Texas Healthcare Trustees

TRUSTEE GUIDEBOOK

INSPIRING EXCELLENCE IN HEALTH CARE GOVERNANCE™

QUALITY AND PATIENT SAFETY

Texas Healthcare Trustees
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TrusteeGuidebook

Inspiring Excellence in Health Care Governance

Quality and Patient Safety

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A special thank you is owed to those who helped create the newest edition of the *Trustee Guidebook: Quality and Patient Safety*. It is with their knowledge and expertise that this resource was produced to help hospital governance leaders effectively carry out their fiduciary duties and provide better care for the public.

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Texas Healthcare Trustees

The Texas Health care Trustees provides education, resources and leadership development to inspire excellence in health care governance. THT is dedicated to keeping health care leaders informed on best governance practices, staying apprised of the continually transforming health care environment and producing innovative resources to help boards govern efficiently and effectively. Created in 1961, THT is the oldest organization of its kind in the country and is an affiliate of the Texas Hospital Association.

Texas Hospital Association Foundation

Support for this resource was provided by the Texas Hospital Association Foundation. Established in 1964, THAF has been at the forefront of providing hospitals and their staff with tools, resources and education on quality and patient safety. As THA's 501(c)3 arm, THAF's mission is to transform health care through education, collaboration and research. THAF brings together hospital leaders, providers, physicians, clinics and others to improve the quality of care for patients and their families and to help find solutions to universal challenges faced by health professionals.

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Quality and Patient Safety

Ensuring quality and patient safety is integral to maintaining the viability of any hospital or health system. In fact, it is fundamentally connected to patients' primary expectations that the hospital will not unintentionally harm them while they are in its care.

It is crucial to understand the leadership role that hospital board members play in overseeing and ensuring quality and patient safety in their organization. In the governance hierarchy, the hospital's chief executive officer is directly accountable to the board for quality and patient safety, and the board is responsible for monitoring the CEO's performance. The board also helps establish priorities for the organization and ensures appropriate resource allocation for quality and patient safety work.

Effective oversight by the governing board is fundamental to achieving the highest standards of care. In order to provide that oversight, a clear understanding of what quality and patient safety means in the organization is needed.

Defining Quality

In today's hospitals, the focus on providing the highest level of care and preventing errors is so deep-rooted that the phrase "quality and patient safety" has become almost a mantra. But what does it actually mean?

Quality and patient safety mean different things to different people. For instance, patients usually say it involves exceptional care or service, positive outcomes and reasonable costs. Physicians and other providers tend to think of it in terms of good clinical outcomes. A hospital's operations personnel see it through a still different lens and may regard it as good clinical outcomes, low costs, efficiency and improved operational performance. Despite the varying interpretation, hospitals are best served by a clear understanding and unified vision around quality and patient safety, so goals can be established.

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The Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (NAM), formerly known as the Institute of Medicine (IOM) , defines “quality” as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

The Current Landscape

Hospitals began to focus sharply on quality and patient safety in 1999, after the publication of the IOM’s landmark report, “To Err Is Human: Building a Safer Health System.” The first in the series of reports on the quality of health care in the United States, its publication quite possibly marked the beginning of the modern field of patient safety. Its impact was so important that, today, references to “the IOM report” are immediately understood in the medical field.

The report stated that as many as 98,000 people die in hospitals each year as a result of preventable medical errors, and some studies estimate the number is much higher. Twenty-two percent of Americans report that a medical error has impacted either them or a family member. Nationally, that translates into 22.8 million people who have experienced a mistake in a doctor’s office or hospital.

There are substantial repercussions for health care for health care organizations for these errors. Preventable medical errors and complications can lead to declining patient satisfaction scores that damage a hospital’s reputation, lower employee morale and, ultimately, reduce business. The financial consequences can be devastating. According to a 2010 report by the Healthcare Financial Management Association (HFMA), “The Human and Economic Costs of Medical Errors,” the cost of medical errors in the United States in 2008 was $19.5 billion. About $17 billion or 87 percent of this amount was directly associated with added medical costs – inpatient care, ancillary services, prescription drug services and outpatient care.

Twenty-two percent of Americans report that a medical error has impacted them or a family member.

How Do Errors Occur?

The National Academies defines "safety"as freedom from accidental injury" and "error" as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim."

Errors are caused by two kinds of failures: (a) either the correct action does not occur, as intended (an error of expectation); or (b) the original intended action is not correct (an error of planning). Errors can happen in all stages in the process of care, from prevention and diagnosis to treatment and follow-up care. Medical errors do not typically occur because of bad people, but are more often due to system failures, human errors, breakdowns in communication and coordination of care and/or drift from best practices.

Government and Payers Respond by Changing the System

Soon after the momentous IOM report was published, the federal government and the private sector began to use the leverage available to them to reduce medical errors and improve patient safety. Increasingly, reimbursement is being linked to patient outcomes and satisfaction. One data source commonly used to measure outcomes is the standardized Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey, which measures patients' perspectives of hospital care. The Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare and Medicaid Programs along with the Children's Health Insurance Program (CHIP), uses HCAHPS surveys as a measure of quality and have tied Medicare reimbursement to patient feedback collected through this survey.

Medicare Value-Based Purchasing and Pay-for-Performance

Historically, Medicare has reimbursed hospitals on a fee-for-service basis, directly

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paying them for each service they provide. The issue with this model is that it rewards volume, regardless of patient outcomes. Over the past few years, both private and public payers have begun shifting the way they reimburse hospitals toward value-based purchasing that links payments to better and/or less-costly care, rather than to the volume of services provided.

One form of value-based purchasing that is gaining ground is the pay-for-performance (PFP) model, which strives to positively impact health care quality by financially rewarding hospitals that achieve or exceed specified quality benchmarks and targets. Characteristics of PFP programs include mandatory reporting, public access to performance data, cost containment, and the use of evidence-based performance measures relating to clinical process of care, patient experience of care, and outcome and efficiency.

Medicare's Hospital Value-Based Purchasing (VBP) Program implemented a pay-for-performance approach to the purchasing system that represents the largest share of Medicare spending. Based on a defined set of measures, the VBP program adjusts a portion of payments to hospitals based on either (a) how well they perform on each measure, compared with all other hospitals, or (b) how much they improve their own performance on each measure, compared with their performance on the same measure during a previous baseline period. The VBP program is designed to promote better clinical outcomes for hospitalized patients and improve their care experience during hospital stays.

Given CMS' experience with its quality programs, certain large commercial payers are incorporating the concepts of value-based reimbursement incentives in their provider contracts.

Critical-Access and Specialty Hospitals

The VBP Program excludes critical access hospitals (CAH) and specialty hospitals such as psychiatric rehabilitation, long-term care, children's hospitals and cancer hospitals. CMS could implement special requirements for these hospitals in future regulations. However, most CAHs and rural hospitals do not have the volume of patients to accurately calculate a reliable performance, which is why measurement in current CMS programs presents a challenge. Currently, those that do not meet the minimal volume requirements will not be rewarded or penalized financially.

Medicaid Value-Based Purchasing

Medicaid and the CHIP are also moving away from reimbursing providers based

on volume to a system where payments are based on quality and efficiency. Texas' Medicaid and CHIP programs make value-based payments to managed care organizations (MCO) and health care providers, including hospitals.

In Texas, Medicaid and CHIP payments to hospitals are adjusted based on the facility's performance on two distinct measures: potentially preventable readmissions (PPR) and potentially preventable complications (PPC). A PPR is a return hospital admission within a set time period that may have resulted from problems in care during a previous hospitalization or follow-up. A PPC is a harmful event or negative outcome, such as an infection or a surgical complication that occurs after a hospital admission and might have resulted from care or lack of care or treatment during the admission.

Medicaid and CHIP payments for inpatient hospitalizations may be reduced for hospitals with high PPR and PPC rates. Alternatively, safety net hospitals – which care for Medicaid and low-income, uninsured patients – may receive incentive payments from Medicaid or CHIP for achieving low PPR and low PPC rates.

Medicaid and CHIP services are delivered primarily through MCO. The Texas Health and Human Services Commission (HHSC) contracts with state-licensed MCOs and pays them a monthly amount to coordinate health services for the Medicaid or CHIP members enrolled in their health plan. The MCO health plans contract directly with hospitals and other health care providers to create provider networks. They are required to provide all covered medically necessary services to MCO members.

HHSC promotes VBP through its contracts with Medicaid and CHIP MCOs. Moving forward, MCOs can lose part of their premium payments or receive additional payments based on their performance on quality measures. MCOs must also implement VBP with contracting health care providers to advance quality care.

Given CMS' experience with its quality programs, certain large commercial payers are incorporating the concepts of value-based reimbursement incentives in their provider contracts.

The Board's Role in Quality and Patient Safety

In the new era of focus on quality and patient safety, the hospital or health care system governing board's oversight is a clearly recognized core responsibility. Indeed, it is central to everything the board does. The board has moral, legal and fiduciary responsibilities to monitor, evaluate and continuously improve the quality of patient care and services provided. Increasingly, boards are subject to regulatory and accreditation accountability.

In the governance hierarchy, the hospital's CEO is directly accountable to the board for quality and patient safety, and the board is responsible for monitoring the CEO's performance. To effectively fulfill this responsibility, trustees must understand that promoting quality care and preserving patient safety are essential to the hospital's reputation.

Legal Obligation to Provide Safe Care

The hospital governing board has a legal obligation to ensure medical care is safe and quality standards are met. One of the board's most significant duties is approving appointments to the medical staff, and physician credentialing is an important step in the approval process. While the board may delegate this responsibility to a medical staff committee, ultimately, the board is accountable for the competency of the hospital's medical staff. Board members need to fully understand the process the medical staff uses to make final recommendations for clinical privileges and should ensure appropriate physician information is collected, validated and evaluated.

Federal courts have ruled that the governing board is responsible if a hospital is not delivering quality care. If the board knew or should have known about substandard care while the organization continued to submit claims to CMS (and other payers), then the leadership – including its board members – can

The board has moral, legal and fiduciary responsibilities to monitor, evaluate and continuously improve the quality of patient care and services provided.

be considered to have committed “quality fraud.” CMS has even withdrawn a hospital’s ability to participate in the Medicare program for violations of various Medicare Conditions of Participation related to quality, including governing body oversight.

Furthermore, the federal Office of the Inspector General (OIG) and the U.S. Department of Justice (DOJ) have increased their interest in and surveillance of quality and patient safety. Because quality is linked to reimbursement for Medicare and Medicaid, the government wants to be sure patients receive the quality of care for which they pay. It may view poor quality care as a “false claim” and inaccurate reporting of quality data as potential fraud. Courts have interpreted the board’s “duty of care” to include a degree of due diligence that requires the board to make “reasonable inquiry” into the hospital’s operations and performance. According to “Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors,” published in 2017 by the OIG and the American Health Lawyers Association, the OIG expects the board to provide general supervision and oversee quality and patient safety.

Widely recognized and public compliance resources are available as benchmarks for hospitals. The OIG’s voluntary compliance program guidance documents and OIG Corporate Integrity Agreements can be used as baseline assessment tools in determining specific functions necessary to meet the requirements of an effective compliance program, and whether the program’s scope is adequate for the size and complexity of the organization.

The hospital governing board is also responsible for ensuring the organization’s leadership and staff submits an annual quality improvement plan; the board generally reviews and approves the plan. The purpose of a quality improvement plan is to provide a framework for a collaboratively planned, systematic and organization-wide approach to improving patient care and organizational performance. The quality improvement plan is a valuable tool in tracking the hospital’s performance in a selection of high-priority areas, including patient safety, timely access to effective care, infection control, quality and emergency management.

Ultimately, the board is accountable for the competency of the hospital’s medical staff.

Regardless of the model used, the hospital should take a systems approach to improving quality and patient safety by engaging employees in all levels of the organization.

Create a Culture of Safety

An organization's culture is comprised of the beliefs and patterns of behavior that become its norms. Boards play an important role in setting the tone and establishing the culture of an organization as culture often originates from the top. The concept of a "culture of safety" originated outside of health care in studies of high-reliability organizations (HRO).

Health care is similar to many other industries – such as nuclear power plants, airlines and chemical manufacturers – in that it is highly complex and error-prone. High-reliability organizations maintain a commitment to safety at all levels, from frontline providers to managers and executives. For this reason, health care has begun to look to these industries for approaches to reducing errors, and some hospitals/systems are moving to the HRO model to provide patient safety.

Many boards work to create a culture of safety for the organization by first defining exactly what that means. The critical characteristics of a culture of safety may include:

Commitment to leadership. It is a priority to involve the governing board, as well as the hospital's clinical and non-clinical leadership, in continuous efforts to improve patient safety and reduce medical errors. A focus on quality and patient safety is aligned throughout the organization, from the boardroom to the front lines of delivering care.

Open communication. A blame-free environment exists where individuals are free to report errors or near misses — unintended events that could have led to an adverse event but didn't — without fear of reprimand or punishment. Collaboration is encouraged across ranks and disciplines to seek solutions to patient-safety issues and the reporting of those issues. The hospital's leadership

An organization's culture is comprised of the beliefs and patterns of behavior that become its norms.

encourages employees to report errors, near misses and other opportunities to improve safety and patient care. This requires a high level of trust among employees.

Continuous learning. Learning is valued among all staff and leadership. The hospital learns from its mistakes and seeks new opportunities for performance improvement.

Accountability. A culture of safety recognizes errors as system failures, rather than as individual failures, but individuals are also held accountable for their actions.

Patient-centered. Staff and leadership are committed to patient-centered care as a core value. Patient-centered care means patients are respected, continually informed and listened to. A patient-centered hospital empowers patients, family and friends to actively participate in care decisions.

Use of data. Data about errors and near misses are collected and analyzed on an ongoing basis, and are used to evaluate processes and identify areas for improvement. This analysis may focus on systems thinking – understanding a system by examining the linkages and interactions between the system's components – as well as human factors. The analyses of data collected are shared, fostering participation and further demonstrating that the goal is improvement, not blame.

Teamwork. The hospital's leadership encourages caregivers to work collaboratively. They ensure team training and team building activities are ongoing. Further, they empower each member of the team to identify and/or act to prevent potential errors.

Evidence-based. Patient care practices are based on evidence. Standardization to reduce variation occurs at every opportunity. Processes are designed to achieve high reliability.

Members of the governing board should be familiar with national trends and understand fundamentals such as how to read a quality dashboard and what questions to ask about improvement initiatives.

Responsibilities for Quality and Patient Safety

Often there is interaction between the board and medical staff on quality and patient safety strategy, and the board receives patient safety and quality measurement reports on a recurring basis.

In order to properly interpret these reports, board members should understand the infrastructure of patient safety and quality in their organization, along with current performance measures. This may include awareness of what data reporting is required, the process and/or technology systems in place, how data is collected, why it's collected and what's done with it. The types of information board members need to understand include: connections among regulatory bodies and their roles in monitoring quality and patient safety, how the hospital ensures employees and medical staff are accountable for quality and patient safety, the content of reports discussed in board meetings, and how the hospital or health system works to achieve clinical excellence. Members of the governing board should be familiar with national trends and understand fundamentals such as how to read a quality dashboard and what questions to ask about improvement initiatives.

As hospitals and systems track their own progress it is helpful to seek information about the best performers in the hospital industry to benchmark against. By doing so, health care leaders begin to explore what successful organizations are doing differently. Reading selected articles and educational materials, as well as attending conferences, will contribute greatly to a member's breadth and depth of knowledge.

In addition to measuring and monitoring the hospital's effectiveness, many boards evaluate their own effectiveness on priority areas as a part of the board's regular self-assessment process. Board composition is often reviewed periodically to determine if certain expertise is needed in quality and patient safety. If so, this becomes part of the criteria used in selecting new board members.

Quality and patient safety can be central to a hospital's short-term and long-term strategies, which the board helps establish.

The Link to Quality and Patient Safety and Strategic Planning

The governing board of a hospital or health system is important to an organization's strategic planning process. A strategic planning process can be used to position the hospital or health system in a rapidly changing environment, identify core areas of focus for an organization, and determine what the organization wants to be in the future and how it will get there.

Quality and patient safety can be central to a hospital's short-term and long-term strategies, which the board helps establish. Additionally, the board may integrate quality and patient safety priorities and goals with their fiduciary responsibilities. For example, the budget and use of financial resources should align with achieving quality and patient safety goals.

Aim High: Goals for Quality and Patient Safety

In order to appropriately and effectively track progress, well-run boards establish clear goals. Hospitals should be encouraged to pursue the highest benchmarks set by best performers, rather than aim solely to meet national averages.

Goals around quality and patient safety need to be specific and measurable. For example, "Our hospital will reduce central line- and catheter-associated infections by 50 percent within 12 months" is specific, measurable and sets a finite time within which the goal must be accomplished.

Hospitals and health care systems aren't alone in their quality and patient safety work. The substantial focus in these areas has led to availability of funding for national and state quality and patient safety programs. Hospitals and systems might consider participating in national quality improvement activities if these activities align with mutual priorities. These programs are often free and, more importantly, they may provide valuable, otherwise unavailable comparative data.

Measure Progress

Identifying indicators and measuring progress are key components to effective oversight. A quality indicator is a measure of an important aspect of the quality of care or the quality of services. It is not itself a direct measure of quality, but acts as a screening tool or reference point to monitor, evaluate and improve care. Quality indicators may be reported as rates or occurrences and are tracked over time to reveal trends or patterns.

Measures help boards prioritize areas of importance and identify opportunities for improvement. It is not necessary for the board to receive reports on all quality indicators monitored throughout the hospital. Instead, the board should receive a broad, representative sample of indicators that address hospital performance, including identified opportunities for improvement. There should be a rationale for selecting the measures presented to the board and the board should understand why certain measures were selected as well as what it will do with the information selected.

Board members need accurate information and materials to enhance their discussions about quality and help prioritize areas of importance. The hospital staff should provide regular reporting to aid board members in these discussions. The reports should utilize easily understood data visualization methods that distill performance data in several key areas into a few succinct metrics, providing boards with easily interpreted, concise "snapshots" of what is typically a complex subject. These snapshots can provide insight into how the organization is doing on its goals and help identify areas of improvement and success.

The hospital staff may also provide the board with updates on quality improvement and patient safety plans and activities. These reports could include information about quality trends and improvement, these reports could include information about quality trends and improvements and be provided on at least a quarterly basis. Discussions of the activities included in performance efforts should take place, but the board does not need to know the specific details of these activities. Periodically, board members should evaluate the information the hospital's management team provides about quality and patient safety issues. They might want to consider the types of information being shared, how it is being shared and whether changes are needed.

There is no magic solution to improving outcomes; quality is related to consistency in performance and delivering the right care, based on scientific evidence. Quality and patient safety should be on each board meeting agenda. This demonstrates the board's commitment to improvement and accountability.

Measures help boards prioritize areas of importance and identify opportunities for improvement.

Written reports may be supplemented with visuals to help evaluate performance and measure improvement. Sustained improvement requires a continuous focus on enhancing care delivery and improvement; constant performance monitoring; collecting and analyzing data; and providing feedback about quality, outcomes and costs.

Governance Structures: Quality Committees

High-performing boards engage with management on substantive and strategic issues that make a real difference in the organization's ability to achieve its mission and vision. One way to do this is through the prudent use of committees. One of the most important is the quality committee, whose purpose is to recommend and oversee achievement of quality aims.

Typically a charter or statement for the quality committee is established that clearly defines the committee's authority, responsibilities, composition and leadership, and assigns a board member to chair the committee to ensure sufficient connection to the rest of the board. The makeup of a quality committee varies among organizations, although a current trend is to include a patient or family representative in its membership to broaden the committee's perspective.

The patient/family member's perspective is important to the work of the quality committee and the governing board. Understanding what patients value is key to knowing where to focus quality improvement efforts and, just as importantly, how to bring about improvement or judge whether it has been achieved. The board may even want to consider including a patient story in the quality section of its agenda to humanize the data, making it more rational, emotional and impactful.

Accountability

Accountability is a key component in ensuring the work gets done and progress is made. The hospital governing board must hold the CEO and leadership accountable for implementing quality and patient-safety strategies, reporting and

The makeup of a quality committee varies among organizations, although a current trend is to include a patient or family representative in its membership to broaden the committee's perspective.

compliance. There are many mechanisms for accountability. One current trend is to tie part of the CEO's compensation or bonus to the hospital's quality of care and patient-safety performance. The board can adopt annual incentive programs that reward executives for achieving year-end goals. Some large health systems also have long-term incentive programs that encourage leaders to achieve targets over multi-year periods.

The board is responsible for ensuring its hospital complies with all licensing and regulatory requirements. A critical element of effective oversight is the process of asking the right questions of management to determine the adequacy and effectiveness of the organization's compliance program, as well as the performance of those who develop and execute that program, and to make compliance a responsibility for all levels of management.

A board must make inquiries to ensure (1) a reporting system exists within the hospital and (2) the system is adequate to assure the board that appropriate information will come to its attention. Once identified issues are brought to its attention, the board must require that they be addressed within an acceptable timeframe.

The hospital board should be aware of external evaluations, such as reports from an accreditation organization, patient satisfaction surveys, National Quality Forum reports, state investigations, etc. Results of surveys highlighting major recommendations and any areas of non-compliance should be shared. If necessary, a plan for corrective action can be developed by the hospital and medical staff. The plan should include an implementation schedule, and should detail how effectiveness of the plan will be evaluated. The CMS and some accrediting organizations require the hospital to review the entire performance improvement program at least annually. Following this review, the plan for the new year must be submitted to the board for its approval and recommendations.

Accrediting Organizations

To receive reimbursement from CMS, a hospital must comply with CMS's

The hospital governing board must hold the CEO and leadership accountable for implementing quality and patient-safety strategies, reporting and compliance.

Conditions of Participation. While states conduct surveys to assess and certify compliance, accreditation organizations that meet Medicare's requirements are allowed to conduct private surveys to determine whether hospitals are compliant with CMS regulations, as well as the accrediting organization's standards. Private survey organizations that are CMS-approved are granted "deeming authority."

The Joint Commission was the primary accreditation organization in the United States until 2008, when DNV GL Healthcare was approved by CMS and granted deeming authority. The American Osteopathic Association's Healthcare Facilities Accreditation Program also offers accreditation and has deeming authority for Medicare. The newest CMS-approved accrediting organization is the Center for Improvement in Healthcare Quality. Hospitals that are both accredited and Medicare-certified must meet both the accrediting organization's standards and the regulatory requirements of Medicare. Surveys by accrediting organizations are unannounced. The board may be involved in the survey process and may be present at determined times during the survey itself.

It is important for the board to understand the CMS Conditions of Participation and how they apply to governance, as well as the significance of Medicare certification. Because most hospitals pursue accreditation to verify their compliance with Medicare requirements, it's helpful to board members to understand the standards of their hospital's accreditation organization.

Improving Quality and Patient Safety

A meaningful hospital performance-improvement and safety-management program is planned, systematic, continuous and covers the entire organization. It focuses on outcomes of treatment, care and services, uses objective measures of quality with predetermined indicators, performance expectations or clinical outcomes and sets goals, targets and benchmarks. The program ensures appropriate follow-up, integrates across department lines and among different quality functions. And it involves staff, providers, patients and families and monitors performance to make sure improvements are maintained.

Partner with Medical Staff

While the medical staff and the board share the common goal of delivering patient quality care as safely as possible, it may be difficult to achieve a shared vision for quality improvement; competing agendas, regulatory pressures,

economic stress and ineffective leadership may create barriers. Yet, the board must forge an effective working partnership with hospital leadership and medical staff to ensure the hospital's quality and patient safety improvement plan is successful.

Forging a close bond between physicians and hospital administration to improve quality results is imperative. With their orders, physicians drive almost everything hospitals do. Because hospital boards will increasingly be held responsible for the results they achieve, solid clinical collaborations with physicians are crucial.

Keeping physicians focused on the board's goals of improving quality and patient safety helps find common ground. Further, physicians should play a major role in developing and implementing quality and patient-safety improvement plans. To accomplish this, hospitals must communicate effectively with physicians about their clinical practice. Micromanagement must be avoided, and trustees should not overstep their bounds in trying to manage the work of the medical staff; that is up to the CEO. However, the medical staff and leadership need to work collaboratively to improve the quality of care.

The Expanding Role of Data and Information Technology

While technology is not a panacea, it can play an important role in improving health care delivery, outcomes and safety. The board should encourage the development of a comprehensive health information technology plan that provides an integrated approach to interoperability. This IT plan may lead to the implementation of electronic health records and other applications to promote safety and tracking of quality data. The plan should, of course, address the financial needs associated with technology requirements, and the board should allocate those funds as necessary.

An effective IT system helps hospitals improve quality and patient safety in numerous ways. It automates order entry, reduces paperwork, supports clinical

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decision-making, and cuts down on duplicative testing and adverse drug events. Providing ready access to evidence-based protocols improves outcomes and helps improve standardization of care, while allowing treatment to be tailored to a patient's individual needs.

Along with emerging technology comes an increased need for enhanced cybersecurity to protect the sensitive information collected in hospitals and health care systems. More and more health care organizations are in the news as being subject to cyberattacks, which can have an impact on millions of Americans. As part of the IT plan, organizations need to be aware of the risk and vulnerabilities, and need to ensure the organization has a response plan in place should something happen.

Engaging Patients and Families

The role of patients and their families in quality and patient safety is critical. While research shows patients are becoming more proactive about their health care, more collaboration between patients, their families and providers is needed. Hospitals must work to ensure that patients have the information they need to make sound health care decisions, patients must provide hospitals complete information about their health status and background, and all must work together to overcome health care disparities. Patient experiences and outcomes can be vastly improved through this type of collaboration.

Patients' Evolving Role in Quality and Patient Safety

Patients and families are encouraged to take a more active role in their health care treatment and delivery. Involving patients and their families helps them achieve their goals, while preserving their dignity and respecting their values.

The following are some of the ways patients and families can help achieve patient safety:

While research shows patients are becoming more proactive about their health care, more collaboration between patients, their families and providers is needed.

- Telling doctors about the medications they take, including all over-the-counter products.
- Asking for and reading written information about potential medication side effects.
- Learning about their condition.
- Advocating for themselves or bringing a friend to function as an advocate.
- Ensuring they receive a written discharge treatment plan that is understandable.

Clinicians have the opportunity to increase patient and family members' knowledge and skills while they are in the hospital. Having policies in place that welcome families into the hospital setting encourages family members to participate in their loved one's care and discharge planning.

Discharge planning aims to reduce the hospital length of stay, prevent unplanned readmissions and improve the coordination of services following discharge. Discharge planning should begin well before the patient is actually discharged. Evidence suggests hospital discharge planning is more effective when there is interdisciplinary communication, open communication between health care workers and family, family education and ongoing support after discharge.

Another way to incorporate patients and families into improving quality and patient safety is through advisory councils, which seek to integrate the perspectives of patients and families into care delivery and the health care environment. Including patients on quality councils or committees orients the board and hospital staff to the patient's point of view. Both forms of patient involvement are excellent ways to help hospital leaders enhance services and programs. They allow for diverse opinions and perceptions, shared insights, and ideas to help strengthen the organization's ability to provide unmatched patient experiences. Engaging with patients and their families in these ways helps them learn from experts, gain a better understanding of health care and be engaged in meaningful change. Patients and their families are often a valuable resource for identifying ways to improve care and communication.

Patients and Families Can Educate Hospital Staff

Hearing a patient's story about a hospitalization first-hand can be a powerful teaching experience. The patient's perspective may be very different from the health care provider's, and hearing a different point of view may help hospital

staff members understand where better communication or explanations are needed or where opportunities for improvement exist.

Former patients also may participate in "simulation-based" training for clinicians and staff. There is nothing like real experience to make the training relevant. Role-playing may help physicians and medical students learn how to explain more effectively when a medical error has occurred.

Health Literacy

Health literacy is the degree to which an individual has the capacity to obtain, process and understand basic health information needed to make appropriate health decisions. Nearly half of all adults have difficulty understanding and acting upon health information. Persons with low health literacy are less likely to adhere to treatment recommendations, and more likely to have poor health, high rates of health care utilization, high rates of mortality and low use of screening and vaccination programs.

Health information can overwhelm even people with advanced literacy skills. Health care is full of jargon and acronyms that are confusing or even meaningless to a non-health care professional. Hospitals and physicians need to communicate in language that is clear and understandable to laypeople. Discharge instructions should be stated in plain language, and should be provided both verbally and in written format.

With the diversity of races and ethnicities in the United States, health care providers must be prepared to communicate in different languages and should be culturally sensitive. Ask patients to review translations to ensure materials are understandable and useful to patients with non-English-language preferences. This interaction helps ensure the meaning is not changed in the translation.

It also is important that information be available in formats that are accessible, usable and understandable for patients, regardless of their level of literacy. Redundancy in communications is prudent because some patients may

Hearing a patient's story about a hospitalization first-hand can be a powerful teaching experience as it may be very different from the health care provider's perspective.

not access social media or have internet service. Some people are visual learners, while others prefer detailed written instructions.

Addressing Health Disparities

Health disparities are inequalities that exist when members of certain population groups do not benefit from the same health status as other groups. They can arise from:

- Differences in quality of care received in the health care system.
- Differences in access to health care, including preventative and curative services.
- Differences in life opportunities, exposures and stresses that result in varying underlying health statuses.

The causes of health disparities can include race, gender, ethnicity, language preference, disability status, gender identity, sexual orientation, veteran status and socioeconomic factors. For example, studies have shown that racial and ethnic minorities are more likely to experience medical errors, adverse outcomes, longer lengths of stay and avoidable readmissions. Racial and ethnic minorities are also less likely to receive evidence-based care for certain conditions.

As hospitals work to achieve health equity – the highest level of health for all people – eliminating health disparities is an important strategy in achieving that goal.

Trustee Education and Leading the Charge

If board members are to answer the challenge of achieving better, safer care and hold the hospital's leadership fully accountable for quality and patient safety, they must fully understand the terms and concepts discussed in the board setting. Board members must carefully review and absorb the data presented in reports, and ask appropriate questions.

Beyond orientation, board members need ongoing education to stay abreast of new developments and trends in today's rapidly changing hospital environment. Education keeps board members – those with quality-related backgrounds, as well as those without – up to date on new quality requirements and improvement knowledge.

The hospital governing board sets the tone for the rest of the organization. They must take the lead in creating a culture of safety and set annual quality

and patient safety goals. Board members represent the community and every individual in it who may one day become a patient in the hospital and depend on the provision of safe, high-quality care.

Hospital and system governing boards should make quality and patient safety a primary focus for the hospital and hold the CEO accountable for making improvements.

Improving quality and enhancing patient safety is a constant activity and the job of everyone in a hospital or health care organization. For the governing board, it is Job One: The board must be persistently vigilant in its oversight and should lead initiatives to continuously improve performance and patient outcomes.

Discussion Questions

1. What is the hospital's current level of performance in terms of quality and patient safety? What do trend data show? How does the hospital compare to other similar facilities? Is there a plan to address identified issues/concerns?

2. Does the board look at the best performers as well as comparable facilities?

3. How would you describe the culture of the organization? Does the hospital have a culture of safety? If so, how can it be enhanced? If not, what are the barriers that must be removed to create a culture of safety?

4. How much do medical errors cost the hospital annually?

5. How engaged is the board in quality/patient safety improvement? Does the board have meaningful discussions about these issues, based on data provided at each board meeting? Do board members participate in external educational programs about quality and patient safety?

6. How could the board's oversight of quality/patient safety issues be improved?

7. Are the dashboards and other reports provided to the board understandable and helpful? Is the board receiving all the appropriate information? How could data be presented more effectively?

8. Does the board review accreditation and other external reports?

9. Is the hospital's medical staff credentialing process rigorous? Is it followed for each and every physician upon initial application and renewal? Is the hospital's peer review process effective?

10. How does the board hold management accountable for quality and patient safety improvement? Are there ways to enhance accountability? Does the hospital encourage reporting of errors, including "near misses"? How are the hospital's quality assessment and improvement processes integrated into overall corporate compliance policies and operations? Do operational policies support clinical quality standards?

11. Does the board establish annual goals for quality and patient safety? Are the goals specific and measurable?

12. How transparent is the hospital with its performance data? How could transparency be enhanced?

13. Is the board allocating adequate resources for quality improvement projects and investing in tools that will enhance quality and patient safety? What additional tools or support are needed?

14. Does the board involve patients and their families in discussions about quality and safety? Do board members talk about quality and safety issues in terms of real people, and not just numbers?

Commonly Used Quality and Patient Safety Terms

Accreditation - An independent assessment and review process of a health care organization to demonstrate the organization's compliance in meeting specific criteria or nationally held standards. Accreditation agencies include The Joint Commission, the National Committee for Quality Assurance and DNV GL Healthcare.

Acute Care - A level of care given to treat an individual's physical or mental condition, usually requiring immediate intervention and constant medical attention, equipment and personnel.

Admission - Formal process allowing entry of a patient into a hospital or other health care setting for the purpose of providing treatment.

Admitting Privileges - Permission granted to a physician (M.D./D.O.), dentist or podiatrist to admit patients to a particular hospital or health care facility for the provision of diagnostic services or treatment.

Adverse Event - An undesirable medical occurrence resulting in unintended physical or psychological harm to the patient caused by an act of commission or omission, rather than by the underlying disease or condition of the patient. This term is associated with the phrase "never events."

Antibiotic Stewardship - A practice that optimizes the dose and duration of antimicrobial therapy with the intent of creating the best clinical outcome while minimizing adverse events associated with antibiotic use and preventing the development of antimicrobial resistance.

Average Length of Stay (ALOS) - Refers to the average number of days that patients spend in a hospital. Calculated by dividing the sum of inpatient days by the number of admissions and discharges during a specified period of time.

Blood Stream Infection - A common quality metric, a bloodstream infection occurs when bacteria enter the bloodstream through a wound or infection, or through a surgical procedure or injection.

Clostridium difficile (C. Diff) - The toxin-producing bacteria clostridium difficile that can result from cross-contamination in care settings; those most at risk are older adults who take antibiotics.

Catastrophic Illness - A severe illness, typically considered life-threatening, that requires extensive treatment and hospitalization.

Catheter-Associated Urinary Tract Infection (CAUTI) - An infection that occurs when bacteria enters the urinary tract through a urinary catheter.

Central Line-Associated Bloodstream Infection (CLABSI) - An infection that occurs when bacteria enters the bloodstream through a central venous catheter, also known as a central line.

Clinical Quality Measure (CQM) - A tool that helps assess and track the quality of health care services and providers. CQMs evaluate various aspects of patient care, including health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagement, population and public health, and clinical guidelines.

Comorbidities - One or more conditions or diseases co-occurring with a primary disease or disorder.

Credentialing and Privileging - Process by which a hospital obtains, verifies

and assesses the qualifications of a practitioner and determines the scope of practice for him or her to provide services in the hospital. Credentials are documented evidence of licensure, education, relevant training and experience, or other qualifications. The criteria for granting privileges is determined by the hospital, is specific to that facility, and is based on credentials, practice history and performance.

Diagnostic Error - A failure in the diagnostic processes that includes misdiagnosis or delayed or missed diagnoses.

Health Disparities - Inequalities that exist when members of certain population groups do not benefit from the same health status as other groups

Hospital-Acquired Condition (HAC) or Infection (HAI) - A preventable medical problem or infection not present on admission that arose during a stay in a facility. CMS' Medicare and Medicaid programs may refuse payment for treatment related to a hospital-acquired infection/condition.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey - A patient satisfaction survey required by CMS for all hospitals in the United States The survey is for adult inpatients, excluding psychiatric patients, and provides the patient perspective of hospital care given.

Hospital Inpatient Quality Reporting Program - In addition to giving hospitals a financial incentive to report the quality of their services, the hospital reporting program provides CMS with data to help consumers make more informed decisions about their health care.

Incident Report - A written report that documents a problem, occurrence or situation for which follow-up action is indicated. Examples include falls, accidental needle sticks and errors. The purpose of the report is to document the exact details of the occurrence while they are fresh in the minds of those who are involved or witness the event.

Medical Error - A preventable adverse event that may or may not be evident or harmful to the patient. These can occur in diagnosis, treatment, preventative monitoring or lab reports or through the use of medical equipment.

Medicare - Federal program under Title XVIII of the Social Security Act that provides hospital and medical coverage to people 65 and over and to certain disabled individuals regardless of age. It has four parts: Part A covers inpatient costs (hospital insurance); Part B covers outpatient costs (medical insurance); Part

C is the Medicare Advantage Program that provides managed care benefits for Part A and Part B; and Part D covers prescription drugs.

Methicillin-Resistant Staphylococcus Aureus (MRSA) - A staph bacteria resistant to many antibiotics. In a medical facility, this can cause life-threatening infections. It is usually caused by contact with an infected wound or contaminated hands/devices.

Morbidity - Incidence and severity of illness or disease in a defined population.

Mortality - Incidence of death in a defined population.

Multi-Drug Resistant Organisms (MDROs) - Microorganisms, predominantly bacteria that have developed a resistance to one or more antimicrobial agents.

Near Miss - An unintended event or error that potentially could have led to an adverse event but was avoided due to chance or intervention. These events can also be referred to as precursor events.

Patient Safety Organization (PSO) - A collaboration of health care organizations that share in the goal of improving the safety and quality of health care delivery by learning from one another through the voluntary confidential sharing of privileged information in a legally secure environment.

Pressure Ulcers - Also known as bedsores, pressure ulcers are injuries to the skin and underlying tissue resulting from constant pressure. They are frequently found in people who are bedridden, chair bound or immobile.

Potentially Preventable Admission (PPA) - A hospital stay that could have been avoided had there been access to ambulatory care or the correct health care coordination.

Potentially Preventable Complication (PPC) - A harmful event or negative outcome with respect to a person, including an infection or surgical complication, that occurs after the person's admission to an inpatient acute-care hospital and may have resulted from the care, lack of care, or treatment provided during the hospital stay rather than from a natural progression of an underlying disease.

Potentially Preventable Readmission (PPR) - A return hospital admission shortly after discharge (usually within 30 days) as a result of problems from the previous hospitalization or a lack of appropriate follow-up.

Principal Diagnosis - The condition, after testing, that causes a patient to be admitted to a hospital.

Quality (Health Care) - The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality Assurance - The process of providing a desired level of quality care on a consistent basis. Quality assurance includes the continual monitoring and evaluation of current processes to determine consistency or areas of improvement.

Quality Improvement Organization (QIO) - Mostly private, nonprofit organizations staffed by doctors and other health care professionals trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care.

Quality Innovation Network (QIN or QIN-QIO) - A product of QIOs, often referred to as a QIN-QIO. These are networks of health care providers who collaborate to improve health care services through education and outreach; sharing practices that have worked in other areas, using data to measure improvement, working with patients and families, and convening community stakeholders for communication and collaboration.

Root Cause Analysis - Systematic process used to identify causal factors that underlie variations in performance or adverse events.

Sentinel Event - An unexpected occurrence or variation that results in a patient's death or serious physical or psychological injury. The event is call "sentinel" because it signals the need for immediate attention, investigation and/or response.

Second Victim - When a member of the medical staff is involved in medical error or an unanticipated adverse medical event that results in harm to the patient, they are called the "second victim" because they often are traumatized by the experience.

Sepsis - The body's systemic and overwhelming response to an infection. This response can trigger other reactions that lead to organ failure, tissue damage and death. Sepsis is also known as systemic inflammatory response syndrome (SIRS).

Surgical Site Infection (SSI) - An infection in the part of the body where a surgery took place that occurs after surgery. Infections can be superficial or occur in the organ or space of the surgery.

Ventilator-Associated Event (VAE) - a complication, non-infection or infection-related event, typically seen in patients receiving mechanical ventilation.

Venous Thromboembolism (VTE) - A blood clot that forms in a large vein; typically this is the most common preventable cause of death in a hospital. There are two categories of VTE: deep vein thrombosis (DVT) and pulmonary embolism (PE). DVT is a clot in a deep vein, typically in the leg. A PE is a blockage in the pulmonary artery typically by a blood clot. The blockage is caused by a blood clot that breaks loose and moves to the lungs and prevents blood from reaching the lungs.

Want to learn more?

The *Trustee Guidebook* series is one of many resources and programs available from Texas Healthcare Trustees, others include:

- Health Care Terms and Abbreviations – Your go-to guide to stay up to date on commonly used acronyms and phrases in health care.
- Trustee Online – The online video series that compliments the Trustee Guidebook providing easily absorbed education around nine core competencies;
- Events and webinars – Face-to-face and online learning events covering timely topics in health care;
- Trends and Insights – Taking a closer look at governance-related topics;
- Governance publications – Bi-weekly leadership news, monthly legislative and health care updates, and quarterly governance features; THT has several publications to share the news you need to know; and
- Much more!

For more information on these resources, visit www.tht.org.

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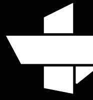

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