Why Boards, Why Now?
Governance Oversight of Quality

December 10, 2012
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Objectives

- After this presentation participants will be able to:
  - Outline the importance of the role of the board in quality and safety as reflected in recent studies and the personal experience of the faculty.
“The great obstacle to progress is not ignorance but the illusion of knowledge.”

Daniel Boorstin
### Safety Hazard Probabilities
(events per million opportunities)

- Acquiring HIV from 1 unit of transfused blood: 0.7
- All heads on 20 coin tosses: 1.0
- Death of commercial airline passenger: 0.04
- Death: General anesthesia: 7.5
- Death: Motor vehicle: 187
- Preventable hospital deaths: 208

### Three Big Questions

1. **Why** does your hospital/system do quality improvement?
2. Does your hospital/system have a definition of quality? What is quality?
3. What can governance and leadership do to improve quality and patient safety?
What Is Quality?

"Quality... You know what it is, yet you don’t know what it is. But that’s contradictory... But when you try to say what quality is, apart from the things that have it, it all goes poof!... If no one knows what it is, then for all practical purposes it doesn’t exist at all. But for all practical purposes it really does exist. What else are grades based on? Why else would people pay fortunes for some things and throw others in the trash pile? Obviously some things are better than others... But what’s the ‘betterness’?

What the hell is quality?

What is it?"

Robert M. Pirsig
Zen and the Art of Motorcycle Maintenance

A Brief History of Quality

The Code of Hammurabi (CIRCA 2,000 B.C.)

“If the surgeon has made a deep incision in the body of a free man and has caused the man’s death or has opened the carbuncle in the eye and so destroys the man’s eye, they shall cut off his forehand.”
I am Called Eccentric for Saying in Public that Hospitals, if They Wish to be Sure of Improvement…

- Must find out what their results are.
- Must analyze their results to find their strong and weak points.
- Must compare their results with those of other hospitals.
- Must care for what cases they can care for well, and avoid attempting to care for cases which they are not qualified to care for well.
- Must welcome publicity not only for their successes, but for their errors, so that the public may give them their help when it is needed.
- Must promote members of the medical staff on the basis which gives due consideration to what they can and do accomplish for their patients.

Such opinions will not be eccentric a few years hence

E.A. Codman, M. D. A study in hospital efficiency, 1916

- The Darling v. Charleston Community Memorial Hospital Case – 1965
- The California Medical Insurance Feasibility Study - 1977
- The Harvard Medical Practice Study - 1991
- The Institute of Medicine Report – 1999
- OIG Study 2010
- 2012 – Partnership for Patients; Health Reform; Health Affairs; Private insurers tie payments to quality
LEGAL RELATIONSHIPS AMONG the BOARD, MANAGEMENT, AND MEDICAL STAFF:

Pre-1965-The Franklin Model

GOVERNING BOARD ➔ MEDICAL STAFF
(Responsible for Finance, Nonmedical Services, Equipment, and Supplies) (Responsible for Direct Medical Care, and presumably Quality)

Delegated to MANAGEMENT

LEGAL RELATIONSHIPS AMONG the BOARD, MANAGEMENT, AND MEDICAL STAFF:

Current Post-Darling Model

BOARD
(Responsibility: Everything! Including Quality)

Delegation and Oversight

MANAGEMENT

Delegation and Oversight

MEDICAL STAFF
1 out of 7 hospitalized Medicare patients are harmed

In October 2008 alone, 134,000 experienced at least one adverse event.

In 1.5% of hospitalized Medicare patients, a harm event contributes directly to the patient’s death

“44% of the harm is clearly or likely preventable”

What Did The OIG Find?

For Medicare Patients Hospitalized in October 2008...

• 13.5% (1 out of 7) had an adverse event
• 0.6% had an NQF Serious Reportable Event
• 1.0% had a Medicare “HAC”
• 1.5% had an adverse event that contributed to death
  • ~ 15,000 deaths in October 2008 alone!
• Adverse events accounted for 3.5% of all Medicare expenditures

“44% of the harm was preventable”
We usually don’t see all the harm: Inpatient Surgical Record Review of 854 patients in 11 US hospitals…

- Found 14.6% of patients had a Surgical Adverse Event (SAE)
- 44% of SAEs caused increase LOS or readmit
- 8.7% required life-saving intervention or resulted in permanent harm or death
- “…Most of the events identified by Trigger Tool review had not been detected or reported via any other existing mechanism.”


See The Problem?

- A Study in the April, 2011 journal of Health Affairs found that on average, 1 in 3 patients admitted into a hospital suffer a medical error or adverse event – nearly 10 times greater than previously believed.
- On any given day, about 1 in every 20 patients is affected by an infection related to hospital care.
- On average, 1 in 7 Medicare beneficiaries is harmed in the course of care, costing the government an estimated $4.4 Billion every year.
- Medicare Readmission rates within 30 days – cost of $26 Billion every year.
- Hospitals Kill between 180,000 and 250,000 people every year!
We know ways to reduce the harm: Comprehensive use of surgical safety checklists reduces complications by 39%, and cuts mortality rate in half


Governance moves to the front page!!
Patients’ care often deficient, study says.
Proper treatment given half the time.
On average, doctors provide appropriate health care only half the time, a landmark study of adults in 12 U.S. metropolitan areas suggests.
C. diff hits half-million Americans every year

The Faces of C. Diff Victims

USA TODAY Investigation

One bacteria, 30,000 deaths

Health

New York Times

No Sponge Left Behind: Strategies For Surgery

By Anahad O'Connor

On an overnight shift in 2006, Sophia Savage, a nurse in Kentucky, felt a crushing pain in her abdomen and started vomiting. The next day she underwent a CT scan, which led to a startling diagnosis: A surgical sponge was lodged in her abdomen, left behind, it turned out, by a surgeon who had performed her hysterectomy four years earlier.
As a general rule, trustees think that their hospital’s quality is much better than the doctors, nurses, and administrators do.

Stages of Facing Reality

- **Stage 1** “The data are wrong”.
- **Stage 2** “The data are right but, it is not a problem”.
- **Stage 3** “The data are right; it is a problem but, not my (our) problem”.
- **Stage 4** “We accept the burden of improvement”.

“In Hopeful Sign, Health Spending is Flattening Out”  NYT April 29, 2012

“In 2009 and 2010, total healthcare spending grew about 4% per year, the slowest annual pace in more than five decades.”

Why??
One Reason…

“Since the recession, hospitals have experienced a decrease in demand for inpatient services, much of which is unlikely to return even if economic growth increases.

… likely to be a permanent loss of demand.”

Moody's Investors Service Special Comment.

“Doing More with Less: Credit Implications of Hospital Transition Strategies in Era of Reform.” May 9, 2012

Bureau of Labor Statistics and Centers for Medicare & Medicaid Services
“If the growth in Medicare were to come down to a rate of only 1 percentage point a year faster than the economy’s growth, the projected long-term deficit would fall by more than one third”

NYT April 29, 2012

“The choice is stark: Chop or Improve.”

Donald M. Berwick, M.D.
IHI National Forum December 7, 2011
Orlando, FL.
What is “High Quality?”


Quality and Resource Use Comparison

THE VM QUALITY EQUATION

\[ Q = A \times \frac{(O + S)}{W} \]

Q: QUALITY
A: APPROPRIATENESS
O: OUTCOMES
S: SERVICE
W: WASTE

Variation in death rates in US hospitals
HSMR vs standardized reimbursement
Top 10 and bottom 10 HSMR hospitals

Doctors Estimate They Wash Their Hands 70% of the Time
Study Shows it was Actually only 9%!!

NEVER EVENTS

WELL...

HARDLY EVER EVENTS

OR,

"When Will We Ever Learn??"

"What, never?"
"No, never!"
"What, never?"
"Well, hardly ever!"
Hospital-Acquired Infections: Expensive

- Central line-associated bloodstream infections (CLABs) resulted in an average loss per case of $26,839.
- Costs of CLABs averaged 43% of the total cost of care.
- CLABs resulted in a total loss from operations of $1,449,306 in 54 cases over three years in 2 ICUs.


Hospital-Acquired Infections: Expensive, Deadly and Preventable!

- 80,000 CLABs per year, causing about 28,000 deaths. Nearly all are preventable!
- In 103 ICUs in Michigan, median CLAB rate per 1,000 catheter days declined from 2.7 to zero, average rate dropped from 7.7 to 1.4 at the 18 month follow-up.
- How? Hand-washing; full barrier precautions; chlorhexidine use; avoiding the femoral site; removing unneeded catheters

Governance and quality…the next fraud frontier?

Avoiding Quality Fraud

If a system is not delivering high-quality care, and the board knew or should have known about it while the system continued to submit claims to Medicare (and other payers) then the system’s leadership (including board members) can be considered to have committed “quality fraud.”

By Alice G. Gosfield, J.D., and James L. Reinertsen, M.D.
The U.S. Department of Justice Asks

- Has there been a systemic failure by management and the board to address quality issues?
- Has the organization made false reports about quality or failed to make mandated reports?
- Has the organization profited from ignoring poor quality or ignoring providers of poor quality?
- Have patients been harmed by poor quality or given false information?

Poor Physician Credentialing Leads to False Claims Billing Charges

- April 7, 2010 – The Feds are alleging in a False Claims Act lawsuit that Satilla Health Services/Satilla Regional Medical Center in Waycross, GA that the hospital submitted claims for medical procedures that a physician was not qualified or properly credentialed to perform, resulting in serious injuries and at least one patient death.
- “We are committed to bringing to justice those who put profits ahead of patient health and safety” Tony West, assistant attorney general for Civil Division of Department of Justice.
Good morning to all from Washington, DC. Today OIG posts a video and an audio podcast by Lewis Morris, Chief Counsel to the Inspector General, about the role of health care boards in overseeing quality and compliance in their organizations. In addition to the podcast, we are also posting a report, an amended Corporate Integrity Agreement and news about enforcement actions. As always, you can use the links provided to go directly to the new material.

- **Video and Podcast: A Toolkit for Health Care Boards**
  - This video and audio podcast provides a "toolkit" of tips to help board members create a corporate culture focused on two goals: promoting quality of care and embracing compliance with the law.
  - Click on [http://go.usa.gov/5no%20](http://go.usa.gov/5no%20) to view this and other PCT video and audio presentations.

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**Headline: “Hospital Changes Procedures After Preemie Deaths”**

- September 2006: Three preemies die after they receive adult doses of heparin at Methodist Hospital in Indianapolis.
- “Sam Odle, CEO of Methodist, said a pharmacy technician with more than 25 years experience accidentally took the wrong dosage from inventory and stocked it in the drug cabinet in the Newborn ICU. Nurses, who are accustomed to only one dosage of heparin being available, then administered the wrong dose. The adult and infant doses have similar packaging.”
November 2007 Headline:
“Dennis Quaid’s Newborn Twins Given 1,000 Times Intended Dose Of Blood Thinner”

- The CMO at Cedars-Sinai Medical Center in LA stated:
  “As a result of a preventable error, the patients’ IV Catheters were flushed with heparin from vials containing a concentration of 10,000 units per milliliter instead of from vials containing a concentration of 10 units per milliliter.”

July 4, 2008:
It happens again.

Christus Spohn Hospital,
Corpus Christi, Texas.

17 Premature infants receive adult doses of heparin.
November 2007 Headline:
“Hospital Repeats Wrong-Sided Brain Surgery”

“For the third time this year, doctors at Rhode Island Hospital have operated on the wrong side of a patient’s head – an action that has brought about censure from the state Department of Health and a $50,000 fine.”

HEY, WHO’S RUNNING THESE HOSPITALS?!
NOV. 2009 HEADLINE:  
“R.I. Hospital Fined $150,000 for Fifth Wrong Site Surgery in 2 years”

“The latest incident last month involved a patient who was to have surgery on two fingers. Instead, the surgeon performed both operations on the same finger. Under protocols adopted in the medical field, the surgery site should have been marked and the surgical team should have taken a timeout before cutting to ensure they were operating on the right patient, the right part of the patient’s body and doing the correct procedure.

The surgical team marked the wrist, rather than each finger, and the surgeon did not mark the site himself. The team did not take a timeout before the second surgery. When they discovered the error, they checked with the patient’s family to see if they should perform the surgery on the correct finger. When they did the surgery on the correct finger, they also did not do a timeout, something Gifford called “amazing” given that they had just made such a serious error.”
Other Well-Publicized Never Events

- 2004: Radiologist in a Seattle hospital injects chlorhexidine instead of contrast medium directly into a patient’s carotid artery. The two solutions were in unmarked containers and looked identical.
- 2008: Urologist in a Minneapolis hospital removes a patient’s good kidney, rather than the cancerous one.

Board Function **DOES** Affect Quality

Emerging research shows that boards can make an enormous difference in improving quality and patient safety.
"We kept waiting for leadership to flinch, because at first we thought it was just another management thing. But they didn't waver."

Virginia Mason Finance VP

"10 Years Later: Virginia Mason Production System Still Going Strong"
Beckershospitalreview.com, September 21, 2011

waver from WHAT?
“You should not use an old map to explore a new world.”

Albert Einstein