear-cut quality measures)?
- How many patients received the wrong medication this month compared to last month, compared to a year ago?
- How many surgical site infections have we had in the last year?
- Are these numbers trending upward or downward?
- What steps have we taken in the past year to reduce medication errors?
- What systems do we have in place to reduce the risk of surgical site infections?

Organizations taking on a population health model are adding population health-related metrics to the quality dashboard as well, such as indicators for diabetes detection and management; obesity reduction; behaviors such as exercise, diet, and tobacco use; and preventable hospitalizations.

Three Specific Board Responsibilities

The first, essential step in ensuring high-quality care is credentialing competent physicians. The board typically delegates a major portion of the credentialing process to the medical staff and management. However, the board is responsible for participating in the development of, and approving, the criteria for credentialing, and for monitoring and maintaining the integrity of the process. The physician's application and supporting documentation are reviewed by the appropriate clinical department. The medical staff's recommendation may go through a board committee before it is forwarded to the full board for action.

In some situations, the board may need to make difficult decisions related to credentialing. Many hospitals have one or two physicians everyone knows aren't functioning well, but there is a pervasive reluctance to speak out against a professional peer. Ultimately, the board is responsible for dealing with them to protect patients.

Second, the board should monitor high-level, system-wide quality markers such as the mortality rate. This is a clear-cut measure, but needs to be risk-adjusted to allow comparisons with other organizations. When the governing board monitors its own hospital's mortality rate over time, it should be checking to see whether it is declining. There are effective steps for decreasing inpatient mortality—this has been clearly demonstrated through the various IHI initiatives over the years, from the 100,000 Lives Campaign to the 5 Million Lives Campaign. We used to think of mortalities as "unfortunate but expected events." Now, we think of each mortality as a potentially preventable death.

Other high-level, system-wide quality markers include:

- Appropriate care score
- HCAHPS 24-month mean
- Overall readmission rate
- AHRQ Patient Safety Measures
- Serious safety event rate
- Infection prevention
- Medication safety

See **Appendix 1** for sample board quality dashboard reports.

Third, the board needs to set the quality agenda for the organization. It needs to weigh a number of worthy issues against each other, and set priorities. As boards become more engaged in quality oversight they are likely to establish specific targets, such as "our top goals for the year," and/or "our five key targets for three years from now." Then the board can ask questions on a quarterly or a monthly basis—are we performing as expected? If not, why not? What is our plan for performance improvement? Using specific targets gives the board a way to monitor and evaluate progress. It means you can discuss what is happening in focused terms, as opposed to an amorphous "we'll try to do better next quarter."

As part of this process, the board may seek members who have expertise in quality issues, either in healthcare or another field, just as governing boards often seek members with expertise in finance.

As another part of this process, the board may encourage physicians to speak in non-technical language when they interact with the board. Some physicians have the skill of summarizing and generalizing clinical quality issues in terms intelligent laypeople find easy to understand. This ability and willingness to share the broad parameters of quality issues with board members is a valuable skill, and one to be appreciated.

Lay board members also bring something valuable to the discussion. Physicians are trained to think in a very precise, detail-oriented, case-related, problem-solving way. Board members often have a more global view of the process as a whole. They ask valuable questions. When clinicians think about "high-quality healthcare" they may define it as a situation where the patient lived, didn't get any new infections in the hospital, and was discharged quickly. A community member, on the other hand, is just as likely to ask whether the family was allowed to visit, food was nourishing and palatable, and pain was well-controlled. From a patient's perspective, the most important question about healthcare quality may be whether a vulnerable person is treated with dignity and respect.

With many factors driving the quality agenda, the board should make quality a strategic focus of its fiduciary oversight activities. A significant amount of time should be dedicated to discussion around quality issues at most board meetings. Making quality a priority also requires integrating into the board decision-making process, at every key juncture, questions as to how the decision will positively impact quality, what steps are being taken to maximize the positive quality impact, and how the positive quality impact will be measured and evaluated as part of assessing the overall success of the hospital or health system's strategic plan.

Tools to Assist in Generative Thinking (Applied to Board Oversight of Quality)

Questions to Consider When Looking Backward

- What best explains recent successes or setbacks?
- If we are what we do, then who are we? (Focus on actions the board has taken.)
- How have we reconciled tradition and innovation?
- What is the organization's theory of change?
- Where has there been resistance and why?
- What is the storyline that drives the product line?
- How are we smarter as a board and an organization than we were a year ago?

Catalytic Questions

- What should we worry about?
- What keeps the CEO and board members awake at night?
- Whom would we serve, and in what ways, if money did not matter?
- What do we do that peers would not do, and why? What do peers do that we would not do, and why?
- What non-traditional competitors should we be comparing ourselves against?
- What will be this board's legacy?

Source: Adapted from Richard Chait, Ph.D., Professor of Higher Education, Harvard Graduate School of Education

The Board's Role in Context

The board is responsible for setting overall direction and strategy, making decisions, and continuing oversight (including holding management accountable for achieving goals), while management implements board directives. The board sets priorities, guided by the organization's mission, vision, and values.

This means the board:

- Assesses organizational needs
- Sets goals and objectives
- Develops a strategic plan
- Turns the plan over to management for implementation

The board is responsible for monitoring progress reports, evaluating what worked or did not work (and why), and using the results of these evaluations to shape future plans.

Measuring and Monitoring

In the context of quality, the board might decide to focus attention on a specific area of critical future importance such as a technology acquisition to improve patient care, or preparing for value-based payment models, or deciding whether to pursue the Baldrige Award. The board may address an emerging quality issue, such as standards for preventing unnecessary readmissions, improving patient experience scores in a certain domain that may be tied to quality concerns, or which new metrics should be added to measure the health/improvement in health of a target population for value-based or population health payment models.

It is essential for the hospital board to formally establish and communicate the organization's strategic goals for quality improvement. There are many ways of defining and measuring quality, but there must be an organization-wide understanding of how leadership has defined quality for the organization. Indicators must be established, measured, and managed. You can only manage what you measure; therefore, deciding which quality indicators to track is a key decision. Metrics must be clearly defined, measured, and progress compared month over month, year over year. If indicators/metrics are compared against others in the community, the region, and/or the country, they should match or exceed the best, not the average.

The board may decide to focus, at a minimum, on traditional indicators such as length of stay, mortality rate, and morbidity for various conditions. Another way is to pay attention to "bundles" of indicators, which taken together dramatically affect outcomes in conditions such as CMS core measures, metrics for CMS bundled payment programs, and AHRQ safety measures.[1] A variety of statistical and graphical methods can make the significance of quality indicators clear at a glance, including comparison charts, run charts, control charts, and trending. And most importantly, the more quality data gathered, the more it needs to be reported on in a meaningful way so that the board quality committee and the full board can make strong decisions on where and how to take action.

What does the board need to know about quality-related programs?

- Is there a written plan with appropriate goals, priorities, and resources?
- Have processes been designed to improve quality in the specific area?
- Are data collected and processes evaluated for effectiveness frequently (ideally, weekly)?
- Is senior management engaged to a significant degree?
- Is responsibility clearly assigned?
- Are design failures adjusted immediately?
- Are design successes monitored on a routine basis, with needed adjustments made?
- What is being done about reducing/eliminating medical errors?

See **Appendix 1** for sample quality dashboard reports.

Population Health Models: Overseeing Quality in Non-Hospital Settings

One of the largest changes in the board's responsibility for quality since the first edition of this publication is that most hospitals and health systems are employing population health models ranging from ACOs to other clinically-integrated network care delivery structures. This involves dealing with a mix of employed and independent physicians, as well as coordinating and overseeing the quality of care provided outside the hospital—clinics and physician offices, skilled nursing and other post-acute care facilities, and any follow up care provided to patients by home health agencies.

1 For more information, visit: CMS core measures: www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualitymeasures/core-measures.html; CMS Bundled Payment Initiatives: https://innovation.cms.gov/initiatives/bundled-payments/; AHRQ safety indicators: qualityindicators.ahrq.gov/measures/psi_resources.

This cross-continuum care affects how well the patient does when he or she is in the hospital, and their recovery after being in the hospital. Boards have more stake in the game as CMS no longer reimburses for certain errors and unnecessary/unplanned readmissions, and hospitals and health systems suffer in population health and value-based payment models when patients receive inadequate care in any of these non-hospital settings.

These issues provide a new, unique challenge for hospital and health system board members. Mechanisms must be put in place to monitor care provided in every care setting. Developing relationships with post-acute care providers and sharing/setting quality expectations and goals with such providers is essential (as is ensuring that your hospital staff knows which post-acute providers provide the level of care that meets expectations, and a process is put in place to transfer patients to only those preferred providers and communicate with those providers regarding patient needs and medication instructions prior to discharge). Independent physicians should be every bit as aware of quality goals as are employed physicians, and a structure built to work together with all physicians to follow clinical care protocols (both in and out of the hospital) so that quality standards can be met.

Addressing Patient Experience as Part of the Board's Responsibility for Quality

Today, most boards believe they are fulfilling their responsibility for improving the patient experience by monitoring HCAHPS (and CG-CAHPS for those who have employed/owned physician groups) survey scores as part of the quality dashboard during quality committee meetings. But this is usually a reimbursement-focused initiative (asking questions such as, "What are we doing to improve our scores?"). This narrow focus can cause experience staff to get lost in the weeds and lose sight of the bigger picture (e.g., does a concerted effort to improve one survey score or domain such as nurse communication truly improve the patient experience overall?). More importantly, it represents a lost opportunity for organizations to tie patient experience to quality and population health efforts, which can help move the dial for all three legs of the stool that much more quickly.

Faced with the need to improve care quality and reduce costs, many health systems have implemented efficiency methodologies such as Lean and Six Sigma. When used effectively, these practices improve patient flow and address quality checklists and safety risks. However, they fail to address some of the greatest barriers to patient care including fragmented communication, broken relationships, unaddressed emotional needs and concerns, and physical barriers to receiving care. According to The Joint Commission, 80 percent of serious medical errors are linked to communication failures during transitions of care.[2] These gaps in the human experience are key drivers of sentinel events,[3] low patient engagement, and poor clinical quality.

2 The Joint Commission Center for Transforming Healthcare, Hand-off Communications (available at www.centerfortransforminghealthcare.org/tst_hoc.aspx).

3 Ashish K. Jha, et al., "Patients' Perception of Hospital Care in the United States," *The New England Journal of Medicine,* October 30, 2008.

A **sentinel event** is defined by The Joint Commission as any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness. Sentinel events specifically include loss of a limb or gross motor function, and any event for which a recurrence would carry a risk of a serious adverse outcome. Sentinel events are identified under Joint Commission accreditation policies to help aid in root-cause analysis and to assist in development of preventative measures. The Joint Commission tracks events in a database to ensure events are adequately analyzed and undesirable trends or decreases in performance are caught early and mitigated.

To unify quality, patient experience, and population health strategies, successful organizations:

1. Create a single project management hub that builds alignment across experience, process improvement, human resources, quality and safety, and value/population health initiatives.
2. Establish a chief experience officer or similar position, which allows the organization to place proper importance on experience, exploit synergies, and find efficiencies in process improvement, data collection, and methodologies.

This centralized structure will help break down silos and enable the creation of unit-level champions, departmental transparency, and proactive development of solutions. A side benefit: there is a definite connection between patient satisfaction and employee satisfaction. It is leadership's job to take good care of staff, through engagement and removal of barriers, so they can provide excellent care to patients.

Successful organizations create a consistent, seamless experience of care from pre-admission to discharge, connecting with primary care physicians, skilled nursing facilities, and other healthcare providers. As healthcare organizations implement patient-centered care models to reconnect patients and care teams, success will be determined by measuring their impact on patient safety, satisfaction, clinical outcomes, health status, and cost.

Like population health and quality, improving patient experience requires access to meaningful data to drive action and further improvement throughout the organization.

The Board Quality Committee

Many governing boards set up a quality committee to focus extra attention on quality-related issues. The quality committee is the only committee for which we consider it a best practice for all organizations to have a standing committee of the board, regardless of organization type or size (primarily due to the amount of work involved in measuring and reporting on quality, and also holding management accountable for implementing actions to improve it). In fact, having a board-level quality committee

has been shown to strongly correlate with improvements in quality and patient safety. Quality committees usually meet monthly; committees at the system-board level tend to meet less often, such as quarterly.[4]

It is essential to seek committee members who can bring intellectual interest and energy to clinical quality issues. Some boards have recruited outside directors with a quality-related background from other industries, education, or another healthcare organization. A hospital's "quality brain trust," including the chief medical and nursing officers, chief of staff, and director of performance improvement, should be represented on the committee either as members or staff.

Physician members play two particularly vital roles: educating other committee members on how to interpret clinical information, and supporting a proactive role for the committee.

Committee Responsibilities by Organization Type

Quality committee responsibilities vary, depending upon whether your board oversees an independent hospital, a health system, or a subsidiary hospital of a health system. The following list of responsibilities are for the quality committee of an independent hospital board:

- Oversee patient care, clinical quality, patient safety, and satisfaction (of patients, physicians, employees, and payers)
- Develop board-level policies regarding patient care and quality
- Set quality goals, parameters, and metrics
- Oversee quality improvement systems, priorities, and plans
- Work with medical staff to set criteria and processes for credentialing and ongoing quality monitoring of clinicians
- Make recommendations to the board on medical staff appointments, reappointments, and privileges
- Monitor performance against policies, goals, systems, and plans
- Review sentinel events and recommend corrective action as appropriate
- Review management's plans to address negative performance and serious errors
- Oversee compliance with quality and safety accreditation standards
- Monitor medical staff credentialing and privileging
- Ensure physician credentialing procedure is disciplined, consistent, and effective

A health system board quality committee would have the following responsibilities:

- Develop board-level policies regarding patient care and quality standards system-wide
- Set system-wide quality goals, parameters, and metrics
- Work with system medical staff leaders to set system-wide criteria and processes for credentialing and ongoing quality monitoring of clinicians by the subsidiary boards

4 K. Peisert, *21st-Century Care Delivery: Governing in the New Healthcare Industry,* 2015 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

- Monitor system-wide performance against policies, goals, systems, and plans by requiring the proper level of reporting from subsidiary boards and quality improvement staff
- Hold subsidiaries accountable for meeting goals and following processes set by the system

A subsidiary board quality committee would have the following responsibilities regarding oversight of its own hospital:

- Oversee patient care, clinical quality, patient safety, and satisfaction (of patients, physicians, employees, and payers)
- Oversee quality improvement systems, priorities, and plans
- Make recommendations to the subsidiary board on medical staff appointments, reappointments, and privileges (or, in the case of a consolidated, system-wide medical staff, the recommendations would be made to the system board quality committee)
- Monitor hospital performance against policies, goals, systems, and plans, and report up to the system-level quality committee
- Review sentinel events and recommend corrective action as appropriate
- Review management's plans to address negative performance and serious errors
- Oversee compliance with quality and safety accreditation standards
- Monitor medical staff credentialing and privileging
- Ensure physician credentialing procedure is disciplined, consistent, and effective

The full board will generally establish a formal "charter" for the board quality committee that lays out its key areas of responsibility, establishing clear distinctions between its role and that of the full board and senior management. Key lessons and related strategies are described below.

Focus on Governance, Not Operations

The committee should clearly function as a board committee, and not be confused with efforts led by physicians, staff, or senior executives to improve quality. Typically, these initiatives should be made accountable to the board-level quality committee.

Create the Same Accountability for Quality/Safety as the Finance Committee Has for Financial Performance

In the same way that the board's finance committee approves budgets brought forward by management, the board quality committee approves and takes ownership over management's "work plan" for quality and safety, setting quality-related goals and monitoring management's progress toward achieving them. Practices and strategies that can help in these areas include the following:

- Develop aggressive, broad, and easily understood organizational goals related to quality and safety for approval by the full board.
- Work with key stakeholders to identify and approve specific quality and safety priorities each year.

- Identify measures and set targets within each priority.
- Hold senior management and clinical leaders accountable for performance, using national benchmarks and monitoring under-performance until issues are resolved. In larger systems, consider using "cascading" levels of accountability, with issues coming to the board quality committee only when efforts at lower levels of the organization to address the problem have not been effective.
- Periodically recommend new policies or policy revisions for adoption by the full board.

Send Clear Signals about Desired Culture of Openness and Transparency

Through its various actions and activities, the board quality committee should send a clear, unmistakable signal to all key stakeholders that the organization is committed to openness, candor, and transparency when it comes to both quality and safety. Specific actions the board quality committee can take to promote such a culture include the following:

- Recommend that the full board adopt a "just-culture" philosophy
- Adopt a "patients as only customer" mantra
- Develop and publicize a strong "disclosure and apology" plan

Structure Meetings and Work Processes for Maximum Effectiveness

The board quality committee needs to structure its work in a manner that allows members to effectively perform its duties and responsibilities. Doing so requires the holding of regular meetings, with an agenda structured in a way that promotes meaningful, open dialogue about quality and safety problems among all key stakeholders, with no fear of retribution or punishment. Key strategies and practices include the following:

- Consider creation of a subcommittee (in larger systems)
- Incorporate additional special meetings as necessary
- Consider use of a standard agenda and reporting format
- Limit (or even) ban the use of presentations
- Start meetings with one or two patient stories
- Allot significant time to reviewing progress toward quality/safety aims
- Briefly review regulatory issues
- Focus on problems, not successes
- Elicit everyone's input
- Do not let the conversation get too clinical or technical in nature
- Encourage provocative questions
- Highlight key areas discussed by the committee at full board meetings
- Make sure quality and safety get adequate discussion time at full board meetings
- Have the quality committee chair meet periodically with his/her peer on the finance committee

Conclusion: Building a Culture of Quality and Safety

Our industry has come a long way in understanding, monitoring, and improving quality of care. However, many boards still take a back seat in this responsibility, delegating too much to management, setting targets that are not aggressive enough, failing to monitor targets with enough frequency, or comparing their performance to other average performers, leaving "above average" as a "good enough" goal and focusing on other issues.

To be successful in quality efforts, hospitals and health systems will have to develop and nurture a strong culture of quality in their organizations. This starts at the top with the board setting the quality agenda.

There are many methods and tools available to boards to proactively pursue and implement a quality agenda. The starting place, however, is to position the commitment to quality centrally in the organization's mission statement and its strategic planning. The mission statement provides the beacon that guides all decision making at the board level and the strategic planning process sets the organization's agenda and milestones over a prescribed term—such as the next five, 10, or 15 years. When quality takes a prominent place in the mission and the strategic plan then it necessarily becomes integrated into all aspects of the decision-making process at the board level.

Quality should be a prominent topic at each and every board meeting. Spending the amount of time necessary on quality issues will make it more likely that organization will have better outcomes because they are taking the time to discuss their current efforts and making plans for quality improvement. Putting quality towards the top of the agenda sends a strong message about the importance of quality to the organization.

Some other ways to recognize a strong cultural commitment to quality and safety include:

- A link between quality/safety and executive and physician compensation
- Transparency around quality/safety performance, through reporting to the general public information on organizational performance, errors, and adverse events
- Internal structures, policies, and technology to support quality and safety initiatives
- A process requiring new clinical programs/services to meet quality-related performance criteria
- Supportive training for staff and leadership
- Acculturation to quality and safety for incoming staff and leadership
- Purposeful efforts for quality and safety improvement
- Demonstrable commitment to accountability and responsibility for the safety of each patient
- Most importantly, measured outcomes showing quality and safety improvement over time

As more and more organizations work towards achieving the Triple Aim, and as quality and finance become more intricately linked, movement towards aggressive quality improvement will intensify. Dashboards and other measurement tools are ubiquitous. Hospitals are embracing best practices that are saving lives, preventing errors, and reducing waste. Information technology is closing communication gaps. Health systems are naming chief quality officers and training physicians in improvement and reliability methodologies. All boards must recognize that quality oversight is their first, and most important responsibility, regardless of what else happens in the industry.

Appendix 1: Sample Quality Dashboard Reports

Measures of Caring Scorecard

STRATEGIC PERFORMANCE

Measures of Caring

Sample Scorecard – July 2016

Strategic Outcomes	Goal	Year-to-date progress	Date this goal last reported
Optimal health & well-being/experience *Improving the health of our patients.*	**Prevention & wellness:** Adult weight screenings & follow-up, chlamydia screenings, depression screenings, influenza immunizations	●	Jul 16
	Acute care: Optimal sepsis; potentially preventable complications	●	Apr-Jun 16
	Living with illness: Asthma care, diabetes eye exams	◆	Jul 16
	End of life: Hospice LOS	●	May-Jul 16
	Care continuum: Potentially preventable readmissions, CTM-3, primary care follow-up, transition conferences	◆	Mar-May 16 May-Jul 16
	Health equity: Colon cancer screenings, glycemic control	■	Jul 16
	Safety: # of PVSRs reported, hand hygiene compliance, controlled substance management, harm index	■	Jan-Jul 16 May-Jul 16 Jun 16
	Patient experience: hospital, ambulatory, home care, appropriate hospital LOS	◆	Jan-Jul 16 May-Jul 16 Mar-May 16
Optimal health & well-being for the community *Improving the health of our communities.*	**Community health:** BMI, smoking status, quality of life/Medicare Wellness Visits	◆	Aug 15-Jul 16 Jan-Jul 16
	Community engagement: # of persons served, volunteer hours, community benefit reporting	◆	Jan-Jul 16
Affordable care for all *Making care more affordable for those served.*	**Affordability:** ACOs: # of members, % performance to affordability target	■	Jan-May 16
Organizational Vitality *Enhancing organizational vitality to best support the "triple aim."*	**People:** Employee engagement, work injuries	No data	Jan-Jun 16
	Financial health: Operating margin	■	Jul 16
	Performance enhancement: 2016 initiatives	●	Jan-Jul 16
	Growth: Unique patients	■	Aug 15-Jul 16

● Meeting or exceeding goal ◆ Progress toward goal ■ Insufficient progress

Sample Board and Executive Quality Dashboard

Composite Measures	FY13 Target	FY16 Target	Ending September 2013	Comments or Notes
Core Measures and HCAHPS				
1. Appropriate Care Score (24-month mean)	95%	100%	96%	Meeting 2013 target
2. HCAHPS (24-month mean)	80%	85%	78%	May miss 2013 target
3. VBP Estimate (% payment and amount)	125%/ $1.9 M	200%/ $3.5 M	97%/$1.6 M	Estimating a partial loss of withhold
Readmissions and Mortality				
1. Overall Readmission Rate (24-month mean)	12.5%	10.0%	12.2%	Statistically significant decrease in January 2013
2. Overall Mortality Rate (24-month mean)	1.9%	1.7%	2.3%	No improvement
Safety				
1. AHRQ Patient Safety Measures (%>AHRQ benchmark, rolling 12 month)	<20%	0%	13.3% (2/15)	Meeting 2013 target
2. Serious Safety Event Rate (rolling 12 months)	0.50	0.20	0.88	Meeting 2013 target
3. Infection Prevention (composite score FYTD)	85%	100%	95%	Meeting 2013 target
4. Medication Safety (composite score FYTD)	85%	100%	63%	May miss 2013 target
Improvement and Savings—All Clinical Dashboards				
1. No. Statistically Improved EBM Measures (FYTD)	15	15	17	Meeting 2013 target
2. No. Statistically Improved Complication Rates (FYTD)	15	15	12	May miss 2013 target
3. No. Statistically Improved Mortality Rates (FYTD)	5	5	7	Meeting 2013 target
4. No. Statistically Improved Readmission Rates (FYTD)	5	5	8	Meeting 2013 target
5. Cost Savings from Outcome Improvements	$20 M	$20 M	$17.25 M	On track to meet year-end goal
Pay-for-Performance				
1. Health Plan A (composite score, FYTD)	100%	100%	100%	100% performance = $6.3 million
2. Health Plan B (composite score, FYTD)	100%	100%	90%	90% performance = loss of $300,000
3. Quality ICP Score (January–March 2012)	90%	100%	93%	Meeting 2013 goal
Other				
1. HAC (occurrences reported by CMS)			12	
2. Readmission Calculator (% payment and amount)			-0.15%/ $23,499	

Note: This dashboard streamlines oversight and review by highlighting a series of measures that blend similar items of data into composite representations of key performance indicators taken from scores of more detailed reports for frontline staff. The dashboard is accompanied by supporting documents, including detailed dashboards or process control charts.

Source: John Byrnes, "Driving Value: Solving the Issue of Data Overload with an Executive Dashboard," *hfm,* October 2012.

Sample Strategic Quality and Safety Plan Dashboard

Focus Area	Goal	Five-Year Target	Fiscal-Year Target	Accountable Executive
Clinical Improvement				
	Maintain core measures in top 10 percentile nationally.	100%	+90%	CMO, CQO, CNO
	Implement evidence-based care in high-volume, high-cost conditions (representing >50 percent of inpatient volume).	20 high-volume, high-cost conditions	Five high-volume, high-cost conditions	CMO, CQO, CNO
	Decrease complications in high-volume, high-cost conditions.	20%	5%	CMO, CQO, CNO
	Decrease cost of treatment for high-volume, high-cost conditions.	5%	2%	CMO, CQO, CNO
Safety				
	Create a culture of safety and high reliability by decreasing the rate of serious safety events (events causing harm).	0.20	0.50	CMO, CQO, CNO
	Improve medication safety.	100%	85%	VP Pharmacy
		Implement computerized provider order entry and bar code administration for medications.	Conduct Institute for Safe Medication Practices survey and correct all deficiencies.	VP Pharmacy
Patient Satisfaction				
	Maintain top satisfaction scores with patients, staff, and physicians.	+90%	90%	CMO, CQO, CNO
	Increase market share as a result of improved satisfaction.	2%	0.5%	CEO, CFO
Operational Improvement				
	Reengineer high-volume processes to improve efficiency.	20%	5%	CEO, CFO, CQO, CMO, CNO
	Reduce errors as a result of reengineering high-volume processes.	50%	15%	CEO, CFO, CQO, CMO, CNO
	Achieve cost savings as a result of reengineering high-volume processes.	$1 million	$250,000	CEO, CFO

Note: This sample Strategic Quality and Safety Plan Dashboard categorizes strategic planning initiatives by the area that is being targeted for improvement, sets goals that can be measured consistently in and across departments, establishes long- and short-term targets, and assigns executive responsibility for performance improvement.

Source: John Byrnes and Joe Fifer, "Moving Quality and Cost to the Top of the Hospital Agenda," *hfm,* August 2010, p. 66.

System Dashboard
Year to Date

Year to Date Apr 2013–Dec 2013 (9 Months), except where footnoted Baseline Period Jan 2012–Dec 2012, except where footnoted

Data for illustration purposes ONLY
NO actual hospital values used

Focus Area / Indicator	Desired Direction	System Goals for Apr 2013–Mar 2014 Threshold	Annual Target	Maximum	Results for YTD Compared to System Goals: System Baseline	System YTD 9 Mo.	Hospital A Baseline	Hospital A YTD 9 Mo.	Hospital B Baseline	Hospital B YTD 9 Mo.	Hospital C Baseline	Hospital C YTD 9 Mo.	Hospital D Baseline	Hospital D YTD 9 Mo.	Hospital E Baseline	Hospital E YTD 9 Mo.
Safe																
Patient Safety																
Mislabeled Specimens	▽	128	64	0	107	68	32	20	21	17	26	18	20	13	8	0
Pressure Ulcers - Unit Acquired Stage II or worse - Acute Critical Care	▽	5.66%	5.51%	4.89%	5.18%	2.59% (17)	0.32%	1.36% (3)	4.95%	2.00% (5)	18.18%	7.53% (7)	2.78%	2.15% (2)	N/A	N/A
Pressure Ulcers - Unit Acquired Stage II or worse - Rehab	▽	0.23%	0.21%	0.18%	0.26%	0.00% (0)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.26%	0.00% (0)
⑤ Preventable Harm Events SSE1-5 **	▽	0.12	0.06	0.00	0.07	0.07 (3)	0.00	0.00 (0)	0.08	0.08 (1)	0.12	0.12 (1)	0.13	0.14 (1)	0.00	0.00 (0)
Device Associated Infections																
Central Line Assoc. BSI per 1,000 line days - Acute Critical Care	▽	1.10	0.66	0.00	0.98	0.40 (5)	0.56	0.25 (1)	0.44	0.18 (1)	2.46	1.44 (2)	2.35	0.59 (1)	N/A	N/A
Cath. Assoc. Symptomatic UTI per 1,000 cath. days - Acute Med/Surg/Tele	▽	0.80	0.48	0.00	0.94	0.44 (11)	0.98	0.40 (2)	0.20	0.42 (3)	3.10	0.46 (2)	0.42	0.48 (4)	N/A	N/A
Cath. Assoc. Symptomatic UTI per 1,000 cath. days - Rehab	▽	0.78	0.74	0.69	0.99	1.02 (1)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.99	1.02 (1)

For measures not reported as counts, the actual count of incidents is reported in parentheses where applicable.

**Preventable = Serious Safety Events with deviation from Generally Accepted Performance Standards (GAPS)

N/A - Not Applicable

Threshold Not Met | Threshold Met | Target Met | Maximum Achieved/Exceeded

Note: Only Threshold Not Met and Maximum Achieved (0) are colored for the Patient Safety Counts and Standardized Infection Ratio with Expected Infections Greater than one (1)

⑤ Fiscal Year Baseline: Jul 2012–Jun 2013 YTD: Jan 2013–Dec 2013

Quarter: Jul–Sep 2013 Baseline Year: Jan–Dec 2012

IOM Dimension / Measure	System Baseline	System Curr Qtr	Hospital 1 Baseline	Hospital 1 Curr Qtr	Hospital 2 Baseline	Hospital 2 Curr Qtr	Hospital 3 Baseline	Hospital 3 Curr Qtr	Hospital 4 Baseline	Hospital 4 Curr Qtr	Desired Direction	System Goals for Apr 2013–Mar 2014 Threshold	Target	Superior
Safe														
Unscheduled Returns to ED within 72 hrs (admitted patients only)	5	5	5	5	5	5	5	5	5	5	↓	0	0	0
Left the emergency department before being seen (LWBS) (OP-22)	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	↓	N/A	1.6%	N/A
Completion of Culture of Safety Training within 90 days of staff hire	60% (10)	60% (10)	60% (10)	60% (10)	60% (10)	60% (10)	60% (10)	60% (10)	60% (10)	60% (10)	↑	N/A	100%	N/A
Timely														
Treat and Release														
Time from Door (Arrival) to Diagnostic Evaluation by a Qualified Medical Professional (OP-20)	30	30	30	30	30	30	30	30	30	30	↓	20	15	N/A
Time from Disposition to Departure	15	15	15	15	15	15	15	15	15	15	↓	N/A	16	N/A
Time from ED Arrival (Door) to ED departure (OP-18b)	150	150	150	150	150	150	150	150	150	150	↓	190	180	N/A
Time to ECG (AMI and Chest Pain) (OP-5)	5	5	5	5	5	5	5	5	5	5	↓	7	5	3
Admitted														
Time from Arrival (Door) to Qualified Medical Practitioner	30	30	30	30	30	30	30	30	30	30	↓	20	15	N/A
Time from Qualified Medical Professional to Disposition	90	90	90	90	90	90	90	90	90	90	↓	N/A	143	N/A
Time from Admit (Disposition) Decision to time of departure from ED (ED-2b)	150	150	150	150	150	150	150	150	150	150	↓	105	79	58
Time from ED Arrival (Door) to physician decision to admit (ED-1b minus ED-2b)	150	150	150	150	150	150	150	150	150	150	↓	160	155	N/A
Time from ED Arrival (Door) to ED Departure (ED-1b)	300	300	300	300	300	300	300	300	300	300	↓	220	N/A	N/A
Effective														
ED visits where patient was admitted as inpatient or observation ^^	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%	↓	26.7%	21.0%	15.5%
Efficient														
Time to Primary PCI in minutes (AMI-8)	50	50	50	50	50	50	50	50	50	50	↓	90	60	47
Diversion Hours in hh:mm (Quarter / Annualized) ^	300:30	30:00/ 120:00	300:30	30:00/ 120:00	300:30	30:00/ 120:00	300:30	30:00/ 120:00	300:30	30:00/ 120:00	↓	N/A	387:42	N/A
Diversion Occurrences (Quarter / Annualized) ^	30	2 / 8	30	2 / 8	30	2 / 8	30	2 / 8	30	2 / 8	↓	N/A	54.7	N/A
Equitable														
Ratio of Time Door (Arrival) to Departure (ED LOS) for behavioral health diagnosis vs other diagnosis - Treat and Release (excludes transfers)	1.77	1.77	1.77	1.77	1.77	1.77	1.77	1.77	N/A	1.77	1	1	1	1
Patient Centered														
Response to question "Overall rating ER care" on Press Ganey ED Survey - treated and released patients only	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	↑	89.3%	89.7%	90.5%
Response to question "Courtesy of Emergency Room Staff" on Press Ganey Inpatient Survey	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	↑	91.2%	91.3%	91.6%

Threshold Not Met | Threshold Met | Target Met | Superior Met

Where only Target is available, goal will either be met (green) or not (red).

Appendix 2: Board Oversight of Credentialing

The following is an excerpt from Todd Sagin, "Credentialing for Physician Leaders," The Governance Institute, May 2016.

> The promotion of high-quality medical care includes the credentialing of practitioners and granting specific privileges to practice medicine in the facilities of a hospital, health system, or accountable care organization.

It has been argued that nothing contributes to the quality of care in a hospital as much as effective credentialing. Credentialing is a process to determine whether a practitioner is competent and meets the hospital's high standards of clinical skill and professional conduct. Basically, this means deciding which doctors are qualified to join the medical staff, which procedures each may perform, and which conditions they may treat. It is a responsibility of board members to ensure that the credentialing process is rigorous and that the safety and well-being of patients is the priority.

Credentialing involves the board, the hospital/health system management team, the medical executive committee (MEC), clinical department chairs (if the medical staff has departments), and other medical staff leaders. The board is responsible for oversight of the credentialing process. Specific steps in credentialing fall into the purview of the board, management, or medical staff as follows:

1. Establish appropriate credentialing policies and criteria of membership and privileges (MEC, governing board).
2. Collect and summarize information about applicants for membership and privileges (management, medical staff leaders).
3. Evaluate applicants and recommend membership and privileges (department chairs, credentials committee, MEC).
4. Review, grant, deny, or approve (governing board).

An important component of credentialing involves establishing the organization's criteria to hold particular privileges. These criteria are developed to ensure practitioners have current competence to perform clinical tasks, and they may differ from organization to organization, or be modified from time to time within the organization. Criteria for specific privileges will be recommended by the medical staff but must be approved by the board. Once the criteria are established (and they should be periodically reassessed), the credentialing process ensures that practitioners are only assigned privileges for which they are currently competent and meet the established criteria. Typically, privileging criteria should enumerate the requirements for education, training, and evidence of current competence to perform a specific task or procedure.

Governing boards will sometimes adopt policies to "close" the medical staff in particular specialties. Policies can also be adopted that require applicants to show how they will advance the mission of the hospital. Sometimes boards adopt physician conflict-of-interest policies, which might restrict access to the medical staff under well-defined circumstances.

Medical staff participants in the credentialing process must be educated carefully in best credentialing practices. It is the duty of the MEC to make formal recommendations to the board regarding requests for medical staff membership, the assignment of specific privileges to practitioners, and the appropriateness of any policies and procedures that should be adopted.

The *final* step is the board's review of the MEC's recommendations and its action to grant, deny, or restrict the membership and/or specific privileges being sought. In general, board members will give the greatest scrutiny to the 5 to 10 percent of practitioners who have some type of unusual event in their past. Although the board is directly involved in the first and last of these credentialing steps (i.e., setting policies and assigning membership and/or privileges), it has oversight over the entire process and must ensure that all steps are carried out diligently, in compliance with the requirements of medical staff bylaws and policies, and consistent with hospital accreditation requirements.

Some Guiding Principles for Credentialing

- **Credentialing exists to protect patients.** Do not lose sight of this crucial justification for credentialing. Many interests come into play when deciding whether a practitioner will have access to the hospital and what he or she may do there. These include the business interests of practitioners, the revenue stream practitioners may generate for the hospital, the considerable costs of a thorough credentialing operation, the competitive positions of physicians with each other and with the hospital, the challenges of recruiting an adequate workforce of practitioners, etc. Sometimes one or another of these interests will put pressure on the hospital to short circuit good credentialing practices, but never forget that we undertake rigorous credentialing to protect patients.
- **Follow the Five "Ps."** The best way to provide clarity for everyone who is affected by the credentialing process is to have it clearly outlined in appropriate policies. Then, on any issue of contention, adhere to the following mantra: "Our **P**olicy is to follow our **P**olicy. In the absence of a **P**olicy, our **P**olicy is to establish a **P**olicy."
- **Place the burden on the applicant.** The hospital will need a considerable amount of data to complete the application process. The hospital should inform each applicant that it is ultimately the applicant's responsibility to provide all of the information the hospital requires to reach a decision. Some applicants may be asked to provide more information than others if something in their backgrounds is different from what is typically seen in applications. If an applicant cannot provide the necessary information in a timely fashion, the hospital should stop processing the application.

- **Excellent credentialing requires clear criteria, applied consistently.** The board, in consultation with the medical staff, should adopt clear criteria for medical staff membership and for the eligibility to hold specific privileges. This allows everyone to understand what qualifications will be needed to join the staff and/or hold privileges. Applications that don't meet the adopted criteria should not be accepted or processed.
- **Never deny membership or privileges except for demonstrated incompetence or unprofessional conduct.** There are two outcomes of the credentialing process that must be reported to the National Practitioner Data Bank (NPDB). The NPDB is a federal compendium of membership and privilege denials made because an institution has determined that a practitioner is incompetent or has behaved in an unprofessional manner that threatens the well-being of patients. Once a practitioner has been reported to the NPDB, the reporting can have a negative impact on his or her ability to gain privileges elsewhere. Therefore, be careful not to report unless your credentialing investigations have clearly demonstrated that someone is incompetent or unprofessional.

Medical staff and board members should insist on periodic education in the latest and best credentialing practices. Not only is this important to assure high quality care, but failures in credentialing have led to a wave of corporate negligence lawsuits against hospitals and medical staffs nationwide. Rigor in credentialing activities may sometimes seem burdensome, but doing it right can save an organization from much greater downstream burden.

Appendix 3: Questions for Board Members to Ask the Quality Committee and Staff

High-Level and Strategy-Related Questions

1. What are we trying to accomplish? (The aim)
2. How will we know that a change is an improvement? (The measures or indicators)
3. What changes can we make that will result in improvement? (The action plan)
4. Is there a process in place so the board can assure itself that the outcomes and processes being measured for quality are the most relevant ones?
5. Can management and the medical staff adequately articulate the outcome and process improvement goals they are setting for themselves—and how these will be measured?
6. Is there a process in place so the board can determine over time whether the medical staff and management team are accomplishing their goals?

Metric-Related Questions

1. What is our mortality rate (and other clear-cut quality measures)?
2. How many patients received the wrong medication this month compared to last month, compared to a year ago?
3. How many surgical site infections have we had in the last year?
4. Are these numbers trending upward or downward?
5. What steps have we taken in the past year to reduce medication errors? What is being done about eliminating medical errors?
6. What systems do we have in place to reduce the risk of surgical site infections?
7. Why aren't we aiming for zero or 100 percent all of the time?
8. What makes achieving zero or 100 percent (or top decile) hard?
9. What percent of errors/undesired outcomes are preventable?
10. Do we know how our (local) competitors are doing?
11. Are our populations comparable? How do we know?

Process-Related Questions

1. Is there a written plan with appropriate goals, priorities, and resources?
2. Have processes been designed to improve quality in the specific area?
3. Are data collected and processes evaluated for effectiveness frequently (ideally, weekly)?
4. Is senior management engaged to a significant degree?
5. Is responsibility clearly assigned?
6. Are design failures adjusted immediately?
7. Are design successes monitored on a routine basis, with needed adjustments made?
8. How do we know that a recommended change has been adopted? How do we know that the recommended change is being sustained?
9. Have we involved patients or family members in our improvement initiatives?
10. Does staff have what they need to keep patients safe?
11. Do we know if and/or how staffing has affected (will affect) our outcomes (pertinent especially if budget issues or reductions are also being discussed with the board)?
12. Is the medical staff engaged in our quality improvement efforts?

Resources

Below is a list of resources that dig deeper into the topics presented in this publication.

"The Board's Role in Quality and Patient Safety Performance Measurement" (*BoardRoom Press* Special Section, June 2014)

"Credentialing for Physician Leaders" (article, May 2016)

Governance for Quality & Safety: The New Reality (Webinar, August 2013)

Making a Difference in the Boardroom: Updated Research Findings on Best Practices to Promote Quality at Top Hospitals and Health Systems (white paper, Fall 2014)

Maximizing the Effectiveness of the Board's Quality Committee: Leading Practices and Lessons Learned (white paper, Fall 2015)

Quality & Patient Safety: The Need for Clinical Integration and a Systems Approach (Working Knowledge Video, December 2012)

Quality Reporting Expands beyond Hospital Walls (case study, June 2013)

"Strategic Quality Oversight by the Hospital/Health System Board of Directors" (*BoardRoom Press* Special Section, October 2014)

Engaging Health System Boards of Trustees in Quality and Safety: Six Must-Know Guidelines

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June 5, 2019, "Health Catalyst"

Around the turn of the 21st century, the National Academy of Medicine (NAM), formerly the Institute of Medicine (IOM), called for profound transformation to improve the culture of patient safety in two landmark reports: To Err Is Human (1999) and Crossing the Quality Chasm (2001). These reports accelerated the pace at which health systems began to understand and implement changes to improve the quality and safety of care.

Several impactful movements and influential studies followed the NAM reports, all continuing the appeal for better, safer care and placing accountability for that change on healthcare leaders. Dr. Donald Berwick, former president and CEO of the IHI, added urgency to the need for transformation when he called 2007 the "Year of Governance," in The Joint Commission Journal on Patient Quality and Safety, placing responsibility for the proper stewardship of healthcare with health system boards of trustees. Leaders needed to own governance, Berwick explained, for improvement to take hold.

Healthcare governing bodies responded to the NAM and Berwick appeals, as well appeals and arguments from other governing bodies, with regulations to incentivize good health system governance and crack down on inadequate leadership. This article looks at the repercussions for health systems of falling short on governance measures as well as how organizations can engage their boards around quality and safety measures to better meet their communities' needs.

Regulators Take a Hard Line on Governance

After Berwick's call to healthcare boards, regulators soon proved they would take a hard line on governance. For example, in 2008, Modern Healthcare reported that a midsized regional medical center faced intense regulatory scrutiny. The organization's leadership and board had failed to transparently present and review clinical information and data that would have exposed serious safety issues, resulting in harm to multiple patients. By not understanding their fiduciary responsibilities and requirement to hold leadership responsible for unsafe conditions, the board failed the community it served.

Following patient complaints, state regulators and the CMS cited the medical center for compliance issues surrounding patient care and governance. In May 2008, the state health department discovered that seven leg wound infections occurred among open-heart patients at this hospital; the state then shut down the open-heart program.

In addition, regulators cited the organization for deficiencies in five areas required for participation in Medicare:

1. Governance.
2. Infection control.
3. Medical staff.
4. Surgical services.
5. Quality assurance.

The Significant Risks and Repercussions of Bad Governance

With the regulatory crackdown on governance, risks and repercussions of bad governance have significant, costly, and long-term impacts. For example, after the state released the findings of its report on the medical center above, the hospital CEO abruptly resigned, one nearby hospital suspended referrals of cardiac patients, and the hospital's owner sent staff over 2,000 miles from the corporate office to provide administrative oversight. Such serious consequences placed greater pressure on health system boards to ensure good governance.

Part of the medical center's correction plan was to ensure that "the [hospital] board is fulfilling its corporate oversight." The organization clearly hadn't taken heed of the growing calls within healthcare to improve quality and patient safety. It failed to establish sound governance practices, despite a growing body of evidence that embracing a culture of patient safety was fundamental for healthcare organizations.

Addressing Urgent Demands for Quality and Patient Safety

While To Err Is Human demonstrated how much needless harm and death occurred in healthcare settings, Crossing the Quality Chasm provided a framework for conceptualizing and defining healthcare quality. This framework, often referred to as the STEEEP framework, laid out six aims for improvement: to provide safe, timely, effective, efficient, equitable, and patient-centered care. Both reports have continued to inform what effective healthcare governance looks like for health system boards.

Although the healthcare industry has improved since these reports' publication, a 2018 IHI analysis demonstrated that many health systems still lack sound governance practices and that work to improve hospital governance has moved slowly. Governing bodies continue to rest transformation of care delivery firmly on health system boards.

Notable campaigns since the NAM reports, such as the following, outline board responsibility and continue to serve as guidelines towards better governance:

A Call to Responsibility

When the National Quality Forum (NQF) issued Hospital Governing Boards and Quality of Care: A Call to Responsibility in 2004,the NQF strongly encouraged "hospital governing boards to become actively engaged in quality improvement" to place emphasis on the relationship between governance and quality of care.

Getting Boards on Board

In 2006, the IHI launched the 5 Million Lives Campaign, which included a call to health systems to join in "getting boards on board." The campaign recommended that hospital boards get data and hear stories about safety. The IHI also set the expectation that boards "select and review progress toward safer care as the first agenda item at every board meeting, grounded in transparency, and putting a 'human face' on harm data."

The IHI campaign developed six key steps for improving governance:

1. Setting aims.
2. Getting data and hearing stories.
3. Establishing and monitoring system-level measures.
4. Changing the environment, policies, and culture.
5. Learning (starting with the board).
6. Establishing executive accountability.

Monitoring Performance and Setting Improvement Aims

At its core, the IHI "boards on board" campaign emphasized key elements in creating a culture of patient safety:

- Effectively deploying a measurement system to monitor performance and set performance improvement aims.
- Leveraging meaningful data that a non-clinical board could understand.

The campaign clarified that hospital boards, including non-clinical volunteer trustees, have a fiduciary responsibility to ensure high-quality clinical outcomes in their hospitals. Simultaneously, however, the increasing pace of value-based purchasing and data transparency—largely driven by CMS, TJC, and National Committee for Quality Assurance (NCQA)—have made it difficult for boards to overlook poor quality and safety performance.

Four Steps for Appropriate Goal Setting

Boards increasingly rely on subcommittees of subject matter experts, including the trustees as well as additional independent external experts, to support the various domains of governance (e.g., finance, quality and patient safety, compliance, and strategy) and identify improvement goals. Hospital or health system staff leadership from these functional areas are then responsible to support their respective board committees.

Goal setting for an organization's quality and patient safety performance follows four steps:

1. **Appropriate measures and targets**: Quality and safety leadership (e.g., the chief clinical officer, chief nursing officer, or patient safety officer) and their teams working closely to recommend appropriate measures and targets to the executive team as well as the board quality and patient safety committee.
2. **Recommendations to the full board**: The safety and quality committee refers its recommendations to the full board of trustees.
3. **Recommendations to the quality and safety committee:** The staff constructs recommendations to the board quality and patient safety committee based on the needs of its patients, moving from microsystem to macrosystem.
4. **Big dot measures:** Ultimately, the board looks for "big dot" macrosystem measures (e.g., overall rate of serious adverse events, system-wide mortality versus heart-failure mortality, or overall patient satisfaction rather than satisfaction with hospital food).

The board will not want to see underlying drivers of the big dot measure, unless the organization is failing to improve. Board committees will, however, want to do deeper dives to understand these drivers. Figure 1 provides a schematic for health systems to view the measurement selection process.

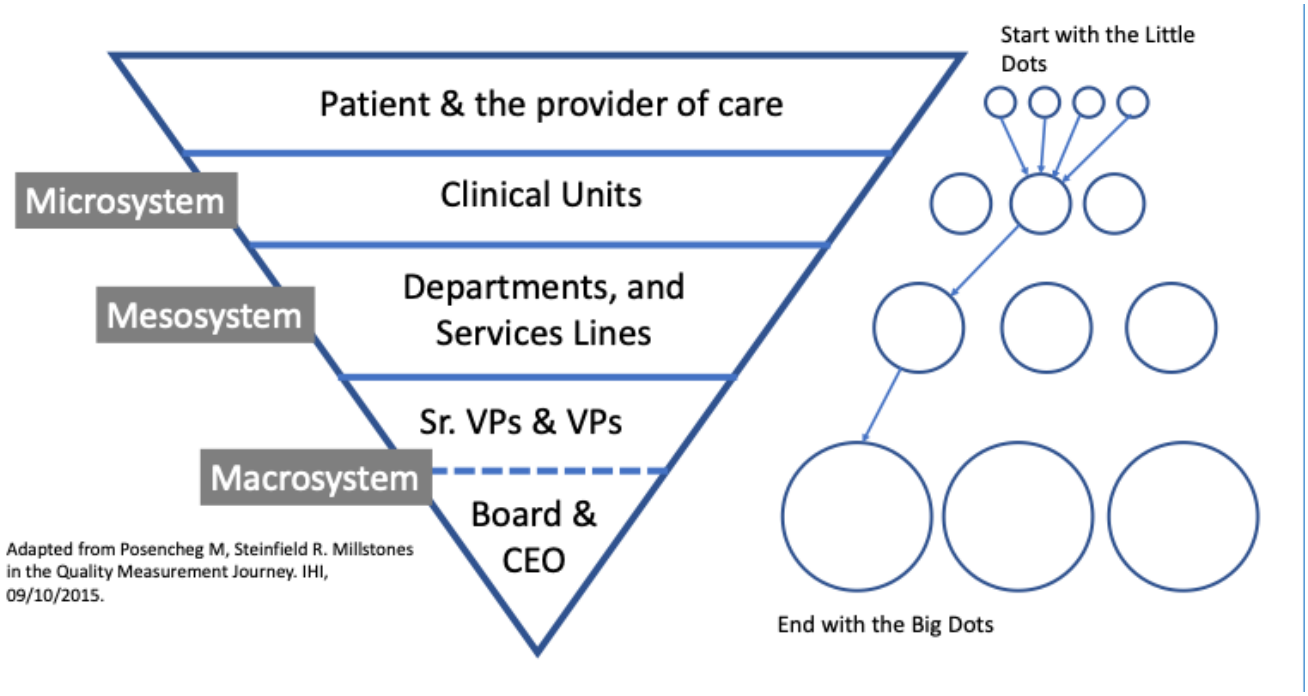

Figure 1. Measurement selection process: inverse pyramid cascading measures from the patient to the board of trustees.

Six Guidelines for Quality and Safety Measures for Engaging Healthcare Boards

Health system boards can follow six guidelines to select quality and safety measures most likely to support good governance and drive improvement for their organizations:

1. Emphasize Quality and Patient Safety Goals

Quality and patient safety goals should easily represent at least half of all measures the board reviews. Typically, an organization will track 10 to 20 objectives. As Table 1 shows, boards can use the STEEEP framework and big dot approach to guide measure selection:

STEEEP Framework	Measure Examples

Safe	Serious safety events (hospital acquired infections [HAIs], serious reportable events [SREs]) Mortality
Timely	Median time from ED arrival to ED departure of admitted ED patients
Effective	Readmissions Evidence-based measures and protocols (e.g., sepsis protocol adherence) Preventable hospitalization
Efficient	Length of stay Cost per case Per-capita cost Time to next available appointments Patient flow measures
Equitable	Timely ambulatory care Performance stratified by race and ethnicity
Patient Centered	Patient experience

Table 1: Measure examples.

2. Leverage NQF-Endorsed Measures

The NQF itself does not develop its own measures; other organizations (e.g., the CMS, TJC, and the NCQA) develop measures of accountability for accreditation purposes. Many organizations select measures endorsed by the NQF consensus development process and link these measures to the six aims of the NAM's Quality Chasm report or the IHI's Triple or Quadruple Aim. Some boards of trustees have actually made it policy to only use NQF-endorsed measures for quality and patient safety objectives, when available.

Specialty societies, such as the Society of Thoracic Surgeons and the American College of Cardiology, often submit their measures to the NQF for endorsement. The NQF established committees of nationally recognized experts to review specific measure sets. Thus, NQF-endorsed measures have not only gone through an internal review and development process by the developer, but also get a second review by a NQF's independent experts. Selecting NQF-endorsed measures reduces the internal debate over the validity of measures within health systems.

3. Use Benchmarking and Risk Adjustment to Select Targets

Meaningful targets are critical. Most boards and CEOs aspire to achieve top performance, but not all measures have a meaningful benchmark. A true benchmark looks at top performers and understands how their process led them to outstanding outcomes. Healthcare providers often simply look at top decile or top quartile performance and strive for that goal without breaking down the process changes required to achieve a better outcome.

There are a few rules to keep in mind:

- Process measures do not require risk adjustment: There is no way to adjust for the failure of a health system to deliver an evidence-based practice based on current guidelines. Variation in performance is not attributed to an underlying risk of a patient population. Examples include the timely reperfusion (therapy to restore blood flow) of a patient arriving with a heart attack or appropriately prescribing discharge medications. Widely available national performance levels

cover virtually all CMS publicly reported measures for comparative purposes. These can help a provider understand performance gaps and prioritize improvement work.

- There is no benchmark for patient harm: Setting a target for an acceptable level of harm is like an airline setting a target for the minimum number of plane crashes per year or a manufacturer setting a target for an acceptable number of employee deaths. Again, CMS and the CDC provide national performance for all measures of harm used for public reporting that are helpful for prioritizing improvement work, but the goal has to be zero harm.
- In contrast, not all mortality, readmissions, or admissions are avoidable: Here, benchmarking against the best in the industry can help drive process improvement. It is important to use appropriate risk adjustment among the multiple models for adjustment available. Ideally, a health system benchmarks against best in class and develops a deep understanding of how a top performer's processes set it apart from the rest of the industry. Realistically, however, top-performing providers do not share enough detail for organizations to benchmark against. Instead, healthcare ranks providers based on risk-adjusted outcomes data against normative performance of the larger population of providers. The industry assumes that those with the best outcomes are high performers. Yet, 20 years of research on care delivery have demonstrated that better may not be best; when healthcare settles on comparing a single provider/hospital/health system against national performance or database performance at the top levels, it's creating proxies for best practices. However, given those limitations, some benchmarks and risk adjustment models are better than others. A disproportionate number of benchmarking systems depend only on administrative or claims data. Benchmarking can, and will, improve as the industry increasingly uses more clinical information and artificial intelligence (AI) to proactively identify where an organization is performing well and where it's underperforming.

4. Access Data Beyond the EHR

A report for the board quality and patient safety committee and the board of trustees requires data from multiple source systems. Although the dramatic growth in EHR usage has yielded an abundance of rich clinical data, an EHR cannot provide all the information a board of trustees needs to see. For example, patient safety data is often collected in separate event or incidence reporting systems; infection data may reside in a distinct surveillance system, and data as part of the revenue cycle process, as well as collected from claims, is also important.

Boards also expect patient experience of care (satisfaction) from multiple settings:

- Hospital.
- Surgical centers.
- Emergency departments.
- Skilled nursing facilities.
- Home care agencies.
- Physician clinics.

The analytics team needs a robust enterprise data warehouse (EDW) or an even more sophisticated data platform, such as the Health Catalyst® Data Operating System (DOS™) to meet the needs of the board. Otherwise, the analytics team will spend much of its time hunting for data and producing reports out of different systems. An integrated data platform will increase the timeliness and consistency of data to provide accurate reporting from across the enterprise.

5. Provide Data and Information for Multiple Organizational Levels

Health system analysts and leadership need to present information to multiple levels in the organization. To determine if its objectives are trending in the correct direction, the full board will typically focus on a single report that includes each of the system's year-to-date performance for the system's or hospital's annual objectives, along with a trend line, spark line, or control chart. Staff will also need to provide an interpretive narrative of the findings for each aim they analyze.

While the board will focus on big dot measures, board committees may also want to understand the organization's outcomes improvement strategy, especially if the organization is falling short of goals.

In a multifacility organization, the subcommittee will also want to determine if certain hospitals, clinics, or other entities are not performing at the same level of the system. Reports that summarize information across multiple facilities run the risk of masking a single facility's poor performance, so reports must drill down from the system level.

Figure 2 shows a dashboard suitable for board-level reporting, as well as for the executives who will need to speak to performance:

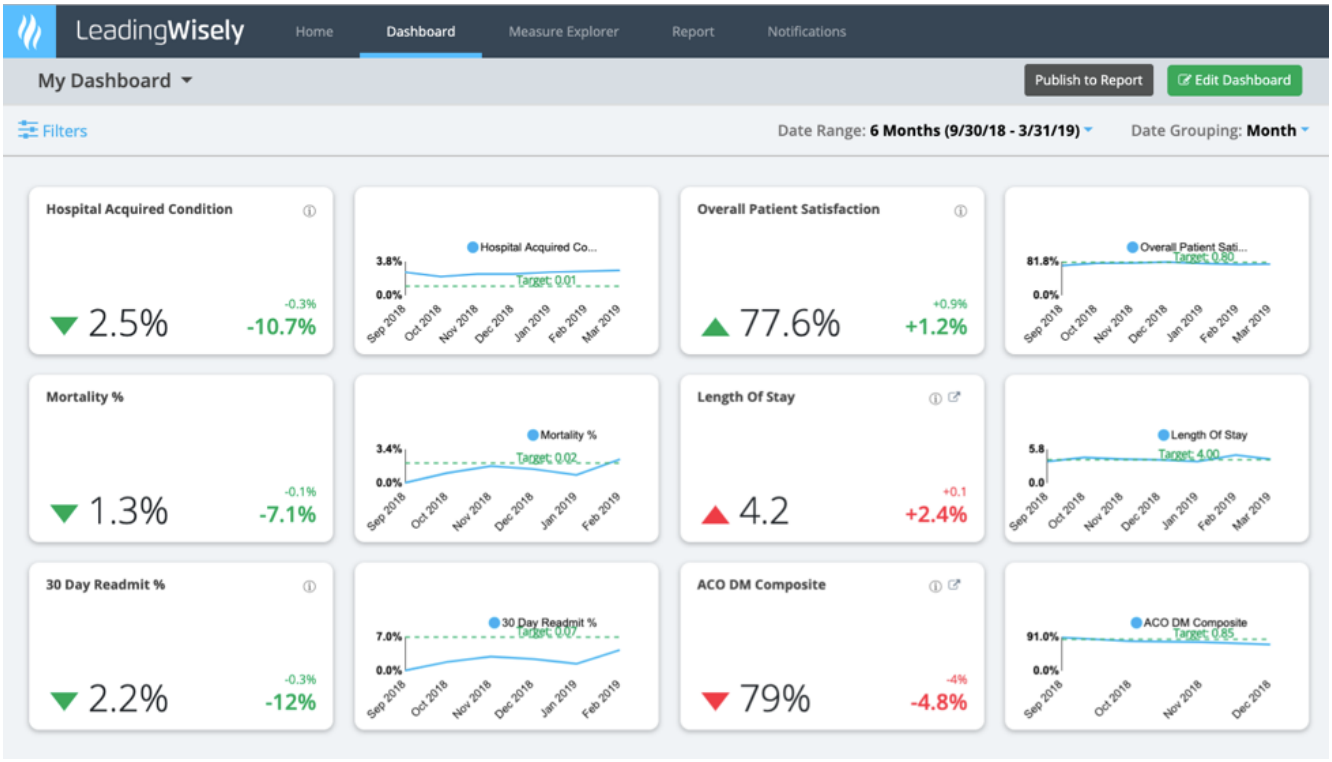

Figure 2: Sample board-level report.

6. Develop a Board-Specific Measurement and Presentation Strategy

Providing information to a board of trustees or a board committee requires a different measurement and presentation strategy than what a service line or department needs to support its operations and performance improvement projects. The most valuable board resource is their time. The trustees consist of a mix of volunteer community members, often with no clinical experience, as well as clinicians from the community. The trustees typically conduct their deliberations with the CEO in attendance as well as other health system leadership. Leadership must present healthcare information clearly so that the board understands performance against meaningful targets but also in a way that empowers the board to raise tough questions about opportunities for improvement. Beyond the staff providing honest and meaningful information, while continuously disclosing failures, a strong board most have sufficient subject matter expertise and independence to hold providers accountable. Presented data must demonstrate that the hospital or health system is placing the safety of the patient first and is looking at the right measures of care. Targets and benchmarks must be clear enough to trustees to encourage them challenge each hospital or health system to improve care and eliminate all patient harm.

The Ongoing, Central Role of the Healthcare Board in Quality and Safety Improvement

Despite the launch of a quality and patient safety movement in the early 21st century, too many hospitals and health systems still lack the resources to give their boards the information required to meet their fiduciary responsibilities. To support safety and quality progress, the industry must accelerate its ability to collect data from an ever-increasing quantity of sources, as well as transform that data into meaningful information for the board of trustees to digest.

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