Sample Report to the Quality Committee of the Board

The following slides include an example of a presentation reviewed by the Quality Committee of the Board at their regular meeting.

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.

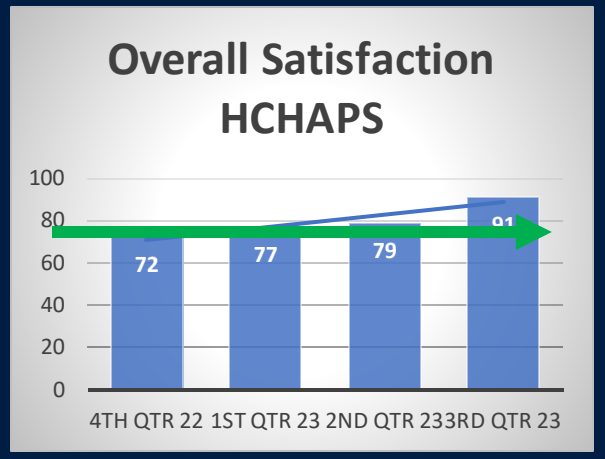
The follow slides provide various report examples.

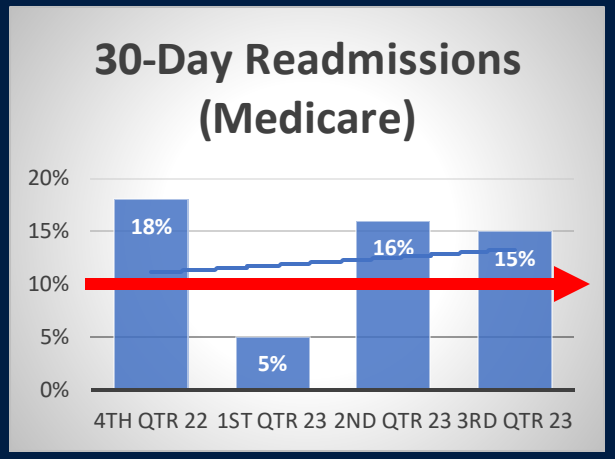
Dashboard Examples

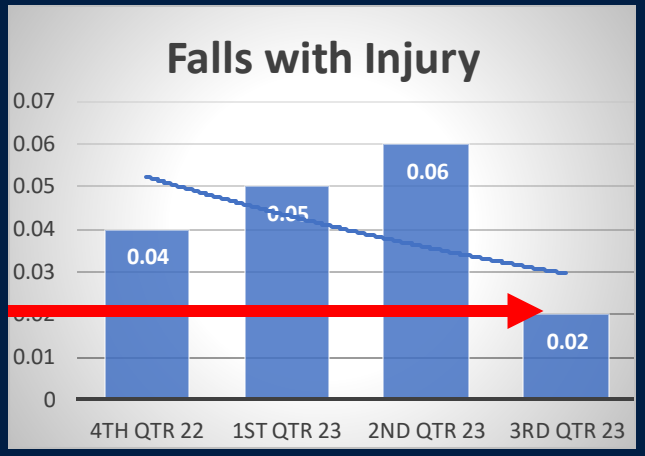
The following examples present various styles of dashboards and information that a Board might review on a monthly or quarterly basis.

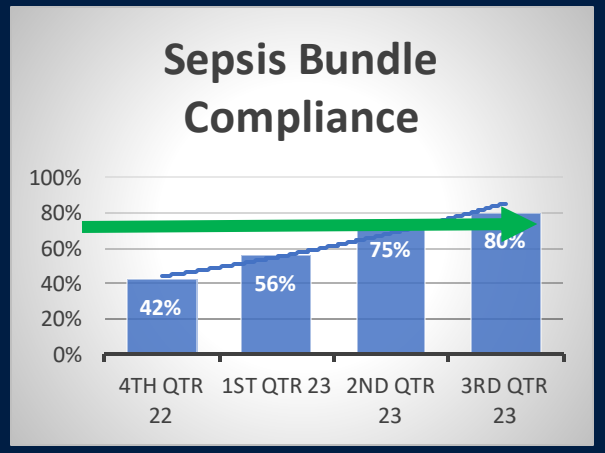
- The data can be in any format that is useful to the Board, but it is recommended that the report always includes external and/or internal benchmarks.
- The data that the Board selects to review should be based on the Board's priorities for the organization. Other indicators may also be included in 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.

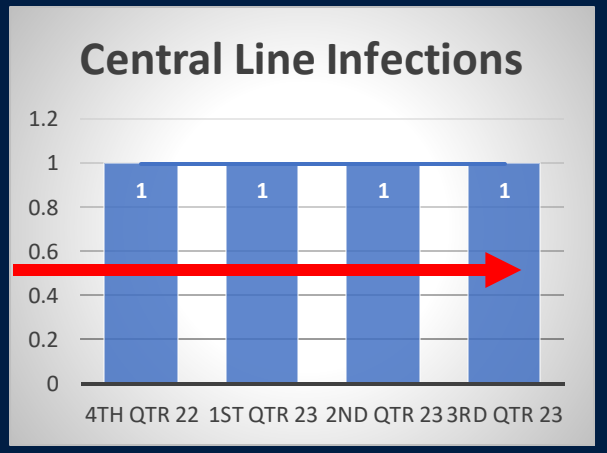
Dashboard Example

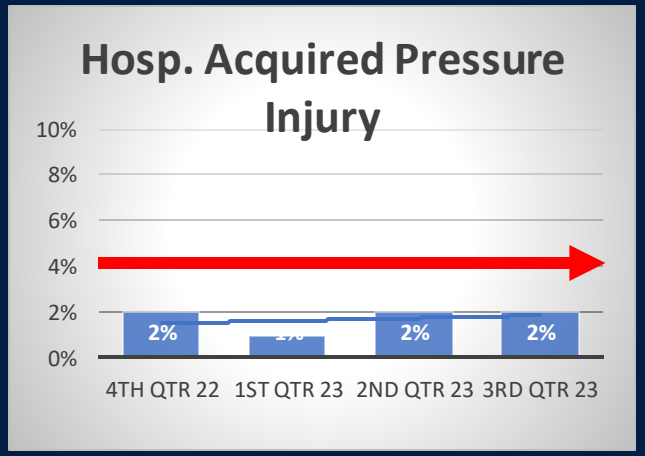












Dashboard Example

Outcome Measures	Indicator	National	Pubic		2022 1st qtr.	2022 2nd qtr.	2022 3rd qtr.	2022 4th qtr.	2023 1st qtr.	2023 2nd qtr.
Overall, % Readmissions within 30 Days, Same Facility, All Payers	Percentage of acute inpatient encounters with an unplanned readmission, due to any cause, to the same facility within 30 days; all payers.					7.43%	6.97%	8.72%	8.22%	
AMI Mortality Note: Quarterly rates are tabulated from a rolling cumulative 4 quarters of data to provide sufficient denominator cases.	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).	12.3%	11.6% (2019/CMS)		0%	0%	0%	0%	0%	
CHF Mortality Note: Quarterly rates are tabulated from a rolling cumulative 4 quarters of data to provide sufficient denominator cases.	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)	11.2%	9.9% (2019/CMS)		0%	0%	0%	0%	0.85%	
Pneumonia Mortality, Adult Note: Quarterly rates are tabulated from a rolling cumulative 4 quarters of data to provide sufficient denominator cases.	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.	15.3%	14.1% (2019/CMS)		5.19%	6.62%	6.72%	8.00%	9.52%	
COPD Mortality Note: Quarterly rates are tabulated from a rolling cumulative 4 quarters of data to provide sufficient denominator cases.	COPD - Mortality Rate, Medicare. Mortality rate for acute inpatient encounters for Medicare patients aged 65 or older with prin diagnosis of Chronic Obstructive Pulmonary Disease (COPD) or prin diagnosis of respiratory failure and secondary diagnosis of COPD.	8.1%	6.6% (2019/CMS)		0%	0%	0%	0%	6.67%	
Hemorrhagic Stroke Mortality Note: Quarterly rates are tabulated from a rolling cumulative 4 quarters of data to provide sufficient denominator cases.	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.	13.5%	13.1% (2019/CMS)		3.23%	0%	0%	0%	0%	
CMS Hip/Knee Arthroplasty, Medicare - Complication Rate		2.4%	2.0% (2019/CMS)		0%	0%	1.98%	2.02%	1.49%	

Infections

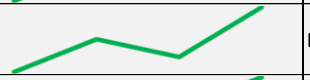
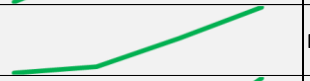
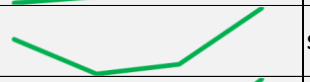
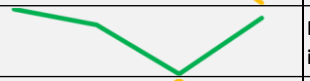
Infections
Healthcare-associated infections, or HAIs, are infections that people get while they're getting treatment for condition in a healthcare setting. HAIs can occur in all settings of care including acute care hospitals, long term acute.

Current CMS Data

Central line-associated bloodstream infections (CLABSI) in ICUs and select wards *Lower numbers are better*	**0.917** No different than national benchmark National benchmark: 1.000
Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards *Lower numbers are better*	**1.067** No different than national benchmark National benchmark: 1.000
Surgical site infections (SSI) from colon surgery *Lower numbers are better*	**1.001** No different than national benchmark National benchmark: 1.000
Surgical site infections (SSI) from abdominal hysterectomy *Lower numbers are better*	**1.324** No different than national benchmark National benchmark: 1.000
Methicillin-resistant Staphylococcus Aureus (MRSA) blood infections *Lower numbers are better*	**0.766** No different than national benchmark National benchmark: 1.000
Clostridium difficile (C.diff.) intestinal infections *Lower numbers are better*	**0.265** Better than the national benchmark National benchmark: 1.000

Retrieved from CMS.gov

Patient Perception of Care

HCAHPS Data % Always Current Qtrs. 1st Qtr. 2023	Current Rate	Star Rtae	Last 4 Quarters Hospital vs. State	Last 4 Quarter Hospital Perfornace	Measure Description
HCAHPS - Nurse Communication - % Always	86.6%	81%			Nurses always communicated well
HCAHPS - Doctor Communication - % Always	86.3%	82%			Doctors always communicated well
HCAHPS - Responsiveness of Hospital Staff - % Always	75.2%	66%			Patients always received help as soon as they wanted
HCAHPS - Communication about Medications - % Always	66.5%	64%			Staff always explained about medications before administering
HCAHPS - Cleanliness of Hospital Environment - % Always	77.6%	72%			Bathroom was always clean
HCAHPS - Quietness of Hospital Environment - % Always	50.1%	51%			Area was always quite at night
HCAHPS - Discharge Information - % Yes	91.9%	89%			Patients answering "YES" when asked if Hospital staff provided information about what to do during their recovery at home
HCAHPS - Care and Transitions - % Always	56.0%	53%			Patients who STRONGLY AGREE that they understood their care when they left the hospital
HCAHPS - Overall Rating	78.6%	72%			Percent of patients who selected the most positive response categories (9 or 10) when rating the hospital

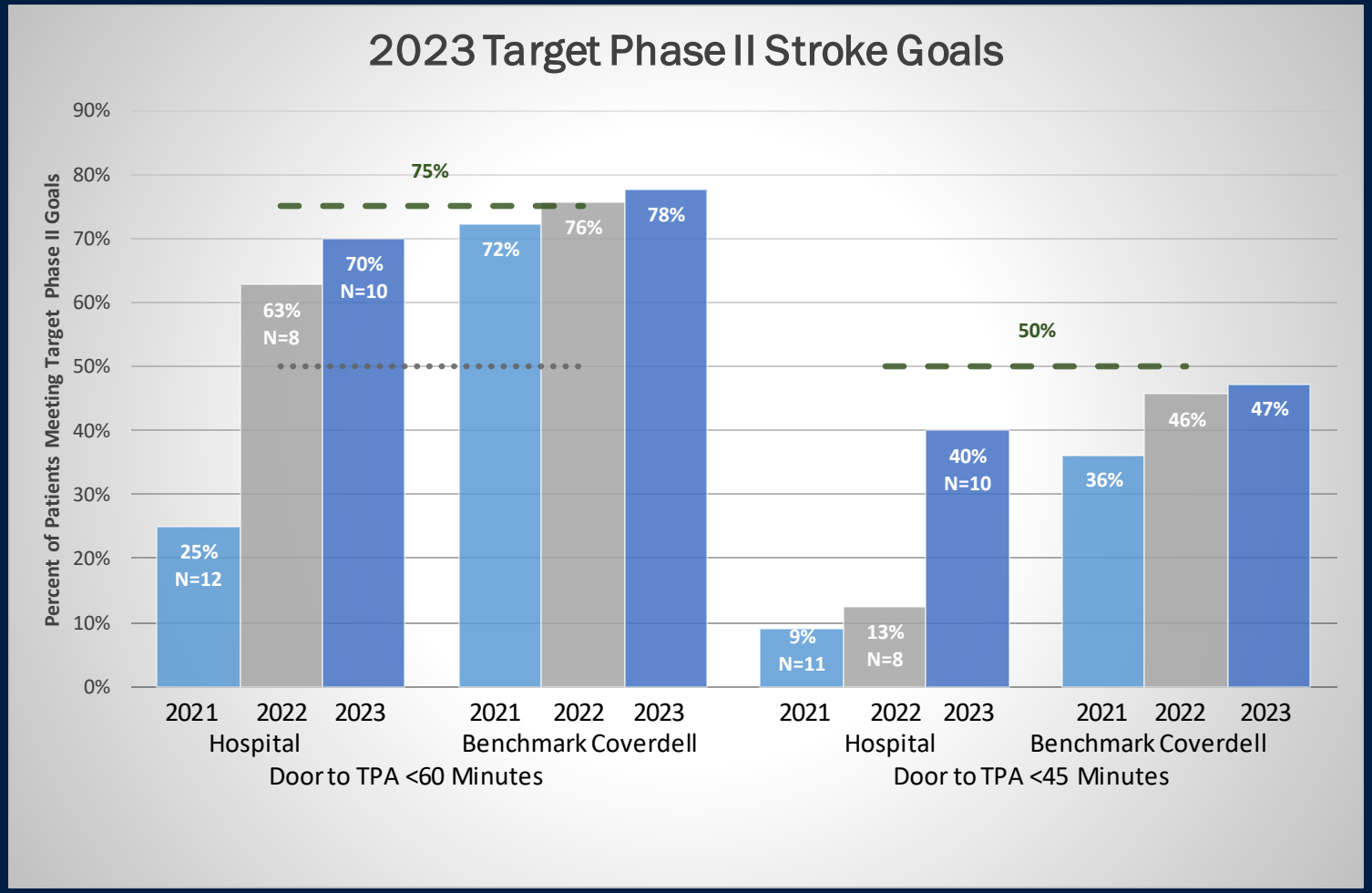
Departmental and Performance Improvement Reports

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.

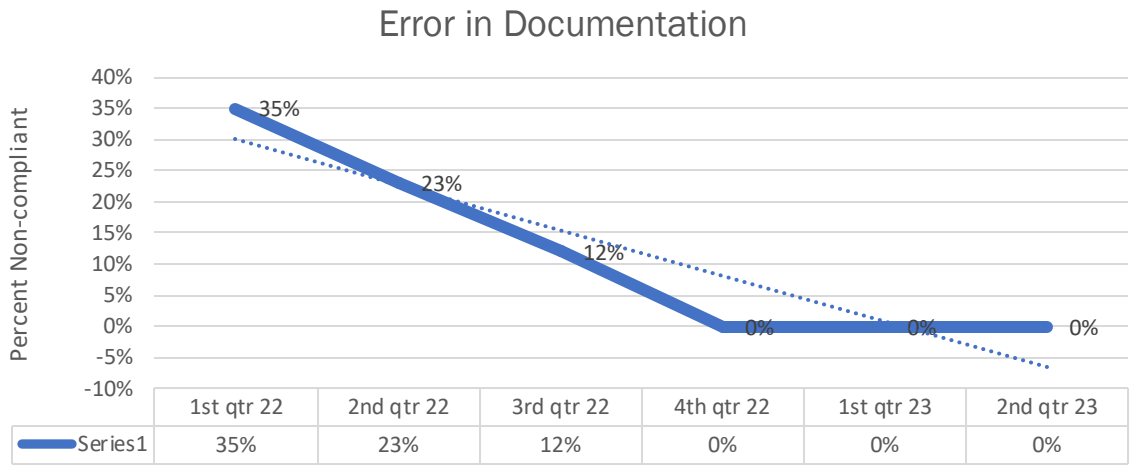
Success Story

Focus: Improving door to alteplase times

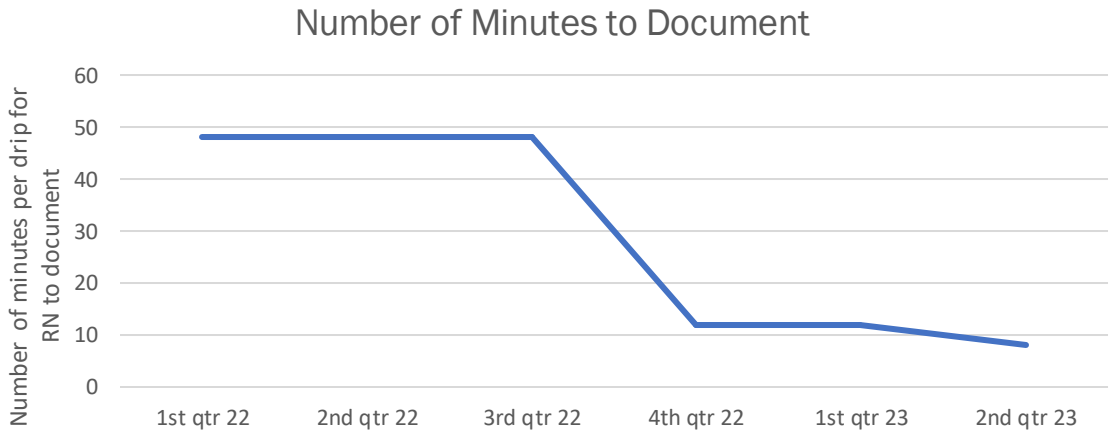


Medication Titration Documentation

Implementation of Block Charting



Goals Achieved



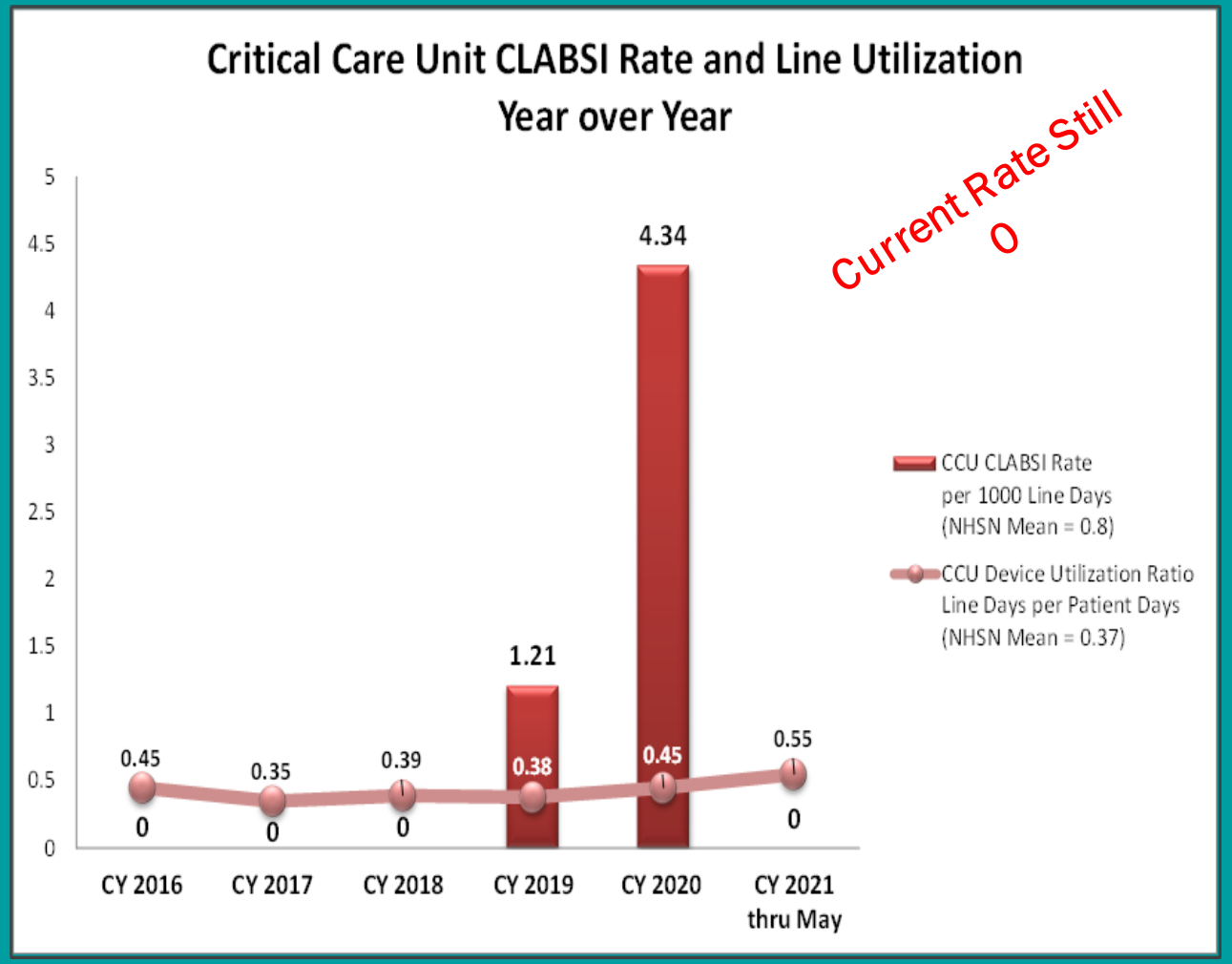
Goals Achieved

Error reduced by 100%

Time to Decommitment decreased by 36 minutes per medication drip

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
Measure MOS 1 - 4
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 mew 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 hospitals post implementation satisfaction was 6/10. The same as their pre-implementation satisfaction. Hospitalists t 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.

Critical Care CLABSI Reduction Project
Implementation of PICC Line Placements



Strategies to Achieve Objective
Train more HCP to insert PICC lines and midlines to provide coverage for the hospital: Surgical PAs to be trained
Implement more adherent dressings for central lines
Explore the use of a suture-less securement device for central lines
Train ED and CCU Nursing Staff in ultrasound guided placement of peripheral intravenous lines to decrease use of central lines needed for access only
Monitoring of compliance with Central Line Insertion Checklist
Daily review for line necessity
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 Competency-based, in-person training for CCU nurses for central line dressing changes
Monthly review of line utilization ratios (device days per patient days), Standardized Utilization Ratios (SUR) and any CLABSI events
Perform an in-depth analysis of central line use in CCU and identify any opportunities for improvement.

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

CONFIDENTIAL

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.