BoardBrief

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Knowledge Resources for Governing Effectiveness

Board Leadership Series on Quality and Patient Safety:

Understanding the Board's Role in Quality

Ensuring high quality and safe care is a critical responsibility for board members. Since 1999 when the then shocking Institute of Medicine report entitled *To Err Is Human* was released, there has been growing discussion and focus around preventable medical errors, increasing patient safety, improved efficiency and effectiveness, building trust and transparency, and creating systems that eliminate the potential for error.

Oversight of quality and safety is a board responsibility that extends across the organization. It cannot be delegated. Accountability in quality and safety encompasses all of the services that the organization provides, well beyond the four walls of the hospital.

The board sets the quality and safety goals and holds the administration and medical staff accountable to achieve them. The board is also responsible for credentialing and re-credentialing of the medical staff, which includes not only physicians but non-physicians who provide a medical level of care when diagnosing and treating patients (including advance practice nurses, physician assistance, psychologists and others).

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The overall objective of credentialing and privileging is to ensure that only qualified doctors and medical staff providers are admitted to and remain on the hospital's medical staff, and that they practice within their scope of experience and competence. There is a separate BoardBrief dedicated to this topic.

The Current State of Safety in Hospitals

Health care in America is criticized for its high cost and low quality. When the Institute of Medicine (now called the National Academy of Medicine or NAM) published its report *To Err is Human* in 1999, it estimated between 44,000—98,000 people died in hospitals annually as a result of preventable medical errors. Since that report, other reports have been published estimating there are significantly more preventable deaths annually, and still others calculating the large amount of financial "waste" that takes place in the U.S. health care system.[1]

For example, research indicates that about *one in ten patients in the U.S. develop an adverse event during hospitalization* (such as a health care acquired infection or preventable adverse drug event). Another study found that half of all surgeries had a medication error or adverse drug event.[9]

According to recent research published in the Journal of the American Medical Association (JAMA),

The Cost of Health Care Waste

In a 2019 study, researchers reported the following about waste in the U.S. health care system: [2]

25% The percentage of U.S. healthcare spending on waste.

$760 – $935 bil. Estimated annual billions of dollars spent on waste in health care.

$191 –$282 bil. Estimated annual savings from implementing the six Institute of Medicine categories to reduce waste (care that is safe, effective, patient-centered,

waste accounts for approximately one-quarter of U.S. health care spending. The authors estimated the waste to be between $760 billion—$935 billion annually. Because no other country spends more on health care than the United States, these numbers seem all the more impactful.[2]

Health care leaders are working to reduce waste and errors, and public and elected officials are concerned and taking action. Yet errors occur in hospitals every day. Regardless of the nature or scope, medical errors significantly impact quality of care, patient satisfaction, medical staff and employee morale, cost of care, insurance contracts and reimbursement.

Boards of trustees must take strong, organized action to establish and nurture an organizational accountability and culture that continually seeks to improve quality and patient safety at every turn. Board members individually, and collectively, can make a big difference in quality and patient safety.

The ultimate goal of excellent care is zero harm. The Joint Commission describes the process of achieving zero harm through highly reliable care. In health care, that means that care is consistently excellent and safe across all services and settings.[3]

A Large Problem: Inadequate Systems

The health care system has wide-ranging opportunity for improvements to be made relating to lack of leadership, lack of a safety-focused culture, lack of sustaining improvements, and inadequate systems.

Physicians and nurses do their best every day to provide great care in the very complex environment of health care. The majority of errors are caused by health care systems or processes which are faulty, too complicated, or fragmented.

For example, medications have brand names and generic names, and the names may look and sound different. In addition, packaging changes, labels, and variations in dosages (such as pill vs. injection) can cause confusion. "Look-alike, sound-alike" drugs aptly describes this challenge, and it is no wonder that adverse drug events are the most common type of health care adverse event.

Case Study: How System Failure Impacts Quality

A patient is in pain. The physician has ordered morphine for severe pain (rated by the patient as 7-10 on the pain scale), and the nurse administers morphine. Although she knows she needs to check back in fifteen minutes to make sure the patient's breathing has not been impacted, she also has another patient that is very sick and is scheduled to receive a CT scan. The patient needing the CT scan is very ill so a nurse must accompany the patient. The nurse decides to go down with the patient who needs the CT scan. Meanwhile, the patient she gave the pain medication to begins to have very shallow breathing from the pain medication.

Understanding the nature of system failure and fragmentation, boards must ask: "What can our hospital do to improve our systems to support safe, high quality care?"

Six Aims for the Health Care System

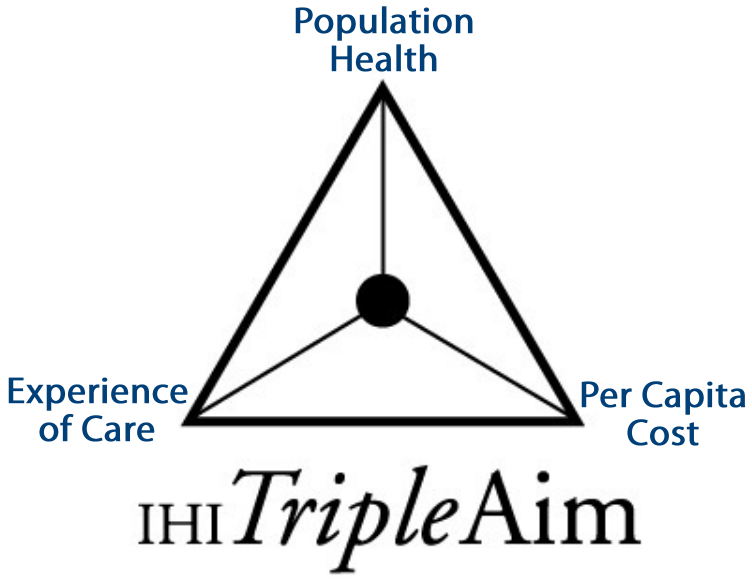
The Institute of Medicine (now the National Academy of Medicine) helps boards by defining "six aims" for the health care system. These are six areas hospital trustees and leaders should watch for in their organization as care is discussed.[4]

- Safe: Avoiding harm to patients from the care that is intended to help them.
- Effective: Providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
- Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Board members must have measures that demonstrate how their organization is performing in each of these six areas.

The Triple Aim

One of the ways health care leaders are working collectively to make a difference in health care quality is by focusing on achieving the Institute for Healthcare Improvement's (IHI) concept of the "Triple Aim" - 1) better health for the population being served, 2) an improved experience of care (including quality), and 3) care provided at a reasonable cost.



For more information, go to ihi.org/Topics/TripleAim.

Quality and Patient Safety are Job One

Too often boards of trustees assume that quality and safety problems are not an issue unless they hear otherwise. Boards should ask questions to identify areas with the greatest need for improvement. Questions boards should be asking include:

- How good is our quality? How do we know?
- Where do we want our quality to be, and by when? How do we sustain our quality improvements?
- What is our "culture" of quality and safety? Are errors reported, including by management to the board?
- What does the public expect from us?

- What should we be measuring?
- Do we publicly disclose our quality and safety performance, and to what degree?
- What quality and safety issues are emerging as areas we should begin to address?

Boards of trustees should embrace their role in patient safety for moral, ethical, legal and financial reasons. Board members must understand that they are liable for the care provided; that medical errors significantly impact health care costs; and that better patient quality and patient safety are key components of "staying on top" in a highly competitive environment.

Patients have the right and expectation to receive excellent care regardless of the size of their health care provider. Board accountability for quality and safety is the same regardless of the size of the organization.

Board Liability. It is ultimately the board's responsibility to ensure that their organization is taking clear, appropriate measures to provide the safest health care in the most efficient and effective manner. By understanding where quality and safety risks are emerging, the board can proactively take steps to eradicate or prevent errors from happening. This essential connection between risk management and quality improvement is key for boards to understand.

IHI: Characteristics of High-Achieving Hospital Boards Committed to Improving Quality and Patient Safety

The Institute for Healthcare Improvement has identified 15 specific governance behaviors that increase the odds of rapid quality improvement throughout hospitals and health systems. High achieving boards:[7]

1. Set a clear direction for the organization and regularly monitor performance
2. Take ownership of quality problems and make quality an agenda item at every board meeting
3. Invest time in board meetings to understand the gap between current performance and the "best in class"
4. Aggressively embrace transparency and publicly display performance data
5. Partner closely with executives, physicians, nurses, and other clinical leadership in order to initiate and support changes in care
6. Drive the organization to seek the regular input of patients, families, and staff, and they do the same themselves
7. Review survey results on culture, satisfaction, experience of care, outcomes, and gaps at least annually
8. Establish accountability for quality-of-care results at the CEO level, with a meaningful portion of compensation linked to it
9. Establish sound oversight processes, relying appropriately on quality measurement reports and dashboards ("Are we achieving our aims/system-level goals?")
10. Require a commitment to safety in the job description of every employee and require an orientation to quality improvement aims, methods, and skills for all new board members, administrators, staff, and physicians
11. Establish an interdisciplinary Board Quality Committee, meeting at least four times a year with a board member sitting on the committee
12. Bring knowledgeable quality leaders onto the board from both health care and other industries
13. Set goals for the education of board members about quality and safety, and ensure compliance with these goals
14. Hold crucial conversations about system failures that resulted in patient harm
15. Allocate adequate resources to ongoing improvement projects and invest in building quality improvement capacity across the organization

> **Inpatient harm reduction is associated with reduced inpatient LOS, mortality, and readmission rates, which will benefit patients. Harm reduction is also associated with lower costs and higher contribution margin for hospitals. Therefore, reducing harm not only is the right thing to do for patients but also financially and clinically prudent.**[5]
>
> *-The Joint Commission*

As a result, continually seeking education about current trends and implications must be a board priority. Boards should regularly review key quality indicators, understand what they are measuring, and take corrective action when necessary.

Cost. The cost of medical errors to the individual, health care system and society is significant. In addition to the costs already discussed, payers and large businesses are increasingly expecting health care partners to demonstrate high quality, efficient care. This has resulted in a growing number of providers being excluded from payer contracts.

Quality and safety at a reasonable cost is fundamental to a health care provider's survival.

Competition. Although quality has traditionally been a matter of perception on the part of patients, an increasing number of organizations are publishing hospital quality ratings and report cards. While many of these agencies use different measures and definitions, awareness of quality and patient safety measurement is growing. Hospitals that encourage a culture of safety and move toward the goal of zero harm have an opportunity to not only improve patient care and reduce expenses, but to also build public trust, confidence and business growth. In contrast, hospitals and health systems that do not put processes in place to reduce serious safety errors risk losing money, employees, consumer confidence and market share.

Sources and Additional Information

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Resources used for research and context purposes have been sourced as accurately as possible at the time of publication. If you believe something has been cited incorrectly, please contact governWell™ at contact@governwell.net.

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