This presentation was made possible by...

Knowledge Points

• Making the Quality Connection in Board Discussions
• Addressing Adverse Events
• Patient Safety Regulations and Reporting
• Patient and Family Engagement
• Discussion points

Quality at the Forefront

Quality ingrained in the organizational DNA...

• Supports highest quality care
• Elevates medical staff, employee morale
• Improves patient satisfaction
• Increases reimbursement

Making the Quality Connection

• Agendas should include regular reviews of quality and patient safety reports/dashboards
• Should inform and inspire probing questions
• High performing board members ask penetrating and insightful questions
• Board sets performance goals and holds managers accountable
Connecting Quality in All Board Discussions

Agenda
- Finance
- Human resources
- Medical staff credentialing
- Physician partnerships
- Compliance

Quality and Patient Safety Implications

Embedding Quality into Finance Discussions: A Worthy Investment

Without adequate resources, consistent quality is not possible

Adequate resources needed to ensure:
- Quality and patient safety improvement
- Technology upgrades
- Ongoing education
- Employee engagement

Monitor connection between capital spending and outcomes

Embedding Quality into Finance Discussions

Consider the impact of budget cuts on quality and patient safety

Beware of Cuts

Negative quality implications impact revenue

Make the “quality connection” to costs

Embedding Quality into Compliance Discussions

Ensuring accuracy of mandated data reports

Top of agenda: new laws, regulations and identifying implications on delivery of quality care

Integrating quality into policies, operations

Embedding Quality into Human Resources Discussions

Orient new hires to quality, safety guidelines, metrics and improvement plans

Measure employee engagement, satisfaction and turnover

Part of human resources discussion and investment

Ongoing employee education, training

Quality Failures and Near Misses

Devote time on the agenda to hear first-hand

Discuss root-cause investigations

Identify preventions
The Board's Role in Quality and Patient Safety 3.0

Ask Why Quality Goals are Unmet...

- A one-time blip, or long-term issue?
- Is it a staffing failure? A process failure?
- Is it a systemic issue or isolated in one area of the hospital?
- How and when will it be resolved?
- Potential for success of the corrective action plan?

A Board Commitment to Resolving Quality Issues

- Requires a trusting partnership with the medical staff and employees
- Not involved in daily operations, but...
  - Understands the resources necessary to address challenges
  - Commitment to allocating resources and understanding their impact is critical

Quality and Safety: Addressing Adverse Events

When Things Go Wrong...

- Notify the board right away
  - Within 30 days: Investigation results and correction action plans
  - Six months later: Status report on prevention strategies

Informed Patients

- Hiding events considered unacceptable
- Patients were uninformed in the past
- Upfront honesty is expected

Transparency is Essential

- Improves patient care and ensures trustful relationships
- Communicates to all that the hospital is:
  - Accountable
  - Human
  - Strongly invested in maintaining trust

The Walker Company
Admitting Error is Not Easy, But...

- Patients and families want to know what happened
- People know when they are not told the truth
- Good relationships among provider, patient, family can preclude lawsuits
- Disclosure helps healing
- People will want to know actions to prevent reoccurrence
- Don't bill for care that harmed patients, or care resulting from harm

Goals When Addressing an Adverse Event

- Treat patients with empathy, respect
- Increase trust
- Provide an opportunity to understand and begin healing
- Enhance accountability and promote transparency


Goals When Addressing an Adverse Event

- Demonstrating a commitment to quality and safety
- Contributing to learning and quality improvement
- Compliance with disclosure laws
- Possibly reducing negative media
- Possibly reducing litigation


Media Requests

- The media may be interested in an adverse event
- Board members should not participate in interviews unless agreed upon by hospital staff

If You Speak to the Media...

1. Define the key message before the interview
2. Don't lie or stretch the truth
3. Use terms the public understands
4. Don't consider anything to be "off the record"
5. Answer the questions
6. Keep messages brief

7. Don't make up an answer
8. Reporters are not your friend, they are looking for a story
9. Reporter doesn't decide headline
10. Don't debate with the reporter
11. Take advice from PR
12. Don't interview alone
Understanding HIPAA

- Protects the privacy of patients and staff
- Violations result in significant fines
- Prevents release of information in many situations, but allows for some public health sharing

Understanding HIPAA

- Restricts access to patient information
- Board members do not have the right to be given information, or to ask questions impacting privacy
- Clinicians can only access information for patients they are caring for
- Patients can choose to release information, but the hospital cannot release information

Other Patient Safety Regulations and Reporting

- Governmental agencies may pass rules that grants them authority
- Regulations often include quality measures to be collected and reported
- Infections and adverse events are the most frequently required

Quality and Safety: Engaging the Patient and Family

Patient and Family Engagement

- Patients more likely to heal with loved one present
- Families provide patients with emotional support
- Families help with early identification of patient decline

- Families offer committees the patient’s perspective
- Patient advisory committee members provide patient insights
- Helps in orienting families of new, very sick patients
Some hospitals have Patient and Family Committees. See the AHA's Hospitals in Pursuit of Excellence: www.hpoe.org. Harmed families may want to become active at hospital to prevent harm. Hospitals should provide meaningful opportunities for input.

Maximizing Patient and Family Committees

Patient and Family Engagement is Good for the Hospital

Better clinical outcomes
Reduced costs of care
Better adherence to treatment regimens
Improved patient satisfaction
Ensures compliance with patient engagement requirements


Quality and Safety: Beyond the Four Walls

Reduced mortality and improved quality of life
Smooth transitions upon discharge and reduced readmissions
Improved health of the community, preventing need for treatment

Readmissions

Indication of a fragmented health care system
Some have rates as high as 30%
Best practice areas are as low as 10%
"Return to hospital" is counted regardless of cause or hospital
Public demands well-coordinated care that results in a positive outcome

Improving Community Health

1. Reduced mortality and improved quality of life
2. Smooth transitions upon discharge and reduced readmissions
3. Improve the health of the community, preventing need for treatment

Mortality
Readmissions
Population Health

Quality of Life and Mortality

Reducing mortality
Improving overall quality of life
Preventing mortality when possible, and honoring patient wishes

The Walker Company
Improving Population Health

Population Health Improvement: Preventing the illnesses most prevalent in the local community

Well-known causes include diabetes, high blood pressure, asthma, obesity

Hospitals are expected to improve health and prevent the need for treatment

Discussion Points

Does your board invest enough time to build board-wide quality literacy?

What measures does your board review in its oversight of quality and safety performance and improvement?

How does your organization identify the potential for adverse events?

How would you describe your approach to patient and family engagement?

Is time devoted at every board meeting to hear about quality failures?

Does your board discuss root cause investigations of events?

What processes are in place for reporting quality concerns and errors?

When concerns are identified, what steps are taken?

Governance Accountabilities and Opportunities in the

The Board’s Role in Quality and Patient Safety 3.0