Quality and Patient Safety
Responsibilities of Governing Boards
Disclosure Statement

All presenters have no relevant financial relationships to disclose.
Disclaimer

The information presented at this program and in the program materials is for general educational purposes only and is in no way intended to serve as medical or legal advice. For advice on handling specific medical/legal problems, always consult with an attorney or your risk management staff.
Objectives

- Define Enterprise Risk Management (ERM)
- Identify governing board functions related to ERM
- Define the governing board's fiduciary responsibility as it relates to quality and patient safety
- Discuss current Minnesota rural health facility quality requirements and challenges
- Describe risk management strategies to improve governing board oversight of quality of care
“Enterprise risk management in healthcare promotes a comprehensive framework for making risk management decisions which maximize value protection and creation by managing risk and uncertainty and their connections to total value.”

## Traditional vs. Enterprise Risk Management

<table>
<thead>
<tr>
<th>Area</th>
<th>Traditional</th>
<th>Enterprise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus</td>
<td>Reactive</td>
<td>Proactive</td>
</tr>
<tr>
<td>Outcome</td>
<td>Asset preservation</td>
<td>Value creation</td>
</tr>
<tr>
<td>Breadth/Depth</td>
<td>Department/silos</td>
<td>Risk prevention</td>
</tr>
<tr>
<td>Activities</td>
<td>Risk mitigation</td>
<td>Risk prevention</td>
</tr>
<tr>
<td>Engagement</td>
<td>Practitioner/staff</td>
<td>Top-down, bottom-up/C-suite</td>
</tr>
</tbody>
</table>

Why ERM? Why Now?

Guiding Principles

• **Advance safe and trusted healthcare**
• Manage uncertainty
• Maximize value protection and creation
• Encourage multidisciplinary accountability
• Optimize organizational readiness
• Promote positive organizational culture which will impact readiness and success
• Use data/metrics to prioritize risks
• Align risk appetite and strategy

ERM Domains

- Strategic
- Financial
- Human Capital
- Legal/Regulatory
- Technology
- Hazard
- Operational
- Clinical/Patient Safety

“The business of healthcare is the delivery of care that is safe, timely, effective, efficient, and patient-centered within diverse populations. Operational risks relate to those risks resulting from inadequate or failed internal processes, people, or systems that affect business operations. Included are risks related to: adverse event management, credentialing and staffing, documentation, chain of command, and deviation from practice.”

“Risks associated with the delivery of care to residents, patients and other healthcare customers. Clinical risks include: failure to follow evidence based practice, medication errors, hospital acquired conditions (HAC), serious safety events (SSE), and others.”

Know Your Role

Fiduciary responsibility

“An individual in whom another has placed the utmost trust and confidence to manage and protect property or money. The relationship wherein one person has an obligation to act for another's benefit.”

Major Governing Board Functions

• Ensuring high quality and safe patient care
• Hiring and retaining an effective CEO
• Mission development and long-range planning
• Oversight of medical staff credentialing
• Financial oversight
• Board education and development, including self-evaluation

Medicare officials fault hospital board

By Areal Writer, Staff Writer, areal@sonomanews.com  Sep 9, 2017
Boards govern, CEOs run operations,

**YET**

The governing board is ultimately responsible for ensuring that high quality care is consistently and effectively delivered to patients.
Institute of Medicine (IOM)

1999 – *To Err is Human: Building a Safer Health System*

2001 – *Crossing the Quality Chasm: A new Health System for the 21st Century*
Patients deserve care that is

• Safe
• Timely
• Effective
• Efficient
• Equitable
• Patient Centered

# Quality vs. Patient Safety

<table>
<thead>
<tr>
<th>QUALITY</th>
<th>SAFETY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficient, effective, purposeful care that gets the job done at the right time.</td>
<td>Lack of harm</td>
</tr>
<tr>
<td>Doing things well</td>
<td>Avoiding bad events</td>
</tr>
<tr>
<td>Raises the bar so the overall care experience is a better one</td>
<td>Makes it less likely that mistakes will happen</td>
</tr>
</tbody>
</table>

The Leapfrog Group. Leapfrog Hospital Safety Grade.  
[http://www.hospitalsafetygrade.org/what-is-patientsafety_m#errors](http://www.hospitalsafetygrade.org/what-is-patientsafety_m#errors).  
According to CMS:

“Quality measures are tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.”

Who Else Is Looking?

Hospital Compare

Health Grades

The Leapfrog Group

Joint Commission Quality Check
Quality Data

• Evidence-based bundles
• Hospital-acquired conditions
• Process measures
• Outcome measures

Inpatient Hospital Quality Measures

• Prospective Payment System Hospital
  ▪ Hospital Value-Based Purchasing Total Performance Score
  ▪ Hospital Readmissions Reduction Program Excess Readmission Score
  ▪ Hospital Acquired Condition Reduction Program Score

• Critical Access Hospital
  ▪ ED-1a: Median time from ED Arrival to ED Departure for Admitted ED Patients – Overall Rate
  ▪ ED-2a: Admit Decision Time to ED Departure Time for Admitted Patients – Overall Rate
  ▪ READM-30-HF: Heart Failure 30-Day Readmission Rate
  ▪ READM-30-PN: Pneumonia 30-Day Readmission Rate
  ▪ REAM-30-COPD: Chronic Obstructive Pulmonary Disease 30-Day Readmission Rate
  ▪ IMM-2: Influenza Immunization
  ▪ PC-01: Elective Delivery

• Prospective Payment System and Critical Access Hospitals
  ▪ Emergency Department Stroke Registry Indicators: Door-to-Imaging Initiated Time and Time to Intravenous Thrombolytic Therapy
  ▪ IQI-91: Mortality for Selected Conditions
  ▪ PSI-4: Death Rate among Surgical Inpatients with Serious Treatable Complications
  ▪ PSI 90: Patient Safety and Adverse Events Composite
  ▪ Health Information Technology Hospital Survey
Challenges

- Geographic isolation
- Small practice size
- Heterogeneity
- Low case volume

Quality and Patient Safety Links
“Fundamentally, patient safety refers to freedom from accidental or preventable injuries produced by medical care. Thus, practices or interventions that improve patient safety are those that reduce the occurrence of preventable adverse events.”

Deviation from Evidence-Based Best Practice

Integration of current best research evidence with clinical expertise and patient values
Clinical/Patient Safety Risks

• Failure to follow evidence-based protocols or policies and procedures
• Serious safety events
• Risks related to care delivery
  ▪ Failure to diagnose
  ▪ Access to care
  ▪ Clinical continuity
  ▪ Inadequate communication and teamwork
Other Risks Related to Care Delivery

- Failure to diagnose
- Access to care
- Clinical continuity
- Inadequate communication and teamwork
11 Core Areas of Harm

1. Adverse Drug Events (ADE)
2. Central Line-Associated Blood Stream Infections (CLABSI)
3. Catheter-Associated Urinary Tract Infections (CAUTI)
4. Clostridium difficile (C. diff) bacterial infection
5. Injuries from falls and immobility
6. Pressure Ulcers
7. Sepsis and Septic Shock
8. Surgical Site Infections (SSI)
9. Venous thromboembolism (VTE)
10. Ventilator-Associated Events (VAE)
11. Readmissions
Adverse Event Reporting

- Mandated reporting of 29 adverse events that may result in patient death or serious disability in numerous states, including both Washington and Minnesota
- Reporting requirements include submission of root cause analysis (RCA) findings and actions with measurement of success
- RCA process requires oversight by the governing board
Adverse Event Management

What we know:

• Provides a record of individual events
• Includes near miss reporting
• Gives the ability to track and trend
• Offers data to prioritize improvement work
• Supports reporting requirements
• Culture impacts willingness to report
“The Joint Commission’s Sentinel Event Database reveals that leadership’s failure to create an effective safety culture is a contributing factor to many types of adverse events – from wrong site surgery to delays in treatment.”

Leading a Culture of Safety

- Vision
- Trust, Respect, and Inclusion
- Behavior Expectations
- Just Culture
- Leadership Development
- Board Engagement
- Zero Harm to Patients, Families, and the Workforce

Leading a Culture of Safety: A Blueprint for Success
“Organizational culture can be described as the set of values, guiding beliefs, or ways of thinking that are shared among members of an organization.”

“Culture is ‘the way we do things around here.’”

A culture of safety emphasizes:
- Blameless reporting
- Successful systems
- Knowledge
- Respect
- Confidentiality
- Trust
Culture is King

- Just Culture
- High-Reliability Organization
- Transparency
- Patient Engagement
Just Culture

- Open reporting and participation in prevention and improvement is encouraged
- Focusing on understanding the root of the problem allows for learning, process improvement, and changes to design strategies and systems to promote prevention
Just Culture

Balance between human and system accountability

• Recognizes that individual practitioners should not be held accountable for system failings over which they have no control
• Recognizes many errors represent predictable interactions between human operators and the systems in which they work
• Recognizes that competent professionals make mistakes
• Zero tolerance for reckless behavior
High-Reliability Principles

- Sensitivity to operations
- Reluctance to simplify
- Preoccupation with failure
- Deference to expertise
- Resilience

Shining a Light: Safer Healthcare Through Transparency

Domains of Transparency

- Between clinicians and patients (disclosure after medical errors)
- Among clinicians within an organization (peer review)
- Between healthcare organizations (regional or national collaboratives)
- Between organizations/clinicians and the public (public reporting of quality and safety data)

Actions for Organizational Leadership

“Leaders and Boards of Health Organizations

• Prioritize transparency, safety, and continuous learning and improvement.
• Frequently and actively review comprehensive safety performance data.
• Be transparent about the membership of the board.
• Link hiring, firing, promotion, and compensation of leaders to results in cultural transformation and transparency.”

Patient Engagement

Patient Engagement – Why?

- Improve quality and safety
- Improve financial performance
- Improve CAHPS® Hospital Survey scores
- Improve patient outcomes
- Enhance market share and competitiveness
- Increase employee satisfaction and retention
- Respond to Joint Commission standards

Source: AHRQ. How Patient and Family Engagement Benefits Your Hospital.
“Leaders of healthcare systems

• Establish patient and family engagement as a core value for the organization.
• Involve patients and families as equal partners in the design and improvement of care across the organization and/or practice.
• Educate and train all clinicians and staff to be effective partners with patients and families.
• Partner with patient advocacy groups and other community resources to increase public awareness and engagement.”
Six Things All Boards Should Do to Improve Quality and Reduce Harm

1. Set Aims
2. Seek Data and Personal Stories
3. Establish and Monitor System-Level Measures
4. Change the Environment, Policies, and Culture
5. Encourage Learning
6. Establish accountability
“Set a specific aim to reduce harm…”

“Make an explicit, public commitment to measurable quality improvement (e.g., reduction in unnecessary mortality and harm), establishing a clear aim for the facility or system.”

Seek Data and Personal Stories

“Select and review progress toward safer care as the first agenda item at every board meeting”

Partner with patients and families and start meetings with case reviews of patients who experienced harm

“Identify a small group of organization-wide ‘roll-up’ measures of patient safety”

Consider facility-wide harm, risk-adjusted mortality data that are continually updated and made transparent to the entire organization and all its customers.

Build cultures of quality and safety

“Commit to establish and maintain an environment that is respectful, fair, and just for all who experience pain and loss as a result of avoidable harm and adverse outcomes”

Encourage Learning

Develop board capability

“Learn about how ‘best-in-the-world’ boards work with executive and [physician] leaders to reduce harm”

Establish Accountability

“Oversee the effective execution of a plan to achieve your aims to reduce harm”

Boards should spend more than 25% of their time in activities related to quality and safety, just as they oversee finance.

Risk Strategies

Require information and materials that will enhance discussions regarding quality and patient safety

- A comprehensive quality dashboard that includes key indicators of clinical quality, patient safety, patient satisfaction, employee and staff member satisfaction, turnover and vacancies
- Executive reports of medical staff quality meetings
- Reports of grievances, adverse events, and potential liabilities
- Progress reports on corrective action plans
- Information about quality improvement and patient safety plans
- Understanding of publicly-reported hospital data and information
- Information about healthcare quality trends
Taking Those First Steps

• Governing board performance self-assessment
• Governing board education and development
• Culture of safety survey

One Organization’s Experience

Riverview Health
We deliver a healthcare experience that consistently exceeds patients’ expectations through EXCEPTIONAL PEOPLE....EXCEPTIONAL CARE....EXCEPTIONAL OUTCOMES
Overall Performance Score =
Previous Month =
• Employee of the month
• Employees who indicate they are very or completely satisfied in employment
• Employee education hours/FTE
• Turnover annualized – all cause turnover
QUALITY

• Patient Safety Initiative – Total Harm Reduction (# of Harms per 1,000 Discharges)
• RVH will complete at least 56% of the Medication Reconciliation Roadmap
• % of Acute patients transferred to alternative facilities for care
• Attain TJC Accreditation for Joint & Spine
Measuring Patients Perception of Care 2018

• Ambulatory Surgery
• ED
• Inpatient Unit
• Home Health
• Medical Practice (Clinic)

• Outpatient Services
• Rehab Services
• Lab
• Diagnostic Imaging
Questions?