Memorandum

To: Special Committee of the Board of the Johns Hopkins Health System

From: Gibson, Dunn & Crutcher LLP

Date: June 26, 2019

Re: JHACH Investigation Recommendations

Review Overview

In December 2018, following a series of Tampa Bay Times articles concerning serious incidents involving the Johns Hopkins All Children's Hospital, Inc. ("JHACH") Heart Institute, the Board of Trustees of the Johns Hopkins Health System ("JHHS") established a Special Committee to review potential deficiencies that may have contributed to these incidents and to develop recommendations to address and correct any deficiencies. The Special Committee retained Gibson, Dunn & Crutcher LLP ("Gibson Dunn") to undertake an external review to identify deficiencies at JHACH and JHHS and to make recommendations in connection with its observations to assist the Special Committee in carrying out its mandate. Clinical issues and questions surrounding standard of care are beyond the scope of Gibson Dunn's review.

As part of the review, Gibson Dunn collected and analyzed documents and interviewed individuals identified as having involvement with or insight into the topics under review. We received and reviewed many categories of documents, including meeting minutes, event reports, personnel files, and employee engagement surveys. We also conducted targeted searches of approximately 6.9 million documents collected from the email inboxes of 26 document custodians, resulting in a review of more than 140,000 documents from those searches.

Over the course of several months, Gibson Dunn conducted 126 interviews with 119 individuals who are current or former employees of JHACH, Johns Hopkins Hospital, or the Johns Hopkins Health System, members of the JHACH Board and others identified as potentially having insight into the topics under review.

Gibson Dunn developed extensive observations from this review. Gibson Dunn briefed the governing boards of Johns Hopkins Medicine ("JHM"), JHHS and JHACH regarding its observations and recommendations on multiple occasions. Specifically, Gibson Dunn reviewed its detailed observations and recommendations with the Special Committee on regular conference calls and one all-day meeting on April 12, 2019. Gibson Dunn gave briefings to the JHM and JHHS Boards of Trustees at their joint March 4, 2019 meeting and the JHM and JHU Executive Committee at their joint May 6, 2019 meeting. Gibson Dunn

also briefed the JHACH Board during an in-person meeting on April 26, 2019 and the JHACH Executive Committee during several conference calls.

This memorandum proposes recommendations to address observations about management and oversight that were identified in the review and informed by the discussions with the JHHS leadership and the briefed boards and committees. Some of these recommendations are focused on JHACH specifically, but some relate to the oversight of the member hospitals by JHHS. For some of these recommendations, we have provided to the Committee and management specific sub-recommendations to facilitate establishing accountability measures for instituting and sustaining these recommendations. Other member hospitals should be evaluated for similar gaps and considered for the potential application of certain of these recommendations. In particular, the Special Committee should consider applying hospital-level recommendations (and sub-recommendations) that begin with an asterisk (*) on a system-wide basis, as appropriate.

Recommendations for Improvement

A. JHACH Management and Culture

A.1. Strengthening Connections Between Leadership, Hospital Staff, and Physicians, and Channels for Reporting Concerns

A.1.1. * Prioritize a culture of absolute commitment to patient safety and of raising and addressing problems and concerns, including throughout the process of hiring and evaluating senior executives. At JHACH and all member hospitals, promote a "see something, say something" culture, which is vital to promoting patient safety. Make clear that this is a core aspect of every job, and that failure to reflect this culture will have compensation and employment consequences.

A.1.2. * Clarify JHACH leadership organization to give physician leaders a stronger voice, create a more robust check-and-balance on the President as a representative of hospital administration, and ensure alignment of strategies between the administrative and medical departments. Consistent with Recommendation C.1.1, review organizational structure of other member hospitals to ensure similar reporting lines of care provider and administrator leadership exist across the system. Physician leaders must be empowered to ensure that their concerns about patient safety are heard and addressed promptly and must be held accountable if they fail to do so.

A.1.2.1. Separate Vice Dean/Physician-in-Chief and Designated Institutional Official roles from the President role and give the Vice

Dean/Physician-in-Chief a direct reporting line to the Executive Vice Dean in the JHU School of Medicine.

A.1.2.2. Restructure the lines of reporting from Institute directors and departmental chairs so that clinical leaders report to the Vice Dean/Physician-in-Chief, not the President.

A.1.3. * Develop a more rigorous annual evaluation process for executive leadership of JHACH and other JHM-member hospitals, including Presidents, to be conducted by JHHS. We recommend that executive leadership, including Presidents, be subject to a "360 review" that gives weight to feedback from hospital staff members, physicians, and the Board.

A.1.4. * Institute a more consistent senior leader engagement rounding process with required participation by all members of the JHACH executive team, including the President, to increase visibility and accessibility of senior leadership. Staff with more opportunity to interact with senior leaders are more likely to feel comfortable raising concerns.

A.1.5. * Take steps to better educate staff and faculty about JHM commitment to transparency and a culture of "see something, say something" and to improve channels to submit complaints and provide for independent review.

A.1.5.1. In the short term, consistent with Johns Hopkins' desire to foster a culture of "see something, say something" and Just Culture policies, augment awareness and usage of the SPEAK2US hotline and the HERO system, including existing options to report anonymously. We understand that JHM has already taken steps relevant to this recommendation.

A.1.5.2. Implement accountability for these measures by improving tracking systems to allow JHHS to monitor completion of complaint handling across all member hospitals. Ensure proper documentation of follow-up.

A.1.6. Consider holding quarterly town halls, regular video updates, and other group communication events, including opportunities for two-way communication.

A.1.7. Incorporate into senior leadership performance reviews an element that assesses and incents their obligations to exemplify Johns Hopkins values.

A.2. Leadership Effectiveness

A.2.1. * Require more strategic planning of clinical program changes, with physician and other stakeholder involvement at the hospital and JHHS, especially for transitions from community-based practice to an employed physician model.

A.2.1.1. Enhance quality monitoring at times of systemic change, such as when moving to an employed model or replacing clinical groups, for clinical programs with potential for high mortality or morbidity.

A.2.1.2. Bolster leadership training and reporting on succession planning. Ensure that more junior staff are identified as a part of succession planning with appropriate development plans in place.

A.2.2. * Create more structure around key personnel actions, more process for hiring of significant positions and disciplining or terminating employed physicians, and more visibility and involvement by JHM in these processes, consistent with medical staff by-law requirements. In making personnel decisions, consider the effect on team dynamics.

A.2.2.1. Increase the involvement of JHM during the hiring and firing process of senior leaders at JHACH who would report to JHM. Ensure a direct line of reporting between JHACH Human Resources and JHHS.

A.2.2.2. Reexamine the criteria for choosing senior leaders in community hospitals to include their demonstration of values as well as competencies, and standardize the hiring process and criteria across the system.

A.2.3. Consistent with Recommendation A.1.2, segregate roles and responsibilities by preventing the same person from occupying multiple leadership positions.

A.2.3.1. Separate the Medical Staff Office responsibilities from the Patient Safety and Quality department responsibilities, which previously were overseen by a single VP of Medical Affairs.

A.3. Confronting Integration Challenges

A.3.1. * Exercise care in how—and how quickly—member hospitals are integrated into the JHM tripartite mission. Consult broadly with stakeholders in developing an integration plan.

A.3.1.1. Integration planning should include conversations with community doctors and legacy staff.

A.3.1.2. Consider developing system-wide program with established metrics for JHM to monitor integration of new members into JHHS.

A.3.2. * Develop mechanisms to increase community outreach and strengthen relationships with surrounding healthcare providers and physician groups.

A.3.3. * Re-engage community doctors in an effort to include their views in JHACH's strategic vision.

A.3.4. * Develop and communicate to JHACH employed physicians a clear vision of advancement and career development opportunities for both academics and pure clinicians.

B. JHACH Systems for Evaluating Clinical Quality and Patient Safety

B.1. Improving Communications Within JHACH

B.1.1. * Take steps to ensure cross-departmental access to information, such as providing the Patient Safety and Quality department access to any hospital information, including risk management databases/reviews. The sharing of information with JHHS is discussed below.

B.1.2. Develop a clear disclosure policy that prioritizes sharing, disclosing, or reporting information needed to self-identify and remedy problems, regardless of concern for legal risk, and ensures that Amendment 7 is not used inappropriately.

B.2. Improving Systems for Physician Self-Monitoring

B.2.1. * Use data more extensively and rigorously as both a compliance tool and to ensure transparency around clinical outcomes. However, data should be a complement to, not supersede, observational information from clinical staff.

B.2.1.1. Create structured, automated data processes to counteract the possibility of health care providers and leaders not sharing

information. Increase access to data so that no one individual or small group controls the data.

B.2.1.2. Go beyond the industry-standards and track data on a more regular basis when appropriate to ensure that emerging trends are not obscured by earlier unremarkable longitudinal data.

B.2.1.3. Conduct routine quality reviews of high acuity programs and tracking of M&M data.

B.2.1.4. Ensure that clinical departments utilize physician-specific data analyses for quality and safety performance reviews.

B.2.2. * Reform the M&M process to make it more effective.

B.2.2.1. Ensure that M&Ms include clinicians from a variety of disciplines to encourage a full and frank review of cases.

B.2.2.2. Adopt more formal procedures (e.g., write-ups) for documenting discussions and findings from M&Ms.

B.2.2.3. Discuss every mortality at JHACH in detail at an M&M conference.

B.2.3. * Enhance peer review analysis processes by adopting clear policies for when cases are subject to a peer review and by providing for peer review by colleagues outside their own Institute or Department, such as by colleagues at other JHHS hospitals or external to JHHS. Adopt processes for peer review that would include all relevant disciplines.

B.3. Enhancing Systems for Evaluating Physician Competency and Performance

B.3.1. * Consistent with Recommendation A.2.2, revise the initial hiring and credentialing process in ways that improve due diligence and vetting prior to hiring a provider.

B.3.1.1. Update JHACH credentialing software to align with JHHS-level data-sharing technology.

B.3.1.2. Ensure that there is a robust credentialing process before a physician begins clinical work at the hospital. Employment should be made contingent on successful completion of the credentialing process, and it should be made clear to the Standards & Credentialing

Committee and other Medical Staff Office personnel that the credentialing process should not be influenced by the fact that the physician has already received an employment contract.

B.3.1.3. Increase training of Standards and Credentialing Committee and ensure that HR-related issues are discussed during the credentialing process.

B.3.2. * Improve the Ongoing Physician Performance Evaluation and Focused Professional Practice Evaluation ("OPPE" and "FPPE") processes by incorporating more clinically robust criteria for evaluation, and creating channels of communication so that OPPE and FPPE can be triggered, as appropriate, by issues identified in the Quality-of-Care Committee structures and/or other regular reviews of physician-specific data recommended above.

B.3.3. * In evaluating cardiovascular surgeon competency, review and weigh physician-specific outcomes data through four-year rolling averages alongside other relevant metrics, such as physician-specific outcomes data over shorter intervals. Consistent with Recommendation C.1.2.2, ensure that this more granular review is shared with appropriate oversight committees.

B.4. Enhanced Monitoring of Employment Complaints and Trends

B.4.1. * Improve HR systems to augment detection and reporting of problems to relevant areas of the health system.

B.4.1.1. Track provider and employee complaint information and better communicate that information to clinical/quality departments.

B.4.1.2. Improve turnover data monitoring with, for example, automated monitoring and routine reporting to the boards and JHHS HR department. Make turnover data available on a unit-by-unit basis as frequently as appropriate to identify any meaningful trends.

B.4.1.3. Regularly conduct and report on structured exit interviews. Regularly track and report to relevant quality committees or boards any patient safety information obtained through exit interviews.

B.4.2. * Encourage a culture that acknowledges and values the fact that observation and lived experience, and not merely quantitative data, are valuable tools in detecting and addressing patient safety issues. To this end, develop a process for analyzing and reporting to relevant stakeholders the qualitative concerns raised in patient safety culture surveys. We understand that JHHS is already

incorporating this Recommendation by ensuring that JHACH board members receive qualitative results of patient safety culture surveys.

B.4.3. * Conduct JHHS-level exit interviews for senior leaders at member hospitals.

C. Clarifying JHHS Oversight of and Collaboration with System Hospitals

C.1.1. * Clarify and augment reporting structure between member hospitals and JHHS.

C.1.1.1. Replace dotted-line reporting between positions at JHHS and entity hospitals with solid-line reporting, such that (i) operational department heads/VPs will formally report both to the hospital president and to a subject-matter counterpart at JHHS, and (ii) employed clinical heads will formally report to both JHHS Department chiefs and/or School of Medicine department chairs as appropriate.

C.1.1.2. Clarify supervisory roles of department chairs of JHU with respect to member hospitals to ensure that department chairs have the ability to adequately oversee the physicians within their specialties.

C.1.2. * Standardize oversight of entity hospitals by JHHS leadership.

C.1.2.1. Ensure that each JHHS department is run by a dedicated JHHS employee, or, if run by someone with dual appointments at JHHS and Johns Hopkins Hospital and/or the School of Medicine, empower a strong deputy to adequately cover the JHHS responsibilities.

C.1.2.2. Empower JHHS leaders to have full access to the data, people, funding, and other information they need to do their jobs. Review current JHHS resources in the medical affairs, nursing, quality, HR, and risk management departments to determine capacity to perform more granular oversight, data review, and site visits. We understand that JHHS is already incorporating this Recommendation by reviewing and reporting every mortality to JHHS.

C.1.2.3. Consider expanding the Armstrong Institute's emphasis from a focus on education and research to include a focus on patient safety oversight within the health system, with accountability for hospital presidents regarding relevant operational matters.

C.1.2.4. Consider adopting JHHS-level policies requiring that member hospitals provide a clear and convincing rationale, to be evaluated and approved by appropriate JHHS personnel, before opting out of any system-wide program, policy, or other administrative or operational initiative.

C.1.3. Improve centralized analysis of incident reporting to automate and strengthen tracking and trending.

C.1.3.1. Consider consolidating analysis of incident reports and hotline complaints with a single person or department to facilitate and improve cross-system analysis.

C.2. * When new hospitals are brought into the JHM family, set specific timeframes for synchronizing policies, reporting capabilities, and management oversight with JHM.

D. Board Oversight at JHACH and JHM Levels

D.1.1. * Take steps to facilitate more direct reporting and access to the relevant hospital patient safety and quality board committees by hospital clinical and quality staff.

D.1.1.1. Involve presenters who are not members of the senior management team.

D.1.1.2. Incorporate Medical Executive Committee session into quality and patient safety subcommittee meetings to facilitate direct reporting of issues of concern by physicians.

D.1.1.3. Empower the quality and patient safety director to collaborate with the Board Chair in determining the agenda and facilitating the discussion in patient safety and quality ("PSQ") board subcommittee meetings. The hospital President should not control the agenda or process. We understand that JHHS is already taking steps relevant to this Recommendation.

D.1.1.4. Facilitate the sharing of important information and/or analyses between JHM and JHACH for reporting to the boards.

D.1.2. * Advance a PSQ subcommittee format that includes reporting on action plan for significant issues and hospital's progress from meeting to meeting. Open each meeting with top three patient safety concerns.

D.1.3. * Examine the composition of the entity Board and individual member qualifications, including the selection of those who represent JHM management.

D.1.4. * Take steps to improve PSQ board subcommittee engagement.

D.1.4.1. Better orient hospital board members to their role as monitors of patient safety issues at the hospital, rather than mere fiduciaries.

D.1.4.2. Increase number of sitting members with health care expertise, and draw on medical staff to provide expert support.

D.1.5. Reconfigure the JHM Board's patient safety and quality committee meetings to better promote hospital accountability and reorient the Board's support of management and oversight toward solving problems at entity hospitals.

D.1.5.1. Reconsider the management discussion and analysis ("MD&A") structure of reporting to develop a better system for identifying both problems at individual hospitals and cross-cutting issues for discussion at the JHHS level. Any alternative structure should include required reporting of key patient safety metrics, including detailed mortality data, with required follow-up on those items at each meeting.

D.1.5.2. Evaluate whether composition of the JHM Board's patient safety and quality committees, as well as the structure of the meetings, facilitates robust discussion of areas of concern. We understand that JHHS is already implementing this Recommendation. Pursue opportunities to continually improve the committees' effectiveness by adopting best practices as they emerge.

D.1.5.3. Consider dividing the JHM Board's patient safety and quality committee meetings into three separate meetings: one for ambulatory, home care and special sites; one for member hospitals; and one for the Armstrong Institute/PSQ subcommittee.

D.1.6. Provide annual trainings to JHM and community hospital board members about their responsibilities and best governance practices. Include a written description of JHM and community hospital fiduciary responsibilities.

GLOSSARY

1. **“FPPE”** means Focused Professional Practice Evaluation.
2. **“Gibson Dunn”** means Gibson, Dunn & Crutcher LLP.
3. **“JHACH”** means Johns Hopkins All Children’s Hospital, Inc.
4. **“JHHS”** means the Johns Hopkins Health System.
5. **“JHM”** means Johns Hopkins Medicine.
6. **“MD&A”** means management discussion and analysis.
7. **“OPPE”** means Ongoing Physician Performance Evaluation.
8. **“PSQ”** means patient safety and quality.