The Board's Role in Quality and Safety

Organizations must ensure their boards are knowledgeable about quality and safety.

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Most board members understand they oversee the finances of the organization and, ultimately, the safety and quality of care delivered to patients. However, unless he or she has a clinical background, the average board member is usually less informed about quality and safety.

Given the healthcare field's focus on the shift from pay-for-performance toward value-based purchasing and online quality comparison, it is not enough for the quality committee to have sole oversight of an organization's quality and patient safety. Each board member should be fluent in the hospital or health system's quality indicators and able to ask sensible questions regarding quality and safety standards.

To ensure each board member is knowledgeable about quality and safety, organizations should provide education and import skills from outside the organization. It also is good practice to periodically rotate members of the quality committee to other committees to ensure it maintains a fresh perspective and expose the entire board to quality and safety issues.

In addition to education, there are other steps that a board can take to ensure the institution they serve is delivering the best quality and safe care to its patients, such as following recommendations made by the National Patient Safety Foundation in its 2015 report, *Free From Harm*—an update to the Institute of Medicine's 1999 report, *To Err Is Human*. There are a total of eight recommendations in *Free From Harm*, including ensuring that all leaders establish and sustain a safety culture, and centralizing and coordinating oversight of patient safety.

Another valuable resource is *Leading a Culture of Safety: A Blueprint for Success*, developed by ACHE and the Institute for Healthcare Improvement/National Patient Safety Foundation Lucian Leape Institute. The blueprint gives CEOs and senior leaders a tool to both assess and advance their organizations' culture of safety. More information can be found at **ache.org/Safety**.

If the board is serious about its responsibility to ensure the safety and quality of an organization's care, then the CEO, administrative and clinical staff will follow.

The CEO or an outside expert should provide the board with education on safety, quality, metrics, and safety culture principles and behaviors on an annual basis. It would be smart to invite the clinical staff leadership to these educational sessions, too.

Additionally, the hospital or health system's governance committee should be responsible for populating the board with members who have clinical, safety and patient/family experience.

Each board member should be fluent in the hospital or health system's quality indicators and able to ask sensible questions regarding quality and safety standards.

Board meeting agendas should dedicate as much time to quality and safety as finance, and the CMO or the chair of the quality committee should present data using a quality and safety dashboard.

Lastly, the board should review the organization's quality and safety scores from Leapfrog, Hospital Compare and other databases, as appropriate.

Memorial Hermann Health System: A Board Role Model

Memorial Hermann Health System, Houston, is a role model for how to implement a quality and patient safety program with board involvement. MHHS has been on a journey to high reliability for the past 11 years. Along the way, it has received national recognition for its quality of care and the safety of its patients and hospital staff, including Memorial Hermann Sugar Land Hospital, which received the Malcolm Baldrige National Quality Award in 2016. Five of the system's 17 hospitals are designated as Magnet status hospitals, and all of its hospitals have recieved an "A" rating from Leapfrog.

The MHHS journey to high reliability began because of a serious safety event in 2006, when a patient received the wrong blood product. In 2007, MHHS designated quality and safety as its No. 1 priority, and invested $18 million to train its more than 16,000 employees and 2,000 physicians.

Although MHHS says its journey is not yet complete, it has succeeded in improving its quality and safety because of the following:

- A commitment to educating its system board on quality and safety events
- Choosing members with the right credentials to serve on the system's quality committee
- Allocating an appropriate amount of time at board meetings to discuss quality and safety events and corrective actions
- Connecting the physician credentialing process to quality and safety
- Providing total transparency on all serious safety events that happen within the organization

The MHHS governance committee also formed a physician council that consists of the chief of staff and the vice chief of staff of its 17 hospitals. This council meets directly with the system board members on a quarterly basis to discuss issues of concern and how to improve quality and safety within the organization. Key senior leaders also are included in these meetings. Additionally, the council holds an executive session intended for physicians to talk directly to the board without management in the room.

The same rigor applied to MHHS governance is exercised throughout the organization to communicate to patients and staff that their safety is of the utmost importance to MHHS. The following mechanisms are in place to hold leadership accountable:

- A monthly operating review where safety and quality are major parts of each facility's operations
- A monthly safety conference call (2–3 hours) with all 17 hospital

C-suite and quality leaders to discuss the previous month's safety events and share solutions

- Quarterly divisional quality meetings to discuss quality and safety initiatives relative to organizational goals; board members are invited to these meetings
- Sharing an organizational scorecard on a monthly basis with the organization
- Sharing a "safety story" at all leadership and board meetings

While MHHS has made great strides, Charles D. "Chuck" Stokes, FACHE, president and CEO, will quickly tell you, "Our work is never done. There is always opportunity for improvement." Stokes, who served as co-chairman of the Leading a Culture of Safety Project that developed the blueprint says, "It takes courage, perseverance, high levels of governance and senior leadership commitment to make quality and safety a priority. We feel the journey is worth taking. It is the moral and ethical thing to do for our patients, staff and community."

Following are additional examples of steps MHHS took at the board level that are worth considering.

First, because approval of physician credentialing is a board function, the board linked quality and patient safety to the credentialing process.

Next, the board formed a system quality committee, and the system board delegated to the committee the authority to approve credentialing actions on behalf of the board. If there are no issues, then the physician's credentials are approved. If there are issues, the application moves to another committee for more rigorous review.

It also is good practice to periodically rotate members of the quality committee to other committees to ensure it maintains a fresh perspective and expose the entire board to quality and safety issues.

The final piece of the board's safety initiative was ensuring there was total transparency of system and hospital quality and safety data.

In the spirit of transparency, the entire board is now able to review serious safety event summaries that provide the patient's first name, age and what occurred.

In addition, the board is able to review what happened to the patient and what mitigating steps management took to prevent the incident from occurring in the future. This information hits home when the board recognizes that there are faces and names behind the data.

The key quality and safety indicators presented to the system board include: Serious safety events, including the overall rate per 10,000 adjusted patient days and a brief description of each individual SSE event; the percentage of sepsis and septic shock mortality; a rollup of National Healthcare Safety Network hospital-acquired infection standardized infection ratios compared with national benchmarks; and a rollup of core outcome measures reported to the Centers for Medicare & Medicaid Services.

MHHS has set a goal of zero patient harm events. This is a lofty and worthy goal and demonstrates that the board is serious about patient safety. This goal is communicated throughout the organization, and each department fully understands it. Departmental and organizational celebrations are used as a motivational tool when zero error goals are reached.

These suggestions work when a board supports an executive who has taken an action because of a patient safety issue. Moreover, no matter the size of an organization, a board displays courage when it stands behind an executive who has stopped a surgery because a leading surgeon is not following a protocol that the clinical staff and the board adopted.

The board must assume its responsibility for quality and make the organization a safe place for patient care. It is always good to remind board members that they, their relatives or friends might someday be patients in their own facility. ▲

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