c|h|a Colorado Hospital Association

BoardBrief

Prepared for Colorado Hospital Association Trustees

The Board's Role in Quality and Patient Safety 1.0

Oversight of quality and safety, though complex, is one of the most rewarding and critical responsibilities for board members. Through their board service, trustees save lives and improve the health of their friends, neighbors, and community.

Oversight of quality and safety is a board responsibility. It can NOT be delegated.

Board accountability for quality and safety extends enterprise-wide and cannot be delegated. Accountability in quality and safety encompasses all of the services that the organization provides, well beyond the four walls of the hospital. The board sets the quality and safety goals and holds administration and medical staff accountable to achieve them. The board is also responsible for credentialing and re-credentialing of the medical staff.

The Current State of Safety in Hospitals

Health care in America is criticized for its high cost and low quality. According to the Institute of Medicine (IOM), over $750 billion is "wasted" on health care annually. The 2012 Institute of Medicine Report *"Best Care at Lower Cost: The Path to Continuously Learning in Health Care in America,"* goes on to show that in comparison, the entire Department of Defense budget is only $650 billion per year. The $750 billion waste per year in health care would be enough to buy groceries for every household in the United States or pay the salaries for all firefighters, police officers, and EMTs for 12 years.

Boards, administrators, and care providers are working to reduce waste and errors. Public and elected officials are concerned and taking action. Yet errors occur in hospitals every day. Regardless of the nature or scope, medical errors significantly impact quality of care, patient satisfaction, medical staff and employee morale, and reimbursement.

Boards of trustees must take strong, organized action to establish and nurture an organizational accountability and culture that continually seeks to improve quality and patient safety at every turn. Board members individually, and collectively, can make a big difference in quality and patient safety.

One of the ways health care leaders are working collectively to make a difference in health care quality is by focusing on achieving the concept of the "Triple Aim." The Institute for Healthcare Improvement's (IHI) Triple Aim was created to optimize the performance of the health system. It brings together three critical elements: 1) better health for the population being served; 2) an improved experience of care (including quality); and 3) care provided at a reasonable cost.

A board member's role is not based on personal interests but on the health care resources and services the community needs, ensuring those services are delivered with high quality, safely, and at a reasonable cost.

Oversight of quality and safety is a board responsibility. It can NOT be delegated.

The Problem: Inadequate Systems

Physicians and nurses do their best every day to provide great care in the very complex environment of health care. The majority of errors are caused by health care systems or processes which are faulty, too complicated, or fragmented.

Consider the complexity of giving patients the right medication. For every medication, there are two names, the trade name and the brand name. Both of these names can be complicated and look and sound totally different. In addition, the medications can be administered in several dosages and as a pill, shot, or IV. To top it off, packaging changes may include

Board members individually, and collectively, can make a big difference in quality and patient safety.

labels with difficult to read text due to color or small printing. Staff may be trying to administer one medication and reach for another medication because the packaging is so similar. It is no wonder that adverse drug events are the most common type of health care adverse event.

Understanding the nature of system failure and fragmentation, boards must ask: "What can our hospital do to improve our systems to support safe, high quality care?"

The Institute of Medicine helps boards by defining "six aims" of care. These are six areas hospital trustees and leaders should watch for in their organization as care is discussed.

- 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, and values, 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.
- Equitable, providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.

Board members must have measures that demonstrate how their organization is performing in each of these six areas.

How Does System Failure Impact Quality?

A patient is in pain. The nurse administers morphine. Although she knows she needs to check back in fifteen minutes to make sure the patient's breathing has not been impacted, she also has another patient that is very sick and is scheduled to receive a CT scan. The patient needing the CT scan is very ill so a nurse must accompany the patient. The nurse decides to go down with the patient who needs the CT scan. Meanwhile, the patient she gave the pain medication to begins to have very shallow breathing from the pain medication.

Quality and Patient Safety are Job One

Too often boards of trustees assume that quality and safety problems are not an issue unless they hear otherwise. Boards should ask questions to identify areas with the greatest need for improvement. Questions boards should be asking include:

- How good is our quality? How do we know?
- Where do we want our quality to be by when?
- What is our "culture" of quality and safety? Are errors reported, including by management to the board?
- What does the public expect from us?
- What should we be measuring?
- Do we publicly disclose our quality and safety performance, and to what degree?

Patients have the right and expectation to receive excellent care regardless of size of their health care provider. Board accountability for quality and safety is the same if your organization is very large or very small.

Boards of trustees should embrace their role in patient safety for moral, ethical, legal and financial reasons. Board members must understand that they are liable for the care provided; that medical errors significantly impact health care costs; and that patient safety is a key component of "staying on top" in a highly competitive environment.

Patients have the right and expectation to receive excellent care regardless of size of their health care provider. Board accountability for quality and safety is the same if your organization is very large or very small.

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, and seek continuing education about current trends and implications. Boards should regularly review key quality indicators, and take corrective action when necessary.

Consider the following:

- Medical liability costs rise as the number and scope of lawsuits increase;
- Fear of liability may cause providers to stop delivering services altogether;

- Doctors that don't stop delivering services may practice "defensive medicine," ordering extra tests and procedures out of fear of liability;
- The public may drive past your facilities because they assume care at the other facilities is better; and
- The cost of lost business, employee morale and a negative reputation from one or two serious patient safety breaches can be very damaging.

Cost. The cost of medical errors to the individual, health care system and society is significant. As an example, more people die annually from medication errors than motor vehicle accidents, breast cancer and AIDS. Adverse drug effects cause approximately 777,000 deaths per year and can cost a hospital $1.56 - $5.6 million annually.[1]

Half of the costs of medical errors come from direct health care expenses, such as increased hospitalization; the other half includes indirect expenses such as lost productivity and disability.[1] Increasingly, payers and large businesses expect that their health care partners demonstrate high quality, efficient care. This is resulting in a growing number of providers being excluded from payer contracts.

Quality and safety at a low cost is fundamental to a health care provider's survival.

Quality and safety at a low cost is fundamental to a health care provider's survival.

Competition. High quality providers are magnets for patient self-referral, physician referrals and managed care contracts, says Russell C. Coile in *"Quality Pays: A Case for Improving Clinical Care and Reducing Medical Errors."* And although quality has traditionally been a matter of perception on the part of patients, many organizations routinely publish reports on the top-rated hospitals for quality. Hospitals that do not put processes in place to reduce medical errors risk losing consumer confidence and market share.

More Questions Trustees Should be Asking About Quality and Patient Safety

1. What quality and patient safety measures should we be collecting and closely monitoring?
2. Who is the best on these measures and how do we compare?
3. What are the top five safety issues at our facility?
4. What is our organization's aim for safety improvements and when will we reach that goal?
5. How will the board hold the executive and medical staff responsible for this year to improve related to our patients' safety?
6. Is it easy and safe to report adverse events at our hospital? What is the process?
7. How much do medical errors cost our hospital annually?
8. What steps have we specifically taken to address the IOM's Six Aims?
9. If we were paid today on the basis of quality, not procedures, how would we do?

Transparency and Public Accountability

The public wants and deserves to know that they will be safe as their care is provided. Hospitals and health systems can demonstrate a commitment to their communities served by selecting leading measures to publically display on their website. Research has shown that public transparency is valued by the public. Transparency does not usually change where the public decides to receive care; however, it does help reassure the public that nothing is being hidden.

Transparency results in faster improvement. Boards that are interested in real improvement across the organization will consider wide-ranging transparency: the more transparent organizations are, the greater the potential for improvement.

Data about individual hospitals and health systems is also available on other public websites, including the CMS Hospital Compare website, the Leapfrog Group, HealthGrades, and the Joint Commission's Quality Check website. In addition, new websites are emerging that combine hospital quality and prices together in an attempt to portray the best health care "value," such as Nerd Wallet and ReferMe. These sites help patients synthesize information, recommending the best hospital for a particular procedure based on price combined with other quality indicators, such as patient satisfaction.

Hospital quality data is also available through many mobile phone or tablet applications. Quality data about your organization is being shared regardless of any opinion you might have on it, and will continue to grow. For example, applications from insurance companies are linking the amount a patient will have to pay out of pocket with the quality scores of the hospital. Board members should be well-familiar with how their organization is reflected on all health care monitoring websites.

The train is way down the track….data on your hospital is available publically. Hospital and skilled nursing home ranking are a part of our world.

Embrace, learn from, and use public data to help provide the best care possible to your patients.

Compare Yourself to the Best. Hospitals seeking to improve quality and patient safety compare their results with the best, not the average. Being average will not provide the competitive advantages organizations need to compete in the rapidly evolving health care environment.

The Media

The media is also an important part of communicating with the public about the quality and safety of health care. The media views it as their obligation to investigate and report on issues significant to the public. This unfortunately means that most of the stories are about problems, not solutions.

Hospital and health system leaders can provide information to the media on the ways in which their organizations are improving quality and patient safety. Hospital associations also help identify topics that are interesting to the media and that will inform policy makers about improvements in health care quality, satisfaction and efficiency.

Board members, if called by the media, should always refer reporters to their CEO or the communications department.

Medicare's Role in Ensuring Quality

In many hospitals, Medicare may comprise 60 percent or more of revenue. In order to be paid by Medicare, the organization must comply with the Medicare Conditions of Participation (CoP). The CoPs were designed in 1966 to ensure the health and safety of Medicare beneficiaries as they receive services, and are updated periodically. These minimum standards are enforced through audits during accreditation surveys such as accreditation conducted by The Joint Commission or DNV. Failure to comply with the 24 CoPs and 75 specific standards may have significant ramifications, including the loss of ability to care for Medicare patients.

IHI: Characteristics of High-Achieving Hospital Boards Committed to Improving Quality and Patient Safety

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 begin their ongoing quest to constantly 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 board members, administrators, staff, and physicians
11. They establish an interdisciplinary Board Quality Committee, meeting at least four times a year with a board member sitting on the committee
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.ihi.org.

Consistent compliance with CoPs is important, as the surveys are performed on an unannounced basis. Because surveyors could arrive any day to review compliance, boards should be made aware anytime their facility is out of compliance with a CoP. The CoPs cover all areas of operating a hospital, from leadership (board oversight) and how care is provided to life safety codes (facility requirements such as sprinklers or fire doors).

The media views it as their obligation to investigate and report on issues significant to the public. This unfortunately means that most of the stories are about problems, not solutions.

Quality Reporting and Measurement

Boards should review meaningful and understandable quality and safety data at every board meeting. The information should ideally be presented in graphs trended over time to help trustees quickly and easily identify improvement, or lack of progress.

Data provided to the board should include benchmarks showing "best practice" data, not averages. The measures should include information on:

1. Achieving quality and safety goals
2. Quality and safety measures used as part of payment
3. Adverse events
4. Hospital Compare: hospital, skilled nursing facility, and physician measures
5. Infection measures
6. Employee safety
7. The health of the community, such as diabetes, obesity, high blood pressure, mental health and dental health data
8. Issues unique which are important to the hospital or health system

Adverse Events. An adverse event is harm that occurs to a patient as a result of medical care. There are several ways to collect data on adverse events. At a minimum, all hospitals, regardless of size, should be monitoring so-called "Serious Reportable Events." The National Quality Forum (NQF) has identified "Serious Reportable Events" as events that should never happen in a hospital and that can almost always be prevented. Examples of Serious Reportable Events include, but are not limited to:[4]

- 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.

Many hospitals have voluntarily agreed not to bill for these events, and several payers will not pay when one of these events occurs.

Hospital Compare. The Hospital Compare website was created through the efforts of the Centers for Medicare & Medicaid Services (CMS), in collaboration with organizations representing consumers, hospitals, doctors, employers, accrediting organizations, and other Federal agencies. The goals of the information on the website are to:

- Help people make decisions about where to get health care, and
- Encourage hospitals to improve the quality of care they provide.

Reporting is required for all acute hospitals which are not small, rural, or Critical Access Hospitals (CAH). Although not required for CAHs, it is important for their boards to discuss and understand how they compare to state and national benchmarks.

The data is available to the public on the Hospital Compare website at www.medicare.gov/hospitalcompare. The information available includes:

1. Survey of patients' experiences (patient satisfaction)
2. Timely and effective care, including heart attack care, heart failure care, pneumonia care, surgical care, emergency department care, preventive care, children's asthma care, stroke care, blood clot prevention and treatment, and pregnancy and delivery care
3. Readmissions, complications and deaths
4. Use of medical imaging

5. Medicare payment
6. Number of Medicare patients and other general information

In addition to hospital-specific data, CMS now offers quality data about nursing home and outpatient physician care. Nursing Home Compare is available at www.medicare.gov/nursinghomecompare.

Physician Compare, which was launched in 2014 and includes a growing amount of data being collected about medical office practices, is available at www.medicare.gov/physiciancompare.

The hospital and nursing home data is a common source for the media to review. The measures are also used for value-based-purchasing where hospitals and nursing homes have payment withheld if they do not demonstrate excellence or significant improvement.

Infection Data: Center for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). The NHSN is a data collection system which was designed by the CDC as a standard way to report infections in hospitals. With growing interest from the public on infections, it has now become the source for standard reporting which is mandated for hospitals in many states and required as part of value-based -purchasing for Medicare.

Statistics hospitals frequently report include:

- Surgical site infections;
- Catheter-associated urinary tract infection;
- Ventilator infections;
- Central line-associated infections (IVs for which go into large veins to measure the pressure, give fluids, and administer medications);
- Methicillin-resistant staphylococcus aureus (MRSA) infections; and
- Clostridium difficile (C. Diff.) infections.

With data on infections, terms such as infections per 1,000 catheter days are used. The rate is multiplied by 1,000 to make the rate easier to understand.

National benchmark data is available for the NHSN data. More information is available at www.cdc.gov/nhsn.

Leading National Organizations

Hospitals and lawmakers are increasingly looking to national organizations such as the Institute of Medicine and National Quality Forum 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. Resources are also available from state hospital associations as well as the American Hospital Association.

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 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 related to systems;
- 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 dramatically 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 which were described earlier.

Centers for Medicare and Medicaid Services. As one of the largest payers, CMS provides services for about thirty-two percent of the population through Medicare and Medicaid programs.[5] For hospitals that provide care for the elderly and sickest patients, the percentage of their payment from CMS can be anywhere from 60 to 80 percent.

The importance of CMS cannot be overstated. This governmental organization is leading the way in quality measurement and improvement, payment based on the quality of care, and demanding accountability through transparency.

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.

Changes in CMS reimbursement is putting hospitals "at risk" of losing up to six percent of their total payment based on their quality scores. There is a direct and significant link between hospital quality scores and the amount paid. As CMS expands its payment based on value, other payers are moving in the same direction.

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 reporting. 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.

The IHI website (www.ihi.org) is an excellent resource for articles and additional materials on board governance. Access to the online documents is free, with the set-up of a user name and password.

Leapfrog Group. The Leapfrog Group is a voluntary organization supported by large businesses that exists to mobilize employer purchasing power to "alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded." The goal is to advance quality and safety best practices beyond where the other reporting systems have gone. For more information, go to www.leapfroggroup.org.

HealthGrades. HealthGrades provides provider ratings for over 5,000 hospitals and over 600,000 physicians, as well as nursing homes and home health agencies. Ratings are provided by category, such as stroke, maternity care, and heart attack. Each hospital is given a "grade" for its performance, with five stars representing "best," three stars indicating "as expected" and one star indicating "poor." Payment is required to use this information which for some is okay and for others gives them pause. For more information, go to www.healthgrades.com.

The Joint Commission. The Joint Commission is an accreditation organization which also advocates with CMS for more clear standards. The Joint Commission maintains a

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. www.iom.edu.

website called Quality Check, which provides information about quality performance based on accountability measures. The Joint Commission also offers unique and well-done tools to help hospitals and health systems improve care. For more information, go to www.jointcommission.org.

DNV. DNV is the second most common accreditation organization. They integrate ISO 9001, which is a commonly used quality standard in the health care industry. For more information, go to http://dnvglhealthcare.com/accreditations/hospital-accreditation.

The Importance of Quality in the Transition from Payment for Volume to Payment for Value

Payers no longer want to pay simply because a service was performed. They expect that the service was necessary, and performed correctly. This is no different then when you get your car repaired, and do not pay if it is not fixed or was damaged while in the shop. The value equation in health care is defined as:

Value = High quality + Low cost + High patient satisfaction

Warranties are also expected by the public for typical goods and services. For example, if you purchase a new carburetor for your car, you do not expect to need to purchase another new carburetor six months later if it fails. In health care, there is growing demand for warranties. For example, open heart surgery is an area where payers are asking for hospitals to warranty their services and pay for repairs or additional services if they are needed after surgery.

CMS now accounts for about 60 percent of payment in many hospitals, and those payments come with penalties and incentives based on hospital quality performance and improvement. The amount of money is growing and significant. Six percent of Medicare reimbursement was "at risk" in 2014, a percentage which will continue to rise for many years to come.

Many quality, patient safety and patient satisfaction measures require coordination with the community, particularly those focused on reducing readmissions or mortality. All require close partnership with physicians and the care they provide.

The transition to payment based on "value" is called Value-Based Purchasing, or VBP. While the payment changes began with CMS, other payers are following their lead.

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. Board members have an opportunity to play a role in bringing the key players together, facilitating conversations about patient safety amongst providers, purchasers, and employers.

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.

Key elements of employee and medical staff commitment to safety include:

- *Accountability:* medical staff and other employee job descriptions should incorporate accountability for safety;
- *Education/Knowledge:* educate employees on the importance of safety, surveillance and expectations for reporting safety concerns and errors, beginning with their orientation as new hires;
- *Evaluation:* employee evaluations should take into account contributions to safety;

- *Disclosure:* reward employees and physicians for disclosing errors, near-misses and safety concerns; and
- *Teamwork:* employees and physicians should work in teams so each member knows his or her responsibilities and those of teammates, and members of the team look out for one another, noticing errors before they cause injury.

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. That patient's role in patient safety includes:

- Informing doctors about medication they are taking;
- Asking for written information about possible medication side effects;
- Choosing hospitals with experience treating their condition;
- Learning about their condition;
- Being a personal advocate or finding an advocate;
- Ensuring prescriptions are legible; and
- Demanding an understandable, written discharge treatment plan.

The Board Role. Too often quality is on the board agenda as a discrete item, such as finance. Boards must recognize that quality and patient safety should be the foundation for everything the board does. Meeting agendas should include regular review of reports on quality and patient safety. 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.

Too often quality is on the board agenda as a discrete item, such as finance. Boards must recognize that quality and patient safety should be the foundation for everything the board does.

Sources and Additional Information

1. To Err is Human: Building A Safer Health System. Institute of Medicine. November 29, 1999. www.iom.edu
2. Coile Jr., Russell C. Quality Pays: A Case for Improving Clinical Care and Reducing Medical Errors. Journal of Healthcare Management. May/June 2001.
3. 5 Million Lives Campaign. How-to Guide: Governance Leadership. Institute for Healthcare Improvement. www.ihi.org.
4. National Quality Forum. Serious Reportable Events. www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx.
5. Day, Jennifer Cheeseman. Medicare and Medicaid, Age and Income. U.S. Census Bureau Random Samplings: The Official Blog of the U.S. Census Bureau. Posted September 17, 2013.