The Board's Oversight Role for Quality and Patient Safety

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Why is board oversight critical?

- Regulatory compliance
  - CMS Condition of Participation requirement
- Fiduciary Responsibility
  - Poor quality/unsafe care is expensive
- Community Trust
  - Reputation is easier to lose than to regain
- Leadership drives culture…and culture drives the organization
  - Never assume

Formal research has found a definite link between higher-quality care and the prioritization of quality by healthcare boards

When Leadership Fails

Culture Shift: Prioritizing profit over safety

- The Fall of a Giant
  - Boeing 737 Max 8
    - Grounded worldwide between March 2019 – December 2020
    - 346 people killed in two crashes
      - Lion Air flight 610 on October 29, 2018 (Indonesia)
      - Ethiopian Airlines flight 302 on March 10, 2019 (Kenya)

- Normalized Deviance
  - Vanderbilt University Medical Center
    - Fatal medication error
    - Multiple contributing factors
    - Pattern of commonly accepted shortcuts

Culture Shift: Prioritizing expedience over safety

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"Downfall: The Case Against Boeing" (2022) Netflix

What is Quality?

According to the Institute of Medicine (IOM)...

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

What is Patient Safety?

According to the Leapfrog Group...

"**Patient safety** is how hospitals and other health care organizations protect their patients from errors, injuries, accidents, and infections."

What is "Oversight"?

According to the 2017 report, *Leading a Culture of Safety: A Blueprint for Success*...

"The board is responsible for making sure the **correct oversight is in place**, that quality and safety **data are systematically reviewed**, and that safety receives **appropriate attention** as a standing agenda item at all meetings."

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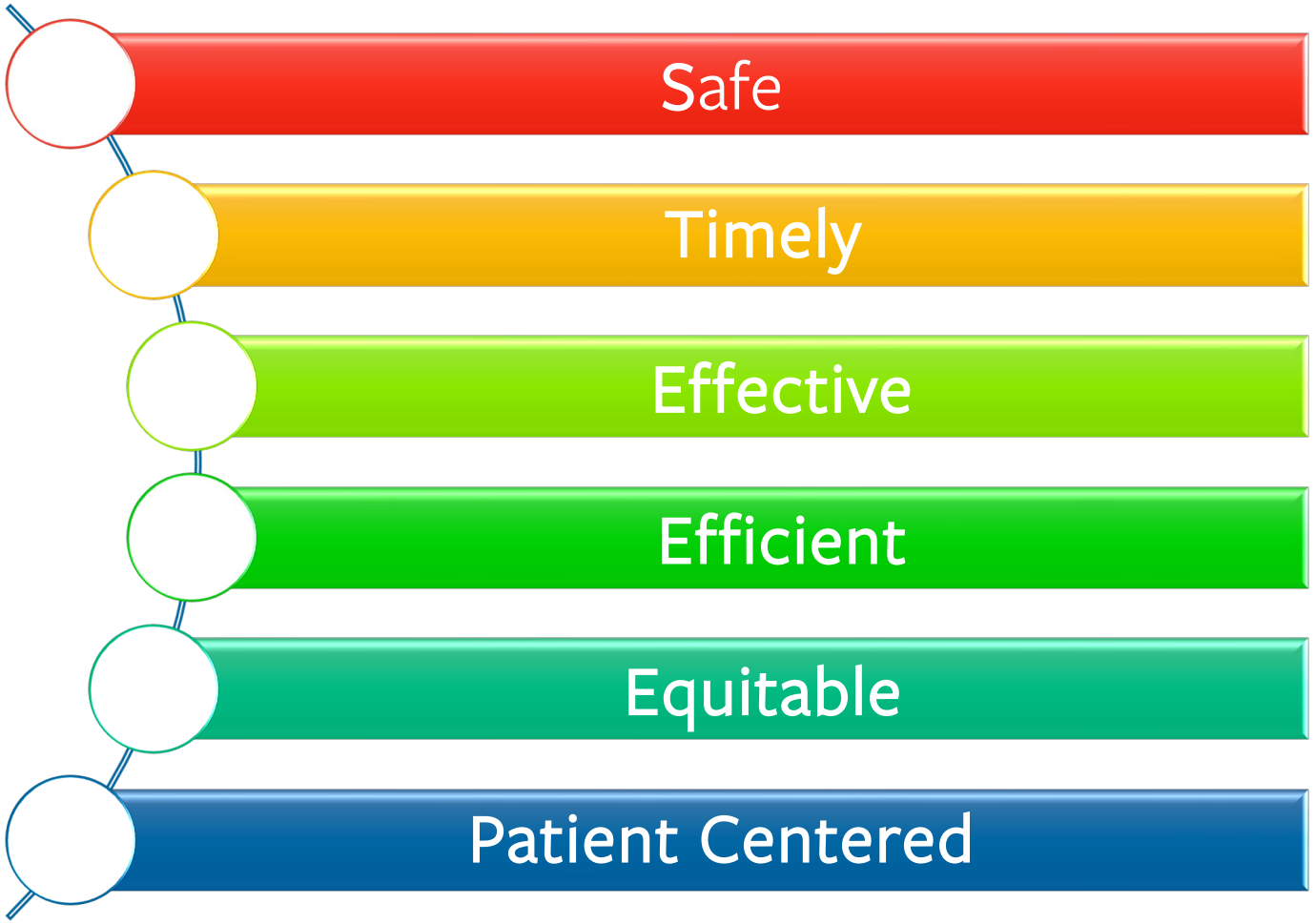
1. Correct Oversight in Place

- Review/approve **Annual Quality/Patient Safety Plan**
  - Provides framework for quality/patient safety program and activities
  - Includes performance indicators for all care sites
- CEO hire/evaluation
  - Job description and evaluation include quality/patient safety accountabilities
- Review physician credentialing and peer review reports
  - Ensure process to monitor adherence to current practice guidelines
- Review reports of quality assurance activities of all departments
  - Organization-wide commitment and shared accountability
- Recommend of appropriate allocation of resources

Plan Based Upon a Defined Framework - STEEEP



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Institution of Medicine (IOM) 2001 report *Crossing the Quality Chasm*

Safe – "Keep me safe"

- Preventable harm vs. adverse outcomes
- Hospital Acquired Conditions (HACs), Safety Events, and Errors
- Just culture and culture of safety
- Journey to high reliability
- Responding to harm events
- Anticipating and mitigating the risk of harm
- Ask: how can we make it harder to make a mistake?

Timely and Efficient – "Help me navigate my care"

- Points of access
- Ease of navigating system
- Identify and remove roadblocks and delays
- Process mapping
- Process Improvement
- Consider impact of electronic health record and health IT systems
- Ask: Who do our processes serve?

Effective – “Provide me with the right care”

- Evidenced-based medicine
- Standards of care
- Compliance with best practice and best practice bundles
- Staff and physician recruitment, training, retention
- Credentialing and Peer Review
- Optimization of electronic medical record
- Participation in state and national quality initiatives and projects
- Ask: How do we know we are not falling behind?

Equitable – “Treat me with respect”

- Accessible care
- Beyond cultural awareness training
- Patient satisfaction, complaints/grievances
- Social determinants of health
- Health literacy
- Stratifying of quality data
- Diversity of workforce
- Ask: do we know whose needs we are not meeting?

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Patient Centered – "Help me stay well"

- Community health needs assessment (CHNA)
- Social determinants of health
- Continuum of care and community partnerships
- Patient/Family Engagement (PFE)
- Ask: how are we meaningfully engaging with our patients/family members?

The Case for PFE

- Reductions in hospital-acquired conditions
- Reduction in Readmissions
- Improved patient experience and higher HCHAPS scores
- Improved outcomes and reduced length of stay
- Reductions in health and healthcare disparities
- Improved efficiency

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2. Data Systematically Reviewed

- Key performance improvement indicators
  - Known, understood, and approved
- Quarterly monitoring of results
  - Feedback to departments/teams
- Review of external reviews and assessments
  - Accreditation and regulatory
  - Community and customer
- Assessment of Risk Management issues
  - Reportable events, real/potential litigation

Know What Your Data is Telling You

Maureen Bisognano, IHI President Emerita and Senior Fellow, challenges boards to be able to answer four analytic questions pertaining to quality:

1. Do you know how good you are as an organization?

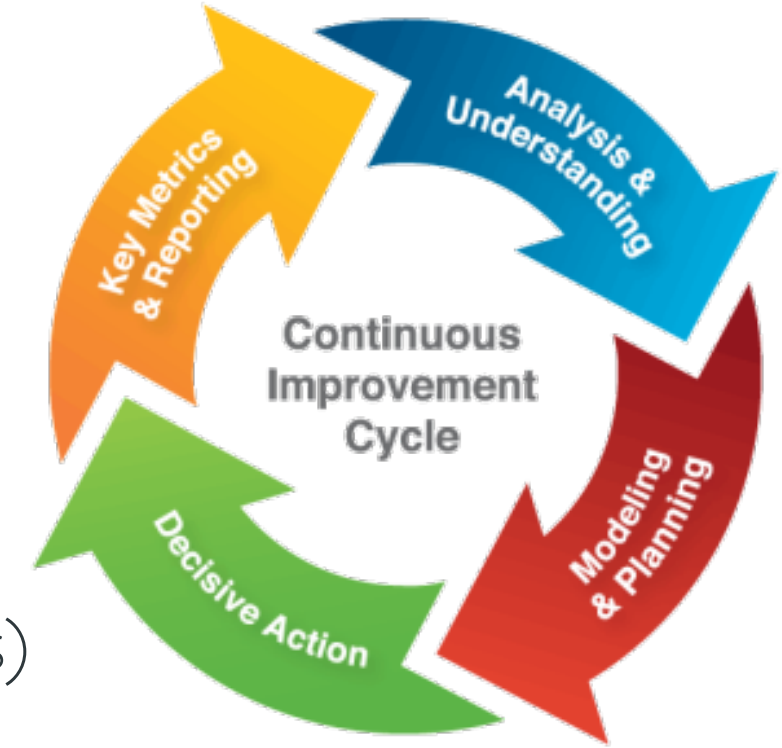
2. Do you know where your variation exists?

3. Do you know where you stand relative to the best?

4. Do you know your rate of improvement over time?

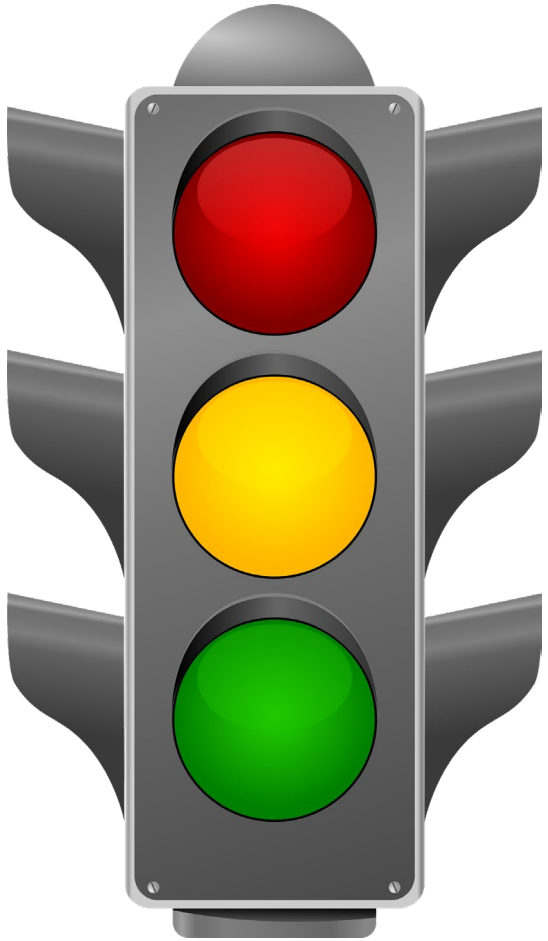
Data is a means, not the end

- Required reporting to regulatory agencies
  - Can drive reimbursement and penalties
  - Questions: Compliant? Concerns?
- Publicly reported data
  - Hospital Compare, STAR Ratings, Leapfrog, etc.
  - Significant data lag…but "new" to the public
- Your organization's Key Performance Measures (KPIs)
  - Identified opportunities for improvement
  - Ensure that improvements are happening and being sustained



Looking at the Data

- Dashboards and Scorecards
  - Goals, trends, often color-coded
- Balanced
  - Finance, Quality/Safety, Customer perspective, Staff/Clinician
- Interventions/activities
  - What is being done to improve?
- Compare to Strategic Plan and Quality/Patient Safety Plan
  - Do priorities need to be adjusted?
  - Are adequate resources allocated?



3. Demonstration of Appropriate Attention

- Official commitment by Board – in writing
- Quality/Patient Safety on every agenda – with at least quarterly monitoring of key indicators
- Minutes reflect engaged oversight – discussion and feedback
- Purposeful engagement with patients/families and community
- Communication reflecting organizational priorities
- Connection between staff safety and patient safety
- Ongoing education of board members

Next Steps

- Learn how your organization has set expectations and prioritized quality
- Build knowledge of core concepts and define your board responsibility
- Read your hospital's current Quality/Patient Safety Plan
- Participate in a culture of inquiry
- Be visible in supporting quality
- Help keep the focus on the patient
- **Keep asking questions!**

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Thank you!

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References

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