

Eliminating Harm, Improving Patient Care: A Trustee Guide



**This resource has been brought to you by the American Hospital Association,
Health Research & Educational Trust, Center for Healthcare Governance and
Trustee Magazine as part of the Partnership for
Patients' Hospital Engagement Network initiative.**



Trustee



www.hret-hen.org

Eliminating Harm, Improving Patient Care: A Trustee Guide

This workbook is designed to be used as a tracking tool for Trustees as they prepare for each module, view the videos and then discuss the key take-aways.

HOW TO PREPARE

Complete the pre-viewing questions prior to watching the video modules to assess current practices and policies. Make notes of any areas that may warrant further action or refinement.

VIEWING

View each module to hear from hospital colleagues and experts in the field speak to the components of quality, connecting each to the role and activity of a Board.

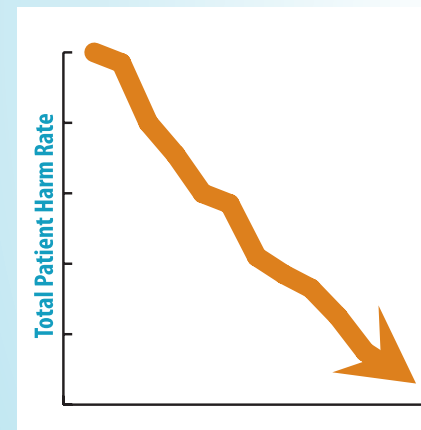
AFTER VIEWING

After watching the videos, consider each module's key take-aways and discuss whether such practices are in place. If not, make note of relevant action items for your organization to address.

Introduction

As hospitals and health care systems across the country continue on the journey of quality improvement, improving safety and reducing harm for the patients they serve, this guide was designed to illustrate the important role that Trustees can play in this on-going journey.

When examining the success of high-performing hospitals and health systems, a common thread often found among such organizations are Trustees who are highly educated on the importance of quality, actively engaged in setting performance goals and committed to advancing quality and safety within the organization.



Eliminating Harm, Improving Patient Care: A Trustee Guide is a tool for all Trustees to use as they work towards the goal of eliminating all patient harm within their organizations. Although there are many measures of safety and quality, all Boards should measure and track their total patient harm rate as they strive for zero patient harm events. When Boards track their total patient harm rate they are monitoring the big picture of patient safety for their organization, cutting across individual measures of harm including infections, adverse drug events or patient falls, and allowing them to employ major strategies intended to improve



patient care every where, every time, for every patient. Measuring and eliminating total patient harm is the Board's strategic imperative.

The video modules are intended to guide Trustees through thinking about a number of key areas such as the context for a Board to engage in quality, as it relates to strategy, process and effectiveness; methods for measuring and eliminating harm that include such elements as collecting and developing a composite harm rate across the board; engaging clinicians; as well as thinking about foundational elements to improving quality like instilling a strong safety culture, eliminating disparities and strengthening patient and family engagement.

PRE-VIEWING QUESTIONS

Module 1

The Role of the Board in Quality Improvement and Eliminating Patient Harm

1. Does your organization have a Board-level quality committee and/or clinical quality committee? If yes, how does the committee fit into the Board reporting structure?
2. Does your organization have a strategic quality improvement plan, with clear goals for improvement that use data and benchmarks?
3. What are your hospital/health system's current methods for monitoring quality and patient harm and are quality measures and harm events reported to the Board?

Module 2

How Boards Can Be Effective in Improving Quality and Eliminating Patient Harm

1. What type of governance education is offered to ensure that Board members thoroughly understand the importance of quality? Do you recruit Board members with quality expertise in mind?
2. Have you assessed your committee's effectiveness in the past two years? If yes, what was your main improvement priority?
3. Does your organization actively look to learn from harm events and implement changes based on such events?

Module 3

The Alignment of Safety and Quality with Financial Performance

1. Do quality improvement and increased efficiency measures play a role in your financial planning?
2. Does quality play a role equal to that of finance within Board meetings?
3. How do your organization's quality improvement strategies impact your financial performance?

Module 4

Boards Must Collect and Review Meaningful Data to Keep Pace in a Changing Landscape

1. What quality measures does your organization currently collect and report?
2. Has your organization already begun moving from the first curve to the second curve?
3. What strategies has your organization implemented to move towards a value-based reimbursement structure?

Module 5

The Importance of Measuring Harm Across the Board

1. Does the Board know the total patient harm rate for the past year or past quarter?
2. What are your organization's biggest strategies to reduce patient harm?

Module 6

Boards Must Have a Clear Organizational Approach and Process for Improving Quality

1. What type of notification process does your organization have in place to both track and react to harm events?
2. What steps does the Board take to learn about and understand a harm event, i.e., the factors involved in why the event occurred?
3. How do you reinforce accountability while continuing to monitor outcomes of care?

Module 7

Ensuring Clinician Engagement is Crucial in Eliminating Patient Harm

1. How frequently does your Board hear from clinical leaders within your organization and in what capacity?
2. Does your Board currently have at least one physician or “quality champion” serving on it?
3. How do you communicate and interact with clinicians regarding quality improvement plans, policies, etc., and how do you ensure clinicians achieve quality goals?

Module 8

The Importance of a Strong Quality Culture

1. Has your organization adopted a culture of safety and taken steps to promote an environment of excellence?
2. How is management engaged? Are financial incentives tied to performance and organizational goals?
3. Do you actively recognize successes and share lessons learned among all parts of the organization?

Module 9

The Importance of Patient, Family and Community Engagement in Improving Quality

1. What methods has your organization employed to engage patients, families and the community in setting quality goals and eliminating patient harm?
2. Do you have an active patient and family advisory council that participates in your organization's improvement efforts?
3. How does your organization work to educate patients about their health and involve both patients and their families in quality improvement efforts?

Module 10

How Diversity in the Board Room Can Help Improve Quality and Eliminate Disparities

1. Does your Board reflect the diversity of your hospital/ health system in terms of staff and the patients and community you serve?
2. Does your Board measure and understand disparities among your patient populations?
3. How does your Board ensure that patient diversity and disparities are accounted for as quality improvement and harm reduction goals are set?

TAKE-AWAYS

Module 1

The Role of the Board in Quality Improvement and Eliminating Patient Harm

- Boards should have written, well-defined leadership and oversight responsibilities for quality.
- Goals for eliminating patient harm and improving quality need to be embedded into the strategic plan and planning process.
- Boards should spend significant and meaningful time and energy discussing quality.

Module 2

How Boards Can Be Effective in Improving Quality and Eliminating Patient Harm

- Organizations must have specific, measurable targets for improving quality and eliminating patient harm. These should be big-picture goals and should be used to hold leadership and staff accountable for performance.
- Boards should assess and continuously improve their quality and safety literacy through education and through working with individuals who possess specific quality expertise.
- Boards should employ strategies like hearing directly from patients to help “humanize” data.

Module 3

The Alignment of Safety and Quality with Financial Performance

- Boards must understand how value-based payment, readmissions penalties and hospital-acquired conditions penalties can significantly impact an organization's financial performance.
- Appropriate resources must be allocated for data collection and to support and implement quality improvement initiatives.
- Boards must have a clear, understood approach to monitor quality that includes a dashboard for monitoring overall performance.

Module 4

Boards Must Collect and Review Meaningful Data to Keep Pace in a Changing Landscape

- Performance needs to be tracked routinely to eliminate patient harm and improve quality and safety.
- Boards must be engaged in asking strategic questions of their organizations to assess readiness to move from the first to second curve and then use the answers to help direct their actions.
- Boards must oversee and ensure that strategies are put in place to help the transition from first to second curve while improving quality for patients.

TAKE-AWAYS (continued)

Module 5

The Importance of Measuring Harm Across the Board

- Hospitals must be tracking and collecting reliable quality and patient safety metrics on a monthly basis and then sharing them with the Board.
- Boards must ensure that metrics are aggregated into the organization's overall patient harm composite rate.
- Boards must play an active role in identifying major organization-wide strategies to eliminate patient harm.

Module 6

Boards Must Have a Clear Organizational Approach and Process for Improving Quality

- Organizations need to have effective quality and safety measures and tracking processes in place that identify if patient harm has occurred.
- The Board and hospital/health system leadership should have an established process for responding to and learning from harm events.
- Boards and leadership need to be transparent about performance in order for learning to occur and must be open to hearing the bad, as well as good, patient stories.

Module 7

Ensuring Clinician Engagement is Crucial in Eliminating Patient Harm

- Boards and hospital/health system leadership should have reliable, on-going mechanisms to communicate and engage with clinicians about quality.
- Boards should have physician members or possess the clinical competencies to truly understand and track performance improvement.
- Identifying and working with clinical champions should be a tactic Boards employ to improve quality and enhance clinician support and engagement.

Module 8

The Importance of a Strong Quality Culture

- Boards must ensure that their hospital/health system has a clearly defined culture that centers around the patient and emphasizes transparency, reward and recognition.
- Boards must oversee the process of assessing their organizations' values, policies and leadership actions against its desired culture and then implement changes as needed.
- Boards must understand that a "safety culture" involves training, education, resources, trust, respect and a clear set of expected values and behaviors – and it is the Board's role to ensure that the desired culture is achieved.

Module 9

The Importance of Patient, Family and Community Engagement in Improving Quality

- The patient voice must be heard in the Boardroom and that must include both positive and negative patient stories.
- Boards and hospital leaders should engage patients and families in learning about the care process and identifying opportunities for quality and safety to be improved.
- Boards should support and encourage engagement that helps educate patients, families and the community allowing them to be active partners in their care.

Module 10

How Diversity in the Board Room Can Help Improve Quality and Eliminate Disparities

- In order for Boards to be most effective, they should reflect the diverse make-up of the patient population and communities served.
- Boards must be aware of and ensure that strategies and tactics for reducing disparities are clearly set and followed-out.
- Disparities in care and patient diversity must be key factors for Boards and hospital/health system leaders when collecting data and setting overall patient care and quality improvement goals.

The Board's Role in Quality Improvement and Eliminating Patient Harm

Trustees can play a critical role in quality improvement and this module helps to outline the structure for Board involvement through established quality committees and clear oversight of quality, the importance of strategic planning related to quality and methods for measuring safety and harm events.

PRE-VIEWING QUESTIONS:

1. Does your organization have a Board-level quality committee and/or clinical quality committee? If yes, how does the committee fit into the Board reporting structure?

2. Does your organization have a strategic quality improvement plan with clear goals for improvement that use data and benchmarks?

3. What are your hospital/health system's current methods for monitoring quality and patient harm, and are quality measures and harm events reported to the Board?

KEY TAKE-AWAYS

- Boards should have written, well-defined leadership and oversight responsibilities for quality.
- Goals for eliminating patient harm and improving quality need to be embedded into the strategic plan and planning process.
- Boards should spend significant and meaningful time and energy discussing quality.

How Boards Can Be Effective in Improving Quality and Eliminating Patient Harm

Boards that engage in governance education and have a high level of "quality literacy" are going to be more effective in overseeing improvement efforts. This module speaks to the importance of setting clear goals, assessing your Boards' effectiveness and learning from harm events.

PRE-VIEWING QUESTIONS:

1. What type of governance education is offered to ensure that Board members thoroughly understand the importance of quality? Do you recruit Board members with quality expertise in mind?

2. Have you assessed your committee's effectiveness in the past two years? If yes, what was your main improvement priority?

3. Does your organization actively look to learn from harm events and implement changes based on harm events?

KEY TAKE-AWAYS

- Organizations must have specific, measurable targets for improving quality and eliminating patient harm. These should be big-picture goals, and should be used to hold leadership and staff accountable for performance.
- Boards should assess and continuously improve their quality and safety literacy through education and through working with individuals who possess specific quality expertise.
- Boards should employ strategies like hearing directly from patients to help "humanize" data.

The Alignment of Safety and Quality with Financial Performance

The connection between quality and cost is increasing and this module examines why Boards must allocate resources to improvement initiatives, as well as understand how overall quality performance and specific quality measures can impact their financial performance.

PRE-VIEWING QUESTIONS:

1. Do quality improvement and increased efficiency measures play a role in your financial planning?

2. Does quality play a role equal to that of finance within Board meetings?

3. How do your organization's quality improvement strategies impact your financial performance?

KEY TAKE-AWAYS

- Boards must understand how value-based payment, readmission penalties and hospital-acquired condition penalties can significantly impact an organization's financial performance.
- Appropriate resources must be allocated for data collection and to support and implement quality improvement initiatives.
- Boards must have a clear, understood approach to monitor quality that includes a dashboard for monitoring overall performance.

"Improving patient safety and eliminating patient harm is job number one for Trustees and this guide gives them the essentials to do so."

— Rich Umbdenstock,
President & CEO, American Hospital Association

"Improving quality is a key competency for all Trustees looking to be transformational leaders and lead their organizations to reduce patient harm. This guide will help Trustees build their knowledge."

— John Combes, M.D.
*Senior Vice President of the American Hospital Association
and President & COO, Center for Healthcare Governance*

Boards Must Collect and Review Meaningful Data to Keep Pace in a Changing Landscape

This module outlines why Boards must be tracking and collecting quality measures and developing strategies to prepare and move more seamlessly from the current, volume-based payment structure to a future structure that will be focused on value.

PRE-VIEWING QUESTIONS:

1. What quality measures does your organization currently collect and report?

2. Has your organization already begun moving from the first curve to the second curve?

3. What strategies has your organization implemented to move towards a value-based reimbursement structure?

KEY TAKE-AWAYS

- Performance needs to be tracked routinely to eliminate patient harm and improve quality and safety.
- Boards must be engaged in asking strategic questions of their organizations to assess readiness to move from the first to second curve and then use the answers to help direct their actions.
- Boards must oversee and ensure that strategies are put in place to help the transition from first to second curve while improving quality for patients.

The Importance of Measuring Harm Across the Board

This module defines what a total patient harm rate is and explains why collecting data and creating a composite metric can be helpful when employing organization-wide strategies to improve quality and reduce patient harm.

PRE-VIEWING QUESTIONS:

1. Does the Board know the total patient harm rate for the past year or past quarter?

2. What are your organization's biggest strategies to reduce patient harm?

KEY TAKE-AWAYS

- Hospitals must be tracking and collecting reliable quality and patient safety metrics on a monthly basis and then sharing them with the Board.
- Boards must ensure that metrics are aggregated into the organization's overall patient harm composite rate.
- Boards must play an active role in identifying major organization-wide strategies to eliminate patient harm.

Boards Must Have a Clear Organizational Approach and Process for Improving Quality

Boards that are active in quality improvement efforts often request notification of harm events and engage with hospital leadership and staff to learn from such events. Additionally, this module outlines why Trustees must reinforce accountability and transparency when setting processes for tracking and learning from harm.

PRE-VIEWING QUESTIONS:

1. What type of notification process does your organization have in place to both track and react to harm events?
2. What steps does the Board take to learn about and understand a harm event, i.e., the factors involved in why the event occurred?
3. How do you reinforce accountability while continuing to monitor outcomes of care?

KEY TAKE-AWAYS

- Organizations need to have effective quality and safety measures and tracking processes in place that identify if patient harm has occurred.
- The Board and hospital/health system leadership should have an established process for responding to and learning from harm events.
- Boards and leadership need to be transparent about performance in order for learning to occur and must be open to hearing the bad, as well as good, patient stories.

Ensuring Clinician Engagement is Crucial in Eliminating Patient Harm

This module delves into how clinician engagement can greatly strengthen quality improvement efforts and how Trustees should work closely with and communicate openly with clinical champions when setting quality goals and priorities.

PRE-VIEWING QUESTIONS:

1. How frequently does your Board hear from clinical leaders within your organization and in what capacity?
2. Does your Board currently have at least one physician or “quality champion” serving on it?
3. How do you communicate and interact with clinicians regarding quality improvement plans, policies and how do you ensure clinicians achieve quality goals?

KEY TAKE-AWAYS

- Boards and hospital/ health system leadership should have reliable, on-going mechanisms to communicate and engage with clinicians about quality.
- Boards should have physician members or possess the clinical competencies to truly understand and track performance improvement.
- Identifying and working with clinical champions should be a tactic Boards employ to improve quality and enhance clinician support and engagement.

The Importance of a Strong Quality Culture

This module looks at why creating and ensuring an organization has a strong culture of safety should be a priority and responsibility of all Boards. Culture is a foundational element for success and encompasses important aspects such as transparency, reward and recognition as well as sharing of best practices.

PRE-VIEWING QUESTIONS:

1. Has your organization adopted a culture of safety and taken steps to promote an environment of excellence?

2. How is management engaged? Are financial incentives tied to performance and organizational goals?

3. Do you actively recognize successes and share lessons learned among all parts of the organization?

KEY TAKE-AWAYS

- Boards must ensure that their hospital/health system has a clearly defined culture that centers on the patient and emphasizes transparency, reward and recognition.
- Boards must oversee the process of assessing their organizations' values, policies and leadership actions against its desired culture and then implement changes as needed.
- Boards must understand that a "safety culture" involves training, education, resources, trust, respect and a clear set of expected values and behaviors – and it is the Board's role to ensure that the desired culture is achieved.

"Measuring, tracking and improving your organization's patient harm rate is a profound process for Trustees as they are accountable for safe, effective, efficient, equitable, patient centered and timely care. This guide gives Trustees the 'how to' to fulfill their fiduciary responsibility."

– Maulik Joshi,
Senior Vice President of the American Hospital Association
and President of the Health Research & Educational Trust

"This resource would serve as a great orientation for every new Board member but also as part of ongoing Board education. Our Board is always looking for educational opportunities to ensure we have the needed competencies to best improve the care we provide for our community."

– Mary Totten,
Board Member, Silver Cross Hospital

The Importance of Patient, Family and Community Engagement in Improving Quality

Engaging patients, families and communities should be considered a fundamental component of all quality improvement efforts. The module stresses that Boards should routinely hear from patients as they work to improve care and that patient education can help improve quality outcomes.

PRE-VIEWING QUESTIONS:

1. What methods has your organization employed to engage patients, families and the community in setting quality goals and eliminating patient harm?

2. Do you have an active patient and family advisory council that participates in your organization's improvement efforts?

3. How does your organization work to educate patients about their health and involve both patients and their families in quality improvement efforts?

KEY TAKE-AWAYS

- The patient voice must be heard in the Boardroom and that must include both positive and negative patient stories.
- Boards and hospital leaders should engage patients and families in learning about the care process and identifying opportunities for quality and safety to be improved.
- Boards should support and encourage engagement that helps educate patients, families and the community allowing them to be active partners in their care.

How Diversity in the Board Room Can Help Improve Quality and Eliminate Disparities

This module speaks to the importance of Board diversity and how ensuring that different patient populations are represented in the boardroom can prompt robust discussion and assist in identifying strategies for reducing disparities in care.

PRE-VIEWING QUESTIONS:

1. Does your Board reflect the diversity of your hospital/health system in terms of staff and the patients and community you serve?

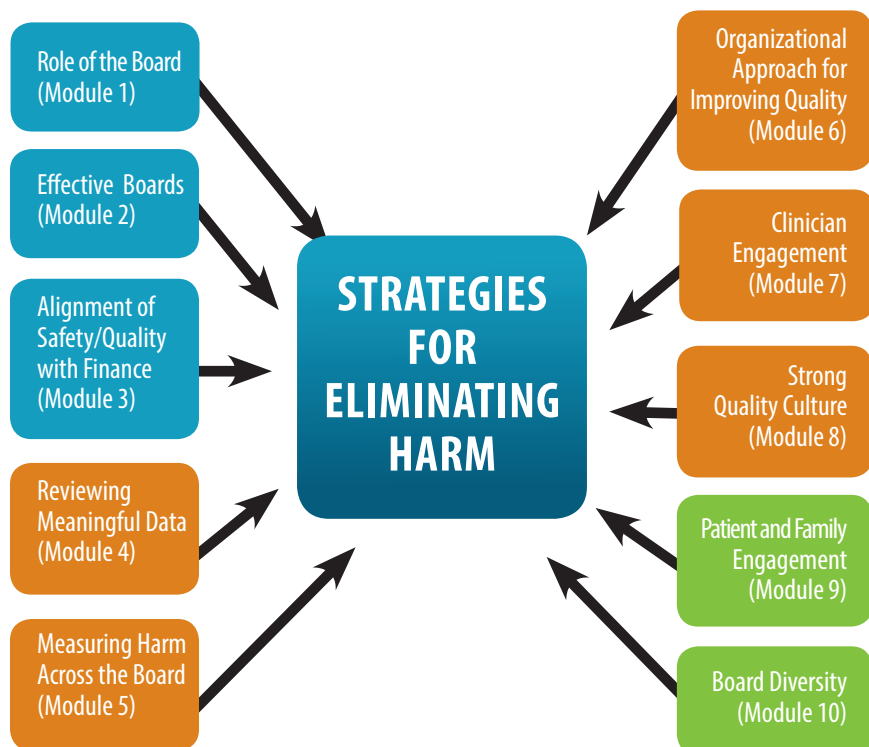
2. Does your Board measure and understand potential disparities among your patient populations?

3. How does your Board ensure that patient diversity and disparities are accounted for as quality improvement and harm reduction goals are set?

KEY TAKE-AWAYS

- In order for Boards to be most effective, they should reflect the diverse make-up of the patient population and communities served.
- Boards must be aware of and ensure that strategies and tactics for reducing disparities are clearly set and followed-out.
- Disparities in care and patient diversity must be key factors for Boards and hospital/health system leaders when collecting data and setting overall patient care and quality improvement goals.

Key Trustee Strategies to Eliminating Patient Harm and Improving Patient Care



Next Steps / Action Items

Please outline what specific actions steps you will take in the next 90 days based on the topics and strategies discussed in this guide.

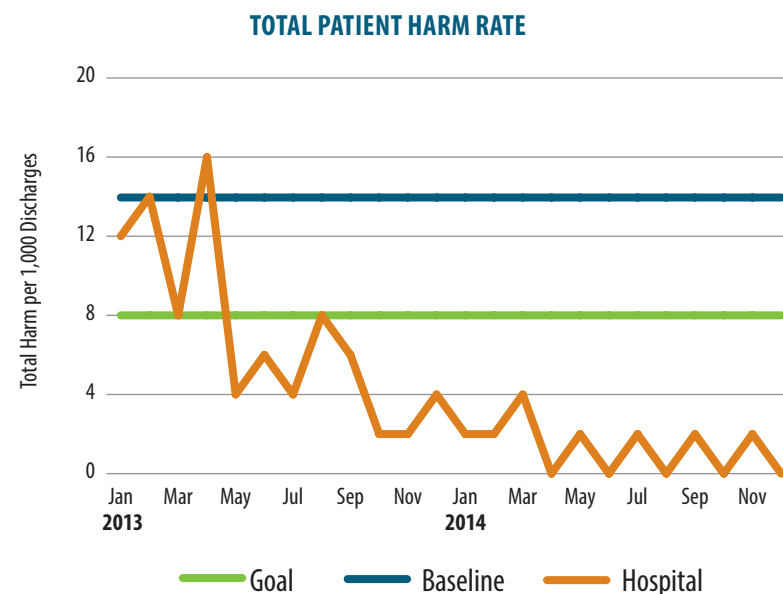
ACTION STEPS

DATE TO COMPLETE

1. _____
2. _____
3. _____
4. _____
5. _____

SAMPLE Total Harm Per Discharge Graph

Boards must measure and track their total patient harm rate on a monthly basis as they strive for zero patient harm events. Additional resources, such as template graphs and storyboards can be found on www.hret-hen.org.



This resource has been brought to you by the American Hospital Association, Health Research & Educational Trust, Center for Healthcare Governance and Trustee Magazine as part of the Partnership for Patients' Hospital Engagement Network initiative. It has been designed with hospital Trustees in mind to help Boards across the country more actively and effectively improve quality, safety and affordability of health care for all Americans.

For more resources including the Harm Across the Board (HAB) template, examples of HAB Storyboards, video vignettes, etc. that can help your hospital improve quality and eliminate harm please visit **www.hret-hen.org**. For any questions please contact hen@aha.org or call 312-422-2651.



Trustee

