Session Objectives

- Describe a framework for understanding a board’s role in overseeing quality and safety
- List three changes they could apply to improve their board’s oversight of quality and discuss three innovative best practices that their board could implement
- Discuss three innovative “best practices” each board can do today
- Identify specific opportunities to decrease direct cost while improving quality
Today’s Agenda

- Welcome, introductions
- What do you want to learn?
- Why boards, why now?
- What do the best boards do?
- Difficult conversations
- Boards and Dashboards
- Action planning

What do you want to learn?

- Take one minute to write down something you’d really like to learn about boards and quality from this program
- Share what you want to learn at your table
- Tell us some of the key things you want to learn
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.
- Understand the role and authority of the board relative to the medical staff and to quality and patient safety.
“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

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### 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

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The Darling vs. 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  \(\rightarrow\)  MEDICAL STAFF
(Responsible for Finance, Nonmedical Services, Equipment, and Supplies)  \(\rightarrow\) (Responsible for Direct Medical Care, and presumably Quality)
Delegated to
Delegated to
MANAGEMENT

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

Current Post-Darling Model

BOARD
(Responsibility: Everything! Including Quality)

Delegation and Oversight  \(\rightarrow\)  MANAGEMENT

Delegation and Oversight  \(\rightarrow\)  MEDICAL STAFF
12/3/2013

Department of Health and Human Services
OFFICE OF INSPECTOR GENERAL

ADVERSE EVENTS IN HOSPITALS: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES

Denzel R. Lettkemeyer
Inspector General
November 2008
OEI-05-08-00000

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

![Graph showing reduction in complications per 100 patients over time in intervention versus control hospitals.]


CHECKLISTS CAN PREVENT SURGICAL ERRORS!

17 surgical teams simulated more than 100 OR emergencies using a robotic patient. Each team used a checklist for half of the simulations and relied on memory and expertise for the other half.

The study found that the teams that used a checklist were 74% less likely to skip a potentially life-saving step during the intraoperative crisis. Specifically, teams with checklists missed 6% of life-saving processes, while teams without checklists missed 23% of such processes.

After completing the simulation, 97% of participants indicated that they would prefer to have a checklist in the event of an OR crisis.

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

Continued from A1

“People are dying needlessly,” says Christian Bishoff, a New York who lost his life to the infection over two years ago. “It’s almost like we’re living in a different world.”

Bishoff, who nearly lost his life to the infection over two years ago, is no longer worried about the disease. Instead, he’s using the experience to help others.

The faces of C. diff victims

Bobit, 43, a self-employed businessman, remembers feeling sick for days before being rushed to the hospital. He was diagnosed with C. diff and spent weeks in the hospital.

Lisa, 32, a mother of two, remembers feeling sick for days before being rushed to the hospital. She was diagnosed with C. diff and spent weeks in the hospital.

Ralph, 65, a retired teacher, remembers feeling sick for days before being rushed to the hospital. He was diagnosed with C. diff and spent weeks in the hospital.

Jeff, 50, a self-employed businessman, remembers feeling sick for days before being rushed to the hospital. He was diagnosed with C. diff and spent weeks in the hospital.

One bacteria, 30,000 deaths

An infection called C. diff is wreaking havoc in US hospitals, causing harm and other medical facilities – and officials could be doing far more to stop it.

Health

The New York Times

TUESDAY, SEPTEMBER 25, 2012

No Sponge Left Behind: Strategies For Surgery

BY ANAHAD O’CONNOR

On an overnight shift in 2005, 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 ago.
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 “I accept the burden of improvement”.

Employers and Payers Getting Aggressive on Cost and Quality!!

Wal-Mart Stores announced Oct. 12 that, as of Jan. 1, 2013, 1.1 million people covered under its employee health insurance will have access to heart and spine surgeries at one of six health systems identified as "Centers of Excellence" for each service. The health systems include Cleveland Clinic; Geisinger Medical Center; Scott & White Memorial Hospital in Temple, Texas; Virginia Mason Medical Center in Seattle; and Mercy Hospital Springfield in Springfield, Mo.
Wal-Mart’s Domestic Medical Tourism

“We’re looking to expand these programs to reduce our associates’ out-of-pocket medical costs and provide the highest quality of care,” said Randy Hargrove, a Wal-Mart spokesman. “And we plan to expand this program to include more procedures and providers.”

And: On January 1, 2014 the program expands to include Total Knee Replacement and Hip Replacement Surgery.

Employers and Payers Getting Aggressive on Cost and Quality!!

TPA in Southern California; 55 School Districts
$500 Million in Healthcare Claims.
Top 10% of Users Account for 60-70% of claims. Sent these records to Best Doctors for 2nd Opinion:
15% had Wrong Diagnosis
60% of Treatments were NOT State of the Art.

What to do??????
Incentivize Employees to Go to BEST PROVIDERS!

High Cost & High Quality
- 16% Premium Contribution
- $1,000 Deductible
- Higher Co-Pay
- Out of Network
- NO Reimbursement

Low Cost & High Quality
- NO Premium Increase
- NO Deductible
- NO Co-Pay

Low Quality at ANY Cost

Mid Cost & High Quality
- 8% Premium Contribution
- Small Deductible
- & Co-Pay

RESULTS?

By Adjusting Premium Contributions, Co-Payments, and Deductibles 87% of Covered Population
Now Go to the Low Cost & High Quality Quadrant of Providers.
Preliminary Savings to the TPA and VEBA (Voluntary Employee Benefit Association) are in the Multiple Millions of Dollars.
What is “High Quality?”

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

NEVER EVENTS
WELL...
HARDLY EVER EVENTS

"When Will We Ever Learn??"
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**

Many boards perceive themselves as safe from fraud because their systems are well designed and controlled. If, however, 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.

1 Travers September 2000
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) 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.”

“R.I. Hospital Fined $150,000 for Fifth Wrong Site Surgery in 2 years”

The Hospital CEO “said in a statement that the hospital was committed to reducing medical errors and had been taking steps to improve patient safety.”

“The order includes a provision that the hospital must assign a clinical employee who is not part of the surgical team to observe all surgeries at the hospital for at least one year. The person will monitor whether doctors are marking the site to be operated on and taking a time out before operating to ensure they’re operating on the proper body part.

It requires the surgeon to be involved in marking the surgical site.

It also gives the hospital 45 days to install video and audio recording equipment in all its operating rooms. Every doctor will be taped performing surgery at least twice every year…”
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.
November 23, 2004

Investigators: Medical mistake kills Everett woman

The Seattle Times

Hospital error caused death

Mary L. McClinton

The Mary L McClinton Patient Safety Award
For Outstanding Teamwork in Making Patient Care Safer

Hands That Make Dreams Come True
Virginia Mason Medical Center, Seattle, Washington
2006 Honorees: CCU Breakthrough Coordinating Group

A tireless volunteer and civil activist, Mary Louise McClinton devoted
her life to helping others. She was an activist advocate for the disabled,
poor, and underprivileged.

She earned adoption of her home state of Alaska, the
name "In-Koo-See" or in English Hands That Make Dreams Come True."

Mrs. McClinton died on November 23, 2004, while she was a patient at
Virginia Mason, due to an avoidable medical error.

To honor her life, Virginia Mason has dedicated itself to eliminating
avoidable deaths and injury.

This award is given annually to a team that has shown extraordinary
effort and devotion to that goal.
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.”
What do Best Boards do?:
The Board’s Role in Quality and Patient Safety

Evan M. Benjamin, MD FACP
Senior Vice President and Chief Quality Officer,
Baystate Health, Associate Professor of Medicine, Tufts University

The Quality & Patient Safety Imperative: The Full Monty

“Every system is perfectly designed to achieve exactly the results it gets.”

Sigma Scale of Measure

- Low Back TX
- Post Heart Attack Medications
- Mammography Screening
- IRS - Tax Advice (phone-in) (140,000 PPM)
- Inpatient Medication Accuracy
- Airline Baggage Handling
- Domestic Airline Flight Fatality Rate (0.43 PPM)

International Comparison of Spending on Health, 1980–2004

American health care "gets it right" 54.9% of the time.

Among Medicare Beneficiaries Enrolled in Managed Care Plans, African Americans Receive Poorer Quality of Care (Schneider et al., JAMA, March 13, 2002)

Today’s Emphasis on Transparency and Accountability

- Costs
- Value
- Quality and Safety at the Center of Healthcare Reform Goals
- Calls for Data Transparency, Improvement in Safety and Quality
  - AHA, Joint Commission, Medicare, State
  - Private foundations advancing quality, safety

Defining Quality in Healthcare

- The Purpose of Healthcare:
  - Decrease morbidity, mortality
  - Increase productivity, QoL
  - Prevention and treatment
- Definitions:
  - Institute of Medicine (IOM)
  - Donabedian
  - Patient-centered definition of Quality IOM Aims
  - Porter Value Outcomes Hierarchy
Adverse Events in Hospitals National Incidence: Medicare Beneficiaries

- An estimated 13.5 percent of hospitalized Medicare beneficiaries experienced adverse events during their hospital stays.

**6,600 Preventable M’care Deaths Monthly**
Which projects to 15,000 patients in a month

- An additional 13.5 percent of Medicare beneficiaries experienced events during their hospital stays that resulted in temporary harm.

- Physician reviewers determined that 44 percent of adverse and temporary harm events were clearly or likely preventable.

- Hospital care associated with ... harm events cost Medicare and estimated $324M in October 2008.


IOM Definition

“...the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”
Donabedian

- **Structure**: measures don’t predict quality
- **Process**: perhaps better; demand up
- **Outcome**: measures are the best but what is actionable and what is risk-adjusted for comparison?

Patient-Centered Definition of Quality

- Patients have **access to care by multiple means**, including the telephone, online and in person
- **Care is based on patient needs and values**, which address the patient’s requirements, desires, and preferences for treatments and therapies
- **Patients are the source of control**, with access to information about their care and participation in care decisions
- **There is shared knowledge and free flow of information**, and patients have access to medical records
- **Decision making is evidence-based**, drawing upon the best current, documented evidence in the scientific literature and not on anecdotes
- **Safety is a fundamental attribute** of the organization at all levels; the organizational culture emphasizes learning from, reporting and dramatically reducing errors
Patient-Centered Definition of Quality (cont’d)

- **The system of care delivery is characterized by transparency**, which provides for patient and public access to information on performance, errors and adverse events
- **Care anticipates needs**, which moves us from a system that reacts to illness to one that focuses on prevention and proactive management
- **Waste is minimized**, as well as efforts to limit access, reduce resources, and erect barriers to care for cost-containment purpose. These tactics ultimately result in higher costs when patients do not receive needed care in a timely and proactive manner
- **There is a high degree of cooperation among clinicians**. Cooperation replaces autonomy. A team approach incorporating standardization is used

IOM Aims

- **Safe**: No patient is injured by care
- **Effective**: 100% adherence to science in care; no needless deaths or suffering
- **Patient-Centered**: Customized care; “Every patient is the only patient.”
- **Timely**: No unwanted waiting anywhere
- **Efficient**: No waste
- **Equitable**: Race and wealth do not predict care or outcomes
The Board’s Connection

- Defining and Shaping the Context in which Services are Delivered
- Infrastructure (Facilities, Medical Staff, Clinical Staff, Ratings, Improvement Capacity)
- Processes (Services, Departments, Procedures)
- Outcomes (Mortality, Infections, Errors)
Accountability for Quality: The Board Must

- Recognize its Role and Responsibility of Ensuring Quality of Care
- Ensure Healthcare Quality Issues are a Primary Focus of Board Activities
- Oversee the Creation of a Culture of Safety
- Recognize the Efforts necessary to Achieve Clinical Excellence
- Become Educated about Quality

National Quality Forum, 2004

Better Outcomes are Associated with Hospital in Which . . .

- The Board spends more than 25% of its time on Quality Issues
- The Board Receives a Formal Quality Performance Measurement Report
- There is a High Level of Interaction between the Board and the Medical Staff on Quality Strategy
- The Senior Executives’ Compensation is based in part on QI Performance
- The CEO is identified as the person with the greatest impact on QI, especially when so identified by the QI Executive

Vaugh T, Koepke M, Kroch et. Al. 2006
Board Practices Impacting Outcomes
A Growing Statistically Significant Evidence Base

<table>
<thead>
<tr>
<th>Practices by Boards</th>
<th>% Practicing</th>
</tr>
</thead>
<tbody>
<tr>
<td>At most Board meetings, devotes a significant amount of time to quality issues/discussion</td>
<td>68.5</td>
</tr>
<tr>
<td>Has a standing Quality Committee of the Board</td>
<td>65.2</td>
</tr>
<tr>
<td>Requires management to base at least some of the hospital’s quality goals on the “theoretical ideal”</td>
<td>63.2</td>
</tr>
<tr>
<td>Requires the hospital to report its quality/safety performance to the general public</td>
<td>39.3</td>
</tr>
<tr>
<td>Both the Board and the medical staff are at least as involved or more involved than management in setting the agenda for the Board's discussion on quality</td>
<td>49.0</td>
</tr>
<tr>
<td>Reviews quality performance measures using dashboards, balanced scorecards, run charts, etc., at least quarterly to identify needs for corrective action</td>
<td>93.7</td>
</tr>
</tbody>
</table>


Levers of Governance

1. Mission
2. Culture
3. Performance
4. Leadership
5. Strategy
6. Resource Allocation
“Attention is the Currency of Leadership”

**Tactics for Board Engagement in Quality**

- Increase Quality Literacy of Board
- Create an Agenda for Quality
- Quality Planning and Focus
- Patient Centeredness, Stories
Best Board Practices to Improve Quality for Boards

1. Establish culture and Build Will
2. Establish Bold Performance Goals
3. Promote Leadership Collaboration:
   - The Medical Staff and Administration
4. Empower a Quality Committee
5. Oversee Progress

Promote a Safety Culture

- Reliance on System Thinking
- Improvement Capacity
- Reliable Processes Using Human Factors
- Put a Face on Data
- Transparency of Data
- Eliminate the Denominator
- Teamwork and Communication
- Walk Rounds
- Apology and Disclosure, Just Culture
Generate Will:

- Talk about the “Big Dots”
  - Mortality
  - Harm
  - Experience
- Put Face on Data
- Eliminate the Denominator

“Will” Allows Actions like these by the Medical Staff of a Hospital System which had the Aim “Eliminate Preventable Birth Trauma in 5 Years”

Baystate Health

- Revised all OB protocols and policies to reflect current evidence-based best practices and adopted them as the standard of practice among all providers, at all hospitals
- Elective induction prior to 39 weeks at Seton was effectively eliminated. There have been ZERO exceptions in 4 years.

“We know we have backup, all the way to the Board”
“Will” Leads to Results

Will

- Eliminate the denominator
- Put a face on the data
- Transparency
- Ask the hard questions
  - Face up to difficult conversations
Transparency and the Board

- If a patient were seriously harmed this week in your hospital, and the initial evaluation of the event indicated that the hospital’s culture and systems were probably the underlying cause, would the Board learn of the event?
  - Which Board Members?
  - When?
  - Would the Explanation be “Spun” to make the Hospital Look as Good as Possible?
  - Would Conversations about the Event be Cloaked in Legal and Risk Management mumbo-jumbo?

- Is the Board sending clear signals about transparency to the Management Team?
Culture Is Related to Clinical & Operational Outcomes

1. Medication Errors
2. Back Injuries
3. Patient Satisfaction
4. Nurse Turnover & Absenteeism
5. Urinary Tract Infections
6. Needle Sticks
7. Re-admissions
8. Malpractice Claims ...and more

Useful References for Culture-to-Outcomes Linkage:
- Hansen et al. (2011)
- Curry et al. (2011)
- Pettker et al. (2009)
- Singer et al. (2009)
- Vogus & Sutcliffe (2007)
- Mark et al. (2007)
- Naveh et al. (2006)
- Hofmann & Mark (2006)
- Katz-Navon et al. (2005)

Michigan Keystone Initiative:
Teamwork Climate Across ICUs Predicts Infection

Strongest predictor of clinical excellence: caregivers feel comfortable speaking up if they perceive a problem with patient care
Medical Error Algorithm

Adapted from: James Reason, "Managing the Risks of Organizational Accidents", 1997

- Baseline culture of safety:
  - Root-cause analysis (RCA)
  - Transparency of care
- Full disclosure
- Apology when appropriate
- Injury compensation:
  - Timely and fair
- Alternative dispute resolution
- “Tort” is the last resort
Best Board Practices to Improve Quality for Boards

1. Establish culture and Build Will
2. Establish Bold Performance Goals
3. Promote Leadership Collaboration:
   – The Medical Staff and Administration
4. Empower a Quality Committee
5. Oversee Progress

Set Performance Goals:
System Level Measures

- IOM Aim of Healthcare:
  – Safe, Timely, Effective, Efficient, Equitable, Patient Centered

- Triple Aim Measures:
  – Population Health
  – Per Capita Costs
  – Patient Experience

- Use Data:
  – Outcomes
  – Process Drivers
Examples of Bold, Specific, System-Level Aims

- “We will achieve a 50% reduction in hospital-acquired infections within 12 months, as measured by the sum of Central Line Bloodstream Infections, Ventilator-Acquired Pneumonias, and Catheter-Associated Urinary Tract Infections.”
  
  WellStar Health System

- “We will reduce Harm by 80%, as measured by Serious Safety Events, within 3 years.”
  
  Cincinnati Children’s

- Baystate Health will eliminate hospital acquired infections with 3 years
  
  Baystate Health

Not-So-Specific Aims

- “Our hospital strives to be in the Top Tier on all Quality Measures”

- “Our Medical Group Aims to Achieve the Highest Levels of Quality in Service of our Community”
  
  As Measured by….?
  By When...?
If your Aim is
“Pretty Good, Someday,”

then your Plan can be
“Somehow, by Someone, Whenever.”

Exercise

- Pair up with your nearest neighbor and Identify which of you is the Newer Board Member
- 1 minute: For the “Junior” Member: State your organization’s Quality and Safety Aims, without reference to documents and PDAs!
  - How good
  - At what
  - By when
  - As measured by...
- 4 minutes: Compare notes at your table. How is your Aim?
Best Board Practices to Improve Quality for Boards

1. Establish culture and Build Will
2. Establish Bold Performance Goals
3. Promote Leadership Collaboration:
   - The Medical Staff and Administration
4. Empower a Quality Committee
5. Oversee Progress

Framework for Improvement

- Strategic Goals
- Microsystems
- Engage Staff
- Infrastructure
Leadership Collaboration

- Ensuring Medical Staff Competency
- Medical Staff Engagement in Quality
- Ensuring Leaders and Medical Staff work together to establish Culture of Safety and Improvement:
  - Multidisciplinary, Team Approach
  - System-based Thinking
  - Standard Work begets Improve Care

Best Board Practices to Improve Quality for Boards

1. Establish culture and Build Will
2. Establish Bold Performance Goals
3. Promote Leadership Collaboration:
   - The Medical Staff and Administration
4. Empower a Quality Committee
5. Oversee Progress
Quality Committee: Best Practices

- **Structure**
  - Lay Chair, and majority of lay trustees
  - Charter: recommend and oversee achievement of Quality Aims
  - Two patient/family representatives
  - Literacy required

- **Process**
  - Meaningful conversation not PowerPoint
  - Agenda:
    - Story
    - Progress toward Aims
    - “Off the rails” exception report
    - Policy recommendation

- **Culture**
  - Everyone’s voice is heard
  - Transparency
  - Ask the important and difficult questions

The Best Quality Committees Have a “Starter Kit” of Good Questions to Ask

- What would be the Right Thing to do for Our Patients?
- Am I the only person who doesn’t understand what you just said?
- Does this set of re-credentialing recommendations fully support our mission, aims, and strategies?
- How many patients is that?
- Who is the best in the world at this?
- Were patients and families involved in making this recommendation?
- Do we have an open and fair culture?
- Do we learn from safety events?
- Do we get the right information?
Quality Committee: Report to the Full Board

- Every meeting
- 1st on the agenda
- 25% of Board time
- Trustee leads with management support
- Review Big Dots with simple language
- Highlight Key Issues committee is dealing with

Board and Board Quality Committee Struggles Observed

- Full Board Disengagement:
  - “The Committee will look at it”
- Board moves from Governance to Operations
  - Into the weeds / No time for generative thinking
- Report Overload
  - No time for discussion or questions
- The “Quality” Trustee
  - “If it is about quality, Paul will catch it”
- The Struggle of the Lay Board Member
  - “What can I say? I’m not a clinician.”
- The Board Member in the Community
  - Transparency and Confidentiality
Best Board Practices to Improve Quality for Boards

1. Establish culture and Build Will
2. Establish Bold Performance Goals
3. Promote Leadership Collaboration:
   – The Medical Staff and Administration
4. Empower a Quality Committee
5. Oversee Progress

Oversee Progress

- Separate performance reports to the board into two “dashboards:”
  – The “Compared To....” dashboard
  – The “Strategic” dashboard
The Best Boards have Separate, Shorter, “Strategic Dashboard” that even a Banker can Understand

- Answers the question “Are we on track to achieve our major strategic aims?”
  - Reduce Harm
  - Improve Outcomes
  - Improve Satisfaction
  - Reduce Costs
  - Grow Market Share
  - Etc.
- Contains a few key measures (2 or 3 at most)
  - Outcomes, Drivers
  - Close to Real time
  - “Good enough to Steer by”

A Board Self Assessment

1. Quality of Care Committee
2. Incorporating patient information
3. Review monitoring
4. Board influence on management
5. Influence on Medical Staff
6. Creating a Culture of Quality
7. Resource allocation
8. Understanding health care
Exercise

Using the Self-assessment Tool

Do a self assessment of your Board and discuss why with your neighbors

Conclusive
Best Boards Practices

1. Quality of Care Committee
2. Establish Culture and Will
3. Establish Bold Performance Goals
4. Promote Leadership Collaboration
5. Empower a Quality Committee
6. Oversee Progress
How Do the Best Boards Manage Conversations: With Each Other, and With Physicians?

James E. Orlikoff

Objectives

After this session participants will be able to:

- identify the skills and tools for having meaningful conversations with other board members
- identify skills and tools for having meaningful conversations with physicians who are members of the board
The quality of governance that was sufficient to get your organization where it is today will be insufficient to get it where it needs to be tomorrow!

What Makes Boards Unique?

- A board only exists when it is meeting.
- The board is an entity, not a collection of individuals.
- The authority of the board derives from the whole, not from any individual member.
What Is the “Fiduciary Duty” of the Board?

1. The duty of __________
2. The duty of __________
3. The duty of __________

Volumes of research suggest that a diverse group of independent directors with access to good information will consistently make better decisions about big picture issues than the most intelligent individuals can.
Then why don’t they?

The Seven Deadly Sins of Ineffective Governance

1. Representational governance
2. Lack of mission focus
3. The tendency to resist change rather than to lead it
4. Bad governance information
5. Reluctance to dump the deadwood from the board
6. Cumbersome, outmoded governance structures
7. No job descriptions
Critical Leadership Questions for the Board

- What do we believe?
- Whom do we serve?
- What do we do?

DISRUPTIVE GOVERNANCE

Innovations/practices that change culture, behavior, and the organization; and create a collective body of knowledge and a new set of habits.
The Typical Board “Flash Points”

- Executive sessions
- Board member performance evaluation
- “Inappropriate” behavior
- Split votes, conflict
- CEO succession planning
- CEO compensation
- Quality issues
- Medical staff credentialing; physician performance/behavior issues

Disruptive Governance

- Do post board meeting mini evaluations; discuss results and adjust practices at next meeting
- Do a “governance audit” once every two years (policies/practices review)
- Use consent agendas
- Use timed agendas but build in one “deep dive” discussion at each board meeting
Disruptive Governance

- Have “meta” conversations at critical points (after a split vote; after a disagreement on the board; after the board has “slipped back” into an old behavior)
- Post board member meeting attendance for all to see
- Do a member performance evaluation one year prior to expiration of term, provide feedback then

Disruptive Governance

- Do a “board composition profile” and review and discuss as a full board each year
- Do “trustee credentialing”; require board continuing education, retreat attendance, etc
- Conduct regular executive sessions of the board
- Practice “decision sequencing”, no surprise decision requests
Disruptive Governance

- Create and embrace a board culture of constructive challenge and respectful dissent; of contrarian thinking and vigorous debate.
  - Recognize that debate, creative tension, and even a “good fight” are acceptable and even desirable aspects of effective governance.
  - Create rules for constructive conflict; process it afterwards.

Boards As Teams

“Real teams don’t emerge unless individuals on them take risks involving conflict, trust, interdependence & hard work.”

Katzenbach & Smith
Great Teams Have Good Fights!

- The complete absence of conflict in a board or committee (team) is *not* harmony, it’s more likely apathy.
- Great teams have these characteristics:
  - they focus on the facts or the tasks
  - they multiply the alternatives
  - they create common goals
  - they use humor
  - they balance the power structure
  - they seek consensus with qualification

Great Boards Have Great Process

- They have defined process for both routine and infrequent situations. They rely upon and follow these processes – and only change them rarely and after a clear decision to do so.
- **They Decide How They will Make Decisions!**
  Different situations may call for different decision-making processes and rules.
- Effective boards make certain that these key processes exist; that they are robust; and they follow them!
Great Boards Have Great Process

When a situation arises where there is no process, the board and its leaders use established principles, protocols, and board culture to establish one. That process is then evaluated, modified, and codified.
“Gentlemen, I take it that we are in complete agreement on the decision here. Then, I propose that we postpone further discussion to give ourselves time to develop disagreement and perhaps gain some understanding of what the decision is all about”

Alfred Sloan: GM Chairman and CEO from 1923-1956
Resolving Conflict at (or Between) Meetings

REMEMBER:
How the board addresses conflict or a problem will be remembered long after the actual conflict is resolved.

Resolving Conflict at Meetings

- Define the problem as objectively as possible and get board members to agree to the definition of the problem before addressing possible solutions or actions.
- Confine the debate and discussion to principles and issues, not personalities.
- At critical moments, use active listening to restate each person's perspective in order to both understand the problem and to demonstrate accurate understanding. Do NOT overuse!
- Facilitate a brainstorming session to generate a list of solutions or alternative approaches
- Take a break and consider the possible solutions at a subsequent meeting.
Tips for Tough Conversations

- Try not to “go it alone”.
- Rehearse the conversation in advance; play out several scenarios and “what ifs”.
- Where possible, de-personalize the conversation. Where not possible, use “I” statements, not “you” statements.
- Be prepared to suggest solutions or alternative approaches.
- At critical moments use “active listening” techniques. Do NOT overuse!

Tips for Tough Conversations

- Focus on data, information, and process. When presented with anecdote, assumption, or denial respectfully challenge with “do you have data to back that up?”
- Use “meta discussion” technique to process the conversation immediately afterwards. “Look at how we handled that... We did something different/we fell back into an old behavior...How comfortable was everyone with the conversation? How should we handle a similar conversation in the future?” Etc....
Tie the issue to the responsibility of the board and the mission and strategic plan of the organization. Use fiduciary duty of the board, external regulators and forces, board liability, job descriptions of the board/board committee, and board/committee workplans as foundation and rationale for the question/conversation.

- Pick your spots!
- Stick to your guns! You are fighting the good fight!

Tips for Tough Conversations

TRUST
IS ABSOLUTELY KEY TO SUCCESS!
Tips on Trust

- Trust does not mean that you always do what others want you to do. It means that you always do what you said you would do, or what was agreed in principle or policy you would do (job description).
- You build trust when you are seen as open, honest, consistent and reliable. Tough conversations are an opportunity to build trust.
- It takes a long time to develop trust, and only a bad moment to break it!

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”.

The data are right; it is a problem but, not my (our) problem.”
The Fallacy of Composition

- What is good for the individual is not good for the group.
- What is good for the group is not good for the individual.
A leader is a person or group that people will follow to places where they would not otherwise go by themselves.
It is not the strongest who survive, or the fastest.  
It is the ones who can change the quickest.
-Charles Darwin

The Board and Integrity

"Leadership is a potent combination of strategy and character. But if you must be without one, be without strategy".

General Norman Schwartzkopf
How good is your hospital or healthcare organization?
How Good…?

- What is the right number of medication errors if you are the patient?
- How many infections would you like to take home with you from your hospital stay?
- How do you explain to your mother that it is perfectly normal and acceptable to spend 8 hours in the ED?
- Why is it ok to discharge a patient from the ED without any real arrangements made for follow-up care?

Are we seeing 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.”

Global Trigger Tool shows that adverse events in hospitals may be ten times greater than previously measured

“This study compared three methods to detect adverse events in hospitalized patients, using the same patient sample set from three hospitals: voluntary reporting, the Agency for Healthcare Research and Quality’s Patient Safety Indicators, and the IHI Global Trigger Tool. The IHI Global Trigger Tool found at least ten times more confirmed, serious events than these other methods. The authors submit that reliance on voluntary reporting and Patient Safety Indicators could produce misleading conclusions about the current safety of US health care and misdirect safety improvement efforts.”


IHI.org Website April 13, 2011

Basic Board Responsibilities

- Set and periodically review the Mission, Values and Goals
- The only employee who reports to the Board is the CEO. The Board must hire, fire and evaluate his/her performance.

**The Board ensures the Quality of Patient Care.**

- The Board ensures the organization’s financial performance.
- The Board has shared responsibility for the health of their community.
- The Board must assume responsibility for itself

Two Key Truths About Boards

- As a general rule, Boards think quality is a lot better than the administrators, doctors, and nurses do.
  - "But you never told us in a way we could understand it."
- Boards make a big difference in quality
  - 25% time, interaction with medical staff, CEO compensation…
  - Vaughn T, Koepke M, Kroch et. al. 2006

Board Dashboards and Scorecards

- The most common question boards ask about dashboards: “What should be on it?”
- Our response:
  - What is your aim?
  - How do you intend to use the data?
A place to start thinking about Quality Aims...

Don’t hurt me
Help me
Be Nice to Me

Don Berwick, MD

IHI Triple AIM

Define “Quality’ from the perspective of an individual member of a defined population

- Core organizational strategy
- Success is “Leadership Dependent”
Quality Aims

- **Quality:** Deliver everything that will help, and only what will help. The goal is 100%
- **Safety:** Do no harm. The goal is 0 Events

A Health Care System’s Core Work

**Inputs**
- Patients
- Staff
- Supplies
- Equipment
- Facilities

**Care Processes**
- Diagnosing
- Treating
- Explaining
- Teaching
- Monitoring
- Documenting

**Outputs**
- Care Outcomes
- Harm Rate
- Patient Satisfaction
- Cost per Case
How This Looks to Many Board Members

Inputs
- Patients
- Staff
- Supplies
- Equipment
- Facilities

Care Processes
- Diagnosing
- Treating
- Explaining
- Teaching
- Monitoring
- Documenting

Outputs
- Care Outcomes
- Harm Rate
- Patient Satisfaction
- Cost per Case

What is this Award Winning Hospital Perfectly Designed to Produce?

- Outcomes/System-level Measures
  - Excellent patient experience
    - 95% willingness to recommend
  - Risk-adjusted inpatient mortality rates that track with US “average”
    - 30-day AMI mortality is 13.0% (better than the US average 16.6%)
  - Low overall costs of care for Medicare population
    - 30-day readmission rates for AMI (16.9%) and CHF (19.5%) better than US norms
But It is Also Designed to Produce...

- Safety events each year
  - 6 sentinel events
  - 12 deaths associated with "occurrences"
  - 9 permanent injuries associated with "occurrences"
  - 12 CLAB infections 10 VAP
  - 40-50 MRSA infections (12 in Q4 2009)
  - ~100 CA-UTI
  - 32 surgical "occurrences" (2 deaths, 2 sentinel events, 6 temporary harms)

- Process Measures: all or none
  - 9% defect rates in CHF care
  - 5% defect rates in pneumonia care
  - 1% defect rate in AMI care
  - 4% defect rates in SCIP measures

Seven Leadership Leverage Points*

- Set measured system-level aims and oversee at the Board level
- Align aims, measures and strategies in a leadership learning system
- Channel leadership attention to aims
- Get the right team engaged, including the patient
- Engage the CFO in this work
- Engage with physicians
- Build deep improvement capability

*ihi.org White Paper: Reinertsen, Pugh and Bisognano, 2009
Is Your Board Dashboard/Scorecard Confusing?

- Too many measures?
- Trying to answer two questions at once?
  - How do we compare to others?
  - Are we on track to achieve our quality aims?
- Columns of numbers instead of graphs?
- Color coding—everything is green?
- Look like eye charts?

How to measure harm

- Try to eliminate the denominator...
  - You don’t need denominators to compare yourself to yourself, over time
  - Denominators are often part of the problem (ADEs per 1000 doses, SSEs per 1000 patient days)
- “Rates” make the problem abstract, rather than personal
What makes more sense… if the right answer is 0?

<table>
<thead>
<tr>
<th>Traditional Display (Rates)</th>
<th>Actual Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>.005 ADEs /1000 doses</td>
<td>35 ADEs last month</td>
</tr>
<tr>
<td>2.67 infections/1000 patient days</td>
<td>220 hospital acquired infections last quarter</td>
</tr>
<tr>
<td>.003 Falls with harm per/1000 patient days</td>
<td>65 Patient falls—16 with harm last month</td>
</tr>
</tbody>
</table>

Risk Management report?

<table>
<thead>
<tr>
<th>Event</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>488</td>
</tr>
<tr>
<td>Medication Error</td>
<td>725</td>
</tr>
<tr>
<td>Readmission for proc/surgery site infection</td>
<td>11</td>
</tr>
<tr>
<td>Birth Injury</td>
<td>9</td>
</tr>
<tr>
<td>Difficult Delivery</td>
<td>42</td>
</tr>
<tr>
<td>Fetal Resuscitation</td>
<td>47</td>
</tr>
<tr>
<td>Maternal transfer to critical care</td>
<td>3</td>
</tr>
<tr>
<td>Delay in diagnosis</td>
<td>456</td>
</tr>
<tr>
<td>Delay in treatment</td>
<td>291</td>
</tr>
<tr>
<td>Mislabeled labs</td>
<td>327</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>3</td>
</tr>
<tr>
<td>Trauma to healthy tissue</td>
<td>117</td>
</tr>
<tr>
<td>Pressure sore</td>
<td>79</td>
</tr>
<tr>
<td>Complications during surgery</td>
<td>56</td>
</tr>
<tr>
<td>Return to OR</td>
<td>79</td>
</tr>
<tr>
<td>Unexpected change in condition</td>
<td>101</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2834</strong></td>
</tr>
</tbody>
</table>
Put a face on the data

Baseline SSER, CY 2010, 46 Events

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Event Type</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>John B.</td>
<td>9/26/2008</td>
<td>Delay in Tx</td>
<td></td>
</tr>
<tr>
<td>Shirley H.</td>
<td>12/3/2008</td>
<td>Post Proced Death</td>
<td></td>
</tr>
<tr>
<td>Florida H.</td>
<td>7/3/2008</td>
<td>Delay in Tx</td>
<td></td>
</tr>
<tr>
<td>Wade W.</td>
<td>7/16/2008</td>
<td>Delay in Tx</td>
<td></td>
</tr>
<tr>
<td>Baby Boy S.</td>
<td>8/6/2008</td>
<td>Wrong Pt. Procedure</td>
<td></td>
</tr>
<tr>
<td>Joseph R.</td>
<td>8/9/2008</td>
<td>Delay in Dx</td>
<td></td>
</tr>
<tr>
<td>Tamika M</td>
<td>4/21/2008</td>
<td>Med Error</td>
<td></td>
</tr>
<tr>
<td>Andrea M.</td>
<td>6/24/2008</td>
<td>Wrong Procedure</td>
<td></td>
</tr>
<tr>
<td>Nancy H.</td>
<td>6/18/2008</td>
<td>Med Error</td>
<td></td>
</tr>
<tr>
<td>Jimmy P.</td>
<td>7/7/2008</td>
<td>Fall</td>
<td></td>
</tr>
<tr>
<td>Joann E.</td>
<td>9/23/2008</td>
<td>Wrong Site Surgery</td>
<td></td>
</tr>
<tr>
<td>Cynthia M.</td>
<td>10/27/2008</td>
<td>Med Error</td>
<td></td>
</tr>
<tr>
<td>Regina D.</td>
<td>12/9/2008</td>
<td>Wrong Site Surgery</td>
<td></td>
</tr>
<tr>
<td>Baby Girl V.</td>
<td>5/12/2008</td>
<td>Delay in Dx</td>
<td></td>
</tr>
<tr>
<td>Kyle W.</td>
<td>9/13/2008</td>
<td>Delay in Tx</td>
<td></td>
</tr>
<tr>
<td>Teodur C.</td>
<td>1/28/08, 12/2/2008</td>
<td>Delay in Tx</td>
<td></td>
</tr>
<tr>
<td>Alvin G.</td>
<td>8/17/2008</td>
<td>Fall</td>
<td></td>
</tr>
<tr>
<td>Nicole S.</td>
<td>1/4/2008</td>
<td>Delay in Dx</td>
<td></td>
</tr>
<tr>
<td>Margaret H.</td>
<td>2/6/2008</td>
<td>Med Error</td>
<td></td>
</tr>
<tr>
<td>Mother's Delay in Tx</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ursula L.</td>
<td>2/14/2008</td>
<td>Post Proced Death</td>
<td></td>
</tr>
<tr>
<td>Sandra M.</td>
<td>12/10/2008</td>
<td>Post Proced Suicide</td>
<td></td>
</tr>
<tr>
<td>Karen G.</td>
<td>8/5/2008</td>
<td>Proced Cx/Delay in Tx</td>
<td></td>
</tr>
<tr>
<td>Cynthia K.</td>
<td>11/10/2008</td>
<td>Delay in Tx</td>
<td></td>
</tr>
<tr>
<td>Lance D.</td>
<td>10/30/2008</td>
<td>Delay in Tx</td>
<td></td>
</tr>
<tr>
<td>Dale W.</td>
<td>10/12/2008</td>
<td>Delay in Tx</td>
<td></td>
</tr>
<tr>
<td>Nicole H.</td>
<td>8/12/2008</td>
<td>Post-proced Cx</td>
<td></td>
</tr>
<tr>
<td>Eugene B.</td>
<td>10/27/2008, 10/28/2008</td>
<td>Med Error, Fall</td>
<td></td>
</tr>
<tr>
<td>Virginia L.</td>
<td>8/12/2008</td>
<td>Delay in Tx</td>
<td></td>
</tr>
<tr>
<td>Chantel E.</td>
<td>8/26/2008</td>
<td>Fall</td>
<td></td>
</tr>
</tbody>
</table>

Incident Reporting - Fall
24 Patients & Events – CY 2012 vs 46 Total for 2010

- Louenee D. 9/23/09 Fall
- Beverly S. 2/4/09 Med Error
- Robert D. 5/12/09 Post Procedure Death
- Karen C. 9/28/09 Delay In Treatment
- Peggy P. 7/1/09 Burn
- Sharenda W. 2/15/09 Med Error
- Edward R. 4/23/09 Wrong Side Procedure
- Brenda R. 10/14/09 Delay In Treatment
- James H. 10/25/09 Post Procedure Death
- Lilliam C. 4/3/09 Retained foreign object
- Dorothy R. 1/28/09 Delay In Treatment
- Yolanda V. 11/25/09 Retained foreign object
- Monroe K. 5/18/09 Post Procedure Death
- Jerry Y. 11/7/09 Delay In Treatment
- Juanita A. 5/14/09 Delay In Treatment
- Johnny B. 11/9/09 Fall
- Michael F. 8/20/09 Retained foreign object
- Willie B. 11/5/09 Med Error
- Helen C. 11/1/09 Delay In Treatment
- Pauline M. 11/2/09 Fall
- Scott G. 9/5/09 Delay In Treatment
- Alma M. 11/6/09 Fall
- Ronnie D. 11/3/09 Delay In Treatment
- Marilyn C. 1/21/10 Med Error

47% Reduction SSER from Dec. 08 Baseline
48% Reduction in # of events year to year

A 78% reduction through Nov. 2013

- Lois R. 4/16/10 Surgical Fire
- Mary B. 5/22/10 Post Procedure Cx
- Lamar A. 6/3/10 Med Error
- Bruce C. 5/29/10 Delay In Dx
- Marilyn C. 1/21/10 Med Error

- Sylvia L. 3/21/10 Delay In Dx
- Ruby B. 5/30/10 Fall

- Frank S. 2/22/10 Surgery Cx
- Doyle L. 7/22/10 Med Error
Color Coded Dashboards
Only As Good As Your Targets

- Simple, and sometimes too simple
- Color coding without numbers can mislead
- Tendency is to assume that only the "red" blocks need attention
- If used, boards need to frequently ask how the targets are set

The Case For All-or-None Measurement

**Governance Question: “What % of Patients Got the Right Care?”**

**Report to the Board Quality Committee**

“Our MI Core Indicators were greatly improved last quarter. Only one measure requires corrective action.”

<table>
<thead>
<tr>
<th>Evidence-Based Care Measure</th>
<th>EBC Compliance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBC 1</td>
<td>80%</td>
</tr>
<tr>
<td>EBC 2</td>
<td>100%</td>
</tr>
<tr>
<td>EBC 3</td>
<td>100%</td>
</tr>
<tr>
<td>EBC 4</td>
<td>60%</td>
</tr>
<tr>
<td>EBC 5</td>
<td>80%</td>
</tr>
<tr>
<td>EBC 6</td>
<td>90%</td>
</tr>
</tbody>
</table>
The Case For All-or-None Measures
Only 30% of Patients Received the Right Care*

<table>
<thead>
<tr>
<th>EBC Compliance %</th>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
<th>Patient 4</th>
<th>Patient 5</th>
<th>Patient 6</th>
<th>Patient 7</th>
<th>Patient 8</th>
<th>Patient 9</th>
<th>Patient 10</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBC 1</td>
<td>8</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
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<tr>
<td>EBC 6</td>
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<tr>
<td>% of Care Elements Received by Patient</td>
<td>83%</td>
<td>100%</td>
<td>67%</td>
<td>83%</td>
<td>83%</td>
<td>100%</td>
<td>67%</td>
<td>100%</td>
<td>100%</td>
<td>83%</td>
<td>30%</td>
</tr>
<tr>
<td>% of Patients Receiving Perfect Care</td>
<td>30%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</table>

*Right Care defined as receiving all of the required EBC elements (based on clinical eligibility)

The Case for Measuring Against Standards/Expectations

- Door to Intervention time proven to be critical to Heart Attack outcomes
- Standard=30 minutes from presentation to (Thrombolytics or 90 minutes to Angioplasty)

Great Report or Not?

Quality Committee Report
- “Our data indicates that we are exceeding the national standard. Our average time for thrombolytics is 29.5 minutes.”
Not: What about the 25% of patients with delayed care?

Door to Therapy-MI
Average = 29.5 Minutes

% of All Patients Beyond the Standard

What Might Be On the Hospital Board’s Balanced Scorecard?

Board performance measures should at minimum include expected aims and results for:

- Employee Satisfaction or Engagement
- Operating Margin %
- Cost per Discharge
- Days Cash on Hand
- Waiting Time/Access Measure
- New: Triple Aim Measures
- Mortality Rate
- Re-admission Rate
- Patient Experience
- % of Patients Receiving Care According to the Evidence
- Number of Patient Harm Events
Current Measurement Systems

- Current system is silo-specific:
  - Site-, provider-, payer-, disease-
  - Hospital care measures
  - HEDIS preventive measures
- Measurement areas are important, however, they do not measure integrated and accountable care

Three Dimensions of Value
Future of Quality Measurement must Integrate

- Outcomes that matter to patients
- Processes/experiences
- Service
- Costs
- Think episodically and comprehensively
- Think “Triple Aim”

Potential Triple Aim Measures: Population Health

- Health outcomes
  - Mortality: Years of potential life lost; Life expectancy; Standardized mortality rates
  - Health/functional status: Single question (e.g. from CDC HRQOL-4) or multi domain (e.g., SF-12)
  - Healthy life expectancy (HLE): Combines life expectancy and health status into a single measure, reflecting remaining years of life in good health
- Disease burden
  - Incidence and/or prevalence of major chronic conditions
- Risk status
  - Behavioral: Smoking, alcohol, physical activity, diet
  - Physiological: Blood pressure, BMI, cholesterol, blood glucose
Potential Triple Aim Measures: Experience of Care

- Standard questions from patient surveys
  - Global questions from US CAHPS or How's Your Health
  - Experience questions from NHS World Class Commissioning or Care Quality Commission
  - Likelihood to recommend

- Set of measures based on key dimensions (e.g., US IOM Quality Chasm Aims: Safe, effective, timely, efficient, equitable, and patient-centered)

Potential Triple Aim Measures: Per Capita Cost

- Total cost per member of the population per month
- Hospital and ED utilization rate and/or cost
- Medicare cost per beneficiary
- Total cost of care
Patient-reported Outcomes

- Definition: Any report of the status of a patient’s health condition that comes directly from the patient, without interpretation of the patient’s response by a clinician or anyone else
- PRO tools measure what patients are able to do and how they feel by asking questions
  - Enable assessment of patient-reported health status for physical, mental, and social well-being
- A wide variety of patient-level instruments to measure PROs have been used for clinical research purposes
  - Examples: How’s Your Health, SF-36, CDC HRQOL, PROMIS

Dashboards

- “Findings…dashboards are generally used to create general awareness rather than used to guide operations and performance management…Greater hospital quality was linked to shorter, more focused dashboards, active use of dashboards for operations management, and strong influence of board quality committees in dashboard content and implementation.”
  Kroch et al., Journal of Patient Safety 2 (1) 10-19, March 2006
Boards often find it useful to employ two types of Dashboards

**Comparison Dashboard**
- How do we compare to...
  - Other hospitals?
  - Regulatory standards?
  - Benchmarks?
  - P4P measures?
- Hundreds of measures
  - Processes
- Measures are typically
  - risk-adjusted
  - apples to apples (rates per procedure e.g.)
  - slow

**Strategic Dashboard**
- Are we on track to achieve our aims?
  - Reduce harm
  - Improve outcomes
  - Improve satisfaction
  - Reduce costs
  - Grow
- A few key measures
  - Outcomes, Drivers
- Measures are typically
  - Close to real time
  - “Good enough”

The Strategic Dashboard Answers the Questions

- Are We on Track to Achieve Our Aims?
- Is Our Strategy Working?
- To answer these questions...
  - The Board Dashboard should parallel the organization’s aims
  - The measures should be weekly or monthly, real time, and displayed as run charts.
  - Measures do not necessarily need to be risk adjusted, or displayed as rates. You can eliminate the denominator in many instances.
  - Management and the board should review the key system-level measures at every meeting.
Serious Safety Events per 10,000 Adj. Patient Days
Rolling 12-Month Average

What questions did the Board ask of management and medical staff leaders at this meeting?

229 Infections Avoided Thus Far!

HAI Reduction through April 09

Chart Updated Through 31 Aug 09 by Art Wheeler, Legal Dept.

* Each point reflects the previous 12 months. Threshold line denotes significant difference from baseline for those 12 months (p<0.05).
** The narrowing thresholds in FY2005-FY2007 reflect increasing concern. Adjusted patient days for FY'07 were 27% higher than for FY'05.

SSEs per 10,000 Adj. Patient Days
Baseline [FY'05-FY'06]
Fiscal Year Goal (FY'07=0.75; FY'08=0.52; FY'09=0.20)
Threshold for Significant Change

229 Infections Avoided Thus Far!
2011 Midwest Health System Board Quality Dashboard

<table>
<thead>
<tr>
<th></th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Mortalities</td>
<td>1,254</td>
<td>251</td>
<td>1,003</td>
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<tr>
<td>Inpatient All-Cause Readmissions</td>
<td>10,392</td>
<td>2,078</td>
<td>8,314</td>
</tr>
<tr>
<td>Harm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related to Medical Management</td>
<td>679</td>
<td>136</td>
<td>543</td>
</tr>
<tr>
<td>Hospital Acquired Infections</td>
<td>1,549</td>
<td>310</td>
<td>1,239</td>
</tr>
<tr>
<td>Related to Patient Care</td>
<td>905</td>
<td>181</td>
<td>724</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>3,147</td>
<td>629</td>
<td>2,518</td>
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<tr>
<td>Sentinel Events</td>
<td>162</td>
<td>32</td>
<td>130</td>
</tr>
<tr>
<td>with harm</td>
<td>75</td>
<td>15</td>
<td>60</td>
</tr>
<tr>
<td>Perfect Care</td>
<td>81%</td>
<td>16%</td>
<td>97%</td>
</tr>
</tbody>
</table>

2011 Midwest Health System Board Detail Report

- Status: Steady Improvement

- Current Focus
  - Infections and Falls
Linking Strategy and Execution

- Leverage Point 2:
  Build an executable strategy to achieve the aims, and oversee the execution at the highest levels of administration
- One of the biggest disconnects in hospitals is that quality efforts are often not aligned with overall aims and strategy
- It might be a good project, but will it help move the Dots?

Tracking is not enough...

- It’s not enough to have a dashboard that tracks your system-level aims and drivers.
- If you are to achieve your goals, the board and senior management must review the key data on big dots and drivers, and respond if needed with changes in strategy or improvements in execution, quickly.
Your Strategic Theory Drives the Creation of the Board “Strategic Quality Dashboard”

| Big Dots  
(Pillars, BSC…) | Drivers  
(Core Theory of Strategy) | Projects  
(Ops Plan) |
|-----------------|-----------------------------|-------------|
| • What are your key strategic aims? How good must we be, by when?  
• What are the system-level measures of those aims? | • Down deep, what really has to be changed, or put in place, in order to achieve each of these goals?  
• What are you tracking to know whether these drivers are changing? | • What set of projects will move the drivers far enough, fast enough, to achieve your aims?  
• How will we know if the projects are being executed? |

Example: A Strategic Theory for the Aim “Reduce Mortality Rate”

| Big Dot Aim  
(Core Theory of Strategy) | Drivers  
(Core Theory of Strategy) | Projects  
(Ops Plan) |
|--------------------------|-----------------------------|-------------|
| • Reduce mortality rate by 20% in 24 months, as measured by Hospital Standardized Mortality Rate (from 105 to 85) | • Culture of teamwork as measured by monthly survey of key nursing units  
• Reliable recognition and early treatment of sepsis as measured by % of septic patients on protocol  
• Improved end of life care as measured by % deaths in home care or hospice | What set of projects will move the drivers far enough, fast enough, to achieve your aims?  
How will we know if the projects are being executed? |
The Ideal Strategic Dashboard Parallels the Strategic Theory

Are we on track with the mortality Aim?
Are we executing our strategy?
**The Ideal Strategic Dashboard Parallels the Strategic Theory**

- Are we on track with the mortality Aim?
- Are we executing our strategy?
- What is your diagnosis?

**Summary: The Strategic Dashboard**

- The Board Dashboard should parallel the organization’s aims and strategic theory.
- The measures should be weekly or monthly, real-time, and displayed as run charts.
- Measures do not necessarily need to be risk adjusted, or displayed as rates. You can eliminate the denominator in many instances.
- Management and the board should review the key system-level measures at every meeting.
What About the Other Important Type of Quality Question?

- How does our quality measure up…
  - To other hospitals like ours?
  - To standards and regulatory requirements?
  - To industry “benchmarks?”
  - …etc.

---

External Comparative Data Need to Knows

<table>
<thead>
<tr>
<th><strong>Upside</strong></th>
<th><strong>Downside</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Often risk adjusted</td>
<td>Time lag (months)</td>
</tr>
<tr>
<td>Apples to apples can be useful</td>
<td>Static (no data over time)</td>
</tr>
<tr>
<td>Source of pride</td>
<td>If you look bad, energy is wasted on “the data must be wrong”</td>
</tr>
<tr>
<td>Source of energy for improvement</td>
<td>If you look good, you become complacent</td>
</tr>
<tr>
<td>Necessary “staying in business” requirement (licensure, deemed status…)</td>
<td>How you look depends on how others perform</td>
</tr>
<tr>
<td></td>
<td>Standards and benchmarks are full of defects (“The cream of the crap”)</td>
</tr>
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</table>
Recommendations for Board Use of Comparative Dashboards

- Don’t use comparative reports to oversee and guide improvement at each meeting.
- Do ask for an “exception report” for any measures that are “off the regulatory and compliance rails.”
- Create a separate dashboard with all your publicly reported ‘compared to others’ data and review it annually.
- Compare to the best, not the 50th %tile.
- Always make sure you know how “green” is determined.

Summary: Good Board Practices for Dashboards

- Separate the “comparison” and “strategic” questions into two dashboards.
- Use the “comparison” dashboard to take stock from time to time, not to steer by.
- Set a few system-level, specific aims, and develop a Strategic Dashboard with timely, “good enough” data that is based on your theory of what needs to happen to achieve the aims.
- Spend time on your strategic dashboard: If you’re not on track to achieve your aims, start asking hard questions.
Dashboard Workshop

- Assess your own quality dashboard.
  - Are major aims crystal clear on the dashboard? (how good, by when, as measured by...)
  - Do you have a clear drivers and “strategic theory” of how to accomplish your aims, evident on the dashboard?
  - Which measures belong on the “how do we compare to others/standards?” dashboard, and which belong on the “Are we on track to achieve our aims?” dashboard?
  - How timely are the measures? How could you improve the time delay in getting feedback on performance?
  - For harm-related measures, does the dashboard answer the question “How many patients was that?”

- List three specific improvements you intend to make in your board’s quality dashboard.

Thank you!

Q&A