



TAHOE FOREST HOSPITAL DISTRICT

# 2017-03-14 Board Quality Committee Meeting

Tuesday, March 14, 2017 at 12:00pm

Eskridge Conference Room - Tahoe Forest Hospital

10121 Pine Avenue, Truckee, CA 96161

# Meeting Book - 2017-03-14 Board Quality Committee Meeting

3/14/17 Board Quality Committee

## AGENDA

2017-03-14 Board Quality Committee\_Agenda.pdf Page 3

ITEMS 1 - 4: See Agenda

## 5. APPROVAL OF MINUTES

2017-01-23 Board Quality Committee\_DRAFT Minutes3.pdf Page 5

## 6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Board Quality Committee Charter & Goals 2017.pdf Page 11

6.2. Patient & Family Centered Care (PFCC)  
No related materials.

6.3. Healthcare Facilities Accreditation Program (HFAP) Survey  
No related materials.

6.4. Medical Staff Quality Committee (MSQAC)  
No related materials.

6.5. Quadruple Aim  
No related materials.

6.6. Board Quality Education.pdf Page 12

ITEMS 7 - 9: See Agenda



# QUALITY COMMITTEE AGENDA

Tuesday, March 14, 2017 at 12:00 p.m.  
Eskridge Conference Room, Tahoe Forest Hospital  
10121 Pine Avenue, Truckee, CA

**1. CALL TO ORDER**

**2. ROLL CALL**

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

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

**4. INPUT – AUDIENCE**

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

**5. APPROVAL OF MINUTES OF: 1/23/2017 ..... ATTACHMENT**

**6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION**

**6.1. Quality Committee Charter and 2017 Focus ..... ATTACHMENT**

Review and approve the Quality Committee Charter and proposed 2017 goals.

**6.2. Patient & Family Centered Care (PFCC)**

**6.2.1. Patient & Family Advisory Council Update**

An update will be provided related to the activities of the Patient and Family Advisory Council (PFAC).

**6.2.2. TIMED ITEM – 12:15 PM - Patient Experience Presentation**

Family member presentation about spouse’s care at Gene Upshaw Memorial Cancer Center and Tahoe Forest Hospital.

**6.3. Healthcare Facilities Accreditation Program (HFAP) Survey**

Provide an update on preparation for the unannounced triennial HFAP accreditation survey in the spring of 2017.

**6.4. Medical Staff Quality Committee (MSQAC)**

Discuss the option of having two Board members attend the open session bimonthly MSQAC meeting instead of having a separate Board Quality Committee meeting.

**6.5. Quadruple Aim**

Discuss plan to obtain physician and staff engagement information with a goal to improve the experience of providing care.

**6.6. Board Quality Education .....ATTACHMENT**

Discuss the Governance Institute white paper on Maximizing the Effectiveness of the Board’s Quality Committee: Leading Practices and Lessons Learned (Fall 2015). The Committee will review and discuss topics for future board quality education.

**7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS**

**8. NEXT MEETING DATE**

The date and time of the next committee meeting, Tuesday, May 9, 2017, at 12:00 p.m. will be confirmed.

**9. ADJOURN**

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

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

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



# QUALITY COMMITTEE

## DRAFT MINUTES

Monday, January 23, 2017 at 11:30 a.m.  
Tahoe Conference Room, Tahoe Forest Hospital  
10054 Pine Avenue, Truckee, CA

### 1. CALL TO ORDER

Meeting was called to order at 11:30 a.m.

### 2. ROLL CALL

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

Staff: Judy Newland, Chief Operating Officer; Janet Van Gelder, Director of Quality and Regulations; Jean Steinberg, Director of Medical Staff Services; Dr. Shawni Coll, Chief Medical Officer; Dr. Peter Taylor, Medical Director of Quality; Martina Rochefort, Clerk of the Board

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

No changes were made to the agenda.

### 4. INPUT – AUDIENCE

No public comment was received.

### 5. APPROVAL OF MINUTES OF: 11/22/2016

Director Zipkin moved approval of the November 22, 2016 Board Quality Committee minutes.

### 6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

#### 6.1. Quality Committee Charter and Goals 2017

The Quality Committee reviewed its charter and proposed 2017 goals.

Director Wong inquired about the purpose of the charter. Director of Quality and Regulations stated the committee originally struggled to state its purpose. The charter was rationale for what was the Committee's focus and goals each year.

Director Wong stated that the Board of Directors bylaws address the committee's goals.

Director Zipkin commented that the charter was vague.

Discussion was held about the value of having a charter.

Staff was directed to keep this item on the agenda for the next meeting. Staff was asked to follow up with General Counsel to see if a charter is needed.

Discussion was held on the number of goals and how some could be revised or deleted.

*Dr. Shawni Coll joined the meeting at 11:38 a.m.*

Director Wong commented a number of the goals are ongoing (i.e., Just Culture). COO stated Just Culture is part of the District's process.

Director Zipkin felt goal #8 was worded to suggest the committee is participating in Just Culture events. Director Wong would like to do away with that as one of the committee's goals. Director Zipkin clarified the Board should support utilizing Just Culture within the institution.

Discussion was held regarding what level of detail the Board is involved in.

Director Wong inquired about the goal related to Patient Family Advisory Council (PFAC) and its initiatives. COO stated the PFAC is still being built.

Director Zipkin stated the issue about whether or not a board member should be part of PFAC is going to come up again.

Goal #2 will be deleted.

On goal #4, Dr. Coll stated the work has been done and structure completed. This can be deleted as a goal.

Goal #5 still needs work and has not been completed.

Quadruple AIM will be a good goal for the Quality Committee to have for the coming year.

Goal #9 originated from a Governance Institute report in 2015. Director of Quality and Regulation will forward the white paper out to the new committee members for reference. Historically no one has overseen the credentialing and peer review process. Director of Medical Staff Services can present the process change and standards for credentialing and peer review again.

Discussion was held about where SBAR and handoff communication training occurs.

The committee will keep goals 1, 3, 5, 6 and 7.

COO added that the list is fluid and can always be added to.

Dr. Taylor inquired if a goal should be added for the new EMR. Dr. Coll agreed and stated the EMR has a huge quality piece to it. The committee discussed adding a goal for the EMR initiative.

Director Zipkin commented the goals listed as is cannot be measured (i.e. achieve 10%). They are more about board oversight.

The committee discussed changing the verbiage of its "goals" to "focus".

**Director Zipkin moved to approve the 2017 Board Quality Committee Focus as discussed.**

*Trish Foley joined the meeting 11:59 a.m.*

## **6.2. Quality Assurance Process Improvement (QA/PI) Plan Policy**

Board Quality Committee reviewed the 2017 Quality Assurance/Performance Improvement Plan.

Director Zipkin commented there are three separate places where Board of Director authorities are “delegated”. The Board of Directors cannot delegate their authority.

Director of Quality and Regulations will update the quality metrics.

Section 5.0 on page 13 of the policy references EPIC under Performance Improvement Initiatives. This should be added as a goal for the committee.

On page 2, delete “to include”.

Quality will send this out to Medical Staff first and then to the Board of Directors at their February meeting.

**Director Zipkin moved approval of 2017 Quality Assurance/Performance Improvement Plan with the changes as discussed. Director Wong seconded.**

## **6.3. Patient & Family Centered Care (PFCC)**

### **6.3.1. Patient & Family Advisory Council Update**

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

The PFAC has been meeting monthly for the last year and a half. It currently has 8 active members.

This year the PFAC will focus on process improvements and the priority index from Press Ganey surveys.

The PFAC met last Tuesday. Lab services and Emergency Department attended and spoke about what they are doing for scheduling appointments online.

John Rust, Director of Emergency Services, spoke about ER yearend scores and addressed concerns about noise and delays. The Emergency Department will utilize more private rooms when they are available.

Director Zipkin inquired if patients are charged more for a private room in the ER. No, patients are not charged more when private rooms are used in the ER.

Discussion was held regarding inpatient room signage and changes that have taken place.

The committee discussed ways to include IVCH and obtain their feedback. A quarterly focus group was suggested.

Discussion was held about the process for service recovery and the Patient Advocate’s role.

Leadership does rounding with patients every day.

PFAC is still looking for new members.

Nancy Woolf has volunteered to participate as a community member representative on the Board Quality Committee.

Director Zipkin inquired if the PFAC would like a board member on their committee. Patient Advocate indicated they would like to keep the council to community members only. The council will reach out if they would like a board member to participate.

### **6.3.2. Patient Experience Presentation**

This items was left this on agenda.

The Board of Directors has had patients come to talk about their experiences in the past.

Quality has not had recent success getting patients to come.

Discussion was held about starting with a list of those patients that have been recommended to the hospital's Patient Advocate for service recovery call.

This should be on Jim Sturtevant & Kerry Milligan's radar as they do rounding with patients.

Patients can start with speaking at Quality Committee and come to a board meeting if they are comfortable sharing their story in that forum.

### **6.4. Patient Satisfaction Survey Process**

Copies of the Patient Satisfaction survey have been attached for review.

Quality has been asked to explore with Press Ganey if "type of service" could be added.

On the ambulatory survey, Press Ganey added "date of service" and "type of service" categories.

They will add "date of service" to the Emergency Department surveys.

There is no "date of service" on inpatient surveys.

Dr. Coll would like to see the name of admitting doctor listed on the survey so patients know who they are rating.

Different sites are being added to the Multispecialty Clinics survey (i.e. newly acquired orthopedic office).

Quality is looking to switch the Cancer Center to Press Ganey surveys so it will be added to the current dashboard.

Director Zipkin suggested a confidentiality disclaimer be added about not using patient information that is provided in the survey.

The inpatient service survey is sent via postal mail per a federal CMS mandate.

Discussion was held about distributing the surveys via email first. Currently, Press Ganey emails surveys only after they do not receive enough paper surveys.

*Trish Foley departed the meeting at 12:31 p.m.*

### **6.5. Healthcare Facilities Accreditation Program (HFAP) Survey**

Director of Quality and Regulations will give an overview of the HFAP survey at the next Board of Directors meeting.

The window is now open and the surveyors can come at any time.

TFH and IVCH will be surveyed separately.

Work is being done to ensure the hospital is compliant.

Discussion was held as to whether or not board members would be part of the survey. HFAP has not historically interviewed board members.

### **6.6. Medical Staff Quality Committee (MSQAC)**

Discussion was held on whether or not to combine the Board Quality Committee as part of Medical Staff Quality Committee. The meetings cover the same topics. It would be good for the board members to hear from the physicians directly about quality issues.

Staff will inquire with General Counsel if this can be done.

This topic will be brought back to the next Quality Committee meeting.

### **6.7. Quadruple Aim**

6.7.1. Sikka, R., Morath, J., & Leape, L. *The Quadruple Aim: care, health, cost and meaning in work.* BMJ Quality & Safety (2015)

6.7.2. Feeley D, Swensen SJ. *Restoring joy in work for the healthcare workforce.* Healthcare Executive. 2016 Sept; 31(5):70-71.

The Quadruple Aim articles were reviewed last year and were included to bring both Board Members up to speed.

In November, the Board Quality Committee met and felt this was focus for the committee. Human Resources conducts an employee engagement survey every 3 years.

Harry would like a survey completed of the medical staff.

Dr. Taylor reminded the committee that Triple Aim does not address the physician engagement side, which is why it has been expanded to the Quadruple Aim.

Employee Survey coming up in March 2017.

Dr. Coll inquired if there was any reason why physicians could not be added to the engagement survey. COO will provide a copy of survey to Dr. Coll and Dr. Taylor for their review.

**6.8. Board Quality Education**

ACHD and The Governance Institute both have quality pieces to their programs.

**7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS**

None.

**8. NEXT MEETING DATE**

The date and time of the next Quality committee meeting was confirmed for Tuesday, March 14, 2017, at 12:00 p.m.

**9. ADJOURN**

Meeting adjourned at 12:57 p.m.

DRAFT

## **Board Quality Committee Focus 2017**

**DRAFT**

1. Monitor quality, service and patient safety metrics and support processes, with a focus on outliers, to achieve top decile performance and measurable improvement.
2. Monitor the Patient Safety Culture Survey plan for improvement progress.
3. Support the Quadruple Aim, including improving the experience of providing care and workforce engagement.
4. Provide appropriate resources to assist the Patient & Family Advisory Council (PFAC) improvement initiatives.
5. Provide direction on how to best educate the community about the TFHD quality and service metrics (i.e., web site, public speaking, social media, quarterly magazine, newspaper articles, etc.).
6. Support the Epic electronic health record implementation with a focus on quality, service, and patient safety.

## **Quality Committee Charter**

Tahoe Forest Hospital District is committed to performance excellence, to delivering the highest quality care and service, and to exceeding the expectations of our patients, physicians, employees, and community. This committee will provide leadership, oversight, and accountability for organization wide quality improvement processes and programs. We will regularly assess the needs of our stakeholders, evaluate proposed quality initiatives, openly debate options, and assure the production of an organization wide strategic plan for quality. We will set expectations, facilitate education, and support the monitoring of the quality of care, service excellence, risk reduction, safety enhancement, performance improvement, and healthcare outcomes. Because of our efforts Tahoe Forest Hospital District will be the best place to receive care, the best place to work, the best place to practice medicine, and a recognized asset to all in our community.

Approved January 22, 2014

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

## Leading Practices and Lessons Learned



A service of  NATIONAL RESEARCH Corporation

A Governance Institute White Paper Fall 2015



## About the Author

**Larry Stepnick** is Vice President and Director of The Severyn Group, Inc., a Virginia-based firm that specializes in conducting qualitative and quantitative research, and writing and producing publications on a wide range of healthcare management issues. In addition to printed materials, The Severyn Group creates Web site content and electronic presentations for training and education purposes. Severyn's clients include a broad spectrum of organizations that represent virtually all aspects of healthcare, including financing, management, delivery, and performance measurement. The Severyn Group assists clients in resolving their most critical strategic concerns.

Prior to cofounding The Severyn Group in 1994, Mr. Stepnick served as senior vice president and an elected officer of The Advisory Board Company, a for-profit membership of more than 1,000 hospitals and health systems. Mr. Stepnick received his bachelor's degree from Duke University, where he graduated summa cum laude. He also holds an M.B.A. from the Wharton School of the University of Pennsylvania, where he graduated with honors.

Mr. Stepnick can be reached at (703) 723-0951 or via email at [larry@severyngroup.com](mailto:larry@severyngroup.com).

## Acknowledgements

The Governance Institute would like to thank the following individuals for participating in the research related to this white paper. Their contributions, both in terms of time and expertise, were invaluable to its creation.

C. Michael Armstrong

*Chair, Patient Safety and Quality Board Committee, Johns Hopkins Medicine*

John R. Ball, M.D.

*Board Vice Chair and Quality Committee Chair, Mission Health*

Michael Kulisz, D.O.

*Chief Medical Officer, KishHealth System*

Eric D. Lister, M.D.

*Managing Director, Ki Associates and Governance Institute Advisor*

Peter Pronovost, M.D.

*Senior Vice President of Quality and Safety, Johns Hopkins Medicine*

James L. Reinertsen, M.D.

*Chief Executive Officer, The Reinertsen Group*

Leonetta Rizzi

*Board Member and Chair, Quality and Credentialing Committee, KishHealth System*

Wyatt S. Stevens

*Board Chair, Mission Health*

## The Governance Institute

The Governance Institute provides trusted, independent information and resources to board members, healthcare executives, and physician leaders in support of their efforts to lead and govern their organizations.

The Governance Institute is a membership organization serving not-for-profit hospital and health system boards of directors, executives, and physician leadership. Membership services are provided through research and publications, conferences, and advisory services. In addition to its membership services, The Governance Institute conducts research studies, tracks healthcare industry trends, and showcases governance practices of leading healthcare boards across the country.



A service of  NATIONAL RESEARCH  
Corporation

## The Governance Institute®

*The essential resource for governance knowledge and solutions*

9685 Via Excelencia • Suite 100 • San Diego, CA 92126

Toll Free (877) 712-8778 • Fax (858) 909-0813

[GovernanceInstitute.com](http://GovernanceInstitute.com)



**Jona Raasch** Chief Executive Officer

**Zuchary Griffin** General Manager

**Cynthia Ballow** Vice President, Operations

**Kathryn C. Peisert** Managing Editor

**Glenn Kramer** Creative Director

**Kayla Wagner** Editor

**Aliya Garza** Assistant Editor



The Governance Institute is a service of National Research Corporation. Leading in the field of healthcare governance since 1986, The Governance Institute provides education and information services to hospital and health system boards of directors across the country. For more information about our services, please call toll free at (877) 712-8778, or visit our Web site at [GovernanceInstitute.com](http://GovernanceInstitute.com).

The Governance Institute endeavors to ensure the accuracy of the information it provides to its members. This publication contains data obtained from multiple sources, and The Governance Institute cannot guarantee the accuracy of the information or its analysis in all cases. The Governance Institute is not involved in representation of clinical, legal, accounting, or other professional services. Its publications should not be construed as professional advice based on any specific set of facts or circumstances. Ideas or opinions expressed remain the responsibility of the named author(s). In regards to matters that involve clinical practice and direct patient treatment, members are advised to consult with their medical staffs and senior management, or other appropriate professionals, prior to implementing any changes based on this publication. The Governance Institute is not responsible for any claims or losses that may arise from any errors or omissions in our publications whether caused by The Governance Institute or its sources.

© 2015 The Governance Institute. All rights reserved. Reproduction of this publication in whole or part is expressly forbidden without prior written consent.

# Table of Contents

<b>1</b>	<b>Executive Summary</b>
<b>3</b>	<b>Introduction: The Case for Board Quality Committees</b>
3	Maximizing the Effectiveness of the Board Quality Committee: Leading Practices and Lessons Learned
<b>5</b>	<b>Quality Committee Key Insights, Strategies, and Practices</b>
5	Committee Charter and Scope of Responsibility
7	Strategies and Practices Related to Committee Size and Composition
10	Strategies and Practices Related to Meeting Frequency, Agenda, and Other Logistical Issues
<b>13</b>	<b>Case Studies</b>
13	Johns Hopkins Medicine
15	Mission Health
16	KishHealth System



# 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:

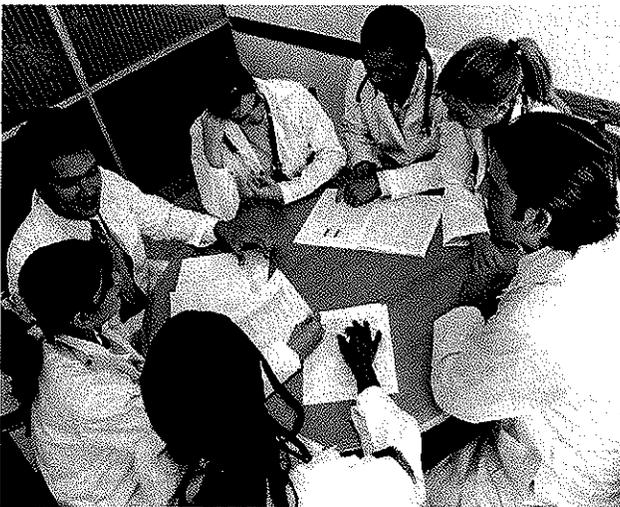
- Meet at least as often as the full board.
- Consider creation of a subcommittee (in larger systems).
- Incorporate additional special meetings as necessary.
- Consider use of a standard agenda and reporting format.
- Limit (or even) ban the use of presentations.
- Start meetings with one or two patient 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.

---

“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>

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.

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.

- **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.

---

“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.

---

“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.

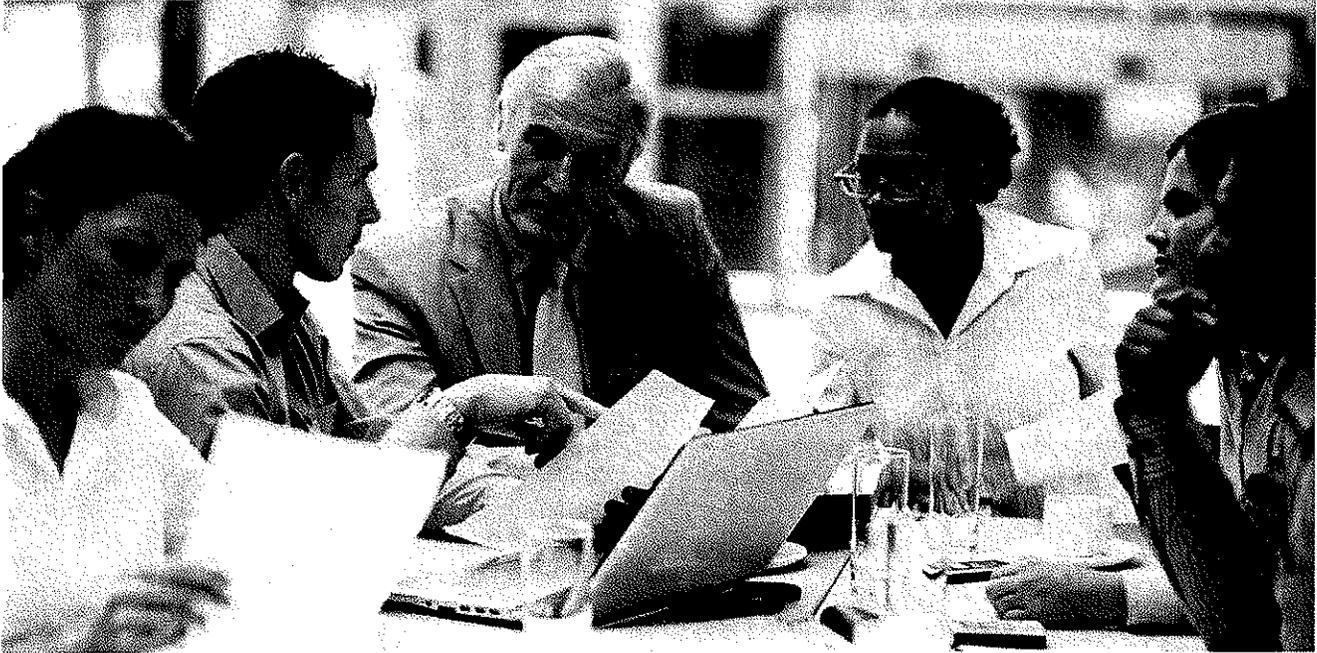
35 H.J. Jiang, C. Lockee, K. Bass, and I. Fraser, “Board Oversight of Quality: Any Differences in process of Care and Mortality?” *Journal of Healthcare Management*. Vol. 54, No. 1 (2009); pp. 15–30.

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 health-care 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.

---

## 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>

---

## 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

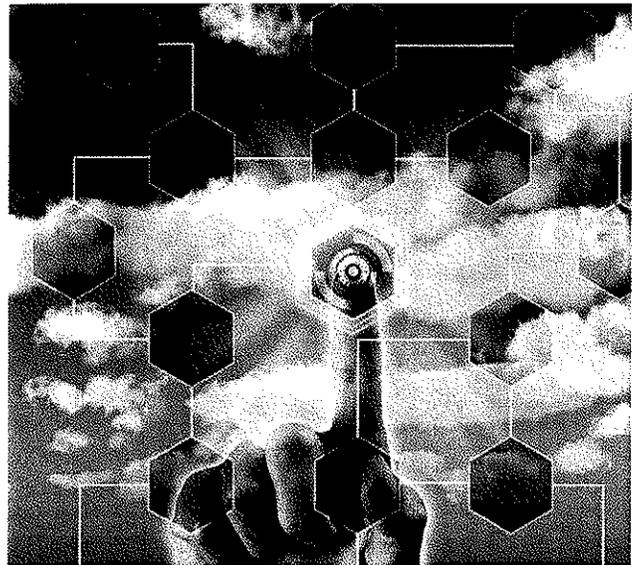
Leading strategies and practices related to how often the committee meets include the following:

- **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.

---

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

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)
- 

## 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.)

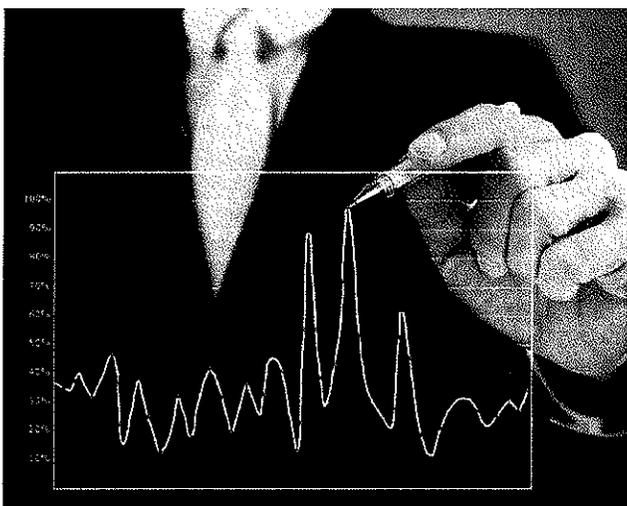
<sup>56</sup> *Ibid.*

---

## 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?



## 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>

---

### 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.

---

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.

### 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

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.

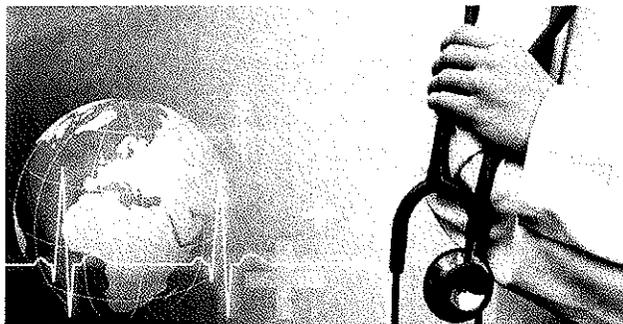
The other board members serving on the committee have varying backgrounds, including physicians and individuals with business backgrounds. Non-voting members of the committee include an expert in the Malcolm Baldrige National Quality Award, a reporter with experience in healthcare quality issues, a nurse,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

### 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.



<sup>66</sup> P.J. Pronovost, et al., May 2015.

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

<sup>65</sup> P.J. Pronovost, et al., February 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.

---

“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

<sup>68</sup> L. Stepnick, 2014.

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.

---

### 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.

---

## 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.

