The MetroHealth System Board of Trustees

QUALITY, SAFETY AND EXPERIENCE COMMITTEE MEETING
Wednesday August 27, 2025
11:00 am – 1:00 pm
MetroHealth Board Room K107 / Virtual

Meeting Minutes

Committee Members:	Ronald Dziedzicki-I, E. Harry Walker, MD-I
Other Trustees:	Michael Summers-I
Staff:	Christine Alexander-Rager, MD-I, Michelle Block-I, Doug Bruce, MD-R, Stacey Booker, RN-I, Nabil Chehade, MD-I, Corryn Firis-I, Joseph Golob, MD-I, Matthew Kaufmann-I, Travis McDonald-I, Dr. Candy Mori-I, Nicole Rabic, RN-I, Tamiyka Rose-I, Laura Schmidt-I, Deborah Southerington-I, David Stepnick, MD-I, Kara Sullinger-I, Maureen Sullivan, RN-I, Mary Wainwright-I, James Wellons-I
Invited Guests:	None
Other Guests:	Guests not invited by the Board of Trustees are not listed as they are considered members of the audience and some were not appropriately identified.

Mr. Dziedzicki called the meeting to order at 11:00 am with a quorum present.

The minutes are written in a format conforming to the printed meeting agenda for the convenience of correlation, recognizing that some of the items were discussed out of sequence.

I. Approval of Minutes

Mr. Dziedzicki requested a motion to approve the minutes of the May 28, 2025, Quality, Safety, and Experience Committee meeting as presented, which was given, seconded and unanimously approved.

II. Information Items

A. Great Catch Story – *S. Booker*

Mr. Dziedzicki introduced Stacy Booker, Director of Patient Safety, who presented a "Great Catch" story to the Committee, along with members of the Emergency Department, to highlight a safety event that exemplified MetroHealth's commitment to patient safety and continuous learning.
Ms. Booker introduced Kara Sullinger, a nurse in the Emergency Department (ED), recognized for her vigilance during a trauma case involving a patient found unresponsive in her apartment. As the patient's heart rate and blood

pressure dropped, the physician ordered a dose of push epinephrine. However, the medication handed to Ms. Sullinger by the pharmacist was phenylephrine, not epinephrine. Ms. Sullinger paused, verified the medication, and sought clarification from the physician, who confirmed the need for epinephrine. Ms. Sullinger's attentiveness prevented a potential medication error and ensured the patient received the correct treatment. Notably, the pharmacist who handed over the incorrect medication self-reported the incident, demonstrating a strong culture of accountability and transparency. The pharmacist had misinterpreted the verbal order due to familiarity with phenylephrine in similar contexts. In response, MetroHealth's medication safety officer initiated educational sessions for pharmacists, especially those attending codes, to reinforce proper medication identification and reduce human error. Ms. Sullinger's actions were praised as a reflection of the ED's judgment-free culture, where staff feel empowered to speak up and report mistakes without fear of disciplinary action. Laura Schmidt, Director of Nursing for Emergency Medicine, and Travis McDonald, Nurse Manager, elaborated on the department's efforts to foster a speak-up culture. They emphasized the importance of mutual respect, open communication, and a non-hierarchical environment where patient safety is paramount. Mr. McDonald highlighted the use of incidents as learning opportunities rather than disciplinary actions, reinforces that most errors stem from process issues rather than intentional harm. This approach has cultivated a culture of continuous improvement and proactive safety measures.

B. **Continuous Performance Improvement at MetroHealth –** *M. Wainwright*
Mr. Dziedzicki introduced Mary Kate Wainwright, representing the Continuous Performance Improvement (CPI) Team, presented on the team's structure and recent Lean Six Sigma initiatives aimed at continuous improvement across clinical and non-clinical engagements. The CPI team, composed of six principals and one analyst, utilizes Lean Six Sigma methodology and various tools, including standard work - described as documented, efficient ways to accomplish tasks, and Rapid Process Improvement (RPI) events, to achieve goals. The process begins with obtaining frontline staff input, performing a root-cause analysis and choosing key performance indicators (KPIs). A major focus of the CPI Team is the Perioperative services engagement, particularly in the Operating Room (OR), to improve patient experience, staff experience, safety, and quality. Key Performance Indicators (KPIs) for this project includes increasing first case on-time starts and reducing turnaround times. Initial efforts included a month of observations, staff interviews, and RPI events with frontline staff. Countermeasures implemented include improving workflows for the Central Sterile Processing Department (CSPD), optimizing case order sets within the EPIC

system to ensure all necessary elements are correct from the start, and developing new standard work for various roles (nursing, scheduling, etc.) to ensure consistency. The team established a "one source of truth" dashboard to track and measure success against their KPIs monthly. Ms. Wainwright also highlighted three successful projects demonstrating impact on quality, safety, and experience. For patient quality, an ED sepsis bundle RPI event improved adherence from 32% to 80% in three months, significantly exceeding the national average. For patient safety, an OR project added status board **icons** for pre-procedure readiness (e.g., H&P, consent) to prevent rework and case delays, resulting in a 96% reduction in non-ready events post-intervention (from 23 to 1). For patient experience, a heart failure clinic visit project used a Current State Value Stream Map to identify non-value-added time, reducing the total visit time from 80 to 62 minutes, a 23% improvement, while maintaining provider time. The team utilizes the A3 document — a single-page storyboard, as a living document and standard problem-solving methodology, coaching other quality improvement committees in its use.

III. Executive Session

Mr. Dziedzicki asked for a motion to move into executive session to discuss hospital trade secrets as defined by ORC 1333.61 and to consider the appointment, employment, dismissal, discipline, promotion, demotion, or compensation of a public employee, or the investigation of charges or complaints against a public official, and to conference with the public body's attorney to discuss disputes involving the public body that are the subject of pending or imminent court action as defined by ORC 121.22(G). The motion was made by Mr. Summers and seconded by Dr. Walker. Upon unanimous roll call vote, the Committee went into executive session to discuss such matters at 11:30 am.

Return to Open Meeting

Following executive session, the meeting reconvened in open session at approximately 12:58 pm. There being no further business to bring before the Committee, the meeting was adjourned at approximately 12:59pm.

THE METROHEALTH SYSTEM

Joseph Golob, M.D.
EVP, Chief Quality and Safety Officer