



Quality and Patient Safety

Engaging Your Board to Take the Lead.

Patient safety became a rallying cry in 1999 when the Institute of Medicine (IOM) released its finding in “To Err Is Human” that as many as 98,000 people in American hospitals die annually as a result of preventable medical errors. These deaths represent the tip of the iceberg in terms of the opportunity to make healthcare safer. For example, with every medication error that results in death, another 10 errors cause non-fatal harm and 100 cause no harm.

The study has brought about many activities, including the JCAHO’s national patient safety goals, the Institute for Healthcare Improvement’s (IHI) 100,000 Lives Campaign, sentinel event reporting, and a plethora of other patient safety activities. Clinical improvement initiatives also have increased, most notably pay-for-performance programs.

Board trustees support the push for patient safety. Sentinel events are out of the closet, reported and discussed by board committees. Boards receive patient safety indicators and monitor improvement projects. Trustees want to do the right thing, and without question they are making our hospitals safer.

Yet the evidence indicates that progress has been incremental rather

than systemic. An analysis conducted by R.M. Wachter, titled “The End of the Beginning: Patient Safety Five Years After To Err Is Human” (*Health Affairs*, Nov. 30, 2004), found greater awareness but few changes in resources, culture and information technology to make a measurable dent in medical errors. Patients count on hospitals to provide safe care and facilities, but preventable deaths equivalent to a jumbo jet crashing every day does not fulfill their trust.

In a *Harvard Business Review* article, “Fixing Healthcare From the Inside, Today,” published September 2005, S.J. Spear, a senior fellow at IHI, describes why the root causes of preventable errors are deeply embedded in the traditional culture and processes of the healthcare system. Healthcare professionals are resistant to the standardization of safe practices and mandatory checklists, which typically are accepted practices in other complex industries, such as air transportation. Hospitals have been slow to adopt fail-safe information systems to prevent medication mishaps and diagnostic errors, impeded by insufficient funding and physician resistance to integrating new information technology into their work habits. Hospital staff respond to flawed processes—to broken processes, such as delaying

getting drugs for patients, and with work-arounds such as stockpiling medications—because they lack the time, resources or management directive to redesign the processes to work better.

These engrained cultural barriers will not change quickly or easily, but rather will require sustained effort and resources. Fundamental change cannot be accomplished without the engagement of board and senior executive leadership.

Why Boards Are Not Leading

Boards and executives need to adopt a deliberate leadership strategy to develop the board’s quality competency and engage its full potential. Most executives try to educate their boards about quality and patient safety and involve them in these initiatives, but CEOs voice frustration that their boards “are supportive but passive, don’t really understand clinical information, get mired in the details and can’t see the big picture.”

Contrast that with how many boards tackle their financial responsibilities. They adopt a laser-like focus on key measures of performance, demand understandable explanations of variances and do not ease up until performance improves. They ask probing questions and support tough decisions.

They bring relevant perspective from private industry. In short, they lead, they do not just follow.

Why are boards not equally tenacious with regard to patient safety and quality? First, there has been an over-reliance on educating trustees in patient safety issues. Education is vital, but to expect that education can transform a group of well-intentioned volunteers into expert quality overseers is simply unrealistic. Just as the Sarbanes-Oxley Act calls for financial experts on corporate board audit committees, healthcare boards need a few members with quality expertise on the quality committee.

Second, there is an almost mystical belief that dashboards will spur improved performance. Performance metrics are important, but as Robert Lloyd, executive director of Performance Improvement at IHI, commented, measures alone are not self-actualizing and thus do not automatically trigger improvement. Many dashboards have so many indicators that trustees lose sight of the vital few measures of mission success which really matter. Dashboards need to be linked to accountability.

Third, a lack of transparency still keeps boards unaware of deep-rooted quality and safety problems. Fear of liability and punishment contribute to a culture in which errors and problems are not openly discussed and solutions are not sought. Board quality committees need to become a forum for candid discussion and exploration of improvement needs.

Finally, and perhaps most importantly, many boards and executives have failed to distinguish a governance role that

adds value to quality and patient safety. Boards have been told they must be the super cops of quality and safety or risk loss of accreditation. Consequently board and quality committees are drowning in detailed reviews of quality-related operations that lead to tedious meetings and occasional meddling.

Instead healthcare boards should refocus their work around the overarching goal of redesigning their part of the healthcare world to be the safest, best quality, most efficient and best-managed organization it can possibly be. The board should approve a limited number of high-level performance goals; require management to redesign the dashboard reports around those goals; support significant investments in culture development, quality measurement and information technology; and truly hold management and physicians accountable for results.

Optimizing the Board's Engagement in Quality and Safety

A board that wants to fully harness its potential to advance quality can build its competency through five stages of development:

1. Recruitment. The board explicitly recruits several members for their competencies in quality, safety and customer satisfaction in both industry and healthcare. Clinicians with a passion for and training in quality improvement and patient safety should be sought. In addition, individuals who can quickly grasp complex issues and ask probing questions—attorneys, college and university presidents, and corporate executives come to mind—can help a board understand quality and safety issues.

2. Awareness. Education is not a panacea, but it is the foundation of effective governance. The board has a formal orientation and continuing education process that makes board members aware of:

- External quality and patient safety requirements in an era of increased governance accountability and transparency.
- The board's responsibilities for clinical quality, patient safety, customer service and (for hospital boards) physician credentialing.
- The need and opportunity to improve quality and safety communicated through objective data (such as the IOM medical errors study) and through powerful stories of real errors made on real patients.
- The organization's programs to measure and improve quality and safety.

3. Literacy. Board education can develop trustee literacy on such issues as:

- How to read scorecards and spot red flags for clinical outcomes, patient/customer satisfaction and employee satisfaction.
- National trends in healthcare quality, such as pay for performance and IHI's 100,000 Lives Campaign.

4. Application. The board abandons passive tendencies and actively engages on quality issues. Examples include:

- Asking when a problem involving a care process will be fixed and when the board (or board quality committee) can expect a report back.
- Ensuring the annual quality and patient safety improvement plans have sufficient resources and are integrated with the organization's strategic and financial plans.
- Challenging a medical staff recommendation that falls short of the board's expectations.
- Incorporating quality and safety goals into the CEO's performance evaluation and incentive compensation.

5. Work that adds value. The board makes a distinctive, substantive contribution to the organization through its work. Examples will vary among organizations but may include:

- Challenging the organization to raise the bar—for example, winning the Malcolm Baldrige National Quality Award or, as one health system has done, setting a goal of zero deaths due to errors by 2008.
- Inspiring management to rethink its approach to integrating information technology into care delivery.

- Communicating the hospital's quality initiatives and results to key stakeholders.

Boards have long represented the best and brightest of the community. Tremendous potential lies in those communities, boards and medical staffs. An intentional approach to board engagement can reap rewards for the entire organization. ▲

Barry S. Bader is a governance consultant based in Potomac, Maryland. He is one of The Governance Institute's governance advisors and counsels boards on practices to enhance their effectiveness. Bader can be reached at bbader@greatboards.org.