ALL MEETINGS ARE OPEN TO THE PUBLIC AND THE PUBLIC IS INVITED TO ATTEND

Any Public Input pertaining to an agenda item is limited to three minutes and a "Request to Address the Board of Directors" card must be completed and submitted to the Board Assistant prior to the meeting.
LEE MEMORIAL HEALTH SYSTEM BOARD OF DIRECTORS

QUALITY & EDUCATION COMMITTEE OF THE WHOLE MEETING

Thursday, August 13, 2009
2:00 p.m.
Lee Memorial Hospital Boardroom

TENTATIVE AGENDA

1. **CALL TO ORDER** *(Nancy McGovern, RN, MSN, Quality & Education Vice Chairman)*
   The meeting of the Quality & Education Committee of the Whole of the Lee Memorial Health System Board of Directors will be called to order. Matters concerning the business of Lee Memorial Health System consisting of Gulf Coast Medical Center & Lee Memorial Hospital/HealthPark Medical Center and its subsidiaries (HealthPark Care Center Inc., Lee Memorial Home Health, Inc., Cape Memorial Hospital, Inc. doing business as Cape Coral Hospital, and Lee Memorial Medical Management, Inc.) may be reported, discussed and recommended by the Committee of the Whole, then referred to the Full Board of Directors for final action.

2. **PUBLIC INPUT:** Any public input pertaining to items on the Agenda is limited to three minutes and a “Request to Address the Board of Directors” card must be completed and submitted to the Board Assistant prior to meeting.

3. Consent Agenda *(Approval)*
   a) June 11, 2009 Quality & Education Committee Meeting Minutes
   b) FY 2009, 3rd Quarter Risk Management Report
   c) FY 2009, 3rd Quarter Corporate Compliance Report

4. Community Representative Appointment: Margaret Byrnes, EdS *(Approval)* *(All Members - 5 min)*

5. Health Performance Improvement (HPI) *(Update)* *(Jim Nathan, President/CEO – 30 min)*


7. Other Items

8. Date of the next REGULAR Quality/Education Committee of the Whole Meeting:
   Thursday, September 3, 2009 at 1:00 p.m.
   Lee Memorial Hospital Boardroom, 2776 Cleveland Avenue, Fort Myers, FL

9. **ADJOURNMENT of QUALITY & EDUCATION COMMITTEE**
PUBLIC INPUT – AGENDA ITEMS:

Any public input pertaining to items on the Agenda is limited to three minutes and a “Request to Address the Board of Directors” card must be completed and submitted to the Board Assistant prior to meeting.

Refer to Board Policy: 10:15E: Public Addressing the Board

Non-Agenda Item:
Individuals wishing to address the Board on an item NOT on the Agenda, the Board office must be notified of subject matter at least seven (7) days prior to the meeting to allow staff time to prepare and to insure the matter is within the jurisdiction of the Board.
3. Consent Agenda: *(Approval)*

A. June 11, 2009 Quality & Education Committee Meeting Minutes

B. FY 2009, 3rd Quarter Risk Management Report

C. FY 2009, 3rd Quarter Corporate Compliance Report
**LEE MEMORIAL HEALTH SYSTEM BOARD OF DIRECTORS**  
**QUALITY & EDUCATION COMMITTEE OF THE WHOLE MEETING MINUTES**  
**Thursday, June 11, 2009**

**LOCATION:** Lee Memorial Hospital Boardroom, 2776 Cleveland Avenue, Fort Myers, FL 33901

**MEMBERS PRESENT:** Kerry Babb, Chairman/Quality & Education Committee; Richard Akin, Board Chairman; Nancy McGovern, RN, MSM, Board Vice Chairman; Marilyn Stout, Board Treasurer; Steve Brown, M.D., Director; Linda Brown, MSN, ARNP, Director; Frank La Rosa, Director; Dawson McDaniel, Director; David Berger, M.D., Community Representative/Quality & Education Committee; Tuck Wilson, M.D., Physician Leadership Council Consultant/Quality & Education Committee

**MEMBERS ABSENT:** Lois Barrett, MBA, Board Secretary; James Green, Director

**OTHERS PRESENT:** James Nathan, CEO/President; Cathy Stephens, Board of Directors' Liaison; Chuck Krivenko, M.D., Chief Medical Officer/Clinical and Quality Services; Donna Giannuzzi, RN, Chief Patient Care Officer; Jon Cecili, Chief Human Resources Officer; Doug Luckett, Chief Administrative and Ancillary Services Officer/GCMC; John Iacuone, M.D., Executive Director/The Children's Hospital; Mark Greenberg, M.D., System Medical Director/Clinical Effectiveness; Christine Crawford, System Director/Standards and Quality; Stanley Padfield, System Director/Health Information Management; Steve Streed, System Director/Epidemiology/Infection Control; Marjory May, Vice President/Post Acute Care; Alex Greenwood, System Director/Operations/GCMC; Nancy Zant, System Director/HealthPark Care Center; Karen Krieger, System Director/Public Affairs; Debbie Kendzierski, Manager/Planning and Strategy; Wayne Daltry, Community Representative/Planning Committee; Jack Eikenberg, Community Representative/Planning Committee; Fred Poller, Community Representative/Planning Committee; Marliese Mooney, Physician Leadership Council Consultant/Planning Committee; Chief Rob Petrovich, Guest; Peter Young, Guest; Jennifer Reed, Reporter/News-Press; Beth Kilgore, Executive Secretary, Board of Directors

**NOTE:** Documents referred to in these minutes are on file by reference to this meeting date in the Office of the Board of Directors and on the Board of Directors website at www.lememorial.org/boardofdirectors, for public inspection.

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DISCUSSION</th>
<th>ACTION</th>
<th>FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEETING CALLED TO ORDER</td>
<td>The QUALITY &amp; EDUCATION COMMITTEE OF THE WHOLE meeting was CALLED TO ORDER at 1:04pm by Quality &amp; Education Committee Chairman Kerry Babb. The Board sits as the Lee Memorial Health System Board of Directors of Gulf Coast Medical Center, Lee Memorial Hospital, HealthPark Medical Center and the Board of Directors of its subsidiary corporations: Cape Memorial Hospital, Inc. doing business as Cape Coral Hospital; Lee Memorial Medical Management, Inc.; Lee Memorial Home Health, Inc.; and HealthPark Care Center, Inc.</td>
<td>A motion was made by Nancy McGovern to approve the Consent Agenda consisting of: A. May 14, 2009 Quality &amp; Education Committee Meeting Minutes B. 2009 Utilization Management Plan Annual Review (Exhibit 1) The motion was seconded by Linda Brown and it carried with no opposition.</td>
<td></td>
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</table>

**PUBLIC INPUT**

There was NO "Public Input".

**CONSENT AGENDA**

Kerry Babb asked if anyone wished to pull any items listed on the Consent Agenda for discussion.

A. May 14, 2009 Quality & Education Committee Meeting Minutes
B. 2009 Utilization Management Plan Annual Review (Exhibit 1)

A motion was made by Nancy McGovern to approve the Consent Agenda consisting of:

A. May 14, 2009 Quality & Education Committee Meeting Minutes
B. 2009 Utilization Management Plan Annual Review (Exhibit 1)

The motion was seconded by Linda Brown and it carried with no opposition.

**HEALTHPARK CARE CENTER ANNUAL REPORT**

Nancy reviewed the HealthPark Care Center (HPCC) Annual Report (Exhibit 3). Marilyn Stout congratulated the HPCC team for their outstanding performance. Linda Brown said she is always impressed by the staff at HPCC and the efficient and organized manner in which they care for their patients. Discussion ensued regarding HPCC filing for a fictitious name of HealthPark Care and Rehabilitation Center, due to the increase in sub-acute rehab patients.

Nancy Zant announced on May 2009 the Agency for Healthcare Administration (AHCA) awarded HealthPark Care Center with a five star rating in eight of nine categories (Exhibit 2). Nancy also reminded everyone of the many services provided by HealthPark Care Center.

(Steve Brown entered the meeting at 1:10pm)

(Frank La Rosa entered the meeting at 1:20pm)

A motion was made by Linda Brown to accept the HealthPark Care Center Annual Report (Exhibit 3). The motion was seconded by Marilyn Stout and it carried with no opposition.

**THANK YOU FROM CHIEF ROB PETROVICH**

Chief Rob Petrovich with the Cape Coral Police Department asked for the opportunity during the meeting to thank the LMHS Board, Lee Memorial Hospital (LMH) and LMHS staff for the wonderful care and attention they have given to Cape Coral Police Officer David Garcia who is a patient at LMH. He said LMH Staff are doing a phenomenal job in caring for Davie and his family during this difficult time. He also thanked Karen Krieger for being so attentive to their needs during this process. He said Karen and her team have been there every step of the way and their support is sincerely appreciated.
<table>
<thead>
<tr>
<th>SUBJECT</th>
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<th>ACTION</th>
<th>FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH PERFORMANCE IMPROVEMENT (HPI) ENGAGEMENT</td>
<td>Chuck Krivenko said in response to a recent visit by John Nance, safety advocate and educator, the System is engaged with Health Performance Improvement (HPI) consultants who are a nationally known consulting firm, helping healthcare organizations improve in patient safety. Chuck Krivenko and Donna Giannuzzi presented the Health Performance Improvement (HPI) Engagement – Patient Safety Initiative Update (Exhibit 4). Chuck said HPI will be performing an assessment of the culture of safety in the System with suggestions for improvement. He said the System-wide evaluation will include multiple interviews throughout the month. He said there will be a full report to the Board on their progress. Kerry Babb asked what the expected timeframe is to fully implement a project of this magnitude. Chuck said the national benchmark is about a year. Discussion ensued with regard to setting a realistic timeframe for implementing the patient safety initiative and importance of System-wide support throughout this process.</td>
<td></td>
<td>Chuck Krivenko Safety Initiative progress</td>
</tr>
<tr>
<td>DET NORSKE VERITAS HEALTH CARE (DNVHC) ACCREDITATION OPTION</td>
<td>Christine Crawford presented the Det Norske Veritas Health Care (DNVHC) Accreditation Option report (Exhibit 5). Discussion ensued regarding the use of an International Organization for Standardization (ISO) as an aide in the continuation of improvement process in the organization. Marilyn Stout said she is impressed with the DNVHC accreditation agency based on their guidelines and methods for assisting in organizational improvement. There was further discussion regarding the selection of specific accreditation companies.</td>
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<td></td>
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<tr>
<td>OTHER ITEMS</td>
<td>There were NO ‘Other Items’.</td>
<td></td>
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<tr>
<td>NEXT REGULAR MEETING</td>
<td>The next <em>REGULAR Quality &amp; Education Committee of the Whole meeting is August 13, 2009, 2:00pm.</em> <em>(There are NO BOARD MEETINGS in July.)</em> Lee Memorial Hospital Boardroom, 2776 Cleveland Avenue Fort Myers, FL 33901</td>
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<tr>
<td>ADJOURNMENT</td>
<td>The Quality &amp; Education Committee of the Whole meeting was ADJOURNED at 2:29 p.m. by Kerry Babb, Quality &amp; Education Committee Chairman.</td>
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Minutes were recorded by Beth Kilgore, Executive Secretary/Board of Directors Office

Linda Brown, MSN, ARNP
Board Secretary
DATE: August 7, 2009  LEGAL SERVICE REVIEW? YES___  NO___

SUBJECT: FY 2009, 3rd Quarter Risk Management Report

REQUESTOR & TITLE: Mary McGillicuddy, Chief Legal Officer

PREVIOUS BOARD ACTION ON THIS ITEM (IF ANY)
(justification and/or background for recommendations - internal groups which support the recommendation i.e. SLC, Operating Councils, PMTs, etc.)


SPECIFIC PROPOSED MOTION:

Motion to Accept Quarterly Risk Management Report for Q3, FY 2009

PROS TO RECOMMENDATION:  
Not Applicable

CONS TO RECOMMENDATION:  
Not Applicable

LIST AND EXPLAIN ALTERNATIVES CONSIDERED:

Not Applicable

FINANCIAL IMPLICATIONS  
Budgeted ____  Non-Budgeted ____
(including cash flow statement, projected cash flow, balance sheet and income statement)

No financial implications

OPERATIONAL IMPLICATIONS  (including FTEs, facility needs, etc.)

No operational implications

SUMMARY:

Quarterly Risk Management Report for 3rd quarter, fiscal year 2009 including:
• Incident Reporting per 1,000 patient days
• Injury Occurrences per 1,000 patient days
• Categories of incident reports
• Risk Management participation in LMHS System Committees and Education
• Liability Claims
• Recommendations
QUARTERLY RISK MANAGEMENT
REPORT TO THE BOARD
April – June 2009

The disclosure of this document and the contents herein does not constitute a waiver of any and all protections afforded Patient Safety Work Product under either Florida state and federal law including but not limited to those under the Patient Safety Quality Improvement Act of 2005 and implementing regulations, 45 C.F.R. Part 3; 42 U.S.C. § 11111; §§395.0193 F.S. and 766.101 F.S.
REPORTING RATES

The graph below shows incident reporting rates for the system for the past 24 months. During this time range the reporting rate has exhibited a slight decline. The reason for this is demonstrated in the individual graphs.

The graphs on page 3 reflect the reporting rates for the four facilities individually. The four graphs also show the last 24 months of activity.
The Reporting Rates at CCH, HPMC and LMH have all demonstrated a slight increase in reporting, while the rate of reporting at GCMC has declined. The rate history for GCMC has been established by combining the data for SWRMC and GCH. This decline is attributed to a change in the types of matter reported which historically included medical observations, returns to the ER, Patient Complaints and other non-incidents. It is anticipated that the rate will eventually level out to a rate similar to those of the other facilities.
The first graph shows the reporting rate and the injury rate for the four facilities during the last quarter.

The second graph shows the percentage of reports without injury. Reporting of no injury incidents are highly encouraged so that “near misses” and potential areas of improvement can be identified. This information allows us to better understand where risks exist, and provides data used in our quality improvement activities throughout the system. More than 70% of the incident reports received involve no injury.

During this quarter, there were two reports to AHCA, as required by Risk Management statute.
The graph to the right shows the rate for the categories of reported incidents from April through June 2009 at all four facilities. Prior reports showed the number of incidents rather than the incident rate. Rates are now being utilized to be consistent with other system reporting. As indicated, the vast majority of these incidents did not involve any injury.

The most reported categories are:

- **Patient Falls**
- **Treatment & Testing** category includes reports of IV infiltrates, Delays and Omissions, Patient Identification issues, etc
- **Other** category includes Exposures, Complaints, burns, skin breakdown, ER issues, AMAs, etc
- **Medication Related Reports**

72% of all reported occurrences fall within one of these four categories.
Risk Management Educational Activities included:

- Risk Management Inservice for Edison Community College Nursing Students
- Risk Management Orientation for new hires
- Risk Management education for Radiology Services at GCMC
- Education provided to LMH Surgical Services in regards to Universal Protocol
- Risk Management education provided to HPCC Nursing staff
- Presentation of FHA Prevention of Surgical Errors webinar
- Risk Management Inservice for the Nursing Intern Program
Malpractice Claims

The third fiscal quarter of FY 2009, April 1, 2009 through June 30, 2009, began with 30 open claims pending. In the quarter, 9 new claims were received, and 7 claim files closed, leaving 32 open files at the end of the quarter.

This stability of the numbers of claims reflects the generally constant claims experience which LMHS has had for the last four three-month periods.

The comparatively low number of malpractice claims experienced by the System is remarkable, considering the size, complexity and range of healthcare services offered.

The terms under which malpractice claims against the System were closed continues to be very favorable to the Health System.

As previously reported, these figures are only just beginning to include claims associated with the two hospitals added to the System in 2006. The current numbers do include two claims alleged to have arisen in those hospitals in the period following merger to date.
Continued participation in system committees including:

- ADE PMT
- Campus Specific ADE Work Groups
- Patient Safety Measurement Committee
- Employee Safety and Wellness
- Ethics Committee
- GCMC Ethics Committee
- Back Safety Sub-committee
- Standards and Compliance
- Policy & Procedure Committee
- Advance Directive Process Committee
- Medication Safety Committee
- Tobacco Free Lee Steering Committee
- Tobacco Free Outpatient Committee
- Tobacco Free Lee Patient Care Committee

Participated in various Intense Analysis Teams
RECOMMENDATIONS

• Continue the implementation of the SoftMed Risk Management Module. Having accomplished 98% online reporting, the focus continues to be on ensuring appropriate notification and timely Director Follow Up.

• Continue to track and trend incidents, provide summary data and work closely with various departments and committees engaged in performance improvement and patient safety activities.

• Continue to work with Education and Organizational Development and management staff to assure that all employees are meeting the annual education requirement for risk management and to provide a module for the Competency activities.

• Continue to utilize pre-litigation procedures to resolve legitimate claims as quickly as the interests of the System and claimants allow.

• Continue development of specialized training materials for risk.

• Work with Patient Relations in regards to new Software program

• Collaborate with HPI with regard to patient safety initiatives.
DATE: August 7, 2009

LEGAL SERVICE REVIEW? YES____ NO____

SUBJECT: FY 2009, 3rd Quarter Corporate Compliance Report

REQUESTOR & TITLE: Charles Swain, Chief Compliance and Internal Audit Officer

PREVIOUS BOARD ACTION ON THIS ITEM (IF ANY)
(justification and/or background for recommendations - internal groups which support the recommendation i.e. SLC, Operating Councils, PMTs, etc.)

The Compliance Program Board Policy 10.47A requires quarterly updates summarizing Compliance activities.

SPECIFIC PROPOSED MOTION:


PROS TO RECOMMENDATION

CONS TO RECOMMENDATION

LIST AND EXPLAIN ALTERNATIVES CONSIDERED

N/A

FINANCIAL IMPLICATIONS

Budgeted ____ Non-Budgeted ____
(including cash flow statement, projected cash flow, balance sheet and income statement)

N/A

OPERATIONAL IMPLICATIONS (including FTEs, facility needs, etc.)

N/A

SUMMARY

This report highlights the Compliance Department activities for the quarter. There were no significant compliance issues or concerns that needed to be brought specifically to the attention of the LMHS Board. The compliance activities are organized under the seven elements of a compliance program as contained in the guidelines issued by the Department of Health and Human Services, Office of Inspector General.
Compliance Report

Reporting Period: April 1, 2009 – June 30, 2009
Status of the Seven Compliance Elements

Element # 1: Written Policies and Procedures.

- Policies regarding Correction of Overpayments to Federal Healthcare Programs, False Claims Statutes, Handling of Calls to Hotline, Reporting Thefts, Vendor Paid Travel, Training and Education were revised for inclusion in the online Policy and Procedure Manual.

Element # 2: Compliance Officer and Compliance Committee.

- Compliance Officer’s activities and accomplishments are contained in other compliance elements that follow. On June 29, 2009, a Compliance Communication meeting was held to review and discuss the latest Compliance information; attendees provided feedback on relevant matters in their respective departments.

Element #3: Education.

- Compliance training including the LMHS Standards of Conduct continues to be part of new employee On-Boarding Orientation and is part of the orientation offered to volunteers and by Medical Staff Services to new physicians.

Element #4: Communication.

A total of 63 issues came to the Compliance Department during the quarter.

- Fifteen of the 63 issues were calls that came to the LMHS Hotline. The allegations involved one Billing, Coding and Documentation issue, two HIPAA issues, six Human Resource matters, one Legal, Risk and Safety issue, three Patient Care matters, and one Timekeeping issue. One additional call was informational (Callers seeking clarification regarding various issues). Seven of the 15 calls were substantiated; this total includes one HIPAA issue, two of the Human Resources matters, the Legal, Risk and Safety issue, two Patient Care matters, and the Timekeeping issue.
Forty-eight of the 63 issues came directly to the Compliance Department.

- Twenty-eight issues categorized as Guidance were inquiries from employees who wanted to verify that they were doing the right thing before proceeding with an action. One of these inquiries involved questions regarding the Employee Conflict of Interest Questionnaire.

- Twenty issues that came to the Compliance Department potentially involved compliance violations.

A breakdown of the 20 issues received during the quarter April 1, 2009 – June 30, 2009 is as follows:

<table>
<thead>
<tr>
<th>Issue Category</th>
<th>Brought Forward</th>
<th>Received</th>
<th>Resolved</th>
<th>Carried Forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing, Documentation and Coding</td>
<td>3</td>
<td>6</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Conflict of Interest/Inducements</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>HIPAA/Patient Confidentiality</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Human Resources/Employee Relations</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Human Resources/Employee Relations</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Legal Interpretations/Risk and Safety</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Patient Care</td>
<td>0</td>
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<tr>
<td>Payroll/Timekeeping</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Physician Matters</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>6</strong></td>
<td><strong>20</strong></td>
<td><strong>22</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
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- Appendix I contains a summary, by category, of the issues received directly by Compliance during the quarter.

**Element #5: Enforcement/Disciplinary Actions.**

- Excluded Party Search System (EPSS) – The Compliance department screened all new employees against the Office of Inspector General and the U.S. General Services Administration databases to be certain they are eligible for participation in Federal healthcare programs. Medical Staff Services performed a bi-monthly screen of physicians and provided the results to the Compliance Department. Vendors and contractors were also screened against the List of Excluded Individuals and Entities (LEIE) and GSA List of Parties Excluded from Federal Procurement and Non Procurement Programs to ensure that none were under exclusion by the Federal government. Research on vendors with similar names has been concluded, thus resolving pending matters.
Element #6: Auditing and Monitoring.

The following compliance reports and/or advisory memos were issued during the quarter:

- Practitioners-in-Training – Documentation guidelines were provided to be applied not only to Medicare and Medicaid patients to all patient visits to avoid dissimilar standards of care between different payer groups.

- Precepting Practitioners-in-Training – Supervision and documentation guidelines were provided regarding billing for services performed in the physical presence of the preceptor.

- Review of Intravenous Immune Globulin (IVIG) Infusions – This follow-up review determined that necessary actions previously identified have been taken to resolve documentation issues.

- External Audit of Evaluation and Management (E/M) Coding – An outside firm conducted an evaluation of physician claims. The net outcome was lost revenue rather than overpayment liability. Opportunities for performance improvement were identified.

Element #7: Pending Actions/Initiatives and Corrective Actions.

- An allegation reported to the Hotline regarding non adherence to timekeeping procedures resulted in corrective action.

- An allegation reported to Compliance regarding posting results of an informal survey resulted in corrective action.
APPENDIX I

Summary of 20 Cases Received by Category:

Billing, Coding and Documentation
6 issues received involved patient transfer, coding, cardiac profile, consults, observation vs. inpatient status, and Medicare credentialing for billing purposes. Five issues were substantiated; these issues included patient transfer, coding, cardiac profile, consults, and Medicare credentialing. Two issues brought forward from the previous quarter regarding Emergency Medical Services (EMS) and kyphoplasty admissions were referred for audit. A third matter brought forward from the previous quarter involving billing for therapeutic services remains open but will be closed next quarter.

2 issues remain open.

Conflict of Interest/Inducements
A matter brought forward from the previous quarter involving secondary employment was substantiated.

Health Insurance Portability and Accountability Act (HIPAA) - Patient Confidentiality
There were no issues reported to Compliance. HIPAA issues reported directly to the Patient Information Privacy Officer are not included in this report.

Human Resources/Benefits/Miscellaneous
1 issue received involving PTO accrual was unsubstantiated.

Human Resources/Employee Relations
4 issues received involved a letter of resignation, request for training, circumventing the chain of command, and posting of informal survey results. Two items were substantiated; these included the matter involving chain of command and posting of the survey results.

Legal Interpretations, Risk Management and Safety
3 issues received involved students in the Operating Room, provision of information to EMS, and review of lease. The matters involving students in the Operating Room and provision of information to EMS were substantiated.

1 issue remains open and will be closed next quarter.

Other
6 issues involved records disposal, malware/spam, records request, charitable event, detrimental conduct, and inquiry regarding a sanctioned individual. The matters regarding records disposal, spam, charitable event, detrimental conduct, and sanctioned individual were substantiated.

Patient Care
There were no issues reported to Compliance.

Payroll/Timekeeping
There were no issues reported to Compliance.

Physician Matters
There were no issues reported to Compliance.
TO: Quality & Education Committee of the Whole Members

FROM: Nancy McGovern, RN, MSM
Vice Chairman, Quality & Education Committee

DATE: August 13, 2009

SUBJECT: Appointment as Community Representative to Committee of the Whole – QUALITY & EDUCATION

Below is the recommended appointment as Fiscal Year 2008-2011 Community Representative to the QUALITY & EDUCATION Committee of the Whole for your approval to fill the vacant position.

The recommended member has been selected in accordance to Board Policy 10.52B: Community Representatives - Appointed to a Committee of the Whole and are appointed to serve a three (3) year fiscal term.

Recommended Member:

1. Margaret A. Byrnes, EdS.

(Previously approved to the team):
2. Denise Heinemann, RN, DrPH
3. David Berger, MD
4. Vacant seat

Enclosed you’ll find background information on Ms. Byrnes, for your review.

Please call Cathy Stephens (334-5370) if you have any questions regarding this appointment.
March 26, 2009

Cathy Stevens
Board Liaison, Board of Directors
Lee Memorial Health System
PO Box 2218
Fort Myers, FL 33902

Dear Cathy,

It is with pleasure that I submit my curriculum vitae to the Board of Directors in consideration of being selected as the community representative of the Quality and Education Committee. I believe that my background as an educator and experience as a Quality trainer and recently retired senior examiner for the Malcolm Baldrige National Quality Award have provided me with the expertise to be a valued member of this committee.

Quality and education are the things that distinguish my professional career. My quest for excellence has been a life-long pursuit. I am committed to continuous quality improvement principles and practices in my business as well as my personal life.

I will be out of town on business the week of March 30-April 3 and will be available for an interview anytime during the week of April 6. I look forward to hearing from you or Mr. Kerry Babb to learn how I might be of help to the Lee Memorial Health System.

Most sincerely,

Margaret A Byrnes, Ed.S.
Managing Associate
Quality Education Associates
Cell: 239-822-4745
margbyrnes@aol.com
Margaret A. Byrnes, EdS  
Quality Education Associates  
17581 Sterling Lake Dr.  
Fort Myers, FL 33967  
239-481-3217 cell: 239-822-4745  
margbyrnes@aol.com

Margaret Byrnes has had a 32-year career as a secondary teacher, nationally certified counselor, school administrator, university lecturer, and Baldrige coach. She has a BS from Michigan State University in secondary education, an MA in Educational Psychology from California State University, Northridge with an emphasis on learning theory, and an EdS in Guidance and Counseling from Southeastern Louisiana University. In addition, Margaret has accumulated over 600 hours of additional training in Quality processes and principles, having learned from Drs. W. Edwards Deming, Joseph Juran, and Peter Senge. She is a certified trainer of Stephen Covey’s 7 Habits of Highly Effective People.

In the late 1980s Ms. Byrnes founded and became the first director of a Vocational Training Institute for disadvantaged adults in Erie, PA, who were unsuccessful during their K-12 educational experience. Within a year the Institute was accredited by the PA Department of Education allowing students to receive Pell Grants to continue their education and become employable.

In 1991 Margaret established Quality Education Associates, an educational consulting and training firm working with schools and school districts nationally to bring the principles of Continuous Quality Improvement and Baldrige systems as a research-based, proven data-driven decision-making approach to achieve educational excellence. She has trained thousands of teachers and administrators nationally and in five foreign countries, and provided leadership coaching to dozens of senior leaders. Ms. Byrnes is the managing associate responsible for business and financial operations, materials development, scheduling, training and consulting with senior leaders.

Mrs. Byrnes is the author or primary author of four books on quality in education published between 1991 and 1997 (The Quality Teacher, Quality Fusion, Dr. Deming and His Amazing Quality Idea!, and Quality Tools for Educators), and primary author on two recent ‘how to’ books on building Baldrige-based schools (ASQ Quality Press, 2006: The Principal’s Leadership Counts! Launch a Baldrige-based School and ASQ Quality Press, 2005: There is Another Way! Launch a Baldrige-based Classroom). Margaret was a contributing editor of Transformation to Performance Excellence: Baldrige Education Leaders Speak Out published by ASQ Quality Press, 2006. She also served as the editor of the ASQ eBrief Newsletter, electronically published six times yearly for the Education Division. She has been invited to speak at quality conferences in Sweden, Russia, Spain, Finland, and Switzerland.

In the mid-1990s, Margaret was the lead trainer during the first three years of New Mexico’s Strengthening Quality in Schools (SQS) program sponsored by the Governor’s Business Executives for Education. SQS was New Mexico’s school reform effort focused on data-driven decision-making and the principles of continuous quality improvement. This effort included training, coaching, analyzing results, and organizing state-wide conferences.
Margaret served on the Malcolm Baldrige National Quality Award Program Board of Examiners for nine years (1998-2005, 2006-07) as an examiner, senior examiner, and alumni examiner. As a senior examiner, she led teams of examiners through the award selection process. Twice Margaret was selected to help with examiner training. Organizations that Ms. Byrnes evaluated include healthcare, education, manufacturing, small business, and government. Prior to serving at the national level, Margaret was an award examiner for the Erie Excellence Award and a senior examiner for New Mexico’s Quality Award program. She was the Baldrige coach for Community Consolidated School District 15, Palatine, Illinois, a 2003 winner of the prestigious Malcolm Baldrige National Quality Award. She has also been a consultant to the Hawaii Department of Education State Superintendent.

Currently, Margaret is involved in two major initiatives. She is the Baldrige coach and trainer for Prince William County Schools (the second largest school district in Virginia) and is leading a Baldrige approach to excellence for seven charter schools in Hawaii. In these roles, Margaret works with leaders and classroom-based educator-leaders to engage students as partners in their education, to identify and understand system gaps, create balanced scorecards and dashboards, and to use the Plan-Do-Study-Act process to improve results. Consequently, many PWC elementary schools, including those with the most challenging populations, have closed the achievement gap with 90+% of all students passing the state standards test. Results across all BiE trained schools have been sustained. This year the effort has expanded to include middle schools.

In Hawaii Ms. Byrnes is coaching school leaders and the Hawaii Charter School Administrative Office to take a systems view and formulate plans for collecting and analyzing school and satisfaction data to better meet the needs and expectations of all charter schools. As a result of my work with the HI charter schools in 2006-2008 the Ke Ali‘i Pauahi Foundation of Kamehameha Schools is underwriting an expansion of the leadership coaching for charter schools that serve mostly Hawaiian-Part Hawaiian students, the most underserved students in the state.

Because of her expertise and understanding of educational systems and the Baldrige, Margaret was invited to assist the Executive Director of the Wisconsin Forward Award (WFA) in the development of a comprehensive state-wide school reform plan. Last year she partnered with the WFA ED to provide leadership training for the 21st century to senior leaders from public and private schools.

Until 2008 Ms. Byrnes was the ASQ Education Division K-12 Vice-Chair and served on the Education Advisory Committee for the ASQ Education Market. She has been recognized by the ASQ Education Division as an ‘expert.’

During the 1990s, she was an evaluator of Literacy and Teen Pregnancy programs and served the US Department of Education as a member of the oversight and evaluation team of Head Start Programs in the Eastern Region.

Margaret has been married to Larry for 43 years and has two children and one granddaughter. The Byrnes’ have lived in Fort Myers since 1999.
Patient Safety Culture Update

Board of Directors
Lee Memorial Health System
13 August 2009
HPI Safety Culture Client Community
Organizations engaged in comprehensive safety culture improvement

39 Organizations – 136 Hospitals
As of July 17, 2009

- Abington Memorial Hospital
- Advocate Health Care (8)
- Asante Health System (2)
- Ascension Health
  - Columbia St. Mary’s (3)
  - Lourdes Hospital
  - Sacred Heart Health System (2)
  - Seton Family of Hospitals
  - St. Thomas Health Services (3)
  - St. Vincent Health (6)
  - St. Vincent’s Medical Center
- Carolinas Medical Center – Lincoln
- Centra Health (3)
- The Children’s Hospital of Philadelphia
- Children’s National Medical Center
- Cincinnati Children’s Hospital Medical Center
- Community Health Network (5)
- Genesis Health System (4)
- Inova Health System (6)
- Lee Memorial Health System (5)
- Memorial Health University Medical Center
- Memorial Hermann (9)
- Mercy Hospital of Catholic Health East
- Nationwide Children’s Hospital
- Novant Health (9)
- OhioHealth (8)
- Palmetto Health Trust Services Ltd (6)
- Prince William Hospital
- Rockingham Memorial Hospital
- Scottsdale Healthcare (3)
- Sentara Healthcare (7)
- Southern Ohio Medical Center
- Spectrum Health
- University Health Systems of Eastern Carolina (7)
- Vanguard Health Systems (15)
- VCU Health System
- WellStar Health System (5)
- William Beaumont Hospitals
- Yakima Valley Memorial Hospital

(Number of hospitals listed in parentheses, if more than one)
SSER JAN 2005: 1.21
SSER JAN 2007: 0.34  71.9% reduction
### Selected Quality Indicators

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>Improvement</th>
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</thead>
<tbody>
<tr>
<td><strong>Falls with Injury</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per 1,000 adjusted patient days</td>
<td>0.63</td>
<td>0.48</td>
<td>0.43</td>
<td>0.42</td>
<td>0.37</td>
<td><strong>41.3% ↓</strong></td>
</tr>
<tr>
<td><strong>Ventilator Associated Pneumonia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per 1,000 ventilator days</td>
<td>4.55</td>
<td>2.23</td>
<td>1.57</td>
<td>0.97</td>
<td>0.42</td>
<td><strong>90.8% ↓</strong></td>
</tr>
<tr>
<td><strong>Blood Stream Infections</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per 1000 device days</td>
<td>3.46</td>
<td>2.35</td>
<td>1.78</td>
<td>2.23</td>
<td>1.05</td>
<td><strong>69.7% ↓</strong></td>
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<tr>
<td><strong>Surgical Care Infection Prevention</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Antibiotic Prophylaxis Compliance</td>
<td>90.8</td>
<td>91.0</td>
<td>90.3</td>
<td>93.8</td>
<td>94.8</td>
<td><strong>4.4% ↑</strong></td>
</tr>
</tbody>
</table>
Loss Cost Per Adjusted Acute Care Bed
East Coast System (7 hospitals)

Source: ASHRM Hospital Professional Liability & Physician Liability 2007 Benchmark Analysis
Typical Improvement Curve

- Apparent increase due to healthier event/problem reporting culture
- Significant performance improvement as a result of prevention activities
- Actual increase due to complacency or reverting to old habits
- Long-term improvement through sustained prevention

Achieved in 1 to 3 years, approximately

Start of Culture Change

Time

Significant Event Rate

Hospital X
The Swiss-Cheese Effect

*Multiple Barriers* - technology, processes, and people - designed to stop active errors (our “defense in depth”)

*Active Errors* by individuals result in initiating action(s)

*Latent Weaknesses* in barriers

**EVENTS of HARM**

**PREVENT**

The Errors

**DETECT & CORRECT**

The System Weaknesses

Adapted from James Reason, *Managing the Risks of Organizational Accidents* (1997)
Influencing Behaviors at the Sharp End

Design of
Policy & Protocol
Design of
Culture
Design of
Work Processes
Design of
Technology & Environment

Design of Structure

Behaviors of Individuals & Groups

Outcomes

“You have to manage a system. The system doesn't manage itself.”
W. Edwards Deming

“A bad system will DEFEAT a good person every time.”
W. Edwards Deming

Adapted from R. Cook and D. Woods, Operating at the Sharp End: The Complexity of Human Error (1994)

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Quality’s Interest in Safety Culture

- **Behavior Accountability**
  - Behavior Expectations
  - Knowledge & Skills
  - Reinforce & Build Accountability

- **Process Design**
  - Evidence-Based Best Practices
  - Technology Enablers
  - Intuitive Work Environment
  - Resource Allocation
  - Continuous Quality Improvement

Optimized Outcomes

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Human Error – A Symptom, Not Cause

Human error is not the cause of failure, but a *symptom of failure*

Human error – by any other name or by any other human – should be the *starting point* of our investigations, not the conclusion

# Human Error Classification

Based on the Skill/Rule/Knowledge classification of Jens Rasmussen and the Generic Error Modeling System of James Reason

<table>
<thead>
<tr>
<th>Activity Type</th>
<th>Skill Based</th>
<th>Rule Based</th>
<th>Knowledge Based</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Familiar, routine acts that can be carried out smoothly in an automatic fashion</strong></td>
<td><strong>Problem solving in a known situation according to set of stored “rules,” or learned principles</strong></td>
<td><strong>Problem solving in new, unfamiliar situation for which the individual knows no rules – requires a plan of action to be formulated</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Error Types</strong></td>
<td><strong>Slips</strong></td>
<td><strong>Wrong rule</strong></td>
<td><strong>Formulation of incorrect response</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Lapses</strong></td>
<td><strong>Misapplication of a rule</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Fumbles</strong></td>
<td><strong>Non-compliance with rule</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Error Prevention Themes</strong></td>
<td><strong>Self checking – stop and think before acting</strong></td>
<td><strong>Educate if wrong rule</strong></td>
<td><strong>Stop and find an expert</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Think a second time if misapplication</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Non-compliance – reduce burden, increase risk awareness, improve coaching culture</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Error Probability</strong></td>
<td><strong>1:1000</strong></td>
<td><strong>1:100</strong></td>
<td><strong>3:10 to 6:10</strong></td>
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</tbody>
</table>
Assessment Inputs

- Analysis of recent events throughout the Lee Memorial Health System
- Interviews with over 650 LMHS team members – Staff, Leaders & Medical Staff
- Rounds and job observations of patient care areas
- Walk through of medication processes and specimen labeling
- Data results from the AHRQ Hospital Survey on Patient Safety Culture
- Review of documents (describing LMHS structures and processes) and data
3-Part Diagnostic Assessment

Analysis

• Analysis of past events for target in the intervention plan

Safety Governance Assessment

• Validate the results of the analysis
• Identify any system or process issues that require remediation
• Analyze capability to systematically improve human performance

Safety Culture Survey

• Assess the cultural strengths and weaknesses that shape human performance

An indicator of past performance
An indicator of current performance
An indicator of future performance
Safety Culture Climate Survey

Composite-Level Average Percent Positive Response

AHRQ Survey Tool:

*Hospital Survey on Patient Safety Culture*

An indicator of future performance:
Perception of cultural and organizational strengths and weaknesses that shape behavior relative to safety

<table>
<thead>
<tr>
<th>Patient Safety Composites</th>
<th>LMHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management Support for Patient Safety</td>
<td>65</td>
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<tr>
<td>Overall Perception of Patient Safety</td>
<td>58</td>
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<tr>
<td>Communication Openness</td>
<td>69</td>
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<tr>
<td>Teamwork Within Units</td>
<td>77</td>
</tr>
<tr>
<td>Teamwork Across Units</td>
<td>51</td>
</tr>
<tr>
<td>Handoffs and Transitions</td>
<td>37</td>
</tr>
<tr>
<td>Non-Punitive Response to Error</td>
<td>41</td>
</tr>
</tbody>
</table>
A real-time measure of High Reliability Organization (HRO) potential

<table>
<thead>
<tr>
<th>Subjective Description</th>
<th>Color Code</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective, systematic approach, fully deployed w/o gaps</td>
<td>Green</td>
<td>&gt; 80</td>
</tr>
<tr>
<td>Effective, systematic approach, fully deployed w/gaps</td>
<td>White</td>
<td>50 to &lt; 80</td>
</tr>
<tr>
<td>Systematic approach, partially deployed</td>
<td>Yellow</td>
<td>30 to &lt; 50</td>
</tr>
<tr>
<td>Beginnings of a systematic approach</td>
<td>Orange</td>
<td>20 to &lt; 30</td>
</tr>
<tr>
<td>No systematic approach</td>
<td>Red</td>
<td>&lt; 20</td>
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Scoring the Safety Governance Index (SGI)

<table>
<thead>
<tr>
<th>Contributor</th>
<th>Criteria</th>
<th>Points</th>
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</thead>
<tbody>
<tr>
<td>Leadership &amp; Strategy</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Operational Systems</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Operational Leadership</td>
<td>8</td>
<td>20</td>
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<tr>
<td>Practice Habits</td>
<td>8</td>
<td>18</td>
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<td>Performance Improvement Programs</td>
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<td>10</td>
</tr>
<tr>
<td>Totals</td>
<td>40</td>
<td>100</td>
</tr>
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</table>

Safety Governance Index = 41.2
Recommendations
Ten Things We Need To Do

1. Safety First – make patient safety a core value of leaders, especially visible at senior leader levels

2. Visibility of Harm – measure overall patient safety using a global, lagging metric such as Serious Safety Event Rate, and make harm visible to staff through a communication tool such as a harm report.

3. Patient Safety Work Group – adjust membership of work group and focus the work group on building Collaborative Interactive Teams (CIT’s) through a behavior-based approach to safety culture.

4. Engage Medical Staff – form a physician work group and focus the work group on building Collaborative Interactive Teams (CIT’s) through a behavior-based approach to safety culture.

5. Red Rules – improve compliance for checks critical to patient safety using a Red Rule approach for staff and medical staff:
   - Patient identification
   - Time-out before procedures
   - Double-checks for high-risk meds & blood
Recommendations
Ten Things We Need To Do

6. Space for Change – make “space” for culture change by reducing span of control at the system level; two possibilities: a Chief Operating Officer and/or a patient safety officer

7. Leaders & Accountability – increase staff accountability by improving leader behaviors thru tools such as 5:1 positive to negative feedback and Just Culture or the Performance Management Decision Guide

8. Leaders Solving Causes – increase the pace of system improvement by increasing leader engagement thru tools such as a Top 10 Problem list and A4 action plans

9. Safer Processes – changes to policy & practice:
   - Physician-to-physician communication for consults
   - Written orders inside the hospitals
   - Common language for patient care

10. Learning from Harm – increase the pace of system improvement by more analyses, using a systems thinking model for analysis, and using a closed-loop evaluation process for lessons-learned (evaluate for applicability at other hospitals)
Power Distance

Geert Hofstede’s Power Distance

- Extent to which the less powerful expect and accept that power is distributed unequally
- Measure of interpersonal power or influence superior-to-subordinate as perceived by the subordinate

USA
- Moderate to low PD (38th of 50 countries)
- Surgeons & anesthesiologists view low
- Nurses view as significantly higher

"Culture is more often a source of conflict than of synergy. Cultural differences are a nuisance at best and often a disaster."

Geert Hofstede, Emeritus Professor, Maastricht University
Assertiveness

- The willingness to state and maintain a position until convinced otherwise by facts
  - Requires initiative and courage to act

<table>
<thead>
<tr>
<th>PASSIVE</th>
<th>ASSERTIVE</th>
<th>OVER-AGGRESSIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Too nice’</td>
<td>Actively involved</td>
<td>Dominating</td>
</tr>
<tr>
<td>Procrastinates</td>
<td>Ready for action</td>
<td>Intimidating</td>
</tr>
<tr>
<td>Avoids conflict</td>
<td>Useful contributor</td>
<td>Abusive</td>
</tr>
<tr>
<td>‘Along for the ride’</td>
<td>Speaks up</td>
<td>Hostile</td>
</tr>
</tbody>
</table>
Strengthening Medical Staff
Improve Relationships

Strategies for Hospital Executives*

Examples:

- Make better relationships with physicians a strategic priority
- Stop reinforcing irresponsible physician behavior
- Create success: measure something important, publicize the metric, push for improvement, hold yourselves accountable, identify a benchmark, beat it, measure something else.

* From Kendall Stewart MD, Southern Ohio Medical Center, Portsmouth, OH
Strengthening Medical Staff
Improve Relationships

Executives—Things not to do!

Examples:

- Leave physicians out of the real decision-making process
- Pretend to involve physicians in the decision-making after it is done
- Tell physicians what they want to hear

*From Kendall Stewart MD, Southern Ohio Medical Center, Portsmouth, OH*
Influencing Physician Behavior
Physician Safety Champion Model

Incorporates the methods proven successful in influencing physician practice:

- Academic detailing
- Active learning
- Audit and feedback
- Coaching
- Commitment to change
- Using influence of local leaders
Getting Started

1. Authentic “safety first” leadership
2. Safety Culture or Safety Climate assessment (to confirm a firm foundation)
3. Safety Governance assessment (to confirm functioning Accountability Systems)
4. Analysis:
   a. Rule-out broken process(es) and knowledge & skill deficiencies as majority causes
   b. Select behaviors indicated by individual failure modes of the acts involving harm
5. Educate leaders, medical staff, and staff
Safety Culture Transformation

Step 1: **Set Expectations**
Define Safety Behaviors & Error Prevention Tools proven to help reduce human error

Step 2: **Educate**
Educate our staff and medical staff about the Safety Behaviors and Error Prevention Tools

Step 3: **Reinforce & Build Accountability**
Practice the Safety Behaviors and make them our personal work habits
Plan The Work & Work The Plan

Diagnostic Assessment

Results Report

1st Quarter

2nd Quarter

3rd Quarter

4th Quarter

5th Quarter

6th Quarter

LM Design

Educate Leaders

EP Behavior Design

Educate Leaders

Prepare Educators

Educate Staff & Medical Staff

Red Rules Design & Implementation

Accountability Systems Design & Implementation
Safety as a Core Value at Seton

Ten Key Safety Beliefs
Seton Medical Center Williamson
Mark Hazelwood, Chief Executive Officer

1. We believe that all injuries are preventable.

2. We believe that SMCM will achieve zero preventable injuries and deaths and that our overall safety performance pertaining to patients, family members, associates, physicians and volunteers will be exemplary.

3. We believe that safety is more important than any other competing priority. In this regard, we view safety as both a moral imperative and an operational standard.

4. We believe that safety must be “lived” 24 hours a day, 7 days a week, at both work and home.
From Your Patient’s Perspective

Don’t hurt me
Heal me
Be nice to me
**DATE:** 08/07/09  
**LEGAL SERVICE REVIEW?** YES___ NO__X__

**SUBJECT:** FY 2009, 2nd Quarter Organizational Performance Measure Scorecard

**REQUESTOR & TITLE:** Dr. Krivenko, Chief Medical Officer/Clinical & Quality Services  
Dr. Greenberg, Medical Director/Medical Staff Services  
Becky Watt, System Director/Clinical Decision Support

**PREVIOUS BOARD ACTION ON THIS ITEM (IF ANY)**  
(justification and/or background for recommendations - internal groups which support the recommendation i.e. SLC, Operating Councils, PMTs, etc.)

The Quality Safety and Management Council reviewed and approved several of the indicators within the Organizational Performance Measure Scorecard on July 8, 2009.

**SPECIFIC PROPOSED MOTION:**

Approve the Organizational Performance Measure Scorecard: 2nd Quarter Fiscal Year 2009.

<table>
<thead>
<tr>
<th>PROS TO RECOMMENDATION:</th>
<th>CONS TO RECOMMENDATION:</th>
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<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
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</table>

**LIST AND EXPLAIN ALTERNATIVES CONSIDERED:**

N/A

**FINANCIAL IMPLICATIONS**  
Budgeted ____  Non-Budgeted ____  
(including cash flow statement, projected cash flow, balance sheet and income statement)

N/A

**OPERATIONAL IMPLICATIONS**  
(including FTEs, facility needs, etc.)

N/A

**SUMMARY:**

N/A
# Performance Measures
Second Quarter Fiscal Year 2009

## ORGANIZATIONAL

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MEASURE</th>
<th>CURRENT QUARTER</th>
<th>PRIOR QUARTER</th>
<th>FISCAL YTD RATE</th>
<th>PREFERENCE</th>
<th>TARGET</th>
<th>CURRENT QUARTER PERFORMANCE</th>
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</thead>
<tbody>
<tr>
<td>Clinical Outcomes</td>
<td>Acute Care - Overall Mortality Rate</td>
<td>1.83%</td>
<td>1.64%</td>
<td>1.74%</td>
<td>Lower</td>
<td>1.91%</td>
<td>***</td>
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<tr>
<td></td>
<td>Acute Care - Overall Complication Rate</td>
<td>5.22%</td>
<td>5.39%</td>
<td>5.30%</td>
<td>Lower</td>
<td>5.68%</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td>Acute Care - 30-Day Readmissions</td>
<td>9.10%</td>
<td>9.78%</td>
<td>9.43%</td>
<td>Lower</td>
<td>8.72%</td>
<td>**</td>
</tr>
<tr>
<td>Safety Outcomes</td>
<td>Acute Care &amp; Rehab - Severity II Medication Errors Per 10,000 Days</td>
<td>1.2</td>
<td>3.1</td>
<td>2.1</td>
<td>Lower</td>
<td>≤ 5 errors</td>
<td>***</td>
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<tr>
<td></td>
<td>Acute Care - Patient Falls Per 1,000 Days/ED Visits</td>
<td>2.19</td>
<td>2.72</td>
<td>2.44</td>
<td>Lower</td>
<td>4.50</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td>Acute Care &amp; Rehab - Hospital Acquired Pressure Ulcers</td>
<td>5.15%</td>
<td>5.59%</td>
<td>5.36%</td>
<td>Lower</td>
<td>4.76%</td>
<td>*</td>
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**KEY:** Stars assigned on Current Quarter values

* Worse than Expected  
** As Expected +/- 5% variance  
*** Better than Expected
## Performance Measures

**Second Quarter Fiscal Year 2009**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MEASURE</th>
<th>CURRENT QUARTER</th>
<th>PRIOR QUARTER</th>
<th>FISCAL YTD RATE</th>
<th>PREFERENCE</th>
<th>TARGET</th>
<th>CURRENT QUARTER PERFORMANCE</th>
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<tbody>
<tr>
<td><strong>Effectiveness</strong></td>
<td><strong>Acute Care</strong>&lt;br&gt; Joint Commission Core Measure&lt;br&gt; Appropriate Care Measure Indicators</td>
<td>0.75</td>
<td>0.71</td>
<td>0.73</td>
<td>Higher</td>
<td>Joint Commission Benchmark Pending</td>
<td>N/A</td>
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<tr>
<td></td>
<td>- Surgical Site Infections (LMH, HP, &amp; CCH)</td>
<td>1.2%</td>
<td>1.5%</td>
<td>1.3%</td>
<td>Lower</td>
<td>1.5%</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td>- ICU Central Line Blood Stream Infections Per 1,000 Central Line Days</td>
<td>2.84</td>
<td>2.42</td>
<td>2.64</td>
<td>Lower</td>
<td>3.0 - 5.0</td>
<td>***</td>
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<tr>
<td></td>
<td>- ICU Ventilator Associated Pneumonia Infections Per 1,000 Ventilator Days</td>
<td>1.30</td>
<td>3.48</td>
<td>2.33</td>
<td>Lower</td>
<td>5.0 - 10.0</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td>- ICU Urinary Tract Infections Per 1,000 Foley Catheter Days</td>
<td>4.75*</td>
<td>6.98</td>
<td>4.34*</td>
<td>Lower</td>
<td>CDC Benchmark Pending</td>
<td>N/A</td>
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</tbody>
</table>

*Indicator revised to include LMH & HP ICU UTI data in January 2009

**KEY:** Stars assigned on Current Quarter values  
*  Worse than Expected  
**  As Expected +/- 5% variance  
*** Better than Expected
# Performance Measures
Second Quarter Fiscal Year 2009

<table>
<thead>
<tr>
<th>ORGANIZATIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CATEGORY</strong></td>
</tr>
<tr>
<td>Acute Care</td>
</tr>
<tr>
<td>Efficiency</td>
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<tr>
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<tr>
<td>Timeliness</td>
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<tr>
<td>Patient</td>
</tr>
<tr>
<td>Satisfaction</td>
</tr>
<tr>
<td><strong>CURRENT QUARTER</strong></td>
</tr>
<tr>
<td>4.55 days</td>
</tr>
<tr>
<td>5.17 days</td>
</tr>
<tr>
<td>42*</td>
</tr>
<tr>
<td>4.4%</td>
</tr>
<tr>
<td>1:42</td>
</tr>
<tr>
<td>53.1%</td>
</tr>
<tr>
<td>60.5%</td>
</tr>
</tbody>
</table>

**KEY:** Stars assigned on Current Quarter values

* Worse than Expected
** As Expected +/- 5% variance
*** Better than Expected
Beginning March 2004, the Hospital Acquired Pressure Ulcers indicator includes data from Southwest Florida Regional Medical Center and Gulf Coast Hospital / Gulf Coast Medical Center. Data collection process revised and indicator edited to mirror the methodology utilized by NDNQI. Stage I & > pressure ulcers are currently being monitored when previously Stage II & > ulcers were tracked.

Beginning July 2008, the Patient Falls indicator excludes data from the Rehab Hospital.

Acute Care – 30-Day Readmission Data Unavailable for September due to FY 2008 DRG Restructure.
Beginning June 2007, the ICU Ventilator Associated Pneumonia indicator includes data from Southwest Florida Regional Medical Center/Gulf Coast Medical Center.

Beginning June 2007, the ICU Urinary Tract Infection indicator includes data from Southwest Florida Regional Medical Center/Gulf Coast Medical Center.

Beginning June 2007, the ICU Central Line Infection indicator includes data from Southwest Florida Regional Medical Center/Gulf Coast Medical Center.

Beginning June 2007, the ICU Ventilator Associated Pneumonia indicator includes data from Southwest Florida Regional Medical Center/Gulf Coast Medical Center.
WHAT WAS THE SYSTEM’S MEDICARE UNADJUSTED AVERAGE LENGTH OF STAY FOR ACUTE CARE?

Beginning July 2008, the Delay Days indicator includes data from Southwest Florida Regional Medical Center and Gulf Coast Hospital. Delays Days data for the 2nd Quarter FY2009 were unavailable.
OTHER ITEMS
DATE OF THE NEXT REGULARLY SCHEDULED MEETING

QUALITY & EDUCATION Committee of the Whole MEETING

THURSDAY, September 3, 2009 1:00pm

Lee Memorial Hospital Boardroom
2776 Cleveland Ave, Ft. Myers, FL 33901