The Board’s Role in Quality and Patient Safety

Knowledge Points

- Current state of hospital safety
- The board’s role: Quality and safety are job one
- Transparency and public accountability
- Quality measurement and reporting

The Current State of Quality and Patient Safety

The Cost of Waste in Health Care

- Partnerships necessary for success with value-based payments
- Discussion points

This presentation was made possible by...

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Better Medicine • Better Lives

The Walker Company
The Cost of Medical Errors

- Deaths from medical errors exceed motor vehicle accidents, breast cancer and AIDS
- Experts:
  - Lapses in patient safety cause 200,000 deaths
  - 2.4 billion extra hospital days
  - $17-$29 billion annually


Medical Errors Have Far Reaching Impacts

- Reimbursement
- Patient Satisfaction
- Quality of Care
- Medical Errors
- Medical Staff Morale
- Employee Morale
- Quality of Care
- Medical Errors
- Medical Staff Morale
- Employee Morale

High Quality Pays

High quality providers have the potential for...

- Improved Payment
- Referrals and Contracts
- Inclusion in Networks

The Cost of Medical Errors Has Wide-Ranging Effects on Patients...

- Loss of trust in the health care system
- Diminished satisfaction
- Physical and psychological discomfort
- Lower overall health status

Source: To Err is Human: Building a Safer Health System. Institute of Medicine.

...and on Health Care Professionals

- Loss of trust in the health care system
- Declining morale and increased frustration
- Diminished job satisfaction
- Lost productivity

Source: To Err is Human: Building a Safer Health System. Institute of Medicine.

The “Triple Aim”

- Better health for the population
- Care provided at a reasonable cost
- Improved experience of care & quality

Source: Institute of healthcare Improvement’s Triple Aim.
Inadequate Systems
The Biggest Quality and Safety Problem

What can or should our hospital or health system do to support safe, high-quality care?

The System is Fragmented...
Patients see different providers for different health issues
Providers have limited access to patient information
Care is poorly coordinated amongst providers

The IOM’s 6 Aims of Care
Safe, avoid injuries to patients from care intended to help
Effective, services based on evidence for those who could benefit
Patient-Centered, care that is respectful and responsive to patient preferences, needs, values
Timely, reducing waits, harmful delays for those receiving and giving care
Efficient, avoiding waste of equipment, supplies, ideas, energy
Equitable, equal care regardless of gender, race, ethnicity, age, geography, socio-economic status

Job One
is Quality and Patient Safety
The Board's Role in Quality and Patient Safety

1.0

What does the public expect from us?

What should we be measuring?

How can we improve? What are our goals?

How good is our quality? How safe is our hospital?

What is our "culture" of quality and safety?

More Important Questions to Ask...

- Do we publicly disclose and discuss our quality and safety performance?
- What are the top safety issues for our hospital or health system?
- What is our aim for safety improvements, how quickly can we achieve our goals?
- How do we compare to organizations that score the best on safety?

More Important Questions to Ask...

- What should we hold the executive team and medical staff responsible for in improving our patients' safety?
- Is it easy and safe to report errors at our hospital? What is the process?
- How much do medical errors cost our hospital annually?
- What specific steps are we taking to address the IOM's Six Aims?

Consider This...

- Medical liability costs are driven by lawsuits
- Liability fears may cause physicians to leave practice
- Liability fears may cause physicians to practice "defensive medicine"
- Loss of consumer confidence and market share

Source: To Err is Human: Building a Safer Health System. Institute of Medicine.

Transparency and Accountability

Taking the Next Step

Is valued by the public

Reassures that nothing is hidden

Drives faster quality and patient safety improvement

Is publicized regardless of your preferences

Transparency...
The Board's Role in Quality and Patient Safety 1.0

Ranking is a Reality

Value websites (Nerd Wallet, ReferMe)

Joint Commission's Quality Check

CMS Compare websites

Health Grades

Leapfrog Group

Reporting and Measurement

Ensuring High Quality, Safe Performance

Do You Measure Up to the Best?

Measure What's Most Relevant

1. Achieving quality and safety goals
2. Quality and safety measures used in determining payments
3. Adverse events
4. Hospital Compare website measurements

Measure What's Most Relevant

5. Infection measures
6. Employee safety
7. Community health (such as diabetes, obesity)
8. Unique issues important to the hospital/health system

Understanding Preventable Errors

Adverse Event
Harm to a patient as a result of the medical care they receive

Events that should never happen in a hospital and that can almost always be prevented.

Serious Reportable Events
Serious Reportable Events

- Operating on the wrong body part or 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


Medicare's Hospital Compare

- CMS first developed Hospital Compare
- Collaborative effort with a wide variety of organizations
- New: physicians, nursing homes, dialysis facilities and home health

www.medicare.gov/hospitalcompare

Meaning Behind the Websites

- Help people make decisions
- Improve quality of care
- Hospitals are required to report (those that aren't should still use it)
- Performance used for value-based purchasing payments

Infection Reporting

- Surgical site infections
- Catheter-associated UTI
- Ventilator infections
- Central line infections
- MRSA infections
- C. Diff infections

For more information: www.cdc.gov/nhsn

Value-Based Payments

The Role of Quality
**The Value Equation**

High Quality  
+ High Patient Satisfaction  
+ Low Cost  
= VALUE

**It Can't Be Done Alone**

Employers  
The Board  
Clinicians and Staff  
Patients

**Employers**

- Champions for safety  
- Promote need for reform  
- Provide leadership

**Patients**

- Honesty and communication  
- Advocate
  - Written information  
  - Choose providers based on evidence  
  - Clear treatment plans

**Clinician and Staff Involvement**

- Everyone plays a role  
- Key elements:  
  - Accountability  
  - Education/Knowledge  
  - Evaluation  
  - Disclosure  
  - Teamwork

**The Board**

- Make quality, safety the foundation  
- On every agenda  
- Set quality and safety goals  
- Hold leadership accountable  
- Infuse quality and safety throughout board discussions
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<th>Discussion Points</th>
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<tr>
<td>Has your board committed to making quality and patient safety a distinct competitive advantage?</td>
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<td>Where is your board on the quality understanding and action continuum?</td>
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<td>What specific ideas do you have for improving your board's “quality literacy?”</td>
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<td>How sure are you that your organization-wide systems are designed to ensure optimal quality and patient safety?</td>
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<td>What initiatives should the board take to better carry out its quality and safety accountabilities?</td>
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