

# Q How does the board ensure that quality is truly job one?

Boards of trustees are responsible for ensuring the quality of care and patient safety provided by their organization, and must take strong, organized action to establish and ensure an organizational culture that continually strives to improve quality and patient safety at every turn.

**W**hile there has been a much-heightened awareness about quality and patient safety in health care, errors still occur in hospitals every day. These errors are not always large and egregious; they may instead be small or unnoticed acts of commission or omission. Regardless of the nature or scope of the problem, quality and patient safety errors have great consequences on an organization's payments, patient satisfaction, medical staff and employee morale, and reputation.

## The Problem: Inadequate Systems

The health care system is fragmented, with patients seeing several different providers for any number of health issues. Each provider has only limited access to patient information, and care is often poorly coordinated amongst the providers. This has resulted in no clear lines of accountability, and oftentimes poor communication between all levels of care providers.

With today's changing reimbursement that incentivizes increasingly coordinated care and alignment across the care continuum, boards must ask: "how can we better align care, increase communication, and eliminate fragmentation in the system?" According to the Institute of Medicine, there are many behavior choices that health care organizations make that can lead to patient injury or death, including:

- Not adhering to protocols/requirements;
- Inadequate investment in systems;
- Inadequate staffing;
- Lack of, or poor provider qualifications;
- Communication inefficiencies and ineffectiveness; and
- Failure to learn and change.

Boards must commit to changing these behavior issues by setting the tone or "culture" for the hospital, including setting patient safety guidelines and priorities and dedicating the resources necessary to provide appropriate, effective, safe care.

## Quality and Patient Safety are Job One

Too often boards of trustees assume that quality and safety problems are not an issue in their hospital unless they hear otherwise. Instead, boards should ask specific questions to identify the hospital's current performance and pinpoint areas with the greatest need for improvement. Questions boards should be asking include:

- How good is our quality? How safe is our hospital? How do we know?
- What is our "culture" of quality and safety? Does everyone in the hospital family understand and embrace it?
- How can we improve?
- What should we be measuring?
- What does the public expect from us?
- How ready are we to publicly disclose our quality and safety performance?

Boards of trustees should be concerned about patient safety for moral, ethical, legal and financial reasons. Board members must understand that they are liable for the care provided at the hospital; that poor quality significantly

**"Board seats in American hospitals have traditionally been relatively honorific positions...it is time for hospital boards of directors – along with executives and physicians – to rise from slumber and view safety as an urgent matter."  
-Donald M. Berwick,  
Former Chief Executive,  
Institute for Health Care Improvement**

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impacts health care costs and reimbursement; and that patient safety is a key component of “staying on top” in a highly competitive environment. In addition, quality outcomes, such as 30-day readmissions and patient satisfaction, directly impact hospital reimbursement. And as hospitals increasingly employ physicians and forge partnerships and alliances in outpatient settings, hospital and health system boards of trustees must equally understand and be responsible for outpatient quality and patient safety.

**Board Liability.** It is ultimately the board’s responsibility to ensure that the hospital is taking clear, appropriate measures to provide the safest health care in the most efficient and effective manner. As a result, trustees need to be aware of and proactive in addressing patient safety in their hospital, and seek continuing education about current trends and implications. Boards should regularly review key quality indicators, and take corrective action when necessary.

**Competition.** Quality has traditionally been a matter of perception on the part of patients, but emerging transparency efforts are allowing patients to make more evidence-based decisions. The growth in quality transparency combined with insurance decisions about who to include “in network” have the power to significantly direct market share. Hospitals that do not put protocols in place to increase quality and patient safety and improve patient satisfaction risk not only lower reimbursement, but also losing consumer confidence and market share.

### Quality Leaders and Standard-Setters

Media scrutiny is increasingly shaping the public’s opinions about health care quality and patient safety. People’s opinions will be shaped by the stories they read and hear, but more importantly, by the “word of mouth” outcomes of those stories.

Hospitals and lawmakers are increasingly looking to national leaders such as the Institute of Medicine (IOM) and National Quality Forum (NQF) for quality measurements and benchmarks and suggested action steps. The Joint Commission patient safety standards are aligned with these recommendations, and underscore the importance of organizational leadership in building a culture of safety.

**Institute of Medicine.** In 1996 the Institute of Medicine launched its effort focused on assessing and improving the nation’s quality of care. The first phase included research and documentation of the nation’s overall quality problem, resulting in the now well-known report, *To Err is Human*. The

Questions Trustees Should Ask About Quality and Patient Safety	
1	What quality and patient safety measures should we be collecting and closely monitoring?
2	What are the top five quality and safety issues at our facility?
3	What is our organization’s plan for quality and safety improvements?
4	What should we hold the executive team responsible for this year to improve our quality and patient safety?
5	Is it easy and safe to report errors at our hospital? What is the process?
6	What steps have we specifically taken to address the IOM’s Six Aims?
7	If we were paid today on the basis of quality, not procedures, how would we do?

study brought national attention to the seriousness and frequency of health care errors, reporting that:

- 44,000—98,000 Americans die each year due to medical errors;
- Medical errors are the 8th leading cause of death in the U.S.;
- The annual cost of medical errors is as much as \$29 billion;
- The majority of problems are systematic;
- Many Americans are injured by the health care that is supposed to help them;
- Less than five percent of these injuries are due to individual errors; and
- Errors can be reduced, but not eliminated.

*To Err is Human* was followed by a second phase of research and the publication of *Crossing the Quality Chasm*, a report describing broader quality issues and defining the “six aims” of care, stating that care should be:

- **Safe**, avoiding injuries to patients from the care that is intended to help them;
- **Effective**, providing services based on scientific knowledge to all who could benefit, and refrain from providing services to those not likely to benefit;
- **Patient-centered**, providing care that is respectful of and responsive to individual patient preferences, needs values

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#### IOM: Simple Rules for the 21st Century Health Care System

The Institute of Medicine's 2001 *Crossing the Quality Chasm* report included specific recommendations for ways health care organizations can improve quality, including the ten rules for care delivery redesign outlined below.

##### *Current Approach:*

- Care is based primarily on visits
- Professional autonomy drives variability
- Professionals control care
- Information is a record
- Decision-making is based on training and experience
- Do no harm is an individual responsibility
- Secrecy is necessary
- The system reacts to needs
- Cost reduction is sought
- Preference is given to professional roles over the system

##### *New Rules:*

- Care is based on continuous healing relationships
- Care is customized according to patient needs and values
- The patient is the source of control
- Knowledge is shared and information flows freely
- Decision-making is evidence-based
- Safety is a system property
- Transparency is necessary
- Needs are anticipated
- Waste is continuously decreased
- Cooperation among clinicians is a priority

Source: *Crossing the Quality Chasm: A New Health System for the 21st Century*. Institute of Medicine. 2001.

and ensuring that patient values guide all clinical decisions;

- **Timely**, reducing waits and sometimes harmful delays for both those who receive and those who give care;
- **Efficient**, avoiding waste, including waste of equipment, supplies, ideas and energy; and
- **Equitable**, providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.

*Crossing the Quality Chasm* included specific ideas of ways to make health care safer, including: 1) health care organizations' purpose should be to continually reduce the burden of illness,

injury and disability; 2) purchasers and health care organizations should work together to redesign health care processes; and 3) purchasers should examine current payment methods and remove barriers that impede quality improvement.

The recommendations made in this document, and continuing research and recommendations by the IOM, have become the new standard for health care safety. It is critical that trustees understand the key components of this research and develop strategies to address these issues in their hospitals.

**The Joint Commission.** Aligning with the IOM's reports on improving patient safety in health care, Joint Commission patient safety standards underscore the importance of strong organizational leadership in building a culture of safety. Such a culture should strongly encourage the internal reporting of medical errors, and actively engage clinicians and other staff in the design of remedial steps to prevent future occurrences of these errors. The additional emphasis on effective communication, appropriate training and teamwork found in the standards draw heavily upon lessons learned in both the aviation and health care industries.

A second major focus of the standards is on the prevention of medical errors through the prospective analysis and re-design of vulnerable patient care systems (for example, the ordering, preparation and dispensing of medications). Potentially vulnerable systems can readily be identified through relevant national databases such as the Joint Commission's Sentinel Event Database or through the hospital's own risk management experience.

Finally, the standards make clear the hospital's responsibility to tell a patient if he or she has been harmed by the care provider. The Joint Commission now requires organizations to develop a policy for informing patients when they have received substandard care or their outcome varies from anticipated results. Those organizations that fear that this will increase litigation may be surprised to learn that the Association of Trial Lawyers of America have stated that this could reduce litigation because "people appreciate honesty and being told what is happening to them or what might happen to them. The more

**The IOM Definition of Quality: "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."**

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#### IHI: Characteristics of High-Achieving, Rapidly Improving Hospitals

Through review of literature, research evidence and best practices, the Institute for Healthcare Improvement identified 15 specific governance behaviors that increase the odds of rapid quality improvement throughout hospitals. The IHI recommends that observing these fifteen actions is the best place for boards to start in their quest to improve quality and patient safety. Best practice characteristics of high-achieving boards include:

1	They set a clear direction for the organization and regularly monitor performance
2	They take ownership of quality problems and make quality an agenda item at every board meeting
3	They invest time in board meetings to understand the gap between current performance and the best in class
4	They aggressively embrace transparency and publicly display performance data
5	They partner closely with executives, physicians, nurses, and other clinical leadership in order to initiate and support changes in care
6	They drive the organization to seek the regular input of patients, families, and staff, and they do the same themselves
7	They review survey results on culture, satisfaction, experience of care, outcomes, and gaps at least annually
8	They establish accountability for quality-of-care results at the CEO level, with a meaningful portion of compensation linked to it
9	They establish sound oversight processes, relying appropriately on quality measurement reports and dashboards ("Are we achieving our aims/system-level goals?")
10	They require a commitment to safety in the job description of every employee and require an orientation to quality improvement aims, methods, and skills for all new employees and physicians
11	They establish an interdisciplinary Board Quality Committee, meeting at least four times a year
12	They bring knowledgeable quality leaders onto the board from both health care and other industries
13	They set goals for the education of board member about quality and safety, and they ensure compliance with these goals
14	They hold crucial conversations about system failures that resulted in patient harm
15	They allocate adequate resources to ongoing improvement projects and invest in building quality improvement capacity across the organization

Source: 5 Million Lives Campaign. *How-to Guide: Governance Leadership*. Institute for Healthcare Improvement. [www.ihl.org](http://www.ihl.org).

people know about their condition, the more favorably they view their doctor."

**The Centers for Medicare and Medicaid Services.** The Centers for Medicare and Medicaid Services (CMS) began by reporting hospital quality using "pay for reporting" on its Hospital Compare website. That has since transitioned to "pay for performance" and value-based purchasing, an ever-changing process that hospital boards of trustees must understand and incorporate into decision-making. Examples include hospital acquired conditions, readmission payment penalties, value-based purchasing, bundled payments and accountable care organizations.

- **Hospital Acquired Conditions (HACs)**—For discharges beginning on or after October 1, 2008, CMS stopped paying for certain HACs. To identify applicable conditions, hospitals are required to report "present on admission" (POA) information on diagnoses for discharges. Under the new rule, hospitals do not receive the higher payment for cases when a HAC is acquired during hospitalization (meaning it was not present on admission). Hospitals are paid if the secondary diagnosis is not present. In April 2011, CMS began to publish hospitals' HAC performance on the Hospital Compare website, and are proposing to add new conditions to the list for non-payment. Beginning in FY 2015, under the ACA, Medicare payments (base DRGs) to hospitals in the lowest-performing quartile for HACs will be reduced by one percent. This payment reduction applies to all Medicare discharges.
- **Readmissions**— In FY 2013, CMS reduced its payments to hospitals with "high rates" of readmissions in an effort to improve quality and reduce costs. Whether a hospital's payment is cut depends on how well the hospital controls its preventable readmissions. The reduction, which applies across all discharges, was limited to one percent in FY 2013, two percent in FY 2014 and three percent in FY 2015 and thereafter.
- **Value-Based Purchasing (VBP)**—Value-Based Purchasing is payment for actual performance rather than payment for just reporting hospital performance. With reporting, the Medicare payment was the same whether the hospital's performance is good or bad. Under VBP, CMS keeps between one and two percent of hospitals' payments – and hospitals will have a chance to earn back the withheld depending on the quality of their care.

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- **Bundled Payments**—the “Bundled Payments for Care Improvement Initiative” was rolled out by CMS under the requirements of the ACA. Designed to improve quality and control costs, a bundled payment is one single payment for multiple services received by a patient from one or more providers during an “episode of care.” According to CMS Administrator Marilyn Tavenner, “The objective of this initiative is to improve the quality of health care delivery for Medicare beneficiaries, while reducing the program expenditures, by aligning the financial incentives of all providers.”
- **Accountable Care Organizations**—For hospitals participating in Accountable Care Organizations (ACOs), additional rules apply for quality incentives and disincentives. In its program analysis after issuing the final rules, the CMS describes the goal of shared savings to “reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first.”

**National Quality Forum.** The National Quality Forum (NQF) is a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. It was developed through a combination of public and private leaders committed to bringing about national change in health care quality on patient outcomes, workforce productivity, and health care costs.

In response to the IOM report, the NQF identified several events that should never happen in a hospital and that can always be prevented. Examples of these Serious Reportable Events (SREs) include:

- Operating on the wrong body part or the wrong patient;
- Performing the wrong procedure;
- Leaving foreign objects in a patient;
- Contamination, misuse or malfunction of products and devices;
- Wrong discharge of an infant;
- Patient disappearance or suicide;
- Death or disability due to a medication error;
- Death or disability associated with a fall, burn or use of restraints;

- Care ordered by someone impersonating a doctor or nurse; and
- Abduction or assault.

The NQF works to promote a common approach to measuring health care quality, and is known as the “gold standard” for the measurement of health care quality.

**The Institute for Healthcare Improvement.** The Institute for Healthcare Improvement (IHI) was established in 1991 to lead the improvement of health care across the world. The IHI estimates that nearly 15 million instances of medical harm occur in the U.S. alone every year – a rate of over 40,000 instances per day. The IHI is striving to achieve health care for all patients with:

- No needless deaths;
- No needless pain or suffering;
- No helplessness in those served or serving;
- No unwanted waiting; and
- No waste.

In an effort to accomplish these aims, the IHI launched its “100,000 Lives Campaign”, with the goal of reducing 100,000 preventable deaths in the U.S. Over 3,000 hospitals participated in the campaign, and in 18 months an estimated 122,000 lives were saved. The combination of the campaign’s success and the desire to address medical errors that may harm patients in addition to preventing avoidable deaths led to the IHI’s launch of its “Five Million Lives Campaign.” It expanded the focus of the 100,000 Lives Campaign, with the goal of dramatically accelerating efforts to reduce non-fatal harm, while continuing to fight needless deaths. The Five Million Lives goal was to protect patients from five million incidents of medical harm over a two-year period, from December 2006 – December 2008.

The campaign included twelve interventions for hospitals to reduce infection, surgical complication, medication errors, and other forms of unreliable care in facilities. While the IHI can’t quantify if a total of five million instances of harm were prevented, according to the IHI, the campaign raised awareness about critical quality initiatives, and brought

**One of the IHI’s twelve interventions is to “get boards on board...by defining and spreading the best-known leveraged processes for hospital boards of directors, so that they can become far more effective in accelerating organizational progress toward safe care.”**

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unprecedented commitments to quality and patient safety with significant results from more than 4,000 hospitals across the country.

### Quality Reporting and Measurement

The increasing push for improved quality and patient safety has resulted in a number of publicly available quality reporting websites. The challenge of reporting hospital quality performance is daunting: hospitals perform a wide variety of services and procedures, and each patient case is unique due to the patient's individual circumstances and co-morbidities. Nonetheless, these sites are the first attempt to capture and compare hospital quality performance.

As the health care reimbursement and delivery landscape changes and patients are increasingly responsible for paying a greater portion of their health care costs and making their own health care decisions, the availability of easily understandable hospital quality data will increasingly influence patient care decisions. In addition, public and private payers are moving toward "pay for performance," utilizing standardized hospital quality performance measures to influence hospital reimbursement.

While new websites are continually emerging, examples of well-known quality reporting sites include the CMS Hospital Compare website, the Leapfrog Group, HealthGrades, and the Joint Commission's Quality Check website. Hospital boards should know how their hospital's quality measures on these pages, how they compare to their competitors, and what the hospital is doing to improve in its quality performance indicators.

### Hospitals and Physicians Can't Do It Alone

Quality improvement requires an understanding and acceptance of mutual responsibilities between all key stakeholders, including employers, clinicians and staff, and patients. Implementing quality and patient safety improvements is an opportunity for board members to be leaders in the community, coalescing all the key stakeholders together around a common purpose.

**Employer Involvement.** Employers have the opportunity to be champions for patient safety, promoting the need for safety reform and providing leadership in action toward the definition, measurement and improvement of quality and patient safety.

Nine Potential Causes of Medical Errors	
<b>1</b>	<b>Fundamental difficulties in medical care</b> <ul style="list-style-type: none"> <li>• Balancing act of over-testing and under-testing</li> <li>• Too much information – impossible to stay up-to-date</li> <li>• Lack of time</li> </ul>
<b>2</b>	<b>Medical industry system problems</b> <ul style="list-style-type: none"> <li>• Under-funded care</li> <li>• Inefficiency of use of funds</li> <li>• Over-worked physicians</li> <li>• Slow adoption of technology</li> <li>• Failure to report medical errors for fear of lawsuits</li> <li>• Unnecessary medical tests for fear of lawsuits</li> </ul>
<b>3</b>	<b>Physician mistakes</b> <ul style="list-style-type: none"> <li>• Human mistakes</li> <li>• Alcohol or drug abuse</li> <li>• Poor handwriting</li> <li>• Poor dosage instructions</li> </ul>
<b>4</b>	<b>Patient mistakes</b> <ul style="list-style-type: none"> <li>• Failure to report symptoms</li> <li>• Delay in reporting symptoms</li> <li>• Failure to report medications</li> <li>• Non-compliance with treatment plans</li> <li>• Dishonesty: Fraud, hypochondria</li> <li>• Fear: Legal, social</li> <li>• Patient pressure on physicians</li> </ul>
<b>5</b>	<b>Pharmacist mistakes</b> <ul style="list-style-type: none"> <li>• Wrong medication</li> <li>• Similar labels and packaging</li> <li>• Similar medication names</li> <li>• Wrong dosage</li> <li>• Failure to communicate instructions</li> </ul>
<b>6</b>	<b>Pathology laboratory mistakes</b> <ul style="list-style-type: none"> <li>• Errors in sample labeling</li> <li>• Cross-contamination during testing</li> <li>• Inherent risks in tests – false positives and negatives</li> <li>• Limitations of tests for certain patients</li> <li>• Human error in examining slides</li> </ul>
<b>7</b>	<b>Pharmaceutical industry mistakes</b> <ul style="list-style-type: none"> <li>• Naming similarities</li> <li>• Inadequate safety testing</li> </ul>
<b>8</b>	<b>Hospital mistakes</b> <ul style="list-style-type: none"> <li>• Nosocomial infections</li> <li>• Surgical mistakes</li> <li>• Errors in transferring and re-labeling of medications</li> <li>• Medication errors: Wrong medication, wrong dosage, wrong patient, wrong time</li> </ul>
<b>9</b>	<b>Surgical mistakes</b> <ul style="list-style-type: none"> <li>• Wrong surgery</li> <li>• Right surgery, wrong site</li> <li>• Medication error before, during or after surgery</li> </ul>

*Source: Causes of Medical Mistakes. [www.wrongdiagnosis.com/mistakes/causes](http://www.wrongdiagnosis.com/mistakes/causes).*

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**Clinician and Staff Involvement.** Accountability for quality and safety should be incorporated into every employee's job description. Regardless if employees have direct contact with a patient, every employee has a role in patient safety, from keeping the facility clean, to arranging the room in the safest manner possible, to ensuring the patient is checked in and registered correctly. Employees should be educated about the quality and safety expectations they are required to meet, as well as how to report safety concerns and errors. These concepts should be ingrained in the workplace culture, and effectiveness and success in meeting specific goals should be recognized and rewarded.

To ensure accountability, employees should work in teams that share responsibility and check one another to ensure protocols are followed. Individuals and groups should be recognized for disclosing errors, near misses and safety concerns, rather than punished.

**Patient Involvement.** Patients play a critical role in quality and patient safety as well. Without patient honesty and clear communication, health care providers may misunderstand a patient's needs, desires or abilities. Patients must be clear with doctors about medications they are currently taking, and they should take ownership in learning about their conditions and the best places to seek care for their unique medical needs. And patients should not be afraid to speak up—for example, to confirm that a provider has washed their hands, to ensure that discharge instructions and treatment plans are understandable, or to ask questions about follow-up care.

**The Board Role.** Boards must recognize that quality and patient safety is the backbone for everything the board does. Meeting agendas should include regular review of reports on quality and patient safety, as well as discussions of errors and near misses, and the steps taken as a result. The board should set performance goals for quality and safety improvement, and hold managers accountable for achieving those goals. Quality and safety expectations should be a major factor in board discussions about services, facilities, medical staff development and workforce development.

### A Call to Responsibility: Improving Patient Safety at Your Organization

While no board or individual trustee sets out to govern low performance, boards can be "unsafe" or perform "governance malpractice" simply through lack of knowledge or understanding about key issues, not talking about quality and patient safety measures and their implications, lack of involvement, or focusing in the wrong areas. A "culture of

safety" should be ingrained in the hospital, beginning with the board. The board is responsible for setting the tone for the hospital, providing the tools necessary for employees to carry out the quality and patient safety vision, and encouraging a safe environment by regularly measuring and monitoring quality measures.

**Creating a Culture of Safety.** The term "culture of safety" is used often, but the definition can be ambiguous. Boards must define what a culture of safety means to their hospital. They should define what the leadership's commitment is to continual improvement in quality and patient safety, and how that will be carried out throughout the organization. Boards and hospital leaders should define how quality errors and near misses will be addressed, engraining in the culture the critical role that each employee plays in ensuring high quality and patient safety.

**Building Physician Partnerships for Quality and Patient Safety.** The medical staff is responsible for delivering the best possible quality to patients in the safest manner, working collaboratively with the board to identify clinical issues that prevent quality and patient safety improvement. Despite this shared quality goal, an eroded sense of shared vision can occur due to competing agendas, economic stress, regulatory pressures and leadership problems.

But working with the medical staff and medical executive team is essential in ensuring a patient safety plan is successful. Physicians don't want to be micromanaged by the board, and trustees don't want to overstep their bounds. But the quality of care provided at the facility is ultimately the board's responsibility, and increasing involvement will help the board better understand the issues and recognize the resources and technology necessary to achieve greater patient safety.

Some trustees may be uncertain about voicing their opinions around members of the medical staff. Trustees who lack medical expertise may be hesitant to challenge members of the medical staff. But to successfully improve quality of care, the board and medical staff must work as a team. That requires the medical staff to translate complex medical issues into "plain English" that trustees can understand, and requires trustees to ask questions and stand up for what they believe is right.

The contrasting cultures of physician independence and autonomy and board shared-decision making may be difficult to overcome, but can be achieved through board-medical staff communication, relationship-building and mutual respect. The board sets the tone for the hospital by creating a culture that is acceptable to both the board and physicians, creating a "practice friendly environment" through strategic

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understanding of the issues, ensuring adequate staffing, quality employees, efficient and effective processes, and providing adequate resources.

Board/medical staff relationships can also be enhanced through additional efforts, such as retreats and workshops, one-on-one meetings or focus groups that allow both groups to understand one another's viewpoints. Conducting a medical staff needs assessment can also help the board to understand physician needs, and physician involvement in strategic planning allows mutual understanding of long-term issues and a shared long-term vision.

#### **Maximizing Employees' Quality Improvement**

**Commitment.** The workforce is responsible for riveting its attention on improving quality and safety within the scope of their jobs, and employees are an integral part of the quality and patient safety improvement team. According to an article in *Hospitals & Health Networks*, to ensure that employees understand their critical role and maximize employees' quality improvement commitment, boards should:

- Demonstrate patient safety as a top leadership priority;
- Actively promote a non-punitive environment for sharing information and lessons learned;
- Routinely assess risk to positive patient outcomes;
- Determine ways employees can learn from one another and share information;
- Involve staff in analyzing causes and solutions to errors and near misses;
- Reward and recognize safety-driven decisions and reporting;
- Foster effective teamwork, regardless of authority, through team training and simulation;
- Implement care delivery processes that avoid reliance on memory;
- Implement care delivery processes that avoid reliance on vigilance; and
- Engage patients and caregivers in the design of care delivery processes.

#### **Implementing a Quality Dashboard**

One effective method for monitoring the hospital's quality performance is to implement a quality dashboard. The dashboard should be reviewed regularly at board meetings, ensuring that trustees are aware of the hospital's actual quality performance, and are empowered to make decisions based on hard facts and evidence rather than anecdotal opinions.

**What is a Dashboard?** Dashboard reports are useful tools that help hospitals convey large amounts of information in a concise manner. A concise display of clinical performance information is an ideal way for board members to monitor clinical aspects of care – similar to how a board scrutinizes financial information. Dashboard reports are easy-to-read updates of progress on those indicators important to the community and to hospital administrators, caregivers and boards.

Quality dashboards help hospitals accomplish the goal of regular trustee review and assessment of patient quality and safety measures. Dashboards are presented in the same easy-to-read format at every board meeting, ensuring that all trustees understand the reports and can make informed decisions about whether the hospital is "on track" with its quality and patient safety goals.

Because each hospital has its own unique goals and progress indicators to track, every organization's quality dashboard will look slightly different. The key is that boards of trustees determine the type of reporting that works best for them to quickly review and interpret their organization's quality performance.

**General Implementation Principles.** Quality dashboards should be simple and concise. The information should be presented in a language easily understood by everyone, avoiding and/or defining acronyms and technical terminology when possible. The best model provides a quick way to report the status of hospital measures. Dashboards should lead with problems identified, followed by areas of progress.

**Choosing Dashboard Measures.** When deciding on measures to present, consider the list of potential measures as a "menu" for board selection. Keep in mind that not all measures are appropriate for all dashboards. Some measures may be fitting for some hospitals to follow and others may be applicable to track only occasionally. Work with the quality and safety committee to determine which measures to report.



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#### Key Questions for Trustees When Implementing a Quality and Patient Safety Program

The board's responsibility in patient safety is simply to monitor performance and demand accountability. Governing bodies should hold themselves accountable for patient safety just as they are accountable for financial performance. According to the American Hospital Association, boards should begin by:

- Asking to see regular reports on quality and patient safety from the facility or organizational managers;
- Requiring root-cause analysis of all errors that lead to injury;
- Setting performance goals for quality and safety improvement; and
- Holding managers accountable for achievable quality and patient safety improvement goals.

In addition, when selecting measures to include, align them with the hospital's strategic priorities. Consider measures that reflect issues determined to be most critical for review by hospital board members. Start with high risk, problem-prone areas. Also, include the hospital's publicly reportable measures, such as the indicators provided on the Hospital Compare website. This ensures that the board sees the same information that the general public sees.

**Presenting Performance Data.** Presenting performance data in a format that everyone understands is critical. The following three steps can help ensure that the dashboard is understood equally by all trustees:

- First, bring attention to the status of the indicators selected. For example, color-coded metrics allow trustees to see the status of quality and safety measures at a quick glance.
- Second, select the "lightning rods," or major areas of concern, for discussion at board meetings. In addition, follow-up on progress from previous meetings. Celebrating quality improvement successes are equally important to addressing current and emerging quality challenges.

**Framework, Benchmarks, and Targets.** It is important to have a common framework across the organization for understanding and communicating information in your quality and safety dashboard (for example, a balanced score card based on the Institute of Medicine's Six Dimensions of Care: Safe, Effective, Patient-Centered, Timely, Efficient, and Equitable). The measures should be reported to the board at the same time as they are reported at the department/service and practitioner levels. Although the metrics may be provided in much greater level of detail at the department and committee level, reporting the same indicators to all

#### Does Your Board Practice These Quality Best Practices?

1	<b>Goal Achievement and Compensation.</b> Tying executive goals and performance to compensation is critical practice. Achieving certain quality goals should be a part of not only the CEO's performance evaluation each year, but of every employee's performance evaluation. Ensure that achievement is rewarded by linking a meaningful percentage of compensation to quality goal achievement. The entire organization should be focused on quality progress, and goals should cascade through all levels of the organization.
2	<b>Adequate Budget.</b> Ensure that quality improvement plans and goals are incorporated into budgets. Identify the resources needed to help guarantee success well enough in advance so they may be incorporated into the hospital's annual budget process. And if budgets need to be reduced, ask what impact those cuts may have on quality.
3	<b>Quality Expertise on the Board.</b> Evaluate the diversity of your board. Do you have members with quality expertise? That expertise might be clinical and it might be an individual with quality performance improvement experience from an outside industry.
4	<b>Board Self-Assessment.</b> Does your annual board self-assessment include an evaluation of board and individual quality expertise and practice? Have you considered those findings as you develop quality and patient safety education for the board?
5	<b>Quality Dashboard.</b> Does your board have a well-defined quality dashboard, which is reviewed regularly at board meetings? The dashboard should continually be updated, and should ensure that board members have the information necessary to make informed decisions.
6	<b>Just Culture.</b> Boards should be familiar with the concept of a "just culture," which recognizes that people make mistakes—however, organizations can have systems in place to prevent those errors before they occur. And if they do occur, employees feel safe identifying an error or bad choice so that the system can be improved and prevent future events.

## Critical Questions Every Hospital Board Needs to be Able to Answer

### Governance Accountabilities in the Quest for Quality

stakeholders at the same time ensures that the key players are “on the same page,” operating with consistent information and working toward the same shared goals.

Reports should also include benchmarks and/or targets for each measure where feasible. Measures should be compared to past performance, benchmarks at state and national levels, or data from published literature.

### The Goal: “Quality Literacy”

A critical tool for advancing quality is continuing governance education and knowledge building. The goal is to build the board’s “quality literacy.”

To start, new trustee orientation should emphasize quality and patient safety. It should include help in understanding quality reports and dashboards, information about quality trends, a summary of legal and regulatory quality mandates, an explanation of quality terms and acronyms, and a review of your hospital’s quality program, initiatives, challenges and issues. In addition, hospitals may consider assigning new trustees to the Quality Committee to provide them with a deeper understanding of the hospital’s quality commitment and efforts. And, very importantly, quality and patient safety education and awareness not be a one-time event that ends with new trustee orientation. In today’s rapidly changing environment, quality education should be an ongoing process for all board members.

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