Sample Report to the Quality Committee of the Board

This type of report is typically presented by an organization senior leader: Chief Executive Officer, Chief Medical Officer or Chief Quality Officer.

This is only an example; additional information and data may be included based on the organization’s priorities.
Quality Committee of the Board Agenda and Presentations

Insert Date
Agenda

1. Call to Order
2. Patient Story
3. Consent Agenda Items
4. Reports on Quality and Patient Safety
5. Regulatory and Accreditation Reports
6. Board Education
7. Confidential Executive Session
8. Adjournment

This agenda is an example of items that a Board or Board Quality Subcommittee would review at a typical meeting.

The following slides provide details about each agenda item.
1. Call to Order

• Roll Call
• Announcements

To begin the meeting there is a call to order which can be followed by a roll call for attendance and current announcements.
2. Patient Story

A patient story can include a positive patient experience or a patient safety event that led to organizational learning. If appropriate, this can be presented by the patient or the patient's family member. Although, not a requirement, it is a helpful way to connect the board with the quality agenda of the organization.
3. Consent Agenda

• Approval of Meeting Minutes
• Report from Policy and Procedure Oversight Committee

Consent Agenda may include: Committee meeting minutes, reports, policy and procedure review, or any item that the board may not need to discuss but needs to approve. The Board Members should review the item in advance of the meeting, and if any member is not comfortable approving, the committee should discussion prior to a vote.
4. Reports on Quality and Safety

• Performance Indicators
• Bi-annual Reports
• Performance Improvement Program Updates

Reports may include:
Dashboards of Performance indicators, updates on performance improvement project, departmental reports and other important programs and projects of the organization.

The follow slides provide various report examples.
The following examples present various styles of dashboards and information that a Board might review on a monthly or quarterly basis.

- The data can be in any format that is useful to the Board, but it is recommended that the report always includes external and/or internal benchmarks.

- The data that the Board selects to review should be based on the Board’s priorities for the organization. Other indicators may also be included in the consent agenda.

- All Joint Commission and Centers for Medicare & Medicaid Services (CMS) indicators should be presented to the Board for review, at least annually.
Dashboard Example
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, % Readmissions within 30 Days, Same Facility, All Payers</td>
<td>Percentage of acute inpatient encounters with an unplanned readmission, due to any cause, to the same facility within 30 days; all payers.</td>
<td>7.43%</td>
<td>6.97%</td>
<td>8.72%</td>
<td>8.22%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMI Mortality</td>
<td>AMI - Mortality Rate, Medicare. Mortality rate among acute care inpatient encounters (no transfers) for Medicare patients aged 65 or older with a principal diagnosis of Acute Myocardial Infarction (AMI).</td>
<td>12.3%</td>
<td>11.6% (2019/CMS)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>CHF Mortality</td>
<td>Congestive Heart Failure - Mortality Rate, Medicare. Mortality rate among acute care inpatient encounters for Medicare patients aged 65 or older with a principal discharge diagnosis of Congestive Heart Failure (CHF).</td>
<td>11.2%</td>
<td>9.9% (2019/CMS)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0.85%</td>
</tr>
<tr>
<td>Pneumonia Mortality, Adult</td>
<td>Pneumonia, Adult - Mortality Rate, Medicare. Mortality rate among acute care inpatient encounters for Medicare patients aged 65 or older with a principal discharge diagnosis of Pneumonia.</td>
<td>15.3%</td>
<td>14.1% (2019/CMS)</td>
<td>5.19%</td>
<td>6.62%</td>
<td>6.72%</td>
<td>8.00%</td>
</tr>
<tr>
<td>COPD Mortality</td>
<td>COPD - Mortality Rate, Medicare. Mortality rate for acute inpatient encounters for Medicare patients aged 65 or older with chronic obstructive pulmonary disease (COPD) or principal discharge diagnosis of chronic obstructive pulmonary disease.</td>
<td>8.1%</td>
<td>6.6% (2019/CMS)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Hemorrhagic Stroke Mortality</td>
<td>Hemorrhagic Stroke - Mortality Rate. Mortality rate among acute care inpatient encounters for Medicare patients aged 65 or older with a principal discharge diagnosis of Hemorrhagic stroke.</td>
<td>13.5%</td>
<td>13.1% (2019/CMS)</td>
<td>3.23%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>CMS Hip/Knee Arthroplasty, Medicare - Complication Rate</td>
<td></td>
<td>2.4%</td>
<td>2.0% (2019/CMS)</td>
<td>0%</td>
<td>0%</td>
<td>1.98%</td>
<td>2.02%</td>
</tr>
</tbody>
</table>
Infections

Healthcare-associated infections, or HAIs, are infections that people get while they're getting treatment for a condition in a healthcare setting. HAIs can occur in all settings of care including acute care hospitals, long term acute care.
## Patient Perception of Care

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>HCAHPS Data % Always</th>
<th>Last 4 Quarters Hospital vs. State</th>
<th>Last 4 Quarter Hospital Performance</th>
<th>Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAHPS - Nurse Communication - % Always</td>
<td>86.6%</td>
<td>81%</td>
<td>Nurses always communicated well</td>
<td></td>
</tr>
<tr>
<td>HCAHPS - Doctor Communication - % Always</td>
<td>86.3%</td>
<td>82%</td>
<td>Doctors always communicated well</td>
<td></td>
</tr>
<tr>
<td>HCAHPS - Responsiveness of Hospital Staff - % Always</td>
<td>75.2%</td>
<td>66%</td>
<td>Patients always received help as soon as they wanted</td>
<td></td>
</tr>
<tr>
<td>HCAHPS - Communication about Medications - % Always</td>
<td>66.5%</td>
<td>64%</td>
<td>Staff always explained about medications before administering</td>
<td></td>
</tr>
<tr>
<td>HCAHPS - Cleanliness of Hospital Environment - % Always</td>
<td>77.6%</td>
<td>72%</td>
<td>Bathroom was always clean</td>
<td></td>
</tr>
<tr>
<td>HCAHPS - Quietness of Hospital Environment - % Always</td>
<td>50.1%</td>
<td>51%</td>
<td>Area was always quite at night</td>
<td></td>
</tr>
<tr>
<td>HCAHPS - Discharge Information - % Yes</td>
<td>91.9%</td>
<td>89%</td>
<td>Patients answering “YES” when asked if Hospital staff provided information about what to do during their recovery at home</td>
<td></td>
</tr>
<tr>
<td>HCAHPS - Care and Transitions - % Always</td>
<td>56.0%</td>
<td>53%</td>
<td>Patients who STRONGLY AGREE that they understood their care when they left the hospital</td>
<td></td>
</tr>
<tr>
<td>HCAHPS - Overall Rating</td>
<td>78.6%</td>
<td>72%</td>
<td>Percent of patients who selected the most positive response categories (9 or 10) when rating the hospital</td>
<td></td>
</tr>
</tbody>
</table>
Departmental and Performance Improvement Reports

The following examples present various styles of reports that the Board might review on a bi-annual, annual, or as requested basis.

• The reports can be in any format that is useful to the Board, but it is recommended that the report demonstrates an overview of the elements of the project, sustainability of the project’s improvements and/or the action plans to improve the performance when thresholds have not been achieved.

• All departments should report on their performance on an ongoing and routine schedule.
Success Story

Focus: Improving door to alteplase times

2023 Target Phase II Stroke Goals

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital Door to TPA &lt;60 Minutes</th>
<th>Benchmark</th>
<th>Hospital Door to TPA &lt;45 Minutes</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021</td>
<td>25% (N=12)</td>
<td></td>
<td>5% (N=11)</td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>63% (N=8)</td>
<td>70% (N=10)</td>
<td>13% (N=8)</td>
<td></td>
</tr>
<tr>
<td>2023</td>
<td>75%</td>
<td>72%</td>
<td>40% (N=10)</td>
<td>46%</td>
</tr>
</tbody>
</table>

Percent of Patients Meeting Target Phase II Goals

2021: 25% (N=12); 2022: 63% (N=8); 2023: 75%

2021: 5% (N=11); 2022: 13% (N=8); 2023: 40% (N=10)

2021: 46% (N=10); 2022: 47%
Medication Titration Documentation
Implementation of Block Charting

Error in Documentation

- Percent Non-compliant
  - Series 1
  - 1st qtr 22: 35%
  - 2nd qtr 22: 23%
  - 3rd qtr 22: 12%
  - 4th qtr 22: 0%
  - 1st qtr 23: 0%
  - 2nd qtr 23: 0%

Number of Minutes to Document

- RN to document
  - 1st qtr 22: 50
  - 2nd qtr 22: 50
  - 3rd qtr 22: 50
  - 4th qtr 22: 50
  - 1st qtr 23: 10
  - 2nd qtr 23: 10

Strategies to Achieve Objective

- Develop data collection tools and satisfaction survives
- Collect pre-project data on MOS 1-4
- Review literature with team including AACN video, TJC standard, Perspective June 2020 article and 2021 standards
- Benchmark with other organizations and look for draft policies
- Revise policy
- Develop new Meditech documentation screens
- Educate ICU staff
- Implement new process

MOS - 1: Nurses are making 3 entries per shift (every 4 hours - 3 time during 12 hour shift. Each entry is taking nurses 4 minutes to complete. This is 12 minutes per shift. This is a decrease of 48 minutes per shift.

MOS - 2: 100% of the nurses scored the new process as a 10/10. The previous average was 3/10

MOS - 3: In 1/3 of the records reviewed the nurses were not ending the block in 4 hours, as required by the policy. 1/3 of the records the nurse kept the block open for the entire 12 hours.

MOS - 4: The hospital's post-implementation satisfaction was 6/10. The same as their pre-implementation satisfaction. Hospitalists report that they can not determine when changes. But 5/10 of them commented that they received fewer calls, which they felt was an improvement.

Error reduced by 100%
Time to Decommitment decreased by 36 minutes per medication drip
Critical Care CLABSI Reduction Project
Implementation of PICC Line Placements

![Graph showing CLABSI rate and line utilization year over year.]

**Critical Care Unit CLABSI Rate and Line Utilization Year over Year**

- CCU CLABSI Rate per 1000 Line Days (NHSN Mean = 0.8)
- CCU Device Utilization Ratio Line Days per Patient Days (NHSN Mean = 0.37)

<table>
<thead>
<tr>
<th>Strategies to Achieve Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Train more HCP to insert PICC lines and midlines to provide coverage for the hospital: Surgical PAs to be trained</td>
</tr>
<tr>
<td>Implement more adherent dressings for central lines</td>
</tr>
<tr>
<td>Explore the use of a suture-less securement device for central lines</td>
</tr>
<tr>
<td>Train ED and CCU Nursing Staff in ultrasound guided placement of peripheral intravenous lines to decrease use of central lines needed for access only</td>
</tr>
<tr>
<td>Monitoring of compliance with Central Line Insertion Checklist</td>
</tr>
<tr>
<td>Daily review for line necessity</td>
</tr>
<tr>
<td>Ongoing assessment of central line dressing integrity, use of protective disinfection caps on all unused ports, and sterile dead end caps on intermittent IV tubing not in use</td>
</tr>
<tr>
<td>Competency-based, in-person training for CCU nurses for central line dressing changes</td>
</tr>
<tr>
<td>Monthly review of line utilization ratios (device days per patient days), Standardized Utilization Ratios (SUR) and any CLABSI events</td>
</tr>
<tr>
<td>Perform an in-depth analysis of central line use in CCU and identify any opportunities for improvement</td>
</tr>
</tbody>
</table>
5. Regulatory Updates

Joint Commission Update

• Initial Assessment of Compliance – Mini Mocks
• Joint Commission Resources Mock Survey
  • Hospital and Behavioral Health Programs
  • Home Health Program
• Regulatory Readiness Committee
  • Charter/Mission
  • Membership
  • Plan

Regulatory Updates are not required, but they are recommended to keep the Board informed. They may include programs such as: Joint Commission, CMS, Leapfrog, Magnet, or any other important accreditations and/or certifications.
7. Executive Session

Review of:
• Medical Staff Credentialing Issues
• Risk Management Report
  - Details of a Sentinel Event
  - Claims or Legal Concerns

Items discussed during the Executive Session should include any issues that the Board considers to be sensitive or legal in nature. This session should only be attended by the actual members of the Board. All guests should be excused.
8. Adjourn

- Meeting Evaluation
- Review of Actions/Decisions
- Next Meeting Date

Closing the meeting may include a brief discussion of how the meeting went (or use a written survey to obtain feedback). This information can be used as part of the overall board evaluation.