Governance Role in Quality and Performance Improvement Webinar

June 1, 2016
CHA Webinar

Welcome

Mary Barker
California Hospital Association
Peggy Broussard Wheeler serves as CHA's vice president of Rural Health Care & Governance. She is responsible for advocating on behalf of small and rural hospitals at the state and national levels. Peggy also staffs CHA's Governance Forum Advisory Board, which promotes opportunities for hospital and health system trustee involvement in policy formulation, and political and legislative activities.

Julianne Morath, RN, MS, CPPS, is president/CEO of the Hospital Quality Institute (HQI), a collaboration of the California Hospital Association and the Regional Associations.

Ms. Morath is a founding and current member of the Lucian Leape Institute of the National Patient Safety Foundation and completed a term with the Board of Commissioners of The Joint Commission this year. She is a distinguished advisor to the National Patient Safety Foundation, past member of the National Quality Forum Best Practices Committee, and member of the Advisory Board to the Association of the Advancement of Medical Instrumentation. Ms. Morath was appointed Fellow to the Salzburg Seminar on Medical Errors. She serves on the Board of Directors of the Virginia Mason Medical Center and Health System and was named by Becker Hospital Review as one of the top 50 experts leading patient safety.
Governance: Driver of Health Care Quality and Patient Safety

Julianne Morath, RN, MS, CPPS
CEO/President
Hospital Quality Institute
Agenda Overview

- Role of governing boards
- Quality as a system
- Questions boards should be asking
- Quality accountability
- Performance measures
- Where to start
### Leading Causes of Death in the US

<table>
<thead>
<tr>
<th>Cause</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>599,413</td>
</tr>
<tr>
<td>Cancer</td>
<td>567,628</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>137,353</td>
</tr>
<tr>
<td>Stroke</td>
<td>128,842</td>
</tr>
<tr>
<td>Accident</td>
<td>118,021</td>
</tr>
<tr>
<td>Error</td>
<td>98,000</td>
</tr>
</tbody>
</table>

Followed by: Alzheimer, Diabetes, Pneumonia, Kidney, Suicide

*Of the 6000 U.S. hospitals, 25% are formally involved in quality improvement.
(Source: Chassin PBS Business Report)

### What is the Scope of Gaps in Quality
US Health Care Annual Estimates

<table>
<thead>
<tr>
<th>Category</th>
<th>Estimate</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>251,454 (BMJ)</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Error</td>
<td>6% to 17% (Institute of Medicine)</td>
<td></td>
</tr>
<tr>
<td>Medication Error</td>
<td>400,000 (Institute of Medicine)</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>721,800 (Centers for Disease Control – based on 2011)</td>
<td></td>
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</tbody>
</table>
Questions for Leaders

1. Is this a safe place to give and receive care?
2. Does our culture encourage employees to tell the truth?
3. How do you know?
4. How do you find out?
5. Could this happen here?

Board Responsibility of System Oversight

Depicted is the number of readmissions each day in California
(786 per day – 33 per hour)

Manage error, prevent failure, create safety and produce effective outcomes and optimal experiences.
Top 6 Mostly Costly Hospital-Acquired Events in California

<table>
<thead>
<tr>
<th>Event</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulcers</td>
<td>$3.1 B</td>
</tr>
<tr>
<td>Sepsis</td>
<td>$2.8 B</td>
</tr>
<tr>
<td>C-Diff</td>
<td>$527 M</td>
</tr>
<tr>
<td>ADE</td>
<td>$424 M</td>
</tr>
<tr>
<td>SSI</td>
<td>$176 M</td>
</tr>
<tr>
<td>VAE</td>
<td>$81 M</td>
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</tbody>
</table>

Incremental Cost of Care $7.1B

Incentives and Penalties
Points to Remember About Quality-Based Payment Reform Programs

- Payment levels are at stake
- Historical data will continue to drive these programs
- Program targets move with national performance, so hospitals need to keep pace with the pack
- There is overlap with other quality-based payment reform programs (double jeopardy)
Create Alignment from Board Rooms to Frontlines

**Virginia Mason Foundational Elements**

- **People**
  - We attract and develop the best talent
- **Quality**
  - We relentlessly pursue the highest quality outcomes for all
- **Service**
  - We deliver extraordinary patient experiences
- **Innovation**
  - We foster a culture of learning and innovation

**Virginia Mason Production System**

- Strong Economics
- Responsible Governance
- Integrated Systems
- Education
- Research
- Virginia Mason Foundation

*Source: Virginia Mason Medical Center

**H0! Board Compact**

<table>
<thead>
<tr>
<th>Organization’s Responsibility</th>
<th>Board Members’ Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Promote Excellence</strong></td>
<td><strong>HQI Programs</strong></td>
</tr>
<tr>
<td>- Facilitate the recruitment and retention of superior board members</td>
<td>- Know vision and mission goals</td>
</tr>
<tr>
<td>- Provide a process for regular evaluation and feedback of effectiveness</td>
<td>- Be familiar with content of strategic Blueprint</td>
</tr>
<tr>
<td>- Provide a thorough orientation process for new board members</td>
<td>- Keep informed on developments</td>
</tr>
<tr>
<td>- Support excellence with adequate resources</td>
<td>- Understand statewide performance and gaps in state and nation related to quality and patient safety trends, challenges and opportunities</td>
</tr>
<tr>
<td><strong>Listen and Communicate</strong></td>
<td><strong>Focus on the Future</strong></td>
</tr>
<tr>
<td>- Share information regarding strategic intent, organizational priorities and business decisions</td>
<td>- Spend one-half of every meeting focused on the future</td>
</tr>
<tr>
<td>- Offer opportunities for constructive dialogue</td>
<td>- Consistently maintain a current work plan</td>
</tr>
<tr>
<td>- Report regularly on implementation of Blueprint and achievement of specific board objectives/directives</td>
<td><strong>Listen and Communicate</strong></td>
</tr>
<tr>
<td>- Disclose to, and inform board on, risks and opportunities facing the organization</td>
<td>- Actively participate in board discussions</td>
</tr>
<tr>
<td>- Provide materials necessary for informed decision making sufficiently in advance of board meetings</td>
<td>- Participate in educational opportunities, and request information and resources needed to provide responsible oversight</td>
</tr>
<tr>
<td><strong>Inform</strong></td>
<td><strong>Take Ownership</strong></td>
</tr>
<tr>
<td>- Provide information and tools necessary to keep members informed and current on quality and safety issues, and trends</td>
<td>- Assure vision and mission</td>
</tr>
<tr>
<td>- Educate board members about HQI, its structures and its guiding documents</td>
<td>- Attend meetings</td>
</tr>
<tr>
<td>- <strong>Lead</strong></td>
<td>- Ask timely and substantive questions at meetings</td>
</tr>
<tr>
<td>- Manage and lead HQI with integrity and accountability</td>
<td>- Prepare for, participate in and support group decisions</td>
</tr>
<tr>
<td>- Create strategies and goals</td>
<td>- Understand and participate in approving annual budget</td>
</tr>
<tr>
<td>- Continuously measure and improve performance</td>
<td>- Serve on committees or task forces as requested</td>
</tr>
<tr>
<td>- Identify, address and resolve conflict</td>
<td>- Require cooperation and collaboration, and make model the same</td>
</tr>
<tr>
<td>- Ensure respect and psychological safety</td>
<td><strong>Promote Effective Changes</strong></td>
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<tr>
<td></td>
<td>- Foster innovation and continuous improvement</td>
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<tr>
<td></td>
<td>- Pursue organizational change</td>
</tr>
<tr>
<td></td>
<td>- Model quality principles</td>
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Escalation of Concern When Complaint or Failure is Evaluated:

- Is this an ISOLATED Event?
- Is there a PATTERN of failure(s) in this area?
- Are there organizational SYSTEMIC ISSUE(s) related to quality performance and oversight?

Example

Quality & Safety Accountability & Reporting Flows

Courtesy of Hospital Quality Institute
Crossing the Quality Chasm

6 AIMS

S  safe
T  timely
E  effective
E  efficient
P  patient-centered (person-centered)
E  equitable
Questions You Should Ask: Connecting the Dots

1. Is there a systemic view, (e.g., planning process, strategy, design, drivers and measures)?
2. Are there measures that answer whether or not strategy is advancing, (i.e., is care getting better, or worse)?
3. How were the measures selected?
4. Why are the measures important to our hospital, patients, workforce and community?

Questions You Should Ask

5. Is there a coordinated process?
6. Can all staff leaders answer the following questions?
   • How does “this” compare to past?
   • How does “this” compare to best-of-class?
   • What are we doing to improve and close the performance gap?
   • What can we predict from what we know?
   • What might be unintended consequences of our improvement efforts?
7. How do we engage frontline caregivers, physicians, and patients and families?
Set goals and monitor progress

Key Performance Indicators
Pennsylvania Hospital - 1754

Number of Patients - 117

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Cured</td>
</tr>
<tr>
<td>Lunacy</td>
<td>Relieved of symptoms</td>
</tr>
<tr>
<td>Dropsy</td>
<td>Irregular behavior</td>
</tr>
<tr>
<td>Consumption</td>
<td>Discharged incurable</td>
</tr>
<tr>
<td></td>
<td>Taken away by friends</td>
</tr>
<tr>
<td></td>
<td>Dead</td>
</tr>
<tr>
<td></td>
<td>Left in the hospital</td>
</tr>
</tbody>
</table>
Data Convinces – Stories Compel

- Real people
- Patient stories
- Testimonials
- Listening and learning
Personalize Harm

“It is by going down into the abyss that we recover the treasure.

Where you stumble, there lies your treasure.”

Joseph Campbell
Anthropologist, Journalist
1904-1987
Sample Chart of Serious Safety Events

Consider Quadruple Aim: Meaningful Work
Quadruple Aim

The Quadruple Aim: care, health, cost and meaning in work

The Quadruple Aim (Q4) is a framework for improving health care that was developed in the early 2010s. It is a set of four interrelated aims that are designed to improve the quality and efficiency of health care. The Q4 aims are:

1. Engage patients and families in managing their health and making decisions about their care
2. Improve the health of the population
3. Improve the safety and reliability of America’s health care system
   • Infection
   • Adverse events
   • Hospital-level mortality rates
   • 30-day mortality rates post hospitalization

National Priorities Partnership

Convened by National Quality Forum

Durable Issues

1. Engage patients and families in managing their health and making decisions about their care
2. Improve the health of the population
3. Improve the safety and reliability of America’s health care system
   • Infection
   • Adverse events
   • Hospital-level mortality rates
   • 30-day mortality rates post hospitalization
4. Ensure patients receive well-coordinated care within and across ALL health care organizations, settings and levels of care

5. Guarantee appropriate and compassionate care for patients with life-limiting illnesses

6. Eliminate overuse while ensuring the delivery of appropriate care

Preconditions: Transparency

- Practiced value
- Characteristic of a quality culture
- 5 areas of transparency
  - with colleagues
  - with patients/families
  - with governance boards
  - between organizations
  - with public

Pre-Conditions: Respect for People

• Meaningful work
• Opportunities to learn and develop
• Respect and engagement
• Freedom from harm


Can Each Person in the Workforce Answer Yes to These 3 Questions Each Day?

1. Am I treated with dignity and respect by everyone each day?
2. Do I have what I need so I can make a contribution that gives meaning to my life?
3. Am I recognized and thanked for what I do?
Simply Stated

Governance: Own vision and mission goals. Require and protect culture of respect, professionalism and excellence.

Leadership: Inspire quality and model the way. Build the system, resource and encourage the heart.

Management: Act to make quality live and transform care/operations.

Frontlines: Has the information to respond and provide wisdom and energy for transformation.

Summary

*Quality care is less expensive care.*

*It is better, more efficient and less wasteful.*

*It is the right care, at the right time, every time.*

*It is reliable.*

\[ Q = \frac{A \times (O + E)}{C} \]
Thank You

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Questions

**Online questions:**
Type your question in the Q & A box, hit enter

**Phone questions:**
To ask a question, hit *1

Upcoming Programs

**California Physician Leadership Program**
Two days per month, October 2016 – April 2017

The California Physician Leadership Program is a comprehensive educational program designed to challenge and grow physician leaders and medical executives. Participants will learn to assume greater leadership, serve as a driver of change and achieve better outcomes for patients.
Cybersecurity: Emerging Threats to Hospitals Webinar
June 9, 1:30 p.m. – 3:30 p.m., PT

Cyberattacks are on the rise and hospitals are being targeted. Learn what the FBI and other government agencies are doing to protect the nation — and hospitals in particular — from cyberattacks. Identify critical strategies you can implement now to protect your hospital from cyberattacks, as well as steps to take if you become a victim.

Upcoming Programs

CHA Publications

Consent Manual
2016 Edition

The most comprehensive and acclaimed resource available to hospitals regarding patient consent for medical treatment, release of information, reporting requirements and more.

Features a new section on the End of Life Option Act.

Visit www.calhospital.org/consent
Thank you for participating in today’s seminar. An online evaluation will be sent to you shortly.

A recording of this program will be available to all CHA members.

For education questions, contact Mary Barker at (916) 552-7514 or mbarker@calhospital.org.