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BoardBrief

Prepared for Colorado Hospital Association Trustees

The Board's Role in Quality and Patient Safety 2.0

Providing high-quality, safe care begins with a culture of safety. 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. Boards should expect transparency, continual improvement, and measurable results from the medical staff and administration in a way that promotes safe and constructive conversations about success and failure. If the administration feels threatened each time a failure occurs, failure will become hidden from the board and buried deep in the organization where there is no opportunity for learning and improvement.

Humans make mistakes. It is up to organizations to create systems that prevent errors from reaching patients. These are called "Human Factors." To address this, hospital and health system leaders should ask questions such as: What is the next error that is likely to occur? How will our systems prevent it? How is our staff working around systems to provide needed care to patients? A common example is placing medications in pockets because it takes too long to get them from the pharmacy. Another example is providing care at night and then asking for an order in the morning because the physician on-call is angry at the nurse if he or she is awakened.

Most errors are caused by systems that do not work when an employee or physician is truly negligent, such as being abusive to fellow care providers. Negligent providers need to be held accountable and told their actions are not acceptable. At the same time, hospital and health system leaders must continually seek out opportunities to improve systems that remove the "Human Factor."

Creating a Culture of Safety

Boards must define what a culture of safety means to their hospital, including the following critical components:

- *Commitment of Leadership:* Active involvement by the hospital's governing body, clinical and non-clinical leadership, with continual improvement in patient safety and medical error reduction as an explicit hospital priority.
- *Open Communication:* Patient involvement in decisions about their care, informing patients of the consequences of the care they receive, and ensuring language that supports the patient safety effort.
- *Engaged Patients:* Hospitals and health systems using best practices have patients provide feedback to the board about quality, patient safety, and the patient experience. This communication enhances the board's discussion.
- *Reporting:* Create an environment of trust to address accountability in a fair and just manner so blame is not automatically placed when an error occurs; encourage employees to view patient safety as an integral part of their jobs, and to internally report errors, "near misses" and other opportunities to improve safety.
- *Informed Action:* Understand and analyze data, including near misses that could have impacted patients but were averted.
- *Teamwork:* Continually train in both team skills and job specific competencies, encouraging caregivers to consistently work in a collaborative manner in which each individual has a responsibility to identify and/or act to prevent potential medical errors.
- *Focus on Improving Systems and Not Blaming Individuals:* The focus should continually be on fixing systems so that the error cannot occur again.

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Ensuring a "Just Culture"

The board's actions set the tone or "culture" for their organization, including setting patient safety guidelines and priorities and dedicating the resources necessary to provide appropriate, effective, safe care.

Physicians and clinical staff must be held accountable for providing superior quality. For example, a physician who does not wash his or her hands or has a high rate of infections needs to be supported and held accountable for improving his or her care.

This matching of the board's role and fixing systemic issues as the cause for patient harm, while simultaneously holding staff accountable when there is reckless behavior, is called a "Just Culture."

A "Just Culture" advances organizations beyond simply saying that human error is unacceptable, which only hides errors and prevents learning. It is important to have a culture where mistakes, regardless of severity, are reported and learned from. Mistakes should be viewed as a learning opportunity, bringing to light systems to fix, unless an obvious lack of judgment is a primary cause.

For more information about the Just Culture concept, see the AHRQ article "Patient Safety and the 'Just Culture': A Primer for Health Care Executives." Marx D. New York, NY: Columbia University. April 2001. http://psnet.ahrq.gov/resource.aspx?resourceID=1582.

Engaging Physicians and Building Medical Staff Partnerships for Quality and Patient Safety

The board is responsible for setting direction, goals, and oversight. This accountability cannot be delegated to the medical staff. High performing organizations have common, aligned goals set by the board and jointly developed by the administration and physicians. The medical staff plays an important role in the delivery of safe, high quality care to patients and in achievement of the organization's goals.

One way to build the relationship is by establishing clear expectations that physicians should anticipate of the organization, and expectations that the organization anticipates of physicians. This is called a "compact." A clearly defined compact can help build alignment with existing physicians and also aid in future recruitment efforts—physicians looking for a partnership and shared vision may be drawn to organizations with a clearly defined compact, while others may be deterred by the concept.

Strengthening Board and Physician Communication. 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 "practice friendly environment" through strategic understanding of the clinical and medical staff 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.

The End Goal: Improved Care. If boards struggle to get physicians on board with a quality and patient safety plan, explaining how implementing the plan will provide their patients with better care will build and sustain physician support. Make sure providers know that the changes will result in fewer errors and less harm to their patients, itemizing the specific desired outcomes as a result of the changes. In addition, demonstrate how the change will take them equal or less time. Engage physicians early with a physician champion playing an integral role in the decision-making and implementation process, clearly communicating that physicians will be instrumental in developing and

Ensuring Success in Patient Safety Programs

- The board is engaged and reviews quality data at each board meeting
- A CEO with a strong track record (results) is engaged in quality and safety
- The CEO's compensation is linked to quality and safety results to at least the same degree as financial success
- There is recognition that patient safety errors occur in the hospital
- There is agreement that the current error rate is unacceptable
- There is a culture of fixing the "system" when errors are identified and discussed
- The organization holds physicians accountable
- Data is posted on units so that care delivery staff see and can participate in progress
- Accountability for quality and safety reporting to the board is in place in all corners of the organization
- The board allocates resources for quality improvement and error prevention
- Physicians are engaged and active partners in achieving quality aims

implementing the patient safety plan. The reward will come for the physicians when they see their patients are receiving the very best care possible.

Physician Credentialing and Provider Peer Review

Medical staff credentialing is one of the most important tasks boards undertake to ensure quality of care in their organizations. The overall objective of credentialing is to ensure that only qualified doctors are admitted to (and remain on) the hospital's medical staff, and that they practice within their scope of experience and competence.

Providers cannot expect to receive reimbursement for substandard care. Readmissions from inappropriate discharges and unneeded tests are two examples of areas where hospitals and providers should ensure they are providing only the necessary care. Proactive boards should consider what areas of care exist in the hospital or health system where this might be an issue.

What is Credentialing and Privileging?
Medical staff credentialing is a two-pronged process that involves establishing requirements and evaluating individual qualifications for entry into a particular medical staff status. Credentialing first involves considering and establishing the professional training, experience, and other requirements for medical staff membership. The second aspect of credentialing involves obtaining and evaluating evidence of the qualifications of individual applicants. Basically, credentialing is verifying that each applicant:

1. Is who he/she claims to be;
2. Has been properly licensed;
3. Has appropriate malpractice insurance; and
4. Meets minimum requirements established by the hospital to be on staff.

Another aspect of the credentialing process is privileging the medical staff applicant. Privileging is a three-pronged process that determines:

1. The diagnostic and treatment procedures a hospital is equipped and staffed to support;
2. The minimum training and experience necessary for a clinician to competently carry out each procedure; and
3. Whether the credentials of applicants meet minimum requirements and allow authorization to carry out requested procedures.

Often called "delineation of clinical privileges," this process determines what procedures may be performed or which conditions each medical staff member may treat. Delineation of privileges is an ongoing process that must not only be flexible enough to add new procedures or conditions to treat, but also be firm, fair and consistent.

The process of credentialing must be based on meeting the criteria necessary for safe practices. It should also reflect support of the strategic goals of the organization. For example, goals to prevent infections may include requirements that each physician demonstrates good hand hygiene, the use of a checklist or bundle elements of evidence-based practices for preventing infections, and low infection rates (no more than one infection in a year for most types of conditions).

The Role of the Governing Board. The board of trustees assumes all legal responsibility for the hospital and is ultimately responsible for approving all medical staff bylaws, policies and procedures. The board has two key functions in credentialing and privileging: 1) Attend to process; and 2) Decision-making.

Attend to process – The board must delineate steps of the credentialing process and specify/approve criteria that it uses to make recommendations or decisions at each step. The board also must ensure that the process is thorough, fair, consistent and functioning effectively.

Most boards have one or more members of the board serve on the Medical Executive Committee (MEC), where the initial recommendations are made. These recommendations are brought to the full board. The Medical Executive Committee is typically comprised of the elected leadership of the medical staff. The CEO and Chief Nursing Officer (CNO) also attend. Composition and who can vote is determined by the medical staff bylaws.

Key questions for the credentialing process are:

1. What is the criteria the medical staff has determined will be used to credential a physician? Does it sound reasonable?
2. Are there quality measures and other checks to ensure that the physicians are practicing in a way that supports quality, safe care for patients?

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3. Is the physician's behavior supportive of teamwork, and does it foster good communication?

4. Was the credentialing criteria administered in a way that is unbiased? (Examples of some of the most common forms of bias are against women, race, or an application by a competing medical group.)

Decision making – The board must ultimately decide which doctors will be admitted to the medical staff (initial appointment), allowed to remain on the medical staff (reappointment), and which procedures they can perform and diseases/conditions they may treat (privilege delineation). Typically the MEC reviews and makes recommendations for initial appointment and privilege delineation together. The board's role is essential to having a high quality medical staff.

Physician Investigative/Correction Action

Even though most organizations go through a stringent process of physician credentialing and privileging medical staff members, there are times when organizations or individuals may want to "reverse the process" and remove a physician from the medical staff.

An investigation may be initiated whenever a practitioner with clinical privileges exhibits behavior – either within or outside the hospital – that is likely to be detrimental to the quality of patient care or safety, the hospital's operations or the community's confidence in the hospital. An investigation may be initiated by any medical staff officer, the chair of the department in which the practitioner holds appointment or exercises clinical privileges, the CEO, the MEC or the governing board. All requests must be submitted in writing to the MEC.

Prior to determination by the MEC if an investigation is undertaken, oftentimes the individual or committee considering the investigation request may ask for an interview with the involved practitioner. This assists in the decision of whether or not there is relevant cause for further examination. If the decision is made to continue the investigation there are two forms of suspensions that may affect the individual involved: automatic suspension, and summary suspension.

Automatic Suspension. Automatic suspension of the involved practitioner will take place if:

- The practitioner's state license or Drug Enforcement Administration (DEA) number is revoked, suspended, restricted, or placed under probation;
- The practitioner fails to satisfy an interview requirement;
- The practitioner fails to maintain malpractice insurance; and/or
- The practitioner's medical records are not completed in a timely manner.

Summary Suspension. The CEO or any member of the MEC or the governing board may initiate summary suspension on the involved practitioner's medical staff status or clinical privileges. Summary suspension is typically initiated whenever a practitioner's conduct requires that immediate action be taken to prevent immediate danger to life, or injury to him- or herself, patients, employees, or other persons present in the hospital.

After a summary suspension, the MEC will typically convene to review and consider the suspension. The MEC may recommend modification, continuation or termination of the suspension. Unless the MEC recommends immediate termination of the suspension, or one of the lesser sanctions, the practitioner is entitled to the procedural rights contained in a fair hearing. Any and all decisions or conclusions that are drawn by the MEC are assessed by the governing board before any final decision is made.

Finally, any applicant who has been denied appointment, clinical privileges or reappointment, or who has been removed from the medical staff during the appointment year, may not reapply to this hospital for a period of one year (12 months), unless specified otherwise in the terms of the specific corrective action.

Board members should understand that alcohol and drug abuse is a problem. In 2014, Medscape reported that physicians abuse alcohol and illegal drugs at the same rate as the general public but are five times more likely to abuse prescription drugs.[2] This is a statistic that Lisa Merlo, PhD, researcher at the University of Florida's Center for Addiction Research and Education, termed a "grim statistic." This use of drugs is typically to reduce stress, physical or emotional pain. Most hospitals have strong referral programs to help physicians overcome these issues. Encouragement of self-reporting in a non-punitive environment should be part of the culture.

Implementing a Quality Dashboard

It is important that hospital trustees understand the quality of care provided at their hospital or health system. A hospital's dashboard is a clear, straight-forward approach for boards to understand if they are providing good, really good, or top-tier quality. A robust dashboard will typically include the following measurements:

- Quality measures posted on the CMS Hospital Compare website;
- Joint Commission Data (maternity measures, accreditation, patient safety goals);
- Patient satisfaction measures posted on the CMS Hospital Compare website;
- Mortality and Sepsis Mortality;
- Readmissions all-cause, and for Critical Access Hospitals, transfers after the first 24 hours;
- Cesarean rate for low risk, first birth women (NTSV);
- Opioid and broad spectrum antibiotic usage;
- Infection measures from the National Healthcare Safety Network (NHSN), including surgical infections, urinary catheter infections, ventilator infections, central line infections, MRSA, and C. diff infection rates;
- Employee injuries;
- Radiation dosage in children;
- Outpatient measures;
- Nursing measures, including falls and ulcers;
- Physician measures (Physician Quality Reporting System (PQRS)), such as aspirin for heart attack and diabetic control with Hemoglobin A1c;
- Adverse events;
- Medication adverse events, such as hypoglycemia, anticoagulation, opioids;
- State-specific reported measures;
- Nurse staffing plans; and
- Other facility specific topics, such as: emergency department (diversion, boarders, waiting time, patients who come more than five times in rolling 12 months); incident reports; medical malpractice claims (open, closed); and community health measures (examples may include diabetes, asthma, and obesity).

"Safety Across the Board" Dashboard. Some hospitals combine their comprehensive quality dashboard measures together into what is called a "safety across the board" measure. The amount and complexity of data can be daunting, and interpretation of the information is important for board members to understand.

Data should be presented in trended graphs. They can either be rates or counts. When interpreting quality data, boards should think about:

- How do we compare with other organizations? Are we in the top 25% of performance? The top 10%?
- Are there five points on a trend graph going in the direction of improvement? One or two points do not show a trend.
- How is the data impacted by seasonal variation?
- Has care improved for all patients, or do certain ethnic groups have different results?

Although staff have the best intentions, too often reports are too detailed and board members either do not have the opportunity or do not feel comfortable asking basic questions about quality reports. When this happens, the opportunity for strategic discussion is lost.

To maximize the impact of quality reporting, graphs should be labeled with terminology that board members understand, and should clearly highlight the trends and information they were designed to communicate.

Staff, Patient and Family Dashboards. Transparency builds trust and a sense of partnership with employees as well as patients and families. Hospitals and health systems should post quality and patient safety data in units relevant to the care provided. Examples of data to post on nursing units are hand hygiene results, pressure ulcers, falls, and infection rates. In addition, if asked, employees, patients and families will often have improvement suggestions. The board should encourage leaders to have a process in place to gather and respond to suggestions for improvements to the patient care experience.

Sources and Additional Information

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