TAHOE FOREST HOSPITAL DISTRICT

2020-11-12 Board Quality Committee Meeting

Thursday, November 12, 2020 at 9:00 a.m.

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, the Boa Quality Committee meeting for November 12, 2020 will be conducted telephonically through Zoom.

Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public b limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be op for the meeting.

Board Committee Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

If you would like to speak on an agenda item, you can access the meeting remotely: Please use this web lin https://tfhd.zoom.us/j/92984708375

If you prefer to use your phone, you may call in using the numbers: (346) 248 7799 or (301) 715 8592, Meeti ID: 929 8470 8375

TAHOE FOREST HOSPITAL DISTRICT

Meeting Book - 2020-11-12 Board Quality Committee Meeting

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
AGENDA

Thursday, November 12, 2020 at 9:00 a.m.

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, the Board Quality Committee meeting for November 12, 2020 will be conducted telephonically through Zoom. Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Committee Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

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Public comment will also be accepted by email to mrochefort@tfhd.com. Please list the item number you wish to comment on and submit your written comments 24 hours prior to the start of the meeting.

Oral public comments will be subject to the three-minute time limitation (approximately 350 words). Written comments will be distributed to the board prior to the meeting but not read at the meeting.

1. CALL TO ORDER

2. ROLL CALL
Mary Brown, Chair; Alyce Wong, RN, 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: 08/18/2020 ..... ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

6.2. Patient & Family Centered Care

6.2.1. Patient Experience Presentation
Patient will share their experience with Tahoe Forest Health System.

6.2.2. Patient & Family Advisory Council (PFAC) Update ..... ATTACHMENT

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

6.3. Patient Safety

6.3.1. BETA HEART Program Progress Report.....ATTACHMENT

Quality Committee will receive a progress report regarding the BETA Healthcare Group Culture of Safety program.

6.4. High Reliability Team (HRT) Progress Report .....ATTACHMENT

Quality Committee will receive an update on the High Reliability Team's activities.

6.5. Quality Assurance/Process Improvement Plan (QA/PI)

Quality Committee will discuss recommendations for QA/PI 2021 Priorities.

6.6. Governance of Quality Assessment (GQA) Tool .....ATTACHMENT

Committee will review the assessment tool and discuss status of 30 core processes the board should perform to effectively oversee quality.

Framework for Effective Board Governance of Health System Quality (2018). Daley Ullem E, Gandhi TK, Mate K, Whittington J, Renton M, Huebner J. Boston, Massachusetts: Institute for Healthcare Improvement.

6.7. Board Quality Education

Committee will discuss the following educational article:

6.7.1. *21st Century CURES Act* .....ATTACHMENT

Retrieved on 10/20/20 at: https://www.healthit.gov/cures/sites/default/files/cures/2020-03/InformationBlockingExceptions.pdf

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE

The next committee date and time 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 telephonic 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 or a reasonable modification of the teleconference procedures are necessary (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.

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
DRAFT MINUTES

Tuesday, August 18, 2020 at 12:00 p.m.

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, the Board Quality Committee meeting for August 18, 2020 will be conducted telephonically through Zoom. Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Committee Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

1. CALL TO ORDER

Meeting was called to order at 12:02 p.m.

2. ROLL CALL

Board: Mary Brown, Chair; Alyce Wong, RN, Board Member

Staff in Attendance: Harry Weis, President & Chief Executive Officer; Judy Newland, Chief Operating Officer; Crystal Betts, Chief Financial Officer; Janet Van Gelder, Director of Quality and Regulations; Dorothy Piper, Director of Medical Staff Services; Todd Johnson, Patient Safety Officer and Risk Manager; Lorna Tirman, Patient Experience Specialist; Dr. Tim Lombard, Medical Director of Infection Control

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

Item 6.6. was removed from the agenda.

4. INPUT – AUDIENCE

No public comment was received.

5. APPROVAL OF MINUTES OF: 05/14/2020

Director Wong moved approval of the Quality Committee minutes of May 14, 2020, seconded by Director Brown.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

Janet Van Gelder, Director of Quality and Regulations, shared a Safety First related to preparedness for the recent accreditation survey.

6.2. Patient & Family Centered Care

6.2.1. Patient Experience Presentation

Mr. and Mrs. Lynn shared their experience with Tahoe Forest Health System. Discussion was held.

6.2.2. Patient & Family Advisory Council (PFAC) Update

Lorna Tirman, Patient Experience Specialist, introduced Kevin Ward as the new Patient and Family Advisory Council (PFAC) representative.

PFAC is always looking for new members.

6.3. Provider STAR Ratings

Patient Experience Specialist reviewed a presentation on provider ratings with the Quality Committee. Ratings are derived from patient satisfaction data and comment reports.

Director Wong shared she did not take a survey after a telemedicine visit because the questions did not apply. Patient Experience Specialist confirmed the District opted to not implement the telemedicine version of the Press Ganey survey because staff was inundated with the COVID-19 pandemic at the time. The District may look into it in the future if telemedicine visits continue. Dr. Lombard commented there are not many telemedicine visits happening anymore.

6.4. Patient Safety

6.4.1. BETA HEART Program Progress Report

Quality Committee reviewed a BETA Healthcare Group Culture of Safety program progress report.

The validation survey took place virtually in June. Tahoe Forest Hospital is the first hospital to achieve validation for all five domains. It will result in approximately $92,000 savings in liability premiums. Validation must take place every year.

Director of Quality anticipates the Culture of Safety survey will take place in January or February.

Director Brown asked why the early resolution domain was given conditional validation. Director of Quality noted BETA had a new form for the process. The District submitted a 20-page in-depth review of a patient case.

6.5. Healthcare Facilities Accreditation Program (HFAP)

Quality Committee received an update on the HFAP accreditation survey process.

HFAP was originally scheduled to come in March but CMS shut down all surveys and travel due to COVID-19. The triennial accreditation survey occurred on August 10-11, 2020 for Tahoe Forest Hospital and August 12-13, 202 for Incline Village Community Hospital. There were some minor deficiencies reported related to process improvement items. There were no patient care deficiencies. The District is waiting for the final report to be issued and then will submit a plan of correction on any needed items. The surveyors were very complimentary of our organization and the care we provide to patients.

6.6. Quality Assurance/Process Improvement Plan (QA/PI)

Item was removed from the agenda.

6.7. Board Quality Education

Committee discussed the following educational articles:

6.7.1. *What's New in the Guidelines* Article

https://www.covid19treatmentguidelines.nih.gov/whats-new/

Dr. Lombard discussed the variety of tests available as well as medication and treatment options.

Current best practices were reviewed.

6.7.2. ***Overview of COVID-19: Epidemiology, Clinical Presentation and Transmission.***

https://www.team-iha.org/files/non-gated/quality/boardbrief-navigating-the-challenges-covid-19.aspx

Dr. Tim Lombard, Medical Director of Infection Control, presented clinical highlights of COVID-19. Clinical presentations of COVID-19 are similar to acute viral illness. This aspect will make flu season more challenging. There are some unique symptoms to COVID-19 such as loss of smell or taste. Some patients are experiencing ongoing pulmonary problems.

Dr. Lombard discussed mutations and viral loads of the virus.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

Director Wong would like to review performance improvement initiatives at the next meeting.

8. NEXT MEETING DATE

The next committee meeting is scheduled for November 12, 2020.

9. ADJOURN

Meeting adjourned at 1:37 p.m.

Patient and Family Advisory Council (PFAC) Summary Report

May 2020 to November 2020

Submitted by: Lorna Tirman, RN, PhD

Patient Experience Specialist

- Plan for 2020 is to continue to review patient feedback and comments from patient experience surveys, help improve quality, safety, and patient experiences.

- Kevin Ward volunteers in the Quality Department tracking our service recovery toolkits, and is now the PFAC member who sits on the Board Quality Committee for TFHD.

- Pati Johnson now serves on our Cancer Committee, which meets quarterly.

- Meetings focus on improving processes and behaviors to continue to provide the Perfect Care Experience to our community and visitors. We will continue to focus on our Outpatient and Clinic visits to improve the patient experience in those areas where the feedback continues to show room for improved patient experiences.

- We agreed to continue to invite departments to PFAC meetings to illicit input where needed, to improve processes or strategies in that specific area.

- At every meeting, an example of a patient complaint is shared to illicit input on how to best perform service recovery and improve the process so the complaint will not happen again to another patient.

- May Meeting: Harry Weis gave another update on COVID-19 and opening up of services while keeping patients and staff safe.

- June Meeting: Updates on Access Center, Diagnostic Imaging, Specialty clinic provider additions and telemedicine visit update.

- September Meeting: Discussed how to continue to provide optimal Patient and Family Centered Care when family members and patient advocates are not allowed to be with patients in all healthcare settings at this time. Discussed and trained all providers and staff to take time to ask patients during rounds and discharge planning to FaceTime or call a family member during visit. Used Safety First Flyer to educate all employees and presentation to hospitalists to remind them to do this with patients. Also discussed new initiative to introduce discharge folders in care settings to optimize written communication with patients. PFAC to review folders and give feedback.

- October Meeting: Four members of PFAC, who attended Patient and Family Centered Care Conference, gave their reports on what they learned from attending this virtual conference. Discussed how we manage our behavioral health patients and will have experts attend November meeting to give updates on this and answer questions. Plan to write a Pacesetter article to remind all staff and providers to include family member during rounds and updates to care.

- We currently have 11 community members serving on our PFAC. We continue to seek and recruit new members to represent our community on our PFAC.

- The Tahoe Forest Hospital Patient and Family Advisory Council meets every month, 9 months in the year. We do not meet July, August, or December.

- Next PFAC Meeting is November 17, 2020.

Current members:

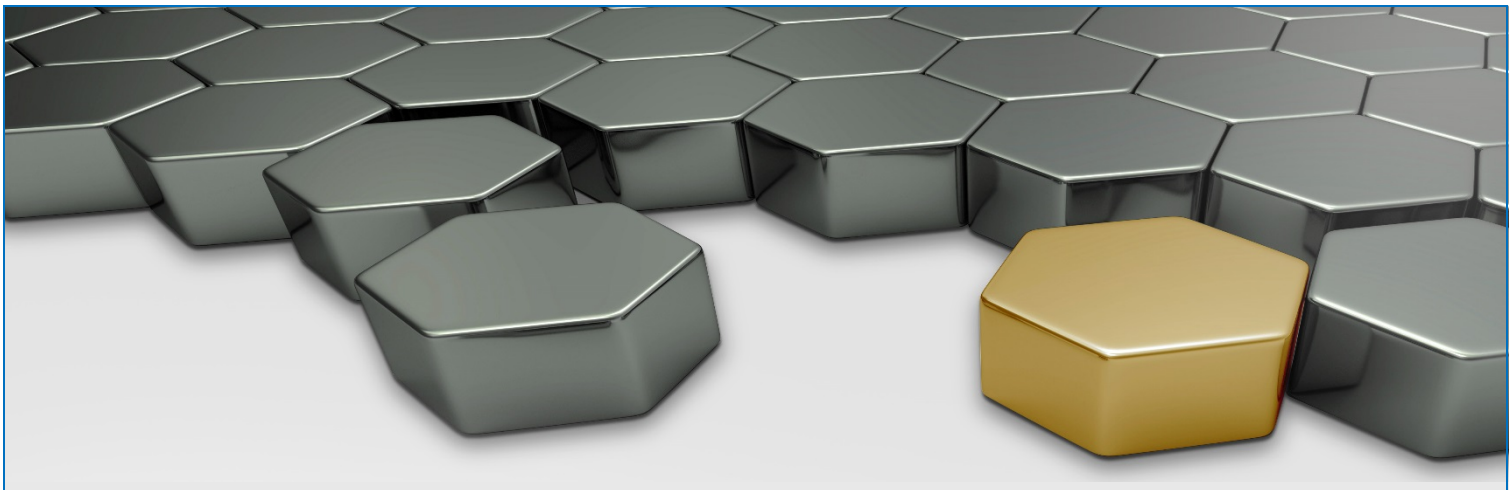
Name of PFAC Volunteer	**Start Date**
1. Doug Wright	2/4/2015
2. Anne Liston	3/9/2016
3. Mary K. Jones	5/17/2017
4. Dr. Jay Shaw	8/11/2017
5. Pati Johnson	3/22/2018
6. Helen Shadowens	5/24/2018
7. Sandy Horn	9/5 /2019
8. Kevin Ward	9/20/2018
9. Parminder Hawkesworth	9/20/2018
10. Violet Nakayama	10/31/2019
11. Alan Kern	2/20/2020

Beta HEART Progress Report for Year 2020 (updated October 28, 2020)

*Beginning in 2020, Beta HealthGroup changed their annual incentive process to be "Annual", meaning that each year the 5 domains have to be re-validated each year to be eligible for the incentive credit. General Updates for 2020:

- Final workshop was held in mid-October – TFHD staff presented a disclosure case for all participants
- SCORE Survey for 2020 (year 3 for TFHD) was canceled and the next survey will be in February 2021.
- Lorna Tirman, RN, will be taking over as the Beta HEART lead for TFHD effective November 2020.

Domain	History of Incentive Credits (2% annually)	Readiness for next Validation	Comments
Culture of Safety: A process for measuring safety culture and staff engagement (Lead: Dawn Colvin)	2019: $13,101 2020: $19,829	100%	Survey for 2020 cancelled – departments are continuing to work on goals. Validated for 2020. SCORE survey for 2021 will be held in February. This will be a topic for Workshop 1 for 2021 to be held in February "virtually". Dates TBD
Rapid Event Response and analysis: A formalized process for early identification and rapid response to adverse events that includes an investigatory process that integrates human factors and systems analysis while applying Just Culture principles (Lead: Todd Johnson)	2019: not validated 2020: $19,829	100%	Beta has changed some of the validation requirements to include an actual event/case review with external committee via Beta. Validated for 2020. This will be a topic for Workshop 1 for 2021 to be held in February "virtually". Dates TBD
Communication and transparency: A commitment to honest and transparent communication with patients and family members after an adverse event (Lead: Janet Van Gelder)	2019: not validated 2020: $19,829	100%	Validated for 2020. Disclosure checklist recently updated with Lorna Tirman as one of the primary contacts. This will be a topic for Workshop 2 for 2021 to be held in May. Dates TBD
Care for the Caregiver: An organizational program that ensures support for caregivers involved in an adverse event (Lead: Stephen Hicks)	2019: not validated 2020: $19,829	100%	Peer support training for many peer supporters was completed 8/21-22/2020. Validated for 2020. Ongoing training and monthly peer support meetings are being organized by lead, Stephen Hicks. This will be a topic for Workshop 2 for 2021 to be held in May. Dates TBD
Early Resolution: A process for early resolution when harm is deemed the result of inappropriate care or medical error (Lead: Todd Johnson)	2019: not validated 2020: $19,829	100%	One case went all the way for Early Resolution and was submitted as the "validation case". The case was well received both by the validation committee and also as presented at the Early Resolution workshop in October. Validated for 2020. Dawn Colvin is organizing the Beta HEART dashboard, and training both Lorna Tirman (new Beta lead) and Todd Johnson (Risk Manager) on the use of the dashboard for tracking of cases that meet all 5 domains. This will be a topic for Workshop 3 for 2021 to be held in September. Dates TBD



High Reliability Project Summary

Tahoe Forest Health System

An Overview: October 2020

SG Collaborative Solutions, LLC™

Designed for Impact. Powered by Partnership.

SGCS Helps TFH Integrate High Reliability and Resiliency Strategies

Introduction and History:

SG Collaborative Solutions, LLC (SGCS) has been working on High Reliability, Resiliency, and Safety Culture at Tahoe Forest Health (TFH). During intensive, on-site engagements with SGCS's Partners, TFH has achieved many milestones in their High Reliability and Just Culture journey. Through most of this engagement, Hilary Ward, PharmD, BCOP and Alex MacLennan, PHR and Chief Human Resources Officer were the primary contacts for SGCS.

Work performed through October 2020:

- Nearly all TFH leaders have been provided some hands-on training in High Reliability and "Just Culture" methods, and most have been exposed to the concepts through other means such as general presentations to staff, case reviews, and on-line training (2014-2020).
- SGCS has assisted TFH Staff as they formed their first Reliability Management Team in early 2018 to engage in cohesive, proactive analyses of clinical and non-clinical risks. This team, currently under the direction of Hilary Ward, PharmD, meets regularly to collaborate and continues to develop subject matter expertise in the methods of High Reliability. All team members have been trained to See and Understand Risk, Evaluate Effectiveness and Resiliency in Systems, and recommend Human Performance improvements in order to manage future risk.
- With SGCS's assistance, TFH has developed a process for evaluating risk events collaboratively. Using principles embraced by the commercial airline industry for years, there is now a coordinated approach to analyzing events, tracking risk and quality issues, and staying current on a myriad of risk inputs throughout the organization. This remains a work in progress, but SGCS believes TFH is on track to engage in an external High Reliability Organization certification and qualification process provided by DNV-GL by the end of 2021.
- Comprehensive and inclusive "Collaborative Case Reviews" are now done. Collaborative Case Review is a socio-technical process designed to identify and categorize contributing factors to risk, analyze these factors, and to suggest and test modifications for both effectiveness and resiliency. At TFH, SG has appreciated the level of engagement by the Reliability Team, which includes the CMO, clinical representatives, safety, logistics staff, and others with a wide variety of experiences.
- Standardized taxonomies have been developed around terms that apply to risk, systems, and human behavior and performance. In particular, TFH and the Human resources staff have identified excellent methods to manage Human Performance Factors (KSA, Cognition, Experience) differently than Human Behaviors.

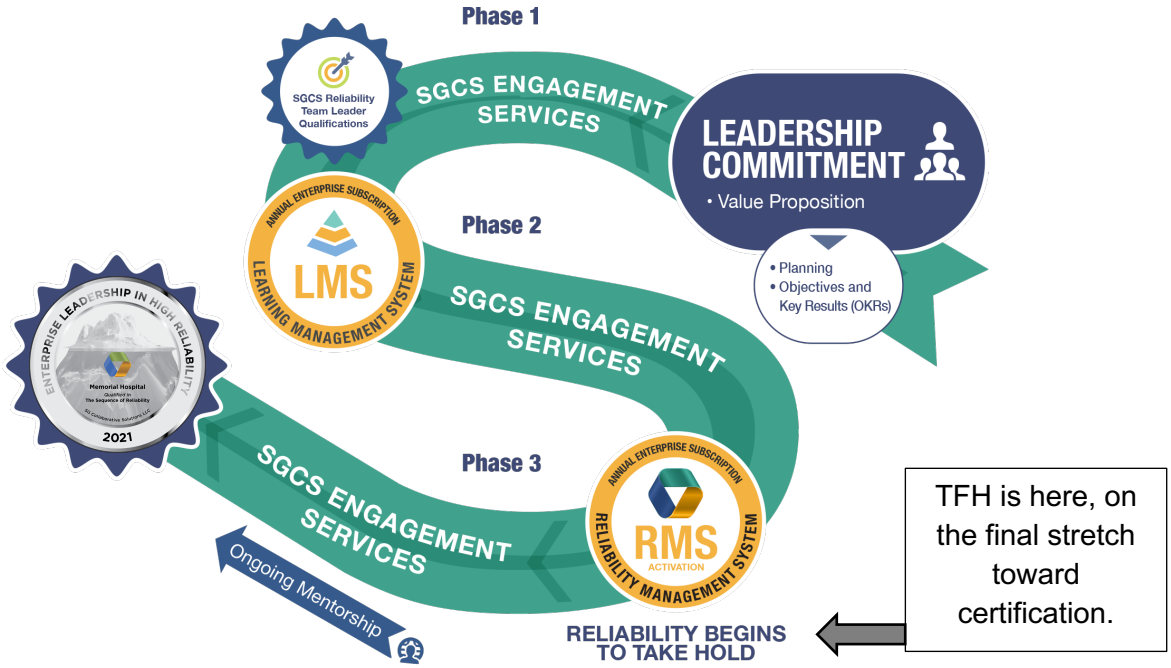
Progress Toward High Reliability

TFH started the journey toward High Reliability through initial “Just Culture” behavioral risk evaluation training in 2014. Within a short period of time, TFH Staff recognized that a more robust, long-lasting High Reliability Organization (HRO) strategy would still provide the necessary “Just Culture” behavioral response, but would also allow a “systems first” approach to analyzing risk. In addition, the HRO method offered a far stronger methodology for analyzing events and risk, and since it was initially developed for the commercial aviation industry, it’s known for being effective proactively.

The methods used to integrate HRO concepts into an organization take longer than most expect, since it requires cultural change and employs some radically different thought exercises associated with risk events. In most healthcare organizations, the journey takes between 7 and 10 years before the organization can become qualified and self-sustaining. This, of course, does not include the extra time added to the journey due to unforeseen events, such as restructuring, leadership changes, and major disrupting events like the COVID pandemic.

At the time of this writing, in October 2020, TFH is well along on their journey toward external certification and qualification. In the rough diagram below (the path is different for every organization, but this provides a fairly accurate progression), TFH is through Phase Two and moving into Phase Three.

Phase Three is where the organization becomes self-sustaining. Instructors are developed for the hands-on training required for Managers and Masters courses (see the Learning Management Process below), the Reliability Management Team becomes a “go-to” group for complex risk issues, and the entire organization understands and takes the “Risk – Systems – Performance – Behavior” approach when faced with a potential undesired outcome or potential risk.



2020 Report

Tahoe Forest Health System's Reliability Management Team (RMT), formed in 2018, currently has 20 members with representation from across the organization. Initially guided by SG Partners Paul LeSage and Dr. Dale Oda, the team is generally now self-managing, with Paul and Dale providing regular "subject matter expert" training, and updates in methodology.

The members of the RMT have undergone a significant amount of specialized training in order to see and understand risk differently as well as apply reliability and resilience concepts to manage risk when it is identified. The RMT continues to grow and develop, promoting the use of reliability concepts, as Tahoe Forest Health District strives to achieve the status of a High Reliability Organization (HRO).

In 2020, the RMT has continued to conduct weekly huddles and monthly meetings where recognized risks are discussed, cases reviewed, and potential system-based solutions are analyzed to ensure we are reliably managing the risk identified. The RMT identified a mechanism for tagging event reports in the online system for case analysis. The RMT has 16 active items on the Risk Register with 22 items in resolved status for the current year.

A focus this year has been organization-wide staff education on reliability management principles. This is done through a combination of online learning modules for all staff and live trainings for Directors, Managers, and Supervisors. Currently, 81.2%% of Directors/Managers/Supervisors and 30% of front line staff have completed the online portion of the training. In person training has been suspended due to the COVID-19 pandemic, but plans for distance learning options are being made. All new employees are now assigned the appropriate modules upon hire. The members of the RMT have had 5 training sessions, 1 of which was a live training and 4 via ZOOM.

Goals for the upcoming year include:

- Train local TFH instructors to do the live Director/Manager/Supervisor portion of the reliability training in house.
- Evaluate the possibility of becoming certified and qualified as a High Reliability Organization through external accrediting by DNV-GL.
- Look for more opportunities to be a resource to the Administrative Council when managing risks and reviewing potential solutions to assess the reliability and resilience of the suggested remedies.
- Overall, continue to work toward our goal of helping the organization see and understand risk differently so we can anticipate or respond to risk in a reliable manner.

2021 Sustainment Plan

The following resources will help Tahoe Forest Health System move toward self-sustainment in 2021:

- Continuation of the Reliability Team, including regular huddles, meetings, and training sessions.
- More persistent and regular use of the Reliability Team to look at complex risk events, in order to continue building an expert cadre of individuals within TFH who can provide ready assistance to any department needing help with risk events.
- Development of internal instructors who will be able to guide practical training sessions that are indicated in the diagram below.
- Further use and practice with the on-line High Reliability learning platform.

Initially, the on-line Learning Management System (LMS) provided for High Reliability was built for "Masters Competency." After COVID, it became apparent that a multi-level platform offering more opportunity for ***quick orientation*** of all staff, and for digital practice sessions was needed. To that end, the current LMS license and platform that TFH has access to for their High Reliability training will be ***enhanced at no additional cost for 2021***. The table below is an ***example*** of the remote training and education opportunities that the Reliability Team may embrace moving into 2021. Prior to initiating any changes, the TFH Reliability Team will work with their SG Partners to discuss best practices associated with how these tools can be implemented.

Importantly, this new platform allows for new employee, physician, and leader orientation around High Reliability principles in only 25 minutes (total), delivered in five short video sessions. It also allows for a shorter, but flexible "manager and Supervisor training component, to be decided by TFH staff.

Last, it still provides for "Masters" competency in high reliability skills for those who regularly manage risk, clinical operations, quality, human resources, and other high-impact positions.

High Reliability Sustainment Packs

	Masters Program	Management	Foundations
Description	• Comprehensive curriculum • Principles of Reliability • Performance & Behavior • Using the Reliability Guide • Essential Supervisor Skills	• High Reliability Orientation • Essential Supervisor skills • Performance vs. Behavior • Using the Reliability Guide (*Opt)	• High Reliability Orientation Series
Audience	• Reliability Team Members • Key Human Resources Staff • Clinical Unit Leaders • Safety, Quality, Risk Staff	• All Managers/Supervisors	• All Staff and New Employee Orientation
Time (hrs.) CPEs	• 10 self-directed online • 3 Live Learning Sessions • 3 Practical Application Sessions • 13 hours total • 6 CEU • Generally 6 months to complete	• 1.5 self-directed online • 2 Live Learning Sessions • 2.5 hours total • 2.5 Hrs CEU • Generally 1 month to complete • "Use of the RRG" Modules is an option depending on area of work and organizational structure	• 20-25 minutes, (Five-5 minute videos), self-directed online • Access to FAQs • Ask the Expert • Complete within 1 month of hiring.

TAHOE FOREST HEALTH SYSTEM

Origination Date:	*09/1996*
Last Approved:	*03/2020*
Last Revised:	*03/2020*
Next Review:	*03/2021*
Department:	*Quality Assurance / Performance Improvement - AQPI*
Applicabilities:	*System, Truckee Surgery Center*

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

PURPOSE:

The purpose of the Quality Assessment/Performance Improvement (QA/PI) plan is to provide a framework for promoting and sustaining performance improvement at Tahoe Forest Health System, in order to improve the quality of care and enhance organizational performance. The goals are to proactively reduce risk to our patients by eliminating or reducing factors that contribute to unanticipated adverse events and/or outcomes and provide high quality care and services to ensure a perfect care experience for our patients and customers. This will be accomplished through the support and involvement of the Board of Directors, Administration, Medical Staff, Management, and employees, in an environment that fosters collaboration and mutual respect. This collaborative approach supports innovation, data management, performance improvement, proactive risk assessment, commitment to customer satisfaction, and High Reliability tenets to promote and improve awareness of patient safety. Tahoe Forest Health System has an established mission, vision, values statement, and utilizes a foundation of excellence model, which are used to guide all improvement activities.

POLICY:

MISSION STATEMENT

The mission of Tahoe Forest Health System is *"We exist to make a difference in the health of our communities through excellence and compassion in all we do."*

VISION STATEMENT

The vision of Tahoe Forest Health System is *"To serve our region by striving to be the best mountain health system in the nation."*

VALUES STATEMENT

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

A. Quality – holding ourselves to the highest standards and having personal integrity in all we do.

B. Understanding – being aware of the concerns of others, caring for and respecting each other as we interact.

C. Excellence – doing things right the first time, on time, every time; and being accountable and responsible.

D. Stewardship – being a community steward in the care, handling and responsible management of resources while providing quality health care.

E. Teamwork – looking out for those we work with, findings ways to support each other in the jobs we do.

FOUNDATIONS OF EXCELLENCE

A. Our foundation of excellence includes: Quality, Service, People, Finance and Growth.

1. Quality – provide excellence in clinical outcomes
2. Service – best place to be cared for
3. People – best place to work, practice, and volunteer
4. Finance – provide superior financial performance
5. Growth – meet the needs of the community

PERFORMANCE IMPROVEMENT INITIATIVES

A. The 2020 performance improvement priorities are based on the principles of STEEEP™, (Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care) and the Quadruple Aim:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations;
3. Reducing the per capita cost of health care;
4. Staff engagement and joy in work.

B. Priorities identified include:

1. Exceed national benchmark with quality of care and patient satisfaction metric results with a focus on process improvement and performance excellence
    a. Striving for the Perfect Care Experience
    b. Identify and promote best practice and evidence-based medicine
2. Ongoing survey readiness, and compliance with federal and state regulations, resulting in a successful triennial Healthcare Facilities Accreditation Program (HFAP) survey
3. Sustain a Just Culture philosophy that promotes a culture of safety, transparency, and system improvement
    a. Continued participation in Beta HEART (Healing, Empathy, Accountability, Resolution, Trust) program
    b. Conduct annual Culture of Safety SCORE (Safety, Culture, Operational, Reliability, and Engagement) survey
    c. Continued focus on the importance of event reporting
4. Focus on our culture of safety, across the entire Health System, utilizing High Reliability Organizational thinking
    a. Proactive, not reactive
    b. Focus on building a strong, resilient system

c. Understand vulnerabilities
d. Recognize bias
e. Efficient resource management
f. Evaluate system based on risk, not rules

5. Support Patient and Family Centered Care and the Patient and Family Advisory Council
    a. Dignity and Respect: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
    b. Information Sharing: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
    c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
    d. Collaboration: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.
6. Promote lean principles to improve processes, reduce waste, and eliminate inefficiencies
7. Identify gaps in the Epic electronic health record system upgrade and develop plans of correction
8. Maximize Epic reporting functionality to improve data capture and identification of areas for improvement

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

ORGANIZATION FRAMEWORK

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

Governing Board

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

B. The Board:

1. Delegates the authority for developing, implementing, and maintaining performance improvement activities to Administration, Medical Staff, Management, and employees;
2. Responsible for determining, implementing, and monitoring policies governing the Critical Access

Hospital (CAH) and Rural Health Clinic (RHC) total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment (CMS 485.627(a))

3. Recognizes that performance improvement is a continuous, never-ending process, and therefore they will provide the necessary resources to carry out this philosophy;
4. Provides direction for the organization's improvement activities through the development of strategic initiatives;
5. Evaluates the organization's effectiveness in improving quality through reports from Administration, Department Directors, Medical Executive Committee, and Medical Staff Quality Committee.

Administrative Council

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

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

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

Board Quality Committee

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

Medical Executive Committee

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

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

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

Department Chairs of the Medical Staff

A. The Department Chairs:

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

Medical Staff

A. The Medical Staff is expected to participate and support performance improvement activities.

B. The Medical Staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the Medical Staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the Departments will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.

C. The Medical Director of Quality provides physician leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the Medical Staff and Health System leaders, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the Medical Staff and engages them in improvement activities. The Director chairs the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Supervisors)

A. Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Medical Staff Quality Committee. Many of these activities will interface with other departments and the Medical Staff. They are expected to do the following:

1. Foster an environment of collaboration and open communication with both internal and external customers;
2. Participate and guide staff to focus on patient safety, patient and family centered care, service recovery, and patient satisfaction;
3. Advance the philosophy of High Reliability within their departments;
4. Utilize Lean principles and DMAIC (Define, Measure, Analyze, Improve, Control) process improvement activities for department-specific performance improvement initiatives;
5. Establish performance and patient safety improvement activities in conjunction with other departments;
6. Encourage staff to report any and all reportable events including "near-misses";
7. Participate in the investigation and determination of the causes that underlie a "near-miss" / Sentinel/

Adverse Event/Error or Unanticipated Outcome and implement changes to reduce the probability of such events in the future.

Employees

A. The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone's responsibility and each employee is charged with practicing and supporting the Standards of Business Conduct: Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.

B. The Nursing Leadership Council consist of Registered Nurses from each service area. This Council is an integral part of reviewing QA/PI data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.

C. Employees are expected to do the following:

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

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Assessment Committee

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

The Medical Staff Quality Assessment Committee:

A. Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Environment of Care Management Program, Emergency Operations Plan, Utilization Review Plan, Risk Management Plan, Trauma Performance Improvement Plan, and the Patient Safety Plan.

B. Regularly reviews progress to the aforementioned plans.

C. Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes;

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

E. Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety

standards that may require further investigation;

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

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

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

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

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

K. Oversees the Trauma Program and monitors compliance with the Trauma Performance Improvement plan.

Performance Improvement Committee (PIC)

A. Medical Staff Quality Assessment Committee provides direct oversight for the PIC. PIC is an executive committee with departmental representatives within the Tahoe Forest Health System, presenting their QA/PI findings as assigned. The goal of this committee is to achieve optimal patient outcomes by making sure that all staff participate in performance improvement activities. Departmental Directors, or their designee, review assigned quality metrics biannually at the PIC (See Attachment C – QA PI Reporting Measures). Performance improvement includes collecting data, analyzing the data, and taking action to improve. Director of Quality and Regulations is responsible for processes related to this committee.

B. The Performance Improvement Committee will:

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

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

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

Performance Improvement Teams

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

volume.

B. Performance Improvement Teams will:

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

PERFORMANCE IMPROVEMENT EDUCATION

A. Training and education are essential to promote a culture of quality within the Tahoe Forest Health System. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees and Medical Staff receive additional annual training on various topics related to performance improvement.

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

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

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

PERFORMANCE IMPROVEMENT PRIORITIES

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

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

1. Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
2. Processes that affect health outcomes, patient safety, and quality of care
3. Processes related to patient advocacy and the perfect care experience
4. Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices
5. Processes related to patient flow
6. Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome

C. Because Tahoe Forest Health System is sensitive to the ever changing needs of the organization,

priorities may be changed or re-prioritized due to:

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

DESIGNING NEW AND MODIFIED PROCESSES/ FUNCTIONS/SERVICES

A. Tahoe Forest Health System designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:

1. Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
2. An external consultant is utilized to provide technical support, when needed.
3. The design team develops or modifies the process utilizing information from the following concepts:
    a. It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
    b. It is clinically sound and current
    c. Current knowledge when available and relevant, i.e., practice guidelines, successful practices, information from relevant literature and clinical standards
    d. It is consistent with sound business practices
    e. It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
    f. Conducts an analysis, and/or pilot testing, to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
    g. It incorporates the results of performance improvement activities
    h. It incorporates consideration of staffing effectiveness
    i. It incorporates consideration of patient safety issues
    j. It incorporates consideration of patient flow issues
4. Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
    a. They can identify the events it is intended to identify

b. They have a documented numerator and denominator or description of the population to which it is applicable

c. They have defined data elements and allowable values

d. They can detect changes in performance over time

e. They allow for comparison over time within the organization and between other entities

f. The data to be collected is available

g. Results can be reported in a way that is useful to the organization and other interested stakeholders

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

PROACTIVE RISK ASSESSMENTS

A. Risk assessments are conducted to pro-actively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. This includes, but is not limited to, the following:

1. A Failure Mode and Effect Analysis (FMEA) will be completed based on the organization's assessment and current trends in the health care industry, and as approved by PIC or the MS QAC.
2. The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.

a. The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.

b. For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.

c. Potential risk points in the process will be closely analyzed, including decision points and patient’s moving from one level of care to another through the continuum of care.

d. For the effects on the patient that are determined to be “critical”, an event analysis/root cause analysis is conducted to determine why the effect may occur.

e. The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.

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

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

3. Ongoing hazard surveillance rounds, including Environment of Care Rounds and departmental safety hazard inspections, are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
4. The Environment of Care Safety Officer and EOC/Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.

5. The Infection Preventionist and Environment of Care Safety Officer, or designee, complete a written infection control and pre-construction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

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

1. Medication therapy
2. Adverse event reports
3. National Quality forum patient safety indicators
4. Infection control surveillance and reporting
5. Surgical/invasive and manipulative procedures
6. Blood product usage, including transfusions and transfusion reactions
7. Data management
8. Discharge planning
9. Utilization management
10. Complaints and grievances
11. Restraints/seclusion use
12. Mortality review
13. Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
14. Needs, expectations, and satisfaction of individuals and organizations served, including:
    a. Their specific needs and expectations
    b. Their perceptions of how well the organization meets these needs and expectations
    c. How the organization can improve patient safety
    d. The effectiveness of pain management
15. Resuscitation and critical incident debriefings
16. Unplanned patient transfers/admissions
17. Medical record reviews
18. Performance measures from acceptable data bases/comparative reports, i.e., RL Datix Event Reporting, Quantros RRM, NDNQI, HCAHPS, Hospital Compare, QHi, CAHEN 2.0, and Press Ganey
19. Summaries of performance improvement actions and actions to reduce risks to patients

B. In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:

1. Quality measures delineated in clinical contracts will be reviewed annually

2. Pharmacy transactions as required by law and to control and account for all drugs
3. Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
4. Records of radio nuclides and radiopharmaceuticals, including the radionuclide's identity, the date received, method of receipt, activity, recipient's identity, date administered, and disposal
5. Reports of required reporting to federal, state, authorities
6. Performance measures of processes and outcomes, including measures outlined in clinical contracts

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

AGGREGATION AND ANALYSIS OF DATA

A. Tahoe Forest Health System believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, run charts (SPC), histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience (See Attachment D for QI PI Indicator definitions).

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

C. Data is analyzed in many ways including:

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

D. Intensive analysis is completed for:

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

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

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

REPORTING

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

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

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

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

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

CONFIDENTIALITY AND CONFLICT OF INTEREST

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

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

ANNUAL ASSESSMENT

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

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

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

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

PLAN APPROVAL

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

Related Policies/Forms:

Medication Error Reduction Plan, APH-34

Medication Error Reporting, APH-24

Infection Control Plan, AIPC-64

Environment of Care Management Program, AEOC-908

Utilization Review Plan (UR), DCM-1701

Risk Management Plan , AQPI-04

Patient Safety Plan, AQPI-02

Emergency Operations Plan (Comprehensive), AEOC-17

Discharge Planning, ANS-238

Trauma Performance Improvement Plan

References:

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

All revision dates: 03/2020, 03/2020, 11/2019, 05/2019, 03/2019, 03/2018, 02/2017, 02/2017, 02/2016, 12/2014, 02/2014

Attachments

A. Quality Initiatives 2020.docx
B. CAH Services by Agreement 2020
C. QA PI Reporting Measures 2020
D. QI Indicator Definitions 2020
E. External Reporting 2020

Approval Signatures

Step Description	Approver	Date
	Janet VanGelder: Director	03/2020
	Janet VanGelder: Director	03/2020

Institute for Healthcare Improvement

WHITE PAPER

Framework for Effective Board Governance of Health System Quality

Content provided by:

Lucian Leape Institute, an initiative of the Institute for Healthcare Improvement, guiding the global patient safety community.

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How to Cite This Paper: Daley Ullem E, Gandhi TK, Mate K, Whittington J, Renton M, Huebner J. *Framework for Effective Board Governance of Health System Quality*. IHI White Paper. Boston, Massachusetts: Institute for Healthcare Improvement; 2018. (Available on ihi.org)

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Acknowledgments:

The authors are grateful to the IHI Lucian Leape Institute members, whose leadership identified the need for support for trustees and health system leaders in governance of quality. We also thank the experts interviewed for this work and the in-depth contributions of the expert group that developed and revised the framework and assessment tool, including Kathryn C. Peisert, Managing Editor, The Governance Institute. This work was created through collaboration with many leading health care and governance organizations, including the American Hospital Association, The Governance Institute, and the American College of Healthcare Executives. Finally, the authors thank Jane Roessner and Val Weber of IHI for their thoughtful editorial review of this white paper and the IHI thought leaders who, over the years, have advanced board commitment to quality.

The Lucian Leape Institute is an initiative of IHI. This paper was generously funded by an unrestricted educational grant from Medtronic, Inaugural Funder of the IHI Lucian Leape Institute. Medtronic had no control or influence over the selection of experts, the content, or the views expressed in this paper.

Contents

Executive Summary

The Institute of Medicine (IOM) reports *To Err Is Human* and *Crossing the Quality Chasm* prompted health care leaders to address the patient safety crisis and advance the systems, teamwork, and improvement science needed to deliver safer care to patients.[1,2] Following the IOM reports, research on health care governance practices identified a correlation between health system board prioritization of quality oversight and higher performance on key quality indicators.[3,4,5,6,7] Quality oversight by a board has been shown to correlate with patient outcomes on key quality metrics, and boards that prioritize quality support a leadership commitment to quality and the incentives and oversight to achieve the quality care that patients deserve.

Two main evolutions have made governing quality more complex for trustees and the health system leaders who support them:

- The definition of "quality" has evolved and expanded over the last decade, from a singular focus on safety to an expanded focus on all six dimensions of quality as identified in the *Crossing the Quality Chasm* report.
- The expansion of health systems beyond hospital walls and the addition of population health oversight have created complexity both in terms of *what* to govern to support high-quality care and *how* to oversee quality outside of the traditional hospital setting and across the health care continuum.

Many health system leaders have worked to ensure that their trustees are sufficiently prepared to oversee quality, but the two factors noted above have increased the need for board education and the time commitment for trustees and the health system senior leaders who support them. Therefore, there is a need for a clear, actionable framework for better governance of quality across all dimensions, including identification of the core processes and necessary activities for effective governance of quality.

Ultimately, the most valuable resource of a board is time — both in terms of how much time they allocate and how they use it — to engage in oversight of the various areas of governance. To help health system leaders and boards use their governance time most effectively, this white paper includes three components:

- **Framework for Governance of Health System Quality:** A clear, actionable framework for oversight of all the dimensions of quality;
- **Governance of Quality Assessment:** A tool for trustees and health system leaders to evaluate and score current quality oversight processes and assess progress in improving board quality oversight over time; and
- **Three Support Guides:** Three central knowledge area support guides for governance of quality (Core Quality Knowledge, Core Improvement System Knowledge, and Board Culture and Commitment to Quality), which health system leaders and governance educators can use to advance their education for trustees.

The framework, assessment tool, and support guides aim to reduce variation in and clarify trustee responsibilities for quality oversight, and also serve as practical tools for trustees and the health system leaders who support them to govern quality in a way that will deliver better care to patients and communities.

Background

Research on health care governance practices has identified a correlation between health system board prioritization of quality oversight and higher performance on key quality indicators.[8,9,10,11,12] However, guidance and practices for board oversight of the dimensions of quality beyond safety are highly variable across health systems. Health system leaders and trustees are looking for greater depth and clarity on what they should do to fulfill their oversight of quality. Governance of quality is a long-overlooked and underutilized lever to deliver better care across all the dimensions of quality.

What to Govern as Quality: Expanding from Safety to STEEEP

The IOM report *Crossing the Quality Chasm* established six aims for improvement, a framework for health care quality in the US: care that is safe, timely, effective, efficient, equitable, and patient centered (STEEEP).[13] Safety is an essential component of quality, and health leaders have become more consistent in the governance of the elements of safety (though many health systems still do not dedicate enough time to quality or are quick to push it to the bottom of the agenda).

Yet governance of the other STEEEP dimensions of quality beyond safety is significantly more variable, providing an opportunity for greater clarity and calibration across the health care organizations and leaders that guide governance of quality. Health system leaders and trustees struggle with whether to govern a narrow definition of quality, driven by metrics defined by the Centers for Medicare & Medicaid Services (CMS) or national oversight organizations, versus governing quality's broader dimensions as put forth in the IOM STEEEP framework.

What to Govern as Quality: Expansion and Complexity of Health Systems

Health care leaders now look beyond the hospital walls to the entire system of care and to social and community factors that impact health outcomes. Thus, health system quality has expanded to include improving the health of communities and reducing the cost of health care and the financial burden facing patients. As health care is increasingly delivered in a range of settings beyond the hospital, from outpatient clinics to the home, leaders and trustees are challenged to define and govern quality in these settings.

The nationwide shift in US health care from standalone and community hospitals to larger, integrated care delivery systems has further increased the knowledge required for trustees to fulfill their fiduciary responsibility of governing quality. Finally, by tying revenue to quality performance, many payment models now add executive financial incentives to governance of quality. Health leaders have struggled to frame governance of quality in the context of the expansion and complexity of both single institutions and health systems.

Call to Action

In the 2017 report, *Leading a Culture of Safety: A Blueprint for Success,* board development and engagement was highlighted as one of the "six leadership domains that require CEO focus and dedication to develop and sustain a culture of safety."[14] According to the report, "The board is responsible for making sure the correct oversight is in place, that quality and safety data are

systematically reviewed, and that safety receives appropriate attention as a standing agenda item at all meetings."

Building on this report, the Institute for Healthcare Improvement (IHI) Lucian Leape Institute identified a need for greater understanding of the current state of governance of quality, education on quality for health system trustees, along with the potential need for guidance and tools to support governance oversight of quality. The IHI Lucian Leape Institute understood the importance of developing this forward-thinking and cutting-edge content collaboratively with leading governance organizations and making it available as a public good for all health systems to access and incorporate in a way that would be most helpful to them.

Assessment of Current Governance Practices and Education

To evaluate the current state of board governance of quality, IHI employed its 90-day innovation process.[15] This work included the following:

- **A landscape scan** to understand the current state of governance education offerings and challenges in quality, drawing on national and state trustee education programs. This scan included more than 50 interviews with governance experts, health system leaders, and trustees; and a review of available trustee guides and assessments for governance of quality.
- **A scan of existing peer-reviewed research** on board quality governance practices and the link between board practices and quality outcomes for health systems.
- **An expert meeting** (see Appendix B) attended by health care and governance experts. The meeting provided critical insights and guidance for the work, including the development of a framework for effective governance of health system quality. This group of thought leaders included representatives from the American Hospital Association (AHA), the American College of Healthcare Executives (ACHE), The Governance Institute, leading state hospital associations, health system CEOs and trustees, and national governance and health care quality experts.

Research and Landscape Scan Highlights

(Note: An in-depth assessment of the current state of board governance of quality and trustee education in support of quality is available in the companion document to this white paper, *Research Summary: Effective Board Governance of Health System Quality*.[16])

The IHI Lucian Leape Institute's research scan, evaluation of governance education in quality, and expert interviews indicated that most trustee education on governance of quality focuses primarily on safety, meaning that such education often does not prepare trustees for governing the other dimensions of quality as defined by the STEEEP framework and the IHI Triple Aim,[17] which also considers population health and health care cost. In the boardroom, quality is often a lower priority than financial oversight. Epstein and Jha found that "quality performance was on the agenda at every board meeting in 63 percent of US hospitals, and financial performance was always on the agenda in 93 percent of hospitals."[18]

Our interviews indicated that the financial and cultural implications of poor quality of care are not often formally considered, noting a difference between putting quality on a board meeting agenda and having a dedicated discussion about quality. Many trustees, while motivated to ensure high-quality care, lack a clear understanding of the necessary activities for effective quality oversight

(the "what" and "how" of their governance work); IHI's research identified the need for more direction on the core processes for governance of quality.[19] Some trustees noted that they were at the mercy of the quality data and information presented to them by their organization's leadership team; they lacked ways of confirming that their quality work was aligned with work at other leading health care organizations and industry best practice.

Health care leaders observed that the many guides and assessments they referenced often had varying recommendations for core governance activities on quality, especially for dimensions of quality beyond safety. We analyzed the available board guides or tools for board members and hospital leaders to evaluate their quality governance activities. The review of existing assessments from national and state governance support organizations identified that many focus on board prioritization of quality in terms of time spent and trustee "commitment" to governance based on a trustee self-assessment. Many assessments offer specific recommendations for key processes to oversee safety, such as reviewing serious events and key safety metrics in a dashboard. However, most assessments offer more variable guidance on the core processes to govern the STEEEP dimensions of quality beyond safety, quality outside of the hospital setting, and overall health in the communities the health systems serve.

With so many assessments and guidance recommending different processes and activities, it is not surprising that those who support trustees struggle to clearly define the core work of board quality oversight. Trustees and health care leaders alike identified a need for a simple framework that sets forth the activities that boards need to perform in their oversight of quality and for calibration across governance support organizations to support a simple, consistent framework.

Barriers to Governance of Quality

The IHI research team sought to understand and identify ways to address the many barriers to governance of quality identified in interviews and the published literature. The most common barrier identified was trustees' available time to contribute to a volunteer board. Often, health care leaders and trustees identified that expectations for trustee engagement on quality issues are not presented with the same clarity and priority as financial and philanthropic expectations for governance. Many interviewees noted that trustees are less confident in the governance of quality because of its clinical nature, which, in many cases, necessitates learning new terminology and absorbing concepts unfamiliar to trustees without a clinical background.

Many trustees and health care leaders we interviewed identified the CEO as the "gatekeeper" for the board, stewarding access to external resources and guidelines related to the board's role in health care quality, often not wanting to overwhelm or burden the trustees, given the demands on their time. However, even when the trustees and health care leaders interviewed indicated that they did have dedicated time and commitment to quality, they were not clear as to whether the specific set of processes or activities they currently had in place were the best ones for effective governance of quality.

Based on insights from IHI's research, landscape scan of current guidance on quality oversight, and extensive interviews, a new framework for governance of quality was created through a collaborative effort of thought leaders and health system leaders to provide clarity, support, and reduced variation in what boards should consider for their oversight of quality. The framework identifies the foundational knowledge of core quality concepts and the need to understand the systems for quality control and improvement used in health systems. The framework also recognizes that board culture and commitment to quality are essential.

A new Governance of Quality Assessment identifies the core processes of board governance of quality, providing a tool for boards and health system leaders to calibrate the governance oversight work plan. When these core processes are approached consistently, organizations can advance governance of quality that, based on previously cited studies, will support the health system's performance on quality.

Current State of Board Work and Education in Health System Quality

- **Governance of quality is primarily focused on safety.**

  Board education in quality is available but inconsistently accessed by trustees; education focuses primarily on safety, with variable exposure to other dimensions of quality.

- **Governance of quality is hospital-centric, with limited focus on population or community health.**

  Most board education emphasizes in-hospital quality; it does not guide boards in oversight of care in other health system settings or in the health of the community.

- **Core processes for governance of quality core are variable.**

  Board quality educational support offerings tend to emphasize general engagement in the form of time, structure, and leadership commitment to quality governance; they focus less on the specific activities (especially beyond safety) and core processes trustees need to employ to oversee quality.

- **A clear, consistent framework for governance of health system quality is needed.**

  Utilizing a consistent framework and assessment tool for key board-specific processes for quality oversight will help improve governance of health system quality and deliver on patient and community expectations for quality care.

- **A call to action to raise expectations and improve support for board governance of health system quality is needed.**

  A multifaceted approach is needed to break through the barriers to trustee oversight of quality, including a greater call to action, clearer set of core processes with an assessment of that work, and raised expectations for time to govern quality.

Framework for Governance of Health System Quality

Achieving better quality care in health systems requires a complex and multifaceted partnership among health care providers, payers, patients, and caregivers. The IHI Lucian Leape Institute's research scan, evaluation of governance education in quality, and expert interviews made it clear that board members, and those who support them, desire a clear and consistent framework to guide core quality knowledge, expectations, and activities to better govern quality. To help make progress in this area, the IHI Lucian Leape Institute convened leading governance organizations, health industry thought leaders, and trustees (see Appendix B) to collaboratively develop a new comprehensive framework and assessment tool for governance of quality.

The framework and assessment tool are designed with the following considerations:

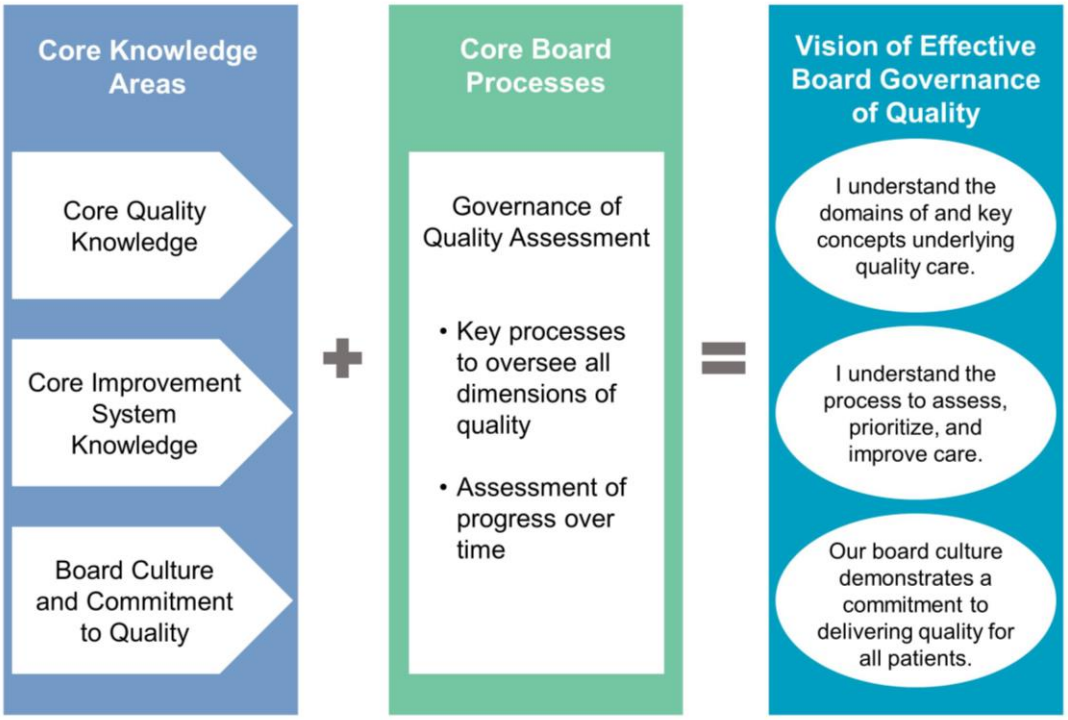
- **Simplify concepts:** Use simple, trustee-friendly language that defines actionable processes and activities for trustees and those who support them to oversee quality.
- **Incorporate all six STEEEP dimensions of quality:** Understand quality as care that is safe, timely, effective, efficient, equitable, and patient centered (STEEEP), as defined by the Institute of Medicine.
- **Include community health and value:** Ensure that population health and health care value are critical elements of quality oversight.
- **Govern quality in and out of the hospital setting:** Advance quality governance throughout the health system, not solely in the hospital setting.
- **Advance organizational improvement knowledge:** Support trustees in understanding the ways to evaluate, prioritize, and improve performance on dimensions of quality.
- **Identify the key attributes of a governance culture of quality:** Describe the elements of a board culture and commitment to high-quality, patient-centered, equitable care.

IHI worked with the expert group to establish an aspirational vision for trustees: With the ideal education in and knowledge of quality concepts, every trustee will be able to respond to three statements in the affirmative (see Figure 1).

Figure 1. Vision of Effective Board Governance of Health System Quality

Having established the vision, the expert group proceeded to define the core knowledge and core processes necessary to realize this vision, resulting in the development of a Framework for Governance of Health System Quality (see Figure 2).

Figure 2. Framework for Governance of Health System Quality



At the heart of the framework [CENTER] is the Governance of Quality Assessment (GQA), which outlines the key processes and activities that, if well performed, enable trustees to achieve the vision of effective board governance of quality [RIGHT]. The GQA serves as both a **roadmap of the key processes the board should undertake** to oversee all dimensions of quality, and an **assessment of how well the board is doing** with respect to those processes.

The expert group also identified three core knowledge areas [LEFT] that support the effective execution of the core processes and activities outlined in the GQA: Core Quality Knowledge, Core Improvement System Knowledge, and Board Culture and Commitment to Quality. The expert group's suggestions for core knowledge are assembled into three support guides (see Appendix A).

Together, the GQA and the three support guides aim to reduce variation in current governance recommendations and practices and to establish a comprehensive framework for the core knowledge and key activities for fiduciary governance of quality. Health system leadership and governance educators can use these tools to calibrate and advance their educational materials for trustees and develop ongoing education.

Patient-Centered Depiction of Quality

The expert group supported the use of a patient-centered framework, like the one introduced at Nationwide Children's Hospital in Ohio,[20] to display the core components of quality and drive home the direct impact they have on care. There is a compelling case for conveying this information to the board using a patient lens, as trustees may find the patient perspective on quality more motivating and actionable than the STEEEP terminology.

This reframed model also bundles some elements of STEEEP together in a way that represents the patient journey and avoids some of the health care terminology that can be off-putting to trustees. For example, the STEEEP dimensions of timely and efficient care are combined into "Help Me Navigate My Care." The STEEEP dimensions of equitable and patient-centered care are aggregated into "Treat Me with Respect." Figure 3 presents a visual representation of the core components of quality from the patient's perspective, with the patient at the center of the delivery system.

Figure 3. Core Components of Quality from the Patient's Perspective

*IOM STEEEP dimensions of quality: Safe, Timely, Effective, Efficient, Equitable, and Patient centered

The new framework and assessment tool will reveal areas for quality improvement to many CEOs and board members. It will take time for board members and health system leaders to incorporate those additional elements of quality into their agendas and work plans, but the changes will help to better align their quality oversight with patient expectations and the evolution, expansion, and complexity of health care delivery. Maintaining the status quo with regard to quality governance will not best serve patients or health systems, which face increasing complexity of patient-, population-, and community-based care in the coming years.

Governance of Quality Assessment: A Roadmap for Board Oversight of Health System Quality

The Governance of Quality Assessment (GQA) serves as both a **roadmap of the key processes the board should undertake** to oversee all dimensions of quality, and an **assessment of how well the board is doing** with respect to those processes. The GQA employs a set of concrete recommendations for 30 core processes of quality oversight organized into six categories, and provides a high-level assessment of board culture, structure, and commitment. The resulting GQA scores (for each core process, each category, and overall total) provide a roadmap for health care leaders and trustees to identify what to do in their work plan — and to assess their progress over time.

Most current board assessments primarily cover elements of safety, patient satisfaction, and/or board culture related to quality oversight. Most assessments do not identify the specific processes for quality oversight beyond safety and do not equally address all the dimensions of quality, including population health and care provided outside of the hospital. Variation across assessments may create confusion among trustees about what really is optimal in the oversight of quality.

The GQA aims to ensure that health system board quality oversight extends beyond the hospital to include the entire continuum of care. While many trustees understand concepts and frameworks like STEEEP and the IHI Triple Aim, they often have difficulty translating those concepts into specific activities they must perform. The GQA is specific, actionable, and tracks the processes that enable excellent quality governance. The GQA is designed for trustees and those who support them; it is written in straightforward, actionable, and trustee-centered language.

GQA Core Processes and Scoring

The Governance of Quality Assessment provides a snapshot of a total of 30 core processes organized into six categories that a board with fiduciary oversight needs to perform to properly oversee quality. The 30 core processes were developed by the expert group based on their expert opinions combined with insights gathered from more than 50 additional interviews of governance experts and health executives in the research and assessment phase of this work.

As referenced in the companion research summary to this white paper,[21] there are limited evidence-based recommendations on core processes for governance of quality beyond a few structural recommendations such as time spent, use of a dashboard, and having a dedicated quality committee. The GQA puts forth a set of core processes for governance of quality that were collaboratively developed, evaluated, and ranked at the expert meeting.

The GQA should be utilized by health systems and results tracked over time to validate the assessment's effectiveness. Certainly, there are additional quality oversight actions a board could undertake (and many already do) beyond those identified in the GQA. However, the expert group and interviewees identified the core processes in the GQA as a starting point for calibration and improvement. With a commitment to learning and improvement, and in recognition of the dynamic nature of health care, the GQA should also be revised as appropriate to incorporate the insights from new research in the boardroom.

The GQA includes a scoring system (0, 1, or 2) for trustees and health system leaders to assess the current level of performance for the 30 core processes, the six categories, and overall. Scores are totaled so that trustees and health care leaders can establish baseline scores (for each process, category, and overall) and then track their progress over time.

Bringing the GQA to the Boardroom

Health system CEOs should complete the GQA annually with their board chair and quality committee chair(s) and/or quality committee to establish a baseline for assessing their current state of oversight of quality; to identify opportunities for improvement; and to track their GQA scores over time as a measure of improving board quality oversight. It is also useful to have the senior leaders who interface with the board complete the GQA to understand and assess their role with respect to trustee oversight of quality.

Once the respondents have completed the GQA, senior leaders and trustees may choose to focus on the lowest-scoring areas to identify improvement strategies. Within larger health systems, the GQA is a useful tool to evaluate the work of multiple quality committees and create a system-wide work plan and strategies for board oversight of quality. We recommend that boards complete the GQA annually to monitor their performance and progress.

The GQA can also be used to guide discussions about which activities should be conducted at which level of governance in the case of complex systems (e.g., which processes are or should be covered in local boards, the system quality committee, and/or the overall health system board). In addition, the assessment can be used as a tool for discussion in setting agenda items for the board or quality committees.

Finally, governance educators might also use the assessment to help design their educational sessions for board members, targeting educational content to the areas where the clients need more support or education.

The expert group also recommended that the assessment tool be utilized for future research to compare how systems are performing relative to each other, collecting data longitudinally to identify which elements of the GQA are most correlated with various components of quality performance and other metrics of culture and management known to be associated with excellence.

Governance of Quality Assessment (GQA) Tool

This assessment tool was developed to support trustees and senior leaders of health systems in their oversight of quality of care by defining the core processes, culture, and commitment for excellence in oversight of quality. A guiding principle in the development of this assessment was for the board to view their role in quality oversight comprehensively in terms of the Institute of Medicine STEEEP dimensions (care that is safe, timely, effective, efficient, equitable, and patient centered) and the IHI Triple Aim.

The Governance of Quality Assessment (GQA) tool should be used to evaluate the current level of performance for 30 core processes in six categories, to identify areas of oversight of quality that need greater attention or improvement, and to track progress over time.

Instructions

The Governance of Quality Assessment organizes the health system board's quality oversight role into six categories that include a total of 30 core processes a board with fiduciary oversight should perform to effectively oversee quality.

Health system CEOs should complete the GQA annually with their board chair and quality committee chair(s) and/or quality committee.

For each item in the assessment, the person completing the assessment should indicate a score of 0, 1, or 2. Scores are then totaled for each category and overall.

Score	Description
0	**No activity:** The process is not currently performed by the board, or I am unaware of our work in or commitment to this area.
1	**Infrequent practice:** The board currently does some work in this area, but not extensively, routinely, or frequently.
2	**Board priority:** The board currently does this process well — regularly and with thought and depth.

Governance of Quality Assessment Tool (continued)

Category 1: Prioritize Quality: Board Quality Culture and Commitment		
Core Board Process	**Score (0, 1, or 2)**	**Process leads to a:**
1. Board establishes quality as a priority on the main board agenda (e.g., equivalent time spent on quality and finance), and time spent on quality reflects board commitment.		Executive committee/governing board that spends a minimum of 20% to 25% of meeting time on quality Agenda that reflects board oversight of and commitment to quality
2. Health system senior leaders provide initial and ongoing in-depth education on quality and improvement systems to all trustees and quality committee members, and clearly articulate board fiduciary responsibility for quality oversight and leadership.		Board that understands the definition of quality, key concepts, and the system of improvement used within the organization
3. Board receives materials on quality before board meetings that are appropriately summarized and in a level of detail for the board to understand the concepts and engage as thought partners.		Board that is prepared for quality oversight and engaged in key areas for discussion
4. Board reviews the annual quality and safety plan, reviews performance on quality metrics, and sets improvement aims.		Board that takes responsibility for quality and performance on quality
5. Board ties leadership performance incentives to performance on key quality dimensions.		Board that establishes compensation incentives for senior leaders linked to prioritizing safe, high-quality care
6. Board conducts rounds at the point of care or visits the health system and community to hear stories directly from patients and caregivers to incorporate the diverse perspectives of the populations served.		Board that sets the tone throughout the organization for a culture of teamwork, respect, and transparency and demonstrates an in-person, frontline, board-level commitment to quality
7. Board asks questions about gaps, trends, and priority issues related to quality and is actively engaged in discussions about quality.		Board that engages in generative discussion about quality improvement work and resource allocation
Category 1 Total Score: (14 possible)		

Governance of Quality Assessment Tool (continued)

Category 2: Keep Me Safe: Safe Care		
Core Board Process	**Score (0, 1, or 2)**	**Process leads to a:**
1. Board regularly tracks and discusses performance over time on key safety metrics (including both in-hospital safety and safety in other settings of care).		Board that reviews management performance on key safety metrics and holds management accountable for areas where performance needs to be improved
2. Board annually reviews management's summary of the financial impact of poor quality on payments and liability costs.		Board that understands the financial costs of poor safety performance
3. Board evaluates management's summary of incident reporting trends and timeliness to ensure transparency to identify and address safety issues.		Board that holds management accountable to support staff in sharing safety concerns to create a safe environment of care for patients and staff
4. Board reviews Serious Safety Events (including workforce safety) in a timely manner, ensuring that leadership has a learning system to share the root cause findings, learning, and improvements.		Board that holds management accountable for a timely response to harm events and learning from harm
5. Board reviews management summary of their culture of safety survey or teamwork/safety climate survey to evaluate variations and understand management's improvement strategies for improving psychological safety, teamwork, and workforce engagement.		Board that holds management accountable for building and supporting a culture of psychological safety that values willingness to speak up as essential to patient care and a collaborative workplace
6. Board reviews required regulatory compliance survey results and recommendations for improvement.		Board that performs its required national (e.g., CMS, Joint Commission, organ donation) and state regulatory compliance oversight
Category 2 Total Score: (12 possible)		

Governance of Quality Assessment Tool (continued)

Category 3: Provide Me with the Right Care: Effective Care		
Core Board Process	**Score (0, 1, or 2)**	**Process leads to a:**
1. Board ensures that the clinician credentialing process addresses concerns about behavior, performance, or volume and is calibrated across the health system.		Board that understands its fiduciary responsibility of credentialing oversight to ensure the talent and culture to deliver effective patient care
2. Board reviews trends and drivers of effective and appropriate care as defined for the different areas of the system's care.		Board that holds leadership accountable to ensure that the system does not underuse, overuse, or misuse care
3. Board evaluates senior leaders' summary of metrics to ensure physician and staff ability to care for patients (e.g., physician and staff engagement, complaint trends, staff turnover, burnout metrics, violence).		Board that holds senior leaders accountable for the link between staff engagement and wellness with the ability to provide effective patient care
4. Board establishes a measure of health care affordability and tracks this measure, in addition to patient medical debt, over time.		Board that understands that cost is a barrier for patients, and that health systems are accountable to the community to ensure affordable care
Category 3 Total Score: (8 possible)		

Governance of Quality Assessment Tool (continued)

Category 4: Treat Me with Respect: Equitable and Patient-Centered Care		
Core Board Process	**Score (0, 1, or 2)**	**Process leads to a:**
1. Board has patient representation, patient stories, and/or interaction with patient and family councils, and engagement with community advocates at every board and quality committee meeting.		Board that connects its quality oversight role with direct patient experiences to build understanding of issues and connection to patients
2. Board reviews patient-reported complaints and trends in patient experience and loyalty that indicate areas where respectful patient care is not meeting system standards.		Board that reviews senior leadership's approach to evaluating, prioritizing, and responding to patient concerns and values a patient's willingness to recommend future care
3. Board evaluates and ensures diversity and inclusion at all levels of the organization, including the board, senior leadership, staff, providers, and vendors that support the health system.		Board that supports and advances building a diverse and culturally respectful team to serve patients
4. Board reviews the health system's approach to disclosure following occurrences of harm to patients and understands the healing, learning, and financial and reputational benefit of transparency after harm occurs.		Board that understands the link between transparency with patients after harm occurs and a culture of learning and improvement in the health system
5. Board ensures that all patient populations, especially the most vulnerable, are provided effective care by evaluating variations in care outcomes for key conditions or service lines based on race, gender, ethnicity, language, socioeconomic status/payer type, and age.		Board that holds senior leaders accountable for health equity (making sure all patients receive the same quality of care) and prioritizes closing the gaps in outcomes that are identified as disparities in care
Category 4 Total Score: (10 possible)		

Governance of Quality Assessment Tool (continued)

Category 5: Help Me Navigate My Care: Timely and Efficient Care		
Core Board Process	**Score (0, 1, or 2)**	**Process leads to a:**
1. Board reviews metrics related to access to care at all points in the system (e.g., hospital, clinics, behavioral health, nursing home, home care, dental) and ensures that access is equitable and timely for all patients.		Board that oversees senior leadership's strategy to improve care access (e.g., time and ability to get an appointment, wait time for test results, delays) for all patients
2. Board reviews senior leadership's strategy for and measurement of patient flow, timeliness, and transitions of care, and evaluates leadership's improvement priorities.		Board that evaluates the complexity of care navigation for patients and monitors senior leadership's work to integrate care, reduce barriers, and coordinate care (e.g., delays, patient flow issues) to support patients
3. Board evaluates senior leadership's strategy for digital integration and security of patient clinical information and its accessibility and portability to support patient care.		Board that holds senior leaders accountable for a strategy to support patients' digital access, security, and portability of clinical information
Category 5 Total Score: (6 possible)		

Governance of Quality Assessment Tool (continued)

Category 6: Help Me Stay Well: Community and Population Health and Wellness		
Core Board Process	**Score (0, 1, or 2)**	**Process leads to a:**
1. Board reviews community health needs assessment and senior leadership's plans for community and population health improvement.		Board that oversees the development of a community health needs assessment and has identified which population health metrics are most relevant to track for its patients (e.g., asthma, diabetes, stroke, cancer screening, flu vaccine, dental, prenatal, opioid overuse, obesity, depression screening) Board holds senior leaders accountable for reaching goals established to improve key community health issues
2. Board reviews performance in risk-based contracts for population health.		Board that evaluates performance on risk-based contracts for populations and strategies for improvement
3. Board evaluates approach to integration and continuity of care for behavioral health patients.		Board that holds senior leaders accountable for integrating care and tracking care coordination data to support screening, access, and follow-up
4. Board reviews leadership's plans to address social determinants of health, including any plans for integration with social and community services.		Board that understands the essential nature of wraparound services to support the wellness of certain patient populations and oversees the strategic integration with those service providers
5. Board evaluates the health system's strategy for supporting patients with medically and socially complex needs and with advance care planning.		Board that ensures senior leaders evaluate high-utilization groups and key drivers to help those users navigate and manage their care
Category 6 Total Score: (10 possible)		

Total Score for This Assessment: **(sum of total scores for Categories 1 through 6)**	
Total Possible Score:	**60**

Interpreting the Overall Governance of Quality Assessment Score

Total Score	Board Performance Level
40 to 60	Advanced board commitment to quality
25 to 40	Standard board commitment to quality
25 or Fewer	Developing board commitment to quality

Using GQA Results to Plan Next Steps

After completing the Governance of Quality Assessment, the CEO, board chair, and board quality chair(s) should review the results and use them as the basis for planning next steps.

- **Review the spectrum of GQA scores:** Are the results similar across your board and committees? Compare the variation of scores across your board, quality committee(s), and senior leaders. If there is high variation in scores, it may be an opportunity to consider clarifying expectations and the work plan for quality oversight.
- **Aggregate GQA scores to identify areas for improvement:** Aggregating the GQA scores (overall and for each category) establishes a baseline score to evaluate the current areas of oversight and identify opportunities to better oversee the dimensions of quality that have lower scores. Could the board agenda or work plan be adjusted to make time to address other quality items (i.e., those with low GQA scores)?
- **Set a target GQA score for next year:** Set a target and a plan for improving the GQA score annually. Focus on the elements of the GQA where you have the greatest gap or that are of the most strategic importance to your organization.

We recommend that boards and leadership teams also evaluate time spent discussing quality and trustee confidence in their knowledge of basic quality concepts in tandem with the GQA.

- **Evaluate time allocation to quality:** Track how much time the board spends each meeting discussing quality. Does the time commitment indicate that quality has equal priority in time and attention with finance? Is quality just an item on the agenda without discussion?
- **Use the GQA to identify board education opportunities:** Review both the initial education and the ongoing education of board members on quality. What topics in the framework and GQA are not covered? Do you provide trustees with supplementary reading, useful articles, and educational opportunities in the areas identified in the GQA?

Conclusion

Excellence in quality must be supported from the bedside to the boardroom; patients deserve nothing less. Health system boards are deeply committed to the patients and communities they serve; however, trustees often require support in order to best understand and fulfill their fiduciary responsibility and commitment to the patients and communities they serve. Trustee knowledge of quality and improvement concepts is essential to their governance role. To be effective, trustees must also pair this knowledge with an effective board culture and a clear set of activities that support oversight of quality.

The framework, assessment tool, and support guides presented in this white paper were created through collaboration with leaders in health care and governance. The immediate goal of these resources is to reduce variation in board oversight of quality and to provide an improved roadmap for health system trustees. The ultimate goal is to ensure that oversight of quality of care for all patients is supported by more effective board education in quality concepts, clarity of core processes for trustee governance of quality, and a deeper board commitment to quality.

Appendix A: Support Guides

The expert group identified three core knowledge areas for effective governance of quality: first, a familiarity with all dimensions of quality; second, an understanding of how improvement occurs in systems; and third, an appreciation of the importance of demonstrating a commitment to quality through the board culture.

Appendix A includes support guides for these three core knowledge areas:

Support Guide: Core Quality Knowledge

The medical terms, health care oversight organizations and processes, and clinical concepts that arise in quality work are often unfamiliar to board members without a medical background, unlike other areas of oversight such as finance. Initial and ongoing education in quality concepts is essential to providing trustees with the necessary context and knowledge for thoughtful engagement.

This support guide is designed to guide hospital leaders and trustee educators in taking the guesswork out of the core quality concepts that are needed to prepare trustees for governance of quality across *all* dimensions and *all* care settings.

The expert group recommended providing governance education to trustees via a simple, patient-centered framework, just as the Governance of Quality Assessment consolidates and clarifies core board processes for governance of quality from the STEEEP dimensions of quality into a patient-centered framework. See Figure 3 (above), which presents the patient at the center of governance quality work, a visual that the expert group found compelling.

All new trustees, not just quality committee members, need to receive a thorough introduction to quality. To oversee quality, board members need fluency in many concepts, which should be introduced in a layered manner (similar to building a scaffold) to avoid overwhelming trustees. An overarching framework that shows how all these elements are necessary for patient care helps connect the dots and build commitment.

Table 1 presents the foundational concepts for board oversight of quality recommended by the expert group, organized by the STEEEP dimensions of quality (care that is safe, timely, effective, efficient, equitable, and patient centered) represented through a patient lens.

Table 1. Foundational Concepts for Board Core Quality Knowledge

Quality Concept	Key Questions	Suggested Educational Concepts
Basic Quality Overview	• What is quality in health care? • What are the benefits of quality? • What are the costs of poor quality? • Who oversees the elements of quality in our organization?	• Brief overview of quality in health care • STEEEP dimensions of quality presented through a patient lens • IHI Triple Aim • Benefits of quality • "Cost" of poor quality: Financial, patients, staff • Quality strategy, quality management • Overview of risk-/value-based care • Structures for quality reporting, assessment, and improvement • Structure for CEO/leadership evaluation
Keep Me Safe *Safe*	• What is safety? • What is a culture of safety? • What are surveys of patient safety culture? • What is "harm"? • What are the types of harm? • How do you decide if an adverse outcome is preventable harm? • How do we learn about harm in a timely manner? • What is our response to harm (i.e., what actions do we take when harm occurs)? • What are the financial and reputational costs of harm? • How do we reduce, learn from, and prevent harm? • How do we track harm in our system and in the industry?	• Preventable harm vs. adverse outcome • Just Culture and culture of safety • Science of error prevention and high reliability • Classification of the types of harm • Knowing about harm: Incident reporting, claims, grievances • Response to harm: Root cause analysis/adverse event review, patient apology and disclosure, legal, learning systems • Costs of harm: Claims/lawsuits, penalties, ratings, reputational, human emotional impact • Harm terminology: HAC, SSI, falls, ADE, employee safety, etc. • Regulatory oversight of safety

Quality Concept	Key Questions	Suggested Educational Concepts
Provide Me with the Right Care *Effective*	• How do we ensure that our health system properly diagnoses and cares for patients to the best evidence-based standards in medicine? • How does leadership oversee whether approaches to care vary within our system? • How do we identify the areas where care is not to our standards? • How do we identify the areas where care is meeting or exceeding our standards? • How do we attract and retain talent to care for patients?	• Evidence-based medicine • Overview of staff and physician recruitment, credentials/privileges, training, retention (burnout, turnover, violence) • Overview of standard of care concept and issues/processes that lead to variation • Trends in care utilization and clinical outcomes • Key care outcomes to be evaluated through an equity lens: race, ethnicity, gender, language, and socioeconomic status
Treat Me with Respect *Equitable and Patient centered*	• How do we evaluate patients' satisfaction and feedback? • What is "equitable care" and how do we evaluate it? • Do some patient groups have worse outcomes? Why? • What is our staff diversity and how may it impact patient care? • How do we ensure that patients are partners in their care? • How do we reduce cost of care? • How do we track medical debt for patient groups?	• Patient satisfaction and patient grievances (e.g., HCAHPS[22]) • Patient-centered care • Care affordability, debt burden • Social determinants of health • Pricing and affordability of care bundles • Total costs of care for conditions • Medical debt concerns/trends • Value-based payment models
Help Me Navigate My Care *Timely and Efficient*	• What do care navigation and care access mean? • What issues result from waiting for care or disconnected care (care that is not timely or efficient)? • Which populations have more complex care needs? What do we do to help them navigate care? • What is the role of a portable medical record and health IT in supporting care navigation?	• Care access, efficiency, and drivers of care navigation • Define "continuum of care" • Focus on key areas that are "roadblocks" in care navigation and their drivers • Define electronic health record, health IT, and the systems to support and secure patient information and patient access

Quality Concept	Key Questions	Suggested Educational Concepts
Help Me Stay Well *Community and Population Health and Wellness*	• What is the difference between population and patient health? • How do we segment patient populations to evaluate population health outcomes? • What unique strategies do/can we deploy to care for and engage areas or populations with worse health outcomes? • How are we compensated (or not) for population health and wellness?	• Define population health vs. patient health[23] • Explain the community health needs assessment (CHNA) • Interpret population health, prevention, and wellness metrics • Define social determinants of health • Explain fee-based vs. risk-based contracts

This support guide can be used as a starting point for hospital leaders and educators to create their system's board education plan, to ensure the concepts are imparted across the dimensions of health care quality to trustees. Health systems will vary in terms of which concepts need to be introduced to all trustees versus only to those who serve on the quality committee. That said, absorbing all these concepts at once would be overwhelming, so teaching the concepts in smaller segments over time is essential, as is reinforcing the concepts with additional learning opportunities and available resources, particularly as new members join the board.

It is also worthwhile to consider different formats for teaching these concepts to various audiences such as a half-day retreat, a full-day education session, or in-depth hour-long programs offered throughout the year. Finally, consider how the concepts should be introduced to new trustees and reinforced for experienced trustees to support a common knowledge base.

Just as most trustees join a board with a conversation about what they can contribute in time, treasure, and talent to support the organization, perhaps there can also be a "learn" expectation to identify the need for continuous growth and learning, even as a trustee, to advance a culture of improvement and quality excellence.

Support Guide: Core Improvement System Knowledge

A 2016 IHI White Paper, *Sustaining Improvement*, identified the drivers of quality control and quality improvement in high-performing organizations and highlighted that boards play an essential role in creating a culture of quality care and quality improvement.[24] Quality knowledge for trustees must include a deep understanding of and comfort with how health system leaders will identify, assess, and improve the elements of care delivery.

Organizations might take many approaches to improvement — from Total Quality Management, to Lean, to high reliability, to the Model for Improvement. Trustees need to understand their health system's improvement methodology and ensure that the health system has the people, processes, and infrastructure to support its improvement efforts.

Trustees might ask health system leaders the following discussion questions to gain an understanding of the organization's improvement system:

- What is the organization's system of improvement, in terms of both evaluating performance and prioritizing areas for improvement?
- How were major quality improvement efforts selected in the last two years? What criteria were used and evaluated to measure their impact?
- How does quality improvement cover the entire health system versus in-hospital improvement only?
- What analytic methods do leaders use to gather insight from the entire system to inform improvement initiatives? What are the gaps in the information and analytics?
- Recognizing that quality improvement is most sustainable when frontline staff members are engaged, how do senior leaders ensure that frontline staff lead quality improvement work, are actively providing ideas for improvement, and are willing and encouraged to speak up?

Health care leaders may educate board members on their organization's improvement system in many ways. For example:

- Virginia Mason Health System board members travel to Japan to learn about the Toyota Production System and Lean principles that Virginia Mason also employs.[25]
- The pediatric improvement network called Solutions for Patient Safety dedicates significant effort to board education on their high-reliability method of improvement and the board's role in understanding the core knowledge of safety and analyzing performance.[26]
- The board at St. Mary's General Hospital in Kitchener, Ontario, "sought out new knowledge about Lean through board education sessions, recruited new members with expertise in Lean and sent more than half of the board to external site visits to observe a high-performing Lean healthcare organization."[27]

Boards must understand how health system leaders perform the functions of quality planning, quality control, and quality improvement throughout the organization — and how that quality work is prioritized and resources are allocated. A 2015 article describes the process that Johns Hopkins Medicine undertook to ensure that the health system could map accountability for quality improvement throughout the organization, from the point of care to the board quality committee.[28] Similarly, in an article for The Governance Institute's *BoardRoom Press*, leaders from Main Line

Health shared their effort to delineate the flow and tasks of the oversight of quality from the boardroom to the frontline operations.[29] While the Johns Hopkins and Main Line Health approaches are unique to their systems, the essential idea they advanced is that a board and leadership should define the components of quality improvement work in their system and identify the accountability for those components throughout the system.

In addition to understanding accountability for quality throughout a health system, it is also essential for trustees to develop analytical skills to review data and engage meaningfully with leadership in generative dialogue about trends in the data. As part of their quality oversight role, health system boards need to understand the organization's key metrics and periodically review areas of performance that are outside of or below established expectations.

Also, educational training for trustees should teach them how to review data over time and request that data be benchmarked against other leading organizations to help them evaluate improvement opportunities. In IHI's interviews, some trustees noted that the way data are presented often impacts their ability to gain insights to oversee and engage leaders in discussions on quality performance and progress of quality improvement efforts.

In her work with health system trustees, Maureen Bisognano, IHI President Emerita and Senior Fellow, challenges boards that they should be able to answer four analytic questions pertaining to quality:[30]

1. Do you know how good you are as an organization?
2. Do you know where your variation exists?
3. Do you know where you stand relative to the best?
4. Do you know your rate of improvement over time?

A board that understands management's system of improvement and is analytically capable of tracking performance will be able to confidently answer those four questions. The board plays a critical role in holding health system leaders accountable for improvement results and should be a thought partner in the system's quality improvement efforts. Understanding the system of improvement and the ways in which an organization identifies and prioritizes areas for improvement is an essential function of quality governance.

Support Guide: Board Culture and Commitment to Quality

A board that understands quality concepts and the organization's system of improvement may still be unable to fulfill its commitment to safe, high-quality, and equitable patient care if it does not also have a culture of commitment to quality and a structure that ensures that the quality functions are effectively carried out. Essential elements of board culture and commitment to quality are incorporated in the Governance of Quality Assessment in recognition that a board that governs quality must not only know the key processes to oversee quality, but also oversee them in a way that demonstrates a cultural commitment to quality.

Many individuals and organizations have contributed thought leadership on building a culture for governance of quality in health care, including leading governance experts (such as Jim Conway, James Reinertsen, Larry Prybil, and James Orlikoff), The Governance Institute, the American Hospital Association, and a few leading state hospital associations. With guidance from the expert group, this support guide focuses on elements of governance culture, structure, and commitment that are unique to supporting trustee oversight of and engagement in quality.

The expert group identified five high-level attributes of board culture and commitment to quality, as described below.

Set Expectations and Prioritize Quality

Quality needs to be a priority for all board members, not completely delegated to the quality committee(s), even if the quality committee is doing more of the oversight. Quality is demonstrated as a board priority in many ways, including dedicating time to engage in discussion about quality issues on board meeting agendas, and linking some component of executive compensation to performance on quality metrics.

For example, before a trustee joins the Virginia Mason Health System board, they are sent a compact (that is then reviewed annually) to reinforce core expectations of trustees, which includes quality oversight.[31] Stephen Muething, Co-Director, James M. Anderson Center for Health System Excellence, Cincinnati Children's Hospital Medical Center, notes that Cincinnati Children's initially assigns all new board members to serve on the quality committee for their first year on the board, indicating that quality is so essential to their operations that every board member must develop core knowledge in quality.

Still, for too many boards, quality is not central to trustee education and not allocated sufficient time for learning and generative discussion.

Build Knowledge Competency and Define Oversight Responsibility of Quality

Knowledge and a clear work plan form a foundation for confident and thoughtful engagement in quality. Once trustees have been educated and are confident in their understanding of the core concepts, health system leaders need to work with trustees to define which issues the quality committee(s) will manage and which issues will be discussed by the entire board. This delineation of activities needs to be clearly articulated in the annual work plan for each group and will vary based on the size, scope, and structure of each organization.

Create a Culture of Inquiry

Board oversight of quality is not intended to micromanage the work of senior leaders, but to engage in thoughtful inquiry to ensure that organizational performance aligns with the expectations established by both leaders and trustees. For example, Henry Ford Health System has an annual quality retreat for its board quality committee and the quality committees of its hospitals and business lines. The trustees and health system leaders use this retreat as a time to dive deep on education, evaluate performance in depth, and have small group discussions to evaluate both quality and governance practices.[32]

Diversity also adds to the culture of inquiry by bringing differing perspectives and community representation to the quality discussions. The size of board and committee meetings can prohibit in-depth dialogue; building in time for small group interactions can help support a culture of inquiry.

Be Visible in Supporting Quality

Boards can support health system leaders in their efforts to improve quality in many ways, including conducting rounds, visiting the point of care, and thanking frontline staff for their contributions to improving care quality and safety. Health system leaders can provide guidance on the best ways for trustees to be visible in supporting quality in the organization.

Focus on the Patient

The board can also support quality work by including time on the agenda to hear patient stories, which personalizes the data. For example, board chair Mike Williams described how "Children's National Medical Center in Washington, DC, has strengthened board engagement with their frontline clinical teams to focus on safety, quality, and outcomes of clinical care. Their 'board to bedside' sessions discuss important topics of care and then move to the bedside to experience how changes are being implemented and gather experiences of patients."[33]

The elements of this support guide are reinforced in the Board Quality Culture and Commitment section (Category 1) of the Governance of Quality Assessment (GQA). Boards that carry out the core processes of governance of quality without a deeper culture and commitment to quality will be more likely to have a "check the box" mentality that the expert group identified as less likely to demonstrate leadership and commitment to advancing quality within the health system in a way that patients deserve.

Appendix B: IHI Lucian Leape Institute Expert Meeting Attendees

Advancing Trustee Engagement and Education in Quality, Safety, and Equity

July 12, 2018

- Paul Anderson, Trustee, University of Chicago Medical Center
- Evan Benjamin, MD, MS, FACP, Chief Medical Officer, Ariadne Labs; Harvard School of Public Health; Harvard Medical School; IHI Faculty
- Jay Bhatt, DO, Senior Vice President and Chief Medical Officer, American Hospital Association; President, Health Research & Educational Trust
- Lee Carter, Member, Board of Trustees, Former Board Chair, Cincinnati Children's Hospital Medical Center
- Jim Conway, MS, Trustee, Winchester Hospital, Lahey Health System
- Tania Daniels, PT, MBA, Vice President, Quality and Patient Safety, Minnesota Hospital Association
- James A. Diegel, FACHE, Chief Executive Officer, Howard University Hospital
- James Eppel, Executive Vice President and Chief Administrative Officer, HealthPartners
- Karen Frush, MD, CPPS, Chief Quality Officer, Stanford Health Care
- Tejal K. Gandhi, MD, MPH, CPPS, Chief Clinical and Safety Officer, Institute for Healthcare Improvement; President, IHI Lucian Leape Institute (Meeting Co-Chair)
- Michael Gutzeit, MD, Chief Medical Officer, Children's Hospital of Wisconsin
- Gerald B. Hickson, MD, Senior Vice President for Quality, Safety, and Risk Prevention, Vanderbilt Health System; Joseph C. Ross Chair for Medical Education and Administration, Vanderbilt University Medical School; Board Member, Institute for Healthcare Improvement
- Brent James, MD, MStat, Member, National Academy of Medicine; Senior Fellow and Board Member, Institute for Healthcare Improvement
- Maulik Joshi, DrPH, Chief Operating Officer, Executive Vice President, Integrated Care, Anne Arundel Medical Center
- Gary S. Kaplan, MD, FACMPE, Chairman and CEO, Virginia Mason Health System; Chair, IHI Lucian Leape Institute; Board Member, Institute for Healthcare Improvement
- John J. Lynch III, FACHE, President and CEO, Main Line Health
- Kedar Mate, MD, Chief Innovation and Education Officer, Institute for Healthcare Improvement
- Patricia McGaffigan, RN, MS, CPPS, Vice President, Safety Programs, Institute for Healthcare Improvement; President, Certification Board for Professionals in Patient Safety, IHI
- Ruth Mickelsen, JD, MPH, Board Chair, HealthPartners

- Stephen E. Muething, MD, Chief Quality Officer, Co-Director, James M. Anderson Center for Health System Excellence, Cincinnati Children's Hospital Medical Center
- Lawrence Prybil, PhD, LFACHE, Community Professor, College of Public Health, University of Kentucky
- Michael Pugh, MPH, President, MDP Associates; Faculty, Institute for Healthcare Improvement
- Shahab Saeed, PE, Adjunct Professor of Management, Gore School of Business, Westminster College; Former Trustee, Intermountain Healthcare
- Carolyn F. Scanlan, Board Member, Penn Medicine Lancaster General Health
- Michelle B. Schreiber, MD, former Senior Vice President and Chief Quality Officer, Henry Ford Health System
- Andrew Shin, JD, MPH, Chief Operating Officer, Health Research & Educational Trust
- Debra Stock, Vice President, Trustee Services, American Hospital Association
- Charles D. Stokes, MHA, FACHE, President and CEO, Memorial Hermann Health System; Immediate Past Chair, American College of Healthcare Executives
- Beth Daley Ullem, MBA, Lead Author and Faculty, IHI; President, Quality and Patient Safety First; Trustee, Solutions for Patient Safety and Catalysis; Former Trustee, Thedacare and Children's Hospital of Wisconsin; Advisory Board, Medstar Institute for Quality and Safety
- Sam R. Watson, MSA, MT(ASCP), CPPS, Senior Vice President, Patient Safety and Quality, and Executive Director, MHA Keystone Center for Patient Safety and Quality, Michigan Health & Hospital Association; Board Member, Institute for Healthcare Improvement
- John W. Whittington, MD, Senior Fellow, Institute for Healthcare Improvement
- Kevin B. Weiss, MD, MPH, Senior Vice President, Institutional Accreditation, Accreditation Council for Graduate Medical Education
- David M. Williams, PhD, Senior Lead, Improvement Science and Methods, Institute for Healthcare Improvement
- Isis Zambrana, Associate Vice President, Chief Quality Officer, Jackson Health System

Appendix C: Members of the IHI Lucian Leape Institute

- Gary S. Kaplan, MD, FACMPE, Chairman and CEO, Virginia Mason Health System; Chair, IHI Lucian Leape Institute; Board Member, Institute for Healthcare Improvement
- Tejal K. Gandhi, MD, MPH, CPPS, Chief Clinical and Safety Officer, Institute for Healthcare Improvement; President, IHI Lucian Leape Institute
- Donald M. Berwick, MD, MPP, President Emeritus and Senior Fellow, Institute for Healthcare Improvement
- Joanne Disch, PhD, RN, FAAN, Professor ad Honorem, University of Minnesota School of Nursing
- Susan Edgman-Levitan, PA, Executive Director, John D. Stoeckle Center for Primary Care Innovation, Massachusetts General Hospital
- Gregg S. Meyer, MD, MSc, CPPS, Chief Clinical Officer, Partners HealthCare
- David Michaels, PhD, MPH, Professor, Department of Environmental and Occupational Health, Milken Institute School of Public Health, George Washington University
- Julianne M. Morath, RN, MS, President and CEO, Hospital Quality Institute of California
- Susan Sheridan, MIM, MBA, DHL, Director of Patient Engagement, Society to Improve Diagnosis in Medicine
- Charles Vincent, PhD, MPhil, Professor of Psychology, University of Oxford; Emeritus Professor of Clinical Safety Research, Imperial College, London
- Robert M. Wachter, MD, Professor and Chair, Department of Medicine, Holly Smith Distinguished Professor in Science and Medicine, Marc and Lynne Benioff Endowed Chair, University of California, San Francisco

Emeritus Members

- Carolyn M. Clancy, MD, Assistant Deputy Under Secretary for Health for Quality, Safety and Value, Veterans Health Administration, US Department of Veterans Affairs
- Amy C. Edmondson, PhD, AM, Novartis Professor of Leadership and Management, Harvard Business School
- Lucian L. Leape, MD, Adjunct Professor of Health Policy, Harvard School of Public Health
- Paul O'Neill, 72nd Secretary of the US Treasury

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[33] Interview with Michael Williams, MBA, Board Chair, Children's National Medical Center, on February 8, 2018.

21st Century Cures Act

In keeping with the 21st Century Cures Act (21CCA), beginning on October 28, all new clinical notes created in Epic will be visible to patients by default through MyChart.

Why Are We Making This Change?

The 21st Century Cures Act says patients have a right to access information that is about them, which includes sharing our notes and other health data (e.g. results) with patients and families.
The sharing of clinical notes benefits both you and our patients:

Patients

- Easier access to their records, including via smartphone and computer.
- Better understanding of health care practices.
- Increased patient satisfaction.

Care Team Members

- Improved communications with patients.
- Assist Health Information Management co-workers by providing alternative, self-service options for patients to access their records.

What This Means for Our Care Teams

- Under 21CCA, "information blocking" (or opting to not share notes and other information with patients) is strictly prohibited – unless it meets one of the exception rules defined in 21CCA.
    - Care team members can choose to not share a note in cases where they believe it qualifies as an exception. All reasons for Information Blocking will need to be documented using new functionality being introduced in Epic.
- Because clinical notes will now be more easily accessible to patients, care team members will want to be thoughtful and intentional in the language they use in their notes.
- Notes created prior to Oct. 28, 2020, will not be impacted by this change. It's worth keeping in mind that clinical notes that have been shared with patients are already included when patients and their authorized representatives make requests for their records in other formats (like print or email).
- 21CCA will also bring changes in how results are shared with patients. More details on these changes will be coming in the weeks ahead.

The attached presentation will be sent to providers and clinical staff as well as be assigned in Healthstream. Please work with your clinical staff to reinforce the following message:

Patients will now have automatic and instantaneous access to clinical notes via MyChart. Be professional, thoughtful, and use objective language when writing all notes.

Thank you for your support as we launch this functionality. I want to recognize the Project Management Office for their time and effort collaborating with key stakeholders for us to achieve timely compliance with this federal law.

If you have any questions about the legislation, please contact Todd Johnson or me.

Janet S. Van Gelder, RN, DNP, CPHQ
Director of Quality & Regulations

Sharing Clinical Notes & Results with Patients through Epic

21st Century Cures Act

21st Century Cures Act (21CCA)

On May 1, 2020, the Office of the National Coordinator published the **21st Century Cures Act (21CCA)**

- It was signed into law on December 13, 2016.
- The 21st Century **Cures** Act is not to be confused with the **CARES** Act of March 27, 2020.

21st Century Cures Act (21CCA)

By November 2020, certain data types within an electronic health record must be made easily available to patients. They include the types listed below.

- Allergies
- Assessment and Plan of Treatment
- Care Team
- Clinical Notes
- Goals
- Health Concerns
- Immunizations
- Labs
- Medications
- Demographics
- Problems
- Procedures
- Place of Origin
- Smoking Status
- Unique Device Identifiers for Implants
- Vitals

Mercy already shares most of these data types with patients.

One major change coming with 21CCA is the sharing of Clinical Notes and Results.

Sharing Notes

To support 21CCA, starting Oct. 28:

- Mercy will make **all new clinical notes created in Epic** visible to patients by default through MyMercy/MyChart.
- All **test results** will be visible by default as well.
    - Notes and results that have been shared with patients are already included when patients and their representatives make requests for their records in other formats (like print or email).

Benefits of This Change

We recognize this is a significant change for care teams, but it brings with it many benefits.

- For patients, it means:
  - Easier access to and control over their health information
  - Better understanding of visit and plan of care
  - Potential improvement in treatment compliance
  - Feelings of greater engagement with their care
- For care team members, it means:
  - New method of communicating with patients
  - Help caregivers engage in care when not present during the visit
- For Health Information Management, it means:
  - Help in the form of alternative, self-service options for patients to access their records

What Kinds of Clinical Notes Will Be Shared?*

- Consultation Notes
- Discharge Summary Notes
- History & Physical
- Imaging Narratives
- Laboratory Report Narratives
- Pathology Report Narratives
- Procedure Notes
- Progress Notes
- Telephone Encounter Notes

** Note: This is not an exhaustive list.*

What Kind of Results Will Be Shared?

All test results will be shared with patients by default as soon as they become available.

Note: For 13-18 year olds, sensitive results will not be shared automatically (in keeping with current practice)

What Is Information Blocking?

- **Information Blocking** means "opting to not share notes and other information with patients."
  - Under 21CCA, Information Blocking is strictly prohibited (unless it meets one of the exception rules).
  - It includes withholding:
    - Any data affecting treatment decisions
    - Certain types of patient data as defined in 21CCA
- Penalties for Information Blocking can be significant
  - For Care Team members, it can mean monetary fines
  - For Mercy, it can mean reduced reimbursement for Medicare/Medicaid programs, and even exclusion from Medicare/Medicaid.

Exceptions to Info Blocking Rules

Exceptions defined in 21CCA which are in the care team's purview include:

- **Preventing Harm**
  Practices that are reasonable and necessary to prevent harm to a patient or another person, provided certain conditions are met.
- **Privacy**
  Not fulfilling a request to access, exchange, or use information in order to protect an individual's privacy, provided certain conditions are met.
- **Security**
  Not fulfilling a request to access, exchange, or use information in order to protect the security of the patient's information, provided certain conditions are met.

Exceptions to Info Blocking Rules

In cases where they believe it meets the criteria for one of 21CCA's exceptions, providers can choose:

- To not share a note.
- To prevent auto-release of test results at the time of order entry.

Reasons for each exception must be documented before a care team member can sign off on a visit.