Governing for Improved Quality and Patient Safety

EXECUTIVE SUMMARY

▶ Board members have a critical oversight role to play in monitoring and providing direction to improve health care quality and safety.

▶ In the emerging environment of health care reform, the board's role in overseeing quality and safety on behalf of stakeholders will become as or even more important than its financial oversight role.

▶ Nurses can expand their impact by joining the ranks of health care organization governing boards to lead and guide the entire health care enterprise to realize the goal of improved care and outcomes for all patients.

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IN THE CURRENT ENVIRONMENT of reform, a national agenda for health care quality and safety is unfolding and there is widespread concern about inadequate progress, especially in hospitals. Although our country has some of the best-equipped hospitals and best-trained clinicians in the world, evidence clearly shows that performance is frequently below par. For example, studies show that U.S. adults receive only about half of recommended care for various conditions and that tens of thousands die annually from preventable errors.

Board members have a critical oversight role to play in monitoring and providing direction to improve health care quality and safety. Nurse leaders are already familiar with current tools and processes used to assess and improve patient care in hospitals. However, knowing how the quality movement has evolved can help them understand the way boards view and monitor

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hospital quality performance to ensure delivery of high-quality, safe care for patients. In fact, quality is now one of the key areas of emphasis for health care organizations and their boards – equally important, if not more critical, than the hospital's financial status.

Defining Quality

Quality typically means different things to different people, and definitions of quality can incorporate various perspectives, depending on what individuals value most. Over the years in health care, we have become more precise in defining quality. While that definition may vary from organization to organization, it has come to be directly associated with the quality and safety of care provided to our patients and is measured objectively through ongoing review of metrics that focus on those things most important to us – and to them.

While health care organizations typically adopt a definition of quality that guides their work, many use the Institute of Medicine's (IOM, 2001) definition of quality: "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." While each health care organization will define quality and develop its own quality plan to make sure it becomes a reality, the IOM's definition is widely accepted and can serve as a touchstone for almost any hospital quality plan.

Beyond this baseline, a hospital must ensure its definition of quality takes into account the perspectives of a broad array of stakeholders and work with the board and other leaders in the organization to prioritize these stakeholders and their needs. Although no hospital can meet every stakeholder's needs, part of the responsibility of the board is to know who the hospital's primary stakeholders are, understand their needs, and ensure the hospital is focused on meeting them.

In addition to understanding what quality means in health care, hospital trustees and leaders need to understand the language of quality and safety. For example, "You can't improve what you don't meas-

ure" is a basic principle underlying quality improvement processes. Measurement has two meanings. It is the process of quantification as well as a number resulting from that process. Therefore, measurement can be both a process and an outcome of a process.

Indicators, which hospital boards and leaders use to track quality and safety processes and outcomes, are valid, reliable measures that quantify a level of performance today or over time. Examples of measures boards might review include medication errors per 1,000 patient days or number of unplanned returns to surgery. In the current environment of reform, boards will also need to expand the measures they monitor to include, for example, hospital re-admissions and hospital-acquired infections, two areas of performance that will increasingly impact hospital reimbursement.

Indicators or performance measures can be used to look at a single organization's performance or to compare an organization's performance to an external standard. This process of comparison, or benchmarking, can help an organization determine whether its own performance should be improved.

The balanced scorecard and dashboard are two common ways of displaying quality and patient safety performance data to help boards and leaders better understand their hospital's performance today and over time.

Enhancing Quality and Safety

In addition to monitoring current performance, boards and leaders need to understand how their hospitals are working to enhance quality and safety performance. Six Sigma, LEAN, and Continuous Quality Improvement are approaches to improving quality and safety used in health care and other industries. The Institute for Healthcare Improvement (IHI), The National Institute of Standards and Technology, the National Quality Forum, the Institute of Medicine, and the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) are leading the way in helping hospitals, and their boards, improve quality and safety performance through standard-setting, assessment, research, and other efforts.

P4P is also an important acronym boards must understand to govern effectively for improved quality and safety. P4P, or "pay for performance," is a trend toward paying hospitals based on how well they perform on a number of measures that include quality and safety. This payment approach, rather than payment based on the volume of services delivered, will become more common under health care reform.

Hospital boards must understand the language of quality and safety to fulfill their fiduciary obligations. A fiduciary is a person who has a legal duty to act primarily for the benefit of others. Good fiduciaries understand the value of their role depends on the support and confidence of the public on whose behalf the fiduciary discharges his or her responsibilities. Because the fiduciary role is most often discussed in terms of stewardship of the organization's tangible assets, many trustees believe that a board's fiduciary role extends only to its financial oversight responsibilities. It is also important for trustees to understand the board's fiduciary responsibilities go beyond financial oversight to include oversight of areas such as organizational compliance with legal and regulatory requirements as well as quality of care and patient safety. In fact, many experts believe that in the emerging environment of health care reform, the board's role in overseeing quality and safety on behalf of stakeholders will become as or even more important than its financial oversight role.

In addition to the IOM, a number of other organizations have defined quality and established guidelines and expectations for health care organizations. Some of these are mandatory, such as requirements of the Centers for Medicare and Medicaid Services and Joint Commission. Others, such as those established by IHI, are voluntary. Some organizations, such as The Leapfrog Group, provide consumers with information about the quality and safety outcomes of the health care organizations they choose.

Linkages to payment, Joint Commission accreditation, and peer pressure from comparison of hospital performance against benchmarks and best practices have made quality measurement and improvement higher priorities for hospital boards and leadership. Understanding how the quality movement has evolved can help put the current emphasis on quality and safety into perspective.

Quality Then and Now

Early quality theorists and advocates such as W. Edwards Deming identified the basic components of continuous quality improvement programs now used across a wide spectrum of industries (Walton, 1986). A primary premise of these models was the need to identify the processes involved in doing a job and then to measure how well those processes were performed. Efforts to improve performance were then tested and data gathered on their effectiveness and used to trend improvement over time.

Joseph Juran, known for the development of quality control in Japan, established a model for quality called the Juran Trilogy. According to Juran (1951), managing for quality is accomplished through:
• Management of quality planning.
• Use of quality control theory.
• Use of quality improvement methods.

Juran's Trilogy has become the *de facto* model for quality improvement initiatives within the American health care industry.

Based on this model, many health care organizations implemented Total Quality Management or

Continuous Quality Improvement programs to improve quality and patient safety and reduce adverse care outcomes. These programs used Quality Circles and Work Improvement Teams to focus and undertake required quality improvement work conducted by professionals responsible for quality and performance improvement activities. These professionals reported to Quality Councils and organization-wide Quality Committees on their findings, progress, and ongoing activities.

This approach to quality improvement focused on the hospital as a system and acknowledged the interrelationships of providers; however, the focus remained on health care professionals and not on the patient. Also, during this evolutionary phase, early-adopting hospital governing boards started to oversee hospital performance based on key quality measures. However, much work remained. Standardized quality, safety, risk, outcomes, and process improvement measures were needed across health care settings in order to establish benchmarks for comparing an organization's own performance over time and across like institutions. Trustees also were not yet active participants in quality committees or councils.

The Patient Factor

The next impetus for change in the health care improvement arena was the IOM's first report on health care quality and safety called "To Err is Human: Building a Safer Healthcare System," released in 1999. For the first time, the effect of the health care industry on the patient – its customer – was viewed as the measure of quality. The number of needless deaths and patient injuries made headlines, with the report estimating that as many as 98,000 Americans die every year because of medical errors.

From this report, patient safety emerged as the top priority in the pursuit of clinical quality and began to expand the quality conversation at hospital board meetings from assuring quality and its return on investment to include the systems needed to improve patient safety. In 2001, the IOM published its report "Crossing the Quality Chasm" that highlighted six key attributes of quality initiatives: safety, effectiveness, patient-centric care, timeliness, efficiency, and equity in providing services.

More recently, a study in *The New England Journal of Medicine* (Haynes et al., 2009) and a book, *Checklist Manifesto,* by Gawande (2010), focus on the efficacy of checklists used in surgeries performed at a diverse group of hospitals and the value of encouraging all members of a surgical team to speak up about potential sources of error. According to Haynes and co-authors (2009), the rate of death was 1.5% before

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the checklist was introduced and declined to 0.8% afterward. Inpatient complications occurred in 11% of patients when the study began and in 7% after introduction of the checklist.

Recognizing Best Practices

Health care leaders recognize there is opportunity to learn from the best practices of other industries.

Following the landmark "To Err Is Human" report, the health care industry began to seek guidance from other industries on improving safety and understanding how best to measure, monitor, and trend safety metrics. The nuclear, road transport, and aviation industries have become key resources to health care organizations because of the major improvements they have made in monitoring safety that have directly translated into saved lives. These industries understand the extreme complexity of the work involved and have utilized human factors science: the power of sharing data, analyzing investigational information from mishaps, and fine-tuning the art of presenting data to understand how humans act and interact with their environment and their impact on safety and quality issues.

Hospitals and health care systems also have adopted tools to help them measure, monitor, and improve quality. These include a rigorous, data-driven decision-making process called Six Sigma. Companies such as Motorola, Kodak, Sony, and General Electric claimed great savings from implementing Six Sigma projects. The premise of this process is to eliminate defects to improve efficiencies and results to the level of Six Sigma: an error/defect rate of 3.4 in 1,000,000. Six Sigma seeks to improve the quality of process outputs by identifying and removing the causes of defects (errors) and minimizing variability. Six Sigma projects follow a defined sequence of steps and have quantified targets that often focus on quality improvement.

The LEAN approach to improving quality considers the expenditure of resources for any goal other than the creation of value for the end customer to be wasteful, and thus a target for elimination. Value is defined as any action or process that a customer would be willing to pay for. LEAN is centered on creating *more value with less work*. Toyota is the company generally credited with bringing LEAN principles to the forefront of the quality movement. While LEAN principles originated in manufacturing environments, health care organizations are finding the methodology can be useful in creating efficiencies and increasing value for patients and other stakeholders.

Medical errors are the leading cause of accidental death in America. Many studies have been done over the past 30 years documenting the added cost medical

errors also incur for hospitals. These studies have shown medical errors add thousands of dollars to the cost of treating an individual patient and preventable errors can cost twice as much as non-preventable errors. On the positive side, research suggests implementing quality improvement can improve financial and cost performance. Evidence also indicates improved quality is not necessarily more expensive and that it is possible to improve quality and decrease costs at the same time.

The Work Ahead

Unfortunately, despite the demonstrated need and advantages of improving quality and safety, progress has been slow. Crowley and Nalder (2009) compared recommendations from the IOM report with actions taken to address them. Their assessment amounts to what they call a "sorry scorecard." They report only 20 states plus the District of Columbia require medical error reporting and 45 states plus the District of Columbia don't provide hospital-specific information about unsafe conditions. The National Patient Safety Center recommended by the IOM report is underfunded and has fallen far short of expectations. Although "patient safety organizations" were established for hospitals to report and learn from medical errors, Congress took 4 years to create rules to govern them. More recent reports suggest the number of deaths due to medical errors is likely more than double that estimated in the IOM's "To Err is Human" report.

Much work has yet to be done to make significant strides in improving health care quality and safety in our nation's hospitals. Nurses play an important role in furthering this agenda through direct involvement in patient care. They also can expand their impact by joining the ranks of health care organization governing boards to lead and guide the entire health care enterprise to realize the goal of improved care and outcomes for all patients. **$**

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