Partnership for Patients -
National Priorities Partnership®
Patient Safety Webinar Series
Getting Your Board on Board

December 9, 2011

Today's Moderator

Bernie Rosof, MD
Chairman, Board of Directors, Huntington Hospital
NPP Co-Chair

Today's Featured Speakers

- Carol Wagner, RN, MBA, Senior Vice President Patient Safety, Washington State Hospital Association
- Rosemary Gibson, MSc, Patient Advocate and Author of The Treatment Trap and Wall of Silence
Patient Safety Webinar Series:
Recurring Themes

- Creating culture change through organizational leadership and empowered frontline providers
- Engaging patients and families in a meaningful way
- Coordinating the efforts of multidisciplinary teams and organizations
- Designing payment models that promote and incentivize quality and safe practices
- Measuring quality consistently and reliably within and between organizations

Objectives for Today’s Webinar

1. Provide an opportunity for thought leaders in patient safety to share best practices, success stories, and strategies for effectively engaging patients and their families to improve systems of care
2. Provide an overview of the PfP-NPP public-private partnership and collaborative efforts under way to improve patient safety in alignment with the National Quality Strategy
3. Generate action in organizations and communities nationwide
4. Provide examples of governance boards working collaboratively with hospital senior leadership to achieve results

NPP Input into the National Quality Strategy

- October 2010: NPP provides input to HHS to inform the development of the NQS
- March 2011: HHS issues NQS based on the triple aim
- September 2011: NPP input to HHS helps to make NQS more actionable:
  - Identification of goals and measures
  - Recommendation of strategic opportunities
  - Consensus across key leaders about where they should drive their organizations
  - Full report is available from the Links tab in the upper left corner of your screen
**NPP INPUT ON HHS’S NATIONAL PRIORITIES:**

**Patient Safety**

**Goals:**
- Reduce preventable hospital admissions and readmissions*
- Reduce the occurrence of adverse healthcare associated conditions*
- Reduce harm from inappropriate or unnecessary care

**Measure Concepts:**
- Hospital admissions for ambulatory-sensitive conditions
- All-cause hospital readmission index*
- All-cause healthcare-associated conditions*
- Inappropriate medication use and polypharmacy
- Inappropriate maternity care
- Unnecessary imaging

*Adverse events include adverse drug events, catheter-associated urinary tract infections, central line bloodstream infections, injuries from falls and immobility, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism, and ventilator-associated pneumonia.

---

**Partnership for Patients Goals**

- **Keep patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010.
- **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010.
Partnership for Patients
Nine Areas of Focus

- Catheter-associated urinary tract infections (CAUTI)
- Central line-associated bloodstream infections (CLABSI)
- Injuries from falls and immobility
- Adverse drug events
- Obstetrical adverse events
- Pressure ulcers
- Surgical site infections (SSI)
- Venous thromboembolism
- Ventilator-associated pneumonia (VAP)

How Will Change Actually Happen?

And how will it happen at scale?

There is no “silver bullet,” but we know we must:

- Engage leadership
- Engage patients and families, authentically
- Work together
- Provide thoughtful incentives
- Assist in the painstaking work of improvement
BRINGING BOARDS ON BOARD

MEDICARE, AND OTHER REGULATORY BODIES AND ACCREDITING ORGANIZATIONS, PLACE THE RESPONSIBILITY FOR QUALITY FIRMLY IN THE HANDS OF THE BOARD OF DIRECTORS

HOSPITAL BY LAWS AND RULES AND REGULATIONS ALSO MAKE THIS VERY CLEAR

PROVIDING THE TOOLS AND EDUCATION

- PROPER ORIENTATION
- ROLES AND RESPONSIBILITIES
- MISSION AND GOALS OF THE HOSPITAL
- STRATEGIC DIRECTION
- QUALITY OF CARE
TOOLS AND EDUCATION

- Achieving excellence requires a commitment to continual improvement.
- Understanding new state and federal regulatory developments often related to quality (value based purchasing, ACO’s).
- Efficiency and resource use.

DUTY OF CARE

- Act in good faith.
- With the care an ordinarily prudent person would exercise in like circumstances.
- In a manner that they reasonably believe to be in the best interests of the institution.

DASHBOARD

- Demonstrates comparative data on measures of performance.
- Specific targets to ensure patient safety and reducing harm.
- Specific processes and systems for increasing quality.
- Partnership for patients.
Tell us about your experience

To ask questions or provide feedback at any time, type into the chat box at the bottom left corner of your screen. To dial into the discussion, call 877-591-4957, confirmation code 6210064. Press *1 to ask a question.

Your questions will be addressed during the audience discussion later in the webinar.

Web Polling Question

How does your organization’s governance board prioritize patient safety?

a. Highly—Patient safety is routinely discussed at meetings; data is regularly presented and patient advocates are actively involved with the board.

b. Moderately—Patient safety is a priority and regularly discussed, but there is room for growth.

c. Minimally—Patient safety is occasionally discussed; a few board members may be interested in raising patient safety as a priority.

d. This question is not applicable

Featured Speaker

Rosemary Gibson, MSc
Section Editor, Archives of Internal Medicine Series, "Less is More,”
Author of The Treatment Trap and Wall of Silence
Engaging Boards in Quality and Patient Safety

Partnership for Patient Safety
National Quality Forum
December 9, 2011
Rosemary Gibson, M.Sc.
Author, The Treatment Trap and Wall of Silence
Section Editor, Archives of Internal Medicine,
"Less is More" Series

Overview of Presentation

- Identify 3 patient-centered principles of patient safety to share with hospital governing boards
- Identify 2 ideas to introduce hospital boards to overuse as a quality and patient safety concern

But First, Obligations of Hospital Board Members

"The basic governance obligation to guide and support executive leadership in the maintenance of quality of care and patient safety is an ongoing task... Board members are increasingly expected to assess organizational performance on emerging quality of care concepts."

Source: Corporate Responsibility and Quality of Care
http://oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf
1. Be honest with patients and family members when harm occurs.

DO: familiarize boards with the emerging literature and good practice in disclosure of adverse events which is reducing medical malpractice claims and premiums (see links to November 27, 2011 Partnership for Patients webinar)

“Commitment to a principled approach eviscerates legal concerns.” Rick Boothman, U. of Michigan

2. Just culture – and fidelity to implementing it hospital-wide – is an essential requirement for a high performing organization

DO: familiarize boards with the principles of just culture and how they apply in a patient safety context

A hospital cannot be honest with patients if it is not honest with itself. If a hospital cannot be honest with itself, it cannot find and fix the root causes of patient harm

Join Culture toolkit: http://www.aorn.org/PractNetResources/ToolKit/justCultureToolkit
3. An unwavering commitment to “The Seven Pillars” of Patient Safety: internal reporting, investigation of the root cause, disclosure, benevolent gestures to patients, patient safety improvement, evaluation of safety improvements, education and training.”

- DO: share the “Seven Pillars” of Patient Safety with board members
- Patients and family members need to be engaged in the root cause analysis: they are the only constant in the course of care.

Source: https://slideplayer.com/slide/6146817

**Put the Human Face on Adverse Events**

- Dashboards and quality and safety performance data are good but not good enough
- Include a picture and a brief bio of a patient who was harmed
- “Every data point is a person”
- Invite a patient or family member to a board meeting to share their experience of an adverse event — or videotape the patient/family member

**Talking to Boards About Overuse**

- Overuse is when the potential for harm of a health care service exceeds the possible benefit (IOM, 1998 National Roundtable on Quality)
- Overuse is an emerging quality and safety issue that can result in harm to patients
Talking to Boards About Overuse

- Last week, The Joint Commission proposed a new National Patient Safety Goal on the topic of overuse.
- Beginning in 2013, accredited hospitals are required to select a treatment, procedure, or test where there is evidence of overuse nationally.
- Areas of overuse suggested include:
  - early induction of labor
  - cardiac stents
  - CT scans

Joint Commission Proposed Patient Safety Goal on Overuse

- Evaluate whether overuse is occurring and how it can be addressed and beginning in 2014, reduce inappropriate use.
- This proposed goal is a measured, incremental step to bring overuse onto the quality and safety agenda.
- It offers the opportunity for board members to understand overuse, the harm to patients, and the role of the hospital to prevent it.

Overuse of Diagnostic Imaging

- The National Priorities Partnership, which is convened by the National Quality Forum, has identified tests, services, and drugs that are overused.
- To identify areas of overuse, medical specialty societies were consulted. Diagnostic imaging including CT scans were identified as overused.

Source: National Priorities Partnership,
Estimates of Harm from Diagnostic Imaging

- NCI researchers estimated that the 70 million CT scans performed in 2007 will cause 29,000 cancers in Americans and 14,500 deaths.
- Two thirds of the projected cancers occur in women.


National Quality Forum: Diagnostic Imaging

- National Quality Forum-endorsed diagnostic imaging measures
- As one example, Medicare’s Hospital Compare publishes hospital’s use of double chest scans.
- With a double CT scan, patients have two imaging tests consecutively, one without contrast and the other with contrast, which yields double radiation dose.

Hospital Compare

Where do you want to find a hospital?

Search information

Location [ZIP Code or City, State]
- e.g. 10005 or New York, NY

Search type [What is this?]
- General
- Medical Conditions
- Surgical Procedures

Search categories
Hospital Compare:
Diagnostic Imaging

- Go to www.hospitalcompare.gov to see your hospital’s use of double chest CT scans.
- Most hospitals use the double chest CT scan sparingly. The median rate was 2 percent of all Medicare patients who received chest scans -- based on data on 3,094 hospitals.
- For 618 hospitals at least 10 percent of Medicare patients had a double chest CT scan.
- In 94 hospitals, nearly half the patients with chest CT scans had double scans — red flag.

Check Your Hospital:
Interactive Map

NY Times June 17, 2011

The Treatment Trap

"A wake-up call for Americans."
Dr. Wayne W. Pintz
Forbes, July 2011
Contact: Rosemarygibson100@gmail.com  www.treatmenttrap.org

Audience Discussion

Tell us about your experience

If you have any questions or comments for today’s speakers, please type into the chat box at the bottom left corner of your screen. To dial into the discussion, call 877-591-4957, confirmation code 6210064.

Web Polling Question

Do patients or patient advocates play a role on your organization’s board, safety advisory panel, or other senior-level committee?

a. Yes
b. No
c. Unsure
d. This question is not applicable
Featured Speaker

Carol Wagner, RN, MBA
Senior Vice President Patient Safety
Washington State Hospital Association

Washington State Hospital Association
Board Leadership

Carol Wagner
Senior Vice President Patient Safety
carolw@wsha.org
(206) 577-1831

December 9, 2011

97 Washington State Hospitals
2005 Washington Begins Patient Safety Program

Washington Hospitals Set Aside Competition to Make Care Safer for Patients

Boards Oversee on the Owners Behalf

1. Mission
2. Strategy
3. Executive Leadership
4. Financial Stewardship
5. Quality of Care and Service
“Leaders are responsible for everything in the organization, especially what goes wrong.”

Paul O’Neill

6th Annual CEO and Trustee Summit

Innovations in Board Practices

Facilitated by Maureen Bisognano
May 2012

Strengthens hospital board’s skills to lead patient safety and quality.

Measured with annual state-wide board survey.

Strengthening Board Skills

2006 - Role of the board in patient safety
2007 - Data boards should review
2008 - Questions boards ask
2009 - Having difficult conversations
2010 - Board’s leadership and medical staff
2011 - Innovations in board practices
Role of Patient Story
Starts Every Summit

Sharing Data and Public Transparency

How often is the topic of quality and patient safety discussed at board meetings?

- 88% Every meeting
- 12% Most Meetings
- 0% At least half of the meetings
- 0% Less than half of the meetings
- 0% I don't know

2008-2011 Measurement of Board Practices
Web Polling Question

At your organization, how often is the topic of quality and safety discussed at your board meetings?

a. Every meeting
b. Most meetings
c. At least half of the meetings
d. Less than half of the meetings
e. I don’t know/not applicable

WASHINGTON STATE HOSPITAL ASSOCIATION

Board Leadership in Patient Safety

“The boards-on-board initiative of the Washington State Hospital Association has transformed our board making us much more effective in meeting our quality and safety oversight obligations to our community. Lives have been saved!”

Judi Brenes
Trustee
PeaceHealth Southwest Medical Center

Audience Discussion

Tell us about your experience

If you have any questions or comments for today’s speakers, please type into the chat box at the bottom left corner of your screen. To dial into the discussion, call 877-591-4957, confirmation code 6210064.
Conclusion

Next Steps, Further Resources, and Concluding Remarks

Further Resources

Resources, links, and PDF documents are available now in the top left corner of your screen in the Links tab, including:

- Partnership for Patients website
- National Priorities Partnership (NPP) website
- National Quality Forum patient safety webpage
- NQF National Quality Healthcare Award - Applications accepted through January 4, 2012
- NQF 2012 Annual Conference “Building a Patient and Family-Centered Health System” on April 4-5, 2012, in Washington, DC
- Information for both available online at www.qualityforum.org

Thank You

A recording of this webinar will be available on the National Quality Forum website within 48 hours. When you exit, you will automatically be directed to an evaluation about this webinar.

For further questions, please contact priorities@qualityforum.org