

**AGENDA**  
**QUALITY, PATIENT CARE AND PATIENT EXPERIENCE COMMITTEE**  
**OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS**

**Monday, February 3, 2020 – 5:30pm**  
 El Camino Hospital | Conference Room A&B  
 2500 Grant Road, Mountain View, CA 94040

**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
<b>1. CALL TO ORDER/ROLL CALL</b>	Julie Klinger, Quality Committee Chair		<b>5:30 – 5:32pm</b>
<b>2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</b>	Julie Klinger, Quality Committee Chair		<b>information</b> <b>5:32 – 5:33</b>
<b>3. CONSENT CALENDAR ITEMS</b> <i>Any Committee Member or member of the public may pull an item for discussion before a motion is made.</i>	Julie Klinger, Quality Committee Chair	<i>public comment</i>	<b>motion required</b> <b>5:33 – 5:35</b>
<b>Approval</b> a. <a href="#">Minutes of the Open Session of the Quality Committee Meeting (12/02/2019)</a> <b>Information</b> b. <a href="#">FY20 Quality Dashboard</a> c. <a href="#">FY20 Pacing Plan</a> d. <a href="#">Progress Against FY20 QC Goals</a> e. <a href="#">Hospital Update</a> f. <a href="#">Quality Committee Follow-up Items</a>			
<b>4. REPORT ON BOARD ACTIONS</b> <a href="#">ATTACHMENT 4</a>	Julie Klinger, Quality Committee Chair		<b>discussion</b> <b>5:35 – 5:40</b>
<b>5. PATIENT STORY</b> <a href="#">ATTACHMENT 5</a>	Cheryl Reinking, RN, CNO		<b>information</b> <b>5:40 – 5:50</b>
<b>6. UPDATE ON PATIENT CARE EXPERIENCE</b> <a href="#">ATTACHMENT 6</a>	Cheryl Reinking, RN, CNO		<b>discussion</b> <b>5:50 – 6:05</b>
<b>7. PATIENT SAFETY INDICATORS</b> <b>4, 18, 19</b> <a href="#">ATTACHMENT 7</a>	Cheryl Reinking, RN, CNO		<b>discussion</b> <b>6:05 – 6:25</b>
<b>8. BOARD QUALITY DASHBOARD REPORT</b> <a href="#">ATTACHMENT 8</a>	Mark Adams, MD, CMO		<b>discussion</b> <b>6:25 – 6:35</b>
<b>9. DRAFT REVISED COMMITTEE CHARTER</b> <a href="#">ATTACHMENT 9</a>	Mark Adams, MD, CMO	<i>public comment</i>	<b>motion required</b> <b>6:35 – 7:05</b>
<b>10. SVMD REPORTING TO QUALITY COMMITTEE</b>	Mark Adams, MD, CMO		<b>discussion</b> <b>7:05 – 7:20</b>
<b>11. PUBLIC COMMUNICATION</b>	Julie Klinger, Quality Committee Chair		<b>information</b> <b>7:20 – 7:23</b>

A copy of the agenda for the Regular Meeting will be posted and distributed at least seventy-two (72) 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.

AGENDA ITEM	PRESENTED BY		ESTIMATED TIMES
<b>12. ADJOURN TO CLOSED SESSION</b>	Julie Kliger, Quality Committee Chair	<i>public comment</i>	<b>motion required</b> 7:23 – 7:24
<b>13. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</b>	Julie Kliger, Quality Committee Chair		<b>information</b> 7:24 – 7:25
<b>14. CONSENT CALENDAR</b> <i>Any Committee Member may pull an item for discussion before a motion is made.</i>	Julie Kliger, Quality Committee Chair		<b>motion required</b> 7:25 – 7:27
<b>Approval</b> <i>Gov't Code Section 54957.2.</i> a. Minutes of the Closed Session of the Quality Committee Meeting (12/02/2019)			
<b>Information</b> b. Medical Staff Quality Council Minutes			
<b>15. Health and Safety Code Section 32155</b> for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Q2 Quality and Safety Review	Mark Adams, MD, CMO		<b>discussion</b> 7:27 – 7:42
<b>16. Health and Safety Code Section 32155</b> for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters: - Serious Safety Event/Red Alert Report	Mark Adams, MD, CMO		<b>discussion</b> 7:42 – 7:47
<b>17. ADJOURN TO OPEN SESSION</b>	Julie Kliger, Quality Committee Chair		<b>motion required</b> 7:47 – 7:48
<b>18. RECONVENE OPEN SESSION/ REPORT OUT</b> To report any required disclosures regarding permissible actions taken during Closed Session.	Julie Kliger, Quality Committee Chair		<b>information</b> 7:48 – 7:49
<b>19. CLOSING WRAP UP</b>	Julie Kliger, Quality Committee Chair		<b>discussion</b> 7:49 – 7:54pm
<b>20. ADJOURNMENT</b>	Julie Kliger, Quality Committee Chair	<i>public comment</i>	<b>motion required</b> 7:54 – 7:55pm

**Upcoming Meetings:**

Regular Meetings: March 2, 2020; April 6, 2020; May 4, 2020; June 1, 2020

Educational Sessions: April 22, 2020



**Minutes of the Open Session of the  
Quality, Patient Care and Patient Experience Committee  
of the El Camino Hospital Board of Directors  
Monday, December 2, 2019  
El Camino Hospital | Conference Rooms A&B  
2500 Grant Road, Mountain View, CA 94040**

**Members Present**  
Terrigal Burn, MD  
Caroline Currie  
Alyson Falwell  
Peter C. Fung, MD  
Julie Kliger, Chair  
Jack Po, MD  
Melora Simon

**Members Absent**  
Krutica Sharma,  
MD  
George O. Ting,  
MD, Vice Chair

Agenda Item	Comments/Discussion	Approvals/ Action
<b>1. CALL TO ORDER/ ROLL CALL</b>	<p>The open session meeting of the Quality, Patient Care and Patient Experience Committee of El Camino Hospital (the “Committee”) was called to order at 5:30pm by Chair Kliger. A silent roll call was taken. Dr. Ting and Dr. Sharma were absent. Dr. Po arrived at 5:35 pm during the discussion about the consent calendar. All other Committee members were present at roll call.</p> <p>Dan Woods, CEO, introduced Interim CQO, John Haughom, MD.</p>	
<b>2. POTENTIAL CONFLICT OF INTEREST DISCLOSURES</b>	<p>Chair Kliger asked if any Committee members had a conflict of interest with any of the items on the agenda. No conflicts were reported.</p>	
<b>3. CONSENT CALENDAR</b>	<p>Chair Kliger asked if any member of the Committee or the public wished to remove an item from the consent calendar. Dr. Fung requested that item 3a Minutes of the Open Session of the Quality Committee (11/4/19) be removed.</p> <p><b>Motion:</b> To approve the consent calendar: For information: FY20 Quality Dashboard; FY20 Pacing Plan, Progress Against FY20 QC Goals; and Hospital Update.</p> <p><b>Movant:</b> Burn <b>Second:</b> Fung <b>Ayes:</b> Burn, Currie, Falwell, Fung, Kliger, Po, Simon <b>Noes:</b> None <b>Abstentions:</b> None <b>Absent:</b> Sharma, Ting <b>Recused:</b> None</p> <p>Dr. Fung suggested it will be important for the Committee to consider oversight of Silicon Valley Medical Development, LLC quality of care. Following discussion, the Committee requested that a discussion about how Silicon Valley Medical Development ,LLC will report up to the Quality Committee be added to the Pacing Plan for the February 3, 2019 meeting.</p> <p><b>Motion:</b> To approve the consent calendar: Item 3a Minutes of the Open Session of the Quality Committee (11/4/19).</p> <p><b>Movant:</b> Fung <b>Second:</b> Burn <b>Ayes:</b> Burn, Currie, Falwell, Fung, Kliger, Po, Simon</p>	<p><i>Consent Calendar approved</i></p>

	<p><b>Noes:</b> None  <b>Abstentions:</b> None  <b>Absent:</b> Sharma, Ting  <b>Recused:</b> None</p>	
<p><b>4. FOLLOW UP ITEMS FROM LAST MEETING</b></p>	<p>Chair Kliger explained that this report will be on future agendas to ensure follow up items from previous meetings are tracked and completed.</p>	
<p><b>5. REPORT ON BOARD ACTIONS</b></p>	<p>Chair Kliger reviewed the Report on Board Actions and the Board Action Plan with the Committee. Chair Kliger requested that the Interim Chief Quality Officer be added to the “Who” for the Quality Oversight sections of the Plan.</p>	
<p><b>6. PATIENT STORY</b></p>	<p>In place of an individual patient story, Cheryl Reinking, RN, CNO Ms. Reinking presented a series of “negative” patient comments from the Press Ganey HCHAPS surveys in the domains of Responsiveness and Discharge Information. Ms. Reinking reported that several issues emerged from these comments including communication inconsistent from shift to shift, responsiveness to call lights on the night shift, and communication regarding the discharge process. She also provided information about process changes implemented to address these issues systematically. The Committee requested that staff also consider bringing patient stories that present challenges that go “deeper” into the organization and are not necessarily nursing related.</p> <p>Chair Kliger suggested that, to improve the discourse and dialogue at the Committee meetings it would be helpful to state in the materials how the Committee can be helpful and to complete the suggested questions section in the cover memo.</p>	
<p><b>7. READMISSIONS DASHBOARD</b></p>	<p>The Committee reviewed All Cause Unplanned Readmission Index Data for Q1FY20. Ms. Reinking explained that this data is important, first, because we want to prevent unplanned readmissions for our patients and second, because hospitals incur a penalty of up to 3% of DRG payments for readmission rates that are above CMS calculated expected for 7 diagnoses and procedures. ECH’s penalty for FY19 based on actual performance was \$354,500. For Q1 FY20 ECH’s Observed /Expected ratio is greater than 1.0 for 3 of the readmission penalty diagnoses: Pneumonia (1.31), Stroke (1.29) and Total Hip and Knee Arthroplasties (sudden spike to 1.79). Dan Shin, MD, Medical Director of Quality Assurance reported that another quarter at least of data needs to be collected for the Total Joint procedures to confirm if this is an anomaly or a trend. The index for Acute Myocardial Infarction (Heart Attack) has decreased to .23 following some work on anticoagulation therapy.</p> <p>There was some discussion about how the Committee can be most useful. Dr. Haughom suggested that the Committee can be most useful if (1) management brings it three things: (a) reports on successes, (b) trends in the data that the Committee needs to know about, and (c) what is being done about quality problems and (2) stays focused on policy.</p>	

	The Committee requested more trending information on the readmissions data.	
<b>8. PATIENT SAFETY INDICATORS</b>	The Committee reviewed the Premier Quality Advisor Report Patient Safety Indicators. There was some concern about the rates in three categories “Death in surgical patients with treatable conditions,” “OB Trauma Vaginal Delivery with instrument” and “OB Trauma Vaginal Delivery without instrument.” Ms. Reinking described work being done to address the OB trauma issues and the Committee requested a deeper dive into whether the vaginal tearing was due to expected causes such as ethnicity and low protein diets. The Committee also requested a deeper dive into the 4 deaths in surgical patients with treatable conditions. The Committee would also like to see regional comparison data and requested that the charts be reformatted so that they are easier to read.	
<b>9. PEER REVIEW PROCESS</b>	The Committee received a presentation from Dan Shin, MD, Medical Director of Quality Assurance, regarding the new Peer Review Process being implemented by the Medical Staff. The new process includes establishing a Multi-Specialty “Practice Excellence Committee” for Peer Review that will absorb smaller departments and result in less bias, better standardization of outcomes, and fewer conflicts of interest. Dr. Qureshi commented that this is going to be a cultural change, but it is a national trend to move Peer Review in this direction.	
<b>10. ANNUAL PERFORMANCE IMPROVEMENT REPORTS</b>	Ms. Reinking reviewed the Annual Performance Improvement Reports for Core Measures, Oncology, Human Resources, and Maternal Child Health. Oncology is meeting benchmarks, lift transfer injuries have improved and RN turnover rate is below benchmark.	
<b>11. PUBLIC COMMUNICATION</b>	There was no written communication. Catharine Walke, President of PRN, thanked the Committee and Dr. Shin for the presentation on the Medical Staff Peer Review Process. Imtiaz Qureshi, MD, Enterprise Chief of Staff, suggested that the Committee consider adding the Chiefs of the Medical to the Committee membership. Chair Kliger asked staff to add that discussion to the Pacing Plan for the February 3, 2019 meeting.	
<b>12. ADJOURN TO CLOSED SESSION</b>	<p><b>Motion:</b> To adjourn to closed session at 7:28pm.</p> <p><b>Movant:</b> Burn</p> <p><b>Second:</b> Kliger</p> <p><b>Ayes:</b> Burn, Currie, Falwell, Fung, Kliger, Po, Simon</p> <p><b>Noes:</b> None</p> <p><b>Abstentions:</b> None</p> <p><b>Absent:</b> Sharma, Ting</p> <p><b>Recused:</b> None</p>	<i>Adjourned to closed session at 7:28pm</i>
<b>13. AGENDA ITEM 18: RECONVENE OPEN SESSION/ REPORT OUT</b>	Open session was reconvened at 7:43pm. Agenda items 13-17 were covered in closed session. During the closed session the Committee approved the consent calendar: Minutes of the Closed Session of the Quality Committee (11/4/2019); and for information: Medical Staff Quality Council Minutes.	
<b>14. AGENDA ITEM 19: CLOSING WRAP UP</b>	Cindy Murphy, Director of Governance Services, reviewed the 8 follow up items requested by the Committee.	

<b>15. AGENDA ITEM 20: ADJOURNMENT</b>	<b>Motion:</b> To adjourn at 7:45pm. <b>Movant:</b> Fung <b>Second:</b> Simon <b>Ayes:</b> Burn, Currie, Falwell, Fung, Kliger, Po, Simon <b>Noes:</b> None <b>Abstentions:</b> None <b>Absent:</b> Sharma, Ting <b>Recused:</b> None	<b><i>Meeting adjourned at 7:45pm</i></b>
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**Attest as to the approval of the foregoing minutes by the Quality, Patient Care and Patient Experience Committee of El Camino Hospital:**

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Julie Kliger, MPA, BSN  
Chair, Quality Committee

**EL CAMINO HOSPITAL  
QUALITY COMMITTEE MEETING COVER MEMO**

**To:** Quality Committee  
**From:** Catherine Carson, MPA, BSN, RN, CPHQ  
Sr. Director/Chief Quality Officer  
**Date:** February 3, 2020  
**Subject:** FY 20 Quality Dashboard for February meeting

**Purpose:** Provide the Committee with a snapshot of the FY 2020 metrics monthly with trends over time and compared to the actual results from FY2019 and the FY 2020 goals.

1. **Situation:** Annotation is provided to explain actions taken affecting each metric.
2. **Authority:** The Quality Committee of the Board is responsible for the quality and safety of care provided to ECH patients. This dashboard provides oversight on key quality metrics.
3. **Background:** These thirteen (13) metrics were selected for monthly review by this Committee as they reflect the Hospital's FY 2020 Quality, Efficiency and Service Goals.
4. **Assessment:**
  - 3 month increase in Mortality Index ended with decrease in December due to more patients w/Palliative care consults and transfer into GIP than Oct/Nov.
  - Readmission Index reduced significantly after increasing over the summer months.
  - Impact of FY 19 ED Throughput teams continues since April 2019 and Enterprise results are below new target.
  - The HCAPS metrics for Responsiveness and Discharge Information both continue above target. The Likelihood to recommend score remains below target though is at a high percentile compared to other hospitals.
  - 2 CAUTIs in December both due to long LOS and catheters for over 24 days.
  - Zero CLABI continues across the Enterprise over 5 consecutive months.
  - Quality Council subcommittee addressing Surgical Site Infections and expansion of ERAS has reduced SSIs since May with only 1 in December.
  - Sepsis Mortality Index is down, below target and previous 2 year pattern of increase in Nov/Dec has changed.
  - Perinatal Measures of Primary C/S (PC-02) and Early Elective Delivery (PC-01) are being address by MCH Service Line and Medical Director.
5. **Other Reviews:** N/A
6. **Outcomes:** N/A

**List of Attachments:**

FY20 Quality Dashboard, December data unless otherwise specified - final results

**Suggested Committee Discussion Questions:** None.

Quality	FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend (showing at least the last 24 months of available data)	Rolling 12 Months Average
	Latest month	FYTD				
<p><b>* Organizational Goal Mortality Index Observed/Expected</b> Premier Standard Risk Calculation Mode Date Period: December 2019</p>	0.72 (1.61%/2.24%)	0.68 (1.29%/1.89%)	0.97	0.90		
<p><b>*Organizational Goal Readmission Index (All Patient All Cause Readmit) Observed/Expected</b> Premier Standard Risk Calculation Mode Index month: November 2019</p>	0.94 (7.27%/7.70%)	1.00 (7.74%/7.76%)	0.99	0.96		
<p><b>Patient Throughput-Median Time from Arrival to Head In Bed</b> (excludes psychiatric patients, patients expired in the ED and Newborns) Date Period: December 2019</p>	MV: 280 min LG: 233 min Enterprise: 257 min	MV: 281 min LG: 227 min Enterprise: 254 min	MV: 304 min LG: 263 min Enterprise: 284 min	266 min (5% improvement from last year's target, 280)		

## Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
<b>Mortality Index (Observed/Expected)</b>	This Index remains below target and reversed the upward trajectory from September 2019, some of which was due to fewer patients transferring into GIP.	Catherine Carson	Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice. For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. <i>LCL is set to '0' if value is less than or equal to zero.</i>	Premier Quality Advisor
<b>Readmission Index - All Patient All Cause Readmit (Observed/Expected)</b>	This Index also dropped back below target. The Readmission Quality Teams continue to try to identify potential readmission patients and act proactively to address post discharge needs.	Catherine Carson	Using Premier All-Cause Hospital-Wide 30 Day Readmission Methodology v.4.0. (Patients with an unplanned readmission for any cause to ECH acute inpatient within 30 days of discharge, CareScience Risk Adjusted). For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average. <i>LCL is set to '0' if value is less than or equal to zero.</i>	Premier Quality Advisor
<b>Patient Throughput-Average Minutes from ED Door to Patient Admitted (excludes Behavioral Health Inpatients and Newborns)</b>	Los Gatos continues to monitor stabilization of improvements identified during their first 2 Rapid Process Improvement Workshops to help improve the initiation of care and ancillary testing. MV is running small experiments during this construction phase to keep throughput going including relocating some staff and equipment in triage area, increasing utilization of hallway beds, adding another ED MD resource, etc. Work is in process to help implement and enhance elements of Daily Management System related to ED throughput on both campuses.	Cheryl Reinking, Dolly Mangla	Population: Includes inpatients, outpatients, observation patients, and Hospital Outpatient Surgery Patients who arrive via the ED. It excludes psychiatric patients, patients who expired in the ED, and newborns. Arrival: Patient Arrived in ED Head in Bed: Patient admitted in unit  <i>LCL is set to '0' if value is less than or equal to zero.</i>	iCare Report: ECH ED Arrival to Floor

Service	FY20 Performance		Baseline FY19 Actual	FY20 Target	Trend	Rolling 12 Months Average
	Latest month	FYTD				
<p><b>4</b></p> <p><b>* Organizational Goal</b></p> <p><b>HCAHPS Discharge Information</b></p> <p><b>Top Box Rating of Always</b></p> <p><i>Date Period: December 2019</i></p>	88.7	87.3	86.7	87.3		
<p><b>5</b></p> <p><b>* Organizational Goal</b></p> <p><b>HCAHPS Responsiveness of Staff Domain</b></p> <p><b>Top Box Rating of Always</b></p> <p><i>Date Period: December 2019</i></p>	68.1	67.3	65.7	67.1		
<p><b>6</b></p> <p><b>HCAHPS Likelihood to Recommend</b></p> <p><b>Top Box Rating of Always</b></p> <p><i>Date Period: December 2019</i></p>	80.8	83.3	83.5	84.2		

## Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
<p style="text-align: center;"><b>HCAHPS Discharge Information Domain Top Box Rating of Always</b></p>	<ul style="list-style-type: none"> <li>Discharge Information – this metric is on target for the quarter and year to date. Strong improvements have been made in Inpatient / Mother baby especially in Los Gatos. Continued work is being done on implementing the proven best practice of post discharge phone calls. “Help at Home” signs are up on five units in order to help foster the discharge discussion.</li> </ul>	<p>Yvette Million Cheryl Reinking</p>	<p>For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average.</p> <p><i>LCL is set to '0' if value is less than or equal to zero.</i></p>	<p>Press Ganey Tool</p>
<p style="text-align: center;"><b>HCAHPS Responsiveness of Staff Domain Top Box Rating of Always, based on Received Date, Adjusted Samples</b></p>	<ul style="list-style-type: none"> <li>Staff Responsiveness – this metric is on target for the quarter and year to date. Current initiatives include Mother/Baby 'commit to sit' where nurses commit to sit daily in order to make a connection and / or address concerns. Communication training for the non clinical staff is also in process. Hourly rounding / purposeful rounding program is being reviewed in order to improve its efficacy. Inpatient units have seen progress due to strong efforts such as call light audits and No Pass Zone implementation enterprise wide.</li> </ul>	<p>Yvette Million Cheryl Reinking</p>	<p>For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average.</p> <p><i>LCL is set to '0' if value is less than or equal to zero.</i></p>	<p>Press Ganey Tool</p>
<p style="text-align: center;"><b>HCAHPS Likelihood to Recommend Top Box</b></p>	<ul style="list-style-type: none"> <li>HCAHPS: Likelihood to Recommend – Likelihood to Recommend is our loyalty score and the industry standard of measuring experience. Although not quite at target, ECH continues to have strong LTR scores and high percentile compared with others in the nation. Continued emphasis on leader rounding, and updating and reinvigorating our service standards will contribute to this metric.</li> </ul>	<p>Yvette Million Cheryl Reinking</p>	<p>For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average.</p> <p><i>LCL is set to '0' if value is less than or equal to zero.</i></p>	<p>Press Ganey Tool</p>

December 2019 (Unless otherwise specified)

		FY20 Performance		Baseline FY19 Actual	FY 20 Target	Trend	
Quality		Latest month	FYTD				
7	<b>Hospital Acquired Infections</b> Catheter Associated Urinary Tract Infection (CAUTI) per 1,000 urinary catheter days Date Period: December 2019	1.55 (2/1289)	0.53 (4/7578)	1.09	SIR Goal: ≤ 0.75		
8	<b>Hospital Acquired Infections</b> Central Line Associated Blood Stream Infection (CLABSI) per 1,000 central line days Date Period: December 2019	0.00 (0/895)	0.20 (1/5066)	0.36	SIR Goal: ≤ 0.50		
9	<b>Hospital Acquired Infections</b> Clostridium Difficile Infection (CDI) per 10,000 patient days Date Period: December 2019	3.52 (3/8515)	1.38 (7/50576)	1.96	SIR Goal: ≤ 0.70		

## Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
<b>Hospital Acquired Infection (SIR Rate) CAUTI (Catheter-acquired Urinary Tract Infection)</b>	2- CAUTI cases in December: 1-79 y/o male developed CAUTI 24 days post insertion, had emergency surgery on arrival post fall with subdural hematoma. Gaps in hygiene (bath/peri care) after review. 2- 90 y/o female developed fever and CAUTI 25 days after admit. Had 5 foley insertions in 25 day period with gaps in hygiene (baths) after review.	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average.  <i>LCL is not visible if value is less than or equal to zero.</i>	CDC NHSN data base - Inf. Control
<b>Hospital Acquired Infection (SIR Rate) CLABSI (Central line associated blood stream infection)</b>	Zero CLABSI in November and December 2019; 5 consecutive months without CLABSI	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average.  <i>LCL is set to '0' if value is less than or equal to zero.</i>	CDC NHSN data base - Inf. Control
<b>Hospital Acquired Infection (SIR Rate) C. Diff (Clostridium Difficile Infection)</b>	3 hospital-onset C. Diff infections in December: 1- 105 y/o female admitted, with negative C.Diff surveillance on admission. 7 days post admit developed C.Diff infection, possibly related to room placement. Previous pt (2 days earlier) had active C.Diff, not UV disinfection done in that room upon previous pt. discharge. 2- 83 y/o male admitted w dusuria, C.Diff surveillance on admission was positive, and correct test (C.Diff toxin) not done until 4 days after admission and was positive, so has to be called hospital-onset. 3 - 88 y/o male admitted from home, no C.Diff surveillance, chronic foley catheter use and several ED encounters for chronic UTI. Developed positive C.Diff toxin after 3 days and 3 antibiotics in use.	Catherine Carson/Catherine Nalesnik	For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average.  <i>LCL is set to '0' if value is less than or equal to zero.</i>	CDC NHSN data base - Inf. Control

	FY20 Performance		Baseline FY19 Actual	FY20 Target	Trend	Rolling 12 Months Average
	Latest month	FYTD				
<p><b>Organizational Goal</b></p> <p><b>10 Surgical Site Infections (SSI)- Enterprise</b>  <b>SSI Rate = Number of SSI / Total surgical procedures x 100</b>                      Date period: December 2019</p>	0.19 (1/540)	0.22 (8/3564)	0.22 (37/7167)	SIR Goal: $\leq 1.0$ CDC NHSN Risk Adjusted Ratio (not an infection rate)		
<p><b>11 Sepsis Mortality Index, based on ICD 10 codes</b> (Observed over Expected)                      Date Period: December 2019</p>	0.86 (12.50%/14.48%)	0.76 (8.32%/10.93%)	1.06	0.90		
<p><b>12 PC-01: Elective Delivery Prior to 39 weeks gestation</b> (lower = better)                      Date period: November 2019</p>	MV: 3.57% (1/28) LG: 0.00% (0/5) ENT: 3.0% (1/33)	MV: 1.39% (2/144) LG: 0.00% (0/20) ENT: 1.22% (2/164)	MV: 1.11% (4/360) LG: 0.00% (0/44) ENT: 0.99% (4/404)	0.0%		
<p><b>13 PC-02: Cesarean Birth</b> (lower = better)                      Date period: November 2019</p>	MV: 27.97% (40/143) LG: 18.75% (3/16) ENT: 27.0% (43/159)	MV: 25.29% (175/692) LG: 15.22% (14/92) ENT: 24.26% (189/779)	MV: 26.28% (425/1617) LG: 14.29% (30/210) ENT: 24.90% (455/1827)	<23.9%		

## Definitions and Additional Information

Measure Name	Comments	Definition Owner	FY 2020 Definition	Source
<b>Surgical Site Infections (SSI) - Enterprise SSI Rate = Number of SSI / Total Surgical Procedures x 100</b>	1 SSI in November, Pt readmitted for resection arthroplasty, placement of antibiotic cement after RTK of September. 1-SSI in December, Pt readmitted after RTK revision arthroplasty in November for I&D complete synovectomy w/revision of single component, and liner exchange.		The standardized infection ratio (SIR) is a summary measure used to track HAIs over time at a national, state, local level. This is a summary statistic that compares the actual number of HAIs reported with the baseline US experience (NHSN aggregate data are used as the standard population), adjusting for several risk factors that are significantly associated with differences in infection incidence. An SIR greater than 1.0 indicates that more HAIs were observed than predicted, accounting for differences in types of patients followed, a SIR less than 1.0 indicates fewer HAIs were observed than predicted. <i>Upper Control Limit and Lower Control Limit are 2+/- the Standard Deviation from the Average.</i>	CDC NHSN data base - Inf. Control
<b>Sepsis Mortality Index Observed over Expected, based on ICD 10 codes</b>	The Sepsis Mortality Index fell in concert with the overall Mortality Index. A review of mortality for Nov/Dec 2018 and 2017 shows a change in the previous rise of mortality index for those months for Nov/Dec. 2019.	Catherine Carson	Updated 7/1/19(JC)- Selection Criteria revised: new criteria include cases with Patient Type=Inpatient and exclude cases with Patient Type=Rehab, Psych & Hospice For the Trends graph: UCL and LCL are 2+/- the Standard Deviation of 1 from the Average.  <i>LCL is set to '0' if value is less than or equal to zero.</i>	Premier Quality Advisor
<b>PC-01: Elective Delivery Patients with elective vaginal deliveries or elective cesarean births at &gt;= 37 and &lt; 39 weeks of gestation completed</b>	A report has been created that will enable prospective interventions to avoid unnecessary deliveries prior to 39 weeks. We are transitioning medical directors and do not yet have a signed contract, should be signed by the end of January.	TJC	Numerator: Patients with elective deliveries Denominator: Patients delivering newborns with >= 37 and < 39 weeks of gestation completed  <i>LCL is set to '0' if value is less than or equal to zero.</i>	IBM CareDiscovery Quality Measures
<b>PC-02: Cesarean Birth Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth</b>	An auditing process has been in development. In addition, OB medical staff and the transitioning medical director will support providers with high rates in efforts to reduce their primary C/S rates.	TJC	Numerator Statement: Patients with cesarean births Denominator Statement: Nulliparous patients delivered of a live term singleton newborn in vertex presentation  <i>LCL is set to '0' if value is less than or equal to zero.</i>	IBM CareDiscovery Quality Measures

**QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE  
FY20 Pacing Plan**

<b>FY2020 Q1</b>		
<b>JULY 2019</b>	<b>AUGUST 5, 2019</b>	<b>SEPTEMBER 9, 2019</b>
<p>No Board or Committee Meetings</p> <p><b>Routine Consent Calendar Items:</b></p> <ul style="list-style-type: none"> <li>▪ <b>Approval of Minutes</b></li> <li>▪ <b>FY 20 Quality Dashboard</b></li> <li>▪ <b>Progress Against FY 2020 Committee Goals</b></li> <li>▪ <b>FY20 Pacing Plan</b></li> <li>▪ <b>Med Staff Quality Council Minutes</b></li> </ul>	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> <li>1. Board Actions</li> <li>2. Consent Calendar</li> <li>3. Progress Against FY19 Committee Goals</li> <li>4. FY20 Quality Dashboard (Discuss - should this be on consent? Only discuss if something outside normal variation? Deeper Dive Quarterly?)</li> <li>5. Hospital Update</li> <li>6. Serious Safety/Red Alert Event as needed</li> </ol> <p>Special Agenda Items</p> <ol style="list-style-type: none"> <li>1. FY19 Quality Dashboard Results (Includes FY19 Org. Incentive Goals)</li> <li>2. LEAN Progress Report</li> <li>3. Q4 FY19 Quarterly Quality and Safety Review</li> <li>4. Physician Engagement</li> <li>5. Committee Recruitment (If needed)</li> <li>6. Who makes up census in the ED?</li> <li>7. draft Board-level QC reporting</li> <li>8. PSI-90 metrics</li> </ol>	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> <li>1. Board Actions</li> <li>2. Consent Calendar</li> <li>3. Progress Against FY20 Committee Goals</li> <li>4. Patient Story</li> <li>5. Hospital Update</li> <li>6. Serious Safety/Red Alert Event as needed</li> <li>7. Introduction of New Members</li> <li>8. Annual Performance Improvement Reports (rotating departments)</li> </ol> <p>Special Agenda items:</p> <ol style="list-style-type: none"> <li>9. Update on Patient and Family Centered Care</li> <li>10. Recommend FY20 Organizational Goal Metrics</li> <li>11. Annual Patient Safety Report</li> <li>12. FY19 Quality Dashboard Final Results (Incl. FY19 Org Goals)</li> <li>13. Pt. Experience (HCAHPS)</li> <li>14. ED Pt. Satisfaction (Press Ganey)</li> <li>15. Quality and Safety Strategic Plan</li> </ol>
<b>FY2020 Q2</b>		
<b>OCTOBER 7, 2019</b>	<b>NOVEMBER 4, 2019</b>	<b>DECEMBER 2, 2019</b>
<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> <li>1. Board Actions</li> <li>2. Consent Calendar</li> <li>3. Progress Against FY20 Committee Goals</li> <li>4. Patient Story</li> <li>5. Hospital Update</li> <li>6. Serious Safety/Red Alert Event as needed</li> <li>7. Annual Performance Improvement Reports (rotating departments)</li> </ol> <p>Standing Agenda Items:</p> <ol style="list-style-type: none"> <li>8. Report on Medical Staff Peer Review Process</li> <li>9. FY20 Org. Goal and Quality Dashboard Metrics</li> <li>10. FY19 Organizational Goal Achievement (M, RA)</li> </ol>	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> <li>1. Board Actions</li> <li>2. Consent Calendar</li> <li>3. Progress Against FY20 Committee Goals</li> <li>4. Patient Story</li> <li>5. Hospital Update</li> <li>6. Serious Safety/Red Alert Event as needed</li> <li>7. Annual Performance Improvement Reports (rotating departments)</li> </ol> <p>Special Agenda Items:</p> <ol style="list-style-type: none"> <li>8. CDI Dashboard</li> <li>9. Core Measures</li> <li>10. Safety Report for the Environment of Care</li> <li>11. Q1 FY20 Quarterly Quality and Safety Review</li> <li>12. Debrief 10/23 Session</li> <li>13. Q&amp;S Plan</li> </ol>	<p>Standing Agenda Items:</p> <ol style="list-style-type: none"> <li>1. Board Actions</li> <li>2. Consent Calendar</li> <li>3. Progress Against FY20 Committee Goals</li> <li>4. Patient Story (Not Positive)</li> <li>5. Hospital Update</li> <li>6. Serious Safety/Red Alert Event as needed</li> <li>7. Annual Performance Improvement Reports (rotate)</li> </ol> <p>Special Agenda items:</p> <ol style="list-style-type: none"> <li>8. Readmission Dashboard</li> <li>9. PSI- Indicators</li> <li>10. Peer Review Process</li> <li>11. Drill Down on Q1 Q&amp;S Review</li> </ol>
<b>FY2020 Q3</b>		

**QUALITY, PATIENT CARE, AND PATIENT EXPERIENCE COMMITTEE  
FY20 Pacing Plan**

JANUARY 2020	FEBRUARY 3, 2020	MARCH 2, 2020
No Meeting	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story (Not Positive) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments)  Special Agenda Items: 8. Q2 FY20 Quality and Safety Review 9. Update on Patient Care Experience 10. <del>Goal Attainment</del> 11. Draft Revised Charter (C&P, Chiefs) 12. <del>SVMD Reporting to Quality Committee</del> 13. <del>Follow up on PSI 4, 18, 19</del>	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments)  Special Agenda Items: 8. Proposed FY21 Committee Goals 9. Proposed FY21 Organizational Goals 10. Update on Patient and Family Centered Care 11. Update on LEAN Transformation 11.12. <del>Goal Attainment</del>
FY2020 Q4		
APRIL 6, 2020	MAY 4, 2020	JUNE 1, 2020
Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story (Not Positive) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments – PLUS Bring Back HIMS, Ortho. Antimicrobial from October)  Special Agenda Items: 8. Value Based Purchasing Report 9. Pt. Experience (HCAHPS) 10. Approve FY21 Committee Goals 11. Proposed FY21 Committee Meeting Dates 12. Proposed FY21 Organizational Goals	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story (Not Positive) 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments)  Special Agenda Items: 8. CDI Dashboard 9. Core Measures 10. Approve FY21 Committee Goals (if needed) 11. Proposed FY21 Organizational Goals 12. Proposed FY21 Pacing Plan 13. Q3 FY20 Quality and Safety Review	Standing Agenda Items: 1. Board Actions 2. Consent Calendar 3. Progress Against FY20 Committee Goals 4. Patient Story 5. Hospital Update 6. Serious Safety/Red Alert Event as needed 7. Annual Performance Improvement Reports (rotating departments)  Special Agenda Items: 8. 9. Readmission Dashboard 10. PSI-90 Pt. Safety Indicators 11. Approve FY21 Pacing Plan 12. Leapfrog Survey

## FY20 COMMITTEE GOALS

### Quality, Patient Care and Patient Experience Committee

#### PURPOSE

The purpose of the Quality, Patient Care and Patient Experience Committee (the “Committee”) is to advise and assist the El Camino Hospital (ECH) Hospital Board of Directors (“Board”) in constantly enhancing and enabling a culture of quality and safety at ECH, to ensure delivery of effective, evidence-based care for all patients, and to oversee quality outcomes of all services of ECH. The Committee helps to assure that exceptional patient care and patient experiences 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.

**STAFF:**      **Mark Adams, MD**, Chief Medical Officer (Executive Sponsor)

The CMO shall serve as the primary staff to support the Committee and is responsible for drafting the Committee meeting agenda for the Committee Chair’s consideration. Additional clinical representatives and members of the Executive Team may participate in the meetings upon the recommendation of the Executive Sponsor and at the discretion of the Committee Chair. These may include: the Chiefs/Vice Chiefs of the Medical Staff, physicians, nurses, and members from the community advisory councils, or the community at-large.

GOALS	TIMELINE	METRICS
1. Review the Hospital’s organizational goals and scorecard and ensure that those metrics and goals are consistent with the strategic plan and set at an appropriate level as they apply to quality	- FY19 Achievement and Metrics for FY20 (Q1 FY20) <b>(Complete)</b> - FY21 Goals (Q3 – Q4) <b>(Paced)</b>	Review management proposals; provide feedback and make recommendations to the Board
2. Alternatively (every other year) review peer review process and medical staff credentialing process; monitor and follow through on the recommendations	Q2	- Receive update on implementation of peer review process changes (FY20) <b>(Complete)</b> - Review Medical Staff credentialing process (FY21)
3. Review Quality, Patient Care and Patient Experience reports and dashboards	- FY21 Quality Dashboard (Q1-Q2 proposal; monthly for review and discussion, if needed) - CDI Core Measures, PSI-90, Readmissions, Patient Experience (HCAHPS), ED Patient Satisfaction (x2 per year) - Leapfrog survey results and VBP calculation reports (annually)	Review reports per timeline – <b>(Paced)</b>
4. Oversee execution of the Patient and Family-Centered Care plan and LEAN management activities and cultural transformation work	Quarterly	Review plan and progress; provide feedback to management – <b>(Paced)</b>
5. All committee members regularly attend and are engaged in committee meeting preparation and discussions	Review quarterly at the end of the meeting <b>(Use Closing Wrap-Up Time)</b>	Attend 2/3 of all meetings in person Actively participate in discussions at each meeting
6. Monitor the impact of interventions to reduce mortality and readmissions	Quarterly	Review progress toward meeting quality organizational goals <b>(Ongoing)</b>

**SUBMITTED BY: Chair:** Julie Kliger, MPA, BSN

**Executive Sponsor:** Mark Adams, MD, CMO

Approved by the ECH Board of Directors 6/12/2019

**Hospital Update**  
**February 3, 2020**  
**Mark Adams, MD, CMO**

### **Finance**

Finance is completing the due diligence process for the SWAP transaction, monitoring interest rates and will be ready to execute following Board approval of Revised Resolution 2019-12. The Finance team is also planning for the new pricing transparency rules, which will require public disclosure of contracted rates, set to take effect January 1, 2021.

El Camino applied for and has been accepted into the Bundled Payment for Care Improvement Advanced Program (BPCI) effective January 1, 2020. We have partnered with Remedy who will be providing the software, analytics, and administrative services that enable hospital providers to participate in Medicare bundled payments contracts through shared-risk partnerships. Remedy is a leading company in this space and will be sharing risk with ECH.

### **Corporate and Community Health Services**

CONCERN launched a new partnership with Talkspace to provide text therapy and added coaching added as a new option.

The FY 2019 Community Benefit Annual Report was distributed widely:

- The email campaign reached more than 1,100 people, a 72% increase
- We mailed hard copies to nearly 300 external stakeholders including elected officials and Community Benefit Grant Partners
- More than 100 copies reached patients and families in waiting rooms around the ECH campus
  
- Recent Sponsorships
  - Pancreatic Cancer Action Network – Purple Stride Walk
  - Abilities United – Authors Luncheon
  - Habitat for Humanity – Cycle of Hope
  - Valley Verde – The Dolores Affect
  - PACT – Leadership Luncheon
  - Silicon Valley Leadership Group – Turkey Trot

The South Asian Heart Center (SAHC) received a major gift of \$25,000 from a new donor, on boarded 10 patients for the El Camino Diabetes Prevention Program, completed Livermore Temple's Health Fair with biometrics and AIM program signups and launched outreach at the Fremont Farmer's Market.

The Chinese Health Initiative (CHI) launched the diabetes prevention program, delivered in Chinese in collaboration with SAHC. The program is culturally and linguistically tailored to the needs of the Chinese community. CHI also partnered with the ECH Cancer Center and New Hope Chinese Cancer Care Foundation to organize a Mandarin Speaker's Bureau workshop "Cancer Treatment Options: Chemotherapy, Targeted Therapy, and Immunotherapy."

The Health Library & Resource Center continues with weekly information tables at the Mountain View Senior Center and the Indian Community Center and also hosted an information table at the Saratoga Senior Center and ECH LG Prostate Support Group.

### **Marketing and Communications**

Marketing partnered with other departments for the Sobrato Pavilion and the new SVMMD @First St. clinic site ribbon cutting events.

To reach consumers in an efficient, location agnostic manner the marketing team has been hosting webinars on key topics of interest for over a year. The recent Lifestyle Medicine webinar with Nurse Barb and Dr. Cate Collings experienced record-setting registration (390 individuals) and participation (35% of those registered). The webinar combined with follow up communications have generated physical class registration and appointments with Dr. Collings and the lifestyle medicine team.

We launched radio spots for our El Camino Health Corporate Brand Awareness Advertising Campaign the week of November 4<sup>th</sup> on local broadcast stations. A targeted direct mail and email campaign launched the week of November 18<sup>th</sup> to promote choosing an El Camino Health physician. The effort generated about 200,000 touchpoints across 74,218 with members aging-in to Medicare, those with Medicare and those among the general population. A targeted direct mail campaign promoting our urgent care centers hit 15,000 of homes the week of November 11<sup>th</sup>.

We finished production of new video content including Taube Pavilion tours, a breastfeeding support video for our new moms, seven heart-healthy videos featuring Chef Jacques and our heart and vascular physicians, and a new Wound Care Center video. Online content to support search and engagement included Brad's Story: Robotic Surgery Resolved Chronic Knee Pain Quickly highlighting MAKO and new Healthperks content for Stay Healthy.

### **Information Services**

Once again, El Camino Hospital received the College of Healthcare Management Executives (CHIME) "Most Wired" certification for making great strides using technology to improve health and care in our community.

### **Silicon Valley Medical Development (SVMMD), LLC**



We are beginning to enroll San Jose Medical Group (SJMG) patients in MyChart; more than 30% of patients across all SVMD sites of care are now enrolled. El Camino Health's SVMD@First Clinic opened on November 1<sup>st</sup>. Two midwives from Bay Area Midwifery have joined us in Los Gatos, SVMD has signed employment agreements with two others who will be joining them in the next two months and SVMD added two primary care physicians in Mountain View through ECMA. SVMD is now conducting patient experience surveys across all of SVMD including SJMG sites.

### **Philanthropy**

During period 4 of fiscal year 2020, El Camino Health Foundation secured \$775,152 in donations. The Foundation has raised a total of \$2,133,849 this fiscal year through Period 4.

### **Auxiliary**

Our dedicated Auxiliary contributed 6,072 volunteer hours in October 2019 and 5,287 volunteer hours in November 2019.

Quality Committee Follow up Item Tracking Sheet (12/5/19)

#	Follow Up Item	Date Identified	Owner(s)	Status	Date Complete
1	Bring "negative" (not only positive) patient stories for discussion	11/4/2019	CR	Noted in Pacing Plan 12/2/19 going forward	Ongoing
2	Copy slide "Committee Responsibilities" from the Joint Board/QC Meeting and provide to those who were not there	11/4/2019	CM	Available at 12/2 Meeting	12/2/2019
3	Add control limits to Annual PI Reports	11/4/2019	CC/MA	Will be added to future reports	
4	Add a discussion around goal attainment to the pacing plan	11/4/2019	CM	Added to 2/3/20 Meeting then moved to 3/2/20 due to full agenda on 2/3/20	
5	Drill down on Q1 Quarterly Quality and Safety Review at 12/2/19 meeting	11/4/2019	CC/MA	On 12/2/19 Agenda	12/2/2019
6	Add a discussion about SVM, LLC reporting to the Quality Committee agenda	12/2/2019	CM	on 2/3/20 Agenda	
7	Add CQO to the "Who" for the quality oversight componets of the Board Action Plan	12/2/2019	CM	Added 12/3/19	12/3/2019
8	Look deeper into the the sytem for non-nursing related issues for the patient stories	12/2/2019	CR	Open	
9	Cover Memos - Make sure to state what the staff wants from the committee/how the committee can be helpful and provide discussion questions	12/2/2019	Executive Team	Open	
10	Provide more trending information on readmissions data	12/2/2019	CC/MA	Open	
11	Follow-Up on PSI 4, 18 and 19: 1. % breakdown by ethnicity, and %age of this population that met the harm criteria (this way we can get a numerator and denominator for ethnic population) 2. % breakdown by low protein/vegan diets, and %age of this population that met the harm criteria (this way we can get a numerator and denominator for diet-based population)	12/2/2019	CC/MA	On 2/3/20 Agenda	
12	Make the charts and graphs easier to read	12/2/2019	CC/MA	Open	
13	Add discusison about adding Chiefs of Staff as members of the Committee to the Pacing Plan	12/2/2019	CM	on 2/3/20 Agenda	

**EL CAMINO HOSPITAL BOARD OF DIRECTORS  
COMMITTEE MEETING COVER MEMO**

**To:** Quality, Patient Care and Patient Experience Committee  
**From:** Cindy Murphy, Director of Governance Services  
**Date:** February 3, 2020  
**Subject:** Report on Board Actions

**Purpose:**

To keep the Committee informed with regards to actions taken by the El Camino Hospital and El Camino Healthcare District Boards.

**Summary:**

1. **Situation:** It is important to keep the Committees informed about Board activity to provide context for Committee work. The list below is not meant to be exhaustive, but includes agenda items the Board voted on that are most likely to be of interest to or pertinent to the work of El Camino Hospital's Board Advisory Committees.
2. **Authority:** This is being brought to the Committees at the request of the Board and the Committees.
3. **Background:** Since the last Quality Committee meeting, the Hospital Board has met twice and the District Board has met once. In addition, since the Board has delegated certain authority to the Compliance and Audit Committee, the Finance Committee and the Executive Compensation Committee those approvals are also noted in this report.

**A. ECH Board Actions:**

**December 11, 2019**

- Approved FY20 Periods 3 & 4 Financials
- Approved Revised SVMD, LLC Operating Agreement
- Approved Letters of Rebuttable Presumption of Reasonableness
- Approved Telepsych Services Agreement

**December 16, 2019**

- Approved Revised Resolution 2019-12 Authorizing Forward Starting Interest Rate Hedge

**B. ECHD Board Actions: December 11, 2019**

- Approved Revised Community Benefit Policy

**C. Finance Committee Actions: November 25, 2019**

- Approved LPCH NICU PT/OT Professional Service Agreement
- Approved LPCH Neonatologist Agreement

**D. Compliance and Audit Committee: None since last report.**

Report on Board Actions  
February 3, 2020

- E. **Executive Compensation Committee Actions:** None since last report.
- 4. **Assessment:** N/A
- 5. **Other Reviews:** N/A
- 6. **Outcomes:** N/A

**List of Attachments:** None.

**Suggested Committee Discussion Questions:** None.

## The DAISY Award for Extraordinary Nurses

### To Nominate an Extraordinary Nurse:

Anyone may thank a deserving nurse by filling out this form and submitting it to El Camino Hospital.

Name of the nurse you are nominating:

Debra Anderson

Unit where this nurse works:

1-South

Please share your story of why your nurse is so special, providing as much detail as possible. See reverse side for sample nomination.

I arrived El Camino ER at a very low place in my life. I came seeking aid through medication but received so much more. A few days after I was unexpectedly admitted to inpatient behavioral health, I met Mrs Debra. Within only a few days there were many things I noticed about her.

From our first meeting she began sharing words of encouragement and wisdom. I saw that she displayed the unique ability to see beyond labels and diagnoses to the real person. She offers herself, not just her job title. She makes herself available to her patients, offering hope and truth. Going beyond what is expected, to offer what is needed.

Mrs Debra is bright, seeming to always smile, yet strong and committed. She is simply beautiful, in the broadest meaning of the term.

After my discharge into outpatient, I secretly hoped I would

run into Mrs Debra in the hall. The day finally arrived, and I was able to share a hug with her and let her know that because of her and the team she was a part of, all was finally well.



**EL CAMINO HOSPITAL BOARD OF DIRECTORS  
COMMITTEE MEETING COVER MEMO**

**To:** Quality Committee of the Board of Directors  
**From:** Cheryl Reinking, RN, MS, Chief Nursing Officer  
**Date:** February 3, 2020  
**Subject:** Patient Experience Update

**Purpose:**

The purpose of this agenda item is to provide an update on patient experience specifically related to direct feedback ECH has received from patients through Press Ganey surveys and the improvement efforts underway to address the themes that have emerged from the comments.

**Summary:** The Quality Committee of the Board of Directors at ECH has been interested in reviewing comments from patients who have experienced care at ECH. ECH leaders review and evaluate this important information routinely and develop and implement best practice initiatives to address the comments/sentiments of our patients. The focus of this presentation is to illustrate the importance of caring and compassionate staff communication.

1. **Situation:** Staff is inconsistent in providing caring and compassionate communication as noted in the Press Ganey comments.
2. **Authority:** Transparency in providing communication from our patients to staff, physicians, leaders and the board of directors is essential to learn how the patient's view their experience at ECH.
3. **Background:** Recent comments were gathered from Press Ganey surveys and included in the presentation that represents a lack of professional or caring/compassionate communication. These comments are not representative of the majority of comments---which are by far mostly positive. However, focusing on areas for improvement is essential for taking ECH to a higher level in perceived patient experience including communication
4. **Assessment:** The hospital has developed numerous improvements strategies to address communication issues which are listed in the presentation such as care team coaching, standards of behavior re-alignment, leader rounding, commit to sit, bedside handoff and hourly purposeful rounding. These initiatives have been described in the literature as best practices and if done consistently will elevate the patient perception of caring and compassionate communication.
5. **Other Reviews:** There are 5 enterprise wide patient experience committees that develop, implement, and monitor best practices.
6. **Outcomes:** The hospital continuously monitors HCHAPS surveys and comments. While not perfect, the hospital is in the 86<sup>th</sup> percentile nationally for the "Likelihood to Recommend" question on the HCAHPS survey. Communication is a key driver of the "Likelihood to Recommend" score.

**List of Attachments:** See Power Point

**Suggested Committee Discussion Questions:**

1. What specific communication tactics have you taught the staff regarding caring/compassionate communication?
2. How do you monitor staff communication in real time?

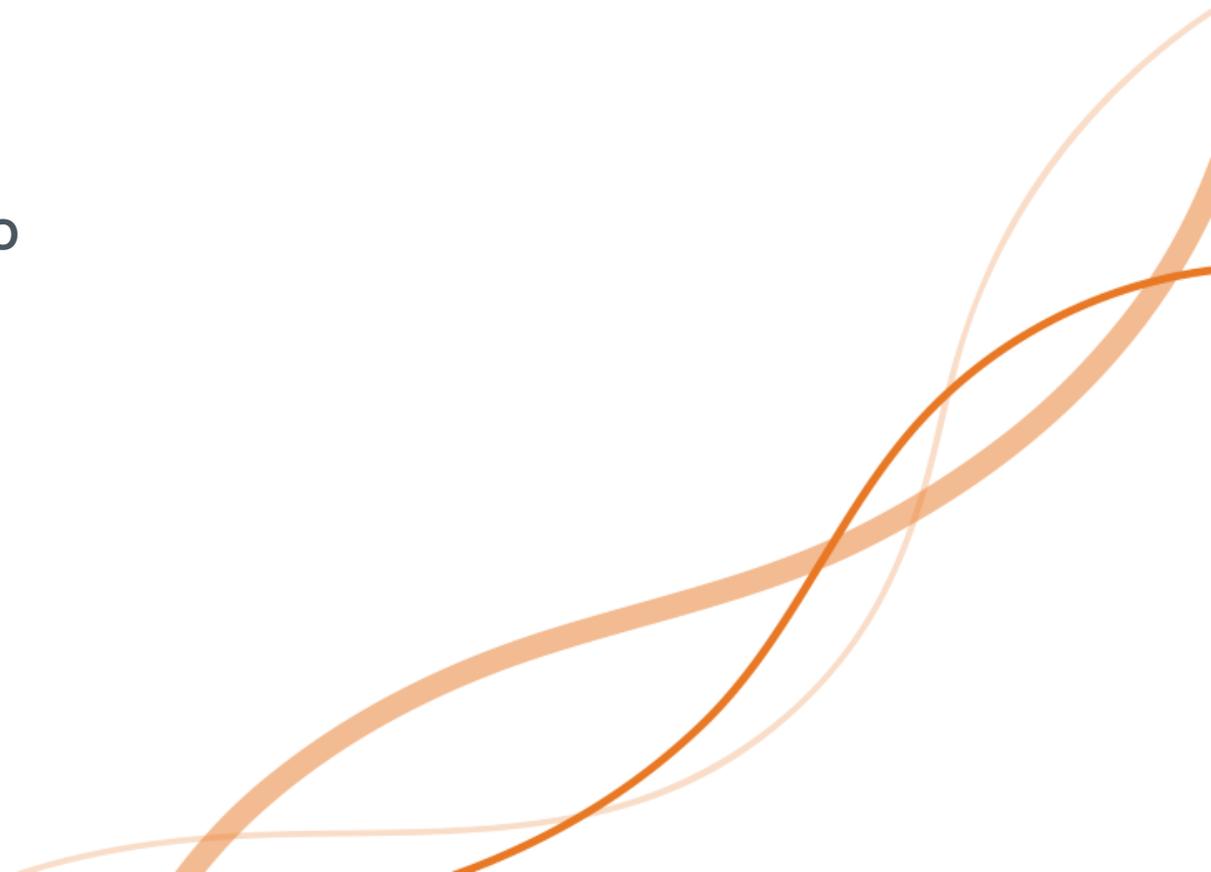
Patient Experience Update  
February 3, 2020

3. Is there anything you need from the board to continue your improvement journey in patient experience?



## **Patient Experience**

**Presented by: Cheryl Reinking, CNO**



## Comment from patients

“My nurse on day of discharge handed me my D/C paperwork & told me to read it and sign it. She did not go over it with me. She also **did not go over my mother care at home. I am very disappointed in this last nurse's professionalism & care.**”

“All the nurses introduced themselves at change of shift except the last one. The **last nurse did not respond to my requests and was rude.** The other nurses were amazing!”

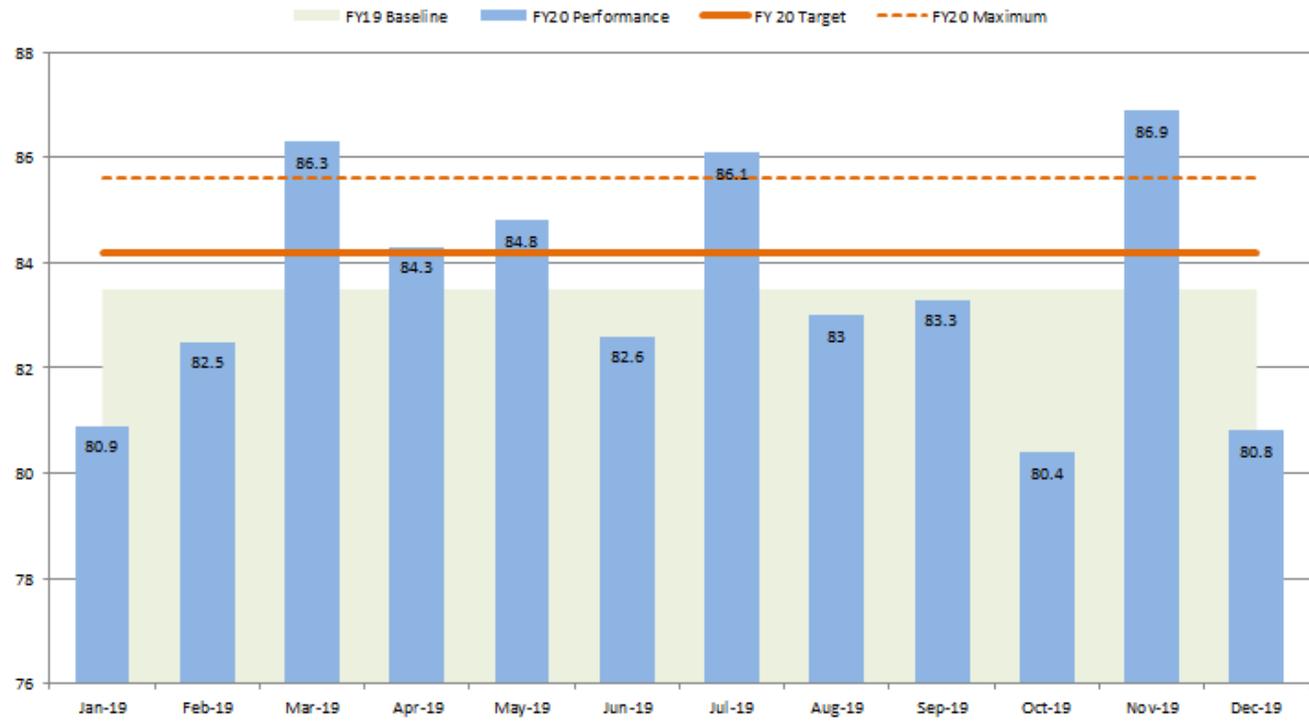
“Literally EVERY nurse I dealt with in L&D & post-partum unit (**except \*Agnes**) were not just good - they were PHENOMENAL. Special shout-out to \*Sharon & \*Felicia in L&D.”

“When the nurse took out the RJ bag (for blood), **she did not care if it was going to hurt,** or how to make it as painless as possible.”

“Night shift nurse **\*Janette was rude & was not treating me & my baby nicely.** Night time is when I needed most support. I would have given v. good for everything if night nurse was just decent.”

## HCAHPS: Likelihood to Recommend

Target	FYTD Performance	Variance: To Target
84.2	83.3	↓ 0.9

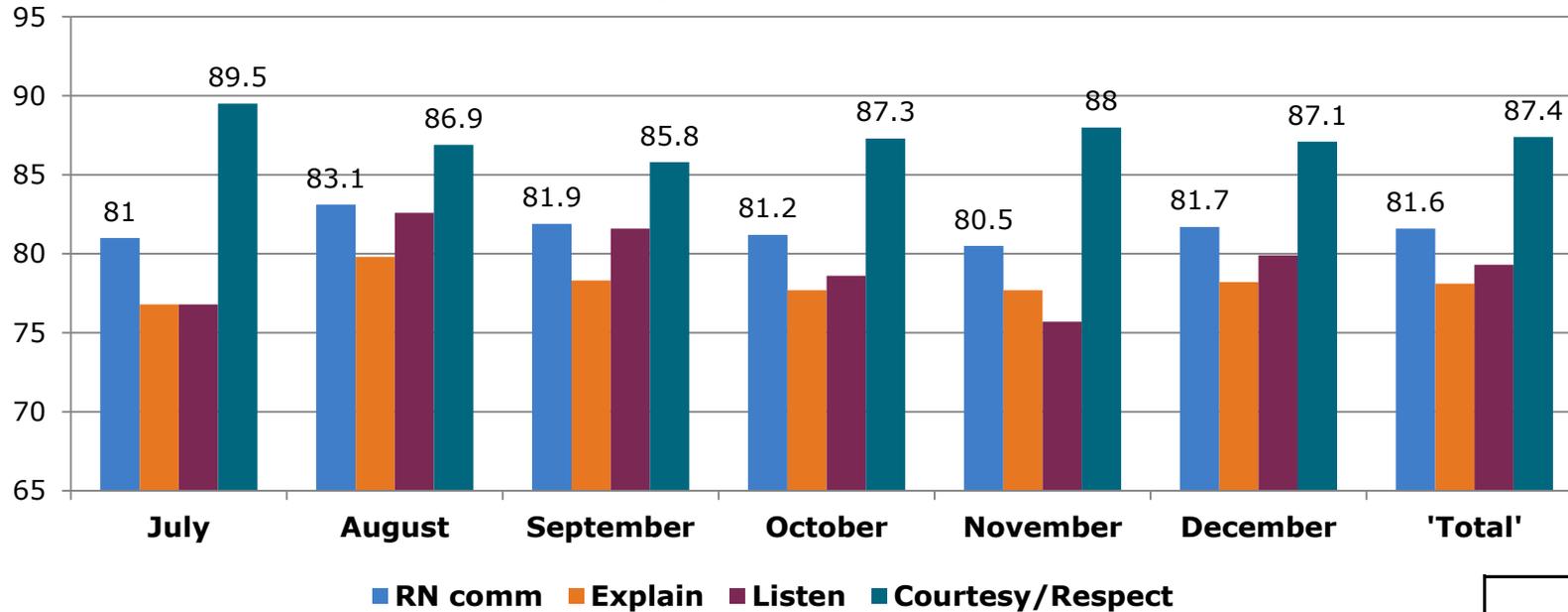


**Likelihood to Recommend**  
 (Target = 84.2% Top Box)  
 Enterprise FY20 to Date = 83.3%

Unit	FYTD	difference from target
<b>MV 2C</b>	84.4 n=141	0.2
<b>MV 3B</b>	90 n=200	5.8
<b>MV 3C</b>	85 n=113	0.8
<b>MV 4A</b>	82.8 n=227	-1.4
<b>MV 4B</b>	88.9 n=153	4.7
<b>MV PCU</b>	82.6 n=23	-1.6
<b>MV CCU</b>	80.8 n=26	-3.4
<b>MV MCH</b>	82.7 n=323	-1.5
<b>LG MCH</b>	88.3 n=77	4.1
<b>LG MS</b>	71.7 n=152	-12.5
<b>LG Ortho</b>	79.8 n=183	-4.4
<b>Total</b>	<b>83.3</b> n=1628	<b>-0.9</b>

# Nurse Communication

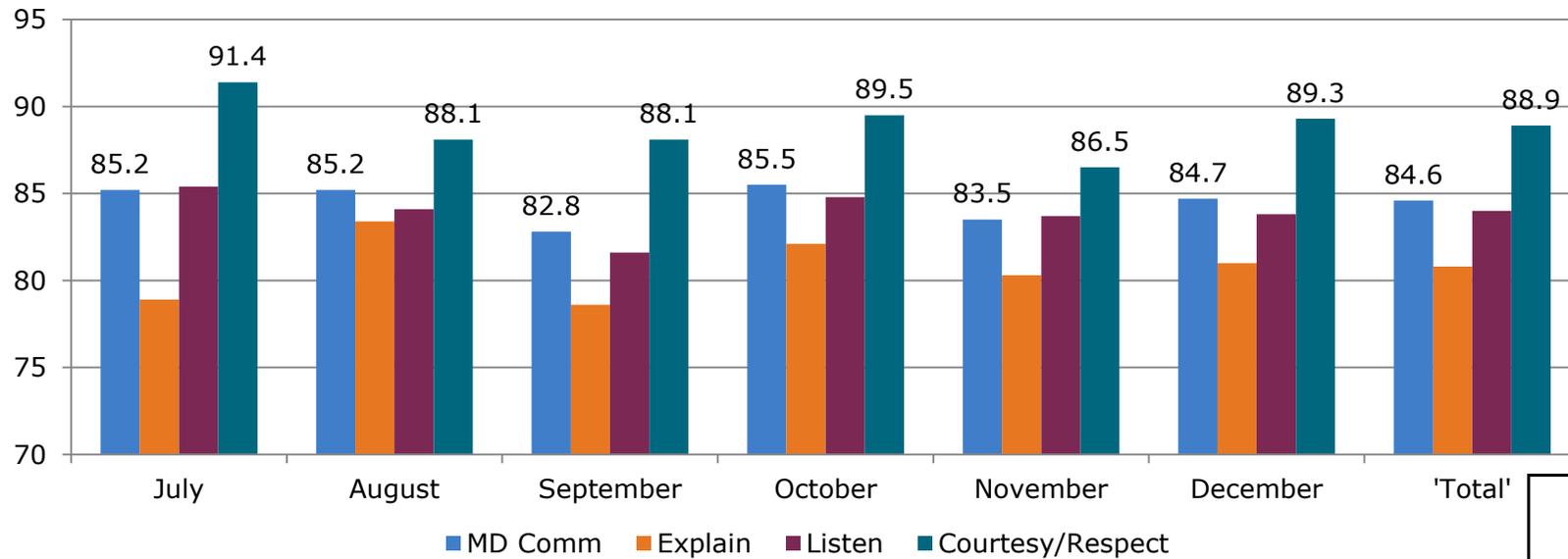
**El Camino Health RN Communication  
FY20 July - December, 2019**



	FY20 (123119)	Current %tile Ranking
RN Communication	81.6	57
Explain	78.1	59
Listen	79.3	60
Courtesy/Respect	87.4	50

# MD Communication

## El Camino Health MD Communication FY20 July - December, 2019

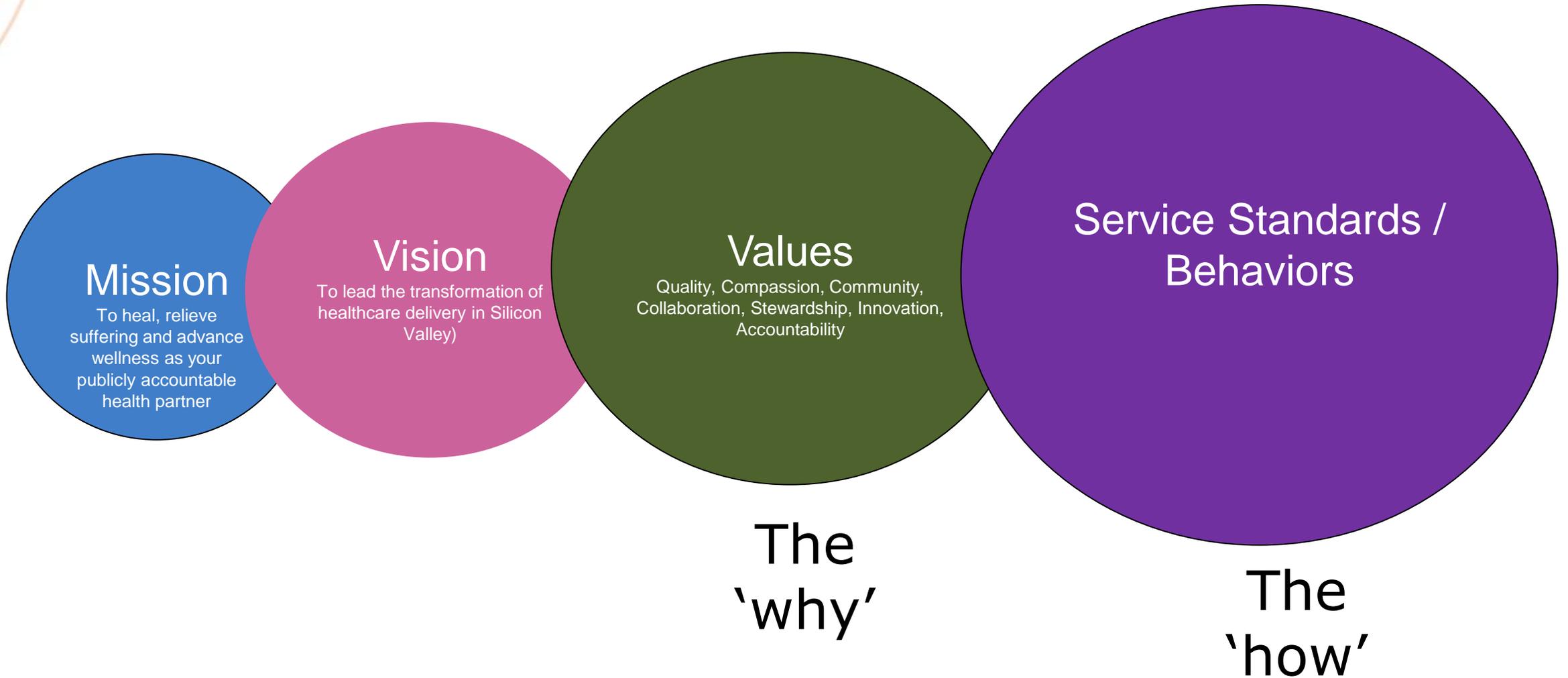


	FY20 (123119)	Current %tile Ranking
MD Communication	84.6	73
Explain	80.8	77
Listen	83.8	76
Courtesy/Respect	88.9	63

## Improving communication at ECH

- Care Team Coaching
- Commit to Sit
- Service / Behavior Standards
- Enhanced Communication
- Leader Rounding

**El Camino Health providing exceptional, personalized experience, always**



**EL CAMINO HOSPITAL  
COMMITTEE MEETING COVER MEMO**

**To:** Quality Committee of the Board  
**From:** Mark Adams, MD, Chief Medical Officer  
**Date:** February 3, 2020  
**Subject:** PSI-04 Analysis

**Purpose:** To review factors affecting PSI 4.

**Summary:**

1. **Situation:** At the last Board Quality Committee meeting, the committee members requested a more detailed analysis of PSI-04 after hearing of four deaths attributable to this metric.
2. **Authority:** This is an area of concern for the governing board as this directly and indirectly impacts the quality and safety of the care delivered to El Camino patients.
3. **Background:** PSI-04 is a controversial patient safety indicator because the definition is misleading: “Death Rate among Surgical Inpatients with Serious Treatable Complications” Failure to Rescue is a more accurate description since some of the “complications” of surgery are actually conditions present on admission prior to the surgery. The four deaths of concern to the committee last month will be reviewed in more detail to help the committee better understand why this indicator is such a challenge to interpret and why many experts within AHRQ have proposed to eliminate it.
4. **Assessment:** While we will continue to track this metric, it should not garner excessive attention as the elements that underlie it are addressed in other quality improvement and peer review activities.
5. **Other Reviews:** None
6. **Outcomes:** The committee members will have a much better understanding of the meaning of this measure.

**List of Attachments:**

1. None

**Suggested Committee Discussion Questions:**

1. None

**EL CAMINO HOSPITAL  
COMMITTEE MEETING COVER MEMO**

**To:** Quality Committee of the Board  
**From:** Mark Adams, MD, Chief Medical Officer  
**Date:** February 3, 2020  
**Subject:** PSI 18, 19, OB Trauma

**Purpose:** To review factors attributable to vaginal delivery trauma.

**Summary:**

1. **Situation:** At a previous Board Quality Committee meeting, there was concern regarding two of the Patient Safety Indicators pertaining to OB trauma, PSI 18 and PSI 19. The Committee members requested that more information be provided to better understand why these indicators were higher than normal at El Camino.
2. **Authority:** This is an area of concern for the governing board as this directly and indirectly impacts the quality and safety of the care delivered to El Camino patients.
3. **Background:** PSI-18 is defined as trauma with vaginal delivery with instrumentation. Trauma is defined as the presence of 3<sup>rd</sup> or 4<sup>th</sup> degree perineal laceration. PSI-19 is defined as trauma with vaginal delivery without instrumentation. Vaginal delivery trauma is closely associated with ethnicity based on several scientific studies. The most vulnerable ethnicities include Asian/Indian and Asian/Chinese. El Camino Mountain View serves a population with the highest percentage of those two ethnicities at 64%. To confirm this correlation, a retrospective review was performed for the time period inclusive of FY19. This demonstrated that of all of the OB trauma cases, 74% occurred in those two ethnicities. We also reviewed the CMQCC (California Maternal Quality Care Collaborative). El Camino MV has a 4% OB trauma rate compare to a 5.1% rate for Santa Clara County. We have established a task force to focus on reducing these vaginal delivery traumas. We have identified a number of interventions and have committed to reducing the OB trauma with instrumentation (PSI-18) by 15% by July 1, 2020.
4. **Assessment:** The higher incidence of PSI-18 and PSI-19 reported at El Camino Health is directly related to our patient demographics based on both extensive scientific studies and our own retrospective review. We are working nonetheless to significantly reduce this rate utilizing a number of interventions guided by a dedicated task force.
5. **Other Reviews:** None
6. **Outcomes:** The committee will be better informed about the contributing factors that impact PSI-18 and PSI-19 and will have detailed knowledge of the effort to reduce the incidence of vaginal delivery trauma at El Camino Health.

**List of Attachments:**

1. None

**Suggested Committee Discussion Questions:**

1. None

**EL CAMINO HOSPITAL  
COMMITTEE MEETING COVER MEMO**

**To:** Quality Committee of the Board  
**From:** Mark Adams, MD, Chief Medical Officer  
**Date:** February 3, 2020  
**Subject:** Board Quality and Safety Dashboard

**Purpose:** To review new Board Quality of the Safety Dashboard.

**Summary:**

1. **Situation:** There is a desire to simplify the enterprise quality and safety dashboard that is reported to the Board of Directors as part of the Quality Committee report to the Board.
2. **Authority:** This is an area of concern for the governing board as this directly and indirectly impacts the quality and safety of the care delivered to El Camino patients.
3. **Background:** In response to this request—simplified quality and safety dashboard that the Board can use as a tool to monitor quality and safety without repeating the oversight work of the Board Quality Committee—a new dashboard has been created. This new dashboard is based on the STEEEP definition of quality and safety that is a national standard adopted by the IHI (Institute for Healthcare Improvement). This will provide a snapshot of key metrics based on those categories. This is a common format used by many other organizations.
4. **Assessment:** The Board Quality Committee will continue to review the more sophisticated control charts and more detailed analysis of topics requiring attention but the Board will receive the new dashboard as a part of the Quality Committee report.
5. **Other Reviews:** None
6. **Outcomes:** The Quality Committee will become familiarized with this new dashboard construct.

**List of Attachments:**

1. Power Point illustrating the new dashboard

**Suggested Committee Discussion Questions:**

1. None



## **FY2020 Quality Committee STEEP Report**

*Mark Adams, MD*  
*Chief Medical Officer*

# Institute of Medicine (IOM) Quality Framework – STEEP

## *Six Aims for a health care system*

- **Safe:** Avoiding harm to patients from the care that is intended to help them.
- **Effective:** Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered:** Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely:** Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient:** Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable:** Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

# SAFE CARE: AVOIDING HARM TO PATIENTS FROM CARE INTENDED TO HELP

Metric	Baseline FY2019	FY2020 Target	Q1 (unless otherwise indicated)	Measure Period
E Risk Adjusted Mortality Index	0.97	≤ 0.90	0.64 (Oct 19)	FYTD
E Sepsis Mortality Index	1.06	≤ 0.90	0.61 (Oct 19)	FYTD
E % of Serious Safety Events (SSEs) Classified	New Program	Establish baseline for SSE rate Proxy Measure: 95% classified in ≤30-days	Begin categorization 12/1/19	FYTD
E Surgical Site Infections (SSI)	0.52 37/7167	SIR Goal ≤1.0 NHSN risk-adjusted ratio (not rate)	0.17	FYTD
E Catheter Associated Urinary Tract Infection (CAUTI) - HAI	1.09	SIR Goal ≤0.75 NHSN risk-adjusted ratio (not rate)	0.27	FYTD
E Central Line Associated Blood Stream Infection (CLABSI) - HAI	0.36	SIR Goal ≤0.50 NHSN risk-adjusted ratio (not rate)	0.37	FYTD
E Clostridium Difficile Infection (CDI) - HAI	1.96	SIR Goal: ≤ 0.70	1.58 (MM)	FYTD
E Modified PSI-90 CMS HAC Reduction Program	0.714852  Q1 FY 19	1.021817	1.010425	FYTD

# SAFE CARE: AVOIDING HARM TO PATIENTS FROM CARE INTENDED TO HELP

## FY2020 Metric Explanation

- **Risk Adjusted Mortality Index** – High performance in Mortality due to the General Inpatient (GIP) hospice program.
- **Sepsis Mortality Index** – Based on ICD 10 codes, observed over expected
- **Rate of Serious Safety Events** – This is a fundamental performance metric of a HRO, which El Camino Health is aspiring to become. Percentage of SSEs classified into the HRO subcategories within 30 days of report, training began in October, with data to begin reporting in Q2.
- **Surgical Site Infections (SSI)** – Enterprise rate = # of SSI/Total surgical procedures x100
- **Catheter Associated Urinary Tract Infection (CAUTI)** – rate per 1,000 urinary catheter days
- **Central Line Associated Blood Stream Infections (CLABSI)** – rate per 1,000 central line days
- **Clostridium Difficile Infection (CDI)** – rate per 10,000 patient days
- **PSI-90 for CMS HAC Reduction Program** – Composite score based on 10 Patient Safety Indicator results, and the finalized CMS measure weights (PSI rates included: 03: Pressure Ulcer, 06: Iatrogenic Pneumothorax, 08: In-Hospital Fall w/ Hip Fx, 09: Peri-op Hemorrhage/Hematoma, 10: Postop Acute Kidney Injury, 11: Postop Resp Failure, 12: Peri-op Pul Embolism or DVT, 13: Post-op Sepsis, 14: Post-op Wound Dehiscence, 15: Unrecognized Abdominopelvic Accidental Puncture/Laceration)

## TIMELY: REDUCING WAITS & DELAYS FOR BOTH THOSE WHO RECEIVE & GIVE CARE

Organizational Goal	Baseline FY19	FY2020 Target	Q1	Measure Period
H Enterprise Patient Throughput – ED Door to Admit Order	FY19 284 min	266 minutes	254 minutes (Oct 19)	FYTD
H ED2b – Admit Decision Time to ED Departure Time for Admitted patients	CY18 95 minutes	CY19 <120 minutes	77 minutes (Q1)	CYTD
H OP18b – Median Time from ED Arrival to ED Departure for Discharged ED patients	CY18 183 minutes	CY19 <180 minutes	174 minutes (Q1)	CYTD

### FY2020 Metric Explanation

- **Patient Throughput** – Performance from Q4 of FY19 has been maintained, despite construction in the Emergency Department.
- **CMS ED2b** – This measure is focused on admitted patients and depends on bed availability in the hospital - part of CMS 5 Star Report
- **CMS OP18b** – This measure is the median time patients spent in the ED department before leaving after the visit

## EFFECTIVE: PROVIDE SERVICES BASED ON SCIENTIFIC KNOWLEDGE AND AVOIDING UNDERUSE AND MISUSE

Goal	Baseline FY2019	FY2020 Target	Q1 (unless otherwise indicated)	Measure Period
H Risk Adjusted Readmissions Index	0.99	≤ 0.96	0.96	FYTD
H CMS SEP-1 Compliance Rate	74%	≤ 80%	82.6	FYTD
H PC-01 Elective Delivery Prior to 39 Weeks Gestation	MV: 1.11% (4/360) LG: 0.00% (0/44) ENT: 0.99% (4/404)	0.00%	0% (0/103)	FYTD
A CMS 165: Controlling High Blood Pressure		TBD		
A CMS 122: Diabetes: Hemoglobin A1c Poor Control		TBD		

# EFFECTIVE: PROVIDE SERVICES BASED ON SCIENTIFIC KNOWLEDGE AND AVOIDING UNDERUSE AND MISUSE

## FY2020 Metric Explanation

- **Risk Adjusted Readmissions Index** – July data received October 25<sup>th</sup> from quality metric vendor. Multiple task-force teams are analyzing the overall data for trends and reviewing each readmission case. 12-month rolling average trend is still decreasing
- **CMS SEP-1 Compliance-** CMS and TJC Core Measure which is scored as 0 or 100% for each patient based on compliance with both the 3-hr and 6-hr bundle metrics
- **PC-01** – CMS and TJC Core Measure, also used in Value-based Purchasing CMS calculations. Elective Delivery Prior to 39 Weeks gestation

## EFFICIENT: AVOIDING WASTE, INCLUDING WASTE OF EQUIPMENT, SUPPLIES, IDEAS, AND ENERGY

Organizational Goal	Baseline FY2019		FY2020 Target	Q1	Measure Period
H Length of Stay	1.00			0.96 (Oct 19)	FYTD
H Arithmetic Observed LOS Average/Geometric LOS Expected for Medicare Population (ALOS/Expected GMLOS)	0.91			0.86 (Oct 19)	FYTD
H OP-8 MRI Lumbar Spine for Low Back Pain	# of Pts 38	State Rate 39.5%	National Rate 38.7%	Q3 2017- Q2 2018 = 52.6%	Annual
H OP-10 Abdomen CT Use of Contrast Material	# of Pts 1,109	State Rate 8.8%	National Rate 8.9%	Q3 2017- Q2 2018 = 4.4%	Annual

### FY2020 Metric Update

- Length of Stay (LOS)
- ALOS/GMLOS ( Medicare definition, MS-CC, Inpatient)
- OP-8 – CMS 5 Star Efficiency Metric, Published annually on Hospital Compare. Q3 2017 thru Q2 2018 data
- OP-10 - CMS 5 Star Efficiency Metric, Published annually on Hospital Compare. Q3 2017 thru Q2 2018 data

# EQUITABLE: PROVIDING CARE THAT DOES NOT VARY IN QUALITY DUE TO GENDER, ETHNICITY, GEOGRAPHIC LOCATION & SOCIOECONOMIC STATUS

Organizational Goal	Baseline	FY2020 Target	Q1	Measure Period
H Hospital Charity Care Support	\$21.6m	\$23.0m	\$6.8m	FYTD
A Clinic Charity Care Support	\$18k	TBD	\$8.8kk	FYTD
H Language Line Unmet Requests	4.6%	<5%	2.9%	FYTD
H Length of Stay Disparity	African American American Indian	None	None	FYTD
<b>FY2020 Metric Update</b>				

# EQUITABLE: PROVIDING CARE THAT DOES NOT VARY IN QUALITY DUE TO GENDER, ETHNICITY, GEOGRAPHIC LOCATION & SOCIOECONOMIC STATUS

## FY2020 Metric Explanation

- **Hospital Charity Care Support** – Hospital charges reduced for patients who meet family income criteria or have incurred high medical costs and are not eligible for any government programs. Support per charity care provided per hospital policy.
- **Clinic Charity Care Support** – Physician/Clinic charges reduced for patients who meet family income criteria or have incurred high medical costs and are not eligible for any government programs.
- **Language Line Unmet Requests** – Total number of unmet requests for translation services divided into total number of requests
- **Length of Stay Disparity** - Comparison of LOS to CMS Geometric Mean with expectation that all races will be within 10% of “ECH average” as indication of equal health and socioeconomic support for recovery from acute illness

## Leading Practices for Using Patient Race, Ethnicity, and Language Data Practice Details

1. **Use an equity scorecard or dashboard to report organizational performance** - Using a dashboard that captures performance on key quality indicators stratified by patient race, ethnicity, and socioeconomic status is an effective tool if updated and reported regularly to senior leadership of the hospital. The dashboard is able to capture progress made in certain areas as well as identify areas of focus. The dashboard also serves to identify patient populations that may be at increased risk for adverse outcomes.
2. **Provide interpreter services** - Communication gaps between providers and patients are often a source of medical errors and may lead to costly and excessive testing. They can also result in delay of necessary care. Collection of patient data can help identify areas where trained and professional interpreter services are needed.
3. **Review performance indicators such as length of stay, admissions, and avoidable readmissions** - Stratifying average length of stay, admissions, and readmissions by patient demographics can help identify any trends associated with specific patient groups, which then can be addressed to improve key performance indicators and quality of care.
4. **Review process of care measures** - Analyzing performance on key process of care measures can identify gaps in care, which could be linked to specific patient groups.
5. **Review outcomes of care** - Reviewing outcomes will help identify any trends, especially poor outcomes that are linked to certain patient groups.
6. **Analyze provision of certain preventive care** - Analyzing delivery of certain services by race and ethnicity will help identify areas where specific groups are receiving less preventive care, especially screening.

Equity of Care: A Toolkit for Eliminating Health Care Disparities / American Hospital Association

### Legend

H = Hospital  
E = Enterprise  
A = Ambulatory

**PATIENT-CENTERED: PROVIDING CARE THAT IS RESPECTFUL, RESPONSIVE & IS  
RESPONSIVE TO PATIENT PREFERENCES, NEEDS, AND VALUES**

Organizational Goal	Baseline FY19	FY2020 Target	Q1	Measure Period
H HCAHPS: Staff Responsiveness	65.7	≥ 67.1	66.4 (Oct 19)	FYTD
H HCAHPS: Discharge Information	86.7	≥ 87.3	86.9 (Oct 19.)	FYTD
H HCAHPS: Likelihood to Recommend	83.5	≥ 84.2	83.2 (Oct 19)	FYTD
H Emergency Department (ED) Satisfaction	66.0	≥ 69.0	70.6 (Oct 19)	FYTD
A OAS CAHPS: Rating 9's & 10's	43 <sup>rd</sup> %tile	≥ 35 <sup>th</sup> %tile	45 <sup>th</sup> %tile	FYTD
A Outpatient Services (CA)	73 <sup>rd</sup> %tile	≥ 35 <sup>th</sup> %tile	72 <sup>nd</sup> %tile	FYTD

# PATIENT-CENTERED: PROVIDING CARE THAT IS RESPECTFUL, RESPONSIVE & IS RESPONSIVE TO PATIENT PREFERENCES, NEEDS, AND VALUES

## FY2020 Metric Explanation

- **Staff Responsiveness** – To accelerate improvement in Responsiveness the taskforce has adapted the leader rounding and inpatient unit rewards programs. Leader rounding now emphasizes our performance in Responsiveness and finding ways to improve, and unit rewards program celebrates our highest performing units. Additionally, the taskforce is rolling out *No Pass Zones* (no employee to pass rooms with an active call light, etc.) to all inpatient units.
- **Discharge Information** – To increase patient satisfaction around discharge information, the team is modifying the After Visit Summary, creating a discharge checklist (both in writing and on the patient room white board), and evaluating various options for implementing the proven best practice of post discharge phone calls. A *Discharge Center* to provide individualized education for patients as they are discharged from the Hospital is also under consideration.
- **HCAHPS: Likelihood to Recommend** – Likelihood to Recommend is our loyalty score and the industry standard of measuring experience. As such, Staff Responsiveness, Discharge Information, and ED Satisfaction impact and may correlate with performance of Likelihood to Recommend, in addition to other HCAHPS metrics. As shown, we are only 0.1 point behind our target year to date and are expected to achieve this target by year’s end due to the significant improvements in the many other HCAHPS domains (including ED satisfaction). Further efforts in Staff Responsiveness, Discharge Information and other highly correlated domains will positively affect the result.
- **ED Satisfaction** – Press Ganey tool: Current performance is ahead of target.
- **OAS CAHPS Rating 9’s & 10’s (CA)** – Outpatient Ambulatory Surgery
- **Outpatient Services** -

Metric	Baseline FY2019	FY2020 Target	Q1 (unless otherwise indicated)	Measure Period
Risk Adjusted Mortality Index	0.97	≤ 0.90	0.64 (Oct 19)	FYTD
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	LG: 0.00% (0/44)		(0/103)	
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Language Line Unmet Requests	4.60%	<5%	2.90%	FYTD
Length of Stay Disparity	African American	None	None	FYTD
	American Indian			
HCAHPS: Staff Responsiveness	65.7	≥ 67.1	66.4 (Oct 19)	FYTD
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**EL CAMINO HOSPITAL BOARD OF DIRECTORS  
COMMITTEE MEETING COVER MEMO**

**To:** Quality, Patient Care, and Patient Experience Committee  
**From:** Mark Adams, MD, CMO  
**Date:** February 3, 2020  
**Subject:** Draft Revised Quality, Patient Care and Patient Experience Committee Charter (“Committee Charter”)

**Recommendation:**

1. To recommend that the Board approve revising the Committee Charter to include the Chiefs of the Medical Staff as *ex officio* voting members of the Committee.
2. To recommend that the Board approve adding “Review the MEC’s monthly credentialing and privileging reports and make recommendations to the Board” to the Committee’s chartered responsibilities.

**Summary:**

1. Situation: As we move toward a high reliability and high performing quality organization, it is vital that our medical staff is aligned with that effort.
2. Authority: The Committee Charter establishes the authority and responsibility of the committee.
3. Background: The organized medical staff primary responsibility is to assure that the highest quality of clinical care is delivered to our patients. This assurance depends on the triad of administration, medical staff, and board of directors functioning in a cohesive and collaborative manner. From a regulatory and historical basis, the organized medical staff and the board of directors must share in this responsibility. Many other healthcare organizations or systems recognize this relationship by including representatives of the organized medical staff on their respective Board Quality Committees. Additionally, since medical staff credentialing and privileging directly impacts the quality of care delivered to our patients, standard Board practice is to engage their quality committees to review medical staff credentialing and privileging.
4. Assessment: In keeping with current standards and expectations for Board performance to oversee quality and safety, it would be prudent for the Quality Committee to include as active members the Chief of the Medical Staff at the Mountain View and Los Gatos campuses; and delegate the review of the medical staff credentialing and privileging activities to the Quality Committee of the Board.

The Governance Institute survey of health systems showed that 56% of Board quality committees have between one to four medical staff voting members. In a specific communication to El Camino, The Governance Institute reported the following: “We commonly do see that the Chief of Medical Staff would be a voting member of the quality committee.”

Feedback from the Chief of Staff: “I believe in the three-legged stool model of governance of the Hospital. In this model the medical staff is an equal custodian of ensuring the quality of care and in my opinion the most important entity that actually delivers care to the patients. Therefore, I think Medical Staff Leaders should be part of the quality steering committee. If we are asked to attend, then we should be members.”

Agenda Item Name Here  
Meeting Date

American Hospital Association standards for a health system Board quality committee include:  
“Reviewing and acting on medical staff recommendations to grant medical staff appointments, reappointments, and clinical privileges.”

5. Outcomes: Improve the quality and safety performance of El Camino Health System

**List of Attachments:**

Draft Revised Quality, Patient Care and Patient Experience Charter  
Article: Physicians in the Boardroom: Contemporary Considerations for a Common Practice  
Excerpt: 2019 Governance Institute Biennial Survey: The Quality Committee  
Article: Maximizing the Effectiveness of the Board’s Quality Committee

**Suggested Committee Discussion Questions:**

1. **How are conflicts of interests handled?**

## El Camino Hospital Board of Directors Quality, Patient Care and Patient Experience Committee Charter

**Draft Revised 2-3-2020**

### Purpose

The purpose of the Quality, Patient Care and Patient Experience Committee (“Quality Committee” or the “Committee”) is to advise and assist the El Camino Hospital Board of Directors (“Board”) in constantly enhancing and enabling a culture of quality and safety at El Camino Hospital and its affiliated entities where ECH is the sole corporate member (“the Organization”). The Committee will work to ensure that the staff, medical staff and management team are aligned in operationalizing the tenets described in the Organization’s strategic plan related to delivering high quality healthcare to all patients. High quality care is defined as care that is: safe, timely, effective, efficient, equitable, and person-centered.

The Organization will provide to the Committee standardized quality metrics with appropriate benchmarks so that the Committee can adequately assess the level of quality care being provided.

### Authority

All governing authority for the Organization resides with the Hospital Board for ECH and with the boards of the affiliated entities except that which may be lawfully delegated to a specific board committee. The Committee will report to the Board at the next scheduled meeting any action or recommendation taken within the Committee’s authority. The Committee has the authority to select, recommend engagement, and supervise any consultant hired by the Board to advise the Board or Committee on issues related to clinical quality, safety, patient care and experience, risk prevention/risk management, and quality improvement. In addition, the Committee, by resolution, may adopt a temporary advisory committee (ad hoc) of less than a quorum of the members of the Committee. The resolution shall state the total number of members, the number of board members to be appointed, and the specific task or assignment to be considered by the advisory committee.

Voting members of the Committee shall include the directors assigned to the Committee and external (non-director) members appointed to the Committee.

### Membership

- The Committee shall be comprised of two (2) or more Hospital Board members. The Chair of the Committee shall be appointed by the Board Chair, subject to approval by the Board. All members of the Committee shall be eligible to serve as Chair of the Committee.
- The Committee shall also include the Enterprise Chief of the Medical Staff and the Los Gatos Campus Chief of Staff as *ex officio* voting members of the Committee.
- The Quality Committee may also include 1) no more than nine (9) Community members<sup>1</sup> with expertise in assessing quality indicators, quality processes (*e.g.*, LEAN), patient safety, care integration, payor industry issues, customer service issues, population health management,

<sup>1</sup> Community Members are defined as Members of the Committee who are not El Camino Hospital Board Directors.

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alignment of goals and incentives, or medical staff members, and members who have previously held executive positions in other hospital institutions (*e.g.*, CNO, CMO, HR) and 2) no more than two (2) patient advocate members who have had significant exposure to ECH as a patient and/or family member of a patient. Approval of the full Board is required if more than nine Community members are recommended to serve on this committee.

- All Committee members, with the exception of new Community members shall be appointed by the Board Chair, subject to approval by the Board. New Community members shall be appointed by the Committee, subject to approval of the Board. All Committee appointments shall be for a term of one year expiring on June 30th each year, renewable annually.
- It shall be within the discretion of the Chair of the Committee to appoint a Vice Chair from among the members of the Committee. If the Chair of the Committee is not a Hospital Board Director, the Vice Chair of the Committee shall be a Hospital Board Director.

## Staff Support and Participation

The Chief Medical Officer (CMO) shall serve as the primary staff support to the Committee and is responsible for drafting the committee meeting agenda for the Committee Chair's consideration. Additional clinical representatives as well as members of the executive team may participate in the Committee meetings upon the recommendation of the CMO and subsequent approval from both the CEO and Committee Chair. This may include the Chief/Vice Chief of the Medical Staff.

## General Responsibilities

The Committee's primary role is to develop a deep understanding of the Organizational strategic plan, the quality plan, and associated risk management/prevention and performance improvement strategies and to advise the management team and the Board on these matters. With input from the Committee and other key stakeholders, the management team shall develop dashboard metrics that will be used to measure and track quality of care and outcomes, and patient satisfaction for the Committee's review and subsequent approval by the Board. It is the management team's responsibility to develop and provide the Committee with reports, plans, assessments, and other pertinent materials to inform, educate, and update the Committee, thereby allowing Committee members to engage in meaningful, data-driven discussions. Upon careful review and discussion and with input from management, the Committee shall then make recommendations to the Board. The Committee is responsible for 1) ensuring that performance metrics meet the Board's expectations; 2) align those metrics and associated process improvements to the quality plan, strategic plan, organizational goals; and 3) ensuring that communication to the Board and external constituents is well executed.

## Specific Duties

The specific duties of the Committee include the following:

- Oversee management's development of a multi-year strategic quality plan (PaCT).
- Review and approve an annual "Quality Dashboard" for tracking purposes.
- Oversee management's development of the Organization's goals encompassing the measurement and improvement of safety, risk, efficiency, patient-centeredness, patient satisfaction, and the scope of continuum of care services.



- Review reports related to Organization-wide quality and patient safety initiatives in order to monitor and oversee the quality of patient care and service provided. Reports will be provided in the following areas:
  - Organization-wide performance regarding the quality care initiatives and goals highlighted in the strategic plan.
  - Organization-wide patient safety goals and hospital performance relative to patient safety targets.
  - Organization-wide patient safety surveys (including the culture of safety survey), sentinel event and red alert reports, and risk management reports.
  - Organization-wide LEAN management activities and cultural transformation work.
  - Organization-wide patient satisfaction and patient experience surveys.
  - Organization-wide physician satisfaction surveys.
- Ensure the organization demonstrates proficiency through full compliance with regulatory requirements, to including, but limited to, The Joint Commission (TJC), Department of Health and Human Services (HHS), California Department of Public Health (CDPH), and Office of Civil Rights (OCR).
- In cooperation with the Compliance Committee, review results of regulatory and accrediting body reviews and monitor compliance and any relevant corrective actions with accreditation and licensing requirements.
- Review Sentinel Events (SE), Seriously Safety Events (SSE), and red alerts as per the hospital and board policy.
- Oversee organizational quality and safety performance improvement for both the Organization's and medical staff activities.
- Ensure that the Organization's scope of service and community activities and resources are responsive to community need.
- Review the Medical Executive Committee's monthly credentialing and privileging reports and make recommendations to the Board.

## Committee Effectiveness

The Committee is responsible for establishing its annual goals, objectives and work plan in alignment with the Board and the Organization's strategic goals. The Committee shall be focused on continuous improvement with regard to its processes, procedures, materials, and meetings, and other functions to enhance its contribution to the full Board. Committee members shall be responsible for keeping themselves up to date with respect to drivers of change in healthcare and their impact on quality activities and plans.

## Meetings and Minutes

The Committee shall meet at least once per quarter. The Committee Chair shall determine the frequency of meetings based on the Committee's annual goals and work plan. Minutes shall be kept by the assigned staff and shall be delivered to all members of the Committee when the agenda for the subsequent meeting is delivered. The approved minutes shall be forwarded to the Board for information.



Meetings and actions of all committees of the Board shall be governed by, and held and taken in accordance with, the provisions of Article VI of the Bylaws, concerning meetings and actions of directors. Special meetings of committees may also be called by resolution of the Board or the Committee Chair. Notice of special meetings of committees shall also be given to any and all alternate members, who shall have the right to attend all meetings of the Committee. Notice of any special meetings of the Committee requires a 24-hour notice.

# Physicians in the Boardroom: Contemporary Considerations for a Common Practice

By Todd Sagin, M.D., J.D., Sagin Healthcare Consulting

Over the past decade there has been growing recognition of the importance of physician leadership in our nation's hospitals and health systems. As these institutions struggle to transform to meet contemporary demands for quality, safety, and cost efficiency, it has become increasingly apparent that physician insight and buy-in are essential factors. Healthcare boards are recognizing this need to enhance physician engagement by exploring new tactics for doctors to participate in and impact the governance of their organizations.

In recent years, more and more boards have decided to increase the number of physicians sitting as directors. Adding clinicians has generally been perceived as a practical necessity as the governance of healthcare entities has become ever more complex. Physicians bring numerous strengths to a hospital board, including clinical expertise, an insider's view of the organization, and operational/frontline experience. Nevertheless, there are many considerations that should be weighed when governing bodies seek greater participation of physicians in their work. This special section will explore these considerations, various tactics for physician engagement in governance, and the potential political, legal, and financial ramifications of the decisions made.

## A Brief History of Physician Involvement in Governance

In the 20th century, there was wide variance in physician presence on hospital governing boards. At most institutions, it was common for the President of the Medical Staff (or Chief of Staff) to be present at board meetings to report on credentialing recommendations and represent the voice of the physician community. These medical staff officers might be at these meetings as a guest, a non-voting board member, or a full voting director. Since the board is charged with oversight of the medical staff, such representation

at the table made good sense. It was also common to find a retired doctor serving as a full board member—in most cases someone who had previously practiced locally and was well-regarded in the professional community.

In non-profit institutions, physician board participation has typically been limited by tax rules that require boards of such organizations to minimize the number of "insiders" serving in governance. "Insiders" are those whom the IRS sees as financially tied to the hospital (e.g., through direct employment, contracts for services, or use of the institution's facilities to generate income) and therefore motivated by their private economic interests.



In past decades, the IRS provided a "safe harbor" from enforcement action if physicians (or other insiders) comprised no more than 20 percent of the governing board's voting membership. Thus, it was rare to see more than one or two doctors on the typical board of a non-profit hospital.

Until recently, hospitals and physicians had a sometimes contentious working relationship, which also limited many boards' willingness to include physicians. In the 1980s and 1990s, managed care frequently undermined formerly collegial relations between doctors and hospitals. In later decades, hospitals and doctors found themselves competing with one another as physician-owned surgical and diagnostic centers multiplied and hospitals moved more aggressively into ambulatory services. Boards often were not willing to let potentially competing physicians into their strategic planning sessions.

The healthcare environment has continued to evolve dramatically as the needs of doctors and hospitals have once again grown more symbiotic with the rise of physician employment. The shift toward value-based purchasing and heightened public concerns

## Key Board Takeaways: Discussion Questions

Should there be more physicians serving as board members? If so:

- What is the right number or percentage of doctors?
- How should they be selected? What qualifications should they possess?
- Should they be voting or non-voting board members?
- Should they be *ex officio* members (e.g., Chief of Staff, CMO, VPMA, or President of the employed physician group)?

Should more physicians be standing guests at board meetings? If so, should they be:

- Medical staff officers?
- Physician executives?
- Representative of employed physician group?
- Physician representatives elected at large?

Should more physicians sit on board subcommittees? If so:

- Which committees (e.g., professional affairs, strategy, quality)?
- How many spots on these committees should be held for physicians?

What alternatives to board membership should be considered that can bring physicians and board members together? For example, should board members participate in a standing joint council that periodically brings together key physician stakeholders, senior management, and trustees/directors?

Should some board members attend medical staff assemblies or standing committee meetings to build social capital with physicians and inform board oversight of the medical staff?

about quality and safety has required hospitals and doctors to increase their collaboration. Hospitals have moved into new territory with the assumption of financial risk through ACOs and clinically integrated networks (CINs). Healthcare organizations are challenged to engage in population health management and expand their footprint outside the traditional walls of their hospitals. To be successful in these changes, hospitals and physicians have needed to partner with greater synergy, forcing governing bodies to be more cognizant of the perspectives and needs of their practitioner communities.

Several other changes have pushed consideration of physician board membership into greater prominence. Enormous consolidation has taken place throughout the industry with ever-greater numbers of hospitals merging into multi-campus health systems. Where historical local hospital boards have been merged into a system governing body, the involvement of medical staff leaders has become more problematic. Furthermore, system board members are less likely to have regular contact with the physicians practicing in their facilities and risk becoming more remote and detached from the perspectives of the medical community. One result has been a push for more physician board members. This has been facilitated by the tax authority's more relaxed posture regarding the number of insiders on the board, which now states that at a minimum, a non-profit hospital or health system should ensure that a majority of voting members of the board are "independent community leaders" who have no personal economic stake in the hospital's strategic decision making; this has allowed more space to appoint physician board members than in the past.

The pressures of recent years have also caused many boards to become more rigorous in their own self-management. It is common for boards to create a grid of needed competencies to inform the selection of future board members or drive a needed expansion of board seats. In particular, the need to

## Why Physicians on the Board?

**Promotion of quality:** Many boards struggle to improve quality and safety in their hospitals. While board members understand the importance of driving the quality agenda, they often feel they lack the expertise to set meaningful quality goals or to evaluate the effectiveness of the medical staff and management in meeting those goals. Physician board members, especially those with extra training in quality improvement and peer review, bring a critical dimension.

**Promotion of hospital-physician alignment:** Ongoing hospital success in a transforming healthcare environment will depend on strong physician integration and collaboration. Having physicians on the board can serve to reassure medical colleagues that physicians' interests will be addressed at the highest levels in the organization. This becomes increasingly important as doctors are asked to relinquish more of their historical autonomy and become part of integrated teams focused on the hospital's mission. Physician board members provide legitimacy to the board in the eyes of the medical community, and provide insight regarding which strategies for physician alignment and engagement are likely to succeed.

**Insight into the institution's frontline challenges:** Because physician board members are often practicing within the hospital, they become important sources of feedback regarding how the institution is functioning on the frontlines. This provides a source other than management to inform board members about issues such as workforce morale, adequacy of staffing and support services, patient perceptions of care, and more.

focus more on quality has driven many boards to bring more physicians into their deliberations.

Boards are anticipating growing problems with physician recruitment and retention, caused by the rise of physician employment by insurers, private equity groups, and large contract single-specialty companies, along with retiring baby boomers creating an acute shortage. At the same time, the retreat from a private practice model to employment has made many doctors

more mobile and transient in their work commitments. An indicator of a health system's attractiveness as a good professional home may be whether it provides an adequate presence of physicians on the board.

## Expanding Physician Presence on the Governing Board

The case for adding physicians to the board is becoming increasingly compelling. Physicians are critical players in driving and sustaining any significant transformation in healthcare structures, processes, and results. The knowledge, insights, and support of doctors are critical to the effective redesign of healthcare delivery systems. Physician leadership in our healthcare institutions has grown exponentially as manifest in an increased number of physicians in executive roles (VPMA, CMO, CMIO, CCO, CCOO, etc.),<sup>1</sup> serving management roles in hospital-employed physician groups, acting as medical directors of hospital service lines, and providing governance to ACOs and CINs.

The upsides of physician boardroom participation are fairly clear. Doctors bring clinical knowledge and a sense of the direction medical science is leading the field; have insider insights into struggles on the frontlines; are acutely tuned to the concerns and complaints



<sup>1</sup> These abbreviations respectively stand for Vice President of Medical Affairs, Chief Medical Officer, Chief Medical Informatics Officer, Chief Quality Officer, and Chief Clinical Operating Officer.

of patients; bring familiarity with tactics to improve the quality of care; can communicate the worries of the medical community; are especially helpful when performing medical staff oversight; and can foster engagement of their peers in the important strategic efforts undertaken at the institution.

However, there are downsides to increased physician board presence. Physicians can be intimidating to lay board members who may be reticent to voice questions and opinions at variance with those of the medical experts in the room. Because physicians on the board are frequently still in practice, they tend to draw board discussion into the weeds where their personal concerns and experiences can be addressed. Adding physician spots on the board may push out opportunities for others or it may increase board size to a point beyond the ideal. Physicians often see their board service as representing the interests of the practitioner community and fail to understand their fiduciary role as a board member. Furthermore, adding physicians to the board can trigger concerns by the IRS that can jeopardize non-profit status.

### Which Physicians Should Serve in Dedicated Board Seats?

Once a board has decided to add physicians to its membership, a key question is, "Which physicians?"

### Medical Staff Officers on the Board

Historically it has been common to have the President of the Medical Staff (or equivalent) attend board meetings. However, there is considerable variation in how this is done. Some boards give these individuals full voting membership, while others choose to grant *ex officio* board status without a vote. Still others make the Medical Staff President a standing guest at board meetings. There are advantages and disadvantages to each approach. Giving a medical staff officer membership without a vote can bind that individual to the fiduciary responsibilities tied to governance but preserve more seats for additional insiders who might be desirable as board members. It can also allay the worries of some lay board members that physician self-interest might bias critical board decision making. However, denying the vote may appear as a diminution of status in



the eyes of the medical community and undermine efforts to make physicians feel like true partners at the leadership table.

Giving the President status as a voting board member makes a statement that the input of clinicians is considered a priority, but it does have downsides. Since medical staff officers typically turn over after one or two years in office, their board membership is relatively fleeting. This means they rarely have the opportunity to build social capital and relationships of trust that enable a board to challenge itself with hard questions and decision making. Furthermore, serving as a full voting board member can create role confusion for an elected medical staff officer who may be torn between a fiduciary duty as a board member to put institutional interests first and his/her responsibility to advocate for the practitioner community that elected him/her to office.

Many boards choose to have the Medical Staff President serve as a standing guest. This eliminates the role confusion and everyone is clear that a medical staff officer sits in the boardroom to represent the voice of the physician community and advocate for practitioner interests. At the same time, it facilitates communication between the medical staff and the board, promotes transparency between these parties, and ensures physician concerns will be heard and considered in critical strategic planning and decision making.

Creating an *ex officio* position on the board for a medical staff leader is

also problematic as more and more hospitals are folded into health systems with a common governing body. Systems with multiple medical staffs need to determine which medical staff officers should attend board meetings. It is neither practical nor wise to have every medical staff represented at the table once more than two or three hospitals comprise the system.

### Other Physician Leaders as Board Members

In contemporary hospitals and health systems, it is common to have physician leaders beyond just those in elected medical staff positions. Boards sometimes look to these clinicians to bring valuable perspectives and expertise to their member ranks. The most common of these leaders are CMOs and Presidents of hospital-employed physician groups. The former is valuable because he or she brings both clinical and executive skills and often works with multiple medical staffs in a multi-hospital system. The latter may be valuable because as more and more physicians become hospital employees organized into a multidisciplinary group practice structure, the health system has a critical interest in the effective functioning of this entity.

### Physician Board Members in Multi-Hospital Health Systems

In multi-hospital health systems, the issue sometimes arises whether each institution needs a physician seat at the system governing body. As already mentioned, this can be impractical when inviting chiefs of staff to attend

board meetings. In most cases, a system board is unlikely to have enough member seats dedicated to physicians to allow someone from each hospital medical community. When creating dedicated physician seats or expanding their number, it is important for the board to communicate that its selections to fill the spots will be based on needed competencies and not geography. In most cases it is inadvisable to let an expectation take hold that each hospital will have a physician “representative” on the system board.

Of course, physicians can be appointed to local or regional hospital boards if these have been maintained in the health system. This makes good sense when such subsidiary boards are carrying out tasks delegated from the system board (e.g., credentialing and privileging).

### Competency-Based Selection of Physician Board Members

Once the board moves beyond *ex officio* spots for physicians, it should fill any additional physician seats as it does any other board vacancy. A best practice is for the board to create a grid of needed competencies and then see where deficits exist in the skill set of the current board complement. It is important to remember that medical

school training alone does not provide doctors with the competencies for which they are often sought. For example, the typical clinician does not have expertise in quality improvement techniques, performance data management, population health, practitioner competency assessment, or other areas where the board members tend to turn to doctors for insight. The selection process for physician board members should be rigorous to ensure that the board’s effectiveness will be enhanced by their addition. In the past it was common for a board to seek out a well-respected, newly retired practitioner to fill an empty board seat. Historic service in the community or high regard for clinical acumen are no longer sufficient attributes alone to justify a seat on most boards. Retired doctors may not be familiar with the challenges that physicians face today in their private offices or in their new settings as employed practitioners. Boards may be better served looking to the ranks of mid-career physicians who have sought out additional management training, had experience in administrative roles, and have demonstrated leadership capabilities. In selecting a physician board member, the board should communicate clearly that it is seeking specific abilities in the individual it chooses. This may

help reduce potential political fallout in various physician constituencies who will be disappointed that their favored candidate was not selected.

### Should Physician Board Members Be Sourced from Inside or Outside the Community?

Many boards add practicing community physicians to their membership. Such individuals can provide the board with the insights of someone actively negotiating the challenges of modern clinical practice and the perceptions of someone who regularly uses the services of the hospital. However, choosing which practicing physician should sit on the board can prove politically sensitive. Should such doctors only be chosen from the ranks of private practitioners? Given that most physicians in private practice are both collaborators *and* competitors with their local hospital, appointing one of their own can assure this group that the board wants “collaboration” to prevail.

Should new appointees to the board be drawn from the growing ranks of hospital-employed doctors? Some argue that such doctors can never serve objectively because their paychecks come from hospital management. On the other hand, excluding this group deprives the board of participation from a physician whose interests are fully aligned with the institution and whose input is not compromised by competing self-interest.

Should physician board members be drawn from influential large practices or from small or solo practices whose voices are less likely to reach the ears of board members? As hospitals focus increasingly on the outpatient setting, should physician board members be drawn from those who are hospital-based or from the expanding cadre of physicians whose professional activities are largely based outside the hospital’s walls? While these are all relevant considerations, a board will be best served by looking to its needed competencies and selecting the physician who can best provide them.

When should a board consider going outside its community to seek board candidates? In some locales it may be difficult to find a physician with the desired competencies to fill an open board seat. Going outside the community lets the board seek out strong options from a national pool



of candidates. For example, the board might seek out a national expert in quality and patient safety or a respected physician executive with deep knowledge regarding the handling of professional affairs. Bringing external experts onto the board is a common practice in many corporate boardrooms outside of healthcare. However, there are some clear downsides to going this route. Such individuals may wish to participate virtually in board meetings to avoid extensive travel. This creates a board member who has less ability to build valuable relationships with board colleagues and fully participate in board discussions. An external or outside candidate may have less credibility with local physicians. In addition, it is sometimes necessary to pay these practitioners for their time and reimburse them for travel expenses. Large health systems may find the cost of an outside board member insignificant relative to the advantages. Smaller hospitals may find it an essential expense because the expertise their boards require is simply not available in their own communities. Of course, paying some board members for their time and not others can create its own problems. Many board members give extraordinary amounts of time and dedication to their institutions and would likely feel affronted by a decision to pay an outsider for their periodic appearances at board meetings.

As discussed further in this article, from wherever physician board members are drawn, issues arise relating to conflicts of interest, potential impact on tax-exempt status, and compliance with the many laws addressing healthcare fraud and abuse.

**A board will be best served by looking to its needed competencies and selecting the physician who can best provide them.**

### Physician Participation on Board Subcommittees

Board subcommittees are often comprised of a mix of board members and non-board members. This provides an opportunity to involve more physicians in governance activities than a



limited number of physician-designated board seats would otherwise permit. These committees also provide an important setting for physicians and board members to interact, communicate, and build working relationships. This familiarity in turn builds social capital and trust that can pay off when controversial issues raise friction between the board and the medical community.

Some subcommittees are better choices than others for physician participation. Obvious candidates are professional affairs committees (commonly focused on medical staff oversight including credentialing, peer review, and corrective actions) and quality and patient safety committees. When boards establish special or *ad hoc* committees to explore strategic options including possible affiliations or mergers, physician involvement should be robust.

Each board subcommittee chair must be sensitive to potential conflicts of interest that may involve physician members. It is also important for the chair to ensure that physicians do not dominate discussion. As clinicians whose livelihood is directly impacted by board work, doctors frequently attend these meetings with passion and strong predilections. These feelings should be

harnessed constructively but need to be kept in perspective by lay members of the committee.

### Legal, Financial, Regulatory, and Ethical Constraints to Physician Membership on the Board

Increasing physician participation in governance implicates a number of legal and tax issues with important ramifications for non-profit health-care organizations. Serving on the board often puts these physicians in a position where they may contribute to decisions that have an impact on their own incomes or those of community physicians with whom they compete. Legal and tax issues that can arise include the following:

- Has the physician board member complied with fiduciary duties of loyalty and duty of care?
- Do the number of physicians on the board create a concern about “insider control” that could jeopardize the organization’s tax-exempt status?
- Is there an issue of “private inurement” or “private benefit” that could jeopardize tax exemption or subject the organization or its physician leaders under the IRS’s “intermediate sanctions” rules?
- Could an outside party claim that physician participation creates an

anti-competitive conspiracy in violation of federal or state antitrust rules?

- Is there a possibility that physician decision making at the governance level will implicate fraud and abuse statutes or regulations?

A complete discussion of these issues is beyond the scope of this article. Boards should always engage knowledgeable legal counsel when making decisions regarding physician participation in governance and whenever confronted with any of these issues.<sup>2</sup>

### Fiduciary Duties of Physician Board Members

All members of a hospital board have fiduciary duties as members. Primary among these is the duty of loyalty, expressed in the Model Nonprofit Corporation Act<sup>3</sup> as: "A director shall discharge his or her duties as a director, including his or her duties as a member of a committee, in a manner the director reasonably believes to be in the best interest of the corporation."

This can be a challenging concept for new physician board members to embrace. Doctors frequently come to the board perceiving themselves as champions on behalf of the physician community. This is especially true if the physician sits on the board as an *ex officio* member because of a position he/she holds as an officer or leader of the hospital medical staff, ACO/CIN, or an employed physician group practice. The physician's fiduciary duty is to subordinate their personal interests *and* those of the group he/she represents to the interests of the hospital or health system.

This duty of loyalty has the potential to be compromised when a transaction being considered or undertaken by the board poses a real or potential conflict of interest for one or more physician board members. Examples include:

- Competition between the hospital and private medical practices or other ambulatory business ventures
- Physician compensation
- Medical staff membership and privileging concerns

- Physician recruitment and retention agreements
- Medical staff development planning
- Network and compensation arrangements with third-party payers

A conflict-of-interest transaction is defined by the Model Nonprofit Corporation Act as "a transaction with the corporation in which a director of the corporation has a direct or indirect interest." A board with diverse physician representatives in its makeup is more likely to find one or more of these members with a conflict on any number of the issues the governing body tackles. Of course, the mere presence of a conflict of interest does not violate the duty of loyalty. But directors with real or potential conflicts *must* disclose them and they and the board must then act carefully to ensure the transactions they undertake are fair and appropriate. Boards that have a significant number of physician members should be especially careful to adopt rigorous disclosure policies and educate all board members in the importance of compliance.

Another fiduciary issue that must be contemplated when boards add physician members is the duty of care. All board members are required to fulfill a duty of care to the organization by acting 1) in good faith; 2) in a manner he or she believes to be in the best interest of the corporation; and 3) with the care an ordinarily prudent person *in a like position* would exercise under similar circumstances.

In looking at this last requirement, courts may take into consideration the special background and qualifications of the individual director. The duty of care compels board members with special expertise or knowledge to use it on behalf of the organization. Therefore, a court might hold a physician board member to a higher standard of care than a lay board member when applying the duty of care to a transaction involving a medical matter. Furthermore, lay board members are entitled to rely more

heavily on their board colleagues who possess specialized medical expertise when such knowledge is needed.

### IRS and Tax-Exempt Considerations

How many physicians can sit on a hospital board?<sup>4</sup> This question is often asked as physicians push for greater representation in governance. The number is of concern because of long-standing worries by tax authorities regarding undue "insider" influence on the decision making of tax-exempt hospitals. Specifically, a non-profit hospital or health system will be unable to maintain its tax-exempt status if it is controlled by physicians or other "insiders" whom the IRS regards as being motivated by their own private economic interests. In decades past, the IRS provided a "safe harbor" from enforcement action if physicians comprised no more than 20 percent of the governing board's voting membership. However, in concert with the trend to place more physicians on

hospital boards and with the growth of complicated integrated delivery systems, the IRS has taken a more relaxed approach in recent years.

At a minimum, a non-profit hospital should ensure that a majority of voting members of the board are "independent community leaders" who have no personal economic stake in the hospital's strategic decision making. This requirement applies to corporate committees with board-delegated powers as well. Practicing physicians affiliated with a hospital, even if not directly employed, are not considered "independent" because of their "close and continuing connection with the hospital" at a professional level. It is important to note that the prohibition against insider control applies not only to physicians but also other hospital employees such as the CEO, CNO, or physician executives such as a VPMA or CMO. On the other hand, this concern might not exist where a physician from outside the community is brought in to provide the board with unique expertise.



<sup>2</sup> This article has been written to provide general information and is not intended to provide specific legal advice on the matters covered. Readers are recommended to obtain competent legal counsel to fully explore the issues discussed in this publication.

<sup>3</sup> The Model Nonprofit Corporation Act, Third Edition, was adopted by the American Bar Association in 1987 with a third edition released in 2008. More than half of the states have adopted it in whole or in part to govern non-profit corporations under state law.

<sup>4</sup> ACO boards structured according to the CMS guidelines for the Medicare Shared Savings Program (MSSP) have different requirements regarding the number of physicians on the board. For more information, see, e.g., <http://bit.ly/2xmTACq>.

## Case Example: Scripps Health

Scripps Health has undergone a dramatic transformation from a struggling health system losing \$15 million a year in 1999 to a \$2.9 billion enterprise (2.3 percent margin) in 2017. The health system has been named to Fortune's "100 Best Companies to Work For" 11 consecutive years.

Unlike many other non-profit health systems, Scripps has opted not to include physicians on its board. Its 16 members represent a variety of industries and eight members are retirees. Despite the lack of physician representation on the board, the importance of physician engagement in decision making is critical at Scripps.

Chris Van Gorder, President and CEO, credits much of Scripps' success during his tenure with the formation of a Physician Leadership Cabinet (PLC), which acts as an advisory committee to hospital leadership and the board. The PLC has significantly enhanced trust and collaboration between medical staff and administration. Physician leaders' voices are consistently heard and acted upon, as demonstrated by the fact that 100 percent of PLC recommendations have been adopted during the 18 years since the PLC's existence.

Physician leaders have also been elevated in the recent restructuring of health system operational leadership. Scripps eliminated the CEO position at each of its regional hospitals and has adopted an operational model by which each hospital is jointly led by a non-physician chief operations officer and a physician operations executive. The restructuring provides more balance to local leadership between administrators and medical staff and is also expected to reduce costs.

Many lawyers advise governing boards to limit "insiders" on the board, including physicians, to no more than 30-40 percent of the board's complement of voting members. They also recommend that in light of the IRS's rules against "private inurement" and "private benefit,"<sup>5</sup> a non-profit hospital should exclude from participation on any compensation committee, practicing physicians who receive (directly or indirectly) compensation from

the organization for services as employees or as independent contractors.

### Antitrust Concerns Relating to Physician Board Participation

Physicians serving on the board are in a position to undermine the business success of competitors on the medical staff. Decisions that can suggest anticompetitive behavior include (but are not limited to) determinations regarding medical staff membership and privileges; the opening or closing of specific clinical services; the selection of other physicians to serve on the board; and decisions about adverse actions or disciplinary measures against other medical staff members. In addition, access by a physician board member to competitively sensitive information about a competing physician can raise concern under antitrust laws. As a prudent practice, physician board members should recuse themselves from discussion and decision making that can give even the appearance of unlawful anticompetitive behavior.



### Fraud and Abuse Statutes and Regulations

Hospital and health system decisions regarding physicians always have potential to run afoul of federal and state efforts to prevent fraud and abuse. Any payment to physician board members should be carefully reviewed by counsel to ensure that fraud and abuse laws are not implicated. A board with strong physician presence must always take care that physician preferences don't push the board into making decisions that could create liability under these laws. A further discussion of this topic is beyond the scope of this article, but resources for further information abound.

Physician participation at the governance level can be increased by allowing more physicians to attend board meetings as invited standing guests and recognizing that they come to represent a specific constituency. This approach avoids problematic growth in board size, inadvisable numbers of insiders on the board, and role confusion on the part of doctors who attend board meetings.

### Preparing Physicians for Board Service

Physicians face some unique challenges when they assume board roles. As already mentioned, they often become confused and conflicted around the tension between their fiduciary duty of loyalty and their desire to represent the hospital medical community. Doctors also tend to be hands on problem-solvers and lack a good understanding of the difference between governance and management. For this reason, they often want to get into the weeds rather

<sup>5</sup> In addition to the general protections against insider control, non-profit hospitals also must take special precautions to avoid financial arrangements with physicians that could be regarded by the IRS as "private inurement" or "private benefit" (i.e., diverting tax-exempt funds for the enrichment of private individuals or entities). The IRS developed intermediate sanctions rules in 1996 to allow the IRS to penalize "insiders" who improperly benefit from dealings with 501(c)(3) or (c)(4) public charities (which includes most tax-exempt hospitals). These provisions impose sanctions on disqualified persons ("insiders") who receive benefit from the not-for-profit hospital that exceeds fair market value. Sanctions can also be applied to "organizational managers," such as board members, who knowingly approve such transactions. Physicians serving on a hospital board are generally considered "insiders" for purposes of intermediate sanctions rules. See Internal Revenue Code, Section 4958. Under the Code, intermediate sanctions may be used as an alternative to revocation of the tax-exempt status of an organization when private persons improperly benefit from transactions with the organization. The sanctions include paying back any "excess" payments that took place, plus stiff penalties.

than focus on larger strategic issues and institutional vision. Physicians are also typically self-confident and are sometimes hesitant to reveal their lack of knowledge about issues being discussed in the boardroom.

Physicians should be given a thorough orientation to board service just as any other new board member will receive. However, some customization may be warranted to address the concerns above. It can also be particularly helpful for new physician board members to be paired with an experienced member as a mentor. Regular discussion with a mentor can reinforce the messages communicated in orientation and provide the new physician with both feedback and a role model.

### Alternatives to Increased Physician Board Membership

Placing a large number of physicians on the board of a hospital or health system is not the only tactic for strengthening trust and alignment with community doctors. Nor is it the only approach to make available to the board the expertise and insights of medical professionals. Hospitals and health systems across the nation utilize a variety of mechanisms for increasing their working relationships with their medical communities.

### Physician Advisory Councils

One such approach is the use of an advisory body of physician leaders who meet periodically throughout the year with members of the board. Many hospital CEOs have done something similar by establishing their own “physician cabinets” to ensure effective communication with the medical staff. For the board, the advantage of such advisory bodies is the opportunity to include broad representation from the medical community, the avoidance of legal and regulatory complications, and the ability to keep the advisory council flexible and informal so its membership and functioning can be quickly adapted to any current crisis. Such bodies might meet quarterly with the board or more often if circumstances warrant. The message communicated to the medical community is that the board values its input and is interested in hearing firsthand about their concerns, without them first being



filtered through intermediaries such as the hospital CEO. This structure also allows the board to hear from physicians other than the officers of the medical staff who traditionally report to the board on physician concerns. As noted above, the elected medical staff leader attending board meetings in any particular year may or may not be an effective communicator or someone who can represent the full diversity of views held by the medical community. Advisory councils allow for input from diverse physician perspectives and can ensure that the board hears from key physician stakeholders even when they are not holding leadership positions on the medical staff. Such councils also make it easier to include the voices of non-physician practitioners, a growing cohort of clinicians at most hospitals.

### Physician Participation in Board Retreats

Another tactic for enhancing communication with doctors is to invite a significant number of formal and informal physician leaders to board retreats. This might be an annual or semi-annual event and it can be a topical retreat or simply an opportunity to foster intense dialogue about the directions in which the board is leading the hospital or health system. As with advisory councils, this approach enhances critical dialogue between the board and physicians and assures doctors that they have the attention of board members even if they do not hold large numbers of board seats. These retreats are also an occasion for building social capital between board members and doctors. If tensions have historically been high between doctors and hospital leadership, these retreats

can be facilitated by an outside expert to take full advantage of this opportunity to break down barriers and find common ground for collaboration.

### Conclusion

The primary reasons for including physicians in governance are: 1) having access to critical medical expertise for the purposes of quality and patient safety improvement and medical staff privileging and credentialing; and 2) to maintain and/or improve relations between the hospital/system and physicians. Whether the physicians are voting or non-voting board members, or engaged via an advisory council, boards must ensure that physicians contribute significantly to strategic-level and quality-related leadership decisions affecting patients and the community. There are many options, as discussed in this special section, that accomplish these goals while appropriately addressing conflicts of interest, representational issues, and other concerns. Boards that do not have sufficient engagement of physicians in governance are putting their organizations in a poorer position to meet today’s increasingly high expectations of survival in a dynamic healthcare industry. ●

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article, and Brian J. Silverstein, M.D., Director, The Chartis Group, and Governance Institute Advisor, for contributing the case example on Scripps Health. Dr. Sagin can be reached at [tsagin@saginhealthcare.com](mailto:tsagin@saginhealthcare.com).

**Committee Variances by Organization Type: Health Systems vs. Subsidiaries**

We try to articulate committee variances between health systems and subsidiaries to determine whether there appears to be a relationship between the committees that tend to be at the system level vs. at the subsidiary level. Examples that stand out this year include:

- 80% of systems have an executive committee, compared with 52% of subsidiaries.
- 94% of systems have a finance committee vs. 58% of subsidiaries.
- 82% of systems have an audit/compliance committee vs. 36% of subsidiaries.
- 86% of systems have a quality/safety committee vs. 69% of subsidiaries.
- 78% of systems have a governance/board development committee vs. 35% of subsidiaries.
- 73% of systems have an executive compensation committee vs. 21% of subsidiaries
- 63% of systems have an investment committee vs. 21% of subsidiaries
- 21% of systems have a community benefit committee vs. 39% of subsidiaries
- 17% of systems have a population health/community health improvement committee vs. 13% of subsidiaries.

**Table 12** shows the prevalence of board committees since 2013 (most prevalent committees for 2019 listed first). For detail by organization type and size (both committee prevalence and meeting frequency), refer to **Appendix 1**.

**The Quality Committee**

The quality/safety 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). The number of organizations reporting a board-level quality/safety committee is higher in 2019 than in prior years, and especially for systems, independent hospitals, and government-sponsored hospitals. Comparisons by organization type can be found in **Table 13**.

**Table 12. Prevalence of Board Committees**

Committee	2019	2017	2015	2013
Finance	83%	81%	84%	76%
Quality and/or Safety	80%	77%	74%	77%
Executive	73%	75%	72%	77%
Executive Compensation	62%	60%	66%	60%
Governance/Board Development	58%	59%	72%	77%
Strategic Planning	55%	52%	57%	57%
Audit/Compliance	53%	38%	51%	34%
Investment	45%	44%	40%	35%
Audit	44%	38%	33%	32%
Compliance	42%	48%	28%	33%
Joint Conference	37%	34%	35%	40%
Facilities/Infrastructure/Maintenance	31%	27%	23%	25%
Physician Relations	31%	22%	21%	19%
Community Benefit	29%	24%	26%	18%
Human Resources	28%	25%	22%	20%
Construction	24%	17%	17%	9%
Population health/community health investment	23%	18%	N/A	N/A
Government Relations/Advocacy	18%	14%	13%	9%

**Table 13. Organizations with a Board Quality Committee**

	2019	2017	2015	2013	2011
Overall	80%	77%	74%	77%	72%
Systems	86%	82%	84%	85%	74%
Independent Hospitals	80%	72%	80%	80%	74%
Subsidiary Hospitals	69%	87%	81%	86%	77%
Government-Sponsored Hospitals	79%	66%	58%	60%	62%

Quality committees continue to meet primarily monthly (for 48% of respondents); 13% meet bimonthly and 34% meet quarterly.

The average quality committee has 11 people and the most common types of positions on this committee include:

- Voting physician board members (75% have between one and four)

- Physicians from the medical staff (employed and non-employed but non-board members; 56% have between one and four)
- Voting board members who are not physicians (47% have between one and three and 41% have four or more)
- Community members at large (36% have between one and four)

# Maximizing the Effectiveness of the Board's Quality Committee:

## Leading Practices and Lessons Learned



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# Executive Summary

**B**ased on a review of the literature and interviews with experts and hospital leaders (board members, administrators, and clinical leaders), this white paper identifies strategies and practices that differentiate the typical (often ineffective) board quality committee from those that truly make a difference.

IT IS INTENDED TO INFORM BOARDS AS THEY SET GUIDELINES related to the composition, standards, and functions of the board quality committee, along with specifications for how the committee should interface with the full board, senior and clinical management, and other board committees, such as the finance committee.

## Strategies and Practices Related to Committee Charter and Scope

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 include the following:

### Lesson 1: 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.

### Lesson 2: Create the Same Accountability for Quality/Safety as the Finance Committee Has for Budget

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.

### Lesson 3: Oversee Integrity and Reliability of the Credentialing Process

The board and its quality committee generally do not get directly involved in credentialing decisions, as this is the responsibility of medical executive committees and other stakeholders within the hospital. However, the quality committee should oversee credentialing and peer review processes, thus reducing the burden on the full hospital board. More specifically, the board quality committee should consider adopting the following strategies related to credentialing:

- Conduct an annual “audit” of the credentialing process.
- Revise credentialing criteria to reflect physician use of best practices and protocols for safety and quality.

### Lesson 4: 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.

## Strategies and Practices Related to Committee Size and Composition

The board quality committee cannot effectively execute its charter or perform its key areas of responsibility unless it has the “right” people in place. Effective committees must be of a manageable size, have the right stakeholders at the table, and have individuals with the requisite skills and expertise to perform committee tasks effectively. Key practices include the following:

- Make sure board members comprise the majority or near majority.
- Be cognizant of the size of the committee and the number of voting members.

- Screen members carefully, putting the most qualified board members on the committee.
- Ensure representation from all key stakeholders, including senior administrators, senior clinicians, and community/patient representatives. In particular, having two patient and family members serve as voting members changes the nature of the discussions that take place.
- Find the right committee chair (typically a lay board member).
- Invest in training on quality and quality improvement, such as annual retreats, formal training programs, educational components during committee meetings, and time spent observing the front lines of care and sitting in on staff-led quality and safety meetings.

### **Strategies and Practices Related to Meeting Frequency, Agenda, and Other Logistical Issues**

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:

- Meet at least as often as the full board.
- 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 present the committee report to the full board.
- Have the quality committee chair meet periodically with his/her peer on the finance committee.

# Introduction: The Case for Board Quality Committees

The board has day-to-day responsibility under federal and state law for reviewing and acting on medical staff activities related to quality, safety, and peer review.

STUDIES SHOW THAT HOSPITALS THAT PERFORM WELL ON various quality metrics tend to have strong committed boards with well-informed, skilled board members who make quality a priority, set clear and measurable goals for improvement, and demand action when the organization fails to meet these goals and/or experiences adverse events.<sup>1,2</sup> The Affordable Care Act (ACA), moreover, requires hospital boards to take an active role in ensuring that both quality and efficiency are improved.<sup>3</sup>

One common strategy many hospital boards use to promote the provision of high-quality care is to create a separate, standing committee of the board charged with responsibility for oversight over quality and patient safety. These quality committees receive and act on reports from the medical staff and management on their respective activities related to quality, oversight, credentialing, peer review, and corrective action.<sup>4</sup>



In 2010, 88 percent of community hospital boards had such committees in place, up from 51 percent in 2003.<sup>5</sup> A more recent survey of the 14 largest health systems in the country found that all but one had set up a standing board committee to oversee quality and patient safety; the one “holdout” was in the process of setting up such a committee at the time of the survey.<sup>6</sup>

This strategy, moreover, appears to have paid off. Hospitals where the board has set up a separate quality committee are more likely to achieve strong performance on quality measures than those without such a committee.<sup>7</sup> Better performance may be due in part to the fact that boards with separate quality committees tend to spend more time on quality improvement (QI) activities.<sup>8</sup>

## Maximizing the Effectiveness of the Board Quality Committee: Leading Practices and Lessons Learned

Simply having a board quality committee, however, is no guarantee that it will work. In fact, some committees appear to make a significant difference in boosting performance while others seem to have little or no impact at all. What, then, determines whether the board quality committee will be effective? The answer is relatively simple. It is the “nuts and bolts” of operations (i.e., how the committee is structured and how it operates and spends its time). In too many circumstances, boards form a quality committee, only to cede control to management and the medical staff. Board members serving on the committee become frustrated because they do not feel their voices are being heard. In many cases, these committees do not talk about the most important issues facing the organization.<sup>9</sup> By contrast, in some hospitals and health systems, the board quality committee does serve as a highly effective body that drives continuous improvement in quality and safety throughout the organization.

1 R. Millar, R. Mannion, T. Freeman, and H.T.O. Davies, “Hospital Board Oversight of Quality and Patient Safety: A Narrative Review and Synthesis of Recent Empirical Research,” *Milbank Quarterly*, Vol. 91, No. 4 (2013); pp. 738–770.  
2 T.C. Tsai, A.K. Jha, and A.A. Gawande, et al., “Hospital Board And Management Practices Are Strongly Related To Hospital Performance On Clinical Quality Metrics,” *Health Affairs*, Vol. 34, No. 8 (August 2015); pp. 1304–1311.  
3 R. Millar, et al., 2013.  
4 R.L. Nagele, “Strategic Quality Oversight by the Hospital/Health System Board of Directors,” *BoardRoom Press*, October 2014, The Governance Institute.

5 L.D. Prybil, R. Peterson, and P. Brezinski, et al. “Board Oversight of Patient Care Quality in Community Health Systems,” *American Journal of Medical Quality*, Vol. 25, No. 1 (2010); pp. 34–41.  
6 L.D. Prybil, D.R. Bardach, and D.W. Fardo, “Board Oversight of Patient Care Quality in Large Nonprofit Health Systems,” *American Journal of Medical Quality*, Vol. 29, No. 1 (2014); pp. 39–43.  
7 R. Millar, et al., 2013.  
8 L.D. Prybil, “Size, Composition, and Culture of High-Performing Hospital Boards,” *American Journal of Medical Quality*, Vol. 214 (2006); pp. 224–229.  
9 Interview with James L. Reinertsen, M.D., The Reinertsen Group, conducted on July 27, 2015.

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“In the best instances, the board quality committee becomes the ‘power’ committee...in these cases, instead of the finance committee, the board’s ‘heavy hitters’ want to serve on the quality committee.”

—James L. Reinertsen, M.D., CEO, *The Reinertsen Group*

This white paper identifies strategies and practices that differentiate the typical (often ineffective) board quality committee from those that truly make a difference. It is intended to inform boards as they set guidelines related to the composition, standards, and

functions of the board quality committee, along with specifications for how the committee should interface with the full board, senior and clinical management, and other board committees, such as the finance committee.<sup>10</sup> Based on a review of the literature and interviews with experts and hospital leaders (board members, administrators, and clinical leaders), it is organized into two parts. The first section reviews key insights and lessons related to various aspects of committee operations, including its charter and scope of responsibility, committee size and composition, and meeting frequency, agendas, and other logistical issues related to committee operations. The second section includes three brief case studies of hospital and health system boards that have set up particularly effective quality committees.

<sup>10</sup> R.L. Nagele, 2014.

# Quality Committee Key Insights, Strategies, and Practices

## Committee Charter and Scope of Responsibility

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 include the following:

### Lesson 1: Focus on Governance, Not Operations

Effective board quality committees focus on governance, not operations.<sup>11</sup> 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.

### Lesson 2: Create the Same Accountability for Quality/Safety as the Finance Committee Has for Budget

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. In addition, the board quality committee must stay abreast of any areas where the organization may not be in compliance with local, state, and/or federal regulatory requirements related to quality and safety.

At Johns Hopkins Medicine (JHM), board leaders created the JHM Patient Safety and Quality Board Committee, giving it two charges—first, that it function with the same rigor and discipline as the board’s audit/finance committee, and second, that it have oversight over the quality and safety of patient care delivered to every JHM patient, regardless of where it is delivered within the system.<sup>12</sup> Living up to this level of accountability requires the development of high-level organizational goals, specific quality and safety priorities related to those goals, specific measures and performance targets within each of those priorities, and ongoing monitoring to ensure that performance meets or exceeds the established targets. Practices and strategies that can help in these areas are detailed below.

**Develop aggressive, broad, easily understood organizational goals related to quality and safety for approval by full board:** In partnership with the full board, the board quality committee often takes a lead role in setting broad, aggressive, and easily understood organizational goals related to quality and safety. Several years ago, the JHM Patient Safety and Quality

Board Committee reviewed its original charter, which laid out the goal that JHM hospitals strive to be “above average” in terms of quality and safety. Committee members decided that “above average” was not good enough, and that the real goal should be to become a “national leader” in these areas. The committee identified two clear goals. First to partner with patients, their loved ones, and others to end preventable harm, to continuously improve patient outcomes and experience, and to eliminate waste in healthcare. Second, to be national leaders in externally reported measures. The full JHM board later endorsed this goal.

**Work with key stakeholders to identify and approve specific quality and safety priorities each year:** Consistent with the broad goals described above, the quality committee works in partnership with administrative and clinical leaders to establish recommended priorities for QI each year. Finance leaders should help in determining priorities based on patient volume and costs, thus ensuring that addressing these areas will have a major impact on both quality and financial performance. Ideally, the measures tracked should go well beyond those used by the Centers for Medicare & Medicaid Services (CMS), which affect only a minority of patients. Rather, measures should target the 10 to 20 highest-volume conditions, and/or those that account for the majority of patient complications and readmissions, and hence affect both quality and costs.<sup>13</sup> These priorities are then vetted and approved by the full board and the full administrative and clinical leadership team, often at the board’s annual retreat.<sup>14</sup>

**Identify measures and set targets within each priority:** Once approved, the priorities become part of the strategic plan, with teams given accountability for driving improvement in each area by reaching measurable goals and targets.<sup>15</sup> In most cases, the board quality committee, senior management, and clinical leaders work together to identify the measures to be used and the specific performance targets for each measure, with the full board then approving these measures and targets. In a survey of the 14 largest non-profit health systems, the full board had responsibility for approving system-wide measures and standards in 11 cases, while in the other instances the board’s standing committee on quality took on this role.<sup>16</sup> Key considerations related to measures and targets include the following:

- **Do not forget stakeholder satisfaction measures:** The most effective board quality committees track not only clinical outcomes, but also three additional datasets that serve as leading indicators of quality—employee, provider, and customer satisfaction.<sup>17</sup>

13 J. Byrnes, “Using the Board Quality Committee to Drive the Value Proposition,” *hfm*, August 2014, Healthcare Financial Management Association. Available at [www.hfma.org/Content.aspx?id=23866](http://www.hfma.org/Content.aspx?id=23866).

14 *Ibid.*

15 *Ibid.*

16 L.D. Prybil, et al., 2014.

17 R.F. Stacey, “Three Datasets Should Drive Governing Boards,” *BoardRoom Press*, December 2014, The Governance Institute.

11 D. Seymour, “Invigorating the Board Quest for Quality Improvement,” *BoardRoom Press*, February 2015, The Governance Institute.

12 Interview with Peter Pronovost, M.D., Senior Vice President of Quality and Safety, and Michael Armstrong, Chair of the Patient Safety and Quality Board Committee, Johns Hopkins Medicine, July 10, 2015.

- **Consider the shift to value and population health:** When approving the organizational quality plan, the board's quality committee should make sure that the plan reflects the shift to accountable care. In other words, the plan should include initiatives, goals, and metrics that cut across the entire continuum of care (not just the inpatient setting), including physician groups, outpatient clinics, home care, rehabilitative services, and long-term care. Similarly, the quality dashboard should reflect measures of population health and chronic disease management, such as readmissions, emergency department (ED) visits, blood pressure control among hypertensive individuals, blood glucose control among those with diabetes, patient-reported health status, and medication adherence.<sup>18</sup>

**Hold senior management and clinical leaders accountable for performance:** The quality subcommittee should review a quality dashboard at every meeting. The dashboard should be published on a monthly basis and made available electronically at least a week before the meeting.<sup>19</sup> The board quality committee should require the leaders of the teams tasked with driving improvement to provide updates to the committee several times a year, thus creating accountability and motivation and providing a forum to discuss progress, offer assistance to teams that are struggling, and celebrate successes with teams that have reached their target. Not requiring teams to deliver such reports—or discontinuing the practice—can significantly undermine progress.<sup>20</sup> The following items are also critical in this regard:

- **Use national benchmarks:** Wherever possible, performance should be compared to nationally reported benchmarks based on standard definitions and data-collection methodologies.<sup>21</sup> Boards that review and track their organization's performance versus national benchmarks tend to have better outcomes with respect to quality than those that do not.<sup>22</sup> In addition to national benchmarks, it is essential to monitor quality performance against the organization's own historical performance and progress on goals.
- **Consider cascading levels of accountability:** In larger systems, consideration should be given to creating 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. For example, while the JHM Patient Safety and Quality Board Committee reviews performance of all entities quarterly, the committee commissions an audit of performance by the Armstrong Institute if that entity fails to bring performance into line for three consecutive reporting periods, and the full JHM board becomes involved only after four reporting

periods. This approach mirrors that used by the JHM board's finance committee. It is an explicit accountability model that brings in additional oversight the longer an entity fails to meet its goals.

- **Monitor under-performance issues until resolved:** Under-performance issues brought to the board quality committee should remain on the agenda until the problem has been resolved and/or performance has rebounded to target levels. To ensure that this occurs, unresolved issues from one meeting should automatically be placed on the agenda for the next one.

**Recommend new policies or policy revisions for adoption by full board:** Effective board quality committees will regularly discuss potential new policies and policy revisions that relate to quality and safety and, as appropriate, recommend their adoption by the full board.

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“Most hospital and health system boards have great accountability for budgets and financial issues, but not for quality and safety. Most boards delegate this responsibility to medical staff leadership, with little accountability for meeting established performance goals. Boards need to address this by using the same discipline in meeting quality and safety objectives as they do with budgets. Board members need not be experts in quality of care, but rather need to be experts in leadership, setting goals, ensuring an infrastructure to meet the goals, requiring plans, and transparently ensuring goals are met, just as they do in their own businesses.”

—Dr. Peter Pronovost, Senior Vice President of Quality and Safety, and C. Michael Armstrong, Chair of the Patient Safety and Quality Board Committee, Johns Hopkins Medicine

### Lesson 3: Oversee Integrity and Reliability of the Credentialing Process

The board and its quality committee generally do not get directly involved in credentialing decisions, as this is the responsibility of medical executive committees and other stakeholders within the hospital. However, the quality committee should oversee credentialing and peer review processes, thus reducing the burden on the full hospital board. Too often hospital boards approve the granting of privileges to a large group of physicians as part of the consent agenda, with virtually no discussion. Yet, in some cases, little or no due diligence has been performed by the board to make sure that these physicians consistently follow the quality and safety protocols established by the organization. If a sentinel event occurs due to the negligence of one of these physicians, the negative repercussions for the organization and the board can be

18 D. Seymour, 2015.

19 D.M. Murphy, “The Board’s Role in Quality and Patient Safety Performance Measurement,” *BoardRoom Press*, June 2014 (special section), The Governance Institute.

20 J. Byrnes, 2014.

21 D.M. Murphy, 2014.

22 R. Millar, et al., 2013.

significant. To avoid this problem, the board quality committee should consider adopting the following strategies:

- **Conduct an annual “audit” of the credentialing process:** Much as the board finance committee conducts a regular audit of the budget, the board quality committee can conduct an annual formal review of the credentialing process. Structured as a separate meeting, this audit brings the credentialing team in to discuss how the credentialing process works, particularly with respect to making sure that physicians follow established quality and safety protocols. This discussion should include a review of how the process identifies and deals with physicians who do not follow such protocols. The purpose of the audit is to reassure the board—through the quality committee—that the hospital has a strong process in place for ensuring that physicians follow the requisite protocols.<sup>23</sup>
- **Revise credentialing criteria to reflect best practices and protocols:** With the movement to value-based payments, hospital board quality committees should consider revising the approach to overseeing the granting of privileges and peer review processes to include utilization of proven best practices and clinical protocols. While physicians must be allowed to exercise clinical judgment and make decisions outside the bounds of the protocols, the board quality committee should set a standard with respect to expectations. Norton Healthcare in Louisville, KY, for example, has adopted a policy setting the expectation that physicians will adhere to proven best practices and protocols as a requirement to practice on the medical staff. Some specialties have designated national best practices while other specialties have developed their own.<sup>24</sup>

#### **Lesson 4: 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. In organizations where the culture still encourages “cover-ups” and “denials,” the board quality committee can serve as the catalyst for shifting to a culture of open transparency.<sup>25</sup> The culture must be such that senior managers and physician leaders feel comfortable revealing mistakes and protocol violations without fear of punishment or shame. Specific actions the board quality committee can take to promote such a culture include the following:

- **Recommend board adoption of “just culture”:** Board quality committees should recommend that the full board adopt a “just-culture” approach to dealing with safety and quality issues. This approach recognizes that bad things happen and that most of them are due to problems with systems rather than individual behaviors. It further pledges that no individual will be held accountable for such systems problems

but rather will be recognized positively for speaking up openly about these problems. Individuals are still held accountable for negligent and reckless behaviors.

- **Adopt “patients-as-only-customer” mantra:** Too often board quality committees are unwilling to adopt potentially controversial actions that are necessary to improve quality and safety, typically because a key stakeholder (e.g., a prominent physician) objects, in some cases threatening to go work at another hospital if the action is taken. To counter such threats, board quality committees should consider recommending adoption of a formal mantra that highlights patients (not physicians) as the hospital’s only customer. At Park Nicollet Health Services in Minneapolis, for example, the board quality committee placed the words “the patient is the only customer” at the top of the agenda for every committee meeting.<sup>26</sup>
- **Develop and publicize a strong “disclosure-and-apology” plan:** The goal should be for the board quality committee and the full board to know about any bad event before reading about it in the newspaper.<sup>27</sup>

#### **Strategies and Practices Related to Committee Size and Composition**

The board quality committee cannot effectively execute its charter or perform its key areas of responsibility unless it has the “right” people in place. Effective committees must be of a manageable size, have the right stakeholders at the table, and have individuals with the requisite skills and expertise to perform committee tasks effectively. Key practices are described in the paragraphs below.

**Make sure board members comprise majority or near majority:** The board quality committee must function as a committee of the board, not of management or the medical staff. To ensure this clarity, experts suggest that board members generally comprise a majority of all committee members, or at least a “near” majority. In larger organizations, board members may be a minority of all members, but should make up a majority of voting members.<sup>28</sup>

**Be cognizant of size and number of voting members:** As with any committee, the board quality committee needs to be large enough to ensure that members collectively have the right background, expertise, and skills to perform effectively, but not so large as to diminish the ability to have the right kinds of conversations and make the (sometimes controversial) decisions that need to be made. As with the full board, the ideal size for the board quality committee is between eight and 12 members, and typically no more than 15. Very large systems may have more members, although in these instances limits may be placed on the number of voting members. At JHM, for example, the board

23 Interview with James L. Reinertsen, M.D., The Reinertsen Group, conducted on July 27, 2015.

24 D. Seymour, 2015.

25 Interview with James L. Reinertsen, M.D., July 27, 2015.

26 *Ibid.*

27 *Ibid.*

28 Interview with Eric D. Lister, M.D., Managing Director, Ki Associates, conducted on July 6, 2015; interview with James L. Reinertsen, M.D., July 27, 2015.

quality committee includes five board members, the chairs of each hospital's board quality committee, the presidents of four JHM affiliates, and the chair of the patient and family advisory council. The presidents of each of the hospitals, and each entity (ambulatory practices, home care, international, ambulatory procedure) staff the committee and present performance data.

**Screen members carefully, put best board members on committee:** The board should appoint its best members to the quality committee, which is considered to be a high-profile assignment, at least as prestigious—if not more so—than being appointed to the finance committee.<sup>29</sup> Consequently, the quality committee should receive the same priority as the finance committee when screening for qualified members, with interest in the position not being viewed as a substitute for expertise and experience.<sup>30</sup> Members must be willing to ask hard questions and exercise serious accountability. It is helpful if the committee's membership remains stable over time to preserve knowledge and experience built up over the years.<sup>31</sup>

**Ensure representation from all key stakeholders:** The board quality committee should be a mixture of board members, senior administrators, and clinical leaders, with the goal of bringing the key stakeholders to the table to discuss and take ownership over quality and safety across the organization.<sup>32</sup> Some board quality committees also include or otherwise get input from community and/or patient representatives. Additional lessons related to each of these stakeholders include the following:

- **Look for the right expertise among board members:** Ideally, board members serving on the quality committee should collectively have expertise in QI methodologies (such as Lean and Six Sigma), safety, statistical process analysis, patient experience, risk and legal issues, and finance (i.e., someone who can translate improvements into potential cost increases and/or savings). Often board members from outside the health-care industry have this type of experience, including those with backgrounds in banking, energy, manufacturing, hospitality, retail, and education. At present, relatively few board quality committees have this type of expertise among standing members.<sup>33</sup>
- **Include senior administrators and clinicians:** The board quality committee should have a mix of clinical leaders and senior administrators. In some cases, these non-board members may not have voting rights when it comes to the committee making formal recommendations.<sup>34</sup> A 2007 Governance Institute survey found that hospitals who had members with clinical expertise on the board quality committee performed significantly better on process and outcomes measures than

did hospitals with no such expertise on this committee.<sup>35</sup> In particular, the presence of physician and nurse leaders can facilitate communication and build trust and confidence.<sup>36</sup> Along with the chief quality officer, CMO/VPMA, and CFO, members might include leaders of hospital-owned or hospital-affiliated group practices, and the chief of medical informatics and/or quality measurement.<sup>37</sup>

- **Consider including two or more community or patient representatives:** Former patients, family members of patients, and/or representatives of the community at large can often contribute effectively as members of the board quality committee. To do so, they must understand the role of the committee and have an adequate understanding of quality and QI issues.<sup>38</sup> James Reinertsen, M.D., CEO of The Reinertsen Group, strongly recommends that two patient and family members serve as voting members of the board quality committee, as their presence serves to change the nature of the discussions that take place. (Having one patient/family representative is not adequate, as this individual may feel isolated and hence not participate in discussions.)<sup>39</sup> Many hospitals have patient and family advisory councils in place, and members of these councils often make for strong members of the board quality committee. As an alternative to having patients and family members as formal committee members, the committee can invite members of local community advisory boards to sit in on meetings and/or ask them to provide their perspectives on particular issues being discussed. The committee can also elicit input by periodically hosting focus groups with patients and community representatives.

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“Having two patient and family representatives as voting members of the committee is a ‘game changer.’ It’s a vital structural element that few board quality committees have in place today. Having them in the room changes the nature of the conversation, even if they do not speak. All the normal excuses for poor quality and safety begin to sound lame when the patient is in the room.”

—James L. Reinertsen, M.D., CEO, The Reinertsen Group

**Find the right chair (typically a lay board member):** The chair of the quality committee should be a board member who has experience in leading continuous QI endeavors. Opinion is divided on whether a physician should play this role. While some

29 J.L. Reinertsen, *Hospital Boards and Clinical Quality: A Practical Guide*, Ontario Hospital Association, 2007.

30 D. Seymour, 2015.

31 R.L. Nagele, 2014.

32 Interview with Eric D. Lister, M.D., July 6, 2015.

33 J. Byrnes, 2014.

34 Interview with Eric D. Lister, M.D., July 6, 2015.

35 H.J. Jiang, C. Lockee, K. Bass, and I. Fraser, “Board Oversight of Quality: Any Differences in process of Care and Mortality?” *Journal of Healthcare Management*. Vol. 54, No. 1 (2009); pp. 15–30.

36 R. Millar R, et al., 2013.

37 D. Seymour, 2015.

38 Interview with Eric D. Lister, M.D., July 6, 2015.

39 Interview with James L. Reinertsen, M.D., July 27, 2015.



physicians may be able to play this role effectively, many cannot. Consequently, in many cases, the most effective committee chairs will be lay board members from outside the healthcare industry who have the requisite experience and skills.<sup>40,41</sup> Regardless of who serves as chair, he or she must be able to elicit input and guidance from all members of the committee and make sure that discussions do not become too technical or clinical in nature and/or too dominated by a few individuals. The chair should also be someone who is passionate about quality and safety and has time to lead the committee's work. For example, at Main Line Health System (a not-for-profit health system serving portions of Philadelphia and its western suburbs), a national expert on quality and QI serves as chair of its quality and patient safety committee and also sits on the system board.<sup>42</sup>

**Invest in training:** Board members in general—and members of the board quality committee in particular—need to be proficient in the use and interpretation of safety and quality metrics.<sup>43</sup> Many boards, however, devote limited time and resources to training and other activities designed to increase the “quality literacy” of board members, which poses particular problems for those board members from outside the healthcare arena.<sup>44</sup> Members need to remain up-to-date on the various domains of quality and how they affect the organization's performance, including its financial performance. To ensure that committee members

have such knowledge and skills, the board quality committees should consider investing in the following training for members:

- **Annual retreats and/or formal training programs:** Committees should hold annual retreats and/or send members to other appropriate training programs hosted by outside organizations.
- **Educational component during meetings:** Each committee meeting can also contain an education component, with an emphasis on concrete examples of how high-quality, safe care can have a positive impact on the organization's financial performance.<sup>45</sup> Committee members should also be provided with access to additional tools that can help ensure they have adequate knowledge and expertise on specific issues that come before the committee.<sup>46</sup>
- **Time spent observing front lines of care:** The chair and members of the board quality committee should periodically spend time on the front lines of care within the hospital/health system, learning about the business and applying their insights and understanding to it.<sup>47</sup>
- **Visits to staff-led quality and safety meetings:** Members of the board quality committee (particularly the chair and vice chair) should periodically sit in as an observer at meetings where staff members discuss quality and safety issues, such as the hospital-level quality oversight and credentialing committees. This experience will give them a better sense of the quality- and safety-related issues being dealt with at the front lines of the organization.

40 D. Seymour, 2015.

41 R.L. Nagele, 2014.

42 L. Stepnick, *Making a Difference in the Boardroom: Updated Research Findings on Best Practices to Promote Quality at Top Hospitals and Health Systems*, The Governance Institute, Fall 2014.

43 R. Millar, et al., 2013.

44 *Ibid.*

45 J. Byrnes, 2014.

46 R.L. Nagele, 2014.

47 R.D. Parsons, M.A. Feigen, “The Boardroom's Quiet Revolution,” *Harvard Business Review*, March 2014.

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## Examples of Board Quality Committee Training Programs

**Spectrum Health, Grand Rapids, MI:** All board members (not just those on the quality committee) attend a two-day retreat focused entirely on quality and safety. They also participate in quality and safety teams where they present the perspective of board member and patient. Special efforts are made to help board members understand the potential of QI projects to reduce costs.<sup>48</sup>

**Main Line Health System, Philadelphia, PA:** Board members on the quality and patient safety committee attend a “safety fair” each year where they go through eight interactive learning stations with a team of clinicians. Every board member is expected to attend a meeting of the quality and patient safety committee at least once each year. The board chair proactively enforces this requirement.<sup>49</sup>

**KishHealth, DeKalb, IL:** Committee members regularly participate in educational activities related to quality, at an intensity level greater than that provided to the full board. Representative topics include briefings on the just-culture concept, the Medicare Physician Quality Reporting System (PQRS), value-based purchasing, preventable readmissions, and data collection and reporting. The CMO and chief nursing officer (CNO) generally present these topics, with other internal staff brought in as needed. For example, the system’s risk manager led a session on “just culture” while the director of quality conducted a review of PQRS.<sup>50</sup>

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## Strategies and Practices Related to Meeting Frequency, Agenda, and Other Logistical Issues

The board quality committee needs to structure its work in a manner that allows members to effectively perform the duties and responsibilities laid out earlier. 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 are described below.

### Meeting Frequency

Leading strategies and practices related to how often the committee meets include the following:

- **Meet at least as often as the full board:** Board quality committees generally meet at least as often as the full board, and sometimes more frequently, with meetings typically lasting

48 J.J. Fifer, “How to Increase Board Engagement in Quality and Finance,” *BoardRoom Press*, The Governance Institute, February 2014.

49 L. Stepnick, 2014.

50 Interview with Michael Kulisz, M.D., Chief Medical Officer, and Leonetta Rizzi, Chair of Quality and Credentialing Committee, KishHealth System, August 7, 2015.



two to three hours.<sup>51</sup> Meetings often take place in advance of the full board meeting, with highlights or issues from the committee meeting subsequently being discussed at the board meeting.

- **Consider creating a subcommittee (in larger systems):** In larger systems, the board quality committee may find that there is too much work for the committee to handle during regular meetings. In these instances, consideration can be given to creating a smaller subcommittee that does additional work between committee meetings. For example, JHM’s Patient Safety and Quality Board Committee meets four times a year, with each meeting lasting roughly two and a half hours. However, several years ago, the full committee created a performance subcommittee made up of a subset of members who also meet every quarter for two to three hours. Much like an audit subcommittee of a board finance committee, this performance subcommittee digs into the “weeds” of quality and safety performance, analyzing issues and making recommendations to the full quality committee. Prior to creating this subcommittee, the full Patient Safety and Quality Board Committee met for four and a half hours each quarter, which proved too long to ensure a productive session.<sup>52</sup>
- **Incorporate additional special meetings as necessary:** The board quality committee should consider holding two special meetings each year—one dedicated to oversight of the credentialing process and a second focused on discussion and adoption of a concrete set of quality and safety goals to be presented to the full board for approval. These issues generally cannot be handled during a regular meeting and hence, a separate time block should be set aside for each every year.<sup>53</sup>

51 D.M. Murphy, 2014.

52 Interview with Peter Pronovost, M.D. and Michael Armstrong, Johns Hopkins Medicine, July 10, 2015.

53 Interview with James L. Reinertsen, M.D., July 27, 2015.

## Meeting Agenda and Structure

The most effective board quality committees use various strategies and practices related to the meeting agenda and structure to maximize the effectiveness of meetings, as outlined below:

- **Consider use of standard agenda, reporting format:** Committee meetings often follow a standard format that calls for discussion of each of the main quality and safety priority areas for the organization. To facilitate understanding, committees also can use standard reporting formats. For example, the JHM Patient Safety and Quality Board Committee requires that a standard format be used, known as MD&A (which stands for management, discussion, and analysis). Each report includes both qualitative and quantitative information related to performance, providing a vehicle to discuss opportunities to do better. (More details on this template can be found in the case study on Johns Hopkins Medicine in the next section.)<sup>54</sup>
- **Limit (or even) ban report presentations:** The vast majority of the meeting (80 percent or more) should consist of meaningful dialogue, not presentations. As with the full board, committee members should receive and read all reports in advance of the meeting, and those presenting should be reminded to keep their prepared remarks quite brief. Committee chairs might consider banning the use of prepared presentations for these reasons.
- **Start with one or two patient stories:** To make the discussion come alive and promote transparency, committee meetings can begin with a summary of one or two patient stories that highlight safety issues to be discussed later in the meeting. In most cases, a committee member will share the story briefly (in one to two minutes), although occasionally a patient or family member might be brought in to share a more detailed first-person story illustrating a particular quality or safety issue within the organization. In general, stories should focus on problem areas, although on occasion a story can be used to illustrate and celebrate successes.<sup>55</sup>
- **Allot significant time to reviewing progress toward quality/safety aims:** The bulk of the meeting should focus on progress since the last meeting in achieving the aforementioned quality and safety goals for the organization.
- **Briefly review regulatory issues:** Each meeting should include a brief review of any regulatory “slip-ups” related to quality and safety. This “exception report” should review any regulatory problems the organization faces at the moment and how these issues are being dealt with by senior management. In addition, the board quality committee should establish a process for immediate (i.e., between meetings) notification whenever a regulatory compliance issue related to quality and safety arises; the notification should include a summary of the plan for addressing the issue in question.

<sup>54</sup> Interview with Peter Pronovost, M.D., and Michael Armstrong, Johns Hopkins Medicine, July 10, 2015.

<sup>55</sup> Interview with James L. Reinertsen, M.D., July 27, 2015.

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## A Good Quality Committee Meeting Agenda (120 Minutes)

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Dr. Reinertsen recommends the following 120-minute standard meeting agenda for board quality committees:

1. Introductions, approval of minutes (5 minutes)
  2. Patient story, illustrating data and/or issue to be reviewed in the meeting (5 minutes)
  3. Review of progress toward strategic quality aims (40 minutes)
  4. Exception report for any regulatory compliance issues that have arisen (20 minutes)
  5. Review of new policies or other recommendations to the full board (30 minutes)
  6. Other agenda items (15 minutes)
  7. Meeting evaluation (5 minutes)
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## Promoting an Open, Transparent Dialogue

The most effective quality committees use various strategies and practices to promote an open, transparent dialogue where all committee members feel comfortable speaking openly and honestly about the critical issues facing the organization:

- **Focus on problems, not successes:** While there is always some room to acknowledge progress and strong performance, the purpose of the board quality committee is to constantly push the organization to do better. Consequently, the bulk of discussion time during committee meetings and during the quality/safety part of full board meetings should focus on problem areas and disturbing trends. To that end, patient stories and progress reports should highlight areas of underperformance, with the goal of stimulating meaningful conversations about how to address these issues.<sup>56</sup>
- **Elicit everyone’s input:** The committee chair should make a concerted effort to elicit input from everyone on the committee, and not let a few individuals dominate the conversation. If necessary, the chair can go around the table to ask each individual his or her opinion.
- **Do not let the conversation get too clinical or technical in nature:** The committee chair must not allow the conversation to become dominated by clinical or technical details, but rather require that committee members “lift up” to focus on important, big-picture issues.
- **Encourage provocative questions:** Committee members should be encouraged to question the information and data they see, play “devil’s advocate,” and otherwise ask provocative questions intended to promote a meaningful dialogue. (The sidebar below provides examples of questions to elicit open, meaningful dialogue.)

<sup>56</sup> *Ibid.*

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## Questions to Encourage Open, Transparent Dialogue about Quality and Safety

Dr. Reinertsen has developed the following set of questions board quality committee members can use to promote an open, transparent dialogue about quality and safety performance:

1. If I understand it correctly, this report displays the rate of this safety event per 10,000 adjusted hospital days. Could someone translate that into the number of patients affected?
  2. Can we dispense with the PowerPoint presentation and discuss some of the hard issues raised by the report in the board packet?
  3. Am I the only person who doesn't understand what you just said?
  4. Does every doctor on this list for re-appointment to staff faithfully follow all of our safety protocols and procedures?
  5. These goals seem tepid. Would they be stronger if they weren't linked to the incentive compensation system?
  6. Could someone remind me what our safety goal is? Is it to be as good or better than other hospitals, or is it to eliminate all harm to patients?
  7. What is our plan for sharing our safety performance data widely with our staff, and with our community?
  8. I see that hospital X is consistently at or very near the very top performance level. Have we talked to its leaders to learn what they do to achieve this level of performance?
  9. The safety data that we see are largely counts of harm events that have happened in the past. But isn't safety a "dynamic non-event?" Don't we also need to know about the reliability of our key safety processes?
  10. How operationally aware and safe are we today?
  11. How well do we anticipate and prepare for safety risks in the future?
  12. How well are we learning the lessons from past safety events?
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## Quality Committee Interaction with the Full Board and Other Board Committees

As detailed below, the most effective quality committees establish formal practices and processes for their interactions with the full board and with other board committees, such as the finance committee:

- **Highlight areas of discussion at full board meetings:** The chair of the quality committee should submit a summary report to be presented at every full board meeting. The report should summarize the organization's performance on quality and safety since the last meeting, highlighting areas of achievement and underperformance, including issues that may overlap with strategic and financial priorities. Examples include patterns of reportable events (not isolated events) and any recommendations related to major capital investments in quality and safety. In this latter instance, the quality committee should make every effort to present a quality and safety "ROI" in terms of the impact of the investment in saving lives, avoiding errors, and improving performance on quality metrics. If possible, financial gains from these improvements should be highlighted as well, such as the cost savings generated by avoiding errors and/or the incremental revenue to be gained on pay-for-performance contracts.<sup>57</sup>
- **Make sure quality and safety get adequate discussion time at full board meetings:** The Institute for Healthcare Improvement recommends that boards spend at least a quarter of meeting time on quality and safety issues.<sup>58</sup> Typically these issues should be identified by the board quality committee.<sup>59</sup> Survey data suggests that many large organizations meet this standard. Among the nation's 14 largest non-profit health systems, boards spend between 10 and 35 percent of meeting time on quality and safety issues, with an average (median) of 23 percent.<sup>60</sup>
- **Have the quality committee chair present the committee report to full board:** The chair of the quality committee should prepare the committee report and lead discussions about quality and safety during the full board meeting. While the CMO, CNO, and other committee members can participate in the discussion, the committee chair should initiate and lead the conversation.<sup>61</sup>
- **Have the chair meet with his/her peer on the finance committee:** The chair of the board quality committee should meet regularly with the chair of the board audit/finance committee to discuss how each can support the other's initiatives and fill the other's data needs. For example, both committees may be seeking to measure quality and safety and/or to quantify the financial benefits of QI activities.

57 D.M. Murphy, 2014.

58 E. Zablocki, "IHI Calls on Boards to Lead on Quality and Safety: An Interview with J. Conway," *Great Boards*, Vol. 7, No. 1, Summer 2007.

59 D.M. Murphy, 2014.

60 L.D. Prybil, et al., 2014.

61 Interview with James L. Reinertsen, M.D., July 27, 2015.

# Case Studies

## Johns Hopkins Medicine

### Background

Headquartered in Baltimore, Johns Hopkins Medicine (JHM) is a \$7 billion integrated global health enterprise and one of the leading healthcare systems in the U.S. Formalized by the trustees of the university and the health system, JHM integrates the governance of Johns Hopkins' medical enterprises, allowing them to respond to changes in medical care delivery while remaining true to the organization's mission of research, teaching, and patient care. JHM operates six academic and community hospitals, four surgery centers, and 39 primary and specialty care outpatient sites. While each hospital had a board quality committee since the late 1990s, the integrated JHM Patient Safety and Quality Board Committee came into existence in 2011, shortly after forming the Armstrong Institute for Patient Safety and Quality and creating a role of JHM Senior Vice President for Patient Safety and Quality.

### Charter and Scope of Board Quality Committee

The JHM Patient Safety and Quality Board Committee provides oversight and ensures accountability for quality and patient safety. Just as the finance committee is accountable for every dollar received and spent throughout JHM, the Patient Safety and Quality Board Committee oversees the quality and safety of care for every patient treated at all JHM entities.<sup>62</sup>

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### Dealing with Joint Commission Requirements

Because Joint Commission accreditation requirements mandate that individual hospitals have their own board quality committees responsible for quality oversight, each JHM hospital had to revise its bylaws to make the JHM Patient Safety and Quality Board Committee a subcommittee of that hospital's board quality committee. In essence, each hospital board quality committee has delegated oversight of quality to the system board quality committee. In reality, however, the oversight relationship is reverse, with the hospital quality committees reporting to the JHM system committee. Taking this step allowed JHM to legally share data and have open discussions throughout the system while still protecting the confidentiality of the data.

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### Establishing Goals and Monitoring Performance

The JHM Patient Safety and Quality Board Committee sets strategic goals for the organization and monitors performance versus these goals. The committee works in partnership with the Armstrong Institute for Patient Safety and Quality, which was launched in 2011 and is charged with coordinating research, training, and operations for QI and patient safety efforts throughout JHM. The Armstrong Institute communicates the goals set by the committee throughout the system and supports individual departments, units, and affiliate groups in meeting them.<sup>63</sup>

Several years ago the JHM Patient Safety and Quality Board Committee took a look at its original charter, which laid out the goal that JHM hospitals should strive to be "above average" in terms of quality and safety. Committee members decided that "above average" was not good enough, and that the real goal for JHM hospitals should be to become "national leaders" in these areas. The committee identified preventable harm, including both deaths and injuries, as the number-one priority, and laid out the ambitious goal of partnering with patients, their loved ones, and others to end preventable harm, continuously improve patient outcomes and experience, and eliminate waste in healthcare. After reviewing performance in various areas, the JHM Patient Safety and Quality Board Committee created a common platform on which to drive patient safety and quality. Previously, each hospital had its own set of measures, datasets, and associated goals and objectives. The committee created uniform accountability throughout the organization by identifying a common set of measurable, reportable metrics and associated goals and objectives. For example, in recent years the focus has been on CMS core measures, hand hygiene, hospital-acquired conditions, patient safety indicators, quality-based reimbursement measures, central line-associated bloodstream infections, surgical site infections, and patient experience measures. Some measures are reported monthly, while others are reported quarterly.<sup>64</sup>

### Cascading Levels of Accountability

The JHM Patient Safety and Quality Board Committee only becomes involved in working with an underperforming entity if that entity fails to bring performance into line for three consecutive reporting periods, and the full JHM board becomes involved only after four reporting periods. This approach mirrors that used by the finance committee of the full JHM board. It is an explicit accountability model that brings in additional oversight the longer an entity fails to meet its goals. Recently the JHM Patient Safety and Quality Board Committee became involved in addressing ED wait times at Johns Hopkins Hospital

62 P.J. Pronovost, C.G. Holzmueller, and N.E. Molello, et al., "The Armstrong Institute: An Academic Institute for Patient Safety and Quality Improvement, Research, Training, and Practice," *Academic Medicine*, May 2015.

63 P.J. Pronovost, M. Armstrong, and R. Demski R, et al., "Creating a High-Reliability Health System: Improving Performance on Core Processes of Care at Johns Hopkins Medicine," *Academic Medicine*, Vol. 90, No. 2 (February 2015); pp. 165–172.

64 P.J. Pronovost, et al., May 2015.

(JHM's main inpatient facility). Performance deteriorated to the point that it was affecting patient satisfaction and health. The hospital attempted to address the issue, but performance continued to lag, after which the hospital was required to report to the committee about its action plan to address the issue. The plan worked and wait times fell, but then they began climbing again. This deterioration in performance led to a lengthy telephone call during which committee members and hospital leaders discussed a new game plan for improvement. (Due to the urgency of the issue, the committee chair did not want to wait until the next quarterly meeting to discuss.) The board quality committee will continue to monitor performance and the issue will remain on its agenda until improvement occurs and targets are met. Similar interventions by the board quality committee have occurred in other areas, including bloodstream infections in the pediatric intensive care unit and patient experience ratings on room cleanliness and nurse communication at several hospitals. In each case, the board quality committee chair held between-meeting phone calls with relevant parties to make sure that improvement plans were put into place. These plans were then reviewed and performance monitored at subsequent quarterly committee meetings, and they will remain on the board agenda until performance targets have been met.

### Committee Size and Composition

The committee currently includes five JHM board members (out of more than 30 individuals who serve on the full JHM board), the presidents of JHM's five hospitals, the chairs of each of the five hospitals' board quality committees, four presidents of JHM affiliates, and the chair of the patient and family advisory committee.<sup>65</sup> Only the JHM board members have the right to vote on any formal actions or recommendations taken by the committee. Historically the JHM board chair served as chair of the committee, but these two positions are not formally tied together. The committee charter does not place strict requirements on who can serve on the committee, with the JHM board chair making recommendations about the size and composition of the committee, including which members have voting rights. The current chair of the committee is a past chair of the JHM board who retired from the full board but continues to serve as an honorary trustee.

The other board members serving on the committee have varying backgrounds, including physicians and individuals with business backgrounds. Non-voting members of the committee include an expert in the Malcolm Baldrige National Quality Award, a reporter with experience in healthcare quality issues, a nurse, and an individual who runs a manufacturing company and hence has familiarity with QI processes such as Lean and Six Sigma.

65 P.J. Pronovost, et al., February 2015.

### Meeting Frequency, Agenda, and Other Logistics

**Frequency:** The JHM Patient Safety and Quality Board Committee meets four times a year for approximately two and a half hours. Replicating a process used by the finance committee, the JHM Patient Safety and Quality Board Committee created a performance subcommittee made up of four trustees that meet with all entity presidents a few days before each full committee meeting to review performance on all safety and quality metrics. Much like the audit subcommittee of a board finance committee, this performance subcommittee digs into the “weeds” of quality and safety performance, analyzing issues and making recommendations to the full quality committee. This strategy frees up discussion time at the full committee meeting.<sup>66</sup> Prior to creating this subcommittee, the full committee met for four and a half hours each quarter, which proved too long to ensure a productive meeting.<sup>67</sup>

**Agenda and Reporting:** Prior to each meeting, the entity presidents and the director of the Armstrong Institute (currently Dr. Pronovost) hold a conference call to identify topics of concern. After that call, the committee chair and the director of the Armstrong Institute discuss what the board members on the quality committee would most like to discuss at the meeting. Based on those discussions, a formal agenda is put together. The typical meeting includes brief presentations from two entity presidents. The JHM Patient Safety and Quality Board Committee requires that a standard format be used, known as MD&A (which stands for management, discussion, and analysis). Each report includes both qualitative and quantitative information related to performance, providing a vehicle to discuss opportunities to do better. Used by all departments throughout JHM, the standardized MD&A template is summarized briefly below:

- **Patient safety/internal risk:** An overview of the entity's greatest risks and steps being taken to address them.
- **Externally reported measures:** An overview of one or two high-priority externally reported measures where performance is not meeting target, along with any other externally reported measures where performance is not meeting target.



66 P.J. Pronovost, et al., May 2015.

67 Interview with Peter Pronovost, M.D. and Michael Armstrong, Johns Hopkins Medicine, July 10, 2015.

- **Patient experience:** An overview of three patient experience domains not meeting target.
- **Enhancing value:** An overview of cost-reduction efforts that maintain or improve quality.
- **Shared learning:** Sharing of lessons learned (including identification of something implemented at the local level in which leaders take great pride) and a discussion of needed support at the health system level.

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“Quality committee meetings are not just ‘rah-rah’ sessions, but rather a vehicle to discuss opportunities to do better.”

—C. Michael Armstrong, Chair, JHM Patient Safety and Quality Board Committee

## Mission Health

### Background

Based in Asheville, NC, Mission Health operates six hospitals, including Mission Hospital (a 795-bed flagship facility), along with numerous outpatient and surgery centers, a post-acute care provider, and the region’s only dedicated Level II trauma center. Over a decade ago, the Mission Health board created a robust quality committee that is the most active of any board committee. The committee acts as the board quality committee both for Mission Health and Mission Hospital.

### Charter and Scope of Board Quality Committee

The board quality committee plays a central role in shaping and approving the annual organizational improvement plan, which lays out the QI priorities for the upcoming year in each of five key areas identified by the full board as important: outcomes, waste/efficiency, safety, patient satisfaction, and organizational learning. Senior management takes the lead in developing the plan, with the board quality committee working with these leaders to develop priority areas and associated performance goals. The committee formally assesses the plan, works with management to revise it as appropriate, and then sends a recommended plan to the full board for final approval. The performance metrics and targets included in the plan tie into the incentive compensation plan for senior executives and management.

### Committee Size and Composition

The committee includes six members of the Mission Health board (out of 19 total board members) along with a number of others not on the board, particularly physicians who have other responsibilities related to quality and safety. All committee members have the right to vote on any formal actions taken by the committee.

Five of the six board members who serve on the quality committee are physicians, including four practicing physicians and the chief executive officer (CEO) of the health system, who is an *ex officio* member of the board. The sixth board member is a community representative with a background in engineering. Non-board members who serve on the board quality committee tend to be physicians with responsibility for quality and safety elsewhere in the organization. To encourage greater levels of integration across the system, the board quality committee also invites relevant stakeholders to be “visitors” at committee meetings, including the chairs of the board quality committees at all affiliated hospitals. Senior clinicians and administrators, including the CMO, CNO, chief quality officer, and other front-line leaders, generally attend board quality committee meetings, playing a leadership role in identifying specific QI opportunities, appropriate goals for each of these opportunities, and accompanying metrics and monitoring systems to gauge progress toward achieving them. As with the full board, committee members focus on asking the right questions and making sure the organization has the resources it needs to succeed.<sup>68</sup> To encourage further input, the board quality committee held a special meeting to identify the strengths and needs of various stakeholders; this meeting highlighted the need for greater system support for local hospitals in the area of risk analyses.

### Meeting Frequency, Agenda, and Other Logistics

**Frequency:** The quality committee meets every other month for approximately one and a half to two hours. The full Mission Health system board holds meetings on a quarterly basis, along with seven additional less formal meetings, known as “fireside chats.”

**Agenda and Reporting:** Each board quality committee meeting follows a standard agenda. After a review of the previous meeting and approval of the minutes from that meeting, the first substantive portion focuses on one of the four key priority areas included in the dashboard—outcomes, waste/efficiency, safety, and patient satisfaction. For example, the June 2015 meeting included a 20-minute panel with patients who shared their ideas about how the health system could improve the patient experience. Other standard sections of the meeting include the following:

- **Discussion and dialogue about safety events, including sentinel events:** The hospital-based quality oversight committee submits a regular report to the board quality committee that describes every safety event, root-cause analysis (RCA) from that event, and what actions have been taken to address the problem(s) that led to the event. Discussion tends to focus on those rare events where follow-up action or continued monitoring is required.
- **Review of the performance dashboard:** The focus tends to be on issues where performance has been lagging over a period of time. For example, concerns recently arose

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among committee members about levels of patient satisfaction in the Mission Hospital ED, the busiest ED in the Carolinas. While Mission is building a new ED that will address this issue over the long term, short-term issues remain, including long waiting times to get admitted to the hospital. Discussion of the issue uncovered the root cause of the problem—the failure to clean rooms promptly after patient discharge. Consequently, to stimulate improvement, the board quality committee has been monitoring performance on room cleaning and ED boarding times.

Regular performance reports monitor progress toward established targets for each of the priority areas. The board quality committee receives more detailed information than does the full board, with the quality committee generally deciding what the full board needs to see. Reports come out at least a week before meetings so as to ensure that both the quality committee and the full board have ample time for discussion.

**Interactions with the Full Board:** The Mission Health board receives the full minutes from each board quality committee meeting as part of its standard packet. During each quality committee meeting, members discuss what issues should likely flow up to the full board for discussion, with the committee chair making the final call on which issues to include in the formal committee presentation to the board, which typically takes up roughly 15 to 20 minutes of the full board meeting.

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### Separate Credentialing Committee

Several members of the Mission Health board quality committee serve on a separate credentialing committee that has, over time, begun to function as a system-wide committee, ensuring consistency across hospitals and ambulatory sites on the best-practice standards to be used for granting privileges. The various hospital boards have delegated final approval of credentialing activities to this committee.

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## KishHealth System

### Background

Based in DeKalb, IL, KishHealth System is a community-owned health system with facilities in DeKalb, Sandwich, Sycamore, Plano, Genoa, Hampshire, Waterman, and Rochelle. The system has two hospitals: Kishwaukee Hospital, located in DeKalb, a 98-bed replacement facility that opened in October 2007, and Valley West Hospital, a critical access hospital in Sandwich that became part of the system in 1998. In addition to offering a full array of inpatient services at its two hospitals, the health system owns a multi-specialty practice with over 40 healthcare

providers in several locations and offers hospice, home health, and behavioral health services.

### Charter and Scope of Board Quality Committee

The full KishHealth board established the board Quality and Credentialing Committee (QCC) in 2007. As its name implies, the QCC has two primary tasks: to monitor, oversee, and promote quality of care throughout the system, and to oversee the credentialing of physicians. In this first role, the committee spends much of its time sifting through data from throughout the health system to evaluate performance versus established targets on a dashboard of key quality indicators, with performance reviewed on a monthly basis to make sure that goals are being met.

### Committee Size and Composition

Five of the 13 members on the full KishHealth System board of directors serve on the QCC, including the system CEO (who is a full voting member of the board). These five board members comprise a majority of the nine individuals who serve on the committee, with other members being the chief of staff at each of the two hospitals and the system CMO and CNO. All QCC members have the right to vote on any formal recommendations to come out of the committee, with the CNO having been given voting privileges relatively recently. A board member generally serves as the chair of QCC. In most cases, the board chair and system CEO make recommendations as to who should chair and serve on the QCC. These decisions are informed by interviews conducted by the board chair with each board member to discuss individual strengths and interests.

### Meeting Frequency, Agenda, and Other Logistics

**Frequency:** The QCC meets every month for approximately one hour, on the Monday before the monthly meeting of the full board, which takes place on a Wednesday.

**Agenda and Reporting:** While a portion of the agenda during some months is taken up by routine credentialing activities, the bulk of most QCC meetings focus on a review of performance against a dashboard of quality and patient safety metrics. The CMO and his team have established a matrix that lays out a schedule of which components of quality and patient safety should be reviewed by the QCC each month, including which dashboard measures should garner particular attention. As necessary, each meeting also includes a review of any current or past sentinel events, with a focus on how issues identified in the RCA are being addressed. (Whenever a sentinel event occurs, a formal process commences that includes immediate notification of the system risk manager, the QCC chair, and the CEO; the initiation of an RCA to identify the underlying cause(s); and the development of plans to address the identified causes, such as policy changes or staff/physician education.)

In those cases where performance may be below target, the QCC will spend time brainstorming how to address the issue. For example, recent data highlighted an opportunity to improve patient satisfaction scores, particularly in the area of communication between patients and physicians/staff. Subsequent

discussions by the QCC identified daily patient rounding as a strategy to improve performance. The CEO and management team have worked to implement this practice, and scores have begun to improve in some areas. QCC members recognize that it will take longer (roughly 10 months) before widespread improvement occurs, and consequently they continue to monitor performance closely and will insist on additional changes if necessary in order to reach established targets.

In addition to time spent reviewing performance, the typical QCC meeting also includes a brief review and update on the system's major quality initiatives.

**Education and Training:** QCC members regularly participate in educational activities related to quality, at an intensity level greater than that provided to the full board. Representative topics include briefings on the just-culture concept, the Medicare PQRS, value-based purchasing, preventable readmissions, and data collection and reporting. The CMO and CNO generally present these topics, with other internal staff brought in as needed. For example, the system's risk manager led a session on just culture while the director of quality conducted a review of PQRS.

**Interactions with the Full Board and Senior/Clinical Management:** The minutes and recommendations from each QCC meeting generally become part of the consent agenda for that

month's full board meeting. In addition, the full board meeting typically includes a presentation and discussion related to one priority item from that month's QCC meeting. In total, the quality component of the full board meeting typically takes at least 15 minutes and sometimes can last for 30 minutes or longer. (Full board meetings generally last roughly two hours.)

The QCC regularly interacts with senior clinical and administrative leaders within KishHealth. Four years ago, KishHealth created the Physician Quality Cabinet (PQC), a multi-specialty group of eight physicians from different specialties who work to move the system forward on quality and QI. The PQC and QCC regularly interact and work together to promote QI. For example, the CMO chairs the PQC and also sits on the QCC; in addition, a board member who sits on the QCC also participates on the PQC.

Several years ago, KishHealth created a "dyad" approach to managing different departments. At the system level, the CMO and CNO work together as a dyad. The same approach is being used in various departments, with a physician leader being paired with a non-physician clinical lead in the ED, anesthesia, radiology, obstetrics, and cardiology. The CMO-CNO dyad hosts monthly meetings with these department dyads to review QI initiatives, patient complaints, and other related issues. These efforts then "role up" to the PQC and the QCC.

