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BoardBrief

Prepared for Colorado Hospital Association Trustees

The Board's Role in Quality and Patient Safety 3.0

Quality and patient safety is the board's number one responsibility. Achieving consistent high quality requires a commitment to excellence at every level in the organization. It requires that all decisions and actions made on behalf of the organization keeps quality at the forefront. Consistent, high-quality care is a natural outflow of an organization that ingrains quality and patient safety into its DNA. This not only creates high levels of quality care, but also improves patient satisfaction, elevates medical staff and employee morale, and improves reimbursement.

Making the Quality Connection In All Board Discussions

Informed, engaged and active participation in quality oversight and leadership should be the foundation for every board agenda. Agendas should include regular reviews of reports or dashboards on quality and patient safety. They should also address the board's responsibility for setting performance goals for quality and safety, and hold managers accountable for achieving those goals. But the board's focus on quality should be infused throughout the board's discussion. Nearly every topic has quality and patient safety implications, whether it is finance, human resources, medical staff credentialing, physician partnerships, or compliance.

Embedding Quality into Finance Discussions. Without the proper financial resources, consistent quality of care is not possible. Adequate resources must be devoted to quality and patient safety improvement, technology upgrades, ongoing education and employee engagement. Boards must monitor capital spending related to quality, ensuring that investments made result in positive quality and patient safety outcomes.

The impact of expense reductions on quality and patient safety must also be considered in finance discussions. In today's increasingly pay-for-value environment, budget cuts in one area may result in a reduction in expenses, but may also lead to negative quality implications that impact revenue as well.

Boards must be able to make the "quality connection" to cost, identifying how quality of care may impact reimbursement and overall operating revenue.

Embedding Quality into Compliance Discussions. One of the board's responsibilities is to ensure the accuracy of mandated data reports by implementing and utilizing internal controls to gather and report data. The board must ensure that quality is integrated into its policies and the organization's operations. Board members must be able to monitor the organization's compliance with standards and regulations - that means securing the right information from the medical staff and employees to ensure informed dialogue. The board must also consider new laws and regulations and their impact on the organization's delivery of quality care. As health care reform and its components are implemented, compliance discussions will increasingly need to be at the top of meeting agendas.

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Embedding Quality into Human Resources Discussions. To ensure a workforce dedicated to quality and patient safety improvement, boards must make an investment in quality proficiency. This begins with implementing an "on-boarding" plan that introduces new hires to the organization's quality and patient safety guidelines, quality metrics, and improvement plans. Human resources discussions must also consider the need to budget for training and development plans for existing employees to gain additional skills that will help improve quality and patient safety.

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Workforce and Budget Cuts Can Have Unintended Consequences

Every extra patient added to a nurse's workload increases the risk of death within a month of surgery by 7%, according to data from 300 European hospitals in nine countries.[1]

The board should also regularly measure employee engagement, satisfaction and turnover rates, and evaluate how those measure in relation to comparable organizations. Employee satisfaction and retention not only have financial implications, they have the potential to significantly impact the organization's quality of care. By including employee participation in quality and patient safety improvement planning and boosting employee morale, the board can ensure a strong workforce is in place to provide high-quality care.

Taking Quality Discussions to the Next Level. The board should devote time at board meetings to hear about quality failures and near misses from the medical staff, employees and patients. Board members should discuss root-cause investigations to identify ways to prevent these failures and near misses. They should also look deeply into the quality dashboard, closely examining where pre-defined goals are not being attained, and ask probing questions about why those goals are not being met. Is it a staffing failure? A process failure? Is it a one-time blip, or a long-term issue? Is it a systemic issue, or is it isolated in one area in in the hospital? Answering these questions will require a close and trusting partnership with the medical staff and hospital employees, as will resolving the issues once they are identified.

Although the board should not be involved in the daily operations of resolving quality issues, trustees need to understand the resources that are necessary to address the shortcomings identified. The board's commitment to allocate the resources necessary and follow up on their impact is a tangible demonstration of their commitment to quality and patient safety for the medical staff and hospital employees.

Addressing Adverse Events

There are times when things do go wrong. The general timeline for board notification includes:

1. Right away: When it is suspected that an adverse event has happened. The hospital staff will then investigate to find the cause.
2. One month later: The board should be informed of the results of the investigation and the plan to prevent similar events from happening again.
3. In six months: Review of status on the implementation of the prevention strategies.

Informing Patients. Patients also need to be informed about the adverse event. In the past, patients were not told about adverse events for fear of malpractice. There was also a belief that the hospital or physician had the right to decide if the patient truly wanted to know about the event.

Today, hiding adverse events is considered unacceptable. Society expects disclosure by all industries. Examples often discussed in the media are the expectation of disclosure of problems by the government, police, and automobile manufacturers, among others. The same expectation is present in health care. Providers are expected to be honest and upfront with their patients. It is not enough to avoid the subject or fail to disclose an event simply because the patient did not ask.

Being hesitant to tell a patient about an adverse event due to fear that they may pursue litigation or because the physician is embarrassed are real feelings. Admitting an error is hard to do and never pleasant. But transparency remains essential to improving future patient care.

There is general agreement that:

1. Patients and families want to know what happened, particularly if harm occurred.
2. Patients and families can often tell when they are not being told the truth. They become afraid and angry. This is frequently the cause of lawsuits.
3. Studies have shown that the best way to avoid a lawsuit is by having a good relationship among the provider, patient and family.
4. Disclosure helps patients and their families begin to heal, and decreases the likelihood of a lawsuit.

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5. Patients and families are human. They will likely become angry when the information is disclosed, and will want to know what the hospital or clinic is doing to prevent the error from occurring again.
6. Patients should not be billed for care that harmed them or for the care that fixes the harm.

The Board's Role. Boards should hold administrators responsible for supporting staff that were involved in the harm. Caregivers come to work every day wanting to help patients get better. Harming another person is devastating, and the risk of suicide by the care provider can be high, particularly if a patient dies.

When errors do occur, the board should ask the following questions:

1. When did we tell the patient or their family?
2. What support are we providing the staff?
3. How are we examining our systems to make sure this will not happen again?
4. Are we blaming nurses or physicians when it was our systems that failed?

The Role of the Media. The media may become interested in the event of an adverse event. Board members should not participate in interviews with the media unless asked by the hospital administrator or public relations staff. These requests are very rare.

In the occasional instance where board members do need to interact with the media, keep in mind the following:

1. Do not lie or stretch the truth.
2. Speak in terms that the public will understand.
3. Do not consider anything off the record.
4. Answer the question. If you are not sure if the reporter understood, ask what he or she heard.
5. Define the message the hospital wants to communicate before beginning the interview.
6. Articulate your message in quick one or two sentence explanations so they are easily quoted.
7. If you do not know the answer, do not make one up. Tell the reporter that someone will get back to him with an answer.
8. Some investigative reporters will try to make you believe they are your friend. Understand that they are doing their job, which is to get a provocative story that will appeal to the public.
9. The titles of the stories are not selected by the reporter. They are determined by another person whose job is to get reader attraction.
10. Don't engage in debate. Remember, they have the pen and you will always lose.
11. Take the advice of the public relations staff. Do not do the interview by yourself.

The Benefits of Disclosing Adverse Events and Near Misses

The act of disclosing an adverse event can communicate to patients that the physician and larger health care organization are accountable for the care provided, are human, and are strongly invested in maintaining the patient's trust. The goals of disclosing adverse events include: [4]

- Treat patients with empathy and respect
- Increase trust between patients and healthcare providers both directly (those impacted by adverse events) and indirectly (the overall patient population)
- Provide an opportunity for patients and families to understand what occurred and begin healing
- Enhance accountability and promote transparency
- Demonstrate to employees an organization's commitment to safety and quality
- Contribute to learning and quality improvement after the event
- Facilitate compliance with disclosure laws
- Possibly reduce undesirable media attention
- Possibly reduce litigation or create a positive overall effect on litigation outcomes

If a bad story comes out or is wrong, it is possible that your organization's public relations department may elect not to respond back to correct the story. A correction often extends the life and attention to the story, which many not be in the organization's best interest.

Patient Safety Regulations and Reporting

In addition to many of the voluntary reporting and accreditation organizations involved in quality and patient safety, several regulations are important for hospital and health system trustees to understand.

The Health Insurance Portability and Accountability Act.
The Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations and state health information laws protect the privacy of patients and staff. If violated, each HIPAA infraction can result in significant fines.

HIPAA in many cases stops the release of information. It does, however, allow for information to be released for public health purposes such as to the Centers for Disease Control or Department of Health.

Patient information cannot be accessed unless it is for a reason permitted by HIPAA, such as treatment of a patient, payment, or health care operations. You as a board member do not have the right to inquire about a friend or neighbor, or to ask other questions which would impact patient privacy.

Physicians and other clinical staff should only be allowed to access patients where they are providing care.

Patients and family members may chose to release information. In the event of an adverse event, the hospital is not allowed to release information about the patient. The patient is allowed to tell others about the event.

Department of Health or Other Government Rules.
Governmental agencies such as the Department of Health can pass rules based on legislation that grants them authority on that topic. These regulations often include quality measures that must be collected and reported. Infections and adverse events are the most frequent types of reporting rules. These rules are frequent in areas where there is legislative or public interest.

Patient and Family Engagement in Quality and Patient Safety

Patients and families are an important component in the healing process following an adverse event, as well as in the development of systems that work for patients. Data has shown that strong patient and family engagement is present in high performing hospitals, and their outcomes are better.

Key areas patient and family engagement can help include:

1. Patients from the smallest newborn to oldest adult are more likely to heal if their loved one is present.
2. Families can provide emotional support for patients who are sick and afraid. They can also ask needed questions.
3. Family members help with early identification of decline of the patient often before the clinical staff pick up through vital signs. By listening to patients and families, care providers can take early action.
4. Family members can ask key questions on committees from a patient perspective, which changes the tone of the conversation.
5. Patient and family input through a patient advisory committee helps provide insight when designing patient care areas, creating brochures for patients, establishing policies, etc.
6. Feedback from previous patients and their families can help orient new families of very sick patients, such as those in an intensive care unit.

Five Ways Patient and Family Engagement Directly Impacts Your Hospital

1. Contributes to better clinical outcomes.
2. Reduces institutional and individual costs of care.
3. Increases adherence to recommended treatment regimens, which can lead to fewer complications and re-hospitalizations.
4. Improves patient satisfaction with care coordination and other patient experience measures that impact the hospital's reimbursement rates from Medicare and other payers.
5. Enables compliance with patient engagement requirements included in Health Information Technology for Economic and Clinical Health (HITECH) Act meaningful use and patient-centered medical home payment models.

Source: American Hospital Association, Hospitals in Pursuit of Excellence. A Leadership Resource for Patient and Family Engagement Strategies. July 2013.

Some hospitals have Patient and Family Committees to support hospitals in their decision making. Information on this topic may be found in the American Hospital Association's Hospitals in Pursuit of Excellence report, entitled *A Leadership Resource for Patient and Family Engagement Strategies.*

As patients and their families who have been harmed begin to heal, they may want to become active in the hospital or health system to help ensure other patients are not harmed. Hospitals should provide an avenue for them to offer meaningful and useful input, as well as incorporate the opinions and insight of other community members passionate about local health care.

Beyond the Four Walls: Mortality, Readmissions, and Population Health

Hospitals and health systems exist to provide high quality care to their communities. Health care providers are accountable for ensuring that their communities and patients are truly benefiting from their care.

Mortality, readmissions, and population health demand integration between inpatient and outpatient services. It also requires proactively helping community members be healthy rather than waiting for illness to set in.

The public wants to know that hospitals and health systems are reducing mortality and improving the quality of life. It is expected that hospitals will prevent mortality when possible and when not, honor patient's wishes including if the desire is to remain home. Mortality is measured by all-cause mortality (not by carving out a small population to count as representation), and also may be reported by mortality from sepsis.

Some experts explain that hospital readmissions are an indication of the health care system's fragmentation and lack of coordination of care across the various health care providers and facilities. In some parts of the country, Medicare patients return to the hospital 30 percent of the time within 30 days. In the best practice areas of the U.S., the Medicare readmission rate is 10 percent. "Return to hospital" is counted regardless of cause, and regardless of which hospital the patient goes to. The public wants to know that when discharged, smooth transitions of their medical care will ensure that they get the needed, timely care to remain in their home.

Health care providers today are being called upon to prevent the illnesses most prevalent in the local community. This is called population health improvement. The impact of diabetes, high blood pressure, asthma and obesity are well-known in causing illness. Hospitals are expected to help improve the health of the population they serve to prevent the need for treatment when chronic conditions progress.

Health Care of the Future

As a board member, taking an active role in quality and safety will support your hospital and be one of the most rewarding roles. Quality and safety will play an ever increasing role in the financing, image, and ability to attract patients.

Sources and Additional Information

1. Aiken, Linda, et al. Nurse Staffing and Education and hospital Morality in Nine European Countries: A Retrospective Observational Study. *Lancet.* May 24, 2014.
2. American Hospital Association, Hospitals in Pursuit of Excellence. A Leadership Resource for Patient and Family Engagement Strategies. July 2013. www.hpoe.org/Reports-HPOE/Patient_Family_Engagement_2013.pdf
3. Patient Safety Primers. Agency for Healthcare Research and Quality. http://psnet.ahrq.gov/primer.aspx?primerID=2.
4. Oregon Patient Safety Commission. Why Should Events Be Disclosed? Oregonpatientsafety.org.