SVHCD QUALITY COMMITTEE
AGENDA
WEDNESDAY, September 25, 2019
5:00 p.m. Regular Session
(Closed Session will be held upon adjournment of the Regular Session)

Location: Schantz Conference Room
Sonoma Valley Hospital – 347 Andrieux Street, Sonoma CA 95476

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to attend a Quality Committee meeting, please contact the District Clerk, Stacey Finn, at sfinn@sonomavalleyhospital.org or 707.935.5004 at least 48 hours prior to the meeting.		
MISSION STATEMENT The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.		
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less, Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.*	*Hirsch*	
3. CONSENT CALENDAR • Minutes 08.28.19	*Hirsch*	Action
4. POLICIES AND PROCEDURES	*Jones*	Inform
5. QUALITY DASHBOARD	*Jones*	Inform
6. QUALITY WORK GUIDE • Proposed revision of the Quality Agenda	*Jones*	Inform/Action
7. CLOSED SESSION: a. Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Hirsch*	Inform
8. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
9. ADJOURN	*Hirsch*	

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
August 28, 2019 5:00 PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Cathy Webber Susan Idell Carol Snyder Michael Mainardi, MD Ingrid Sheets		Howard Eisenstark, MD	Danielle Jones, RN Director of Quality and Risk Sabrina Kidd, MD CMO Mark Kobe, RN CNO

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	5:02 pm	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR		Action
• QC Minutes, 07.24.19		**MOTION:** by Webber to approve, 2nd by Snyder . All in favor.
4. ANNUAL RISK MANAGEMENT REPORT	*D. Jones*	
	Ms. Jones reviewed the annual risk management and patient safety report for fiscal year 2019. This included dept. accreditations, physician peer review process revision, patient safety survey, and event reporting to CHPSO, education, Midas risk/patient relations committee, claims reports, good catches and work place violence training. The status of the goals from fiscal year 2019 were as follows: • Investigate IHI framework for improving joy in work – goal met.	

AGENDA ITEM	DISCUSSION	ACTION
	• Communicate department specific data related to patient safety and patient relations event reporting. Goal met by creation of SBAR for event reporting. • Refocus on management of patient relations including the complaint and grievance process- goal met by establishment of monthly multidisciplinary committee • Process improvement related to Good Catch investigation and review – goal met by the update of the internal process for review and creation of a quarterly report for staff and leadership communication. • Align event types with national patient safety reporting best practice and standard formats. Goal met • Provide at least one training in risk mitigation for leaders – goal met by providing BETA onsite education. Ms. Jones reported that the fiscal year 2020 goals are: • Train new leadership in e-notifications and complaint/grievance process • Provide training in risk mitigation for leaders • Create risk management STATIT indicators for real time process control • Develop "Make the Call for Safety" a voicemail system that allows staff, visitors and family to report unexpected events or good catches.	
5. BOARD QUALITY REVIEW	*D. Jones*	
	Ms. Jones spoke about the structure and format of the committee. There will be an information on other quality programs emailed out for the committee to review and respond to.	
8. CEO DASHBOARD	*D. Jones*	
	Ms. Jones reviewed the CEO dashboard.	
9. POLICIES AND PROCEDURES	*Jones*	

AGENDA ITEM	DISCUSSION	ACTION
NEW CAIR Utilization PC8610-188 Continuity of Operations Plan (COOP) EP8610-107 **REVISIONS:** Aggressive Behavior Management – Code Grey CE8610-102 Prevention of Surgical Site Infections IC8610-132 **DEPARTMENTAL** **RETIRE:** A Woman's Place Policies - TOC	Ms. Jones reviewed the new policies and the previous policy revisions.	**MOTION**: by Mainardi to approve 2nd by Sheets. All in favor.
10. CLOSED SESSION	*Hirsch*	
	Called to order at 5:47 pm	
11. REPORT OF CLOSED SESSION	*Hirsch*	
	Medical Staff credentialing was reviewed. Ms. Jones gave a brief note on a reportable event.	**MOTION:** by Mainardi to approve credentialing, 2nd by Sheets. All in favor.
12. ADJOURN	*Hirsch*	
	5:53pm	

Policy and Procedures – Summary of Changes
Board Quality Committee, September 25th, 2019

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

ORGANIZATIONAL

REVISIONS:

Injury Due to Medical Device Equipment CE8610-150
Revision includes formatting and responsibility title changes and adding regulation language from FDA website "User facilities must report a suspected medical device-related death to both the FDA and the manufacturer on Form FDA3500A within 10 work days of becoming aware. User facilities must report a medical device-related serious injury to the manufacturer, or to the FDA only on Form FDA3500A if the medical device manufacturer is unknown."

DEPARTMENTAL

SURGERY DEPARTMENT
REVISIONS:

Pre-Operative Skin Preparation of Patients 7420-142
Updated policy according to AORN current guidelines to cover detail missing from current policy that is part of our practice.

Quality View: Quality Committee SVHBOD

Status	Indicator	Current Value	Target	SPC Alert	Updated
Quality > Autopsies Mortalities					
▼	Acute Care Mortality Rate (M)	0.0%	n/a		Sep 2019
▼	DV Acute Care - Risk-adjusted Mortality_ OE Ratio (M)	0.00	n/a		Sep 2019
Quality > Core Measures					
★ ▲	Core ED-2b - Admit Decision Time to ED Departure Time - Reporting Measure (M)	152.12	160.00		Jul 2019
✕ ▼	Core OP-18b - Mean Time ED Arrival to ED Departure - Reporting Measure (M)	188.36	134.00		Jul 2019
✕ ▼	Core OP-23 - Head CT/MRI Results for STK Pts w/in 45 Min of Arrival (M)	50.0%	100.0%		Jun 2019
▽ ▲	Core OP29/ASC9 - Colonoscopy:F/U for Avg Risk Pts (M)	76.9%	90.0%		Jun 2019
Quality > Core Measures > Sepsis					
★ ▲	Core SEPa - Early Management , Severe Sepsis 3 Hour Bundle (M)	100.0%	100.0%		Aug 2019
★ ▲	Core SEPd - Septic Shock 6 Hour Bundle (M)	100.0%	100.0%		Jul 2019
▽ —	SEP1aa - severe sepsis - initial lactate management not in 3hr (M)	1	0		Dec 2017
▽ ▲	SEP1ab - severe sepsis - broad spectrum antibiotic not in 3hr (M)	2	0		Mar 2019
▽ —	SEP1ac - severe sepsis - blood cultures not in 3hr (M)	1	0		Jul 2019
▽ —	SEP1da - septic shock - vasopressors not in 6hr (M)	1	0		Feb 2019
Quality > Core Measures > Stroke					
★ —	Core STK-4-Thrombolytic Therapy (M)	100.0%	100.0%		Jul 2019
Quality > Patient Safety					
▽ —	Sentinel Events (M) volume	1	0		Aug 2019
Quality > Patient Safety > CMS HAC Reduction					
★ —	Catheter Associated UTI - Per 1000 ACA (M)	0.00	0.00		Aug 2019
★ —	Infection from Central Venous Catheter - Per 1000 ACA (M)	0.00	0.00		Aug 2019
★ —	Poor Glycemic Control - Per 1000 ACA (M)	0.00	0.00		Aug 2019
★ —	Pressure Ulcers, NPOA, All Stages - Per 1000 ACA (M)	0.00	0.00		Aug 2019
★ —	Pressure Ulcers, NPOA, Stages III and IV - Per 1000 ACA (M)	0.00	0.00		Aug 2019
★ —	Surgical Site Infections, Bariatric - Per 1000 ACA (M)	0.00	0.00		Aug 2019
★ —	Surgical Site Infections, CIED - Per 1000 ACA (M)	0.00	0.00		Aug 2019
★ —	Surgical Site Infections, Orthopedic - Per 1000 ACA (M)	0.00	0.00		Aug 2019
Quality > Patient Safety > Coded Complications of Care					
★ —	Air Embolism NPOA - Per 1000 ACA (M)	0.00	0.00		Sep 2019
★ —	DVT/PE, Orthopedic, NPOA - Per 1000 Inpatients w/ Total Knee/Hip Replacement (M)	0.00	0.00		Sep 2019
★ —	Iatrogenic Pneumothorax NPOA - Per 1000 ACA (M)	0.00	0.00		Sep 2019
★ —	Iatrogenic Pulmonary Embolus NPOA - Per 1000 ACA (M)	0.00	0.00		Sep 2019
★ —	Retained Foreign Body NPOA- Per 1000 ACA (M)	0.00	0.00		Sep 2019
★ —	Transfusion Reaction, all types NPOA- Per 1000 ACA (M)	0.00	0.00		Sep 2019

Quality > Patient Safety > Coded Complications of Care					
★ —	Air Embolism NPOA - Per 1000 ACA (M)	0.00	0.00		Sep 2019
★ —	DVT/PE, Orthopedic, NPOA - Per 1000 Inpatients w/ Total Knee/Hip Replacement (M)	0.00	0.00		Sep 2019
★ —	Iatrogenic Pneumothorax NPOA - Per 1000 ACA (M)	0.00	0.00		Sep 2019
★ —	Iatrogenic Pulmonary Embolus NPOA - Per 1000 ACA (M)	0.00	0.00		Sep 2019
★ —	Retained Foreign Body NPOA- Per 1000 ACA (M)	0.00	0.00		Sep 2019
★ —	Transfusion Reaction, all types NPOA- Per 1000 ACA (M)	0.00	0.00		Sep 2019
Quality > Patient Safety > Falls					
✗ ▲	RM ACUTE FALL- All (M) per 1000 patient days	3.72	0.00		Jul 2019
✗ ▲	RM ACUTE FALL- WITH INJURY (M) per 1000 patient days	3.72	0.00		Jul 2019
Quality > Readmissions					
★ ▲	07-DV Inpatients - Percent Readmit to Acute Care within 07 Days (M)	3.2%	8.0%		Sep 2019
★ ▲	14-DV Inpatients - Percent Readmit to Acute Care within 14 Days (M)	3.2%	8.0%		Sep 2019
★ ▲	30-DV Inpatients - Percent Readmit to Acute Care within 30 Days (M)	3.2%	8.0%		Sep 2019
★ ▼	All Payer - Risk-adjusted 30-Day Readmissions O/E Ratio (M)	0.00	0.00		Sep 2019
★ —	AMI, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	0%		May 2019
★ —	COPD, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	0%		Sep 2019
★ —	HF, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	0%		Aug 2019
★ ▼	Medicine, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	0%		Sep 2019
★ —	PNA, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	0%		Sep 2019
★ —	Sepsis, Any Diagnosis - % Readmit within 30 Days (M)	0%	0%		Aug 2019
★ ▼	Surgery, CMS Readm Rdctn -% Readmit within 30 Days_ ACA |M|	0.0%	8.0%		Sep 2019
★ ▼	TJP, CMS Readm Rdctn - % Readmit within 30 Days, ACA (M)	0%	0%		Sep 2019

Status Legend

- ★ The most recent period meets or exceeds the Target
- ▽ The most recent period is between the Target and Alarm
- ✗ The most recent period violates the Target (and Alarm if applicable)
- ▲ The current value increased signifying improvement from the previous period
- ▲ The current value increased signifying deterioration from the previous period
- ▼ The current value decreased signifying deterioration from the previous period
- ▼ The current value decreased signifying improvement from the previous period
- — The current value did not change from the previous period
- ☑ The indicator has not been validated
- ✓ The indicator has been validated
- The indicator is public
- The indicator is private

SPC Alert Legend

- Most recent period is below Lower Control Limit
- Most recent period is above Upper Control Limit
- Process shift: Most recent 8 periods are all above the Center Line
- Process shift: Most recent 8 periods are all below the Center Line
- Most recent 6 periods are all increasing
- Most recent 6 periods are all decreasing

Green border: The alert is in a positive direction
Red border: The alert is in a negative direction
No border: There is no target direction for the indicator

Hospital Quality Institute

Leadership in quality and patient safety

CEO, Leader, and Governance

Quality Work Guide

1215 K Street, Suite 800, Sacramento, CA 95814 | www.hqinstitute.org
(916) 552-7600 | info@hqinstitute.org

Quality Work Guide

For CEO & Board Governance

From: Julie Morath, RN, MS, President/CEO

Hospital Quality Institute (HQI) is pleased to provide these materials for your review and use. These materials are intended to provide guidance in the development of a system of continued improvement and safety system for an organization, specifically focused on executive and governance oversight. The materials provide examples or a template that an organization can adapt for its use to fulfill Quality and Patient Safety requirements.

HQI Blueprint for Advancing Quality and Patient Safety

California Hospital Patient Safety Organization Membership Brochure

"Becoming a Patient Safety Organization" by Rory Jaffe, MD, MBA, Executive Director of CHPSO; Published in the AHRQ *Perspective*, July 2011.

HQI Improvement Pocket Guide: DMAIC

Board Leadership: A Driver of Health Care Quality

Quality as a System

Questions a Board Needs to Ask

Example: Quality and Patient Safety Committee Charter

Example: Operational Quality and Patient Safety Performance Improvement Plan (QAPI)

Example: Quality and Patient Safety Accountability and Reporting Flows

Cascade of Alignment: Connecting the Dots of Specific Initiatives to Overarching Quality and Patient Safety Aims to Move the Dial for Better Care

Governance and Board Readiness Assessments

We look forward to working with you as you develop your quality improvement and patient safety plan. For editable/electronic files, please contact HQI at HQIOperations@HQInstitute.org or (916) 552-7600.

Board Leadership:
A Driver of Health Care Quality

The Developing Requirements and How to Meet Them

The purpose of this brief is to provide an overview of the evolving role and expectations for hospital Boards in achieving higher levels of clinical quality and patient safety.

Situation

It is well established that hospital governing Boards have responsibility for the quality of care provided in their institutions.[1] Historically, how Boards fulfilled this responsibility has been open to interpretation and varying practices. In recent years, the changing social, political and economic environment has led to a new era of publicly reported comparative quality measures, transparency, and new reimbursement models that reward performance. The role of hospital Boards in assuring quality of care in this context is more focused that ever before.[2] A challenge in meeting these evolving expectations was framed in a recent study that raised questions about whether hospital Boards are sufficiently educated about and engaged in oversight of quality.[3] Hospital Boards that have met this challenge, however, demonstrate great positive impact on institutional and patient outcomes.

Background

Momentous events occurred during the course of the last decade that are an impetus for today's heightened expectation that hospital Boards exercise active oversight of the quality of care delivered by their organizations. First, the Institute of Medicine (IOM) published two seminal reports, *To Error is Human*[4] and *Crossing the Quality Chasm*[5], in 2001 and 2002, respectively. These reports documented the serious and pervasive nature of the nation's overall quality problem, finding nearly 100,000 deaths per year from medical errors, as well as systemic failure to provide evidence-based care nearly half of the time. Second, concurrent with the release of the IOM reports, the for-profit business sector experienced a series of ruinous accounting fraud scandals leading to the bankruptcies of Enron and WorldCom, and the related demise of Arthur Anderson. Additionally, the notorious $1.3 billion bankruptcy of the Allegheny Health, Education and Research Foundation reverberated with many of the issues

Key Points

- Engaged Boards improve quality outcomes
- The nation has a serious quality and patient safety problem
- There are new expectations for governance oversight of quality
- Quality is at the center of healthcare reform
- Best practices for Boards are available

demonstrated by the infamous commercial failures, but within non-profit healthcare. These examples mark unconscionable lapses in corporate integrity and governance oversight leading to an increased scrutiny of Boards and higher standards of accountability. In 2002, Congress responded by passing the Sarbanes-Oxley legislation which introduced major changes to the regulation of corporate governance and public finance.[6] While charitable organizations are largely not covered by its provisions, the law has affected and strengthened Board practices in not-for-profit organizations. Some predict, however, that a direct ". . . Sarbanes-Oxley for quality is around the corner."[7] Third, while many aspects of the US healthcare system are exceptionally advanced, the care provided is too often unsafe and inefficient. Exacerbating the patient safety issues are federal forecasts that predict US healthcare spending will exceed $4.1 billion by 2016, representing 20% of the gross national product.[8] In response to the demand for better quality, patient safety, and cost efficiency, policy leaders and patient organizations have called governing Boards to enhance their oversight function on quality of care. In March 2010 Congress passed the Patient Protection and Affordable Care Act[9] which addressed multiple changes to the current healthcare delivery system. Payors are moving into value-based purchasing models using financial incentives targeted at providers, consumers, or both, linked to measures of health care quality and efficiency.

These events usher in a new era of accountability for health system Boards. The change is welcomed as evidence shows that highly engaged Boards focused on quality of care can impact outcomes in very positive ways.

Assessment

Boards face important new issues related to how quality of care affects matters of reimbursement and payment, efficiency, cost controls, and collaboration between organizational providers and individual and group practitioners. "These new issues are so critical to the operation of health care organizations that they require attention and oversight, as a matter of fiduciary obligation, by the governing Board."[10]

Historically, Boards delegated to medical staff and management the operational responsibility for safe care. Hospital Boards are beginning to realize that they can no longer regard the quality and safety of care in the hospital as the sole responsibility of the doctors, nurses and executives. Even though most hospital Board members are not clinically trained, they are nevertheless ultimately responsible for everything that goes on in the hospital, including the quality of clinical care.[11] Training in quality principles and methods, as well as attuned organizational structures and processes are critical to enable Board effectiveness.

Recent studies show that the majority of hospital Boards are not prepared to meet the new level of expectations and accountabilities for quality of care. In a national survey of Board chairs, a study conducted by researchers at the Harvard School of Public Health found that fewer than half of the Boards rated quality of care as one of their top two priorities. Few reported receiving training in quality. Moreover, using publically reported quality data, the researchers assessed Board engagement relative to high-performing and low-performing hospitals. They identified large differences in Board activities and engagement between high-performing and low performing hospitals. Highly engaged and trained Boards who exercised active oversight of quality realized significantly higher quality performance.[12]

Recommendations

Many excellent resources are available to suggest potential strategies to support Boards in meeting their oversight of quality.[13] Most of these resources share common themes in their recommendations. A succinct statement of recommended Board activities was advanced in a recent study by researchers at the Johns Hopkins Quality and Safety Research Group.[14] The recommendations include:

1. Boards should have a separate quality and patient safety committee that meets regularly and reports to the full Board. Evidence suggests Boards with such a committee spend more time on improvement activities, and their hospitals may have better outcomes.

2. Boards should ensure the existence and annual review of a written quality improvement and patient safety plan that reflects systems thinking, contains valid empirical measures of performance, and is consistent with national, regional, and institutional quality and safety goals.

3. Boards should have an auditing mechanism for quality and safety data, just as they do for financial data. While data quality control principles apply to clinical research and apply to financial data through generally accepted accounting principles, data quality in measuring quality and patient safety has received little to no attention in most health-care organizations.

4. Boards should routinely hear stories of harm that occurred at the hospital, putting a face on the problem of quality and patient safety. Stories may be case reviews presented by staff or interactions with patients or families who suffered harm.

5. In conjunction with the CEO and medical staff leaders, boards should identify specific, measurable, valid quality indicators consistent with strategic goals and hospital services, and review performance against the indicators no less than quarterly. Such review should include:

    a. Regular quantitative measurement against benchmarks;
    b. Reported compliance with rigorous data quality standards;
    c. Performance transparency;
        i. Weekly or monthly reports of harm;
        ii. Sentinel event and claims review for quality and safety problems;
    d. Methods for active intervention to improve care;
        i. Survey of quality and safety culture;
        ii. Use of survey results to shape improvement efforts;
        iii. Routine mechanism to tap the wisdom of bedside caregivers.

[1] Lister E, Cameron DL. The role of the Board in assuming quality and driving major change initatives – part 1: maintaining organizational integrity. *Group Practice Journal*. 2001;50:13-20.

[2] Miller TE, Gutmann VL, "Changing expectations for Board oversight of healthcare quality: the emerging paradigm," *J Health Life Sci Law 2009 Jul;2(4):31, 33-77.*

[3] Jha, A and Epstein, A, "Hospital Governance and the Quality of Care," *Health Affairs 29 (1):182-187*.

[4] To Err is Human: Building a Safer Health System (2000), Institute of Medicine

[5] In Crossing the Quality Chasm: A New Health System for the 221st Century (2001), the Institute of Medicine (IOM) identifies six aims of the healthcare quality system: that it should be safe, effective, efficient, timely, patient centered, and equitable.

[6] Sarbanes-Oxley Act of 2002, PL 107-204, 116 Stat 745

[7] Nash DB, Medical Executive Post, March 9, 2008. See also, Royo MB, Nash DB. 2008. "Sarbanes-Oxley and Not-for-Profit Hospitals: Current Issues and Future Prospects," *American Journal of Medical Quality*, 23(1):70-72

[8] Poisal JA, et al, "Health Spending Projections Through 2016: Modest Changes Obsure Part D's Impact," Health Affairs 26 (2):w242-w253 (2007)

[9] Patient Protection and Affordable Care Act, PL 111- 148

[10] Callendar et al, Corporate Responsibility and Health Care Quality: A Resource for Health for Health Care Boards of Directors, American Health Lawyers Association, 2007

[11] National Quality Forum, Hospital Governing Boards and Quality of Care: A Call to Responsibility, 2004

[12] Jha, A and Epstein, A, "Hospital Governance and the Quality of Care," *Health Affairs 29 (1):182-187*.

See also, Carlow DR, "Can Healthcare Boards Really Make a Difference in Quality and Safety?" Law & Governance, 13(8) 2010;

Jaing JH, "Enhancing Board Oversight on Quality of Hospital Care: An Agency Theory Perspective," AHRQ, 2011

[13] See:
Governance Certification for Tennessee Hospital Trustees and Boards, Tennessee Hospital Association, 2006;
Competency-Based Governance Enters the Health Care Boardroom, The American Hospital Association's Center for Healthcare Governance, 2010;
Hospital Governing Boards and Quality of Care: A Call to Responsibility, National Quality Forum, 2004;
Great Boards: Promoting Excellence in Health Care Governance, The American Hospital Association;
Reinertsen, JL, Hospital Boards and Clinical Quality: A Practical Guide, Ontario Hospital Association, 2007;
Conway J, Getting Boards on Board: Engaging Governing Boards in Quality and Safety, The Joint Commission Journal on Quality and Patient Safety, Volume 34 Number 8, April 2008

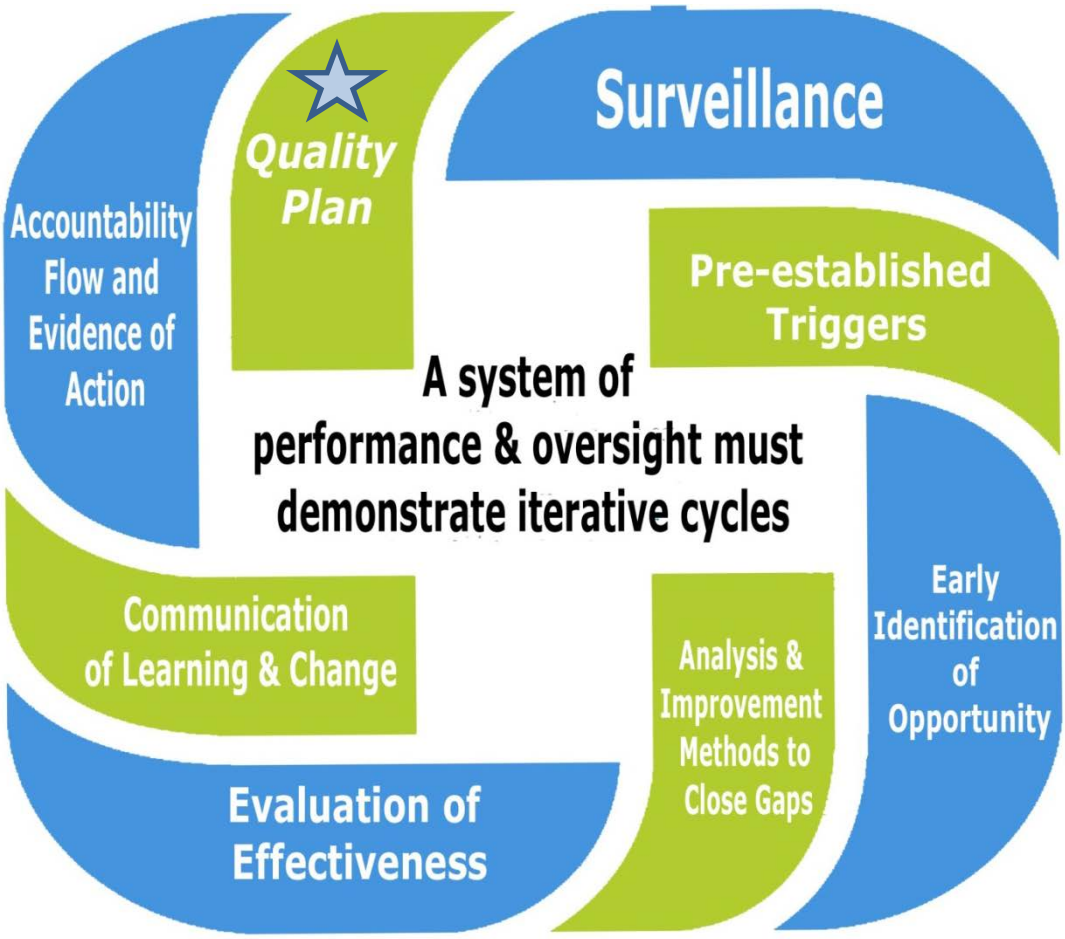
[14] Goeschel CA, Wachter RM, Pronovost PJ, "Responsibility for Quality Improvement and Patient Safety: Hospital Board and Medical Staff Leadership Challenges," Chest 2010;138;171-178

Quality and Safety as a System:

Escalation of Concern When Complaint or Failure is Evaluated:

1. Is this an ISOLATED Event?
2. Is there a PATTERN of failure(s) in this area?
3. Are there organizational SYSTEMIC ISSUE(s) related to quality performance and oversight?

A system of performance and oversight must demonstrate iterative cycles of:



Governance Oversight of Quality

Key Questions for Boards

1. Is there a systemic view for strategy, e.g. planning process and strategic plan?
2. Are there measures that answer whether or not strategy is advancing, i.e.: Is care getting better or worse?
3. How were the measures selected? What are the criteria?
4. Are there contexted measures and metrics? For example:
   - upper/lower control limits if appropriate
   - target
   - actual absolute numbers, not percentages; or both
   - comparison to history and targets
5. Is there a coordinated process? Is there conformance and predictability in presentations, data displays, etc.?
6. Is the focus on the core product(s) of clinical care, such as core measures, eliminating harm, other specific and relevant topics?
7. Can all staff leaders answer the following questions?
   - how does “this” compare to past?
   - how does “this” compare to best-of-class?
   - what are we doing to improve and close the performance gap?
   - what can we predict from what we know?
   - what might be unintended consequences of our improvement efforts?
8. What is the relevance to the front line caregivers and providers? Where is street level example that ties “front office to front line?”

Quality and Patient Safety Committee

[ORGANIZATION]

Organization and Policy Statement

The Quality and Patient Safety Committee (Committee) is responsible for guiding and assisting the Executive Leaders, Medical Board, and the Governing Board in fulfilling their responsibility to oversee safety, quality, and effectiveness of care at [ORGANIZATION]; and to meet or exceed standards and regulations that govern health care organizations.

Responsibilities

The Committee has three broad sets of responsibilities. The first is to directly oversee that quality assurance and improvement processes are in place and operating in the hospital and clinics. The second is to enhance quality across and throughout the technical, patient care, and operations of the [ORGANIZATION]. The latter encompasses all aspects of the interface and experience between patients, families, and the community. This also includes coordination and alignment within the organization. The third is to assure continual learning and skills development for risk surveillance, prevention, and continual improvement.

The committee tests all activities against the Institute of Medicine's Six Aims for Improvement: safe, effective, patient[/family]-centered, efficient, timely, and equitable. These aims are the drivers to the Triple Aim: Better Care, Better Health, Lower Cost.

In fulfilling these responsibilities, the committee expressly relies on the confidential protections afforded by law to review activities conducted for the purpose of reducing mortality, morbidity and improving the care provided to patients.

A. Oversight

As the governing body, the Governance Board is charged by law and by accrediting and regulatory organizations (e.g., The Joint Commission [TJC]) with insuring the quality of care rendered by hospital and clinics through its various divisions and departments. To help meet this responsibility, the Quality Committee exists to:

- Develop the quality goals and blueprint (priorities and strategies) for [ORGANIZATION], using an inclusive and data driven-process.
- Review and monitor patient safety, risk mitigation, quality assurance, and improvement plans and progress.
- Have the authority to initiate inquiries, studies, and investigations within the purview of duties assigned to the Committee.
- Perform, on behalf of the Governance Board and Medical Leadership, such other activities as are required by the TJC, Centers for Medicaid and Medicare Services (CMS), National Committee for Quality Assurance (NCQA) and other external accrediting and regulatory bodies.
- Perform such other activities as requested by the Executive Leadership of [ORGANIZATION].

- Render reports and recommendations to the Executive Leadership Committee of [ORGANIZATION], and Medical Board on its activities.
- The Committee has the delegated authority to establish accountability in medical staff and management to assure improvement is occurring and targeted outcomes are achieved.

B. Quality Integration

1. The Committee monitors the quality assurance and improvement activities of [ORGANIZATION]'s entities to enhance the quality of care provided throughout the hospital or medical center system and encourage a consistent standard of care. Monitored activities include but are not limited to: *(List as relevant to the organization)*
2. The Committee assures the coordination and alignment of quality initiatives throughout [ORGANIZATION].
3. The Committee may initiate inquiries and make suggestions for improvement.
4. The Committee conducts annual reviews of the following key areas:
   a. Improvement goal achievement
   b. Clinical outcomes (priorities and improvement)
   c. Patient Safety/Event Analysis/Risk Trending
   d. Culture of Patient Safety
   e. Accreditation and Regulatory Reviews
   f. Environment of Care and Disaster Management plans
5. The Committee monitors the progress of quality assurance and improvement processes and serves as champion of issues concerning quality to other committees.
6. The Committee identifies barriers to improvement for resolution and systematically addresses and eliminates barriers and excuses.

Guidelines

Guidelines are designed to govern the operations of the Committee. They will be developed over time as the Committee functions and performs its responsibilities.

1. Handling of Confidential Documents
   Absent a specific request, confidential documents will not be forwarded to Committee members who have indicated they will not be attending a meeting. Confidential documents will be distributed ahead of meetings with the standard agenda package. They will be separately identified, numbered and logged. They will be collected following review at meetings. A return envelope will be forwarded to Committee members unexpectedly unable to attend a meeting so they will have a convenient method of returning these materials. If sent electronically, appropriate security will be used.
2. Standard Agenda[1]
   The standard Agenda for the council will include:
   - Quality Performance Indicator Set
   - Clinical Priorities (clinical outcomes/process improvement), including: *(List relevant services)*
   - Patient harm

[1] Reports are not made on each agenda item in each meeting.

- Patient safety (adverse event reduction, healthcare acquired infection reduction, risk mitigation)
- Performance to accreditation and regulatory standards and requirements
- Environmental safety and disaster management

Rules

Authority to Act	Yes, within charter and as directed by Executive Leadership and Board
Composition	Medical and Clinical Staff Leadership appointments; Operations, Executive Staff, and Board Members Patient/ Families membership should be considered
Meeting Schedule	Ten meetings per year
Recommend Size:	Based on organization
Quorum Requirement:	Based on organization
Chair	Board Chair or Chief Executive Officer (CEO)
Major Staff Support	Chief Quality and Patient Safety Officer, Quality Staff
Notices Forwarded To	Committee Members, Presenters, CEO, Chief Medical Officer (CMO) and Chief Nursing Officer (CNO)
Non-member attendees	Staff resources as requested Subject matter experts as requested

Summary of Quality and Patient Safety Committee Roles and Responsibility

Provides the operational oversight to assess that quality and its measurement are anchored [ORGANIZATION]'s Vision and Mission; and to assess the ability of [ORGANIZATION] to execute against identified Quality and Safety strategies. The Board is ultimately responsible for the work of [ORGANIZATION] and quality of that work and is assisted by the work of the Quality and Patient Safety Committee.

The Quality and Patient Safety Committee has the following specific responsibilities:

3. Inspiring top-tier outcome performance in all clinical programs.
4. Requiring consistency of purpose in achieving best practice in clinical outcome and safety.
5. Keeping improvement as the focus against the theoretical limits of what is possible: aiming for zero defect care.
6. Evaluating whether or not processes are in place and operating to demonstrate improvement is occurring.
7. Reviewing key initiatives.
8. Requiring measures.
9. Focusing on performance results.
10. Escalating barriers to progress to appropriate forums for resolution.
11. Evaluating if community needs are met, which includes public accountability and regulatory compliance.
12. Leading celebration of gains made.
13. Improving its own methods.

Operational Quality and Patient Safety Performance Improvement Plan

[Organization]

PURPOSE

The purpose of the Quality and Patient Safety Performance Improvement Plan is to improve outcomes of care, establish reliability in delivering care, and advance patient safety, by creating a culture that facilitates:

- Recognition and acknowledgement of risks and adverse events;
- Analysis of reported risks to identify underlying causes and systems changes needed to reduce the likelihood of recurrence;
- Analysis of contributing factors to adverse events and near misses;
- Initiating actions to recover, reduce risk, and prevent recurrence;
- Reporting internally on risk reduction initiatives and their effectiveness;
- Supporting transparency of that knowledge to affect positive change in culture and behavioral changes in health care practice both internally and with other organizations;
- Focusing on processes and systems in a context of Just Culture;
- Prospective review of selected clinical programs or services before an adverse event occurs to identify system design to error proof the system;
- Organizational learning about the epidemiology of error and performance improvement principles and processes;
- Integration of Quality and Patient Safety Improvement priorities into the new design and redesign of all relevant processes, functions and services;
- Systematic planning, analysis and monitoring of performance to improve and sustain advances in processes and outcomes of patient care through interdisciplinary teamwork;
- Regular establishment and reassessment of organizational Quality and Patient Safety Improvement priorities;
- Meeting and exceeding patient / family (customer) needs and expectations;
- Research into ways to improve patient safety and quality;
- Use of evidence-based practice and decision support; and
- Public transparency of reportable performance measures.

The approach to improving quality and patient safety delineated in this plan is based on the [Organization] Quality and Patient Safety Strategy and requires a coordinated and collaborative effort to operationalize. Multiple departments and disciplines are involved in establishing the plans, processes and mechanisms that comprise health care safety and quality activities throughout [ORGANIZATION]. The Quality and Patient Safety Performance Improvement Plan has been developed with broad interdisciplinary input, Quality and Patient

Safety Committees and Forums and is approved by the relevant committees, and Executive and Governance Leadership.

[Organization] endorses the six aims that the Institute of Medicine's (IOM) Advisory Commission on Consumer Protection and Quality in the Health Care Industry delineates in the report, *Crossing the Quality Chasm*. Specifically, health care should be:

- Safe – eliminating injuries 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, inappropriate use, and overuse)
- Patient[/family]-centered – providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide clinical decisions
- Timely – reducing waits and delays for both those who receive care and those who give care
- Efficient – avoiding waste, in particular waste of equipment, supplies, ideas and energy.
- Equitable – providing care that does not vary in quality because of personal characteristics such as gender identity, ethnicity, sexual orientation, geographic location and socioeconomic status.

SCOPE AND ACTIVITIES

This plan applies to all service and sites of care provided at [ORGANIZATION]. The Quality and Patient Safety Performance Improvement Plan establishes a system that includes an ongoing assessment, using internal and external knowledge and experience, to prevent errors and maintain and improve health care safety and quality. [ORGANIZATION] recognizes that patients, physicians and staff, visitors and other customers have the right to expect the best possible clinical outcomes, a safe environment and an error/failure-free care experience. Therefore, [ORGANIZATION] commits to continuously analyzing data, and designing, monitoring, improving and sustaining performance while undertaking a proactive approach to identify and mitigate health care risk and error. The organization responds quickly, effectively, and appropriately when errors occur. We recognize that the patient has the right to be informed of the results of treatments or procedures whenever those results differ from anticipated results. [disclosure]

The Quality and Patient Safety Performance Improvement System, as described in this plan, includes the activities of relevant committees/teams, including, but not limited to:

[list as relevant to organization].

Additional program specifics include:

1. All departments within the organization (patient care and non-patient care departments) are responsible for on-going performance improvement and quality assurance activities. These efforts are monitored through the organizational leadership structure and key indicators are reported via the *Quality Performance Indicator Report*, condition specific dashboards and other methods.
2. All departments within the organization (patient care and non-patient care departments) are responsible to report health care safety events, near-misses, risks and hazards. [ORGANIZATION] has

an event reporting system, to report unexpected events and near misses. Summary data from the event reporting system is aggregated and presented periodically to the Quality and Patient Safety Committee and other appropriate forums that determine further safety (risk reduction) activities as appropriate.

3. The organization selects at least one high-risk safety process for proactive risk assessment (FMEA) annually. This is accomplished through review of internal data reports and reports from external sources (including, but not limited to reports from evidence-based medicine, the Agency for Healthcare Research and Quality (AHRQ), Centers for Medicaid & Medicare Services (CMS) Hospital Compare and other federal and state organizations, The Joint Commission and Current Literature).
4. Upon identification of a medical/health care error, the patient care provider will immediately:
    - Perform necessary health care interventions to protect and support the patient's clinical condition.
    - Perform necessary health care interventions to contain the risk to others, as appropriate to the event.
    - Contact the patient's attending physician and other physicians, as appropriate, to report the event, carrying out any physician orders as necessary.
    - Preserve any information related to events, including physical evidence (e.g., removal and preservation of a blood unit for a suspected transfusion reaction, preservation of IV tubing, fluids bags and/or pumps for a patient with a severe drug reaction from an IV medication, preservation of any medication labels for medications administered to the incorrect patient). Preservation of information includes documenting the facts regarding the event to the immediate supervisor, and to the organization using the event reporting system, and reporting algorithm to Risk Management.
5. An effective Quality and Patient Safety Performance Improvement Plan must exist within an environment of reporting of medical/health care errors and events. [ORGANIZATION] adopts the principles of a Just Culture in management of errors and events. All physicians and staff are expected to report suspected and identified medical/health care errors and should do so without the fear of reprisal in relationship to their employment. [ORGANIZATION] supports the concept that errors occur due to a breakdown in systems and processes, and focuses on improving systems and processes. An accountable, Just Culture approach will be used with involved physicians and staff.
6. Quality and Patient Safety Improvement includes a periodic assessment of patients, families, physicians, and staff perceptions and suggestions for improving patient safety and clinical outcomes.
7. Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, or when the outcomes differ from the anticipated outcomes. Guidelines and training for disclosure are provided through the organization using expert resources.
8. New employee and leadership orientation provides initial education and training, including the need and methods to report, PDSA cycles of improvement, and Quality goals. Training, such as provision of health care through interdisciplinary teamwork, is coordinated throughout the [ORGANIZATION] educational resources. Clinical programs and workshops are identified for an emersion in quality improvement and safety science. Ongoing offerings to managers, leaders, physicians, and staff are provided as well.
9. Medical/health care events, including sentinel events, are reported in accordance with all state, federal and regulatory body rules, laws and requirements.

10. Education and orientation is provided to patients to partner for safety through the admission process and distributed materials. Patient/Family Advisory Committees are engaged to help create strategies and tools for [ORGANIZATION].
11. Systematic feedback is an aim for leaders to recognize staff when they have advanced a safety issue.

EXAMPLE

[Organization can define its own methods]

QUALITY IMPROVEMENT METHODOLOGY

The evaluation, monitoring, and improvement methodology utilized by [ORGANIZATION] is the DMAIC and/or PDSA process. The steps are:

- **D**efine
- **M**easure
- **A**nalyze
- **I**mprove
- **C**ontrol

- **P**lan the improvement and continued data collection
- **D**o Improvement, data collection and analysis
- **S**tudy the results to inform the next test of change
- **A**ct to hold the gain and to continue to improve the process

[ORGANIZATION] also employs tools for process improvement and/or system design that incorporate elements of Statistical Process Control, Six Sigma; and Lean Systems Thinking and Operations Engineering to reduce system variation, delays, and unnecessary complexity that are barriers to optimal patient care.

QUALITY IMPROVEMENT PRIORITIES

Leaders plan and ensure implementation of the Quality and Patient Safety Improvement System. The criteria used to prioritize opportunities for improvement include, but are not limited to:

- Vision and Mission
- Clinical quality outcomes
- Patient safety assessments and event analysis findings
- Patient Safety Climate Survey
- Benchmarking and identification of opportunity
- Participation in improvement collaboratives
- National Patient Safety Goals and other regulatory/accrediting standards
- Customer satisfaction
- Aspirational aims for the future of health care
- IOM six aims of care that is safe, timely, efficient, effective, patient[/family]-centered, equitable

Quality improvement priorities and activities may be reprioritized based on significant organizational performance findings or changes in regulatory requirements, patient population, environment of care, and expectations and needs of patients and communities served. Priorities are identified each year in [ORGANIZATION] quality goals and cascaded throughout the organization. Sub goals or drivers of the goals that are locally relevant, conceptually linked, and contribute to achieve the desired outcomes are identified.

Previously prioritized activities are evaluated and are incorporated into standard practice, based on positive findings from these evaluations. Further tracking and trending of these measures are continued if overall quality surveillance measures suggest that formal reevaluation is warranted.

TOOLS TO GUIDE CLINICAL PRACTICE

Tools to improve quality of care and reduce unintended variation exist throughout [ORGANIZATION]. These tools include evidenced-based guidelines, standardized order sets, protocols and clinical pathways in addition to improvement methodologies described above. There are other activities that are not part of this Quality and Patient Safety Improvement Plan that are carried out throughout the organization where algorithmic approaches exist. Research and experimental study design oversight is conducted by the [designated review board]. Research in safety systems and improvement exists throughout [ORGANIZATION]. [*optional text, based on type of organization:* Medical resident quality improvement projects and a developing maintenance of certification program contribute to an enriching environment.]

CONFIDENTIALITY

Confidentiality and peer review protections are essential to a successful quality and patient safety improvement process. Deliberations of quality committees and teams where quality and patient safety improvement issues are discussed are protected. Additionally, names of specific individuals (patients, physicians, staff, etc.) are deindentified. Quality and patient safety improvement data, reports, and other work products are maintained in secure files and databases.

EVALUATION

The effectiveness of the Quality and Patient Safety Improvement Plan is evaluated and reported annually to the senior leaders, Medical Board, and Governance Board. This evaluation is based on comparisons of annual goals and objectives with program activities and achievements.

ACCOUNTABILITY

The executive responsibility for the Quality and Patient Safety Performance Improvement Plan is through the CEO. The Medical Board, Hospital-Clinic Systems, senior leaders, and the Quality and Patient Safety Council ensure implementation of an integrated program throughout the organization. A qualified Chief Quality and Patient Safety Officer reports to the CEO to oversee the portfolio of activity and ensure the system of improvement is operating and effective.

The office of Quality and Patient Safety, led by Chief Quality and Patient Safety Officer, is responsible for advancing strategy and guiding implementation with operations leaders.

MEDICAL BOARD

The Medical Board has responsibility for the oversight of the safety and quality of medical and patient care rendered by the medical center. It regularly reviews and evaluates performance data and makes recommendations for further action or commissions studies when needed. The Medical Board shares responsibility with the [ORGANIZATION] Administration for developing and reviewing policies and recommending standards for other [ORGANIZATION] staff whose conduct directly influences the safety and quality of patient care.

QUALITY AND PATIENT SAFETY COMMITTEE

The Quality and Patient Safety Committee (Committee), which represents leadership across [ORGANIZATION], is responsible and accountable for the success of the [ORGANIZATION]'s performance in quality and patient safety activities. The Committee synthesizes and coordinates quality and patient safety activities of the [ORGANIZATION]. The Committee ensures that activities throughout the organization are consistent with the priorities established by leadership. The Committee systematically reviews reports from patient safety and quality related committees and subcommittees to identify key areas of opportunities. The Committee identifies specific high volume, high risk and problem-prone aspects of care, instructing the appropriate committee(s), as delineated in the Medical Staff Bylaws, to prioritize their efforts accordingly. Intradepartmental performance improvement activities, when appropriate, are shared with the Committee to assure coordination of efforts. The Committee evaluates progress in achieving quality qoals and recommends priorities to senior leaders for goal setting.

The Committee provides quality and patient safety improvement leadership, including but not limited to:

1. Assuring compliance with national recommendations for patient safety, including the National Patient Safety Goals.
2. Overseeing and setting/resetting priorities for [ORGANIZATION] comprehensive, interdisciplinary improvement efforts.
3. Developing an environment that encourages and empowers staff to identify and address issues through the performance improvement process in a collegial, non-punitive manner.
4. Empowering committees to identify opportunities, design performance improvement activities and resolve issues.
5. Monitoring patient safety and quality-related functions.
6. Reviewing reports from organizational committees and making recommendations regarding safety and quality of care issues.
7. Overseeing performance measures that are required by accrediting and licensing agencies related to patient safety and quality.
8. Obtaining input for improvement opportunities from committee representatives, department heads or representatives, administrative reports including third-party reports, survey findings from professional organizations such as TJC, departmental quality assessment reports, and continuous hospital-wide trend reports on mortality and readmission.
9. Identifying opportunities for interdisciplinary approaches as needed to resolve problems efficiently and effectively.

10. Chartering performance improvement teams and program evaluations, addressing organizational priorities and reviewing their activities.
11. Referring issues to appropriate improvement teams, clinical services, departments or committees.
12. Facilitating dissemination, discussion and understanding of clinical Performance Improvement and Patient Safety data.
13. Reporting to the Executive Leadership and Board on significant issues.
14. Assuring compliance with accreditation standards and regulatory agency requirements.
15. Monitoring sentinel events and event analysis findings and action plans.
16. Selecting, approving, and reviewing Failure Mode and Effects Analyses (FMEA) performed by the organization.
17. The Medical Board will receive minutes and Quality Performance Indicator Reports.

EXECUTIVE STEERING COMMITTEE

The Executive Steering Committee is composed of organizational leaders who are responsible for establishing expectations and priorities in order to manage the clinical performance and patient safety improvement system. They remove barriers and/or assign resources as needed. They ensure that processes are in place to measure, assess, and improve the hospital's patient care/safety functions. The key charge of this group is to ensure that the appropriate quality and safety priorities are identified and addressed, remove barriers to progress, and to approve strategies for quality communication inside and outside the hospital.

STAFF RESPONSIBILITIES FOR SPECIFIC INFORMATION

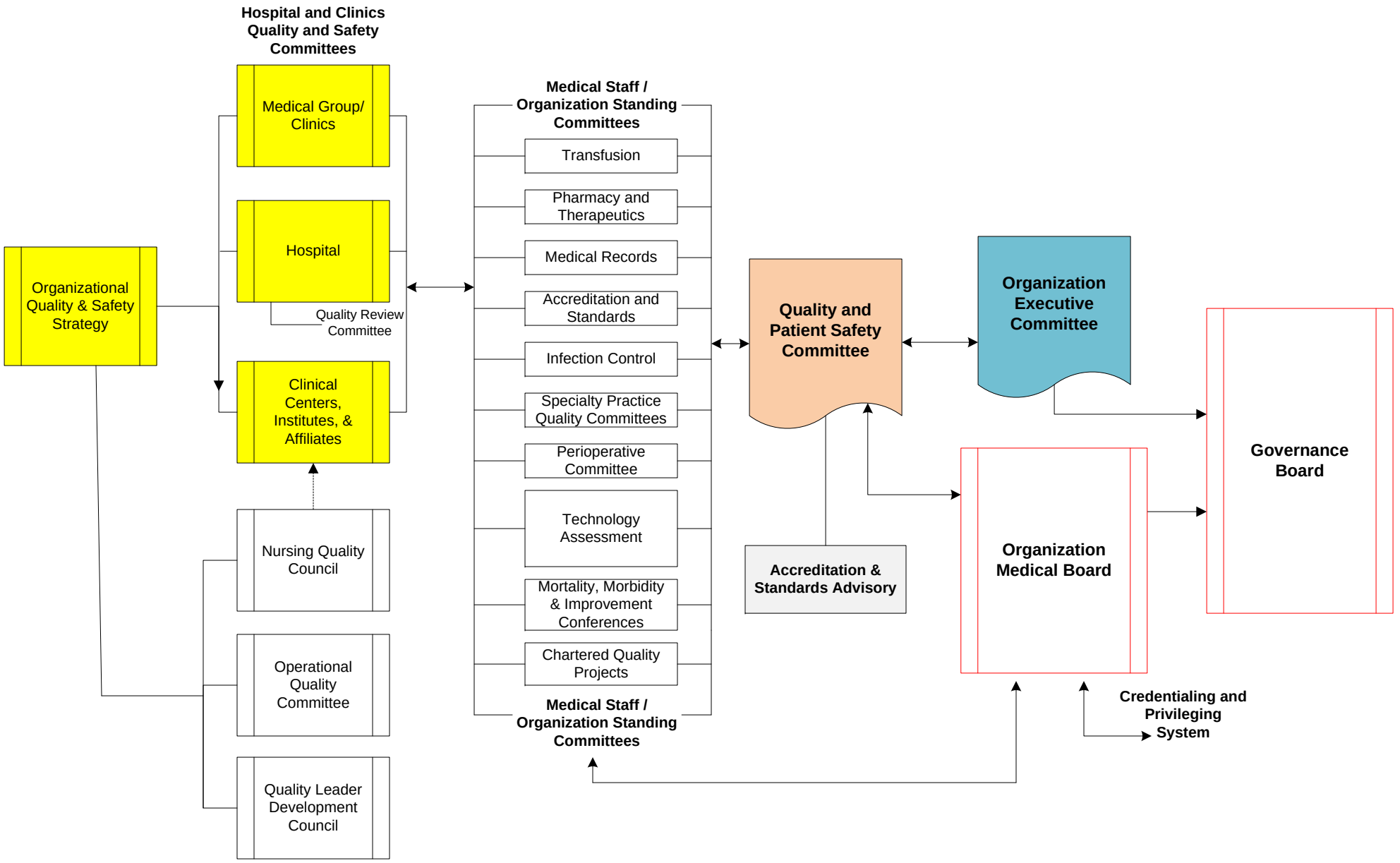
- All staff from every hospital department are responsible to report patient safety events, risks, and near misses.
- Infection Control and Prevention aggregates and analyzes data related to health care associated infection, infectious disease exposure, contact tracing, and multi-drug resistant organisms.
- The Safety Officer aggregates and analyzes data related to environment of care surveillance and risks, including: safety, security, hazardous materials, and fire prevention.
- Clinical Engineering aggregates, analyzes and reports data related to medical equipment preventive maintenance, incidents, and risks.
- Pharmacy aggregates, analyzes and reports data related to pharmacist interventions, pharmaceutical inspections, and medication use.
- Risk Management aggregates, analyzes and reports data related to actual potential risk management issues and patterns.

[Refer to Organizational Quality & Patient Safety Accountability Flow]

Roles and Responsibilities of Committees for Quality

Hospital, Clinics and Medical Specialties	**Organization-wide**	**Executive Oversight**	**Medical Staff Governance**	**Governance**
Local Quality Committees • Develops tactics and aligns improvement efforts to achieve organizational quality goals • Identifies local trends and patterns to inform improvement efforts • Develops relevant quality assurance and improvement plans and priorities • Assures follow up to close identified gaps in care from event analysis and safety reports • Monitors progress and speed and removes barriers to effective action • Engages providers and frontline staff in improvement, using standard methods, tools, and techniques. • Uses survey data and other listening posts to create a culture of safety • Monitors NQF best practice implementation and compliance to regulatory and accreditation standards • Fosters continual learning and skills for risk prevention and improvement • Produces reports and tracks performance • Recognizes accomplishments and celebrates gains made	*Quality and Patient Safety Committee* • Facilitates development of quality goals and initiatives • Establishes priorities and plans • Oversees quality assurance and improvement processes of organization through standard reports and presentations • Provides quality alignment and integration • Monitors measured performance against goals and priorities • Reviews event analysis outcomes and risk trending • Monitors NQF best practice implementation and compliance to regulatory and accreditation standards • Recommends actions to close gaps in care/performance • Fosters culture of safety and habitual excellence • Assures continual learning and skills for risk prevention, improvement, and outcomes management • Identifies need for policies and procedures • Recognizes and celebrates gains made	*Executive Leadership* • Endorses quality goals and plans • Endorses metrics for external and internal reporting • Systematically reviews quality improvement measures, metrics, and processes • Monitors NQF best practice implementation and compliance to regulatory and accreditation standards • Provides resources and support • Removes barriers and excuses from progress • Catalyzes action • Commissions studies and reports • Accepts standard quality performance indicator reports and annual patient safety report	*Medical Board* • Provides oversight of the quality of care • Assures credentialing and privileging process and actions • Approves clinical policies and procedures • Monitors NQF best practice implementation and compliance to regulatory and accreditation standards • Accepts reports: CME, medical staff committees and departments, patient safety, quality performance indicators • Reviews risk prevention report and directs action • Acts on quality matters as referred/identified • Improves its own methods	*Governance Board* • Assumes responsibility and accountability for patient safety and quality performance • Assures improvement is occurring • Requires constancy of purpose in the quality journey • Holds Senior Leadership accountable for results • Assures community needs are met through compliance to regulatory and accreditation standards • Leads celebrations of gains made • Improves its own methods

Example
Quality & Safety Accountability & Reporting Flows



Courtesy of Hospital Quality Institute, www.hqinstitute.org

Cascade of Alignment:

Connecting the Dots of Specific Initiatives to Overarching Quality and Patient Safety Aims to Move the Dial for Better Care

Hospital Quality and Safety areas of focus generate multiple individual measures and initiatives, but sum to five broad strategic aims.

They are:

1. Increase the survival of patients cared for in the hospital environment to levels that meet or exceed the best care in the U.S.
2. Provide harm free care through reliable performance and elimination of defects that harm or have the potential to harm our patients.
3. Demonstrate top performance in clinical care, by achieving 100% compliance to evidence-based practices.
4. Create value through efficient, integrated systems of care that reduce the utilization of resources and costs associated with poor quality and preventable readmissions.
5. Advance hospital performance to achieve high reliability to take excellence to scale with zero defect in care delivery.

Quality and Safety Focus: Rationale and Actions*

Strategic Aim: INCREASE THE SURVIVAL OF PATIENTS CARED FOR IN THE HOSPITAL ENVIRONMENT TO LEVELS THAT MEET OR EXCEED BEST CARE IN THE US

Definition	Rationale	Highlights of Actions / Strategies in Place for Success
Index of Observed Inpatient Deaths divided by Expected Inpatient Deaths. Emphasis is on reducing observed mortality.	• Key outcome indicator of survival. • Lives saved • Used as indicator of overall excellence for complex, tertiary/quaternary organizations caring for the sickest patients as well as teaching and community hospitals. • Indicator for rankings in Hospital Compare, UHC , US News World Report, Consumer Portals.	• Sepsis Protocol and training • Obstructive sleep apnea protocol / screening / management • General Unit monitoring capabilities • Handovers / escalation of chain of command / critical communications • Rapid Response Teams • Transfer management (Care Transitions throughout continuum) • Opiod administration monitors • Trauma Extravasation Protocol (TEP), Massive Transfusion Protocol (MTP). • Planning for ICD—IO Coding optimization • Case review of deaths • Palliative Care and Hospice programs and referrals • Use of PEWS/MEWS as an anticipatory care model
Actual mortality rate	• Real time • Internal monitor • Deaths / patient days or deaths / discharges • Complement external comparison • Already collected by most	

Quality and Safety Focus: Rationale and Actions

Strategic Aim: DEFECT-FREE CARE

Provide harm free care through reliable performance and elimination of defects that harm or have the potential to harm our patients

Definition	Rationale	Highlights of Actions / Strategies in Place for Success
Preventable Patient Harm Metric: A composite metric of the monthly rate from CMS definitions, includes CDC, and others **Healthcare Acquired Condition:** 1. Pressure ulcer 2. Falls / Trauma 3. EED and maternity measures **Healthcare Acquired Infection:** 1. CLABSI 2. Catheter-associated UTI 3. VAC (formerly VAP) 3. Surgical site infection 4. Immunization rates workforce 5. Hand hygiene	• Harm events and healthcare acquired definitions is based on standard definitions of the 10 CMS-defined "Healthcare Acquired Conditions" • **Aligns with NQF Safe Practices: 22, 25, 26, 27, 28, 32, 33** • This metric can be generated in real time. • These metrics are already being produced. • The falls and pressure ulcer metrics correspond to those provided to the Leapfrog survey; NDNQI • Publically reported elements / greater transparency; HEN participation • Patient Safety Performance affects risk profile / claims and lawsuits • Adds to cost burden • Pay for performance implications ♦ CMS penalties and rewards in reimbursement ♦ Payor / contracting focus • Affects reputation and ranking • Safety indicators gaining greater weight in quality assessments • Affects pain, suffering of patients, families, and staff • TJC scrutiny and standards in development • Competitors / best performers mandatory measures	**HAC Pressure Ulcer** • CalHEN membership (179 hospitals) • Children's Ohio HEN (OCHCN) 7 Children's Hospitals • Aggressive Awareness Campaign • Education emphasis shift from staging to prevention • Focused, intentional rounding • Prediction / screening tools • Medical staff involvement and education for POA documentation **Falls** • CalHEN and OCHCN participation • Aggressive Awareness Campaign • Rounding • Prediction / screening tools • Environmental risk mitigation (lighting) and use of devices (lifts, raised toilet seats, alarms) **EED and Maternity Measures** • CalHEN • Patient Safety First Includes physican education and and "hard stop" policy • CMQCC • ACOG participation • Community partnership—March of Dimes **HAI Prevention** • CalHEN and OCHCN • HQI and HAI State Committees; APIC partnership • Robust implementation evidence with CLABSI to spread outside of ICUs • New CDC definitions and measures for (VAP) VAC • Mandatory Immunizations emerging; 2020 TJC standard for immunization rates • Hand hygiene accountability model • California Joint Replacement Registry (CJRR) • American College of Surgeon NISQIP, SCIP, SSI

Quality and Safety Focus: Rationale and Actions

Continued from page 3

Definition	Rationale	Highlights of Actions / Strategies in Place for Success
Medication Events 1. Definitions remain in development	Participate in national definition through CalHEN work	Medication Events and Near Misses • Medication Safety Committee • High risk medication improvement focus: ♦ Opiods ♦ Vancomycin ♦ Anticoagulants ♦ Insulin ♦ Medication reconciliation • Increase profile and leadership of PharmD content experts • Process mapping, FMEA, of medication management system • Focus on pharmacy processes and nursing administration processes • Double check for high risk drugs • California Association of Health System Pharmacists
Other areas of Preventable Harm in study / actions 1. Retained surgical items (RSI) 2. Air embolism 3. Blood type incompatibility 4. Manifestation of poor glycemic control 5. DVT ,VTE, or PE associated with knee or hip surgery; obstetrical care Never Events are enduring areas of focus: 1. Wrong site, wrong procedure, wrong patient	CMS metrics with same consequences as HAC, HAI. Publically reportable for retained objects, blood transfusion event	• Instrument and sponge count procedures • Intraoperative handovers for relief in cases, and multi-surgical teams • Line management • Reliable system design for blood management • Robust glycemic control process, informatics alert, consulting team, quality metrics and reporting • DVT /VTE/PE tracking added to CalHEN • Universal Protocol / Time out expanding to outpatient procedural areas of high volume and high risk from surgical operating rooms as well as bedside procedures • Surgical debriefs

Quality and Safety Focus: Rationale and Actions

Strategic Aim: TOP PERFORMANCE IN CLINICAL CARE

Aim: Demonstrate top performance in clinical care, by achieving 100% compliance to evidence-based practices

Definition	Rationale	Highlights of Actions / Strategies in Place for Success
Inpatient Core Process Quality Metric: An aggregate score, based on compliance with multiple CMS inpatient core measures in these areas: AMI, Heart Failure, Pneumonia, Surgical Care (SCIP). Core measures. Anticipate addition of chronic obstructive pulmonary disease and stroke Asthma care for children	• This aggregate metric samples care quality across four important clinical areas. • The individual inpatient care measures are based on CMS Proposed Rule (Issued Jan, 2011. Amended April 29, 2011) on Value Based Purchasing (VBP) for Medicare Patients; TJC for all patients. • The aggregate metric ("VBP Process Domain Score") is available for monthly tracking of performance. • Measures are publically reported, impacting payment (revenues and penalties) as well as ratings and reputation. • This single numeric score (a percentage of achieved vs. potential) reflects both current level performance and improvement during the time interval of reporting. • Note: This metric does not include the HCAHPS portion of VBC points.	• Opportunities for core measures • Define issue and scope of any gaps • Is Pneumonia discharge trigger and immunization protocol in place? ♦ Implement discharge advisor to deliver pneumococcal and influenza vaccines. • Status of Asthma care for pediatrics • SCIP opportunity is typically acute pain service and surgery service coordination in management • ED to inpatient identification is operational • Psychiatry/mental health emerging

Quality and Safety Focus: Rationale and Actions

Strategic Aim: TOP PERFORMANCE IN CLINICAL CARE

Continued from page 5

Definition	Rationale	Actions / Strategies in Place for Success
Outpatient Core Process Quality Metric: A composite score based on compliance with four primary care prevention measure for diabetes care (LDL & A1C outcome measures) and cancer prevention (breast &, colon cancer screening). Outpatient OPPS is a core measure relating to ambulatory surgical population Measures of prevention are still in consideration Status of ambulatory measures are being released	• This aggregate metric samples primary care quality across important prevention areas • The individual metrics are already being tracked. • These metrics are consistent with those used for TJC, NCQA, and CMS reporting, and payer contracting. • Consistent with Meaningful Use • Implications for differential payment	**Hospitals /Hospital Systems** • Meaningful Use is an enabling platform • OPPS focus in antibiotic selection and administration in outpatient procedures • Status of ambulatory quality measures in early stages of development • Readmission measures

Quality and Safety Focus: Rationale and Actions

Strategic Aim: REDUCE COSTS OF CARE

Through efficient, integrated systems of care that reduce the utilization of resources and costs associated with poor quality and preventable readmissions

Transitions of care across continuum

Definition	Rationale	Highlights of Actions / Strategies in Place for Success
Optimizing Care Transitions / Continuity of Care Metric: Rate of Readmissions within 30 days (based on CMS definition of readmission for HF, AMI and Pneumonia). All readmissions for all reasons in definition; focus on unplanned, related readmissions for AMI, HF, PN populations. COPD is being added.	• Readmission rate reflects important coordination of care across inpatient / outpatient boundaries. • Indicator for effectiveness in continuum of care development and partnerships • Driver for differential reimbursement. • Consistent with goal for Optimizing Care Transitions. • Data are generated and can be reported daily, weekly, and monthly. • Studies are in process for predictive models to identify and mitigate risk for readmissions. • Programs for continuing care identified and in process ♦ Post-Acute Care ♦ Medical Home ♦ Skilled Nursing Facility (SNF) capacity/partnerships/access ♦ Transition clinics • Home Care Services are part of care continuum • Case management program and services track at risk patients/populations	• Measure in CalHEN, OCHCN • Explore predictive model intended to trigger protocol for patients at high risk for readmission for more focused discharge plans and resources • Optimal discharge planning teams • Patient education for discharge instruction / patient – centered plan • Post D/C follow up phone calls to include continuing care assessment • PharmD participation in discharge process for medication reconciliations to reduce readmission through appropriate medication management • Meaningful Use implications support this goal • Daily, weekly, monthly readmit reports with chart reviews to understand interconnections of discharge status to reason for readmission. • Readmission for psychiatry needs definition • View patient flow as a value stream • Work with Post-Acute care and Continuing Care agencies and facilities to effectively achieve transitions, especially access • Mental health not yet well understood • Readmissions collaboratives • Why admission in the first place?

Quality and Safety Focus: Rationale and Actions

Advance Culture of Safety, Improvement, Reliability with a Learning and Improvement System

Advance hospital performance to achieve high reliability to take excellence to scale with zero defect in care delivery.

Definition	Rationale	Highlights of Actions / Strategies in Place for Success
HealthCare Reliability Organizing (HCRO) provides knowledge, structure and process consistent with and in support of reliable performance in care delivery.	• Aligns with NQF Safe Practice 4: "Systematically identify and mitigate patient safety risks." • Leadership and reporting is foundational to a culture of safety. • Knowledge, skills, tools are required for improvement at frontlines of care • Leapfrog / TJC/QAPI	**Patient Safety First** • Mobile Simulation Center Sepsis Project and Team Training • TeamSTEPPS **CHPSO** • Curriculum and mentors to the programs identified and being recruited • Structures: ♦ Purposeful rounding, disciplined and intentional ♦ Handovers ♦ Universal protocol and timeouts ♦ Huddles and debriefs ♦ Escalation in chain of command • HCRO curriculum in final development • Human factors expertise • Culture of safety survey opportunity • NPSF certification program • PSO feedback and engagement • Attention of Leadership: fluency in performance, inquiry, recognition • Alignments in HR partnerships, peer review models, mortality and morbidity review formats and conduct • Codes of conduct **Transforming Concept from Lucian Leape Institute** • Through the Eyes of the Workforce—Creating Workforce and Patient Safety • Transparency
Culture survey results create data base for understanding and targeting improvements.	• Results can affect HCAHPS results that roll up into the Value Based Purchasing scores.	
Create psychological safety for reporting and improvement. Engage and align leaders, faculty, staff and residents in continual learning and improvement within defined clinical microsystems. Create cultural tipping point for reliability, and resilience in frontlines of care and with clinical leaders.	• Survey is required for Leapfrog submission • Handovers and reliable communication are causal variables in events of harm and near misses and central to this goal. • Readiness / demand has been expressed by stakeholders • Capability / capacity of frontline essential to advance habitual excellence • 353 member PSO with data to inform areas of focus • Learning Management System (LMS) and Reliability Management System with Gateway Practices, Support Person-Centered Care and the Triple (Quadruple) Aim	

Governance Board Readiness Assessments:

QI and Patient Safety in Health Care Organizations

Claire Manneh, MPH

Director of Programs

Hospital Quality Institute

Leadership in quality and patient safety

22 April 2014

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ABSTRACT

This review is an attempt to conduct a survey of relevant board readiness instruments used to assess the work of health care organizations on quality improvement and patient safety for California hospitals and health systems. While research on the usefulness of these assessment tools is limited, adopting assessments ensures sustainability, meets patient needs, and restores the values and mission of the organizations. A copy of each these instruments are available in the appendix.

INTRODUCTION

California is home to the most hospitals and healthcare facilities in the nation, each healthcare organization equipped with a board of directors. More than ever, hospital trustees, executives, and clinicians face a multitude of challenges. They are met with legislative pressures coupled with transformations to the healthcare system, and competition to keep up with those demands, particularly in the patient safety and quality improvement spaces. Board members' use of self-assessment tools can help the organization understand where their opportunities lie and areas of improvement.

A variety of organizations and researchers have come up with instruments for governance boards to understand how they tackle patient safety efforts. Although errors in hospitals exist, the failures in the process may be harmful to patients. Changing the culture to reduce error and improve quality in the healthcare system is an underlying goal in these assessments.

ASSESSMENTS

American Governance Center

In a recent study by the American Governance Center, Governance Practices in an Era of Health Care Transformation, researchers found that these tools are beneficial to both hospital and health system boards, particularly in the adoption governance practices to lead their organizations through the significant changes in care delivery. The Center's Readiness Assessment is available for free. The assessment is a high-level survey to help boards determine how their current practices compare with key transformational governance practices identified in the study. Board members have the option to complete the assessment either manually or electronically. Results can be used for discussion about board strengths and opportunities to further improve governance.

HQLAT

In 2004, the University of Iowa and the Oklahoma Foundation for Medical Quality led a major national initiative, under contract with the Centers for Medicare & Medicaid Services (CMS), to align health care leadership with clinical performance improvement. Advisors from 96 industry organizations and over 600 supporting partners created the Hospital Leadership and Quality Assessment Tool (HLQAT), to help health care organizations identify and adopt quality-oriented leadership systems and ultimately improve clinical care processes and

outcomes. According to the research, respondent groups of hospitals (Board members, C-Suite, Clinical Managers) who on average had positive perceptions on the HLQAT domains also had higher quality scores. Further, "differences in the average domain responses between Board, C-Suites and Clinical Managers were smaller for high performing hospitals than for low performing hospitals" (HLQAT). The instrument is available online and free for hospitals. At least 13 surveys per hospital are required to receive a HQLAT report: three board members, four members of the executive team, and six to ten clinical managers. (Case-by-case exceptions to the minimum threshold can be made for small hospitals). Hospitals will have access to view reports as well as evidence based resources. Earlier versions of the survey were pretested over a variety of hospitals and in 2008, Westat conducted a pilot test to determine the association between hospital leadership attributes and hospital performance by comparing the high-performing hospitals with lower performers. Their findings led to a revision based on psychometric analysis results with high reliability (WeStat).

IFC – International Finance Corporation

An international level tool, the Self-Assessment Guide for Health Care Organizations, provides practical advice to organizations and companies that aim for international standards, including those who may wish to achieve some form of international accreditation. The guide uses a structured self-scoring methodology to lead management teams through a comprehensive assessment of their organizations. It focuses on 31 key standards based on accreditation standards of the foremost international health care accreditation body, the Joint Commission International.

The guide was developed by IFC health sector specialists with support from the Joint Commission Institute and international medical experts. It includes references to free online resources, including reputable sources of evidence-based medical practices.

IHI

The IHI's "Protecting 5 Million Lives from Harm: Governance Leadership – Boards on Boards (2008)" report provides samples of good practice to improve quality and reduce harm. Instead of using an automated system like the HLQAT or the American Governance Center's self-evaluation tools, the IHI's approach revolves around discussions and patient narratives, recommending boards to devote a quarter of the board meeting time on quality and safety issues. Further, the IHI recommends the entire board to conduct a patient interview on an individual who has experience serious harm within the past year. Six aims the Million Lives campaign asks leadership to focus on are: setting aims; getting data and hearing stories; establishing and monitoring system-level measures; changing the environment, policies, and culture; learning, starting with the board; and establishing executive accountability. The holistic approach of the IHI instrument focuses on qualitative aspects presented at board meetings using the hospital's existing metrics or dashboard, as opposed to a measurable, survey instrument.

The Monitor Group

Another international and UK-based level tool was created by the Monitor Group, who developed a Framework in 2010. The Framework can be relevant and translated to patient safety and quality improvement efforts for California. Assessing themselves against this framework allows boards to continuously monitor and improve the quality of health care provided and that areas highlighted through the process as requiring further work are effectively addressed. Questions include, Does the board provide a clear steer on the strategic and operational quality outcomes it expects the organization to achieve? Or Do you know that a quality culture exists across the different layers of clinical and non-clinical leadership. What is your evidence for this? The tool also encourages participation from patients, such as children, older people those with mental health conditions. A good patient story will strengthen the footprint on the hospital's effort to improve quality and safety. This guidance lays out one way of gaining assurance that such requirements have been met effectively and comprehensively.

RECOMMENDATIONS

The HQLAT will provide hospitals the opportunity to bring their Board members over a discussion on quality, identify the differing viewpoints of quality between all stakeholders, and recognize opportunities for process improvements. The benefit to using either the American Governance Center's or the HQLAT's instruments are the post-assessment resources they make available. Further, both tools are available electronically, allowing for convenient data collection and synthesis. The HQLAT also has a benchmarking tool hospitals can use to compare with other systems, a benefit the other instruments do not measure. The IFC, IHI, and Monitor tools may be used electronically if one were to enter the questions into an online survey database, such as Survey Monkey. While these resources are limited, there is a tool used for a study by Bataldan and Stoltz as well as one by Kane et al, which are both available with a PubMed subscription.

APPENDIX

American Governance Center Tools

AHA_Governance Tools for Transformat

HQLAT: Sample Senior Manager Survey

HLQAT-Senior-Manager-Survey_Final.pdf

IFC: Promoting Standards – Quality Measurement and Improvement, Patient Safety, and After the Assessment Modules

IFC_4QltyMsurImprv.pdf

IFC_5PtntSfty.pdf

IFC_7AftrSlfAssem.pdf

IHI Guide

IHIboardhowtoguide.pdf

Monitor Group Guide – refer to page 38

Monitor_QualityGovGuide22April13FINAL.p

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Proposed Board Quality Agenda

1. Quality Performance Indicator Set
    a. Mortality
    b. Preventable Harm Events
    c. Healthcare Acquired Infection
    d. Medication Events
    e. Never Events
    f. Core Measures
    g. Readmissions
2. Patient Experience
3. Accreditation & Regulatory Standards
4. Quality Assurance Performance Improvement
5. Culture of Safety
6. Risk Event Reports
7. Policies & Procedures